A Genealogical Analysis of the Deployment of Personality Disorder in the UK Psychiatric Context since 1950

Corpus Linguistics as an adjunct to a Foucauldian Discourse Analysis of Diachronic Corpora of Psychiatric Texts from 1950 to 2007

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Abstract

In order to examine how personality disorder and related concepts have been deployed in UK psychiatric literature over the last 50 years, a number of methodological and theoretical approaches are initially examined. It is concluded that a Foucauldian discourse analytic approach, supported and informed by findings from Corpus Linguistic techniques would provide a means of uncovering discourses surrounding the use of personality disorder in such literature. A new combined methodology is proposed that uses evidence from a Corpus Linguistic analysis to support Willig's six step methodology for Foucauldian Discourse Analysis (Willig 2001b). Three diachronic corpora of UK psychiatric articles are created, covering the 1950s, 1970s and 2000s. These are interrogated using word frequencies, concordance and collocational approaches in order to uncover patterns which reflect discourse changes over these periods.

Evidence for a move from Narrative Discourses towards a dominant Statistical and Scientific Discourse is presented and discussed along with the implications and subject positions associated with these.

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Chapter 1: Introduction

As a mental health worker in the NHS, I have noticed changes in the use of the term 'personality disorder' in medical and policy discourse over the last 25 years. It seems to have moved from defining a troublesome group, untreatable by psychiatry and therefore not its concern, to becoming an indicator for new service development, particularly by the Department of Health (Department of Health 2003; NIMH(E) 2003c). The concept of personality disorder itself has long been acknowledged to be a problem (Tyrer et al. 1979a), and its use has been criticised both by opponents of medical psychiatry such as Pilgrim (2001) or Bracken (1999) and by mainstream views, the latter perhaps best summed up by Moran in a report cited by the above policy statements.

> *Despite over two decades of extensive research, psychiatrists and psychologists remain divided as to how these disorders should be conceptualized. ... In addition, clinical and research methods for diagnosing personality disorders diverge and the level of agreement between schedules is generally very poor.* (Moran 2002: 1)

However, despite these conceptual problems, the last ten years has seen increasing attention paid to personality disorder from the media and the concomitant development of a policy for 'Dangerous and Severe Personality Disorder' (DSPD) (Batty 2002). More recently, the Department of Health has signalled a change in attitude towards personality disorder by the publication of the policy titled 'Personality Disorder: no longer a diagnosis of exclusion' (NIMH(E) 2003c) and a framework outlining the capabilities required by staff to work with personality disorder (NIMH(E) 2003a). There continue to be increasing amounts of research

attempts to refine the concept, to establish its epidemiology and to develop services (Department of Health 2003) based on emerging evidence for effective treatments. However such treatments are at an early stage of validation, applicable to relatively small subcategories of personality disorder, of limited success and labour intensive (Bateman et al. 2002), hence emergent treatments alone may be insufficient to account for the new prominence of personality disorder in psychiatry.

These initial considerations prompted an interest in exploring how the notion of personality disorder has been deployed in the UK, in what way this deployment may have changed over the last 50 years and what the implications of this might be. To set the scene, Chapter 2 outlines the definitions and history of the diagnostic concepts of personality disorder and what is generally viewed as its earlier terminological manifestation, psychopathy. It makes the case that personality disorder has been available as a fully formed diagnostic category within the two main classification manuals since the 1940s (American Psychiatric Association 1952; World Health Organisation 1948), and that the actual changes in these classification systems are insufficient to account for the growth of personality disorder in literature from the 1980s, and in policy over the last ten years in the UK.

In the literature review of Chapter 3 it is argued that little research has been done into how personality disorder and psychopathy have actually been used in language and that attempts to account for the growth of the use of personality disorder have tended to concentrate on broad societal changes rather than examining personality disorder in use. A number of linguistic studies are examined which approach this issue but which have tended to focus on a few texts and rely on a Critical Discourse Approach, which itself has been significantly critiqued. Such

studies examined in this chapter are often unable to dissociate themselves from a positivist concept of mental disorder that both allow and constrain it to be approached using the scientific method, although a number of Foucault-inspired approaches have attempted to take this into consideration. Chapter 4 examines this theoretical issue in more depth in an attempt to inform a methodology that would enable an examination of the use of personality disorder over time, which would avoid positivist assumptions and deal with a sufficiently representative sample of data to draw generalisable conclusions.

Having made these investigations, a more refined version of the research question is then formulated: whether conclusions can be drawn using relevant textual data, about changes in the way in which personality disorder and its synonyms have been deployed in psychiatric journals in the UK over the past 50 years. The discussion then moves to how the usage of such terms can be examined linguistically, along with associated questions, such as the links between language use and practice, the debate between saliency and representativeness, and the limits of a textual analysis.

What is then proposed in Chapter 5, is a new combined methodology using Corpus Linguistics (CL) to explore salient samples of psychiatric literature from three time periods: the 1950s, the 1970s and the 2000s. This is informed by a Foucauldian Discourse Analytic approach, formalised by Willig (2001b), which helps interpret the CL findings in terms of discourses and subject positions. This chapter justifies and describes this methodology in more detail, including the creation of the corpora, the justification of the time periods, the sampling strategy for the corpus articles and the actual analytic approach carried forward in the next chapters.

Chapter 6 commences the analysis proper, describing the distributions of the commonest lexical items in each corpus, the nouns, adjectives, and verbs. Wordsmith Tools (Scott 2004) is used as the analysis software as it has also been applied to other corpus based health studies (Adolphs et al. 2004). One of the initial findings was that, while *personality disorder/s* had been available to clinicians since the 1940s, there were many different formulations of the research object in the 1950s and 1970s corpora, for example, *psychopath*, character disorder, personality deviance, oligophrenia* and *schizosis*. By the 2000s corpus *personality disorder/s* is completely dominant and used to such an extent that it rivals common word frequencies in the corpus such as *with*, *in* and *a*. A graphical method for demonstrating the changes in word usage across the three corpora is developed and it is argued that particular collections of word usages indicate particular discourses at work in each corpus, although the connection between word use and discourse is not seen as straightforward.

Having evidenced discourses at work, subject positions are approached through the corpus analysis of concordance lines around the commonest occurrences of *personality disorder* or its equivalents in each corpus. This is contained in Chapter 7, and a methodology is developed to identify the positioning effects of corpus statements through an identification of whether they imply particular attributes for their subjects, particularly in factual and modal statements.

Chapter 8 summarises these results by initially collecting the evidence for discourses and discourse change from the preceding chapters. This, along with the evidence for positioning, is then applied to Willig's (2001b) six step approach to Foucauldian Discourse Analysis in order to explore the operation of such discourses

and their implications for textual subjectivities. One of the key findings from this whole process is the move from a predominantly narrative discourse in the 1950s corpus, calling on the author for its authority, to the dominance of a statistical/study discourse relying on the scientific method for its authority in the 2000s corpus. These discourses are also linked respectively to *psychopath** and *personality disorder/s* shown particularly when both these terminologies are present in significant numbers as in the 1970s corpus. This leads to the observation that while, for example, *personality disorder* and *psychopath* may be seen as being equivalent clinically, they have different discourses operating on them and hence different positioning effects. The particular positioning effects of operationalising aspects of life, necessary to develop the scientific approach, are explored in this chapter, an example being the disappearance of the space for individual accounts of distress in the present day psychiatric article. That such experience may then have to be seen through these operationalised concepts, such as *negative* or *positive life-events*, *psychosocial functioning*, *self-defeating*, is discussed as a matter of concern.

Chapter 9 then reflects both on the strengths and weaknesses of this new methodology, as well as commenting on the findings and indicating how this approach may be taken forward in further studies. Briefly, although a time consuming process, this approach is seen as a new method of evidencing discourses at work within large bodies of text across a period of time, and of interpreting such changes in terms of their positioning effects on participants.

Throughout this thesis, there is potential for confusion as to whether the concept or the words are being discussed in relation to personality disorder or psychopathy. In order to minimise this, the convention is adopted that, when actual

language is being referred to it will be in italics. Thus, for example, discussion of the lexical terms in the corpus will use *personality disorder* and *psychopathy*, and further, where different forms of the lemma are being discussed at once, an asterisk will be used for brevity. Thus the words *psychopath, psychopathy, psychopathic, psychopaths* are subsumed under *psychopath**

Chapter 2: Personality Disorder: an introduction to the concept, its history and its disputes

As noted in the introduction personality disorder, while remaining a contentious concept, has become a much more prominent topic in mental health in the UK over recent years. This chapter covers this ground in more detail by introducing the definitions of the concept in use currently, critically examining views on its history, and outlining what have been identified as the main conceptual problems. Some questions to be taken into the subsequent analysis are also raised.

Personality Disorder is currently defined as a condition worthy of psychiatric attention through its appearance as a diagnostic category in the two major health classification systems the 10th Edition of the International Classification of Diseases (ICD 10) (World Health Organisation 1992) and the text revision of the 4th edition of the Diagnostic and Statistical Manual (DSM IV-TR) (American Psychiatric Association 2000). Expanded definitions and the sub-categorisations of each system are included in Appendix 1, however the overall descriptions of the diagnosis are shown below.

> *These types of condition comprise deeply ingrained and enduring behaviour patterns, manifesting as inflexible responses to a broad range of personal and social situations. They represent extreme or significant deviations from the way in which the average individual in a given culture perceives, thinks, feels and, particularly, relates to others. Such behaviour patterns tend to be stable and to encompass multiple domains of behaviour and psychological functioning. They are frequently, but not always,*

associated with various degrees of subjective distress and problems of social performance. (World Health Organisation 1992: 200)

A Personality Disorder is an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment. (American Psychiatric Association 2000: 123)

These show that the diagnostic category of personality disorder seems to cover a wide range of behaviour and experience which is seen as distinctly different from that generally accepted in a society and which may be associated with distress or interference in everyday life.

A History of the Diagnosis

Most recent texts which contain a history of the development of the diagnostic category see the definitions outlined above as the best, albeit flawed, attempts to describe a set of conditions whose history can be traced back commonly to the 19th century (Lewis 1974; Livesley 2001), although some commentators see the origins in Greek and Indian medicine (Tyrer 1988). There is however a commonality in the history from the 19th century, which generally begins with Pinel's 1801 account of *manie sans délire*. This described people whose perceptions, judgement, imagination and memory were intact but who were subject to affective disorders including blind

impulses to acts of violence. J.C. Pritchard in 1835 was then seen as elaborating this category by describing 'moral insanity' which comprised a 'morbid perversion of the natural feelings, affections, inclinations, temper, habits, moral dispositions and natural impulses, without any remarkable disorder or defect of the intellect or knowing and reasoning faculties and particularly without any insane illusion or hallucination' (Lewis 1974: 133). This provoked two main strands of conceptualisation, first the distinction between understanding and emotion and second the idea of degeneration, pervasive ideas even up to the present.

Degeneration was typified by the work of Morel describing it in 1839 as 'a morbid deviation from the normal human type, transmissible by heredity, and evolving progressively towards extinction' (Lewis 1974: 134), although Lewis suggests that in French *moral* was often used to describe affective mental functioning. In England however *moral* came to be used with an ethical meaning, hence Maudsley in 1874 was able to describe an 'absence of moral sense' resulting from descent from a insane family, and even in 1932 Henderson and Gillespie in their term 'constitutional psychopathic inferiority' included 'emotional and moral defects' (Lewis 1974: 134).

The division of understanding and emotion expressed itself in debates around the medicolegal aspects of the conditions being described, in particular responsibility for actions. Thus Maudsley described manifestations of 'moral insanity' as being similar to vice or crime and comprising the dominance of egoistic desires over moral feelings, but when an offence was committed a 'modified responsibility' was appropriate. This is further extended in Lombroso's idea of the 'born delinquent', but all seem to agree to sequestration in extreme cases. In the UK 'moral insanity' seems

to have been the dominant term, albeit with reservations such as those of Tuke and of Savage, who felt it was 'easier to describe what the condition is not' (Lewis 1974: 135), however Koch is credited with the next classificatory advance.

In 1891 Koch coined the term 'psychopathic inferiorities' which was to include 'all mental irregularities ... which influence a man in his personal life and cause him, even in the most favourable cases, to seem not fully in possession of normal mental capacity...'(Lewis 1974: 135). The term 'psychopathic' was specifically chosen to describe the causation of the condition either in congenital or acquired brain physiology, although neither was demonstrable at the time (or since). Kraepelin, the great classifier of psychiatry, adopted the term 'psychopathic personalities' and moved in his textbooks from a congenital aetiology in 1887, through models of degeneration to a less causal classification by 1915, describing the psychopath as 'showing inferiority in affect or the development of mature volition,' dividing the group into those with morbid predisposition (obsessional neurosis, impulsive insanity, and sexual deviation) and those with the stamp of personal peculiarity (Lewis 1974: 136).

Lewis notes that in the UK the terms 'moral insanity' and 'moral imbecility' continued alongside psychopathy into the 1920's, possibly supported by the usage of 'moral imbeciles' in the 1913 Mental Deficiency Act and 'moral defectives' in the 1927 Amending Act. However there were moves even in 1922 to borrow from the classifications of the Surgeon General of the US Army, itself based on Kraepelin's approach and including such subdivisions as inadequate personality, emotional instability, paranoid personality, pathological lying and sexual anomalies. Lewis was unflattering about the further attempts at classification and description through the

20th century, including Henderson's (1939) influential threefold categories of psychopathy (the predominantly aggressive, inadequate and creative), the psychologically informed attempts of Allport or Foulds, and the eugenically inclined approaches of Eysenck (1947; 1959) and Cattell (1954), which were so influential in introducing factor analysis into the discriminations of personality types.

However Livesley (2001) credits Schneider's 1923 volume, translated as *Psychopathic Personalities* (Schneider 1958), with heavily influencing the subsequent developments in classification and description. In particular the use of personality was an attempt to prevent the confusing use of such terms as temperament and character, and further, the basis for later classification was laid by distinguishing 'abnormal personality', an extreme variation of normal personality, from 'psychopathic personality', the dysfunctional subgroup which in the oft quoted maxim 'either suffer personally because of their abnormality or make a community suffer because of it' (Schneider 1958: 3). This latter had 10 subgroups very reminiscent of the present approach: hyperthymic, depressive, insecure (sensitives and anankasts), fanatical, attention seeking, labile, explosive, affectionless, weak-willed, and asthenic. Throughout his work, which extended to 1950, Livesley suggests that Schneider was keen to point out that his classification was not confined to antisocial behaviour, but that rather this was the characteristic of some psychopathic personalities, and secondary to the psychopathy itself (Livesley 2001: 5).

Of note also was Cleckley's work on psychopathy in the US published originally under the title 'The Mask of Sanity' (Cleckley 1941), but referring, as was the custom in the US, specifically to antisocial personality (Cleckley 1976: viii), and

running to a fifth edition in 1976, reprinted in 1988. Based largely on case histories, so influential were the 16 categories of psychopathy Cleckley outlined, that they were incorporated almost unchanged into the 1982 DSM III, and formed the bulk of Hare's psychopathy checklist, recommended for use to identify dangerousness in the UK to the present day (Department of Health 1999c: 50; NIMH(E) 2003c: 27; Warren et al. 2003: 164).

Livesley credits a number of theorists and clinicians with the evolution of the current categories of personality disorder, but is unclear on how and when this term displaced *psychopathic personalities*. Thus he feels that psychoanalytically influenced practitioners such as Abraham and Reich theorised links between psychosexual development and character, and paved the way for 'modern concepts of borderline personality disorder.'(Livesley 2001: 6). He is also clear on the contribution of psychologists such as Allport, in developing the idea of personality itself in the early 20th century and notes the confusion that terms like 'character' and 'temperament' have sown in the attempt to classify what is seen as a psychiatric condition. However the change to personality disorder as the main means of speaking about the subject is not covered. Tyrer (1988: 6) is similarly coy about accounting for the appearance of personality disorder; in one paragraph talking about 'psychopathic personality' in the 1959 Mental Health Act, in the next about 'psychopathic personality disorder' which is replaced without explanation by 'personality disorder' in the next sentence and for the remainder of the book. The implication of this and of Livesley's account is that the same concept is being talked about throughout; there is simply a name change sometime in the 1950s or 1960s, which does not need to be

explained. Whether this is in fact the case is certainly a question to be borne in mind for the later analysis.

Into this narrative of flawed but valiant attempts to wrestle with a resistant clinical entity, commentators have introduced a number of problems. These conveniently divide into historical critiques and conceptual critiques, both of which undermine the neat narrative often presented. The conceptual critiques will be covered later on in this chapter but on the historical side, even the genesis of the story is threatened as Berrios (1999) argues convincingly that linking Pritchard's concept of *moral insanity* with later notions of psychopathic personality and by extension personality disorder has the status of legend rather than fact, due to its persistence in the face of convincing evidence to the contrary. Most damningly this evidence includes analysis of both Pritchard and Pinel's actual case examples which most accurately reflect descriptions of mood disorders rather than personality disorders as currently defined; thus his cases had late onset, were either suffering from gloom or excitement (in Pritchard's terms a form of *moral derangement* (Berrios 1999: 115-6)), and often recovered.

Returning, however, to the narrative of personality disorder, so far the account has been very much that of individuals attempting to grapple with a complex condition which all accept is there, but which defies attempts at description. This approach is gradually subsumed under the attempts from the 1940s onwards to agree on a classification for all medical and psychiatric conditions. These are the projects that became the DSM in the USA and ICD in Europe. Livesley sees this process as culminating in the development of diagnostic criteria and the placing of personality disorders on a separate axis in DSM III in 1980, prefigured by the beginnings of

empirical work such as that of Walton and Presly (1973). However, in fact, the criteria for personality disorder were largely in place from the late 1940s as described below. That the DSM III is generally seen as pivotal in the expansion of empirical research in personality disorder is evidenced by the growth in literature following its publication (Von Knorring et al. 2000), however whether DSM is the cause, as is posited by Livesley and others, or the effect is open for question at this stage and is another useful point to take into the analysis.

The first version of the now familiar DSM series, was published in 1952, titled *Diagnostic and Statistical Manual: Mental disorders* (American Psychiatric Association 1952). This was based on a previous series termed *Standard Nomenclature of Diseases and Operations* whose first edition was in 1933, followed by editions in 1935, 1942 and in 1952 (American Psychiatric Association 1952: v). A further edition in 1961 ran parallel to the DSM system which eventually superseded it.

In the *Standard Nomenclature of Diseases and Operations* (Thompson et al. 1952) the section relevant to psychiatric classification and on which the DSM was based is termed *Diseases of the Psychobiologic Unit* . The whole classification is shown in Appendix 2, along with the classifications of personality disorder from this point onward up to the present DSM IV. Despite the changes in nomenclature there is a consistency about the classifications over time in relation to personality disorder, particularly if one sets aside the sections listing sexual deviation, addiction and physical disturbances, all of which eventually found homes in other parts of the classification system. Thus while the early language reflected the psychoanalytic origin of some categories and would be expected to become erased as time and

fashion proceed, in fact current categories like narcissistic, histrionic and borderline have clear links with this school of thought. Further, paranoid, schizoid, antisocial and obsessive-compulsive are virtually unchanged, while the remainder bear a striking resemblance to their forbears.

In Europe similar efforts were being made to classify diseases for epidemiological purposes. From its origins in classifications of causes of death in the nineteenth century and the foundation of statistical societies in France and England, the first *International Classification of Causes of Death* was produced in 1900 and revised in 1910, 1920, 1929, and 1938, it being agreed at the latter conference to extend the next revision to a classification of diseases. Personality disorder appears immediately in this revision as shown by the title of the relevant chapter 'V. Mental, Psychoneurotic, and Personality Disorders' (World Health Organisation 1948: vii). The entry in this ICD 6 is shown in Appendix 3 along with the changes in the categories relating to personality disorder up to the present edition ICD 10 (World Health Organisation 1992). In a similar way to the history of the DSM, of the 8 specific subdivisions of personality disorder in ICD 10, Paranoid, Schizoid, Emotionally unstable, Dissocial, Dependent are strongly related to the 1948 categories, while histrionic, and anxious (avoidant) can be mapped onto inadequate personality. Only anankastic is new and that is very similar to the obsessive-compulsive category in DSM.

Thus in both classification systems, available to clinicians since the 1940s, there is considerable continuity of the categories through time, in effect personality disorder as a diagnosis was as comparably elaborated and described in the 1940s as it is in the present day. However initial examination of the UK psychiatric literature over this period seems to show its actual usage is not significant until the 1970s,

varieties of *psychopathy, abnormal personality* and *character disorder* being preferred. This is explored in more detail in the subsequent analysis.

The standard history however proceeds from the 1970s as an account of increasing attempts to develop instruments to measure personality disorder, validate the diagnostic categories, and to develop and support competing theories of personality disorder. Livesley (2001: 22) cites Walton and co-workers (Presly et al. 1973; Walton et al. 1970; Walton et al. 1973) as well as Tyrer (1979a) as key influences in the development of assessment schemes and dimensional models of personality disorder. That this enterprise is currently still in a disputed state is shown by the extensive conceptual critiques covered later in the chapter.

In more recent times in the UK the story has acquired a political and public dimension following the murder of Lynn and Megan Russell in 1996. The man accused a year after the event, Michael Stone, was reported to have been refused treatment by psychiatric services due to untreatable personality disorder, at which point Jack Straw, Home Secretary at the time, vilified psychiatrists in the House of Commons,

> *Quite extraordinarily for a medical profession, they have said they will only take on those patients they regard as treatable. If that philosophy applied anywhere else in medicine there would be no progress whatsoever. It's time, frankly, that the psychiatric profession seriously examined their own practices and tried to modernise them in a way that they have so far failed to do.*
> (Hansard 26 Oct 1998)

The president of the Royal College of Psychiatrists, Dr Kendell, responded by saying that 'the convicted man, Michael Stone, was not mentally ill but had what

psychiatrists call an antisocial personality disorder ' (Warden 1998). The National Confidential Inquiry recommended in 1999 that 'Clear policies on the clinical management of personality disorder should be disseminated by the Department of Health' (Department of Health 1999b: para 29, p98) and in 2001 reported progress on this recommendation in terms of reforming the Mental Health Act (Department of Health 2001a) and the establishment of pilot units (Department of Health 2001b: 158). This led to significant debate in mainstream and specialist media in the deployment of personality disorder, related to the proposed changes in the Mental Health Act which proposed powers of detention under a new category of Dangerous and Severe Personality Disorder (DSPD) (Department of Health 2003).

To bring the story up to date, after considerable discussions in both Houses of Parliament, along with consistent lobbying from interest groups like MIND and professional groups such as the Royal College of Psychiatrists, the proposals were introduced into law as the Mental Health Act 2007 (2007). At first sight the references to personality disorder seem to have been effaced; the DSPD provision does not appear and the category of psychopathy has been removed and replaced by a wider definition of mental disorder. However looking further at the code of practice, it is clear that the Act is intended specifically to cover all categories of personality disorder, not just the psychopath exhibiting 'unusually aggressive behaviour' as in the 1983 Act:

> *35.1 The Act applies equally to all people with mental disorders, including those with either primary or secondary diagnoses of personality disorder.* (Department of Health 2008: 321)

Indeed an entire chapter of the Code is devoted to outlining how personality disorder might be considered under the Act, including Assessment, Appropriate Treatment, and Community Treatment (Department of Health 2008: 321-325).

More widely still the documents being produced for the review of the DSM prior to the proposed development of DSM V in 2012 already contain comprehensive suggestions for research needed for this enterprise (Kupfer et al. 2005), and a chapter devoted to 'Personality Disorders and Relational Disorders: A Research Agenda for Addressing Crucial Gaps in DSM' (First 2005). This latter comprised a detailed critique of the definition and categorization problems current in the field and edges towards proposing a dimensional model for the new DSM, recently supported by further articles from the American Psychiatric Association (Widiger et al. 2008). Although not the focus of this thesis, the proposal for a new category of relational disorders which are seen to reside not in the individual but between people (First 2005: 157-9), cannot fail to lend weight to the argument about the psychiatrisation of everyday life.

Thus it is clear that personality disorder has become a very pervasive diagnosis, reaching into the right to detain people against their will as well as everyday psychiatry in a way that was simply not the case even ten years ago. Having outlined the history, we can now turn to some of the conceptual problems that have been identified over the years.

Conceptual Problems

Before personality disorder was commonly used in psychiatry in the UK, the concept of psychopathy attracted considerable and eminent criticism throughout the early 20th century. Thus Curran and Mallinson in surveying the state of knowledge in relation to psychopathic personality in 1949 note the lack of agreement on classification and confusion in terminology, a lack of clarity on aetiology (Curran et al. 1944: 266-9), as well as excessive broadening of the overall label such that 'the only conclusion that seems warrantable is that, at some time or other and by some reputable authority, the term psychopathic personality has been used to designate every conceivable type of abnormal character,' (Curran et al. 1944: 278). Palmer in 1959 concurs.

> *In the United States in 1942 the American Psychiatric Association published its classification of psychopathic personalities, which included so many diverse varieties, extending over such a wide range of inferiorities, instabilities, and antisocial tendencies as to render the expression useless. But the trend in England had already changed, and by 1939 Henderson was trying to restrict the use of the expression to a few well-defined types. And a few years later Curran and Mallinson pointed out that, when given an all-embracing connotation the expression " psychopathic personality " could cover "every conceivable abnormal character from Joan of Arc to Popeye the Sailor* ". (Palmer 1959)

Lewis, as mentioned above, is similarly gloomy about attempts to agree a definition and to establish any causality: 'The diagnostic groupings of psychiatry

seldom have sharp and definite limits. Some are worse than others in this respect. Worst of all is psychopathic personality, within its wavering confines. Its outline will not be firm until much more is known about its genetics, psychopathology, and neuropathology' (Lewis 1974: 139).

Curiously the situation does not seem to have improved with the introduction of personality disorder. Thus Livesley, the foremost authority on personality disorder and editor of the comprehensive Handbook of Personality Disorder (Livesley 2001), opines that the current classification is:

> *An uneasy combination of concepts derived from conceptual models that are not always consistent with each other. Under these circumstances it is not surprising that the operating characteristics of the system in terms of diagnostic overlap, coverage, and reliability are poor.* (Livesley 2001: 16)

Livesley provides a succinct overview of the conceptual problems in the use of personality disorder as a diagnostic category. This includes the failure to correlate the diagnostic category with the numerous psychological models of personality derived from multivariate analysis (Livesley 2001: 19-25). He also notes the diverse conceptual origins of the subcategories of personality disorder (Livesley 2001: 16) for example the psychoanalytic origins of *histrionic*, the social learning roots of *avoidant*, and the psychiatric lineage of *schizotypal.* The lack of consistency and compatibility of models, he feels, tends to work against the establishment of an overall theoretical rationale for the category of personality disorder.

The manifestation of these conceptual problems surfaced recently in the Independent Review into the Care and Treatment of Anthony Hardy (Robinson et al. 2005) where personality disorder and mental illness became implicated in a series of murders. In particular the report comments on the relationship between psychiatry and personality disorder in an attempt to clarify the issues in relation to Mr Hardy's diagnosed bi-polar disorder for which he had been hospitalised and issues subsumed under the label personality which related to his antisocial actions.

> *... psychiatrists define and limit, by the use of diagnostic criteria, what they regard as a personality disorder. In so far as psychiatry interests itself in abnormalities of personality it generally does so with a view to treatment. In Mr Hardy's case, as we discuss in the chapter of this report on personality disorder, those who assessed him found that he neither met the diagnostic criteria for antisocial or dissocial personality disorder, nor were his abnormalities of personality amenable to treatment.* (Robinson et al. 2005: 10)

and

> *10.3.8 Thus applying standard diagnostic criteria rigorously, a diagnosis of personality disorder cannot be made. On the other hand, there is substantial evidence that Mr Hardy has abnormalities of personality entirely consistent with those expected of a personality disorder.* (Robinson et al. 2005: 147)

In many ways these seem to reflect a continuing lack of resolution of what is actually being talked about, an attempt to couch an argument in the well worn paths

of diagnosis and treatability but leaving the reader with a sense of unanswered questions around the issue of personality disorder: what is it if it is not just an account of behaviour? Why should treatment be relevant to diagnosis? This contrasts with much clearer and more productive discussions on the relations between dangerousness, the media and the public elsewhere in the report (Robinson et al. 2005: 9-12). For example:

> *Mr Hardy was detained because he was assessed as being mentally ill and in need of treatment for mental illness. It is not the proper role of Mental Health Services to contain people who may be violent but whose violence is not connected to the mental illness for which they are being treated. If society wishes to detain people who are thought to be potentially violent, or otherwise to manage them so as to reduce the risk that they will behave violently, this is distinct from psychiatric treatment.* (Robinson et al. 2005: 11)

Thus, despite the efforts of medical and psychological science, problems identified in the early 20th Century still beset the clear identification of what is being talked about when personality disorder is used to describe people. This points towards the need for an analysis of the language surrounding personality disorder in order to inform how it is used, rather than an attempt to find out what it 'is'. This takes the discussion beyond the historical critiques of the story of personality disorder and the conceptual problems which have beset it throughout, into a problem inherent in the general usage of personality disorder as a medical diagnosis; that it is very difficult to

talk about personality disorder without making a positivist assumption about its existence, its investigation and its treatment.

To make such a positivist assumption in order to explore the deployment of personality disorder means accepting that there is a real disorder underlying the language and attention which is observed in the texts and which has vastly increased in quantity over the last 20 years. This assumption thus channels the research question to two main areas, which are not mutually exclusive, whether personality disorder is becoming more prevalent due to societal changes, or whether it is simply becoming the focus of more societal attention. This limits the analysis beforehand to the sort of conclusion that can be reached. If however this assumption is set aside it does not affect a study of what language use conveys about how personality disorder has been conceived of over this time, and further may provide evidence that can inform the more positivist perspectives. That there is debate about the status of personality disorder strengthens the case for suspending belief in the essential nature of the concept.

These themes will be revisited in Chapter 4 where the theoretical basis for the analysis will be further developed and possible methodologies explored. However before this the literature concerning investigations into personality disorder and related subjects will be examined.

Chapter 3: Literature Review

As outlined in the introduction the focus of the thesis is exploring how the notion of personality disorder has been deployed in the psychiatric context in the UK, in what way this deployment may have changed over the last 50 years and whether this exploration can inform debates about how its continued appearance in psychiatry might be understood despite its problems as a concept. Chapter 2 indicated that *psychopathy* also needed to be included in any search of the literature pertaining to these issues. The review of medical, sociological and nursing literature revealed several attempts to theorise this change (Bracken et al. 1999; Manning 2001; Manning 2002; McCallum 1997; Nucknolls 1992; Ramon 1986) but a lack of qualitative research in relation to the specific questions. There are, however, significant bodies of qualitative research looking at psychiatric diagnosis and categorisation, the analyses of mental health policy and the textual analyses of psychiatric writings. Hence the literature review will cover these broader areas as well as those specifically concerned with personality disorder and psychopathy.

Analyses of the Deployment of Personality Disorder, Psychopathy and other Psychiatric Diagnoses

This section reviews the literature relevant to a social exploration of the deployment of personality disorder. The first part covers studies that have looked directly at the growth in the use of the concept in the UK and elsewhere. As this remains a relatively underdeveloped area the second part looks at explorations of

other psychiatric concepts to see whether these may be relevant in refining the research question. In order to uncover work in these areas, the major social science, nursing, medical and psychological data bases – Psyinfo, Assia, WoK, Bids, Cinahl and Medline – were interrogated using combinations of the following words – *personality disorder, psychopath*, sociological, sociology, concept, history, discourse, critical discourse, Foucault,* and *psychiatry/psychiatric, mental health, schizophrenia, depression.* In addition the following key journals were searched by hand from 2000 for relevant articles – *Discourse and Society, Sociology of Health and Illness, Critical Social Policy, Social Science and Medicine, Journal of Social Policy,* and the *Journal of Health Psychology.* Further, as articles and books were read the references also provided sources of additional material.

Analyses of the Deployment of Personality Disorder and Psychopathy

In the UK the main recent interest in personality disorder has related to the proposed changes in the Mental Health Act (Department of Health 2001a) which included powers of detention under a new category of Dangerous and Severe Personality Disorder (DSPD) (Department of Health 2003). Although now enshrined in law as the Mental Health Act 2007 without the DSPD provision, it still specifically targets Personality Disorder (see Chapter 2). As such these developments lend themselves to an understanding of the growth of personality disorder in legislation and policy that might be termed the 'fear theory' of mental health policy development. This is outlined by Laurance (2003) and Muijen (1996), but also

appears as a background to discussion around the new legislation, for example in exchanges in the psychiatric journals (Appleby et al. 1997; Howlett 2000; Persaud 2000). This view places mental health policy development within a relatively straightforward narrative, which runs roughly as follows. Breakdowns in the community care system led to increased homicides by people with mental illness, most notably schizophrenia, culminating in media exposure which reached an all time high after Christopher Clunis murdered Jonathan Zito on 2nd December 1992 (Ritchie et al. 1994). In response, the requirement for inquiries was set up (Steering Committee of the Confidential Inquiry into Homicides and Suicides by Mentally Ill People 1996) and the move towards a psychosis and risk based mental health service gained momentum (Department of Health 1999a). As outlined in Chapter 2 the murder of Lynn and Megan Russell in 1996 and the media and political attention on the supposed failings of psychiatric services in relation to the accused Michael Stone, were seen as focussing policy on personality disorder and particularly on the reluctance of psychiatry to treat people perceived as dangerous. This led to the proposals for creating a legal category of people suffering from Dangerous and Severe Personality Disorder (DSPD) (Department of Health 2003) which would allow their detention on medical grounds alone, rather than on a crime committed.

In essence the fear theory states that mental health policy and service development is fuelled by governments having to be seen to act in the face of particular publicly perceived dangers. Government policy is then used to compel the mental health services, led by territorially aggressive psychiatrists, to accept the responsibility and funding to manage these risks. However, there are number of problems with this reading of events in relation to personality disorder.

Personality disorder was already clearly identified as a category for service development before the debate surrounding the Stone killings and as a significant factor both in relation to homicide and suicide (Steering Committee of the Confidential Inquiry into Homicides and Suicides by Mentally Ill People 1996). Interestingly the Report of the Independent Inquiry into the Care and Treatment of Michael Stone (Francis et al. 2006), although written in 2000, was only published in 2006 due to legal challenges. It concluded that services had not refused to treat Michael Stone and that in fact it was his treating psychiatrist who brought him to the attention of the police, although it could be argued that the absence of this very information perpetuated a connection between violence due to personality disorder and the refusal of services to deal with it. However Paterson and Stark (2001) have also thrown doubt on the unproblematic acceptance of the 'fear theory' itself by analysing the idea of 'moral panic' as used by Muijen above. They found insufficient evidence that actual levels of anxiety in the general public about these issues increased over the early 1990s. They also felt that it was not clear how some events and issues become privileged in this way over others, which may have equal shock value due to factors of rarity, deadliness, generalisability and publicity (Paterson et al. 2001: 265).

An alternative approach is provided by Manning who looks at both the rise of the DSPD category (Manning 2002) and the growth of personality disorder as a general term (Manning 2000; Manning 2001). Using actor-network theory to allow 'an explanation about the nature of knowledge-in-construction' (Manning 2002: 661), he explores how human and non-human actors interact in the moves to establish pilot projects and policy developments around the contested concept of personality

disorder. In order to use actor-network approaches Manning finds it necessary to make the link between psychiatric practice and the sociology of science, where this approach was developed (Kendall et al. 1999).

> *The process of psychiatric classification and diagnosis involves the construction of representations of aspects of the patient in terms of a presumed underlying reality, constructed as part of biological, medical or social science. The use of these representations in clinical situations involves the practical application of scientific knowledge to solve problems as understood by psychiatrists and others in the clinical setting.* (Manning 2000: 624-5)

Manning posits that the contested nature of personality disorder represents a site of innovation and, drawing on the work of Latour and Woolgar, looks at how an object, such as personality disorder, becomes 'discovered' from initial positions of statements about the object, which then become inverted such that it becomes the reason for the statements. Applied to 'borderline personality disorder', he suggests this came to prominence in the US as a group of people in society were unable to respond to the changes of the 1960s, with its focus on personal development and close personal relationships and hence began to appear in mental health systems. The need to categorise this group due to restrictions on the insurance based US health system, then routinised the category into everyday use. Thus 'borderline' 'became inverted from a statement about difficult patients, to the discovery of an already pre-existing and coherent patient type' (Manning 2000: 623).

Manning acknowledges the critique of actor-network theory which has tended to focus on successful outcomes where ambiguity has been overcome, but appeals to its explanatory power in 'making sense of the DSPD story' (Manning 2002: 664). However throughout the paper there is a sense that underlying the concept of personality disorder there is an equivalent reality of difficult people. There is a 'typical trail of interpersonal mayhem that patients with the disorder leave in their wake' (Manning 2000: 629) and work with them is 'dirty' (Manning 2000: 637) . Further, the justification for the use of the sociology of science can be critiqued on the basis of the unscientific nature of psychiatry (Boyle 1990), and for the unproblematic insistence that attitudes and personality can be approached from a positivist stance (Potter et al. 1987). Thus Manning's sociological approach differs from the 'fear theory' in taking personality disorder as a contested concept, but still seems to use it as a property inherent in people.

An alternative analysis is provided by Nucknolls (1992), who acknowledges the contested nature of personality disorder as a psychiatric category, and approaches its analysis through the suggestion that interactions between cultural and psychiatric models may be a factor; 'that these categories may be culturally conditioned and therefore spurious as medical labels true in some 'absolute' sense.'(Nucknolls 1992: 37). To illustrate this he notes the gender difference in diagnosis between antisocial and histrionic personality disorder, and the associated gendered language associated with the diagnoses themselves. Thus antisocial is associated with independence, strength and superficial charm, as well as lying, cheating, violence and criminality; histrionic is associated with dependence, but also attractiveness and seductiveness as well as being over-emotional and infantile. Using Weber's analysis of materialism

and moralism in western-style capitalism, he proposes that the diagnostic categories have been formed partly in relation to the splitting of these contradictory features and traces their gestation through a series of cultural prototypes such as the 'beautiful invalid' and the materialist consumer (Nucknolls 1992: 45). While the analysis appears to make sense of these gendered diagnostic trends and certainly serves to illuminate them, and while an entry into the language surrounding personality disorder is a useful pointer towards methods in relation to the deployment of personality disorder, the actual evidence for his initial assertions are largely anecdotal and based in a general reading of texts which the reader is supposed to trust. Further the category of personality disorder as a whole is not addressed at all.

Ramon (1986) looks at the emergence of the term *psychopathy*, displaced by *personality disorder* during the 1980s (Ramon 1986: 235), through an examination of contemporary textbooks, correspondence in medical journals, parliamentary debates and policy. She locates the beginning of its appearance as a societal issue in the moves to rehabilitate psychiatrically disturbed soldiers during and after the Second World War and the growth of the Therapeutic Community movement. Ramon parallels Rose's (1999) readings of the development of the psychologisation of both socially desirable and undesirable behaviours during this period. She explores how the psychopathy category, although still poorly defined, became specified as separate from mental disorder in the 1959 Mental Health Act and suggests this functioned to categorise and regulate particular behaviours which could not be handled within the criminal justice system as no crimes had been committed, yet were also excluded by the psychiatric system as having no mental illness.

Ramon's analysis depends on a close reading of contemporary documents, very much in a Foucauldian style, and as such suffers from some of the critiques aimed at Foucault himself (see Chapter 4). Further, like Manning, what is not explored is what is actually being deployed when *psychopathy* is used, its patterns of usage and how this may have changed over time; all of which would provide much needed evidence for the conclusions reached.

Parker et al. (1995) focus a Foucauldian deconstruction on the field of psychopathogy, very much informed by the methods outlined in Parker's Discourse Dynamics (1992). The point is made that in an analysis of this kind one encounters the fundamental problems confronted by Foucault in Madness and Civilisation - the difficulty in talking about behaviour without dichotomising reason and unreason. To counter this Parker et al (1995: 60) explore six dichotomous 'pre-givens' of clinical categorisation; Individual – Social, Reason –Unreason, Pathology – Normality, Form – Content, Pure categories – Messy life, Professional – Popular. They suggest that it is not enough to take an oppositional view to the medical/clinical since this simply reproduces the dichotomies, instead what is needed is to look at whether the dichotomies are accepted and whether it is possible to think or express outside them.

Following Parker's (1992: 32) lead that discursive conditions limit the regions in which people can 'make' discourse, Harper (2004) argues that narrative and discursive analysis can be applied to the 'meta-narratives' of policy discourses. He uses evidence from the *National Confidential Inquiry into Suicide and Homicide by People with Mental Illness* (Department of Health 2001b) to illustrate that real risk is considerably less than media defined risk. He then goes on to use Potter and Edward's Discursive Psychology (DP) (1992) to analyse the White Paper, *Reforming*

the Mental Health Act (Department of Health 2001a), focussing in particular on the changes relating to DSPD. In keeping with the Discursive Psychology approach the focus is on how the document establishes the case for warranting reform rather than placing this in a social context. The language of the document is explored and reveals the storying of a version of the 'fear theory' mentioned above:

> *Current laws only allow treatment in hospital > most patients are in the community > patients have been allowed to lose contact > and refuse treatment > lives have been put at risk > especially from those with severe personality disorder > the proposed changes in legislation will remedy this*
>
> (Harper 2004: 7)

Harper argues that this discursive positioning has effects both on users and professionals, notably the othering of service users and positioning of professionals as agents of surveillance and actuarial assessors of risk. Thus this study uses the idea of subject positions to explore the implications of actual language use, a dimension missed by the preceding analyses. However, methodologically, Discursive Psychology is noticeably reluctant to engage in claims that cannot be warranted within the actual text under study. Thus in a summary of the Discursive Psychology method Edwards states that 'The key to analysis is to locate psychological and other issues in participants' own practices of accountability.' (Edwards 2006: 46)

Accordingly Harper has to look beyond a strict Discursive Psychology approach to actually address questions about societal influences, choosing the

findings of Foucault-inspired analysts. Thus Harper's claims of extrapolating subject positions from the study do not sit well with Discursive Psychology's claims of the variability and inconsistency of attitudes and beliefs. Indeed an exchange in *Discourse and Society* between Martin Hammersley and Jonathan Potter (Hammersley 2003a; Hammersley 2003b; Potter 2003) clarified this Discursive Psychology position. Potter felt that there were very specific grounds on which other analytic methods could be introduced into a DP based approach, namely that realist claims about the social world needed to be examined first for the influence of the action orientation of discourse upon their own findings and conclusions (Potter 2003: 785). This further strengthens the position that for an analysis of the discourses surrounding personality disorder the realist claims for its existence need to be explored.

From a more purely Foucauldian perspective, McCallum (1997) takes the position of language as 'intellectual technology' in order to explore 'how it has become possible to 'think' the problem of dangerousness and violation of social order within the psycho-medical category of personality disorder' (McCallum 1997: 57). He acknowledges that Foucault's approaches have attracted criticism from a historical accuracy perspective, however he is keen to point to how Foucault's 'histories of the present' approach has allowed workers to look at current issues in mental health from a new perspective. He explores nineteenth and twentieth century attempts to both separate and confuse categories of insanity and depravity while the category of moral imbecility, a 'congenital inability to distinguish between right and wrong, and to be influenced by punishment' (Mercier 1911) in (McCallum 1997: 65), became

increasingly distinguished by means of techniques distinct from medicine provided by the emergent discipline of psychology.

Out of this process emerged the DSM-III entry of personality disorders as 'enduring patterns of perceiving, relating to and thinking about the environment and oneself'. McCallum comments on the circular definition of these patterns defining the disorder, which in turn becomes sufficient explanation for these habits. This he sees as cloaking the class, race and gender prejudices of a particular middle class white male grouping of psychiatry: 'in the end, the description of an anti-social personality disorder is essentially that of a 'hoodlum from a poor and disadvantaged family' (McCallum 1997: 61). McCallum expanded this thesis in his 2001 book, subtitled *Genealogies of antisocial personality disorder* (McCallum 2001), further exploring how the development of psychological testing technologies opened a space for the definition of personality and statistical approaches delineated its deviance (McCallum 2001: Chap 5).

While providing a perspective on the development of personality disorder that is not reliant on assuming the presence of a medical condition, there are a number of critiques that can be offered to this approach. With its focus on dangerousness and personality disorder the argument tends to be directed inevitably towards the medico-legal area for explanatory power, thereby minimising other possible viewpoints. Further and in a similar way to Ramon's approach, the analysis depends on the close reading of many documents spread over a lengthy historical period. While, like many studies, this means the reader must trust the author's analysis in order to accept the argument, the lack of access to the evidence for how personality disorder is actually used in each period lays any claims open to charges of selective use of data. The

analysis is also confined to the Australian context and while there are sufficient parallels to allow its application to the UK, these are in the end only by implication. Finally, in a similar way to Rose's (1999) analysis, there is a significant reliance on the influence of psychology during the latter part of the 20th century in the defining of personality and personality disorder. However, as was shown in Chapter 2, certainly in the UK and indeed the US contexts it has been psychiatry that has dominated the definition and classification of personality disorder, with psychology being peripheral, although influencing some sub-categories.

Another recent approach to exploring personality disorder is Janet Wirth-Cauchon's (2001) exploration of Borderline Personality Disorder. She uses an overtly Foucauldian approach, drawing on 'Foucault's method of "genealogy" to trace these changing meanings of the borderline construct' (Wirth-Cauchon 2001: 40). Her raw material is the psychiatric writings of the Nineteenth Century, the discussions of the psychoanalytic movement, the DSM debates in the 1980s and individual patient narratives. From these she argues for the term's origin in designations of patients who were 'neither mad nor sane', yet 'transgressed Victorian social codes' (Wirth-Cauchon 2001: 41). The rise of psychoanalytic approaches in the USA defined a group who were said to lack the 'conscious self-as-object', were unstable and difficult patients. This powerful lobby then moved to include Borderline in the DSM III (American Psychiatric Association 1980: Chap 2; Wirth-Cauchon 2001). Applying a feminist analysis to the autobiographical accounts of women diagnosed with Borderline Personality Disorder and extrapolating this to earlier case descriptions, she argues for the cultural construction of borderline concepts such as 'fragmented selves', 'unstable self', 'lost', 'empty', out of the gendered nature of

women's positions in society. She concludes that narrative approaches to apprehending people's experience are more useful in this context than the gender biased psychiatric ones.

This study is of particular interest for its use of a genealogical approach, however, while its analysis ranges widely from psychiatric writings to individual experience, producing viable alternatives to a medical view of distress, the use of autobiography tends to modulate its descriptions through the lens of literature; people making a certain type of sense of an experience after the event. The more messy, compromised and problematic experiences of lived existence and lived distress and its effects on the self and those around remain somewhat at a distance, tending to render participants and professionals dichotomised as good and bad respectively by the analysis.

Analyses of Other Psychiatric Categories

A number of works explore the implications of the deployment of other psychiatric categories. Mary Boyle (1990; 1994) looked at the claims for schizophrenia as a scientific and medical concept and found it lacking on several grounds; the poverty of evidence for a physical basis, the 'status and power of the profession ... dependent on holding certain types of theory' (Boyle 1994: 403), and resistance to non-biological theories due to implications of blame. She accounts for the survival of schizophrenia as a concept in terms of its functions in society. Thus for psychiatrists the use of the language of illness to describe a phenomenon distinguished by behaviours is seen as providing validation for their medical status.

For the public schizophrenia is seen as locating accounts for bizarre behaviour within the individual rather than society or the family, thus somehow absolving 'the 'victim', relatives or society in general from responsibility for having caused the person's disturbing behaviour' (Boyle 1990: 180). These themes are worth bearing in mind for the later analysis.

Using a methodology based on Foucault's archaeology, Reuter (2002) traces the development of the concept of agoraphobia from case accounts between 1871 and 1930. By looking at the case histories Reuter attempts to demonstrate that the development of the phenomenon as a concept are the effects of 'power-knowledge systems and boundary-drawing projects that make some identities or attributes intelligible to the exclusion of others, but the identities or attributes that are measured as part of such boundary objects do not represent inherent properties of subjects or objects.' (Reuter 2002: 765-6). In this she draws heavily on Hacking's approaches to multiple personality disorder (Hacking 1995) and feminist theories of performing gender to show that the reiteration of case histories begin to form a norm within which subsequent observations are contained. This is of particular interest to the establishment of psychopathy and personality disorder given the role in their history of the repetition and replication of clinical cases, in particular in the style of the influential works of Cleckley (1941), Henderson (Henderson 1939) and the textbooks of Henderson and Gillespie (Henderson et al. 1962).

Hacking (1995) himself explored multiple personality disorder from a historical and philosophical perspective. His approach centres on an exploration of 'memoro-politics' (Hacking 1995: 210-20), by which he means biography, case history and correct remembering become the issues which are problematised and

thereby contested, rather than the morality of what is remembered. His overall approach seems to draw on and at times acknowledges Foucault's archaeology, but in the end relies on persuasive argument to map out a view of multiple personality disorder that runs across both supporters' and critics' views of both the disorder and the treatments. His account of how and why this categorisation developed draws on a historical treatment, featuring media presentations of cases from the 1950s, the growing public awareness of child sexual abuse, along with the strong US slant towards psychodynamic explanation. Accompanied by the idea of a growing social movement, redolent of Manning's policy network analysis (Manning 2002), this culminates in the inclusion of the diagnosis in DSM-III in 1980 (American Psychiatric Association 1980). As such it falls short of looking behind the concept to see what is being offered in its use, apart from a description of a disorder whose shape has been formed strongly by social factors. However the historical perspective used is of relevance to this study even though the actual diagnosis of multiple personality disorder is not commonly used in the UK, being absent from the relevant recent policy documents (NIMH(E) 2003a; NIMH(E) 2003c).

Hacking (1999) also examined how description and classifications of learning disability, while seeming at each point in time to be the correct label, and to be an improvement on previous ones, when looked at historically appear highly contingent on the medical and social attitudes of the time. Further, each label became associated with particular regimes of treatment based around the rationale for naming. Manning (2006: 1968) notes the relevance for the current classifications of personality disorder.

There are a number of studies looking more generally at how concepts are at work in psychiatry. Heinimaa (2000) analyses a psychiatric text (Davidson et al. 1992) using a textual analysis based on the work of Charles Taylor (1985) in order to explore the uses to which concepts of the person, such as 'self', 'sense of self' or 'person' are put in psychiatric discourse. Two parallel discourses are uncovered by this process, firstly a 'psychiatric' discourse in which human beings are encountered as essentially flawed in their 'selves' and secondly an everyday 'person' discourse where people are encountered as 'having a voice of their own' (Heinimaa 2000: 133). Unlike Boyle this analysis explicitly does not challenge the assumptions of psychiatric discourse. Its methodology is purely descriptive and its aim is 'to describe the structural conditions of this form of human activity, not to offer proposals toward the end of changing these conditions' (Heinimaa 2000: 135), however the detailed linguistic approach is convincing in what it tells about discourses at work in psychiatry.

A more critical analysis of the diagnostic process itself is Crowe's (2000) exploration of how the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (American Psychiatric Association 1994) 'defines mental disorder and the theoretical assumptions upon which this is based.' (Crowe 2000: 69).

Crowe uses Fairclough's (1992) position of language as a form of social practice, but also draws on Lupton's (1998: 8) understanding of discourses as patterns of differing ways in which we represent ourselves and our relationships with others in language. In this argument mental disorder can be seen as a product of the meaning established by discourses rather than simply reflecting or describing a reality (Crowe 2000: 40). A thematic analysis of the diagnostic categories is translated into new

themes to reflect the social nature of people's participation in the world – *productivity*, *unitariness*, *moderation* and *rationality*. An argument is then made that the definition of mental disorder is overly reliant on claims of internal individual causality, with excessive reliance on clinical judgement without visible pathology, while also failing to meet the challenge of alternative explanations in terms of social causal factors. The nature and resulting importance of clinical judgement is put forward as a claim to strengthen the validity of seeing diagnosis as a discursive process such that 'psychiatric meaning is attached to some behaviours and not to others'(Crowe 2000: 72) thereby constructing normality and abnormality for patients and professionals. However this implies that, to examine this process of construction, what would need to be explored would be the actual discourse (talk/interaction) of professionals and patients rather than the manual that is used. However Crowe's thesis is convincing on its own terms and effective in challenging the assumptions of a diagnostic process, but by setting itself firmly against the methods of the DSM, his argument runs the risk of underplaying the genuine attempts of clinicians to describe and understand forms of mental suffering. In other words, while presumably not the intention, there is a danger of conflating the constructed nature of a diagnosis with the actual experience of distress, such that the experiences on which a diagnosis is based may come to be seen as less real and upsetting.

Manning (2006) also looks at the DSM specifically in relation to personality disorder. He makes the case that DSM III (American Psychiatric Association 1980) appeared just as Reagan had been elected in the context of spiralling health care costs (Manning 2006: 166) and that personality disorder was placed on a separate axis from the major mental disorders for the first time in this edition. The DSM provided a

means to manage both the liability of the central and state governments and the insurance based providers by removing uncertainty and linking diagnosis to cost-defined treatments. He acknowledges that this both effaces individuality and idiosyncrasy in patients while also giving the diagnosis the status of a hidden entity revealed. Over time the DSM is seen as becoming too embedded in healthcare, insurance and research to change easily despite the ongoing criticisms. Thus a strong case is made for the inertial nature of the persistence of personality disorder as part of this behemoth, however to counter this, we have seen in Chapter 2 that radical critiques from within the DSM revision committee itself mean it may not continue in its present form. Further the growth in personality disorder may well follow its placing on Axis II, but it is not clear that this placing caused its rise as is generally suggested. Manning's analysis strongly suggests that a major factor is that it became caught up in the rise of the whole DSM at this time.

The Analysis of Health Policy

As previously mentioned, personality disorder has acquired a significant political dimension over the last 10 years, culminating in several broad policies advocating its inclusion within psychiatric services (NIMH(E) 2003a; NIMH(E) 2003c) and backed by specific funding (NIMH(E) 2003b). With this in mind, an additional area of literature that may shed some light on the research question, in particular its current political relevance, is the field of policy analysis. Whilst by no means exhaustive, this section aims to lay out some of the principles that have been used to analyse policy, in particular mental health policy.

Carpenter (2000) provides an overview of the social democratic, neo-Marxian and poststructuralist accounts of changing mental health policy development in the UK and US. The social democratic or 'social conscience' approach places policy changes in the context of a neutral and benevolent state and institutional changes within the context of a developing welfare state. Marxist structuralism is seen as an economic reductionist theory typified by Scull (1977), that takes a generally pessimistic view of progressive change within capitalism and uses Marx's economic model to account for changes in mental health policy. In this model community care becomes possible in response to welfare capitalism's provision of social security benefits along with the economic crisis of the large institution. Poststructuralist or 'discursive' accounts, typified by Rose's work (1994; 1996; 1998; 1999), draw on Foucault's work to explore for example how 'psycomplex', the disciplines associated with mental health work, have developed technologies and influences that have been used both to extend the influence of government but also to co-opt the population and the disciplines themselves into participation in internal and external social controls. Power is seen as working at all levels of society and analyses in terms of class or domination become supplanted by analyses of risk and individualisation.

In comparing these approaches Carpenter urges an acknowledgement of the discursive elements at work in policies, but stresses the need to see these within political and economic analyses and not to succumb to the temptation to uncover the negative but rather also see wider pictures of reform and achievement such as seen in sections of the systems in Sweden, Italy and UK.

An alternative analysis is contained in the ideas developed and outlined by Michael Foucault in his lecture 'Governmentality' (Foucault 1991). In this he

attempts to track the emergence and development of the concept and practice of governing, as societies became increasingly complex and urban. Laws become a less important means of managing this process and the concept of governmentality becomes more prominent. Governmentality or governmental rationality is 'the conduct of conduct' (Gordon 1991: 2), the conduct of the populace conducted by many pragmatic means, not simply by rule or legislation. Foucault thus sees liberal and neoliberal governments as in the process of devising methods of governmentality, which ensure their survival as governments by the perceived good fortune of the population. Through this view the problems of government become the problem of cost, risk, the individual, market non intervention etc. managed not by law and punishment alone but by a knowledge of 'things', that which works, rather than that which is believed. Governmentality thus describes the use of forms of authority outside the state in order to govern, hence a relationship between the state and particular authoritative expertise is developed. Medical expertise, while particularly useful for this governmentality function, for example in governing sickness, work and malingering, is however then required to be under closer political scrutiny, than when purely treating people (Bunton 1997).

Castel (1991) argues further that the process of governmentality in certain areas leads to increasing discrimination of groups by risk. This then sets up a society where differently assessed risk populations have different sets of lives and expectations and are policed in differing ways. The development of policies around 'Dangerous and Severe Personality Disorder' (Department of Health 2003) could thus be seen as an experiment in how to give different rights to a defined risk group, an experiment which may be developed further in relation to more general personality

disorders. In this way a place is made alongside the population but not with it (Castel 1991).

Corbett and Westwood (Corbett et al. 2005) have looked at the emerging policy category of 'Dangerous and Severe Personality Disorder (DSPD). They utilise Castel's (1991) governmentality analysis of the development of risk categories and link this to Beck's concepts of risk society. DSPD is thus seen as a manifestation of Beck's risk appraisal and the quantification and prediction of 'risk', although what is being predicted is harm rather than risk. As such it adds little to the debate that has not already been said, however it does raise the need within this section to consider whether Beck's concept of risk society is adequate to the task of exploring the deployment of personality disorder. There seem to be two areas where this is problematic. Firstly risk in Beck's terms seems to stem from an analysis of the development of what he terms emerging reflexive modernity (Ritzer 1996), a sense that people are operating more from their own rather than from received positions, such as class. He compares this advanced modernity to classical modernity where solidarity was achieved through the search for equality. In the new modernity solidarity is found in the goal of being spared from dangers. In this formulation advanced modernity may create the risks but it also develops populations' ability to become aware of and reflect on risk. Thus while the proposed legal and policy categorisation of DSPD could be seen as a response to a perceived 'fear theory' danger from irrationality, this could not be applied to other categories of personality disorder than Antisocial Personality Disorder, and in any case it could not apply to the whole clinical categorisation of personality disorder, since this is not linked to claims of the current ability of professional systems to treat or contain a perceived

danger. Secondly this approach does not look beyond personality disorder as a fact of which DSPD is seen to be a response, and as such suffers from essentialist critiques outlined in Chapter 4.

Burton and Carlen's work on Official Discourse (1979) used an early discourse analytic approach to explore how certain official publications achieved the 'reparation of fractured images of justice'. They called upon political and social theory from Althusser and Habermas along with an attempt to conceive of both the emerging subjectivities and the motivation for the process from both Lacan and Freud. The whole was informed by Foucault's approach to the conception and analysis of discourse; mainly that contained within the Archaeology of Knowledge (Foucault 1972). They term their investigation an 'archaeology of the discursive practices of the state' (Burton et al. 1979: 119). Within the context of the official publications concerning law and order they identify an Official Discourse, a Judicial Discourse and running through them all a Discourse of Empirical Rationality. The Official or State Discourse 'uses the language of administrative rationality, normative redeemability and consensual values to indicate itself as functioning within a democratic mode of argument' (Burton et al. 1979: 46). Further, using selective histories of events the discourse resolves a situation to produce an 'apposite history' in order to capture future conventions but also allow future adaptation as necessary (Burton et al. 1979: 137-8). Thus abusive police are storied as exceptions in order to allow the continued anticipation of the generality of police as dedicated to justice.

Sykes et al. (2004) have recently applied a Foucauldian methodology, based on the approach developed by one of the authors (Willig 2001a), to the health promotion policy of the European Union. The formulation of the research question

depended on Deborah Lupton's work (1997b) arguing for the socially contextual nature of public health work privileging self regulation and self control. Thus the analysis was an exploration of the document firstly to see whether Lupton's observations were evident and secondly to 'offer an understanding of how discourses may influence behaviour and what implications the discourses may have for the practice of health promotion' (Sykes et al. 2004: 133).

Willig's model (2001a: Chapter 7), outlined in more detail in the next chapter, is initially used to identify discourses at work in the policy, such as Religious, Military and Scientific Discourses, and then is employed to explore the implications of constructing health promotion through these. Thus the religious discourse can serve to show health promotion as good and charitable, but also an inspiring activity as though a mission. The scientific discourse can minimise resistance to recommendations through the adoption of facts from scientific methods and the assumption of an expert position (Sykes et al. 2004: 138). The final stage is to follow these implications through to the consequences of taking up subject positions based on these discourses. Thus, for example, the public may be positioned as passive subjects by the scientific discourse, which may lead to guilt at not feeling actively involved in health promotion initiatives. This latter part of the analysis is highly interpretative; an understanding of subject positions is itself based on a number of assumption about how language may operate to constrain participants, and these issues will be looked at further in relation to Davies and Harre's work in Chapter 4 (Davies et al. 1990). However, by making the process of interpretation explicit and placing it within a clear and well argued analytic framework Willig's model does

allow the development and justification of an argument to be understood in a much clearer way than previous papers.

As a final point, the consideration of power within the studies mentioned above differs in significant ways. Heinimaa (2000) demonstrates an implicit sovereign use of power (Taylor 2001) in the acceptance of the status quo of psychiatric discourse. Crowe (2000) and Boyle (1990) deploy a more explicit version of sovereign power in their critiques of psychiatry, while Sykes et al. (2004), Burton and Carlen (1979) and Ramon (1986) use a more complex Foucauldian notion of Power/Knowledge situated at all levels within the context of study. The latter seems more relevant to use in this study, as it challenges the common sense notion of power as received and possessed by few, and can be used as a theoretical superstructure to gain access to a more complex understanding of how a notion like personality disorder can remain functioning in society, especially within the complex world of the NHS where power resides at all levels.

Linguistic Approaches to the Analysis of Health Discourses

At points in the preceding review of the literature, it was noted that there was a dearth of studies examining the actual use of personality disorder in language, either in texts or in interactions. In Chapter 2, it was also noted that, in order to study how personality disorder is deployed, a starting point might be to explore its actual usage through time. This section will therefore look at how more linguistically oriented studies have approached analysis of health and related issues.

As Sarangi (2004) notes in his review, language and communication studies in the healthcare field, although having at least a 30 year history, have tended to focus on 'the study of encounters between health/social care professionals and patients/clients' (Sarangi 2004: 2), a view echoed by Adolphs (2004: 10). Sarangi specifically argues for a 'communicative turn in medical and healthcare' as a 'recognition of the limitations of a biomedical model of disease and health.' (Sarangi 2004: 3), seen as the prioritisation of scientific methodologies and explanations, reductionist and exclusionist tendencies, and a particular professional-client relationship. However Sarangi also notes a wider interest in these studies in how discourses work in the healthcare setting, both in the linguistic sense of discourse as components of language use and in the more Foucauldian meaning. He is concerned that discourse analysis may be seen as reductionist in its focus on discovering patterns of occurrence, yet run into problems of generalisability and reliability when used with a critical stance on a limited corpus of data. This point will be explored more in looking at Critical Discourse Analysis in Chapter 4. In response to these concerns, over recent years there has been a move to apply techniques developed in the linguistic analysis of large bodies of text, and known collectively as Corpus Linguistics, to derive data in a more transparent and explicit way, which can then be used for discourse/ideological analysis. Hence, in this section, papers were searched specifically for the combined use of corpus linguistics with discourse analysis, which mainly returned combinations of corpus linguistics with critical discourse analysis.

Krishnamurthy's (1996) study on the use of the terms *racist, ethnic* and *tribal* is of particular interest in combining Critical Discourse Analysis with Corpus Linguistics, as he utilises a number of approaches to triangulate his findings. He first

looks at newspaper articles using these terms as applied to Britain, Kenya, South Africa and the former Yugoslavia. The sample is small and it is not clear how the articles are chosen, but in essence they are used to raise questions and develop hypotheses rather than as evidence for a case at this stage. Dictionary definitions are then examined within the context of the acknowledged biases of lexicographers; 'far from being the objective record of the language that they are popularly conceived to be' (Krishnamurthy 1996: 129). This examination indicates further that *ethnic*, *racial* and *tribal* are seen to have different connotations; *racial* having more negative associations, *ethnic* having more technical appearances such as in academic use and *tribal* being used more pejoratively and also humorously.

He then turns to the corpus data from COBUILD, a large corpus of common genres of English language, to look at frequency data, collocations and usage within subsets of the corpus. He is able to track changes in the frequency of use of the three terms pre- and post- 1985 and similarly to look at different collocates which support his earlier hypothesis.

While the corpus analysis does thus lead to conclusions that can be attested through large scale analysis, it is the first section looking at six newspaper articles that is of most relevance in establishing links between text and positioning, showing how particular word usage in a particular context can have profoundly different effects, only noticeable on closer analysis and by comparing word use in texts about different countries. However the corpus analysis does indicate that some hypotheses are not supported by large-scale investigation, thus tempering the claims of a CDA analysis and lending strength to the combination of approaches.

Atkinson (1999) uses a diachronic corpora to explore changing scientific discourses in the transactions of the Royal Society of London from 1675-1975. He combines corpus techniques with rhetorical analysis to identify and evidence changes in the discourses of scientific writing over this period and identifies three trends in which both linguistic and rhetorical analysis agree. These are a decline in author-centred rhetoric, a growth of abstract language and a decline in narrative elements (Atkinson 1999: 142-147). His approach is praised by Stubbs as 'impressive'(Stubbs 2001: 163) in his key paper suggesting ways to enhance Critical Discourse Analysis using Corpus Linguistics, and Atkinson's use of Rhetorical Analysis and CL provides one of the very few rigorously worked examples of a multi-modal approach to discourse analysis using diachronic corpora to study discourse change.

Adolphs et al. (2004) combine a corpus linguistic approach with insights from conversation analysis to explore communication patterns between callers and advisors in the NHS Direct health advisory service. The analysis was in three stages. Initially transcripts of interactions were viewed by the research team to uncover patterns that they felt may be particular to this type of interaction. Then the language of the transcripts were compiled into two corpora of health professional utterances (35,014 words) and caller utterances (26,967 words) such that they could be compared to the five million word CANCODE corpus of spoken English used as a baseline of relative frequencies in everyday speech. From comparisons of frequencies and collocations a variety of patterns were then identified from which a smaller set were chosen for more detailed analysis.

A keyword analysis compared the frequencies of words that occurred more frequently within the patient and advisor corpora than in the baseline CANCODE

corpus and then identified where these occurred within the interactions. Certain features could then be related to particular phases in the interaction, for example, securing caller involvement by the very frequent use of *you* and *your* by the advisor in the early stages of the interaction. Additionally advisors made more frequent use of politeness markers, such as model items like *may* and *if* which, on examination of the concordances, were found to operate to soften the categorical listings of side effects or conditions or advice, giving an impression that the caller had choices in their responses to the advice.

The authors acknowledge the limitations of this study, in that it does not stretch beyond the interactions, which were staged to some extent by having prepared callers ring in, hence they can be accused of failing to use naturalistic data (Sacks 2001). Also the effect of particular communication strategies could not be tied to outcomes such as compliance or perceived usefulness of the advice. The corpus data is used in this study to back up the insights of the research team and also to provide some more substantial data for the CA analysis of interactions, given the criticisms of the latter for lack of generalisability. The strength of this approach, however, is in the ability of the corpus analysis to 'ground qualitative insights in a firm grasp of their regularity, frequency and significance.' (Adolphs et al. 2004: 25), an observation which has great relevance for the discourse analysis of personality disorder texts.

Orpin, in her study of the language of sleaze (Orpin 2005), acknowledges Stubbs' criticisms of the small sample sizes typical in CDA, described in more detail in Chapter 4, and takes on his suggestion to extend CDA by using CL to compare features of texts with language norms. She acknowledges a similarity to Krishnamurthy's (1996) approach to racial language by using both concordance and

collocation tools to provide semantic profiles of words and their associations. This then provides a basis for the CDA analysis which follows the CL analysis, through the use of Sinclair's concept of semantic prosody – 'the connotative meanings of words can be coloured by the collocates they attract' (Orpin 2005: 39). Starting from a wish to explore the suspected differing uses of *sleaze* and *corruption* Orpin extended this search using thesaurus and collocates in the British National Corpus focussing on the associated words that occurred at least 15 times in the sub corpus of four British newspapers (namely the Guardian, Independent, Times and Today – between 1990-1996). This led to a specification of the research question – an investigation of the occurrence of *bribery, corruption, croneyism, graft, impropriety/ies, malpractice, nepotism* and *sleaze* in British newspapers compared over this period and with a corpus of pre-1985 texts.

The word frequencies in each corpus were then examined for trends and concordances were scanned manually to gauge the senses in which these words were used. The most frequent lexical collocates of each word were then examined, both those that were shared and those that were unique to the word, the latter being linked to lexical choice and the possible ideological consequences of such choice. This then allowed the common domains associated with each word use to be established such as *bribery* being linked to the field of business and sport while *malpractice* linked to financial, legal and medical institutions or practitioners.

She explores possible accounts of the above trends, noting the growth of *sleaze* in the British press through the latter years of Tory government, and the 'massive structural' adjustments, generating in Fowler's (1991) terms, relexicalisation - the coining of a new term to imply a new phenomenon – and

overlexicalisation – 'an excess of quasi-synonymous terms to talk about entities and ideas that are a particular problems or concern within a culture's discourse' (Orpin 2005: 57). The analysis at this point is sketchy and she does not particularly link her findings to these terms, rather leaving the reader to come to their own conclusions implying that the increase in use of *sleaze* and *corruption* are examples of overlexicalisation in the context of structural change. Further she notes that a relative constant during this period is the tendency to use more negatively associated words to describe foreign countries linking to ideological underpinnings for word use.

The details of this particular study are reported in some detail as they may be useful for informing a methodology for approaching the analysis of corpora of material relating to personality disorder and psychopathy over time, but there may be a danger of producing data with no means for exploring wider implications or interpretations. This is where linking with a more Foucauldian approach may have some benefits.

An alternative approach to such lexical analysis is provided by Brown and Rubin (2005) in their study of tobacco industry documents in the US. They explore their corpus specifically for whether there are different usages and contexts to *because,* expressing strong causality and *since* or *and,* expressing a weaker disjunctive relation. They also take an interesting further step in the justification of the approach by looking at the psycholinguistic research into the effects of direct (using *because*) and indirect (expressed by *since*) causal expressions on comprehension and recall, finding that there was evidence the latter took longer for subjects to process, and were less helpful in facilitating comprehension, recall and retention.

They were able to develop a specialised corpus for their research as the Tobacco industry had been required legally to make 3.5 million confidential documents, available to the public maintaining an on-line computer searchable archive until 2007.

From this they were able to develop a corpus of 521,000 words, out of which they were able to identify all uses of the key causal markers which were then rated by two independent raters with regard to five categories of 'responsibility valence' (Brown et al. 2005: 805), namely exculpating and incriminating (blame from tobacco companies), advantageous and adverse marketing, and a neutral category. Exploring each cell of the correlation matrix from a Chi-Square Test showed that constructions conveying both incriminating and adverse marketing outcomes were characterised by a lower incidence of *because* and a higher incidence of *since* than would be expected to occur by chance alone, while constructions conveying exculpating attitudes and advantageous marketing outcomes showed higher incidences of *since*.

Thus they were able to conclude that strong causal associations were used when the tobacco industry was exculpating its actions or demonstrating advantageous marketing outcomes while weaker, disjunctive causality was expressed in the fewer instances when culpability was admitted for adverse health effects or marketing outcomes. They were able to suggest a systematic pattern which could influence social consciousness, but they feel that, while other parts of the tobacco lobby's approach demonstrate intentionality, this use of causal markers is likely to be more a manifestation of internalised rules of the effects of different causal markers and hence relates perhaps more to the unconscious ideologies in an Althusserian sense, 'a

representation of the imaginary relationships of individuals to their real conditions of existence' (Williams 1999: 74).

This review of literature, throws up a number of possible avenues for exploring the deployment of *personality disorder* and *psychopathy* before it, in particular the following main methodological perspectives: Discourse Analysis (Burton et al. 1979), Foucauldian Discourse Analysis (Willig 2001a: Chapter 7), Critical Discourse Analysis (Fairclough 1995; Van Dijk 2001) and Textual Analysis (Iannantuono et al. 1997) with particular attention to Corpus Linguistics (Adolphs et al. 2004; Biber et al. 1998; Orpin 2005). The details of the methodologies in some of the studies combining a discourse approach with corpus linguistics (Brown et al. 2005; Krishnamurthy 1996; Orpin 2005) are of particular interest, but, before proceeding to discussions concerning the final methodology, the following chapter will explore the theoretical dimensions to the issue of personality disorder as a medical concept.

Chapter 4: Theoretical Considerations

Introduction

The literature review indicated that studies that have addressed the increasing use of the contested concept of personality disorder have often tended to take for granted the existence of an underlying disorder which manifests socially in terms of personality disorder (Blashfield et al. 2000; Corbett et al. 2005; Manning 2002). This chapter aims to examine the problems associated with taking this stance..

The chapter is divided into sections, the first of which lays out the grounds for making the assertion that personality disorder is currently deployed in positivist terms, and explores the difficulties in performing an analysis without making positivist assumptions. The second section examines the problems with taking a positivist stance to the analysis and the third section looks at a series of alternative models. The final section looks at a means of approaching the central dilemma – how to investigate a concept defined in positivist terms without having to assume the reality of the concept.

The Positivist Conception of Mental Disorder

There are certain core assumptions that comprise a positivist conception of phenomena. The most fundamental is an acceptance of the empiricist account of the natural sciences (Benton et al. 2001: 23); that knowledge claims can only be tested by observation or experiment, in other words the scientific method (Benton et al. 2001:

14). What is implied by this is the 'standard view of science' summed up by Mulkay (1979: 19-20): the natural world is real and objective and science is concerned with providing an accurate account of that world. The judgements, preferences or intentions of observers do not affect this process of knowledge acquisition. Scientific laws are developed as statements about recurring patterns of experience, such that, to explain a phenomena scientifically is to show that it is an instance of a scientific law (Benton et al. 2001: 14). If science is thereby seen as the only genuine form of knowledge, then a positivist approach to exploring mental health would adopt the scientific method with its assumption of investigating real mental phenomena through observation and experiment.

As seen in Chapter 2, personality disorder is a term that is currently inextricably linked to the diagnostic criteria concerning mental disorders enshrined in ICD-10 (World Health Organisation 1992) and DSM-IV (American Psychiatric Association 1994). That the links to the DSM are particularly strong in the UK is shown in the most recent policy statement about personality disorder, which uses this diagnostic system rather than the ICD in the section 'How common is personality disorder?' (NIMH(E) 2003c: 9-11). The DSM-IV describes mental disorder as being:

> *conceptualized as a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom. In addition, this syndrome or pattern must not be merely an expectable and*

culturally sanctioned response to a particular event, for example, the death of a loved one. Whatever its original cause, it must currently be considered a manifestation of a behavioral, psychological, or biological dysfunction in the individual. Neither deviant behavior (e.g., political, religious, or sexual) nor conflicts that are primarily between the individual and society are mental disorders unless the deviance or conflict is a symptom of a dysfunction in the individual, as described above.

(American Psychiatric Association 2000: xxxi)

Further, the purpose of the DSM is described clearly as:

to provide clear descriptions of diagnostic categories in order to enable clinicians and investigators to diagnose, communicate about, study, and treat people with various mental disorders.

(American Psychiatric Association 2000: xxxvii)

These statements show clear positivist assumptions and that the classification system is there to enable investigations of real mental dysfunctions within individuals using the scientific method. As commentators (Crowe 2000: 71-2) have noticed, there is a circularity in the above statements, which imply that people can be classified by observed behaviours according to the DSM, such that they can now be studied as having a mental disorder. This is then seen as 'a manifestation of dysfunction in the individual' not defined in any way external to that classification system.

This definition of mental disorder in the DSM is however surrounded by a number of caveats, for example:

In DSM-IV, there is no assumption that each category of mental disorder is a completely discrete entity with absolute boundaries dividing it from other mental disorders or from no mental disorder. There is also no assumption that all individuals described as having the same mental disorder are alike in all important ways. The clinician using DSM-IV should therefore consider that individuals sharing a diagnosis are likely to be heterogeneous even in regard to the defining features of the diagnosis and that boundary cases will be difficult to diagnose in any but a probabilistic fashion.

(American Psychiatric Association 2000: xxxi)

Diagnostic assessment can be especially challenging when a clinician from one ethnic or cultural group uses the DSM-IV Classification to evaluate an individual from a different ethnic or cultural group. A clinician who is unfamiliar with the nuances of an individual's cultural frame of reference may incorrectly judge as psychopathology those normal variations in behavior, belief, or experience that are particular to the individual's culture.

(American Psychiatric Association 2000: xxxiv)

However, despite these, it is clear that the DSM sees personality disorder, as a mental disorder, as a manifestation of a behavioural, psychological, or biological dysfunction in an individual, distinguishable from other mental disorders, and comprising a number of subcategories, distinguishable from each other and suitable for intervention by psychiatry. There have been continuing challenges to most parts of this statement even from within the psychiatric community. These are conveniently

summarised in a standard textbook on psychiatry (Reich et al. 2000), which concludes that, while various tools, questionnaires and interview schedules exist for establishing a diagnosis of personality disorder the following problems have been noted:

- Measures tend not to agree with each other on specific diagnoses
- Measures tend to over-report disorders
- Most measures are affected by the co-morbidity of other emotional disorders such as depression
- Some tests use informants as well as direct interviews; there is no satisfactory way at present to resolve ratings, which disagree between informant and subject.
- There are problems with discriminant validity, the ability of a diagnostic system to diagnose non-overlapping disorders.
- ICD-10 and DSM-IV tend as a rule to diagnose multiple disorders thus throwing doubt on the existence of separate categories of disorder
- Clinician opinion and standard measures routinely disagree
- Test – retest reliability has not been well established
- The methods tend to have been standardized on psychiatric inpatient or outpatient populations hence their applicability to epidemiological studies in the community is not known (Reich et al. 2000: 953-959)

There has even been debate in the psychiatric press about whether personality disorder should be the subject of psychiatry at all. Kendell, the then president of the Royal College of Psychiatry, discussed whether personality disorder could be classified as a mental illness (Kendell 2002a). He concluded that its position was ambiguous, although this may be resolved by future genetic and clinical evidence, a hope for causative factors redolent of Koch's approach to psychopathy (see Chapter 2). This provoked a series of responses in the *British Journal of Psychiatry,* from calls for the abandonment of the concept in psychiatry as it is primarily 'socially negotiated' (Pilgrim 2002: 77), to promotion of a particular treatment model (Ryle 2002), its replacement with 'challenging behaviour' (Bennett 2002: 76) and preferred use of a dimensional rather than a categorical model (Kendell 2002b).

However, apart from Pilgrim (2001; 2002) both objections and proposed solutions tend to be couched within positivist terms, critiquing the classification system rather than the assumptions of the diagnostic process. As an example, the highly influential *Handbook of Personality Disorders*, sees the way forward in terms of marrying trait theory to the psychiatric classification in order to seek a closer match with reality (Livesley 2001), thereby maintaining the positivist stance. It is also noticeable that there is a tendency within most current publications relating to personality disorder of acknowledging the conceptual problems at the beginning of an article, then proceeding to use variations on the scientific method as though the concept was uncontested. Two examples are shown below in Moran's and Bateman & Tyrer's articles supporting the recent policy on personality disorder. The initial paragraphs acknowledge the conceptual problems:

It is only possible to make meaningful statements about the epidemiology and management of a health problem, if an agreed definition of that problem exists. Unfortunately, health professionals do not agree about how best to define personality disorders, nor indeed whether the term personality disorder has any use at all. Despite over two decades of extensive research, psychiatrists and psychologists remain divided as to how these disorders should be conceptualised. Whilst a diagnosis of personality disorder can now be made reliably with a number of interview schedules, there is no consensus as to how to assess personality disorders. In addition, clinical and research methods for diagnosing personality disorders diverge and the level of agreement between schedules is generally very poor. (Moran 2002: 1)

and

the literature on personality disorder is difficult to interpret for a number of reasons. These include problems of case identification, comorbidity, randomisation, specificity of intervention, and poor agreement on which outcome measures to use (Bateman et al. 2002: 1)

The rest of the articles then comprise positivist statements about personality disorder or personality disordered people:

Because some personality-disordered people engage in impulsive and dangerous behaviour, they have an elevated mortality rate. (Moran 2002: 5)

... it is highly unlikely that patients will persevere with treatment with either medication or with frequent face-to-face sessions necessary for psychological

treatment unless careful attention is paid to the relationship between the treaters, the service, and the patient. (Bateman et al. 2002: 14)

Thus it seems safe to conclude that the dominant epistemology concerning personality disorder within the psychiatric literature makes positivist assumptions: that is there is a belief that knowledge is inherently neutral, human values can be kept out of an analysis and a scientific method based on observation and deduction and taken from the physical sciences is applicable to this field of study (Ritzer 1996: 284). Further even critiques of the current conception of personality disorder lie within this assumption, hence it is important in an analysis of personality disorder to take a wider view and both examine the positivist assumption and explore alternatives.

Critiques of positivism

There have been a number of critiques of positivism and its basis in empiricism. Initially I will briefly cover some of the general philosophical objections and then look in more detail at the challenges to the extension of positivism to the mental and social arenas.

Philosophical objections

The problems seem to centre on three mains aspects of the positivist stance: the relationship between the real and the observation; the nature of testable laws; the problems with the distinction between facts and values. Thus Kant initially challenged the idea of pure empiricism by arguing that basic organising concepts like

time, cause and location could not be derived from experience and hence had to be both innate and universal (Benton et al. 2001: 31). In addition 'reality' is mediated both by sense organs and by language use before it is formulated as a conscious thought or communication. Advances in neurology have shown how perception depends on internal models of the world with a degree of active prediction, while Chomsky argued that language acquisition could not take place without an innate knowledge of 'depth grammar'(Benton et al. 2001: 30).

The problems with testability are contained in the objection that however many experiments or observations one makes this remains an infinitesimal proportion of the number one could make, hence one cannot conclude laws on the basis of such limited observation. Popper attempted to counter this by developing the idea that the criterion for theoretical adequacy should be its ability to withstand attempts at falsification (Mulkay 1979: 54), however this runs into problems if, as Quine (1951) argued, a single scientific statement or hypothesis cannot be tested against experience individually in an atomistic way, as this would mean any hypothesis could be retained, even if it did not appear to fit with our experience, by making modifications elsewhere in our system of beliefs.

That cultural norms and values cannot be disentangled from scientific knowledge-claims has been challenged by science studies which demonstrate the influence of values on knowledge production even within the natural sciences (Gilbert et al. 1984) and, when extended to medical science can appear in stark relief, as in the following quote from 1951:

This article sets out to study normal mentality and mental derangement in the African, especially in regard to their peculiarities as compared with their counterparts in the Western European. It is considered, on the evidence of leucotomy in Europeans, that all the observed African peculiarities can be explained as due to a relative idleness of his frontal lobes. This frontal idleness in turn can be accounted for on cultural grounds alone, but the possibility of anatomical differences, is not hereby excluded. Finally, a plea is voiced for expert anatomical study of the African brain, and in view of his resemblance to a certain type of European psychopath, of the brains of the latter also. (Carothers 1951: 46-47)

Objections to Applying the Positivist Model to the Mental Realm

One of the chief objections to extending the positivist model beyond the natural sciences concerns the fundamental ontological differences between human life and the facts of nature that are the subject of the hard sciences (Benton et al. 2001: 28-9). Thus, for example, humans are seen as inherently individually unpredictable, social life tends to be governed by social rules rather than scientific laws and there is debate as to the role of consciousness and meaning in how individuals act and behave. Further the relationship between observer/experimenter and subject is different from that of the natural scientist, both in the role of values, morals or politics in the choice of experiment and observation, and in the reflexivity of a thinking subject responding to that observation or experiment on the basis of their own theories.

In the specific case of a positivist analysis of how personality disorder is being deployed, there are additional epistemological assumptions that need to be made, namely:

- That people possess an essential quality of personality
- That this is generally enduring, observable and reliably and validly measurable
- That there is an established range within these measurements that defines normal personality and thereby disorders of personality

The concept of stable personality associated with enduring and measurable attitudes has been challenged by the work of Discursive Psychology (Potter et al. 1987). In exploring attitudes Potter and Wetherall evidence three problem areas, namely, 'the status of the 'object' which the attitude assesses, the dubious translation from participants' terms to analysts' categories, and the assumption that attitudes are enduring entities which generate equivalent responses from occasion to occasion.' (Potter et al. 1987: 53). Starting from language theories which root language in the human practice of its use (such as the work of John Austin, 1911-60) they focus on what the language is doing (termed its performative nature), who is doing it and in what context (its indexicality). Hence the area for investigation becomes the discourse rather than the inner state. Discourse in the context of this analysis is the collection of relevant written or spoken, language based media. Methods of analysing discourse are described and three phenomena uncovered, which they feel, have been neglected in traditional attitude research.

1) "*Contextual information* gives the researcher a much fuller understanding of the detailed and delicate organisation of accounts. In addition, an understanding of organisation clarifies the action orientation of talk and its involvement in acts such a blaming and disclaiming."

2) "...*variability*... Widely different kinds of accounts will be produced to do different things. Variability of the kind seen in detailed studies of discourse is thus a considerable embarrassment to traditional attitude theories."

3) "..*the construction of the attitudinal object in discourse*. The customary view is that attitudes are about distinct entities... Yet when we examined actual discourse.. it is clear that the attitudinal object can be constituted in alternative ways, and the person's evaluation is directed at these *specific* formulations rather than some abstract and idealised object." (my italics) (Potter et al. 1987: 46-53)

On paying attention to the details of interviews, speeches and documents, the concept of attitude as an enduring property of the person begin to break down and what is found expressed are variable, context-bound statements constructed in the discourse: 'Given the essentially performative and indexical nature of language use, how can researchers construe it as a neutral record of secondary phenomena, in this case cognitive or mental states?' (Potter et al. 1987: 145).

As a consequence of this Potter and Wetherall feel doubt is thrown on the reliability and validity of anything that is measured through a language process, in particular through interviews, questionnaires and Likert Scales, the key tools of personality measurement (Pilgrim et al. 1993; Tyrer 1979). Further, in an analogous way to Boyle's work with schizophrenia (Boyle 1990; Boyle 1994), the diagnosis of personality disorder is arrived at entirely through the observed and expressed

behaviour of the patient (American Psychiatric Association 1994; World Health Organisation 1992: Chap 5), hence there is no triangulation with another system such as the physical, that would allow tracking of the phenomenon and hence some verification of its real status.

As noted above, one of the characteristics of a positivist account of personality disorder is its relationship to normal personality. In this respect, Canguilhem's arguments in *The Normal and the Pathological* are relevant, as he explores the relationship between clinical medicine as practised and the knowledge gained about physiology through experiment. In particular he looks at the relation between norms and average (Canguilhem 1989: 151). In the section *Disease, Cure, Health* (Canguilhem 1989: 181-201) he makes the point that population averages are not the same as norms for an individual. What is a physiological norm for an individual may be outside the normal range but individuals can still perform a normative function i.e. make new norms when circumstances demand. This challenges the positivist view of absolute norms against which deviance can be measured; individuals can have norms of reacting to the world, which are different from the average and still be normal as an individual, if a flexibility of adaptation is retained.

Canguilhem makes the further point that if physiology and pathology are reduced to statistical facts then one may have to deal with the extension of this; that there is 'no difference between a healthy life and a sick life' (Canguilhem 1989: 219), hence one may need to invoke biological values to ground this in experience e.g. distinguishing food from excrement cannot be done purely on physicochemical grounds (Canguilhem 1989: 220). He is critical of the positivist conception of the

objects of medicine: "It is easy to specify *how* physiology is a science in terms of its method, less easy to specify *of what* in terms of its object" (Canguilhem 1989: 203) – how much more true of the 'scientific' studies of personality, indeed where is the physiology to psychiatry's pathology?

Canguilhem extends his analysis to pursue the analogy of norms in the social body and the physical body and notes several problematic differences. The social organisation is characterised by the invention of new organs, which change through time, an example being the organisations associated with statistical knowledge. These have moved, over the course of the last century, from observation to the use of these tools for social planning. Further an organism's norms are fitted to its environment while the relation between the social body and its environment is more complex as they significantly influence each other. Thus social norms are not finalised like physical norms, as there is no given environment by which to judge them. They thus exist as a form of compromise on numerous points, and, further still, the fact that these norms can be questioned implies they are not accepted for all members of a society (Canguilhem 1989: 256). These reflections are particularly pertinent to the consideration of personality disorder whose diagnostic criteria enshrine particular social norms in their very definitions as quoted in Chapter 2. These arguments challenge the basis of the positivist assumption that personality disorder, as an object of study by the scientific method, is somehow separate from the social world in which the investigator lives, and that the worldview of the investigator is unconnected with what is observed or concluded. These critiques foreshadow those developed by Michel Foucault, who further developed approaches to study psychiatry and classification which will be looked at later in this chapter.

To summarise, all three assumptions necessary to conceptualise personality disorder as a realist entity are challenged. The essential nature of personality is compromised by the social nature of its observation, judgement and measurement. Actual attempts to define and measure personality disorder are not reliable or disagree and the idea of personality disorder as a deviation from the norm is severely undermined by Canguilem's arguments. Thus, having outlined the relevance of the critiques to the positivist conception of personality disorder, it is necessary to move on to a consideration of alternative views.

Alternative Positions to Positivism in Investigating Mental Health

In the light of these critiques, this section looks at alternative models of conceiving research into mental health issues, in particular, Critical Realism, the work of Bourdieu, Heterodoxy and Orthodoxy, the work of Foucault, and Critical Discourse Analysis.

Critical Realism

Parker (1992; 1995) and Pilgrim and Rogers (1997) suggest that Critical Realism (Bhaskar 1989) may be an appropriate grounding for an exploration of processes in the social world particularly in mental health. Using arguments based on the question 'What must be the case for scientific experiments to be possible?' Bhaskar derives two realms for the apprehension of objects in the social worlds. There is the intransitive realm, which comprises the material conditions for the

production of thought; what the world must be like for experiments to be possible. There is also the transitive realm; what investigators must be like for them to be able to conduct experiments, from which derive the theories used to apprehend the objects (Benton et al. 2001: 123). The one cannot operate without the other.

Bhaskar also notes that scientific laws tend to have been predicated on closed systems, while human systems are complex interacting and open, hence they resist such reductionism. He stresses the role of theory in the way it structures phenomena and as a means to apprehend reality, presupposing a world independently of experience. This leads to a particular conception of science as engaged in uncovering stratified levels of reality; the empirical level of observed events, the actual flows of events under experimental conditions or in the world, and the real world of mechanisms and tendencies which is the final goal.

Parker (1992) argues the Critical Realist position in four stages. First, social phenomena are considered as complex interacting systems, which resist reductionism. Second, human systems are seen as open rather than closed. Third, the role of theory is seen as crucial in the way it structures phenomena. Finally there is seen to be a relationship between explanation and prediction such that it is only purely possible to perform these in controlled closed systems. Thus, for Parker, the powers of discourse operate on three interrelating realms where things have ontological object status, epistemological object status and moral/political object status. The ontological corresponds to Bhaskar's 'intransitive' realm, the material conditions for the production of thought; the epistemological corresponds to the 'transitive' realm (Bhaskar 1989). Ontological status is not enough to obtain knowledge about things; we need theories to apprehend them hence objects have entered discourse and by

extension discursive analysis. This position is certainly supportive of a discourse analytic approach, however both this and Bhaskar's view would structure a research programme into personality disorder by encouraging a focus on the types of theory that are used to apprehend the flows of behaviour and thought produced by a core reality; an assumption that there is an ultimate provocation to the theory-building about personality disorder and that this lies within the individual. Thus there remains a core of realist assumption which would appear to rest on some form of cognitive process within the individual, as Bhaskar appears to favour a model of intentionally acting human subjects (Benton et al. 2001: 133).

Bourdieu – Habitus and Field

Within an overall project of overcoming the antinomy between subjectivist and objectivist perspectives (Ritzer 1996: 536), Bourdieu's analysis of societal features in terms of habitus and field (Ritzer 1996: 540-548) may supply an alternative means of analysing the deployment of personality disorder. In Bourdieu's terms a field is 'a network of relations among the objective positions within it' (Ritzer 1996: 542), but it is not the interactions or ties between individuals. Thus the field is seen as a market place where various kinds of capital are deployed for various advantages. In particular in his broadening of the concept of capital to 'social capital', 'cultural capital', 'symbolic capital' etc., he challenges the assumption that these practices are non-economic or somehow disinterested in people's economic situations. Capital in various forms can thus be accrued and transformed into economic advantage but not reduced to it. His studies focus on the processes of

control over the value of symbolic and linguistic resources, which regulate access to other social, cultural and economic advantage. This attempts to walk the line between the objectivism of economic reductionism and the subjectivism of reducing social transactions to communicative events and thus could provide a means of exploring personality disorder without signing up to the positivist project.

In some ways Ritzer's description of how to proceed with an analysis using habitus and field in a three-step method is reminiscent of Foucault's Genealogical approach to power/knowledge looked at later in this section, thus he suggests:

1) Tracing out the relationship of any specific field to the political field (reflecting the primacy of the field of power)

2) Mapping out the objective structure of the relations among positions within the field

3) Seeking to determine the nature of the habitus of the agents who occupy the various types of positions within the field. The positions of agents are determined by the amount and relative weight of the capital they possess. (Ritzer 1996: 542)

The model implies struggle over a space through the use of strategies for advancement, though Bourdieu appears to imply that these strategies do not necessarily follow conscious rules or aim at premeditated goals, rather strategies are lines of action that safeguard or improve participants' positions and which depend on their positions in the field. Bourdieu looked at taste and class, and there is a sense in which this analysis has a bearing on personality disorder, as this, one suspects has strong class divisions, between those doing the diagnosing, those being diagnosed, those treating, those caring, those occupying active user roles, those most disturbed and so on.

In applying this approach to language, Slembrouk (2006) suggests that the key concepts of Bourdieu in relation to a linguistic analysis are "*linguistic/symbolic capital* and *linguistic habitus*, their positioning in *linguistic markets* and their role in the production of communicative legitimacy (with attendant effects of social reproduction, domination, exclusion and situated silencing)." (Slembrouk 2006: 25). In the notion of linguistic habitus, Bourdieu refers to the individual speaker's competence, but in the strategic sense of the ability to put language resources to practical use, to anticipate their reception and to profit from this. At the same time it is an 'internalised disposition of objective structures' (Slembrouk 2006: 27), for example accent and dialect, the way one speaks based on one's family and schooling in the widest sense. It is continually being sanctioned by its successes and failures as a practice in the market of linguistic exchanges, which implies a theory of linguistic practice rather than system, and habitus is in a sense discourse adjusted to a situation seen as a market or in Bourdieu's terms a field.

From the point of view of the evolution of language around personality disorder the high status medical talk is sanctioned by its bringing success to participants who engage in it thereby giving it high capital status. This contrasts to an application of Bakhtin's position around official language as applied to psychiatry (Good 2001), where the dominant discourse imposes its position upon other discourses orbiting around it.

Bourdieu's position has been criticised for tending 'towards a sociology of self-perpetuating dominance' (Slembrouk 2006: 28), however the approach does allow for occasions of crises in the symbolic markets, where the mutual reinforcement of language and capital collapses, and also the relation between habitus

and the specific historical circumstances implies the potential for change. In terms of personality disorder one might see potential for crises as the contradictions between the user experience, the user discourse and the allowed positions in medical language become acute. At the present time the growing financial crisis of the NHS will also undoubtedly have an influence on what developments or services are sanctioned for the future.

Most crucially perhaps for the study of personality disorder, the stress on the strategic nature of communication means that Bourdieu retains an assumed subject at the very centre of his theory, that is rational to the extent that gains and losses are weighed up in the process of communication, although in his overall project he is keen to stress the inseparable nature of objective structures in society, social space and the mental structures through which these are apprehended. Indeed Ritzer makes clear that habitus does not necessarily imply a rational uni-logical sense-making subject (Ritzer 1996: 541), however despite attempting to sideslip the structure/agency divide, a subject still remains. Given the attack on the subject over the last thirty years this is a difficult position to maintain as central. However Ritzer suggests that Bourdieu although developing a coherent theory over his career eschewed the title of theorist (Ritzer 1996: 548). By shunning a general theory of social life and suggesting instead that the nature of the actual relations between fields is always an empirical question and that the nature of habitus changes with altered historical circumstances, he can be seen as aligning himself with Foucault's attempts to seek localised analyses rather than grand narratives. With this in mind the investigation of personality disorder should proceed empirically such that theory does not overcome local evidence.

Thus while Bourdieu's approaches do not seem to fit the research question as presently conceived, they do provide a rich model for potential avenues of interpretation and further study, for instance, the interaction between the habitus of clinicians and users, the field of personality disorder and psychiatry and sections of the legal field. The application of this theory to a subject such as psychiatry also poses a question of who is struggling over what. One could conceive of personality disorder as a site of struggle between professionals, utilising distress to develop their capital, the lower rankings adopting the language and culture of the higher medical echelons in order to acquire their capital, such that nurses become therapists, and psychology becomes more dominant. Particular trends thus might get taken on less for their therapeutic power than for their cultural capital.

Heterodoxy and Orthodoxy

Recent studies looking at branches of medicine from the point of view of a belief system may also be of relevance in conceptualising personality disorder through the relationship between its requirements of belonging to the medical 'church' and the need to resist dissenting voices. In his editorial to the edition of Social Science and Medicine devoted to this theme, Jones (2004a) introduces a number of approaches to conceiving the history of medicine in terms of an orthodoxy in a relation to heresies or heterodoxies, such as complementary medicine, placebos and 'medical risk'(Skrabanek et al. 1994).

Martin (2004) suggests models by which 'competition over an assumed unitary truth leads to the dynamics of orthodoxy and dissent/heresy' (Martin 2004: 716), looking at

methods of domination and marginalisation within this model and strategies for dissenters and heretics. Jones (2004b) looks at the interdependence of orthodoxy and heresy (Jones 2004b: 704-5) and the conception of scientific development, not towards truth as all paradigms are ultimately unprovable, but towards a series of paradigms vying for power which, in themselves, contain incommensurate theories. He gives the example of physics embracing both quantum theory and relativity, neither of which can explain the other, nor be accounted for by an overall theory.

Dean (2004) looks at how public health imitates the positivist regime to maintain its status as a medical science, with particular reference to maintaining a search for single causal solutions to complex environmental problems. The dominance of cause-effect models and not interaction between variables is commented on and alternative statistical tools suggested, however it is noted that the lack of training in alternatives and journal preferences, further serve to enhance orthodox dominance. This is of particular relevance to an epidemiological approach to personality disorder where what tends to be studied is the contribution of the single variable, personality disorder, to societal and health service burden. Not surprisingly then, it is found prevalent in working class communities, for example in Moran's study of GP attenders in inner cities (Moran et al. 2000), although the lack of alternative routes to managing personality difficulties other than health-based ones is not examined.

Gillett (2004) discusses how surgery and surgical innovation remain problematic in terms of the dominance of the 'statistically valid prospective double blind randomised controlled study' (Gillett 2004: 731), particularly because of the individualistic unreproducable nature of the surgeon's craft which often depends on

local knowledge. He makes the point that in general we "deprive ourselves of the most important perspective on patient care by effectively discouraging the patient from taking an intelligent part in the design of the regimen of intervention for their illness." (Gillett 2004: 736), by making the medical account unintelligible to the lay person and by silencing dissent and lay voices. On a critical level Gillett does not question the doctor or clinician role itself, thus he see doctors and clinicians as leading the engagement with the subjectivity of the oppressed in designing therapy regimes (Gillett 2004: 737).

Bearing these discussions in mind one could thus conceive that part of the elaboration and development of personality disorder over the last 50 years, could be seen as a response to the many dissenting voices critiquing the concept; as though it were insecure in its membership of the church of psychiatry and hence needed to try harder to appear scientifically valid. As a consequence personality disorder increased its complexity of diagnosis, moved into the hands of the elite specialist clinician, thereby becoming less accessible to the lay user. Dissenting voices may be seen to have to fit within this conception of personality disorder in order to be heard as valid, further cementing the status of the insecure and contested concept.

While these approaches do allow some thinking about the nature of struggles around the concept of personality disorder, they tend to have the flavour of an extended metaphor with limited evidence in their favour and thus lack the rigour of other approaches discussed in this section.

Foucault's Approach

As can be seen from the literature review, in order to theorize in relation to discourses it is necessary to engage with the work of the person most cited in relation to evolving schools of discourse analysis, Michel Foucault. I will start by outlining key features of his approach taken from the *Inaugural Lecture at the College de France* in 1970 (Foucault 1981). At this stage he had published *Madness and Civilisation*, *The Birth of the Clinic*, *The Order of Things* and *The Archaeology of Knowledge*.

The Order of Discourse outlines the methods by which Foucault approached his analyses of discourse at the point at which he was moving from 'archaeology', his approach to the history of systems of thought towards 'a more directly political mapping of the forms of power exercised in discursive and other practices' (Foucault 1981: 48).

> *In every society the production of discourse is at once controlled, selected, organised and redistributed by a certain number of procedures whose role is to ward off its powers and dangers, to gain mastery over its chance events, to evade its ponderous, formidable materiality.* (Foucault 1981: 52)

He explores processes by which he sees this as occurring, such as prohibitions of discourses through, for example, the division of reason and madness and the subsequent rejection of the latter. Within this he also identifies the 'will to truth' which exerts 'a sort of pressure and something like a power of constraint on other

discourses' (Foucault 1981: 55). Here he is identifying the rooting of claims for authority and power in the, now taken for granted, nature of truth claims based in rationality. Foucault also looks at how things must be conceived before they can be entered into disciplinary speech, thus personality disorder for example may have to look like an illness before it can enter texts. He sees the taken-for-granted nature of our own subjectivity and everyday signs as buttressing us against fear of 'this great incessant and disordered buzzing of discourse.' (Foucault 1981: 66).

Summarising the methodological implications Foucault writes:

> *if we want to ...analyse it (this fear) in its conditions, its action and its effects, we must, I believe, resolve to take three decisions which our thinking today tends to resist and which correspond to the three groups of functions which I have just mentioned: we must call into question our will to truth, restore to discourse its character as an event, and finally throw off the sovereignty of the signifier.* (Foucault 1981: 66)

Foucault (1981: 67) lays out four principles by which to manage such an analysis: the principle of reversal – identifying the author, the discipline, or the will to truth not as sources of the discourse but as cutting it up; the principle of discontinuity – 'Discourses must be treated as discontinuous practices, which cross each other, are sometimes juxtaposed with one another, but can just as well exclude or be unaware of each other.'; a principle of specificity – 'we must not resolve discourse into a play of pre-existing significations' and the rule of exteriority – 'we must not go from discourse towards its interior ...towards a signification supposed to be manifested in it, instead one moves towards its external conditions of possibility, towards what

gives rise to the aleatory or chance series of these events (discourses) and fixes their limits.' (Foucault 1981: 69).

Thus the sense in which Foucault appears to be conceiving of discourse is distinct from many of his followers who have attempted to develop methodologies. There is an impression that discourse is hard to apprehend; it is behind reality as experienced through the taken-for-granted, yet it is not reducible to it. It defies causal explanations and analysis needs to focus on what it gives rise to rather than what it means. Thus a concept like personality disorder could be explored from an examination of psychiatric and policy documents in order to give access to what discourses are made available to use and what are opposed and excluded. The formation of new discourses about personality disorder could be examined through the ways in which a 'new regularity' (Foucault 1981: 72) is formed in the interplay of the above factors, in which parts of earlier discourses prefigure the new formations. The examination of correspondence in key professional and user journals would allow an examination of the processes of control that are applied to bolster and attack the new discourse thus giving access to counter discourses.

Foucault has also specifically explored the sphere of health. In *The Birth of the Clinic* Foucault (2000) uses three theoretical devices to conceptualise the growth of medical discourses. Crucial is the development of the clinical gaze, a particular way of seeing the body from which derive both the classification of symptoms and decisions about the person: 'the eye that knows and decides, the eye that governs' (Foucault 2000: 89). This is accompanied by a new definition of the patient in society 'the establishment of a certain relationship between public assistance and medical experience, between help and knowledge' (Foucault 2000: 196). The third factor he

proposes as the repositioning and reconceptualising of death from the 'macabre' to the 'morbid', from the homologous to 'constitutive of singularity' (Foucault 2000: 171), in other words from a general conception to one which related to signs and symptoms within individuals and individual bodies. He suggests that by engaging with this conception of death the possibility of a science of individuality was then realised. In his overall enterprise, Osborne suggests that Foucault follows Canguilhem in looking at medicine as 'a technique of establishing or restoring the normal, which cannot be reduced to a single form of knowledge' (Canguilhem 1989: 34) in (Osborne 1994: 32). He proposes that, by forgoing a critique of what is right or wrong with medicine, Foucault is abandoning a totalising account of medicine in favour of the analysis of particular contexts or rationalities. Further, by isolating one rationality, the clinic, Foucault indicates that many further can be analysed.

Nikolas Rose in a series of articles and books has taken up this challenge by exploring the relationship between the development of the 'psy' disciplines and society (Rose 1996; Rose 1999). Utilising Foucault's governmentality approach (Foucault 1991) as well as adapting his method, his studies have direct relevance to any approach to conceptualising the deployment of a concept like personality disorder, so intimately bound up with debates around the status of diagnosis, the policing of society and the present and future role of the 'psy' disciplines in society. In *Medicine, History and the Present* (1994) Rose summarises Foucault's understanding of the role and development of medicine as being linked to the realisation of the human person as a possible object for 'positive knowledge'. This is seen as taking the form of expertise combined with emerging governmental forms and the secularisation of ethical regimes.

the history of medicine ...is bound up with the historicity of all the different ways in which we have come to understand what is involved in making us better than we are. (Rose 1994: 49)

In keeping with Foucault's exposition of his approach, Rose sees the overall task to 'decompose the great certainties in which medicine and our present are bound together' (Rose 1994: 50). Following this, Lupton (1997a) derives a useful summary of the operation of power that using a Foucauldian perspective implies. It is:

a disciplinary power that provides guidelines about how patients should understand, regulate and experience their bodies. The central strategies of disciplinary power are observation, examination, measurement and the comparison of individuals against an established norm, bringing them into a field of visibility. It is exercised not primarily through direct coercion or violence ... but rather through persuading its subjects that certain ways of behaving and thinking are appropriate for them. (Lupton 1997a: 99)

In the medical context this might be thought of as the power of medical discourse to bring into being the subjects 'doctor', 'patient' and the phenomenon of 'illness', where doctors are links in a set of power relations rather than figures of domination. In this formulation power is not possessed by groups but is relational and dispersed, not a single medicine but a series of 'loosely linked assemblages with different rationalities' (Osborne 1994: 42).

As mentioned in Chapter 3, Willig (2001a) has developed a six step approach to a Foucauldian Discourse Analysis (FDA) and has applied it to analysing policy (Sykes et al. 2004). The analysis is grounded in previous attempts to formalise discourse analysis, the 20 step guide of Potter and Wetherall (Potter et al. 1987) and the 10 steps of Ian Parker (Parker 1992), and aims to explore subjectivities within the following six-stage process.

1. Identifying discursive constructions
2. Examining discourses in operation
3. Exploring discourses in action – what work do they do
4. Outlining the subject positions allowed for by the discourse
5. Exploring how discursive constructions and subject positions open up or close down opportunities for actions
6. Exploring the subjectivities – the consequences for people of taking up the various subject positions. (Willig 2001a: 109-111)

This process thus allows a visible development of the analysis from text to subjectivities. Inevitably perhaps, this involves some degree of compromise between Foucault's reluctance to prescribe methodologies and later interpreters' attempts to describe a process of analysis. Earlier texts tended to shy away from explicitly prescribing a methodology preferring a 'bricolage' of theories (Burton et al. 1979), or a method that continually refers to intuition while suggesting 'there is no analytic method' (Potter et al. 1987: 169). Later texts such as Parker (1992) or Willig (2001a) attempt to pin down a method while acknowledging the problems in making it sequential or complete. In the end perhaps, as Taylor notes in her study of evaluation

in Discourse Analytic research, it is the transparency of the method, the richness of detail and the strength and coherence of argument that is necessary in judging the analysis (Taylor 2001: 320-1). However Taylor is also keen to emphasise the necessity to explore deviant cases, inconsistency in developing interpretations, and using more than one data form to triangulate findings. These reflections suggest Willig's approach as a possible candidate for a methodology that matches the research question, as it attempts to link text, discourses and the implications of these for subjects.

However, on a general level, Foucault is relevant to this study on three levels; firstly his method of genealogy, the tracing of discursive practice through time, secondly in his findings where the rationale for focussing on personality disorder can be found in the challenge to how subjectivity is conceived and managed, and finally in his governmentality approach which allows the subjective and the political to be linked coherently and more importantly in a manner that can open space for action. There have however been a number of critiques aimed at this approach and these will be explored next as well as developments such as Critical Discourse Analysis that are intended to take these criticisms into account and advance the Foucauldian project.

Critiques of Foucault

Elliott (2001) summarises a number of critiques of Foucault and the approaches based on his theories. He feels Foucault's disciplinary society denies the agency and knowledgeability of individuals, however it is clear, from the discussions above, that Foucault developed a conception about discourse setting limits, within and against which people have agency. In addition Elliot maintains that Foucault

overestimates the spread of medical and 'psy' discourse in the 19th century with its low literacy rates, however one could argue as Hacking (1995) does that discourses at work in the middle classes in the 19th Century spread in the 20th Century through literacy and media. Possibly more crucially Elliot says that 'Foucault nowhere confronts the possibility that self realisation is itself embedded within realms of mutuality. Foucault's perspective is, in short, an individualistic version of the self.' (Elliott 2001: 94). However Rose sees Foucault as linking the 'ethical question of how we should behave to the scientific question of who we truly are and what our nature is as human beings, as life forms in a living system, as simultaneously unique individuals and constituents of a population.' (Rose 1994: 67-8).

An important critique is Foucault's lack of consideration of gender; implying care needs to be taken in appropriating his themes. However some writers have seen Foucault's work as converging with feminist approaches at points, in terms of its focus on power and the female body, while also using Foucault's rejection of totalising accounts to counter the moves towards definitive versions of Feminist critique (Martin 1988).

Lupton (1997a) acknowledges a further critique of Foucauldian work in relation to medicine, notable in some of his followers such as David Armstrong (1983). This is the tendency to focus on official texts rather than on how practitioners and patients experience medicine. Further to this Lupton discerns a tendency to emphasise the dominant and coercive nature of medicine and the passivity of patients in relation to this 'gaze'. Contrasting this with the critique that Foucault overgeneralises the concept of power and ideology until meaning and usefulness is

lost (Eagleton 1991: 8), it would appear that Foucauldian work can both over and under-emphasise the nature of dominant power relations.

However, within an overall study of the use of personality disorder Lupton's phenomenological approach would be important in exploring how discourses around the concept are enacted in practice and the resistances that may be encountered, as in Lupton's own uncovering of differing power relations within the medical encounter with patients veering 'between wanting and appreciating care and resenting it' (Lupton 1997a: 105). But there is also a step before this, an exploration of what is being deployed around a medical concept in its dominant official form, which would inform further research into how this is being enacted in the world. Additionally, a study based solely in present observations of how personality disorder is being used would leave the historical dimension untouched. The advantage of generating a history of the discourses surrounding personality disorder is that those which may have been obvious in the past, may still be in operation today, but be much harder to detect, without this historical knowledge. This is one key sense in which Foucault coined the term 'history of the present' to characterise his genealogical approach.

Critical Discourse Analysis

Responding to critiques of Foucault's apparent neglect of structural factors and ideology, summarised in Eagleton's views on the dangers of broadening a definition of power (Eagleton 1991: 8), a number of people have developed forms of Critical Discourse Analysis that explicitly incorporate an ideological basis to their approach, notably Ian Parker, Norman Fairclough and Teun van Dijk.

Parker's 1992 *Discourse Dynamics* (1992) outlines seven 'basic and necessary principles', each of which contain methodological implications (Parker 1992: 6-16) and which broadly follow Foucault's lead. He then goes on to explore three more principles, based on institutions, power and ideology, which are an attempt to tie the practice and theory of Discourse Analysis into wider social theories and practices (Parker 1992: 17-20). This is claimed as a form of action research (Parker 1992: 21). Objects are called into being, given a moral/political status, researched (given epistemological status) and treated as if they existed (given ontological status). Discourse analysis, as a critical response, studies certain objects as objects of discourse thereby allowing deconstruction, but implying the making of moral/political choices.

Van Dijk (1997) analyses discourse from four perspectives Action, Context, Power and Ideology. Action is the process by which a piece of discourse enacts functions at different levels. Context is primarily conceived as cognitive; the things we know, what we understand the audience to know, our social models. This is van Dijk's route to individual subjectivities, however it suffers from the critique of cognitivism itself, that it presupposes a rational subject, albeit subject to conflicting or opposing discourses. Power is clearly a sovereign model concerning control of resources or ideas, often enacted through a dominant group. Ideology is seen as sets of representations of beliefs and values, sometimes hegemonic, and the struggle over meaning leaves traces within the language that can be discerned.

Fairclough (2003) situates his conceptualisation of discourse analysis within critical realism like Parker (1992), but also applies Margaret Archer's (1995) ideas of structure and agency. In effect individual human agency can change and affect

meanings within a framework of the possible, people are socially constrained but not socially determined (Fairclough 2003: 24). Combining Foucault, cultural studies and Systemic Functional Linguistics his approach to analysis involves three major types of text meaning:

- Action; what is enacted in the text, power, relationships, etc. which he terms *genre*
- Representation; ideational, what is represented in the text, which he terms *discourse*
- Identification; how attitudes desires and opinions of those involved in the text are displayed, which he terms *style*.

Thus:

> *When we analyse a text as part of specific events, we are doing two interconnected things: (a) looking at them in terms of the three aspects of meaning, Action, Representation, Identification, and how these are realised in the various features of texts (their vocabulary, their grammar, and so forth); (b) making a connection between the concrete social event and more abstract social practices by asking, which genres, discourses, and styles are drawn upon here, and how are the different genres, discourses and styles articulated together in the text?*
> (Fairclough 2003: 28)

Fairclough further explores how meaning moves from one social practice to another and how this can work in chains to transform meaning for particular

purposes. Thus a policy text is seen as a crucial part of such a genre chain in the mediation of meaning from practice, scientific research and user comments, through to changing practice in the workplace. This type of genre he sees as 'sustaining the institutional structure of contemporary society' (Fairclough 2003: 32) and hence a 'genre of governance'.

Fairclough's conception of genre chains and governance might be a useful way of tying a policy document to wider social processes, but this conception of governance is a very hierarchical one. Behind it is the figure of sovereign power with policy being seen as a method of control even before the analysis. Fairclough does however separate out discourse seen as a form of a text from the patterns at work within it, and lays out a theoretical conception of how one might understand what a text is achieving on different levels.

Critiques of CDA and arguments for combination with Corpus Linguistics

Critical Discourse Analysis has been used in a number of areas relating to the workings of society, Van Dijk (1993; 1997; 2001) primarily in relation to parliamentary debates and media representations and Fairclough in relation to management ideology and the discourse of New Labour (Chiapello et al. 2002; Chouliarski et al. 1999; Fairclough 2000). However, having a declared critical stance, these approaches have at times laid themselves open to criticism. Stubbs (1997) for example sees instances of poor interpretation of data, where description appears to be provided in support of a preconceived position by data whose representativeness is

unclear. A related objection is the potential for CDA researchers to advance their own ideological positions by using these to ascribe particular motivations to participants in their analysis (Tyrwhitt-Drake 1999). Stubbs also raises the question of the relationship between the claimed use of particular language and its ideological effect, warning against simplistic use of links between grammar or lexis and ideology, given the variation in linguistic registers within clusters of associated features, and is suspicious of a one to one correspondence between form and function. He also feels the actual relations between the production of a text, the addressor and the addressee are seldom explored and hence leave a gap in the argument from language to its production and reception, crucial to sustaining a link between a text and ideology. He suggests that the link between language use and cognition is unelaborated and often circular and tends to lack a comparative dimension, thus language in analysed texts is not looked at in comparison with a norm. However he sees the overall enterprise of CDA as of sufficient import to suggest some ways of overcoming the perceived current shortcomings:

Firstly, an ethnographic dimension to the study of text production would provide an authenticity to the links between society and the text.

Secondly, analysing co-occurring linguistic features in a systematic manner could provide more weight to arguments currently based on limited data.

Thirdly, comparing texts and corpora with each other and with reference samples can allow greater validity to an argument.

Fourthly, studying dissemination and audience reception of texts completes the link between social production of a text, its analysis and its receptive effect.

The second and third points indicate the role he sees Corpus Linguistics as playing in the strengthening of arguments based around CDA, a role illustrated in his study of language in two geography textbooks examined from the point of view of evidence for their ideological stance (Stubbs 1994). His criticisms have been acknowledged by some Critical Discourse Analysts, for example in Fairclough's later work he attempts to establish a more theoretical and linguistic basis for the method (Fairclough 2003). There have also been suggestions that Corpus Linguistics may provide a complementary methodology that can provide some quantitative support to the interpretive hypotheses of CDA (Hardt-Mautner 1995; Koteyko 2006; Mautner 2009).

Widdowson, however, has criticised this initiative from the point of view of a defence of Applied Linguistics, which he defines as a discipline that requires that the 'findings from Linguistics can only be *made* relevant in reference to other perceptions and perspectives that define the context of the problem.' (Widdowson 2000: 5). He contrasts this to Linguistics Applied, which he sees as a formal approach with its own worldview. Thus he sees Corpus Linguistics as being unable to explore the ethnographic descriptions of language use; it is 'the description of text, not discourse'(Widdowson 2000: 6). Critical Discourse Analysis, which he sees primarily as making 'inferences about the ideological intent on the evidence of textual features' (Widdowson 2000: 10), he critiques on two main counts. He is concerned that CDA, in order to derive a discourse from a text, requires a recognition of intentionality, raising the question of on what basis intentionality can be ascribed to an author. In addition, one person's assignment of intention may differ from another, especially if one's intention is to 'discover ideological intentions which are deliberately disguised

to persuade opinion'(Widdowson 2000: 11). He thus questions whether one can be sure that the analyst's perspective is preferable to another's 'less informed' perceptions.

His evaluation of Stubbs' (1994) study is based on a view that CDA assumes 'all linguistic usage encodes representations of the world', hence he questions how one knows which aspect of a text to analyse. He further critiques Stubbs' choice of ergativity[1] as an indicator of ideological intent and casts doubt on the necessary link between a grammatical construction and society. In this he very much seems to be in agreement with Stubbs' critiques of CDA itself. Widdowson makes the point that contextual analysis is necessary and difficult as there may be things hidden or left unsaid, deliberately or through an assumption of being taken for granted, hence there are no textual signs to be read off. For Widdowson (and Fairclough) this implies an analysis of the production and consumption of texts, by not doing this one is not 'dealing with discourse at all but only with its textual trace.' (Widdowson 2000: 22).

Stubbs answered these challenges in a subsequent article (Stubbs 2001). Following Widdowson, he first takes Hymes' components of communicative competence in distinguishing what is formally possible, contextually appropriate and actually attested within a language (Stubbs 2001: 151). He then makes the case that Widdowson wrongly characterises Corpus Linguistics by opposing the possible to the attested, rather than seeing it as an investigation into what frequently and typically occurs, the probable. He looks at and acknowledges the problems of interpretation: 'how do you know which words or constructions are relevant to your interpretation of

[1] In Stubbs' terms the ability of some verbs in English to be used either to imply agency or non-agency, e.g. *Brazil has expanded its steel production* and *Britain's cities have expanded outwards*. Stubbs, M. 1996. *Text and Corpus Analysis*. Oxford: Blackwell. P137.

part of a text's meaning?' (Stubbs 2001: 153), but critiques Widdowson's technique of analysis through invented sentences, 'introspective ingenuity applied to invented sentences tells us nothing about what usually occurs' (Stubbs 2001: 156).

He makes the point that context is taken into account in corpus linguistics through the concordance, and that previous work has shown how often only the few words either side can distinguish a meaning or evaluative connotation (Stubbs 1995; Sinclair 1991 and Clear 1996). His view is that it is up to critics to show how and why more context is necessary of the ethnomethodological variety, however this does appear somewhat disingenuous as one cannot fail to bring some 'ethnomethodological' knowledge even informally if one's interpretation is to go beyond the trivial. He acknowledges problems in the relation of how frequency, routine and convention and interpretation interact but cites Krishnamurthy (1996) as taking these into consideration. Further he follows Carter and Sealey (2000) in emphasising how patterns of language use and interpretations are different objects. They claim that linguistic correlations with social variables require an 'analysis of the relations between these phenomenon and the other domains of social life' (Carter et al. 2000: 13). Thus linguistic trends cannot be understood on their own terms but need interpreting through other social models and observations. Therefore Stubbs concludes by summarising three levels of description necessary to uncover ideological functions of a text: individual linguistic features, their function in a textual sequence, and their cognitive or social function. This provides a useful rationale for the methodology developed further in the next chapter.

Regarding Widdowson's critique of Stubbs' own work in combining Corpus Linguistics and Critical Discourse Analysis, he feels firstly that Widdowson did not

represent fully the variety of linguistic features compared in the study and recognises that future research needs to explore :

> *The instance (an individual sentence of an individual text)*
>
> *The norm for the text-type by using comparison corpora*
>
> *The norm for the language (as represented by a large general corpus)*
>
> (Stubbs 2001: 161)

Secondly Stubbs feels Widdowson did not recognise that he was correlating a series of linguistic feature frequencies with the attitudes of authors in two texts. i.e. 'the ideological stance is given' (Stubbs 2001: 162). However he identifies an important dilemma in how a corpus linguistic analysis can seem superficial, while a closer analysis of fewer texts seems ungeneralisable. Additionally he observes a tendency within corpus linguistic interpretation to see counter examples to the statistical norms as explainable on an unrelated set of ad hoc grounds (Stubbs 2001: 168).

From these exchanges it would appear that Stubb's arguments support the analysis of individual linguistic features and their concordances in order to shed light on discourses at work in a corpus of texts. However the role, production and consumption of these texts also needs to be borne in mind, as does their cognitive and social function in order to substantiate the links between text and discourse in society. These points will be taken forward into the methodology described in Chapter 5.

Interim Summary and the Need for Tools to Explore Subjectivity

At this point in the thesis, having examined the issues around personality disorder and the problems inherent in its positivist conception, the possible elements of a methodology to approach the original research question become clearer. In particular, an overall Foucauldian approach would enable a focus on the discourses surrounding the use of personality disorder without necessitating a realist assumption to the concept. Willig's (2001b) methodology might provide a stepwise approach to the analysis and it would be advisable to incorporate methodology and insights from Corpus Linguistics into this process in order to evidence these steps using a representative body of data. Before taking the last step in deciding on a methodology in Chapter 5, a final theoretical exploration needs to take place in order to examine how Willig's methodology might be complemented by a Corpus Linguistic perspective.

Positioning and its role in the analysis

From the theoretical section, a significant body of evidence and opinion suggested a strong link between language used and ideology or discourses at work, however what still needs to be established is a framework for the analysis, both theoretically and methodologically. Willig's (2003; 2001b) Foucauldian methodology, utilising Harre's concept of subject positions, although not well developed in this area, is suggested for consideration. This section aims to explore positioning and subject positions further and to illustrate how these may be combined

with the corpus linguistic method to illuminate the subjectivities implied by language use in corpora of material related to personality disorder.

In the influential *Changing the Subject,* Hollway (1984: 236) introduces the concept of positioning in relation to discourses: 'discourses make available positions for subjects to take up. These positions are in relation to other people'. Thus a particular position does not stand in isolation but rather exists and functions in relation to other positions. For example Harre and van Langenhove (1999: 1-2) indicate that, in positioning someone as powerful others are positioned as powerless. Davies and Harre (1990) acknowledge that Paul Smith (1988), in challenging the idea of a single definable individual subject, first used the idea of subject-positions, "the individual" being understood as 'the misleading description of the imaginary ground on which different subject-positions are colligated.' And the "subject" is seen as a 'series or the conglomeration of *positions,* subject-positions, provisional and not necessarily indefeasible, into which a person is called momentarily by the discourses and the world that he/she inhabits.' (Smith 1988: xxxv).

However, it is Harre and his collaborators who have taken forward the idea of positioning and subject positions and developed it into an analytic tool. In their 1990 paper Davies and Harre (1990) develop their own model of subject positioning. They describe positioning as 'largely a conversational phenomenon' (Davies et al. 1990: 45), a point I will return to later, and that people are positioned through the action of 'discursive practices', again largely seen as interactional phenomena. Their idea of subject positions is introduced through their model of how a sense of self is developed through stages in social learning:

- Learning categories of inclusion and exclusion e.g. male/female

- Participating in discursive practices through which meaning is allocated to these categories, including story lines through which different subject positions are elaborated
- Positioning of self in terms of these categories and storylines
- Recognition of oneself as having characteristics that locate oneself as a member of various sub classes of dichotomous categories and not of others, seeing the world from this position, with an emotional commitment and moral system organised around this belonging (Summarised from (Davies et al. 1990: 47))

These processes are seen as arising in relation to a theory of self as historically continuous and unitary, implied by pronoun grammar. Hence contradictions are experienced as problematic. Subject positions are seen as related to role, being made available by and within a particular discourse (Davies et al. 1990: 53), for example, the two major complementary positions available within the discourse of romantic love, that of the hero with agency and the heroine needing saving.

As mentioned above, a potential limitation of this approach is highlighted by the statement that positioning 'is largely a conversational phenomenon' repeated in the later volume on positioning theory (Davies 1999: 35). Although at first sight this appears to disqualify it from use in textual analysis, later in the same volume, the theory is turned to examine scientific writing (van Langenhove et al. 1999a), cultural stereotypes (van Langenhove et al. 1999b) and national identity (Berman 1999).

Thus van Langenhove and Harre argue that social scientists' written explanations of the world that involve the idea of individual persons, can be seen as acts of positioning, since they are an attempt to account for behaviour and thereby can be investigated as a 'storyline of ...'scientific positionings'.' (van Langenhove et al. 1999a: 103). They further suggest that in such scientific writing there is an implicit act of self-positioning; the claim to authority achieved through the act of publishing itself (van Langenhove et al. 1999a: 107). From this it would follow that the publishing of articles in psychiatric journals about a diagnosis that aims to describe and account for individual behaviour, involves a self-positioning of authority and a corresponding mutual positioning of the subjects of that diagnosis. This is the basis on which the analysis of subject positions proceeds in the analysis chapter.

Lynn Berman (Berman 1999) goes on to demonstrate how positioning theory can be used with an understanding of metaphor to elucidate the relative positions of authority and the populace through an analysis of newspaper articles. She also gives examples of how such positioning can be challenged and bypassed. Thus, although in this thesis the focus will be on what subject positions are made available through the discourses observable within the texts, it is important to note Harre's comments on positioning as a dynamic process (Harre 2002: 284), such that, although positioned as a patient for example, one need not automatically concede expertise and authority to the psychiatrist: 'Positions can be challenged and reassigned in the course of an episode'(Harre 2002: 285).

Before concluding this chapter, a final link is suggested between the concept of positioning and subject positions and actual language use.

Subjectivity, Modality and Factual Statements

Carter and Nash (Carter et al. 1990) argue that writers wish to gain attention and persuade, but not at the risk of displacing the reader from a secure place in the normal scheme of things, hence there is a resort to more subtle methods which can be exposed by analysis, and in which modal expressions play an important part.

Thus in attempting to explore the subjectivities implied by statements around personality disorder and its synonyms, an additional perspective may be gained by looking at factual and modal statements. Thus for example, factual statements might include 'People with personality disorder are/were...', thus giving an insight into implied subjectivities. However further insight could be provided by modal statements such as 'People with personality disorder should/may/might...'.

Modality has recently been defined as the grammatical term referring to 'a speaker's or writer's attitude towards, or point of view about, a state of the world' (Carter et al. 2006: 638). The most significant expression of this is by means of modal verbs, the core modals being: *can, could, may, might, will, shall, would, should, must.* In addition, however, there are semi-modals (such as: *dare, need, ought to, used to*...) as well as verbs used modally (for example: *hope, manage, suppose, seem, wish, want, be about to, would rather, tend to, expect, require* ...) and adjectives, adverbs and nouns (as in: *clear(ly), obvious(ly), seeming(ly), certainty, possibility, probability, necessity*...).

There have been a number of attempts to make sense of the usage of modal expressions in English and these will be briefly explored before looking at how this can be linked to an exploration of subjectivity. Palmer (1990) emphasises a separation

between epistemic modality, to do with language as information, the 'expression of the degree or nature of the speaker's commitment to the truth of what he says' and deontic modality, concerned with language as action, mostly with the expression by the speaker of his attitude towards possible action by himself and others' (Badran 2002: 102-3). Epistemic modality should include speculative, deductive and quotative types of utterances, which can be judgements by the speaker (of inference and confidence) or reports indicating the kind of evidence the speaker has for what he is saying. Thus this mainly illuminates the subjectivity of the speaker/writer position rather than that of the subject or object of discourse, however the latter should be inferable from judgement statements as well as statements of evidence. Deontic modality on the other hand is split into directives – getting our hearers to do things, and comissives – where we commit ourselves to doing things. Both of these indicate a positioning process at work both for the speaker and the object of the deontic statement.

Halliday (1994) looks at modality by distinguishing expressions of probability and usuality as well as obligation and inclination, which also include a dimension of the strength of the modal expression. He emphasises that there is not a simple one to one correspondence between lexical items and semantic inferences, as the context and understanding of speaker positions is vital and ambiguity is inevitable with different readings. Simpson defines modality as concerning 'a speaker's attitude towards' or opinion about, the truth of a proposition expressed by a sentence' and an attitude 'towards the situation or event described by a sentence' (Simpson 1993: 47). He classifies modality as follows:

Deontic: expressing a system of duty and to do with obligation. There is a continuum of commitment, similar to Halliday's, but divided into permission, obligation, and requirement.

Boulomaic: containing expressions of desire, paralleling Halliday's inclination.

Epistemic: expressing the degree of the speaker's confidence in the truth of a propostion expressed (Simpson 1993: 48) and thus similar to the probability category of Hallday.

Perception: regarded as a sub category of epistemic because the degree of commitment is predicated on a reference to perception.

Thus there are grounds for looking towards statements of modality and factuality to illuminate the values and ideology held within a text, however these do depend on a very broad definition of ideology. Further, while much of the literature on modality covers the expression of the writer or speaker's mood, it clearly is also possible to use it to illuminate the subjectivities and subject positions available to both speakers and subjects of statements. Both Simpson's and Halliday's approaches to classifying modals are, as outlined above, very relevant to the exploration of subjectivities, however in the field of analysing medical writing in particular, Vilha (1999) has combined Halliday's (1994) and Simpson's (1993) classifications of modality into three categories of modals expressing – *possibility*, *likelihood/certainty*, and *obligations/recommendations* (Vihla 1999: 51-62). Her work also provides a useful series of lexical lists for different functions of modality, which have been tested on a corpus of varied types of medical writing; hence these lists can be used as the basic

tool of the initial general analysis of modality in the corpus. The application of this to the methodology is explored in the next chapter.

Conclusions

This chapter outlines the problems inherent in making a positivist assumption in order to explore the deployment of personality disorder, and explores alternative models. The discussions around investigations of language use suggest that a corpus-based approach may be relevant, both in evidencing discourses at work and, by using textual data at different time periods, allowing the historical dimension of the research question to be realised.

This suggests a refinement of the research question: what conclusions can be drawn using relevant textual data, about changes in the way in which personality disorder and related concepts have been deployed in psychiatric texts in the UK over the past 50 years. However this then raises methodological questions about how to investigate what language is associated with its use, the links between language use and practice, the debate between saliency and representativeness, and the limits of a textual analysis. While Pilgrim and Rogers (1997) have reservations about discursive and post-structuralist approaches, there is a strong sense in which truth claims about personality disorder cannot be handled in a purely realist fashion, hence such methodologies will run into the very difficulties already inherent in defining the concept itself. To avoid this I am taking a view that what can legitimately be investigated is how personality disorder appears as an object in discourse(s) and the implications of this deployment. Thus in analysing a psychiatric text, for instance,

what personality disorder refers to need not be assumed beforehand, but the tools needed to apprehend this need to be transparent. The theoretical issues explored in this chapter suggest that methodologies derived from Foucault's theories of discourse, provide the most appropriate approach to this question for a number of reasons. They explicitly lay aside the assumptions of a positivist conception of the object of study (Foucault 1972), there is a large body of research in the psychiatric field based on his approach, and there are indications that this approach can be combined with corpus linguistics to evolve a powerful tool to analyse text documents. This will be developed into a practical methodology in the next chapter.

Chapter 5: Developing the Methodology

Introduction

In the review of literature and the considerations of theoretical issues, covered in Chapters 3 and 4, it was argued that an appropriate approach to the research question would involve a methodology which did not have to make the assumption that personality disorder was a real phenomenon imperfectly described by science, and which did not come with ideological preconceptions through which the analysis was performed. It was suggested that a Foucauldian conception of discourses was most fitting and that the concept of subject positions within such an analysis (Willig 2003) provided a way to extend the discourse analysis into the implications for people involved in personality disorder, such as clinicians and patients, without the need to apply a Critical Discourse Analysis perspective with the critiques that this has attracted. Further, it was argued that, to ground the analysis in a wider body of data than is customary with discourse analytic approaches, and to enable a transparent link between the texts and the conclusions, a Corpus Linguistic approach was to be used with corpora constructed with the research question in mind. To explore the historical dimension diachronic corpora can be used, in a similar way to Atkinson's study (1999).

This chapter aims to establish the appropriate corpus linguistic approaches relevant to the refined research question and the Foucauldian Discourse Analysis proposed for the methodology. The key areas explored are the decisions involved in

the construction of the corpus itself and the selection of corpus linguistic techniques appropriate for the analysis of discourses and subject positions.

Linking Corpus Linguistics with Foucauldian Discourse Analysis

Corpus Construction

In constructing a corpus with a particular question in mind, Lynne Flowerdew summarised the issues that should be addressed in building such a specialised corpus (2004: 25-27). These cover the choice of genre or text type, the size of the corpus, the representativeness of the corpus along with sampling decisions that may need to be made and finally any tagging or marking up decisions. In addition, for diachronic corpora, the choice of time periods needs to be justified in relation to the original purpose of the corpora.

In making a choice of material for the corpus O'Farrell notes (2005: 77) that in studying a 'problem' Foucault concentrated on texts that promoted an ideal practice at the time under investigation. Further, Koteyko notes that texts that make a claim to represent a particular discourse should have the following features:

> *they deal with a particular theme ... are interconnected in accordance with the specific purpose of the communication .... are defined by specific parameters such as time period, area, segment of society, or text type ... are*

characterised by .. textual or semantic connections with makes a corpus an intertextual entity (Koteyko 2006).

Thus the texts chosen should have been produced contemporaneously over a particular period and represent an 'official' voice, expressing explicit or implicit views about how personality disorder could and should be seen. This could potentially cover all policy documents and articles in psychiatric and medical journals concerning personality disorder, as well as textbook references, articles in nursing and other health professionals' popular and specialist journals and, in addition, appearances of personality disorder in the media. However, I would argue that the most influential voices are those of psychiatry in shaping the experiences of those with personality disorder in the mental health system, and that there is in fact a lack of material relating to personality disorder in the other areas mentioned above, before the 1990s, while there is significant material in the UK psychiatric journals from the 1940s onwards. Thus the corpus could be selected from articles concerning personality disorder within key psychiatric journals since 1948, as they are uncontaminated with historical recall, not subject to revision after publication and rich in detail. This allows a diachronic focus on the changing discourses, which is most relevant to the research question. The focus on published psychiatric articles for comparison across time also gives some consistency of genre features in the analysis, in effect allowing a mapping of a changing discourse community (Koteyko 2006).

An initial search for material for the corpus thus concentrated on the main journals relevant to UK psychiatry, as well as the two chief general medical journals as outlined below:

Psychiatric:	*British Journal of Psychiatry* (*Journal of Mental Science* – prior to 1964)
	Acta Psychiatrica Scandinavica
	Psychological Medicine (started 1970)
	British Journal of Medical Psychology
	Journal of Nervous and Mental Disease (based in the USA but tended to include often cited articles by British psychiatrists specialising in personality disorder)
	Eugenics Review (containing articles cited in the main journals)
General:	*British Medical Journal*
	The Lancet

Current evidence shows that the *British Journal of Psychiatry* and the *British Medical Journal* are read by a majority of psychiatrists and have considerable impact on their practice (Jones et al. 2004). Three of the other journals are the next most popular general psychiatry journals in this study, while the *British Journal of Medical Psychology* and the *Journal of Nervous and Mental Disease* are included as they often appeared in specialist searches related to personality disorder. Thus these journals represent the dominant arena for innovation and discussion of current issues in relation to psychiatry and mental health throughout the period in question and appear to have been influential in affecting discourses about personality disorder over

this time period. Outside psychiatry, the actual number of articles in publications by other disciplines is lacking until quite recently as shown by a preliminary search in nursing journals.

To sample literature from the whole period would both be impractical due to the large number of texts and also uninformed by events in the wider world. There are a number of historical features in relation to personality disorder that suggest a selection of key time periods from which the corpora could be drawn and which could then usefully be compared. Firstly Rose (1999) and Ramon (1986) see the Second World War as a key period in the extension of psychiatric categories to aspects of everyday life and in particular the emergence of the category 'psychopathy'. Although an exploration of the emergence of personality disorder in textbooks and classification systems tends to throw some doubt on this, the years following the post war period would provide a starting point to the collection of articles. Thus initially searching a period from 1945-1959 in the key UK psychiatric journals reveals a potential corpus of around 40 articles comprising about 90,000 words, which would comprise all the relevant articles within this time period. These preliminary searches show that the following range of synonyms and variations needed to be looked for:

personality disorder, character disorder, disordered personality, psychopath, abnormal personality, trait disorder* (including plurals)

These searches also revealed a number of articles around the 1970s which have continued to be influential and frequently cited, even in the supporting

documents to the current policy (NIMH(E) 2003c). These appear in Appendix 4 along with more details of the strategy and the final corpus compositions. In addition Manning (2000: 632) suggests the late 1960s as a period when aspects of personality disorder, particularly the borderline diagnosis began to emerge as a social phenomenon due to changing societal pressures. These form the core of a further potential corpus around this time period, 1968-1980.

The period from 1995 to the present, allows a collection of articles cited by the recent policy as well as the recent special issues of the *British Journal of Psychiatry* (182 Supplement 44) to be collected together. The growth of articles around personality disorder means that, to keep the corpus size comparable to the first two, more stringent selection criteria need to be applied as described in Appendix 4.

Having made this initial decision to explore articles available within these time periods, the iterative nature of the process of selection is illustrated by the refinement of these periods and the documents included. This is briefly described below for each corpus.

The '1950s': The initial search was performed over the period 1948 – 1961. This selection attempted to capture the post war conception of psychopathy as explored by Ramon and Rose, although from the references of the articles collected initially linguistic usage also included *personality types*, *oligothymia* and *schizosis*, hence a wider selection of search terms was used. This is the period of the founding of the NHS, competing theories of personality and the influence of the dimensional systems of Eysenck and Cattell (Presly et al. 1973: 269), as well as the origins of the therapeutic community movement (Haigh 2002: 65).

Following the database and hand searches, documents were classified according to the following 3 criteria:

1) Is it directly to do with personality disorder or related terms?

2) Does it say something about influences on the development of personality disorder (e.g. Eysenck or Cattell's personality theories).

3) Does it take personality disorder for granted? (e.g. as a category in an epidemiological study).

The final 1950s corpus was then selected by choosing the documents which met all of the above criteria plus the following:

4) Unless the document deals with personality disorder, character disorder, psychopathy, or other synonyms like oligothymia or schizosis in general terms, it is rejected. Hence papers that dealt solely with sub-categories of personality disorder were rejected.

After this process was complete, the actual period covered by the corpus was 1950 to 1961. The 1950s corpus comprised 30 documents with 81,273 words. On looking at the articles, and indeed skimming the titles in Appendix 4 one gains a flavour that this is a period where there may be multiple ways of approaching personality and the deviations that trouble the psychiatric system. Hence this period is also useful in investigating whether the methodology can shed any light on this apparent diversity.

The '1970s': Initially the period from 1968 – 1981 was searched. The current policy and related documents (Moran 2002; NIMH(E) 2003a; NIMH(E) 2003c) cite a number of articles during this time period which have clearly been influential in the

creation of the current concept of personality disorder, hence these were included, along with contemporary articles, in order to give a flavour of how personality disorder was being deployed at this time. The references from these articles also flagged up which of the 1950s articles had been particularly influential and confirmed that all these had already been included in the 1950s corpus thus providing a triangulation for the sampling strategy.

Following database and hand searches, documents were selected according to the four criteria outlined for the 1950s corpus. In addition it was possible to obtain a guide to how influential the articles may have been through the number of times they had been cited since publication. Due to the numerous difficulties in reliably linking number of citations with impact (Seglen 1997), this was only intended as an approximate measure to ensure the most cited articles were included and no conclusions were intended to be drawn about relative citation numbers.

Particular caution needed to be exercised when classifying whether *psychopathic* referred to the widest range of personality problems after Henderson (loc cit) or to its increasing use as a sub-category linked to delinquent behaviour. If the articles focussed mainly on the latter it was rejected from the corpus.

After this process the final 1970s corpus spanning the period 1969 to 1980 comprised 19 documents with 67,123 words, smaller than the 1950s corpus but containing several highly influential documents still cited to this day.

Current time period: 1996-2007: As outlined in Chapter 2, the Russell murders in 1996 and subsequent arrest of Michael Stone led to public debate about the place of personality disorder in psychiatry. Subsequent to this, an extensive policy was

published promoting the inclusion of personality disorder within psychiatric and general medical services (NIMH(E) 2003c), and signifying a marked change in the political and medical status of personality disorder. Hence this time period is of significance both for looking at this change, and for examining what is implied by personality disorder within the documents that surround these events, for practitioners and patients today.

In order to contain the vast increase in articles on personality disorder the 2000 corpus focused on two main journals; the *British Journal of Psychiatry* as the journal read by most psychiatrists and *Acta Psychiatrica Scandinavica* which is also extensively read (Jones et al. 2004) and over this period published articles by several UK specialists of personality disorder, notably Tyrer and Moran, as well as containing regular articles on the Collaborative Longitudinal Personality Disorders Study, the most comprehensive analysis of personality disorder in the UK to date. *The Lancet* and the *British Medical Journal* were also searched but only returned articles on sub-categories of personality disorder, *The Lancet* mainly on Borderline Personality Disorder and the *British Medical Journal* mainly on DSPD. Hence these were not included in the corpus.

The four criteria used for the previous corpora were applied to determine the composition of the core corpus. Likely titles from the journal search that turned out to be book reviews were excluded from the corpus on the grounds of being a different genre. Due to the recent nature of the articles the number of times cited, although included, will be less relevant than the 1970s corpus as some articles have not yet had time to be cited extensively.

The time period covered by the corpus extends from 1998 (post the effects of the Stone enquiry but not the publication of the actual report), until 2007. This gives a core corpus of 29 documents with a count of 86,339 words.

Wordsmith Tools was chosen as the analytic software having been used for other recent studies in the healthcare field (Adolphs et al. 2004; Crawford et al. 1999). In preparing the main documents for analysis as text documents, they lost their graphic character, which is of relevance in a documentary analysis, however they were tagged for sections to ensure that some of the structure was retained. In addition a decision was made to remove all references at the end of each article to retain a focus on the main text of the document. Each corpus comprised between 67,000 and 87,000 words, which is relatively small by current large corpus standard but met the criteria for small specialised corpora used to look at specific research questions (Flowerdew 2004).

A broad examination of the literature over this period suggests that language use of the main concepts of *psychopathy* and *personality disorder* are relatively discrete over this time i.e. in the 1950s it is almost entirely *psychopathy*, in the 2000s it is almost entirely *personality disorder*, and in the 1970s there is an overlap but this period is before the main exclusive use of *psychopathy* as equivalent to anti-social personality disorder, notable in scanning the potential articles of the 1980s. This can be noted this for the later analysis particularly in Chapter 7, however, having constructed the corpora it is now necessary to refine and describe the analytic approach.

Corpus Linguistic Approaches Relevant to Foucauldian Discourse Analysis

As described in the theoretical chapter, the application of corpus linguistic approaches to discourse analysis generally seems to use Critical Discourse Analysis as a framework, creating and comparing corpora from sources that are seen to reflect different ideological positions, for example broadsheet and tabloid newspapers (Bednarak 2005) or different sides of an argument (e.g. smoking (Brown et al. 2005) or fox hunting (Baker 2006: 121-149)). Alternatively a word or phrase is chosen for its ideological relevance and then explored using concordances and keyword analysis, examples are *sleaze* (Orpin 2005) and *risk* (Hamilton et al. 2007). In contrast to these studies I am proposing a new methodology, a ground-up approach, working from an analysis of word frequencies to discourses and then to subject positions. This is akin to Atkinson's (1999) study of scientific discourses, but while he used multi-dimensional analysis of corpus style coupled with Rhetorical Analysis, a different route to evidence discourse is outlined here.

Several studies of corpora focus on an initial exploration of word frequencies (Adolphs et al. 2004; Baker 2006). Stubbs suggests however that word lists thus generated can be divided into lexical and other words, and that the lexical items, in particular nouns, adjectives and verbs indicate the 'aboutness' (Phillips 1989) of the corpus while the non-lexical words reflect more the style of the corpus. Baker (2006: 54) further suggests, in particular, that lexical words provide a way of identifying discourses within a corpus, however he suggests that these need to be supported by

other evidence, such as an analysis of common clusters and in particular the exploration of context through concordance and collocates (Baker 2006: 67-8).

In addition to this Baker (2006: 121-149) and others (Adolphs et al. 2004) utilise lists of keywords, comparing the corpus under study to a large reference corpus, to determine words which occur more frequently than in 'general language use' (Baker 2006: 138). However Baker then uses this in a way similar to Bednarak (2005) above in comparing ideologically pre-sorted corpora and identifying differences, rather than using it to uncover discourses 'from scratch' as he did with the raw frequency data. Further, using keywords as an initial analysis tool may identify word use indicative of discourses that are different from general usage, but may obscure the evidence for common discourses at work in the corpora.

Thus the analysis of the three corpora in Chapter 6 begins with a comparison of raw frequencies of lexical items, in order to make an initial identification of discourses at work. The lexical items are checked using concordances to establish their meaning in context to see if this confirms or disconfirms the initial indications of discourses at work. At this stage there may be evidence for the emergence of some subject positions, which can then be used for the second stage of the analysis.

However in order to take this further into an exploration of subject positions and subjectivities available in relation to personality disorder, the notion of subject positions needs to be developed in relation to the corpus analysis.

In 2002 Harre summarises positions as clusters of 'rights and duties to think, act and speak in certain ways...linked with the kinds of acts that a person in that position can be 'seen' or 'heard' to perform by the use of meaningful signs' (Harre 2002: 154).

When positioning is used to analyse texts or groups of texts, it is at the level of the statement that the evidence is found (Berman 1999; Sykes et al. 2004). These statements are not necessarily based on a sentence, rather they are the text/context surrounding particular key words, for example in Berman's study the phrases *third parties, outside influences* and *groups* reoccur to help position those inside and outside the established order (Berman 1999: 148-9). Further, as discussed in Chapter 4, numerous studies in Critical Discourse Analysis depend on such levels of statement analysis. Applying this to the personality disorder corpora, what is proposed is an analysis of the statements surrounding the commonest positions evident from the noun analysis, namely *subject/s, psychopath/y/s/ic, and personality disorder/s.*

The concordance lines provide a direct way of accessing these statements in each corpus, however, in order to make sense of the potentially large amounts of data in terms of positioning, it would be useful to first classify the statements on the basis of the essential components of a subject position as established by theorists in the field. As a first step towards this Harre's and Davies' view of what comprises a subject position can be summarised as follows:

- A categorisation of the position - its name, its characteristics
- A set of rights and duties to think, act and speak in certain ways (Harre 2002: 154),
- These are linked to acts that a person can be seen and heard to perform.(Harre 2002: 154)
- A moral system organised around the belonging to the position (Davies et al. 1990: 3)

- A story line which elaborates subject positions and in which the subject position acts as a character description (Davies et al. 1990; Harre 2002: 154)

While the first four of these seem applicable to subject positions derived from texts, the concept of story line may be problematic as it functions in the theory, largely in interactions, for example positioning people in talk as victim and rescuer. This suggests that, to investigate a position around a discursive object, statements should be sought that illuminate the following categories:

The attributes of someone in this position

The acts that can be performed from this position

The degree of agency available from this position

The moral system that stems from this position

With these in mind the following classification system for statements is proposed, after an initial pilot examination of *subject/s* in the 2000s corpus (Appendix 21), followed by an examination of *the psychopath* in the 1950s, described in more detail at the beginning of the Chapter 7. From this analysis there was an initial division of statements between those that concern the individual and are therefore related to positioning, and those that do not, but may still be of relevance to the analysis. These latter statements seem largely to concern conceptual issues around in this instance psychopathy and hence were collected under **Conceptual Issues.**

The statements concerning the individual were then classified as follows:

Categorisation: - **Diagnostic** e.g. what medical category the position may be described as

Groups e.g. gender, age, social class

Attributes: -	**Psychological** equates to the personal attributes of a position
	Social effects on society or others e.g. criminal convictions, effects on services
Physical:-	equates to the embodied category above and includes brain damage or development
Behaviour:-	equates to what acts can be performed from this position
Agency:-	**Acting on the world**
	Being acted upon – Treatment, assessment, object of study

What are clearly missing from this categorisation are the moral aspects implied by the position. From the pilot described in Appendix 21, these do not seem to be directly represented by statements within the concordance lines, however, it is suggested at this stage that the analysis and discussion using the existing categories will enable these areas to be filled in. This is in keeping with the exploratory nature of this methodology. Part of the purpose of the analysis is to determine whether the classifications can be applied at all to the statements in the corpora and further, whether the resultant groupings of statements actually illuminate subject positions. It was also suggested that examining modal and factual statements may also inform positioning at work in the corpus. As outlined in Chapter 4, there have been numerous attempts to classify English modals, however, for this analysis, Minha Vilha's (1999) exploration of modality in medical writing is used. This part of the analysis would therefore involve an investigation of the occurrences of factual statements within the corpus along with modals, based on Vilha's word lists as follows:

For expressions of possibility (Vihla 1999: 51):

can, could, may, might, maybe, perhaps, possibly, possible, possibility

For likelihood/certainty (Vihla 1999: 56):

appear, seem: apparently, certainly, clearly, definitely, evidently, likely, (adj+adverb), obviously, plausibly, presumably, probably, supposedly, surely, undoubtedly

For exploring obligations and recommendations (Vihla 1999: 62):

advice(-se,-able), contraindicate (-tion), demand, indicate (-tion), must, need, oblige,(-ation, -atory), of choice, permit (-ission), prohibit (-ion, ive), recommend (-ation), require (-ment), should

This approach is developed and applied in Chapter 7.

It is thus proposed that the corpus linguistic techniques support the Foucauldian analysis at each stage, from the exploration of which discourses may be shown to be at work in relation to *personality disorder* and *psychopathy*, through the identification of subject position and towards textual subjectivities. While, as Willig acknowledges, the latter parts of the analysis become more speculative, the inclusion of corpus data at these stages, enables both a transparency to the argument that is sometimes lacking in discourse analysis and a representativeness that is not possible using smaller bodies of data. Further, even the most speculative part of the analysis, the implication of the usage of personality disorder for practitioners and users of psychiatric services today, which attempts to move beyond psychiatric texts, does

appeal to the analysis of a significant amount of identifiable data within the texts to support its conclusions.

The following Chapter will now proceed with the lexical analysis of the three corpora to examine evidence for discourse and discourse changes. Chapter 7 will explore the evidence for subject positions and subjectivities. The evidence from these chapters will then be brought together in the analysis of discourses and subjectivities utilising Willig's method in Chapter 8.

Chapter 6: Analysis of Lexical Trends in the Diachronic Corpora

Introduction

In this chapter the initial analysis of the three corpora is approached through a comparison of the most frequent raw word frequencies, as outlined in the previous discussion of methodology. Nouns are explored first as indicators of the 'aboutness' of each corpus and their commonest meanings in context are obtained through an analysis of their concordances and collocations. These are then used to suggest some of the discourses at work within the bodies of articles. The changes in frequency of these nouns, both in their absolute values and using a test of significance, are then analysed and an initial indication of discourses changing over time is discussed.

Applying Willig's overall framework for Foucauldian analysis (Willig 2001b), these steps correspond to Stages One and Two. Thus the discursive constructions in the text relevant to the research question are identified through the most common nouns, which also identify the commonest synonyms of the primary object of study *personality disorder*. In the second stage the noun analysis then gives an indication of overall discourses at work within the text, that are contributing to the construction of the discursive object, in this case personality disorder and its synonyms.

This same process is then followed for adjectives and verbs, also cross-checked through concordances for meaning. This provides further indications of discourses at work and also helps triangulate the initial findings. It is to be noted that this chapter is not written as the description of a finalised and fully tested

methodology, as such a methodology does not yet exist for the exploration of discourses in corpora. Instead the intention is to give an account of how the analysis proceeded from an initially wide exploration of the corpus, the findings of which then guide and inform subsequent investigation. Thus, as the analysis progresses the number of potential avenues of exploration increases, in particular the possibility of more detailed concordance examination of trends and differences in word usage. Given the limitations on space and the large amount of data that a corpus analysis can potentially develop, it will not be possible to follow all these avenues, however what is examined and to what depth is guided by the search for discourses relevant to personality disorder.

As this is a developing methodology, these processes are described much more fully than would be the case for an established approach, in order to illustrate and evidence the reasoning at each step. The transparency of the method, it is hoped will allow other researchers to utilise what appears to work best and, in the concluding chapter, there are reflections on and recommendations for future methodologies in this area. This chapter is thus mainly a description of the lexical patterns observed with some comment; these are then summarised with a more in depth analysis in Chapter 8, following the analysis of subject positions in Chapter 7.

As a note, when talking about the corpora the phrase '2000s' is sometimes used interchangeably with '2000s corpus', and similarly with the other decades. This is purely for shorthand and in this chapter is not meant to represent any conclusions about the actual decade.

Lexical Analysis of Commonest Nouns in the Diachronic Corpora

To gain an initial picture of each corpora a word frequency list was compiled for each corpus using Wordsmith Tools. The 100 most frequent words for each corpus are shown in Appendix 5.

Examining these some broad observations can be made. There are a number of words common to all the corpora which comprise the grammatical words like *the, and, of* etc, that are common in all bodies of English (Baker 2006). There are also certain words like *personality, treatment, patient(s)* that are common in each corpus and give an indication of the most frequent subjects of interest. In terms of discursive constructions, *Psychopath/ic* seems to fall out of the commonest usage after the 1950s corpus, while *personality* and *disorder/s* becomes extremely common in the 2000s corpus. In passing, the presence of *e* in the 1970s is due to the occurrences of *i.e.* and *e.g.*, while the frequency of *p* in the 2000s is due to the 147 instances of reporting significance values in this corpus, compared to 31 in the 1970s and 4 in the 1950s corpora.

However with this relatively unsorted data, it is difficult to gain a clear picture of what themes may be present and what significant and salient changes may be occurring between corpora. Hence an initial exploration of the commonest nouns in each corpus will both reveal the 'aboutness' of the individual corpora (Baker 2006: 55) and will begin to identify the discursive constructions (Willig 2001b: 109) present in the texts, which were initially chosen to represent psychiatric statements about *personality disorder* and *psychopathy* in general. The meanings of the commonest

nouns can then be clarified through analysis of concordances to show the context of their usage and then they can be grouped into themes representing the first attempt to uncover discourses at work in each corpus (Baker 2006: 54), thereby moving to Stage 2 of Willig's analytic approach (Willig 2001b: 109-110). In this way the selection criteria along with the corpus analysis of nouns enable a link to be made between the subject of the texts and the discourses represented by the commonest noun usage in the corpora.

A table of the top 52 nouns for each corpus is shown in Appendix 6. These give an immediate impression of some similarities in what the corpora are about, as *personality, patient*, treatment, study*, are very frequent in all corpora. It is also immediately noticeable how *personality* is the most frequent noun in all corpora, but further, that it becomes by far the most frequent over time, along with *disorder**. In addition, *psychopath, psychopaths* and *psychopathy,* appear to be common in the 1950s corpus and to a lesser extent in the 1970s, but have disappeared from the top 52 by the 2000s corpus.

In Willig's terms these patterns begin to point to particular discursive constructions of the object of study, but to uncover these further, and to confirm if the rise in *personality* is linked to the increasing use of the phrase *personality disorder*, Wordsmith Tools provides a means to look at the most common word clusters in the corpora.

A comparison of the first 40 2-word clusters between each corpus is included in Appendix 7. This confirms that the rise in frequency of *personality* is linked to the increase in its use with *disorder/s*. By the 2000s corpus 1086 usages of the 1359 occurrences of personality occur in this formulation, and it is clearly also an

increasingly common usage in the 1970s corpus. However, the 2-word clusters also indicate that *abnormal personality* is also a common discursive construction in the 1970s corpus. It is also of note that *the patient/s* in the 1950s and 1970s corpus, and *patients with* in the 1970s and 2000s corpus are common 2-word clusters that may be worth exploring as possible subject positions.

This initial view of the corpora gives an indication of the varieties of discursive construction of the main object of study, and that these appear to have changed over time roughly as follows:

In the 1950s: *psychopath/s, psychopathy*

In the 1970s: *personality disorder/s, abnormal personality, psychopaths*

In the 2000s: *personality disorder/s*

Categorising the Commonest Nouns in Each Corpus

One of the major challenges in corpus analysis is dealing with the potential amount of data that can be generated, both in terms of selecting which techniques to apply, and in sorting that which is produced in order to make it accessible to interpretation (Baker 2006: 178). In order to make more sense of the noun frequencies in each corpus, a first step was to see whether the commonest nouns can be grouped into any broad themes, based on their meanings in context, determined through examination of their concordance lines and collocations (Baker 2006), in a very similar way to corpus based lexicographical examinations of meaning (Carter et al. 2006). In some cases a limited number of collocates clarified a usage as in the case of *body* in the 1950s corpus. More often, many different words would collocate in L1

and/or R1[2] but these would fall under similar broad themes such as medical usage as in the case of *terms* below.

In going through this process with the 1950s corpus most of the most frequent nouns fell into three main categories namely, Terms Relating to Personality, Medical Usage, and Statistical/Measurement Approaches. Those that did not appear to fit these easily were collected in a separate category for further analysis.

This initial very broad categorisation is shown in Table 1. The comments following a word refer to the observations from the examination of the concordance lines and are intended to clarify the decision making process in categorising these nouns. These lists are arranged alphabetically.

Table 1: Initial Categorisation of the Most Frequent 52 Nouns in the 1950s Corpus

Terms relating to personality
character
personality
psychopath/psychopathy/psychopaths
state – usually *emotional* or *psychiatric state*, sometimes preceded by *psychopathic*, occasional use of *state of USA*.
traits
type/types

Terms relating to medical usage
behaviour – largely negative and relating to personality diagnosis– e.g. *abnormal/ antisocial/criminal/sexual/unpredictable/wayward*
body – almost entirely *body size/build/type* – relating to theories of personality and body type.
diagnosis
case – 77 out of 118 relate to a medical use of *case*, the remainder are *case* as example
cases – 124 out of 130 relate to a medical use of *case*

[2] These refer to the number of words to the left and right of the search word within which the collocates appear.

hospital
intelligence – mixture of usages both as a factor in studies but also in discussions of intelligence and psychiatric conditions – therefore straddles the categories but there were more appearing with the psychiatric usage.
man – largely used to describe individual cases
patient/s
treatment
symptoms
service
terms – 32 out of 69 were *in terms of* and in this sense largely related to describing psychiatric concepts - the rest were largely about terms as defining a concept, also mainly psychiatric
years/age – largely to do with patient ages or time periods of treatment or illness, very small amount to do with times of study or testing

Terms relating to statistical/measurement approaches
analysis
data
differences – collocates with *significant, between, individual, group* and *sex,* in the sense of measuring differences.
number – collocates frequently with *of* and often refers to studies e.g. *number of studies/variables/intercorrelations/sets of factors* etc
fact – 24 occurrences of *in fact* and 30 of *the fact that* out of 67 total. Nearly all relating to discussions of studies
factor/factors
measures – largely concerning test/diagnostic and personality measures
men – largely used to describe aspects of a study *men and women, hysteroid men*
results
study
table – all referring to Tables in the articles
test/tests

Words that do not fit into the above themes
individual – largely *the* or *an individual* as part of discussion sections
life- collocates with *adult/civilian/home* – 7 instances of *purpose of life* from one author. – in the former senses it is used in medical descriptions.
normal – varying usage in the senses of usual/ good mental health/ control group.
people – usually talking about a group of people defined by a characteristic – *young, these, other, most, normal*
problem – 56 examples with varying usage mainly as *the problem*
self – almost entirely hyphenated and descriptive– *self-deprecating/ centred/discipline/dissatisfaction/esteem/evaluation/gratification/pitying/respecting*
time – very varied usage including some idiomatic
work – three main senses – work as employment, work of an expert or school of thought, psychiatric work
one/two/three

Observations on noun usage in the 1950s corpus

At this stage it would be premature to begin to deduce what discourses may be operating from these initial themes for a number of reasons. Firstly the categories are of different natures and have different functions. For instance, the first category is primarily a linguistic one in that it lists different ways that personality is talked about, in order to track how this may change over the corpora. Secondly, while terms relating to medical positioning may strongly indicate a medical discourse at work and the terms relating to statistical and measurement approaches do show the prevalence of this type of language, it would be useful to triangulate these initial impressions with further data. Thirdly, and following from the last point, there may be more subtle variations of medical and statistical discourse that can be distinguished as the analysis proceeds. Fourthly and finally, the process of comparison may help to further understand what is being observed. At present these findings stand in isolation and their meaning can only be drawn out through measuring them against something else, at this stage, largely one's own knowledge of the field. As described in Chapter 5, it is proposed that this understanding is enhanced through comparing the corpora from the three time periods with each other.

However, notwithstanding these objections, some preliminary thoughts can be ventured. Some words which initially do not seem to fall into the three main categories, on further examination do appear to fit them in much of their usage. For example, both *people* and *individual* are used to indicate categories for the purposes of psychiatric discussion. Other words are revealing of potential discourses themselves and would warrant further investigation. Thus *life* and *work* while used in

this medical context have an everyday feel to them in their usage; a sense that a lay discourse is allowed into these texts. Further, *problem/s* may be of interest to investigate in more detail as it may indicate the changing sites of problematisation over the corpora. These points will be picked up later as the analysis proceeds.

This same process can now be applied to the 1970s corpus and the results are shown in Table 2.

Table 2: Initial Categorisation of the Most Frequent 52 Nouns in the 1970s Corpus

Terms relating to personality
personality/personalities
psychopaths
traits
type/types

Terms relating to medical usage
admission
anxiety
attempts – very common collocation with suicide
behaviour – overwhelmingly negative and clinical in its 141 instances – e.g. *abnormal* (5), *antisocial* (4), *criminal* (3), *destructive* (7), *manipulative* (8), also *impulsive, immature, violent* and *psychopathic.*
diagnosis/diagnoses
disorder/disorders
degree – used mainly in the clinical sense of *degree of abnormality, symptom severity* etc, but also used sometimes in a statistical sense e.g. *degree of inter-rater reliability.*
hospital
illness
patients/patient
psychiatrists
relationships – of its 63 occurrences this has commonly collocates with *personal* (22) and *interpersonal* (12), and with *disturbance* hence it is classified under medical, as its usage is in describing elements of a diagnosis.
symptoms
terms – 34 were in the form *in terms of* and related to psychiatric discussions of behaviour or symptoms, also 6 occurrences of *diagnostic terms*
time – a more consistent usage than in the 1950s corpus, relating to studies and to clinical descriptions, but with more frequent examples of the latter
treatment

Terms relating to statistical/measurement approaches
agreement – overwhelmingly about agreement between scores
age – mainly in relation to studies – *age of onset, age on admission* etc
analysis
factors/factor
items
level – mainly about levels of *agreement, reliability* and *significance*
men – this mostly referred to men in studies
number – 16 out of 61 were in the form of *a number of* and 8 of these referred to discussions about clinical issues, the remainder of these and the rest of the occurrences of *number* related to statistical studies.
reliability
results
scale
scores
study
table – all referring to tables illustrating aspects of studies
years – mainly about age of participants in studies, but a small proportion relating to case studies
year – predominantly studies – *x year period/follow up* etc.

category/categories
classification
criteria
group – 288 instances almost entirely relating to studies
groups – 104 also relating to studies

Words that do not fit into the above themes
people – a usage of shorthand for the social world – *relating to other people, most people* etc.
one/two/three

Observations on noun usage in the 1970s corpus

What is immediately apparent is that more of the commonest nouns in the 1970s corpus fit into the three categories developed in the 1950s corpus. Further there appears to be a distinct increase in statistical and study language, as well as a case for separating language around categorisation from that of statistical study. This has not been done at this stage as the analysis of the 2000s corpus may suggest

further or different discriminations. However there are indications of the development of a nosological discourse obsessed with naming.

With this in mind the 2000s corpus can now be approached.

Table 3: Initial Categorisation of the Most Frequent 52 Nouns in the 2000s Corpus

Terms relating to personality
personality/PD/BPD
people – people with personality disorder 45 out of 89 were of this form, other usages of *people* were usually to identify a medical group, with some usage as referring to the general population.

Terms relating to medical usage
assessment
costs
diagnosis/diagnoses
disorder/disorders
DSM/axis/cluster
health
outcome
patients/patient
prevalence
risk - of the 106 instances, 53 concerned *risk factors*, 13 were around *high risk* and *risk to the public*, 4 were *suicide risk*, and the remainder were about the medical risk of developing a condition
suicide
treatment

Terms relating to statistical/measurement approaches
analysis
data
events – many *life events* but also *negative/positive/stressful events* and almost entirely related to measurement scales.
factor/factors
findings
functioning – very varied collocations but almost entirely as an operationalised variable in studies – *psychosocial functioning score*, *adult personality functioning assessment* etc
informant
mean

model – used extensively in relatively few texts, 125 instances in 4 texts – these mainly relate to theoretical models of personality disorder, with only 9 instances of *models of care* or *service.*
number – almost entirely *number of x* where x varied in content but whose theme was studies e.g. x=*categories, limitations, patients, stressors, studies ...*
research
results
sample
scores
self – hyphenated in all its usage and several common collocates – *self-defeating, self-report (measures), self-transcendence* – these all were formulaic uses relating to scales of measurement. There was a smaller but significant usage as a clinical term in self-harm.
study/studies
subjects/subject
years – almost entirely to do with details of ages in studies

categories
criteria
group/groups – mainly to do with research

Words that do not fit into the above themes
life – 52 out of 103 were *life event/s* and mainly related to scales although the phrase was also used descriptively, more in the singular, the rest were mainly relating to scales *life experience/expectancy/satisfaction*, although around 20 remained a lay usage of life as in *time of life* and so on. Only 2 were *quality of life.*

problem – 48 of the 88 were *problem-solving* and often *social problem solving* therapy, however there were also significant amount of the *problem with classification, treatment* etc.

time – less consistent usage compared to the 1970s corpus, with a lot of idiomatic usage such as, *over time, at this time.*

two/one/four/three

Observations on noun usage in the 2000s corpus

This analysis seems to support the hypothesis of increased statistical and measurement language, as well as a continuation of the categorisation discourse. Further there seem to be differences in the medical language between the 1970s and

2000s. These issues are explored in the next section where changes in noun use between corpora are explored in more detail.

It is also of note that in the 2000s corpus some subject positions seem to emerge such as *people with personality disorder* and *subjects*. These are explored in more detail in the next chapter through closer analysis of concordances. Positions implied by labels such as *patients* seem to have been in frequent use since the 1950s however we can examine the concordances to see whether the actual usage can shed any light on how their deployment may have changed.

It is of note that *self, problem* and *life* make a return to the most common nouns in the 2000s corpus, but that there is much more formulaic usage than in the 1950s corpus, e.g. *self-report, problem-solving* and *life-events*.

Exploring Changes in Noun Usage From Corpus to Corpus

Another way to uncover changes in the use of nouns over the three corpora is to look at which words have moved in and out of the top 52 words from corpus to corpus. The first 52 most common nouns from each corpus comprise a total of 97 different nouns. In order to begin to bring out changes over time the words that change from corpus to corpus are shown below, grouped using the categories outlined above, and omitting number words which did not appear to correspond to particular discourses.

Words appearing in the 52 most frequent nouns in the 1970s but not in the 1950s corpus.

personalities

admission, anxiety, attempts, disorder, disorders, degree, illness, psychiatrists, relationships,

agreement, items, level, reliability, scores, scale, year,

classification , category categories, criteria,

Words appearing in the 52 most frequent nouns in the 2000s not in the 1970s corpus

PD, BPD

assessment, axis, costs, cluster, diagnoses, disorder, DSM, health, outcome, prevalence, risk, suicide,

events, findings, functioning , informant, model, sample, subject, subjects, studies

criteria

Observations

These trends again speak strongly for the case of an increase in statistical talk in the texts as well as concerns about categorisation, which can be taken forward into the more rigorous part of the analysis to follow.

Additionally in the medical category, in the 1970s a group of words appears more frequently for the first time – *admission, disorder/s, illness, psychiatrists.* This could indicate a prominence of what might be termed a traditional medico/psychiatric discourse, focusing on a model of disease process and hospital. These have largely disappeared from the top 52 by the 2000s apart from *disorder/s* possibly indicating submergence rather than a disappearance of this discourse. What comes to the fore in the 2000s is a focus on the diagnostic manual (*DSM, cluster*), identification

(*assessment, prevalence, risk*), and product (*costs, outcome*). In many ways, given the evolution of the health service in the UK, this is not surprising, however it is of note that these are occurring, not in public or policy journals, but in specialist psychiatric journals, indicating the discourse of health economics has thoroughly penetrated the clinical world.

The influence of DSM in the 1970s corpus is not readily evident in the noun analysis, as though the DSM-III took a while to filter through to acceptance, however by the 2000s it seems to be very dominant and prevalent in its usage.

Another feature of note is the pluralisation of *personality* and *disorder* in the 1970s and then *diagnosis* and *disorder* in the 2000s. One could hypothesise that there is an increasing elaboration in the talk about personality in response to the studies made and the categorisations developed, however we need further analysis to support this conjecture.

Within the theme of statistical/measurement approaches we can see the rise of *findings, model, studies* tending to suggest a referral back to earlier work, a sense of the developing field but also a sense that it is going in a particular direction, with the rise of *functioning, informant, sample, subject/s* which represent a highly classically psychologised way of working with operationalised variables and experimental subjects. We can investigate later what this may imply for subject positions.

In the terminology used to describe the subject under study, we can see a falling away of favour with the term *psychopath* and also the description of *personality* in terms of *states, traits* and *types*. However we also see a narrowing of the way in which personality is talked about, as *character* disappears from the top 52

and by the 2000 corpus the only remaining popular phrase is *personality disorder/s,* which numerically is extremely dominant.

Analysis of Trends in the Commonest Nouns in the Diachronic Corpora

The changes in absolute frequencies of these 97 nouns can now be compared across the corpora, with a view to seeing whether this provides any insight into discourses at work and changing discourses over time. This part of the methodology is based on the lexical analysis of workers such as Baker (2006; 2008), Stubbs (1994) and Krishnamurthy (1996), as well as the suggestions for combining discourse analysis with corpus linguistics proffered by Hardt Mautner (1995), Stubbs (1997; 2001) and Koteyko (2006) and its use in the health setting by Adolphs et. al. (2004). However there are two elements that are new in the application to discourse analysis. Firstly the examination of noun trends across three genre-consistent corpora, whose contexts and contents have been selected with a precise research question in mind, is presented in graphical form, themed according to the direction of the trends in frequency. Secondly it is argued that these representations of trends provide an insight into the movement of discourses over time, backed by more representative data than is usually the case with such claims.

In methodological terms, all 97 nouns, excluding the numbers, are followed across each corpus. The raw frequencies and relative frequencies, expressed as Words/1000, are listed and then grouped according to how the latter changes over time. Given that between one corpus and another the measure of Words/1000 can

either increase, decrease or stay the same, there are nine possible sets of variations across the three corpora as shown in Table 4 below.

Table 4: Possible Permutations of Change in Word Frequency Between Corpora

Change in Words/1000 from 1950s to 1970s corpora	Change in Words/1000 from 1950s to 1970s corpora	Title of Graph
up	up	Nouns increasing in frequency
up	same	Nouns increasing in frequency only from 1970s corpus
up	down	Nouns peaking in frequency only in 1970s corpus
same	up	Nouns increasing only from 2000s corpus
same	same	Nouns remaining unchanged in frequency
same	down	Nouns decreasing in frequency only from 2000s corpus
down	up	Nouns dipping in frequency only in 1970s corpus
down	same	Nouns decreasing in frequency only from 1970s corpus
down	down	Nouns decreasing in frequency

The data for the trends in the most frequent nouns are shown in Appendix 8 and the plots are shown in Appendix 9, but will also be reproduced in this section to aid the reader. Most changes involve a range of around 0-2 Hits/1000, but a few words markedly exceed this range and these are plotted separately in order to display changes in an accessible fashion (Appendix 9, Graph 1). Thus the discussions of each graphed trend below also refer to nouns included in this plot.

Examining the groups of graphs in Appendix 9 as a whole, the first thing to notice is that very little stays the same. There are continual changes between corpora such that the type of language used changes drastically. As an example *personality, disorder* and *disorders,* change too much over this period to be included on any of the graphs without rendering other noun changes unreadable, and hence are included in the table below to allow a brief discussion.

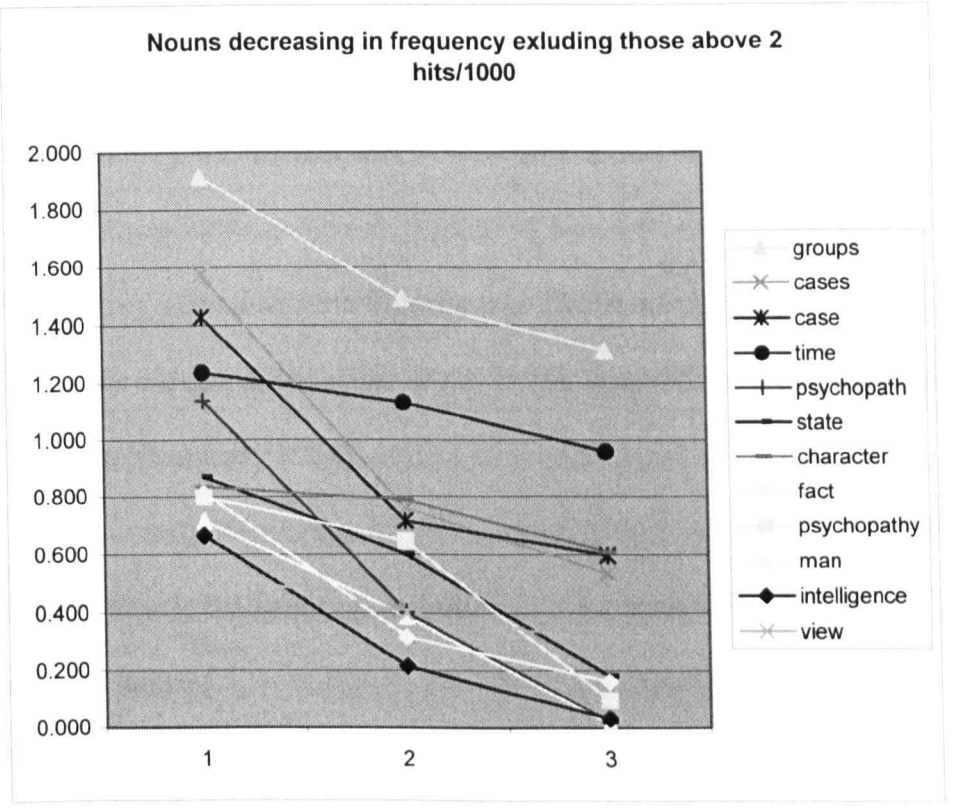
Table 5: Changes in Frequency in Hits/1000 of *personality* and *disorder/s*

Noun/Hits/1000	1950s	1970s	2000s
personality	4.60	10.61	14.51
disorder	0.53	4.22	10.40
disorders	0.38	1.81	6.95

When the concordances of these are examined it is found that, in the 1950s corpus *personality disorder/s* is not used at all, despite its appearance as a diagnostic category in the first DSM of 1952 (although 'Disorders of Character' is preferred in the ICD 6 of 1948). In the 1970s there are 185 appearances but by 2000s there are 720. Similarly *personality disorders* occurs 94 times in the 1970s corpus and 366 in the 2000s. Further, *personalities,* which is prominent in the 1970s corpus, has almost disappeared by the 2000s corpus and was not that frequent in 1950s. The concordance in the 1970s shows a particular usage as *abnormal/hysteroid/ psychopathic personalities,* which appears very similar to the 2000s use of the singular form. Thus it is clear that not only has *personality disorder/s* become the main way of expressing this concept, but by the 2000s it has become the only way, a feature discussed further in Chapter 8.

The other trends will now be discussed with the proviso that, on examining the noun changes, there are five main trends out of the possible nine, namely: nouns decreasing over time, increasing over time, dipping in the 1970s, peaking in the 1970s and those increasing only from the 1970s to the 2000s.

Nouns decreasing over time (Graph 2, Appendix 9)



(Note that in this and the subsequent graphs the corpora are represented as follows; 1 = 1950s corpus, 2 = 1970s corpus, and 3 - 2000s corpus; the y axis scale is Hits/1000)

Looking at this graph alongside the graph of nouns with frequencies over 2 Hits/1000 (Graph 1, Appendix 9), we can see that there is group of words that falls almost into disuse by the 2000s corpus, namely:

type, intelligence, man, psychopath, psychopathy, fact, state

Other changes are more modest but there is still a notable falling off of *case* and *cases*. In order to investigate these changes further, the actual usages of these nouns can now be explored from their concordances and collocations.

From the concordance most examples of *man* occur in descriptions of case histories hence we can hypothesise that the decrease may be due to a decrease in the use of these and, further, by its replacement elsewhere by an ungendered *people.* For instance this is not a phrasing that one would come across in 2000.

> *The man of normal test-intelligence who kills a man for his new suit and leaves his old one at the scene of the crime, is a striking example of this sort of defect.* (Kennedy 1954)

Also of note is the gender distribution of the corpus with 8 occurrences of *woman* to 59 of *men.*

Given the selection of the material for the corpus, *psychopath/y, type, state, case* and *cases* are particular ways of describing the subject of study. In order to gain a sense of what may be being deployed when they are used in the 1950s corpus we can explore their commonest collocates searching between L5 and R5, thus:

psychopath – the, is, may, the term, inadequate, aggressive

psychopathy – the, is, central fact, clinical

type – sub, personality, is, was, depression, found, self, anxious, rigid, schizophrenic, inadequate, body, contains, depressed, paranoid, aggressive, depressive, psychology

state – of, patients, hospital, anxiety, personality, is, are

case – was, is, in the ... of, personality, note/s, data, would

cases – per cent, were, are, such, these, correctly, presented (also frequently associated with a number)

These positions will be explored in much greater detail later in the chapter through the analysis of the concordances, and *psychopath** will be covered more in Chapter 7, in the analysis of subject positions. However even at this stage we can gain a sense that there are particular negative associations with *psychopath,* and that *psychopathy* may be used in a different way for conceptual discussions. *Type* seems particularly associated with sub categories of personality disorder and other mental illnesses, as all its uses occur with contemporaneous DSM diagnoses. The fall of *case/s* may well be associated with the reduction in case history descriptions mentioned above, but will be examined in context later in this chapter, and the overall picture may gain more meaning when compared with the equivalent expressions in the later corpora.

The falling off of *fact* seems to be largely to do with assertions of authority. Its usage is mainly *in fact* and *the fact that* as well as *the central fact of psychopathy* (1950s only). In the 2000s corpus it is used only 15 times and these are mainly in relation to displaying evidence from studies, thus:

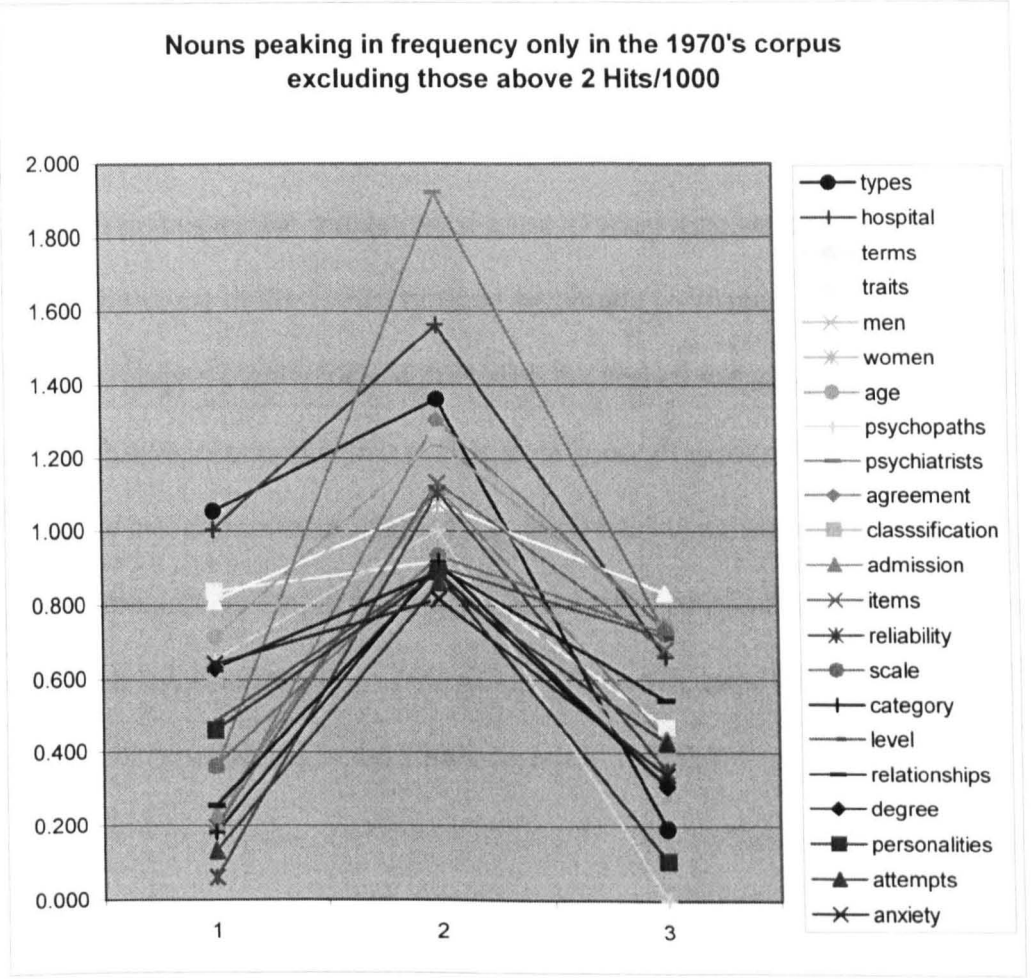
> *This may in part reflect the fact that the APFA was administered to the subject or informant before the M-PAS so may have influenced it,*...(Hill et al. 2000)

Compare this to the 1950s where it is used to enhance the authority of the writer as in the example below:

Treatment of the patient by the physician alone is in fact a sheer waste of time. (Sturup 1952)

From the Other Trends graph (Appendix 9, graph 3) we can also see *body* disappearing after the 1950s in response to the falling off of interest in body build and personality. Also *work* is most frequent in the 1950s and this will be examined later.

Nouns peaking in the 1970s (Graph 4: Appendix 9)



This is the densest section of data hence it is chosen next for analysis. Out of the graph we can identify a number of words, which become very prevalent in the 1970s but fall out of use by the 2000s. These are:

psychopathy, personalities, types, degree, normal, anxiety, reliability

A number of others show a sharp rise in the 1970s, these are:

Patients, group, illness, symptoms, behaviour, psychiatrists, hospital, agreement, classification, items, traits, admission, scale, level, relationships, terms, classification, attempts

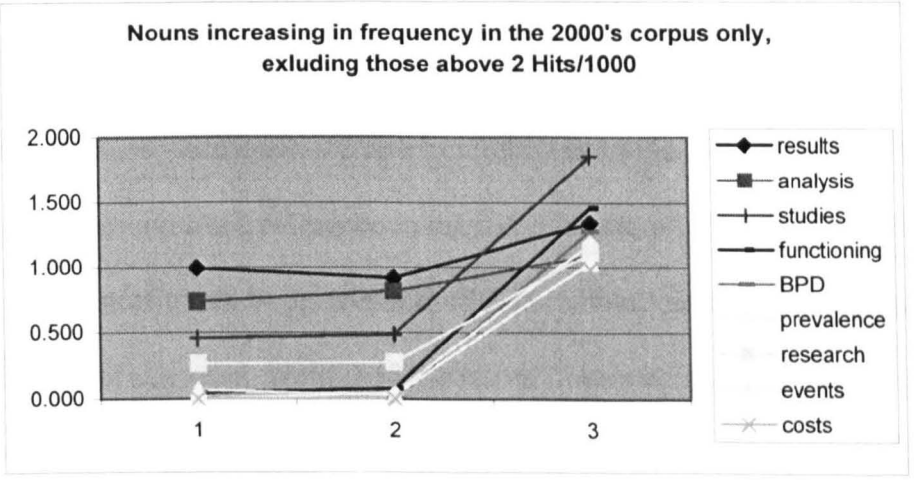
Also *diagnoses* from the Other Trends graph.

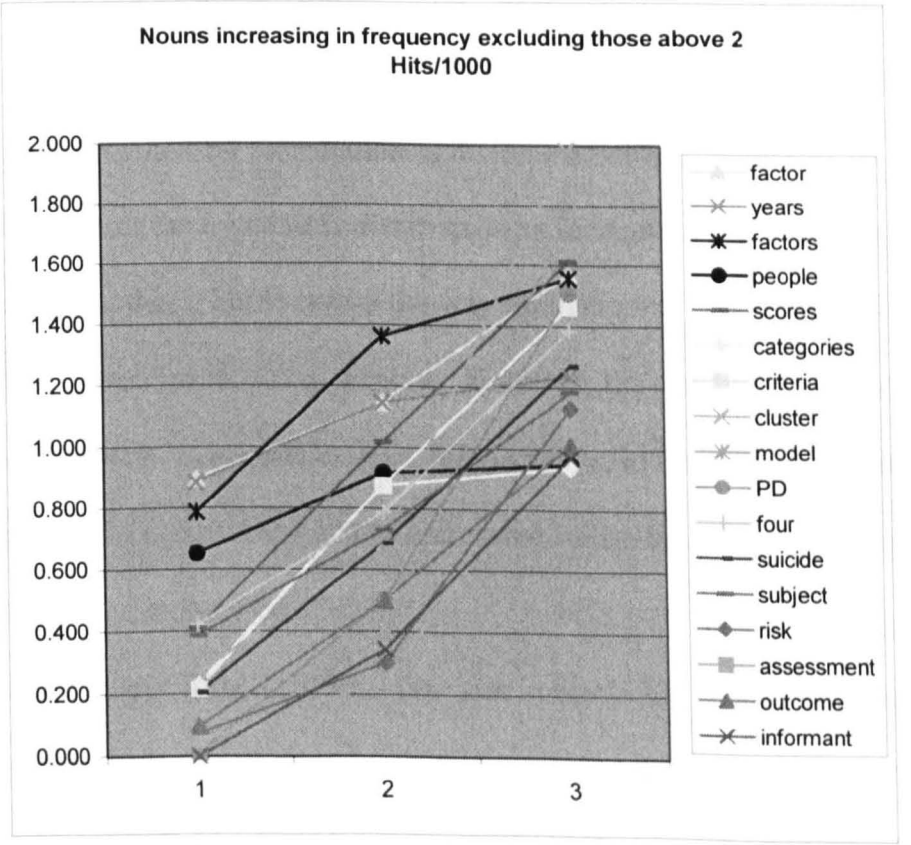
There is thus a clear indication of a use of what may be termed a medico-psychiatric discourse in the 1970s typified by *patients, illness, symptoms, psychiatrists, hospital, admission,* confirming the earlier suggestion above.

Another observation is that at first sight some of these trends seem to contradict the initial impression gained that there has been a steady rise in statistical/measurement language, in particular the fall of *reliability, agreement, items, scale, level, relationships, terms.* This will be discussed further in comparison with the rise of other words in the 2000s corpus.

Nouns rising in frequency over time (Graph 5 and 6, Appendix 9)

In this section two graphs will be looked at simultaneously, the nouns increasing in frequency only in the 2000s corpus and those increasing from corpus to corpus.





It is noticeable that there are a number of words which are used rarely before the 2000s corpus; *costs, events, prevalence, BPD, functioning, axis, DSM.*

There are a number of others, which make a very sharp increase from the 1970s to become common in the 2000s. These are, *disorder, disorders, health, sample, subjects, research, studies, cluster, model, scores, PD, criteria, suicide, subject, risk, assessment, outcome, informant.*

We can clearly see again the rise in references to the diagnostic manual, but also how the, now common, reference to the three 'clusters' of personality disorder in DSM have been prefigured by its use in the 1970s without reference to DSM.

The rise of *disorder, health* and the fall of *illness* is of note, however *health* as it appears in the 2000s is not deployed as a contrast to *illness,* rather it has a number of formulaic appearances as in *Department of Health, public health, World Health Organisation, health service*, and *non-health service costs*. Hence we cannot conclude that a less medical formulation of distress is being promoted.

In terms of the hypothesis that there is an increase in the language of statistics and tests, this is borne out by the very dramatic increases in *sample, subject, scores, informant* and particularly *subjects.* However, the peaking of the terms *reliability, agreement, items, scale, level, relationships,* in the 1970s was noted above as apparently going against the trend of increasing statistical language. These nouns will now be studied in more detail.

Reliability – This had 77 occurrences in the 1970s which are entirely statistical in usage (8 – *levels of*, 8- *interrater*, 10, *temporal,* 8- *high/low/highest,* 6- *study*), and 33 in 2000s (6- *test-retest,* 13 *inter-rater*, 3 – *diagnostic*). The

concordances indicate a greater preoccupation with reliability of studies in the 1970s and a narrower focus on aspects of reliability in the 2000s.

Agreement – There were 91 instances in the 1970s corpus, 21 of these concerned people agreeing about issues, and 69 examples in the 2000s corpus, 9 of which were this context while the remainder were entirely about statistical agreement between scores. In the 1970s corpus however a substantial number of occurrences concerned agreement between raters, patients and psychiatrists in studies. This seems to echo the concerns with reliability in this decade noted above.

Items – This had 64 occurrences in the 2000s, all meaning items in a test. There were 78 in the 1970s also with the same meaning, but collocating with personality.

Scale – In the 2000s the 68 occurrences were largely to do with particular named scales, with occasionally colloquial use (e.g. *large scale*) In the 1970s, 65 examples were also largely to do with particular scales but different ones.

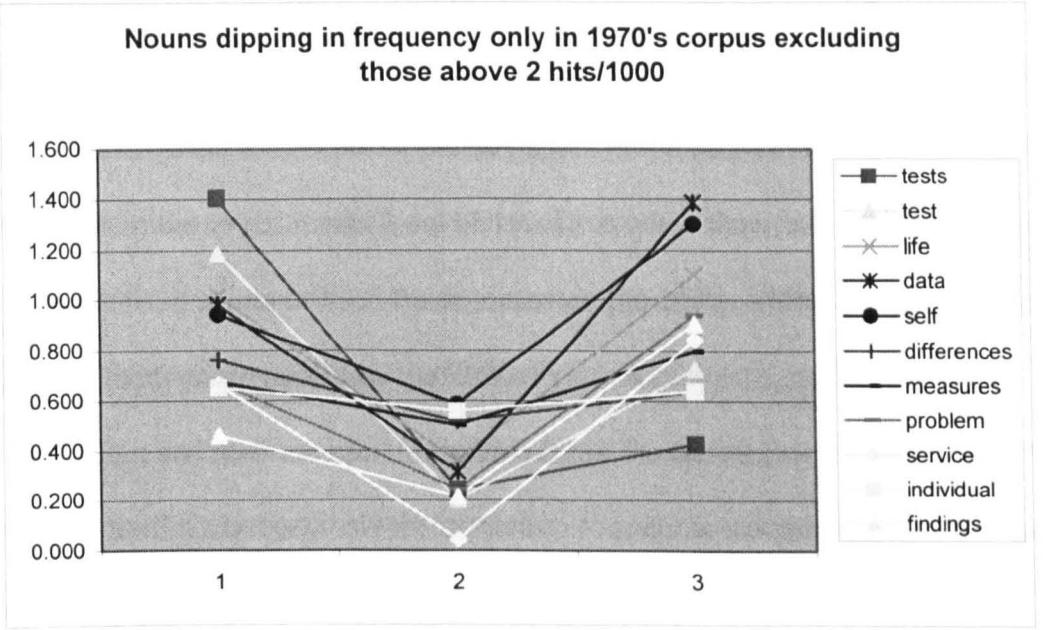
Level – In the 1970s there are 63 examples, 21 of which concerned statistical levels. There were 67 occurrences in the 2000s, 15 of which concerned statistical levels.

Relationships – The 63 occurrences in the 1970s were entirely to do with personal relationships, as were most of the 51 in the 2000s, 8 concerning relationships between concepts. Thus *relationships* was rarely used much in these corpora in a statistical sense, although its use did point to another discourse of interpersonal considerations, which will be looked at later in this chapter.

Following these explorations, the hypothesis about the increasing use of statistical language can be refined. There is a large overall increase in the use of

studies involving subjects to establish facts about personality disorder through the use of operationalised variables expressing social and psychological concepts. So much so that this becomes the primary way of expressing the meaning of personality disorder in the 2000s corpus. However within this there has been an increase and then decrease in mentions of studies to define and refine personality disorder itself, as expressed in the preoccupation with reliability of tests containing items, scales and levels. In effect the concept is established by the 2000s corpus, such that *epidemiology*, *prevalence*, *costs, assessment* and *outcomes* can be talked about frequently, despite the still profound issues about reliability and validity of the studies on which these are presupposed. The problems about reliability and validity are still there, but the talk is as though they are not.

Nouns dipping in frequency in the 1970s (Graph 7, Appendix 9)



This is the final graph to consider. There are a number of words which show a marked dip in the 1970s and then become common again in the 2000s. These are:

service, findings, test, tests, problem, data, life, self

Problem will be looked at specifically later, less in terms of its change in frequency over time, and more about what it can tell us about what was considered a problem at the time. *Life* and *self* have been discussed above and will be covered in more detail later.

In the 2000s corpus *findings* collocates strongly with *confirm* and *support* which does not happen in the earlier corpora, where *findings* tend to be reported. This suggests an active use of the statistical/survey language to shape the implications of personality disorder through the appearance of the direct appeal to studies.

Since, on examining the collocations and concordances, the usage of *data* in the sense of study information is similar throughout the corpora, its variation may reflect the changes in the nature of the papers in the corpus over time. In the 1950s the word is spread over 9 out of the 30 papers in the corpus. By 2000s it is 20 out of 29, while in the 1970s it was 8 out of 19. Thus while there is significant use of *data* in the 1950s, it is less utilised for argument in the 1970s while it becomes spread through many more papers by the 2000s.

Test and *tests* are used more broadly in the earlier corpora but by the 2000s they are used almost exclusively in relation to specific statistical tests e.g. Mann-Whitney.

Service is used in the 1950s corpus mainly in relation to military service, but also *prison, in-patient and social* are usages. After its near disappearance in the 1970s it reappears mainly in relation to *Health Service* in the 2000s corpus.

Discussion

These changes in noun frequencies have been presented in the form of relatively unprocessed data. They are the observed changes in frequency of nouns from corpus to corpus and they hint at changing discourses at work within the time periods. However three crucial questions arise in relation to their incorporation into this chain of argument. The first is whether these changes are statistically significant, in other words, can it be shown to be improbable that the changes are due solely to chance. The second is whether these changes are salient, in this instance, whether they have a meaning and relevance in relation to the investigation of changing

discourses around personality disorder, in other words, whether they are markers of notable discourse features of the corpora or simply artefacts of more general trends in grammar or usage. The third is whether these changes point to or are associated with changes in discourses at work in the texts over time, where, for the purposes of this study and following the discussions of Chapter 4, a Foucauldian conception of discourses is to be used.

The first of these questions is dealt with in the next section. The second question was discussed in the methodology chapter, and will also be covered in more detail in the discussion about this whole chapter, where the differences between statistical significance and salience are approached. The final question has been alluded to in the theoretical and methodological sections previously, however, in terms of the analysis this is revisited in the discussions at the end of the thesis summing up what can be concluded about discourses from these corpus based analyses. In brief this suggests that there is no one-to-one correspondence between linguistic features and discourse, as discourse is broader than language, however, when language is examined from many different angles using a corpus based approach, this information can be usefully combined in the identification of discourses and their changes over time.

Analysis of Significant Trends in the Commonest Nouns in the Diachronic Corpora

Investigating the Statistical Significance of Noun Changes

In considering whether changes in noun frequencies from corpus to corpus can be ascribed to chance or not, Baker (2006: 125-128) suggests that Wordsmith Tools provides a useful feature to examine which words occur statistically more frequently in one corpus as compared to another. He notes that a Wordlist can be created for each corpus, listing all the words and their frequencies. The Wordlists from two corpora can then be compared such that Wordsmith Tools performs either a Chi Square or Log Likelihood test on each word taking into account the size of each corpus. This produces a figure termed Keyness, which if positive means the word occurs more often than would be expected by chance in comparison with the other corpus, while, if negative, less often.

In this analysis the Log Likelihood test is preferred as word frequency data tends to be inevitably skewed due to author choice, grammatical rules and so on, (Baker 2006: 126), hence the assumptions of a normal distribution required for a Chi Square Test cannot be made. In addition there are unresolved concerns about the application of statistical tests to linguistic data, in particular the assumption of independence of observed events, in this case the occurrences of words (Aston et al. 1998: 41; Stubbs 1996: 153). Thus the calculation of Keyness also produces a p value for each word, a number between 0 and 1 which is a measure of the confidence that a word is key, due to chance alone. The smaller the value of p, the greater the confidence that the word's presence in the corpus is not due to chance, but rather a

'choice to use that word repeatedly' (Baker 2006: 125). A cut off point for p can be set to select out the most-key words for inspection. However, in language data, using a value of p at 0.001, a practice common in social science statistical approaches, tends to over-include words as key, since it is over-sensitive to low values of word frequency (Baker 2006: 126-127). While Baker (2004: 351) notes that there is probably no possible consensus on the most suitable cut off point, as different corpus linguists work with varying types of corpora for many different purposes, a very low value of p reduces the influence of low word frequencies and also has the effect of allowing a greater selectivity to the analysis (Scott 2004).Thus, as in Baker's (2004) and Scott's (2006: 77) studies, a cut off of $p<0.000001$ is chosen for the analysis outlined below and, in addition, words below frequencies of 3 in both corpora are selected out in the calculation to avoid including small changes in rarely used words. This process, by selecting only the most significant changes aims to reduce the effects of natural word clustering in documents as well as filtering out spurious significance due to low frequency word use.

In order to investigate the statistically significant changes from the 1950s corpus to the 1970s corpus, the word lists for both corpora are created and then a keyword list is created from the 1970s corpus by comparing it to the 1950s corpus. This produces a list of key words, an extract of which is shown in Appendix 10, with a ranking at the top of those words whose increases from the 1950s to the 1970s have been most statistically significant, but then listing in reverse order those words whose decreases from the 1950s to the 1970s have been most significant.

Thus, for example, from this table the increases in *disorder/s, personality, patients, diagnoses* from the 1950s to the 1970s are all highly unlikely to be due to

chance alone. Conversely, the decreases over this time in *body, build, test/s, cases* and *service* are also unlikely to be due to chance.

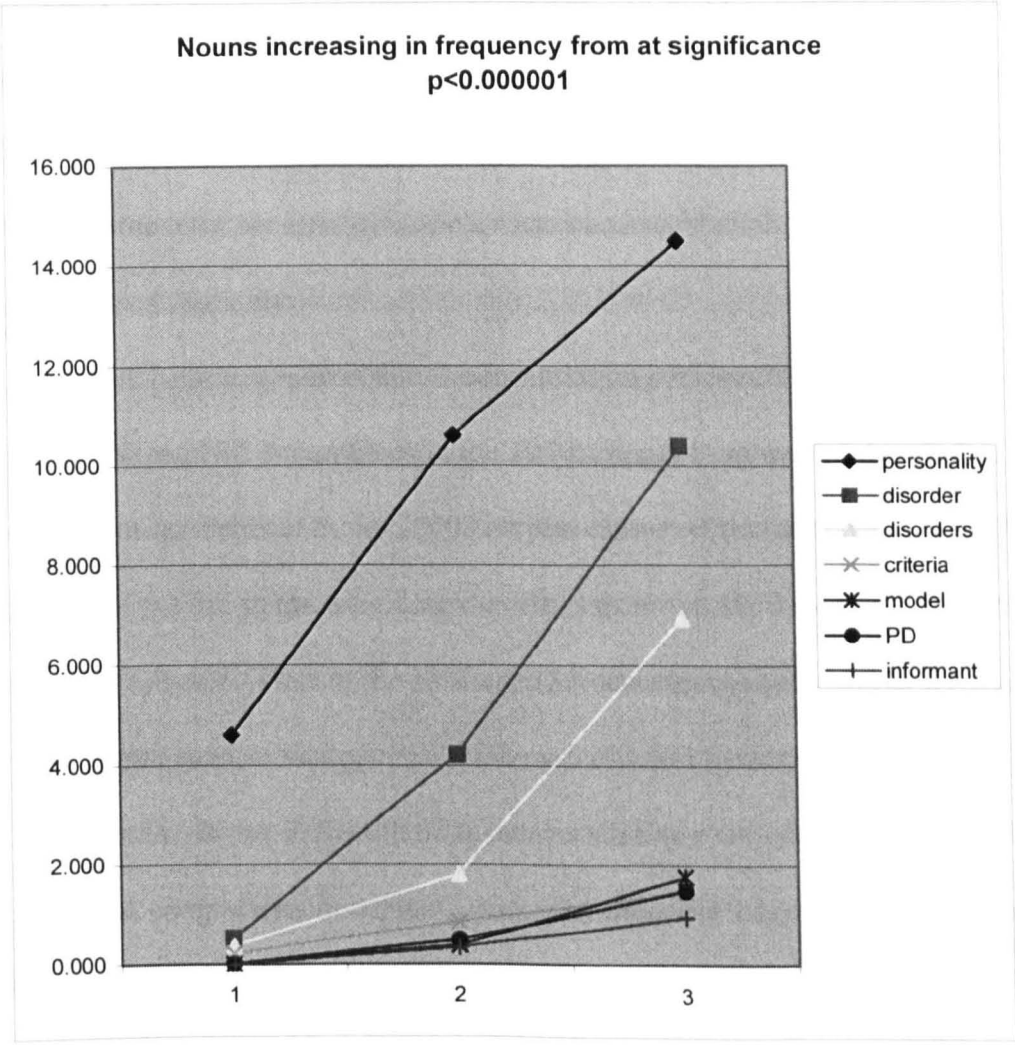
This same process can now be applied to changes from the 1970s corpus to the 2000s corpus to give a picture of the statistically significant changes from corpus to corpus. Combining these, allows us to identify the most statistically significant trends over the three corpora. We can now refine the graphs in Appendix 9 in order to produce a set showing the most significant changes in noun frequency between the three corpora; only the changes at level $p<0.000001$ are regarded as increases or decreases and trends which are not statistically significant are thus moved to the Same category. An additional feature for clarity is that the numbers *one/two/three/four* have been removed. These plots are contained in Appendix 11. These will be discussed individually in the next section.

However, before looking at these results in more detail, and as this is a developing methodology, the process was applied again to both periods covered above, but this time setting $p<0.05$. From this we find that, of the changes in the most frequent nouns from the 1950s to the 1970s corpus, all are significant at the level $p<0.05$ apart from: *types, factor, years, traits, people, terms, degree, number, men, analysis*. In the changes in the most frequent nouns from the 1970s to the 2000s corpus, all the changes are significant at the level $p<0.05$.This enables us to check which of the changes illustrated by the graphs in Appendix 9 are at least statistically significant at this level, and hence can at least be considered as supporting evidence for discourse change, and which are much more likely to be due to chance. This set of graphs is contained in Appendix 12.

A final point to consider before further analysis is that a linguistic or discourse attribution can only be made concerning significant changes in frequency of a word, if its actual meaning in context has remained similar over the corpora. This may seem an obvious point, but it stresses the need to check the concordances in order to determine whether usage has changed over time. If it has, this does not necessarily mean the change is no longer significant, for example with *PD* below, the change in meaning between corpora does not affect its importance as a discourse marker, indeed its appearance in the 2000s corpus is rendered more significant and certainly salient.

The changes in noun usage at significance level $p<0.000001$ between the corpora shown graphically in Appendix 13 are now examined in more detail.

Nouns increasing significantly over time (Graph 1, Appendix 11)



In this graph it is clear that the rise in *personality* and *disorder/s* from corpora to corpora are both numerically large and statistically highly significant, and are accompanied by a significant rise in the use of *PD*. However even these apparently obvious changes need to be examined further through the concordances to check actual usage.

PD in the 1950s appears only once in the whole corpus and stands for *Psychopathic Deviate*, a subscale of the MMPI. While more prevalent in the 1970s

corpus, PD occurs only in one text (Foulds 1971), and stands for *Personality Deviance*. All the 2000s corpus usage stands for *Personality Disorder*. Thus the increase in the usage of *PD* relating to personality disorder only occurs between the 1970s and the 2000s corpora. One could suggest that this is evidence of how accepted the term *personality disorder* has become, such that its abbreviation can now be used routinely.

We have seen above that the formulation *personality disorder/s*, has a very limited usage of 16 occurrences in the 1950s, rising to more common use in the 1970s and becoming plentiful in the 2000s corpus. However this also needs to be seen in the context of the fall in the use of *personalities* from the 1970s to the 2000s corpus shown in Graph 6. Thus in the 1950s the 38 occurrences collocate in L1 with the contemporaneous sub-categories *abnormal, obsessive-compulsive, obsessive, psychopathic*. In the 1970s the 62 instances similarly collocate with *abnormal, antisocial, compulsive, hysterical, hysteroid, insecure, obsessiod, anankastic, psychopathic, schizoid*. This usage disappears by the 2000s corpus. Thus within the 1950s and 1970s for example *obsessive personalities* is used in the same contexts as *obsessive compulsive personality disorder* in the 2000s corpus. However, even with this in mind the increase in *personality disorders* from the 1970s to the 2000s is extremely large and requires interpretation. This will be expanded in the discussion of subject positions in Chapter 7.

Returning to Graph 1, *criteria, model* and *informant* also show a significant increase over time. Referring to the themes outlined above, these fall within Words Relating to Statistical/Measurement Approaches. However with the information from the concordance we can again be more nuanced in the interpretation. Thus we have

seen that *model* related to a rise in writing about models of personality disorder. *Informant* is used in the context of statements about a particular personality disorder assessment pioneered by Tyrer which involves collecting information from someone who knows the patient (Tyrer et al. 1979b), and thus indicates an increase in interest in this assessment tool. Looking at the concordance for *criteria* we find the following collocates and clusters in each corpus:

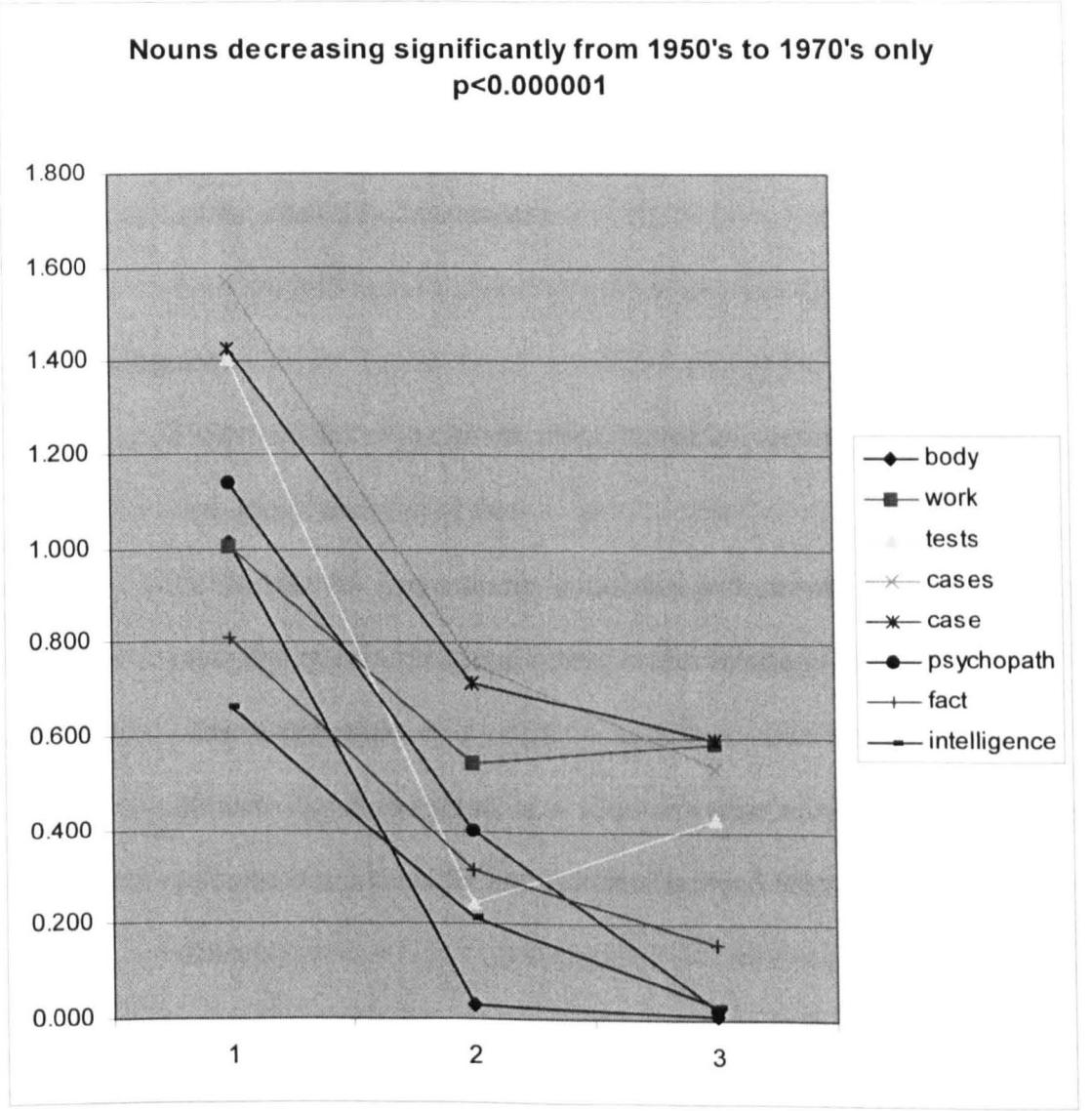
1950s: *the criteria* (but mainly in relation to overall psychiatric diagnosis)

1970s: *diagnostic, symptoms, clinically, used/ing, arrived, meet: the criteria for, symptoms to fulfil the criteria, the diagnostic criteria, meet the criteria* (mostly usage in relation to *personality disorder/psychopathy*)

2000s: *personality, disorder/s, diagnostic, met: met criteria for, DSM criteria, personality disorder criteria* (almost entirely in relation to personality disorder and often for distinguishing sub-categories)

Thus the significant increase in the occurrences of *criteria* can be linked to an increase in its usage in relation to personality disorder as a whole in the 1970s and to distinguishing sub-categories through research in the 2000s. This supports a notion that there is more talk in relation to a pluralisation of personality disorder in the 2000s corpus, linked to the discussions around the increase in *disorders*.

Nouns decreasing significantly from the 1950s to the 1970s corpus (Graph 2: Appendix 11)



Looking at Graph 2 we can see how the usage of *psychopath* falls significantly from the 1950s to the 1970s corpus and then almost disappears. It is of note that *psychopathy* also falls over time, but only significantly in the 2000s corpus, while *psychopaths* rises in the 1970s corpus, but then falls into disuse by the 2000s (both in Graph 6). The main collocates and clusters are shown below:

psychopath

1950s: *the, inadequate, aggressive, is: of the psychopath, the psychopath is, the term psychopath*

1970s: *the, is*

2000s: *the* (only 2 instances)

psychopathy

1950s: *of* (linked to *classification, causation, aetiology, syndrome, definition*), *the central fact*

1970s: *the, of, symptomatic* (collocates with *prevalence of, concept of, category of, criteria of* and other phrases relating to psychopathy-as-clinical-concept)

2000s: (9 instances, linked to Hare's psychopathy checklist, historical references to Schneider and Henderson, but 3 uses as a contemporary concept)

psychopaths

1950s: *of, the* (linked to *criminal, aggressive, Henderson's* and as such functions as a label for a clinical condition possessed by a person)

1970s: *of, the, personality, treatment, disorders*

2000s: (0 instances)

Thus in the 1950s, *psychopath* is mainly used in the context of descriptions of a clinical entity, while *psychopathy* is used more in discussions of a concept. *Psychopaths* again tends to refer to a clinical entity, but it is clear that in the 1970s corpus it is the vehicle for discussion about issues around the subject in hand, including treatment, and is also being linked to *personality.*

Returning to the graph, the significant falls in *body* and *intelligence* do seem to reflect the falling off in interest from the 1950s in linking body type and intelligence with personality.

The falls in *case* and *cases* need to be distinguished. *Cases* is primarily used to mean medical cases, hence this fall is consistent in meaning across the corpora. *Case* on the other hand is used frequently in the 1970s as *in the case of*, while in the 1950s it is used much more in the sense of a medical case. Thus the fall in usage of *case/s* as medical case from the 1950s to the 1970s is even more pronounced than at first sight and supports the idea of a change in discourse over this period.

In terms of *work,* in the 1970s 24 of the 38 instances relate to work as activity, the remainder relate to academic or clinical work. By the 2000s, 22 out of 55 relate to work as activity, while in the 1950s 35 out of 83 are to do with work as activity, hence breaking down the meaning through concordance reveals that the decrease in this context is less significant than in the overall word use.

On the other hand *test* falls significantly from the 1950s where it is used mainly to describe various psychological tests; by the 2000s its use is almost entirely in relation to statistical tests. Thus this trend comprises a fall in one particular aspect of measurement and identification of personality, and a rise in another, further indication of the difficulties in tracking word frequency alone. However we can

suggest at this stage that this change in the usage of *test* may mirror three tendencies across the corpora: an increase in purely statistical language in the 2000s, a decrease in reliance on psychological tests developed for personality measurement, and an increase in tools developed, largely in the 1970s, for personality disorder assessment. This point will be returned to later.

Turning to *fact* the collocates and clusters are shown below:

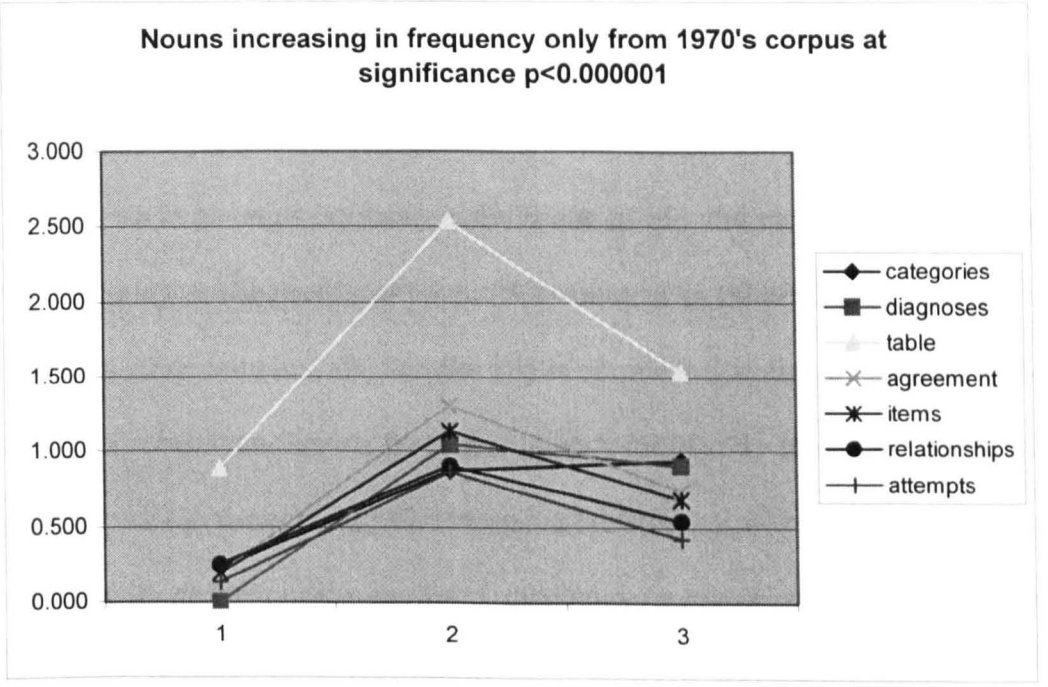
1950s: *the fact, in fact, the fact that, the central fact of psychopathy*

1970s: *the fact that, in fact*

2000s: *the fact that, in fact*

Thus usage is similar over time, but frequency significantly falls after the 1950s. Along with the previous discussion around fact and expression of authority, this would suggest a movement away from authoritative language towards a more hedging academic approach. If so this would function in a discourse sense to allow a contested concept to appear more valid through association with the scientific process, rather than relying on authoritative voices alone to lend validity.

Nouns increasing significantly from the 1950s only (Graph 3, Appendix 11) and those peaking in the 1970s corpus (Graph 4)

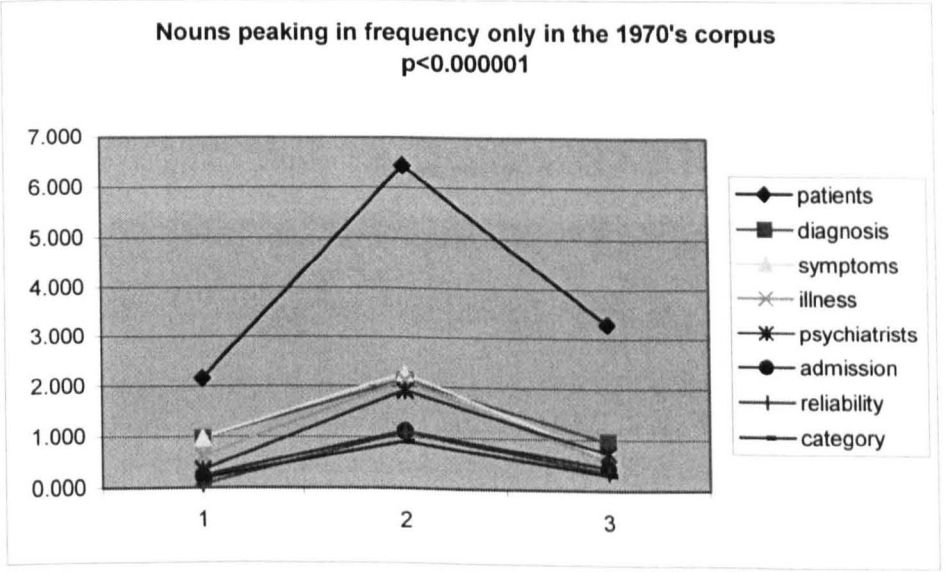


In this graph we see significant trends of nouns increasing from the 1950s corpus. Thus *diagnoses* does not occur at all in the 1950s corpus, but is frequent in both the 1970s corpus, where it collocates in L1 with *clinically established, personality disorder*, *psychiatric* and *the*, and in the 2000s where it collocates in L1 with *axis I, axis II, personality disorder, PD.* Thus it is used more generally in the 1970s compared to its more specific use in the 2000s corpus, which may account for its greater frequency. Further, looking at Graph 4 below, *diagnosis* peaks in the 1970s, and collocates with *established psychiatric, personality disorder, classification, patients* and *illness,* while in the 2000s corpus it strongly collocates with *personality disorder, DSM, Axis*, and *differential.* In the 2000s corpus both usages are more restricted to the technical diagnosis of personality disorder as related

to the diagnostic manuals, while in the 1970s corpus it is used chiefly to refer to general diagnosis of personality disorder, but also to other psychiatric conditions. This move towards a manualised usage needs to be interpreted in the light of other changes in language, as it seems to imply a meaningful change in discourse around this part of the subject.

The rise in *attempts* is almost entirely due to an increase in talk about *suicide attempts*, relating to one particular paper (Suominen et al. 2000). *Relationships* on the other hand is more complex. Within the 1950s corpus this is almost entirely related to relationships between factors, for example *body build* and *personality*. In the 1970s it mainly appears in the context of interpersonal relationships and in a negative sense, collocating with *disturbance, superficial, avoidance, impairment.* In the 2000s corpus its appearance is more mixed, collocating in L1 with *constructive, romantic, maladaptive, intimate,* although the negative was still predominant. In this area we see a discourse around relationships appearing in the 1970s corpus in a somewhat formulaic construction, but becoming more nuanced and variable in the 2000s. This does perhaps reflect a change in the ability of academic writing to attempt to include more human aspects in examining a problem from a psychiatric point of view. Such language may not have been acceptable in this context in the 1970s and this is the very point at which language and discourse in a Foucauldian sense interact. By the 2000s more variety in expression about relationships is allowed, reflected also in some of the titles of the pieces in the corpus (Appendix 4). This seems to portend an area where further discourse development could occur to increase the flexibility of clinicians to approach a problem, which is in danger of becoming bogged down in classificatory arguments.

Returning to Graph 3, *agreement* shows a move from agreeing about a case or theory, to increasing use in the statistical sense until nearly all its usage in the 2000s corpus relates to statistical agreement. Similarly *items* is used across the corpora in relation to statistical and survey processes, both of these together pointing towards an increase in such language and discourse between the 1950s and 1970s, but with a greater precision in its appearances in statistical senses in the 2000s. This is mirrored by the change in *table,* which is entirely used in all the corpora to refer to tables of data or information apart from the text. Its behaviour over the corpora is thus an indicator of how the 1970s show a distinct peak in this activity.

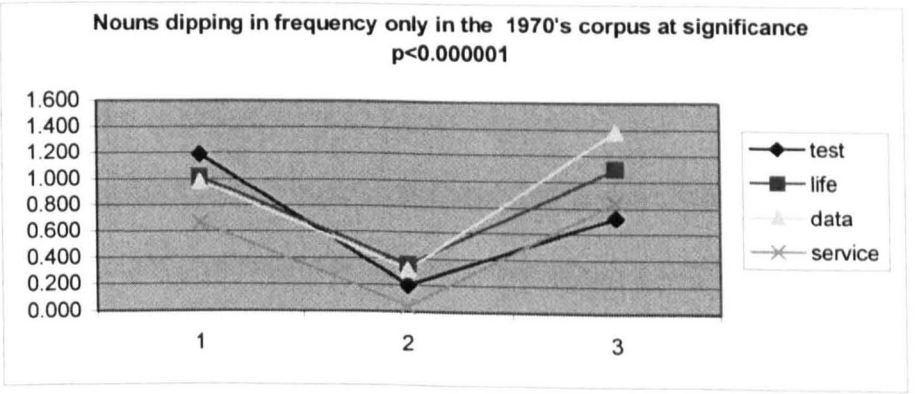


Moving on to Graph 4 above we can see that a number of nouns that relate to a strongly medical model of psychiatry peak within the 1970s corpus. These are *patients, diagnosis, symptoms, illness, psychiatrists, admission.* These confirm the prominence of the 'medico-psychiatric discourse' during this period and suggest two

main hypotheses; that this discourse has changed in its importance over time, or that it may change in its presentation through language over time. These issues will be returned to in the discussion in Chapter 8.

Finally *reliability,* hardly used at all in the 1950s, peaks significantly in the 1970s where it is used in the context of inter-rater, temporal and diagnostic reliability, in a very similar way to its use in the 2000s corpus. This would reflect the increase in statistically based research observed above in the changes in *agreement* and *items*, but would further indicate less of a concern with reliability itself by the 2000s, as previously mentioned.

Nouns dipping significantly in the 1970s (Graph 5, Appendix 11)



As we have seen above *life* in the 1950s corpus has a varied usage, from medical usage in terms of describing for example *home life*, to the more general *purpose of life*. By the 2000s corpus there is a significant amount of formulaic usage as *life event/s,* which effectively transform the process of living into a series of either causative or risk factors for developing a condition. There are also a number of examples of *life expectancy*, although there remains some lay usage, such as *time of*

life. The main reduced usage in the 1970s is quite varied as in *phantasy life, institutional life, stresses of life, adult life* and so on. Thus there are perhaps two trends overlapping in this pattern, a decrease in the use of a lay sense of *life* over time along with a notable increase in formulaic representation of human existence between the 1970s and 2000s.

We have noted the reduction in *tests* over time above, but *test* shows a dip in the 1970s only. In the 1950s corpus it relates almost entirely to specific psychologically derived tests such as Matrices, Thematic Apperception, Intelligence, Tapping etc. In the 2000s it relates to testing hypotheses and statistical testing, which are the same senses in which its reduced usage appears in the 1970s corpus. Again it would seem there are overlapping trends acting on the use of the word: the reduction and eventual disappearance of the use of previously derived psychological testing to describe personality over time, and the rise of statistical testing as applied to this area, commencing in the 1970s.

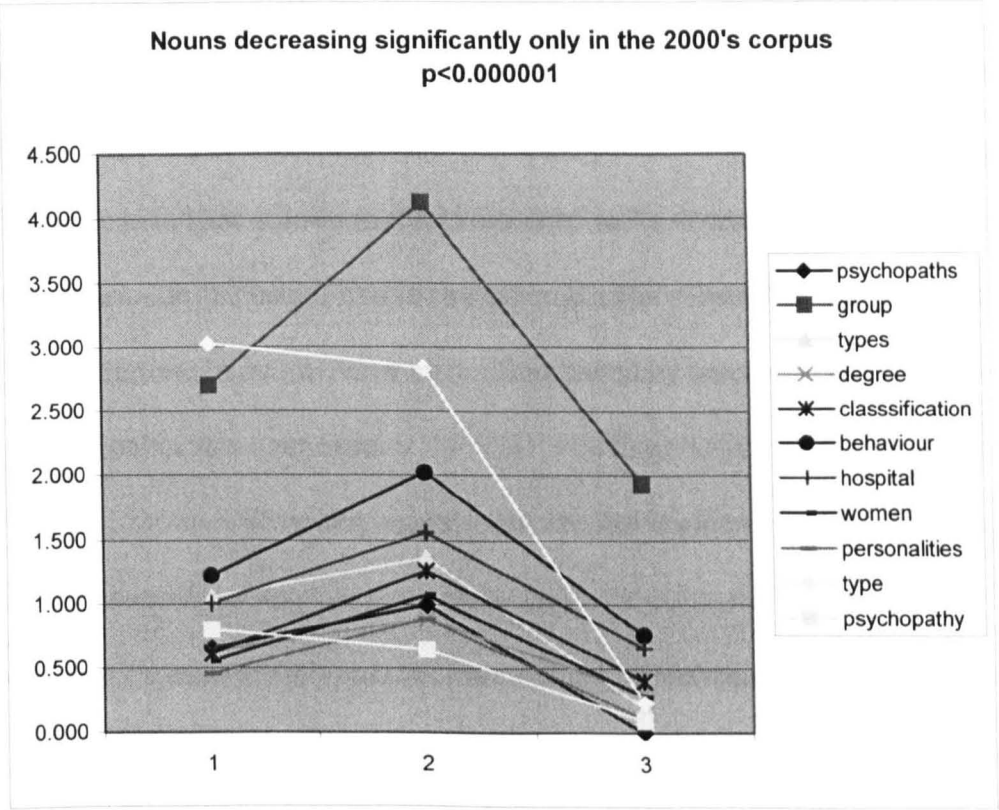
An analogous trend is found in the changes in *data*, where, in the 1950s corpus its usage mainly relates to descriptive data about groups which is then dealt with narratively rather than statistically, while by the 2000s *data* is used in the context of complex statistical analysis and the collection of survey information. The reduced usage in the 1970s comprises mainly statistical and survey references.

These trends point towards a much more nuanced view of discourse change over this time, with overlapping usage of words in quite difference contexts. However we can begin to see evidence of a change between the 1970s and the 2000s corpus in the reliance on statistical and survey approaches referring to personality disorder. Further from the 1950s there is a significant decrease in the use of psychological

personality assessment tools developed in the 1930's and 40's to apprehend psychopathy and the beginnings of signs of their replacement by new tools to specifically identify personality disorder. It could be argued that this knowledge could be obtained by simply reading all the documents in the corpus, however with this approach the changes in language use from which these conclusions can be drawn become more accessible. However it is not a replacement for a sequential reading of the texts.

Service has a pattern all its own. In the 1950s it refers almost entirely to military service reflecting post war concerns and describing information about patients who had been in the war, while in the 2000s corpus its appearance is mainly the *health service*. Its drop in frequency in the 1970s thus reflects on an increased usage of *health service* in more recent times. Thus while the NHS existed in the 1970s there did not seem to be a need to refer to it, while in the 2000s corpus the collocates are *health service utilisation*, *use* and *costs*, an initial indication of discourses around fiscal and societal responsibility which will be discussed further in Chapter 8.

Nouns decreasing significantly only in the 2000s corpus (Graph 6, Appendix 11)



In graph 6, we have already discussed the changes relating to *psychopath, psychopathy* and *personalities* above. *Type* and *types* are not used much in the 2000s corpus, but in the 1970s both mostly refer to *personality type/s*, while in the 1950s corpus they are used both in relation to *personality* and *body types.* The falling off of *hospital* is in keeping with the decline of the medico-psychiatric discourse alluded to above in the 2000s; this is supported by the remaining usage in the 2000s corpus which refers to specific hospitals in relation to personality disorder, such as the Henderson and Cassell, rather than hospital treatment in general as in the 1970s.

Although *degree* falls in the 2000s corpus, its appearance is quite varied and colloquial throughout the corpora, but tends to follow a pattern of being preceded by a word representing quantity, as in *some degree, least degree, considerable degree, significant degree.* As such it seems to represent a rhetorical device to indicate a significant weighting to a presentation of an argument or fact, and indeed its most significant use is in case studies in the 1950s corpus. Its decrease might therefore signal a reduction in the use of narrative case studies as substantial parts of articles.

The decrease in *behaviour* may be illuminated by an examination of its noun and adjective collocates over time.

1950s: *patterns, disorder, social, patients, antisocial, psychopathic: patterns of behaviour*

1970s: *impulsive, manipulative, violent, temper tantrums, suicide, patterns, symptoms, destructive, frequency*

2000s: *personality, suicidal, disorder*

Thus there is a clear sense that in the 1970s *behaviour* acts as a focus of negative attributes, most of which have effects by implication on the clinical team involved and the people around the patient. This aspect has shrunk by the 2000s, while in the 1950s its use was much more with identification of patterns that would aid diagnosis. This negative attribution certainly supports the stereotype of personality disorder which is supposed to be challenged by the new policy, however only this year I heard a psychiatrist say 'we don't readily apply a label of personality disorder as there is then nothing you can do, you have to write them off.'

At first sight the reduction in the use of *classification* appears to contradict the assertions above that statistical and survey language increases notably between the 1970s and 2000s corpus. The collocates and clusters are shown below:

1950s: *the, of,* (mainly more general psychiatric classification)

1970s: *of, the, International Classification of Diseases, system of classification, classification of personality disorders/s*

2000s: *the, of, classification of personality disorder, DSM*

In terms of raw frequencies, *classification* remains frequent in all corpora, however, from the above, there does seem to be an increase in language around classification of personality disorder in the 1970s but this is accompanied by numerous mentions of the ICD in full, rather than abbreviation. There may be a sense in which classification as an issue has become less prominent by the 2000s corpus, perhaps resolved by the rise of the DSM.

Group is also a common word in all the corpora but falls off to a significant extent in the 2000s corpus. The collocates and clusters show:

1950s: *the, a, this, a group of, of the group, in a group* (mixture of narrative use, experimental use, and others such as *group therapy*)

1970s: *patients, poorer/better outcome, age, group i/ii, social*

2000s: *study, control, BPD, one/two stage* (almost entirely to do with experimental groups)

This appears to follow a pattern of decreasing narrative use of a word and an increasing technically precise use, to do with statistical approaches. That these begin to dominate in the 2000s corpus is increasingly apparent, and that this appears to be at the expense of more human narrative styles.

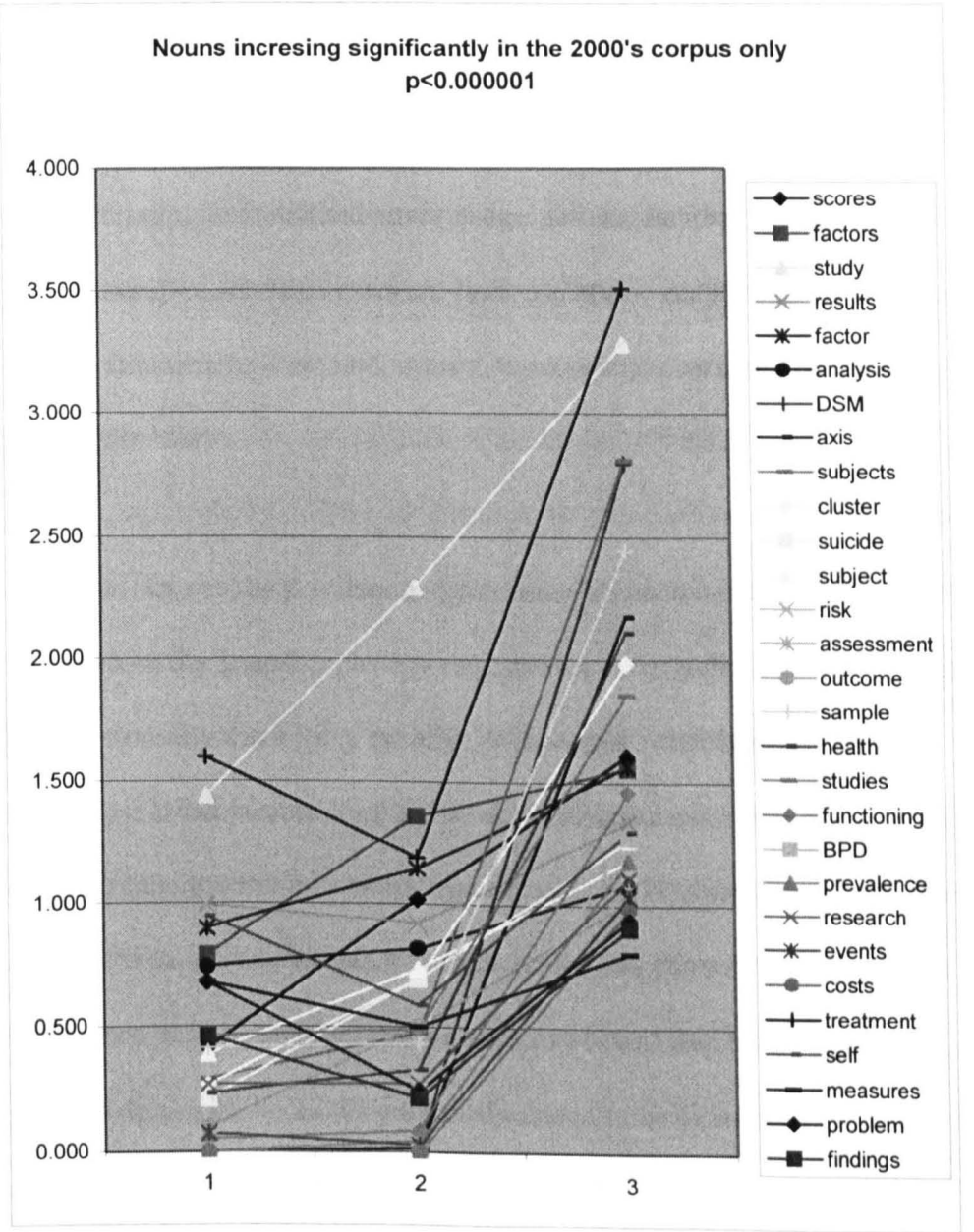
Women also decreases after the 1970s corpus. In the 1950s there is a lot of usage as *men and women* or *men* compared to *women*, as well as collocates with *dysthymic, hysteroid* and *psychoneurotic*. The 1970s corpus also sees the *men and women* usage, but also discussions of personality issues *in women.* However these appear much less in the 2000s corpus and are almost entirely comparing *men* and *women* in the results of studies. Again the narrative aspects of the text have been almost lost and replaced by figures and statistical facts. Compare the following:

> *As shown in Table 4, the odds of having a cluster A disorder were four times greater in men than women, controlling for all other characteristics in the model.* (Samuels et al. 2002)

> *Lewis and Mapother (1941) use the following descriptive terms for the hysterical personality: "they are over-active, unsatisfied with their own capacities and, therefore, pose and pretend; they show lability of affect and exuberance of fancy, egotism, untruthfulness, longing for prestige, sympathy and love; they use illness to satisfy these needs; they show heightened suggestibility, hypomnesia is common; it occurs more frequently in women who may be both coquettish and frigid".* (Foulds et al. 1958)

Something is both lost and gained in this transition. A representation of scientific accuracy is gained while the transparency of discourse is lost. One suspects that when the first quote is translated into clinical practice, it looks something like the second.

Nouns increasing significantly only in the 2000s corpus (Graph 7, Appendix 11)



This graph shows the nouns increasing significantly in the 2000s corpus only. In order to make sense of this they can be themed initially using the categories outlined previously in this chapter:

Terms relating to personality: *BPD*

Terms relating to medical usage: *DSM, axis, cluster,*

suicide, health, treatment.

risk, prevalence,

Terms relating to statistical/study usage: *scores, factor/s, analysis, subject/s,*

sample, studies, research, findings, study, results

assessment, outcome, events, functioning, costs, self, measures.

Other: *problem*

Thus we can see the privileged appearance of the sub-category *BPD* (for Borderline Personality Disorder) as a preoccupation for psychiatry even in the articles which treat personality disorder generally. We can also clearly observe the emergence of the DSM terminology in its use with *axis* and *cluster.* The prominence of *suicide* is largely due to one article (Suominen et al. 2000), which contains 95 of the 116 instances in the whole 2000s corpus, hence this cannot be considered a marker of a more general emergence of concerns around this area. The 198 occurrences of *health* in the 2000s corpus also need to be examined in context and reveal a number of common clusters, namely, *health service costs* – 26, *World Health Organisation* – 25, *Department of Health* –15, *public health* – 30, *mental health* – 32, *National Health Service* – 8, 136 in total). This shows some influence of the ICD, although not as direct or prevalent as the DSM, but it also reveals frequent collocation

with *costs* (42 occurrences within 5L to 5R[3]). *Mental health* is mainly used with *staff, services, professionals* and *legislation*, hence this increase in usage is not associated with any increase in talk of the health of individuals, rather it is part of a more general conception of health, associated with a population and health services. This point will be revisited a little later.

Treatment is highly collocated with *personality disorder*, however, due to the very high frequency of *personality disorder* in the 2000s corpus this is not surprising, as most words will tend to collocate with it. However the link is more specific than general, as shown by the 35 occurrences of the phrase *treatment of/for personality disorder/s*, and an examination of the concordance, which indicates the majority of the usage is in relation to treatment for personality disorder. Thus we have a clear indication of a significant increase in the talk around treatment, its study and claims for efficacy.

Risk and *prevalence*, as we saw when initially exploring the nouns in the 2000s corpus, are terms very much associated with discussions of the medical risk of developing a disease, and the rate of its occurrence in a population. Thus they give a further indication of a particular discourse around public health, initially revealed by the usage of *health* above. If we then look at the increase in language around statistical methods and study, we find a collection of nouns to do with this approach, such as *scores, factor/s, subjects, sample, findings*, etc. These thus indicate a significant increase in the noun usage around this area, and a growing use of this particular discourse in the 2000s. The implications for subject positioning will be

[3] These refer to the number of words to the left and right within which the collocates are searched. Thus *costs* occurs 42 times within 5 words to the left and right of *health*.

looked at in detail in the next chapter, however we can note here that, in order to deploy this discourse, a particular conception of people is necessary in order for the discourse to function.

Alongside this general deployment of study discourse there is clearly an increase, and also a first appearance of nouns associated particularly with study into health: *assessment, outcome, events* (mainly as *life events*), *functioning* (usually as operationalised variable as in *psychosocial functioning*), *costs, self* (used in relation to scales of measurement like *self-defeating*), *measures* (almost entirely in relation to variables in a study, e.g. *outcome measures*).

These point to the emergence and deployment in the 2000s corpus of a discourse specifically to do with the translation of life into a form which is amenable to statistical study, i.e. operationalisation. This is not prominent in the preceding corpora, and is, I feel, distinguishable from the general usage of statistical and study language, which also increases. Thus the initial broad categorisations utilised at the beginning of this chapter can be refined into sub categories which inform the identification of particular changing discourses over time;

Terms to do with;

Personality – to identify the subject of the discourse in each decade

Medico-psychiatric discourse

General statistical and study language

Statistical and study language of health - requiring the operationalisation of life e.g. *life events* as opposed to a narrative, *self*

defeating as opposed to a story in context, *measures* as opposed to happenings.

The language of management - the business of treatment and health represented by the use of *outcome, costs*, and *assessment.*

Discussion of Noun Analysis

Reflecting on the above methodology, there would appear to be a degree of redundancy in exploring and theming the most frequent nouns first, then looking at absolute changes in frequency between corpora and finally exploring the most significant changes. The same information is appearing in different ways and also the final exploration of most significant changes both encapsulates the previous data and also reveals more nuanced versions of the changes observed earlier, hence this appears to be the most useful way of approaching the corpora from a discourse point of view. Thus, while the initial exploration and theming of nouns was useful in terms of gaining an overall impression of discourses at work, it is not felt necessary to repeat this with further analysis of other linguistic features.

However the analysis clearly shows that there are a large number of changes in usage of the most frequent nouns between corpora that are very unlikely to be due to chance alone. What therefore are they due to? Baker suggests author choice, either conscious or unconscious (Baker 2006: 125), however this seems a highly cognitive model of explanation and the discussions of Chapter 4 would suggest that it is the deployment of discourses that necessitates particular language use at particular times. The changes in contemporaneous usage are clearly a factor in the changes, particular

sections have been quoted illustrating the 'archaic' use of language, however other words have retained their meaning over time, and the observed changes are not therefore accounted for by this explanation. Instead we are confronted with statistically significant changes in word usage, which are reflecting a particular play of discourses around the concept under study, defined in this case by the selection of the texts relating to personality disorder in a psychiatric journal context. These will be summarised and discussed in more detail in Chapter 8 but before this it is necessary to look at the significant changes in the other lexical categories, adjectives and verbs.

Lexical Analysis of Adjectives in the Diachronic Corpora

The most frequent 40 adjectives were identified in each corpus (Appendix 13), less than for the noun analysis, as it became clear that much more examination of the collocates would be required to identify how the adjectives might be functioning as discourse markers than for the nouns, hence a balance needed to be struck between exhaustive analysis and what was manageable. From Appendix 13, an initial impression can be gained as with the nouns, from the first appearance of adjectives in the lists, thus:

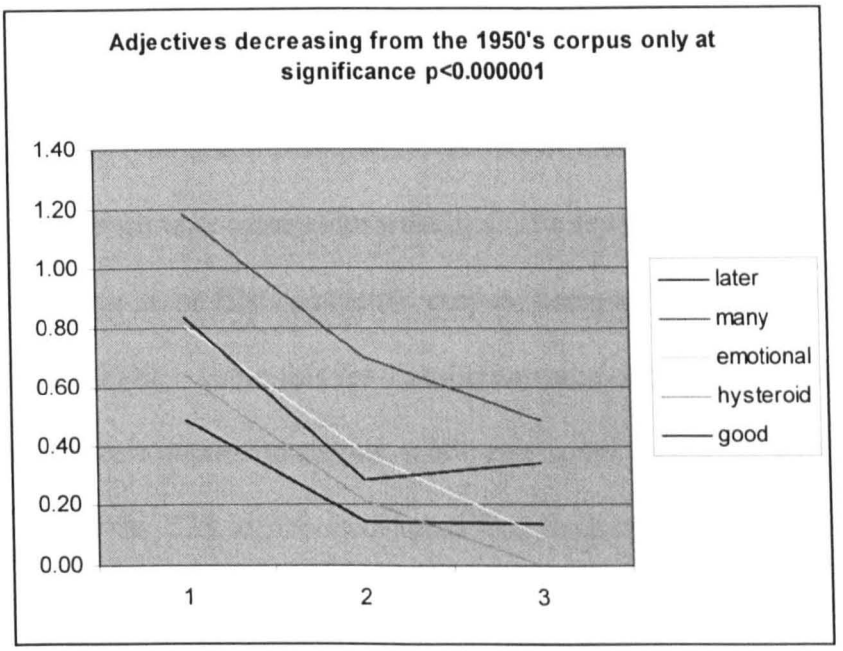
> Adjectives that appear in the 1970s top 40 for the first time:
> *abnormal, personal, normal, high, schizoid, serious, antisocial, second, male, previous, higher, obsessional, aggressive, low, dependent, deviant, moral, descriptive.*

> Adjectives that appear in the 2000s top 40 for the first time:
> *borderline, specific, avoidant, compulsive, current, disordered, positive, statistical, demographic, least, schizotypal, important.*

From this we can see terminological changes, but also new avenues of investigation in the grouping *abnormal, normal, deviant* and *moral* in the 1970s and also a potential further confirmation of the prominence of statistical/study language in the 2000s corpus. As outlined above, rather than first examining the changes in absolute frequency, the analysis of adjectives proceeds from an identification of the

most significant changes from corpus to corpus as measured by Keyness with a significance level of $p<0.000001$. The resulting plots are shown in Appendix 14. We can immediately see a number of terminological changes such as the decrease in *hysteroid* and *hysterical*, as well as the peak in the use of *obsessional* and *schizoid* in the 1970s and the rise of *compulsive, schizotypal*, and *borderline* in the 2000s. However a more detailed look requires the examination of each trend in the context provided by concordance and collocation analysis.

Adjectives decreasing significantly from the 1950s corpus only (Graph 1, Appendix 14)



In this graph it is immediately apparent that the categorisation developed with the nouns, does not readily apply. Further, the analysis of adjectives which have a general rather than a specialist linguistic usage, such as *later, many*, and *good*, are each a potentially extremely complex and detailed process, which the time and space of this research does not fully allow. Thus, as is often the case with corpus analysis one is presented with the need to find a compromise between the quantity of data available and the depth and accuracy of the analysis, in effect a similar issue of selectivity outlined in the choice of p for the analysis of significant change. In this instance a solution to this issue is to perform a keyword analysis for these words on each corpus, comparing their frequencies to a large standard body of English, such as the British National Corpus (2007), and then focussing the analysis on those

adjectives which occur significantly more frequently in the corpora than in the comparison. As this is a developing method we can try this for the 1950s corpus and see what emerges, before dealing with the advantages and disadvantages of this approach.

The 1950s corpus is compared with a subset of the BNC containing academic language, in an attempt to compare like with like. The results show 529 words used more frequently than in the BNC academic corpus, using a log likelihood test at significance $p<0.000001$. From this *later* and *many* are not used significantly more in the 1950s than in the comparison corpus, while *emotional, hysteroid*, and *good* are. Similarly, in the 1970s, 535 words occur more frequently at the same level of significance, *later, many* and *good* are not used significantly more than in the comparison corpus, while *emotional* and *hysteroid* are. From the 747 words used more frequently in the 2000s corpus than the reference corpus *many* is used less frequently. These results are shown below in Table 6.

Table 6: Comparison of Frequencies and Keyness (when compared to the Academic Subset of the BNC) for adjectives decreasing from the 1950s Corpus at significance level $p<0.000001$

	1950s corpus		1970s corpus		2000s corpus	
Adjective	Frequency	Keyness	Frequency	Keyness	Frequency	Keyness
later	40	*	10	*	13	*
many	98	*	49	*	46	-29.9
emotional	67	236.2	26	56.33	9	*
hysteroid	53	562.9	15	164.3	0	*
good	69	33.6	20	*	32	*

* = $p>0.000001$

This illustrates a number of issues, the first of which is the danger of skewing the significance of words through their rarity. Thus although *hysteroid* is statistically

significantly more used in the 1970s corpus than in the reference corpus (where in fact it is not used at all), in the 1970s it is only used 15 times and by 3 authors (Foulds 1971; Presly et al. 1973; Vinoda 1969). A spurious significance can be attributed through the keyword process when the frequencies are low, either in the corpus under study or its comparison.

A second point is illustrated by *later* which would be unlikely to be highlighted as of statistical interest through this process, despite its significant decrease from the 1950s. When the distribution of this is examined through the tagging outlined in Appendix 4, we find that 15 out of its 40 occurrences in the 1950s corpus are in the context of case descriptions, a context which is absent from their usage in both the 1970s and 2000s, thus providing further evidence for the effacement of the narrative style and its replacement by the descriptive/statistical study. This shows how the identification of words through Keyness in relation to a reference corpus, does not allow an examination of the context before words may be discarded as of no interest. Thus a word like *later* may be used at no significantly greater frequency in one or more corpora, as compared to a reference, but its context in them all may be different in a non-statistical way which is of crucial importance to an appreciation of discourses at work.

Thus, while keyword analysis has the advantage in applying a selective process to the mass of data, by which one is in danger of being overwhelmed, this process itself can serve to efface important information about discourses. Hence the analysis of adjectives proceeds from the significant changes in absolute frequencies as graphed in Appendix 16, with the proviso that the detailed examination of some general adjectives may not be possible given the overall aims of the research. In

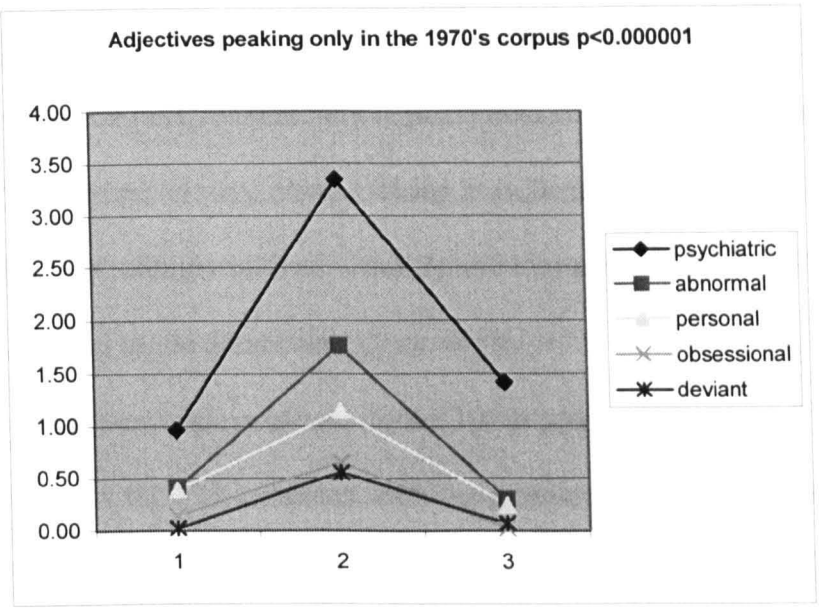
effect, while the statistically significant changes are identified in adjective usage, the ones that appear most relevant to discourse change, are selected out. While this clearly opens the process to charges of bias, the transparency of the choices allows these to be judged in context.

With this in mind, *emotional* is analysed in more detail. In the 1950s there is a majority of collocations with negative nouns in R1 (*emotional abnormalities, difficulties, disorders, flattening, immaturity, instability, maladjustment, problems, stress, tension* and *upset*), as well as wider negative associations like *poverty of emotional responses*. This pattern continues in the 1970s corpus with *emotional abnormalities, blunting, disturbance, instability,* and *turmoil*, although there is evidence of some positive associations in *emotional maturity* and *potential*, albeit confined to one author in relation to Therapeutic Community treatment (Whiteley 1970). By the 2000s corpus it has almost disappeared from general usage, having a formulaic usage in relation to the Cluster B of DSM (*dramatic, emotional or erratic* (see Appendix 1)), and similarly in relation to particular psychological concepts such as *emotional distance, emotional involvement, emotional stability, cognitive/emotional/behavioural patterns*.

Here there is a clear sense of the varied and wide ranging negativity of the 1950s, becoming condensed into the shorthand of the Cluster B terminology, where *emotional* comes to stand for a group of people difficult for services and professionals to manage. While clearly helping in defining and refining the classification for study, what appears to be lost is the considerable elaboration and richness of description present in the 1950s, and with it the potential for creative avenues of thought. Further, the positives which were nascent in the 1970s, have been somewhat reified by the

psychology discourse, working to operationalise and name increasingly tenuous concepts at the loss of rich description.

Adjectives peaking only in the 1970s corpus (Graph 2, Appendix 14)



Here, *obsessional* marks a change in terminology between the *obsessive*, associated with *hysteroid* in the 1950s corpus and the *obsessive-compulsive* of the 2000s corpus. It is of note that *obsessive* makes a significant dip in frequency in the 1970s corpus (Graph 3, Appendix 14). Comparing this change in usage with the DSM and ICD changes of the period, Hysteroid or Obsessional do not feature at all in either classification at any time (Appendix 2), while Obsessive-Compulsive appears in the DSM II of 1968 (American Psychiatric Association 1968). In this context it is also of note that *schizoid*, part of the DSM and ICD categorisations from the 1940s and 50's, only features to a major extent in the 1970s corpus. There has thus been a complex

relationship between the DSM/ICD categories and clinicians' own formulations, up until the 2000s corpus, by which time the DSM standardisation has completely taken over.

From a discourse point of view the peak in *psychiatric*, mirrors the peaking of the nouns *patients, illness, symptoms, psychiatrists, hospital, admission* and further supports the prominence of a medico-psychiatric discourse during this period.

In looking at adjectives that may indicate discourses at work, *abnormal, personal* and *deviant* are clearly worth looking at in further detail. In the 1950s *abnormal* collocates strongly with *personality* and *character* in R1, but also with observations relating to the diagnosis e.g. *abnormal EEG/behaviour/aggressiveness/ideas.* In the 1970s *abnormal personality/ies* account for 97 out of the 123 instances, with the remainder being phrases relating to *abnormal personality* or to symptoms like *behaviour* or *suspiciousness.* In the 2000s corpus the 28 instances mostly concern *abnormal personality development/traits/types/styles.* Thus we see a distinct rise in the 1970s corpus of the formulation *abnormal personality* to describe a particular condition, a usage which has fallen out of favour by the 2000s, but which will be looked at in more detail in terms of its subject positions in Chapter 7. However, by the 2000s corpus, *abnormal* seems to signify the deployment of a psychological discourse rather than the normal/abnormal discourse implied by the 1970s usage.

Alongside this we can examine the occurrence of *deviant*, with only 2 instances in the 1950s corpus, one connected with MMPI scales the other *deviant personality types*, and the 7 instances in the 2000s corpus relating to *deviant personality/ personality characteristics/behaviour.* In the 39 occurrences in the

1970s corpus, the collocates are with *traits, normal traits, personalities, groups, behaviour*, and *socially deviant*. Thus there is a strong indication of the normal/abnormal discourse again, particularly linked to the social world and the characteristics that mark one as different.

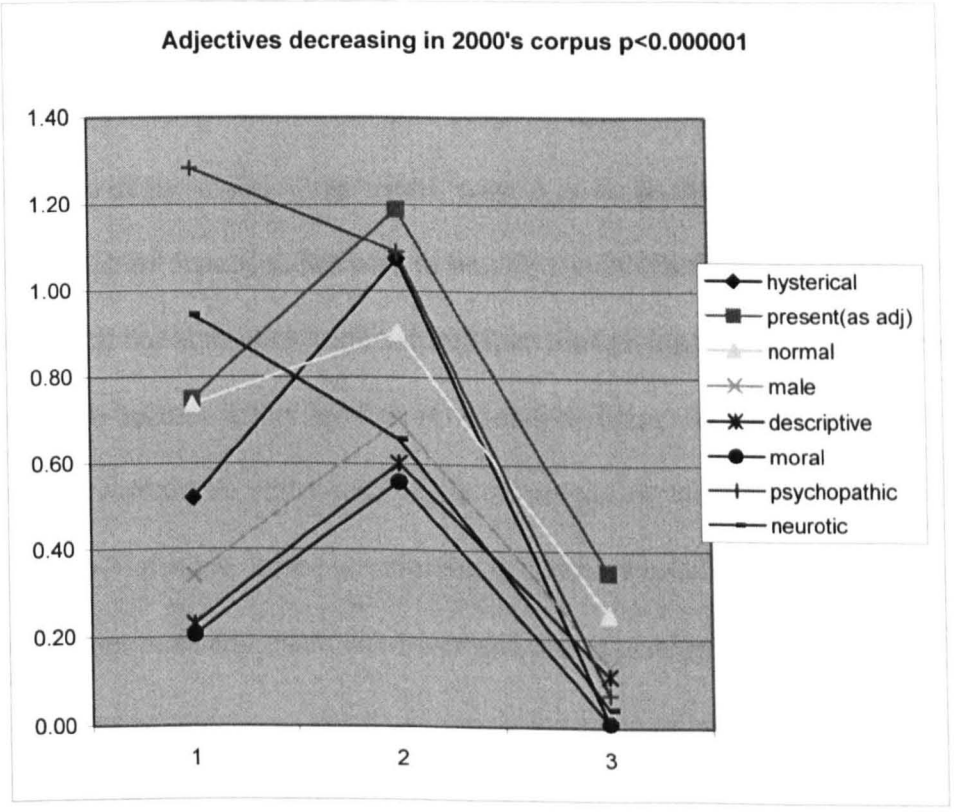
Examining the occurrences of *personal* in the 1950s corpus we find an extremely varied usage from *personal effort, personal communication*, to *personal bias* and *personal weakness*. There is not a clear discourse association. In the 1970s on the other hand there is frequent use of phrases around disturbed personal relationships, as well as formulaic and technical usage such as *personal illness*, *personal constructs*, and *personal disturbance*. The 2000s corpus although reduced in frequency, sees prosodies like *personal environment, personal and social*, and *personal* microcosm. Thus attached to *personal* in the 1970s were discourses around relationships, particularly disturbance in relationships, a meaning which has become disconnected in the 2000s corpus

Adjectives dipping significantly only in the 1970s corpus (Graph 3, Appendix 14)

Having mentioned the dip in *obsessive* above, the behaviour of *new* is the other item of interest in this graph. In the 1950s there are many collocates including *symptoms, index, possibilities, York, approach*, however it is used in too many contexts to draw any conclusions. The optimistic use of *new* is balanced by hedging or expressions of doubt. In the 1970s the context is similarly varied but the usage is minimal. In the 2000s corpus there are clear collocation with a range of developments

related to personality disorder: *new approaches, models, programmes, research, services*, and *treatments,* and these are most often expressed without hedging or doubt. We can thus see some evidence in the 2000s corpus for the emergence of a more optimistic future-orientated discourse in relation to understanding and treating personality disorder.

Adjectives decreasing significantly only in the 2000s corpus (Graph 5, Appendix 14)



In this graph we can see a number of psychiatric terms almost extinguished in usage by the 2000s corpus. Thus *psychopathic* mirrors the falling off in usage of the nouns *psychopath* and *psychopathy*, while *hysterical* also falls out of use, perhaps having been replaced by *histrionic* in the 1980 DSM III. *Neurotic* also decreases in

use from having clear association in the 1950s with *constitution, depressions, groups, symptoms, traits*, all indicating a confident usage as a psychiatric category. In the 1970s *neurotic* participates additionally in the medico-psychiatric discourse by association with *illness, disorder* and *patients*.

In terms of discourses, the reduced appearance of *normal* in the 2000s corpus is also of note. In the 1970s the concordance shows it is contrasted in phrases with *abnormal* and *deviant*, used frequently with *personality* and *traits*, as well as having a statistical usage in *normal controls* and *normal variation* in a sample. In the 1950s corpus, these uses are also present, along with a more colloquial sense of normal as in *thrown off one's normal balance.* In both corpora, apart from the statistical usage, the dominant sense of normal is of the 'right' way to be or do things, as opposed to the deviant or wrong or unacceptable way to be. By the 2000s these various senses are still in operation but at a much-reduced level, as though the discourse of the right way to be has had to become either less overt or less prevalent. We can see other discourses are working to place a scientific gloss over the difficulties of personality disorder, and policies are aimed at reducing the unacceptability of this diagnosis to professionals, services and users, however this diminution in the normal/abnormal discourse and its implications alerts us to look for signs of its continued functioning under other guises.

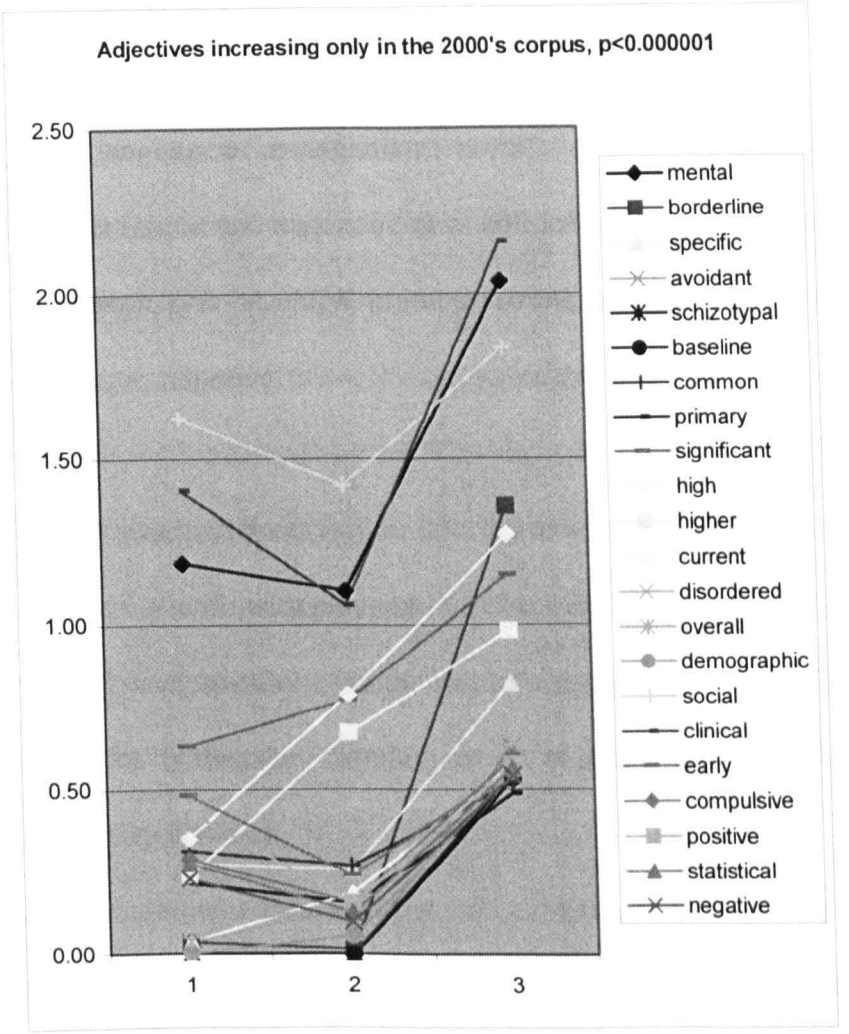
The peak in the use of *male*, seems to be largely due to its frequent use in a limited number of articles especially in the 1970s, along with a general fall of its use in this literature, along with *men* and *women* as noted in the nouns. It would be of interest to see if this correlated more generally with a reduction in the number of studies in this field which involve gender explicitly. *Descriptive* also appears to be

skewed by a very precise and frequent usage in two main articles in the 1970s by one author (Walton et al. 1970; Walton et al. 1973).

In the 1950s *moral* collocates with *character, qualities*, and *values* along with *defect, insanity* and *imbecility*. However by the 1970s although more frequent, this is almost entirely in relation to the occurrences of *moral insanity* and *imbecility* in Lewis's article outlining the history of personality disorder (Lewis 1974). By the 2000s corpus it has almost disappeared. Thus there is more a sense of gradual disappearance than the frequencies alone would suggest. In this context the other uses of *moral* may have been submerged due the highly negatively construed language around moral insanity and imbecility, a reaction to the historical association outlined in Chapter 2.

Adjectives increasing significantly only in the 2000s corpus

(Graph 6, Appendix 14)



In this graph we have a clearer sense of many adjectives rising in frequency in the 2000s corpus. As before, in order to make sense of this a first step is to see if they can be categorised according to the themes outlined above at the end of the noun section, thus:

Terms to do with;

Personality: *borderline, avoidant, schizotypal, compulsive, disordered*

Classical medical discourse: *mental, clinical*

General statistical and study language: baseline, significant, statistical, demographic

Statistical and study language of health: none

The language of management: none

Other (so far uncategorized until collocates examined): *specific, common, primary, high, higher, current, overall, social, early, positive, negative.*

We can now examine these further in order to ascertain the meanings in context. Thus the terms to do with personality reflect the increased usage of terms relating to the DSM categorisation, and the rise of *disordered* in the 2000s corpus is entirely accounted for by the new formulaic usages of *personality disordered* and *disordered personality function.*

Likewise the frequent use of *mental* (191 times) in the 2000s corpus corresponds to the frequent appearance of *mental disorder/s* (86 instances), *mental illness/es* (40 instances) and *mental health,* relating to *staff, services* or *Act* (30 instances). In the 1970s corpus these are also present but in lesser numbers, in addition to a frequent use of *mental hospital*, while the 1950s usage is more varied but with *mental disease* as a frequent collocate. *Clinical* on the other hand has very varied collocations throughout all corpora, for example *clinical implications/characteristics/ populations/ practice* in the 2000s corpus, *clinical presentation/use/diagnosis/ information* in the 1970s and *clinical approach/diagnosis/data* in the 1950s. However its general meaning as a marker of

medical practice rather than theory is consistent but, as a general trend, the clusters are more common in the 2000s corpus. Thus its increased usage signifies greater talk about the world of medical practice, while also confirming a general trend towards greater use of formulaic phrases.

In terms of statistical language *baseline, significant* and *statistical* are used within all the corpora almost without exception in the statistical context; hence their increase over time directly correlates to more talk about statistical tests. Baseline in particular only appears in the 2000s corpus, with varying association for example, of *assessment, measures* and *characteristics.*

Demographic also only appears in quantity in the 2000s corpus, chiefly with *characteristics* but also with *sub-groups* in R1, and contrasted with *historical data* or *clinical variables.* In essence it appears to stand for information about populations, and as such, confirms a particular discourse of statistical language, but also stands for the reification of human characteristics reduced to figures.

We can now turn to the adjectives initially classified as Other. *Specific*, along with its less frequent *non-specific* is mainly associated with *diseases* and *disorders* in the 2000s corpus, but also has a significant statistical usage, in *specific associations/co-occurrences* and links to *risk* as in:

> *Borderline cases experienced a non-specific range of both adverse early environmental factors and neuropsychiatric risk factors.* (Coid 1999)

Thus, given its relatively low frequency in the previous corpora, its increase is in keeping with the increase in statistical language, but also the transformation in

language about people, from the narrative and individual to the statistical and operationalised, as in the example above.

Common shows a marked increase in the 2000s corpus, partly due to the use of *common mental disorder/s* and partly by its use as *common in* for reporting study results as in:

> *Paranoid*
>
> *This category is more common in males and persons of lower social class, and more common among relatives of probands with schizophrenia than among relatives of controls.* (Coid et al. 2006)

In the 1950s and 1970s corpora the use is much more colloquial, for example *in common, common good*, etc. The rise in *primary* in the 2000s corpus seems to be due to the new usage of *primary care.*

High in the 2000s corpus is used very frequently in the reporting of results, thus *high rates, high prevalence*, but also in the context of *high-risk. Higher* follows a similar pattern in result reporting appearing as *higher levels/order/mean/prevalence/rates* and *than.* The appearance in reporting in the 1970s and 1950s is similar with the additional use of *high/er frequency.* The overall increase in usage in the 2000s corpus therefore again corresponds to an increase in the reporting of study results. It also represents the tendency, very evident in the 2000s corpus, of talking about human issues as scores, an example being:

Our findings indicate higher rates of negative events in subjects with more severe PDs and suggest that negative life events adversely impact multiple areas of psychosocial functioning. (Pagano et al. 2004)

Current, relatively infrequent before the 2000s corpus, is used here with quite varied collocates, *current study/symptoms/models/investigation/debate...*, however the overall sense is of a kind of self reflexivity, a marker of the nowness of the writing. It is current but in transition and hints of a discourse of change, of a field that is aware that it is in transition, and not fixed. This discourse is not expressed explicitly, it remains just below the surface.

Overall also is used rarely before the 2000s corpus and appears primarily in result reporting e.g. *overall prevalence/agreement/health...*

Social is quite common through the corpora but does show a significant increase in the 2000s corpus. In the 2000s corpus of the 172 occurrences, there are several frequent collocates in R1 such as *social problem solving* (23), *social adjustment* (10), *social class* (21), *social functioning* (16), *social dysfunction* (5), *social phobia* (14), *social roles* (9). Thus while it contributes to the medical discourse and the statistical/study discourse, its main usage is in phrases which encapsulate aspects of being human, as in the following quote.

If that is the case it would support our previous proposal (Hill et al, 1989; Hill & Rutter, 1994; Hill et al, 1995) that persistent dysfunctional patterns of social role and interpersonal performance may be common to many of the personality disorder categories. (Hill et al. 2000)

What appears to be identified in this usage are features of personality disorder, however what these features actually comprise seem much more vaguely specified than the narrative tales of the 1950s. This construction thus effaces the subjective and descriptive social dimensions of behaviour and interpersonal interactions, replacing them by a vague label, which can then be applied in the circular definitions previously critiqued. Further research may be required to investigate whether ready-made phrases like 'persistent dysfunctional pattern of social role' are transferring into the clinical setting with real people and at what consequence.

In the 1970s corpus there are different collocates for *social*, *adjustment/deterioration/deviance/group/withdrawal* and *workers*. This provides further indication of the normal/abnormal discourse at work in this decade. In the 1950s corpus *social* has an extremely wide collocation including all the above, but also *social obligations* and *responsibility*, a discourse that has disappeared from even the 1970s corpus.

Early is common in both the 1950s and 2000s corpus. In the 1950s it collocates strongly with *adverse influences*, *deprivation, development, experiences* and *life,* thus indicating frequent textual referent to causal factors in the development of the condition. This is virtually absent in the 1970s corpus, perhaps reflecting the greater influence of the medico-psychiatric discourse. However this discourse of developmental influence returns in the 2000s corpus but yet again in a more codified form as *early (environmental) adversity*. Thus there is simultaneously acknowledgement of the effects of poor parenting and abuse on the development of personality disorder, along with the effacement of what these actually are through

naming, and also what the mechanism of cause and effect may be. In this process the lack of knowledge at the centre of personality disorder is hidden.

Negative is not frequent before the 2000s corpus and there it appears linked to the statistical discourse through *negative associations* and *negative predictive value.* However its chief usage is with *events* or *life events,* another formulaic phrase representing a more messy reality, and supporting the thesis that there is a strong tendency to operationalisation aspects of life at work in the 2000s corpus. *Positive,* although more frequent before the 2000s corpus, where it is used with statistical language, shows a very similar pattern to *negative* and collocates strongly with *events.*

Following this examination, we can reassign adjectives that increase significantly only in the 2000s corpus, to the themes as follows, noting that some changes in adjective frequencies are accounted for by changes in more than one theme:

Terms to do with;

Personality: *borderline, avoidant, schizotypal, compulsive, disordered*

Classical medical discourse: *mental, clinical, common, primary*

General statistical and study language: *baseline, significant, statistical, demographic, specific, common, high, higher, overall, positive, negative*

Statistical and study language of health: requiring the operationalisation of messy life –*social, early, positive, negative*

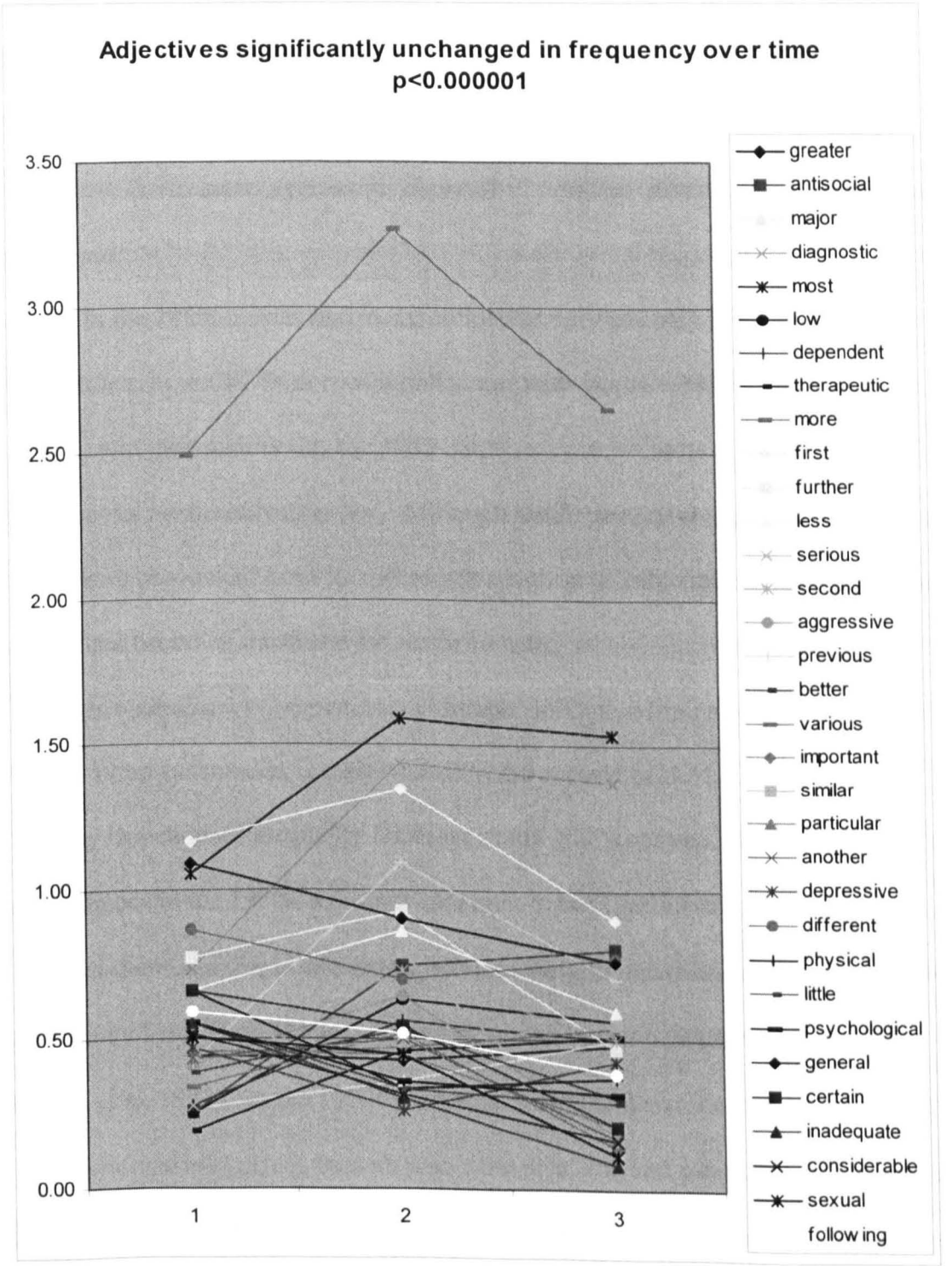
The language of management, the operationalisation of treatment and health represented by the use of *outcome, costs*, and *assessment*: none

A discourse of transience: *current*

To summarise, although it requires considerably more work examining collocations and concordances to ascertain the functions of the commonest adjectives in discourse in these corpora, they do reveal strong links to the themes already emergent from the noun analysis, as well as indicating other possible discourses at work.

Adjectives significantly unchanged in frequency over the corpora

(Graph 7, Appendix 14)



This graph displays 33 adjectives whose changes over the corpora are not significant at the level $p<0.000001$ and which could potentially be set aside in the analysis. However, given the previous observations on significance and salience, a number of adjectives will be examined from this group which suggest potential information about subject positions, discourses or labels. These are *antisocial, dependent, therapeutic, aggressive, depressive, physical, psychological, inadequate,* and *sexual.*

In the 1950s corpus *antisocial* collocates very strongly in R1 with *behaviour* and *conduct.* In the 1970s corpus it collocates with *behaviours* and *acts*, but most strongly with *personality.* By the 2000 corpus it occurs almost entirely in the context of *antisocial personality disorder.* Although the frequency change is not significant, we do see a movement from its use as a description of behaviour to a diagnostic label, which then becomes shorthand for the behaviour.

In a similar way, *dependent*, although with some limited use in the sense of dependent on substances, is mainly used in the context of the DSM diagnostic category Dependent Personality Disorder in the 2000s corpus. Although not available as a category in the 1970s, as it first appeared in the 1980 DSM III (see Appendix 2), it is used there in a diagnostic sense, but according to individual usage, thus *passive-dependent* (Tyrer et al. 1979a), *dependent* or *dependent type* (Presly et al. 1973; Walton et al. 1973). In the 1950s corpus, it is used to a small extent in the context of *dependent type* but collocates with *weak*, but also, *shy* and *submissive.* Thus we can see again the move from a descriptive category, with quite clear associations with negative aspects of character, into a defined and agreed diagnostic category. However

what is of interest is that the discourses associated with the early use of dependent may still be in operation and evident from the study of subject positions later.

Inadequate shows a non-significant decrease over time, and in the 1950s it collocates strongly with *personality, psychopath* and *aggressive,* and is used largely to describe an agreed category of personality disorder for example in article 'The Inadequate Psychopath at Camp Hill Prison' (Knox 1960). Although a vague category, people within it are described as having shown:

> ... *a weakness of personality from an early age. Many give histories of screaming fits, of severe nightmares, of bed wetting, of truancy from home or school, of visits to psychiatrists as children, of quarrels with parents or other members of the family... Their total disregard for the needs or conveniences of others, their lack of foresight, their tendency to satisfy immediate needs at the expense of future good are marked features in their lives and have led them into much social trouble.* (Knox 1960: 1471)

Indeed *weak* tends to occur in the descriptions where inadequate is used although it does not appear as a collocate to 5L or 5R. Further, in this article it is contrasted with *aggressive*, whereas in others *aggressive* appears as part of the category (Monro 1955). Hence one can see how overlap in categories may have appeared in the 1950s, particularly with different authors using different personal classifications. In the 1970s there is again varied usage as a category *inadequate personality* being described as 'ineffectual and socially inept'(Presly et al. 1973), or 'insecure and unstable' (Walton et al. 1970). By the 2000s this usage as a category

has disappeared, and the main usage in relation of patients is the sense of *feels inadequate*. Thus in a reverse sense to *antisocial*, *inadequate* has moved from a common, albeit woolly, category in common use, to a more lay usage to describe a feeling. However, in order to access the sense in which it is used, as a feeling is it not necessary to call up the discourses present when it was used as a category, i.e. ineffectual, insecure? This usage may then have moved out of psychiatry into the mainstream in a similar way to anxiety, depression, and schizophrenia. This raises the question as to whether the discourse story can be seen simply as changes evident in language use, or whether significant background knowledge as a language user is required in order to interpret what is going on.

In the 2000s corpus, *aggressive* is used rarely in the sense of behaviour, and most commonly linked with *passive-aggressive*, referring to the DSM III category of personality disorder (Appendix 2). In the 1970s it is used frequently in relation to Henderson's three categories of psychopath (see Chapter 2), as well as other authors' individual category systems, and collocates with *behaviour* and *acting out*. This is a similar distribution to the 1950s although the *acting out* phrase is particular to the 1970s. Thus there is a similar but more muted pattern to *antisocial*, where actual description is eschewed over time in favour of ready-made labels. As an aside if we look at *violent*, we see a similar move from usage as violent acts and behaviour to exclusive use of general phrases such as *violent crime* or *violent death*, as well as an overall decrease in use, further confirmation of this movement from messy life to neat phrases, encapsulating much, but losing intensity and meaning in the process.

In the 2000s corpus, *depressive* mainly occurs with the collocate *disorder* and frequently as *major depressive disorder*, or *depressive syndrome*, and is thus used

mostly in a defined clinical fashion. In the 1970s it is less used, and when so it is mainly as a diagnostic label such as *depressive illness*, *psychotic depressive* or *depressive neurosis*. It usage again in the 1950s is clinical with *depressive psychosis/psychotics* common but also in relation to personality as in *depressive group of traits* or *depressive psychopath*.

Therapeutic increases gradually but not significantly over time. In the 1950s the usage is very wide from *therapeutic community* to *therapeutic possibilities* and *results*. By the 1970s *therapeutic community* dominates the usage, but largely due to the one text covering this area (Whiteley 1970). By the 2000s corpus, this is still dominant but appears in more texts, often discussing earlier studies in this area, while *therapeutic relationships* also becomes a common collocate. Thus here we can see the emergence of the therapy discourse in relation to personality disorder, and specifically the move from residential and social treatment to a focus on the relationships between professionals and patients. However this is still clearly a minority interest in this particular literature.

Physical is commonest in the 1950s, tends to be contrasted with *mental*, and has a number of common collocates in R1, namely *attributes, condition, constitution, health, illness, inferiority, symptoms* and *types*. In the 1970s corpus there are no commonest collocates but *illness, symptoms, treatment* and *cause* are present. In the 2000s corpus *physical function/ing score* accounts for a third of the usage, with the next commonest collocation being *abuse*. It tends to be contrasted with *social* and *psychological*. Here we see the emergence of talk about the social concomitants of personality disorder, but there is also confirmation of the discourse of turning life into scores.

Psychological is also commonest in the 1950s, where *test* and *testing* are its commonest collocate. *Correlates, attributes* and *traits* are also present. In the 1970s corpus, it is least used, and *tests* is still the commonest collocate, followed by *constructs*. In the 2000s corpus there is a range of collocates in R1, *approaches, difficulties, functions, literature, morbidity, problems*, and *treatment,* but none particularly common. In these trends we can see further indications of the hypothesis mentioned above; of the 1950s taking the psychological testing of the earlier decades and applying it to psychopathy, the 1970s seeing the emergence of specifically designed tools for apprehending the concept, while by the 2000s the explicit debt to psychology is effaced.

Sexual is also commonest in the 1950s corpus although its usage changes radically over time. In the 2000s corpus it is not common, but occurs largely connected with *abuse* or *assault,* in the 1970s it is associated with *deviation* and in the 1950s there is mention of *promiscuity* and *perversion* but its main context is of *excitement*, along with *desires* and *advances*, all occurring within case history descriptions. Thus we can see the disappearance of concerns about the patient's sexuality in general terms, but the emergence of the identification of the links between sexual abuse and personality disorder. However the nature of these links is not specified, what is identified is an event which can be counted, and then termed a risk factor.

> *Subjects were asked whether they had experienced penetrative intercourse (vaginal or anal) with a first-degree relative or adult second-degree relative, to constitute 'incest' (n=44, 17%), whether they had experienced rape or other*

sexual assault involving a stranger (but not including exhibitionism or propositioning) (n=46, 18%) and whether their siblings (n=91, 35%) or parents (n=52, 20%) had received criminal convictions. Only 48 (18%) subjects had experienced none of these risk factors. (Coid 1999)

Discussion of adjective analysis

From the above analysis we can see that the adjective changes require considerable study in order to extract information around discourses at work and discourse change. They do not readily fall into the categories used with nouns, but their examination does enable further evidence to be examined for the discourses uncovered in the noun analysis and provide information that points toward other discourses at work at various times, for instance the normal/abnormal discourse prominent in the 1970s, and not immediately evident from the noun analysis.

Potentially however, there is a criticism that the information they provide is used selectively to bolster the evidence from the noun analysis, while that which does not fit is excluded. While it is acknowledged that many avenues are not explored in more detail, it is felt that the adjectives that are examined most, are chosen as they emerge from frequency tables and significant changes over time, as well as their relevance to the specialist language of personality disorder and psychiatric articles that has a rationale in the refined research question.

Lexical Analysis of Verbs in the Diachronic Corpora

In approaching the verb analysis the first step, as before, was to develop a list of the most frequent verbs in each corpus, however it was noticeable that the decline in frequencies down the resulting table proceeded at a much greater rate than with the nouns and adjectives, hence only the first 30 are included in the list in Appendix 15 to avoid including low frequency words. In addition the modal verbs such as *can, may* and *would*, although frequent were not included in this list of most frequent verbs as they are being covered in much more detail in the following chapter concerning subject positions. With this in mind, from Appendix 15 we can look at the overall changes in the most frequent verbs over time.

Verbs that disappeared from top 30 after 1950s: *show, called, became, seem, say, cannot, felt.*

Verbs that appear in top 30 for the first time in the 1970s: *diagnosed, associated, admitted, using, included, applied, rated.*

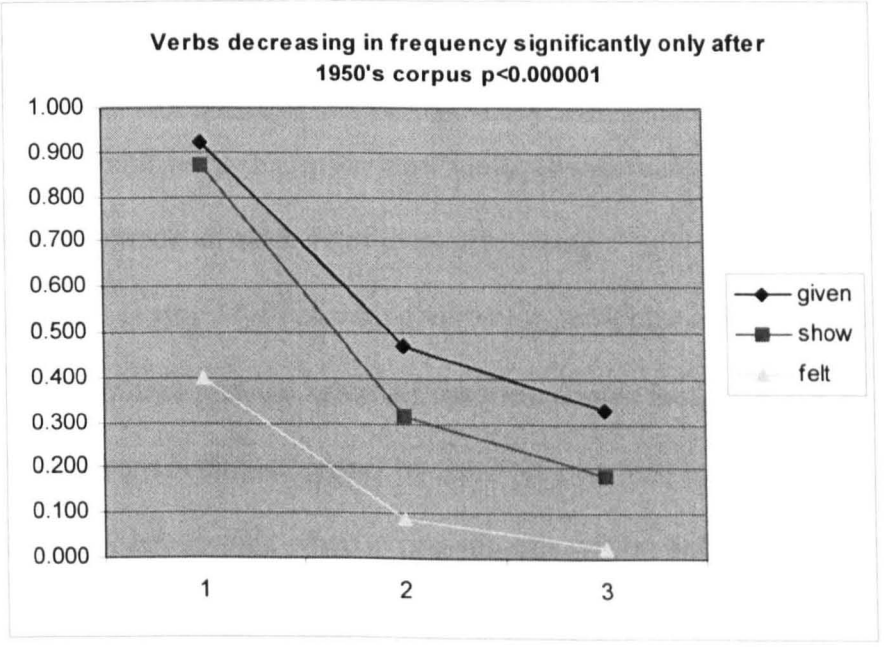
Verbs that appear in top 30 for the first time in the 2000s: *based, compared, reported, obtained, assessed, identified, having.*

Looking at these we again have a sense of the hospital/medical focus of the 70's, a more human and authorial writing in the 50's and the dominance of classification in the 2000s.

We can now explore the changes at significance level $p<0.000001$ and these graphs are shown in Appendix 16. At first sight this appears to give a lot less

information about significant changes than does the noun analysis, or even the adjective analysis, as the majority of changes are not significant at the level chosen. However, overall the graphs of significant change do reveal some salient changes which are examined below.

Verbs decreasing significantly after the 1950s corpus (Graph 1, Appendix 16)



Here we see three verbs falling in frequency quite markedly over the corpora, however the links to changing discourses are difficult to demonstrate. Thus, for example, *given* in the 1950s corpus, has numerous different senses, such as *given situations, treatment given, information given, given a chance, given a review, given in the table below* and so on. Further, the commonest collocates down to 5 to 5L or 5R, are not nouns or adjectives which give an indication to discourses, rather they are prepositions such as *of, to, as* and versions of the verb *to be*, such as *is, are, was, were*. When examined in the 1970s corpus and the 2000s corpus a similar pattern of usage emerges, the only difference being in the 1970s *personality, disorder,*

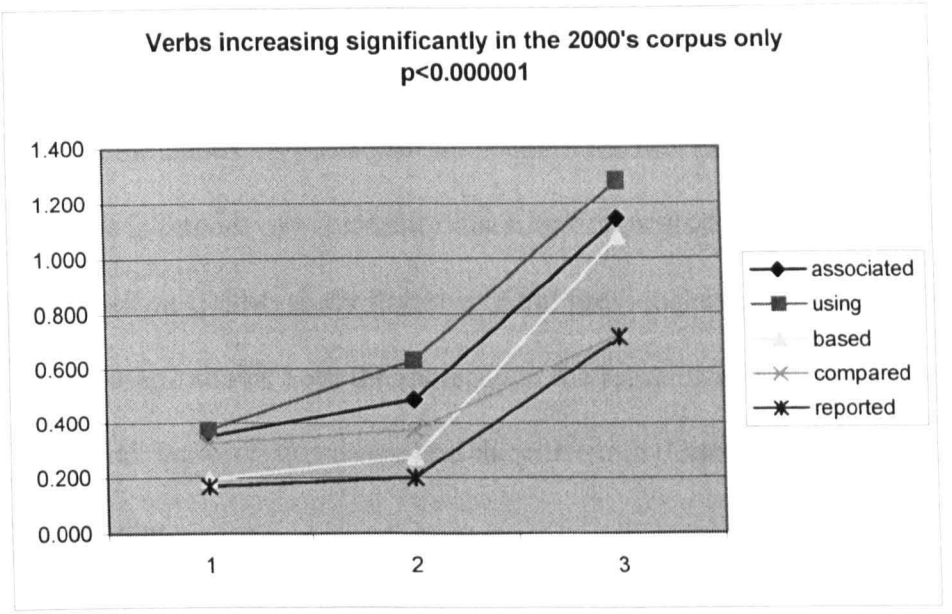
diagnosis and *patients,* occur as low frequency collocates and in the 2000s, *table.* Thus while the 1970s collocates provide further albeit weak evidence for the emergence of the medical discourse around personality disorder, overall, all that can be concluded is that there is a general decrease in the use of *given* over time, which may simply reflect a change in language style, an investigation beyond the scope of this study. *Show* shows a similar wide pattern of use which decreases over time and which appears to be unconnected with particular discourse changes. This may reflect a particular issue with verbs that often have multiple uses in language and are therefore harder to track as markers of discourse change.

However it is still worth checking verbs for particular usages before moving on, and indeed, *felt* does provide some information about changes in the discourses, particularly because it is almost extinct by the 2000s corpus. In the 1950s it is used in two main senses, *it is/was felt*, when expressing the writers reflections on a case, and *he/she felt*, when describing that case. These usages are still present in the 1970s corpus but in reduced numbers, thus providing another marker of the move away from case description and reflection, but they further show the nature of what is lost in this transition; that is both the views of the patients, albeit translated through the writer, and the views of the writer about the stories of the patients. This significantly both decreases the arena for patients to have their stories told as a routine part of psychiatry, and also decreases the arena for discussion and challenge of the writer's position. They can no longer be questioned on what they feel about a particular issue, only on the scientific veracity of the study. Thus the author's own particular views are effaced and, instead, the reader is invited to come to the same conclusions as the author through the transparency or opacity of the evidence.

Verbs decreasing/increasing significantly over time, dipping in the 1970s and 2000s (Graphs 2,3,4,6, Appendix 16)

Examining the changes in these graphs involves looking at *is, are, be, have, has, was, had, seen* and *were*. *Is, are, be, was* and *were*, are, as expected extremely common and used in such a variety of instances and with no common collocates that would give an indication to discourses at work, that their changes over time will not be examined further in this section, however, their involvement in delineating subject positions will be explored in the next chapter. *Has* and *had,* are used similarly commonly and broadly in terms of usage and do not present any common clusters or prosodies so will not be examined further in this section. The falling off of *seen* seems to be largely due to the virtual absence in the 2000s corpus of the prosody, *it is/can be seen*, common in the 1950s and particularly the 1970s, when reporting results. This does not necessarily mean a challenge to the thesis that result reporting has increased over time, however, as indicated in the next section, it does mean the way in which it is reported has shifted. The formulation *seen* (by a service or professional) seems to be fairly consistent through the decades.

Verbs increasing significantly in the 2000s corpus only, p<0.000001 (Graph 5, Appendix 16)



Here we see a notable increase in *associated, using, based, compared,* and *reported,* all of which are worth examining in more detail as they seem to imply particular discourse usage.

In the 2000s corpus, the frequency of *associated* is accounted for by the increased usage of the phrase *associated with,* most often used to describe statistical results, and further confirming the rise in this discourse.

In the 1950s *using* is most associated with using tests, either psychological or statistical. In the 1970s this refers to statistical tests, but also *diagnostic criteria for research*, while in the 2000s corpus, the links are with statistical tests, *data,* and tests specific to diagnosing personality disorder. Thus the use of *using* reflects the general increase in statistical language noted above in the 2000s corpus, but also the move

from the application of general psychological techniques to personality disorder to diagnosis-specific tools.

Based, in the 1950s is not common, but where used, it is largely in the sense of *based on* (tests, factors, techniques). In the 1970s the usage is very similar and also not common. In the 2000s corpus *based on* is again the most common usage. The general structure is (model of personality disorder/diagnosis/treatment/statistical techniques) *based on* (DSM, study findings/ data/ previous results). Hence the increase in this usage shows both the increase in the reliance on statistical studies, but also the direct link between this usage and the current understanding and treatment of personality disorder.

> *In this paper, we explore the underlying dimensional structure of personality disorder, propose a novel approach to its diagnosis, and outline our concepts of its etiology and treatment based on the seven factor psychobiological model of temperament and character* (Svrakic et al. 2002: 189)

> *The required criteria were those that occurred most frequently, based on prior studies in eastern Baltimore* (Samuels et al. 2002)

> *The two raters, a psychiatrist (SK) and a psychologist (AO), administered a semistructured interview based on the Adult Personality Functioning Assessment measure* (Parker et al. 2004)

The pattern is not readily evident until these types of statements are collected together, when we see how models influence research design, which influences the studies, which influence treatment and how people with personality disorder are ultimately perceived.

Compared is used across all corpora in the same way, either to describe the details of a statistical study or report its results, thus the marked increase in the 2000s corpus is again confirmation of the trend of increasing talk about studies and particularly statistical studies.

In the 1950s and 1970s corpora *reported* is generally used infrequently in the context of referring to previous articles or studies. In the 2000s corpus this usage increases, but is also joined by a significant use of *self/subject* reported data. Thus we have both further indications of the interdependence of study discourse, but also the apparently missing patient voice. However this is a voice which has been altered and translated almost beyond recognition in the 2000s corpus, compared to the use of *felt* in the 1950s corpus. Thus we can recognise:

> *She felt "hopeful" that she might be helped but was not able to state for what.* (Diethelm 1960)

and

> *He felt depressed, suffered from headaches and insomnia. He had phases when he felt as if he were standing apart from his body; as if it were a puppet controlled by himself and somebody else;* (Davis 1950)

However the following extracts have come on a long journey from their original experiences, and have lost considerable nuances and individuality in the process.

> *Personality disorder was confirmed when the subject reported three or more of: prolonged unemployment when expected to work; physical abuse or cruelty to family members on three or more occasions;* (Coid 1999)

> *BPD subjects reported significantly more total negative in comparison with all other groups ($P < 0.01$), and significantly more health and social stressors than AVPD subjects ($P < 0.01$)* (Pagano et al. 2004)

> *The severity of self-reported mood and psychiatric symptoms also improved substantially relative to the control group.* (Bateman et al. 2000)

Verbs unchanged significantly from corpus to corpus (Graph 7, Appendix 16)

This is the largest group within the categories of significant change amongst the verbs and will not be covered in detail, as the changes do not reach the required significance level. However we can note in passing that *diagnosed* shows a distinct peak in the 1970s, perhaps reflecting the more explicit use of the medical model in this corpus, while the falling off in the 2000s may be accounted for by the decrease in studies specifically trying to link diagnosis with diagnostic tools, such as those of

Walton (1973) or Tyrer (1979b) in the 1970s. By the 2000s the issue of diagnosis is being taken for granted, and instead the links between personality disorder and other factors are being examined, hence the increase in *identified* in the 2000s corpus, generally referring to *personality disorder* and concepts such as *attachment* or *risk*. *Assessed* is also noted to increase after the 1950s corpus and in the 1970s its collocates are *patient/s* and *raters,* while by the 2000s it is *personality disorder* and *using*.

Discussion of verb analysis

The verb analysis seems to proceed slightly differently from the noun and adjective analysis perhaps due to the multi-use quality of verbs. What is however generally being identified are the salient verbs, those which have a meaning in the context of the research area. Thus although not as readily analysable as the nouns or even the adjectives, verbs do provide information of discourses at work and also how those discourses may link together in language use. It seems to be this latter point which is particular to the verb analysis, for example in the usage of *based on* to connect the statistical treatment of personality disorder with its usage as a clinical entity. In terms of further research the verb analysis could probably be extended much further.

What is the problem?

Finally in this analytic section, as mentioned above in the noun analysis, we will look specifically at the nouns *problem* and *problems*, to see if these give an insight into what may be seen as problematic in each corpus. These words are distributed as follows through the corpora.

	1950s corpus		**1970s corpus**		**2000s corpus**	
	Frequency	**Hit's/1000**	**Frequency**	**Hit's/1000**	**Frequency**	**Hit's/1000**
problem	56	0.678	17	0.244	88	0.939
problems	47	0.569	30	0.431	52	0.555

The concordance lines for the occurrences of *problem/s* were searched in each decade and only those phrases extracted which referred to a general problem being mentioned at that point in the article, concerning specifically *psychopathy*, *personality disorder* or other equivalents. Thus individuals' problems were not included, either of clinicians or patients, for example *emotional problems, marital problems, clinical problems*, nor phrases referring to particular therapies, such as *problem- solving* in the 2000s corpus which related to both therapy and a particular model of public health epidemiology. Of further note is that, in the 1970s corpus, while there were many fewer instances of *problem*, nearly all of them concerned conceptual issues around personality disorder or psychopathy, as the usage of *emotional* or *personal problem* had almost disappeared in this decade.

The statements relating to general problems were then collected and classified according to the issues to which they refer, in order to facilitate an examination of

any trends. These problems themes covered Definition and Classification, Conceptual Issues, Social Issues, Epidemiology, Treatment, Research. This is only a rough classification, not intended for rigorous analysis as the statements often contain multiple referents, which can cover several categories, however it is sufficient to appreciate the concerns relating to *problem/s* in each corpus. These descriptions were collected under the themes in Appendix 17. Note that these are not direct quotes but involve reading the text around the phrase and summarising the issue that is described as the problem, but using the descriptions in the texts where possible.

Examining Appendix 17, we can clearly see penetrating and incisive comments in each corpus concerning the difficulties presented by psychopathy and then personality disorder as a concept, spanning all corpora. Indeed the quality of thought and the some of the issues addressed have not changed substantially since the 1950s. Thus in 1953 Valenstein is concerned with lack of understanding of fundamental issues in relation to the psychology of the person, before even the concept of personality and disordered personality can be approached (Valenstein et al. 1953), while Kendell in 2002 is concerned about the limited understanding of the cerebral mechanisms behind them (Kendell 2002a). The definition and classification of personality disorder remains an issue through each corpus, while anti-social behaviour is also a recurrent concern, reframed as high-risk or burden to the criminal justice system in the 2000s corpus. We can see issues in distinguishing normal from abnormal personality surfacing in the 1970s corpus, still present in the 2000s corpus, and, in addition, the differentiation of mental illness from personality disorder raised by Walton and Foulds in 1970s is still being debated by Kendall and others in the 2000s corpus, without any sense of resolution.

There are differences over time however. In particular it is clear that, while research issues appear to be contemporary concerns in both the 1950s and 2000s corpus, the 1970s does not connect these as much to the idea of a problem. The language of research is also clearly different in the 2000s corpus, in ways which have been explored above in the noun analysis.

Finally the running theme of treatment does not seem to follow an expected pattern of emerging only in the 2000s corpus, instead we see complex and varied approaches from therapeutic community to physical and psychological models mentioned in the 1950s corpus, falling away in frequency in the 1970s but then not being associated with *problem* in the 2000s corpus. Instead the focus of the problem is researching therapies on personality disorder and the technical issues involved. This does seem to signify a shift where in the 1950s corpus there was a set of discourses around treatment involving stories about successes and problems; a discourse of engaging with the problem directly by trying things. In the 2000s corpus the discourse is firmly with defining and researching the problem as the only way of tackling it, thus closing any alternatives.

Reading the corpora through the perspective of statements associated only with *problem/s* allows another sense of what may be different between the corpora to emerge to that arrived at through a sequential reading of documents across time. One may critique that these statements are taken out of context and hence their meaning may be distorted, but on the other hand, it is precisely this taking out of context that allows a different interpretation to be practised. The compromise is ensuring that sufficient context is maintained around the concordances such that the meaning of the words in context is clarified. In the case of *problem/s*, to engage with what they were

referring to, often required the examination of neighbouring sentences but rarely more than one paragraph either side. This retained the context sufficiently to extract the themes, which could then be placed side by side and examined together for large scale changes over time.

At this stage further discussion of the findings of this chapter will be postponed to Chapter 8, in order to incorporate the examination of subject positions in Chapter 7 in this final discussion.

Chapter 7: Analysis of Subject Positions in the Diachronic Corpora

Introduction

In this chapter the statements around the most frequent discursive constructions *psychopath** and *personality disorder** will be examined in each corpus using the approach based on subject positions as described in Chapter 5, and the categorisations developed in the pilot study described in Appendix 18. In this method the collocations around the most frequent versions of the lemma are first examined to uncover any common phrases. The concordance lines around these are then categorised and examined with a view to exploring the positioning process at work in the deployment of these words or phrases. In addition, the discursive construction *abnormal personality* common in the 1970s corpus will also be examined as well how *patient/s* is used in the corpora. In each corpus, the analysis of the variations on the lemma will be followed by an analysis of the associated factual and modality statements, in order to shed further light on the subject positions implied by their use in the texts.

Psychopath in the 1950s corpus*

The discussion of 2 word clusters in Chapter 6 and an examination of Appendix 7 show that *the psychopath* and *psychopathic personality* are two frequent appearances of the lemma *psychopath** in the 1950s corpus, however, before investigating further, all the other forms are collected in Table 8.

Table 8: Forms of *psychopath and their frequencies in the 1950s corpus**

Word	Frequency in 1950s corpus	Hits/1000	No of texts
psychopath	94	1.14	14
psychopathic	106	1.28	18
psychopathies	2	0.02	2
psychopathologic	5	0.06	1
psychopathological	3	0.04	3
psychopathology	8	0.10	4
psychopaths	54	0.65	13
psychopath's	1	0.01	1
psychopathy	66	0.80	7
*psychopath**	339	4.11	24

Based on these frequencies *psychopath* and *psychopathic* will be investigated first, followed by *psychopaths* and *psychopathy.* The collocates of *psychopath* are shown in Table 9.

Table 9: Collocates of *psychopath* in the 1950s corpus

Word	Total	Total Left	Total Right	L5	L4	L3	L2	L1	Centre	R1	R2	R3	R4	R5
THE	126	99	27	11	14	6	14	54	0	4	6	6	5	6
PSYCHOPATH	104	5	5	0	3	2	0	0	94	0	0	2	3	0
OF	54	44	10	6	5	5	25	3	0	0	0	5	2	3
AND	33	11	22	2	2	1	5	1	0	11	0	0	5	6
IS	26	6	20	1	2	1	2	0	0	14	1	1	2	2
A	26	11	15	1	0	1	2	7	0	3	7	4	0	1
IN	25	14	11	7	3	1	3	0	0	5	1	2	1	2
TO	22	9	13	1	4	2	2	0	0	2	3	2	3	3
THAT	19	12	7	3	0	0	9	0	0	1	2	2	0	2
AS	16	6	10	1	1	3	1	0	0	3	3	2	1	1
BE	14	5	9	3	2	0	0	0	0	0	3	3	0	3
WITH	11	4	7	0	2	1	1	0	0	2	1	1	1	2
OR	10	4	6	2	0	2	0	0	0	1	0	1	0	4
BY	10	0	10	0	0	0	0	0	0	3	1	2	1	3
HE	9	1	8	0	1	0	0	0	0	1	3	2	1	1
MAY	7	1	6	0	1	0	0	0	0	3	1	0	2	0
TERM	6	6	0	0	0	0	0	6	0	0	0	0	0	0
CAN	6	2	4	1	1	0	0	0	0	3	0	0	1	0
INADEQUATE	6	6	0	0	1	0	0	5	0	0	0	0	0	0
WHO	6	0	6	0	0	0	0	0	0	3	0	0	2	1
HIS	6	0	6	0	0	0	0	0	0	0	2	2	1	1
AGGRESSIVE	6	4	2	0	0	1	0	3	0	0	0	1	0	1
THIS	5	0	5	0	0	0	0	0	0	1	0	1	1	2
IT	5	1	4	1	0	0	0	0	0	1	0	1	0	2
NOT	5	1	4	0	0	0	1	0	0	0	3	0	0	1
AN	5	3	2	1	0	0	2	0	0	0	2	0	0	0

From this table we can see that *inadequate* and *aggressive* collocate to a small extent particularly in L1, but by far the commonest collocate is *the* in the left positions, amounting to over half the total occurrences in L1 alone. The 54 concordance lines involving *the psychopath* were collected and then sorted according subject position statement categories developed in the pilot study (Appendix 18)[4]. Examining this, it is noticeable that, unlike *subject/s,* there is only one line in **Categorisation Groups** and that is qualified by *often.* Several of the statements in the

[4] Due to the limits on word count for the thesis, the concordance lines will not be included in the Appendices, however they are available for inspection as required

group **Categorisation Diagnostic** are also qualified, for example with *hope*, *can* or *for the moment*. Reading these statements together one gains both a sense of uncertainty in the diagnostic process, but also of attempts to place *the psychopath* within existing systems but with some degree of equivocation. This impression is further enforced by the doubts expressed in the **Conceptual** section, where its medical status is under question; issues which have surfaced again recently (Kendell 2002a).

The category of **Attributes Psychological** illustrates a number of theories at work; namely, psychoanalysis, Eysenck and extroversion, developmental theories, behaviourism, sexual causation, and intelligence. In short there is a diversity of quite explicit models, a point which Livesley notes, remains the case in the present classification system (Livesley 2001). These statements also mostly have a neutral or technical orientation.

Attributes Social focuses on *the psychopath* causing suffering, fear and people to feel ill at ease. This is of particular interest in terms of positioning, since it clearly places the psychopath as other, and, almost as a defining feature, a cause of discomfort to people and society. This positions society as functioning comfortably and the psychopath as a disturbance.

Attributes Physical concern the possible causes of psychopathy in damage to or development of the brain, again a current preoccupation with the development of brain scans.

Examining **Behaviour**, the focus is on anti-social behaviour, and in terms of **Agency**, *the psychopath* appears to have none, however the one statement about

treatment describes changing the social environment which precisely described Tyrer's proposed new treatment of nidotherapy! (Tyrer 2002).

Taken together, these statements delineate a position that appears to relate closely to current conceptions of personality disorder due to the number of links to contemporary concerns. However to explore this further we need to look at the positioning involved in *personality disorder* in similar detail.

Exploring factuality statements in relation to *psychopath* by searching *is* to R5 produces only six statements that have not already been covered. These all fall under **Categorisation Diagnostic**.

Looking at modality, there are 10 examples of expressions of possibility. These reflect a similar pattern of conceptual doubts and concern with intelligence as the previous analysis, but also a degree of optimism in their construction.
There is only one statement involving likelihood/certainty falling under **Categorisation Diagnostic**, indicating a real lack of definitive statements in relation to *psychopath*.

Searching for modals of obligations and recommendations reveal only one statement, concerned with aggressive tendencies, defined as a predatory social attitude.

Thus we gain a sense that, while hedged by doubts and cautious optimism about its classification, and containing numerous and contradictory models of its genesis, *psychopath* does imply a certain positioning of its subject regardless of these. In essence, *the psychopath* is almost defined by the discomfort that is produced in an assumed-to-be right-functioning social setting. The only cause specified for this is anti-social behaviour, however this sense of producing fear and people being ill at

ease seems to be present as a defining factor without the need for explanation of what this involves. This may, of course, be assumed within the context of clinicians talking to each other within a specialist journal, however, I would suggest that given the expressed doubts about cause and classification what is actually definite is only this quality of producing social unease.

Turning to psychopathic *the collocates are set out in Table 10.*

Table 10: Collocates of *psychopathic* in the 1950s corpus

	Word	Total	Total Left	Total Right	L5	L4	L3	L2	L1	Centre	R1	R2	R3	R4	R5
1	PSYCHOPATHIC	106	0	0	0	0	0	0	0	106	0	0	0	0	0
2	THE	63	41	22	7	7	9	5	13	0	1	3	5	9	4
3	OF	53	41	12	7	4	3	9	18	0	0	1	2	2	7
4	PERSONALITY	41	0	41	0	0	0	0	0	0	41	0	0	0	0
5	IN	32	21	11	4	6	1	4	6	0	2	4	3	1	1
6	TO	25	12	13	1	3	1	3	4	0	0	1	5	5	2
7	IS	24	7	17	3	1	1	0	2	0	2	11	1	3	0
8	AND	18	4	14	2	0	0	0	2	0	2	7	2	1	2
9	PERSONALITIES	15	1	14	0	0	1	0	0	0	14	0	0	0	0
10	A	15	6	9	1	1	0	0	4	0	0	0	2	4	3
11	WITH	14	6	8	1	2	1	0	2	0	0	3	0	2	3
12	AS	14	9	5	0	1	2	1	5	0	0	2	0	1	2
13	BE	13	5	8	0	1	1	0	3	0	0	1	3	1	3
14	THAT	12	7	5	2	0	0	2	3	0	0	2	2	0	1
15	WHICH	11	2	9	0	1	0	1	0	0	0	6	0	0	3
16	OR	11	9	2	2	4	1	1	1	0	0	1	0	1	0
17	MAY	10	4	6	1	1	1	1	0	0	0	3	2	1	0
18	ARE	9	3	6	0	1	1	0	1	0	0	3	2	1	0
19	WHERE	8	4	4	0	0	1	2	1	0	0	0	0	0	4
20	BY	7	3	4	0	0	2	0	1	0	1	1	0	0	2
21	BEHAVIOR	7	2	5	0	0	0	2	0	0	5	0	0	0	0
22	TERM	7	6	1	1	1	0	1	3	0	0	0	1	0	0
23	WE	6	5	1	1	2	2	0	0	0	0	1	0	0	0
24	FOR	5	3	2	0	1	1	0	1	0	0	1	1	0	0
25	I	5	2	3	0	1	1	0	0	0	0	2	1	0	0
26	FROM	5	0	5	0	0	0	0	0	0	0	1	2	1	1
27	CONCEPT	5	4	1	0	0	0	4	0	0	0	0	0	0	1
28	THESE	5	3	2	0	1	1	0	1	0	0	0	1	0	1
29	BEHAVIOUR	5	1	4	0	0	1	0	0	0	3	1	0	0	0

Here there is explicit mention of behaviour however, of the 106 occurrences the most frequent collocation is in R1 with *personality* and *personalities.* Hence we will investigate these first.

For *psychopathic personality* the **Categorisation Diagnostic** and **Conceptual** statements demonstrate considerable debate, ranging from certain opinion to 'I do not think we can speak of psychopathic personality' (Thompson 1958). **Attributes Psychological** include neurosis, anxiety, resentment and impulsiveness, along with lack of maturity, compulsiveness and impulsiveness, while the **Attributes Social** involve crime, acting as a social irritant, the ability to adjust to hospital rules and a specifically social view of psychopathy. There are no statements around agency.

Examining the 5 statements where modals of possibility occur with *psychopathic personality* reveals further the diagnostic and conceptual doubts expressed above. The 3 statements containing modals of likelihood/certainty fall under **Behaviour** and **Attributes Social** and **Psychological**, while the only obligation or recommendation concerns the inadvisability of using punishment to develop a moral system. This latter is a first direct indication of a moral aspect of positioning directly concerning a subject position, and is clearly implying that the position of psychopath is deficient in morals and that a development of these needs to be a focus of treatment. Later on we can explore the instances of statements using *moral*/right*/duty/duties* to see if there is further direct evidence of this aspect of positioning in each corpus.

From these statements we see that *psychopathic personality* has a number of psychological attributes which differ from those associated with *the psychopath* in not being so explicitly associated with a particular model of psychology. Rather they are

more specific in character including being impulsive, compulsive and immature. There are explicit links with crime although the nature of this is not specified, and further that it is a societal problem. A large range of doubts and concerns about the category are again expressed.

Psychopathic personalities occurs only 13 times in 4 papers, however the social attributes theme continues with *psychopathic personalities* being liable to rejection by other patients in a group. **Attributes Psychological** seems preoccupied in one author's case by sexual disinhibition, and the concerns about classification continue.

Let us now turn to the use of *psychopaths.* The collocates are shown below.

Table 11: Collocates of *psychopaths* in the 1950s corpus

	Word	Total	Total Left	Total Right	L5	L4	L3	L2	L1	Centre	R1	R2	R3	R4	R5
1	PSYCHOPATHS	54	0	0	0	0	0	0	0	54	0	0	0	0	0
2	THE	27	16	11	3	4	2	2	5	0	2	1	2	3	3
3	OF	26	19	7	4	1	3	5	6	0	0	0	2	5	0
4	TO	17	6	11	1	2	1	1	1	0	2	3	1	4	1
5	IN	13	4	9	2	0	1	0	1	0	2	4	1	1	1
6	AND	12	4	8	0	0	0	1	3	0	6	0	0	1	1
7	AS	10	6	4	0	1	1	0	4	0	1	2	0	1	0
8	THAT	10	6	4	2	1	0	1	2	0	0	0	2	1	1
9	ARE	8	5	3	2	2	1	0	0	0	0	0	0	2	1
10	FOR	8	6	2	1	2	1	0	2	0	0	0	1	0	1
11	WHICH	7	2	5	2	0	0	0	0	0	0	1	2	1	1
12	BY	7	2	5	0	0	1	1	0	0	2	0	1	0	2
13	NOT	6	0	6	0	0	0	0	0	0	0	2	2	0	2
14	A	6	2	4	1	1	0	0	0	0	0	1	1	0	2
15	SOME	5	3	2	0	0	0	0	3	0	0	1	0	0	1
16	WITH	5	4	1	0	1	0	2	1	0	0	0	0	1	0
17	HAD	5	0	5	0	0	0	0	0	0	2	3	0	0	0
18	BEEN	5	5	0	1	2	2	0	0	0	0	0	0	0	0
19	BE	5	1	4	0	0	1	0	0	0	0	0	1	0	3
20	HAVE	5	2	3	1	1	0	0	0	0	2	0	0	0	1
21	OR	5	0	5	0	0	0	0	0	0	3	0	1	0	1
22	I	5	2	3	0	1	1	0	0	0	3	0	0	0	0
23	HYSTERICS	5	4	1	0	0	1	3	0	0	0	1	0	0	0

As there are no strong collocates here, all 54 occurrences in 13 texts of *psychopaths* were categorised.

In the **Categorisation Diagnostic** and the **Conceptual** themes, there appears no real doubt expressed about the existence of *psychopaths,* in contrast to the uncertainty expressed in statements around *psychopath* and *psychopathic personality*. This might indicate that *psychopaths* is the means of expressing the perceived reality of clinicians' experience while other phrases are used to deal with the uncertainty in classification.

Within **Attributes Psychological** there is an enormous range of attributes, from the almost anecdotal faulty appreciation of time and musical appreciation, to the more medical attributions of *insight*, *neurosis* and *hysterical*, but including the more loaded *crude and primitive.* Thus there seem to be many differing certainties about what clinicians are writing about when they use *psychopaths*.

It is in the **Attributes Social** and **Behaviour** categories where the commonality of clinicians' views appear to emerge in the descriptions of criminal behaviour linked to *psychopaths*. However checking the origin of these we find that all but one of these references are from one article from the latest part of the corpus (Gibbens 1961). What this may indicate is the beginnings of the move from *psychopaths* as a general term, towards *psychopaths* as specifically referring to anti-social behaviour, a practice which develops in the 1960s to 70's, perhaps prompted by the definition of psychopath in the Mental Health Act 1959.

Attributes Physical mentions incompatibility with other diagnostic psychiatric categories and the encephalogram, while the **Acted Upon** category mostly

comprises broad comments about treatment, with one mention of being acted upon as a subject in a statistical study.

There are a small but significant number of positive statements in relation to *psychopaths* acting on the world, being heroic figures in combat, being gifted, successful and settling down by middle age and fitting in with the world. These are distributed over three authors (Diethelm 1960; Kennedy 1954; Valenstein et al. 1953) and their significance lies, not so much in their relative frequency, rather, as the later analysis shows, in their being there at all.

Looking at modality statements, expressions of possibility show a distinct optimism about future developments in the field. The statements with modals of likelihood/certainty mainly involve *seem, appeared* and *probably,* indicating a degree of hedging around the concepts discussed, although, as mentioned above, open doubt and debate are not visible. The only recommendation is a statement around psychopaths needing individual investigation, as there are many possible manifestations of an underlying condition that *psychopaths* share.

Finally we turn to *psychopathy* which has 66 occurrences but only in 7 documents, 36 of these in one text (Davidson 1956) and whose collocates are shown in Table 12.

Table 12: Collocates of *psychopathy* in the 1950s corpus

	Word	Total	Total Left	Total Right	L5	L4	L3	L2	L1	Centre	R1	R2	R3	R4	R5
1	PSYCHOPATHY	66	0	0	0	0	0	0	0	66	0	0	0	0	0
2	OF	63	54	9	6	6	3	3	36	0	0	3	4	1	1
3	THE	47	31	16	3	17	9	1	1	0	2	3	5	2	4
4	IN	21	5	16	2	1	0	0	2	0	3	3	4	1	5
5	TO	21	8	13	3	1	0	3	1	0	0	3	3	3	4
6	IS	15	2	13	2	0	0	0	0	0	8	3	1	0	1
7	THAT	14	12	2	1	3	2	2	4	0	0	1	0	1	0
8	A	13	4	9	0	3	1	0	0	0	1	3	0	5	0
9	AS	11	3	8	1	0	2	0	0	0	4	0	1	0	3
10	AND	10	5	5	1	2	0	1	1	0	4	0	1	0	0
11	FACT	7	6	1	0	0	0	6	0	0	0	0	1	0	0
12	BE	7	1	6	1	0	0	0	0	0	0	2	3	1	0
13	SO	6	4	2	1	0	1	2	0	0	2	0	0	0	0
14	CENTRAL	6	6	0	0	0	6	0	0	0	0	0	0	0	0
15	CLINICAL	6	6	0	1	0	5	0	0	0	0	0	0	0	0
16	HAS	6	1	5	0	0	0	1	0	0	3	0	1	0	1

Of psychopathy is clearly a frequent construction and its concordance lines mostly fall into the **Categorisation Diagnostic** and **Conceptual** themes, containing little evidence of the contested nature of the disorder. Common collocates to the left are *true nature*, *central fact*, *clinical syndrome*, suggesting another way of handling certainty in an uncertain concept.

Attributes Psychological includes references to *affectivity* (specifically poverty of emotion), *lack of guilt feelings, abnormal aggressiveness and narcissistic self evaluation.*

Attributes Social comprises an inability to maintain normal social contact, while **Behaviour** involves alcoholism, criminality and anti-social behaviour.

In passing we can also note that there are a number of factual statements involving *is* which mainly concern conceptual and diagnostic issues and, while there is some expression of doubt by the occurrence of *if*, *in so far as* and *increasing*

amount of evidence that, as a whole the statements read as arguments in favour of particular views rather than critical examinations of the concept as a whole.

Discussion of *psychopath** in the 1950s corpus

Overall there are differences in the usage of the varieties of *psychopath**. While *psychopathic personalit** and *the psychopath* allow expressions of doubt about the concept and its place in medicine and psychiatry, when using *psychopaths* and *psychopathy* there is unproblematic certainty about what is being talked about. *Psychopaths* in particular seem to encapsulate a range of attributes and behaviours that are seen as essential to the diagnosis from each author's point of view. It also is the focus of a number of positive statements about people with the diagnosis. However the commonality of criminal behaviour is evident. Treatment is also a feature of these usages, however it is confined to therapeutic communities. Statements around agency are completely absent.

Psychopath in the 1970s corpus*

The initial investigation in Table 13 shows the distribution of the varieties of *psychopath** through the 1970s corpus.

Table 13: Forms of *psychopath and their frequencies in the 1970s corpus**

Lemma	Frequency in 1970s corpus	Hits/1000	No of texts
Psychopath	28	0.40	7
Psychopathia	1	0.01	1
Psychopathic	76	1.09	12
Psychopathie	1	0.01	1
Psychopathischen	1	0.01	1
Psychopathies	0	0.00	0
Psychopathologic	0	0.00	0
Psychopathological	2	0.03	2
Psychopathologies	1	0.01	1
Psychopathology	5	0.07	3
Psychopaths	70	1.00	9
Psychopath's	0	0.00	0
Psychopathy	45	0.65	10
Psychopath*	230	3.30	12

The distribution is broadly similar to the 1950s although *psychopath* has diminished somewhat in frequency, and its collocates are shown in Table 14.

Table 14: Collocates of psychopath in the 1970s corpus

	Word	Total	Total Left	Total Right	L5	L4	L3	L2	L1	Centre	R1	R2	R3	R4	R5
1	PSYCHOPATH	30	1	1	0	0	0	1	0	28	0	1	0	0	0
2	THE	23	18	5	2	3	1	4	8	0	1	1	2	1	0
3	OF	14	10	4	1	1	1	4	3	0	1	0	0	1	2
4	TO	10	5	5	1	1	2	1	0	0	0	2	3	0	0
5	AND	9	3	6	0	3	0	0	0	0	3	0	1	2	0
6	A	7	5	2	0	1	0	0	4	0	0	2	0	0	0
7	IS	7	1	6	1	0	0	0	0	0	1	1	2	0	2
8	AS	5	3	2	0	0	3	0	0	0	1	0	0	0	1
9	IN	5	3	2	2	1	0	0	0	0	1	0	0	1	0

Given the low frequency of *psychopath* we can examine and categorise all its occurrences. Under **Categorisation Diagnostic** there is some mention of the problems with the diagnosis (Maddocks 1970), but contemporaneously there is also use of Henderson's 1930's categories, not surprising perhaps as the author is describing treatment at the Henderson Hospital (Whiteley 1970). The category of *Creative Psychopath* does seem to allow for positive statements about the *psychopath*; while **Attributes Psychological** focuses on aggression and acting out as well as lack of guilt, there is also space for personality growth. **Attributes social** is again about difficulties in fitting into social groups and crime (also present in the **Behaviour** and **Conceptual** categories), however there is the possibility of settling down. **Attributes physical** is confined to a mention of genetic causes.

The collocations of *psychopathic* can now be examined in table 15.

Table 15: Collocates of *psychopathic* in the 1970s corpus

	Word	Total	Total Left	Total Right	L5	L4	L3	L2	L1	Centre	R1	R2	R3	R4	R5
1	PSYCHOPATHIC	76	0	0	0	0	0	0	0	76	0	0	0	0	0
2	THE	46	25	21	5	6	5	9	0	0	0	4	5	7	5
3	OF	36	29	7	3	5	4	6	11	0	0	1	0	2	4
4	PERSONALITY	26	1	25	0	0	0	1	0	0	24	0	1	0	0
5	IS	20	4	16	0	0	3	0	1	0	0	10	1	2	3
6	A	19	7	12	3	1	2	0	1	0	0	3	3	4	2
7	TO	15	7	8	2	1	2	2	0	0	1	1	4	2	0
8	AS	13	9	4	0	1	0	0	8	0	0	1	0	2	1
9	PERSONALITIES	13	1	12	1	0	0	0	0	0	11	0	1	0	0
10	DISORDER	10	1	9	0	1	0	0	0	0	8	0	0	0	1
11	IN	10	3	7	1	0	1	0	1	0	1	2	1	0	3
12	AND	9	6	3	1	0	1	2	2	0	0	2	0	1	0
13	THAT	9	6	3	2	2	1	1	0	0	0	0	2	1	0
14	TERM	9	8	1	0	0	0	2	6	0	0	0	1	0	0
15	THIS	7	3	4	1	0	1	1	0	0	0	2	0	1	1
16	IT	7	2	5	2	0	0	0	0	0	0	0	1	3	1
17	FOR	7	3	4	0	2	0	1	0	0	0	0	0	3	1
18	BE	6	2	4	0	0	1	1	0	0	0	0	2	0	2
19	BEHAVIOUR	6	1	5	0	1	0	0	0	0	2	2	0	1	0
20	OR	6	2	4	1	0	0	1	0	0	1	3	0	0	0
21	HE	6	3	3	1	1	1	0	0	0	0	1	1	1	0
22	STATES	5	2	3	0	1	0	1	0	0	3	0	0	0	0

There is a clear and frequent collocation with *personality/ies* so these will be examined first. *Psychopathic personality* is mainly linked to statements around diagnosis and concept, containing a significant number of both negative remarks and statements problematising the concept. In addition there are statements that appear to be definitive but on examination are so broad as to lack meaning, such as:

> *As is the case in the aetiological consideration of most psychiatric conditions, psychopathic personality is in all probability the final common pathway reflecting the interaction of genetic, environmental, biochemical, electrophysiological, and endocrine factors.* (Rollin 1975: 665).

Psychopathic personalities is similarly associated with statements around diagnostic and conceptual issues, with particular reference to Schneider's work of the same name. In terms of its positioning, antisocial acts are the only behaviour, however there is the possibility of treatment through the Henderson Hospital.

Psychopathic disorder, the other notable collocation, occurs in 3 articles and is entirely involved in discussions about the lack of clinical usefulness of the term in the 1959 Mental Health Act.

The collocations of *psychopaths* are as follows.

Table 16: Collocates of psychopaths in the 1970s corpus

	Word	Total	Total Left	Total Right	L5	L4	L3	L2	L1	Centre	R1	R2	R3	R4	R5
1	PSYCHOPATHS	78	4	4	1	1	1	0	1	70	1	0	1	1	1
2	OF	39	26	13	1	1	5	8	11	0	2	1	1	7	2
3	THE	34	23	11	3	6	7	2	5	0	2	1	1	3	4
4	TO	20	11	9	2	3	1	2	3	0	3	1	2	3	0
5	OR	18	8	10	1	1	1	2	3	0	3	1	3	3	0
6	ARE	15	6	9	1	0	2	1	2	0	4	1	0	0	4
7	A	14	4	10	0	1	3	0	0	0	2	5	0	2	1
8	THAT	13	10	3	0	3	0	3	4	0	1	1	0	0	1
9	AND	12	5	7	0	4	0	0	1	0	2	3	0	2	0
10	IN	10	4	6	1	1	0	1	1	0	1	0	1	3	1
11	AS	10	7	3	2	4	0	0	1	0	3	0	0	0	0
12	IT	8	4	4	3	1	0	0	0	0	0	0	1	1	2
13	WHO	8	1	7	0	1	0	0	0	0	4	0	0	2	1
14	FOR	8	6	2	0	2	1	0	3	0	1	0	0	0	1
15	PERSONALITY	7	4	3	1	1	1	1	0	0	1	2	0	0	0
16	TREATMENT	7	6	1	1	0	2	3	0	0	0	0	0	0	1
17	HAVE	7	1	6	0	0	1	0	0	0	3	2	0	0	1
18	BE	6	2	4	0	1	1	0	0	0	0	2	0	1	1
19	IS	6	3	3	1	2	0	0	0	0	0	1	0	1	1
20	AT	5	2	3	0	0	2	0	0	0	1	1	0	0	1
21	ALL	5	3	2	0	0	1	0	2	0	0	0	1	0	1
22	NOT	5	2	3	1	0	1	0	0	0	0	0	3	0	0
23	DOWN	5	0	5	0	0	0	0	0	0	0	2	1	1	1
24	DISORDERS	5	1	4	0	1	0	0	0	0	0	1	2	1	0
25	SOME	5	4	1	1	0	0	0	3	0	0	0	0	1	0
26	BY	5	0	5	0	0	0	0	0	0	2	0	0	1	2

There is not an obvious collocate to direct the examination, however *of* does occur frequently in the L1 to L5 position and these concordances are collected and explored first.

In looking at these, a new category emerges under **Acted Upon**, that of Object of Study. Given the increase in this type of language noted in the noun analysis we can expect the 2000s corpus to make further use of this category. It is also of note that doubts are expressed about the concept in such constructions as *so-called psychopaths*. There is mention of the social aspect of maturing and settling acting as a counterweight to the socially destructive alcoholism and criminal behaviour. Treatment options such as Grendon Prison and in-patient units are also in evidence. **Attributes Psychological** includes low intelligence, extraversion, lack of empathy and treating others as objects.

Searching for statements involving *psychopaths* and *are* 10L to 10R produced 13 occurrences. In the **Categorisation Diagnostic** we can both see attempts to discriminate between *psychopaths* and *personality disorders*, while elsewhere they are equated with *or*. **Acted Upon** focuses on in-patient treatment and treatability.

The **Attributes Psychological** are mainly relating *psychopaths* to personality categories and as such appear to show further evidence of the linking of the concepts, however in the sense of subject positions, there is seen to be 'egocentricity, lack of empathy, and treating others as objects'. In this set of collocates it is the **Attributes Social** that are most notable, and these include criminality as well as being socially disruptive and destructive, with a definition where *psychopath* is equated with *a*

balance of personal public interest and freedom ... intolerable to the vast majority (Foulds 1971: 225).

With modals of possibility, *psychopaths* reveals strong links with the hospital and justice systems and the benefits of rigid discipline are noted. Of particular note with the modals of likelihood/certainty, is the rare appearance of a statement about agency and also self awareness.

There were no occurrences of statements involving the commonest modals of obligation and recommendation. In general these are lacking through the corpora so far in relation to *psychopath**.

The collocates of *psychopathy* are shown below.

Table 17: Collocates of psychopathy in the 1970s corpus

	Word	Total	Total Left	Total Right	L5	L4	L3	L2	L1	Centre	R1	R2	R3	R4	R5
1	PSYCHOPATHY	51	3	3	2	0	1	0	0	45	0	0	1	0	2
2	OF	38	30	8	4	6	1	1	18	0	1	2	3	0	2
3	THE	33	20	13	2	4	14	0	0	0	5	0	3	3	2
4	IN	16	7	9	2	2	1	1	1	0	3	0	2	1	3
5	IS	13	3	10	1	2	0	0	0	0	4	2	1	2	1
6	A	11	3	8	2	0	0	1	0	0	1	3	2	2	0
7	TO	10	6	4	0	3	0	0	3	0	0	1	2	0	1
8	AND	8	4	4	0	1	1	1	1	0	2	0	0	1	1
9	AS	8	3	5	0	2	0	1	0	0	2	1	1	1	0
10	SYMPTOMATIC	6	5	1	0	0	0	0	5	0	0	0	0	1	0
11	OR	6	3	3	0	1	0	0	2	0	2	0	0	1	0
12	BE	5	2	3	0	0	2	0	0	0	0	2	1	0	0

All 45 occurrences were categorised and comprised a significant number of diagnostic and conceptual statements, which account for the occurrence of *symptomatic* in the collocates; it occurs as a technical term linked to *psychopathy*.

The **Attributes Social** does contain the first mention of outcomes, while the first mention of prevalence occurs in the diagnostic category.

Discussion of psychopath* in 1950s and 1970s corpus

Compared with the 1950s, the 1970s corpus shows a similar lack of agency from the positions around *psychopath**, with the one exception mentioned above. Neither are there a great many statements concerning being **Acted Upon**, although there is some mention of **Treatment** and **Study**. This implies a position from which there is very little room for decision making or promoting one's own view of events, one is rather an object of definition. While the **Attributes** are largely negative, there is space for a positive view, more so in the 1950s corpus. In general both also contain multiple views of the correct way of looking at the issue which implies multiple positions in relation to these. For example, if you are seen as a psychopath through a psychodynamic mechanism this implies a different perspective on oneself than if seen through behaviour theory, a point returned to later in the discussions of Chapter 8. The social dimension remains constant through both decades, being mainly expressed through the possibility of social disruption, thereby positioning the person as outside a normal functioning society, rather than as a part of its diversity.

Statements around obligation are rare in both corpora, effectively implying low expectations; that the patient is simply there to be treated by the current order in the way it thinks best. However there is considerable evidence for debate around the concept and its place in psychiatry in both decades. Within the 1950s corpus this is confined to particular ways of talking about *psychopathic personality* and *the psychopath*, which are not evident in the 1970s.

While explored more fully in the next section, there are very few direct statements around morals and rights in the collocations with *psychopath**, however there is some inference that the position is seen as lacking in morals in relation to an

implied normal society, as opposed perhaps to possessing a different set of morals. The model of moral deficit implies that the worldview of the psychopath does not need to be understood, it needs to be at best corrected, but, as expressed consistently over the corpora, more usually observed and commented on by psychiatry, without any necessary obligation to treat or offer solutions.

Examining morals, rights and duties in the three corpora

An important aspect of analysing subject positioning outlined in Chapter 5, is exploring the morals, rights and duties of a position. We have seen above how this can be inferred from statements surrounding a word or phrase indicative of a discursive construction such as *psychopath** above, however it may also be useful to interrogate the corpora specifically for their use of these words to see how this may change over time. Thus concordances were prepared for all occurrences of *moral, morals, right, rights, duty* and *duties* in each corpus.

In the 1950s military duty is a frequent usage, but there are also 25 instances of *moral* used in the sense of distinguishing right and wrong. This usage is quite varied and there is talk of *lack of moral sense* and *moral defect* as well as *good* or *poor moral character.* There is also mention of *building up moral sentiments* and *moral qualities. Duty* is used less in a personal sense, though when deployed it is mainly in describing a *sense of duty* acting as a counterweight to the effect of psychopathy in an individual. *Right* is also used infrequently, but in the sense of citizens' rights.

In the 1970s *right/s* in the sense of entitlement has disappeared, personal duty has almost disappeared and *moral* is mostly used with the meaning of affect, when describing the historical narrative of psychopathy. In the 7 instances where *moral* is used in the sense of knowing right or wrong, it is mostly used to describe moral failings in the psychopath.

In the 2000s corpus all uses of these words have declined. Of the three instances of *moral*, two are used in the context of a questionnaire, as is the case for both instances of *duty*. *Right** appears mainly in the context of Human Rights.

Thus we can see a quite drastic move away from the complex and varied expressions of these words in the 1950s, particularly *moral*, involving as it does both negative and positive relationships to the perceived conduct of the psychopath. By the 1970s the implication is mostly negative in the sense of moral failings and by the 2000s corpus there appears to be no significant use of these concepts in the corpus. There is a clear sense that this particular explicit discourse is no longer considered to belong in the psychiatric article. However, as evident later in the chapter, it is clear that *personality disorder** in its usage does imply particular, largely negative associations with right and wrong behaviour in relation to society and to services.

Examining discursive constructions in the 1970s corpus

From the noun analysis it is clear that, while *psychopath** is prevalent in the 1950s corpus and *personality disorder** is dominant in the 2000s, the 1970s corpus provides a possible insight into a period of overlap. To gain a picture of this the occurrences of *personality disorder** across the documents of the 1970s corpus are compared in Table 18 below along with *psychopath** and the two most common other terms *character disorder** and *abnormal personalit**.

Table 18: Comparison of commonest terms relating to personality disorder in 1970s corpus

Article (journal, date, author)		**Personality disorder***		**Psychopath***		**Character disorder***		**Abnormal personalit***	
	Words	Hits	per 1,000	Hits	per 1,000	Hits	per 1,000	Hits	per 1,000
bjp 1969 Vinoda	2,131								
bjp 1970 Maddocks	2,527			31	12.27				
bjp 1970 Nielsen	1,811					21	11.6		
bjp 1970 Smail	2,080			1	0.48				
bjp 1970 Walton	7,960	36	4.52	8	1.01	6	0.75	50	6.28
bjp 1970 Whiteley	6,287	2	0.32	24	3.82	4	0.64		
bjp 1973 Liss	2,360	40	16.95						
bjp 1973 Presly	4,067	7	1.72	10	2.46			9	2.21
bjp 1973 Walton	5,468	16	2.93	8	1.46	7	1.28	18	3.29
bjp 1973 Welner	2,940	22	7.48						
bjp 1979 Standage	2,294	15	6.54	3	1.31			1	0.44
bjp 1979 Tyrer classification	1,701	38	22.34					5	2.94
bjp 1979 Tyrer&alexander	3,363	25	7.43					4	1.19
bjpm 1969 Brooks	3,793							6	1.58
bmj 1975 Rollin	1,862	6	3.22	30	16.11				
pm 1971 Foulds	6,659	34	5.11	29	4.36	1	0.15	2	0.3
pm 1974 Lewis	4,146			53	12.78			1	0.24
pm 1974 Shepherd	3,116	42	13.48	5	1.6			1	0.32
pm 1976 Gunn	2,160	2	0.93	28	12.96				

Note: bjp=British Journal of Psychiatry, bjmp=British Journal of Medical Psychology, bmj= British Medical Journal, pm=Psychological Medicine

This table shows that there are two texts that use only *personality disorder**, and two that use only *psychopath**, while one uses only *character disorder**, and the

rest mostly use combinations. Only one uses none of these forms and that is Vinoda (1969) talking of *personality characteristics* of *suicide attempters*. The occurrences of each form are spread throughout the decade and the overall impression is confirmed of a period of language and terminology in transition. We have examined how the discursive construction around *psychopath** implies particular subject positions in the 1970s and we will go on to compare this with *personality disorder**, however it is clearly important to also examine *abnormal personality* in the 1970s corpus, to see whether this is used in particular ways.

Abnormal personality in the 1970s corpus

Table 19: Collocations of *abnormal personality* in the 1970s corpus

Word	Total	Total Left	Total Right	L5	L4	L3	L2	L1	Centre	R1	R2	R3	R4	R5
ABNORMAL PERSONALITY	83	0	0	0	0	0	0	0	83	0	0	0	0	0
OF	62	54	8	4	3	3	1	43	0	0	3	0	1	4
THE	47	26	21	6	13	7	0	0	0	0	5	5	4	7
A	21	10	11	7	2	0	1	0	0	0	4	2	2	3
IN	18	8	10	1	4	1	1	1	0	0	4	1	1	4
AND	17	11	6	5	2	3	0	1	0	0	3	2	0	1
TO	13	7	6	2	0	0	2	3	0	0	1	3	0	2
WITH	13	10	3	1	2	2	2	3	0	0	0	0	3	0
FOR	12	11	1	0	1	1	6	3	0	0	0	0	1	0
BY	10	0	10	0	0	0	0	0	0	0	3	0	2	5
IS	10	3	7	1	2	0	0	0	0	0	6	0	1	0
PATIENTS	8	5	3	1	3	1	0	0	0	0	0	1	1	1
TYPES	8	5	3	0	0	0	5	0	0	0	2	1	0	0
TYPE	8	5	3	0	2	1	2	0	0	0	0	1	1	1
SYSTEM	7	7	0	1	0	4	2	0	0	0	0	0	0	0
ILLNESS	7	3	4	0	2	0	1	0	0	0	0	1	1	2
ARE	7	0	7	0	0	0	0	0	0	0	5	2	0	0
CATEGORY	6	6	0	0	3	0	3	0	0	0	0	0	0	0
BE	6	0	6	0	0	0	0	0	0	0	0	3	3	0
CLASSIFICATION	5	5	0	2	0	2	1	0	0	0	0	0	0	0
AS	5	0	5	0	0	0	0	0	0	0	0	2	1	2
FORMS	5	5	0	0	0	0	5	0	0	0	0	0	0	0
THREE	5	2	3	0	0	2	0	0	0	0	1	0	0	2
THAT	5	4	1	0	2	0	1	1	0	0	0	1	0	0

This table shows that there is a frequent occurrence of *of abnormal personality*, but further that *abnormal personality* itself is strongly implicated in the medical discourse of the 1970s by its association with *illness* and *patients*, and also with concerns about *category* and *classification*. When we look at the concordance for *of abnormal personality*, this latter hypothesis is confirmed by the large number of statements concerning categorisation issues, and, in particular, statements concerning sub divisions of this class developed by Walton (1970). The **Attributes Psychological** points towards the subject positions implied by these sub divisions, termed Types some of which are summarised below from Walton's article.

> *Type 1 male patient: This type of man has marked personality assets: he is notably autonomous, likeable, well able to fit into his social group, responsible and conscientious, with firm control over his impulses; he is not at all antisocial, and is capable of foresight; he meets his obligations and learns from his experiences.*

> *Type 3 male patient: The men typical of this cluster meet the descriptive criteria classical of the psychopath. They are not likeable; they cannot fit into the social group; they are defective in conscience; they control their impulses poorly; they behave antisocially; they lack foresight; they lack consideration for others; they evade obligations; they cannot profit from experience; they are guilt free; they act out aggressively.*

These categories are described by Walton as clusters emerging from tests of association between sets of psychiatrist ratings of a group of people described as abnormal personalities. One can see a clear prefiguring of the clusters of the DSM, however what is also very noticeable is the presence of positive features, most notably in the Type 1 categories of both genders. This is absent from the DSM clusters. Thus while each of these categories contains clear positioning statements with implications of how people with *abnormal personalities* are expected to behave and think, the range of these behaviours are much greater than the negative positioning of the later DSM sub-categories.

Returning to the concordance lines, the study discourse is also evident here and in those of *abnormal personalities*. There is also evidence of discourses surrounding measurement and assessment of the condition, discourses which, as seen in the lexical analysis, become much more prevalent in the 2000s corpus. At several points in the concordance the origins in Schneider's and Jasper's typology are evident and on a number of lines *abnormal personality* is equated with *psychopathy* and *personality disorder*. Thus we can see the use of *abnormal personality/ies* as a bridging between the clinical descriptions of Schneider and Jaspers, and the talk of the many subcategories of personality disorder evident in the 2000s corpus, the methods that support the latter diagnostic system in evidence here in embryonic form.

Examining the factuality and modality statements around *abnormal personalit** reveals familiar debates about whether it should be the concern of psychiatrists, and the complexity of its links with psychiatric illness, prefiguring Kendall's debate (2002a). There is also talk of the distinction between *abnormal personality* and *personality disorder*, thus showing that while some authors equate

the two, others distinguish them. This renders problematic the narrative of the history of personality disorder as an enquiry into a single disorder across the years, which has simply had different names. Instead one could suggest clinicians and researchers employing the discourses of their times to apprehend particular problematised issues.

This investigation of *abnormal personalit** displays some similarities with the discussions on *psychopath** above, such as concerns with diagnosis and categorisation and a number of similar negative social and psychological attributes such as lack of remorse, aggressiveness and difficulties in fitting into social groups. However there are also a number of features that are different, including the beginnings of concerns about assessment and measurement, the development of subdivisions through factor analysis, and the presence of positively construed sub-groupings. We can now move to an exploration of *personality disorder** to investigate the subject positions implied by the use of this term through the corpora.

Personality disorder in the 1950s corpus*

An exploration of *personality disorder** has been left to last, mainly due to concerns that its extreme dominance in the 2000s corpus might distort the evolution of the method of analysis. The same methodological approach will be used as for *psychopath** in order to uncover the particular subject positions that may be implied by and associated with the use of the term. Of initial note is that, compared to the multitude of forms of *psychopath**, as outline above, *personality disorder** only has two, the singular and plural forms, the occurrence of both of which will be examined below.

Searching for *personality disorder** in the 1950s corpus, produces 16 examples in 3 texts (Clarke et al. 1959; Craft 1959; Diethelm 1960), however only one of these, mentioning *psychopathic personality disorder,* is not related to Craft's article titled Personality Disorder and Dullness.

It is of note however that in these texts there is mention of Henderson and Schneider's concepts of personality disorder, while in the rest of the corpus these authors are associated with psychopathy, hinting at some isomorphism between the concepts at this time.

A further point is that there is significant mention of *adverse early influences*, which have been categorised under social attributes, but are indicative of a conception of causality, not evident in the *psychopathy* discussion.

Personality disorder in the 1970s corpus*

Analysis of *personality disorder* in the 1970s corpus

Looking at the collocations of the 184 instances of *personality disorder* (Appendix 19), we find *patients, illness* and *discharged* to be frequent, linking to the medical discourse outlined in the noun analysis. Further, *diagnosis/ed/es, decisions, types,* and *classification* point to the concerns with classification previously evidenced in the 1970s. However there are also frequent occurrences of *of* and *a* in L1 which will now be examined.

The 37 occurrences of *of personality disorder* are spread over 8 texts, and group chiefly into **Categorisation Diagnostic**, which, as with *psychopathy* includes some statements of doubt around the issue, which also appear within the **Conceptual** category. The statements referring explicitly to *personality disorder* as an object of study are more numerous than with *psychopath** in the 1970s, and looking more closely at the diagnostic category reveals that many of these statements also relate to the use of diagnosis in studies.

Attributes Psychological includes hysteria in woman, general impulsiveness, and conscience defect. **Behaviour** is confined to the anti-social, while the statements around physical attributes seem to express problems in finding physical causation.

Looking at the 25 instances of *a personality disorder* across 7 texts shows its frequency in relation to diagnosis, thus further supporting the prominence of this discourse in the 1970s.

Collecting the concordances of *personality disorder* with *is* to 5L and 5R we find a number of **Attributes Psychological**: associated psychiatric illness,

particularly hysterical disorder in women, and more generally extreme egocentricity, inability to empathise and to treat others as objects. **Attributes Social** are being socially disruptive and having impaired personal relationships, while **Behaviour** is confined to harming others. In all however there is a very limited selection of statements compared to those around *psychopath**.

In looking at the statements involving modals of possibility, we find a few **Attributes Social**; not being antisocial, being relatively likable, but being grossly passive and dependent and unable to achieve a social adjustment.

With modals of likelihood/certainty we have attributes of unlikeability, antisocial acts and acting out, with guilt and anxiety for women and none for men. Further there is a likelihood of impulsive and manipulative behaviour, temper tantrums, suicide attempts or marital discord. Thus while there is less expression of the positions implied by personality disorder, what there is, is extremely detailed and explicit.

With modals of obligation/recommendation, the indication is that extreme scores on extrapunitiveness, expediency, suspiciousness and poor control link to deviant traits associated with personality disorder. This type of statement seems to indicate that the circular definitions of personality disorder mentioned in relation to earlier critiques of psychopathy and reiterated by McCallum's critique of antisocial personality disorder (McCallum 2001) are still in operation, albeit disguised by the language of scales and studies. In this section we can also note the return to earlier language of *passive* and *dependent* in the search for accurate categorisation.

Thus to summarise, the collocations and concordances associated with *personality disorder* demonstrate very frequent usage in diagnostic discussions but

with limited direct expression of what this label implies. Where this is expressed, it is mainly in lay language such as likeability, temper tantrums, socially disruptive. There is a very little evidence of the more psychologically based measures. There is some evidence of expression of doubt around the concept but these are somewhat swamped by the number of statements which use the term unproblematically. Further there are a significant number of statements around personality disorder as the object of study. Treatment is present but in very limited form.

Analysis of *personality disorders* in the 1970s corpus

Turning to *personality disorders* we find 94 occurrences of *personality disorders* in 12 documents, the collocations shown in Appendix 20 indicating *of* and *with* in L1 to be the most frequent. Additionally *diagnosed/is* and *classification* are regular collocates as with *personality disorder*. Of note also is the occurrence of *patients* in L2 which is accounted for by the particular prosody *patients with personality disorder* examined later in this section.

Apart from anti-social behaviours and criminality, the collocates of *of personality disorders* mainly involve diagnostic statements and those involving **Treatment, Study** and the new sub-category of **Assessment.**

The occurrences of *with personality disorders* show a distribution between **Diagnosis, Treatment, Assessment** and **Study**, and also the common phrase *patients with personality disorders*. The one statement around behaviour is worth quoting more fully, both for its positioning implications and for its links with terms around *psychopath.*

It would be wrong to believe that people with personality disorders show their imperfections in respect of only, say, pathological lying, cheating, aggression, or sexual perversion. Invariably the whole personality is affected. This is particularly demonstrable in what in extreme cases has come to be known as psychopathic personalities, or psychopaths. (Rollin 1975: 665)

It is of note that these very explicit positioning statements occur in an article for the more general medical population. One might conclude that for the specialist psychiatric population the positions no longer need spelling out, and/or that attempts to clarify the position of personality disorder simply end in confusion and generalisation as we have seen above, and hence are avoided.

Turning to statements of factuality and modality, we find concerns with **Diagnosis** and **Treatment** with *are*, while collocates with *have* also focus on **Assessment** and **Study**, along with another extended description of social attributes involving difficulties in social adaptation, dependency, failure to meet obligations and self absorption. With modals of possibility the concordance lines mainly refer to **Treatment** and **Study**. The other modal groups indicate a likelihood of treatment in mental hospitals and a requirement for reconsideration of subdivisions, however again the statements involving obligation or recommendation are extremely limited.

There are only 7 examples of *personality disordered* which is mainly used in the phrase *personality disordered groups* to describe objects of study.

Looking at the collocates of *personality disorder** it is clear that *patient** is significant; this is therefore looked at in more detail as a potential guide to implied

subject positions. There are 450 occurrences of *patients* and 168 of *patient* through the 1970s corpus, and their collocates indicate a common association with *with*. Of the 88 occurrences over 15 documents of *patient** with *with* to 5L, 30 involve *disorder* or *character disorder*, and 20 to *stature* (Nielsen et al. 1970). In order to distinguish the use of *patients* when referring to *personality disorder* from that with *psychopathy*, *patients* was searched with these terms 15L and 15R.

This produced 5 results with *psychopath** and 42 with *personality disorder**. The statements with *psychopath** concerned **Treatment** and **Study**. The statements with *personality disorder** contained a large number concerned with **Study**, and many of those under **Categorisation Diagnostic** also were in the context of studies. However there were also a number of psychological attributes which we have covered before.

Given there are 339 occurrences of *psychopath** and 285 of *personality disorder**, it would appear that *patients* has a much stronger association with the latter, perhaps reflecting a changing discourse around the subject at hand, from a more anecdotal style to one that is beginning a move towards scientific discourses, typified by its connection with study language.

Summary of personality disorder* in the 1970s corpus

*Personality disorder** in the 1970s corpus seems at first sight to be used either interchangeably with *psychopath**, or as a general term subsuming the latter. However examining the collocates reveals a more complex usage pattern. *Personality disorder** is used much more in relation to being an object of assessment

and study, much more in statements about diagnosis and, within the specialist psychiatric journals, tends to be associated more with *patient** and less with anecdotal styles of account. It appears not able to support the positive statements that appear with *psychopath*, and instead the attributes are much less often expressed, although still include social disruption. When they are expressed such attributes are often described in some detail.

We will now turn to *personality disorder** in the 2000s corpus to see how this compares.

Personality disorder in the 2000s corpus*

In stark contrast to the 1970s the 1,106 occurrences of *personality disorder**, appear in all texts in significant quantities and dwarf the 12 instances of *abnormal personalit**, the one occurrence of *character disorder** and even the 35 statements involving psychopath*, as shown in Table 20.

Table 20: Comparison of commonest terms relating to *personality disorder in the 2000s corpus**

		*Personality disorder**		*Psychopath**		*Character disorder**		*Abnormal personalit**	
File	Words	Hits	per 1,000						
acta 2000 mcglashan	3,773	10	2.65						
acta 2000 moran	2,934	56	19.09						
acta 2000 suominen	3,239	99	30.56	1	0.31				
acta 2002 sanislow	4,859	66	13.58	3	0.62				
acta 2002 svrakic	3,512	68	19.36	1	0.28				
acta 2002 tyrer	2,060	21	10.19					1	0.49
acta 2004 pagano	4,081	11	2.7	1	0.25				
acta 2004 parker	4,733	9	1.9						
acta 2006 moran	1,556	36	23.14						
bjp 1999 coid	4,170	80	19.18	6	1.44			4	0.96
bjp 2000 bateman	4,088	30	7.34	1	0.24				
bjp 2000 chiesa	4,260	21	4.93	2	0.47	1	0.23		
bjp 2000 hill	3,828	33	8.62	2	0.52				
bjp 2001 spence	558	11	19.71	1	1.79				
bjp 2001 tyrer	2,774	37	13.34	3	1.08			2	0.72
bjp 2002 bennett	350	8	22.86						
bjp 2002 kedell reply	657	13	19.79	1	1.52				
bjp 2002 kendell	4,561	85	18.64	6	1.32				
bjp 2002 pilgrim	514	9	17.51						
bjp 2002 rendu	2,596	60	23.11						
bjp 2002 ryle	553	7	12.66						
bjp 2002 samuels	3,758	66	17.56	3	0.8			2	0.53
bjp 2003 coid	5,520	85	15.4	1	0.18			2	0.36
bjp 2003 davies	2,146	14	6.52						
bjp 2003 tyrer	980	29	29.59						
bjp 2005 bradley	4,158	13	3.13	3	0.72				
bjp 2006 coid	4,543	78	17.17					1	0.22
bjp 2007 crawford	1,535	26	16.94						
bjp 2007 huband	4,038	25	6.19						

Analysis of *personality disorder* in the 2000s corpus

Examining the collocates of the 720 instances of *personality disorder*, we find, due to its high frequency, 241 collocates with over 5 occurrences; the first 55 of these are shown in Appendix 21. This shows that *borderline* and *antisocial* are the most popular sub categories of personality disorder within the corpus, and also confirms the influence of the DSM, through the frequency of *DSM* and *clusters*. *Treatment* is also significantly associated with *personality disorder*, particularly in the prosody *treatment of personality disorder* (25 instances), while a similar pattern is noted with *prevalence of personality disorder* (19 instances). Compared to the 1970s, where there was one instance, there are 5 instances of *patients with personality disorder*, but 13 of *people with personality disorder*, a formulation not present in the 1970s. In terms of most frequent collocates *with* in L1 will be examined first followed by the commonest collocate *of* in L1, the factuality statements involving *is* and then the modal statements.

The 47 statements involving *with personality disorder* are spread over 15 documents and show a range of similar prosodies such as *those with*, *individuals with*, *adults with* and *offenders with*, as well as *patients with* and *people with* mentioned above. There is also a markedly different distribution of concordance lines within the categories from those described above in the 1970s corpus. There is a very large section concerning **Treatment**, which contains both optimistic and cautionary statements. The section dealing with **Study** has grown significantly and the **Diagnostic** category shrunk to one statement suggesting much less of a concern with this issue in the 2000s corpus. The **Attributes Psychological** include low self esteem,

struggle with identity, low cooperativeness and also the development of personal and social dysfunctions due to personality traits. **Attributes Social** are concerned with social dysfunction and interpersonal problems in a similar way to previous decades, however there is also the appearance of *costs, public health* and *treatment.*

The commonest collocate *of* has 215 instances in L1 alone over 24 documents hence, in order to examine this a stratified sample of 69 statements was used, selected randomly but proportionally from each document. In the 1970s statements involving this construction were dominated by diagnostic statements however the 2000s sample has a much greater emphasis on **Treatment** and the **Categorisation Groups** has re-emerged largely due to an increased focus on prevalence and epidemiology. **Attributes Psychological** are persistence, mental disorder, slow spontaneous improvement, universal counter-transference, and early fear and/or anger in the etiology. It is of note that these are framed much more within the context of medical intervention than in the lay language noted of *psychopathy* in the 1970s, for example by using the concept of counter-transference rather than clinicians feeling uncomfortable. In a similar way the social aspects are framed as *family history*, or *burden* and *costs to society* rather than the more general but direct *disruption to society*. This is discussed in Chapter 8 in terms of the move towards more formalised and formulaic language to describe human experience.

Turning now to the factuality statements, the concordance for *personality disorder is* is spread across 15 documents and comprises a large group of **Conceptual** statements containing both definite and critical comments around the idea. The **Categorisation Groups** appears again designating younger age groups, and inner cities. A broad range of treatments is cited, and there is some mention of *personality*

disorder as the object of assessment and study. **Attributes Psychological** are really confined to technical clinical issues such as comorbidity, and similarly **Attributes Social** mainly links to epidemiological concerns, with some mention of school drop-out, homelessness and raised mortality in early adulthood. Apart from these, this section of concordances seems to use *personality disorder* as a conceptual and diagnostic category, rather than as descriptive of actions and states.

In the analysis of modals, there are 41 statements containing *personality disorder* with modals of possibility to 10L and 10R spread over 15 documents. The largest category is the **Conceptual** in which the modals mainly indicate the propositional nature of the suggestions around diagnosis and categorisation. In a similar way to the previous set of concordances, **Attributes Psychological** are mainly confined to diagnostic interlinking rather than direct expressions of attributes. The **Attributes Social** concern danger and burden to society, perhaps expressing the changing environment for discussion post-Michael Stone.

The modals of likelihood/certainty are much less frequent, which would certainly mirror the frequent use of the modals of possibility to suggest the disputed nature of the concept. With modals of obligation/recommendation there is also a small selection and, when read, the statements seems to indicate more what should be done to clarify the issues rather than what should be done about people with personality disorder.

Overall, in considering the concordances around *personality disorder*, there is a sense that it is used infrequently with language that describes what it is or what is being talked about or how it relates to behaviour or cognition. Rather it is mostly used in language that is treating it as a concept, relating to subsets of itself, but also other

concepts based on the operationalisation of life. This conveys a sense of distance from the subject, not evident in the earlier corpora, and certainly not with discussions around *psychopath**.

Analysis of *personality disorders* in the 2000s corpus

Turning now to *personality disorders,* the collocates of its 366 occurrences over 27 documents are shown in Appendix 22 down to word frequency 12. As noted before, the appearance *of suicide* and *attempters* are entirely linked to one paper (Suominen et al. 2000). *DSM, clusters* and *IV* are very frequent and show the clear linking of *personality disorders* with DSM rather than ICD, that latter appearing only 10 times as a collocate. The study language of *subjects, study* and *sample* are also present, along with *prevalence*, confirming the public health concerns of the 2000s corpus, and *costs,* showing the links between personality disorders and the health economic discourse appearing for the first time in the 2000s corpus.

The commonest collocates in any one position are *of* and *with* in L1. Looking first at the concordances of *of personality disorders*, compared with the 1970s results, we find a preponderance of **Categorisation Groups**, reflecting the interest in prevalence investigations. Again there is a very limited selection around **Attributes Psychological**; effectively confined to only one mention of irritability and aggressiveness. **Attributes Social** focus on undesirability of personality disorder, cost and marital and educational achievements, the latter odd categorical bedfellows. As with all the concordances the only agency is being acted upon rather than acting, and this again divides into **Assessment, Study** and **Treatment.**

With personality disorder occurs 64 times over 16 documents and collocates in L1 mostly with *people, individuals, patients* and *suicide attempters*. The social attributes are dominated by cost, and the ideas that patients with personality disorder use services excessively, or consult services more frequently than others, while there is simultaneously optimism about treatment, however also mentioning professional unreadiness. Thus there seems to be a different way of talking about the personality disordered when they are going to services based on their own decisions, to when they are going to what are seen as the right services. In terms of positioning this means a different set of rights and obligations in each arena. In one you are a person defined as having a bona fide problems and owed at least an assessment, in the other you are a person defined as troublesome. The **Behaviour** and **Attributes Psychological** categories are dominated by the paper on suicide attempters mentioned above (Suominen et al. 2000). The **Treatment** category contains some degree of optimism although the debates and discussion about appropriateness and capacity of services are in evidence. It is of note that in this set of concordances and in the last, *personality disorders* alone does not attract descriptions of social or psychological attributes, but the phrase *x with personality disorders* does link to a number of social attributes.

Looking at the factual statements, the 41 instances of *personality disorders are* are spread over 12 documents and largely focus on debates around the concept.

The concordances of *personality disorders* with the modals of possibility are spread over 13 documents and the social category is worth examining in more detail. There are statements concerning *burden* on services, mention of manipulative behaviour causing inappropriate service response, and that services were *certainly not*

designed for people with personality disorder (Crawford 2007: 283). These have a cumulative positioning effect such that services are seen to be originally correctly designed for the right sort of ill people, and people with personality disorder are simply failing to fit in with this. This formulation thus disables the question of who services were designed for and, indeed, whether design is the right concept to apply to the growth of such a complex entity with its powerful staff interest groups and changing policies. There have been criticisms that psychiatric services are most suited to help people who are rarely in crisis, are able to keep appointments, often far from their home, do not have problems in the evenings and weekends and in general do not bother the service outside the time in which they are allotted. Personality disorder in this understanding is able to define those who are awkward, which label then explains their awkwardness.

Discussion of *personality disorder** in the 2000s corpus

In all the concordances examined in this corpus, there were significant numbers of statements around conceptual and diagnostic problems with *personality disorder**. There was also a notable increase in the language of scientific study compared to the 1970s. There were many less direct accounts of what personality disordered people do and feel in the 2000s corpus than with in the *psychopath** of the 70's and 50's, and this was similar to the *personality disorder* * of the 70's. Thus one might conclude that the erasure of the 'stigmatising' label of the *psychopath* and its replacement by *personality disorder* was also accompanied by another process, that of a 'sanitisation through science'. Concepts of *burden, cost, family history,*

prevalence and *risk* take the stage from *disruption* and *uncomfortable*, but also the space for positive attributes disappears. *Personality disorder* becomes entirely a problem to be assessed and dealt with rather than an aspect of a human condition. As the person becomes the object of scientific study, the ability to be considered individually becomes more constrained. These themes will be explored further in the following chapter.

Chapter 8: Interpretation and Discussion of Corpus Exploration

Introduction

The lexical analysis in Chapter 6 and the analysis of subject positions in Chapter 7 have revealed a number of significant trends and changes across the three corpora. Many of these are argued to be indicative of discourse change, while others signify a more historical transformation. The latter will be discussed briefly at the start of this chapter before proceeding to a more detailed examination of the discourses revealed by the corpus explorations and their implications for subject positions. As described in Chapter 5, Willig's methodology will then be used to analyse these discourses in terms of their implications for subject positioning and subjectivities, based on the corpus evidence collected.

Historical changes

The dominance of *personality disorder/s* in 2000s corpus

While it is not surprising that a collection of papers on psychopathy and personality disorder contains many references to each, what is immediately striking on comparing the word frequencies of the corpora is the extremely large usage of *personality disorder/s* in 2000s corpus (Appendices 5, 6 and 7). The frequencies are comparable to extremely common grammatical words like *with* and *for*, most unusual for nouns and certainly not replicated in either of the other corpora or the BNC. It is the dominant way of expressing the discursive construction in the 2000s corpus and

as such can be seen as an attempt at 'closure' of a scientific concept as explored by Manning (2000: 626) in relation to personality disorder and its contested status. We can also perhaps see this dominance of *personality disorder/s* as reflecting the triumph of the DSM system enabling clinicians to speak one agreed language for research and treatment, one of the main aims of the manual as outlined in Chapter 2, however the scale of the use still remains a puzzle.

This over-use is possibly a clue to understanding what is going on, constantly referring to something as both a clinical entity and a valid and measurable concept does appear to make it so, and the statistical and study discourses dominant in the 2000s corpus both enable and are enabled by the use of a defined object of study. This also needs to be seen in the context of personality disorder moving to centre stage of psychiatry. While it was marginal, difference and discord could be tolerated, as borne out by the differing models of psychopathy in the 1950s as well as the differing names used in both the 1950s and 1970s. However if this diversity persisted the scientific and statistical approaches required by personality disorder aspiring to mainstream acceptance could not be developed.

One can therefore posit an interplay between the 'scientific capital', to adapt Bourdieu, accrued by using statistical approaches, and the move to enable *personality disorder/s* to fit this discourse, resulting in *personality disorder/s* itself acquiring some of that capital. Thus *personality disorder/s* itself comes to embody this approach, however, even backed by this discourse and by previous studies the profound problems still exist as outlined in Chapter 2. Thus one can see the overuse of *personality disorder/s* as an attempt to drown out this dissent through the production of more and more evidence that it is used in scientific studies. One can

also link to this the uncertainties that any social science may experience in relation to the approaches of 'hard' science, particularly in the necessity to operationalise life, which will be discussed later in this chapter.

A further addendum to this discussion is the use of *PD* in the 2000s corpus only, indicating perhaps a further means of stabilising the concept, and taking it 'beyond reach' by use of its abbreviation.

The prominence of talk about the DSM and the pluralisation of *personality disorder/s* in 2000s corpus

It is noticeable that talk about the Diagnostic and Statistical Manual or its abbreviation *DSM* only occurs with any frequency in the 2000s corpus. There is no mention of it (nor of the ICD) in the 1950s corpus and only one mention of DSM II (American Psychiatric Association 1968) in the 1970s corpus, compared to the 22 instances of *International Classification of Diseases* or *ICD* in that corpus. By contrast, in the 2000s corpus there are 262 occurrences of *DSM* and *axis, cluster, BPD* and *DSM* all appear in the list of the most frequent nouns (Appendix 6). Talk of the sub-categories *borderline, avoidant, schizotypal,* and *compulsive,* is also most prominent in the 2000s corpus (Appendix 13) along with the usages *antisocial personality disorder* and *dependent personality disorder.* Combined with this, as has been mentioned in Chapter 6, *diagnosis/es* in the 2000s corpus is used to refer to manualised diagnosis as opposed to more general talk of personality disorder as a whole.

This all comprises very strong confirmation of Manning's thesis that the American DSM system has become embedded in relation to personality disorder in the UK psychiatric system, both by providing a point of certainty in relation to a contested concept (Manning 2001) and from the point of view of 'technological path-dependence' where the times and costs invested in its use underpin its own success (Manning 2006: 1967). While its rise in the USA in relation to the need for a 'billable diagnosis' makes sense (Manning 2000: 623), it remains curious that in the UK the DSM remains highly preferred to the ICD by psychiatric writers and researchers as well as UK policy makers (NIMH(E) 2003c). It is often cited that the move from personality disorder as a primary diagnosis, which it remains in the ICD, to its own Axis in DSM III (American Psychiatric Association 1980) prompted the explosion in research. However this does not seem in itself a drastic enough move to explain the change. As seen in Chapter 2 the basic sub-category structure has remained unchanged and available to clinicians from its 1940s precursors, and through the early 1970s as seen in this quote.

> *A diagnosis of personality disorder is commonly used in psychiatry. It is generally agreed to refer to a disorder manifested by limited adaptive flexibility and certain relatively fixed ineffectual modes of behaviour... However, of twenty or more different types of personality disorders only antisocial personality has been differentiated by rigorous criteria as a distinct diagnostic entity.*
>
> (Liss et al. 1973: 685)

It is also clear that in the 2000s corpus, personality disorder is talked about as a diagnosis in it own right, a clinical condition similar to the Axis I diagnoses, rather

than as a diagnostic axis concerning underlying personality, on a par with, for example, Environmental Factors, which comprise Axis IV.

However, the DSM III did contain more description of the sub-categories perhaps allowing clinicians to utilise these to categorise from their clinical experience. Crucial to the rise in *personality disorder* however is the debate about its place in psychiatry, particularly whether personality disorder is a mental disorder, since, unlike a disease entity, it is with the person for their life, in effect it is part of their self. The recent policy reflects that psychiatrists in the UK have been and still are noticeably reluctant to have people with personality disorder in their service. This has effectively been by-passed by the creation of specialist services for those most severely affected, with acknowledgement of the 'burden' that personality disorder places on the rest of the services.

In addition to this, in the 2000s corpus the concept becomes a plurality as encapsulated in the usage of *personality disorders* in the 2000s corpus such that, at 366 occurrences, it is the fifth most frequent two-word cluster in the whole corpus (Appendix 7). It is used to refer to either all the sub-categories of the DSM as in:

However, we stress that our selection process did not exclude subjects with other DSM-IV personality disorders. (Sanislow et al. 2002: 34)

or to those in a particular cluster, as in the following quote:

This was explained by apparent over-identification of cluster B personality disorders by the informant compared to self-report. There was, however, better agreement between the instruments with regard to cluster A and cluster C personality disorders. (Moran et al. 2000: 56)

Thus it appears as an unproblematic label for a medical condition.

This usage pattern is different from the use of *personalities* in the 1970s, which do refer to individual sub-categories, but in much lesser numbers. There are also no equivalent '*psychopathies*' or '*abnormal personalities*' in the 1950s or 1970s corpora and thus no similar vehicle for pluralisation in the same way. This pluralisation also defines both an expertise group and by extension a specialist group. Thus there are those, and they are well represented in the 2000s corpus, whose expertise is in identifying, researching, treating and managing personality disorders. The plurality shows that the sub-categories are taken for granted as differing clinical entities thus positioning people as experts in identifying and distinguishing them. In effect, the more elaborate the diagnostic system the more the need for experts and specialists to interpret and manage the field. This lends itself to the heterodoxy and orthodoxy approach outlined in Chapter 4, such that these experts become the mediators between distress and its understanding, effectively priests in the hierarchy of personality disorder with their own language and techniques. This orthodoxy argument would also contribute to the understanding of the over-use of *personality disorder/s* in the 2000s corpus, as, in effect, it is the deployment of this phrase which then gives authority to the priests, not unlike the visible trappings of their position.

However one can also see a counter trend as the use of the DSM and its clusters becomes the norm, this also reflects a change in discourse from that of a clinical psychiatry to a manualised psychiatry, from a clinical expertise to a written guide, which must be followed in order to practice and be considered expert. Simultaneously this undermines the mystique of expertise as one now simply follows the book.

The rise in talk about treatment for personality disorder in the 2000s corpus

We have noted in Chapter 2 that psychiatrists calling on the untreatability of personality disorder to justify the refusal to see patients, was roundly criticised by the then Home Secretary in the wake of the Michael Stone murders. This untreatability argument had existed for many years in particular with regard to the Psychopath category in the Mental Health Act (1959 and 1983), which required the existence of treatments for a mental disorder in order to justify detention in hospital. However the marginalisation of personality disorder through lack of effective medical treatments had become a cornerstone of psychiatric practice and was cited in the recent policy (NIMH(E) 2003c: 5), whose title 'Personality Disorder: No longer a diagnosis of exclusion' was aimed to bring the subject back into the concern of mainstream psychiatry.

It is of interest then that there is a notable increase in language around treatment although, when examined further, both the 1950s and the 2000s corpus contain significant amounts of text about treatment, often very insightful, as the following quote reveals.

> *It is thus clear that these tasks can be accomplished only through united medical, psychological and sociological effort; and the basic condition for this being fruitful is that each of these three different approaches possesses sufficient knowledge of the potentialities and methods of the other two. It is hardly necessary to emphasize that those persons who are engaged in these tasks must themselves be emotionally well-balanced.* (Sturup 1952: 38)

In the 2000s corpus however there is an increase in the direct collocation of *treatment* with *personality disorder* and also the prosody *treatment of personality disorder* which can be seen in the **Acted Upon (Treatment)** category in the concordance of *with personality disorder* in the 2000s corpus. *Therapeutic* also increases gradually but not statistically significantly over time. In the 1950s the usage is very wide from *therapeutic community* to *therapeutic possibilities* and *results.* By the 1970s *therapeutic community* dominates the usage, but largely due to the one text covering this area (Whiteley 1970). By the 2000s corpus, this is still dominant but appears in more texts often discussing earlier studies in this area, while *therapeutic relationships* also becomes a common collocate. Thus there is an emergence of the therapy discourse in relation to personality disorder, and specifically the move from residential and social treatment to a focus on the relationships between professionals and patients. However this is still clearly a minority interest in this particular literature, and rather than suddenly springing into existence in response to the policy, treatment options have been around for quite some time, perhaps not however the political or psychiatric will to develop them.

The fall in references to military experience after the 1950s corpus

A notable feature of the 1950s corpus is its references to military service. Here it is used in two main ways, firstly when describing case histories where clearly the proximity of the war means that many patients had had war experience. Its second sense is of duty, where only *military duty* is talked about in the 1950s corpus in the

analysis of morals, rights and duties. In these cases the talk of wartime military service seems to act as a bridge across professional and patient boundaries as, while sometimes the experience is 'honourable' and at other times less so, it nevertheless has been shared by many during these times. An equivalent commonality is hard to imagine at the present time and perhaps only serves to reinforce the patient/professional division despite the talk of reducing stigma and patient voice. The shared wartime experience one suspects did induce a shared respect. This is perhaps evident in the following quotes:

> *As a staff sergeant he refused a commission to avoid responsibility. He served in the Middle-East campaign and flew in sorties to Arnhem. He was vague about his life since demobilization in 1945.* (Davis 1950: 1008)

> *These men gave an average of three good years of military service, and showed no permanent damage after they broke down. With rest and psychotherapy, they are generally restored to their pre-depressive states.* (Valenstein et al. 1953: 446)

> *In November, 1939 he joined the Army and had seen seven months' service in Egypt when he was wounded in a shell burst. Of 8 men in a pit, 2 were killed and another was wounded besides him. He was concussed and had a dislocated shoulder. In and out of various military hospitals for 2 1/2 years he was finally discharged with "neurosis" in September, 1943.* (Hordern 1952: 636)

The appearance of *duty* is of interest in illustrating the assumption in the 1950s that people would fight for the country; a sense that has shifted radically. As the main appearance of *duty* in any of the corpora is with this sense, it does seem to signify that military service was the main carrier of this meaning. Thus one could hypothesise that, as this sense became less important the further in the past common military service was, there was no other object of sufficient import to transfer this sense onto, hence it disappeared from these texts. The corpus data certainly suggests that it did not get transferred to an explicit talk of duty to society or to oneself.

Discourse changes

In this section evidence for discourse changes will be reviewed and discussed. It is worth briefly revisiting at this point the sense in which discourse is meant in this study, as was made clear in the theoretical discussion. The particular Foucauldian sense of discourse is summarised by Mills (1997: 55) as 'sets of sanctioned statements which have some institutionalised force, which means they have a profound influence on the way individuals think and feel', and by Willig as facilitating and limiting 'what can be said by whom, where and when.'(Willig 2001b: 107). Thus the corpus analysis collected particular common patterns in usage which, it is argued below, imply particular ways of going about constructing positions around *psychopathy* or *personality disorder*.

Most of these have been identified in the previous chapters, but this section starts with a consideration of the major change in discourse deployment evident from the corpora, to which a number of other discourse changes contribute. That is the move from what may be termed a Narrative Discourse calling upon personal authority and experience in the 1950s corpus, to a Statistical and Study Discourse calling upon the authority of the scientific method in the 2000s corpus. The changes in both of these over time are evidenced from the statements within the corpora, identified and collated through the corpus analysis, but these discourses also constrain the ways in which the discursive object can be viewed in each corpora. After examining the evidence for the discourses at work, the positioning effects on the discursive objects *psychopath** and *personality disorder* will then be examined through Willig's 6 step analysis (Willig 2001b).

The move from the Narrative Discourse of personal authority to the Statistical/Study Discourse

This overall change can be concluded from a number of other trends which will now be examined and which, in themselves, hold implications for how *psychopathy* or *personality disorder* can be apprehended in each corpus. These trends are as follows: the reduction in language associated with case histories; the reduction in language signifying the author's authority; the increase in statistical language; the increase in specialised health study nouns; the decrease in human and lay language; the increase in formulaic usages of words and phrases; the increase in an epidemiological conception of personality disorder; and an increase in statistical study language and its association with *personality disorder** rather than *psychopath**

from the 1970s corpus. These will now be looked at in turn from the point of view of their supporting evidence and their implications.

Reduction in case history language:

In Chapter 6 a number of common words were found to be used largely with descriptions of individual patients and their treatment, as well as formal case histories. Some were linked specifically to case history descriptions such as *case/s,* and *man,* while others reflected particular rhetorical devices found largely in case history description such as *degree* and *later*. These all show a significant decrease after the 1950s corpus. Alongside this the use of *data* moves from the narrative to the statistical, while the decrease and disappearance by the 2000s corpus of *he/she felt* in case descriptions, also marked the decrease in case study language as well as extinguishing of the only route for patient voice present in the whole corpora. *Sexual* also decreases and changes its usage from a context of *excitement*, along with *desires* and *advances*, all occurring within case history descriptions, commonest in the 1950s to less common usage in the 2000s corpus largely connected with *abuse* or *assault.* The 1970s finds it associated with *deviation.* Thus this is another marker of decrease in case study language but also the disappearance of concerns about the patient's sexuality, or indeed the patient as an individual with human qualities, recognisable to the lay person.

One could argue that this decrease in case studies can be seen simply by looking at the articles themselves and noting the number of case descriptions. Prior to analysis, the texts were marked up to include sections identifiable as case histories (Appendix 4), and when these sections are counted we find 6 sections in the 1950s,

10 in the 1970s and one in the 2000s corpus. However the changes outlined above do not follow this pattern of increase in the 1970s, and many of the words observed fall outside the parts of the texts marked up specifically as case histories. Instead what seems to be occurring in the 1950s is a more general use of appeal to case description in the body of the texts, in a way which decreases significantly over time.

It can be seen above that this decrease in case study language also has consequences for the routes for expressing the individuality of patients and their feelings. Effectively this route becomes closed off.

Reduction in use of author's authority language

There are a number of grammatical features commonest in the 1950s that indicate a particular style of writing calling upon the author as authority. This is typified by the use of *in fact, the fact that, the central fact* and also the decrease in *it was felt* from 1950s through 1970s to absence in 2000s.

One could suggest that this reflects a movement away from authoritative language towards a more hedging academic approach. If so this would function in a discourse sense to allow a contested concept to appear more valid through association with the scientific process, rather than relying on authoritative voices alone to lend validity.

Increase in statistical language

The most marked change however is the increase in statistical language over the course of time. Thus there are very dramatic increases in *sample, subject, scores, informant* and particularly *subjects,* in the 2000s corpus, as well as *baseline,*

significant and *statistical*. In addition, the measure of significance *p* appears very frequently in the 2000s corpus compared to the others (Appendix 5). A number of other words change their usage to become part of the language of statistics in the 2000s corpus. For example *test* and *tests* are used more broadly in the earlier corpora but by the 2000s they are used almost exclusively in relation to specific statistical tests e.g. Mann-Whitney. *Group* also shows a pattern of decreasing narrative use of a word and an increasing technically precise use, to do with statistical approaches, as does the increase in *items* used in a statistical/survey sense, and also *agreement*.

Specific and *non-specific* are both associated with the statistical/study process applied to human distress in the 2000s corpus and there is more use of *compared* in statistical and study context in 2000s corpus. *High/higher* is generally used over the corpora in reporting study results, hence their increase in an indicator of how scores are used to report results.

However, although there is a clear and significant increase in statistical language in the 2000s corpus there are also some nuances to this picture. The peaking of the terms *reliability, agreement, items, scale, level, relationships,* in the 1970s and then its falling off in the 2000s was noted as signifying a more explicit concern with reliability and agreement of scales in the 1970s. Although these doubts are still there in the 2000s corpus, as seen in the discussion of *problem* in Chapter 6, this is no longer such an area of attention. However, by setting these explicit doubts aside the progress of the concept towards a manageable variable that can take its place as an object of study is enabled. This change does seem to be very direct evidence of how a contested problem can be handled using the scientific method, by setting aside aspects of an issue in order to progress others.

We have also seen in Chapter 6 that several tendencies can be at work across the corpora on specific words, for example the changing uses of *test* showed an increase in purely statistical language in the 2000s, a decrease in reliance on psychological tests developed for personality measurement from the 1950s, and an increase in tools developed, largely in the 1970s, specifically for personality disorder assessment.

Some words and phrases associated with this statistical study language point towards active processes at work in relation to personality disorder. Thus in the 2000s corpus *findings* collocates strongly with *confirm* and *support* which does not happen in the earlier corpora where *findings* tend to be *reported.* This indicates an active use of the statistical/survey language to shape the implications of personality disorder. It was noted before that there is a common usage of *based on* in the 2000s corpus with a general structure:

(model of personality disorder/diagnosis/treatment/statistical techniques)

based on (DSM, study findings/ data/ previous results)

This allows us to see a direct linguistic link between understandings of personality disorder and study findings with the DSM as an important component.

The corpus examination summarised above both provides evidence for the prominence of this statistical talk in the 2000s corpus, but also gives clues as to the effects of this on positioning. Thus the reporting of results with *high/higher* reflects how these scores have been obtained through operationalising aspects of life, and how these scores then come to stand for the experience itself. These aspects of positioning are drawn out later in this section, particularly those implied by the use of *subject/s* (Appendix 18).

Rise in specialised health study nouns and the rise of operationalised life

Along with this general deployment of statistical language in the 2000s corpus there is an increase in and also a first appearance of nouns associated particularly with study into health, the most common being *assessment, outcome, events* (mainly as *life events*), *functioning* (usually as an operationalised variable as in *psychosocial functioning*), *self* (used in relation to scales of measurement like *self-defeating*), and *measures* (almost entirely in relation to variables in a study, e.g. *outcome measures*).

At the heart of this process is operationalisation, a process that by-passes the difficulties in measuring human qualities by substituting the tool or operation used to measure it (Brown et al. 2003: 78). A typical example in the corpus is Pagano et. al.'s (2004) use of the Life Events Assessment (LEA) to measure whether stress in life was related to the ability to function with a personality disorder. The ability to function was also operationalised through another questionnaire, the Longitudinal Interval Follow-up Evaluation (LIFE), and talked about through the article as *psychosocial functioning*. Stress in life was operationalised through the LEA described as follows:

> *LEA items were grouped by stress domain categories: 27 items pertained to work or school (20 negative, seven positive); 16 items pertained to family or living circumstances (10 negative, six positive); 13 items referred to love relations with a spouse or partner (eight negative, five positive); 12 items referred to crime and legal matters (10 negative, two positive); seven items referred to financial matters (five negative, two positive); and four items*

pertained to physical health (three negative, one positive); three items referred to social matters (three negative, zero positive). In total, 59 items were considered to be negative and 23 items were considered to be positive events. (Pagano et al. 2004: 424)

This allows the article to then describe relationships between negative life events, psychosocial functioning and personality disorder. This is the way in which the operation comes to stand for aspects of life. There is a requirement in this process to generalise aspects of the individuality of experience, in order to make them amenable to definition and study by statistical means, and the aim, as illustrated above, is to make general statements about the relationship between particular operationalised variables. Operationalisation has to reduce and generalise experience as it cannot reflect all aspects of a particular individual, be it antisocial behaviour, the ability to cook, or one's relationship with a treating team. To do so would no longer be operationalisation it would be narrative description of individual's experience, where the importance placed on individual items is by the individuals themselves rather than by the researcher. The danger in this process lies in losing sight of the existence of a process, such that operationalised statements come to stand for aspects of life and study results override the individuality of treatment.

In this transformation the connection of the human quality and the operationalised variable become distanced, as a complex situation is made amenable for study. Thus for example *negative life events* efface what these are while also becoming the primary descriptor, a code which people may begin to use without

discrimination of what is negative, who is evaluating the negativity, and what any mechanism may be connecting life events with psychopathology.

Pagano et. al.'s paper also provides an instance of the operationalisation of personality disorder itself as represented by the use of the Diagnostic Interview for DSM-IV Personality Disorders to identity the presence of personality disorder. This illustrates the trend, noticed in Chapter 6, towards the increase in specific tests and diagnostic measures for personality disorder, where previously operationalised concepts from psychology were applied to personality disorder, as in the use of Eysenck's scales or intelligence testing. It is this process which, despite the expressed caveats about reliability, comorbidity and validity, reifies personality disorder, and encourages the view that there is an entity waiting to be measured and discovered. When more generalised psychological tests are used to apprehend aspects of the person, then there remains an implication that the subject of these tests is still on the human continuum. When specific tests are used to identify a condition so fundamentally defined as a part of the person as personality disorder, and this is applied as a medical diagnosis, then this is inherently an othering process.

This type of operationalised health study language also carries over into the reporting of conclusions or opinions leading to highly coded utterances. Thus as we have seen before the phrase occurring in correspondence *people with personality disorder experience disadvantage in their socio-political environment, often due to their behaviour* (Bennett 2002), does not state what the disadvantage or behaviour is, but is clearly meant to be read with shared knowledge that can fill in these gaps. Having explored the 1970s and 1950s we can confidently say these are likely to be violence and argumentativeness, and the disadvantage is poor service, neglect or

reciprocated aggression. That these are not specified is part of the sanitisation process that accompanies the use of health study language, the cleansing of messy life, to use one of Parker's (1995) dichotomies.

The decrease in lay language, and the increase in formulaic usages of the same words

This section collects together a number of observations on word trends, in which a word is used with its common meaning in the 1950s corpus, a usage I have termed lay language, but by the 2000s corpus this has become formalised and repetitive, often as a result of the operationalisation process mentioned above. A prime example was uncovered by the observation of *life* dipping in the 1970s. On analysing the concordances there seem to be two trends overlapping in this pattern, a decrease in the use of a lay sense of *life* over time along with a notable increase in formulaic representation of human existence between the 1970s and 2000s, typified by *life-events*.

Another instance is *social,* showing a distinct increase in the 2000s corpus; of the 172 occurrences, there are several frequent collocates in R1 such as *social problem solving* (23), *social adjustment* (10), *social class* (21), *social functioning* (16), *social dysfunction* (5), *social phobia* (14), *social roles* (9). Thus while it contributes to the medical discourse and the statistical/study discourse, its main usage is in phrases which encapsulate aspects of being human:

> *If that is the case it would support our previous proposal (Hill et al, 1989; Hill & Rutter, 1994; Hill et al, 1995) that persistent dysfunctional*

patterns of social role and interpersonal performance may be common to many of the personality disorder categories. (Hill et al. 2000)

It was also noted in Chapter 6 that there was a varied and wide ranging negativity in the 1950s centring on *emotional*, that became condensed into the shorthand of the Cluster B terminology, where *emotional* comes to stand for a group of people difficult for services and professionals to manage.

This provides an illustration of how discourses may still be at work but become hidden from obvious sight. The 2000s corpus suggests that a contemporary worker in psychiatry may identify that Cluster B means emotional and that means trouble, however this is not evident from the word alone in the DSM, and the elaboration of this sense of trouble may not be possible due to the contraction of the concept in use. Looking at its history through psychiatric time allows us to see what the negativity comprises, how it may still potentially be at work and whether a more helpful elaboration can be attempted. Enabling this shorthand to be unpacked could offer more avenues for understanding than seeing the diagnosis as an end in itself, implying narrowed treatment options and goals.

Associated with this trend is a move from word use which expresses an observation, to word use which expresses a diagnosis e.g. the change in use of *antisocial,* linked to *behaviour, conduct* and *acts* in the 1950s and 70's corpora to *antisocial personality disorder* in 2000s. Thus *antisocial behaviour* becomes inextricably linked to a medical condition such that they imply each other. The issue of will or responsibility becomes muddied through the intervention of medicine, and

the actual nature of the acts and their impact becomes a symptom rather than a process in the social world.

The use of *aggressive* primarily in *passive-aggressive*, in the 2000s corpus, associated with the DSM III category demonstrates a similar but more muted pattern to *antisocial*, where actual description is eschewed over time in favour of ready made labels. As an aside if we look at *violent*, we see a similar move in its usage from violent acts and behaviour to the exclusive use of general phrases such as *violent crime* or *violent death*, as well as an overall decrease in use. This provides further confirmation of this movement from 'messy life' to 'pure categories' (Parker et al. 1995: 60), encapsulating much, but losing intensity and meaning in the process. The common use of *physical functioning score* in the 2000s corpus, contrasted with more lay usage of *physical* in the earlier corpora also supports this trend. Thus, while these changes support the existence of one of Parker's dichotomies, what they actually show is that they are not, as Parker suggests linked at one end to the concept of psychopathology. Instead the evidence shows rather that psychopathology as practised in the 1950s favours one pole of the dichotomy while the 2000s practice favours another. There has been a radical shift over time.

In the concordances associated with *of personality disorder* in the 2000s corpus, psychological attributes include *mental disorder, universal counter-transference,* and *early fear* and/or *anger in the etiology.* It is of note that these are framed more in technical terms than in the lay language noted of *psychopathy* in the 1970s. In a similar way the social aspects are framed as *family history*, or *burden* and *costs to society* rather than the more general but direct *disruption to society.* In the concordances of *personality disorders are*, the statements around psychological

attributes have a vague and general feel, as do those around the social, and include phrases like *impaired social functioning, impinging on clinical practice, adverse consequences*, with *manipulative* also making a return. In the 1950s it was noted that psychopathy was like an elephant; one knows what it is, but one can't define it (Bartholomew 1958). In the 2000s corpus it would appear as though the elephant is still in the room.

However these trends do not go uncontested, and the corpus analysis provides distinct evidence for some degree of growth in language that allows a more nuanced talk about people and events, a reverse of the trend described above albeit appearing less often; *relationships* being mentioned previously as an example of this.

A major problem with the use of the formulaic language is that the connection may be lost between behaviour and any causative event. We have seen that there is recognition within the 2000s corpus that sexual abuse is linked to borderline personality disorder but there is no mechanism within psychiatry to account for this. In addition, this 'eventifying' of life makes an assumption that something happens and then there is a reaction. However, at what point does the something stop happening? Is it reasonable to see abuse as an event, which the person has to cope with, or rather as an unfolding process? This counting of events also undermines any individuality in what occurred. There is simply the fact of something happening, there is no interaction between the person's psychology and the environment and their family or context. All sexual abuse for example is rendered similar, as a risk factor in the development of borderline personality disorder, for example. One could argue that to do this type of study requires this type of approach, and one would be right, but the consequence of this type of talk then becoming mainstream is not known. This

again points to further research examining whether this type of language is in use in clinical practice and how it links to clinicians and patient's interactions.

Increase in study language and its association with *personality disorder rather than *psychopath** from the 1970s corpus**

In general we have seen that *psychopath** is the dominant discursive construction in the 1950s corpus while *personality disorder* *is even more dominant in the 2000s corpus. Study language has increased over this period as shown above, thus it could be construed that a single disorder with different names was simply being approached differently in different decades, as might be deduced from the following quotes.

> *The Henderson Hospital is a 68 bed unit for the in-patient treatment of young people of both sexes who are described as psychopaths, sociopaths, personality disorders or character disorders.* (Whiteley 1970: 517)

> *Foulds (1951) showed that the style of performance on Porteus Mazes of psychopaths (used loosely to include all personality disorders) was more like that of hysterics than of anxiety states, neurotic depressives, or obsessionals. Such results may have been more a function of personality than of diagnostic types.* (Foulds 1971: 223)

However the 1970s corpus analysis provides some evidence that the name change is more significant than that. In this corpus collocations of *patient** with *psychopath* and *personality disorder* showed that *patients* has a much stronger association with the latter term.

Also in considering the concordances around *personality disorder* described in Chapter 7, the evidence is that it is used infrequently in conjunction with language that describes behaviour or cognition, being mostly used in conceptual language. This is not evident with *psychopath** which we have seen often is involved in colourful and detailed descriptions. Thus there is a distancing, notable in the 2000s corpus, a moving away from direct description of human experience encapsulated by the move from *psychopathy* to *personality disorder*

Thus there is strong evidence that the change in name allowed a more discursive style to be effaced in favour of the new scientific turn. In effect, *personality disorder*, while possibly being clinically similar, is not used in the same way as *psychopath**, in particular the versions which supported a narrative and sometimes positive view, namely *the psychopath.*

The increase in an epidemiological conception of personality disorder

Alongside the increases in study language outlined above is the appearance in the 2000s corpus of epidemiological concerns around personality disorder. As we have seen this is evidenced by the significant rise in *risk* and *prevalence* and the appearance of *demographic* in the 2000s corpus linked to *characteristics* and *sub-groups*. Indeed *prevalence of personality disorder* is reasonably common for a four-word phrase in the 2000s corpus (19 instances). *Public health* is also used

increasingly in the articles. The rise of *associated with* in the 2000s corpus is linked to the presentation of this type of data and clearly presents the reader with an association, but no causality or explanatory mechanism, as in the following example:

> *Personality disorders are associated with impaired social functioning and high rates of mental disorder.* (Moran et al. 2000: 52)

As a consequence there is no possibility of discussing explanations; this becomes outside the discourse in Foucault's terms. Without causality or sense making activities all that is left is the association, the linking in discourse of personality disorder, social functioning, criminality, poor prognosis, and so on. These thus become facts about personality disorder without the need to explain. The response to these epidemiological findings then is likely to occur on a policy level rather than the human, and although these should be concordant, their separation in this context can allow apparently logical policies to fail on a human level in practice.

Unfortunately, while it may be claimed that the move to an evidence culture is of benefit to patients by allowing them to receive the most efficacious treatments, the move in this instance seems to require the extinguishing of a more lay and human approach to writing about personality disorder. The two discourses do not seem to coexist happily, and this is perhaps the most pressing challenge to current psychiatry, how to retain the human in an evidence culture. Are they mutually antagonistic as appears to be the case when operationalisation is evident (Brown et al. 2003: 105) or are there potential models that can marry the two, such as narrative (Greenhalgh et al. 2004) or post modernist approaches (Brown et al. 2003).

The peaking in 1970s of a Medico-Psychiatric Discourse

As was mentioned in Chapter 6 there is evidence for the explicit deployment of a medical discourse particularly in the 1970s corpus. This was first indicated by *admission, anxiety, illness*, and *psychiatrist*s appearing for the first time in the top 52 of the 1970s corpus. Further, the following words significantly peak in frequency in 1970s corpus: *patients, illness, symptoms, psychiatrists, hospital, admission,* as well as *psychiatric*. There is also the use of *neurotic* in the 1970s collocating with *illness, disorder* and *patients* and the common use of *mental hospital*, as well as *clinical presentation/use/diagnosis/information*. Finally there are frequent collocations of *personality disorder* with *patients, illness* and *discharged* in the 1970s corpus.

These peaks and association strongly suggest a prominence of what may be called a Medico-Psychiatric Discourse during this period, the term aiming to reflect a particular disease/illness model of psychiatry. This has been the subject of considerable scrutiny particularly in Foucault's original work (Foucault 1997; Foucault 2000) and Lupton's further analysis (Lupton 1997a). Such a discourse allows one to talk about a condition resident in a person, but tends to disallow social and psychological conceptions. The evidence of its prominence in the 1970s suggests two main hypotheses, that this discourse has changed in its prominence over time, or that it has changed in its presentation through language over time. These issues will be expanded further in the Foucauldian Discourse Analysis later in this chapter.

The peaking of an explicit Normal/Abnormal Discourse in relation to personality disorder in the 1970s

In Chapter 6 it was noted that the appearance of a number of words was indicative of a particular discourse overt in the 1970s, that of the normal/abnormal. This was signified by the peaking of the use of *abnormal*, and particularly the formulation *abnormal personality* in the 1970s as well as the presence of *deviant* and the collocates *social adjustment/deterioration/deviance/group/withdrawal.*

In the 1970s the concordance shows *normal* is contrasted in phrases with *abnormal* and *deviant*, used frequently with *personality* and *traits*, as well as having a statistical usage in *normal controls* and *normal variation* in a sample. Similar uses in the 1950s show that in both corpora, the dominant sense of *normal* is of the 'right' way to be or do things, as opposed to the deviant or wrong or unacceptable way to be. This particular usage sets apart those with personality disorder from the rest of humanity; they are abnormal, by definition and categorisation. This implies that the treatment goal is to rejoin normality, or if treatment is not possible to render the effects of that abnormality non-toxic to normal people.

The effacement of this explicit discourse in the 2000s writing is of interest since the entire statistical process itself implies a normal/abnormal construct when applied to medical conditions, but is effectively no longer overt. As explicit, even if controversial, discourses move out of view they become harder to challenge.

Further evidence that in the 2000s corpus this normal/abnormal discourse is not explicit but still seems to be strongly at work is provided by the **Attributes Social** category of *personality disorders* with modals of possibility . It was noted in Chapter

7 that there was a cumulative positioning effect of these statements around burden and inappropriate service use, such that services appear to be designed for the 'right sort of client'. Thus while normal/abnormal is no longer explicit, by implication, normal people use services reasonably, while abnormal people don't. It is not explicit that services are to be used in a particular way, how often and in what manner, it is only clear when these norms are broken, hence those who break them are deemed abnormal.

The rise in a discourse of categorisation from the 1970s corpus onward

We can see the language around categorisation rising in importance in the 1970s corpus from the words appearing for the first time in the 52 most frequent nouns: *classification, category categories, criteria.* There are also frequent collocations of *personality disorder* with *diagnosis/ed/es, decisions, types,* and *classification* in the 1970s corpus.

Classification falls significantly after the 1970s, indicating a more complex trend than initially suggested. There does seem to be an increase in language around classification of personality disorder in the 1970s but this is partly accounted for by numerous mentions of the ICD in full, rather than in abbreviation. There may be a sense in which classification as an issue has become less prominent by the 2000s corpus. Indeed there is a falling off of diagnostic statements in the 2000s corpus in the concordance of *with personality disorder*, suggesting less concern with establishing or defending the diagnosis, even though, as we have seen, there is still

debate and doubt. Perhaps the issue has been solved by the rise of the DSM as the primary means of discussing personality disorder in the 2000s corpus.

The discourse of the market appearing in 2000s corpus

This is clearly shown in the words appearing for the first time in top 52 of 2000s corpus: *costs, outcome, risk.* Also, analysing the use of *service* from its military usage in the 1950s to its collocations with *health service utilisation, use* and *costs*, shows an indication of discourses around fiscal and societal responsibility, as well as the production line mentality (Crawford et al. 2007). Indeed it has been argued that there is a direct link between the evolution of psychology in the military services and its deployment in measures for suitability in work and for services in the NHS (Rose 1999): is it a coincidence the change is encapsulated in the same word?

This particular discourse also supports Foucault's ideas of governmentality outlined in Chapter 3, where the use of risk enables a 'knowledge of things', defining a group by risk such that it may be policed by a medical discourse.

The increasing specialisation of psychology discourse applied to personality disorder

This has been alluded to above in the discussion of the move from the application of general psychological tools to apprehend personality disorder towards the development and use of specialist tools, however this hypothesis is confirmed by further direct evidence. *Psychological* is commonest in the 1950s, where *test* and *testing* are its commonest collocates, along with *correlates, attributes* and *traits.* In the 1970s corpus, it is least used, and *tests* is still the commonest collocate, followed

by *constructs*. In the 2000s corpus there is a range of collocates in R1, *approaches, difficulties, functions, literature, morbidity, problems*, and *treatment,* but none particularly common. To summarise previous discussions, we see in the 1950s the taking of the psychological testing of the earlier decades and applying it to *psychopathy*, while the 1970s sees the emergence of specifically designed tools for apprehending the concept, but by the 2000s the explicit debt to psychology is effaced.

Evidence for the patient voice

The discussion of *he/she felt* in the 1950s above concluded that this did provide a route for the patient voice which has now been silenced in the psychiatric articles of the 2000s. However there is another part to this story. In the 1950s and 1970s corpora *reported* was generally used infrequently in the context of referring to previous articles or studies. In the 2000s corpus this usage increases, but is also joined by a significant use of *self/subject* reported data (28 out of the 67 instances). Thus we have indications of the apparently missing patient voice. However this is a voice which has been altered and translated almost beyond recognition in the 2000s corpus, compared to the use of *felt* in the 1950s corpus. It has lost its direct connection with the patient him or herself, and is translated through questionnaires to become data.

Evidence for a discourse of developmental and environmental causes for personality disorder

Despite the dominance of the Statistical/Study discourse requiring the use of operationalised variables which efface causality in favour of statistical associations and risk, there is some evidence of counter discourses allowing the discussion of links and causes. Thus *early* is common in both the 1950s and 2000s corpus. In the 1950s it collocates strongly with *adverse influences, deprivation, development, experiences* and *life,* thus indicating significant talk about causal factors in the development of the condition. This is virtually absent in the 1970s corpus, perhaps reflecting the greater influence of the classical medical discourse of psychiatry, and appears in the 2000s corpus but in a more codified form as *early (environmental) adversity*. There is also use of *physical abuse* in relation to personality disorder in the 2000s corpus, although it is not common, while there is some use of *sexual* in the 2000s corpus largely connected with *abuse* or *assault.*

Thus there is simultaneously acknowledgement of the effects of poor parenting and abuse on the development of personality disorder, alongside the effacement of what these actually comprise, or what the mechanism of the effect is. The lack of knowledge at the centre of personality disorder is again hidden by apparent scientific veracity.

Evidence for a disappeared discourse of social responsibility

This has been discussed in the section on rights, duties and morals in Chapter 7 but in brief there is a drastic reduction in reference to these characteristics after the 1950s

corpus, for example, the use of *moral* in relation to descriptions of right and wrong decreasing in use. This eliminates the space to describe positive and negative aspects of morality in relation to patients and staff within the framework of psychiatric articles. Further, in the 1950s corpus *social* also has collocations of *social obligations* and *responsibility*, a discourse that has disappeared from even the 1970s corpus.

An emerging discourse of optimism

This is a small but persistent discourse that appears most strongly in the 2000s corpus. There is a particular and frequent use of *new*, collocating with a range of developments related to personality disorder *new approaches, models, programmes, research, services*, and *treatments,* and these are most often expressed without hedging or doubt. Thus while gloom and confusion have been characteristic of the 1950s and 1970s corpus as evidenced by the discussions around *problem/s* outlined in Chapter 6, there appears to be space for optimism for the future treatment and understanding of personality disorder.

A Foucauldian Discourse Analysis of the diachronic corpora

The preceding discussions brought together evidence from the corpus analysis for a number of discourses at work throughout the corpora. These can now be explored using Willig's approach of working from discourses to subject positions in the six stage process described in her outline of a methodology for Foucauldian Discourse Analysis (Willig 2001b) of a given object of study, in this case personality disorder.

Stage 1: Identifying the discursive constructions in the texts

Willig suggests the first stage in a Foucauldian Discourse Analysis is to identify all the sections of text in which the discursive objects are constructed (Willig 2001a: 109). Informed by the historical review of personality disorder in Chapter 2, the initial examination of the nouns in the corpora established the main words and phrases used in relation to the object of study. These are arranged below for each corpus in order of frequency of use:

1950s: *the psychopath, psychopathy, psychopathic personality/ies, psychopaths,*

1970s: *personality disorder, personality disorders, abnormal personality, psychopaths, psychopathy, psychopathic personality/ies, the psychopath, character disorder*

2000s: *personality disorder, personality disorders*

Examining the collocates and concordances, particularly in Chapter 7, revealed the context around their occurrences and hence how they were constructed in the different corpora. This revealed significant points of difference between different discursive constructions. Thus in the 1950s the use of *psychopathic personality/ies*, and *the psychopath* seemed to allow expressions of doubt about the concept and its place in medicine and psychiatry, while the deployment of *psychopaths* and *psychopathy* did not. *Psychopaths* in particular seemed to be the site of author's certainties and also of both negative and positive statements about the attributes of people to whom it applied. Thus we see, concerning a sub category of psychopaths:

> *Its members are conscientious, reliable, responsible, painstaking and persevering, as well as being patient, loyal, honest, self-denying and kind. For the most part they are friendly, well-mannered and co-operative, and many have some artistic talent. They tend to be imaginative, musical and interested in the arts.* (Monro 1955: 338)

Psychopath tended to be used as a clinical entity and therefore utilised a medical discourse. *Psychopathy* was used more when being discussed as a concept and then additional philosophical discourses were brought into play.

In the 1970s there were significant negative associations with *psychopathy,* however there also remained a number of positive statements connected to its use. In contrast, with *personality disorder,* collocates of *behaviour* indicated solely negative associations in the 1970s. Further, *personality disorder** was used much more with being an object of assessment or study than was *psychopath**, and it was also

associated more with the position of *patient*, and less with anecdotal styles of account.

*Abnormal personalit** showed similarities with the use of *psychopath** in the 1970s, with its concerns on diagnosis and categorisation and similar themes of lack of remorse, aggressiveness and difficulties in fitting into social groups. There were also differences in that *abnormal personalit** was involved in statements about assessment and measurement, and also associated with subdivisions, some of which were positively construed. The statements around *abnormal personalit** also revealed familiar debates about whether it should be the concern of psychiatry, and there was also talk of the distinction between *abnormal personality* and *personality disorder*, thus showing that while some authors equated the two others distinguished them.

In the 2000s *personality disorder** becomes completely dominant as the discursive construction and is used most frequently in the sense of a concept relating to other concepts, such as subdivisions of itself or operationalised variables. As such it appears in numerous statements around assessment, treatment and study. This is also associated with the rise in the 2000s of a number of discourses which have been outlined above and which contribute to the nature of the subject positions around *personality disorder**. These and the other discourses at work through the corpora will now be summarised below.

Stage 2: Identifying discourses at work that contribute to the construction of the discursive object

This step involves locating the discursive constructions of the object personality disorder within wider discourses (Willig 2001a: 110). In this context of searching for evidence of discourses, it is helpful to have in mind Foucault's ideas of discourses outlined above, as well as Rose and Parkers' interpretations in the mental health field covered in the theoretical section. Chapter 6 provided evidence for the discourses commonly at work in each corpus and these were discussed in the earlier part of this chapter. As the selection of material for the corpora was designed to focus specifically on articles most relevant to the construction of the discursive object at the time, these discourses can be seen as the most prominent in the construction of *personality disorder*, *psychopathy* or their synonyms, in psychiatric texts of the period.

The most evident discourses are summarised below:

Narrative discourse: psychiatry as individual stories and opinions, characterised by case history language and the use of the author's authority. This was most common in the 1950s corpus.

Study discourse: psychiatry as measurement, life as measurement, characterised by specialised health study nouns, phrases characterising operationalised variables, linked closely to the discursive construct *personality disorder**, but prefigured by *abnormal personalit**.

Statistical discourse: psychiatry as statistical evidence characterised by statistical language, epidemiological concerns and is a subset of the study discourse, overwhelmingly common in the 2000s corpus.

Lay discourse: psychiatry as practised by people, characterised by everyday use of key words, common in the 1950s and associated with the author's authority of the case history discourse, and by close description of events.

Medico-psychiatric discourse: psychiatry as medicine, characterised by medical nouns, diagnoses and peaking explicitly in the 1970s. This is closely associated with the position of the patient.

Abnormal/normal discourse: psychiatry as the study of the abnormal, characterised by use of these terms and others like *deviance*. This is explicit in the 1970s corpus, but there is evidence of submerged workings in the 2000s corpus.

Categorisation discourse; psychiatry as classifying and naming, and characterised by noun usage and peaking in the 1970s.

Market discourse: psychiatry as business, characterised by statements around *assessment, costs, outcome* and *risk*. This appears for the first time in the 2000s corpus.

There was some evidence of:

Developmental discourses: psychiatry as investigating causes

Social responsibility discourse: psychiatry as recognising the responsibilities of clinicians and patients to the wider community

Optimism discourse: psychiatry as improving things, making people better

Essentialist discourse; psychiatric disease as residing within the person

A Discourse of transition: psychiatry as temporary and contingent knowledge

Psychological discourse: psychiatry as taking on the models of psychology

Stage 3: Examining the action orientation of the text.

Having identified the occurrences of the discursive object and the discourses at work in the text, Willig suggests the next step is to examine what the use of a particular discourse in relation to the object of study does. In order to uncover what is gained from constructions of the object in these ways, it is necessary to closely examine the 'discursive contexts within which the different constructions of the object are being deployed' (Willig 2001a: 110). In this study the evidence for the action orientation of the texts has been uncovered in the exploration of the

concordance lines around *psychopath**, *abnormal personality/ies* and *personality disorder/s* in Chapter 7.

From this we can see that deploying the **Narrative Discourse** in the 1950s corpus does enable a patient voice to be expressed in the text by the use of *he/she felt* in the case history accounts. It also allows a great deal of description of behaviours and attributes to be made available in an accessible and meaningful form to the reader through the individual detail included.

However it is also dependent on the author's authority and this appears to manifest in multiple opinions about how the subject of study should be conceived. This discourse does not appear to enable any agency to be expressed in the patient's relation to the clinician, however the **Lay Discourse** and in particular the case history language, effectively ascribe agency to the person in the world through a description of their actions and decisions.

The **Medico-Psychiatric Discourse** most prominent in the 1970s corpus, places patient and doctor in a particular power relation. It locates those who are responsible for labelling and managing the patient and effectively creates both positions through the positioning of expertise, residing in the psychiatrist. It locates authority and the nature of empowerment and disempowerment and, as we have seen, places personality disorder as being a serious mental illness in its own right. The quote below is illustrative of this point, and it is of note that although disagreements in diagnosis are mentioned, those who make it are unquestioned.

> *The three independent psychiatrists agreed on the diagnosis of eight patients, including the putative attention-seeking, sensitive, explosive, asthenic,*

depressive, affectionless, and weak-willed types. In the case of the putative anankastic personality, they disagreed with my diagnosis, but were unanimous in their choice of the sensitive type. (Standage 1979: 240)

Another example illustrates how this discourse also allows distress and difficulty to be linked to treatment and care.

On the basis of the present study we suggest that this personality diagnosis can usefully be confined to women whose relationships are grossly disturbed and who are both egocentric and also passive and dependent; the term loses its discriminating value when applied to women who are aggressive and antisocial. (Walton et al. 1970: 510)

So pervasive is this link that its construction might be seen more clearly by positing some alternative discourses, for example linking distress and difficulty to fate, or to trauma, sympathy and support. Thus rather than, for instance, the discourse of survivors experiencing chaotic or violent emotions due to abuse or neglect, we are presented with a categorisable condition causing distress and difficulty. The medical discourse also allows in a rational empiricist theme. People are constructed as experiencing distress or difficulty because of a disorder; an internally situated malfunctioning whose manifestation appears to create difficulties. This is thus both something possessed but also a phenomenological place to see from. The disorder accounts for how the world is experienced both by patients and clinicians.

Although we have seen that the overt manifestations of this discourse becomes less prevalent in the 2000s corpus, it underpins the application of a number of the other trends we have seen. For example, in the 2000s corpus the themes of specialism and expertise become further elaborated through the pluralisation of *personality disorders*.

> *Diagnoses of the specific personality disorders were generated by algorithms based on DSM-IV and ICD-10 criteria, as operationalised by Loranger et al (1994).* (Samuels et al. 2002: 539)

This medical discourse also allows personality disorder to be explored through epidemiology rather than sociology, thus enabling the deproblematisation of societal questions raised by McCallum (1997). The language then has a determinist, fatalist quality; things are just happening, measurements are being made, there is no sense of agency or causal models at work.

> *Antisocial personality disorder was associated independently with a range of factors, including parental loss, being in care, raised in poverty, parental discord, cruelty, sexual assault by a stranger, delinquent siblings and criminal parents. Self-defeating personality disorder was associated with cruelty, incest and local authority care. Borderline personality disorder was associated with a non-specific range of factors and specific experience of parental discord. Passive-aggressive personality disorder demonstrated non-specific associations with a range of early adversity factors. Schizoid and*

compulsive personality disorder were characterised by the absence of early environmental adversity. (Coid 1999: 532)

The **Categorisation Discourse** most prevalent in the 1970s is also crucial to the use of the later discourses such as the **Statistical** and **Study Discourses** emerging in the 1970s and extremely frequent by the 2000s. In a sense it displaces the **Narrative Discourse** of the 1950s corpus, as its workings are quite different. Where the authorial style of the earlier corpus is concerned with description in order to address the question 'What is psychopathy, in my opinion?', the **Categorisation Discourse** is more concerned with 'Who can be termed as having what sort of personality disorder?', the question of aetiology being set aside, as no answer had yet been found. This is a crucial shift, heralded by the prominence of *classification*, *reliability* and *validity* in the 1970s, but then superseded by the multiple categories of the DSM and their application to statistical processes.

This discourse, as applied to *personality disorder/s* thus has the action of reducing the need for the individual description prevalent in the 1950s, as this simply no longer needs to be said. Instead what becomes important is the identifying and naming of particular groupings that can accommodate individual presentations. As this discourse shows a movement from concerns about classification in the 1970s to the use of classification systems in the 2000s corpus, the focus of psychiatry becomes how to place the patient in a category for treatment or study, thus also eliminating the place of agency on the individual level. In this process agency then appears as a series of trends uncovered by studies, such as that investigating excessive use of GP's (Moran et al. 2000), which, while resulting from individuals' decisions, become

divorced from those individual decisions. They become expected characteristics of someone with personality disorder. In this way the loop is closed in that these characteristics then become what someone in that category should have. Thus:

> *The odds of having a cluster C personality disorder were nearly seven times greater in subjects who had never married compared with those who were married or widowed. In addition, subjects who had graduated from high school, but had not continued their education, had a ninefold increase in the odds of having a cluster C disorder, compared with those who were not high school graduates* (Samuels et al. 2002: 539)

It is also suggested that this process of categorisation allows space for a political dimension to enter psychiatry. McCallum has outlined how political expediency has affected the actual process of categorisation in the DSM III and DSM III-R (McCallum 2001: 141-2), thus throwing doubt on the scientific purity of the process. However, in addition he suggests that this also allows this classificatory process of personality disorder to move into other arenas of governing people's lives such as the court.

Another action of the **Statistical Discourse** is that it allows authority to be expressed without the need for personal/clinical opinion as the arbiter. On the one hand this makes potential claims based on studies more transparent and easier to critique, however its disadvantage is its distancing from human experience.

The explicit **Abnormal/Normal Discourse** of the 1970s, as was discussed in the theory chapter in relation to Canguilhem's work, has the action of othering; of

placing a person in a relation of being outside an assumed normal society. It enhances the authority of the normal at the expense of the abnormal, by the very process of the normal defining the abnormal. In this process, as seen in the corpus, it is not necessary to explicitly define what is meant by normal, and indeed Canguilhem suggests that engaging in this discussion will be hindered by the problems in using the concept of normal in relation to health at all. Thus the patients' abilities to comment on this process, or object to their labelling, become undermined in a series of ways. Firstly they are seen as not normal, secondly they are not part of the expert group able to categorise and therefore are excluded from the debate, and thirdly as definitions of normal are not available, a key part of a rational basis for objection is disallowed. This becomes particularly insidious when, as was suggested above, this discourse of normality, while an inherent part of the **Categorisation, Study** and **Statistical Discourses** in the 2000s corpus, is no longer explicit.

The **Market Discourse** works closely with the **Categorisation** and **Study Discourse** to transform the discourse of social responsibility into talk of appropriate utilisation of resources. This has been observed as a trend in Health and Social Services both in the UK and in the USA, Prince terming it fiscalisation and defining it as 'when financial concerns ... dominate deliberations on setting public policy priorities and contemplating social reforms' (Prince 2001: 6). What is of particular note however is that the 2000s corpus, does not contain any policy material; it is composed purely of articles from the most commonly read psychiatric journals in the UK. Thus this discourse, to be noticeable from the corpus analysis, must be frequently represented within professional psychiatric writing and thereby have become an integral part of psychiatric thinking. We have seen some of its

manifestations in previous discussions about *burden*, however there is a significant amount of more direct economic talk as in the example below:

> *By examining the economic impact of the whole diagnostic group of patients with personality disorders, we have shown that personality disorders could have a subtle effect on non-health service and total costs through an interaction with psychiatric comorbidity.* (Rendu et al. 2002)

A further action orientation of the **Market Discourse** is to place the patient as a consumer, a potential subject position, which will be examined in the next section.

Stage 4: Identifying subject positions implied by the use of these discourses

Willig (2001a: 110-11) sees this stage as involving an examination of the subject positions within a discourse, utilising Davies and Harre (1990) who, as outlined in Chapter 5, see particular discourses as providing locations for persons from which to speak and act.

Thus, for example, the construction of personality disorder within the **Medico-Psychiatric Discourse** prevalent in the 1970s, as both Boyle (1990) and Parker (1995) have shown, allows a number of very well established subject positions to be activated. These include power positions of specialism and expertise, in which the user voice is subsumed as helper rather than as equal (NIMH(E) 2003c: 34, para 83). Alternative approaches are positioned as marginal while health service responses

are seen as central and legitimated. In general, as noted by Parker (1995) these positions tend to dichotomise; you are either for or against medical understanding, inside or outside the profession.

In this stage of the analysis the findings of Chapters 6 and 7 are combined in order to inform how the discourses construct subject positions. Thus, in the 1950s *the psychopath* is mainly constructed through the use of the **Narrative Discourse, Lay Discourse** and the **Medico-Psychiatric Discourse.** This produces a position with both great detail but also variability. We have seen in Chapter 7 how *the psychopath* is characterised by causing suffering, fear and discomfort to others, with anti-social behaviour as the main concomitant. There is the possibility of treatment within this position but agency is absent. The above discourses allow a great variation in personal models of *the psychopath* hence there is space within this position for confusion, differing understandings being subsumed under the same term. These realities however are generally apprehendable through lay language; hence criticisms tend to be deployed through authorial means.

Psychopathic personality/ies is another common position in the 1950s, whose attributes include neurosis, anxiety, resentment, impulsiveness and lack of maturity. It is also characterised by crime, ability to adjust to hospital rules and being liable to rejection by other group members. This position is not so directly associated with the variety of models seen in *the psychopath,* however the lack of agency statements is again present. There is also mention of the possibility of treatment, with the proviso that punishment is inadvisable in the development of a moral system. This effectively positions *psychopathic personality* outside the moral system, with psychiatry as the arbiter.

The position of *psychopathy* in the 1950s is characterised by lack of guilt feelings, abnormal aggressiveness, an inability to maintain normal social contact, alcoholism, criminality and antisocial behaviour. It is used much less as a conceptual vehicle than the preceding two positions, and as such is used to convey the 'factual' nature of the position.

In the 1970s corpus the main discourses helping construct the positions around *psychopath** are the **Medico-Psychiatric Discourse**, the **Categorisation Discourse**, the **Normal-Abnormal Discourse** and the beginnings of the **Statistical and Study Discourses.** Thus, while the **Attributes** in *the psychopath*, *psychopathic personalities* and *psychopathy* are similar to those in the 1950s, largely negative, but with space for a positive view, there is some mention of treatment and the first appearance of study. This implies a position from which there is very little room for decision making or promoting one's own view of events, one is rather an object of definition. Compared with the 1950s, the 1970s corpus shows a similar lack of agency from the positions around *psychopath**. However we have noted previously that agency, although largely absent in relation to explicit statements concerning this position in relation to clinical concepts, is present within the corpus, as part of the narrative descriptions of people being in and acting on the world.

There is considerable evidence for debate around the concept and its place in psychiatry, within the 1950s this is confined to particular ways of writing about *psychopathic personality* and *the psychopath*, which is not evident in the 1970s. In general both corpora also contain multiple views of the correct way of looking at the issue which implies multiple positions in relation to these, for instance if you are seen as a psychopath through a psychodynamic mechanism this implies a different

perspective on oneself than if seen through behaviour theory. This would include, for example, a set of internalised causes implying a psychotherapeutic solution as opposed to behavioural modification. The social dimension remains constant through both decades being mainly expressed through the possibility of social disruption, thereby positioning the person as outside a normal functioning society, rather than within it.

In terms of the story line of these positions, it is basically summed up by that of a patient, who has a condition which is somewhat mysterious and deserving of thought and debate within a medical framework, but which should only really be of concern when social rules are broken.

Personality disorder in the 1970s corpus is not specified in detail as often as *psychopath**. However what we glean from Chapter 7 is that what is expressed are qualities of impulsiveness, conscience defect, inability to empathise, treating others as objects, being relatively likeable, grossly passive and dependent. There is a gender difference of guilt and anxiety for women and none for men. Behaviour is antisocial and with temper tantrums. The position is more associated with being an object of study than the varieties of *psychopath**, and there is also some possibility of treatment. *Personality disorders* is associated with statements around treatment and study, showing these discourses are prominent in its construction, but it is also the site of the first appearance of assessment, part of the **Categorisation Discourse**. Statements around agency are largely absent, and with the diminution of the **Narrative Discourse**, the space for agency is virtually eliminated, a trend that continues into the 2000s corpus.

Personality disorder of the 2000s is mainly constructed through the **Statistical** and **Study Discourse**, aided as described previously by the **Medico-Psychiatric Discourse** and the **Market Discourse**. This implies a position of subject of study. This analysis of *subject/s* in the 2000s corpus (Appendix 21) reveals that this is a highly restricted position. Agency is confined to responding to researchers, and in general, those occupying the position are acted upon, for example being *asked, compared, interviewed, pre-screened, recruited* and so on. They are also categorised by gender, educational level, or income. This is a highly passive position, with no space for interaction on any other level, such as the interpretation of findings, study design or the use to which findings are put. This is very notable when compared with more user integrated studies into personality disorder such as Castillo (2003) described as a 'co-operative inquiry by service users ... where current users of psychiatric services have investigated, analysed and redefined their conferred diagnosis, and have presented a new construct for consideration by mental health professionals and legislators.' (Castillo 2003)

Returning to *personality disorder/s* in the 2000s corpus, its main use is as a diagnostic concept which can be used in research and study and from which statistical conclusions can be drawn. The attributes of the position are very rarely outlined explicitly and what there is concerns irritability, low self-esteem, aggressiveness and social dysfunction. However what has replaced this explicitness from the previous corpora are the operationalised descriptors of aspects of life: *life events* or *risk factors*. Alongside these are the epidemiological statements concerning *personality disorder/s*; *family history, burden, costs to society*. These still exert a positioning effect in that from previous quotes and from the concordances, the position of

*personality disorder** in the 2000s corpus is seen as a drain on society and services. The more positive and individualistic aspects of the previous corpora are now no longer possible within these formulations. The particular dominance of the **Statistical Discourse** applied to *personality disorder/s* also constrains criticism except in its own terms; criticism of method and experiment, rather than its implications.

However even within this apparent dominance of discourse and position, there remain open avenues for change and challenge. For example, the **Market Discourse** clearly implies a position of consumer. This can be framed negatively in terms of personality disorder not fitting with what is on offer and being a difficult customer, a burden. However this discourse also could allow a positive frame. If the consumer is refusing the services on offer or not using them as they were designed, then this implies market research is needed in order to shape services to what the consumer will use. This further implies the key to change is gaining the consumers cooperation rather than researching their characteristics.

Stage 5: Examining how discursive constructions and the subject positions open up or constrain opportunities for action

In this stage Willig suggests using the discourses and subject positions to explore what possibilities for action are both opened up and closed down. Thus one looks at how particular constructions of the world, and the positioning of subjects within them, limit what can be said and done (Willig 2001a:, 111). In this way Willig is trying to formalise Foucault's aim of elucidating the possible within discourses. As an example, the positions associated with the **Medico-Psychiatric Discourse** open up a technical language for describing and labelling experience and close down non-

medical formulations – fate, natural reaction, grief, loss, sadness. These become positioned as lay usages and therefore less legitimate, while this position also opens up the concept of treatment as being appropriate to address distress.

However, as noted previously, treatment is present throughout the corpora. There are significant mentions of therapeutic community as well as physical and psychological approaches in the 1950s corpus, although these fall in frequency in the 1970s. The 2000s corpus, concentrates on researching therapies for personality disorder and the technical issues involved. This does seem to signify a shift in the action orientation of treatment in the texts. In the 1950s corpus this involved stories about successes and problems; the action is engaging with the problem directly by trying things. In the 2000s corpus it is firmly with defining and researching the problem as the only way of tackling it, thus closing any alternatives.

The **Normal/Abnormal Discourse** overtly at work in the discursive constructions in the1970s, and covertly so in the 2000s, has a clear action of othering a particular population. This allows a group to be seen as a burden or require specialist input without the need to question any other aspect of society.

The move from the positionings associated with the **Narrative Discourse** of the 1950s to the **Statistical** and **Study Discourse** of the 2000s corpus illustrates how the change in the dominant discourse can imply different possibilities for action. Thus we have seen that the **Narrative Discourse** allows as many positions as can be argued authoritatively by the writers. This both allows creativity in multiple avenues for dissent, but also potential confusion. It also effectively disallows the sharing of an approach, particularly of a statistical nature, validity resting with author's authority rather than scientific method.

However the move from case study to operationalised statistical language, while opening up the possibility of a shared approach also comes with limitations. In particular the concordance evidence shows the increase in the use of shorthand or formalised phrases, whose meaning is hard to interpret, some of which have been explored in this and earlier chapters. These types of generalisation of actual events might be seen as both a consequence and a necessity of the statistical and study language on the rise in the 2000s corpus. The operationalisation of life into category variables apprehended through scales, necessary to apply statistical techniques, would tend to also require the grouping of conclusions into such words as *disadvantage*, or *negative life events*. Generalised statements need to be made to report and justify the research, but only generalised statements can be made; one cannot operationalise all the particular sorts of disadvantage for study, otherwise the operationalisation is no longer useful. This tends to produce statements containing phrases like the above whose meaning can be read in a variety of ways, and whose main action may be simply to confirm the 'difficulty' of the client group rather than help understanding.

The language used in relation to the reporting of results within this **Study Discourse** also has other effects. For example, we have seen the use of *associated* in the 2000s corpus, which closes down a particular action, that of examining causes and explanatory mechanisms, as in:

> *In this sample, borderline personality disorder was associated with female gender...* (Coid 1999)
>
> *Cluster B disorders were associated with early institutional care and criminality.* (Coid et al. 2006)

Personality disorders are often associated with a poor prognosis for the treatment of associated mental illness... (Rendu et al. 2002)

In this type of construction we are presented with an association, but no causality or explanatory mechanism and, as mentioned above, the possibility of discussing explanations is thus restricted by being outside the discourse. These statements then become facts about personality disorder disconnected from the need for explanation.

Another of the action orientations of the **Study Discourse** on personality disorder is found in analysing *common,* used in reporting study results in the 2000s corpus. This is a sufficiently vague term, which can cover a range of actual findings and also carries the implication of normal/abnormal and of truth. Thus something that is *common* becomes something that is largely true and which the majority would agree with. *Common* thus effaces the exceptions to the rule, the individuality in life and recruits readers to a particular opinion. *Overall* is used in a very similar way. Thus here the concordance study points to particular mechanisms by which the discourse works to generalise opinion and thought about personality disorder, rather than promoting an exploration of individuality in patients.

We have seen that the positioning of *subject/s* in relation to the **Study** and **Statistical Discourse** is a very passive one with highly restricted agency. Willig herself suggests, in relation to health promotion, that positioning the public as passive itself legitimises the use of scientific methodology (Sykes et al. 2004: 139). This study suggests rather that there is a mutual reinforcement between the two; the prevalence of the statistical language supports the passivity of the subject, as evident

through the lack of agency statements, other than as a study participant. In an analogous way, the positioning by **Medico-Psychiatric Discourse** of the person as having a condition resulting in particular behaviours renders them passive recipients of classification and healthcare rather than active participants in their recovery. This can lead to contradictions, although these do not appear within these corpora, as the psychological discourses around treatments indicate the necessity for therapeutic relationships and active collaboration. This is particularly clear in the section on psychological treatment in the recent policy on personality disorder where it is stated 'therapy aims to formulate these processes collaboratively', and 'the therapist and patient maintain a collaborative therapeutic alliance' (NIMH(E) 2003c: 24).

The **Medico-Psychiatric Discourse** combines with the **Study Discourse** to place the problem within the individual, thereby obscuring the possibility of personality disorder being seen as a product of the interaction between the social world and the patient. Thus the way the service is organised, or its personnel examining their behaviour and their expectations become much less accessible to reflection. We have also seen that the use of the epidemiological framework involving talk of *risk* and *association* closes down the need to explore causes or to develop models of causality. When the field consists of attributes and categories linked by statistical statements, there is not a discourse at work here that supports a causal approach.

Stage 6: Subjectivity, investigating what can be thought, felt and experienced from the subject positions

Willig acknowledges that this final stage of the analysis is the most speculative (Willig 2001a: 117); 'since there is no necessary direct relationship between language and various mental states, we can do no more than to delineate what *can* be felt, thought and experienced from within various subject positions' not necessarily what actually is thought or felt (Willig 2003: 179). However the aim is to explore the consequences of taking up various subject positions for the participants' subjective experience, on the grounds that these psychiatric writings do reflect psychiatric thinking at a given time.

Thus within the **Narrative Discourse** patients may feel individually listened to and their stories heard, which may be empowering, however the dependence in the 1950s corpus of this discourse in authority, means that many different opinions may be encountered, along with a very hierarchical interaction. This may lead to confusion, acquiescence, anger or rebellion.

The positioning of the **Medico-Psychiatric Discourse** allows a set of subjective views around its placement as an illness: 'it's not my fault', 'it's the doctor's responsibility to get me better'. This might imply feelings of passivity, anger at the system, critiques of those responsible for recovery and generally the placing of behaviours that may be a problem to oneself or others, outside one's responsibility, as symptoms rather than as one's own actions. From these positions one collaborates with the experts rather than taking things into one's own hands, in fact, subjectively taking things into one's own hands becomes fraught with risk. One is forsaking

medical judgement, going against medical advice, hence there may arise feelings of fear, isolation and rejection which may permeate the adoption of a counter position to that of patient.

From the staff perspective the subjectivities available are those of classifier and expert, which, in the face of the descriptions of *psychopathy* and *personality disorder*, may induce a particular set of contradictions in being positioned as the helper but being unable to help. One can see the potential for frustration and anger.

The positions around being an object of categorisation and study imply a degree of passivity and cooperation that people may rebel against or unquestioningly accept. However the possibility of engaging with the process with equal status to the researcher or psychiatrist is disallowed, potentially inducing anger, hopelessness, or passive rebellion.

The translation of experience into operationalised variables that are then fed back into an understanding of personality disorder as associations and statistical trends potentially has a number of effects. Firstly it may distance the clinician from the individuality of a situation; the business becoming labelling and treating rather than engaging with the person. With both sides then essentially speaking different languages or at least utilising different incommensurate discourses, this has the potential for poor communication and considerable frustration. Secondly by effacing the need for causality and explanation, curiosity and individual exploration into experience can be closed off. This could be frustrating for both staff and patients, as potentially enriching and useful avenues may be disallowed, not being seen as evidence based or supported by studies. Thirdly there is a danger that the power of statistical findings may override the information obtained from an individual and

from observation, thus disconfirmation of experience may lead to anger and hopelessness from a patient within this power imbalance.

The general lack of agency within most positions outlined in the above analysis may engender either feelings of hopelessness and passivity in response to the lack of options for acting on the clinical process, or active opposition and rebellion stemming from a desire to claim a degree of agency within these confines. However there is also a strong sense that emotions are disallowed within the discourses of the 2000s corpus. *Personality disorder** is elaborated much more in terms of being an object of measurement, assessment, study and statistical manipulation, than in terms of everyday life description. The real-life mistakes and decisions are transformed into scores, but are then translated back, not into lessons for life, but into common tendencies, trends or most successful treatments. There simply does not seem room for thoughts and feelings within this dominant episteme, although there is evidence of counter-discourses in operation such as the psychological discourses, and therapeutic optimism, which do not disallow emotion in this way.

Having summarised and discussed the evidence from Chapters 6 and 7 in terms of a Foucauldian Discourse Analysis, the final chapter will reflect both on the findings outlined in this chapter and on the methodology by which they were reached.

Chapter 9: Conclusions and Reflections

Following the Literature Review and Theoretical Chapter, Chapter 5 suggested that a combination of Corpus Linguistics with Foucauldian Discourse Analysis, previously untried, could be used to evidence and analyse the changes in the working of discourses and subject positions within a selected series of texts from the 1950s onward in order to tackle the original research question. This new approach was applied in Chapters 6 and 7, with Chapter 8 summarising the evidence for discourses at work and arguing for the positioning effects of these. In reflecting on this whole process, both issues concerning the methodology as well as the validity, usefulness and applicability of the findings themselves need to be considered. These are covered under a separate heading below, however inevitably some findings will be used to reflect on the methodology as this is considered first.

Reflection on the Methodology

The methodology for this analysis comprised a series of steps which aimed to provide evidence for discourses at work in the corpora of each decade. In this process both the selection of the time periods to be studied and the selection criteria used to build the corpora were crucial, the justification for these being contained in Appendix 4. Establishing the relevance of the texts to the research question lays the basis for all subsequent argument, if the corpora do not relate to the subject of the study in an intimate way then one is reasoning from a flimsy pretext. Hence this reasoning was laid out in detail and the process by which texts were rejected was as important as the

logic of what was included. The transparency of this sampling strategy was very important to the argument and there were a number of advantages to this particular method. Firstly the genre was maintained as a constant through time, thus allowing a comparison of like with like. Secondly the corpus was comprised of whole texts (isotextual), rather than taking sections of texts to construct a corpus with balanced lexical items (isolexical). The former is seen as more appropriate if texts are, as in this case, to be seen as communicative acts, 'all the language used to perform that act needs to be available for study' (Oakey 2009: 149). Thirdly, having selected widely for all relevant texts in each decade and then refined this down using a protocol, the size of the corpus is still large enough to make claims about the findings being representative for each period, but it is also small enough that the researcher can still manage to contain a reader's perspective of the articles included. This would not be possible if the corpora were much larger.

However there do remain a number of issues with regard to the creation of the corpus prior to analysis. There is an asymmetry of the gaps between the three corpora; ten years between the 1950s and 1970s corpora, but twenty between the 1970s and 2000s corpora. Significant changes are observed between each corpus but the rate and actual period of change is sometimes hard to assess. A potential solution would be to sample texts from the whole period from 1950 to 2009, and when questions of rate or time of discourse change arise, to perform a corpus linguistic analysis on particular features over a continuous time period. The sampling strategy however means that one cannot guarantee papers from every year, or an even distribution of texts from year to year hence a compromise solution would be to take a rolling five or ten year period to ensure the representativeness of the corpus is

maintained by its size. The creation of the corpus would be time consuming initially but, once the relevant papers were prepared in the correct format, it would be relatively easy to create a series of corpora consisting of articles in overlapping time periods and to interrogate it for specific questions that have been raised by this corpus analysis, for example at what point does *psychopathy* disappear and when and at what rate does the DSM appear explicitly.

Another critique of this corpus approach is related to the translation from actual articles to the electronic form in which the corpus analysis can take place. What is lost in this process is the format, diagrams and in this study, the references, however, while potentially important sources of information, these are secondary to the textual content which contains the bulk of the information required to evidence discourses at work. These formats however could be re-examined after the lexical analysis. Thus diagrams and table formats could be collected together and changes looked at through time, the references could be treated as separate corpora and interrogated for the influence of particular authors, although some of this information is apparent in the actual corpus selection process itself.

In the next stage of the analysis the corpora were interrogated for features that were both common and salient to the research question. These were then examined more closely in a lexicographical fashion to uncover their meanings from the context of their usage in the concordance lines. This was then used to evidence discourses operating in each corpora and their changes over time. This could thus aptly be called lexicographical discourse analysis. This type of computer assisted analysis of the corpora allowed a different reading to take place than the usual sequential style expected by both author and reader. It allowed one to see slices through the corpus,

where items usually separated through time by the reading process, become united around a word or phrase and thereby become present in time in a way which is in keeping with Foucault's idea of evidencing discourses. Foucault defines discourses as the group of statements that 'belong to a single system of (discursive) formation' that discursive formation being the 'principle of dispersion and redistribution ... of statements' (Foucault 1989: 121). By statements he does not mean the sentence or a group of signs, rather the 'modality of existence proper to that group of signs... a modality that allows it to be in relation with a domain of objects, to prescribe a position to any possible subject' (Foucault 1989: 120). The corpus-enabled collection of concordances around a particular discursive object such as *personality disorder* allows the researcher to notice the regularities, repetitions and common language which comprise the statements associated with that object, from which the discourses and positioning can then be inferred. Thus for example there are collections of language involving *hospital*, *patient*, and *psychiatrist* in the 1970s corpus, constructing a number of statements which together imply the workings of a medical discourse. In effect this is the process operating in Chapters 6 and 7 and summarised at the beginning of Chapter 8. Willig's (2001b) stepwise method provided a means of ordering the analysis once the discourses were identified, and then providing a means to evidence subject positions from the concordance lines.

The advantage of access to this approach is that statements and discourses can be rapidly evidenced and hypotheses created and tested from the data produced. However there are concomitant dangers of either becoming overwhelmed with the potential data or simply using the wealth of data selectively to enhance particular favoured hypotheses. Willig's method explored in the thesis aimed to reduce these

dangers, by methodically working through the commonest nouns, verbs and adjectives in a repeatable and transparent way, to adduce evidence for the most prominent discourses at work, prior to moving on to further analysis. This process also identified the sites of the common discursive constructions like *psychopath, personality disorder, subject* which were then be examined more closely through the concordances to explore what their usages implied for subject positions.

In this approach there is a dialogue at work. The first part of the exchange is the framing of a research question, a curiosity; the reply is a consideration of the state of play with respect to this question – the literature review. In response to this a philosophical and methodological answer is evolved (itself obviously composed of dialogic steps as are each of these main stages in the argument). Thus the setting up of the corpus methodology is in itself a dialogic process. From this further calls and responses produce the sampling strategy and the creation of the corpus and finally the electronic form. The potential mass of data extracted from the corpus is a further question and is replied to by statements asking for it to be made more manageable. The response to this determines the next steps and by focusing on common usage it limits the study to dominant discourses at the expense of lesser but possibly important ones. This interaction between the quantity of data and the means to manage it selectively is a particular feature of the analysis. Thus once the common words are extracted the question arises as to which are salient or relevant to the research question, hence each step in the above dialogue includes within it a response to the previous step, but also a response to the initial question.

What emerged from this process was that the analysis of the commonest nouns allowed the most straightforward access to discourse information. Adjectives

and particularly verbs had much more varied usage and hence required often prohibitive amounts of analysis to uncover their usages. Despite this the selection of adjectives was both confirmatory of the trends noticed in the noun analysis but also gave some insight into hidden discourses. Verbs and other words, although even more general in their usage, did enable some insight into the links between discourses and indeed some less prominent discourses were evidenced during this analysis, indicating that perhaps not only the dominant discourses were identified at this point.

The graphical evidence of the fluid nature of word frequencies through time appeared particularly effective in identifying trends and discourse features, as well as raising a general point that language and discourse were fluid, even within an apparently tightly controlled professional genre. A particular issue in this respect was the labour involved in producing these graphical images. Apart from the corpus preparation, the commonest nouns, verbs, adjectives and other words had to be identified by hand from the word frequency tables produced by Wordsmith Tools. Two different Excel tables of significant word frequency differences between corpora had then to be combined into one table of trends between the corpora and then sorted by hand into the nine trend categories, before being formatted into graphical form. This latter process could be automated such that the trends of lexical frequencies between corpora could be more easily generated. The issue of identifying parts of speech may be approached by parsing and tagging software, although this is beyond the scope of this present study.

It was noticeable that it was not sufficient to examine significant word changes alone, the actual usage and change in usage was key to understanding how the language was relating to discourse change. If the usage remained similar, then the

frequency changes could be interpreted as indicators of discourse change, if the word and its usage could be shown to have a discourse function. On the other hand some words completely change usage for example, *service*, and others shift the balance in their usage in ways do which inform the investigation of discourse trends, for example *test* and *data*.

The methodological framework chosen in this study is also open to criticism. Willig herself notes that personal bias may creep into the interpretation stages (Sykes et al. 2004: 141). This tendency however is probably more noticeable in the latter more speculative steps in this study since the Corpus Linguistic approaches aim to provide evidence for claims about discourses and subject positions. It is probably noticeable however that, as in Willig's study of Health Promotion, personal knowledge of the field inevitably informs parts of the interpretations even of the CL findings, but hopefully the availability of supporting data such as word lists and collocations, allows readers to make this judgement. However the Foucauldian basis of the approach does also open it to critiques of this model outlined in Chapter 4. In particular, the framing of discourses used is not one shared across linguistic disciplines as Sarangi notes (Sarangi 2004).

A further critique of this study is that it focuses on psychiatric texts and not on how personality disorder is currently deployed in the clinical setting. As outlined in Chapter 5 the textual route was chosen mainly in order to provide a reliable set of historical linguistic data from which to work, since the original question involved examining personality disorder over time. However this does mean a part of the connection between discourses and current practice is missing. However the study does show the potential for evidencing discourses from corpus data, and with the

increasing amount of work on spoken word corpora, particularly in the health field (Adolphs et al. 2004), there is considerable potential to apply the learning from this approach to a relevant corpora of spoken words relating to personality disorder in the current UK health context. This could include transcripts of psychiatric interviews, multidisciplinary discussions, ward handovers, GP consultations and so on.

Overall this approach gave greater evidence for large-scale changes in discourse than has been possible with previous methods, however it clearly misses the small-scale analysis of fine grained discourse features evident through CDA approaches. However, while of great interest, these can only ever be localised analyses, their generalisation is problematic, nonetheless the two approaches may well be complementary.

Reflections on the Findings

In terms of findings, the main advance in this approach is the way in which evidence for the changing discourses is found. Previously these general trends have been inferred from individual readings of bodies of texts over time, in this approach the visible traces of discourse change can be evidenced in a repeatable way and the steps of the interpretation can be made much more visible and transparent.

The noun analysis provided an immediate impression of the terminology used to describe the subject in each corpus. We could see a falling out of favour with the term *psychopath* over time and also the description of *personality* in terms of *states, traits* and *types* in the 1950s corpus. We could also see a narrowing of the way in which *personality* was talked about, as *character* disappeared from the top 52 and, by the 2000 corpus the only remaining popular phrase was *personality disorder/s,* which

became overwhelmingly dominant. The pluralisation of *personality* and *disorder* in the 1970s and then *diagnosis* and *disorder* in the 2000s was also clear from the initial analysis and this led to the hypothesis that there was increasing elaboration in the description of *personality disorder*, linking with the discourses supporting expertise and specialism. It was also of note that the influence of DSM in the 1970s corpus was not readily evident in the noun analysis, as though the DSM-III, took a while to filter through to acceptance, however by the 2000s it seemed to be very dominant and prevalent in its usage.

This allows us to approach the question of the dominance of *personality disorder* in the 2000s corpus. It suggests that, in the move from Narrative to Statistical Discourse an important language change also takes place in relation to the object of study. Within the Narrative Discourse, one is describing and telling stories about the discursive object, while in the Statistical Discourse one can only refer to it and its relations to other variables, hence one is constantly having to refer to *personality disorder* rather than express it in terms of description. In effect the Statistical Discourse requires the constant naming of *personality disorder*, it cannot be approached in any other way.

This lexical analysis then also supported the observations of large-scale discourse changes across the corpora from the Narrative and Authorial styles of the 1950s, to the dominance of the Statistical and Health Study approaches of the 2000s corpus, with clear evidence of their emergence in the 1970s corpus. Within this theme the rise of *findings, model,* and *studies* suggested a referral back to earlier work, a sense of a developing field, while the rise of *functioning, informant, sample,* and *subject/s* represented the influence of psychology using operationalised variables and

experimental subjects. Willig's method allowed this to be extended into an analysis of subject positions implied by such language.

In the 1970s the group of words, *admission, disorder/s, illness,* and *psychiatrists* was seen as indicating the prominence of a Medico-Psychiatric Discourse, focusing on a model of disease process and hospital. These have largely disappeared from the top 52 by the 2000s apart from *disorder/s*, which was taken to indicate a submergence rather than a disappearance of this discourse, as it was shown that this underpins and enables the use of the Statistical and Study Discourse in these later articles. What seems to replace the Medico-Psychiatric Discourse in prominence in the 2000s is a focus on the diagnostic manual (*DSM, cluster*), identification (*assessment, prevalence,* risk), and product (*costs, outcome*). In many ways, given the evolution of the health service in the UK post-Friedman from 1979 this is not surprising, however, as noted before, this language is occurring, not in public or policy journals, but in specialist psychiatric journals, indicating the discourse of health economics has thoroughly penetrated the clinical world.

The analysis also showed more nuanced changes in the nature of the statistical language between the 1970s and 2000s. Although personality disorder was still contested, the emphasis on reliability and validity was replaced by concerns with category, criteria and model; the doubt expressed in the 1970s was replaced by the 'talk of facts' in the 2000s. In this process the nature of the statistical process, with its reliance on levels of validity had been obscured, still present but unchallenged.

The overall lexical discourse analysis revealed some features that prompted a more focussed discourse analysis, for example the look at *problem*, in Chapter 6. This produced more detail concerning the content of arguments in the corpus. It

showed that robust and penetrating debates about the concept were present in all corpora, not immediately apparent from the analysis of commonest features. It also supported the conclusion that there the debates and studies around reliability and agreement of scales and tests in the 1970s that had largely disappeared by the 2000s, replaced by the formulaic acknowledgement of these problems enabling the deployment of an apparently unproblematic concept. These thus seem to be evidence of particular mechanisms at work in language to turn a contested concept into a fact. This process also appears to be supported by the use of abbreviations, the accepted use of diagnoses and clusters from the diagnostic manual as authority, and the extremely frequent usage of *personality disorder*.

In a similar way to how lexicographers identify new words appearing in the language, this corpus approach also identified 'new' words or coinages appearing in the 2000s corpus, ones that were very uncommon in the previous corpora e.g. *PD, functioning, BPD, prevalence, events, outcome,* and *costs*. Such words tell us something about discourses at work in the present, but often only by comparison with past corpora. In this instance they seem to describe human behaviour in such a way as to allow measurement – breaking it down into functioning, events and outcomes. This makes sense within the context of a scientific endeavour but when applied to individuals clinically there needs to be a translation, not just a blind acceptance. If we see an individual as a series of events, levels of functioning and outcome we may have already lost the battle in terms of making sense of problems involving individuals personality and behaviour.

This move to operationalise life was also explored in terms of subject positions. People may seem to be positioned less negatively and strongly, as the

language is more general and distant, however, the discourses are still at work, the positioning goes on but it is harder to see directly. Those resisting the discourse of personality disorder have nothing to push against but official categories, and policies, not real people and decisions. Tracking changes diachronically however shows discourses that used to be explicit still operating such as the overt Medico-psychiatric Discourse and the Abnormal/Normal Discourse of the 1970s. This type of information allows access to discourses that used to be challengeable directly but now cannot be. However by raising them up again by this process can provide a starting point to resist the medical discourse, or to provide a spur to develop alternative means to talk about distressing experiences (Nolan et al. 1997).

In the process of evidencing subject positions in Chapter 7 the categorisation process seemed particularly useful in extracting statements that could be evidence of such positions. In this respect **Attributes Psychological, Attributes Social, Behaviour** and **Agency** were particularly helpful however the **Diagnostic** and **Conceptual** statements did illustrate an overall position of 'subject', which it was possible to analyse (Appendix 18)

As mentioned previously, the differing discourses applied to the changing discursive object over time challenge the narrative of the history of personality disorder as an enquiry into a single disorder across the years, which has simply had different names. The analysis suggests that this use of different discourses at different times has a profound influence on how people with a perceived condition can be thought. In this respect it is of particular interest how the *psychopath** was constructed with positive statements, case histories and detailed description while *personality disorder/s* comprised negative, generalised statements embroiled in study

language. It is as though *psychopathy** became extinct in the face of a competitor more suited to the changing healthcare environment of the late 20th Century. There was simply no niche for it in psychiatry. One might wonder if dealing with individual stories has become separated from mainstream psychiatry and this niche has been occupied and elaborated by the user movement.

In his review of health communication, Sarangi challenges such studies to 'report something which is both a discovery and can be potentially useful' (Sarangi 2004: 7). Hence another question is whether the methodology outlined in this thesis is simply a very time consuming way of obtaining obvious conclusions. Some findings can certainly be considered at least accessible from a general reading of the papers in the corpus, for example the disappearance of *psychopath** and the dominance of *personality disorder*, the existence of similar debates about the concept in each decade, the disappearance of case study language and the rise of reliance for authority on statistical studies. However what is crucial is that the corpus allows these to be evidenced in a replicable manner, and further that nuances in the uses of *psychopath** and *personality disorder* can be shown such as the linking with positive and detailed description with *psychopath* only. Beyond this, what is new is the evidencing of the positions implied by the most common usages of words in each corpus. This is not immediately accessible from the sequential reading; it is only noticeable when the corpus analysis collects statements together. An example is the change in focus from reliability and validity in the 1970s corpus to unproblematic use of personality for statistical studies in the 2000s corpus. Similarly the use of DSM is immediately apparent from the lexical analysis in a way which would require considerable manual research to adduce from sequential reading.

It may also be wondered whether the use of a discourse framework renders the findings irrelevant to someone who does not share this perspective. The corpus data means that, even without the discourse framework, one is still left with a large amount of replicable evidence of the sort of language that is and is not used with particular concepts in particularly large bodies of text. Thus *psychopath** and *personality disorder/s* are on a very basic level used with different sorts of words, the former with some positive interpretations and case studies, the latter with no positive features and statistical language. However without an interpretive model one cannot proceed beyond this step, and it is Willig's model of Foucauldian Discourse Analysis which enables the move to subject positions, and to more extensive interpretation.

Some of the steps of Willig's methodology do seem to lend themselves to using a corpus approach to provide evidence. Thus in the Step One, the identification of Discursive Constructions, the analysis of most frequent nouns enables the commonest phrases around personality disorder and psychopathy to be identified. The lexical analysis of Chapter 6 leads directly to the uncovering of discourses at work in Step Two, which then leads on to combining these two steps in the examination of the action orientation of text in Step 3. Evidence from the concordance examinations in Chapter 7 is also used in this step. The identification of the details of subject positions is the aim of Chapter 7 and this fits well with the use of positioning theory in order to extend the discussion from discourses to their potential effects on people. However, although evidence from Chapters 6 and 7 is used to inform the discussions of Step 5, exploring how the positioning affects opportunities for actions, it is here that the reasoning becomes a little more speculative, a trend which continues into the last step of exploring subjectivities.

However at least recognising the speculative nature of these steps and the points at which there are and are not supported by the corpus evidence, does allow a space to be opened up for discussion of effects of positioning produced by the texts of the corpora, and also enables the reader to make a judgement on what to accept. These steps may well be enhanced if a similar study were made on a corpus of actual current spoken material relating to personality disorder in the clinical setting, at which point it would be quite possible that firm evidence of subjectivities, not just related to written textual positioning, could be uncovered.

A further point is that, having gone through this whole process using a particular formulation of Foucauldian Discourse Analysis, there is now an opportunity, not taken up for reasons of space in this thesis, to re-theorise such a discourse analysis in the light of the types of findings and methodologies that have been attempted here. In particular this might include introducing more explicitly Foucault's later ideas of Power/Knowledge, perhaps enhancing Step 5 with the question - what forms of Power/Knowledge are operating in the corpus? The more overt links between the corpus analysis process and Foucault's ideas of Discursive Formation, Statement, and Discourse (Foucault 1989), hinted at earlier in this chapter could also be explored.

Concluding Remarks

Combining the reflections on findings and method, the study provides several new avenues in the exploration of discourses. Firstly, in Foucauldian terms, the discourses are evidenced in a way that has not been previously attempted. Discourses as collections of statements are revealed by frequent lexical usage and by collecting

concordances with particular commonalities around the discursive construction, in this case personality disorder and its synonyms. Secondly, the corpus techniques make visible these collections in ways not possible in sequential reading. Thirdly, by focussing on the commonest patterns the dominant discourses can be revealed. Fourthly, the concordances provide evidence for the positioning effects of the discourses, and the further analysis of language around the discursive objects reveal the linguistic methods by which this positioning occurs. Fifthly, tracking this over time in three corpora allows discourse change to be tracked in a way not attempted before. Each step is evidenced and transparent.

There are a number of disadvantages to this approach however. Firstly, it is very labour intensive. The selection and preparation of the corpus material is time consuming, particularly as is likely in diachronic studies much of the material is not electronically available, hence scanning and checking are necessary. Secondly, the method is untried and there is not a body of similar work to compare it with. In particular, some of the linguistic changes may simply be general rather than genre specific. It would be very helpful to track another discursive object in this way, for example diabetes. Thirdly, it focuses on written texts and can only hint at what may be happening in the actual clinical setting at the present time in the UK. However what it would contribute to this research is an understanding of possible discourses at work and their manifestations in psychiatric talk. It would be interesting to see how some of these discourses penetrate to different parts of the psychiatric system and further, whether some of the 'old' discourses are still at work in the clinic, such as the normal/abnormal discourse of the 1970s.

Although the overall analysis suggests that the dominance of the statistical and study discourse in the 2000s corpus has a number of negative effects on positioning and the ability of people so positioned to be seen to act positively on the world, it is not all gloom. There is developing talk about treatment options, thus widening the discourse around personality disorder to include the possibility of change, however against this is balanced the complete lack of a possibility of it being positive to have a personality disorder. There is an embryonic human discourse, although this is in danger of being swamped by the perceived necessity to operationalise aspects of life in order to make them amenable to study, leading to formulaic and sterile statements about people. Worrying too is the loss of any patient voice in the 2000s corpus. One could argue that these are academic texts for psychiatrists to read, however this did not stop patients appearing through case histories and their own words on occasions through the earlier corpora. Prior corpus research on the recent policy documents and their associated literature (Parnell 2007) had indicated that the user voice in personality disorder policies and their associated literature tended to be mostly confined to 'user' papers or user sections of a policy, the main technical papers did not allow of this perspective. This separation seems fundamentally flawed as the conception of psychological treatment in personality disorder depends on the relationships between clinicians and patients. If clinicians do not routinely hear the voices of patients to the same extent that they hear summaries of statistical articles on epidemiology and outcome, where is the common ground on which relationships can be built, and further, if those statistical articles have greater professional capital than someone explaining their life, then how is it implied that the individual's experience even matters.

A final question is whether this is, as its title suggests, a genealogical analysis in the Foucauldian sense. That was certainly the intention when the project was started. On the affirmative side there is a sense of the family tree of discourses, evolving over time with old family members leaving and new one's joining, of less space being available for patient stories, as the discourse of study and statistical authority becomes dominant. However the breadth of the study could be seen as too narrow to accommodate a full genealogical analysis. Links can be made between the rise of the statistical discourse, the rise of evidence-based medicine, and the claims of psychiatry to 'proper science', however these areas are not included explicitly in the examination of discourses These parts are borrowed from elsewhere, from other studies. Inevitably perhaps, the study, while not complete, stands as part of a genealogical analysis of the field of personality discourses within psychiatric texts. It is a method that echoes Foucault who, quoting Nietzsche in *Human All Too Human*, sees the findings of genealogy as constructed from *discreet and apparently insignificant truths according to a rigourous method* (Foucault 1977: 140). And further, that:

> *if the genealogist refuses to extend his faith in metaphysics, it he listens to history, he finds that there is "something altogether different" behind things: not a timeless and essential secret, but the secret that they have no essence or that their essence was fabricated in a piecemeal fashion from alien forms.* (Foucault 1977: 142)

References

2007. Mental Health Act; Chapter 12.

Adolphs, S., Brown, B., Carter, R., Crawford, P., & Sahota, O. 2004. Applying Corpus Linguistics in a Health Care Context. *Journal of Applied Linguistics* 1 (1): 9-28.

American Psychiatric Association. 1952. *Diagnostic and Statistical Manual: Mental disorders*. Washington: American Psychiatric Association.

American Psychiatric Association. 1968. *Diagnostic and Statistical Manual of Mental Disorders: 2nd Edition*. Washington: American Psychiatric Association.

American Psychiatric Association. 1980. *Diagnostic and Statistical Manual of Mental Disorders: 3rd Edition*. Washington D.C.: American Psychiatric Association.

American Psychiatric Association. 1994. *Diagnostic and Statistical Manual of Mental Disorders: 4th Edition*. 4th ed. Washington, DC: American Psychiatric Association.

American Psychiatric Association. 2000. *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision*. 4th Edition, Text Revision ed. Washington, DC: American Psychiatric Association.

Appleby, L., Shaw, J., & Amos, T. 1997. National Confidential Inquiry into Suicides and Homicides by People with Mental Illness. *The British Journal of Psychiatry* 170 (2): 101-2.

Archer, M. 1995. *Realist Social Theory: The morphogenetic approach*. Cambridge: Cambridge University Press.

Armstrong, D. 1983. *Political Anatomy of the Body: Medical knowledge in Britain in the twentieth century*. Cambridge: Cambridge University Press.

Aston, G., & Burnard, L. 1998. *The BNC Handbook*. Edinburgh: Edinburgh University Press.

Atkinson, D. 1999. *Scientific Discourse in Sociohistorical Context: The philosophical transactions of the Royal Society of London, 1675-1975*. Mahwah, New Jersey: Laurence Erlbaum Associates.

Badran, D. 2002. Ideology Through Modality in Discourse Analysis (Unpublished PhD thesis), Department of English, University of Nottingham, Nottingham.

Baker, P. 2004. Querying Keywords: Questions of difference, frequency and sense in keywords analysis. *Journal of English Linguistics* 32 (4): 346-359.

Baker, P. 2006. *Using Corpora in Discourse Analysis*. London: Continuum.

Baker, P., Gabrielatos, C., Khosravinik, M., Kryzyzanowski, M., McEnery, T., & Wodak, R. 2008. A Useful Methodological Synergy? Combining critical discourse analysis and corpus linguistics to examine discourses of refugees and asylum seekers in the UK press. *Discourse and Society* 19 (3): 273-306.

Bartholomew, A. 1958. Psychopathic Personality. *British Medical Journal* 1: 219-220.

Bateman, A., & Fonagy, P. 2000. Effectiveness of Psychotherapeutic Treatment of Personality Disorder. *British Journal of Psychiatry* 177: 138-143.

Bateman, A., & Tyrer, P. 2004. *Effective Management of Personality Disorder* Department of Health, 2002 [cited 15.7 2004]. Available from http://www.publications.doh.gov.uk/mentalhealth/batemantyrer.pdf.

Batty, David. 2002. Q&A: Dangerous and severe personality disorder. *Guardian*, 17th April.

Bednarak, M. 2005. *Evaluation in Media Discourse: Analysis of a Newspaper Corpus*. London: Continuum.

Bennett, C. 2002. Personality Disorder. *British Journal of Psychiatry* 181: 76.

Benton, T., & Craib, I. 2001. *Philosophy of Social Science: The philosophical foundations of social thought*. Houndmills: Palgrave.

Berman, L. 1999. Positioning in the Formation of a 'National' Identity. In *Positioning Theory: Moral contexts of intentional action*, edited by R. Harre, & van Langenhove, L. Oxford: Blackwell.

Berrios, G.E. 1999. J.C.Prichard and the Concept of 'Moral Insanity'. *History of Psychiatry* x: 111-116.

Bhaskar, R. 1989. *Reclaiming Reality: A critical introduction to contemporary philosophy*. London: Verso.

Biber, D., Conrad, S., & Reppen, R. 1998. *Corpus Linguistics: Investigating language structure and use*. Cambridge: Cambridge University Press.

Blashfield, R., & Intoccia, V. 2000. Growth of the Literature on the Topic of Personality Disorders. *American Journal of Psychiatry* 157: 472-473.

Boyle, M. 1990. *Schizophrenia: A scientific delusion?* London: Routledge.

Boyle, M. 1994. Schizophrenia and the Art of the Soluble. *The Psychologist* (September 1994): 399-404.

Bracken, P., & Thomas, P. 1999. The Politics of Personality Disorder. *Open Mind* 97 (May/June): 16.

The British National Corpus, version 3 (BNC XML Edition). Distributed by Oxford University Computing Services on behalf of the BNC Consortium.

Brown, B., Crawford, P., & Hicks, C. 2003. *Evidence-Based Research: Dilemmas and debates in health care*. Maidenhead: Open University Press.

Brown, C., & Rubin, D. 2005. Causal Markers in Tobacco Industry Documents: The pragmatics of responsibility. *Journal of Pragmatics* 37: 799-811.

Bunton, R. 1997. 'Popular Health, Advanced Liberalism and Good Housekeeping Magazine'. In *Foucault's Medicine*, edited by A. Petersen, & Bunton, R. London: Routledge.

Burton, F., & Carlen, P. 1979. *Official Discourse: On discourse analysis, government publications, ideology and the state.* London: Routledge & Kegan Paul.

Canguilhem, G. 1989. *The Normal and the Pathological.* Translated by C. Fawcett. New York: Zone.

Carothers, J. 1951. Frontal Lobe Function and the African. *Journal of Mental Science* 97 (406): 12-48.

Carpenter, M. 2000. 'It's a Small World': Mental health policy under welfare capitalism since 1945. *Sociology of Health and Illness* 22 (5): 602-620.

Carter, B., & Sealey, A. 2000. Language, Structure and Agency: What can realist social theory offer to sociolinguistics? *Journal of Sociolinguistics* 4 (1): 3-20.

Carter, R., & McCarthy, M. 2006. *Cambridge Grammar of English*. Cambridge: Cambridge University Press.

Carter, R., & Nash, W. 1990. *Seeing Through Language*. Oxford: Basil Blackwell.

Castel, R. 1991. 'From Dangerousness to Risk'. In *The Foucault effect: Studies in governmentality*, edited by G. Burchell, Gordon, C., & Miller, P. London: Harvester Wheatsheaf.

Castillo, H. 2003. *Personality Disorder: Temperament or trauma?* London: Jessica Kingsley.

Cattell, R., Dubin, S., & Saunders, D. 1954. Personality Structure in Psychotics by Factorization of Objective Clinical Tests. *Journal of Mental Science* 100 (418): 154-176.

Chiapello, E., & Fairclough, N. 2002. Understanding the New Management Ideology: A transdisciplinary contribution from critical discourse analysis and new sociology of capitalism. *Discourse and Society* 13 (2): 185-208.

Chouliarski, L., & Fairclough, N. 1999. *Rethinking Critical Discourse Analysis*. Edinburgh: Edinburgh University Press.

Clarke, A., & Clarke, A. 1959. Personality Disorder and Dullness. *Lancet*: 988.

Cleckley, H.M. 1941. *The Mask of Sanity: An attempt to reinterpret the so-called psychopathic personality*. St. Louis: C.V. Mosby co.

Cleckley, H.M. 1976. *The Mask of Sanity: An attempt to reinterpret the so-called psychopathic personality*. 5th ed. St. Louis: C.V.Mosby co.

Coid, J. 1999. Aetiological Risk Factors for Personality Disorders. *British Journal of Psychiatry* 174: 530-538.

Coid, J., Yang, M., Tyrer, P., Roberts, A., & Ullrich, S. 2006. Prevalence and Correlates of Personality Disorder in Great Britain. *British Journal of Psychiatry* 188: 423-431.

Corbett, K., & Westwood, T. 2005. 'Dangerous and Severe Personality Disorder': A psychiatric manifestation of the risk society. *Critical Public Health* 15 (2): 121-133.

Craft, M. 1959. Personality Disorder and Dullness. *The Lancet*: 856-858.

Crawford, M. 2007. Can Deficits in Social Problem-solving in People with Personality Disorder be Reversed? *British Journal of Psychiatry* 190: 283-284.

Crawford, P., & Brown, B. 2007. Fast Healthcare: Brief communication, traps and opportunities. *Communication, Medicine & Ethics (COMET) International conference, 28-30 June, Lugano, Italy.*

Crawford, P., Johnson, A., Brown, B., & Nolan, P. 1999. The Language of Mental Health Nursing Reports: Firing paper bullets? *Journal of Advanced Nursing* 29 (2): 331-340.

Crowe, M. 2000. Constructing Normality: A discourse analysis of the DSM-IV. *Journal of Psychiatric and Mental Health Nursing* 7: 69-77.

Curran, D., & Mallinson, P. 1944. Psychopathic Personality. *Journal of Mental Science* 90: 266-286.

Davidson, G. 1956. The Symdrome of Oligothymia (Psychopathy). *The Journal of Nervous and Mental Disease* 124 (2): 156-162.

Davidson, L., & Strauss, J. 1992. Sense of Self in Recovery from Severe Mental Illness. *British Journal of Medical Psychology* 65: 131-145.

Davies, B., & Harre, R. 1999. Positioning and Personhood. In *Positioning Theory: Moral contexts of intentional action*, edited by R. Harre, & van Langenhove, L. Oxford: Blackwell.

Davies, B., & Harre, R. 1990. Positioning: The discursive production of selves. *Journal for the Theory of Social Behaviour* 20: 43-63.

Davis, D. 1950. A Case of Schizosis with Dual Personality. *Journal of Mental Science* 96 (405): 1008-1014.

Dean, K. 2004. The Role of Methods in Maintaining Orthodox Beliefs in Health Research. *Social Science & Medicine* 58: 675-685.

Department of Health. 1999a. Modern Standards and Service Models: National Service Framework for Mental Health. London: Department of Health.

Department of Health. 1999b. *Safer Services: National confidential inquiry into suicide and homicide by people with mental illness*. London: Department of Health.

Department of Health. 2001a. *Reforming the Mental Health Act*. Vol. Cm 5016-I and amp; Cm 5016 II: Department of Health.

Department of Health. 2001b. *Safety first: Five year report of the national confidential inquiry into suicide and homicide by people with mental illness*. London: Department of Health.

Department of Health. 2004. *The DSPD Programme* 2003 [cited 1,06 2004]. Available from http://www.dspdprogramme.gov.uk/media/pdf/dspd%20gen%20fact%20sheet.pdf.

Department of Health. 2008. *Code of Practice: Mental Health Act 1983*. London: The Stationary Office.

Department of Health, Home Office. 1999c. *Managing Dangerous People with Severe Personality Disorder*. London: Home Office.

Diethelm, O. 1960. A Clinical Consideration of Psychopathic Personalities. *Journal of Mental Science* 106 (444): 906-911.

Eagleton, T. 1991. *Ideology*. London: Verso.

Edwards, D. 2006. Discourse, Cognition and Social Practices: The rich surface of language and social interaction. *Discourse Studies* 8 (1): 41-49.

Elliott, A. 2001. *Concepts of the Self*. Cambridge: Polity Press.

Eysenck, H. 1947. The Measurement of Socially Valuable Qualities. *Eugenics Review* XXXIX (3): 103-107.

Eysenck, H. 1959. Some Recent Criticisms of the Dimensional Analysis of Personality. *Journal of Mental Science* 105 (438): 220-223.

Fairclough, N. 1992. *Discourse and Social Change*. Cambridge: Polity Press.

Fairclough, N. 1995. *Critical Discourse Analysis*. London: Longman.

Fairclough, N. 2000. *New Labour, New Language?* London: Routledge.

Fairclough, N. 2003. *Analysing Discourse: Textual analysis for social research*. London: Routledge.

First, M., Bell, C.,Cuthbert, B., Krystal, J., Malison, R., Offord, D., Reiss, D., Shea, T., Widiger, T., & Wisner, K. 2005. Personality Disorders and Relational Disorders: A Research Agenda for Addressing Crucial Gaps in DSM. In *A Research Agenda for DSM-V*, edited by D. Kupfer, First, M., & Regier, D. Washington, D.C.: American Psychiatric Association.

Flowerdew, L. 2004. The Argument of Using English Specialized Corpora to Understand Academic and Professional Language. In *Discourse in the Professions: Perspectives from Corpus Linguistics*, edited by U. Connor, & Upton, T. Amsterdam: John Benjamin.

Foucault, M. 1972. *The Archaeology of Knowledge*. London: Tavistock.

Foucault, M. 1977. Nietzsche, Genealogy, History. In *Language, Counter-Memory, Practice: Selected essays and interviews*, edited by D. Bouchard. Ithaca: Cornell University Press.

Foucault, M. 1981. The Order of Discourse: Inaugural lecture at the College de France, given 2 December 1970. In *Untying the Text: A post-structuralist reader*, edited by R. Young. London: Routledge and Kegan Paul.

Foucault, M. 1989. *The Archaeology of Knowledge*. London: Routledge.

Foucault, M. 1991. 'Governmentality'. In *The Foucault Effect: Studies in governmentality*, edited by G. Burchell, Gordon, C., & Miller, P. Hemel Hempstead: Harvester Wheatsheaf.

Foucault, M. 1997. *Madness and Civilisation*. London: Routledge.

Foucault, M. 2000. *The Birth of the Clinic*. London: Routledge.

Foulds, G. 1971. Personality Deviance and Personal Symptomatology. *Psychological Medicine* 1: 222-233.

Foulds, G., & Caine, T. 1958. Psychoneurotic Symptom Clusters Trait Clusters and Psychological Tests. *Journal of Mental Science* 104 (436): 722-731.

Fowler, R. 1991. *Language in the News: Discourse and ideology in the press*. London: Routledge and Kegan Paul.

Francis, R., QC., Higgins, J., & Cassam, E. 2006. *Report of the Independent Inquiry into the Care and Treatment of Michael Stone*: South East Coast Strategic Health Authority, Kent County Council, Kent Probation Area.

Gibbens, T. 1961. Treatment of Psychopaths. *Journal of Mental Science* 107 (446): 181-186.

Gilbert, G., & Mulkay, G. 1984. *Opening Pandora's Box: A sociological analysis of scientists' discourse*. Cambridge: Cambridge University Press.

Gillett, G. 2004. Clinical Medicine and the Quest for Certainty. *Social Science & Medicine* 58: 727-738.

Good, P. 2001. *Language For Those Who Have Nothing: Mikhail Bakhtin and the landscape of psychiatry*. Hingham: Kluwer Academic Publishers.

Gordon, C. 1991. 'Governmental Rationality: An introduction'. In *The Foucault Effect*, edited by G. Burchell, Gordon, C., & Miller, P. London: Harvester Wheatsheaf.

Greenhalgh, T., Hurwitz, B., & Skultans, V. 2004. *Narrative Research in Health and Illness*. London: BMA Books.

Hacking, I. 1995. *Rewriting the Soul: Multiple personalities and the Sciences of Memory*. Princeton: Princeton University Press.

Hacking, I. 1999. *The Social Construction of What?* Cambridge: Harvard University Press.

Haigh, R. 2002. Therapeutic Community Research: Past, present and future. *Psychiatric Bulletin* 26: 65-68.

Halliday, M. 1994. *An Introduction to Functional Grammar, 2nd edition*. 2nd ed. London: Edward Arnold.

Hamilton, C., Adolphs, S., & Nerlich, B. 2007. The Meanings of 'risk': A view from corpus linguistics. *Discourse and Society* 18 (2): 163-182.

Hammersley, M. 2003a. Conversation Analysis and Discourse Analysis: Methods or paradigms? *Discourse and Society* 14 (6): 751-781.

Hammersley, M. 2003b. Doing the Fine Thing: A rejoinder to Jonathan Potter. *Discourse and Society* 14 (6): 795-798.

Hansard. 26 Oct 1998. Column 9. *Hansard*.

Hardt-Mautner, G. 2005. *'Only Connect.' Critical Discourse Analysis and Corpus Linguistics* University of Lancaster, 1995 [cited 13.04 2005].

Harper, D. 2004. Storying policy: Constructions of risk in proposals to reform UK mental health legislation. In *Narrative Research in Health and Illness*, edited by T. Greenhalgh, Hurwitz, B., & Skultans, V. London: BMA Books.

Harre, R. 2002. *Cognitive Science: A philosophical introduction*. London: Sage.

Harre, R., & van Langenhove, L. 1999. The Dynamics of Social Episodes. In *Positioning Theory: Moral contexts of intentional action*, edited by R. Harre, & van Langenhove, L. Oxford: Blackwell.

Heinimaa, M. 2000. Ambiguities in the Psychiatric Use of the Concepts of the Person: An analysis. *Philosophy, Psychiatry and Psychology* 7 (2): 125-136.

Henderson, D. 1939. *Psychopathic States*. New York: W.W.Norton & Compancy, Inc.

Henderson, D., & Batchelor, I. 1962. *Henderson and Gillespie's Textbook of Psychiatry*. London: Oxford University Press.

Hill, J., Fudge, H., Harrington, R., Pickles, A., & Rutter, M. 2000. Complementary Approaches to the Assessment of Personality Disorder: The Personality Assessment Schedule and Adult Personality Functioning Assessment compared. *British Journal of Psychiatry* 176: 434-439.

Hollway, W. 1984. Gender Difference and the Production of Subjectivity. In *Changing the Subject: Psychology, social regulation and subjectivity*, edited by J. Henriques, Holloway, W., Urwin, C., Venn, C., & Walkerdine, V. London: Methuen.

Hordern, A. 1952. The Response of the Neurotic Personality to Abreaction. *Journal of Mental Science* 98 (413): 630-639.

Howlett, M. 2000. Commentary: On the back foot. *Psychiatry and Community Care* 24: 287-8.

Iannantuono, A., & Eyles, J. 1997. Meanings in Policy: A textual analysis of Canada's "Achieving Health For All" document. *Social Science & Medicine* 44 (11): 1611-21.

Jones, R. 2004a. Introduction to: Heresy and orthodoxy in medical theory and research. *Social Science & Medicine* 58: 671-674.

Jones, R. 2004b. Schism and Heresy in the Development of Orthodox Medicine: The threat to medical hegemony. *Social Science & Medicine* 58: 703-712.

Jones, T., & Burns, T. 2004. What British Psychiatrist Read: Questionnaire survey of journal usage among clinicians. *British Journal of Psychiatry* 185: 251-257.

Kendall, G., & Wickham, G. 1999. *Using Foucault's Methods*. London: Sage.

Kendell, R. 2002a. The Distinction Between Personality Disorder and Mental Illness. *The British Journal of Psychiatry* 180: 110-115.

Kendell, R. 2002b. Personality Disorder. *British Journal of Psychiatry* 181: 77-78.

Kennedy, A. 1954. Psychopathic Personality and Social Responsibility. *Journal of Mental Science* 100 (421): 873-881.

Knox, J. 1960. The Inadequate Psychopath at Camp Hill Prison. *Journal of Mental Science* 106 (445): 1471-1474.

Koteyko, N. 2006. Corpus Linguistics and the Study of Meaning in Discourse. *The Linguistics Journal* 1 (2): 132-157.

Krishnamurthy, R. 1996. Ethnic, Racial and Tribal: The language of racism? In *Texts and Practices: Readings in critical discourse analysis*, edited by C. Caldas-Coulthard, & Coulthard, M. London: Routledge.

Kupfer, D., First, M., & Regier, D. 2005. *A Research Agenda for DSM V.* Washington, D.C.: American Psychiatric Association.

Laurance, J. 2003. *Pure Madness: How fear drives the mental health system*. London: Routledge.

Lewis, A. 1974. Psychopathic Personality: A most elusive category. *Psychological Medicine* 4: 133-40.

Liss, J., Welner, A., & Robins, E. 1973. Personality Disorder. 1. Record Study. *British Journal of Psychiatry* 123 (577): 685-692.

Livesley, W. 2001. Conceptual and Taxonomic Issues. In *Handbook of Personality Disorders*, edited by J. Livesley. New York: The Guilford Press.

Lupton, D. 1997a. Foucault and the Medicalisation Critique. In *Foucault Health and Medicine*, edited by A. Petersen, & Bunton, R. London: Routledge.

Lupton, D. 1997b. *The Imperative of Public Health: Public health and the regulated body*. London: Sage.

Lupton, D. 1998. *The Emotional Self*. London: Sage.

Maddocks, P. 1970. A Five Year Follow-up of Untreated Psychopaths. *British Journal of Psychiatry* 116: 511-515.

Manning, N. 2000. Psychiatric Diagnosis Under Conditions of Uncertainty: Personality disorder, science and professional legitimacy. *Sociology of Health and Illness* 22 (5): 621-639.

Manning, N. 2001. Psychiatric Diagnosis Under Conditions of Uncertainty: Personality disorder, science and professional legitimacy. In *Rethinking the Sociology of Mental Health*, edited by J. Busfield. Oxford: Blackwell Publishers Ltd.

Manning, N. 2002. Actor Networks, Policy Networks and Personality Disorder. *Sociology of Health and Illness* 24 (5): 644-665.

Manning, N. 2006. DSM-IV and Dangerous and Severe Personality Disorder - An Essay. *Social Science & Medicine* 63: 1960-1971.

Martin, B. 1988. Feminism, Criticism and Foucault. In *Feminism and Foucault: Reflections of resistance*, edited by I. Diamond, & Quinby, L. Boston: Northeastern University Press.

Martin, B. 2004. Dissent and Heresy in Medicine: Models, methods, and strategies. *Social Science & Medicine* 58: 713-725.

Mautner, G. 2009. Corpora and Critical Discourse Analysis. In *Contemporary Corpus Linguistics*, edited by P. Baker. London: Continuum.

McCallum, D. 1997. Mental Health, Criminality and the Human Sciences. In *Foucault, Health and Medicine*, edited by A. Petersen, & Bunton, R. London: Routledge.

McCallum, D. 2001. *Personality and Dangerousness: geneologies of antisocial personality disorder*. Cambridge: Cambridge University Press.

Mercier, C. 1911. *Crime and Insanity*. London: Williams and Norgate.

Mills, S. 1997. *Discourse*. London: Routledge.

Monro, A. 1955. Psychiatric Types: A Q-Technique study of 200 patients. *Journal of Mental Science* 101 (99): 330-343.

Moran, P. 2004. *The Epidemiology of Personality Disorders* DoH, 2002 [cited 28,05 2004]. Available from http://www.doh.gov.uk/mentalhealth/pdpaulmoran.pdf.

Moran, P., Jenkins, R., Tylee, A., Blizard, R., & Mann, A. 2000. The Prevalence of Personality Disorder Among UK Primary Care Attenders. *Acta Psychiatrica Scandinavica* 102 (1): 52-57.

Muijen, M. 1996. 'Scare in the Community: Britain in moral panic'. In *Mental Health Matters: A reader*, edited by T. Heller, Reynolds, J., Gomm, R., Muston, R., and Pattison, S. Houndmills: Macmillan Press Ltd.

Mulkay, M. 1979. *Science and the Sociology of Knowledge*. Edited by T. Bottomore, & Mulkay, M., *Controversies in Sociology*. London: George Allen & Unwin.

Nielsen, J., & Tsuboi, T. 1970. Correlation Between Stature, Character Disorder and Criminality. *British Journal of Psychiatry* 116: 145-150.

NIMH(E). 2003a. *Breaking the Cycle of Rejection: The personality disorder capabilities framework*. London: Department of Health.

NIMH(E). 2004. *Funding available for training in support of new Personality Disorder capabilities framework: Friday, December 05, 2003* NIMH(E), 2003b [cited 17.8. 2004]. Available from http://www.nimhe.org.uk/whatshapp/item_display_news.asp?id=389.

NIMH(E). 2004. *Personality Disorder: No longer a diagnosis of exclusion* DoH, 2003c [cited 28.05. 2004]. Available from http://www.doh.gov.uk/mentalhealth/personality.pdf.

Nolan, P., & Crawford, P. 1997. Towards a Rhetoric of Spirituality in Mental Health Care. *Journal of Advanced Nursing* 26: 289-294.

Nucknolls, C. 1992. Toward a Cultural History of the Personality Disorders. *Social Science & Medicine* 35 (1): 37-47.

Oakey, D. 2009. Fixed Collocational Patterns in Isolexical and Isotextual Versions of a Corpus. In *Contemporary Corpus Linguistics*, edited by P. Baker. London: Continuum.

O'Farrell, C. 2005. *Michel Foucault*. London: Sage.

Orpin, D. 2005. Corpus Linguistics and Critical Discourse Analysis: Examining the ideology of sleaze. *International Journal of Corpus Linguistics* 10 (1): 37-61.

Osborne, T. 1994. On Anti-medicine and Clinical Reason. In *Reassessing Foucault: Power, madness and the body*, edited by C. Jones, & Porter, R. London: Routledge.

Pagano, M., Skodol, A., Stout, R., Shea, M., Yen, S., Grilo, C., Sanislow, C., Bender, D., McGlashan, T., Zanarini, M., & Gunderson, J. 2004. Stressful Life Events as Predictors of Functioning: Findings from the Collaborative Longitudinal Personality Disorders Study. *Acta Psychiatrica Scandinavica* 110: 421-429.

Palmer, F. 1990. *Modality and the English Modals*. 2nd ed. London: Longman.

Palmer, H. 1959. Psychopathic Personality - Definition and Use of the Term. *Lancet*: 40-41.

Parker, G., Hadzi-Pavlovic, D., Both, L., Kumar, S., Wihelm, K., & Olley , A. 2004. Measuring Disordered Personality Functioning: To love and to work reprised. *Acta Psychiatrica Scandinavica* 110 (3): 230-239.

Parker, I. 1992. *Discourse Dynamics: Critical analysis for social and individual psychology*. London: Routledge.

Parker, I., Georgaca, E., Harper, D., McLaughlin, T., & Stowell-Smith, M. 1995. *Deconstructing Psychopathology*. London: Sage.

Parnell, M. 2007. Investigating the Language of Psychiatry for People with Personality Disorder, patients and users: Corpus Linguistics as an adjunct to Foucauldian Discourse Analysis. Paper read at First International Conference on Language and Healthcare, at University of Alicante.

Paterson, B., & Stark, C. 2001. Social Policy and Mental Illness in England in the 1990s: Violence, moral panic and critical discourse. *Journal of Psychiatric and Mental Health Nursing* 8: 257-267.

Persaud, R. 2000. Psychiatrists Suffer From Stigma Too. *Psychiatric Bulletin* 24: 284-5.

Phillips, M. 1989. *Lexical Structure of Text, Discourse Analysis Monograph 12.* Birmingham: University of Birmingham.

Pilgrim, D. 2001. Disordered Personalities and Disordered Concepts. *Journal of Mental Health* 10: 253-265.

Pilgrim, D. 2002. Personality Disorder. *British Journal of Psychiatry* 181: 77.

Pilgrim, D., & Rogers, A. 1997. Mental Health, Critical Realism and Lay Knowledge. In *Body Talk: The material and discursive regulation of sexuality, madness and reproduction*, edited by J. Ussher. London: Routledge.

Pilgrim, J., Mellers, J., Boothby, H., & Mann, A. 1993. Inter-rater and Temporal Reliability of the Standardized Assessment of Personality and the Influence of Informant Characteristics. *Psychological Medicine* 23: 779-786.

Potter, J. 2003. Discursive Psychology: Between method and paradigm. *Discourse and Society* 14 (6): 783-794.

Potter, J., & Edwards, D. 1992. *Discursive Psychology*. London: Sage.

Potter, J., & Wetherall, M. 1987. *Discourse and Social Psychology: Beyond attitudes and behaviour.* London: Sage.

Presly, A., & Walton, H. 1973. Dimensions of Abnormal Personality. *British Journal of Psychiatry* 122: 269-76.

Prince, M.J. 2001. How Social is Social Policy? Fiscal and Market Discourse in North American Welfare States. *Social Policy and Administration* 35 (1): 2-13.

Quine, W. 1951. Two Dogmas of Empricism. *The Philosophical Reivew* 60: 20-43.

Ramon, S. 1986. The Category of Psychopathy: Its professional and social context in Britain. In *The Power of Psychiatry*, edited by P. Miller, & Rose, N. Cambridge: Polity Press.

Reich, J., & Girolamo, G. 2000. Diagnosis and Classification of Personality Disorders. In *New Oxford Textbook of Psychiatry*, edited by M. Gelder, Lopez-Ibor, J., & Andreasen, N. New York: Oxford University Press.

Rendu, A., Moran, P., Patel, A., Knapp, M., & Mann, A. 2002. Economic Impact of Personality Disorders in UK Primary Care Attenders. *British Journal of Psychiatry* 181: 62-66.

Reuter, S. 2002. Doing Agoraphobia(s): A material-discursive understanding of diseased bodies. *Sociology of Health and Illness* 24 (6): 759-770.

Ritchie, J., Dick, D., & Lingham, R. 1994. *The Report of the Inquiry into the Care and Treatment of Christopher Clunis*. London: HMSO.

Ritzer, G. 1996. *Sociological Theory*. 4th ed. New York: McGraw-Hill.

Robinson, R., Coleman, K., & Sensky, T. 2005. *The Independent review into the Care and Treatment of Mr Anthony Hardy*. London: HMSO.

Rollin, H. 1975. Psychological Medicine: Personality Disorders. *British Medical Journal* 1: 665-667.

Rose, N. 1994. Medicine, History and the Present. In *Reassessing Foucault: Power, medicine and the body*, edited by C. Jones, & Porter, R. London: Routledge.

Rose, N. 1996. *Inventing Our Selves: Psychology, power, and personhood.* Cambridge University Press: Cambridge.

Rose, N. 1998. Living Dangerously: Risk-thinking and risk management in mental health care. *Mental Health Care* 1 (8): 263-266.

Rose, N. 1999. *Governing the Soul: The shaping of the private self*. 2nd ed. London: Free Association Books.

Ryle, A. 2002. Personality Disorder. *British Journal of Psychiatry* 181: 76-77.

Sacks, H. 2001. Lecture 1: Rules of conversational sequence. In *Discourse Theory and Practice: A reader*, edited by M. Wetherall, Taylor, S., & Yates, S. London: Sage.

Samuels, J., Eaton, W., Bienvenue III, O., Brown, C., Costa Jr, P., & Nestadt, G. 2002. Prevalence and Correlates of Personality Disorder in a Community Sample. *British Journal of Psychiatry* 180: 536-542.

Sanislow, C., Morey, L., Grilo, C., Gunderson, J., Shea, M., Skodol, A., Stout, R., Zanarini, M., & McGlashan, T. 2002. Confirmatory Factor Analysis of DSM-IV Borderline, Schizotypal, Avoidant, and Obsessive-compulsive Personality

Disorders: Findings from the Collaborative Longitudinal Personality Disorders Study. *Acta Psychiatrica Scandinavica* 105: 28-36.

Sarangi, S. 2004. Editorial: Towards a Communicative Mentality in Medical and Healthcare Practice. *Communication and Medicine* 1: 1-12.

Schneider, K. 1958. Psychopathic Personalities. London: Cassell.

Scott, M. 2004. *WordSmith Tools Help Manual. Version 4.0*. Oxford: Oxford University Press.

Scott, M., & Tribble, C. 2006. *Textual Patterns: Key words and corpus analysis in language education*. Amsterdam: John Benjamins Publishing Company.

Scull, A. 1977. *Decarceration: Community treatment and the deviant - a radical view*. Englewood Cliffs: Prentice Hall.

Seglen, P. 1997. Why the Impact Factor of Journals Should Not be Used for Evaluating Research. *British Medical Journal* 314: 497.

Simpson, P. 1993. *Language, Ideology and Point of View*. London: Routledge.

Skrabanek, P., & McCormick, J. 1994. *Follies and Fallacies in Medicine*. Glasgow: Tarragon Press.

Slembrouk, S. 2006. *What Is Meant by "Discourse Analysis"?* 20.03.06 2006 [cited 22.03.06 2006]. Available from http://bank.rug.ac.be/da/da.htm.

Smith, P. 1988. *Discerning the Subject*. Minneapolis: University of Minnesota Press.

Standage, K. 1979. The Use of Schneider's Typology for the Diagnosis of Personality Disorders - An Examination of Reliability. *British Journal of Psychiatry* 135: 238-42.

Steering Committee of the Confidential Inquiry into Homicides and Suicides by Mentally Ill People. 1996. *Report of the Confidential Inquiry into Homicides and Suicides by Mentally Ill People*. London: Royal College of Psychiatrists.

Stubbs, M. 1994. Grammar, Text and Ideology: Computer-assisted methods in the linguistics of representation. *Applied Linguistics* 15 (2): 210-23.

Stubbs, M. 1996. *Text and Corpus Analysis*. Oxford: Blackwell.

Stubbs, M. 1997. Whorf's Children: Critical comments on critical discourse analysis (CDA). In *Evolving Models of Language*, edited by A. Ryan, & Wray, A. Clevedon: Multilingual Matters.

Stubbs, M. 2001. Texts, Corpora and Problems of Interpretation: A response to Widdowson. *Applied Linguistics* 22 (2): 149-172.

Sturup, G. 1952. The Treatment of Psychopaths in Herstedvester. *British Journal of Medical Psychology* 25 (1): 31-38.

Suominen, K., Isometsa, E., Henriksson, M., Ostamo, A., & Lonnqvist, J. 2000. Suicide Attempts and Personality Disorder. *Acta Psychiatrica Scandinavica* 102 (2): 118-125.

Svrakic, D., Draganic, S., Hill, K., Bayon, C., Przybeck, T., & Cloniger, C. 2002. Temperament, Character, and Personality Disorders: Etiologic, diagnostic, treatment issues. *Acta Psychiatrica Scandinavica* 106: 189-195.

Sykes, C., Willig, C., & Marks, D. 2004. Discourses in the European Commission's 1996-2000 Health Promotion Programme. *Journal of Health Psychology* 9 (1): 131-141.

Taylor, C. 1985. *Human Agency and Language: Philosophical papers 1*. Cambridge: Cambridge University Press.

Taylor, S. 2001. Evaluating and Applying Discourse Analytic Research. In *Discourse as Data: A guide for analysis*, edited by M. Wetherall, Taylor, S., & Yates, S. London: Sage.

Thompson, E., & Hayden, A. 1952. *Standard Nomenclature of Diseases and Operations*. 4th Edition ed. New York: McGraw-Hill Book Company, Inc.

Thompson, R. 1958. Psychopathic Personality. *British Medical Journal* 1: 402.

Tyrer, P. 1988. *Personality Disorders: Diagnosis, management and course*. London: Wright.

Tyrer, P. 2002. Nidotherapy: A new approach to the treatment of personality disorder. *Acta Psychiatrica Scandinavica* 105: 469-471.

Tyrer, P., & Alexander, J. 1979a. Classification of Personality Disorder. *British Journal of Psychiatry* 135: 163-7.

Tyrer, P., Alexander, J., Cicchetti, D., Cohen, M., & Remington, M. 1979b. Reliability of a Schedule for Rating Personality Disorders. *British Journal of Psychiatry* 135: 168-74.

Tyrer, P., Alexander, J., Cicchetti, D., Cohen, M., & Remington, M. 1979. Reliability of a Schedule for Rating Personality Disorders. *British Journal of Psychiatry* 135: 168-74.

Tyrwhitt-Drake, H. 1999. Resisting the Discourse of Critical Discourse Analysis: Reopening a Hong Kong case study. *Journal of Pragmatics* 31 (8): 1081-88.

Valenstein, A., Michaels, J., & Evje, M. 1953. Aspects of Character in the Neurotic Veteran. *Journal of Nervous and Mental Disease* 117 (5): 445-457.

Van Dijk, T. 1993. Principles of Critical Discourse Analysis. *Discourse and Society* 4 (2): 249-83.

Van Dijk, T. 1997. Discourse as Interaction in Society. In *Discourse as Social Interaction. Discourse Studies: A Multidisciplinary Introduction. Volume 2.*, edited by T. Van Dijk. Thousand Oaks: Sage.

Van Dijk, T. 2001. Multidisciplinary CDA: A plea for diversity. In *Methods of Critical Discourse Analysis*, edited by R. Wodak, & Meyer, M.

van Langenhove, L., & Harre, R. 1999a. Positioning and the Writing of Science. In *Positioning Theory: Moral contexts of intentional action*, edited by R. Harre, & van Langenhove, L. Oxford: Blackwell.

van Langenhove, L., & Harre, R. 1999b. Positioning as the Production and Use of Stereotypes. In *Positioning Theory: Moral contexts of intentional action*, edited by R. Harre, & van Langenhove, L. Oxford: Blackwell.

Vihla, M. 1999. *Medical Writing: Modality in focus*. Edited by J. Aarts, & Meijs, W., *Language and Computers: Studies in practical linguistics*. Amsterdam: Rodolpi.

Vinoda, N. 1969. Personality and the Nature of Suicidal Attempts. *British Journal of Psychiatry* 115: 791-795.

Von Knorring, L., Ekselius, L., & Alton, V. 2000. Growth of Interest in Personality Disorders. *American Journal of Psychiatry* 158: 1168.

Walton, H., Foulds, G., Littmann, S., & Presly, A. 1970. Abnormal Personality. *British Journal of Psychiatry* 116: 497-510.

Walton, H., & Presly, A. 1973. Use of a Category System in the Diagnosis of Abnormal Personality. *British Journal of Psychiatry* 122: 259-68.

Warden, J. 1998. Psychiatrists Hit Back at Home Secretary. *British Medical Journal* 317: 1270.

Warren, F., Preedy-Fayers, K. , McGauley, G., Pickering, A., Norton, K., Geddes, J., & Dolan, B. 2003. *Review of Treatments for Severe Personality Disorder.* London: Home Office Online Report.

Whiteley, S. 1970. The Response of Psychopaths to a Therapeutic Community. *British Journal of Psychiatry* 116: 517-529.

Widdowson, H. 2000. On the Limitations of Linguistics Applied. *Applied Linguistics* 21 (1): 3-25.

Widiger, T., & Lowe, J. 2008. A Dimensional Model of Personality Disorder: Proposal for DSM-V. *The Psychiatric Clinics of North America* 31 (3): 363-378.

Williams, G. 1999. *French Discourse Analysis: The method of post-structuralism.* London: Routledge.

Willig, C. 2001a. *Introducing Qualitative Research in Psychology: Adventures in theory and method.* Buckingham: Open University Press.

Willig, C. 2003. Discourse Analysis. In *Qualitative Psychology: A practical guide to research methods*, edited by J. Smith. London: Sage.

Willig, C. 2001b. Foucauldian Discourse Analysis. In *Introducing Qualitative Research in Psychology: Adventures in theory and method*, edited by C. Willig. Buckingham: Open University Press.

Wirth-Cauchon, J. 2001. *Women and Borderline Personality Disorder: Symptoms and stories.* New Brunswick: Rutgers University Press.

World Health Organisation. 1948. *Manual of the International Statistical Classification of Diseases, Injuries, and Causes of Death.* Sixth Revision ed. Vol. 1. Geneva: World Health Organisation.

World Health Organisation. 1992. *The ICD-10 Classification of Mental and Behavioural Disorders: Diagnostic criteria for research.* Geneva: World Health Organisation.

Appendices

Appendix 1: DSM IV and ICD 10 categorisations of personality disorder

Extracted from Chapter on Personality Disorders from DSM IV - TR (American Psychiatric Association 2000)

Personality Disorders

Paranoid Personality Disorder is a pattern of distrust and suspiciousness such that others' motives are interpreted as malevolent.

Schizoid Personality Disorder is a pattern of detachment from social relationships and a restricted range of emotional expression.

Schizotypal Personality Disorder is a pattern of acute discomfort in close relationships, cognitive or perceptual distortions, and eccentricities of behavior.

Antisocial Personality Disorder is a pattern of disregard for, and violation of, the rights of others.

Borderline Personality Disorder is a pattern of instability in interpersonal relationships, self-image, and affects, and marked impulsivity.

Histrionic Personality Disorder is a pattern of excessive emotionality and attention seeking.

Narcissistic Personality Disorder is a pattern of grandiosity, need for admiration, and lack of empathy.

Avoidant Personality Disorder is a pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation.

Dependent Personality Disorder is a pattern of submissive and clinging behavior related to an excessive need to be taken care of.

Obsessive-Compulsive Personality Disorder is a pattern of preoccupation with orderliness, perfectionism, and control.

Personality Disorder Not Otherwise Specified

The Personality Disorders are grouped into three clusters based on descriptive similarities. Cluster A includes the Paranoid, Schizoid, and Schizotypal Personality Disorders. Individuals with these disorders often appear odd or eccentric. Cluster B includes the Antisocial, Borderline, Histrionic, and Narcissistic Personality Disorders. Individuals with these disorders often appear dramatic, emotional, or erratic. Cluster C includes the Avoidant, Dependent, and Obsessive-Compulsive Personality Disorders. Individuals with these disorders often appear anxious or fearful. It should be noted that this clustering system, although useful in some research and educational

situations, has serious limitations and has not been consistently validated. Moreover, individuals frequently present with co-occurring Personality Disorders from different clusters.

Extracted from Chapter V Mental and behavioural disorders (F00-F99) on Personality Disorders from ICD 10 (World Health Organisation 1992)

F60 Specific personality disorders

These are severe disturbances in the personality and behavioural tendencies of the individual; not directly resulting from disease, damage, or other insult to the brain, or from another psychiatric disorder; usually involving several areas of the personality; nearly always associated with considerable personal distress and social disruption; and usually manifest since childhood or adolescence and continuing throughout adulthood.

F60.0 Paranoid personality disorder

Personality disorder characterized by excessive sensitivity to setbacks, unforgiveness of insults; suspiciousness and a tendency to distort experience by misconstruing the neutral or friendly actions of others as hostile or contemptuous; recurrent suspicions, without justification, regarding the sexual fidelity of the spouse or sexual partner; and a combative and tenacious sense of personal rights..

F60.1 Schizoid personality disorder

Personality disorder characterized by withdrawal from affectional, social and other contacts with preference for fantasy, solitary activities, and introspection. There is a limited capacity to express feelings and to experience pleasure.

F60.2 Dissocial personality disorder

Personality disorder characterized by disregard for social obligations, and callous unconcern for the feelings of others. There is gross disparity between behaviour and the prevailing social norms.

F60.3 Emotionally unstable personality disorder

Personality disorder characterized by a definite tendency to act impulsively and without consideration of the consequences; the mood is unpredictable and capricious.

F60.4 Histrionic personality disorder

Personality disorder characterized by shallow and labile affectivity, self-dramatization, theatricality, exaggerated expression of emotions, suggestibility, egocentricity, self-indulgence, lack of consideration for others, easily hurt feelings, and continuous seeking for appreciation, excitement and attention.

F60.5 Anankastic personality disorder
Personality disorder characterized by feelings of doubt, perfectionism, excessive conscientiousness, checking and preoccupation with details, stubbornness, caution, and rigidity.

F60.6 Anxious [avoidant] personality disorder
Personality disorder characterized by feelings of tension and apprehension, insecurity and inferiority. There is a continuous yearning to be liked and accepted, a hypersensitivity to rejection and criticism with restricted personal attachments, and a tendency to avoid certain activities by habitual exaggeration of the potential dangers or risks in everyday situations.

F60.7 Dependent personality disorder
Personality disorder characterized by pervasive passive reliance on other people to make one's major and minor life decisions, great fear of abandonment, feelings of helplessness and incompetence, passive compliance with the wishes of elders and others, and a weak response to the demands of daily life.

F60.8 Other specific personality disorders

F60.9 Personality disorder, unspecified

Appendix 2: DSM comparison table

Standard Nomenclature (1952)	*DSM I (1952)*	*DSM II (1968)*	DSM III (1980)	DSM III-R (1987)	DSM IV (1994)	DSM IV TR (2000)
-x PERSONALITY DISORDERS *WITHOUT CLEARLY DEFINED* TANGIBLE CAUSE OR STRUCTURAL CHANGE	*Personality disorders (in standard* nomenclature	V. PERSONALITY DISORDERS AND CERTAIN OTHER NON-PSYCHOTIC MENTAL DISORDERS (301-304)	SPECIFIC PERSONALITY DISORDERS	PERSONALITY DISORDERS		PERSONALITY DISORDER
-x40 Personality pattern disturbance (not further specified) -x41 Inadequate personality -x42 Schizoid personality -x43 Cyclothymic personality -x44 Paranoid personality -x45 Immature personality -x46 Emotuionally unstable personality -x465 Passive-aggressive type -x466 Passive-dependent type -x467 Aggressive type -x47 Compulsive personality -x48 Hysterical personality -x59 Personality pattern disturbance, other -x60 Sociopathic personality (not further specified) -x61 Antisocial personality (unspecified) -x615 Violent type -x616 Stealing type -x617 Cheating type -x619 Other specified types -x62 Dyssocial personality -x63 Sexual deviation (unspecified) -x635 Homosexual type -x636 Voyeur-exhibitionist type -x639 Other types -x64 Addiction -x641 Alcohol addiction chronic -x642 Drug addiction -x643 Alcohol and drug addiction, combined types -x70 Special symptom disturbance (not further specified) -x71 Hearing disturbance -x72 Speech disturbance -x73 Enuresis, persistent -x74 Sonambulism -x79Other special symptom disturbance	000-x40 Personality pattern disturbance 000-x41 Inadequate personality 000-x42 Schizoid personality 000-x43 Cyclothymic personality 000-x44 Paranoid personality 000-x50 Personality trait disturbance 000-x51 Emotionally unstable personality 000-x52 Passive-aggressive personality 000-x53 Compulsive personality 000-x5y Personality trait disturbance, other 000-x60 Sociopathic personality disturbance 000-x61 Antisocial reaction 000-x62 Dyssocial reaction 000-x63 Sexual deviation 000-x64 Addiction 000-x641 Alcoholism 000-x642 Drug addiction 000-x70 Special symptom reactions 000-x71 Learning disturbance 000-x72 Speech disturbance 000-x73 Eneuresis 000-x74 Sonambulism 000-x7y Other 000-x80 Transient situational personality disorders	301 Personality disorders 301.0 Paranoid personality 301.1 Cyclothymic personality (Affective personality) 301.2 Schizoid personality 301.3 Explosive personality (Epileptoid personality disorder) 301.4 Obsessive compulsive personality (Anankastic personality) 301.5 Hysterical personality 301.6 Asthenic personality 301.7 Antisocial personality 301.81 Passive-aggressive personality * (what does the star mean?) 301.82 Inadequate personality * 301.89 Other personality disorders of specified types (Immature personality, Passive-dependent personality, etc.) * 301.9 [Unspecified personality disorder] 302 Sexual deviations 303 Alcoholism 304 Drug dependence	People in this cluster often appear 'odd' or eccentric 301.00 Paranoid Personality Disorder 301.20 Schizoid Personality Disorder 301.22 Schizotypical Personality Disorder People in this cluster often appear dramatic, emotional or erratic 301.50 Histrionic Personality Disorder 301.81 Narcissistic Personality Disorder 301.70 Antisocial Personality Disorder 301.83 Borderline Personality Disorder People in this cluster often appear anxious or fearful 301.82 Avoidant Personality Disorder 301.60 Dependent Personality Disorder 301.40 Compulsive Personality Disorder 301.84 Passive-Aggressive Personality Disorder 301.89 Atypical, Mixed, or Other Personality Disorder	People in this cluster often appear 'odd' or eccentric 301.00 Paranoid Personality Disorder 301.20 Schizoid Personality Disorder 301.22 Schizotypical Personality Disorder People in this cluster often appear dramatic, emotional or erratic 301.50 Histrionic Personality Disorder 301.81 Narcissistic Personality Disorder 301.70 Antisocial Personality Disorder 301.83 Borderline Personality Disorder People in this cluster often appear anxious or fearful 301.82 Avoidant Personality Disorder 301.60 Dependent Personality Disorder 301.40 Obsessive ompulsive Personality Disorder 301.84 Passive-aggressive Personality Disorder 301.90 Personality Disorder NOS Changes from DSM III to DSM II-R are from (DSM III-R, p428-429)	Cluster A Personality Disorders 301.0 Paranoid Personality Disorder 301.2 Schizoid Personality Disorder 301.22Schizotypal Personality Disorder Cluster B Personality Disorders 301.7 Antisocial Personality Disorder 301.81 Borderline Personality. 301.50 Histrionic Personality Disorder 301.81 Narcissistic Personality Disorder Cluster C Personality Disorders 301.82 Avoidant Personality Disorder 301.6 Dependent Personality Disorder 301.4 Obsessive-Compulsive Personality Disorder 301.9 Personality Disorder Not Otherwise Specified	Cluster A Personality Disorders 301.0 Paranoid Personality Disorder 301.20 Schizoid Personality Disorder 301.22 Schizotypal Personality Disorder Cluster B Personality Disorders 301.7Antisocial Personality Disorder 301.83 Borderline Personality. 301.5 Histrionic Personality Disorder 301.81 Narcissistic Personality Disorder Cluster C Personality Disorders 301.82 Avoidant Personality Disorder 301.6 Dependent Personality Disorder 301.4 Obsessive-Compulsive Personality Disorder 301.9 Personality Disorder Not Otherwise Specified

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Appendix 3: ICD comparison table

ICD 6 (1948)	ICD 7 (1955)	ICD 8 (1965)	ICD 9 (1975)	ICD10 (1992)
DISORDERS OF CHARACTER, BEHAVIOUR, AND INTELLIGENCE (320-326)	***Disorders of character, behaviour and intelligence (320-326)***	***Neuroses, personality disorders and other nonpsychotic mental disorders (300-309)***	***Neurotic disorders, personality disorders and other nonpsychotic mental disorders (300-316)***	Disorders of adult personality and behaviour (F60-F69)
320 Pathological personality	**320 Pathological personality**	**300 Neuroses**	**300 Neurotic disorders**	F60 Specific personality disorders
320.0 Schizoid personality	320.0 Schizoid personality			F60.0 Paranoid personality disorder
320.1 Paranoid personality (this title excludes paranoid states (303)	320.1 Paranoid personality	**301 Personality disorders**	**301 Personality disorders**	F60.1 Schizoid personality disorder
320.2 Cyclothymic personality	320.2 Cyclothymic personality	301.0 Paranoid	301.0 Paranoid personality disorder	F60.2 Dissocial personality disorder
320.3 Inadequate personality	320.3 Inadequate personality	301.1 Affective	301.1 Affective personality disorder	F60.3 Emotionally unstable personality disorder
Constitutional inferiority		301.2 Schizoid	301.10 Affective personality disorder, unspecified	F60.4 Histrionic personality disorder
Inadequate personality NOS		301.3 Explosive		F60.5 Anankastic personality disorder
320.4 Antisocial personality	320.4 Antisocial personality	301.4 Anankastic	301.11 Chronic hypomanic personality disorder	F60.6 Anxious [avoidant] personality disorder
Antisocial personality		301.5 Hysterical		F60.7 Dependent personality disorder
Constitutional psychopathic state		301.6 Asthenic	301.12 Chronic depressive personality disorder	F60.8 Other specific personality disorders
Psychopathic personality: NOS with antisocial trend		301.7 Antisocial		F60.9 Personality disorder, unspecified
		301.8 Other	301.13 Cyclothymic disorder	F61 Mixed and other personality disorders
320.5 Asocial personality	320.5 Asocial personality	301.9 Unspecified	301.2 Schizoid personality disorder	
Asocial personality			301.20 Schizoid personality disorder, unspecified	F62 Enduring personality changes, not attributable to brain damage and disease
Moral deficiency			301.21 Introverted personality	F62.0 Enduring personality change after catastrophic experience
Pathological liar			301.22 Schizotypal personality	
Psychopathic personality with amoral trend			301.3 Explosive personality disorder	F62.1 Enduring personality change after psychiatric illness
			301.4 Compulsive personality disorder	F62.8 Other enduring personality changes
320.6 Sexual deviation	320.6 Sexual deviation		301.5 Histrionic personality disorder	F62.9 Enduring personality change, unspecified
Exhibitionism		**302 Sexual deviation**	301.50 Histrionic personality disorder, unspecified	
Fetishism		302.0 Homosexuality		F63 Habit and impulse disorders
Homosexuality		302.1 Fetishism	301.51 Chronic factitious illness with physical symptoms	F63.0 Pathological gambling
Pathological sexuality		302.2 Paedophilia		
Sadism		302.3 Transvestitism	301.59 Other histrionic personality disorder	F64 Gender identity disorders
Sexual deviation		302.4 Exhibitionism	301.6 Dependent personality disorder	F64.0 Transsexualism
320.7Other and unspecified	320.7 Other and unspecified	302.5 Voyeurism	301.7 Antisocial personality disorder	F64.1 Dual-role transvestism
Pathological personality NOS		302.6 Sadism	301.8 Other personality disorders	F64.2 Gender identity disorder of childhood
		302.7 Masochism	301.81 Narcissistic personality	F64.8 Other gender identity disorders
321 Immature personality	321 Immature personality	302.8 Other	301.82 Avoidant personality	F64.9 Gender identity disorder, unspecified
321.0 Emotional instability	321.0 Emotional instability	302.9 Unspecified	301.83 Borderline personality	
Emotional instability (excessive)			301.84 Passive-aggressive personality	
321.1 Passive dependency	321.1 Passive dependency		301.89 Other	F65 Disorders of sexual preference
Dependency reactions			301.9 Unspecified personality disorder	F65.0 Fetishism
Passive dependency				F65.1 Fetishistic transvestism
321.2Aggressiveness			**302 Sexual deviations and disorders**	F65.2 Exhibitionism
321.3Enuresis characterising immature personality	321.2 Aggressiveness		302.0 Ego-dystonic homosexuality	F65.3 Voyeurism
Enuresis specified as a manifestation of immature personality	321.3 Enuresis characterising immature personality		302.1 Zoophilia	F65.4 Paedophilia
			302.2 Paedophilia	F65.5 Sadomasochism
321.4 Other symptomatic habits except speech impediments	321.4 Other symptomatic habits except speech impediments		302.3 Transvestism	F65.6 Multiple disorders of sexual preference
			302.4 Exhibitionism	F65.8 Other disorders of sexual preference
Symptomatic hatbits other than enuresis and speech impediments, specified as manifestations of immature personality			302.5 Trans-sexualism	F65.9 Disorder of sexual preference, unspecified
			302.6 Disorders of psychosexual identity	
321.5 Other and unspecified	321.5 Other and *unspecified*		302.7 Psychosexual dysfunction	F66 Psychological and behavioural disorders associated with sexual development and orientation
Immature personality NOS			302.8 Other specified psychosexual disorders	
Immaturity reaction NOS			302.9 Unspecified psychosexual disorder	F68 Other disorders of adult personality and behaviour
322Alcoholism	**322 Alcoholism**	**303 Alcoholism**	**303 Alcohol dependence syndrome**	
323 Other drug addictions	**323 Other drug addiction**	**304 Drug dependence**	**304 Drug dependence**	F68.0 Elaboration of physical symptoms for psychological reasons
324 Primary childhood behaviour disorders	**324 Primary childhood behaviour disorders**	**305 Physical disorders of presumably psychogenic origin**	**306 Physiological malfunction arising from mental factors**	F68.1 Intentional production or feigning of symptoms or disabilities, either physical or psychological [factitious disorder]
325 Mental deficiency	**325 Mental deficiency**	**306 Special symptoms not elsewhere classified**	**307 Special symptoms or syndromes not elsewhere classified**	
326 Other and unspecified character, behaviour, and intelligence disorders	**326 Other and unspecified character, behaviour and intelligence disorders**	**307 Transient situational disturbances**	**308 Acute reaction to stress**	F69 Unspecified disorder of adult personality and behaviour
		308 Behaviour disorders of childhood		
		309 Mental disorders not specified as psychotic associated with physical conditions		

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Appendix 4: The construction and composition of the corpora

Introduction

Chapter 5 outlined the rationale for the selection of time periods for the corpora along with a brief description of the selection criteria. This appendix describes the details of the search and selection strategy for the construction of the three corpora, the final composition of each corpus and a discussion of some of the issues involved in corpus creation. A list of the rejected material is available on demand.

The '1950's Corpus'

For the period 1948 to 1961 the *Journal of Mental Science*, the *British Journal of Medical Psychology* and the *Eugenics Review* were hand searched. The following terms were explored in the index: *personality, trait, character, psychopath/y/ic, psychiatr/y/ic, mental disorder*, and *delinquency*. These terms were arrived at from studies of the whole index of a number of issues for terms of relevance to the study. In addition the journals were searched by hand for titles which may have a bearing on the development of personality disorder or related concepts, and epidemiological articles were looked at for reference to personality disorder and a number of examples uncovered. An electronic search of the period using the above terms was also conducted and checked against the articles uncovered in the hand search.

The *British Medical Journal* and the *Lancet* were searched electronically using the same terms, and then, when articles were returned, the vicinity of the period was explored for any related articles or correspondence.

This process produced a list of articles that pertained to personality disorder for this period and then the criteria 1) to 4) outlined in Chapter 5 were applied to each article

This process produced a corpus of articles covering the period from 1950 to 1961. It comprised 30 documents and contained 81,273 words. The 1950's Corpus is listed below.

1950's Corpus

Journal of Mental Science

Reference	Title	Words
(Davis 1950)	A Case of Schizosis with Dual Personality	4012
(Rees 1950b)	Body Size, Personality and Neurosis	3113
(Rees 1950a)	Body Build, Personality and Neurosis in Women	2601
(Hordern 1952)	The Response of the Neurotic Personality to Abreaction	7927
(Kennedy 1954)	Psychopathic Personality and Social Responsibility	5512
(Monro 1955)	Psychiatric Types: A Q-Technique study of 200 patients	6633
(Foulds et al. 1958)	Psychoneurotic Symptom Clusters Trait Clusters and Psychological Tests	4377
(Storms 1958)	Discrepancies Between Factor Analysis and Multivariate Discrimination Among Groups as Applied to Personality Theory	3396
(Foulds et al. 1959)	Symptom Clusters and Personality Types among Psychoneurotic Men Compared with Women	2190

(Foulds 1959)	The Relative Stability of Personality Measures Compared with Diagnostic Measures	1766
(Monro 1959)	The Inadequate Personality in Psychiatric Practice	3880
(Mowbray 1960)	The Concept of the Psychopath	3440
(Diethelm 1960)	A Clinical Consideration of Psychopathic Personalities	3160
(Knox 1960)	The Inadequate Psychopath at Camp Hill Prison	2295
(Gibbens 1961)	Treatment of Psychopaths	3402
	TOTAL	**55,938**

Journal of Nervous and Mental Disease

Reference	Title	Words
(Valenstein et al. 1951)	Aspects of Character in the Neurotic Veteran	1629
(Valenstein et al. 1953)	Aspects of Character in the Neurotic Veteran	4735
(Davidson 1956)	The Syndrome of Oligothymia (Psychopathy)	5424
	TOTAL	**11,788**

British Journal of Medical Psychology

Reference	Title	Words
(Sturup 1952)	The Treatment of Psychopaths in Herstedvester	5210
	TOTAL	**5,210**

British Medical Journal

Reference	Title	Words
(Bartholomew 1958)	Psychopathic Personality	691
(Stengel 1958)	Psychopathic Personality	271
(Thompson 1958)	Psychopathic Personality	416
(Turner 1958)	Psychopathic Personality	107
(Roe 1958)	Psychopathic Personality	99
(Allen 1958)	Psychopathic Personality	251
(Anon 1958)	Inadequate Personality	250
	TOTAL	**2,085**

Lancet

Reference	Title	Words
(Palmer 1959)	Psychopathic Personality - Definition and Use of the Term	1598
(Craft 1959)	Personality Disorder and Dullness	2021
(Clarke et al. 1959)	Personality Disorder and Dullness	403
	TOTAL	**4,021**

Eugenics Review

Reference	Title	Words
(Eysenck 1951)	Neuroticism in Twins	2231

The '1970's Corpus'

For this period it was necessary to rely more on electronic searching as the number of potential articles had increased. Thus the Web of Knowledge was used as it contains all the relevant journals for the period. The initial searches used the terms for the 1950's but also included *personality disorder/s,* and the selection criteria where then used to construct the corpus.

After this process the 1970's corpus covered the time period from 1969 to 1979 and comprised 19 documents with 67,123 words and is listed below.

Note that the citation frequencies for this and the 2000's corpus were obtained on 13th July 2008.

1970's Corpus

British Journal of Psychiatry

Reference	Title	No. of times Cited	Words
(Vinoda 1969)	Personality and the Nature of Suicidal Attempts	13	2131
(Walton et al. 1970)	Abnormal Personality (cited by Tyrer 2003 and Livesley 2001)	19	7961
(Maddocks 1970)	A Five Year Follow-up of Untreated Psychopaths	40	2527
(Whiteley 1970)	The Response of Psychopaths to a Therapeutic Community	35	6286
(Nielsen et al. 1970)	Correlation Between Stature, Character Disorder and Criminality	3	1821
(Philip 1970)	Traits, Attitudes and Symptoms in a Group of Attempted Suicides	44	4071
(Smail 1970)	Neurotic Symptoms, Personality and Personal Constructs	6	2080
(Walton et al. 1973)	Use of a Category System in the Diagnosis of Abnormal Personality	57	5469
(Presly et al. 1973)	Dimensions of Abnormal Personality	58	4069
(Liss et al. 1973)	Personality Disorder. 1. Record Study	15	2360
(Wellner et al. 1974)	Personality Disorder. 2. Follow-up	19	2940
(Tyrer et al. 1979a)	Classification of Personality Disorder	50	1,701
(Tyrer et al. 1979b)	Reliability of a Schedule for Rating Personality Disorders	89	3366
Standage 1979	The Use of Schneider's Typology for the Diagosis of Personality Disorders – An Examination of Reliability	21	2294
	TOTAL		**49,076**

Psychological Medicine

Reference	Title	No. of times Cited	Words
(Foulds 1971)	Personality Deviance and Personal Symptomatology	28	6660
(Shepherd et al. 1974)	Personality Disorder and International Classification of Diseases	27	3118
(Lewis 1974)	Psychopathic Personality: A most elusive category	48	4146
(Gunn et al. 1976)	Psychopathic Personality: A conceptual problem	21	2161
	TOTAL		**16,185**

British Medical Journal

Reference	Title	No. of times Cited	Words
(Rollin 1975)	Psychological Medicine: Personality Disorders	0	1862

The '2000's Corpus'

As outlined in Chapter 5, the 2000 corpus focused on two main journals, the *British Journal of Psychiatry* and *Acta Psychiatrica Scandanavica.* These were searched electronically using all the terms mentioned above, then the four selection criteria were applied.

The time period covered by the corpus extends from 1998 (post the effects of the Stone enquiry but not the publication of the actual report), until 2007.

This process produced a corpus of 29 documents with a count of 86,339 words and is listed below.

2000's Corpus

Reference	Title	Words	Times cited
	British Journal of Psychiatry		
(Bateman et al. 2000)	Effectiveness of Psychotherapeutic Treatment of Personality Disorder	4,079	40
(Bradley et al. 2005)	Transference patterns in the psychotherapy of personality disorders: empirical investigation	4,149	6
(Chiesa et al. 2000)	Cassel Personality Disorder Study: Methodology and treatment effects	4,256	23
(Coid 1999)	Aetiological Risk Factors for Personality Disorder	4,174	6
(Coid 2003)	Epidemiology, public health and the problem of personality disorder	5,506	4
(Coid et al. 2006)	Prevalence and Correlates of Personality Disorder in Great Britain	4,568	7
(Crawford 2007)	Can deficits in social problem-solving in people with personality disorder be reversed?	1,530	0

(Davies et al. 2003)	Therapeutic Community Treatment of Personality Disorder: Service use and mortality over 3 years follow up	2,136	1
(Hill et al. 2000)	Complementary Approaches to the Assessment of Personality Disorder: The Personality Assessment Schedule and Adult Personality Functioning Assessment compared	3,825	9
(Huband et al. 2007)	Social Problem-solving Plus Psychoeducation for Adults with Personality Disorder:Pragmatic randomised controlled trial trial	4,061	2
(Kendell 2002a)	The Distinction Between Personality Disorder and Mental Illness	4,561	23
(Bennett 2002)	Personality Disorder	350	0
(Ryle 2002)	Personality Disorder	553	0
(Pilgrim 2002)	Personality Disorder	514	0
(Kendell 2002b)	Personality Disorder	656	0
(Rendu et al. 2002)	Economic impact of personality disorders in UK primary care attenders	2,606	13
(Samuels et al. 2002)	Prevalence and Correlates of Personality Disorder in a Community Sample	3,764	7
(Spence 2001)	Personality Disorder; Agency and Responsibility	557	0
(Tyrer 2001)	Personality Disorder	2,771	4
(Tyrer et al. 2003)	Ramifications of Personality Disorder in Clinical Practice	980	1
	TOTAL	**55,596**	
	Acta Psychiatrica Scandinavica		
(McGlashan et al. 2000)	The Collaborative Longitudinal Personality Disorders Study: Baseline Axis I/II and II/III diagnostic co-occurrance	3,769	93

(Moran et al. 2000)	The Prevalence of Personality Disorder Among UK Primary Care Attenders	2,933	21
(Moran et al. 2006)	Dimensional Characteristics of DSM-IV Personality Disorders in a Large Epidemiological Sample	1,566	0
(Pagano et al. 2004)	Stressful Life Events as Predictors of Functioning: Findings from the Collaborative Longitudinal Personality Disorders Study	4,084	8
(Parker et al. 2004)	Measuring Disordered Personality Functioning: To love and to work reprised	4,726	2
(Sanislow et al. 2002)	Confirmatory Factor Analysis of DSM-IV Borderline, Schizotypal, Avoidant, and Obsessive-compulsive Personality Disorders: Findings from the Collaborative Longitudinal Personality Disorders Study	4,866	17
(Suominen et al. 2000)	Suicide Attempts and Personality Disorder	3,235	20
(Svrakic et al. 2002)	Temperament, Character, and Personality Disorders: Etiologic, diagnostic, treatment issues	3,511	31
(Tyrer 2002)	Nidotherapy: A new approach to the treatment of personality disorder	2,053	9
	TOTAL	**30,743**	

Issues in corpus creation

Once the articles had been chosen for the corpus it was necessary to render them all into Rich Text Format required by Wordsmith Tools. The entire 1950's corpus and most of the 1970's articles required scanning and amalgamation into Word documents. These were then initially checked against a paper copy of the original to correct the scanning mistakes then spell-checked and irregularities checked against the paper copy. If the error was a misspelling in the original text then, if the

meaning was unambiguous, it was changed so that Wordsmith Tools could find it (eg *mechanism* for *mechansim* in Kennedy 1954 p 875).

As a final check of accuracy a random sample of five papers from each corpus was sent to external checkers who checked them against the paper original, they were told to mark every difference in text. An average of 1 error per 1000 words were picked up at this stage.

In order to focus on the language around *personality disorder* or *psychopathy* the following operations were performed on the scanned and corrected documents:

Title and authors names were retained

Addresses of authors were removed

References and acknowledgements were removed

The content of tables and figures were largely removed, only titles of tables and figures were retained along with any textual part of a table that was not simply a category. This was not felt to affect the overall distribution of language and discourses as the tables or figures were generally discussed within the text

Formatting such as Italics and Bold were lost

Appendices were retained if they were discursive, for example the rules of an establishment or essentials of a therapy, not if they were data tables.

Paragraphs were retained in the word version

The resulting word version was then converted to Rich Text Format (RTF).

Tagging

Clearly some of the formatting and sectioning of the original articles was lost in the conversion to a form that could be read by the concordance software. However

it was felt useful to try to retain an idea of where particular language appeared in the different sections of an article, accordingly a tagging scheme was developed. This enabled Wordsmith Tools to recognise particular parts of the text marked by the tagging scheme, such as headings, appendices, case histories, tables, abstracts, quotes, author name and body of text. The full tagging scheme is available on demand.

Corpus References

Allen, C. 1958. Psychopathic Personality. *British Medical Journal* 1: 1003-1004.

American Psychiatric Association. 2000. *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision.* 4th Edition, Text Revision ed. Washington, DC: American Psychiatric Association.

Anon. 1958. Inadequate Personality. *British Medical Journal* 2: 808.

Bartholomew, A. 1958. Psychopathic Personality. *British Medical Journal* 1: 219-220.

Bateman, A., & Fonagy, P. 2000. Effectiveness of Psychotherapeutic Treatment of Personality Disorder. *British Journal of Psychiatry* 177: 138-143.

Bennett, C. 2002. Personality Disorder. *British Journal of Psychiatry* 181: 76.

Bradley, R., Kegley Heim, A., & Westen, D. 2005. Transference patterns in the psychotherapy of personality disorders: empirical investigation. *British Journal of Psychiatry* 186: 342-349.

Chiesa, M., & Fonagy, P. 2000. Cassel Personality Disorder Study: Methodology and treatement effects. *British Journal of Psychiatry* 176: 485-491.

Clarke, A., & Clarke, A. 1959. Personality Disorder and Dullness. *Lancet*: 988.

Coid, J. 1999. Aetiological Risk Factors for Personality Disorders. *British Journal of Psychiatry* 174: 530-538.

Coid, J. 2003. Epidemiology, Public Health and the Problem of Personality Disorder. *British Journal of Psychiatry* 182 (44): 3-10.

Coid, J., Yang, M., Tyrer, P., Roberts, A., & Ullrich, S. 2006. Prevalence and Correlates of Personality Disorder in Great Britain. *British Journal of Psychiatry* 188: 423-431.

Craft, M. 1959. Personality Disorder and Dullness. *The Lancet*: 856-858.

Crawford, M. 2007. Can Deficits in Social Problem-solving in People with Personality Disorder be Reversed? *British Journal of Psychiatry* 190: 283-284.

Davidson, G. 1956. The Symdrome of Oligothymia (Psychopathy). *The Journal of Nervous and Mental Disease* 124 (2): 156-162.

Davies, S., & Campling, P. 2003. Therapeutic Community Treatment of Personality Disorder: Service use and mortality over 3 years follow up. *British Journal of Psychiatry* 182 Supplement 44: 24-27.

Davis, D. 1950. A Case of Schizosis with Dual Personality. *Journal of Mental Science* 96 (405): 1008-1014.

Diethelm, O. 1960. A Clinical Consideration of Psychopathic Personalities. *Journal of Mental Science* 106 (444): 906-911.

Eysenck, H. 1951. Neuroticism in Twins. *Eugenics Review* XLIII: 79-82.

Foulds, G. 1959. The Relative Stability of Personality Measures Compared with Diagnostic Measures. *Journal of Mental Science* 105 (440): 783-787.

Foulds, G. 1971. Personality Deviance and Personal Symptomatology. *Psychological Medicine* 1: 222-233.

Foulds, G., & Caine, T. 1958. Psychoneurotic Symptom Clusters Trait Clusters and Psychological Tests. *Journal of Mental Science* 104 (436): 722-731.

Foulds, G., & Caine, T. 1959. Symptom Clusters and Personality Types among Psychoneurotic Men Compared with Women. *Journal of Mental Science* 105 (439): 469-475.

Gibbens, T. 1961. Treatment of Psychopaths. *Journal of Mental Science* 107 (446): 181-186.

Gunn, J., & Robertson, G. 1976. Psychopathic Personality: A conceptual problem. *Psychological Medicine* 6: 631-634.

Hill, J., Fudge, H., Harrington, R., Pickles, A., & Rutter, M. 2000. Complementary Approaches to the Assessment of Personality Disorder: The Personality Assessment Schedule and Adult Personality Functioning Assessment compared. *British Journal of Psychiatry* 176: 434-439.

Hordern, A. 1952. The Response of the Neurotic Personality to Abreaction. *Journal of Mental Science* 98 (413): 630-639.

Huband, N., McMurran, M., Evans, C., & Duggan, C. 2007. Social Problem-solving Plus Psychoeducation for Adults with Personality Disorder: Pragmatic randomised controlled trial trial. *British Journal of Psychiatry* 190: 307-313.

Kendell, R. 2002a. The Distinction Between Personality Disorder and Mental Illness. *The British Journal of Psychiatry* 180: 110-115.

Kendell, R. 2002b. Personality Disorder. *British Journal of Psychiatry* 181: 77-78.

Kennedy, A. 1954. Psychopathic Personality and Social Responsibility. *Journal of Mental Science* 100 (421): 873-881.

Knox, J. 1960. The Inadequate Psychopath at Camp Hill Prison. *Journal of Mental Science* 106 (445): 1471-1474.

Lewis, A. 1974. Psychopathic Personality: A most elusive category. *Psychological Medicine* 4: 133-40.

Liss, J., Welner, A., & Robins, E. 1973. Personality Disorder. 1. Record Study. *British Journal of Psychiatry* 123 (577): 685-692.

Maddocks, P. 1970. A Five Year Follow-up of Untreated Psychopaths. *British Journal of Psychiatry* 116: 511-515.

McGlashan, T., Grilo, C., Skodol, A., Gunderson, J., Shea, M., Morey, L., Zanarini, M., & Stout, R. 2000. The Collaborative Longitudinal Personality Disorders Study: Baseline Axis I/II and II/III diagnostic co-occurrance. *Acta Psychiatrica Scandinavica* 102: 256-264.

Monro, A. 1955. Psychiatric Types: A Q-Technique study of 200 patients. *Journal of Mental Science* 101 (99): 330-343.

Monro, A. 1959. The Inadequate Personality in Psychiatric Practice. *Journal of Mental Science* 105 (438): 44-50.

Moran, P., Coffey, C., Mann, A., Carlin, J., & Patton, G. 2006. Dimensional Characteristics of DSM-IV Personality Disorders in a Large Epidemiological Sample. *Acta Psychiatrica Scandinavica* 113: 233-236.

Moran, P., Jenkins, R., Tylee, A., Blizard, R., & Mann, A. 2000. The Prevalence of Personality Disorder Among UK Primary Care Attenders. *Acta Psychiatrica Scandinavica* 102 (1): 52-57.

Mowbray, R. 1960. The Concept of the Psychopath. *Journal of Mental Science* 106 (443): 537-542.

Nielsen, J., & Tsuboi, T. 1970. Correlation Between Stature, Character Disorder and Criminality. *British Journal of Psychiatry* 116: 145-150.

Pagano, M., Skodol, A., Stout, R., Shea, M., Yen, S., Grilo, C., Sanislow, C., Bender, D., McGlashan, T., Zanarini, M., & Gunderson, J. 2004. Stressful Life Events as Predictors of Functioning: Findings from the Collaborative Longitudinal Personality Disorders Study. *Acta Psychiatrica Scandinavica* 110: 421-429.

Palmer, H. 1959. Psychopathic Personality - Definition and Use of the Term. *Lancet*: 40-41.

Parker, G., Hadzi-Pavlovic, D., Both, L., Kumar, S., Wihelm, K., & Olley , A. 2004. Measuring Disordered Personality Functioning: To love and to work reprised. *Acta Psychiatrica Scandinavica* 110 (3): 230-239.

Philip, A. 1970. Traits, Attitudes and Symptoms in a Group of Attempted Suicides. *British Journal of Psychiatry* 116: 475-482.

Pilgrim, D. 2002. Personality Disorder. *British Journal of Psychiatry* 181: 77.

Presly, A., & Walton, H. 1973. Dimensions of Abnormal Personality. *British Journal of Psychiatry* 122: 269-76.

Rees, L. 1950a. Body Build, Personality and Neurosis in Women. *Journal of Mental Science* 96 (402): 426-434.

Rees, L. 1950b. Body Size, Personality and Neurosis. *Journal of Mental Science* 96 (402): 168-180.

Rendu, A., Moran, P., Patel, A., Knapp, M., & Mann, A. 2002. Economic Impact of Personality Disorders in UK Primary Care Attenders. *British Journal of Psychiatry* 181: 62-66.

Roe, J. 1958. Psychopathic Personality. *British Medical Journal* 1: 1004.

Rollin, H. 1975. Psychological Medicine: Personality Disorders. *British Medical Journal* 1: 665-667.

Ryle, A. 2002. Personality Disorder. *British Journal of Psychiatry* 181: 76-77.

Samuels, J., Eaton, W., Bienvenue III, O., Brown, C., Costa Jr, P., & Nestadt, G. 2002. Prevalence and Correlates of Personality Disorder in a Community Sample. *British Journal of Psychiatry* 180: 536-542.

Sanislow, C., Morey, L., Grilo, C., Gunderson, J., Shea, M., Skodol, A., Stout, R., Zanarini, M., & McGlashan, T. 2002. Confirmatory Factor Analysis of DSM-IV Borderline, Schizotypal, Avoidant, and Obsessive-compulsive Personality Disorders: Findings from the Collaborative Longitudinal Personality Disorders Study. *Acta Psychiatrica Scandinavica* 105: 28-36.

Shepherd, M., & Sartorius, N. 1974. Personality Disorder and International Classification of Diseases. *Psychological Medicine* 4 (2): 141-146.

Smail, D. 1970. Neurotic Symptoms, Personality and Personal Constructs. *British Journal of Psychiatry* 117: 645-648.

Spence, S. 2001. Personality Disorder; Agency and Responsibility. *British Journal of Psychiatry* 176: 558.

Standage, K. 1979. The Use of Schneider's Typology for the Diagnosis of Personality Disorders - An Examination of Reliability. *British Journal of Psychiatry* 135: 238-42.

Stengel, E. 1958. Psychopathic Personality. *British Medical Journal* 1: 402.

Storms, L. 1958. Discrepancies Between Factor Analysis and Multivariate Discrimination Among Groups as Applied to Personality Theory. *Journal of Mental Science* 104 (436): 713-721.

Sturup, G. 1952. The Treatment of Psychopaths in Herstedvester. *British Journal of Medical Psychology* 25 (1): 31-38.

Suominen, K., Isometsa, E., Henriksson, M., Ostamo, A., & Lonnqvist, J. 2000. Suicide Attempts and Personality Disorder. *Acta Psychiatrica Scandinavica* 102 (2): 118-125.

Svrakic, D., Draganic, S., Hill, K., Bayon, C., Przybeck, T., & Cloniger, C. 2002. Temperament, Character, and Personality Disorders: Etiologic, diagnostic, treatment issues. *Acta Psychiatrica Scandinavica* 106: 189-195.

Thompson, R. 1958. Psychopathic Personality. *British Medical Journal* 1: 402.

Turner, C. 1958. Psychopathic Personality. *British Medical Journal* 1: 710.

Tyrer, P. 2001. Personality Disorder. *British Journal of Psychiatry* 179: 81-84.

Tyrer, P. 2002. Nidotherapy: A new approach to the treatment of personality disorder. *Acta Psychiatrica Scandinavica* 105: 469-471.

Tyrer, P., & Alexander, J. 1979a. Classification of Personality Disorder. *British Journal of Psychiatry* 135: 163-7.

Tyrer, P., Alexander, J., Cicchetti, D., Cohen, M., & Remington, M. 1979b. Reliability of a Schedule for Rating Personality Disorders. *British Journal of Psychiatry* 135: 168-74.

Tyrer, P., Duggan, C., & Coid, J. 2003. Ramifications of Personality Disorder in Clinical Practice. *British Journal of Psychiatry* 182 Supplement 44: 1-2.

Valenstein, A., Michaels, J., & Evje, M. 1951. Aspects of Character in the Neurotic Veteran. *Journal of Nervous and Mental Disease* 113 (1): 76-79.

Valenstein, A., Michaels, J., & Evje, M. 1953. Aspects of Character in the Neurotic Veteran. *Journal of Nervous and Mental Disease* 117 (5): 445-457.

Vihla, M. 1999. *Medical Writing: Modality in focus*. Edited by J. Aarts, & Meijs, W., *Language and Computers: Studies in practical linguistics*. Amsterdam: Rodolpi.

Vinoda, N. 1969. Personality and the Nature of Suicidal Attempts. *British Journal of Psychiatry* 115: 791-795.

Walton, H., Foulds, G., Littmann, S., & Presly, A. 1970. Abnormal Personality. *British Journal of Psychiatry* 116: 497-510.

Walton, H., & Presly, A. 1973. Use of a Category System in the Diagnosis of Abnormal Personality. *British Journal of Psychiatry* 122: 259-68.

Wellner, A., Liss, J., & Robins, E. 1974. Personality Disorder. 2. Follow-up. *British Journal of Psychiatry* 124: 329-366.

Whiteley, S. 1970. The Response of Psychopaths to a Therapeutic Community. *British Journal of Psychiatry* 116: 517-529.

World Health Organisation. 1992. *The ICD-10 Classification of Mental and Behavioural Disorders: Diagnostic criteria for research.* Geneva: World Health Organisation.

Appendix 5: 100 Most Frequent Words in Each Corpus

Freq. represents the total number of times the word occurs in the corpora
% represents the percentage of the corpus made up by the word
Texts represents the number of texts in which the word occurs at least once

1950's Corpus

N	Word	Freq.	%	Texts
1	THE	4910	5.95	30
2	OF	3565	4.32	30
3	AND	2392	2.90	30
4	TO	2257	2.73	30
5	IN	2022	2.45	29
6	A	1634	1.98	30
7	#	1552	1.88	28
8	IS	1081	1.31	30
9	THAT	871	1.05	29
10	WITH	758	0.92	29
11	AS	745	0.90	26
12	WAS	719	0.87	26
13	BE	695	0.84	29
14	FOR	654	0.79	27
15	IT	649	0.79	29
16	THIS	592	0.72	27
17	ARE	577	0.70	25
18	BY	547	0.66	28
19	OR	545	0.66	28
20	WHICH	508	0.62	25
21	HE	504	0.61	24
22	ON	421	0.51	27
23	NOT	417	0.50	29
24	WERE	391	0.47	23
25	PERSONALITY	380	0.46	29
26	HIS	376	0.46	26
27	FROM	315	0.38	28
28	AN	311	0.38	29
29	THEY	307	0.37	24
30	HAVE	304	0.37	26
31	AT	283	0.34	28
32	ONE	276	0.33	27
33	MAY	275	0.33	28
34	HAD	268	0.32	23
35	BUT	267	0.32	25
36	THEIR	264	0.32	23
37	TYPE	250	0.30	17
38	THERE	240	0.29	26
39	HAS	228	0.28	29
40	THESE	228	0.28	24
41	WHO	228	0.28	27
42	I	225	0.27	27
43	GROUP	223	0.27	25
44	WE	212	0.26	19
45	MORE	206	0.25	23

46	BEEN	198	0.24	26
47	BETWEEN	182	0.22	22
48	PATIENTS	179	0.22	19
49	SOME	177	0.21	25
50	SUCH	177	0.21	26
51	THAN	168	0.20	23
52	OTHER	164	0.20	24
53	CAN	162	0.20	22
54	SHE	162	0.20	6
55	WOULD	159	0.19	22
56	GROUPS	158	0.19	17
57	ALL	157	0.19	23
58	PATIENT	154	0.19	18
59	IF	142	0.17	24
60	NO	139	0.17	25
61	TWO	138	0.17	24
62	SO	137	0.17	23
63	SOCIAL	134	0.16	22
64	THOSE	133	0.16	24
65	TREATMENT	132	0.16	15
66	WHEN	132	0.16	21
67	HER	131	0.16	5
68	CASES	130	0.16	18
69	INTO	124	0.15	23
70	FOUND	119	0.14	23
71	STUDY	119	0.14	17
72	CASE	118	0.14	17
73	CLINICAL	116	0.14	21
74	TESTS	116	0.14	13
75	ONLY	115	0.14	22
76	PER	107	0.13	15
77	WILL	107	0.13	23
78	PSYCHOPATHIC	106	0.13	18
79	ALSO	104	0.13	23
80	VERY	104	0.13	19
81	TIME	102	0.12	21
82	WELL	102	0.12	20
83	BEHAVIOUR	101	0.12	19
84	ITS	101	0.12	19
85	CENT	99	0.12	13
86	MANY	98	0.12	23
87	MENTAL	98	0.12	22
88	TEST	98	0.12	12
89	DO	96	0.12	25
90	EACH	96	0.12	18
91	FIRST	96	0.12	22
92	AFTER	94	0.11	19
93	PSYCHOPATH	94	0.11	14
94	HOWEVER	92	0.11	23
95	OUT	92	0.11	22
96	OFTEN	91	0.11	19
97	OUR	91	0.11	13
98	ABOUT	90	0.11	20
99	GENERAL	90	0.11	21
100	OTHERS	90	0.11	20

1970's Corpus

N	Word	Freq.	%	Texts
1	THE	3953	5.67	19
2	OF	3002	4.30	19
3	#	2154	3.09	19
4	AND	1927	2.76	19
5	IN	1622	2.33	19
6	TO	1493	2.14	19
7	A	1347	1.93	19
8	PERSONALITY	740	1.06	17
9	IS	689	0.99	19
10	WITH	588	0.84	19
11	FOR	581	0.83	19
12	WAS	578	0.83	19
13	BE	562	0.81	19
14	THAT	543	0.78	19
15	AS	534	0.77	19
16	OR	501	0.72	19
17	WERE	497	0.71	19
18	ARE	496	0.71	19
19	PATIENTS	450	0.65	18
20	THIS	418	0.60	19
21	BY	392	0.56	19
22	NOT	355	0.51	19
23	ON	343	0.49	19
24	IT	325	0.47	19
25	FROM	299	0.43	19
26	WHICH	295	0.42	18
27	DISORDER	294	0.42	15
28	GROUP	288	0.41	17
29	AN	252	0.36	19
30	HAD	235	0.34	17
31	PSYCHIATRIC	234	0.34	18
32	AT	230	0.33	19
33	MORE	228	0.33	19
34	ONE	227	0.33	19
35	I	226	0.32	19
36	HE	224	0.32	16
37	BUT	210	0.30	18
38	WHO	210	0.30	19
39	THESE	204	0.29	19
40	HAVE	200	0.29	18
41	TYPE	198	0.28	15
42	OTHER	183	0.26	19
43	THEY	181	0.26	18
44	THAN	180	0.26	19
45	HIS	178	0.26	15
46	TABLE	178	0.26	16
47	ALL	177	0.25	18
48	TWO	177	0.25	19
49	PATIENT	169	0.24	17
50	THEIR	162	0.23	19
51	STUDY	160	0.23	15
52	SYMPTOMS	157	0.23	14
53	BEEN	155	0.22	19
54	THERE	155	0.22	18

55	PER	153	0.22	13
56	CENT	150	0.22	12
57	MAY	150	0.22	19
58	SOME	150	0.22	18
59	DIAGNOSIS	149	0.21	16
60	ILLNESS	148	0.21	14
61	BETWEEN	143	0.21	19
62	BEHAVIOUR	141	0.20	17
63	HAS	137	0.20	18
64	PSYCHIATRISTS	134	0.19	15
65	DISORDERS	126	0.18	13
66	ABNORMAL	123	0.18	11
67	ONLY	121	0.17	19
68	UP	117	0.17	14
69	WHEN	112	0.16	17
70	MOST	111	0.16	18
71	NO	110	0.16	19
72	HOSPITAL	109	0.16	14
73	CAN	104	0.15	18
74	GROUPS	104	0.15	15
75	DIAGNOSTIC	100	0.14	12
76	FOUND	100	0.14	18
77	II	100	0.14	17
78	ALSO	99	0.14	18
79	IF	99	0.14	19
80	SOCIAL	99	0.14	16
81	SUCH	99	0.14	18
82	PRESENT	98	0.14	15
83	THREE	98	0.14	17
84	FACTORS	95	0.14	11
85	FIRST	95	0.14	17
86	TYPES	95	0.14	13
87	BOTH	94	0.13	18
88	EACH	94	0.13	17
89	THOSE	94	0.13	19
90	WOULD	93	0.13	16
91	AGREEMENT	91	0.13	10
92	ANY	88	0.13	18
93	CLASSIFICATION	88	0.13	14
94	OUT	88	0.13	16
95	AGE	87	0.12	14
96	USED	87	0.12	15
97	ABOUT	84	0.12	16
98	TREATMENT	83	0.12	12
99	E	81	0.12	14
100	FACTOR	80	0.11	13

2000's Corpus

N	Word	Freq.	%	Texts
1	THE	4470	4.77	29
2	#	4206	4.49	29
3	OF	3585	3.83	29
4	AND	2836	3.03	29
5	TO	1909	2.04	29
6	IN	1837	1.96	29
7	A	1506	1.61	29
8	PERSONALITY	1359	1.45	29
9	WITH	1080	1.15	29
10	DISORDER	974	1.04	29
11	FOR	955	1.02	29
12	THAT	766	0.82	29
13	WERE	736	0.79	25
14	IS	691	0.74	29
15	DISORDERS	651	0.69	28
16	WAS	623	0.66	25
17	OR	561	0.60	29
18	AS	540	0.58	28
19	BE	490	0.52	29
20	ARE	474	0.51	29
21	ON	474	0.51	28
22	BY	473	0.50	29
23	THIS	453	0.48	29
24	FROM	378	0.40	29
25	NOT	378	0.40	29
26	HAVE	343	0.37	28
27	TREATMENT	329	0.35	26
28	PATIENTS	310	0.33	26
29	STUDY	308	0.33	22
30	IT	301	0.32	29
31	ET	283	0.30	22
32	AL	281	0.30	22
33	BETWEEN	280	0.30	27
34	THESE	269	0.29	26
35	SUBJECTS	263	0.28	16
36	AN	262	0.28	28
37	DSM	262	0.28	24
38	AT	252	0.27	26
39	MORE	248	0.26	29
40	WHICH	244	0.26	28
41	WE	238	0.25	24
42	SAMPLE	229	0.24	19
43	TWO	205	0.22	24
44	AXIS	204	0.22	20
45	CLINICAL	202	0.22	25
46	THAN	201	0.21	24
47	HEALTH	198	0.21	23
48	MAY	197	0.21	27
49	BEEN	194	0.21	28
50	MENTAL	191	0.20	25
51	HAD	190	0.20	24
52	THEIR	190	0.20	25
53	CLUSTER	186	0.20	14
54	NON	186	0.20	22

55	ONE	182	0.19	25
56	GROUP	181	0.19	22
57	HAS	179	0.19	29
58	STUDIES	174	0.19	23
59	SOCIAL	172	0.18	24
60	I	168	0.18	26
61	MODEL	166	0.18	16
62	WHO	166	0.18	25
63	ALL	165	0.18	26
64	BUT	165	0.18	27
65	OTHER	163	0.17	27
66	PATIENT	162	0.17	21
67	THOSE	162	0.17	26
68	II	161	0.17	17
69	IV	159	0.17	19
70	P	158	0.17	19
71	SCORES	151	0.16	12
72	THEY	151	0.16	26
73	THERE	148	0.16	23
74	FACTOR	147	0.16	15
75	FACTORS	146	0.16	16
76	MOST	144	0.15	22
77	TABLE	144	0.15	18
78	PD	141	0.15	6
79	CRITERIA	137	0.15	21
80	FUNCTIONING	137	0.15	16
81	BASED	135	0.14	24
82	OVER	135	0.14	26
83	OUR	133	0.14	19
84	PSYCHIATRIC	133	0.14	24
85	BOTH	132	0.14	26
86	EACH	131	0.14	21
87	DATA	130	0.14	20
88	FOUR	130	0.14	20
89	OUT	130	0.14	25
90	DIAGNOSTIC	129	0.14	21
91	THREE	129	0.14	22
92	BORDERLINE	127	0.14	23
93	NO	127	0.14	24
94	RESULTS	126	0.13	22
95	ASSOCIATED	125	0.13	22
96	SUCH	124	0.13	26
97	GROUPS	123	0.13	18
98	ALSO	122	0.13	27
99	SELF	122	0.13	22
100	BPD	120	0.13	6

Note: # represents all variations of numerals in the Wordsmith Tools Program output, individual numbers are not considered separately

Appendix 6: Commonest nouns in the diachronic corpora

	1950's CORPUS			1970's CORPUS			2000's CORPUS		
	NOUN	FREQUENCY	Hits/1000	NOUN	FREQUENCY	Hits/1000	NOUN	FREQUENCY	Hits/1000
1	personality	380	4.602	personality	740	10.611	personality	1359	14.505
2	one	276	3.342	patients	450	6.452	disorder	974	13.966
3	type	250	3.028	disorder	294	4.216	disorders	651	9.335
4	group	223	2.701	group	288	4.13	treatment	329	4.717
5	patients	179	2.168	one	227	3.255	patients	310	4.445
6	groups	158	1.913	type	198	2.839	study	308	4.416
7	patient	154	1.865	table	177	2.538	subjects	263	3.771
8	two	138	1.671	two	177	2.538	DSM	262	3.757
9	treatment	132	1.599	patient	169	2.423	sample	229	3.284
10	cases	130	1.574	study	160	2.294	two	205	2.939
11	study	119	1.441	symptoms	157	2.251	axis	204	2.925
12	case	118	1.429	diagnosis	149	2.136	health	198	2.839
13	tests	116	1.405	illness	148	2.122	cluster	186	2.667
14	time	102	1.235	behaviour	141	2.022	one	182	2.61
15	behaviour	101	1.223	psychiatrists	134	1.921	group	181	2.595
16	test	98	1.187	disorders	126	1.807	studies	174	2.495
17	psychopath	94	1.138	hospital	109	1.563	model	166	2.38
18	types	87	1.054	groups	104	1.491	patient	162	2.323
19	body	84	1.017	three	98	1.405	scores	151	2.165
20	life	84	1.017	factors	95	1.362	factor	147	2.108
21	hospital	83	1.005	types	95	1.362	factors	146	2.093
22	work	83	1.005	agreement	91	1.305	table	144	2.065
23	results	82	0.993	classification	88	1.262	PD	141	2.022
24	data	81	0.981	age	87	1.247	criteria	137	1.964
25	diagnosis	81	0.981	treatment	83	1.19	functioning	137	1.964
26	symptoms	81	0.981	factor	80	1.147	data	130	1.864
27	self	78	0.945	years	80	1.147	four	130	1.864
28	factor	74	0.896	time	79	1.133	three	129	1.85
29	three	74	0.896	admission	78	1.118	results	126	1.807
30	table	73	0.884	items	79	1.133	groups	123	1.764
31	years	73	0.884	reliability	77	1.104	self	122	1.749
32	state	72	0.872	traits	75	1.075	BPD	120	1.721
33	character	69	0.836	women	75	1.075	suicide	119	1.706
34	terms	69	0.836	diagnoses	73	1.047	years	116	1.663
35	fact	67	0.811	scores	71	1.018	prevalence	111	1.592
36	traits	67	0.811	psychopaths	70	1.004	subject	111	1.592
37	psychopathy	66	0.799	scale	65	0.932	risk	106	1.52
38	factors	65	0.787	category	64	0.918	research	104	1.491
39	differences	63	0.763	people	64	0.918	life	103	1.477
40	men	63	0.763	results	64	0.918	analysis	102	1.463
41	number	62	0.751	terms	64	0.918	assessment	100	1.434
42	analysis	61	0.739	level	63	0.903	events	97	1.391
43	age	59	0.715	relationships	63	0.903	outcome	95	1.362
44	man	59	0.715	degree	62	0.889	costs	92	1.319
45	measures	56	0.678	personalities	62	0.889	informant	91	1.305
46	problem	56	0.678	categories	61	0.875	diagnosis	90	1.29
47	intelligence	55	0.666	criteria	61	0.875	time	90	1.29
48	service	55	0.666	number	61	0.875	people	89	1.276
49	individual	54	0.654	attempts	60	0.86	categories	88	1.262
50	people	54	0.654	year	60	0.86	problem	88	1.262
51	psychopaths	54	0.654	men	58	0.832	diagnoses	85	1.219
52	anxiety	53	0.642	analysis	57	0.817	findings	85	1.219

Appendix 7: Comparison of two word clusters

N	Word 1950's	Freq.	Texts	Word 1970's	Freq.	Texts	Word 2000's	Freq.	Texts
1	OF THE	723	28	OF THE	623	19	# #	1118	22
2	IN THE	470	25	IN THE	468	19	PERSONALITY DISORDER	720	29
3	TO THE	280	27	# #	370	19	OF THE	635	28
4	IT IS	223	27	TO THE	186	19	IN THE	417	28
5	TO BE	209	27	PERSONALITY DISORDER	185	11	PERSONALITY DISORDERS	366	27
6	# #	180	18	TO BE	183	19	OF PERSONALITY	336	29
7	AND THE	176	25	PER CENT	150	12	ET AL	281	22
8	WITH THE	168	25	# PER	145	12	AL #	276	22
9	THAT THE	167	26	ON THE	126	18	# AND	235	25
10	ON THE	158	21	THAT THE	119	19	TO THE	204	28
11	OF A	153	24	AND THE	113	19	FOR THE	179	27
12	FOR THE	142	24	FOR THE	108	18	TO BE	172	28
13	IN A	138	23	OF #	107	18	AND THE	150	28
14	AS A	117	21	WITH THE	106	19	P #	147	16
15	HE WAS	116	6	OF A	105	19	OF #	146	22
16	BY THE	114	25	OF PERSONALITY	104	16	ON THE	143	24
17	MAY BE	107	24	AND #	102	17	TABLE #	140	18
18	FROM THE	100	24	# AND	95	17	AND #	137	22
19	THE PATIENT	99	14	PERSONALITY DISORDERS	94	12	DSM IV	134	17
20	PER CENT	98	13	THE #	93	14	IT IS	124	25
21	# PER	93	12	IT IS	90	18	WITH PERSONALITY	118	23
22	OF #	89	18	FROM THE	84	19	THAT THE	116	23
23	THERE IS	83	24	WITH A	84	19	WITH THE	114	27
24	# AND	82	19	ABNORMAL PERSONALITY	83	8	# THE	113	22
25	THEY ARE	80	15	AS A	81	16	AXIS II	108	14
26	AND #	74	17	IN A	81	15	N #	104	11
27	IS A	74	23	BY THE	80	15	# P	98	16
28	IN THIS	73	24	THE SAME	71	18	ASSOCIATED WITH	96	22
29	IT WAS	73	20	FOLLOW UP	69	4	PATIENTS WITH	96	20
30	TYPE #	71	4	MAY BE	69	17	# OF	94	19
31	THE SAME	70	16	THE PATIENTS	69	13	# YEARS	94	22
32	TO A	70	21	THE PATIENT	66	13	DISORDER AND	94	23
33	OF THIS	65	19	PATIENTS WITH	65	13	FROM THE	94	24
34	AT THE	64	19	TO A	64	17	BY THE	92	25
35	CAN BE	63	19	IN THIS	63	16	AXIS I	86	17
36	IS NOT	62	18	# THE	60	15	BASED ON	86	21
37	HAS BEEN	61	18	OF THIS	58	14	IN A	86	25
38	IN #	60	14	THE PERSONALITY	57	13	AS A	85	23
39	THAT HE	60	10	CAN BE	54	17	THE #	85	19
40	HAVE BEEN	58	21	# PATIENTS	53	9	IN THIS	83	25

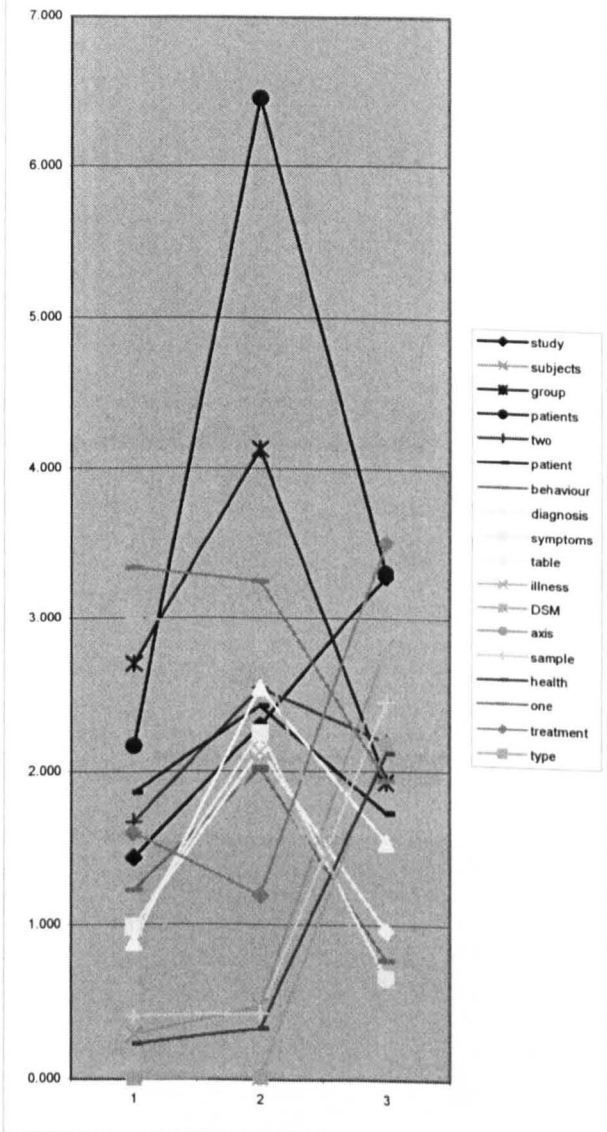
Appendix 8: Trends in Most Frequent Nouns across the Corpora

WORD and TREND	1950's corpus		1970's corpus		2000's corpus	
	Frequency	Hits/1000	Frequency	Hits/1000	Frequency	Hits/1000
Up up						
personality	380	4.602	740	10.611	1359	14.505
study	119	1.441	160	2.294	308	3.287
factor	74	0.896	80	1.147	147	1.569
years	73	0.884	80	1.147	116	1.238
factors	65	0.787	95	1.362	146	1.558
people	54	0.654	64	0.918	89	0.950
disorder	44	0.533	294	4.216	974	10.396
disorders	31	0.375	126	1.807	651	6.948
scores	34	0.412	71	1.018	151	1.612
categories	19	0.230	61	0.875	88	0.939
criteria	18	0.218	61	0.875	137	1.462
subjects	24	0.291	33	0.473	263	2.807
cluster	22	0.266	48	0.688	186	1.985
model	1	0.012	27	0.387	166	1.772
PD	1	0.012	35	0.502	141	1.505
four	35	0.424	55	0.789	130	1.387
suicide	17	0.206	48	0.688	119	1.270
subject	32	0.388	51	0.731	111	1.185
risk	6	0.073	21	0.301	106	1.131
assessment	4	0.048	17	0.244	100	1.067
outcome	8	0.097	35	0.502	95	1.014
informant	0	0.000	24	0.344	91	0.971
Up same						
three	74	0.896	98	1.405	129	1.377
number	62	0.751	61	0.875	77	0.822
diagnoses	0	0.000	73	1.047	85	0.907
year	26	0.315	60	0.860	82	0.875
Up down						
group	223	2.701	288	4.130	181	1.932
patients	179	2.168	450	6.452	310	3.309
two	138	1.671	177	2.538	205	2.188
patient	154	1.865	169	2.423	162	1.729
behaviour	101	1.223	141	2.022	72	0.768
types	87	1.054	95	1.362	18	0.192
hospital	83	1.005	109	1.563	62	0.662
diagnosis	81	0.981	149	2.136	90	0.961
symptoms	81	0.981	157	2.251	61	0.651
table	73	0.884	177	2.538	144	1.537
terms	69	0.836	64	0.918	44	0.470
traits	67	0.811	75	1.075	78	0.832
men	63	0.763	58	0.832	38	0.406
women	46	0.557	75	1.075	27	0.288
age	59	0.715	87	1.247	70	0.747
psychopaths	54	0.654	70	1.004	0	0.000
illness	52	0.630	148	2.122	53	0.566
psychiatrists	29	0.351	134	1.921	68	0.726
agreement	16	0.194	91	1.305	69	0.736
classsification	51	0.618	88	1.262	38	0.406
admission	19	0.230	78	1.118	41	0.438
items	16	0.194	79	1.133	64	0.683
reliability	5	0.061	77	1.104	33	0.352
scale	30	0.363	65	0.932	68	0.726
category	15	0.182	64	0.918	29	0.310
level	40	0.484	63	0.903	67	0.715
relationships	21	0.254	63	0.903	51	0.544
degree	52	0.630	62	0.889	29	0.310
personalities	38	0.460	62	0.889	10	0.107
attempts	11	0.133	60	0.860	40	0.427
anxiety	53	0.642	57	0.817	32	0.342
Same up						
results	82	0.993	64	0.918	126	1.345
analysis	61	0.739	57	0.817	102	1.089

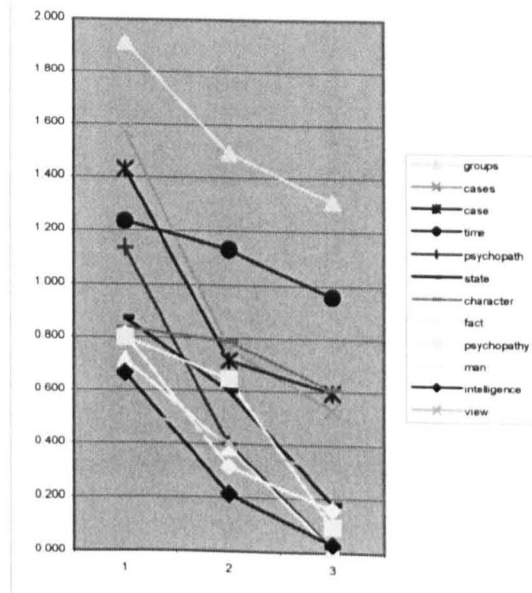
DSM	0	0.000	1	0.014	262	2.796
axis	0	0.000	1	0.014	204	2.177
sample	34	0.412	30	0.430	229	2.444
health	19	0.230	23	0.330	198	2.113
studies	38	0.460	34	0.488	174	1.857
functioning	4	0.048	6	0.086	137	1.462
BPD	0	0.000	0	0.000	120	1.281
prevalence	0	0.000	3	0.043	111	1.185
research	22	0.266	19	0.272	104	1.110
events	6	0.073	2	0.029	97	1.035
costs	0	0.000	0	0.000	92	0.982
Same same						
		0.000		0.000		0.000
Same down						
one	276	3.342	227	3.255	182	1.942
Down up						
treatment	132	1.599	83	1.190	329	3.511
tests	116	1.405	17	0.244	40	0.427
test	98	1.187	14	0.201	68	0.726
life	84	1.017	25	0.358	103	1.099
data	81	0.981	22	0.315	130	1.387
self	78	0.945	41	0.588	122	1.302
differences	63	0.763	36	0.516	60	0.640
measures	56	0.678	35	0.502	75	0.800
problem	56	0.678	17	0.244	88	0.939
service	55	0.666	3	0.043	79	0.843
individual	54	0.654	39	0.559	60	0.640
findings	38	0.460	15	0.215	85	0.907
Down same						
body	84	1.017	2	0.029	1	0.011
work	83	1.005	38	0.545	55	0.587
Down down						
type	250	3.028	198	2.839	22	0.235
groups	158	1.913	104	1.491	123	1.313
cases	130	1.574	53	0.760	50	0.534
case	118	1.429	50	0.717	56	0.598
time	102	1.235	79	1.133	90	0.961
psychopath	94	1.138	28	0.401	2	0.021
state	72	0.872	42	0.602	17	0.181
character	69	0.836	55	0.789	57	0.608
fact	67	0.811	22	0.315	15	0.160
psychopathy	66	0.799	45	0.645	9	0.096
man	59	0.715	27	0.387	1	0.011
intelligence	55	0.666	15	0.215	3	0.032
view	45	0.545	28	0.401	28	0.299

Appendix 9: Plots of Noun Trends across the Corpora

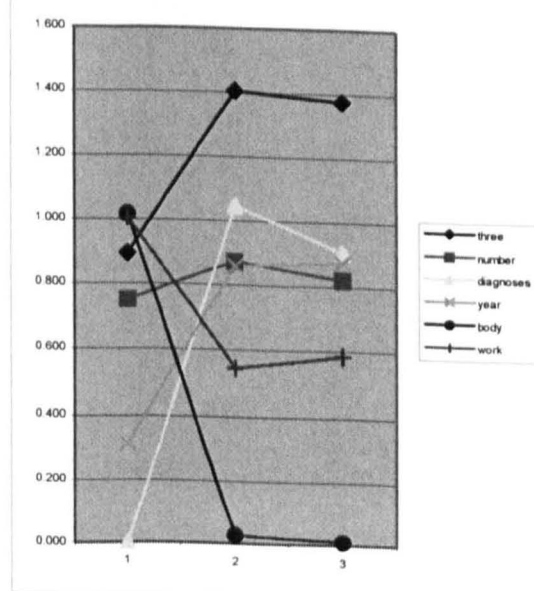
Graph 1: Noun changes over 2 hits/1000, omitting personality, disorder/s



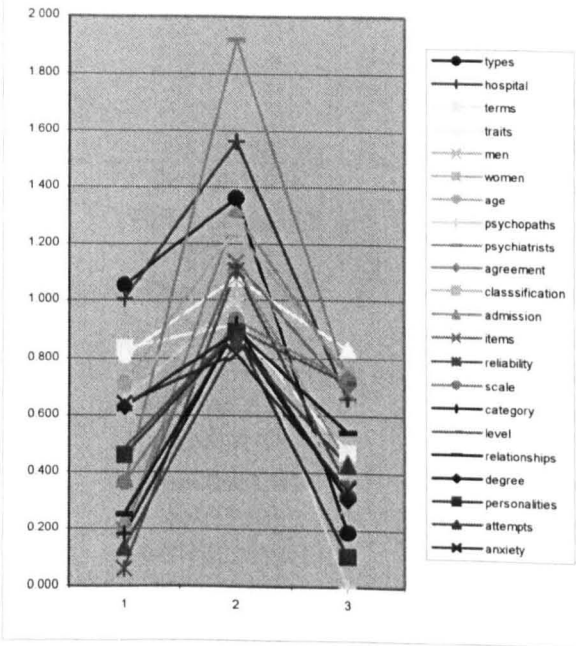
Graph 2: Nouns decreasing in frequency exluding those above 2 hits/1000



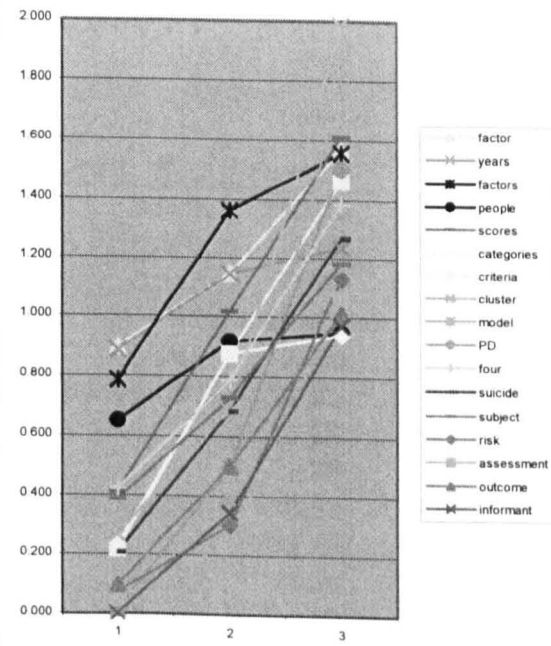
Graph 3: All other trends in first 50 nouns excluding those above 2 hits/1000



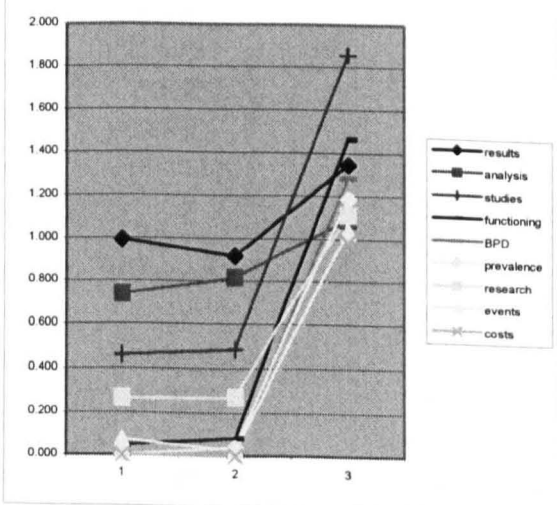
Graph 4: Nouns peaking in 1970's excluding those above 2 Hits/1000



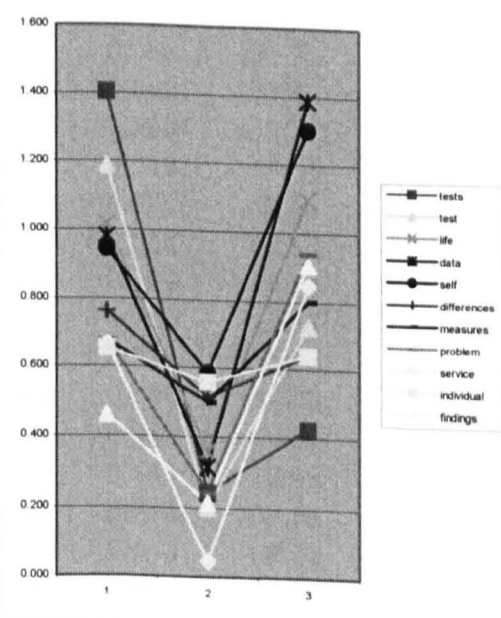
Graph 5: Nouns with increasing frequency excluding those above 2 Hits/1000



Graph 6: Nouns rising in frequency in 2000's only, exluding those above 2 Hits/1000



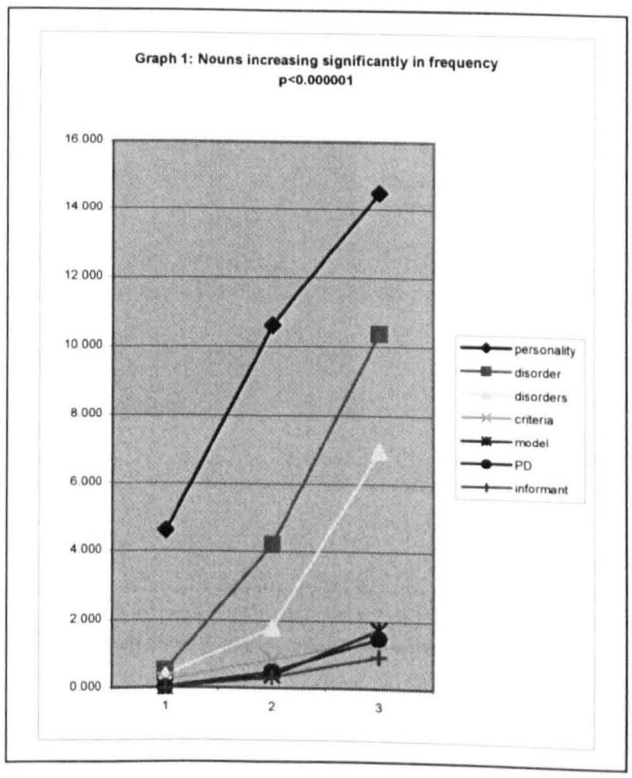
Graph 7: Nouns dipping in frequency in 1970's excluding those above 2 hits/1000

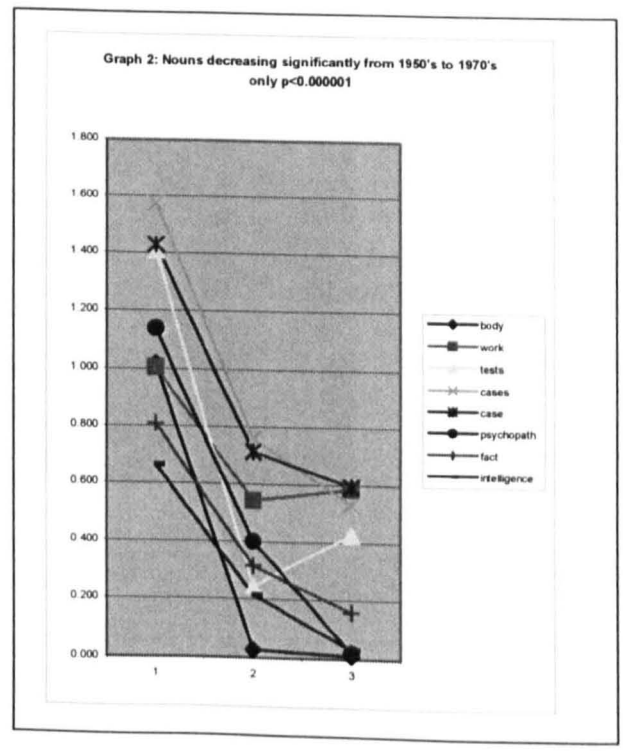


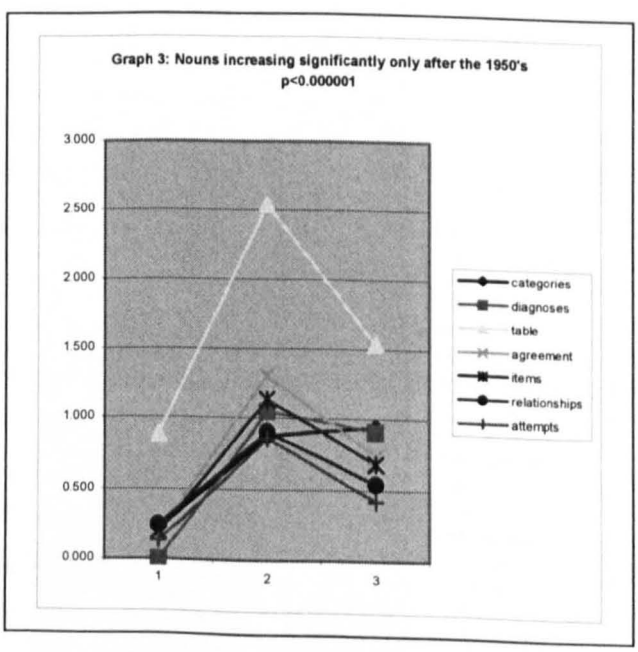
Appendix 10: Extract from keyword list for 1970's corpus compared to 1950's corpus using Log Likelihood Test with p<0.000001

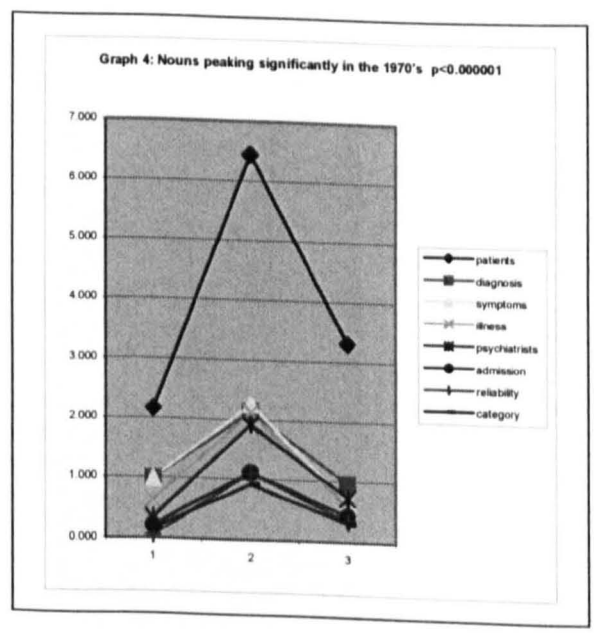
Key word	Freq. in 1970's	%	Freq. in 1950's	%	Keyness
DISORDER	294	0.422	44	0.053	252.29
PERSONALITY	740	1.061	380	0.460	187.96
PATIENTS	450	0.645	179	0.217	171.62
DIAGNOSES	73	0.105	0		114.09
PSYCHIATRIC	234	0.336	80	0.097	107.36
PSYCHIATRISTS	134	0.192	29	0.035	92.32
RELIABILITY	77	0.110	5		88.80
SEVERITY	51	0.073	0		79.70
DISORDERS	126	0.181	31	0.038	78.88
RATERS	50	0.072	0		78.14
AGREEMENT	91	0.131	16	0.019	71.53
ABNORMAL	123	0.176	34	0.041	69.80
ILLNESS	148	0.212	52	0.063	65.76
CASES	53	0.076	130	0.157	-47.80
SERVICE	3		55	0.067	-48.44
SCHIZOPHRENIC	0		31	0.038	-48.44
WAS	578	0.829	719	0.871	-48.84
SIZE	2		41	0.050	-50.34
WE	71	0.102	212	0.257	-51.78
TECHNIQUE	2		43	0.052	-53.28
TWINS	0		35	0.042	-54.69
TO	1493	2.141	2257	2.733	-55.77
TEST	14	0.020	98	0.119	-57.51
THEY	181	0.260	307	0.372	-57.85
BUILD	1		43	0.052	-58.87
BY	392	0.562	547	0.662	-58.94
WITH	588	0.843	758	0.918	-60.37
MAY	150	0.215	275	0.333	-61.63
IT	325	0.466	649	0.786	-62.46
ABREACTION	0		41	0.050	-64.07
TESTS	17	0.024	116	0.141	-66.98
THIS	418	0.599	592	0.717	-67.16
HE	224	0.321	504	0.610	-68.73
AS	534	0.766	745	0.902	-80.40
A	1347	1.931	1634	1.979	-99.35
BODY	2		84	0.102	-114.74
IN	1622	2.326	2022	2.449	-140.91
AND	1927	2.763	2392	2.897	-164.16
OF	3002	4.305	3565	4.317	-198.83
THE	3953	5.668	4910	5.946	-348.73

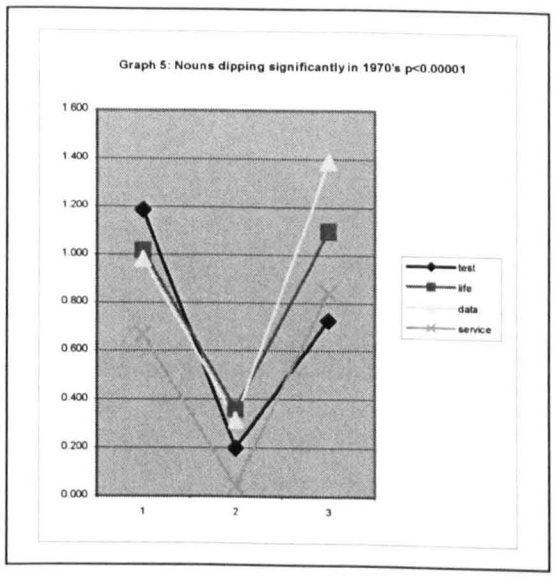
Appendix 11: Plot of trends in noun frequencies at significance p<0.000001

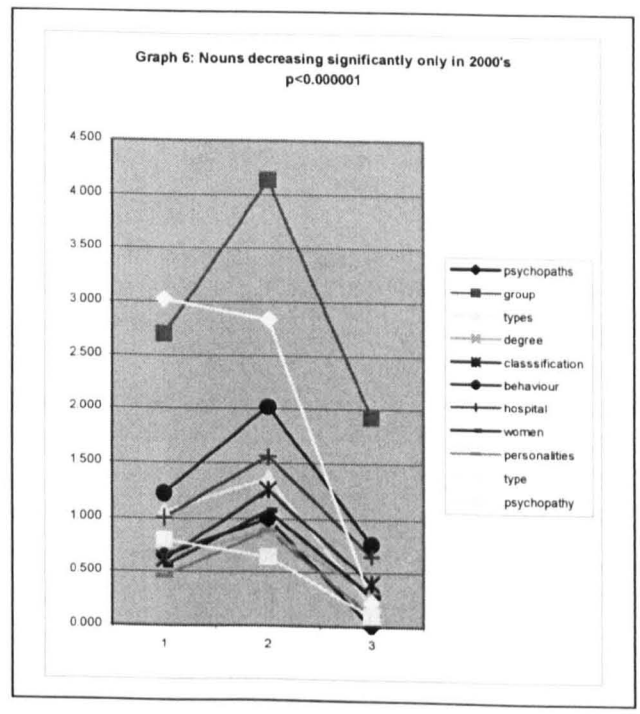


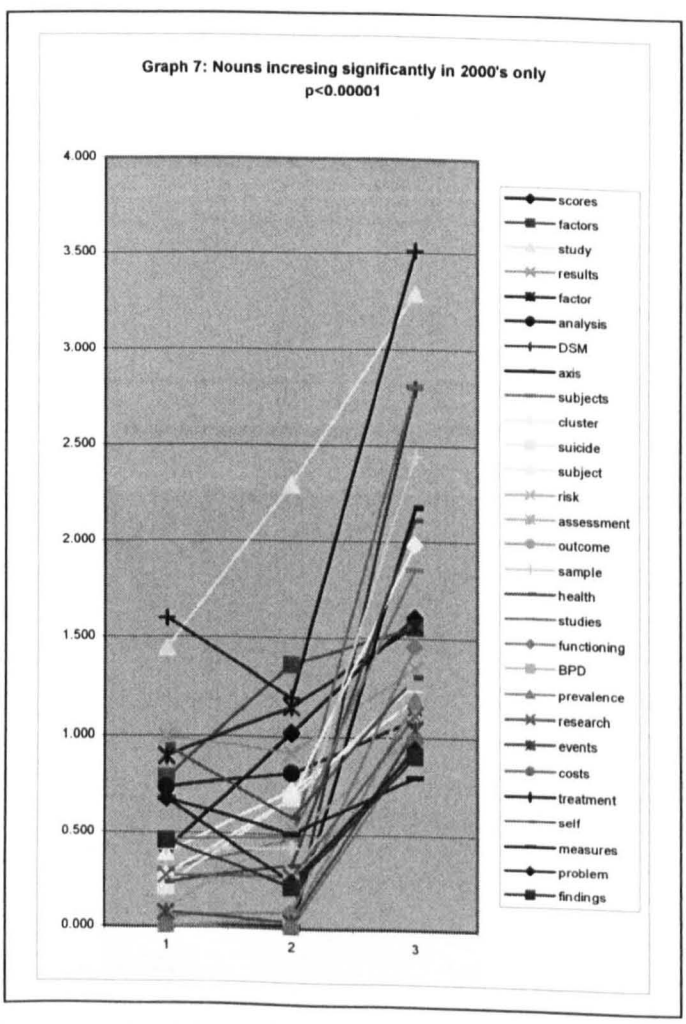


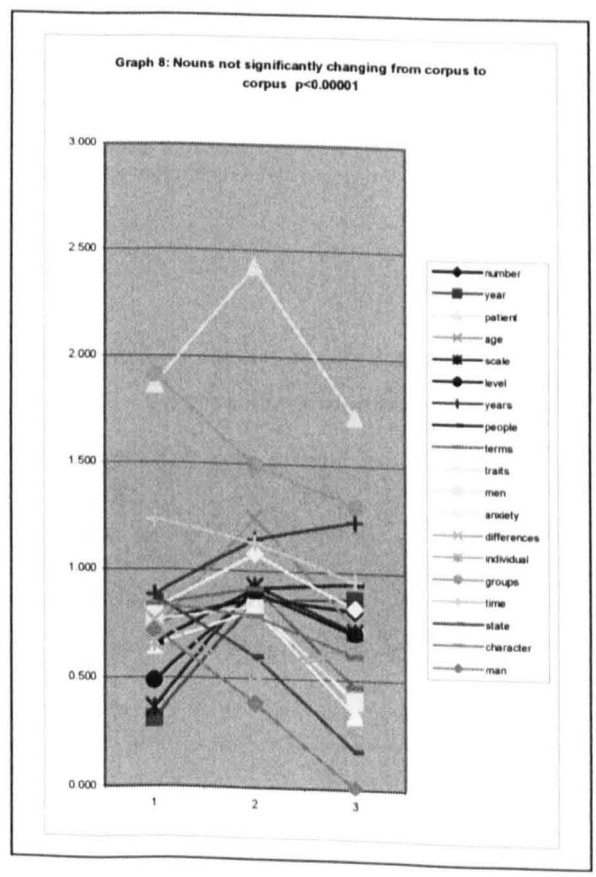




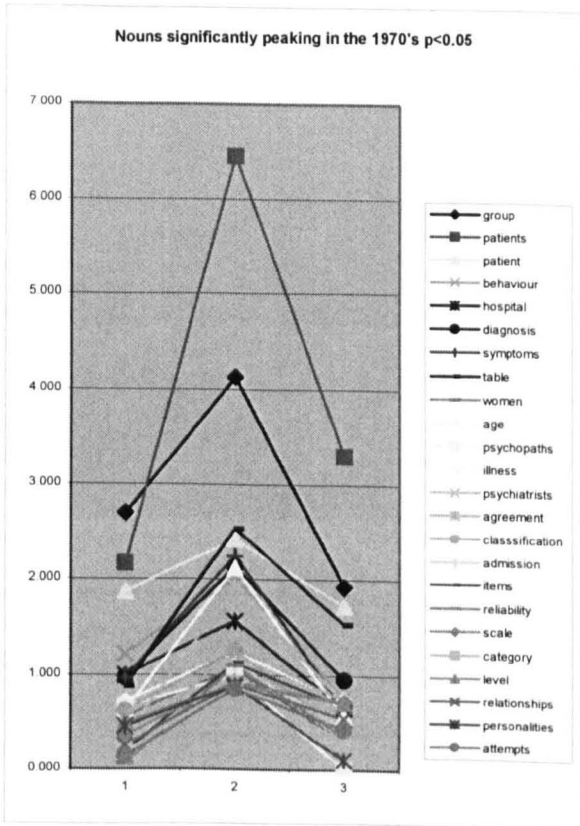

Graph 5: Nouns dipping significantly in 1970's p<0.00001
1.600
1.400
1.200
1.000
0.800
0.600
0.400
0.200
0.000
1
2
3
test
life
data
service

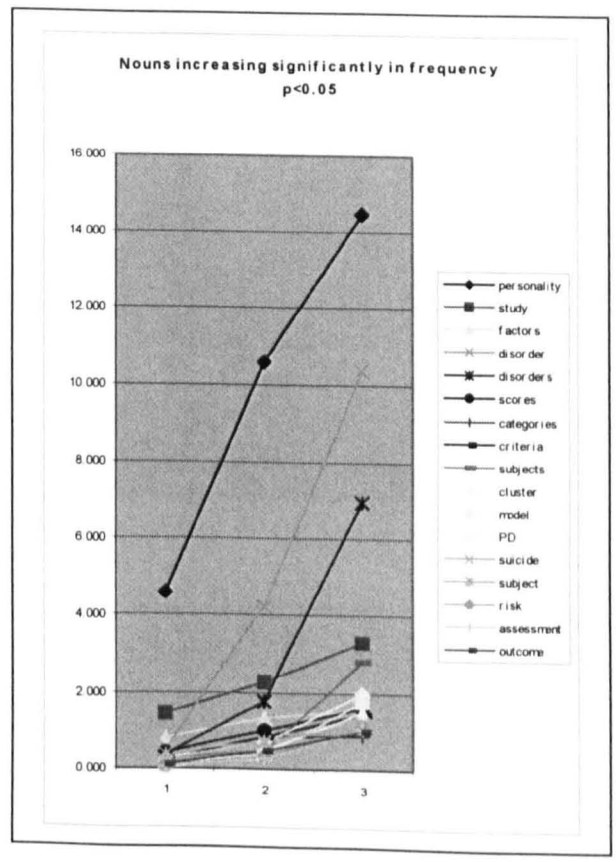

Graph 6: Nouns decreasing significantly only in 2000's
p<0.000001
4.500
4.000
3.500
3.000
2.500
2.000
1.500
1.000
0.500
0.000
1
2
3
psychopaths
group
types
degree
classsification
behaviour
hospital
women
personalities
type
psychopathy

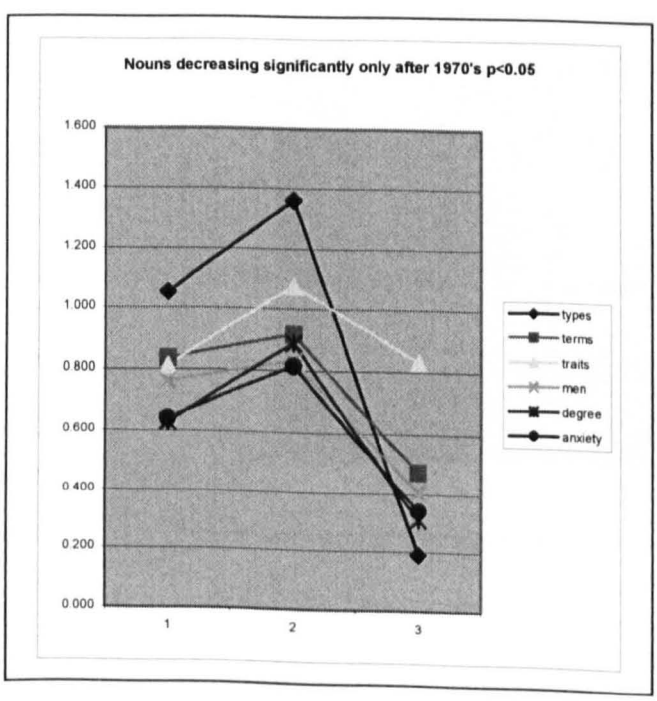

Graph 7: Nouns incresing significantly in 2000's only
p<0.00001
4.000
3.500
3.000
2.500
2.000
1.500
1.000
0.500
0.000
1
2
3
scores
factors
study
results
factor
analysis
DSM
axis
subjects
cluster
suicide
subject
risk
assessment
outcome
sample
health
studies
functioning
BPD
prevalence
research
events
costs
treatment
self
measures
problem
findings

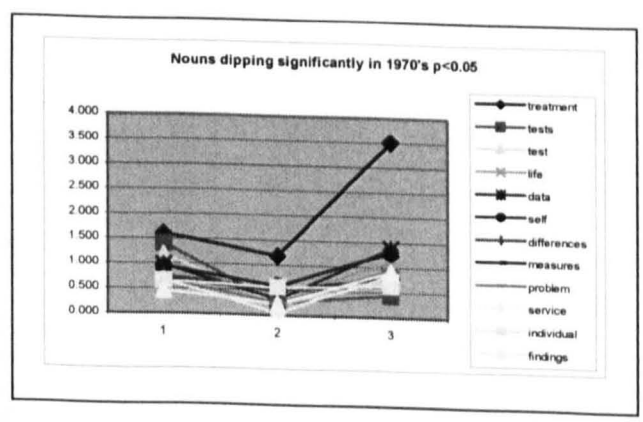

Graph 8: Nouns not significantly changing from corpus to
corpus p<0.00001
3.000
2.500
2.000
1.500
1.000
0.500
0.000
1
2
3
number
year
patient
age
scale
level
years
people
terms
traits
men
anxiety
differences
individual
groups
time
state
character
man

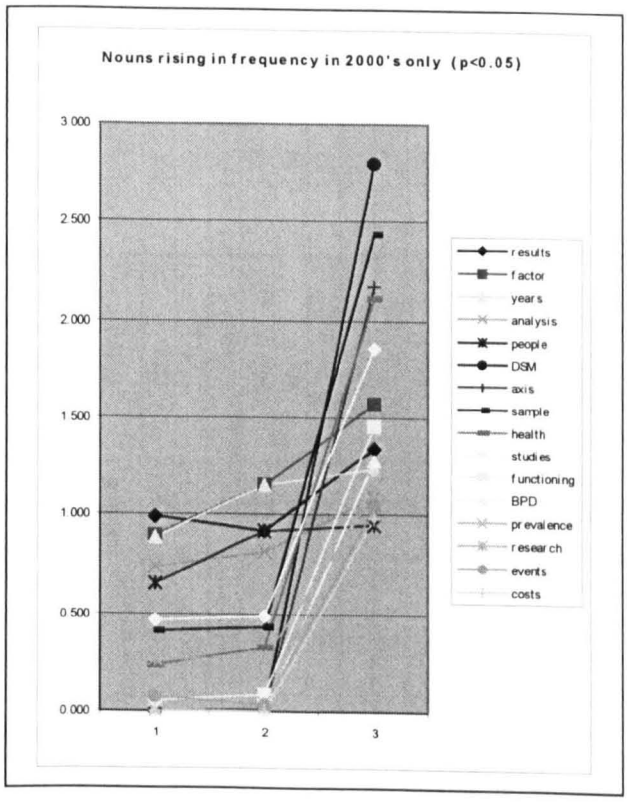
Appendix 12: Plot of trends in noun frequencies with significance p<0.05

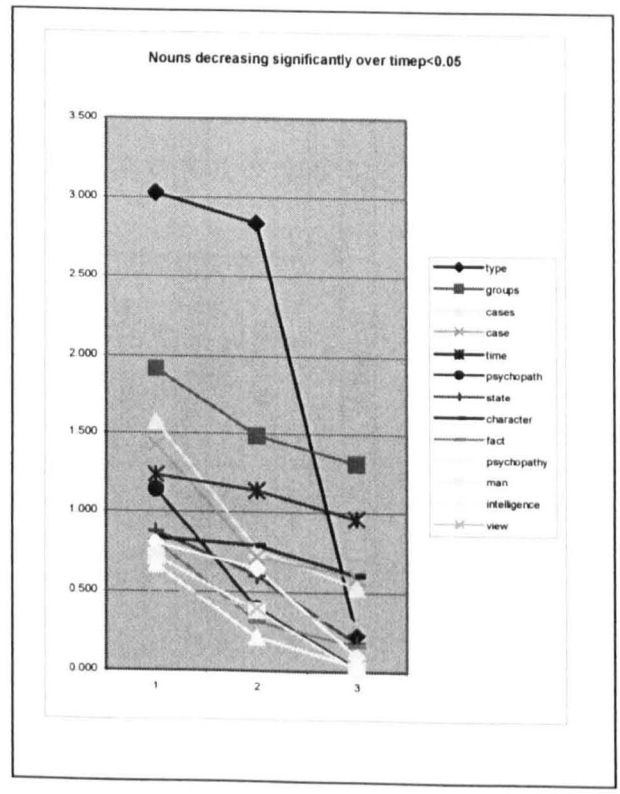


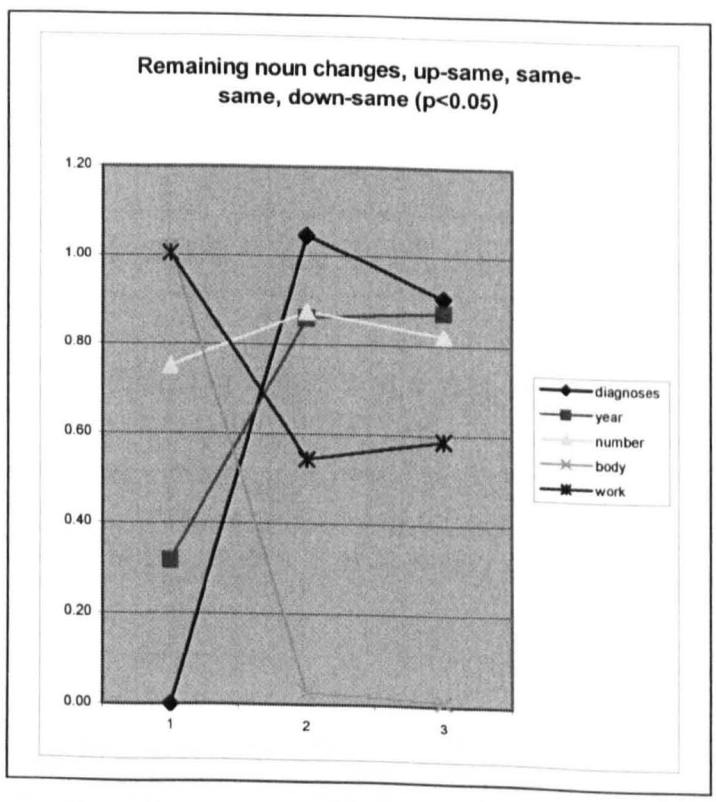







Nouns rising in frequency in 2000's only (p<0.05)
3.000
2.500
2.000
1.500
1.000
0.500
0.000
1
2
3
results
factor
years
analysis
people
DSM
axis
sample
health
studies
functioning
BPD
prevalence
research
events
costs


Nouns decreasing significantly over timep<0.05
3.500
3.000
2.500
2.000
1.500
1.000
0.500
0.000
1
2
3
type
groups
cases
case
time
psychopath
state
character
fact
psychopathy
man
intelligence
view

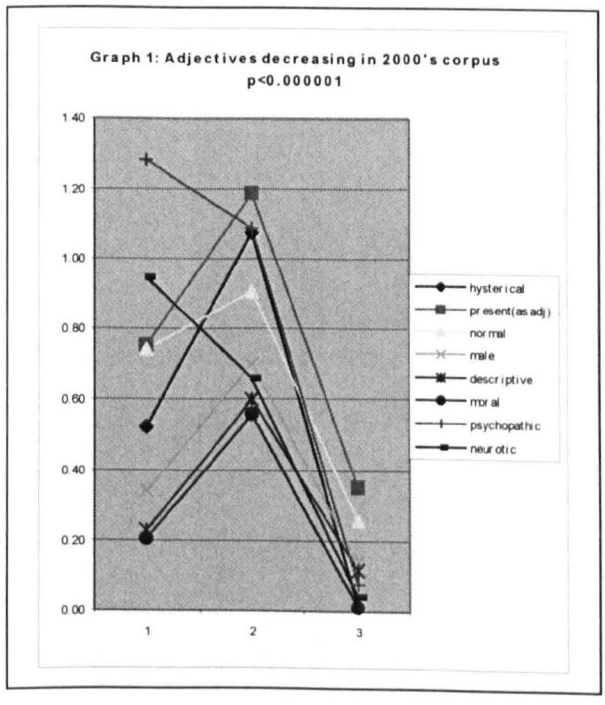

Remaining noun changes, up-same, same-same, down-same (p<0.05)
1.20
1.00
0.80
0.60
0.40
0.20
0.00
1
2
3
diagnoses
year
number
body
work

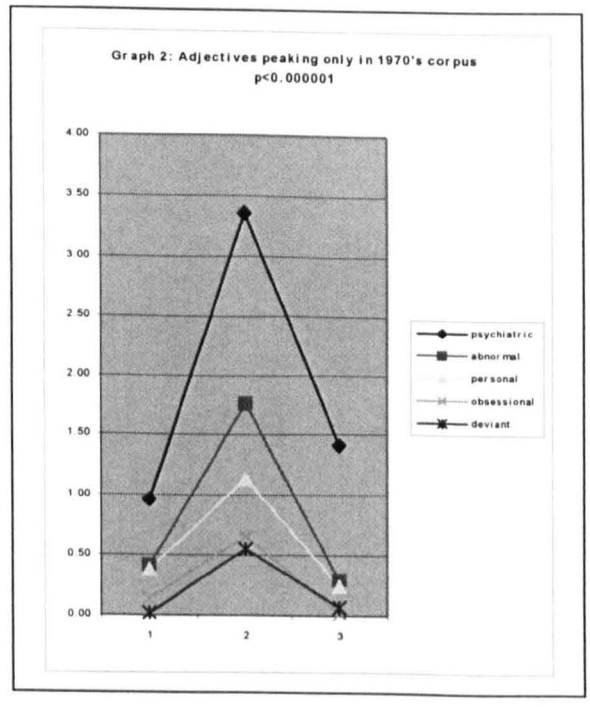
Appendix 13: 40 Commonest Adjectives in each Corpus

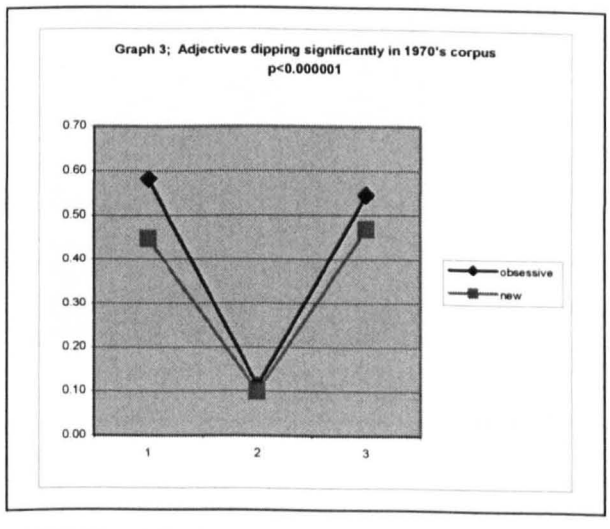
	1950's				1970's				2000's		
	Place	Word	Frequency	No of documents	Place	Word	Frequency	No of documents	Place	Word	Frequency	No of documents
1	45	more	206	23	31	psychiatric	234	18	39	more	248	29
2	63	social	134	22	33	more	228	19	45	clinical	202	25
3	73	clinical	116	21	66	abnormal	123	11	50	mental	191	25
4	78	psychopathic	106	18	70	most	111	18	59	social	172	24
5	80	very	102	19	73	diagnostic	100	12	76	most	144	22
6	86	many	98	23	80	social	99	16	84	psychiatric	133	24
7	87	mental	98	22	85	first	94	17	90	diagnostic	129	21
8	91	first	96	22	82	present(as adj)	83	22	92	borderline	127	23
9	99	general	90	21	101	personal	80	12	102	high	119	20
10	103	most	87	20	107	mental	77	16	109	significant	108	20
11	117	psychiatric	80	18	110	previous	76	10	126	higher	92	20
12	120	neurotic	78	17	111	psychopathic	76	12	135	first	85	24
13	132	different	72	20	112	hysterical	75	11	164	specific	77	17
14	138	good	69	16	116	clinical	74	15	165	antisocial	76	15
15	140	emotional	67	14	132	further	65	14	173	different	73	24
16	148	further	64	18	139	general	63	18	178	general	72	21
17	154	present(as adj)	62	19	142	normal	63	13	193	previous	66	16
18	155	diagnostic	61	14	152	less	60	16	214	overall	60	15
19	158	normal	61	18	166	high	55	13	216	avoidant	59	16
20	171	certain	55	19	167	schizoid	55	6	225	compulsive	56	11
21	173	less	55	18	168	serious	55	7	235	current	54	18
22	175	physical	55	14	173	significant	54	12	236	disordered	54	10
23	184	hysteroid	53	4	177	antisocial	52	9	245	early	53	14
24	187	significant	52	12	183	second	51	12	239	positive	54	16
25	196	obsessive	48	7	191	different	49	16	245	early	53	14
26	207	inadequate	46	12	193	male	49	9	248	low	53	14
27	208	little	46	19	194	many	49	15	251	statistical	53	16

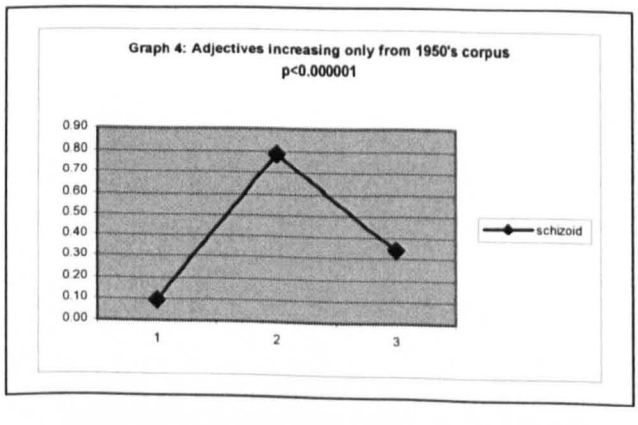
28	210	psychological	46	14	197	higher	47	13	253	demographic	52	12
29	227	considerable	43	12	204	neurotic	46	10	256	schizotypal	52	19
30	229	hysterical	43	10	205	obsessional	46	8	257	similar	52	12
31	236	sexual	42	8	208	aggressive	45	10	260	important	51	18
32	248	early	40	16	216	low	44	14	261	negative	51	19
33	251	later	40	13	220	very	44	14	262	obsessive	51	10
34	253	depressive	39	12	226	descriptive	42	5	266	baseline	50	11
35	272	particular	38	15	245	dependent	39	7	274	common	49	7
36	280	greater	37	14	246	deviant	39	6	277	therapeutic	48	17
37	282	new	37	12	252	moral	39	5	279	dependent	47	13
38	284	similar	37	16	254	certain	38	12	281	major	47	15
39	286	another	36	17	259	better	37	14	283	second	47	16
40	290	important	36	12	266	following	36	15	291	primary	46	16

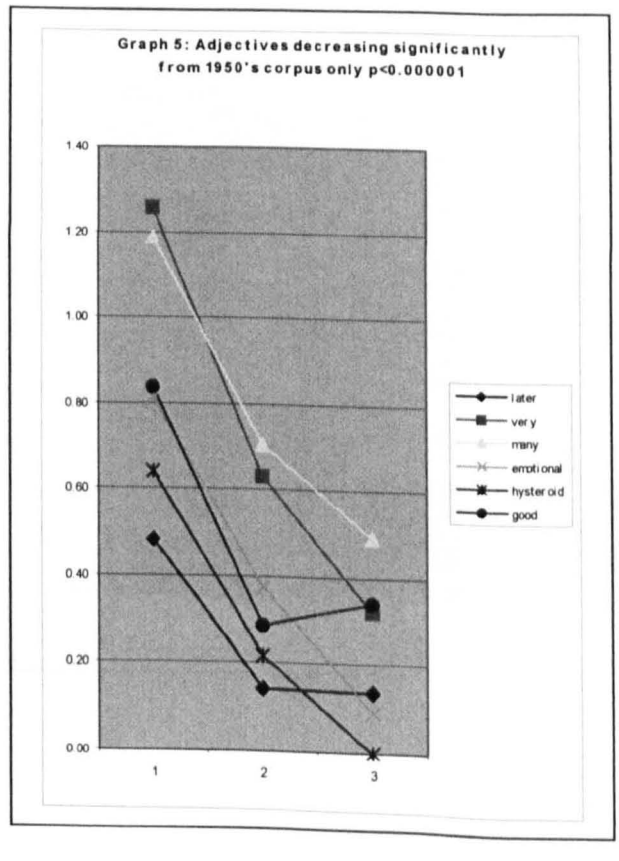
Appendix 14: Plot of trends in most frequent adjectives at significance p<0.000001



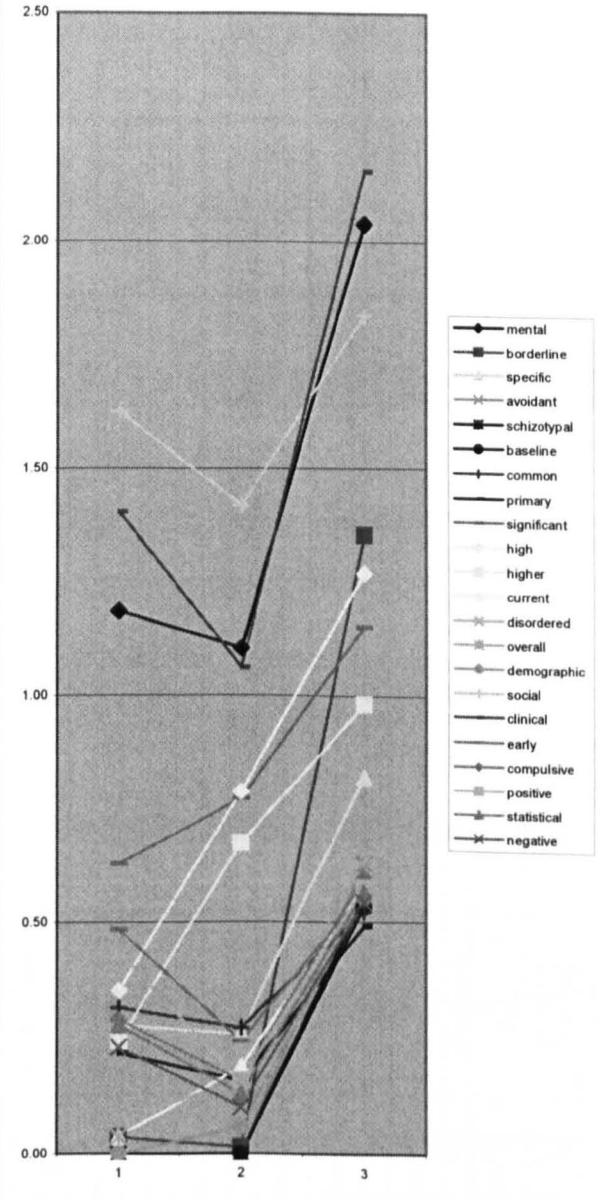




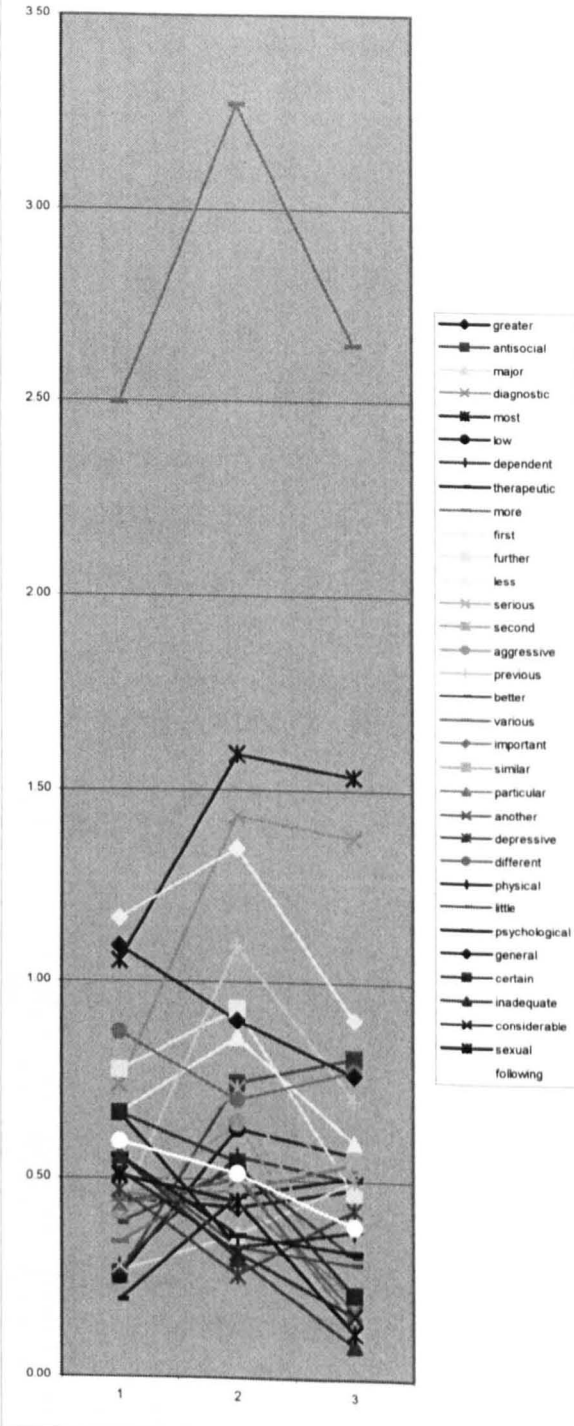




Graph 6: Adjectives increasing only in 2000's corpus, p<0.000001



Graph 7: Adjectives significantly unchanged in frequency over time p<0.000001



Appendix 15: 30 Most Frequent Verbs in each Corpus

	1950's verbs				1970's verbs				2000's verbs		
Place	Word	Frequency	No of documents	Place	Word	Frequency	No of documents	Place	Word	Frequency	No of documents
8	is	1081	30	9	is	689	19	13	were	736	25
12	was	719	26	12	was	578	19	14	is	691	29
13	be	695	29	13	be	562	19	16	was	623	25
17	are	577	25	17	were	497	19	19	be	490	29
24	were	391	23	18	are	496	19	20	are	474	29
30	have	304	26	30	had	235	17	26	have	343	28
34	had	268	23	40	have	200	18	49	been	194	28
39	has	228	29	53	been	155	19	51	had	190	24
46	been	198	26	63	has	137	18	57	has	179	29
70	found	119	23	76	found	100	18	81	based	135	24
77	will	107	23	96	used	87	15	95	associated	107	22
89	do	96	25	121	made	71	8	101	using	120	22
118	being	79	19	131	being	66	17	104	used	117	23
122	given	76	19	138	will	64	15	148	found	82	19
124	used	75	20	159	diagnosed	57	12	177	did	72	20
129	made	73	22	164	do	55	15	185	compared	68	18
134	show	72	18	172	shown	54	14	190	reported	67	18
146	described	64	16	178	associated	34	13	212	included	60	19
189	does	51	19	190	described	49	16	267	being	50	22
174	make (as verb)	51	18	211	seen	45	13	275	made	49	16
193	called	49	11	214	admitted	44	10	282	obtained	47	14
206	considered	46	20	218	using	44	14	285	will	47	20
218	shown	45	18	227	did	42	13	287	described	46	15
221	became	44	8	232	does	41	12	301	including	44	17
254	did	39	14	251	make	38	14	316	shown	42	17
292	seem	36	15	280	included	35	16	325	do	40	17
293	seen	36	17	289	applied	34	9	337	assessed	39	14
306	say	35	16	302	given	33	14	339	identified	39	17
312	cannot	34	16	310	considered	32	16	353	rated	38	9
327	felt	33	8	340	rated	29	12	357	having	37	15

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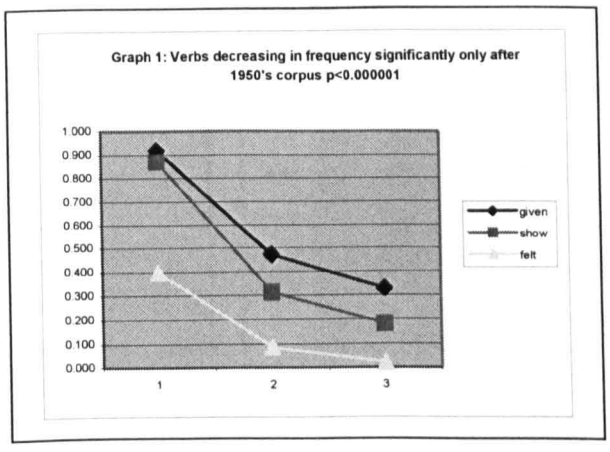
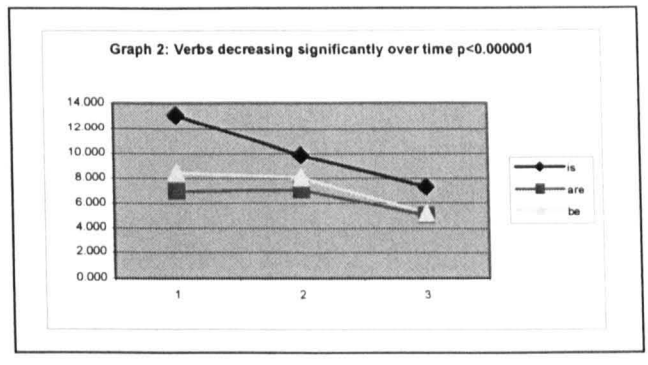
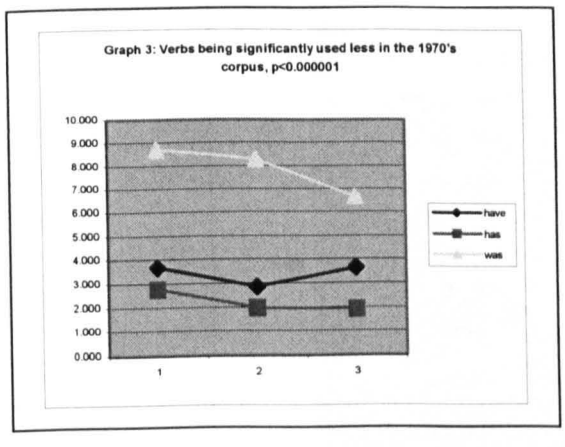
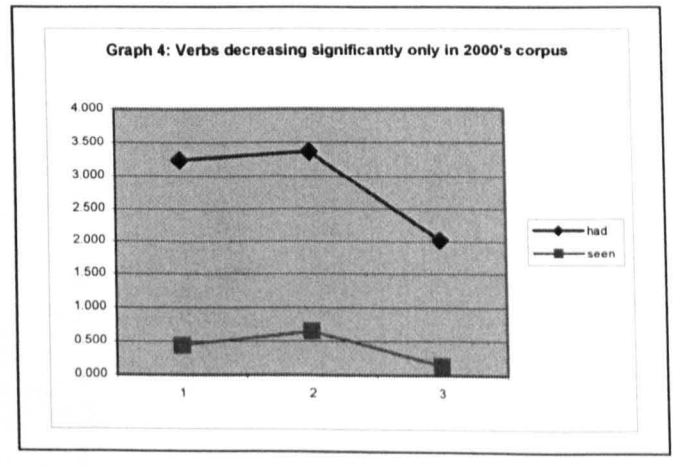
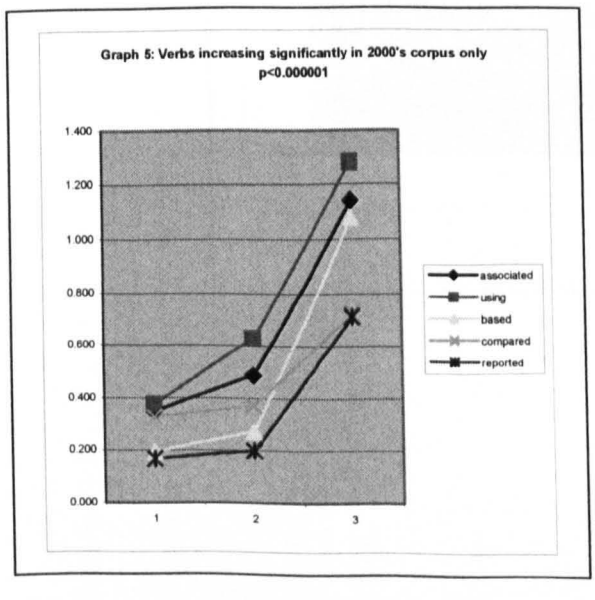
Appendix 16: Plot of trends in verb frequencies at significance p<0.000001

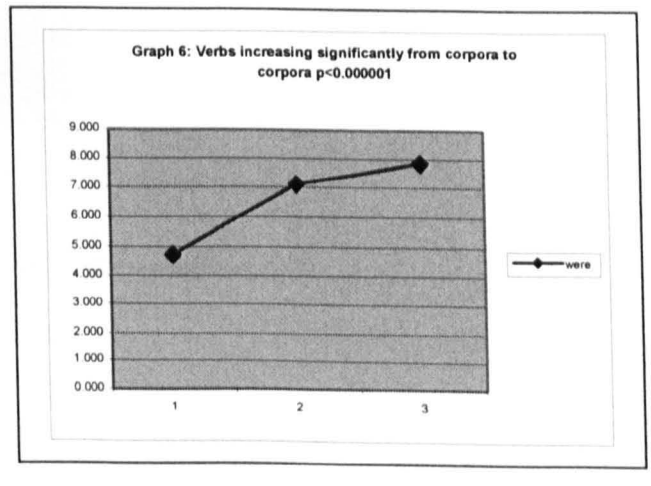




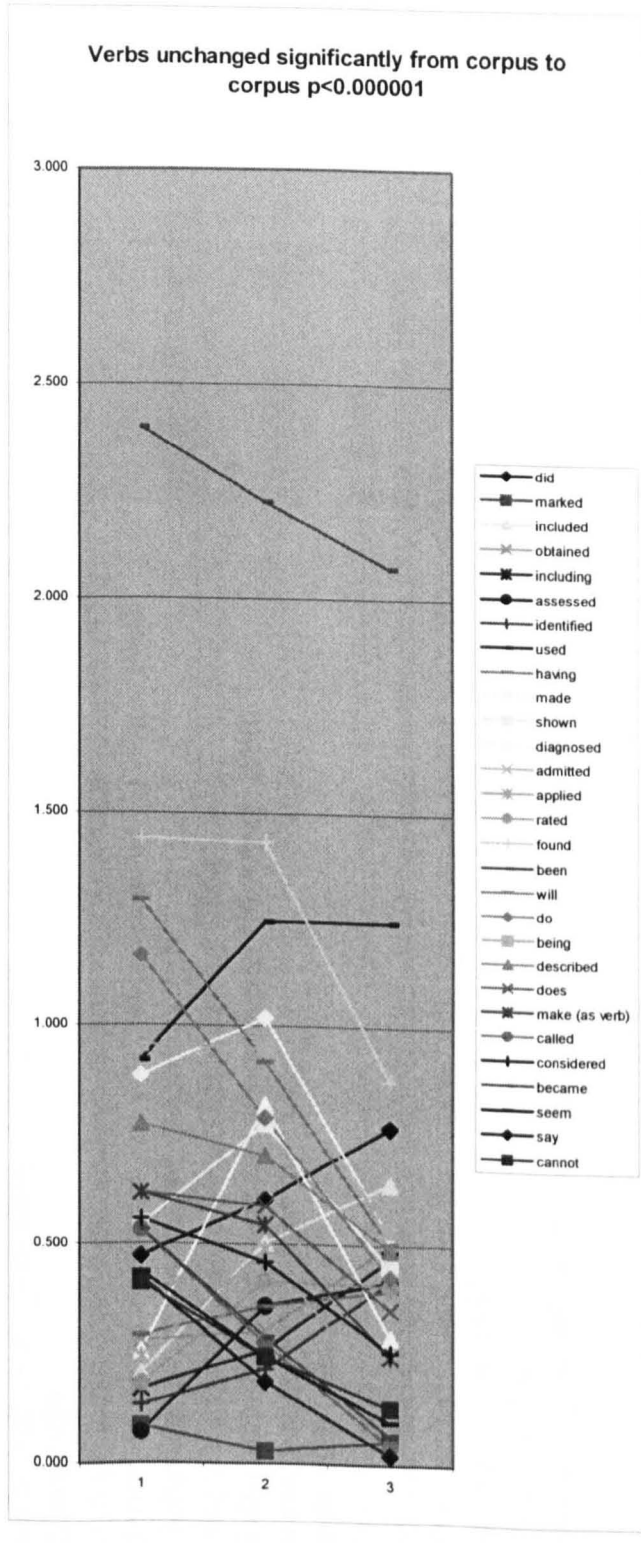








Graph 7:


Verbs unchanged significantly from corpus to corpus p<0.000001
3.000
2.500
2.000
1.500
1.000
0.500
0.000
1
2
3
did
marked
included
obtained
including
assessed
identified
used
having
made
shown
diagnosed
admitted
applied
rated
found
been
will
do
being
described
does
make (as verb)
called
considered
became
seem
say
cannot

Appendix 17: What is the problem?

1950's

Problem:

Recognition and definition of psychopathy (3) (Bartholomew 1958)
Classifying early and mild cases of inadequate personality (Monro 1959)
Classifying inadequacy (2) (Monro 1959)
Validity of factors extracted from principal component analysis of personality variance (Storms 1958)
The 'constitutional psychic inferior' in the prison service, the weak and inadequate (3) (Knox 1960)
The delinquent and antisocial behaviour of the psychopath (Mowbray 1960)
The medical status of the psychopath, as a medical problem (2) (Mowbray 1960)
Interpreting and defining EEG abnormalities in the case of the psychopath (Mowbray 1960)
Measuring the extent of psychopathy nationally (Mowbray 1960)
Finding treatment for psychopaths (Gibbens 1961)
Quantitation and validation of psychologic data about personality (3) (Valenstein et al. 1951; Valenstein et al. 1953)
Dealing with qualitative data by quantitative methods in relation to personality and case examination (Valenstein et al. 1953)
Reducing aspects of human behaviour to isolated specific variable which can then be expressed mathematically (Valenstein et al. 1953)
What constitutes character (Valenstein et al. 1953)
Defining psychopathy (4) (Davidson 1956)
'psychosis with psychopathic personality' should more readily be diagnosed as schizophrenia (Davidson 1956)

Problems

Constitutional psychopathy acting as a receptacle for the problems of psychiatry causing harm to reasonable treatment of people (Sturup 1952)
Treatment of criminal psychopaths due to the closed nature of the institutions required and the open ended nature of the stay (Sturup 1952)
The extent of the teamwork and communication necessary to effect psychiatric treatment on criminal psychopaths (Sturup 1952)
Stemming from new treatments such as narcosynthesis, anamnestic analysis and other transference therapies (Sturup 1952)

Methodological issues in dimensional analysis in relation to neuroticism (2) (Bartholomew 1958)
Of the behaviour within organized society of psychopathic personalities (3) (Kennedy 1954)
The classification of inadequate personality, where Q technique is useful (Monro 1955)
Relating the results of factor analysis to differences among groups (Storms 1958)
The organism's interpretative apparatus, a psychology of the self, learning theory, the organisation of the personality, the meaning of experience (Monro 1959)
Of a clinical nature in which the validity and reliability of data have not as yet been resolved in qualitative terms much less quantitative ones (Valenstein et al. 1953)
In treating veterans without going beyond the combat experience and considering infantile conflicts that affected personality development. (Valenstein et al. 1953)

1970's

Problem

The contribution of personality to symptomatology (Smail 1970)
The association between different types of psychiatric illness and various forms of abnormal personality (Walton et al. 1970)
Containing and treating psychopaths in a therapeutic community (Whiteley 1970)
Distinguishing character types from diagnosis of disorders in mild deviations of character (Walton et al. 1973)
The inadequacy of the nosology in the diagnosis and classification of personality, the solution of a dimensional system (Walton et al. 1973)
The reliable assessment of the less typical cases, who constitute the majority of patients with personality disorder (Standage 1979)
The issue of needing treatment versus wanting treatment, burked by failure to distinguish personal illness from personal disturbance (Foulds 1971)
How to agree on the range of the normal personality and the tenable criteria of mental illness as evidenced by absurd variation in epidemiological figures (Lewis 1974)
Identifying psychological factors in the diagnosis of psychopathy (Lewis 1974)
The standardization of diagnosis, classification and statistics of personality disorder, severely hampered by the lack of scientific data. (Shepherd et al. 1974)
The lack of a precise delineation of how personality disorders may be differentiated from normal variants of personality, and the sociocultural, cross cultural and comparative aspects of this (Shepherd et al. 1974)

The concept of psychopathic personality (Gunn et al. 1976)
The elusive and nebulous nature of the concept of psychopathic personality (Gunn et al. 1976)

Problems

Diagnostic and terminological confusion around the concept of personality disorder (Shepherd et al. 1974)
Classification when personality disorder is associated with organic factors such as drugs (Shepherd et al. 1974)
Relating a diagnosis of 'personality disorder' to varied physical and mental conditions as well as mental retardation (Shepherd et al. 1974)
The relationship of personality disorders to criminality and anti-social behaviour (Shepherd et al. 1974)
Fundamental problems with personality disorder that cannot be resolved without further research (Shepherd et al. 1974)
Distinguishing personality disorder from normal variants of personality, traits from disorder, and the use of a multiaxial system of recording personality disorder (Shepherd et al. 1974)
Diagnosing 'psychopathic personality' is not helpful shorthand to convey clinical information useful to the treatment and understanding of a patient, more information always needs to be gathered, instead what this label conveys is that the patient is difficult and probably unpleasant. (Gunn et al. 1976)
In trying to rate the presence of absence of personality abnormality without allowing for variation over time (Gunn et al. 1976)

2000's

Problem

Personality disorder has become a major medical and social problem (Svrakic et al. 2002)
The distorting influence of abnormal meal state and reporting bias on self-report and semi-structured interviews used to rate the presence of personality disorder (Moran et al. 2006)
The expense and logistics involved in keeping an RCT running for a long time period with an adequate number of subjects (Bateman et al. 2000)
Caring for individuals with personality disorder (Bateman et al. 2000)
Low subject-informant agreement for personality disorder measures(Hill et al. 2000)
Commentators from within the psychiatric profession not believing or not wishing to bear the consequences of findings about personality disorder that imply it is a legitimate concern of psychiatry (Spence 2001)
Of whether personality disorder is a mental illness or not (Kendell 2002b)
The limited understanding of the cerebral mechanisms underlying basic psychological functions (Kendell 2002a)

Potential underpowering of the calculation that failed to detect an association between personality disorder and cost (Rendu et al. 2002)
The quantification of burdens on healthcare, social and criminal justice agencies and case definition of personality disorder (Coid 2003)
The epidemiology of personality disorder (5) (Coid 2003)
Defining personality disorder (2) (Coid 2003)
Measuring severity of personality disorder using current diagnostic construct; additional measures are currently necessary such as burden, financial costs, criminality and the effects of behaviours on others (Coid 2003)
Defining the true nature and size of the problem posed by personality disorder in the UK (5) (Coid 2003)
That screening may miss a substantial number of individuals who still pose a high risk to the public (Coid 2003)
Examining personality disorder form the public health perspective (Tyrer et al. 2003)

Problems

Associated with disorder co-occurrence, and diagnostic overlap have persisted (Sanislow et al. 2002)
Presented by a categorical system for personality disorder, leading to arbitrary distinctions between 'normal' and 'abnormal' personality (Parker et al. 2004)
Case identification, comorbidity, randomisation, specificity of treatment and outcome measures are inadequately addressed in studies of the effectiveness of psychotherapeutic treatment of personality disorder (2) (Bateman et al. 2000)
Revealed by literature review that need to be addressed if future research on personality disorder is to be fruitful (Bateman et al. 2000)
Case identification in research into personality disorder due to the cluster system only having face validity and general poor cross-classificatory reliability. (2) (Bateman et al. 2000)
Of implementing RCT's for the efficacy of psychotherapeutic treatments (2) (Bateman et al. 2000)
In conceptualising and defining personality disorder, in separating it from other mental disorders and in designing treatment trials with adequate internal and external validity (Bateman et al. 2000)
Of unclear diagnostic criteria, subjective outcome measures and retrospective research design in studies of inpatient treatment of personality disorder attempting to be overcome (Chiesa et al. 2000)
Created by the success of using DSM by psychiatrists and mental health workers with no interest in research (Tyrer 2001)
In distinguishing personality disorders from mental illness categories (Kendell 2002a)
In test-retest reliability for diagnostic categories (Coid 2003)
Of implementing policies concerning pubic protection from high-risk offenders compounded by continuing opposition from the Royal College of Psychiatrists (Coid 2003)

Appendix 18: Pilot Development of Categories: Analysis of subject positions using *subject/s* in 2000's corpus

Introduction

In Chapter 5 is was suggested that, to manage and interpret the statements surrounding a potential subject position, a first step would be to identify and group particular statements according to the properties of a subject position as theorised by Davies and Harre (1990). The decision of which position to explore was informed by a number of factors; the word or phrase to be examined needed to be easily interpreted as a position, common within the corpora, not one of the main objects of study, and also common in the British National Corpus in order to provide some triangulation of the approach. This effectively ruled out *the psychopath* and *personality disorder* both of which concern the main object of study and are also uncommon within the BNC. *Subject/s* was thus chosen as, from the noun analysis (Chapter 6) it is common in the 2000's corpus and also used in the 1970's corpus. In its use it is almost entirely used in the sense of 'subject of a study or experiment' and hence its rise over time is strongly linked to the overall increase in statistical and study language observed in the lexical analysis, and thus would be an indicator of a subject position associated with the application of a statistical and study discourse.

Method

The proposed method is based on the discussions of Chapter 5, hence *subjects* is first examined in the 2000's corpus, to discover its commonest collocations, which are then explored through concordance lines. There is an initial attempt to see if these form any particular groupings in order to facilitate an understanding of the implications of the use of *subjects* as a subject position in the corpus. These

groupings are seen as provisional at this point. Statements involving modality and factual statements involving variations of *to be*, are then examined and a similar grouping process applied. This process is repeated for *subject* in the 2000's corpus. *Subjects* was then explored in the BNC and those concordance lines where it was used as 'subjects of study or experiment' were collected, grouped and compared with the grouping already produced.

The method will then be used with the 1970's corpus to provide a comparison (there are only 24 occurrences in the 1950's corpus) and the resulting groupings for the whole process reviewed. The final step, which comprises the first part of the subject position analysis described in Chapter 7, was to apply this process and the categorisation to *the psychopath* in the 1950's corpus to see if this approach worked with the object of study.

Subject/s in the 2000's

There are 111 instances of *subject* in the 2000's corpus and 263 of *subjects. Subject* appears in two forms one of 'subject as to topic' and the other as 'subject of an experiment'. The latter meaning is exclusively that of *subjects.*

Taking the most numerous usage first, the collocates of *subjects* are shown in Table 1 below.

Table 1: Collocates of *subjects* in the 2000's corpus

	Total	Left	Right	L5	L4	L3	L2	L1	Centre	R1	R2	R3	R4	R5
SUBJECTS	285	11	11	3	2	3	3	0	263	0	3	3	2	3
OF	115	88	27	12	11	16	29	20	0	2	1	3	8	13
THE	114	74	40	14	13	7	18	22	0	4	14	10	6	6
AND	86	47	39	15	5	6	19	2	0	21	2	4	7	5
WERE	76	9	67	4	5	0	0	0	0	42	12	2	5	6
WITH	61	15	46	4	2	0	4	5	0	39	1	5	0	1
PERSONALITY	57	19	38	4	1	5	9	0	0	1	8	11	9	9
IN	48	29	19	8	5	8	3	5	0	9	3	3	1	3
TO	45	13	32	5	2	3	3	0	0	4	5	7	13	3
A	30	11	19	3	7	0	1	0	0	1	6	3	2	7
WHO	25	0	25	0	0	0	0	0	0	23	0	0	0	2
HAD	25	2	23	1	0	1	0	0	0	11	8	2	0	2
OR	24	6	18	2	1	1	1	1	0	1	3	2	7	5
DISORDER	23	8	15c	3	2	1	2	0	0	0	0	5	3	7
FOR	22	12	10	3	2	1	4	2	0	1	1	3	0	5

This shows that *subjects with, subjects were* and *subjects had* and *subjects who* are particularly common constructions, comprising between them 136 of the total occurrences. These constructions provide a ready point of access for investigating what is implied by *subjects.*

As a first pass at categorisation the 42 instances of statements including *subjects were* can be examined and placed into four groups[1]. The first are **Factual Statements** largely about age, race or gender. The second concerns **Categorisation** of *subjects.* The third comprises a set of **Attributes** with a limited range thus;

[1] Due to the word limit on the thesis and the high word count involved in including concordance lines, these will not be included in the thesis, however they are avaibable as Appendices on demand

Subjects were

able to support themselves in the community

moderately anxious

more likely to be; GHQ-12 case, report previous psychological difficulties, attend their GP in an emergency, have psychiatric morbidity, living as single, less likely to belong to social classes I and II.

In the final category subjects are **Acted Upon**, *they are administered, allocated, asked, compared, interviewed, pre-screened, re-interviewed, recalled, receiving treatment, recruited, traced.*

32 out of 38 instances of *subjects with* refer to *personality disorder*, however 19 of these are found in one text (Suominen et al. 2000), suggesting a bias in frequency due to a particular author's usage. This emphasises the need to check for the dispersion of concordances across the corpus before making general inferences. Indeed looking at the concordance lines **Attributes** are dominated by suicide attempts, although there is mention of impulsiveness, substance misuse and the inability to describe their own deviant traints. However, overall the categories used in the previous analysis seem to hold, although there may be some value in separating **Behaviour** out from **Attributes**.

Looking at the instances of *subjects had* and *subject who* the same categorisations can be made, with an additional category of **Acting**, in other words subjects having agency. However this is confined to agreeing to participate or not, giving informed consent and reporting.

The most frequent collocate of *subject* is *of* which mostly occurs before *subjects*. Of these 88 occurrences, 67 of have already been covered above and the

remainder fitted the existing categories, the 7 **Acting upon**, involved being scored, evaluated, cross-examined and examined and sampled and investigated.

Statements involving modality can now be examined, and following Vilha's (1999) work these can be divided into three categories using searches around the commonest modals of possibility, likelihood/certainty and obligation/recommendation. For modals of possibility, **Attributes/behaviour** is the biggest class and reveals a number of doubts about the accuracy of assessments, placing the reason firmly with the subjects (and informants) abilities.

Modals of Likelihood/certainly occur exclusively as *were likely* and are all **Attributes/behaviour.** There is only one statement involving modals of Obligations/recommendations already covered. Thus although the analysis of modality does not add significantly to the data gained from the initial analysis, a few salient points emerge. Where doubt is expressed in relation to personality disorder, there is an indication that it is the behaviour of the subjects that is seen to introduce problems.

A further point is almost complete absence of obligations and recommendations in relation to *subjects*. Taken along with the primary positioning of *subjects* this suggests they are outside the need for such constructions. They are simply required to provide data, other obligations do not need to be specified.

Thus to summarise the implications for subject positions, *subjects* are characterised by certain factual dimensions such as gender, race, levels of income and education. They are classified largely by diagnostic systems. They have a range of limited attributes, being able to support themselves in the community, moderately anxious, more likely to have mental and physical health problems, access GPs in an

emergency, live as single, belong to lower social class and be a suicide risk. In terms of positioning their agency is limited to reporting and completing assessments.

Unlike *subjects*, *subject* occurs in the 2000's corpus both with meanings other than as the subject of a study, however once these are identified the statements can be categorised using the terms already identified. These mostly fell into **Attributes/ behaviour** but with a significant quantity of **Acting** statements around reporting, describing and being in discussion with. Further the **Attributes/behaviour** category is wider, involving the usual negatives such as having unstable relationships and causing distress, but also being married or basing a reply on feelings. Comparing this to *subjects,* the latter seems narrower in its range suggesting a process operating on the position of subject such that, as findings are collected, there is less need to explore what is already known hence the research and the position defined by talk about it, become narrower. The danger is that as areas like feelings and relationships move out of the talk they also move out of the position, *Subjects* and by extension people with personality disorder become disallowed with regard to these aspects of humanity.

In reviewing this process of classifying concordance lines, the categories derived so far, do seem to assist an understanding of what the use of a given word or phrase implies for its positioning effect. This is particularly evident in the **Attributes/behaviour** category as well as the small but significant **Acting** statements. However the **Acted Upon** category also provides useful information about positioning by collecting together statements which effectively summarise the expectations of that position, in the case of *subjects,* it is largely to be *asked, compared, allocated* and so on, further illustrating the limited agency of this position.

When *subjects* is explored in the BNC, a similar categorisation can be used. The **Factual** statements concern age, gender, and health measurements, while **Attributes** include being healthy. **Acted upon** involves statements about receiving training, being asked, lying down, and **Acting** is more prevalent in the BNC than in the 2000's corpus and includes reading, learning, straining and refusing. This suggests a more passive positioning of *subjects* in relation to personality disorder than in its usage in the larger corpora of general English.

Investigating these statements in the 1970's and 1950's corpora revealed that these categorisations could also be used for these time periods.

Review and the categories and their initial use with collocations of *the psychopath*

From these investigations a prototype methodology for exploring subject positions from concordances emerged. Having identified potential subject positions from the lexical analysis, the collocates should first be examined for any frequent usages. These could then be themed, according to the categories developed above. If there are no obvious common usages then all the concordance lines should be examined, and if this is not feasible, a representative sample. Following this the modality and factuality statements should be examined and similarly themed. This is the method that is put into practice in the analysis of subject positions in Chapter 7. However before proceeding to this section there were a number of reflections on the actual themes to take into account.

The themes developed during the analysis of subject/s, were **Factual, Attributes/behaviour, Categorisation, Attributes/behaviour, Acted upon** and **Acting.**

On reviewing these and their application to the psychiatric concepts of *psychopath** and *personality disorder**, it was felt useful to reorder the **Factual** and **Categorisation** themes into **Categorisation Groups** and **Categorisation Diagnostic** to help quantify the concerns about diagnosis and categorisation in each corpus. In the first application of this analysis to *the psychopath* (Chapter 7) a further category emerged, that of **Conceptual,** which contained statements about an understanding of the condition rather than a person. In addition the category of **Attributes/Behaviour** was separated and the former broken down into **Psychological, Social** and **Physical.** At this stage the categories were compared with the categories derived from the investigation of positioning theory outlined in Chapter 5 and the final full version as described in this chapter was then used to reclassify *the psychopath*, before going on to be used for the remaining analysis.

Appendix 19: Collocations of *personality disorder* in the 1970's corpus

Word	Total	Total Left	Total Right	L5	L4	L3	L2	L1	Centre	R1	R2	R3	R4	R5
DISORDER	198	12	186	2	4	3	3	0	0	184	0	0	1	1
PERSONALITY DISORDER	184	0	0	0	0	0	0	0	184	0	0	0	0	0
THE	104	62	42	16	15	11	9	11	0	0	6	11	14	11
OF	79	66	13	10	4	5	10	37	0	0	2	2	5	4
A	55	39	16	4	1	8	1	25	0	0	0	9	5	2
AND	45	20	25	4	7	4	1	4	0	0	10	5	4	6
DIAGNOSIS	34	17	17	1	0	5	11	0	0	0	14	0	0	3
PERSONALITY	33	17	16	7	3	5	1	1	0	0	1	3	3	9
WITH	33	24	9	3	5	1	8	7	0	0	3	0	3	3
IN	29	21	8	4	12	3	2	0	0	0	1	4	1	2
TO	24	11	13	4	2	2	3	0	0	0	3	1	8	1
AS	24	21	3	1	4	0	3	13	0	0	1	1	1	0
PATIENTS	23	21	2	2	6	10	3	0	0	0	0	1	0	1
TYPE	22	12	10	3	3	2	2	2	0	0	0	9	1	0
HYSTERICAL	20	6	14	0	0	0	0	6	0	0	8	2	0	4
IS	18	3	15	1	1	1	0	0	0	0	10	3	1	1
BY	15	5	10	2	1	1	1	0	0	0	3	1	2	4
DECISIONS	13	7	6	0	1	0	2	4	0	0	0	0	5	1
DIAGNOSED	13	11	2	0	0	1	9	1	0	0	0	1	0	1
THAN	13	5	8	2	1	1	0	1	0	0	3	5	0	0
BE	13	2	11	1	0	0	1	0	0	0	0	7	1	3
WERE	13	6	7	2	3	0	1	0	0	0	1	3	2	1
ILLNESS	12	7	5	1	2	0	4	0	0	0	0	1	4	0
THAT	12	6	6	1	2	1	1	1	0	0	0	3	0	3
WAS	11	5	6	2	2	0	0	1	0	0	2	2	1	1
FOR	11	6	5	3	0	0	1	2	0	0	0	1	1	3
OTHER	11	3	8	1	0	1	1	0	0	0	5	0	2	1
3	11	5	6	0	2	0	2	1	0	0	2	2	2	0
ARE	11	6	5	2	0	3	0	1	0	0	0	2	3	0
2	10	5	5	0	0	0	4	1	0	0	1	2	1	1
NO	10	7	3	0	2	1	0	4	0	0	0	0	2	1
DISCHARGED	10	10	0	3	0	4	3	0	0	0	0	0	0	0
SCHIZOID	10	3	7	0	0	2	0	1	0	0	5	0	1	1
FROM	10	5	5	1	1	0	2	1	0	0	3	1	1	0
WITHOUT	9	7	2	0	0	3	1	3	0	0	0	0	1	1
GROUP	9	5	4	1	0	2	2	0	0	0	4	0	0	0
CLASSIFICATION	9	7	2	1	2	1	3	0	0	0	0	1	0	1
WHO	9	6	3	5	0	1	0	0	0	0	1	2	0	0
OR	8	4	4	0	3	0	1	0	0	0	2	0	0	2
THIS	8	4	4	3	0	1	0	0	0	0	1	1	2	0
I	8	4	4	0	0	2	0	2	0	0	1	3	0	0
DIAGNOSES	8	3	5	0	0	2	1	0	0	0	5	0	0	0
TABLE	7	3	4	0	2	0	1	0	0	0	2	1	0	1
CLINICALLY	7	1	6	0	0	0	1	0	0	0	0	1	5	0
PSYCHIATRIC	7	5	2	1	2	2	0	0	0	0	0	0	0	2

1	7	4	3	0	0	2	0	2	0	0	1	1	1	0
ASSOCIATED	7	7	0	0	2	0	4	1	0	0	0	0	0	0
ANTISOCIAL	7	2	5	1	0	0	0	1	0	0	0	0	5	0
BETWEEN	7	6	1	0	1	0	3	2	0	0	0	0	1	0
WHICH	7	2	5	2	0	0	0	0	0	0	1	3	1	0
OVER	6	2	4	1	1	0	0	0	0	0	0	4	0	0
AN	6	3	3	2	1	0	0	0	0	0	0	1	2	0
CLINICAL	6	3	3	0	0	3	0	0	0	0	0	0	0	3
ONE	6	3	3	1	0	0	0	2	0	0	0	0	1	2
HAD	6	3	3	0	1	1	1	0	0	0	0	2	0	1
4	6	5	1	2	0	2	0	1	0	0	0	0	0	1
NOT	6	3	3	0	0	3	0	0	0	0	0	0	1	2
OBSESSIONAL	6	3	3	0	0	1	0	2	0	0	1	0	0	2
5	6	3	3	0	0	0	1	2	0	0	0	1	0	2
WOMEN	5	4	1	2	1	1	0	0	0	0	0	0	0	1
MODERATE	5	5	0	0	0	1	0	4	0	0	0	0	0	0
TYPES	5	5	0	0	1	3	1	0	0	0	0	0	0	0
E	5	4	1	2	1	0	1	0	0	0	0	1	0	0
PRIMARY	5	5	0	0	2	0	0	3	0	0	0	0	0	0
PERSONALLY	5	5	0	0	0	0	5	0	0	0	0	0	0	0
ESTABLISHED	5	2	3	2	0	0	0	0	0	0	0	0	0	3
B	5	0	5	0	0	0	0	0	0	0	4	0	0	1
COULD	5	1	4	0	1	0	0	0	0	0	1	2	1	0
GIVEN	5	2	3	0	0	0	2	0	0	0	2	0	1	0

Appendix 20: Collocations of *personality disorders* in the 1970's corpus

Word	Total	Total Left	Total Right	L5	L4	L3	L2	L1	Centre	R1	R2	R3	R4	R5
PERSONALITY DISORDERS	94	0	0	0	0	0	0	0	94	0	0	0	0	0
THE	60	39	21	10	10	12	2	5	0	0	4	10	2	5
OF	59	47	12	10	2	7	10	18	0	0	0	5	2	5
AND	25	12	13	1	0	3	5	3	0	0	6	1	3	3
IN	21	8	13	3	1	1	0	3	0	0	3	3	4	3
WITH	17	14	3	0	1	1	0	12	0	0	0	1	1	1
AS	16	9	7	0	1	2	3	3	0	0	3	1	2	1
TO	14	7	7	1	1	2	3	0	0	0	2	2	2	1
ARE	13	6	7	2	0	1	2	1	0	0	5	1	1	0
PATIENTS	13	11	2	1	2	0	8	0	0	0	0	1	0	1
PERSONALITY	12	5	7	1	1	2	1	0	0	0	0	2	3	2
A	12	8	4	2	5	1	0	0	0	0	2	0	2	0
FOR	11	11	0	2	3	2	3	1	0	0	0	0	0	0
OR	10	8	2	3	0	0	1	4	0	0	2	0	0	0
THAT	10	6	4	0	1	2	1	2	0	0	0	2	1	1
WERE	8	4	4	2	1	1	0	0	0	0	3	1	0	0
BE	7	0	7	0	0	0	0	0	0	0	0	1	5	1
DIAGNOSED	7	6	1	1	0	2	3	0	0	0	0	0	0	1
HAVE	6	2	4	0	0	0	0	2	0	0	1	2	1	0
DIAGNOSIS	6	6	0	1	2	0	3	0	0	0	0	0	0	0
BUT	6	3	3	0	2	1	0	0	0	0	3	0	0	0
IS	6	0	6	0	0	0	0	0	0	0	4	0	2	0
WHICH	5	1	4	0	0	1	0	0	0	0	2	0	2	0
ONLY	5	2	3	1	0	1	0	0	0	0	1	1	1	0
MORE	5	3	2	1	2	0	0	0	0	0	0	1	0	1
CLASSIFICATION	5	3	2	0	1	0	2	0	0	0	0	1	0	1

Appendix 21: First 55 collocates of *personality disorder* in the 2000's corpus

Word	Total	Total Left	Total Right	L5	L4	L3	L2	L1	Centre	R1	R2	R3	R4	R5
PERSONALITY DISORDER	720	0	0	0	0	0	0	0	720	0	0	0	0	0
OF	410	353	57	29	37	39	33	215	0	0	4	9	15	29
THE	336	194	142	45	48	73	13	15	0	0	17	50	32	43
AND	199	89	110	13	28	19	18	11	0	0	69	15	8	18
IN	161	61	100	14	28	9	6	4	0	0	49	13	18	20
WITH	160	124	36	9	12	11	45	47	0	0	5	4	17	10
A	126	68	58	16	13	15	1	23	0	0	4	27	18	9
FOR	123	107	16	10	19	23	18	37	0	0	6	1	3	6
TO	105	53	52	9	22	7	12	3	0	0	5	24	11	12
IS	86	18	68	6	9	2	0	1	0	0	42	9	10	7
BORDERLINE	56	49	7	0	0	0	1	48	0	0	1	0	2	4
TREATMENT	51	42	9	4	2	3	33	0	0	0	1	2	4	2
THAT	50	33	17	7	8	3	10	5	0	0	2	5	4	6
AS	48	18	30	4	3	4	5	2	0	0	12	5	8	5
WAS	45	6	39	0	2	0	3	1	0	0	28	4	1	6
DSM	45	37	8	6	8	4	17	2	0	0	0	2	4	2
BETWEEN	41	38	3	6	7	3	7	15	0	0	2	0	1	0
ANTISOCIAL	39	35	4	0	1	2	1	31	0	0	0	1	2	1
PREVALENCE	37	33	4	3	3	8	19	0	0	0	1	0	2	1
DIAGNOSIS	37	27	10	3	1	3	20	0	0	0	4	0	3	3
ARE	35	4	31	2	1	1	0	0	0	0	15	5	4	7
THIS	34	13	21	4	2	6	0	1	0	0	4	7	3	7
PERSONALITY	34	19	15	7	5	5	2	0	0	0	3	5	5	2
NOT	33	7	26	3	2	0	2	0	0	0	2	14	8	2
ON	33	11	22	3	3	0	0	5	0	0	5	12	3	2
WERE	33	4	29	2	1	0	1	0	0	0	15	7	4	3
BY	32	10	22	3	2	1	1	3	0	0	4	6	6	6
CATEGORIES	32	15	17	3	2	0	10	0	0	0	16	0	0	1
IV	31	27	4	6	4	4	0	13	0	0	0	0	2	2
OR	29	21	8	4	2	9	4	2	0	0	3	3	2	0
HAVE	28	13	15	3	1	2	4	3	0	0	4	0	3	8
BE	26	6	20	3	1	2	0	0	0	0	1	6	11	2
PATIENTS	23	22	1	1	6	10	5	0	0	0	0	0	1	0
IT	23	7	16	2	3	1	1	0	0	0	4	8	2	2
BASED	22	8	14	2	2	2	1	1	0	0	10	1	1	2
PEOPLE	22	22	0	1	0	8	13	0	0	0	0	0	0	0
ASSOCIATED	22	7	15	4	0	1	2	0	0	0	0	9	4	2
MOST	22	7	15	1	3	2	1	0	0	0	4	1	7	3
CLUSTERS	21	5	16	0	0	1	4	0	0	0	14	0	0	2
HAS	21	3	18	1	1	0	0	1	0	0	13	1	1	3
CRITERIA	21	14	7	3	1	6	3	1	0	0	5	0	1	1
THOSE	20	10	10	1	1	5	3	0	0	0	0	4	4	2
FROM	20	7	13	2	3	0	2	0	0	0	6	2	2	3
BUT	19	6	13	1	2	1	1	1	0	0	7	0	3	3
STUDY	19	10	9	3	3	0	4	0	0	0	2	4	1	2
DISORDERS	17	12	5	4	6	1	1	0	0	0	0	1	0	4
HIGH	17	11	6	3	5	3	0	0	0	0	0	3	2	1
SUBJECTS	16	13	3	4	2	5	2	0	0	0	1	1	0	1
ALL	16	10	6	0	2	2	1	5	0	0	2	1	3	0
NARCISSISTIC	16	15	1	0	0	2	1	12	0	0	0	0	1	0
CLINICAL	16	7	9	3	0	3	1	0	0	0	2	2	2	3
STUDIES	16	7	9	1	2	1	3	0	0	0	0	3	6	0
AN	16	9	7	3	1	5	0	0	0	0	0	3	0	4
MAY	16	5	11	1	3	1	0	0	0	0	8	1	2	0
INDIVIDUALS	15	12	3	2	0	3	7	0	0	0	0	0	2	1

Appendix 22: Collocates of *personality disorders* in the 2000's corpus down to total word frequency 1

Word	Total	Total Left	Total Right	L5	L4	L3	L2	L1	Centre	R1	R2	R3	R4	R5
PERSONALITY DISORDERS	366	0	0	0	0	0	0	0	366	0	0	0	0	0
OF	155	122	33	18	9	25	14	56	0	0	0	3	13	17
THE	155	90	65	25	17	33	9	6	0	0	13	25	12	15
WITH	134	117	17	7	12	26	8	64	0	0	2	3	6	6
AND	91	46	45	8	6	18	13	1	0	0	31	2	2	10
IN	67	19	48	4	10	2	3	0	0	0	29	2	7	10
FOR	58	50	8	6	10	19	5	10	0	0	0	3	2	3
A	54	17	37	5	9	2	0	1	0	0	5	16	8	8
TO	54	31	23	13	5	4	7	2	0	0	1	4	6	12
ARE	49	4	45	2	0	0	2	0	0	0	41	1	2	1
WITHOUT	43	35	8	1	4	2	0	28	0	0	1	4	1	2
THAT	38	26	12	1	4	7	2	12	0	0	1	3	1	7
DSM	38	38	0	3	4	9	19	3	0	0	0	0	0	0
OR	35	24	11	4	3	4	13	0	0	0	4	1	0	6
SUICIDE	35	29	6	9	1	18	0	1	0	0	1	2	1	2
WERE	34	3	31	2	1	0	0	0	0	0	25	1	4	1
ATTEMPTERS	28	25	3	2	3	0	20	0	0	0	0	1	1	1
HAVE	28	11	17	4	0	4	2	1	0	0	8	6	2	1
PREVALENCE	27	21	6	0	7	2	12	0	0	0	0	1	2	3
IV	27	24	3	1	3	4	0	16	0	0	0	3	0	0
PEOPLE	25	23	2	4	2	1	16	0	0	0	0	0	1	1
CLUSTER	24	19	5	2	0	0	17	0	0	0	0	2	1	2
PATIENTS	23	22	1	1	2	4	15	0	0	0	0	0	0	1
IS	22	5	17	1	2	1	1	0	0	0	6	2	6	3
MENTAL	22	4	18	1	2	0	1	0	0	0	0	13	4	1
NOT	21	4	17	2	0	1	0	1	0	0	1	12	1	3
SUBJECTS	21	19	2	4	7	3	5	0	0	0	0	1	0	1
PERSONALITY	21	9	12	1	5	1	2	0	0	0	1	4	5	2
AS	20	4	16	0	0	1	2	1	0	0	9	2	1	4
THOSE	19	17	2	1	4	0	12	0	0	0	0	1	1	0
BORDERLINE	19	12	7	1	3	1	0	7	0	0	3	1	2	1
MORE	17	5	12	1	1	2	0	1	0	0	3	6	2	1
AMONG	16	12	4	2	3	7	0	0	0	0	2	0	1	1
B	16	15	1	2	0	1	0	12	0	0	0	0	1	0
BY	15	4	11	2	1	0	1	0	0	0	3	2	3	3
BE	15	4	11	0	3	1	0	0	0	0	0	7	2	2
FROM	15	8	7	1	3	2	1	1	0	0	1	2	1	3
FOUR	14	12	2	0	1	0	2	9	0	0	1	0	0	1
ASSOCIATED	14	2	12	0	0	0	2	0	0	0	0	6	3	3
STUDY	13	4	9	0	0	2	2	0	0	0	7	0	2	0
IT	13	2	11	2	0	0	0	0	0	0	6	2	0	3
COSTS	13	12	1	3	8	1	0	0	0	0	1	0	0	0
SAMPLE	13	3	10	1	2	0	0	0	0	0	1	0	3	6
WAS	12	2	10	1	0	0	1	0	0	0	6	1	2	1
BETWEEN	12	10	2	4	0	1	0	5	0	0	0	0	0	2
WHETHER	12	11	1	0	1	3	0	7	0	0	0	0	0	1
AVOIDANT	12	8	4	1	5	1	0	1	0	0	0	0	4	0