Personal Construct Psychology and Person Centred Care

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This paper seeks to elaborate the contribution of Personal Construct Psychology (Kelly 1955, 91) not only to understanding the experience of dementia from the point of view of the person diagnosed, the family care giver, health professionals, you and I, but also as a framework for describing the process of person centred care that is seen to be central to good practice for this client group.

Introduction

There is a great deal of discussion in the literature about person centred care, which is widely recognized as the critical shift in philosophy required in the development of the 'new culture of dementia care'. The range of creative approaches to communicating, working with, and designing appropriate environments for people with dementia is ever increasing: Naomi Feil's Validation Therapy (1982); Stokes and Goudie's Resolution Therapy (1999); Charles Murphy's Life Story Work (1994) ; Tom Kitwood's concept of 'personhood' and 'well-being' (2001); Gary Prouty's Pre-Therapy (1999); and Yale's group therapy for early stage Alzheimer's (1995) to name but a few. But there is also a great deal of criticism about the practicality of achieving this 'ideal' in the 'real world' (Packer 2000).

Working with people with dementia at all stages of the disease, but perhaps particularly so in the more advanced stages, is extremely stressful. Staff recruitment and retention problems are pervasive, and low morale and burn out are the norm in many of the care facilities

both in the UK and across the world. The recognition of the economic benefits of nurturing your staff that is commonplace in business settings has yet to have the same influence in the public and health service sectors.

It is not uncommon to come across creative and well motivated staff who return from inspiring courses, only to find they are 'unable' to put what they have learnt into practice because of pressures of time. The 'new culture of dementia care' has been elaborated in relation to the client group and the responsibility lies with the formal care-givers to put this into practice, but without reference to the organizations within which they work. Change is difficult at the best of times, but it seems to me that it is an empty gesture to invest money in training individuals unless all members at all levels of the organization have made a commitment to the goal of person-centred care.

Part of the story, but by no means the only answer to the problem of facilitating a change in the culture of an organization, is the issue of non managerial clinical supervision. It is recognized that family care-givers benefit from sharing their experiences in support groups, and yet formal care-givers are often expected to work long hours and provide quality care for people with a disease that has enormous social stigma, can induce terrible suffering, and for which there is no cure, only an inevitable death. A tall order by any standards.

Time out from the tasks of work in order to reflect on interventions made, how these could be done differently, and to problem solve situations that seem insurmountable, not only improves practice but makes staff feel of value and promotes a sense of being able to make a difference, despite the relentlessly progressive nature of the syndrome of dementia. A personal sense of 'making a difference' is

one of the crucial elements in averting low morale and burn out in formal and informal care-givers, something that I hope to illustrate in the elaboration of the experience of dementia for all those involved.

The Need for a Theory

Many of the creative interventions for this client group have their own philosophies and rationales and are often seen as distinct approaches. Killick and Allan (2001) point out that what all these approaches have in common is a "person-centred focus". They argue that communication is central to all approaches to dementia care, and in elaborating ways to communicate with people at all stages of dementia, they stress the importance of care givers seeking to understand themselves and the way their own processes impact on their caring role.

Tom Kitwood coined the term 'personhood', the concepts of which are "complex ideas, slippery and intangible as soon as you start to think about them" (Killick and Allan 2001). Kitwood's theory of personhood is rooted in philosophy, elaborating ways of being and relating, and maintains that no one can flourish in isolation. The need to connect with another is inherent in human nature, and therefore is a 'normal' need of any person, including people with dementia. Care giving without this 'meeting' is felt to lead to dehumanization, and this is elaborated in his account of "malignant social psychology". Malignant social psychology refers to the ways caregivers may interact with people with dementia and contribute to the secondary handicaps associated with dementia. Essentially his writing puts the emphasis on the PERSON with dementia, as opposed to the stereotypic view of the person with DEMENTIA.

Bere Miesen (1999) advocates that "first, we need to understand what is happening to them", and to do this we need to understand the nature of cognitive impairment in order to help the person experiencing those symptoms "find a handhold". Gemma Jones' "Reminiscing Disorientation Theory" (1997) elaborates this notion by describing the problem of disorientation as a problem of the transit between "reminiscing disorientation" and reality, whether voluntarily or automatically. Fundamentally, she sees the person with dementia trying to make sense of, or find meaning in their environment, under the circumstances of increasingly threatening cognitive and emotional chaos.   Miesen (1999) has applied Bowlby's Attachment Theory to the experience of dementia. He points out that 'attachment behaviours' (proximity and closeness seeking behaviour) exist in people at all stages of their lives, particularly when they feel unsafe and insecure. The "awareness context" describes the observation that people with dementia continue to feel that strange things are happening to them at all stages of the disease. He also relates this to the experience of the care giver; there is an interdependence of closeness giving behaviour and the need to "maintain enough distance". In order to recognize potential signs of "over involvement, meddling, or a sense of total helplessness", it is important for care givers to reflect on their own feelings about their work.

Ian Morton (1999)) traces the undoubtedly important influence Carl Rogers and person centred counseling has had on the development of a variety of approaches in the 'new culture of dementia care'. He is concerned that not all so-called 'person-centred' approaches conform to their origins in Rogerian theory and practice. He feels there is a danger in the term 'person-centred' becoming "synonymous with good quality", and seeks to clarify the principles of client centred therapy

and their implications for person centred care in dementia. Whilst theory and techniques are important, he talks of Rogers' stress on the attitude of the therapist, and ways to create a "helping relationship".

The experience of dementia has been elaborated in various ways, therefore, from a more abstract and philosophical perspective to the elaboration of practical ways to communicate and intervene, and each has an important role. At the heart of all of these theories and approaches is the person, however it seems that a satisfactory definition and theory of person centred care has yet to emerge. What is this 'thing' that so many people have identified, but which is so elusive to description? Does it matter? We can all intuitively tell when a particular intervention is working, or not as the case may be. Why do we need a theory?

Everyone needs a theory in order to give meaning to their actions and develop personally and professionally. For example formal caregivers will all have a theory about the nature of the syndrome of dementia, and some may be more informed than others. The belief that a particular resident of a care home cannot communicate may mean that the carer does not talk to him or her, and may carry out intimate nursing tasks whilst talking to a colleague. I have witnessed how a formal caregiver, after attending a validation group with a resident such as this, completely changed her perception of what this person could and could not do, subsequently changing her approach. The way we individually make sense of events (our personal theory) guides our actions.

Furthermore all services are funded on the basis of efficacious intervention that is an economically viable way to deal with the problem of dementia, rather than an altruistic motive to keep everyone as happy as possible. We still need to show that person centred care makes economic sense, that it is achievable on a restricted budget, and that it keeps staff happier, healthier and wanting to come to work.

A meta theory that can make sense of and provide us with a way of describing how people interact with the world in any situation, at any level of awareness, with or without symptoms of dementia, may well be a way of describing the nature of person-centred care, and indeed the lack of it. At the heart of good and not so good practice are people, each with their own theory of events that informs and determines their behaviour.

Personal Construct Psychology (PCP) is one such meta theory, an individual psychology which can capture the experience of people in the task of living, that can be applied equally to the person with dementia at all stages of the disease; family and formal care-givers; and you and me. It is a framework which can describe the process of therapy from the individual's perspective in any situation, and consequently can integrate the eclectic influences of the cultural revolution in dementia care (Morris 2000). Bender (2002 in press) also promotes PCP as a useful "overarching theoretical approach" for describing person-centred care for people with dementia.

Importantly Personal Construct Psychology is an approach to understanding the experience of people generally. Any approach which can make sense of the way anyone behaves and the choices that are made, including the behaviour and choices of people with

symptoms of cognitive impairment, has to be a very respectful way to attempt to understand the experience of dementia. Whatever chronic illness may befall someone, the threat of becoming 'a patient and nothing but a patient' seems to be paramount for many people. This issue is fuelled by society's view of disability generally, and in particular diminishing cognitive ability.

In this same vein, PCP is not an *alternative* therapy for people with dementia, something that should be seen as in competition or in any way negating or detracting from other therapies. On the contrary, PCP is more of an 'umbrella' theory or meta theory that makes sense of why these approaches work in many situations and why they might not work in others. It is a framework that could go a long way towards describing the *process* of therapy, the process of person centred care and how 'personhood' is achieved in people generally.

Rehabilitation, learning and motivation.

Central to all theories of therapy is an appreciation of what is known about the way people learn, how we account for motivation and the therapeutic relationship. Issues of transference or in medical and research contexts what is often termed the 'placebo effect' have always entered the debate as to what is actually taking place in effective therapy. It is beyond the scope of this chapter to give a historical outline of the long and unresolved disputes in neurological rehabilitation, but it appears to me that these issues are the very same as those that are being addressed in the person centred approaches to working with people with progressive cognitive impairment. Medical 'rehabilitation' is usually provided only for those

who have a stable condition, and directed towards improving a particular skill. The process of rehabilitation, psychotherapy, and communicating with people with a diagnosis of dementia all have one thing in common: the person with their own theory of what is happening to them and what might be done about it.

When a specific programme, technique, or therapeutic approach is ineffective, there are numerous ways this 'resistance' is explained, and the issue of motivation on the part of the patient is often raised. In medical research design, particular attention is paid to eliminating the effect of 'placebo'. In neuropsychological research an attempt is made to control for the effect of the therapeutic relationship. These are issues known to have an important influence in bringing about change, but so far have proved elusive to description.

Attempting to 'control', or cancel out, the unique and powerful influence in therapy of what it means to be human is difficult. This process may always defy measurement, but with advances in the understanding of behaviour from the study of neuroscience, and a theory which can elaborate the role of the person in all these situations, we can evaluate in greater detail the nature of people's responses to our interventions, whether they are successful, or whether we meet with 'resistance'. In this way the scientific method is applied to designing more and more effective intervention for the *individual*, rather than pursuing the expectation that a particular approach will be effective in all those with a particular condition. In neuropsychological rehabilitation, advances in understanding of the unique way language, memory and perception can break down in individuals has given credence to the value of single case design in therapeutic research (Howard 1986).

Personal Construct Psychology (PCP)

George Kelly's Theory of Personal Constructs (1955, 1991) is a comprehensive theory about how people go about the process of living. It's starting point is a philosophy coined "Constructive Alternativism", which makes the assumption that there is a real world out there, but people can only construct a version of that reality. Our construction of the world is constantly under review and change, hopefully improved upon, but the *TRUTH* is never attained in any absolute sense. Importantly however, the way a given person makes sense represents the truth for them at that particular time. Constructing reality is seen as 'man and woman's nature', the very fact of being alive is a continual striving to make sense of the world around him or her.

This premise has important implications for people with dementia, people whose nature it is to construct a version of reality at any given moment in time, but whose perceptual, memory, and language impairments might well mean their experience of events is very different from those who do not have such impairments. The vastly different ways two people might, and frequently do, construe an event in everyday life is hugely magnified by these highly debilitating, progressive, and often fluctuating cognitive changes.

PCP and Motivation

Fransella (1984) describes PCP as "starting from the premise that we, each one of us, is a process. We are alive. One feature of living matter is that it inherently changes. There is therefore no need for a theoretical concept of energy to explain what "motivates" the person

to act." Making sense of events is seen to be a fundamental property of being human. The comprehensive theory captures and accounts for all those instances where people fail to demonstrate this natural tendency, and lack motivation or 'resist' our attempts to help them, however well planned and appropriate we feel our therapy to be, and however much from the outside we may consider it to be against that person's interest. Instead of feeling demoralized (invalidated) by our futile attempts to help a given person who 'lacks motivation', this theory can help us to make sense of their 'choice', and in some but maybe not all cases design an intervention that does 'make a difference'.

The Person As Scientist

The metaphor of 'person the scientist' underpins the PCP approach to describing how people go about the task of living. People are seen to construct their own personal theory of people, objects and events, test this theory through their actions, and modify it according to the 'results' of their 'experiment'.   The results of this experiment are either *validated*, confirming our personal theory, or *invalidated,* suggested that our theory is wrong and requires revision. Revision of our theory of events is what is involved in the process of change.

This idea is a simple and practical one, and is fully elaborated in the body of the theory itself, some important parts of which I will try to share with you in this chapter. George Kelly's Theory of Personal Constructs is, however, very comprehensive and it would be inadvisable to try to condense his two volumes into one short chapter, therefore I will limit my discussion to that which helps to illustrate

some important issues, in the hope that it will whet the reader's appetite to explore the richness of this approach to understanding people further. The essence of the theory is an abstract framework in which it is possible to understand a person's behaviour by attempting to see the world through their eyes, whether this is deemed 'normal' or 'deviant'.   All behaviour is seen to make sense in light of the way the individual perceives events, and as such we ask the question: "To what problem is this behaviour the solution?". The notion that all behaviour is meaningful is likewise crucial to all the person-centred approaches to working with people with a diagnosis of dementia.

'Reflexivity'

Reflexivity refers to the property that this theory of the PERSON applies to everyone: practitioner and client; child and adult; each and every one of us as we go about our business. It is not a pathological model, but applies equally to you and me, people with severe and enduring mental health problems, people with learning disabilities, as well as people with a diagnosis of dementia and those attempting to care for them. This brings respect and humanity to the experience of dementia that the stigma of this disease erodes, and has an important influence to bear on the nature of the therapeutic relationship.

Angela Cotter (2001) describes the dominant perspective of our society as being individualism, independence, and an overvaluing of cognitive skills over creativity and understanding, in terms of Jung's 'Shadow'. This is a Jungian concept which stands for "those rejected aspects of ourselves that are cast in darkness: repressed because individuals or societies feel they are not acceptable". To look in the

light where it is easy to see as opposed to stepping into the shadow and "an ill-defined world", is likened to the problem of caring for people with dementia, a need to dare to explore the unknown, our shadows. PCP can help to give structure to this venture, something to help guide our intervention in what seems like uncharted territory. The same framework describes the processes in ourselves as care-givers, and the importance of doing this is advocated by other leading authors (Killick and Allen 2001; Miesen 1999).

The metaphor for therapy advocated by George Kelly is one of partnership, similar to that between a research student and their supervisor. The person in therapy is the expert on himself or herself, and the therapist is the expert in the nature of change. This starting point in therapy has proved to be an empowering one, particularly so for people with enduring mental illness or progressive cognitive impairment, in stark contrast to the way society would construe their situation. This stance allows the practitioner to feel more comfortable with not having the answer, handing the responsibility for change to the 'client' or 'patient', and creating a platform from which to 'elaborate the complaint' (Kelly 1955, 91), a strategy with which to dare to look in Jung's Shadow for the context of behaviour that is outside our immediate understanding. An example of this can be found in Rose, my first referral in a new job in psychiatry, one year post graduation as a Speech and Language Therapist. The analogy of looking in the shadow described by Angela Cotter has great resonance in trying to formulate a plan to intervene with a woman of nearly sixty, referred for an "agonizing stammer", who presented without any verbal communication, rocking, moaning and attempting unsuccessfully to vomit in her lap. 'Looking in the light" would have probably prompted an attempt to apply usual strategies for the

assessment of her stammer with the conclusion that it would be impossible to work with this woman until she was able to discuss her complaint. Looking in the 'shadow' involved working non verbally, in a similar way as one would with someone with advanced dementia, in order to make contact and develop a therapeutic relationship. What followed is a very long story, however after some twenty years of regular readmissions to hospital, Rose has now been well for in excess of eight years, with no sign of relapse.

Behaviour is an Experiment

As 'personal scientists', in every action and interaction we are making predictions and testing them out, as I am in writing this chapter. The results of our experiment, or the outcome of our behaviour, either validates or invalidates our theory of events. Our responses to the evidence derived from our experiments determines whether, and how, we adapt and change in relation to events.

Validation

 If we are right in our prediction, then we are validated, and will repeat our 'experiment', continue with the behaviour, and even make more elaborate experiments along the same theme to develop our understanding of the world. This in 'Kellyan' terms is known as *aggression*. Aggression to Kelly means the active elaboration of our personal theory of the world, and in most cases would be seen as a desirable state of affairs.

The elaboration of PCP in relation to the experience of dementia has been a long process with 'experiments' to test an evolving personal theory in a variety of contexts, some more 'validating' than others, but all contributing important 'evidence' in order to refine and develop a more comprehensive understanding of the process of therapeutic work with people with dementia and their families. Writing this chapter represents further testing of the prediction that this approach will make sense of something for you.

Some of the important sources of validation for a person with dementia are successful communication, feeling understood, and exercising choice. These are areas of validation for all of us, and seriously compromised by the experience of dementia. The experience of validation in therapy at the time is by no means to be underestimated in terms of its significance, however the extent to which it can be transferred into that person's everyday life is the true yardstick. Helping families, residential staff members, as well as the general public, to understand the nature of neurological disabilities, and how to help compensate for them, will help to increase the experience of validation for the individual with dementia in daily life.

Invalidation

Should our prediction turn out to be wrong then we are invalidated, as I would be if I found that what I am trying to express, is meaningless to you. Life is full of ups and downs for everyone. We experience invalidation at regular intervals, but when we are coping well this is

balanced by validation in other ways, and we can always change the way we do things.

Invalidation is not always a bad thing, but a vital part of the process of change and our own personal evolution. An example of this for people with dementia is the notion that if you have difficulty remembering things you are stupid, something that it is important to invalidate. This is society's construct internalized in many of us. Perhaps only by coming to know a person with dementia well, and by having an understanding of the nature of cognitive disabilities, can one begin to appreciate the intelligence and creativity with which people manage their disabilities.

A younger person with dementia will be invalidated in their sense of competence much of the time through having to give up work and finding 'busybodies' interfering in their life by providing 'help'. Care staff are invalidated by not being able to provide person-centred care through resource constraints or because people do not respond to their interventions

So what can we do in the face of invalidation? Most situations can be accounted for by the following alternatives. Each response is seen to be adaptive, and serves to help us to maintain control in the face of invalidation. People are not seen to be passively reactive, but actively engaged in the process of making sense, whether at a conscious level or at a lower level of awareness.

1.   **We can try again**.

We do not throw aside our personal theory of an event lightly. Maybe there is something 'in the weather', or we are having an 'off day'. We can dissociate ourselves from the possibility that our theory is faulty,

put the invalidating evidence down to freak chance and repeat our behaviour. This strategy is seen in people with dementia too. An example of this is Albert (Packer 2000) who eventually lost his temper after repeated invalidated attempts to discover his circumstances on admission to hospital. As caregivers we are all likely to have been in the position of deciding to try a particular strategy again. Maybe we are unsure of what else to do at the time.

2. **We can re-evaluate our theory**, **generate an alternative hypothesis, and so conduct a different experiment by behaving differently***.*

We do however get things wrong and need to revise our personal theory. In light of the invalidating evidence from talks in the early years of my career, I reconstrued the way I presented the material and gave a great deal more thought to the likely expectations of those in the audience. It could be argued that the person with brain injury may be limited in their ability to re-evaluate their theory because of the nature of cognitive disability. However I have witnessed *reconstruction* in some of my clients.

Gina reconstrued Alzheimer's Disease, as did her husband. This was achieved through giving her time to talk in a confidential environment, and helping her to 'put her cards on the table' in order to problem solve the issues arising as a result of her condition. She discovered that by being more open about her disability with family, friends and some but not all acquaintances, the task of living with AD was less of a burden. When others understood more about the nature of her experience and how they could make things easier (they have a more detailed theory on which to base their predictions), many people responded more often in a way that was validating for Gina. For

example when she explained about her word finding problems and how it helped to be given time, people were less embarrassed and more likely to tolerate the long silences in the pursuit of meaning. Gina came to describe her condition as "not the end of the world".

Change is difficult at the best of times, and with neurological deficits that affect flexibility and organisation of your thinking, it could be expected to be much more difficult. Whilst people in the earlier stages of dementia can and do reconstrue their circumstances, the onus is likely to be on the caregiver to change *their* behaviour to accommodate the neurological deficits of the person with dementia in order to enable **reconstruction**, or possibly in many cases we are attempting to compensate for deficits in order to facilitate the ability to make sense and therefore encourage 'appropriate' behaviour. This has been demonstrated by various approaches to caring for people with dementia, including building design, communication strategies and activities that help the person with dementia to better predict and feel safe in their environment. Attention to altering the environment or context in which our client is living is not confined to people with dementia but all client groups, and indeed ourselves in our own lives. We change and evolve with new experiences, changes in circumstances, and with each new person we come to know. Our theory of the world needs updating, and this is a very significant part of the picture when working psychotherapeutically with anyone using this framework. In the earlier example of Rose, almost all interventions were directed towards altering her environment, and while there was significant, profound, and lasting change, she never volunteered what she thought had changed, except in a very concrete way.

3.   We can refuse to accept the outcome of our 'experiment' and cling to our original prediction.

Theories very dear to a person's heart are very resistant to change. If we don't like the evidence we can choose to interfere with it.   'Denial' may manifest itself in anger, aggression, and the tendency to blame others or find excuses because to acknowledge the 'truth' is untenable. A family caregiver may be unable to appreciate the nature of language disorder in neurological disease, and is likely to be protecting themselves from the awareness that the person they love and care for is losing the ability to express themselves as before. A common reaction is to insist the person with aphasia access the 'right' word, e.g. 'meat' is wrong when you mean 'beef', possibly fuelled by the widespread belief that 'if you do not use it you lose it'. The importance of the pursuit of meaning can be lost when we are faced with communicating with people whose language is affected (Morris 2000), and we can feel the influence of society's construing of linguistic competence in this example. *Hostility*, as it is known in PCP terms, is the continued effort to extort validational evidence, or in other words 'cook the books' to maintain a particular way of seeing things, and is a label that requires caution. Does the person actually *know* they are wrong? There is always a very good reason for hostility, and it plays an important part in protecting the core of our being. It is frequently seen in the early stages of dementia, perhaps because acknowledging that your faculties are slipping is likely to be very threatening to one's sense of being a person, and has been described as worse than death itself.

For Rebecca (Morris 1999b) and many other people with dementia it is just too threatening to face up to what she <u>knows</u> is happening.

Despite being in an advanced stage of an inherited dementia, where her speech and language, memory, and mobility among other things were all affected in a similar way to her mother, and despite having both her young children in full time nursery care, Rebecca talked of returning to work once her children were older. Shortly after this conversation she handed her purse to the cashier in her local store for her to take the right money for her shopping. Her refusal to accept professional input could be better understood in terms of her own personal goal to ignore validational evidence and insist that life was going according to plan. But she was certainly not unaware of her difficulties.

'Confabulation', angry or aggressive behaviour, refusing to co-operate and blaming others are all possible signs of *hostility* in a person who needs to distort the 'evidence' in order to maintain some degree of control and composure in everyday life. It is important to respect denial rather than try to orientate people to the 'error of their ways'. This is not a recommendation to collude with denial, but to try to validate the person's life experience. Rebecca had a great deal to contribute about the nature of her work as a make up consultant, without it being necessary to go along with her claim that she would ever be returning to work. Trying to provide support for people with dementia and their families can be a very frustrating business and often health care professionals are 'forced' into confronting denial in order to carry out their remit. The experience of caring for your son or daughter who is dying from the human form of BSE in cattle, known as variant CJD (Creutzfeldt Jacob Disease) must represent every parents nightmare, and some people have only been able to cope with caring for their relative by believing that their son or daughter will get better, which in their heart of hearts they know will not be the case. The

advent of a possible treatment has fuelled this response. Discussion and decisions about alternative feeding, ignoring recommendations that the affected person is fed upright and fluids thickened, refusing to use hoists or any other symbol of 'disability' or incapacity is common, causing no end of difficulty for health care professionals who need to adhere to standards and policies. There is no set answer to these situations, however, listening to families; focusing on the affected person's needs and quality of life; demonstrating validating strategies, activities and interventions; coming to know them as a person and not just a patient; and above all being flexible; helps to maintain a therapeutic and supportive relationship where the appropriate decisions are made as they arise and can no longer be ignored. Health professionals need to anticipate deterioration in planning service provision, however families often cannot.
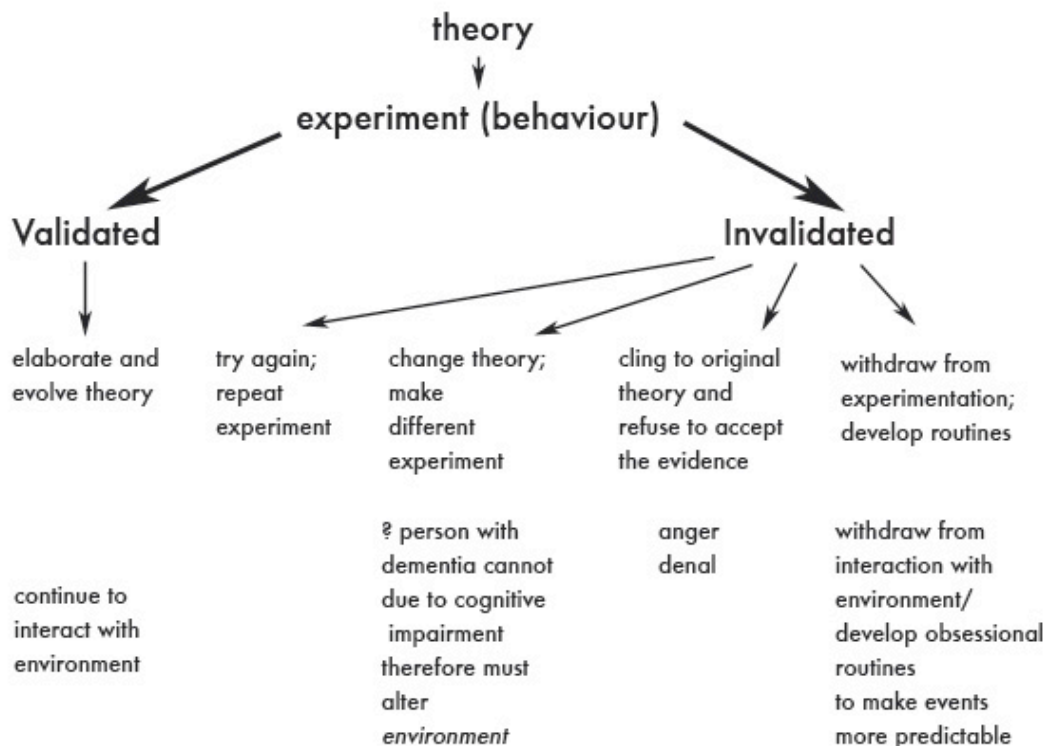
**4.	We may choose to withdraw from 'experimentation' in order to avoid putting our 'faulty' theory to the test**.

This can manifest itself either passively or actively, as in physical withdrawal from the environment, or obsessive compulsive behaviour which attempts to increase predictability of the person's world. *Constriction* (the term given to this withdrawal from experimentation) is enforced to a great extent in neurological disease; difficulty expressing yourself will tend to restrict conversation; visual and perceptual deficits will mean you miss out on information or it is distorted. Further constriction takes place with repeated invalidation, illustrated by the way people with Alzheimer's gradually withdraw from interaction with their environment: people may often take to their bed for very long periods; and people with frontal lobe degeneration such as Pick's Disease often develop 'obsessional' routines to cope with their

anxiety. One gentleman, when he attended clinic, would at regular intervals leave the interview and march out of the hospital, up to a lamp post, touch it and march back. When asked why he did this, he said because it made him "feel lucky, unlike this Pick's thing". Perhaps it was a way of creating a small island of validation for himself, as the lamp post was always there to be touched. Likewise, Bill (Packer 2000), who created a 'no-go' area around himself, was perhaps constricting in response to the perceptual problems common in some forms of dementia. If events fail to make sense and people's actions do not appear as they are intended, but are frightening and unpredictable, or if you are responding to hallucinations, then creating a 'no-go' zone is a practical solution to the problem. (Morris 1999, 2000).

The Personal Scientist:

theory

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experiment (behaviour)

Validated   Invalidated

Validated		Invalidated		
elaborate and evolve theory	try again; repeat experiment	change theory; make different experiment	cling to original theory and refuse to accept the evidence	withdraw from experimentation; develop routines
continue to interact with environment		? person with dementia cannot due to cognitive impairment therefore must alter environment	anger denial	withdraw from interaction with environment/ develop obsessional routines to make events more predictable

Levels of Awareness

Our 'theory' of the world is built up of **constructs**, which are discriminations of similarity and difference about events around us. These constructs are built up over a lifetime, possibly from the moment of conception, but more easily recognizable after we are born. A baby quickly learns to recognize 'mother' from 'not mother', hunger versus satisfied, warmth versus feeling cold. The infant learns how to effect a change in their environment, gradually building up a more and more elaborate, non verbal, theory of the world around him or her. This theory is elaborated in the mother-child relationship: "an exchange, par excellence, of people making people" (Shotter 1970). As language develops, children learn to express their discriminations through language, and our theories of the world continue to be elaborated with the help of language. It is important however, to stress that constructs are NOT the verbal labels we use to communicate our construing.

So construing is developing very early in life, before the development of language, and is not purely a cognitive affair. Those parts of our construing we are actually able to verbalise is probably only the 'tip of the iceberg'. How many times do you get a 'gut' feeling about something you cannot or have difficulty in putting words to? Have you ever met someone for the first time and had a strong sense of whether you liked or disliked them, which you could only put an explanation to several meetings later? Preverbal and non verbal construing is related to the very essence of our being, the spiritual dimension that has an enormous impact in the field of dementia care.

In the same way as our theories of events do not exist purely in conscious awareness, nor are our 'experiments' or behaviour

necessarily something we are consciously aware of formulating. We 'construe' or experiment and change with our whole bodies and we may never notice or articulate the process. An illustration of this is to be found in sitting down. We make a prediction as to how hard or soft a chair is by glancing at it, then the whole of our body is tuned into the experiment of sitting in that chair without falling on the floor. The experience of invalidation is felt when it is harder or softer than expected, or when it breaks or wobbles. Our theory of sitting behaviour is very elaborate, built up over a lifetime, requires the involvement and co-ordination of many different muscles, all finely tuned to enable us to sit down gracefully in a range of sitting contexts, simply by glancing at the seat. When it goes wrong we might be more cautious next time, but essentially our theory remains intact. If we break a leg, we have to reconstrue the whole process; if neurological disease interferes with our functioning, again we must reconstrue. A condition known affectionately as 'bottom apraxia' makes this explicit. If every time you try to sit down, you are unable to co-ordinate your body successfully, your theory of sitting is going to be invalidated, and is likely to affect your behaviour and activity. Perhaps you might constrict and pace up and down, wander, or sit for long periods taking 'possession' of your favourite chair. Perhaps you might get very angry and irritable, 'blaming' people around you for interfering. If those trying to help you are unaware of the nature of your struggle, they may well try to encourage you to do things that frighten you. If your condition is stable, you may 'reconstrue' and find ways of adapting to your disability. With a progressive condition affecting cognition and mobility, this is likely to be much more difficult. Certainly one of the most difficult things for people in this situation is trying to do "two things at once": for example listening to instructions and trying to co-ordinate limbs that won't do as they are willed; walking and having a

conversation; using a knife and fork and following what others are saying.

'Gut' Construing

Construing at lower levels of awareness could be described as 'gut' construing. How is it people with memory impairment can benefit from therapeutic work when they can't remember what has been said? Margaret has moderately severe vascular dementia and was part of a validation group for two years. It was a shock to the nurses to discover she could speak, although she was unable to contribute fully to the conversation in the group. However she used to join in songs and make occasional comments such as: "It is better to have loved and lost than never to have loved at all" and "my brain is going up the wall". After 18 months in the group, she was able to say what she liked about the group, whilst not actually in the group or the group room. She liked to "see what everyone is wearing". Once cued in to the fact it was time for the 'meeting', she could 'remember' the good feelings that had taken place over time. People with dementia often recognise and remember people who have very pleasant or very unpleasant associations. Oliver Sacks (1985) gives an account of an 'experiment' to shake hands with a man with amnesia when he had a drawing pin in his hand, demonstrating this 'gut memory'; he refused to ever shake hands with him again but could not remember what had happened nor explain why.

Validation, invalidation, and all these alternative responses to invalidation take place at all levels of awareness, and at the level of 'gut' construing, it would appear that memory may be relatively preserved in people with memory disorders. At this level of awareness therefore, new experiences do have an influence on our construing of

events. We are not totally dependent on a conscious and articulate evaluation in order to reconstrue, which has important implications for therapeutic intervention in neurological disease.

Core construing

It is important to account for the fact that some aspects of ourselves and the way we make sense of the world are more important than others. For example, if I were to burn the food at a dinner party, I would be far less traumatized by the experience than Delia Smith might be. Some aspects of our being in the world are far more central than others. Core roles, such as being a woman, a parent, being a good communicator and someone who makes a difference to those around me, have a much greater bearing on my functioning than producing high quality cuisine. For Delia Smith this may be a different story, but there may be some commonality there too. The stereotyping and stigma of dementia represents society's construing of the symptoms of memory failure, intellectual decline, dependence on others, and odd behaviour. These constructs form part of our own core construing too, and have an important influence on the way we respond to the appearance of these symptoms in ourselves. Preverbal and non verbal construing is part of our 'core', and the closer a construction is to our core, the more resistant it will be to change. Choice, competence and independence are 'core' for most people, however culinary expertise and constructions of cleanliness or tidiness may have a good deal more variability in terms of their importance for different people. We see the influence of core construing in the behaviour of people with dementia, an example of which can be found in the management of continence. Some people are far more tolerant

of the standard ways of managing incontinence than others: regular toileting, wearing pads, and being cleaned up. Many a placid person kicks and hits out when this particular nursing intervention is carried out. Maureen, with advanced dementia, was causing considerable management difficulties for nursing staff, who needed to hold her down in order to change her due to being doubly incontinent. She was in denial, barging out of the toilet with "bloody cheek", and lashing out when being changed. Her background as a school matron, a conscientious mother and housewife who set a lot of store by cleanliness, her comment when attempts were made to toilet her regularly (perhaps she associated this with being treated like a toddler) all pointed towards core construing, something that would be highly resistant to change. By approaching her and inviting her to come for her morning wash, she was fully co-operative, becoming upset and distressed when she discovered her incontinence, but never violent. It became possible to validate her feelings about her incontinence in private, and it became unnecessary to restrain her.

To achieve meaning, to make contact, is validation at a core level. This can be achieved in many different ways, and whilst cooking may not be a core issue for everybody, eating is. Some people enjoy eating more than others, and some people are eating disordered, but food is an issue central to all of us and crucial to survival. It is also often the one activity that can still be pleasurable (and therefore validating) for people with advanced dementia. Newton and Stewart (1997) describe an approach to nutrition which seeks to tap into tacit memories of eating, and invites us to make every day a party. Dr Stewart's background in Personal Construct Psychology is evident but unstated, in the way he roots nutritional and physical disability issues in the culture and context of people's eating behaviour. The need for

both professionals and family caregivers to "make a difference" to the person they are caring for is also seen as paramount.

Sociality

People not only require social interaction for their well-being, but it is through trying to predict the way *others* make sense of events that we enter into a relationship. Our predictions and therefore theory may be wrong, but the attempt to do so is what, in PCP terms, is termed *sociality*. The attempt to stand in the shoes of another is the way we achieve relationship, and therefore psychological contact. It feels good when someone accurately subsumes your experience; it feels less good when your needs and feelings are not understood; but it also helps when you can sense that the attempt is made. Furthermore, "it is important to remember that any interaction between two people who are making attempts to understand each other's construction system (Sociality) leads to each playing a social role in relation to each other, and this may in turn lead to changes in both construct systems" (Dalton and Dunnet 1990). The mother-child relationship described by John Shotter as "people making people" highlights this. It is not just the baby who is changing and learning, the mother (father, other siblings, extended family and so on) are all undergoing change as a result of construing the baby's needs. Furthermore this transcends language. Discrimination, anticipation, and validation are at the heart of any relationship, and it is this we need to promote in those whose relationships are compromised through cognitive disability.

In PCP, any prediction made about another's experience is *propositional* (tentative and seeking clarification). This is a very useful platform from which to plan person-centred dementia care, as it frees us to try things out, evaluate their benefit and change or develop the approach. In the case of the person with dementia who is 'unaware' of our presence; are they really unaware, or so *constricted* that they are unable or unwilling to respond? Is response delayed so long that we are already involved in something else? It is always important (but not necessarily easy) to assume the person is aware. To reconstrue "unaware of my presence" is to free yourself from the invalidation of caring for someone who does not acknowledge your existence. Careful observation of the person's behaviour may provide clues to a way to make contact sometimes. If we don't have training and most importantly supervision, reconstruing situations such as these is far more difficult. Add to this the time-pressured reality of continuing care, and we might be tempted to *constrict* by withdrawing and focusing on other residents, or we might be *hostile* and punitive. This stance provides us with a more validating path to follow, a hopeful one in which we might be able to make a difference.

Steven Wey (personal communication 2001) works therapeutically with people with dementia, using a variety of techniques and frameworks, and is influenced by PCP. He uses the technique of 'mirroring' a great deal, where an apparently meaningless or undirected action is mirrored in order to facilitate social exchange. This does not have to involve words, in fact some powerful examples involve no speech at all: throwing and catching a ball, or round object, involves predicting the response of others.   This is sociality, and where the exchange is successful, the experience will be validating.

Bipolar Nature of Construing

In PCP terms, one of the most important properties of a construct (our theory is made up of many linked constructs) is that it is bipolar. We only know exactly what someone means, when we know what they *don't* mean. Bill's construing of mealtimes (Packer 2000) was very different to other aspects of his day, as this was the only time he would allow anyone near him. The following hypothesis emerges:

Validated	Invalidated
Eating Permits interaction	Creates no-go zone ? all other situations – no trust

By observing his behaviour it is possible to build up a profile of situations where Albert permits interaction and allows proximity and where he does not. In what circumstances would this behaviour make sense? To what problem is a given behaviour the solution? (Morris 1999). By creating a 'no-go' zone, Bill is **constricting** his world to make it more manageable in light of the way *he perceives events.* Predictions could be made about how he is seeing, hearing, remembering and feeling in relation to our theories of how this could be distorted from our perception of events. With these predictions we

can plan intervention and try alternative strategies. The more elaborate the theory we have of his likely perceptual difficulties, the more specifically we can design intervention strategies that compensate for them. (Morris 1999, 2000) There will always be times when we are unable to find ways to validate but there is therapeutic value in the stance we take towards it.

Anxiety Threat and Guilt

Anxiety, Threat and Guilt are terms used in everyday conversation but have very specific meaning in Personal Construct Psychology.

Anxiety is defined as the awareness that events are outside the range of convenience of your construct system, you literally don't have an adequate theory with which to make sense of events. Threat is the awareness that there is going to be a comprehensive change in your core construing, such as Delia Smith might experience if she burnt the dinner. The most extreme form of threat is death. Guilt is dislodgement from your core, as was experienced by Maureen when she became aware of her incontinence.

In Allan and Killick (2001) John Killick describes his feelings when first left in a room with people with advanced dementia who he was unable to understand what they were trying to say or do, what might be motivating them. This represents Kellyan anxiety, and whilst this is a very powerful example, perhaps we can all recognize similar feelings in

our experience. He experienced fear of harm and of contamination, and found his expectations of 'normality' were completely overturned. He could sense no reason, no empathy and no love. He describes the basic part of being human is the belief that we all share something that is recognizable and communicable.   Without this belief we are threatened to the core.

 By living for a week with the residents he found that "every person was unique and responded to a different approach" and that there was a need in people with advanced dementia to "continue in relationship despite the difficulties encountered". It was through communication and successful exchange that personhood became a reality. He comments that this is where the crucial issues in the care of people with dementia lie.

Through spending time with the residents, John Killick found it was possible to find ways to relate to each individual. Anxiety in this situation gave rise to elaboration of his personal theory of the world and reconstruction, as it did for me when faced with Rose's behaviour. Once validated in his attempts to make contact with the residents, the threat of harm and contamination dissipated.

Anxiety and threat do not always lead to elaboration and reconstruction. We may well choose to constrict and withdraw, such is the threat to our core construing. As caregivers anxiety and threat will certainly raise their heads from time to time, but it is possible to use it constructively, and the more we become aware of our own construing, the more we can anticipate these situations. For the person with dementia with, among other disabilities, a failing memory, anxiety and threat are going to be daily, if not hourly or constant states.

If intervention strategies induce **Threat**, such as will occur when denial is confronted, we can expect a rough ride. Dealing with Maureen's incontinence in the context of helping her with her daily washing routine validated her core sense of herself as a person who washes regularly and avoided the threat induced by needing to be 'cleaned up'. Restraint was no longer necessary, and it became possible to comfort her in the unavoidable realization that she had been dislodged from her core perception of herself as clean, hygienic, and in control of her body (**Guilt)**

Allistair, an elderly gentleman, diagnosed with Alzheimer's Disease was referred for an assessment of his aphasia. Unable to cope with the threat and invalidation experienced in being brought face to face with the elaboration of his disability, Allistair chose to withdraw and refused language testing. A change in approach to the use of pictures to facilitate communication about his likes and dislikes, brought about a very different response in Allistair: he enjoyed being able to communicate important things about his life, and ways to facilitate communication was fed back to other members of the multidisciplinary team. A year later, long after sessions to facilitate communication had ceased, Allistair was very distressed and conveyed that he would like to sit down and discuss recent events with his wife. He had begun to experience hallucinations, for which he had been prescribed melleril, which unfortunately had not prevented hallucinations, but had caused postural problems so that he was unable to walk very far and could no longer accompany his wife to the supermarket. She would have to lock him in their flat and poke his fingers back through the gap in the door, as he struggled not to be left behind. It appears that the validating experience of successful communication was in some way 'remembered', despite his severe memory impairment.

Allistair deteriorated and died within three months, but only after communicating his love for his wife and his sorrow at the distress he was causing her. He conveyed at this time that it was not dying he was frightened of, but living with these symptoms.

In working with people who are asymptomatic but at risk of a familial dementia, the choices at stake in pursuing genetic counseling will be between the anxiety of not knowing whether or not you carry the mutation, or the threat of discovering you do carry the gene for the disease in your family. Each time you forget what you went upstairs for, each time you lose something you *know* you put in a safe place, these feelings will be brought to the fore. Threat and Guilt is often experienced by those discovering that they have escaped inheriting the mutant gene.

The Relevance of PCP to other approaches to Care-giving in Dementia

The crucial feature of PCP is that all behaviour is defined in terms of the experience of the PERSON doing the behaving. This comprehensive and abstract framework has resonance in many approaches to caregiving for this reason, and a brief review of some of these in relation to PCP follows.

In elaborating a model for communication, Jones (1992) studied the interactions between nursing staff and residents of a nursing home. The study concluded that low quality interactions arise in part due to the limited use of case history information, a limited understanding of the pathology, and little notion of the meaning of the experience of

dementia to the resident themselves. In Kellyan terms this amounts to **Anxiety**. Caregivers who do not have an elaborated theory of what it means to have dementia, from a theoretical, practical or personal perspective, have little to inform their behaviour (the experiment to test out their theory of the situation at hand). In the absence of any other information, it is not surprising that the care-giver falls back on society's construing of the person with dementia as a helpless dependent person who is unaware, unable to communicate, and doesn't remember anything you say. A lost cause to be cared for in the physical and custodial sense. **Sociality** is likewise relevant here. By coming to understand something of a person's history and the nature of their disabilities, it is possible to try to stand in the shoes of the person with dementia, and therefore begin to play a social process in relation to them, in contrast to custodial care.

Validation Therapy (Feil 1982) has been an important influence in the development of my work with people with dementia and their families, providing a set of techniques that fit with the abstract philosophy and framework of PCP. The construct **validation-invalidation** provides a more elaborated concept of what we might be trying to achieve in caring for and communicating with people with dementia. By subsuming the unique construing of each individual we are able to identify both what is personally validating, in addition to those areas that are likely to be validating for all of us, which in this analysis Validation Therapy techniques seek to achieve. Feeling listened to, feeling understood, sharing an experience, and being given time are all stances that validate 'personhood', and in PCP terms represent commonality in the core construing of the majority of people.

The guidelines for communicating with people at different stages of dementia have been a vital platform from which to elaborate my own

construing of how to interact with my clients. For example a handshake forms a very important part of my assessment when meeting someone with dementia for the first time, giving an instant sense of that person's personal space. The use of formal conventions is respectful and therefore *validating*. This, along with an approach to therapy which sees the client as an equal partner, is powerfully *validating* in stark contrast to the person with dementia's experience in the big wide world. It is significant that for many of my clients in Stage 1, within a short space of time I am greeted with a hug and a kiss in the middle of out patients, much to the surprise of other patients and staff! For others there will always be a more formal relationship. Perhaps some of these differences are as much related to the personal construction systems of the individual, and therefore the unique experience of the syndrome of dementia for each person.

Reminiscing Disorientation Theory (RDT) (Jones 1992), mentioned at the beginning of this chapter, provides in my view a neat alternative explanation for those behaviours which are commonly diagnosed as 'delusions' or 'psychosis'. The fundamental assumption that people are striving to make sense of their environment whilst in "emotional and cognitive chaos" is compatible with the notion of a personal scientist; people construct their own version of reality, and as a result what you see is true for you. RDT reduces Kellyan **anxiety** for the caregiver who is confronted with bizarre communications that bear no resemblance to their view of 'reality', and facilitates **sociality** by helping the caregiver to subsume the experience of cognitive disorder which distort the person with dementia's interpretation of their environment. The more we consider the personal experience of neurological symptoms, the more the secondary symptoms of

'challenging', 'dangerous', 'problematic' or merely 'annoying' behaviour can be understood as arising from that individual's 'reality'.

Loss and attachment is discussed a good deal in the literature (Miesen 1992, 1997, 1999). Any framework which develops understanding of the difficult behaviours associated with dementia promotes **sociality**; if we can recognize these behaviours as appropriate reactions to loss we can begin play a social social in relation to that person, that is have a meaningful relationship, "make contact". The terms 'living bereavement', 'loss of self', and 'loss of role' all have pertinence for people with dementia, and their families and care-givers. Loss in PCP terms involves any or all of the **constructs of transition (anxiety, threat, guilt** and **hostility**), as would arise in any form of change, whether forced upon suddenly, gradually, or whether it is what you choose to do. Miesen has elaborated the concept of 'awareness-context' which relates to the person with dementia being aware that strange things are happening. This is **anxiety**: the world doesn't add up anymore, the person can't make sense of what is happening to them, in contrast to there being nothing to construe, as would be the case if the person was truly unaware of there being anything wrong. This state of *anxiety* is in itself **threatening** to most people, as it is likely to involve the "awareness of an imminent and comprehensive change in core role structure" (Kelly 1955, 91) to find that you are unable to make sense, your 'competence' and **commonality** with other people is in question. It would appear that *threat* is far greater for the person who cannot make sense (and is therefore perhaps crazy?), than for the person who is aware that there is potentially something very serious wrong with them. For example a young girl diagnosed with variant CJD was told by her family that her symptoms were due to a virus in her brain, after some months of living with the

belief that her symptoms were psychiatric, and therefore "all in her head". . She heaved a sigh of relief and commented "I knew there was something wrong with me".

Attachment behaviours which are expressed by all of us throughout life, vary a great deal in their content, and their success in achieving their goal of reassurance and security. Demands for attention can frequently drive people away, and might in some instances be an expression of **hostility** in that person. Miesen (1999) suggests that attachment behaviours in a person with dementia follow the pattern demonstrated throughout their life, which in turn have their roots in early childhood. **Preverbal construing** and construing at low levels of awareness is the part of Personal Construct Theory that helps to make sense of what is happening for the individual. The experience must in some ways be similar to the experience of a young baby who only knows one person. Turning to or searching for something you know makes perfect sense in light of the experience of progressive and/or fluctuating cognitive impairment. Seeing that goal and only that goal is a form of **constriction**, in order to simplify the problem of making sense.

Human experience is bound to have **commonality** and as such generalizations and observations about the experience of dementia are likely to hold true for most situations, greatly improving the ability to intervene in a way that makes a difference. For those people who present an even more challenging picture, a PCP analysis can be used to problem solve what might be going on for the individual specifically, in order that the most appropriate approach for that person at that time in relation to a particular situation can be selected and tested out. Accurately subsuming someone's experience leads to our interventions being validated and working. It is also true to say that even if we are

wrong, and have to stand back, revise our hypotheses and try something new, we are still exercising sociality, and it is this process that is of therapeutic value.

It is interesting to comment here that in providing psychotherapy for people with issues of *guilt* the need for frequent contact with the client and considerable issues concerning transference are discussed in the literature (Winter 199). Again it is comforting to know that the experience of loss in dementia has resonance in terms of therapeutic intervention for ANYONE experiencing dislodgement from a core sense of themselves for whatever reason.

Conclusion

PCP does not represent an alternative approach for working with people with dementia, but a meta theory of therapy and interpersonal processes which transcends all client groups and circumstances, and provides a unified rationale for the 'person centred focus' of the wide range of creative approaches within the 'new culture of dementia care'. It has proved to be a very useful framework for understanding the experience of dementia from the perspective of the person with cognitive impairment, their family and formal care givers, and can help to conceptualise and problem solve behavioural problems in people at any stage of the disease. Furthermore, it is an approach to understanding how people in general go about the task of living. I wonder how you and I would cope with living with the onset of progressive cognitive impairment?

GLOSSARY	
PCP terminology involves many words in common usage to describe constructs and psychological processes, however they have been given very specific definitions. The words retain contact with their common meaning, but are subtly redefined "to broaden the concept or lose some commonly held prejudicial associations" (Dalton and Dunnet 1990). Kelly *always* defines his terms on what is happening within the person, and *not* how someone else would experience this. Kellyan terminology used in this chapter has been summarised below.	
Constructs	Discriminations of similarity and difference that make up our 'theory' of events and the world about us. Constructs are 'bipolar', for example some people are kind, as opposed to cruel, warm as opposed to distant, controlled as opposed to goes with the flow. Sometimes people are similar in terms of their **constructs**, others use constructs which have different 'poles', for example controlled versus all over the place. **Constructs** are the discrimination rather than the verbal labels, and these verbal labels may not be limited to a single word, but an entire phrase or explanation.
Construing	The collection of constructs used to make sense of a situation represents our **construing**. This is NOT the same as thinking: we construe as we look, listen, touch, feel, and move, in order to interpret the situation, event or action.
Core construing	**Core construing** represents those parts of our construct system that are very important, central to our sense of self. Our **core** represents our identity and maintenance of our core structures is vital to functioning.

Non verbal construing	**Non verbal construing** involves constructs at a low level of awareness, but which can become verbalized as they are discovered in therapy for example. The non verbal construing involved in sitting down is likely to involve both **pre-verbal** and **non verbal constructs**.
Preverbal construing	**Preverbal constructs** develop before the onset of language, but continue to be important in everyday life despite not being available to conscious awareness. They are usually connected to love, warmth, feeding and so on.
Propositional constructs	Constructs are **propositional** when they are 'tried on for size', a stance that is useful when making sense of new situations. This is in contrast to being pre-emptive, which sees something as being a certain quality and only that quality, for example prejudice may be based on pre-emptive constructs.
Reconstruction	Reconstruction refers to a change in a person's theory of events, and usually arises from invalidation.
Validation – invalidation	The outcome of our behaviour (an experiment to test out our personal theory) either validates or invalidates our view of events.
Constriction - Dilation	Constriction is the narrowing of the perceptual field in order to minimize apparent incompatibilities in our theory of the world. We can choose to shut out what makes us uncertain, confused or invalidated. Dilation, on the other hand is the broadening of our perceptual field in order to take in more aspects of our environment.
Commonality and Individuality	The extent to which people are similar or individual in their theory of the world.

Sociality	The extent to which we attempt to step into the shoes of another person in order to see the world as they do. This is the basis for relationship and a necessary part of the process of change, promoting the evolution of our personal theory of the world.
Constructs of Transition	The dimensions in PCP which describe reactions to change from the individual's perspective.
Hostility	Hostility arises in people when core construing is threatened: it is the "continued effort to extort validational evidence in favour of a type of social prediction which has already been recognized as a failure" (Kelly 1955, 91). The person does not 'like' the outcome of their experiment, and so tries to 'cook the books' by manipulating people or events to fit their existing view of the world. Hostility is not necessarily a 'bad' thing, as it protects our 'core', and is not the same as not recognizing evidence. For a person to be hostile, at some level they need to *know* they are wrong.
Aggression	Aggressiveness is the "active elaboration of one's perceptual field" (Kelly 1955, 91). It is a person's nature to make sense of events, and aggression is seen in most situations to be a positive attribute where this is engaged in proactively. For example a person might show aggression in the area of learning to play football (because this is validating) but never go swimming because they are not 'good at swimming', are frightened of water, and so on.

Anxiety	"The awareness that events with which one is confronted lie outside the range of convenience of his construct system" (Kelly 1955, 91), or in plain English, the person simply does not know what to do, as his or her theory of the world is inadequate for the situation at hand. **Anxiety** is seen as the 'harbinger of change'. A certain level of **anxiety** is necessary to lead us to be **aggressive** in developing our theory to deal with more and more events.
Threat	"The awareness of an imminent comprehensive change in one's core structures" (Kelly 1955, 91). Threat feels extremely uncomfortable, is often associated with outrage or panic. Often people respond to threat with the fight or flight reaction (hostility or constriction), which may be expressed physically or psychologically.
Guilt	"The awareness of dislodgement of the self from one's core role structure" (Kelly 1955, 91) We become **guilty** when we find ourselves behaving in a way that goes against our **core**. **Guilt** can be very debilitating, and for any individual, the events that induce Kellyan guilt may be vastly different: what is trivial to one person may be of core importance to another.

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