

**AN ANALYSIS OF STAFF ACCOUNTS OF WORKING WITH WOMEN
WITH PERSONALITY DISORDER DIAGNOSES**

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Thesis abstract

The personality disorder (PD) concept has attracted widespread criticism (see Cromby, Harper & Reavey, 2012). Research suggests those who receive this diagnosis are often stigmatised by mental health professionals. Psychological approaches to understanding staff views about PD have been dominated by realist methodologies which are limited in their capacity to attend to the complexity, contradictions and context of health professionals' views. Recently, studies have explored the ways that mental health staff talk about their work and account for their treatment decisions; these studies show how dominant categories and practices are produced and maintained through staff talk (see Harper, 1995; Parker, Georgaca, Harper, McLaughlin, & Stowell-Smith, 1995). A central aim of this thesis is to contribute to the body of research which has explored staff discursive practices, their function and their relationship with wider discourses. This study set out to explore the PD construct and how staff make sense of distress within this diagnostic framework. This research is informed by a social constructionist perspective. Semi-structured interviews were used to elicit talk regarding PD, diagnosis and what staff constitute as key elements of their work. Staff were recruited from across a multidisciplinary (MDT) team; all participants (n = 11) worked in a secure, inpatient PD ward in an independent hospital. The analysis was informed by discursive psychology (Potter & Wetherell, 1987) and Foucauldian discourse analysis (Foucault, 1979). Staff both drew on and resisted the practice of diagnosis. Staff foregrounded a biopsychosocial framework for understanding PD and variably questioned the status of PD as a mental illness. Staff talk about the challenges and goals of their work centred on constructions of emotion and emotional control. Implications are discussed in terms of staff decisions about care, the role of clinical psychologists within MDT's and the wider socio-political context around PD. The current findings draw attention to the construction of psychological concepts in understanding PD, and the essentialist treatment of diagnosis, as well as the complexity and flexibility of implementation of these strategies to justify decisions. There is a need to foster space to explore staff

values, mainstream categories and to reflect on dominant ideologies which will influence staff work with people with a PD diagnosis.

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Statement of contribution

I, Victoria O'Key, declare that this research is the product of my own work designed, conducted and written as part of the Trent Doctorate in Clinical Psychology. The research was developed in consultation with my research supervisors Dr. Roshan das Nair and Dr. Nichola Christiansen, from whom I received regular guidance and supervision. I have been the sole researcher, responsible for obtaining ethical approval, collecting and analysing the data and writing this thesis. Appropriate recognition has been given to others throughout.

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SYSTEMATIC REVIEW

**Meta synthesis of staff perspectives regarding working with people with a
personality disorder diagnosis***

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Abstract

Personality disorder (PD) diagnosis has tended to attract a range of negative and disparaging connotations. Evidence indicates that professionals report working with people with this diagnosis to be challenging. A meta-synthesis of qualitative research exploring staff perceptions and experiences working with people with this diagnosis is reported here. Twelve relevant articles were identified and synthesised using a coding approach comparable to grounded theory. A key findings was that staff tend to assume that those with a PD diagnosis have control over their behaviours and use these in a calculated way to cause difficulties and distress to staff. Staff accounts were characterised by descriptions of threat, disempowerment and hopelessness. It was evident in the synthesised literature that both authors and participants uncritically accepted PD diagnosis. Future research would benefit from challenging the dominance of diagnosis as a way of making sense of patient difficulties. In doing so, this may open up alternative, more helpful ways for staff to make sense of their experiences with this population.

Keywords:

Personality disorder; diagnosis; staff; meta-synthesis; qualitative.

Introduction

Personality disorder (PD) diagnoses have become the dominant way in which professionals make sense of difficulties including interpersonal problems, self injurious behaviour and unstable mood. PD diagnoses are currently defined by the DSM-IV (APA, 2000, p. 629) as ‘an enduring pattern of inner experience and behaviour 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’. Previously policy did not characterise PD as a mental health problem; this has had a long lasting impact on its viewed treatability (Wright, Haigh & McKeown, 2007). As services change the way they view PD, staff are engaged in their own process of making sense of this diagnosis influenced by service pressures, policy and cultural resources.

PD remains a highly contested diagnosis, synonymous with the ‘difficult’ patient (Wright et al., 2007). Up until the last 20 years, few studies had explored staff experiences of working with people with a PD diagnosis (Nehls, 1994). An early study into staff attitudes suggested that those with a PD diagnosis were deemed manipulative (Lewis & Appleby, 1988). A range of quantitative studies have since looked at the prevalence of PD diagnoses amongst patients staff describe as ‘difficult’ (e.g. Deans & Meocevic, 2006; James & Cowman, 2007; Markham, 2003; Markham & Trower, 2003; Schafer & Nowlis, 1998). Predominantly using surveys to capture staff attitudes, findings consistently report negative staff attitudes towards PD. It has been reported that find those with this label to be irritating, attention-seeking and difficult to manage (Cleary et al., 2002). It is also reported that staff interactions are less empathic than with patients with other diagnoses, and that there is greater

pessimism regarding treatment (Markham, 2003). This has implications for how 'worthy' of treatment patients are perceived to be.

Usefully, quantitative studies have drawn attention to PD diagnosis as a possible risk to developing positive staff-patient relationships (Gross et al., 2002). However, they fail to address variability and contradiction in staff experiences and assume that by measuring staff attitudes underlying beliefs and internal states (e.g. feelings) can be accessed (Potter & Wetherell, 1987). Furthermore, they are restrictive (they predetermine the descriptive categories available to participants, offering a limited range of choices, and often accommodating only one response per question) and despite contentiousness surrounding PD diagnosis, tend to treat these labels as unproblematic, measureable categories. They are therefore unable to attend to individual staff meanings or to offer detailed understanding of the complex issues involved in why staff hold certain views (Woollaston & Hixenbaugh, 2008). Conversely, qualitative methods are well suited to exploring the varied ways in which people interpret phenomena. These approaches are interested in individual experience and can attend to multifaceted perceptions and multiple realities surrounding staff experience.

The aim of this review is to synthesise recent qualitative literature looking into staff perspectives (e.g. views, experiences, accounts) of working with people with a PD diagnosis. In particular, this review aims to identify the key issues staff report in relation to working with people with a PD diagnosis and how these issues are being constructed. This interest is embedded in current debates around how personality is theorised (e.g. as a social construction, as a defensive structure) as well as difficulties with diagnosis (Boyle, 2002).

In integrating qualitative studies, it is often necessary to bring together a range of epistemologies. To integrate studies with different epistemologies implies it is possible to identify a shared reality. Reid (2009a) suggests that it is not necessary to subscribe to a realist ontology in order to do this, but that phenomena can be treated as both real and constructed (e.g. staff experiences and perceptions are oriented to as being real, in so far as they are grounded in the socio-political context of the time). The synthesis of this literature therefore adopts a critical realist (CR) stance (as recommended in Reid, 2009a; 2009b; Gomersall et al., 2011) in which the synthesis involves a third order analysis; the first order being participants accounts, the second, the authors reconstruction of the data within their selected theoretical framework, and thirdly, the synthesis reconstruction of these findings within a CR lens.

Method

Inclusion/exclusion criteria

The inclusion criteria were that articles should (a) be published between 1990 and 2012 in peer review journals. Other inclusion criteria were deliberately broad; papers were included if (b) participants had direct contact with people with a PD diagnosis (as defined by the ICD or DSM). Studies carried out with a range of participants (e.g. staff, service users, carers) were included where it was possible to distinguish staff contributions (other data was not considered); (c) papers use a qualitative or mixed methodology. Mixed method papers were included if there was a clearly defined qualitative approach (quantitative data was not considered); (d) they were available in English. Studies were excluded if they were (a) quantitative only; (b) service user perspectives only; (c) methodological, theoretical or discussion papers; (d) where the focus was primarily on treatment evaluation; (e) where there were multiple diagnoses

being discussed and it was not possible to distinguish experiences specific to PD diagnoses; (f) and where the PD being discussed is not defined in the ICD or DSM (e.g. Dangerous and Severe Personality Disorder).

Search strategy

Deliberately broad, the initial search aimed to capture the breadth of qualitative research conducted. Searches were inclusive of a wide range of clinical and mental health staff. Identifying relevant literature began by searching electronic databases. The following databases were searched in order to capture as much of the literature as possible; CINAHL, MEDLINE, EMBASE, PsycInfo, AMED, Web of Knowledge. The reference lists from relevant studies were hand searched. An additional internet search using Google scholar was also conducted.

The search strategy was inclusive of all subcategories of PD. A broad range of search terms were used and truncated where appropriate (appendix b). The search terms for staff were designed to include people likely to have direct contact with those with an identified PD diagnosis. As well as 'qualitative' specific search terms relating to different kinds of methodology were used (as advocated for accurate searching of qualitative literature by Dixon-Woods, Booth & Sutton, 2007). Three groups of terms were combined in the search: a) personality disorder b) terms relating to qualitative methodologies and c) terms relating to staff roles.

The titles of all retrieved articles were checked for relevance. At the outset studies were excluded if they very clearly met any one of the exclusion criteria. Where relevance was unclear the abstracts were read and if relevance was still unclear the full report was obtained. The results of this strategy are presented in figure 1.

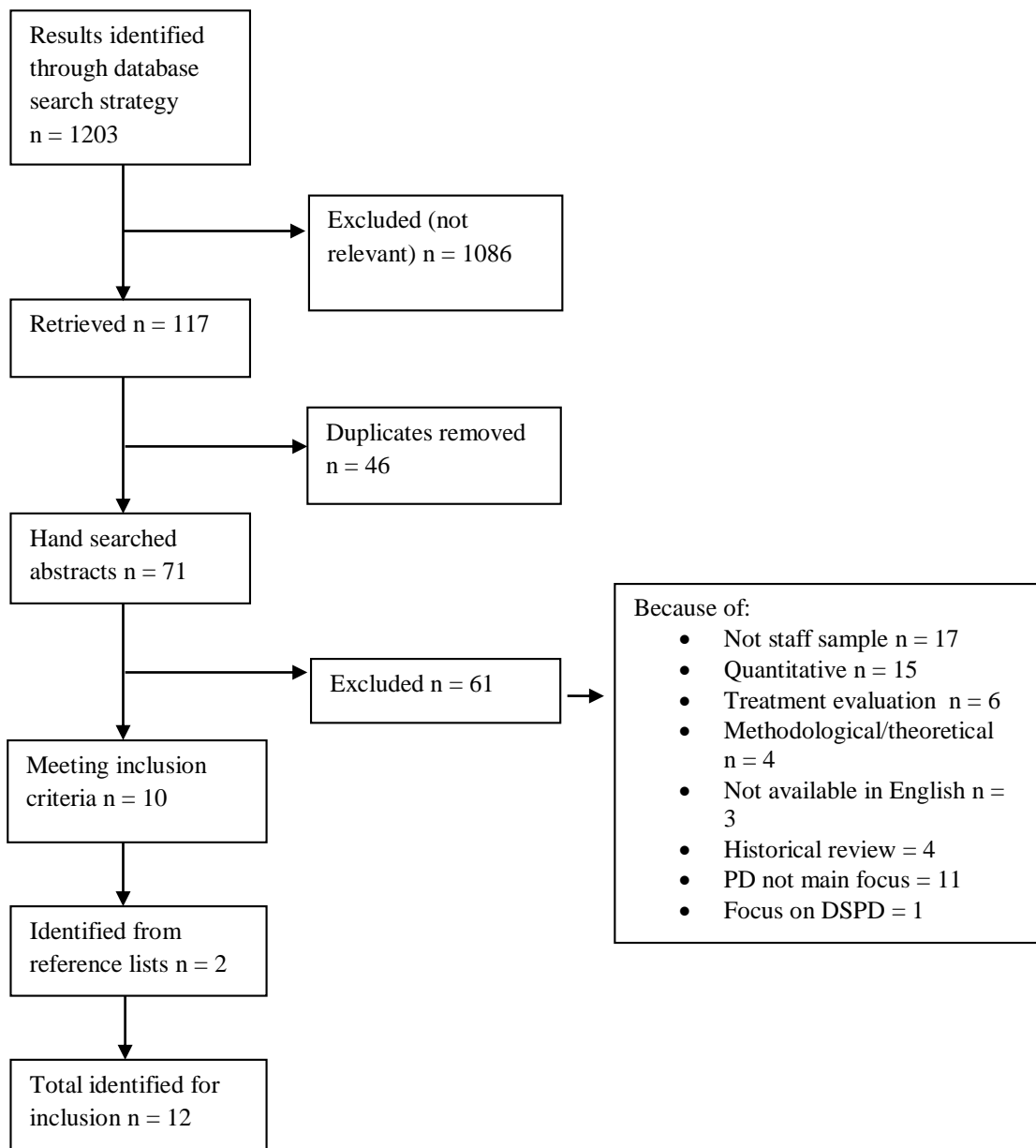


Figure 1: Identifying relevant studies

The following information was extracted from all studies where possible in order to systematically identify key features of the literature: (a) country of origin; (b) main aim; (c) location of study; (d) characteristics of participants; (e) method of data collection and analysis and (f) major findings. In reporting the major findings the terms of the categories and sub-categories (or themes) used in the papers themselves are presented.

Quality criteria

A critical appraisal of the studies was conducted. There is currently little consensus in the literature regarding the best method for how best to judge the quality of qualitative studies and the wide array of epistemological positions adopted (Dixon-Woods et al., 2004). The quality assessment framework drawn on here was published by the UK National Centre for Social Research (appendix a). While this framework has been criticised for being somewhat cumbersome in length and scope, it goes some way to ensuring that the synthesis not be distorted in favour of untrustworthy findings (Dixon-Woods et al., 2007). In order to attend to the diversity within qualitative approaches, the framework was developed based on 29 existing frameworks along with interviews with researchers in the field (Dixon-Woods et al., 2004). It offers 18 criteria each with supporting questions to aid application. It has been convincingly argued elsewhere that the evaluation of qualitative studies needs to include epistemology (Madill et al., 2000) and the framework used here benefits from its inclusion of a criterion which pays attention to the theoretical clarity of the studies.

Using the 18 criteria, each study was assigned a grade; (A) no/few flaws, (B) some flaws, (C) significant flaws, (D) untrustworthy. An overall grade (A to D) was then given to each study based on the most frequently occurring grade (see table 1). Given the small number of studies which met the criteria for inclusion, a decision was made to prioritise relevance over methodological quality (Dixon-Woods et al., 2006). Appraisal of the studies was therefore conducted not as a means of deciding which would be included in the review, but to attend to the value of each study and serve as a guide for weighting in favour of those with greater rigour and transparency (as indicated by the grade).

Table 1: Quality appraisal of studies

Appraisal Question	Bergman & Eckerdal 2000	Crawford et al.	Fortune et al.	Hazelton et al.	Langley et al.	Ma et al.	McGrath & Dowling, 2012	Nehls 1994	Nehls 2000	O'Brien & Flote, 1997	Treloar 2009	Woolaston & Hixenbaugh, 2008
1 How credible are the findings?	B	C	C	C	C	A	B	C	B	B	B	A
2 How has knowledge/ understanding been extended by the research?	B	C	C	C	C	A	B	B	B	B	C	A
3 How well does the evaluation address its original aims and purpose?	B	B	C	C	B	B	A	A	A	B	B	A
4 Scope for drawing wider inference – how well is this explained?	B	C	C	C	C	B	B	C	C	C	C	C
5 How clear is the basis of evaluative appraisal?	C	C	D	C	C	B	C	C	C	C	D	C
6 How defensible is the research design?	A	B	C	C	C	B	A	A	A	B	C	B
7 How well defended is the sample design/ target selection of cases/documents?	B	C	C	C	A	A	B	A	B	B	C	B
8 Sample composition/case inclusion – how well is the eventual coverage described?	B	D	D	D	B	B	A	C	C	C	C	B
9 How well was the data collection carried out?	B	C	D	C	C	B	A	B	B	B	C	A
10 How well has the approach to, and formulation of, the analysis been conveyed?	B	C	C	D	C	B	C	B	B	C	B	B
11 Contexts of data sources – how well are they retained and portrayed?	B	C	C	D	B	B	B	B	C	C	B	A
12 How well has diversity of perspective and content been explored?	B	C	D	C	C	B	B	B	C	B	B	B
13 How well has detail, depth and complexity (i.e. richness) of the data been conveyed?	B	C	C	C	C	B	B	B	B	B	C	B

14	How clear are the links between data, interpretation and conclusions?	C	B	D	C	C	B	B	C	B	B	B	A
15	How clear and coherent is the reporting?	C	C	D	D	C	B	B	C	B	B	B	A
16	How clear are the assumptions/theoretical perspectives/values that have shaped the form and output of the evaluation?	C	D	D	D	D	C	D	D	D	C	D	C
17	What evidence is there of attention to ethical issues?	D	D	D	D	C	B	C	D	D	B	D	D
18	How adequately has the research process been documented?	B	C	D	C	C	B	C	C	B	B	C	A
	Total	B	C	D	C	C	B	B	B	B	B	C	B

Analytic approach for synthesis

Qualitative synthesis intends to offer new insights and interpretations based on reading a body of literature concerned with the same phenomena. The procedure used here is similar to the development of themes (or codes) using a grounded theory approach (Strauss & Corbin, 1998). The synthesis began with a close reading of hard copies of the studies, with the aim of identifying key themes. A note was made of where these themes reoccurred as well as conflicting findings. This involved a process of continual comparison between the data in the papers and the emerging themes in order to generate higher order themes (Dixon-Woods et al., 2006). Extracts relating to these factors was copied and numbered, and then where possible, findings were subsumed under common terms to construct themes. In accordance with this approach the data was summarized in as few themes explaining as much of the data as possible.

Results

Characteristics of identified literature

Studies were conducted in a range of countries; five in the UK, two in America, two in Australia and one in New Zealand, Sweden, Taiwan and South Africa. Sample sizes ranged from 6 to 140, all participants were clinical or health professionals, the majority were nurses. Methods of analysis included thematic, phenomenological, GT and discourse analysis; two studies described a descriptive qualitative approach without reference to a specific kind of method (Langley & Klopper, 2005; Ma et al., 2009). The majority of studies used semistructured interviews; two studies used mixed methods (interviews and surveys) (Crawford et al., 2010; Hazelton et al., 2006), one a combination of interviews and focus groups (Langley & Klopper, 2005) and one analysed written responses based on an open ended questionnaire (Treloar, 2009). The majority of papers focussed on staff experiences working with those with a Borderline

personality disorder (BPD) diagnosis. Three papers did not specify a particular kind of diagnosis but referred to PD generally (Crawford et al., 2010; Fortune et al., 2010; Treloar, 2009).

There were a range of aims across studies; most fell within aiming to exploring staff experiences, perceptions and meanings around those with a PD diagnosis (Bergman & Eckerdal, 2000; Fortune, et al., 2010; Hazelton et al., 2006; Ma et al., 2009; McGrath & Dowling, 2012; Nehls, 2000; Treloar, 2009; Woollaston & Hixenbaugh, 2008). Two studies were interested in staff experiences in the context of training (DBT course, Hazelton et al., 2006; new hospital treatment program, Nehls, 1994). One study focussed upon levels of burn out (Crawford et al., 2010) and one prioritised what staff found helpful in their work with people with this diagnosis (Langley & Klopper, 2005). Despite some differences in aims, it was possible to draw out staff accounts of their work with people with a PD diagnosis. A summary of these characteristics is detailed in table 2.

Table 2: Summary of Participants, Design, and Findings of the Synthesized Articles

Study details	Country of Origin	Location	Study aims	Sample	Design/Methodology	Findings
Bergman & Eckerdal 2000	Sweden	Psychiatric organization	The experiences and beliefs of staff working with people with a BPD diagnosis	N = 29 63% licensed nurses, 15% physicians, 11% social counsellors 11% psychologists	Semistructured interviews with grounded theory	Higher order categories: (i) professional skills of mental health workers and (ii) frame of work organization.
Crawford et al., 2010	UK	Community based PD services	Examine staff responses to working with people with PD diagnosis. Focus on job satisfaction and burnout.	89 mental health service providers Range of staff roles; front line staff to managers.	Mixed method; survey and interviews. Semistructured interviews using thematic analysis	Themes: (i) feelings staff have about working with PD; (ii) the importance of personal qualities that staff need for working with PD; (iii) factors that help maintain a healthy working environment.
Fortune et al., 2010	UK	Inpatient medium secure ward, residential and community services	To describe the experiences of staff working in PD forensic services	22 mental health staff 18 months to 3 years experience	Semistructured interviews using thematic analysis	Findings discussed in terms of delivering treatment and areas for improvement
Hazleton, Rossiter & Milner 2006	Australia	Psychiatric hospital/unit	To explore attitudes, knowledge and experience of staff working with people with a BPD diagnosis before and after DBT training	94 mental health service staff	Mixed method; survey and focus group data with training intervention. Focus group data using discourse analysis	Themes: (i) difficult consumers; (ii) ineffectiveness of current treatments
Langley & Klopper, 2005	South Africa	Psychiatric community services	What do clinicians feel is helpful in working with people with a BPD diagnosis?	N= 10 2 consultant psychiatrists, a psychiatrist, 4 psychiatric nurses, a	Semistructured interviews (N = 4) and a focus group (N = 6), using an interpretive, descriptive approach.	Theme: (i) Trust as essential for establishing and maintaining a therapeutic alliance; (ii) a working alliance; (iii) focus; (iv) constancy and commitment.

				counselling psychologist		
				Each with 'extensive' experience		
Ma et al., 2009	Taiwan	Acute rehab unit	Explore the factors contributing to staff decision making in their work with patients with BPD	15 mental health nurses Min. 3 years experience	Semistructured interviews with descriptive qualitative analysis	Themes: (i) shifting from honeymoon to chaos stage; (ii) nurses expectations for positive and negative outcomes; (iii) practicing routine vs. individualized nursing care; (iv) adequate or inadequate support from healthcare team members; (v) differences in care outcomes.
McGrath & Dowling, 2012	UK	Psychiatric community day setting, community psychiatric residential setting.	To explore common themes in nurses experiences of working with people with a BPD diagnosis	17 psychiatric nurses Mean 15 years experience	Semistructure interviews using grounded theory	Themes: (i) challenging and difficult; (ii) manipulative, destructive and threatening behavior; (iii) preying on the vulnerable resulting in splitting staff; (iv) boundaries and structure.
Nehls 1994	US	General adult inpatient unit	Staff experiences of working with people with BPD in the context of a new hospital treatment program	N = 13 5 inpatient nurses 8 community mental health clinicians	Semistructured interviews using hermeneutic phenomenological approach	Themes: (i) controlling empowerment; (ii) mandated care.
Nehls 2000	US	Community mental health centre	Explore the experience of case managers for those with a BPD diagnosis	17 case managers for people with BPD diagnosis Min 6 months experience	Semistructured interviews using hermeneutic phenomenological approach	Key issues: self monitoring; (i) monitoring self; (ii) monitoring boundaries.

O'Brien & Flote, 1997	Australia	Inpatient psychiatric unit	To explore the subjective experience of nurses caring for a patient with a BPD diagnosis	6 psychiatric nurses Min. 12 months experience	Semistructured interviews using hermeneutic phenomenological approach	Themes: (i) being unsure; (ii) being in conflict; (iii) struggling to make sense of patients experience; (iv) being traumatized.
Treloar 2009	New Zealand	Emergency and mental health services	Explore clinicians experiences working with people with a PD diagnosis	140 mental health practitioners 69.3% nursing, 17.1% allied health, 13.6% medical	Written responses to a request for 'comments about experience of working with PD' using thematic analysis	Themes: (i) BPD patients generate an uncomfortable personal response in the clinicians; (ii) specific characteristics of BPD that contribute to negative clinician and health service response; (iii) inadequacies of the health system in addressing BPD patient needs; (iv) techniques and strategies needed to improve service provision with BPD.
Woollaston & Hixenbaugh, 2008	UK	Acute adult ward, community mental health team	To explore nurses perceptions of patients with a BPD diagnosis	6 psychiatric nurses 2-17 years of experience	Semistructured interviews using thematic analysis	Core theme: Destructive whirlwind Subthemes: (i) care giving; (ii) idealized and demonized; (iii) manipulation; (iv) threatening.

This section offers a brief discussion of the characteristics of the studies, focussing on issues raised by the critical appraisal.

Context

The studies are discussed here in terms of transparency of context; this reference to the transparency of data sources and the broader settings of data collection. Papers all included some information about the setting in which staff were based (e.g. psychiatric hospital, medium secure inpatient ward) although they varied in the level of detail. Fortune et al., (2010) included information such as the kinds of treatment programmes offered by the wards and how long the team had been formed; they suggested these features accounted for some of the interpersonal challenges staff reported.

Purposive sampling was used in all studies. None discussed reasons for non-participation. In five studies mixed professional groups were recruited (Bergman & Eckerdal, 2000; Crawford et al., 2010; Fortune et al., 2010; Langley & Klopper, 2005; Hazelton et al., 2006); within these papers no rationale was offered and there was no discussion as to whether there were differences in accounts across staff groups. The inclusion criteria for most studies was broad (i.e. staff working in the selected service); three studies referred to an inclusion criteria of a minimum amount of post registration experience (McGrath & Dowling, 2010; Nehls, 2000, O'Brien & Flote, 1997). Langley & Klopper (2005) stated 'extensive experience' as a criterion for inclusion but this was not defined further.

Only a handful of papers offered information regarding the amount of experience staff had working with those with a PD diagnosis. In addition, it was often unclear whether time in service equated to overall experience (or simply time in that particular service). This information would have been useful given that experience has

been argued to impact upon staff views surrounding diagnosis (Woollaston & Hixenbaugh, 2008). Few studies included other demographic information (exceptions; Ma et al., 2008; Woollaston & Hixenbaugh, 2008).

Method

Ten studies (exceptions Crawford et al., 2010; Hazelton et al., 2006) described audio recording the data and verbatim transcription. Langley & Klopper (2005) and Crawford et al., (2010) described also using field notes, although it was unclear how these were transcribed and integrated into the analysis, and there was no reflection on the implications of bringing together different kinds of data. The choice of semistructured interviews in the majority of studies was not accompanied by a rationale and the limitations of these were not discussed. Three studies assigned data extracts to individual participants (McGrath & Dowling, 2012; Fortune et al., 2010; Langley & Klopper, 2005) and Woollaston & Hixenbaugh (2008) made reference to the number of participants who described similar experiences (e.g. ‘four participants described...’). This aided transparency as it was possible to see whether certain participants’ contributions had not been more heavily relied on than others. Only two studies were felt to offer sufficient detail regarding the topics guiding the interview schedule, (Nehls, 2000; Woollaston & Hixenbaugh, 2008). Hazelton et al., (2010) described how they formulated a focus group topic, but did not include the question. None of the studies incorporated researcher questions or responses alongside participant excerpts; this compromised the transparency of the data as it was not possible to attend to the interactional context of participant responses (Potter & Hepburn, 2005). Only four studies discussed the limitations of their approach (Crawford et al., 2010; Fortune et al., 2010; Ma et al., 2009; McGrath & Dowling, 2012).

Analysis

Three studies did not offer a clear rationale for their choice of analysis or clear descriptions of how this was conducted (Crawford et al., 2010; Hazelton et al., 2006; McGrath & Dowling, 2012). It was therefore difficult to assess the rigour of the analysis, particularly given the potential variability in how this could be approached; for instance, discourse analysis has no prescriptive method and Hazelton et al., (2006) stated only that they used a ‘type’ of discursive analysis. There was also inconsistency in their analysis where findings were reported in terms of staff attitudes and ‘meanings’, while they had stated their aim was to explore the ‘structure and function’ of staff discourses. There was a similar inconsistency with regards the analytic method in Langley & Klopper’s (2005) study which made reference to an ‘interpretive descriptive’ approach but then described using a systematic textual analysis (also ill-defined).

Two studies failed to go beyond a description of the findings in their analysis (Fortune et al., 2010; Hazelton et al., 2006) in some cases the aim was to offer a rich ‘description’ (Fortune et al., 2010). Few studies discussed rigour or quality with regards their analysis (exceptions; Ma et al., 2009; Nehls, 1994; 2000). These studies along with Fortune et al., (2010) referred to having multiple researchers code the findings, enhancing their credibility. Triangulation was mentioned in Crawford et al.’s (2010) study although it was unclear if/how they went about conducting this. None of the studies reported on whether saturation of data was achieved, and neither did they reflect on their own role within the analysis. The absence of this reflexivity was particularly notable in the phenomenology studies.

Ethical issues

There was an absence of discussion of ethical issues across studies. It is possible that discussions with staff surrounding their work raised sensitive issues, for instance, participation in the research may have raised tensions where it was reported that staff were feeling unsupported or lacking in sufficient skills to carry out their work. How these difficulties were managed would have added valuable context to the findings.

Theoretical stance

None of the studies referred to the ontological or epistemological stance taken. It appeared from the conclusions of the studies that participant responses were taken at face value, suggesting that findings were situated within a predominantly realist paradigm. Amongst other implications, the theoretical position of a study has consequences for how it should be evaluated (Madill et al., 2000). The absence of this information made assessment of the quality of these studies problematic

Value

All studies discussed their findings in terms of existing knowledge and considered how their findings extended previously research. While all studies made recommendations for clinical practice, these tended to be confined to discussions about staff training and few linked findings to broader policy implications. It was also notable that none of the studies discussed their findings in terms of diagnosis and problems with this framework for conceptualising distress. There were only a handful of studies which explicitly made reference to possible directions for future research (Nehls, 2000; Treloar, 2009; Woollaston & Hixenbaugh, 2008).

Synthesis of findings

The aim of the synthesis was to identify the key issues presented by staff surrounding their work, and how these issues were constructed. The following section presents the four themes resulting from this analysis; (i) attributions of intention; (ii) unreciprocated efforts and hopelessness; (iii) feeling under threat and (iv) ‘never boring’ (summarised in table 3).

Table 3: Articles contributing to each theme

Article	Theme 1	Theme 2	Theme 3	Theme 4
Bergman & Eckerdal, 2000		X		X
Crawford et al., 2010	X	X		X
Fortune et al., 2010	X		X	
Hazleton, Rossiter & Milner, 2006	X	X	X	
Langley & Klopper, 2005		X		
Ma et al., 2009	X	X		
McGrath & Dowling, 2012	X	X	X	
Nehls, 1994				X
Nehls, 2000	X	X	X	
O’Brien & Flote, 1997	X	X	X	
Treloar, 2009	X	X		
Woollaston & Hixenbaugh, 2008	X	X	X	

Theme 1: Attributions of intention

Across all studies staff put forward a range of challenges to working with patients¹ with a PD diagnosis, including interpersonal difficulties, self harm, suicide attempts, unstable emotional patterns and anger. Throughout the literature it was assumed and argued that these difficulties were being expressed purposefully. Staff descriptions

¹ The term ‘patients’ is used throughout to refer to those with an identified PD diagnosis. ‘Patient’ was selected for conciseness and as this is consistent with the terminology most used in the selected literature.

attributed intention to the behaviours and emotions of patients, suggesting they set out to be ‘difficult’ or cause ‘trouble’ (Hazelton et al., 2006),

“I wonder if BPD is just an excuse for bad behaviour and nastiness” (Treloar, 2009, p. 31). Staff described patients as setting out to ‘exaggerate their feelings’ to gain attention and ‘manipulate’ staff (Hazelton et al., 2010; McGrath & Dowling, 2012, p. 5; Woollaston & Hazelton, 2008), intimating that emotional expression is under patients’ volitional control. Where behaviours were viewed as intentional ‘strategies’ these were taken less seriously; for instance, the seriousness of self harm was downplayed when framed as ‘attention-seeking’ (McGrath & Dowling, 2012). Authors suggested staff descriptions were indicative of negative and prejudicial attitudes (Treloar, 2009; Woollaston & Hixenbaugh, 2008). Moral views about patients were evident in staff accounts as well as the interpretations offered by researchers (e.g. patient behaviours were described by authors as ‘inappropriate’) (McGrath & Dowling, 2012, p. 3).

In five studies, patients with a BPD diagnosis were characterised as untrustworthy. Inconsistencies in patient accounts were put down to deceitfulness and dishonesty. In Crawford et al.’s (2010) study, staff described inexperience as a risk factor for being ‘sucked in’ by patients. Participants reported that over time they had become less ‘naive’ and more able to see patients’ ‘real’ intentions. It was presented as necessary to be on guard in order to spot patients’ hidden ‘agenda’ (O’Brien & Flote, 1997; Woollaston & Hixenbaugh, 2008, p. 707). In some instances being on guard was presented as ‘self-awareness’ and a necessary skill to carry out successful care (Crawford et al, 2010; Woollaston & Hixenbaugh, 2008), while in other cases being on guard was conceptualised as scepticism which was related to having distance from patients (Bergman & Eckerdal, 2000). Given it was presented as was necessary

not to get too close to patients as this would make staff vulnerable to manipulation, authors discussed these findings in terms of implications for building therapeutic relationships (O'Brien & Flote, 1997). While participants suggested trust to be central to good working relationships, they felt the motivation of PD patients, to manipulate, made this impossible (Langley & Klopper, 2005; Treloar, 2009). This was also presented as a challenge for developing empathy; staff described it as inherently difficult to be empathic towards those with a PD diagnosis (McGrath & Dowling, 2012; Hazelton et al., 2010; Woollaston & Hixenbaugh, 2008).

Patients were reported to have 'self destructive impulses' and that it was something 'inside' patients making them behave in difficult ways presented as immutable characteristics (Hazelton et al., 2006). It was therefore inferred that these difficulties were immutable features of personality. It might have been thought that this would have gone some way to reducing patient accountability, instead patients continued to be presented as attention-seeking saboteurs. This theme suggests staff draw on an individualistic stance, including the notion of a rational self, capable of exerting control over behaviour. Individual responsibility was used to account for staff limiting their engagement with patients,

“you know if someone says they are going to kill themselves it is not about you it is about them . . . you have to realise I can't help” (McGrath & Dowling, 2012, p. 5)

In attributing agency to patients, staff agency was minimised; one nurse described how,

“someone with BPD was having an argument with another patient . . . I intervened . . . then they decided to turn all their anger and aggression onto me and I ended up pinned up against the wall” (Hazelton et al., 2006, p. 126).

The intentionality of the patient was emphasised, while the nurse is presented as comparatively passive. Staff described feeling at the mercy of patients offering a fairly one sided account of their interactions; “you must not forget that they transfer their feelings onto you” and that difficulties arise from “the emotions they bring out in you” (Bergman & Eckerdal, 1999, p. 248; Crawford et al., 2010, p.201). In one case, patient agency was presented in terms of empowerment; however this was against the backdrop of an ongoing ‘power battle’ between staff and patients (Nehls, 1994).

Theme 2: Unreciprocated efforts and hopelessness

Related to the intention ascribed to patients’ actions, staff reported feeling their efforts to help were not appreciated, and in some cases were sabotaged by patients. Staff described a sense of injustice as a result of feeling they fulfil their role but do not receive a ‘fair’ or appreciative patient response. Staff expectations of patient cooperation and gratitude (indicated by patients improving or reducing their ‘difficult’ behaviours) featured in these accounts of injustice. One nurse reported,

“ . . . you give them time, support and encouragement and in turn they usually continue with behaviours such as deliberate self harm, threatening suicide and absconding” (McGrath & Dowling, 2012, p. 5).

For some, those with PD diagnoses were “stable in their aggressiveness” regardless of staff care (Bergman & Eckerdal, 2000, p. 248), while in three studies staff described a dramatic shift (Ma et al., 2010; McGrath & Dowling, 2012; Woollaston & Hixenbaugh, 2008). This was characterised by patients and staff initially getting along and an investment of staff time however, seemingly without warning this would change (“suddenly there will be a big bust up”), and patients would become accusatory and staff demonized (McGrath & Dowling, 2012, p. 5). Some staff

conceptualised this as a testing of limits associated with the diagnosis and felt it was important “not to take it personally” (Crawford et al., 2010, p. 199), others reported a sense of injustice and one which justified withdrawing their support. Related to this, patients were deemed to need care but be unable (or unwilling) to accept it (“they seem to shout help me help me but you can’t”) (Woollaston & Hixenbaugh, 2010, p. 706).

It was common for staff to describe feeling victimised and hurt as well as irritated by the perceived lack of patient reciprocation and attempts to “sabotage your best efforts” (Crawford et al., 2010, p. 199; Ma et al., 2009). These experiences appear to be heightened by the emotional and mental effort described as necessary in working with these patients (e.g. “you feel drained” “completely worn out”) (Fortune et al., 2009, p. 190). The emotional intensity of staff work appears to add to feelings of injustice. Nurses in one study reported caring for patients as akin to being “chewed up and spat out” (McGrath & Dowling, 2010, p. 5). These findings were discussed in terms of the personal qualities staff need to work with this population (e.g. emotional resilience) (Fortune et al., 2009).

The move from feeling valued to worthless was closely linked to feelings of frustration and hopelessness. Hopelessness was argued to be a risk factor for positive patient care (Ma et al., 2010). In some studies hopelessness and lack of mutuality caused staff to wonder how deserving of care patients with PD diagnoses were (Nehls, 2000). Staff questioned the appropriateness and value of caring for these patients,

“to me it wasn’t necessary to spend so much time with them since they wouldn’t change” and “caring for them wastes time and money . . . our efforts would not help them change their personalities” (Ma et al., 2009, p. 444)

This choice of language could be taken as a further example of the immutability associated with PD, as ‘curing’ patients becomes an unattainable goal.

Theme 3: Feeling under threat

Staff described people with a PD diagnosis as a threat to themselves, other patients and staff. Self-harm was characterised as a threat to patient and staff well being; staff felt threatened by virtue of witnessing this,

“I think it is very threatening to see someone maliciously harm themselves”
(O’Brien & Flote, 1997, p. 143).

In one study staff talked about feeling traumatised as a result (O’Brien & Flote, 1997). Expressions of suicidal intent were also seen as a threat to staff values; one participant suggested it forced her to put her own needs over and above the patient,

“It really is just to protect yourself – and you don’t always make the best decision for her because you’re worrying about yourself” (O’Brien & Flote, 1997, p. 143).

Across all studies, staff described having felt threatened by patient anger and aggression; “I felt quite intimidated . . . I felt scared of him” (Fortune et al., 2009, p. 190). Patients were also accused of targeting other ‘weaker’ patients, posing a risk to others’ recovery (McGrath & Dowling, 2012).

Patients were perceived as a threat to staff relations as they were described polarizing and causing ruptures within teams (O’Brien & Flote, 1997). Feeling threatened also appeared to relate to powerlessness, with one staff member feeling that patients “always seem to come out on top” (Nehls, 1994, p. 37), implying a power battle between staff and patients. Patients were presented as both unpredictable (Ma et al., 2009) and conversely predictably always in crisis (Nehls, 1994). Their ‘chaotic’

lifestyles were constituted as threatening structured ways of working; in six studies staff talked about the importance of boundaries (Fortune et al., 2010; Nehls, 2000; Langley & Klopper, 2005; Ma et al., 2009; McGrath & Dowling, 2010; O'Brien & Flote, 1997). Typically it was assumed staff need a degree of control over patients, with boundary setting one way of achieving this. Staff described boundaries as necessary to protect themselves from patients overly encroaching on their lives,

“they don't know their own boundaries . . . they very much infringe on other peoples boundaries” (McGrath & Dowling, 2010, p. 6).

Conflicting feelings about boundaries were reported; some staff described boundaries as necessary but a barrier to relationship building and thus at times, they had no choice but to break boundaries to provide sufficient care for patients (Crawford et al., 2010, Nehls, 2000). At other times it seems boundaries were a way of legitimating distance from patients (Nehls, 1994).

Theme 4: 'Never Boring'

Three studies reported positive staff descriptions surrounding their work with people with a PD diagnosis (Bergman & Eckerdal, 1999; Crawford et al., 2010; Woollaston & Hixenbaugh, 2008). In Crawford et al.'s (2010) study staff stated it was 'never boring' and that these patients were easy 'to relate' to. While descriptions were not always wholly positive (“there is frustration but also attraction”) staff reported patients to be interesting and engaging (Bergman & Eckerdal, 1999, p. 248). Positive characteristics attributed to patients included; creativity, sensitivity and supportive of other patients. In these instances, staff presented their roles as being about harnessing these strengths and resources (and not just about managing difficulties). Perceived successes with these patients were described as highly rewarding; unsurprisingly,

good experiences were typically put forward in relation to treatment successes (Woollaston & Hixenbaugh, 2008). Descriptions of positive experiences with this patient group were comparatively minimal within these studies; it may be that this is driven by a research interest in challenges. In many of the studies, researchers suggested that the negative experiences of staff were also attributable to challenges within services and lacking of training opportunities (e.g. Bergman & Eckerdal, 1999).

Discussion

This synthesis draws out the dominant ways in which staff present their difficulties working with people with a PD diagnosis. Staff reported feeling their efforts were not valued and that caring for those with this diagnosis was unlikely to lead to positive outcomes. There was also evidence that staff experienced those with a PD diagnosis as threatening (personally and professionally), although, some described positive elements of their work. Dominating descriptions was that patient behaviours staff found challenging were carried out intentionally by the patient in order to subvert staff care. A consequence of this was that staff descriptions were morally loaded (e.g. focussed on accountability). It also infers the dominance of an individualistic understanding of distress.

PD has been described as a 'situational disorder' which needs to be understood as context specific (Wright et al., 2007). Across studies there was little emphasis on context, in terms of patient behaviours, staff accounts or the research itself. In terms of research, it may be that an interest in staff 'attitudes' led an absence of attention to context. Often, qualitative research is situated within the social, cultural and historical context. While there was some discussion of broader service level pressures, studies

mainly focussed upon micro and interactional pressures and inter-subjective experiences. It is suggested here that the interpretation of findings would benefit from being situated within the socio-political context.

One study acknowledged the role of power in staff-patient interactions (Nehls, 2000); the lack of discussion of power relations within the literature seemed to reflect an assumption about the necessary direction of control within health settings as staff talked about struggling to 'control' patients. The implications of staff feeling threatened and disempowered for patients were rarely discussed in the findings of the papers; it may be that these feelings are a risk factor for a more punitive approach.

Previous research has argued that a PD diagnosis is stigmatising and evokes moral judgment (Glen, 2005; Wright et al., 2007), and that deciding what constitutes a 'disorder' is based on arbitrary assumptions surrounding normality (Tyrer, 2005). Despite this, there was a lack of critical analysis surrounding diagnosis within the papers. Instead the literature tended to discount these questions in favour of how to use the findings to address staff training needs. The lack of critical discussion within the papers corresponds with an absence of discussion about diagnosis within staff narratives. Staff tended to refer to people with a PD label as a collective, unified group suggesting that diagnosis was a central way of making sense of behaviour. This work would warn against reifying diagnosis and, given the range of disparaging connotations associated with PD, it would seem beneficial to consider alternative ways of making sense of distress (Bowers, 2003). In addition, minimal reference was made to the origins of distress associated with PD in spite of growing evidence that these difficulties relate to sexual abuse and negative childhood experiences (e.g. Castillo, 2003). Greater awareness of this may provide staff with an alternative way of

making sense of PD which reduces blame and increase levels of empathy (McGrath & Dowling, 2012).

Limitations

This synthesis is heavily weighted to staff perceptions of patients with a BPD diagnosis. This may reflect that BPD diagnosis is the one most likely to bring people into psychiatric services (Crowe, 2008; Hazelton et al., 2006) however, it does limit the discussion of these findings (with any confidence) to BPD. Similarly, the majority of participants were nurses, and it would seem that experiences of other mental health staff are relatively under researched. It would have been interesting to explore gender in staff accounts as women outnumber men 3:1 in the diagnosis of BPD (Bjorklund, 2006); the lack of demographic information in these studies meant this was not possible. Related to this, the lack of detail in reporting meant it was not possible to attribute extracts to particular staff members. This limited focus on contextual detail make the transferability of findings difficult.

None of the studies clearly described their epistemological position; Madill et al. (2000) states ‘qualitative researchers have a responsibility to make their epistemological position clear, conduct their research in a manner consistent with that position, and present their findings in a way that allows them to be evaluated appropriately’ (p. 17). The absence of this information was particularly problematic for ascertaining the credibility and consistency of papers particularly surrounding the claims they make for practice.

To some degree the present synthesis could be criticised for being far removed from participant data. While the constant comparative approach enabled close attention to the original data to be paid, this does not negate the additional level of

interpretation the synthesis brings to the data. The search strategy was intended to be comprehensive, however it is recognised that potentially relevant literature may have been missed (although attempts were made to minimise this following Dixon-Woods et al.'s search recommendations). Also the search focussed on peer reviewed journals, and while this may be viewed as limited, it was hoped that this would provide a kind of preliminary quality criteria.

Summary

Recent qualitative literature on staff experiences of working with patients with a PD diagnosis draws attention to some important implications for staff-patient relationships and well-being. This synthesis reveals a lack of critical literature surrounding the assumptions underlying staff and researcher accounts of diagnosis and PD. Future research would benefit from situating current findings in a more social constructionist framework and paying attention to the wider systems impacting upon staff experiences.

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Appendices

Appendix a: Critical Appraisal Tool

FINDINGS	SAMPLE
<p>How credible are the findings? Findings/conclusions are supported by data/study evidence (i.e. the reader can see how the researcher arrived at his/her conclusions; the 'building blocks' of analysis and interpretation are evident) Findings/conclusions 'make sense'/have a coherent logic Findings/conclusions are resonant with other knowledge and experience (this might include peer or member review) Use of corroborating evidence to support or refine findings (i.e. other data sources have been used to examine phenomena; other research evidence has been evaluated: see also Q14)</p> <p>How has knowledge/ understanding been extended by the research? Literature review (where appropriate) summarising knowledge to date/key issues raised by previous research Aims and design of study set in the context of existing knowledge/ understanding; identifies new areas for investigation (for example, in relation to policy/practice/substantive theory) Credible/clear discussion of how findings have contributed to knowledge and understanding (e.g. of the policy, programme or theory being reviewed); might be applied to new policy developments, practice or theory Findings presented or conceptualised in a way that offers new insights/alternative ways of thinking Discussion of limitations of evidence and what remains unknown/unclear or what further information/research is needed</p> <p>How well does the evaluation address its original aims and purpose? Clear statement of study aims and objectives; reasons for any changes in objectives Findings clearly linked to the purposes of the study – and to the initiative or policy being studied Summary or conclusions directed towards aims of study Discussion of limitations of study in meeting aims (e.g. are there limitations because of restricted access to study settings or participants, gaps in the sample coverage, missed or unresolved areas of questioning;</p>	<p>How well defended is the sample design/ target selection of cases/documents? Description of study locations/areas and how and why chosen Description of population of interest and how sample selection relates to it (e.g. typical, extreme case, diverse constituencies etc.) Rationale for basis of selection of target sample/settings/documents (e.g. characteristics/features of target sample/settings/documents, basis for inclusions and exclusions, discussion of sample size/number of cases/setting selected etc.) Discussion of how sample/selections allowed required comparisons to be made</p> <p>Sample composition/case inclusion – how well is the eventual coverage described? Detailed profile of achieved sample/case coverage Maximising inclusion (e.g. <i>language matching or translation; specialised recruitment; organised transport for group attendance</i>) Discussion of any missing coverage in achieved samples/cases and implications for study evidence (e.g. <i>through comparison of target and achieved samples, comparison with population etc.</i>) Documentation of reasons for non-participation among sample approached/non-inclusion of selected cases/documents Discussion of access and methods of approach and how these might have affected participation/coverage</p>

<p>incomplete analysis; time constraints?)</p> <p>1</p> <p>Scope for drawing wider inference – how well is this explained?</p> <p>Discussion of what can be generalised to wider population from which sample is drawn/case selection has been made</p> <p>Detailed description of the contexts in which the study was conducted to allow applicability to other settings/contextual generalities to be assessed</p> <p>Discussion of how hypotheses/propositions/findings may relate to wider theory; consideration of rival explanations</p> <p>Evidence supplied to support claims for wider inference (either from study or from corroborating sources)</p> <p>Discussion of limitations on drawing wider inference (e.g. re-examination of sample and any missing constituencies: analysis of restrictions of study settings for drawing wider inference)</p> <p>How clear is the basis of evaluative appraisal?</p> <p>Discussion of how assessments of effectiveness/evaluative judgements have been reached (i.e. whose judgements are they and on what basis have they been reached?)</p> <p>Description of any formalised appraisal criteria used, when generated and how and by whom they have been applied</p> <p>Discussion of the nature and source of any divergence in evaluative appraisals</p> <p>Discussion of any unintended consequences of intervention, their impact and why they arose</p>	
<p>DESIGN</p> <p>How defensible is the research design?</p> <p>Discussion of how overall research strategy was designed to meet aims of study</p> <p>Discussion of rationale for study design</p> <p>Convincing argument for different features of research design (e.g. reasons given for different components or stages of research; purpose of particular methods or data sources, multiple methods, time frames etc.)</p> <p>Use of different features of design/data sources evident in findings presented</p> <p>Discussion of limitations of research design and their implications for the study evidence</p>	<p>DATA COLLECTION</p> <p>How well was the data collection carried out?</p> <p>Discussion of:</p> <ul style="list-style-type: none"> • who conducted data collection • procedures/documents used for collection/recording • checks on origin/status/authorship of documents <p>Audio or video recording of interviews/discussions/conversations <i>(if not recorded, were justifiable reasons given?)</i></p> <p>Description of conventions for taking fieldnotes <i>(e.g. to identify what form of observations were required/to distinguish description from researcher commentary/analysis)</i></p> <p>Discussion of how fieldwork methods or settings may have influenced data collected</p> <p>Demonstration, through portrayal and use of data, that depth, detail and richness were achieved in collection</p>
<p>ANALYSIS</p>	<p>REPORTING</p>

<p>How well has the approach to, and formulation of, the analysis been conveyed? Description of form of original data (<i>e.g. use of verbatim transcripts, observation or interview notes, documents, etc.</i>) Clear rationale for choice of data management method/tool/package Evidence of how descriptive analytic categories, classes, labels etc. have been generated and used (<i>i.e. either through explicit discussion or portrayal in the commentary</i>) Discussion, with examples, of how any constructed analytic concepts/typologies etc. have been devised and applied</p> <p>Contexts of data sources – how well are they retained and portrayed? Description of background or historical developments and social/organisational characteristics of study sites or settings Participants’ perspectives/observations placed in personal context (<i>e.g. use of case studies/vignettes/individual profiles, textual extracts annotated with details of contributors</i>) Explanation of origins/history of written documents Use of data management methods that preserve context (<i>i.e. facilitate within case description and analysis</i>)</p> <p>How well has diversity of perspective and content been explored? Discussion of contribution of sample design/ case selection in generating diversity Description and illumination of diversity/multiple perspectives/alternative positions in the evidence displayed Evidence of attention to negative cases, outliers or exceptions Typologies/models of variation derived and discussed Examination of origins/influences on opposing or differing positions Identification of patterns of association/linkages with divergent positions/groups</p> <p>How well has detail, depth and complexity (i.e. richness) of the data been conveyed? Use and exploration of contributors’ terms, concepts and meanings Unpacking and portrayal of nuance/subtlety/intricacy within data Discussion of explicit and implicit Explanations Detection of underlying factors/influences Identification and discussion of patterns of association/conceptual linkages within data</p>	<p>How clear are the links between data, interpretation and conclusions – i.e. how well can the route to any conclusions be seen? Clear conceptual links between analytic commentary and presentations of original data (<i>i.e. commentary and cited data relate; there is an analytic context to cited data, not simply repeated description</i>) Discussion of how/why particular interpretation/significance is assigned to specific aspects of data – with illustrative extracts of original data Discussion of how explanations/theories/conclusions were derived – and how they relate to interpretations and content of original data (<i>i.e. how warranted</i>); whether alternative explanations explored Display of negative cases and how they lie outside main proposition/theory/hypothesis etc.; or how proposition etc. revised to include them</p> <p>How clear and coherent is the reporting? Demonstrates link to aims of study/research questions Provides a narrative/story or clearly constructed thematic account Has structure and signposting that usefully guide reader through the commentary Provides accessible information for intended target audience(s) Key messages highlighted or summarized</p>
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<p>Presentation of illuminating textual extracts/observations</p>	
<p>REFLECTIVITY NEUTRALITY How clear are the assumptions/theoretical perspectives/values that have shaped the form and output of the evaluation? Discussion/evidence of the main assumptions/hypotheses/theoretical ideas on which the evaluation was based and how these affected the form, coverage or output of the evaluation (<i>the assumption here is that no research is undertaken without some underlying assumptions or theoretical ideas</i>) Discussion/evidence of the ideological perspectives/values/philosophies of research team and their impact on the methodological or substantive content of the evaluation (<i>again, may not be explicitly stated</i>) Evidence of openness to new/alternative ways of viewing subject/theories/assumptions (<i>e.g. discussion of learning/concepts/ constructions that have emerged from the data; refinement restatement of hypotheses/theories in light of emergent findings; evidence that alternative claims have been examined</i>) Discussion of how error or bias may have arisen in design/data collection/analysis and how addressed, if at all Reflections on the impact of the researcher on the research process</p>	<p>ETHICS What evidence is there of attention to ethical issues? Evidence of thoughtfulness/sensitivity about research contexts and participants Documentation of how research was presented in study settings/to participants (<i>including, where relevant, any possible consequences of taking part</i>) Documentation of consent procedures and information provided to participants Discussion of confidentiality of data and procedures for protecting Discussion of how anonymity of participants/sources was protected Discussion of any measures to offer information/advice/services etc. at end of study (<i>i.e. where participation exposed the need for these</i>) Discussion of potential harm or difficulty through participation, and how avoided</p>
<p>AUDIBILITY How adequately has the research process been documented? Discussion of strengths and weaknesses of data sources and methods Documentation of changes made to design and reasons; implications for study coverage Documentation and reasons for changes in sample coverage/data collection/analytic approach; implications Reproduction of main study documents (<i>e.g. letters of approach, topic guides, observation templates, data management etc</i>)</p>	

Appendix b: Search history

Search Term	Results
personality disorder	198074
content analysis	33098
focus group	55256
narrative analysis	1925
qualitative method	15457
personal construct	2619
qualitative research	49386
phenomenology\$	53404
Dialogical	1891
Discourse	42093
Discursive	6956
Narrative	43470
Interview	674741
semi structure	46010
Hermeneutic	5755
Thematic	25408
grounded theory	17417
general practitioner	121601
Staff	385349
health care assistant	400
health practitioner	78122
health professional	25795
social worker	1019
psychiatrist	80176
Psychologist	32235
Nurse	563930
(qualitative method or qualitative research or content analysis or focus group or narrative analysis or semi-structured or interview or discursive or discourse or grounded theory or phenomenology\$ or thematic or dialogical)	1223455
(general practitioner or staff or health care assistant or health practitioner or health professional or social worker or psychiatrist or psychologist or nurse)	879729
personality disorder and (qualitative method or qualitative research or content analysis or focus group or narrative analysis or semi-structured or interview or discursive or discourse or grounded theory or phenomenology\$ or thematic or dialogical) and (general practitioner or staff or health care assistant or health practitioner or health professional or social worker or psychiatrist or psychologist or nurse)	1203

JOURNAL PAPER

**WORKING WITH WOMEN WITH PERSONALITY DISORDER: A
DISCURSIVE ANALYSIS OF EMOTION***

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Abstract

Research shows that professionals report strong emotional reactions to working with people with this diagnosis. Personality disorder diagnoses represent socially constructed psychological categories. Critics suggest that personality disorder has become a label for those service users that mental health professionals 'dislike' and find it difficult to work with (e.g. Cleary, Siegfried & Walter, 2002; Lewis & Appleby, 1988; Markham & Trower, 2003). This paper examines how staff working within a multidisciplinary team constructed emotion in descriptions of their work on a female borderline personality disorder inpatient ward. This study examines how the discursive category of emotions served to account for staff experiences and challenges working with people with a personality disorder diagnosis. Discursive analysis of interviews with staff (n = 11) identified three ways in which emotion was constructed: (i) emotional control as a professional imperative, (ii) service users as emotionally predatory and (iii) service user emotion as a symptom of past trauma. These constructions related to the assumption that emotion needed to be controlled. Being emotionally controlled was one way in which staff distinguished themselves from service users, who were presented as comparably unable to 'manage' their emotions. Different constructions were apparent in terms of the triggers of staff and service user emotion. Staff presented controlling their emotions as highly valued, and as a professional requirement. This paper explicates the ways emotion was talked into being and the implications for staff and service users. It draws attention to the varied and complex ways in which emotion talk can function to support the dominant rhetoric of control, and justify treatment decisions.

Practitioner points

- The impact of dominant discourses about personality disorder and emotion should be a legitimate area for consideration in clinical practice. These discourses have implications for how staff experience their work and for how they make sense of service users.
- Opportunities for staff teams to reflect on their language use within the clinical setting could be provided, where staff can think critically about the ideologies which often unquestioned as part of clinical practice.
- Those supporting staff working in these settings would benefit from exploring what staff foreground as highly valued in their role and the implications of these values for how staff negotiate the emotional impact of their work.

Introduction

This study takes a discursive approach to the topic of emotion. A social constructionist perspective is adopted, meaning that emotions are treated as discursive acts, situated in the social world and made possible through culturally available discursive resources (Howard, Tuffin & Stephens, 2000; McNaughton, 2013). This paper begins by drawing attention to the current literature surrounding personality disorder and emotion, before arguing for the contribution of discourse analysis to understanding emotion talk and how it is deployed in the accounts of staff working with people labelled as personality disordered.

Personality disorder and emotional control

Diagnostic systems are based on the assumption that through the use of scientific methods, it is possible to describe valid, reliable and universal features of disordered behaviour. Personality disorder is a category of difficulties, defined by taxonomic systems the International Classification of Diseases (ICD) (World Health Organization, 2008) and the Diagnostic and Statistical Manual of Mental Disorders (DSM) (American Psychiatric Association, 2013). The DSM-5 (APA, 2013, p. 629) describes personality disorder as ‘an enduring pattern of inner experience and behaviour 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.’ Within mental health services, personality disorder diagnoses are a dominant way of making sense of difficulties including interpersonal problems, self injurious behaviour, extreme emotionality and impulsivity (Pollack, 2005).

The borderline personality disorder (BPD) diagnosis has attracted the most interest from researchers and clinicians (Cromby, Harper & Reavey, 2012). BPD is sometimes referred to as ‘emotionally unstable personality disorder’, and central to this construct are the concepts of ‘emotional dysregulation’ and ‘impulse control’. Psychiatry and the practice of diagnosis have been instrumental in the medicalisation of emotion, such that what once could be understood as normal, and perhaps expected, responses to an event can now be classified as pathological (Shaw & Woodward, 2004). This medicalisation is indicative of a broadening of the clinical gaze (i.e., to internal emotional states)

(Foucault, 1988), and demonstrates how medical terminology (such as dysregulation) can serve to pathologise a lack of control over emotions. In terms of BPD, medicalising difficulties in impulse control also represents an extension of the pervasive social disapproval of those who fail to conform to contemporary values of control and rationality (Rose, 1999). The BPD diagnosis can therefore be located within broader cultural ideologies around what is acceptable and what is condemnable, imputing personal and moral qualities to emotional states. As such, diagnosis and emotion-related talk has implications for identity, for staff and service users.

Theoretical texts about BPD suggest a neuro-biological basis for emotional dysregulation (Gratz et al., 2006). Quantitative studies relying on pre-defined notions of distress tolerance and emotional sensitivity have tended not to find support for the hypotheses that there is a biologically based hypersensitivity or dysregulation in those labelled personality disordered (e.g., Herpertz et al., 1999; Lynch et al., 2006). Despite this, treatment approaches for BPD have centred on 'emotion regulation skills' and techniques for 'reducing vulnerability to the emotional mind' (e.g., Linehan, 1993). Dialectical Behaviour Therapy (Linehan, 1993) has grown in popularity in the treatment of BPD and is recommended in National Institute for Health and Care Excellence (NICE) (2009) guidelines for treatment of women with BPD (www.nice.org). This approach draws on socio-cultural discourses which dichotomise emotion and rationality (Edwards, 1999), distinguishing between emotional and rational mind. The emotional mind is problematised on the grounds of irrationality, with a shift to rational mind necessary in order to think about things 'accurately', and

achieve a balance between emotion and cognition. Psychology and psychological therapies therefore contribute to and maintain an expectation that individuals will exert self-control and self-govern (Pollack, 2005; Rose, 1996). Elsewhere, it is shown how emotion tends to be invoked to undermine rationality and control, such that the legitimacy of an account can be undermined by presenting this as driven by emotion rather than rational judgement (Edwards, 1999).

The 'rhetoric of control' (Rosaldo, 1978) dominates the category of emotions and contains the idea that emotions are to be dealt with and managed. Emotional control is part of the cultural imperative to be responsible, self-regulating citizens. Rose (2000) describes the process through which individualisation and 'responsibilization' have become shared moral norms, with a lack of emotional control seen as unhealthy and even dangerous (Harre & Parrott, 1996). The moral privileging of emotional control has implications for those labelled with BPD where it is assumed that emotional sensitivity is a cause of behaviours such as self-harm. Professionals are also subject to the cultural imperative for rationality and control, where rationality is critical to competence (Howard, Tuffin & Stephens, 2000; McNaughton, 2013).

Mental health professionals' attitudes toward personality disorder

Attitudinal research suggests staff hold more negative views towards people attributed a BPD label than other diagnoses (e.g. depression, schizophrenia) (Markham & Trower, 2003). Previous qualitative studies exploring the experiences of mental health professionals have shown that staff report service

user behaviour (rather than emotion) as challenging (e.g. manipulation, pushing boundaries, 'splitting' staff). Some studies referenced the emotional impact of work on staff; for instance, Crawford et al., (2010) found that staff explained difficulties in their work in terms of service user emotions, specifically anxiety. Elsewhere, staff described people with a BPD label as emotionally demanding and the cause of emotional stress (Ma et al., 2009). The aforementioned studies have taken language as indicative of intrapersonal realities, and the language of emotions as representing a state that exists within a person (Gergen, 1995). In doing so, this work fails to acknowledge the socially and culturally situated nature of emotions. The majority of these studies have focussed upon mental health nurses, with fewer studies having examined meaning across professional disciplines. Interdisciplinary teams commonly feature in inpatient settings and working within these teams is a central part of the clinical psychology role (Christofides, Johnstone & Musa, 2012) In exploring concepts, assumptions and values of staff in their work with personality disorder, this study aims to offer some suggestions for how clinical psychologists can support staff in their work.

Emotion as discourse

This paper adopts a social constructionist approach to language, such that talk is seen as constructive and oriented toward action (i.e., language serves particular social functions) (Potter & Wetherell, 1987). What is said is deemed to be rhetorically organized to serve particular functions (such as building credibility, deflecting blame) (Lee & Roth, 2004; Willig, 2000). Language constructs one of many possible versions of social reality at a given time and

this study is interested in those 'realities' that staff present as relevant to their work. In contrast to traditional psychological theories, where emotions tends to be conceptualised as discrete intra-psychic phenomena (Howard, Tuffin & Stephens, 2000) expressed outwardly and surmised from observations of external behaviour (Edwards, 1999), here, emotions as subjective feelings are not distinguished from emotions as discursive resources. Instead this study is interested in how emotions are talked into being (Edwards, 1999).

Etymology studies have shown how emotions are closely tied to the development of psychology (Edwards, 1997). Emotion words have been explored using discursive methods, not for what they 'mean' but for what they do (Edwards, 1997), and while emotion and emotional support is recognised as a core feature of the work of mental health professionals, few studies have explored the construction of emotion in professional practice. Edwards put forward a number of contrasting ways in which emotions are flexibility worked up in conversation (e.g. emotion as rational, irrational, dispositional, temporary). He went on to explore the effects of emotion words in managing accountability; demonstrating how emotional control serves to dichotomise what a person accountably feels (i.e. having an emotion) and what they accountably do (i.e. expression of the emotion) (Edwards, 1999). McNaughton (2013) looked at prevailing discourses of emotion within medical education. Her study demonstrates the flexibility and variability of emotion talk and how these constitute different expectations for practice. In interviews with police offices, Howard, Tuffin and Stephens (2000) noted competing versions surrounding the expression of emotion based on the context; for instance in reference to expectations of others, participants drew on an emotion discourse that

prescribed expressing your emotions (i.e. as approved and necessary). A 'discourse of non-emotion' was used when the moral demands of the police organization for control and order were invoked (Howard, Tuffin & Stephens, 2000, p. 311). Emotion talk can therefore be seen to be 'put to work' in various ways to manage issues of accountability.

Discursive research is also well suited to exploring what is at stake for staff in terms of their professional identities. For example, Harper (1999) detailed how the talk of professionals surrounding psychiatric medication took up a range of positions in order to account for times when medication failed. Language is therefore understood to be rhetorically organized. Different ways of talking serve to construct one of many possible versions of social reality at a given time. By taking a discursive approach to emotion, this study does not deny the very real distress that service user's experience, nor the difficulties staff face in a psychiatric environment. Instead, the intention is to explore the ways in which emotion discourses provide conceptual resources for staff in understanding personality disorder and service users with this diagnosis.

Methods

Design

This study was concerned with how staff constructed BPD and emotion and how these constructions functioned (e.g. to position staff and service users in various ways), therefore, discourse analysis was deemed the most appropriate analytic framework. Interviews were carried out with staff working in an independent secure hospital in the UK. Staff worked primarily in a low secure

female inpatient ward specifically for women with a diagnosis of 'emotionally unstable personality disorder'². The kinds of behaviours which have brought women into this service include severe self harm, suicidality, violence and fire setting.

Theoretically, this paper subscribes to a position whereby 'realities' are deemed to be constituted through language, and knowledge is understood as socially, culturally and historically mediated. This social constructionist stance holds a relativist epistemology, and is not concerned with 'truths' (Nightingale & Cromby, 1999). As such the claims made within this analysis do not refer to individual intentions or attitudes, but the discursive effects.

Procedure

Participants were recruited from across the multidisciplinary team (MDT) (including psychiatrists, clinical psychologists, occupational health therapists, social workers) which typifies the psychiatric inpatient setting. This allows for an exploration of a range of discursive resources from staff across professions. All staff were currently carrying out direct work with service users, and had been in their roles for 6 months or more. The analysis aimed to identify the ways of talking about emotion that were available to the participants (i.e. what range of things could be said about emotion in the context of staff role with service users).

² All women had a primary diagnosis of BPD. The majority also have other diagnoses including, other personality disorder diagnoses.

The study received ethical approval from the Institute of Work, Health and Organisations at the University of Nottingham, and complied with ethical principles suggested by the British Psychological Society. Participants were provided with an information sheet explaining that the study hoped to elicit staff views on working with people with personality disorder diagnoses, including what they think about the diagnosis, what they have found helpful in their work and how they have managed challenges. Having read the information sheet, participants' signed consent was gained.

Participants

Participants were 11 staff working in the inpatient unit. Based on previous research (e.g. Stevens & Harper, 2007; O'Key & Hugh-Jones, 2010), 11 interviews were felt to provide a sufficient amount of data from which to explore a range of descriptions, discursive strategies and resources being used to construct personality disorder and emotion. Due to the size and specificity of the sample, demographics are presented for the whole group and not individually to minimise the risk of participants being identified (Stevens & Harper, 2007). In addition, extracts are not identified by job role. Ten participants were female and one was male. The majority of staff were White British, with one staff member identified as White European. Participant experience of working in mental health settings ranged between 6 months and 30 years. As the study was interested in the ways of talking across disciplines a purposive sampling strategy was used. Participants identified their roles as consultant forensic psychiatrist, ward manager, assistant psychologist,

healthcare assistant, occupational therapist, social worker, charge nurse and associate specialist.

Data collection

This study was interested in how staff describe and account for their work and so semi-structured interviews were a suitable method for approaching this concern. The limitations of interview data are acknowledged here (see Potter & Hepburn, 2005; Speer, 2002; Wetherell, 2007 for debate). The present data are conceptualised in line with the view that interviews are 'a source of evidence about the constructional work on the part of the informant (and perhaps also the interviewer)' (Hammersely, 2003, p.120). The interview is conceptualised as both a resource (e.g., for seeing what kind of accounts are being produced) and a topic (e.g., a process of co-construction, a particular kind of social interaction) (Lee & Roth, 2004). It is not treated as a substitute for data collected in naturalistic settings, but instead tells us about the interactional work being done within this setting. That said, there are not an infinite number of ways in which to construct an account and so interview data can elucidate routinised discourses which speakers will use across interactional contexts (see Wetherell's, 2007 discussion of 'personal order'). On this basis, the discussion section speculates on other analogous contexts in which these kinds of accounts may be seen.

The semi-structured interview schedule included questions which aimed to capture: staff talk about PD diagnosis (e.g., 'does the diagnosis inform the work you do?'); the kinds of difficulties they see with the people they work with (e.g., 'what kinds of difficulties do you tend to see on the ward?') and the history,

causes and consequences of the difficulties the women have. Staff reactions to service user behaviour and interventions were also asked about (e.g., 'can you tell me about your work with a particular client?', 'What do you feel contributes to successful ways of working?').

Interviews were conducted at participants' work place. They were audio recorded and lasted between 45 and 90 minutes. Transcription was outsourced; therefore, during analysis the audio recordings were listened to alongside the typed verbatim transcripts to increase researcher familiarity and attend to features of intonation. Those sections of the interview drawn on in the analysis were then transcribed according to the principles of a Jeffersonian-lite style of transcription (Potter & Wetherell, 1987) i.e., verbatim with the inclusion of linguistic and paralinguistic features that appeared relevant to interpretation of the text (e.g. laughter, pauses, emphasis).

Analytic approach

The analysis presented here makes reference to 'discourses', which in the broadest sense can be understood as 'sets of linguistic material that have a degree of coherence in their content and organization...[can] perform constructive functions in broadly defined social contexts...can be invoked to construct any object, person, event or situation in a variety of ways' (Lyons & Coyle, 2007, p. 101). The present analysis draws together discursive psychology (Potter & Wetherell, 1987) and Foucauldian discourse analytic interests (Willig, 2008). Both take language as their topic, although discursive psychology is mostly concerned with local discursive practices (e.g. turn taking

in conversation) whereas Foucauldian discourse analysis prioritises socio-cultural discursive resources (e.g. broader social discourses which offer and limit ways of talking). Wetherell (1998) advocates this dual, (or 'middle range') approach to analysis (Alvesson & Kärreman, 2000), on the basis that this allows for (1) a detailed focus on the local interactional features of the talk (e.g., the contextualised interview talk) whilst also attending to, (2) wider discourses (e.g., institutional discourses).

Analysis began with a coding of the transcripts. This was carried out in light of the research question, with references to personality disorder and emotion attend to as well as noting broadly what the text appeared to be doing and how it was being accomplished (e.g. identifying particular words or phrases) (Willig, 2008). Once coded, extracts were grouped together into discursive themes, focussing on a limited number of ways of talking which represented the different ways participants positioned themselves and the service users. In line with the research interests, and to focus the analysis, a number of questions were posed: (1) what are the main features of the talk around staff work with personality disorder? (2) what concepts do staff draw on (to describe/explain PD and emotion)? (3) what roles/positions do staff construct themselves/service users in? The complementary and contradictory relationships between discourses were examined. The implications of these discourses for staff and service users were also considered.

Analysis

Emotional control was demonstrably relevant to staff in understanding and making sense of their role with service users. All participants talked about challenges in their work in relation to emotions and emotional control. Emotional control talk was in relation to participants' own emotions, as well as the emotions of colleagues and service users. Throughout the analysis we illustrate how the ideology of emotions as controllable was foregrounded and a lack of service user emotional control given primacy in making sense of personality disorder. This analysis focuses on the ways in which emotions were 'put to work' within the interviews to account for the ways staff made sense of personality disorder.

A number of emotion concepts were evident; a professional imperative for emotional control, service users as emotionally predatory and service user emotions as a symptoms of past trauma. These concepts all related to the ways in which staff expressed and legitimised the importance of emotional control.

A lack of emotional control: the professional imperative

The formulation of service users as lacking in emotional control was put forward as challenging for staff, disruptive for the ward and debilitating for service users. This participant subscribes to the view that service users are inherently unable to exert control over their emotions. While exerting control over your emotions is present as difficult for staff but necessary:

Interview 3: '*You know they just can't control their emotions and they just - over absolutely anything and then you say 'OK let's just calm down' and they just keep on shouting and at times like that I just shout at them back no you have to stop yourself from doing that so controlling your emotions basically'*

A lack of service user emotional control is problematised on two grounds: (i) it leads to over-sensitivity and irrationality (*over absolutely anything*) and (ii) it challenges staff ability to control their own emotions (*you have to stop yourself*). The participant suggests it is imperative staff do not shout back. The use of 'have to' often presents a contrast with doing what you might otherwise not wish to do (Te Molder & Potter, 2005). Previous research argued that this phrase serves to present emotional control as a professional imperative (Howard, Tuffin & Stephens, 2000).

The participant described overcoming the initial urge to shout back, which adds weight to the presentation of self-control. Edwards (1999) describes how one of the rhetorical uses of emotion words [e.g. service user anger] is 'to focus on inner feelings *rather than* the events in the external world that they are directed at, just as talk of emotional reactions [e.g. staff responses] can be a way of specifying the nature of the events that provoke them' (p. 281). Here, the internal state of the service user is foregrounded such that it is removed from any reasonable external trigger. This serves to undermine the rational accountability of the emotions attributed to service users. Emotional discourse is evoked in such a way that service user reactions are presented as internally driven, rather than understandable in the face of particular social action

(Edwards, 1999). In contrast the participant presents their emotional response as having a clear external precipitant (i.e. service user shouting), and as being comparatively reasonable (*ok let's just calm down*).

The impact of a lack of emotional control was emphasised. For instance, one participant commented that emotional disturbance '*had a domino effect and you had the place just going bananas and it was like Beirut*'. As service users were often presented as unable to control their emotions, there was a moral imperative that staff could exert this control and offer containment for service user emotions. Formulating this as a necessary part of their role relied on the construction of emotion not as an internal state or disposition but as a broad-reaching state that could permeate the ward. One participant described service users as carrying out certain behaviours which were disruptive on the ward in order to '*get that emotion out of themselves*' as they could not control it internally. Emotions were presented as fluid and needing to be soaked up to contain their disruptive effects. Participants referred to their ability to control or absorb emotion as a skill which can and needs to be learnt ('*have to*');

Interview 7: 'I think that working with women with personality disorder evokes a lot of strong emotional responses from us and we have to learn how to manage those (.) absorb them (.) understand then make sense of them.'

Conceptualising emotional control as a skill you are required to acquire, leaves staff members who do not, as accountable. As well as absorbing emotion, staff presented themselves as receptacles for difficult emotion, akin to emotional

sponges, 'soaking' up negative feelings and getting them under control or at least diluting the extent of the disruption for instance. In this sense, the service users are presented as creating the chaos, and the professional emotionally intelligent enough to deal with it. Emotional control could therefore be seen to function to differentiate staff and service users, and to socially elevate staff on the grounds of them having more control.

Emotional predators

Negative emotions of service users which became out of control were presented as fuel for further negativity and disruption among service users. Staff suggested service users 'feed' off negative emotions with detrimental consequences for both staff and service users. The extract below starts out with this concern. Here controlling emotions involves keeping them concealed:

Interview 11: 'I think it's [the work] very emotional for staff you have to try and keep your emotions in when there's something happening for the better of the ladies and stuff and I think that's similar with my old job you have to obviously not show them that you're if you're a little bit scared or you're a bit anxious you try not to let them feed off that'

The idea of service users 'feeding off' evokes an animalistic response to emotion; with service users preying on staff. The participant minimises the amount of worry or fear (*a little bit*), functioning to present their feelings as reasonable and moderate. Despite, this there remains a need to keep their fear and anxiety hidden. 'You have to' and 'obviously' work to confer that this is a

normative, taken for granted rule for staff; it also suggestive of the threat that service users could pose. The precise danger of service users feeding off emotion is ambiguous. In previous research emotions were presented as a threat to professional competence on the grounds that they undermine rationality and control (Howard, Tuffin & Stephens, 2000). In the extract below, staff are presented as trying to avoid service users exploiting staff fears or worries:

Interview 3: 'No matter how boundaried you are now that always gets turned around on you there's one of them that consistently turns it around and becomes angry about entering (0.5) because of this interpretation of what she's saying and so you have to adjust everything to their personality again but basically yes it's sticking to the boundaries they can really once you let them have a little bit of leeway they will misuse it not on purpose but that is just the way they are they will just if they see any little chink in your armour they will go for it and they will make a big hole in that armour because they're clever that way'

The use of 'armour' is indicative of a 'battle' or even 'war', which has to be fought in order to prevent the spread of emotional chaos from service users to staff. While this extract does not rely explicitly on a description of service users *feeding off* emotion it offers an insight into what might be at stake should staff not maintain emotional control. Invoking the metaphor of armour here intimates that anxiety and fear leave staff vulnerable and unprotected, and therefore at risk should service users see beneath the controlled exterior. The participant

suggests that despite extensive efforts, there is little possibility that you can be boundaried enough and it is inevitable that service users will transform a '*chink*' into a '*big hole*', highlighting the danger for participants of losing control. This functions to augment the imperative for control.

That service users can exploit staff emotions served to account for the need for boundaries. Being boundaried is presented as not being too flexible or too easily manipulated (not giving too much *leeway*) and involves staff protecting themselves from potential blame (*that always gets turned around on you*). The construction of intention changes through this extract; on the one hand service users are not deemed to be intentionally exploiting staff (*not on purpose*), although the presentation of service users as '*clever that way*' infers conscious action. The service user is formulated as conniving, and having sufficient emotional intelligence to abuse other's emotional weakness.

Emotion as symptom of past trauma

This final section looks at how staff accounted for the relative lack of service user control, by presenting this as a consequence of distant trauma or abuse. Historical factors were fore-grounded such that emotional instability was constructed as stemming from the past, but being replayed in the present. There were two ways in which historical factors were presented as having their effect on staff-service user relationships; (i) these were that past relationships were being '*played out*' with staff and that (ii) emotions as a result of past trauma were being projected onto staff.

Here, the challenges of working on the ward are presented in terms of service user fear, of abandonment and being discharged into the community. These fears are constituted as deriving from past experience, but being '*played out*' now:

Interview 2: 'And therefore they're kind of playing out patterns of their relationships that you know they've seen like growing up really lots of instability where they don't really want to get too close to people because of that fear of kind of being abandoned we see that quite a lot'

It is assumed here that relationships witnessed when younger have long term effects and that current difficulties mirror those of the past. Use of the generic term '*people*' functions to suggest that service users will have problems in all relationships with all people, thereby resisting the possibility that these difficulties are attributable to certain staff relationships. In addition to obscuring the role of the present environment, these constructions also serve to present staff as relatively passive in their role with service user emotions. In this final extract, the participant explains that service user are driven to behave aggressively towards staff as a result of feelings about abusive others from their past. Emotions in the present are therefore removed from the current context:

Interview 1: 'And the aggression is through the years of abuse but also a lot of anger which basically is anger against the abusers but the abusers aren't here so it gets projected on to the staff members on to their peers who are then the recipients of it'

Here aggression and anger toward staff as a projection of feelings about historical others serves to downplay events in the present and inoculate staff against the claim that service users are rationally angry with them (or their peers). In this way, staff can position those from the past as accountable for negative interactions with service users in the present. Presenting staff as simply '*recipients*' intimates a one way trajectory of internally driven emotion from service user onto staff, ascribing a large amount of power to service users' misdirected emotions. This conceptualisation of irrational emotionality as stemming from the past may work to justify giving less attention to current interactions on the ward.

Discussion

The emotional impact of staff work with service users with BPD diagnosis is well documented. A lack of emotional control is strongly associated with a range of psychiatric diagnoses, but appears particularly central to the BPD construct. This study examined the ways in which staff constituted the emotional work they do, whereby emotions are taken as discursive practices shaped in institutional settings. This examination of the ways staff orient towards emotional control is also an examination of the current 'truths' about BPD, emotional control and staff roles (Parker, 1998). Staff oriented to a moral imperative to control their emotions, such that professionalism was manifest in their ability to control themselves. There are a range of discursive practices used to present emotion as under or beyond individual control; these constructions have implications for the attribution of agency as well as the legitimacy afforded to service user and

staff emotions. Here, the implications of these ways of talking about emotion are discussed. This section also draws attention to the importance of language for clinical psychologists working in MDTs in comparable settings.

Losing control was presented as dangerous for staff on the grounds it could leave them at risk of being exploited by service users, or risk making service users feel unsafe by replicating earlier abuse experiences. Lutz (1997) has shown how constructing emotions as in opposition to reason, attributes to them a chaotic and dangerous quality. It was further implicated that staff loss of control would be detrimental for colleagues. Staff appealed to ongoing self-scrutiny as a necessary part of maintaining control. Rose (1996) argues that a feature of contemporary individualism is the requirement that people comply with regimes of control, in which the individual is encouraged to continually act upon themselves. In this way, staff can be seen to be subject to individualist discourses whilst also maintaining and reproducing these in their talk about service users. Part of the arrangement of the staff–service user relationship is that staff will be controlled, even if service users are not. There are therefore different entitlements and expectations on staff and service users. For instance, staff are expected to conceal their feelings, while in keeping with established Western discourses around emotion, service users will be required to disclose theirs (albeit in a controlled way) in order to maintain psychological wellbeing (Georges, 1995; Howard, Tuffin & Stephens, 2000).

Staff appeared to orient to the expectation that those with BPD attract considerable stigma and that mental health professionals have been criticised for their pejorative use of this label (e.g. for patients they find 'difficult') (Hazelton,

Rossiter & Milner, 2006), and lack of empathy. Previous research demonstrated a tendency for staff to attribute intention to difficulties associated with BPD (McGrath & Dowling, 2010). One way in which explicit attributions of blame were side stepped in the present study was through foregrounding emotions, rather than cognition. If it is taken that service users' inability to exert emotional control stems from abuse and trauma in childhood, for staff to position themselves as condemning of service user behaviour would be morally dubious. Understanding emotional instability as past trauma can therefore be seen to inoculate staff against the widespread criticism of health professionals' views toward PD, and counter the notion that those with BPD are 'bad people'.

Presenting past trauma as playing a central role in current interactions works to establish the parameters for what is to be taken into account when explaining service user emotions (Edwards, 1997). Staff legitimised not considering their actions in relation to service user emotionality by presenting this as a consequence of past trauma. Through this lens, current interactions and settings are downplayed, and can be explained away by distant factors now out of reach. This had implications for accountability, as staff are deemed responsible for keeping service user emotions under control, but not for how they come about. While this way of knowing about service user emotions may be associated with greater staff empathy, if always driven by emotional pathology (as a result of trauma) this leaves little discursive room for service users to be seen to be 'doing' appropriate or reasonable emotional expression. Researchers have also argued that the concept of emotional intelligence, which appears related to emotional control, defines emotion as private and internal conceals the social and cultural context in which they take place (McNaughton,

2013). In the same way that emotion as skill could be argued to obscure possible situated inequities for staff (such as structural or material constraints) by privileging individual abilities, current interactions could also be obscured in terms of making sense of service user emotions (such that emotions are seen as removed from current factors).

Context and limitations

Discourse analysis provides a way in which to explore the performative function of inner mental states, such as emotions (Potter, 2005). This approach recognises that talk is fluid, value-laden and driven by issues of stake and interest (Potter & Wetherell, 1987). As such language is best understood in the context in which it is produced. Potter and Hepburn (2005) critique interview data on those grounds. However, others have argued that interview data can be seen to have ethnographic relevance as speakers are limited with regards the number of discursive resources at their disposal and will (re)produce routinised discourses in other similar settings (Griffin, 2007; Wetherell, 2007). Research in other institutional settings has gone on to explore how different professional talk invites and discourages patients from expressing certain ideas or feelings in interaction (Horton-Salway, 2001). It is suggested that talk similar to that identified here, is likely to be generated in analogous contexts such as multidisciplinary and multiagency staff meetings, supervision and to some degree, in conversations with service users. Future research into staff-service user interactions could make it possible to identify which constructions of emotion are routine and which context specific (see Hugh-Jones & Madill, 2009).

Application

Treating psychological approaches and concepts as productive and contextualised is necessary in order for professionals to remain cognizant to the ways in which realities and truths become credible. Recommendations for clinical psychologists working within MDTs include that practitioners have good knowledge of the system, the socio-political context and can both support and challenge staff in teams (Christofides, Johnstone & Musa, 2012). Clinical psychologists have an opportunity to foster discussion of the constructs around BPD and how these are related to dominant ideological discourses. One difficulty of this may be that providing space for staff to reflect on ambiguities around PD, where there is already confusion, could foster greater uncertainty and leave staff feeling stuck. In exploring different conceptualisations it will be important to ground these in some aspects of care which cut across differing agendas; for instance, compassion, empathy and encouragement.

It is suggested here that staff would benefit from exploring language use and the impact of concepts privileged in staff talk (e.g. emotional instability vs. rationality). Clinical psychologists could facilitate staff reflection on how staff talk will impact on service user's views about their difficulties (e.g. are service users trapped as victims of their past?) (Ahn, Proctor & Flanagan, 2009). Where concepts are abstract (e.g. power) it will be necessary to consider how these can be operationalised in clinical examples; for instance, understanding service user 'resistance' as perhaps indicative that staff interpretations are not consistent with service users' understandings. The concepts of 'usefulness' in

formulation could free staff up to consider alternative ways of working, rather than as 'the truth' which service users need to accept in order to 'get better.'

It seemed that staff carried out much discursive work to avoid attributions of blame. If service users are *not* to blame for their lack of control and staff are more capable of control and rationality, then logically, it would not make sense for staff to feel angry or upset at service user behaviour. This raises questions as to how staff manage when such feelings arise. Clinical psychologists offering supervision would therefore benefit from understanding what is at stake should staff have difficult feelings towards service users. Understanding how professional identities are bound up with values around emotional control and therefore tied to issues of accountability will impact on how staff feel about their work, and perhaps how open they are to sharing difficult feelings. Clinical psychologists are well placed to explore these feelings with staff. If done sensitively, with emphasis on the unavoidable impact of values on the practices used in mental health, as well as the positive impact of attending to these values, staff can be supported to utilise their own reactions to make sense of how service users may also experience similar conflicts around power and responsibility.

Conclusion

The prevailing implications for staff suggest that emotions remain powerful ways in which staff explain and account for their decisions. Problematizing a lack of emotional control served to rationalise the need for staff to exert control. At the same time, staff rationality and control are challenged by service user emotional sensitivity. With emotional control morally loaded, this analysis goes some way

to explaining how staff align themselves with this moral imperative. Service users are subject to a less morally viable position through their emotionality. This is to some degree tempered by the construction of service user difficulties as stemming from the past; suggesting that these are ingrained, longstanding and ultimately, that service users are not to blame for these inherent problems. Having rationalised the need for emotional control and presented this as highly valued, staff conceptualised themselves as skilled in this area, but accountable should they be seen to fail to remain controlled.

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EXTENDED PAPER

1.0 Extended Introduction

1.1 The study

This thesis uses a discursive methodology, from a social constructionist epistemological framework, to explore the ways in which a range of staff working on an inpatient ward talk about personality disorder (PD) and their work with service users with this diagnosis. Within this thesis, it is taken that an exploration of talk can illuminate something of how participants produce various social 'realities' about PD and service users, and the rhetorical functions of these realities. The focus is on ways in which talk functions to achieve social objectives. It is *not* assumed that talk offers an objective representation of external reality or participants' internal states.

This thesis starts with an overview of the PD diagnostic categories and then goes on to take a critical look at diagnosis, in favour of understanding diagnosis as social practice, accomplished through discourse.

1.2 Personality disorder

The DSM (American Psychiatric Association, 2013) (APA) and ICD (World Health Organization, 2008) have nine and 11 subcategories of PD, respectively. Both classify the following disorders of personality; paranoid, schizoid, histrionic, borderline, anxious (avoidant) and antisocial (dissosocial) and personality disorder unspecified. There is also some variation with regards the labels used to define these disorders, for instance a preoccupation with a sense of control and perfectionism is described as obsessive compulsive (DSM) and anankastic (ICD), respectively. The DSM also contains a category for narcissistic personality disorder and schizotypal (which is distinguished from schizoid). In developing the recently published DSM-5 (APA, 2013) clinicians debated the suitability of a categorical model for PD (i.e. you have it or you do not have it), in favour of a dimensional model, which includes personality trait domains (www.dsm5.org). This would continue to view the essential features of PD as impairments in identity (e.g. self-directedness) and in the capacity for effective interpersonal functioning (i.e. empathy), however individuals would be

rated as to how impaired they are and how extreme their pathological trait is. These debates stemmed from a desire to address concerns about the arbitrariness of cut off points within a categorical model. At the present time, the proposed hybrid dimensional-categorical model has not replaced the current structure, but is included in section III (emerging measures and models) for future consideration.

PD diagnoses have been shown to suffer from poor construct validity, inter-rater reliability, test re-test reliability and internal consistency (Blanchard & Brown, 1998; Fowler, O'Donohue & Lillenfield, 2007; Zimmerman, 1994). Literature surrounding the aetiology of PD is argued to be disparate contradictory and disjointed (Bourne, 2011; Cloninger & Svrakic, 2008; Livesley, 2001). The lack of consensus reveals that many aetiological explanations simply map onto the various theoretical assumptions of the approaches, suggesting that difficulties are conceptual as well as empirical (e.g. Fonagy, 1999, psychoanalytic explanation and Kraepelin, 1905, biological explanation) (Livesley, 2001). There is widespread evidence that people who get labelled as personality disordered, particularly borderline, have suffered childhood trauma in the form of physical and sexual abuse (Castillo, 2003; Crowe, 2004). It has been argued that the PD construct serves to obscure such aetiological factors (Ramon, Castillo & Morant, 2001; Shaw & Proctor, 2005). For instance, the ongoing focus on intrapsychic phenomena avoids a close examination of the social and historical dimensions of PD (Bourne, 2011), as well as concealing the value judgements inherent in this character diagnosis. Psychological theories can therefore be seen to impact upon individual experience, practitioner focus and interventions at a local and societal level.

1.3 Diagnosis, clinical psychology and personality disorder

Diagnostic systems are based on the assumption that through the use of scientific methods, it is possible to discover the true essence of a disorder, where disorders are seen as natural fact, and the principles and patterns applicable across time and culture. Advocates argue diagnostic manuals bring together a wealth of scientific studies looking at brain physiology, genes and the

environment and offer standardised tools for clinicians to accurately assess psychiatric disorders, revealing causes and treatments (www.dsm5.org). The dominance of psychiatric concepts within mental health settings has led to a plethora of research based on the assumption that observations of patterns in behaviour and emotion can reveal underlying pathology. Critics argue that this diagnostic framework, originally developed for understanding bodily problems, is fundamentally incompatible with understanding psychological distress³ (Boyle, 2007). There is growing evidence of dissatisfaction with diagnosis systems. For instance, statements against diagnosis have been issued from some professional bodies (e.g. Division of Clinical Psychology Position Statement on Classification, 2013) on the grounds that diagnosis fails to address the complexity or personal impact of psychological distress. In addition, diagnosis has been criticised within the service user movement for being stigmatising and dehumanising (Beresford, 2005).

Specific concerns with the PD diagnosis are also in evidence. Research has documented widespread concern about the PD category amongst mental health professionals, with 56% of those asked in Maser, Kaelber and Weise's (1991) study reporting the category to be problematic. PD has been described as a 'diagnosis of last resort', where nothing else seems to fit (Cromby, Harper & Reavey, 2013). Previous policy distinguished PD from other mental health problems, which some have argued has had a lasting impact on views about treatability (Wright, Haigh & McKeown, 2007), leading to claims that PD has been a 'diagnosis of exclusion' (National Institute for Mental Health in England, 2003) (NIMHE).

1.3.i History of the personality disorder concept

The PD concept is said to be unhelpful and stigmatising (NIMHE, 2003). It is argued that the stigmatising effect of this concept is in part related to the association between pathology and the dominant concept of the self (i.e.

³ The terms psychological or mental distress are favoured here in order not to subscribe to one particular theory underlying the experiences of those accessing services, whilst acknowledging the very real suffering which is a feature of these experiences.

personality). It is common place and feels natural to talk about our own and others personalities, however the concept of personality did not exist prior to the late 18th/early 19th century (Speed, 2011; Stainton-Rogers, Stenner, Gleeson, & Stainton-Rogers 1995). It has since become a primary way in which we understand ourselves and others, as bounded, individual selves with fairly stable and lifelong characteristics (Stainton-Rogers et al., 1995). Dominant ideas about traits and characteristics have become naturalised, and enshrined in institutional practices (Harper, 1995). The current understanding of personality (as reflecting a bounded individual self) is also reflected in personality theories, where these approaches set out to measure a thing called 'personality' (Cromby, Harper & Reavey, 2012). The constructs of traits and dispositions assume that people are relatively consistent across time and situations. Questionnaire measures reflect this, attempting to measure personality factors irrespective of context. As well as being de-contextualised, critics argue that research consistently suggests a lack of correlation between 'personality' and how people behave. Stainton-Rogers et al. (1995) emphasise the role of culture and construction in personality arguing that personality scales simply reflect the extent to which the scale-designer and participant 'share a common understanding of "what people are like"' (pp. 50-51).

Personality is embedded in and constitutive of assumptions about what normal personality 'should' be which has led some theorists to argued that PD has more to do with behaviours seen to contravene moral codes than mental health (Cromby Harper & Reavey, 2012). For instance, PD is seen as the extreme manifestation of 'normal' traits, with the normal-abnormal distinction created through diagnostic categories. The broad definitions encompassed in the PD categories mean that a vast number of behaviours could be inappropriately labelled and ultimately serve to pathologise what can arguably be better evidenced as understandable responses to adverse circumstances (Albee, 1986; Johnstone, 2000; Stoppard, 1999). In addition, personality traits serve evaluative functions in day to day conversations (e.g. they are used to account for whether or not we like someone) (Stainton-Rogers et al., 1995). Thus perhaps more than any other diagnosis, PD is imbued with value judgements and normative expectations.

While this study is more concerned with problematic aspects of the diagnostic category of PD and how this diagnosis is taken up or resisted in staff talk, it is acknowledged here that for some diagnosis can have positive consequences (e.g. access to services, feeling that their problem is better understood). Research suggests a variety of responses from service users ascribed the borderline personality disorder (BPD) diagnosis, including a proportion reporting receiving a diagnosis as helpful, in that they felt this gave them some control (Stalker, Ferguson & Barclay, 2005). However, typically more negative aspects of the diagnosis were described (e.g. uncertainty, rejection) (Horn, Johnstone & Brooke, 2007). This would suggest that the PD label does not confer the same potential benefits that other diagnoses might; for instance, receiving a physical health diagnoses can reduce uncertainty, facilitate access to a collective identity or support groups or provide the start point for change (e.g. see Calhoun & Tedeschi, 2007 'post-traumatic growth'). As has been suggested previously, the PD label can restrict access to services, offers the individual an inherently pathologised identity and research suggests that service users are often confused about the diagnosis and what it means for them (Stalker, Ferguson & Barclay, 2005). Despite concerns and controversies, psychiatry and diagnosis continue to be the dominant discourses in mental health and the PD label continues to be widely used in practice (Rogers & Pilgrim, 2010). The importance of the way in which kinds of distress are constituted through language is central to the discursive approach used here. In which talk is viewed as social practice which is orientated toward action, i.e. it has the capacity to do something.

1.3.ii Diagnosis and Foucault

While diagnostic systems claim to study universal disorders, medical anthropologists and philosophers have pointed to the cultural values and assumptions that under-pin psychiatric classification (Bracken & Thomas, 2001). It has been ably argued that diagnosis serves as a powerful social tool with implications for how people become positioned as sick, in relation to healthy others (see Willig, 2011). Diagnosis affords professionals the power to

name distress and research has indicated that mental health professionals invest in the scientific status of their expert knowledge position (Barrett 1996; Horsfall, Stuhlmiller & Champ, 2000). Conceptualising distress and disorder has implications for the ways in which service users come to understand their difficulties. Diagnosis contributes to what is understood as normal, and how services frame service user behaviour will function to shape what it is that service users are required to do to reclaim 'normality' (Crowe, 2000). This classification system is embedded in power exchanges constituted in part through language. Foucauldian theory is useful here for considering the ways in which professional and scientific discourses relate to and are dependent upon knowledge and power (Foucault, 1979). Foucault argues that where there is power, there is resistance and so staff can also resist discourses, drawing on alternative or marginalised frameworks. Foucauldian theory challenges the realist assumptions inherent in diagnostic systems and argues that diagnosis is shaped by ideology and culturally reinforced (McNamee & Gergen, 1992). Professionals can therefore be understood as being influenced by service pressures and policy (e.g. situated within these discourses) and engaged with their own process of everyday meaning making.

2.0 Current literature

This section offers an overview of the literature exploring professionals' attitudes and experiences toward working with people with a PD diagnosis. Research conducted to date has tended to treat staff talk as indicative of attitudes towards personality and psychopathology (rather than how these concepts are being used or contested within staff accounts). Where research has been interested in the impact and views on PD diagnoses amongst staff, these studies have predominantly used the realist paradigm and relied on attitudinal questionnaires. There is little empirical work looking at staff accounts of PD or providing care for people with this diagnosis in terms of what this talk is functioning to achieve and what values it is embedded in. A brief review of the literature around staff attitudes toward PD will be presented here, moving on to discuss what a discursive perspective can add to this area of research.

2.0.i Research interests surrounding staff attitudes towards personality disorder: Quantitative studies

One of the first studies concerned with staff attitudes toward people with a PD diagnosis concluded that staff deemed these patients⁴ to be manipulative (Lewis & Appleby, 1988). A range of quantitative studies have since looked at the prevalence of PD diagnoses amongst those patients staff describe as 'difficult' (e.g. Deans & Meocevic, 2006; James & Cowman, 2007; Markham, 2003; Markham & Trower, 2003; Schafer & Nowlis, 1998). Predominantly using surveys, research has consistently reported negative staff attitudes towards PD. For instance, James and Cowman (2007) asked psychiatric nurses about their attitudes towards patients with different diagnoses; they found that 80% viewed patients with PD as more difficult to care for. Similarly, when compared with 'depression' and 'schizophrenia', Markham and Trower (2003) found staff described people the behaviour of those with a BPD diagnosis as more challenging and attributed those with this label as having greater control over their behaviour. Elsewhere descriptions of this label include that patients are irritating, attention-seeking, difficult to manage (Cleary, Siegfried & Walter, 2002), and dangerous (Markham, 2003). It is also reported that there is greater pessimism regarding treatment for PD (Markham, 2003). With regards behaviour, studies suggest that staff interactions with those with a BPD label are characterised by less empathy, and more contradictory and belittling responses (Gallop, Lancee & Garfinkle, 1989; Markham, 2003). A PD diagnosis may therefore pose a challenge to ensuring positive staff-patient relationships (Gross et al., 2002). Some research has employed the same methodology in prison settings; Rutherford and Taylor (2004) found that women prisoners with a diagnosis of PD waited significantly longer for a hospital bed when compared to others. The majority of these studies have relied on views from mental health nurses and were specific to the BPD diagnosis (e.g. Cleary, Siegfried & Walter, 2002; Markham, 2003).

⁴ The term patients is used throughout these sections where it reflects the terminology used within the studies

There is an extensive body of attitudinal literature indicating that cross-culturally, professionals report working with people with this diagnosis to be challenging (e.g. Cleary, et al., 2002 (Australia); James & Cowman, 2007 (Ireland); Giannouli et al., 2009 (Greece)). Some behaviours seen in a proportion of people with a PD label can cause distress for staff, such as service user self harm and aggression. Bodner, Cohen-Fridel and Iancu (2011) reported attitudes toward the suicidal tendencies of those diagnosed with BPD; psychiatrists and nurses reported higher levels of 'antagonist judgements' when explaining suicidal tendencies of patients with this diagnosis compared to others. Newton-Howes, Weaver and Tyrer (2008) also reported that PD labels were associated with difficult to manage patients; the authors stated that ratings of patient aggression, need and social functioning did not explain why staff believe those with a PD label are harder to manage, suggesting a role for the label alone in producing negative evaluations. Aviram, Brodsky & Stanley (2006) suggested that staff stigma, surrounding BPD, independently contributed to poor intervention outcomes in this population.

There is a reliance on questionnaires within these studies which is inevitably restrictive (e.g. they predetermine the descriptive categories available to participants, offer a limited range of choices, and often accommodate only one response per question). Also despite contentiousness surrounding the label these studies tend to assume that PD is a taken-for-granted, measurable category that can be used as an a priori way of understanding distress and can act as a dependent variable of some kind. Objective measures such as these fail to allow for variability and contradiction (Potter & Wetherell, 1987). They are unable to attend to individual staff meanings or to offer detailed understanding of the complex issues involved in why staff hold certain views (Woollaston & Hixenbaugh, 2008). In the last 20 years, a number of studies have taken a qualitative approach to staff experiences of working with people with a PD diagnosis (Nehls, 1994). The findings from these studies are summarised below and aim to draw attention to the complexity of influences on staff experiences.

2.0.ii Qualitative studies

Generally speaking, the qualitative studies reviewed here share an assumption that what, where and how staff understand and work with service users is tied up with social interactions, and that meanings surrounding PD and professional roles are important. These methods are well suited to exploring the varied ways in which people interpret phenomena. One feature of staff descriptions of the 'PD patient' evident across studies was of these patients as actively and intentionally trying to subvert staff efforts to care for them. A consequence of this was that staff descriptions were morally loaded (e.g. focussed on accountability, responsibility) (Hazelton, Rossiter, & Milner, 2006; McGrath & Dowling, 2012; Woollaston & Hixenbaugh, 2008; Treloar, 2009). For instance, Treloar (2009) reported that mental health practitioners questioned whether the BPD labelled was simply 'an excuse for bad behaviour and nastiness' (Treloar, 2009, p. 31). Other research similarly reported that staff felt service users set out to 'exaggerate their feelings' to gain attention and 'manipulate' staff (McGrath & Dowling, 2012, p. 5; Woollaston & Hazelton, 2008). That those with PD were seen as motivated to manipulate staff added weight to staff claims that it was inherently difficult to trust (Langley & Klopper, 2005), or be empathic towards those with this diagnosis (McGrath & Dowling, 2012; Woollaston & Hixenbaugh, 2008). In addition, behaviours that were viewed as intentional 'strategies' were taken less seriously; for instance, the seriousness of self harm was downplayed when framed as 'attention-seeking' (McGrath & Dowling, 2012).

In a number of studies service users were described as aggressive and unpredictable with staff reporting feeling threatened (personally and professionally) (O'Brien & Flote, 1997; Ma, Shih, Hsiao, Shih & Hayter, 2010; McGrath & Dowling, 2012; Woollaston & Hixenbaugh, 2008). It was common for staff to describe feeling victimised and hurt as well as irritated by service users lack of gratitude (Crawford, Adedji, Price & Rutter, 2010; Ma et al., 2010). Crawford et al., (2010) interviewed a range of community mental health professionals about PD. Their thematic analysis suggests that those with a PD diagnosis were experienced as less cooperative and less grateful for staff input.

Staff based this judgement, in part, on whether patients improved or reduced their 'difficult' behaviours. In some studies, staff described a lack of reciprocity from service users; this appeared to relate to how deserving of care people with PD diagnoses were deemed to be (Nehls, 2000).

A study by Stalker et al., (2005) set out to interview service providers and service users to explore their views about the meaning of PD and the difficulties experienced by people who receive this label. Using semi structured interviews and thematic analysis, the authors suggested that service providers attribute difficulties related to PD (e.g. distressing emotions, strained relationships) to childhood trauma. There were a range of views as to where current difficulties were located; some staff explained PD in terms of individualistic and intra-psychic explanations. Others argued that PD unhelpfully locates the 'problem' within the person. This was predicated on the claim that negative and judgemental attitudes towards those with PD diagnosis were rife within community services. This is one of the few studies to have explored the views from a range of staff, having recruited service providers who represented the diversity of staff roles within community mental health teams. Some of these studies have questioned the assumptions of psychiatric diagnosis (e.g. Stalker, Fergusen & Barclay, 2005 who argue in favour of a social model of distress), however others make claims based on contested diagnostic categories and so the findings should be treated with caution. For instance, while situating themselves within a critique of diagnosis some research continues to employ categories to make sense of their findings (e.g. treating diagnoses as real entities, but which clinicians were failing to use objectively). This body of research suggests there are a range of ways in which staff constructions of service users with PD diagnoses may be implicated in clinical decision-making.

2.0. iii Summary of previous research

The research discussed above indicates a general pattern whereby staff hold comparatively more negative attitudes towards people with a PD diagnosis. The quantitative and qualitative literature reveals similar 'themes' in staff views (e.g. people with PD are manipulative and difficult), although within the qualitative

studies it is possible to see how these attributions and explanations are justified and maintained by certain views of PD (e.g. as ungrateful, intentionally antagonist). There is a consensus across this literature that staff conceptualisations of PD have significant clinical implications for their work with service users. The methods through which staff views on PD have been assessed predominantly subscribe to a realist epistemology. The discursive approach presented next contests this conceptualisation of language and psychological phenomena. The following section expands on the interest in language, and how this came about as a challenge to cognitivism and its dominance (Stokoe & Wiggins, 2005).

2.1 Discursive practices and staff talk

Potter (2012) distinguishes discourse analytic work from mainstream psychology in terms of the treatment of language; namely, this resists the idea that language offers a pathway to putative mental objects, and instead talk is studied in terms of action and social performance. Arguing in favour of a discursive approach, Wiggins and Potter (2003) offer a critique of two main areas relating to attitude measures; (i) the reliance on questionnaires, and (ii) that this approach does not attend to what it is people may be *doing* with their talk (e.g. accounting, defending, justifying). Potter and Wetherell (1987) challenge the notion that language “maps onto reality in any straightforward manner” (Edley, 2001, p. 434). Discursive psychology (DP) is instead agnostic to the presence of cognitive processes and focuses on the way in which understandings of cognitive functioning are formed in and through language. Realist understandings of identity are also critiqued by discursive theorists; rather than the notion of identity as stable identities are treated as co-constructed through talk, as serving particular rhetorical functions and as best understood as fluid, multiple and negotiated in interaction (e.g. self as victim, self as aggressor) (Gough & McFadden, 2001).

Discourse analysis (DA) is an umbrella term for a range of methods (with different theoretical perspectives and analytic principles) used to analyse text and talk. The term discourse is used within this thesis to refer to talk and text as

social practice (e.g. as performing social acts). DA is concerned with the production of meaning through language, whereby language is seen as actively constructing meaning. The following section looks at the suitability of DA for examining professionals' accounts in mental health practice. These studies vary in how they conceptualise discourse, but share a subscription to a social constructionist epistemology in which language is understood as performative and constitutive such that different ways of talking serve different functions (e.g. persuading, justifying) (Wetherell, Taylor & Yates, 2001).

The importance of language within mental health services lies in the understanding that staff and service users are subject to socially determined ways of speaking (Georgaca, 2012) and that staff work and service user distress is only knowable through "particular cultural and historical frames or discourses that structure that reality" (Burman, 2003, p. 83). Burman and Parker (2005) argue that a key concern for psychologists should be with the way that culturally and historically specific psychological assumptions reappear in staff talk and the implications of these. Discursive research is well suited to delineating discursive resources and the positions afforded through their use as well as for considering how diagnostic categories are used (historically or interactionally) (Harper, 2007). Parker (1999) argues that such concepts function within institutions to position and pathologise those to whom they are applied. Various psychological, diagnostic entities have been subjected to DA (e.g. anxiety (Hallam, 1994), PD (Swartz & Ismail, 2001), paranoia (Harper, 1994), anorexia (Hepworth, 1999) and hallucinations (Blackman, 2001)); these studies take a historical, de-constructive approach to the development of these categories. The key strength of these studies has been to reveal the underlying assumptions of psychopathological categories and how they are produced within specific socio-historical conditions (Georgaca, 2012).

DA has previously been used to explore the accounts of health professionals in a variety of contexts (e.g. with general practitioners' (GP) talk about ME and GP and nurses' constructions of men's health) (Horton-Salway, 2001; Seymour-Smith, Wetherell, Phoenix, 2003). In terms of mental health professionals, interviews have been carried out on a range of topics of mental health practice,

and subject to DA. Some authors interviewed staff about their conceptualisation of disorders (Thomas-MacLean & Stoppard, 2004) and diagnosis (Harper, 1994, 1995). The discursive approach is well suited to exploring contentious or contested topics, and for examining the implicit oppositions in people's accounts (e.g. between normal and pathological) (Harper, 1994). Others have applied the method to medical texts; for instance, the construction of patient experiences of electroconvulsive therapy (ECT) in journal articles (Johnstone & Frith, 2005) and how the objectifying language of medicine dominates patient notes (Hamilton & Manias, 2006). These studies have shown how different ideological discourses are taken up or resisted within staff knowledge claims (e.g. the language of medicine). These studies show how powerful institutional discourses (e.g. psychiatry, medicine) can be used to support certain claims (e.g. Johnstone & Frith, 2005), and justify treatments, including medication (Harper 1999; Liebert & Gavey, 2009). In addition, DA studies have shown how rhetorical strategies such as constructing patients as severely unwell can serve to justify the use of problematic practices (e.g. ECT) (Stevens & Harper, 2007).

Drawing attention to questions such as, how do discursive practices specify forms of behaviour, interiority and other taken for granted 'psychological' notions, discursive studies highlight the complexity of mental health practices and how they are implemented in talk. Benson et al., (2003) looked at the attribution of blame in staff and service user descriptions of service user aggression. It was notable that both employed strikingly similar discursive resources to manage accusations of blame (e.g. whether the violent or aggressive behaviour was mad or bad), but with varying effects. DA can therefore attend to the different ways in which language functions, and show how pathological identities can be invoked to justify staff roles; for instance, eating disorder nurses constructed patients as challenging, cunning and manipulative therefore justifying the need for surveillance and control (Ryan et al., 2006). DA studies also demonstrate how gender is employed as a discursive resources (e.g. to account for female aggression in terms of menstrual cycle) (Wilcox et al., 2006), and the way hegemonic discourses around masculinity and femininity are implicated in professionals' accounts of their patients (e.g. Seymour-Smith, Wetherell, Phoenix, 2003). One study has looked at staff talk

in the context of BPD; the intention was to explore the discourses of a group of staff before and after DBT training. The discursive 'themes' included 'ineffective treatments' and 'difficult consumers' (Hazelton et al., 2006). While this study used a form of Potter and Wetherell's (1987) DA, little attention was paid to the kind of rhetorical strategies staff used, nor to the wider institutional discourses taken up by participants. It was also narrow in its focus, concerned primarily with evaluating the impact of DBT training.

Researchers have also demonstrated the usefulness of DA for examining therapy sessions (e.g. Angus & McLeod, 2004; McLeod, 2001; McNamee & Gergen, 1992; Perakyla, Antaki, Vehvilainen, & Leudar, 2008). These studies subscribe to the concept of psychological problems as discursive and interactional phenomena "that are created, maintained, and dissolved in and through language and social interaction" (Karatza & Avdi, 2011, p. 215). This body of research has used DA to explore the different positions which are constituted (and constrained) by certain understandings. While it is not the focus of this research to directly explore interactions between staff and service users, it can be speculated how certain constructions serve to position service users; whether this is in terms of the position from which staff speak, the position which this places the person they refer to in, or how staff and service users come to be positioned through particular ideological discourses (Karatza & Avdi, 2010). These studies bring into focus the contextual nature of talk, and the important of interactional processes and socio-cultural discourses for understanding professional practice and the psy-complex⁵ more generally (Georgaca, 2012).

2.2 Clinical psychology in multidisciplinary teams

In being concerned with identifying the ways in which PD is given meaning through staff talk, and how staff manage issues of stake and interest in the context of ongoing debates surrounding the PD diagnosis, this study also has implications for clinical psychologists working within multidisciplinary teams

⁵ "The psy-complex is the network of theories and practices concerned with psychological governance and self-reflection in Western culture" (Parker, 1998, p.79).

(MDTs). Participants in the present study work in a low secure inpatient unit with women with a range of PD diagnoses. A wide range of professions are represented within this unit and work closely together to meet a broad range of service user needs. Working in MDTs is a central part of the clinical psychology role (Christofides, Johnstone & Musa, 2012). In these settings, clinical psychologists are expected to offer psychological knowledge, draw attention to the importance of psychological processes within teams and supervise staff (Onyett, 2004). Research indicates that these contributions are valued by team members and service users (Onyett, 2004). Specific to clinical psychology, team work and supervision are recognised as core competencies and part of the 'specific value' of the profession (Falender et al., 2004). Despite this clinicians have expressed surprise at the minimal role given to supervision and team work within clinical psychology training (Falender et al., 2004).

Clinical psychologists would benefit from being aware of the views staff hold about PD, as these will shape staff interactions with service users, and service users' views about their difficulties (Ahn Proctor & Flanagan, 2009). Recommendations for working in this setting include that there is consensus within the team surrounding the client group (i.e. what is needed for people with a particular diagnosis should be unambiguous) (Brown, Crawford & Darongkamas, 2000; Mental Health Commission, 2006). It is further recommended that clinical psychologists working in teams have good knowledge of the system, the socio-political context and can both support and challenge staff in this setting. It is suggested here that clinical psychologists would benefit from paying attention to language use within MDTs, what concepts are being privileged and what the implications may be. In addition, offering support to staff could be improved by understanding how professional identities are bound up with particular values and therefore tied to issues of accountability. While the applicability of social constructionist research is contested (Burr, 1995), this study aims to explore the value of a focus on language for clinical psychologists, working in comparable settings.

3.0 Extended methodology and method

3.0.i Methodology

Two main approaches to DA are used in the present research, namely discursive psychology (Potter & Wetherell, 1987) and Foucauldian discourse analysis (FDA) (Foucault, 1979). Alvesson and Karreman (2000) offer two dimensions from which to understand differences in these approaches to discourse; one dimension relates to the level at which discourse is conceived (e.g. local and interactional or at a broader, societal level) and the other to the level at which meaning is posited (e.g. transient, occurring within a specific interaction only, or durable, in that it exists beyond the immediate context). These dimensions are drawn on throughout this study to distinguish between discursive approaches and to discuss application. Firstly the two approaches are described in more detail.

3.0.ii Discursive psychology (DP) and Foucauldian discourse analysis (FDA)

DP argues that psychological phenomena are produced, constructed and brought into being through language. Discursive psychologists are interested in how the discursive treatment of these concepts functions in conversation, and how psychological categories are constructed moment to moment (Alvesson & Karreman, 2000). DP privileges language as the primary site for the creation and negotiation of meaning (Stokoe & Wiggins, 2005). DP is social constructionist in its orientation, in this sense it puts aside questions about 'reality' of things, but rather how they are talked into being (Willig, 2008). Furthermore, it does not conceptualise talk in terms of truth, but explores the many different ways in which the world can be constructed (Gillies, 1999). Potter & Wetherell, (1987) emphasis three major components of discourse:

- Firstly, they argue that language is constitutive, performative and productive. In this sense, talk gives rise to particular versions of reality, and bring 'understandings' into being. How language is used, and to what effect, is of central interest (Willig, 2008).

- Secondly, they claim that language is functional and oriented to action, such that talk achieves social acts through discursive practices such as justifying, blaming, and attributing. Ways of talking can therefore be understood as discursive resources, functioning rhetorically to fulfil particular social goals. Therefore, talk needs to be understood in relation to conversational stake and interest (Willig, 2008). DP typically makes no claims about intentionality, although some have argued this is inconsistent with the conceptualisation of the speaker as a strategic user of language (Madill & Doherty, 1994).
- Thirdly, it is taken that variation and contradiction are key features of talk. There is always more than one way of describing something, and people have access to a range of competing versions (Willig, 1999). Although there are multiple versions of reality which can be produced through talk, ways of talking about the self are limited; thus people will be positioned and constrained by the discourses which are available to them (e.g. a medicalised discourse will dominate the medical profession, but will not be universally available) (Potter & Wetherell, 1987).

The DP approach is focussed upon understanding talk in local interaction, and does not typically concern itself with wider socio-cultural discourses. Discourses are deemed contingent solely on the context in which they are (re)produced and should be read as situated within these local contexts (Willig, 2008). Accordingly, DP is concerned with 'micro-contexts' (Alvesson & Karreman, 2000, p.1133). FDA is similarly interested in how talk constitutes knowledge and treats language as functional, active and oriented to action, however this perspective is concerned with how language functions at a macro level to offer, and draw upon, culturally and historically situated accounts (Alvesson & Karreman, 2000).

FDA is concerned with the way language brings versions of the world into being and how these versions of reality become rationalised and legitimised (Parker, 1997). FDA assumes that meanings (constituted through socio-culturally mediated language) are to a degree, durable and standardised (Willig, 2008).

These socio-cultural accounts are powerful in that they limit and influence the available ways of constituting versions of events and subjectivity (e.g. how are subjects positioned in, and by, the discourses which are available?). Discourses offer 'ways of being in the world', locating people into particular positions (subject positions) (Willig, 2008, p.113). Power and language are argued to be inseparable, with the availability of dominant and subordinate discourses related to entitlements (e.g. who has the right to speak about a topic) (Willig, 2008) and will support and validate some positions, and marginalise others (Alvesson & Karreman, 2000). In addition, language produces understandings which, over time, become taken for granted and treated as 'realities'. These taken for granted understandings enact power in that they become the dominant ways of reproducing knowledge (and not everyone will have access to these).

3.0.iii. Combining DP and FDA

DP has criticised Foucauldian approaches for failing to take the close range aspects of language seriously (for example, how power can be negotiated in on-going interaction) (Alvesson & Karreman, 2000). In turn, with DP's focus solely on the discursive, FDA might argue that DP is reductionist, leading to an impoverished account which cannot attend to the extra discursive (Alvesson & Karreman, 2000; Parker, 1992). FDA has a broader concern with socio-cultural discursive resources (which offer and limit ways of talking), and power (e.g. the regimes of truth embedded in scientific discourses). While there is difference between the levels in which DP and FDA are interested (micro vs. macro) (Alvesson & Karreman, 2000), these differences are by no means incommensurate (Wetherell, 1998; Willig, 2008). Previous research has used this dual pronged analytic approach successfully (e.g. Malson & Ussher, 1996; O'Key & Hugh-Jones, 2010; Wetherell & Edley, 1999). In terms of the present research, using both approaches enables the socio-culturally available ways of talking about mental distress, personality and psychological constructs (e.g. emotions) to be explored, as well as how these ways of talking are 'emergent and locally constructed' (Alvesson & Karreman, 2000, p.1134). This study positions itself between the micro analytic concerns of the local action orientation of talk producing a detailed analysis of how language is used in

interaction, and a macro interest in how long range discourse (e.g. psychiatric categories) are organised into broader patterns and systems of language (Burman & Parker, 1993).

3.0.iv Epistemological concerns

A social constructionist framework underpins this thesis. This means taking an epistemologically relativist position, therefore treating reality (including perception of reality) as a construct (Gillies, 1999; Edwards & Potter, 1992), and an agnostic position with regards ontology (in the sense that it does not speculate on 'realities' themselves) (Madill, Jordan & Shirley 2000). From this perspective there are no absolute truths or knowledge, but rather many 'knowledges', constructed through language. Knowledge is treated as socially, historically and culturally mediated (Willig, 2008). Social constructionism makes no appeals to human nature (other than to suggest that the 'real' nature of things is not simply reflected through language). This encourages a critical approach to language and knowledge claims and offers a challenge to our shared assumptions about reality. Psychology is there seen as a set of psychological practices each of which have their own cultural and historical position (Gergen, 1999).

3.0.v Interviews and application

The research relied on semi-structured interviews for data collection. Interviews are useful for understanding how people make sense of particular phenomena (Smith, 2005). They can encourage expansive discussion and can capture the contradictions and inconsistencies present in peoples' everyday talk (King & Horrocks, 2010). This format can obtain valuable, rich, in-depth talk about complex issues (King & Horrocks, 2010; Smith, 1995, 2005). The semi-structured format involves a number of core, open ended questions and prompts (Madill, 2012). Semi-structured interviews are the most popular data collection method for qualitative data (Madill, 2012); the popularity of this method may lie in the balance between interviewer control (i.e. focus on the research question) alongside free flowing discussion, which approximates normal conversation (Houtkoop-Steemstra, 2000; Madill, 2012).

Debates surrounding the appropriateness of interview data have centred on concerns that the interview setting is contaminated by the research agenda (Madill, 2012) (see Potter & Hepburn, 2005; Potter, 2002; Speer, 2002a; 2002b, Ten Have, 2002). There are different ways in which the interview, and the data generated from this encounter, have been conceptualised. In a realist conceptualisation, the interview would be seen as a neutral mechanism which unproblematically captures people's views and opinions. Critics suggest this offers a naive understanding of the interview as a mirror through which the world is reflected (see Potter & Wetherell, 1995; Potter, 1997; Speer, 2002a; Wetherell, 2007) and assumes that interview talk as an accurate representation of mental processes (Hammersley, 2008). Instead, it is argued here, language is context driven and never disinterested (Glanzberg, 2002), thus the interview is best conceptualised as an interaction in which talk is co-constructed, played out between participant and researcher. It is assumed that participant and researcher will have their own agendas and interests which will affect the interview (Potter & Wetherell, 1995; Speer, 2002a, 2002b).

Some theorists suggest that interactional features should be the primary, or even sole, focus of the analysis. It is argued here that while the interactional features are important (for instance, how do these features relate to the ways in which the researcher agenda and participant agenda interact?) that the interview is also a way of exploring people's conceptualisations of, in this case, PD and what this means for staff and service users (Smith, 2005).

With its focus on construction, variability and performance, DA is well suited to exploring the productive nature of the interview. However, it has been argued that the interactive nature of interviews is problematic with regards what claims can be made about the data (Potter, 1997; Potter & Hepburn, 2005). For instance, it has been argued that the interview dictates a research agenda which limits how participants can respond (e.g. in terms of content, the length of participant responses) (Wiggins, 2004) resulting in distorted data (Potter, 1997). Those who have defended the use of interviews argue this over simplifies the interview, as it suggests that the participant cannot contest or bring their own agenda to the interview (Griffin, 2007). In practice, there are

many opportunities for participants to digress from or resist questions (see Griffin, 2007).

Speer (2002a, 2002b) argues that the distinction between naturally occurring and interview data is not sustainable. She problematises the superior status afforded to naturally occurring data and questions the notion that 'naturally occurring' data could ever exist wholly independent of the researcher (Speer, 2002a). In addition, formulating the interview interaction as the 'whole' (and only) context places unnecessary limits on the extrapolation of findings beyond the research encounter (Griffin, 2007).

People's talk contains repeated patterns in terms of general discursive content, structure and function (Wetherell, 2007). Wetherell (1998) demonstrated how identities and ways of accounting are mobilized in similar sites. Participant discursive interests, investments and socio-cultural conventions, are indicative of collective resources, conventions and shared knowledge (Hammersley, 2008). It is therefore suggested that the interviews conducted in the present study will elicit talk comparable with other occasions in which participants engage in conversations about PD (e.g. team meetings, supervision) and how to make sense of the difficulties associated with this. It is therefore possible to reflect (conservatively) on the discursive resources and patterns of talk within the interviews as ones which may be drawn on in other similar contexts (Wetherell, 2007). Generally speaking, it would seem, the better the match between the context of data collection and application, the more valid the extrapolation of the findings is likely to be. This research speculates on the effects of participant discourses and considers what alternative constructions are possible, while acknowledging that the reality or materiality to which these suggestions refer is not directly perceptible or knowable.

3.1 Research aims

The aims of this research are:

- To conduct a discursive analysis, informed by social constructionism, which explores the ways staff talk about PD⁶ and their day to day work with people with this diagnosis.
- To explore the locally contingent features of staff talk about PD, BPD and their decisions around caring for those with this diagnosis (e.g. what is the language of diagnosis and PD and how does this language affect the construction of staff reality?)
- To pay attention to the socio-political relations in which participant talk is situated.
- To offer a discussion of the implications of the ways of talking elucidated by the analysis in terms of the role of discursive psychology for informing clinical practice and in terms of how the findings can be used to inform the role of clinical psychologists within similar MDT settings.

3.2 Ethics

This study was approved by a University of Nottingham Ethics Committee (appendix i). The independent hospital from which participants were recruited was content with University Ethics board approval. Hospital management approved the study following confirmation from the University Ethics board. A recruitment information sheet was produced for all participants (appendix ii). This sheet intended to make participants aware; (i) of the purpose of the research; (ii) of what the project involved; (iii) who was invited to participate; (iv) the duration of the research; (v) that transcripts would be anonymised; (vi) that participation was voluntary; (vii) how the information provided by participants would be used; (viii) that the study has been approved by an overseeing body and (ix) that participants were free to withdraw their data up to two weeks after interview. These details were made explicit within the recruitment documents

⁶ PD, rather than BPD, is typically used through the analysis and discussion. This reflects the range of diagnoses that service users had; while all had a BPD diagnosis the majority also had other concurrent PD diagnoses. In addition, participants tended to refer to PD generally rather than to specific PD diagnoses and so this is reflected here. Where participants are specific about which diagnosis they are referring to this is acknowledged.

(i.e. recruitment sheet, consent form). Both of these documents were sent out to potential participants via email. In a bid to ensure that participants had read this information and to foster an opportunity for participants to ask questions, participants were also invited to read the recruitment information sheet at the outset at the first meeting between researcher and participant. Data collection did not begin until participants had signed to confirm their understanding.

3.2.i Ethical considerations

Attempts have been made to ensure that participants remain anonymous. There are relatively few independent private hospitals from which to recruit participants working predominantly with people with PD diagnosis, as such additional details about the hospital (e.g. general location) have not been included. Participants were assured, both on the recruitment leaflet and consent form (appendix iii) that their data would be anonymised. Participant details which may have made them identifiable (e.g. personal information, length of time working at hospital) were altered or removed from the transcripts and other records. Participants were informed who would see the transcripts in their entirety, as well as how quotes would be used in dissemination. Where applicable, pseudonyms were used during the analysis, with a record of actual names and how these related to the interviews stored in a lockable file case accessible only to the researcher. Given the small sample size, demographic information has been presented for the group of participants rather than individuals in order to further protect anonymity. The interviews were audio recorded onto a dictaphone; each interview was downloaded from the dictaphone to a password protected computer file, after which the data was deleted from the dictaphone. The transcription was outsourced after obtaining a confidentiality statement (appendix iv). Designed to be more secure than email, the Dropbox facility was used to transfer audio files to the transcription service.

3.3 Pilot interview

A pilot interview was conducted in order to reflect on the scope of the interview schedule and the appropriateness of the interview questions. A trainee on the clinical doctorate was invited to take part in the pilot; the trainee was approached due to the similarities between her past clinical experience and that of the participants (e.g. having worked on an inpatient unit, having been part of an MDT working specifically with people with a PD diagnosis). While the intention was not to use the data from this interview within the analysis, the trainee was given an information sheet and asked to sign a consent form, in case it was later decided that this interview would be included. This was made clear to the trainee at the outset. The pilot revealed a number of possible refinements to the interview schedule (appendix v), summarised here:

- The structure and phrasing of some questions was changed to encourage broader discussions around PD diagnoses, as well as specific examples. Recommendations for interviews include asking questions grounded in examples; this is on the basis that general questions may require participants to reflect conceptually on a topic which they typically would not consider in this way (Potter & Hepburn, 2005). Thus the unfamiliarity of these questions may leave participants struggling to answer (Madill, 2012). While acknowledging the usefulness of questions grounded in examples, the pilot interview indicated that questions were eliciting detailed responses about specific people such that broader views on diagnosis and understanding 'personality' were neglected. There was therefore a balance to be reached between these two styles of question.
- There was little opportunity to talk more positively about working with PD and so more 'positively' oriented questions were included (e.g. what do you enjoy about your work?).
- The pilot interview also drew attention to the terminology used to refer to diagnosis. For example, my own position on diagnosis was reflected in my questions (e.g. 'people with a diagnosis of') which contrasted with that of the participant (e.g. 'people with PD'). The different terms used to talk about those within services was also noted (e.g. patients, clients,

service users). Given the co-constructed nature of interview data, in response to becoming aware of these differences, I made efforts to notice and use participant terminology to temper the impact of my agenda.

- The pilot provided an opportunity to pay attention to my style of asking questions. I noted a tendency to use long questions, which could be difficult to follow. Madill (2012) recommends the use of short questions (whilst paying attention to rapport in case these are perceived as curt).

The interview data generated from the pilot interview was read and first impressions regarding the material were made. On this basis it was felt that the interview schedule was appropriate for generating material relevant to the analysis. Due to changes to the interview schedule following the pilot and the different job role of the trainee, data from the pilot interview was deemed sufficiently distinct from the research interviews to warrant it not being included within the analysis.

3.4 Sample rationale

The study set out to add to the research exploring staff understandings and assumptions surrounding their work with people with a PD diagnosis. To date, discursive research has not explored staff talk specifically in relation to PD. The study aimed to recruit between 10 and 12 participants; previous studies employing discursive approaches have used sample sizes of between five and fifteen participants. Eleven participants were recruited, consistent with other discursive studies exploring professionals' accounts of mental health (Harper, 1995; Madill, Gough, Lawton & Stratton, 2005).

This research aimed to recruit staff from a MDT in order to obtain a breadth of perspectives which represent the cross-professional involvement which typifies this setting. The analysis did not seek to identify interviewees talk by role. While it is acknowledged that the social background and training of professionals may lead them to reinforce particular dominant discourses (Waitzkin, 1991), our analysis is interested in how this is done and the function it serves, rather than with mapping this to particular professions. In addition, the study approached

recruitment from the perspective that action (i.e. discourse) is at least in part institutionally situated, with psychological resources produced and made relevant to the business of the setting in which they occur (Potter, 2012). It is therefore recognised here that participants will experience certain constraints or certain issues with service users (e.g. forensic histories), which may be less prevalent to staff working within other settings (e.g. community teams). This research therefore wishes to increase the knowledge base relating to the meanings staff attribute to their work and the people they work with in this setting, taking account of these factors.

3.5 Recruitment

a. Designing the recruitment information

A detailed recruitment information letter outlined the purpose of the study, what was involved for participants and what their interview data would be used for. In keeping with the discursive analytic stance of this research, how to manage the impression of the research was carefully considered. For instance, it was anticipated that some prospective participants may have been discouraged from taking part as a result of negative media stories which criticise service provider care. The information sheet was thus carefully worded to convey the ethos of the study (i.e. 'little is known about staff experiences of working with those with this disorder and how useful staff find personality disorder diagnoses').

b. Recruitment strategy

Potential participants were approached via a gatekeeper at the hospital. This person emailed all staff eligible to take part using the hospital email system. This hospital was selected as the research all those within the ward were currently working directly with people with this diagnosis. This avenue also provided access to staff across the MDT.

3.6 Interview schedule

The interview schedule (appendix vi) included topics considered *prima facie* to be of relevance (e.g. what was the person's role at the hospital, how did people get admitted, what kinds of difficulties did staff tend to see in those who were admitted). The interview began with these questions in order to gain background information (e.g., see situating the sample in Elliott, Fischer, & Rennie, 1999) and to build rapport. These provided a useful framework on which to base subsequent questions; for instance, some questions would not be appropriate for all staff (e.g. not all staff 'delivered interventions'). Some question topics were gleaned from the literature (such as around diagnosis more generally, helpful therapeutic approaches, working as a team). Phrasing which was prescriptive (e.g. narrow, closed questions), which alluded to dominant psychological constructs (e.g. attitudes, emotions) or which used psychological terminology (e.g. impulse control, emotional dysregulation) was avoided. In addition, efforts were made not to use either-or questions, or questions based on interpretations (e.g. that must be difficult?) (see Madill, 2012).

Questions around service user difficulties were, relatively speaking, quite general (e.g. what kinds of difficulties do you see, what's your view about what may contribute to these difficulties?). Diagnosis was not privileged within the questions. Past and current experiences of work are one way in which people make sense of, and justify, their approach; participants were asked to reflect on these episodes (e.g. can you tell me about a piece of work you did with someone that you feel was successful?).

3.7 Transcription

The 11 interviews were outsourced to a transcription firm where they were transcribed verbatim (appendix vii). Time was taken to familiarise myself with the interviews listening to them on first reading and revisiting the audio recordings during the analysis. Varying levels of transcription have been advocated in discourse analytic studies; in recent debates a highly detailed level

of analysis (akin to the used by conversation analysts) has been advocated (e.g. Potter & Hepburn, 2005). Elsewhere, a lighter form of transcription has been favoured and shown to be appropriate for use with DA (e.g. Hugh-Jones & Madill, 2009; Snejder & te Molder, 2009). In the current study, the lighter form of transcription was selected as it enabled the analysis to be grounded in the talk, while not impeding the clarity (Frith & Kitzinger, 2001; Willig, 2008). For sections of the interviews clearly demarcated as important to the research aim additional attention was then paid to the more palpable features relating to stress, intonation and laughter (see appendix viii for transcription conventions). This enabled some of the subtler features of the interaction to be included, while not drawing attention away from the substantive topic (Smith, 2005). Punctuation such as full stops and commas were not included, although question marks were used grammatically as they aided clarity in reading the extracts.

3.8 Conducting the analysis

As discussed in the methodology, the present analysis takes a meso level approach to understanding discourse; this involves “being relatively sensitive to language use in context but interested in finding broader patterns and going beyond the details of the text and generalizing to similar local contexts” (Alvesson & Kärreman, 2000, p. 1133). The analysis set out to achieve a balance in attending to local features and broader discursive resources. A focus on ‘grand’ discourses (Alvesson & Kärreman, 2000) can prematurely turn to extrinsic reasons to explain an account (Speer, 2007), before having firstly explored these in terms of the local context and interaction. On a practical level, this meant that participant orientations and concerns were used to direct the interest in macro-level features of the talk. It was hoped that using this approach would prevent abstract discourses from being posited onto the talk.

There is no prescriptive method for conducting a discursive analysis; selecting which approach to use is best based on each data set, taking into consideration the text and its context (Burman & Parker, 1993). Described as a ‘way of reading’ (Willig, 2008, p. 99), the analyst is interested in how actions and

practices are achieved linguistically (Lyons & Coyle, 2007). The guidelines for conducting the analysis presented here were informed by Potter and Wetherell (1987), Willig (2008) and Parker (1992). The analysis therefore aimed to identify which positions and ways of talking were culturally available to participants (i.e. what range of things could be said about PD by staff).

After reading and re-reading the transcripts to get a broad sense of what the interview as a whole was functioning to do (e.g. apologising, defending) (Willig, 2008) coding was carried out on the transcripts, taking account of interesting and potentially relevant material (Potter & Wetherell, 1987). At this stage the data was broken down into 'chunks' of talk, some of which appeared in multiple codes, although broad patterns within and across interviews began to be identified (Potter & Wetherell, 1987). As the discursive objects of interest began to be identified (i.e. understandings of diagnosis, emotions), attention was paid to how these were being constructed (Willig, 2008) and the positions being constituted (Parker, 1999).

The process of analysing the text was iterative; patterns were identified and then abandoned when they left too much unaccounted for. A dual search for variability and contradictions was carried out, to look at how versions of the same action could function differently. The search for wider 'discourses' also began at this stage (Willig, 2008); for instance, in staff talk about PD biological and developmental categories were sometimes drawn on to make sense of the development of the difficulties. A list of questions taken from the literature were also used to guide analysis (appendix ix). Some of these questions were driven from early readings of the data and some from the literature. It is important to note that the extracts presented in the analysis are not 'representative' (in any statistical sense) of the range of ways of talking of about PD. Instead, the analysis is understood as one, of many possible readings.

3.9 Quality

The positivist criteria reliability, validity and generalisability are largely irrelevant in evaluating the quality of qualitative studies (see Finlay, 2006). Qualitative

researchers have argued that studies should be evaluated their own terms, therefore paying attention to the research methodology, epistemology and assumptions (Finlay, 2006; Madill, Jordan & Shirley, 2000). Researchers should be transparent in terms of their aims and how they have carried out their research consistent with these (Madill, Jordan & Shirley, 2000). While there is no consensus on qualitative quality criteria, there is much overlap between suggested frameworks. Ballinger's (2004) criteria for quality evaluation have been selected for guiding the present research. Ballinger offers four criteria; coherence, systematic conduct, convincing interpretations and sensitivity to the role of the researcher. She demonstrates how these criteria can be used flexibly to fit different epistemologies. In keeping with the present study each of these considerations are addressed in line with a relativist stance. The criteria are consistent with the overall claims of the research, and that rather than revealing truths, this study demonstrates the effects of social discourses. These criteria are discussed briefly here in relation to the present study:

- *Coherence*: This refers to the extent to which the aims and methods of the study are consistent with the way the researcher makes sense of their role. In the present study, I have made clear my position in terms of the interviews (e.g. co-constructed interaction) and in terms of the analysis (e.g. as my reading, and one of many possible readings).
- *Systematic and careful conduct*: I have evidenced a detailed look at the extracts within the analysis, I have accounted for the level of transcription and where possible included the interview questions. I have also been transparent in how the analysis was conducted.
- *Convincing and relevant interpretation*: A number of strategies have been used to put across the findings in a convincing way, including showing interview numbers alongside quotes (to show that 'themes' were not overly weighted within one/two interviews). I have included quotes which contest or resist the dominant position being discussed in order to address variability and contradictions and have been transparent about where words or phrases are ambiguous in their meaning. I also used supervision to discuss alternative readings and to check out how persuasive the analysis was felt to be.

- *Role of researcher:* In keeping with a discursive analysis reflexivity is not attended to by revealing certain things about ourselves as researchers, but rather the analytic process involves a deconstructing of ‘truths’ (including those evident in the interview questions). I have been clear about the conceptualisation of the interview as a particular kind of encounter. I have also attempted to make clear where text could be made sense of differently (e.g. attending to multiple readings).

4.0 Extended Analysis

This analysis begins by drawing attention to the broad terminology participants used to conceptualise the service users they work with. Staff talk about diagnosis and their explanations served to construct what service users ‘are like’, and the implications for their work. The conceptualisations of PD and what skills are needed to work with people with this diagnosis have a number of implications for the positions made available to staff and service users. From a discursive perspective, the ways in which staff construct service users has consequences for how they are located within prevailing discourses. Staff talk about PD is understood as influenced by social relations and as having a wide range of socio-political implications.

4.1 Terminology

Participants used different terms to refer to the collective of people on the ward, including ‘*patients*’, ‘*service users*’, ‘*the women*’ and ‘*the ladies*’⁷. While this terminology will not be a major focus of the analysis we felt it was necessary to briefly reflect on the terms which have entered the discursive canon of staff in this setting (see Speed, 2006). These descriptions are considered discursive types, which have different association and effects.

⁷ Inverted commas will be used in initial instances to highlight participant terms; where mentioned after this inverted commas will not be used but these terms continue to be treated as constructed categories. Direct quotes contained within the text will be italicised.

'Patient' was used infrequently within interviews. This term is associated with a medical model of distress in which a person is understood as suffering from an illness. This term foregrounds the role of biology, and down plays the possibility of individual agency. Commentators have argued that patient positions the individual within a sick role, as a repository of pathology and a recipient of care (Speed, 2006). Sometimes presented in contrast to patient, the term service user has become increasingly common in services (Beresford, 2010). While some suggest this term continues to imply a passive role for individuals within services, others have argued in its favour on the grounds that it infers greater agency (e.g. person is a consumer of services, enacting a degree of choice over their treatment).

Patient and service user represent established terms within services, and the consequences of their use have been considered within UK health literature (see Speed, 2006). In comparison, the gendered descriptions (ladies, women) which appear in the present analysis have not been attended to. It may be that their use is unusual or that it has been overlooked as a result of a lack of attention to language use in staff-service user interactions. 'Women' was the most frequently used term. Gendered descriptions represent the organisation of the ward by gender, and so are likely to be more prevalent in inpatient settings structured this way, however we were interested in the implications of these descriptors. As generic collective nouns both terms imply that the women on the ward are a collective, with commonalities (beyond gender). They also bring gender to the forefront, implying the construction of a particular female identity, associated with a particular kind of distress. They do not imply a medical or legal context in the way 'patients' does, but evoke a more informal relationship with staff, possibly neutralising the differences between staff and service users. It is notable that while the staff team is predominately female, they do not refer to themselves using the same collectives but instead distinguish colleagues based on their professional titles. Within feminist literature, the term 'ladies' has been argued to be, at best, outdated and at worst, a cultural repository for expectations of 'ladylike' behaviour, passivity and compliance.

For the purposes of the present analysis I have chosen to use the term service user(s). While not unproblematic, as it implies a degree of choice, freedom and

working 'with' the system, I have selected this term as it tends to be situated in the middle of a continuum of positions from 'patient' to 'survivor' (Speed, 2006). While not independent of one another, the patient discourse is typically associated with an acceptance of diagnosis, while the survivor movement grew from anti-psychiatry discourses. Service user (and consumer) discourses reflect the negotiation and debate around acceptance and resistance of the dominance of psychiatry and the medical model (Reaume, 2002; Speed, 2006). It was therefore felt that this term can better present the range of positions those within the psychiatric service may occupy.

4.2 Overview of analysis

The analysis is split into three sections which characterise staff talk in different ways:

Section 4.2.i: Participants constructed PD in various ways. This section elucidates the variability in staff talk about PD; for instance, some constituted PD as an actual pathology, others an umbrella term for a number of difficulties.

Section 4.2.ii: This section explores tensions around how staff make sense of PD. It looks at the positions staff took around the status of PD as a 'mental illness', followed by the ways in which staff oriented to and negotiated tensions around diagnosis. The final part of this section looks at how PD was constructed as a biological vulnerability triggered by psychosocial factors.

Section 4.2.iii: This section expands on the analysis presented in the journal paper, and further explores how staff position themselves and others in relation to the presentation of emotions, PD and emotional control.

4.2.i. The PD category

This section explores the ways in which client difficulties were characterised with respect to the PD label. It also provides a brief look at staff concepts surrounding personality, disorder and distress. Here psychological terms are treated as "a set of practices, descriptions and explanations" which have their own cultural and historical context (Edwards, 1997, p. 238; Gergen 1999). How

PD is constructed will serve to rationalise and legitimise treatment decisions and care, as well as how staff make sense of their work. The concepts about personality and disorder discussed here are in evidence throughout the subsequent themes; this section is therefore not a standalone topic but provides necessary context to the talk subsequently presented. Staff talked about PD generally and BPD specifically, which likely reflects the range of diagnoses attributed to the service users.

Commonly, staff constructions of PD invoked the ideological assumption that PD is an objective entity. The reality of mental distress experienced by service users is said to be constructed by psychiatric discourse, which the DSM-IV and DSM-5 (APA 2000, 2013) and ICD-10 (WHO, 2008) represent (Parker, 1999). Most participants therefore spoke about PD as a disorder which exists within the individual. A notable feature of the extracts below is the subtlety with which PD reified:

Extracts 1,2,3

'...a lot of the women have a mix of dysfunctional personality traits...'

(10⁸)

'...they are personality disordered...' (5)

'...I worked with a guy who had a borderline personality disorder...' (3)

While there was a tendency not to explicitly state that PD is a 'real' entity, the realism of dominant psychiatric and personality concepts as ways of knowing are instead assumed and pervasive within staff talk. In accepting that there is a 'real' mental illness, participants are aligning themselves with a disease model. Most staff also used diagnostic medical language to list behaviours which were presented as symptoms of the underlying PD; including, '*disturbed behaviour, eating problems, self harming behaviours, physical aggression*' (10). While it may seem common sense that staff draw on diagnostic discourses as a way of knowing, this highlights the ways broad power structures (i.e. psychiatry) are

⁸ Numbers after quotes refer to the interview from which they are taken.

circulated and maintained in local contexts, and reproduced at the individual interactional level (Hall, 2001).

Diagnostic systems construct mental illness as a consequence of underlying, internal dysfunction (Grossman, 2004). That mental distress emanates from within the individual has become naturalized within cultural practice (Bourdieu, 1977), and functions to ignore how behaviours are shaped by culture and social context (Parker, 1999). Somewhat incongruously, the DSM states that in order to be diagnosable a disorder must be situated within the person, while also cautioning against a 'common misconception' that the diagnosis classifies 'the person' (rather than the disorder). Despite this disclaimer, Grossman (2004) lists the ways in which diagnostic criteria encourages the view that difficulties lie within the person. He suggests it is therefore unsurprising that the language which dominates services includes that the person 'is personality disordered'. The general form of the discipline of labelling and categorising individuals as disordered in some way is maintained across the interviews (section ii looks at different conceptualisations of disorder, such as mental illness, response to trauma and maladaptive coping style).

On occasion, PD was presented as disorder present in underlying traits. Common sense understandings of personality are that characteristics are relatively fixed entities possessed by an individual; they are assumed to be internal, relatively stable and lifelong (Stainton-Rogers et al., 1995). Throughout the interviews, staff drew on this concept of 'personality', suggesting that personality is value-free and representational of an underlying psychological reality. One feature of this position was the assumption that personality could be objectively captured and measured. The use of diagnostic tools were presented as a way of adding validity to the formulation of PD as real and existing; in the extract below, this participant justified the use of PD diagnostics on the grounds that this provides a more conclusive look at personality:

Extract 4: Interview 10

'...[diagnostic tools are used] if we need to kind of more definitively look at the makeup of someone's personality...'

Diagnostic tools, such as personality measures, rely on the supposition that participant responses represent fairly stable, internal cognitive states, accessible through certain questions (Willig, 2008). Similarly, the accurate categorising of difficulties through diagnostics is grounded in the assumption that disorders are empirically testable, had a definitive cut off (between normal and abnormal) and can distinguish between different categories (e.g. BPD vs. antisocial PD).

Not all staff described PD as a real entity, some participants presented PD as simply a category. While this was less common, the quotes below evidence this occasioned presentation of PD as a label:

Extracts 5 & 6

'...those labels of like borderline personality disorder...' (8)

'...that kind of made us think that that label might be appropriate to her...' (1)

Compared with the extracts above in which PD is the problem, here, these extracts make explicit reference to PD as a label, suggesting that there is a socially constructed element to diagnosis. The final way of conceptualising PD presented here, is the construction of PD as a coping strategy. Three staff members described PD in this way. At these times, personality was defined by behaviours which were deemed to represent service user's (in)ability to manage stressors. Here, participants were asked how they made sense of the difficulties associated with PD:

Extracts 7 & 8

'...it's been like a coping strategy for some people for a long time...' (5)

'...they have these problems it's not the person it's the problems they have and it's coping deficits...' (6)

Within health care, coping refers to actions (overt or mental) through which individuals manage demands associated with their disorder (Salmon & Hall, 2003). Thus while this conceptualisation infers a role for the environment (e.g. there are things external to the individual which need to be coped with), the concept of 'coping' maintains that the individual is primarily responsible. For instance, the individual is understood as mediating the relationship between the challenge and its effects (Chiesa, 1998). Constructing service users' difficulties as dysfunctional coping skills or disordered traits may therefore have similar implications for how staff make sense of their role (e.g. supporting service users to help themselves). The concept of coping may be rhetorically more useful for staff, as it implies behaviour that can be learnt, inferring greater possibility for change. It is notable that all these concepts of PD share a focus on deficits and difficulties.

4.2.ii. Dilemmas in staff talk around making sense of PD

This section explores the frameworks staff drew on to make sense of PD. These include (a) whether or not PD can be understood as a mental illness, (b) tensions around the utility and morally viable nature of the PD diagnosis and lastly, (c) the use of the biopsychosocial model for making sense of PD. There were a range of contradictions and tensions within these explanations, and were not distinct from one another but could be drawn on within the same interviews at different times. These ways of talking appear to have in common recognition that PD is controversial. In addition, variation in defining PD reflects wider ideological debates about the nature of mental health suggesting that nosological debates spill out into clinical practice, even within the same staff team.

(a) Contesting PD as mental illness

Controversy surrounding PD diagnoses within mental health services has been characterised by arguments as to the treatability of PD (NIMHE, 2003). These

arguments are related to whether or not PD is seen as a mental illness. Some theorists suggest that typically PD has been distinguished from mental illness, and instead seen as a developmental disorder (Davison, 2002). Here, participants tended to distinguish PD from mental illness, however this did not function to present PD as untreatable but had implications for the accuracy of diagnosis and how staff experience their work.

Identifying PD was presented as not without its problems. PD was constructed as masquerading as other mental illnesses. Staff presented themselves as sufficiently skilled at distinguishing PD from mental illness despite this difficulty. The extract below is from two time points across the same interview. Here, it is assumed that PD and mental illness are different:

Extract 9: Interview 8

'We've had one or two people come to us with a diagnosis of personality disorder who have ended up actually having schizophrenia...we've had at least two women who have actually had mental illness because of the way they presented they were seen as having personality disorder'

That the presentation (i.e. behaviours) of the service user alone could not be relied upon to make an accurate diagnosis serves to account for the confusion. In this extract clinical judgement was put forward for how to recognise a 'misdiagnosis'. The use of '*actually*' when describing the 'correct' diagnosis serves to present this as true (albeit contrary to expectations). Intimating that a 'correct' diagnosis is possible (it's just a matter of finding it), reifies the PD concept. This demonstrates another function of the reification of PD and mental illness (e.g. here, it serves to account for times when diagnosis goes wrong). A further difficulty of distinguishing PD from mental illness was that both could be present at the same time. In the extract below, it is suggested that PD lies beneath mental illness, presenting PD as more deep rooted or as having a role in the development of mental illness. This participant adds a certain verisimilitude to their account with the words '*clearly*' and '*certainly*' when describing the identification of PD:

Extract 10: Interview 3

'...although we have females with PD- on the PD ward there's clearly one or two certainly that have the underlying PD with a co-morbid mental illness'

The certainty with which this knowledge is presented distinguishes this participant from those who are responsible for misdiagnosing and therefore 'less expert' about PD. Warranting the certainty with which these accounts are put forward is perhaps dependent upon the existence of a shared understanding of this setting as a specialist PD ward, and thereby the staff as having specialist skills. One way for staff to manage these expectations is to invoke an unidentified 'other' who was responsible for mislabelling disorders. Where category members (i.e. staff) are expected to possess certain skills (Edwards & Potter, 1992), invoking this 'other' can function to maintain their category entitlement (i.e. to know the difference between PD and mental illness). A third way in which staff distinguished PD from mental illness related to whether distress can be understood as normative in the circumstances. This participant offered the following example to illustrate this difference between an understandable response to difficult life events and PD:

Extract 11: Interview 10

'...some of them might have like depression from a bereavement but it can be labelled into some other things into personality disorder but it might actually just be depression or something like that you know?'

Offering a reason for depression (i.e. *bereavement*) functions to present this as an understandable response to loss, while the PD label is (when properly ascribed), indicates abnormality.

PD and mental illness were also differentiated in terms of cause and management. To take these in turn, one staff member differentiated PD on the grounds that it cannot be caused by drug use, while mental illness can:

Extract 12: Interview 8

'It's a mental health service for men but...there are personality traits coming through as well where you know somebody might have a mental illness which may have been drug induced'

Constructing mental illness as triggered by drug use infers that underlying states can be activated, by a chemical trigger, while the disordered traits are co-occurring. With regards treatment, PD was presented as not amenable to medication. For instance, here schizophrenia was seen to be bio-medically controlled, while the disordered traits remain out of control:

Extract 13: Interview 6

'I've worked long term with a guy with lots of kind of personality disorder traits along with (0.5) he had a diagnosis of schizophrenia but that was really well controlled [by medication] it was just kind of the personality traits that were causing difficulties.'

Stating that they had worked 'long term' with the service user adds authority to this participants' account; it could also be understood as a feature of the assumption that traits are fairly immutable, and related to the aforementioned debate around the treatability of PD. Frequently mental illness was presented as more manageable and amenable to medical treatment than PD. These positions on PD (as similar or different to mental illness) therefore have implications for how staff talk about treatment and recovery. PD as illness is perhaps more likely to fit with the notion of treatment, recovery and cure. Whereas disordered traits are deemed ingrained and immovable. One way staff managed the tension between immutable traits and their role expectations involved suggesting that service users could learn to control their disorder:

Extract 14: Interview 11

'...hopefully they'll soon be able to go into the community be able to control their disorder (0.5) if they still have it...'

It is notable that at this point service user agency is invoked. While this is hedged with hope, this extract implies that being hospitalised will enable service users to exert more control over their difficulties when discharged.

PD and mental illness were also presented as distinct in terms of what it feels like experience working with these kinds of difficulty:

Extract 15: Interview 2

'The only way I can really describe it is how I feel so if I'm working with somebody with a mental health problem yes it can be chaotic at times if they're unwell (0.5) or you kind of go with it and I think that you I suppose on an unconscious level you kind of just accept it and you know it's more OK that person's unwell today or shall we do this instead? And it seems like you're a lot more flexible with individuals with mental health diagnosis...But then how you feel (.) when you're working with individuals with a personality disorder diagnosis is like I said that kind of split feelings that you have so one week it's brilliant we're doing really well and you know the insight this week is brilliant and you know you're able to connect these thoughts and feelings and then when the next week you're feeling really frustrated it's just different I just don't feel that with the women or guys that have diagnosed with mental health difficulties it's just not that same frustration or want to move forward I suppose (0.5) kind of accept that if you've got a diagnosis of mental health that you (.) that's always going to be there and even though it's exactly the same for personality disorder it's funny it's like you get more and more frustrated and you really want to progress people'

The participant invokes feelings of frustration to account for differences in her work with PD and mental illness. While it is suggested that working with service users is always chaotic, this appeal rests on the presentation of work with those with PD as less predictable, less consistent and more extreme ('brilliant' to 'really frustrated'). This problematises inconsistency, inferring that this is a consequence of the disorder and therefore pathological, rather than indicative of typical fluctuations. Putting forward feelings as a legitimate way to

differentiate between PD and mental illness privileges the participant's subjective experience. The participant mitigates against possible criticism that they are offering a more negative evaluation of those with PD through a number of strategies including changes in pronoun use (e.g. from I to the generic 'you') as well as by suggesting that their ability to accept these differences occurs at an unconscious level. Their feelings are constricted as inexplicable and outside of their control (*it's funny*). It is notable that similarity between PD and mental illness is predicated on the fixedness of the diagnosis, as both are '*always going to be there*'. It is somewhat ambiguous as to whether this is in reference to the label or the difficulties accompanying it.

Not all participants presented PD and mental illness as distinct. Two interviewees took the position that PD is a mental illness. They argued that giving these labels the same status is morally viable. There appears to be a sensitivity within this talk to the idea that if PD is distinguished from mental illness service users with this diagnosis are at risk of not having their problems taken seriously:

Extract 16: Interview 3

'...but saying you've just got a personality disorder you haven't got a mental illness it's absolutely terrible to do it and to say it to those people because they have got mental health illness...'

Here, the minimiser 'just' (see Pomerantz, 1986) works to bolster the stance that others have belittled the difficulties associated with PD. The same participant proceeded to draw on a biological argument to add weight to her account that PD should not be differentiated from mental illness. The Presenting knowledge about the brain adds authority to the argument. The participant suggests that because PD elicits a change in the brain (with the evidence for this seen on scans) it is a mental illness, and as severe as others (such as schizophrenia):

Extract 17: Interview 3

'...But I don't actually agree with that really because the changes in the brain (0.3) is that profound with personality disorder if you look at a scan their brains look similar to people with schizophrenia which is a major mental illness of a patient so I don't really agree with that distinction... because people then say (0.5) I mean at some stage they say 'oh you've just got a personality disorder there's nothing wrong with you' which is you know that's a horrific thing to say there's a lot wrong with you when you've got a personality disorder'

The interviewee presents and heightens the argument that service user pathology is serious (*there's a lot wrong with you*); presenting this as morally preferable to being told they are not ill. Here a 'severe end' rhetoric is drawn on to account for similarities between PD and mental illness. This rhetorical device has been seen elsewhere in interviews with mental health professionals, where it served to warrant a controversial treatment approach (see Stevens & Harper, 2007). The contrast structure 'there's nothing wrong' and 'there's a lot wrong' serves to augment the seriousness of PD. Presenting PD as a mental illness functions to give credence to PD as treatable. Presenting PD as negative and disabling could be seen within the context of wider debates around PD as a diagnosis of exclusion. Such that it may reflect staff awareness that PD has been stigmatised and seen as less worthy of care than other difficulties. It appears here that pathology, as discursive resource, works to support the severity of PD, and therefore warrant intervention. This suggests that when PD is differentiated from mental illness there is little discursive room for staff to put forward the severity of the difficulties, without positioning service users as disordered or damaged.

(b) Conflicting constructions of diagnosis

The second part of this section looks at staff talk around PD diagnoses. This look at diagnostic talk differs from that presented in section i; here, the analysis examines the ways staff resisted and reworked the usefulness of PD diagnoses. Interviewees were asked whether diagnosis informed their work. There were a

range of positions on the PD diagnosis taken up across the staff team. There were also variations and contradictions within interviews, suggesting individual tensions around diagnosis. When presenting PD diagnosis as useful or necessary, participants did this on the grounds that naming is a feature of the system in which they worked and/or a helpful tool for clustering together symptoms (e.g. behaviours, emotions) of an underlying disorder. Participants also oscillated between acceptance and critique of diagnosis on ethical grounds. At times, PD diagnoses were constructed as blaming and were therefore negatively evaluated for pathologising and damaging. PD diagnosis as a negative term, which unhelpfully and pejoratively labels the individual, was most frequently invoked when responding to direct questions about diagnosis (rather than being spontaneously offered in discussion of their work). These positions implicate diagnosis in good and bad ways of working.

Some participants contested PD diagnosis for being stigmatising. In the following extract, the participant presents diagnosis as an additional abuse inflicted on service users:

Extract 18: Interview 4

'...It [diagnosis] can feel quite insulting really all the stuff that these people live through and then at the end of it to be told you know 'actually it's your personality that's defective' it's like (0.5) the final insult really and you know how it's then kind of homed in on you know they're the danger they're the people that we need to put in the hospital and maybe not enough kind of time spent looking at all you know (0.5) wider kind of issues of you know people living in poverty and you know child abuse and all those societal things and it's all kind of all the blame is you know pushed on to the victim of it which you know kind of reflects maybe you know past abuse where that's happened where they've been told 'well actually you know it's your fault and you're the one to blame''

The rebuttal of PD diagnoses is predicated on moral grounds. This account is augmented by likening diagnosis to an insult. The participant presents diagnosis as attributing responsibility to the individual for their difficulties which supports

the construction of similarities between diagnosis and victim blaming. Not being acknowledged as a victim is presented here as leaving service users open to being treated as dangerous, which functions to present the two positions as incompatible (e.g. cannot be a victim and be dangerous). The participant uses generalities when suggesting that diagnosis is being used to justify hospitalisation (e.g. *then it's kind of homed in on*), and does not directly implicate others in this process. One effect of this is to inoculate the current setting from potential accusations of victim blaming. It would be interesting to see how individual work within a compulsory hospital setting could be discursively reconciled with this position. In other discursive research looking at staff accounts of treatment in mental health, it was shown that the victim position is used to sanction treatment on the grounds that this offers necessary protection (Stevens & Harper, 2001). Elsewhere it is argued that where diagnosis infers a malfunctioning personality, labelling becomes a badge of blame. Ryan (1971) wrote 'that even the most well-meaning observers have a powerful tendency to attribute causal responsibility for social problems to their victims' (p.19). This talk indicates sensitivity to managing the deviant identities often ascribed to PD as well as knowledge of high rates of sexual abuse implicated in the difficulties associated with PD.

Some suggested the term 'personality' was particularly problematic with regards diagnosis, on the grounds that personality infers problems within the whole person:

Extract 19: Interview 7

'I think it's quite a controversial diagnosis because who's to say that your personality is wrong? Because like it's basically saying that the way they are is wrong'

This critique draws on the naturalisation of personality as moral character. The participant does not contest the notion of personality, but rather questions what authority someone has to label another's personality as defective. This criticism therefore rests on an appeal to personality as a way of making a judgment about

a person's character, with the authority associated with diagnosis contested through this moral argument.

On the whole, participants discounted the PD diagnosis specifically, rather than dismissing diagnosis generally. Thus while the term 'personality' was rejected, another more helpful label was presented as reasonable. In the extract below a morally loaded argument against diagnosis is put forward on the basis that diagnosis is dehumanising:

Extract 20: Interview 6

Interviewer: Does the personality disorder diagnosis (0.5) is that something that informs the way that you work?

Participant: I try not (0.5) not me personally no to me they're all human beings and it's really weird I've worked in personality disorder but I actually don't like the word and I don't know what word I would use (0.5) I don't like the title I don't know why I can't tell you why but I just think it's like a horrible I think it's like walking around with it tattoo'd on your forehead

Interviewer: And do you think that's different from other kinds of diagnosis?

Participant: I think all diagnosis are stuck on your forehead really I think it's something that you're labelled (0.5) it's a stigma isn't it? It's like you know (0.5) I spoke to my parents because they were [profession] too and it's sort of like a stigma if you like it's always been stuck in it was just mental health wasn't it at one time? and that was it you didn't discuss it did you? (0.5) at all

Interviewer: And you said that you're not quite sure what it is about the personality disorder bit that you don't like-?

Participant: I don't know what phrase I would I don't know (0.5) I've never thought about it's just I don't like the word (0.5) I like working with the word and things like that but not calling it.

The participant presents their discomfort with the PD term as unique or unusual (*it's really weird*), which seems to be predicated on them still working in a PD

unit. The interviewee offers a vehement rejection of the PD label on the basis that it is 'horrible', permanent ('it's like a tattoo') and extremely visible (*stuck on your forehead*). However this was not accompanied by a complete rejection of diagnosis. Instead this resistance was attenuated, with the participant concluding '*I don't know what word I would use*'. Support for diagnosis suggests that service users are deemed to have sufficient commonalities that can be captured in a label (or that there is an essentialised disorder to be named). Here it is a case of finding a better label. Stigma around mental distress is presented here as having improved, such that previously any mental health issue had to be shrouded in secrecy, whereas now this is limited to only some diagnoses. This could be argued to function to justify the participant's backing of diagnoses in general.

In the following extract, the participant suggested that the biggest difficulty with diagnosis concerns how you discuss this with service users. Below diagnosis is problematised when it comes to talking about change, where this is predicated on the grounds that PD is distinct from other problems such as eating disorders:

Extract 21: Interview 9

Interviewer: Has there been a time that you can remember and what that was like, talking about that label with somebody?

Participant: That's something, now I'm just a bit like, they ask me, you know, the service users ask me, what's wrong with me, is my personality wrong or is it, what can I change? Compared to like an eating disorder, where it's, you know, that's a problem.

Here diagnosis is presented as a way of explaining '*what's wrong*' with someone. It is implied that it is morally less problematic to tell someone that it is their eating (i.e. behaviour) that is disordered, than their character. It is ambiguous as to what is meant by '*that's a problem*', although, it would seem to be linked to the previous sentence in which an eating disorder is '*a problem*' (external to the person, while PD infers that the person is the problem). The participant presents the service user as seeking help in identifying and naming their mental distress, legitimising staff's role in this. The authority to name the

problem carries considerable power although, at the same time, the controversy of the PD label challenges the expectation that staff can offer a label which is helpful.

Interviewees negotiated awareness of debates around the PD label with justifying using this label. For instance, in the extract above the participant predicated her dilemma, in part, on not having an alternative available. Similarly in the extract below, the participant outlines that they are constrained by the discourse of diagnosis and its use in the system:

Extract 22: Interview 4

‘...many people, even though they’re being called that, still don’t know what their diagnosis are and don’t know what it means (0.5) so yes (0.5) then it is a case of explaining to say ‘sorry for this word because we all hate this word but that’s what it’s currently being called’

The participant positions themselves as regretful about the term, but justifies its use by invoking this as the only available label at the current time. The participant therefore distances themselves from the system that has come up with this name. It may be that one way in which staff managed tension surrounding having the authority to inform service users about their difficulties, and feeling uncomfortable with the label was to position themselves as ultimately constrained by diagnosis; such that they have to use it, but when they do it is couched in an apology. Information giving, in the form of diagnosis, regardless of whether professionals consider the label itself to be in the patient’s best interests, was therefore put forward as necessary and unavoidable.

Some suggested that despite how they felt about diagnosis it was helpful for clients. This participant was asked if they had discussed diagnosis with clients:

Extract 23: Interview 6

‘Yes they did say yes I do (0.5) I am that sort of thing and they were quite comfortable with it and I think it was more distressing for me talking to them about it because I hadn’t done it before’

That diagnosis can capture the characteristics and behaviour of a person (*I am that sort of thing*) works to legitimise its usefulness. The participant presents any disquiet as simply due to a lack of experience. They also suggest that there is a self-sacrifice to discussing diagnosis, as they put aside their discomfort for the good of the service user. Justifying the use of diagnosis for capturing someone's difficulties tended to involve the presentation of service users as accepting the label as an accurate description of their distress. In the extract below, the participant presents diagnosis as helpful for enabling service users to access appropriate diagnosis-driven treatment:

Extract 24: Interview 8

Interviewer: and were there people who because you said a lot of them weren't happy with the diagnosis-?

Participant: I think some of them sort of realised that it's quite useful because they then now they have the diagnosis they can get their treatment suited to that diagnosis and they did sort of acknowledge that some of the traits and stuff like that (0.5) the symptoms are is what they're like.

The participant response works as a rejoinder to my reference to the previous comment that service users are not happy with their diagnosis. The participant counters my assertion that 'a lot' of people were unhappy with a down shift (*some*). In addition, service users are presented as conceding to the characterisations of themselves offered up by the diagnosis. This further serves to legitimise diagnosis as helpful. In a similar way to the previous extracts, the symptoms offered by diagnosis are reified, and flawed character traits accepted as 'symptoms' of an underlying disorder. Staff also presented the service user as better able to recognise their problematic traits when given a diagnosis. Diagnosis was put forward as one way to help service users become aware of what they were 'really' like:

Extract 25: Interview 9

'I remember talking to a patient here and they didn't know what it meant and we talked about it and it was like 'oh am I really? Am I really? Do I

really show those traits?’ and this that and the other (0.5) and it was something they were totally unaware of.’

The participant invokes personal experience and active voicing to warrant the claim that diagnosis can serve as a revelatory practice. Other participants also suggested diagnosis provides people with ‘*an explanation of why they are the way they are*’ (3). That diagnosis can satisfying service user questions about their personhood serves to present it as highly unlikely that a client would not be happy with a diagnosis. The authority of staff to be able to label and reinforce service user identities appears to override the construction of service users’ subjective knowledge about themselves, when this does not fit with their diagnosis.

Some participants positioned themselves in support of diagnosis on the grounds that it provides a necessary way to categorise difficulties. In the extract below, this participant suggests diagnosis provides a useful structure for fostering shared understandings for service users and staff, countering a potential accusation that diagnosis favours clinicians. Interestingly, in this extract the participant orients to diagnosis as being a way of understanding the idiosyncrasies and individual needs of each client (*what are the issues for this person?*). However, in addition to diagnosis, she also suggests that it is necessary to attend to each person on an individual level (implying that diagnosis does not fully achieve this):

Extract 26: Interview 9

‘I think diagnosis is important in that it gives kind of like a framework or it gives you an understanding of what are the issues for this person?...But in that as well everybody is individual (0.5) so I wouldn’t say ‘you’re all emotionally unstable borderline PDs you’re all antisocial’ whatever everybody has their own narrative we like to think about people in terms of their formulation but I think diagnosis is important in terms of giving an umbrella understanding in a framework within which both the patient and the clinicians can work’

The initial position on diagnosis as able to address each person's 'issues', serves to counter the criticism that diagnosis is reductionist (Johnstone & Dallos, 2006). In this sense, at stake for staff who advocated diagnosis, for brevity and ease was the accusation that this would be at the cost of attending to individual differences. A superficial or crude use of diagnosis, worked up through the repetition of the extreme case formulation (Pomerantz, 1986) 'you're all', is built and then refuted, serving to distance the participant from a seemingly unsophisticated use of diagnosis. The participant continues to counter this with the argument that it does work to meet service user needs.

(c) PD as a consequence of vulnerability and trauma

Many participants presented PD as having developed as a result of the interplay between genetics and the environment. Staff accounts of the cause of PD draw on a stress vulnerability (or biopsychosocial) argument; here, an underlying biological pathology was presented as placing the individual at risk of developing disordered traits given certain environmental stressors. This section examines the ways in which staff drew on these concepts (e.g. to present the 'disordered' nature of service users' characteristics as a consequence of pre-existing vulnerabilities and historical stressors) and considers the consequences of this discourse for how service users are positioned. Within the present analysis, participants did not allude to specific vulnerabilities, but suggested that the catalysts to triggering such predispositions were abuse or trauma predominantly in early life. Drawing on biopsychosocial understandings of PD appeared to be one way in which participants managed concerns that a PD diagnosis leads staff to attributing blame to service users for behaviours which can cause staff distress or difficulty.

The extract below shows how temperament was linked to biological factors and trauma. Trauma was put forward as psychological, physical or sexual abuse. Prior to this the interviewee had been asked how they make sense of the difficulties service users with a PD diagnosis have:

Extract 27: Interview 3

'...the temperament of someone's biological or genetic make up any trauma the earlier the trauma the more likely I think there is to have problems later on because their personality is evolving and it's kind of stopped at a point earlier on- the younger you are the less likely I think that things can recover as easily'

This participant concludes that trauma experiences are more damaging if they occur earlier in life, on the basis that personality is malleable in the early years, and therefore more vulnerable to trauma. This suggests that the 'normal' evolution of personality has been interrupted by trauma. The participant's response is hedged by repetition of '*I think*', which serves as a disclaimer as to the factuality of this statement. This formulation of early trauma as more detrimental may lead to reduced optimism for 'recovery' for those who have experienced abuse in childhood. Others suggested that, as well as early trauma, difficulties later in life could have a similar effect on the underlying susceptibility within people's temperaments. In the following extract, it is suggested that later life stressors can also unleash disordered traits:

Extract 28: Interview 10

'...certainly we've had some women in the service who haven't been sexually abused but there's been a lot of psychological and emotional abuse and they tend to be the ones that actually do achieve in life and then something awful happens and suddenly all this Pandora's box is opened...'

PD is presented as lying dormant, with disordered traits akin to a time bomb of difficulties waiting to go off. Here this serves to account for times when service users have not been sexually abused or suffered early trauma but present with similar difficulties. The talk here intimates that for those who '*do achieve in life*' this success may be only temporary. The participant differentiates between different kinds of trauma, suggesting that sexual abuse is more commonly associated with a PD diagnosis, or perhaps that sexual abuse is more damaging. Although not directly stated here, one possibility is that it is the type

of abuse which differentiates between those who achieve (albeit temporarily), and those who do not. This would ascribe a role for the kind and level of trauma that the individual has experienced in whether they will develop PD. While trauma was often attributed causal status, at times staff talked about trauma as '*uncovering difficulties*' (1), inferring that these are present before, but revealed by abuse.

One basis on which trauma was presented as having an effect on personality was through causing physical changes to the brain:

Extract 29: Interview 3

'...and then it [abuse] landed them in places like this- to the enormous psychological trauma and physical trauma to the brain you know physical changes to the brain that results...'

This biomedical discourse serves as a powerful nomenclature for adding facticity to this account of PD. The phrase '*landed them in places like this*' implicates the perpetrators of abuse as morally culpable for service user difficulties. Responsibility is attributed retrospectively, often to parents or care givers. This extract is one of the few occasions in which the hospital environment is referred to; where '*places like this*' implies a negative evaluation of the setting. Here, this functions as part of the moral critique of caregivers. In general, invoking genetic vulnerabilities and trauma served to present service users as not to blame and attenuated any claims that staff hold service users accountable for their difficulties.

Previous literature has shown that staff working with PD reported feeling that service users were causing difficulties 'on purpose' or 'pushing boundaries.' These formulations imply active resistance or provocation on the part of the service user. If it is taken that service users are doing this intentionally, it becomes apparent what is at stake for staff (and service users) in terms of how 'cause' is presented. In the present interviews, culpability was mostly placed at the door of those who had provided a '*really bad upbringing*' (5). These constructions position service users as victims, damaged by these experiences

and therefore discredit claims of service user intentionality. The position of victim is in contrast to the blame and shame which critics have suggested are synonymous with the PD construct (Bourne, 2011). Therefore positioning service users as fragile, victims of their genetics and life experience affords greater empathy. At the same time, the subject position of victim offers little in the way of service user agency and is associated with other stigmatising attributes (e.g. passivity, damage, weakness).

The following section is taken from a lengthy response in which the interviewee is describing her work with service users. Highlighting the conflict between not blaming service users and the role demands and expectations to promote service user change, a limit is placed on the generosity of understanding of the victim role,

Extract 30: Interview 2

'... I suppose helping- I think the psycho education part of it is important because it validates that actually it's not your fault but that we're not looking for someone to blame it's not your fault however you know you're an adult now so you have got a choice in whether you start to make changes or not as a child where we're evolving a personality where we're developing we don't get any choice about the environment we live in the people we're with what's done to us'

This extract represents a moral dilemma between not attributing culpability to service users, while also attending to the network of obligations staff are situated in. Within this extract the categories of child and adult are invoked, with adults afforded less tolerance for their difficulties. This is predicated on normative assumptions about the agentic capacity of children and adults, and the expectation that adults should take more responsibility. That adults are ascribed greater agency to change seems to conflict with the understanding of adult personality as fully (albeit 'abnormally') developed and therefore immutable. If service users are understood as lacking to change this can account for those who do not get 'better', and inoculate staff against potential accusations of not fulfilling their role. However, this may also impact on staff

and service user hope, and raise questions as to the ethics of incarceration under the 'guise' of treatment or protection.

4.2.iii Constituting the emotional challenges of working with PD

This section serves as an adjunct to the journal paper. To summarise the findings reported in the paper, staff constituted service user difficulties in terms of a lack of emotional control. A prominent feature of this talk involved the ways in which staff managed their emotions at work and how these related to their constructions of PD. Staff attributions regarding difficult emotions were extensively used to account for why their work was challenging. Here, a further example from the discursive theme 'emotion as a symptom of past trauma' is included, as this shows a further way in which staff and service user emotions were differentiated. The final section focuses on the power attributed to service user emotions and the implications for staff-service user power relations.

(a) Emotion as symptoms of past trauma

This section adds to the discussion within the journal paper which specifies the ways in which interviewees constructed instances of service user emotionality as stemming from past relationships (rather than current interactions). Service user difficulties were typically referred to in terms of distant and historical factors, in contrast, staff frustrations were often constituted as driven by present interactions:

Extract 31: Interview 2

'...oh I wonder what that's about' you know? Why do I feel so frustrated? And I suppose there's lots of different theories behind it whether you're just picking up their frustrations or they're playing that out in you...'

Active voicing works to demonstrate self reflection (*oh I wonder what that's about?*). This kind of reflection was distinguished from the problematised emotional irrationality associated with service users. It also suggests a further

example of staff self containment, in which reasoning is carried out in private. Again, this contrasts with the public displays of service user anger. The participant presents themselves as knowledgeable to different ways of explaining their own feelings. The two explanations for frustration are hedged as 'possible' theories; the first explanation offered (*picking up on*), is related to self reflection such that being emotionally self aware can enable staff to identify, and even experience, the emotional states of others. In this sense, the interviewee is presented as actively employing their reflective skill. This is in contrast to the second construction (*playing out*), whereby the interviewee is positioned as passive and subject to service user frustrations. This account serves to distance staff from what may be seen as problematic feelings towards service users, by inferring a lack of ownership or control over their emotional states; which may be one reason why the lack of emotional control is not problematised in the same way as when it is attributed to service users. In this way, a large amount of power is ascribed to service users' emotions and their ability to impact on staff.

(b) Service user emotions as powerful and predatory

Service user emotions and the effects these had on staff were presented as extremely powerful. For instance in previous sections, working with service users was presented as a threat to staff well being (e.g. 'it's *extremely draining*'). In addition, a position of power was ascribed to service users in terms of their ability to influence staff in such a way that this justifies the idea that staff need to have special skills in order to inoculate themselves and their team. This section looks at other discursive features associated with service user emotions and the potency to service user emotions. Service users were constructed as suddenly and inexplicably changing the way they felt about staff. In the following extract, the unpredictability of service user emotions is problematised:

Extract 32: Interview 7

'...and because they have such emotional relationship problems they'll like not manipulate you but because they're emotionally unstable they

can sort of (0.5) one day they'll like be your best friend the next minute they'll hate you (0.5) that sort of thing'

An explicit accusation of manipulation is resisted here. Changes in service user feelings toward staff are presented as a direct consequence of underlying emotional problems, and as extreme and unreasonable (e.g. through contrast structures '*best friend*' vs. '*hate*'). Here, the attribution of emotional pathology serves as a way to justify what may otherwise appear to be unwarranted '*hate*' from service users. This talk positions staff as at the mercy of unpredictable and unprovoked changes in service user feelings towards them. In these instances staff tended to attribute greater power to service users than is evident elsewhere (e.g. when presenting service users as victims of past trauma).

Service user emotions are also constituted as powerful in terms of being able to trigger uncomfortable feelings in staff. Service user feelings are given agency here, presented as able to directly influence staff feelings, specifically, drawing out or placing in staff the same feeling that is attributed to the service user:

Extract 33: Interview 2

'...what it draws out in you as well because sometimes you can be in one to one sessions or groups and you get that sudden I suppose fear or anxiety that they might be experiencing or they might split you one week you might really want to kind of work with them protect them and feel quite like they're doing really well in therapy and then the next week they could reject you you know be verbally aggressive or tell you that you don't like them anymore'

Referencing fear, anxiety and the sudden onset of these feelings, serves to present this experience as unsettling. Extreme case formulations (*really want to...doing really well*) emphasise how well things were going before having been 'split'. This serves to suggest there is no logical explanation for the change. The interviewee draws on the psychoanalytic concept of splitting as a way to legitimate conflicting feelings about her work with service users. As a way of

making sense of changes in service user behaviour, this concept appears to offer a way of detaching aggression from what at other times would be read as motivated by dislike. The concept of splitting as something which service users do to staff, negates a role for staff agency. Instead rejection is presented as a 'symptom' of PD. The use of agency is further interesting as the pronoun use intimates staff agency when discussing the positive elements of the work, however, this shifts to attributing agency to the service user when there are difficulties (*they could reject you...tell you they don't like you anymore*). The construction of agency also serves to position staff and service users interchangeably, as victim and persecutor; with the participant's initial description of wanting to 'protect' service users (i.e. as victims), to presenting them as the aggressors. This section shows how service user emotional control (or lack of) is evoked within staff accounts to make sense of rapid and seemingly illogical changes in service user's behaviour towards staff. These extracts also indicate a complex relationship between the concept of emotionality, the position of victim (and persecutor) and the psychological explanations which make up the PD diagnosis.

5.0 Extended discussion

5.1 Summary of findings

This research has examined the ways in which staff, from a range of professional backgrounds, conceptualise PD and service users within interview talk. Staff talk offers a way of examining the current 'truths' about PD, and the positions available to staff and service users within the institutional setting (Parker, 1998). This study has explored the interactional impact of these 'truths', and how they are being constructed. It has also looked at which aspects of their work staff orient to as highly valued (e.g. being emotionally controlled), as well as what is at stake for staff in terms of the understandings they invest in (e.g. service users as victims). In doing so, this study has met its aims to explore the details of staff talk, while also considering how these relate to the psy-complex more broadly. This study demonstrates that staff rely on various norms of expression (e.g. diagnosis as necessary, biological vulnerability as aetiology),

that their talk produces varying effects (e.g. gives impression of service users as out of control, legitimates the need for 'boundaries') and indicates what is privileged and valued in terms of professional identity (e.g. emotional control). Staff described their decisions about how to support service users in terms of their day-to-day management of emotional instability, unpredictability and making sense of the past. Tensions and variability characterised staff talk about 'what PD is', as well as the current status of diagnosis and mental illness. Staff reproduced, reworked and resisted dominant discourses around these concepts. The variability around diagnosis may reflect current debates and confusion within services surrounding the validity of the PD construct (e.g. Kim & Tyrer, 2010). Many of the tensions appeared grounded in the way that PD has been historically understood as untreatable and those with this diagnosis have been seen as manipulative and dangerous. Many constructions offered by staff served to counter these assumptions, and went beyond such historical constructions. This discussion reiterates the key findings of the analysis and discusses them in terms of the literature and implications for clinical practice. How this study might inform future research with staff and service users surrounding PD is also explored. It concludes with some personal reflections on conducting the research.

5.2 Status of diagnosis and mental illness

Participants tended to talk about PD in essentialist terms (e.g. as a natural disorder which is 'diagnosable'), and as such, tended to maintain that there is a need for diagnosis. That staff conceptualised disorders as real entities conflicts with previous research which found that, on the whole, clinicians did not subscribe to a realist view of mental illnesses (Ahn, Flanagan, Marsh & Sanislow, 2006). It may be that differences in these findings reflect the different methodologies. For instance, Ahn et al., (2006) asked participants to rate statements said to tap whether or not clinicians held essentialist beliefs about mental disorders. These forced choice responses reveal little about the way diagnosis might be taken up in practice. In the present study, staff resisted a completely unquestioning stance toward diagnosis (i.e. being naively accepting of this term), but did tend to essentialise diagnosis in much of their talk. It may

be that the pervasiveness of diagnosis is such that, broadly, it remains unquestioned, however as a feature of being asked to account for their stance on diagnosis, participants tempered their acceptance of the PD label. For instance, staff did then fore-ground concerns about the PD term specifically. Perhaps a wholly accepting stance toward diagnosis is not a viable position for staff in the context of wider discussion around PD, diagnosis and stigma.

In the present study, there were contradictions surrounding staff descriptions of PD as a legitimate diagnosis, but not a mental illness. This may reflect widespread confusion around the terms illness and disorder, and indeed mental illness and mental health (Kendall, 2002). It is notable that here differentiating PD from mental illness (where mental illnesses were seen to be depression, schizophrenia) this served as one way in which staff made sense of differences in the difficulties service users had. It was also a way of explaining why some mental health difficulties improved with medication ('that will be the schizophrenia') whilst others maintained (seen to be the disordered traits). In this sense, differentiating between the two constructs could account for a lack of progression, or times when progress appeared to be thwarted (e.g. as PD is comparatively more ingrained). The function of talk around PD and mental illness differs from that within policy, where this distinction has been used to justify exclusion from treatment (NIMHE, 2003).

5.3 Emotional control

This section extends the journal paper discussion regarding the construction of emotions as controllable. Harre and Parrott (1996) argue that the notion of wrestling with an internal psycho-physiological state conceals the socially constructed nature of emotions. This study addresses this concern, exploring the impact of emotion as a socially situated, discursive resource. Emotional control was constituted by staff as highly valued, and a necessary requirement in order to work well with service users. The sheer power of the emotions associated with PD was put forward as a challenge to staff's capacity to fulfil this requirement. Presenting challenges at work in terms of emotional effort, was in keeping with other research where staff working with PD described

feeling 'drained' and 'completely worn out' (Fortune et al., 2010, p. 190). Such was the power attributed to the emotional impact associated with PD, this accounted for why staff need specialist skills in emotional control, to inoculate themselves against this. A further part of the staff role involved ongoing self monitoring, in order to prevent emotions from being revealed to service users. Self-monitoring is a pervasive feature of the psy-complex (Parker, 1997), and is central to some psychological approaches and interventions (e.g. keeping a mood diary, psycho-education, medical compliance). In other research with PD, staff reported self surveillance as necessary in order to spot service users hidden 'agenda' (O'Brien & Flote, 1997; Woollaston & Hixenbaugh, 2008, p. 707). Here, self monitoring was essential for staff in order not to place themselves at risk. There was therefore a moral imperative for staff to have control over their emotions on the grounds that being overwhelmed by the emotion on the ward could be damaging to everyone. Elsewhere, discourses around risk, danger and a lack of control have been used to justify confinement in mental health policy (see Moon, 2000). Here emotional instability served to warrant (and arguably, create a moral imperative) that staff can offer control or containment to service users. In terms of emotional control, it seems staff are required to be doing the opposite to that which service users are doing; for instance, in the same way that service user emotionality was presented as extreme in its expression (e.g. evidence by self harm behaviours), staff control also had to be extreme.

Attributing an inherent lack of emotional control to service users, worked to reduce the potential that service users would be held responsible for behaviours thought to be a consequence of their emotional instability (e.g. shouting, being aggressive). This contrasts with previous research in which those with PD were typically presented as intentionally ramping up their feelings (e.g. Hazelton et al., 2006; McGrath & Dowling, 2012). This suggests that the concept of emotionality may be useful for avoiding attributions of blame. However, others have argued that foregrounding the 'problem' in the individual (i.e. emotionality) turns the person from a sufferer into an agent in managing the suffering, from which, it is argued to be a small step to locating within the individual the moral responsibility to change (i.e. to become 'well') (Herzlich & Pierret, 1987). Bourne

(2011) argues that self control becomes *the* way to manage difficulties when an individual's capacity for reasoning is intact. Bourne (2011) argues that through the distinction between PD and mental illness, volition becomes central to the PD concept.

5.4 Foregrounding the past

Current difficulties were constituted as stemming from service users re-enacting past relationships which served to justify giving less attention to present interactions in making sense of difficulties. It may be that service user emotions will be seen as unintelligible or unreasonable if understood as an old template of emotional and behavioural responses (e.g. an extreme response in the context of the precipitant). That emotional pathology stems from the past is given further explanatory power through orienting to a stress-vulnerability and psychoanalytic framework. These perspectives set the parameters of relevance for making sense of distress as primarily individual or historical. To take these in turn, while staff did not explicitly draw on psychoanalytic concepts in their talk, the idea that emotions are transferred or projected unconsciously onto others and can be attributed to past experiences is in keeping with a psychoanalytic conceptualisation (Kernberg & Caligor, 2005). Parker (1997) suggests that psychoanalytic jargon is culturally pervasive, and structures and facilitates subjectivities. Psychoanalytic ideas foreground intrapsychic, pathological internal structures, relatively, downplaying events in the present. The stress vulnerability, similarly gives a central role to difficulties from the past. In addition, a stress vulnerability or biopsychosocial framework infers that one element alone (e.g. abuse) is not enough to justify distress (but rather someone must have a biological weakness as well) (Boyle, 2011; Johnstone, 2011). In the present study, most staff placed weight on the psychosocial, however rarely was abuse put forward without the addition of genetics to explain PD. In a similar way, current interpersonal and situational factors were on their own, not considered enough to warrant service user reactions, and so historical factors or unconscious motives were recruited to explain them.

5.5. Service users as 'victims'

Previous research has shown how identities are 'talked up' in the process of building a psychosocial explanation (Horton-Salway, 2001), whereby the notion of vulnerability can lead to the attribution of a 'victim' identity. Across the interviews, participants variably positioned service users as both victims, of the past, and as powerful, in the present. Most participants presented service users as victims of either biology or abusive others, or both. The victim role functioned to provide a morally sanctioned explanation for service user actions. Thus, while this way of understanding service user difficulties worked to absolve service users of blame, the 'victim' position is problematised in the literature. It is argued that this position invokes a range of negative attributes; Lamb (1999) writes that the victim label should be avoided in "a culture that has grown to call victims 'whiners'" (p. 9), such that "it is shameful to be a victim in our culture . . . no matter what therapists tell victims, they feel that they have been weak, and weakness is shameful" (1999, p. 119–20).

Elsewhere, there is recognition of the emotional consequences of 'victimhood' (Lamb, 1999); for instance, linguistic techniques seen within the international rape crisis movement attempt to circumvent these consequences by re-labelling victims as survivors (Alcoff & Gray, 1993). The term survivor was absent from staff talk. Albeit a relatively recent discourse, authors have begun to explore the ways in which people are positioned as victims or survivors within dominant discourses around domestic abuse, violence and trauma (e.g. Alcoff & Gray, 1993). Some have argued that these two discourses are at opposite ends of a spectrum, with the survivor movement inferring a conscious redefining of the self, while victims are held to be passive and damaged. In the present study, this position and how it functions has implications for service users. For instance, in order to negotiate and deflect attributions of blame, service users may be required to accept the victim position. This does not afford much space for assertiveness and change, on service users' own terms (Barry, 1979), neither does it encourage a position from which to theorise a change in the person's relationship to their difficulties.

5.6 BPD, gender and emotion

Prevalence studies show that proportionally more women are given a diagnosis of BPD than men. It has been argued that this is down to biased sampling, gender stereotypes and socio-cultural factors (e.g. sex roles, sexual abuse rates) (Bjorklund, 2006). In the present study, some staff distinguished between their role on the male and female ward. While this was not a dominant feature of staff talk, the way staff constructed emotion benefits from being considered in terms of gender. Edwards (1999) argues that emotionality has long been equated with femininity. Within the category of emotions, women have been seen to be more emotional than men, less able to control their emotions and more emotionally fragile (Fivush & Buckner, 2000). Lutz (1997) further argues that the concepts of 'female' and 'emotion' are similarly constituted as irrational, chaotic and uncontrollable. Emotionality is therefore seen as a disadvantage when compared with the more valued rationality and self control (Lutz, 1997).

There is evidence that gender plays a role in how sense is made of emotion. For instance, gendered attributions regarding emotional behaviour have been demonstrated, such that for women emotion is seen as evidence of an emotional nature, while for men, emotional behaviour is treated as evidence that the situation warrants this behaviour (Barrett & Bliss-Moreau, 2009). Attributing emotionality to female disposition, rather than situational factors was also seen within staff explanations of their own and service users' emotions. Other discursive research looking at staff constructions of challenging behaviour, demonstrated a similar function of gendered discourses, whereby only when talking about females service users did staff present the source of the challenging behaviour as coming from within the person (Wilcox, Finlay & Edmonds, 2005). Wilcox et al., (2006) showed how this served to warrant staff attempts to control the female service user (e.g. by refusing demands), rather than making modifications to the environment. The BPD diagnosis and its association with disordered characters, only serves to maintain this attribution of the source of difficulty as within the individual, and perhaps suggests that female service users are more likely to be subject to individualising discourses. Rhetorically, constructing female emotionality as internal pathology questions

the legitimacy of some emotional experiences over others. The impact of dominant discourses about gender and the implications for staff understandings should continue to be a legitimate area for consideration in clinical practice.

5.7 Implications for practice

Critics have contested the applicability of social constructionism on the grounds that this perspective claims that “nothing exists outside language” (Hall, 1997, p. 73). While there are limitations to applying findings from this theoretical stance, it is more accurate to say that constructionist theory argues that “nothing has meaning outside of discourse” (and *not* that objects do not have real material structures which exist in the world) (Hall, 1997, p. 73).

The meso-level approach to DA taken in the present study allows for tentative suggestions beyond the interview context to be made. The ways of talking presented here will be affected by broader organisational discourses (e.g. surrounding PD, diagnosis, expectations of staff) which will influence the ways of talking which are available to participants (Parker, 1998). These discourses will both open up and place limits on what is knowable. Staff talk reflects and reworks these discourses, and has implications for staff (e.g. the normative ideal around emotional control places limits on the possibilities for staff action) (Alvesson & Karreman, 2000). This study looks at the claims and logics which are at work within this setting and treats discourses as structuring or constituting forces. However, in keeping with the epistemological framework, this study stops short of making generalised claims about ‘subjective reality’ or subjectivities (Alvesson & Karreman, 2000). In summary, DA cautions against accepting what staff say about service users, diagnoses and their understanding of distress as straightforward representations of their mental states. Instead, exploring staff talk can reveal culturally and professionally accepted ways of legitimising staff practices.

Any conclusions drawn from this data set are necessarily tentative because of questions about how representative the discursive strategies and resources offered by the interviewees are to staff working in other inpatient PD settings.

That said, while retaining a necessary contingency within suggestions for application, Wetherell (2007) argues that DA has shown that everyday talk is not 'chaotic and arbitrary', but is often 'highly ordered' (p. 677). It is suggested here that attention be paid to staff terminology and values, and the ways these may be connected and embedded in theoretical frameworks and related to service user diagnoses. The present findings therefore offer insight for staff working with people with PD, as well as for clinicians supporting staff and managing teams in similar settings. The following subsection attempts to offer suggestions, in more concrete terms, as to the application of these findings. This section is separated into two parts; the first focuses on changes to discourse; the second on the mechanisms for implementing change. Throughout these sections the potential barriers are highlighted with suggestions for tackling these.

Re-considering discourse

The assumption that providing space for dialogue is an effective way of facilitating learning is evident in the work of Paulo Freire. Freire's (1995) work is consistent with social constructionist ideas. He argued that approaches to education should be collaborative and involve non directive working with, (rather than on), and he was concerned to look for words that have the possibility of generating new ways of naming and acting in the world. Clinical psychologists who adopt a social constructionist approach will be required to consider the role of values, ethics and responsibility in their work and the effects these have on the practices they use. Dialogic approaches to intervention can serve to elicit and deconstruct the values which underpin staff approaches. While this more informal approach to educative practice is likely to be unfamiliar in mental health services, it can be integrated with other more typical pedagogical approaches.

- Professional discourses and the positions they offer service users will, to some degree, be internalised. As such, it would be beneficial to explore the possible impact of conceptualisations of service users as vulnerable⁹

⁹ Boyle (2003) argues that vulnerability maintains a focus on the individual, and prevents service providers from looking externally and focussing on what it is people are supposedly vulnerable to.

or as victims, and how this conflicts with ideologies around adulthood, autonomy and responsibility. For instance, how do staff and service users reconcile the victim position with the need to learn to better control emotions? In addition, as staff talk implicates the expectations that they help service users 'get better', I wonder if this position is complicated by the setting and the PD label; how would staff account for their role in the incarceration of service users who are understood to be victims without the possibility for change?

- Staff rarely referred to the setting being a secure ward in which service users had not chosen to be. Issues of collaboration and service user autonomy are inherently limited by this setting. While speculative, it may be there are contradictions and tensions in bringing together a caring role with the other duties and responsibilities related to compulsory aspects of the ward. Other theorists have argued that compulsory aspects and safety concerns need to be reconciled with collaboration (Anthony & Crawford 2000). While these expectations on staff may remain in opposition, it would likely be helpful to have more explicit conversations about these tensions and the constraints of this setting.
- There was little expansion on the concept of boundaries within the interviews. Maintaining boundaries was advocated as important for the good of the ward. This rationale served to legitimate boundary keeping, but offered less opportunity to explore what this may look like in practice. Do staff have a shared understanding of boundary keeping?
- Staff conceptualisations of difficulties (e.g. service user anger) as stemming from the past was in one sense helpful, as it avoided discourses saturated with attributions of blame. At the same time, this may obscure conversations about causes in the present tense. Having an awareness of the different ways in which explanatory frameworks function can help to prevent these explanations from going unquestioned.
- Staff made a number of distinctions between themselves and service users. Staff appeared particularly invested in presenting these distinctions in terms of emotional control. It may be useful to look at

similarities in staff and service user experiences, and how these are constituted in different ways in order to gently challenge these (e.g. staff blowing off steam in supervision vs. service users losing control), in a way which does not threaten staff values.

- What else do staff value in their role with service users? Perhaps focussing on values in addition to emotional control will reduce the chances of staff feeling they have 'failed' in the face of difficult interactions.

Implementing change

- As this study cautions against 'truth' claims, it may be useful to draw on Mason's (1993) concept of safe uncertainty, in which uncertainty is a central part of working with service users, such that service users do not feel that staff are offering up an 'answer' to their difficulties and staff do not feel responsible for getting it right (Harper, 2005). This stance could promote something similar to the 'not knowing' approaches advocated in systemic ways of working (Andersen, 1992; Anderson & Goolishian, 1992).
- There was some confusion around PD, suggesting staff may benefit from a place to discuss the different conceptual issues surrounding diagnosis and mental illness (e.g. what do staff understand to be the difference between trauma, PD and mental illness?) as well as how these differences impact on the work staff do and what they feel service users are in need of. For instance, PD was understood in terms of service users requiring emotional containment; is this the same for other mental illnesses?
- While some advocated abandoning the term PD, diagnosis more broadly tended to be supported. It may benefit staff to have space to consider the effects of labelling and how their role with service users can serve to reinforce labels. Formulation may offer a way to avoid a reductionist conceptualisation; in which case, there is a clear role of clinical psychology in supporting staff to develop formulations beyond diagnosis.

It may be useful to consider how and why service users resist understandings offered by staff, and how this is being conceptualised? (e.g. denial, cognitive distortion, lack of insight?). Clinical psychologists can encourage reflection on the implications of the explanations both they and other staff rely on and what might be at stake for service users.

- There appear to be some theoretical frameworks which may have advantages over others in terms of the ways participants construct issues in their work. For instance, the emphasis on intra-psychic processes and controlling these, appears to place a great deal of pressure on staff. It may be that a systemic framework which takes a more relational approach to emotions would be beneficial (e.g. emotional interdependence rather than independence), which may also encourage staff to explore current interactions. A functional approach could also offer a way of constituting emotions as serving a purpose, rather than as problematic and in need of controlling. It is worth stating, that advocating some theories over others here is not to suggest that these are more 'true', but simply as alternative ways of making sense.
- At times when service users were attributed power and control, this tended to be problematised. Supervision may be a useful forum for exploring ideas and possibilities around service user power such that there is an opportunity to understand these as reasonable and legitimate (and not a symptom of pathology or irrelevant emotions from the past).

5.8 Reflections

It is recognised here that the outcome of any qualitative analysis represents an interaction between researcher, participant accounts and the interpretative framework. This section offers some personal reflections on the decisions made throughout the research process.

5.8.i Terminology

I am not wholly comfortable with the term service user. While I have discussed my decision to select this term at the beginning of this analysis, in making this

choice, it highlighted a tension between conducting a piece of research which was concerned with how service users are being constituted, without including service user voices. While this does not detract from staff talk as a worthwhile area for study, it perhaps demonstrates a broadening of my research interests to considering how best research can work with and for service users.

5.8.ii Tensions: what's at stake for whom?

I found it a struggle to balance a focus on implications for staff (e.g. what ideological discourses are they subject to?) and service users. I was keen to recognise the wider ideological discourses that both are subject to, however given that professional talk can often hold more weight (e.g. staff have access to more authorial or privileged discourses), it felt important to consider the findings in terms of what these may mean for how service users are positioned, but without simply 'staff blaming'.

5.8.iii. Researcher positioning

In terms of the interview, it may be that participants adopted a particular position to PD and their work based on my role as a trainee clinical psychologist. It may also be that the role of research interviewer was more relevant to participants. Closer examination of the interview questions could offer some insight into which of these positions participants were variably oriented to. Some may have felt that, by virtue of my role, I had a different view to them on PD (see Lutchman et al., 2001) although I would suggest that my position as trainee clinical psychologist shares some overlap with the 'epistemic community' of staff from some roles (i.e. sharing some similar claims to knowledge) (Madill, 2012).

5.8.iv Expectations

There were some topics that I was surprised did not come up more in the interviews. I was expecting that staff would foreground risk in explaining their decisions. I had thought that particularly with regards talk about emotional control, along with the institutional setting and high levels of self harm that risk and safety might have been invoked more often to account for this control.

Perhaps risk management is such a pervasive part of staff work, and understandings of PD, that in talking about emotional control it is assumed the audience recognises the role of risk.

I was also expecting that staff would orient more to the constraints of the institutional context, and the challenges of being a secure unit. I wondered if there would be a tension between the setting and some of the participant hopes for service users (e.g. empowerment). However, the setting tended not to be referenced as a barrier or difficulty. It may be this reflects a lack of consideration of the impact of the setting or an assumption that this is beyond the staff remit (e.g. taken for granted that the system is unchangeable).

5.8.v Methodology

In deciding to use semi-structured interviews, I was aware of the arguments for and against interviews, and in favour of naturally occurring data. However, once I accepted and attended to the question of what the interview represents, I felt more comfortable with this chosen method. A criticism levelled at the interview is that it tends to elicit talk which relates to general patterns and typical examples; while I think generalities were a feature of staff talk (e.g. on PD diagnosis), there were also specific descriptions (e.g. examples of discussing the diagnosis with service users).

I chose to use a social constructionist framework in part because in my previous work I found that despite initially being tied to the idea that it is necessary to go 'beyond the talk' to speculate on, for example, 'real' constraints. In practice, this was not necessary to produce a detailed, comprehensive analysis. I feel for the purposes of this study the way underlying structures are accounted for, rather than what those are was an appropriate focus. I continue to grasp a more nuanced understanding of social constructionism, and was able to see that there were alternative stances to the 'straw person', versions of relativism (in which there is deemed to be no such thing as reality) (Speer, 2007, p.128).

At times it felt uncomfortable to be writing about staff descriptions of service user abuse as 'ways of accounting'. While the method does not claim that these are purely discursive strategies the social constructionist stance may be less ethical for some topics than others. Some researchers have challenged this perspective, arguing that it is immoral to reduce all topics to text (e.g. poverty, discrimination, murder) (Riley, Sims-Schouten & Willig, 2007). Equally, for research which has an interest in application, it is not always preferable or viable to use a stance which relativises moral concerns (Parker, 1997).

5.8.iv Ethics

I have found myself questioning the ethics of the approach in terms of gaining participant consent; while no participant can give 'full informed' consent to an interview on the basis that there is no way of knowing what will come up in discussion (Harper, 2007), I wonder if it is necessary to let potential participants know that the interviews will be subject to a deconstructive analytic approach.

5.8.vii Application

Burman and Parker (2005) describe how DA is necessarily disruptive and deconstructive, taking practice and approaching it critically. While I feel this is a key strength of the approach, practically, the method does not lend itself particularly well to being disseminated back into staff teams. I would speculate that it will be difficult for those working with staff and service users with these difficulties to see their talk deconstructed outside of the context of behaviour.

5.9 Future directions

It is argued that the ways of talking about PD and service users detailed in the current research, can be understood as rehearsed accounts and arguments which may be reproduced in other occasions (e.g. in conversations with other mental health professionals, supervision, MDT meetings). In terms of the applicability of current findings, it would be useful to understand how specific these particular ways of talking are to the research context and to inpatient settings. Understanding which aspects of these ways of talking are stable

across interactions and dominant in similar services would enable the application potential of these findings to be better understood.

Also related to the applicability of the present findings, an exploration of naturalistic interactions between staff and service users could show which discursive resources are drawn on in these contexts (e.g. are the resources different, but the discursive consequences similar?). Little research has explored the views of those who have received a PD diagnosis. While some researchers have begun to address this (Castillo, 2003; Haigh, 2003; Nehls, 1998; Ramon, et al., 2001; Stalker, et al., 2005), how staff and service users negotiate these understandings in interaction would provide a useful addition in this area.

Given the impact of the researcher on the interview process, it would also be interesting to (where possible) have multiple researchers carry out interviews with staff, to explore the impact of different interviewer characteristics (e.g. whether they are qualified, their role, age). This may expand that can be said regarding stake and interest of participants.

Given the participants' multidisciplinary backgrounds, focus groups would be another clinically relevant avenue for data collection. The focus group would allow for some direction from the researcher whilst also allowing for greater spontaneity of talk. This would perhaps allow more to be said regarding how possible discourses are drawn on and contested in an MDT setting (e.g. team meetings).

Researchers have criticised the overreliance on quantitative and cognitive approaches (Potter, 2003) and have argued for merits of broadening the range of approaches used (Roy-Chowdhury, 2003; Slade & Priebe, 2006) seldom are these abandoned in favour of other kinds of research questions. DA has gained momentum in its use within clinical psychology (see Georgaca, 2012), however findings from these studies are typically not been taken up by mainstream research. It may be that a strong relativist position offers little encouragement in terms of creating a research base across methodologies. As little

contemporary research within the quantitative or qualitative realm would position itself with a completely naïve view of reality, a critical realist framework could be a more accommodating stance for creating collaboration between discourse and other research paradigms.

5.10 Conclusion

The ways of talking presented here can be understood to reflect ideas that characterise the social and professional worlds of staff within this setting (Willig, 2001). It is hoped that by questioning ideologies, this thesis has contributed in a modest way to those studies with aim to bring the moral and political into focus in terms of understanding distress and the discipline of psychology. It is suggested here that exploring staff discourses about their work and PD can go some way to highlighting the potential difficulties with some psychological constructs, in terms of what they obscure whilst also recognising that staff are themselves limited by the availability of discourses. This thesis has demonstrated tension surrounding the PD diagnosis and complexity in staff explanations of PD, as well as how these are inextricable from issues of accountability, morality and assumptions about normality.

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APPENDICIES

Appendix i: Ethics approval

Institute of Work, Health & Organisations
<http://www.nottingham.ac.uk/iwho>



**The University of
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05/10/2012

Victoria O'Key

Dear Victoria

I-WHO Ethics Committee Review

Thank you for submitting your amendment to your study entitled "An analysis of staff discourse surrounding personality disorder". This amendment has now been reviewed by I-WHO's Ethics Committee to the extent that it is described in your submission.

I am happy to tell you the Committee found no problems with your amendments. If there are any further significant changes or developments in the methods, treatment of data or debriefing of participants, then you are obliged to seek further ethical approval for these changes.

We would remind all researchers of their ethical responsibilities to research participants. The Codes of Practice setting out these responsibilities have been published by the British Psychological Society. If you have any concerns whatsoever during the conduct of your research then you should consult those Codes of Practice and contact the Ethics Committee.

Responsibility for compliance with the University Data Protection Policy and Guidance lies with all researchers.

Ethics Committee approval does not alter, replace or remove those responsibilities, nor does it certify that they have been met.

Yours sincerely

Professor Nadina Lincoln
Chair IWHO Ethics Committee

Appendix ii: Recruitment information leaflet



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Brayford Pool
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Participant Information Sheet: **Staff interviews surrounding Personality Disorder**

Trainee Clinical Psychologist: Victoria O'Key E-mail:
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Supervisors:

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I would like to invite you to take part in this study. Before you decide, it is necessary for you to understand why the research is being done and what it would involve for you. Please take time to read the following information and talk to others about the study if you wish.

I will be available to go through the information sheet and answer any questions you have.

Who is conducting the study?

This study is being carried out as part of the Trent Doctoral training programme in clinical psychology, under the supervision of Dr. Roshan Das Nair and Dr. Nichola Christiansen.

What is the study about?

This study has been designed to explore staff experience of working with people with personality disorder diagnoses. I am interested in your work with people with personality disorder diagnoses, what you think about the diagnosis, what

you've found helpful in your work as well as how you have managed any difficulties you have had. Little is known about staff experiences of working with those with this disorder and how useful staff find personality disorder diagnoses. I am also interested in your views on current services, therapeutic interventions and treatments.

Am I eligible to take part?

A range of staff are being invited to take part in the study including clinical psychologists, psychiatrists, mental health nurses and other professionals who are currently working with those with a personality disorder diagnosis.

What will it involve?

The study will involve a one off interview. It will last around an hour (and no more than two hours). The interview will be arranged at a convenient time for you. While I have some questions I would like to ask I am also keen to know your views about personality disorder. With your permission our discussion will be tape recorded. The audio data will only be heard by myself. At no point will your identity be divulged and any information that you give will be used within the full context of professional confidentiality.

You have the right to withdraw from any stages of the study at any time and without giving a reason. You can also request to have any of your data withdrawn from the study and destroyed at anytime during the study.

This research is subject to ethical guidelines set out by the British Psychological Society, and has been approved by the *Institute of Work, Health & Organisations Ethics Committee, University of Nottingham* ethics committee.

These guidelines include principles such as obtaining your informed consent before research starts, notifying you of your right to withdraw, and protection of your anonymity.

This sheet will hopefully provide you with enough information about the study to allow you to make an informed decision about participation. However, if you have any questions or would like to discuss anything with me please don't hesitate to contact me.

I very much hope that you would be willing to participate in this study, as your involvement would be invaluable. If you are willing to be involved, or if you have any questions, please contact me via the email address or postal address above.

Thank you for your time and I look forward to hearing from you

Appendix iii: Consent Form

Consent Form: Staff interviews surrounding Personality Disorder

The purpose of this form is to make sure that you are happy to take part in the study and that you know what is involved.

Have you had the opportunity to ask questions and discuss the study? YES / NO

If you have asked questions, have you had satisfactory answers to them? YES / NO / N/A

Do you understand that you are free to end the study at any time? YES / NO

Do you understand that you have the right to withdraw from the study, without giving a reason, including that you can request to have your data withdrawn from the study and destroyed up to three weeks after participating? YES / NO

Do you understand that you are free to choose not to answer a question without having to give a reason why? YES / NO

Do you agree to take part in the study? YES / NO

Do you agree to the meeting being audio recorded? YES / NO

Do you grant permission for extracts to be used in reports of the study on the understanding that your anonymity will be maintained? YES / NO

Signed.....

Name in block letters

Date.....

Thank you very much for agreeing to take part in this study.

Appendix iv: transcription confidentiality statement

Confidentiality Agreement Transcription Services

I, _____, agree to maintain full confidentiality in regards to any and all audiotapes and documentation received from Victoria O'Key related to her doctoral study. Furthermore, I agree:

1. To hold in strictest confidence the identification of any individual that may be inadvertently revealed during the transcription of audio-recorded interviews
2. To not make copies of any computerized files or transcribed interview texts, unless specifically requested to do so by Victoria O'Key.
3. To store all study-related materials in a safe, secure location as long as they are in my possession;
4. To delete electronic files containing study-related documents from my computer hard drive and any backup devices.

I am aware that I can be held legally liable for any breach of this confidentiality agreement, and for any harm incurred by individuals if I disclose identifiable information contained in the audiotapes and/or files to which I will have access.

Transcriber's name (printed) _____

Transcriber's signature _____

Date _____

Appendix v: Pilot Interview Schedule

Background information

How long have you been in your current role?

How much contact do you have with those with personality disorder diagnoses?

- Range of diagnoses?
- Men or women?
- Age ranges of service users typically see?

What kinds of therapies/treatments do you offer?

Diagnosis

How useful do you find the PD diagnosis? Are there difficulties with these categories?

How important do you feel diagnosis is to your work?

Have you discussed diagnosis with people you work with?

What are their views on upcoming changes to the DSM-IV surrounding the PD categories?

Understanding distress

What kinds of difficulties and distress have the people you've worked had?

What do you feel is (most) important in working with service users with PD?

What, if any, kinds of difficulties have you experienced in your work?

Team

Do you find differences within your team/across job roles in terms of ways of understanding PD?

How would you say PD is understood within your service?

Interventions

What have you found to be therapeutic in?

What interventions have been beneficial?

Appendix vi: Interview schedule

Background information

Current role/previous role

What kind of work do you have with those with personality disorder diagnoses?

- Range of diagnoses? Men or women? Age ranges?

How do SU come into the service?

Diagnosis

In general, does the diagnosis inform your work?

How important do you feel diagnosis is to your work?

Have you discussed diagnosis with people you've worked with? Example...(how have you done this/how have ppl responded?)

What has brought ppl into your service?

What kinds of difficulties and distress do you tend to see in those with a PD diagnosis?

What are your thoughts on what might cause these kinds of difficulties?

What do you feel is (most) important in working with those with a PD diagnosis?

Have there been any challenges...? (in general....with specific people?)

Are some approaches more/less unhelpful?)

What do you enjoy about your role? (working with people with these specific difficulties?)

Interventions

Can you tell me about your work with a particular service user?

What kinds of therapies/interventions have you used?

What have you found to be helpful/therapeutic in working with those with a PD diagnosis?

What interventions have been beneficial?

Successful/less successful piece of work?

What contributes to successful ways of working?

Team

Do you find differences within the team in terms of ways of understanding or working with PD?

If there are team differences, how do they come about/how are they resolved?

What do you feel would be helpful/improve working with ppl with PD?

Appendix vii: Example transcript

has been offered the opportunity to engage with psychology and all but one has. And that's, I mean I think that's like what we should strive for. So I think in that sense, we do really well to offer that. And we have a big input, obviously, from OT and we have a CBT Therapist and Drug and Alcohol Therapist. So I think we do offer them a lot but these clients do need a lot.

Q: So it's quite inclusive, in the sense that people aren't selected based on views about insight, and it's kind of quite an MDT, so there's lots of different people involved at different levels?

A: Yes.

Q: Just in terms of your own work specifically, what is it, thinking maybe about the one to one work, kind of what, if you were sort of describing what that would look like, what are the things, I suppose, that you feel are therapeutic and important in what you do?

A: I mean I think relationship's central. I mean there are some, there's one woman that I see that has, you know, really quite significant cognitive difficulties at the moment. She's very, she finds it very hard to tolerate any distress that would come from talking about, you know, the past or even just current issues kind of on the ward. But I meet with her still weekly and that's more about just kind of her having that experience of a relationship that's kind of boundaried. And that she has, you know, like a time to speak to people and just build some trust in people, more than any kind of like doing any specific psychological work that we're doing. It's more just providing that relationship as an experience for her.

Q: And if you, I suppose more generally, in terms of other work with clients, you've mentioned the relationship being really important, are there other things that you've found to be really helpful in working with people with these difficulties?

A: I mean I draw a lot on like the DBT stuff, just because it's something that I know quite well. I mean a lot of people have problems in those areas, you know, that DVT kind of tries to address like, you know, the social skills and distress tolerance, you know, people have great gaping holes there. I mean filling those holes is a big part of a lot of the work that we do. My mind's gone blank.

Q: What do you feel is the most important thing in working successfully with somebody with a PD diagnosis?

A: The relationship, having a relationship where they feel safe with you, where they feel safe to talk to you, where they trust you enough, you know, just to let you in a little bit.

Appendix viii: Transcription conventions

Symbol	Use
...	Used to denote when the extract starts or stops mid speech
[]	Denotes overlapping talk
(.) (0.5)	Micro pause less than 0.2 seconds. Timings included for pauses of longer lengths
-	Used to represent a cut off or self interruption
Underlining	Stress or emphasis (loudness or pitch)
(())	Used to mark the transcribers comments
()	When all or part of an utterance is in parentheses, this indicates uncertainty on the transcribers' part but represents a likely possibility
' ... '	For reported speech
(inaudible)	Indicates that something is being said but could not be heard

Appendix ix: Questions for analysis

What are the (main) features of the talk oriented towards?

What concepts do the participants' construct or draw on (e.g. to explain, to describe)?

Are these ways of talk working to rebut a potential alternative? (Frith & Kitzinger, 2001) and what can this tell us about the participants' stake within their talk (e.g. who would benefit and who would be disadvantaged by these ways of talking (Parker, 1999)?

How are staff accounting for diagnosis and their decision-making processes? And to what problems might these accounts be solutions? (Gillies, 1995)

What roles/positions do they construct themselves/each other in? and what are the implications for their rights and responsibilities? (Parker, 1999)

What kinds of discursive resources are available to staff? (Willig, 2001)

How do these discourses reflect, rework or reject broader cultural/social discourses (e.g. do they speak to wider discourses around gender roles, responsibilities), what do they naturalise (and how?) (Parker, 1999)