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Clinicians' talk about 'emerging personality disorder' in adolescents: A discursive psychological exploration.

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Thesis Abstract

Introduction

Recently, a growing focus within the literature on the application of personality disorder diagnoses to adolescent populations has been met with concern from mental health professionals. Existing research highlights a reluctance to use the diagnoses among professionals, with concerns including their legitimacy in a younger population and the stigmatising impact of the label. The term 'emerging personality disorder' is being used increasingly in clinical practice to describe adolescents' difficulties, however, it remains a largely undefined construct. Some researchers have suggested that its continued use relates to uncertainty surrounding diagnostic criteria, and to the perceived negative effects of labelling. However to date, no research has specifically focused on the use and function of 'emerging personality disorder' as a construct.

Objective

This study uses discourse analysis to explore how clinicians working in Child and Adolescent Mental Health Services (CAMHS) construct 'emerging personality disorder' in reference to their work with adolescents. The research aims to contribute to the growing literature on personality disorder in adolescence, and is to the authors' knowledge the first study to specifically explore 'emerging personality disorder' as a construct.

Method

Clinicians were recruited from a large Child and Adolescent Mental Health Service (CAMHS), from varied teams and professional backgrounds (n=10). Semi-structured interviews were used to elicit talk relating to the topic of personality disorder in adolescence. The analysis of the interview transcripts was informed by discursive psychology (Potter & Wetherell, 1987) and Foucauldian discourse analysis (Foucault, 1979).

Results

Clinicians constructed 'emerging personality disorder' by firstly building up constructions of personality disorder as an adult diagnosis with lifelong stigmatising consequences. Within this discourse, clinicians were positioned as

moral guardians, with the role of protecting adolescents from the effects of a diagnosis. There was tension however between this position and a need to talk about the difficulties faced by adolescents. For some, ‘emerging personality disorder’ was constructed as an alternative to an ‘adult’ personality disorder diagnosis that offered greater hope, flexibility and room for recovery. For others, a discourse of concern surrounding the use of ‘emerging personality disorder’ was used to justify alternative ways of talking about the same difficulties that provided distance from personality disorder terminology. Some clinicians drew on discourses of attachment and trauma to explain the distress young people presented with, and others constructed behavioural descriptions for the same difficulties. Across accounts, clinicians spoke about personality disorders with marked hesitance and tentativeness, employing a range of discursive devices to negotiate disputed territory, present accounts as factual, and clinicians as reflective, considerate and reasonable professionals.

Discussion

This study offers a detailed exploration of clinicians’ talk around personality disorder in adolescence, with a specific focus on the use of ‘emerging personality disorder’. The current findings draw attention to the discourses of concern and caution surrounding the use of personality disorder terminology in an adolescent population. Implications are discussed in terms of the potential impact of the varied conceptualisations of the same presenting difficulties, and the potential value of a reflective space for clinicians to consider the impact of these for their adolescent clients.

Statement of Contribution

I, Hannah Little, declare that this research is the product of my own original work conducted as part of the Trent Doctorate in Clinical Psychology. I was primarily responsible for designing the study, applying for ethical approval, organising recruitment, reviewing the literature, recruiting participants, collecting and analysing data and the study write-up. These activities were all done in consultation with the research supervisors, Professor Roshan das Nair and Dr Anna Tickle, and field supervisor Dr Axel Lofgren, who also supported the recruitment of participants.

JOURNAL PAPER

Clinicians' talk about 'emerging personality disorder' in adolescents: A discursive exploration.[1]

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Abstract

Objective: A growing focus on the application of personality disorder diagnoses to adolescent populations has been met with concern from mental health professionals. The term 'emerging personality disorder' is being used increasingly in clinical practice to describe adolescents' difficulties however it remains a largely undefined construct. This study uses discourse analysis to explore how clinicians working in Child and Adolescent Mental Health Services (CAMHS) construct 'emerging personality disorder' in reference to their work with adolescents.

Method: Clinicians were recruited from a large CAMH service (n=10). Semi-structured interviews were used to elicit talk relating to the topic of personality disorder in adolescence; the transcripts were then subject to discursive analysis.

Results: The findings suggest that 'emerging personality disorder' sits at the heart of a conflict for clinicians, between a need to protect adolescents from the effects of a personality disorder diagnosis, and the need to talk about and put a name to their difficulties. Within their accounts, clinicians drew on various discourses of the broader personality disorder concept that influenced their constructions of 'emerging personality disorder' and its use. A range of discursive devices were used to portray these accounts as factual, and clinicians as reflective, considerate and reasonable professionals.

Conclusions: Key discourses are discussed in light of existing literature, and recommendations made for reflective space for clinicians to consider the impact of these discourses on their adolescent clients.

[1] This journal paper will be submitted to the Journal of Child and Adolescent Clinical Psychology. Please see Appendix H for the author guidelines.

Key words: discourse analysis; personality disorder; adolescent; diagnosis; social constructionist;

Introduction

Personality disorder

The term 'personality disorder' (PD) refers to a category of psychiatric diagnoses which describes difficulties broadly defined as '*an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture'.* (American Psychiatric Association, 2013, p.629). These difficulties are also said to be '*pervasive and inflexible, stable over time, have onset in adolescence or early adulthood and lead to distress'*. (APA, 2013). Although the onset of such difficulties is said to occur during adolescence or early adulthood, personality disorder diagnoses have been restricted to adult populations, and are often used to describe difficulties including interpersonal problems, self-harm, extreme emotionality and impulsivity (Kaess, Brunner, & Chanen, 2014).

Taxonomic systems such as the International Classification of Diseases (ICD) (World Health Organisation, 2008) and the Diagnostic and Statistical Manual of Mental Disorders, (DSM 5) (APA, 2013), detail 11 and 10 subcategories of personality disorder respectively. Of these, the most commonly used diagnoses include obsessive-compulsive, narcissistic and borderline personality disorder (BPD) (Sansone & Sansone, 2011). However, personality disorder diagnoses have been a topic of great debate and disagreement within the field of mental health. Common criticisms include poor construct validity (O'Donohue, Fowler, & Lilienfeld, 2007), reliability (Blanchard & Brown, 1998) and a lack of clarity around diagnostic boundaries (Board & Fritzon, 2005). Furthermore, those who receive such a diagnosis are said to face stigma, both from within and outside of mental health services (Aviram, Brodsky, & Stanley, 2006; Griffiths, 2011; Sheehan, Nieweglowski & Corrigan, 2016). In part, the debate surrounding the personality disorder construct is linked to the disparate and contradictory aetiological explanations (Livesley, 2001). Various models pertaining to the development of BPD for example have been proposed, including biosocial theories (e.g. Linehan, 1993), and those with origins in

attachment theory (e.g. Bateman & Fonagy, 2004) and trauma (e.g. Herman, Perry & Van der Kolk, 1989). It has been argued, however, that the personality disorder construct itself serves to obscure key aetiological factors (Ramon, Castillo & Morant, 2001; Shaw & Proctor, 2005. [2]

Diagnosis in adolescence

In recent years, there has been a growing focus on the use of personality disorder diagnoses with adolescents, with particular interest in BPD. There has been rapid growth in research concerning BPD in adolescence, with a five-fold increase in studies over a 10-year period (Sharp & Tackett, 2014). Within this literature, several authors argue that BPD in adolescence is a stable and reliable diagnosis, with structure and features resembling BPD in adults (Chanen et al., 2008; Miller, Muehlenkamp, & Jacobson, 2008a; Sharp & Romero, 2007). These findings have led some authors to call for personality disorder to be treated as a 'unitary construct' across the lifespan (Chanen & McCutcheon, 2013; Chanen, 2015). With this in mind, potential treatments are being trialled (Chanen et al., 2008; Mehlum et al., 2014; Rossouw & Fonagy, 2012) with a focus on prevention and early intervention.

Despite researchers arguing that BPD is a stable diagnosis in adolescence, longitudinal studies investigating the stability of 'symptoms' over time have been met with criticism. Studies have reported great variability in the number of adolescents in community samples who continue to meet the criteria for the diagnosis at follow up (National Institute for Health and Care Excellence [NICE], 2009). Furthermore, when 'symptoms' of BPD were assessed in a non-clinical adolescent community sample, they were seen to naturally decline as individuals matured from adolescence into adulthood (Bornovalova, Hicks, Iacono, & McGue, 2009). This raises questions as to whether in clinical practice, a diagnosis given in adolescence has relevance for the individual going into adulthood.

At present, there are no official criteria for personality disorder in adolescents. However, existing classification systems detailing adult psychiatric diagnoses do not restrict personality disorder categories to those over the age of 18, with the exception of antisocial personality disorder. The DSM-5 advocates caution when

[2] See Extended Introduction 1.2 for further discussion of personality disorder

using the adult criteria with adolescents, suggesting diagnosis is warranted only when 'the individual's particular maladaptive personality traits appear to be pervasive, persistent and unlikely to be limited to a particular developmental stage or another mental disorder' (APA, 2013; p.647). Within the ICD-10, such diagnoses are not recommended for individuals under the age of 17 years (World Health Organisation, 1992).[3]

Concerns over diagnosing adolescents

The notion of diagnosing those under 18 with a personality disorder has provoked controversy and clinicians from various professional backgrounds are reluctant the use the label with their clients (Laurenssen, Hutsebaut, Feenstra, Van Busschbach, & Luyten, 2013). The reasons for such hesitation by clinicians appear myriad. Many are concerned about the transient nature of personality in adolescence, and the danger of pathologising what might be a typically 'stormy developmental phase' (Laurenssen et al., 2013; Shapiro, 1990). Some raise the issue of separating features of a personality disorder from the typical developmental trajectory of an adolescent in adolescence (Becker et al., 1999; Meijer, Goedhart, & Treffers, 1998; Miller, Muehlenkamp, & Jacobson, 2008b), and share their fears that such a diagnosis may expose adolescents to stigma, or impact on their self-concept (Baverstock & Wright, 2015; Kernberg, Weiner, & Bardenstein, 2000).[4]

Perhaps due to these concerns, there is widespread uncertainty within mental health teams surrounding the application of the diagnosis to adolescents (Baverstock & Wright, 2015). The limited research thus far that considers how the diagnoses are used in actual clinical practice highlights the tendency for clinicians in adolescent services to avoid sharing such diagnoses with adolescents, with personality disorders becoming 'diagnoses behind closed doors' (Baverstock & Wright, 2015; Koehne, Hamilton, Sands, & Humphreys, 2013).

Some of these concerns are not unique to personality disorder diagnoses. The application of diagnoses such as bipolar disorder and schizophrenia to adolescent populations has also been met with reluctance by clinicians (Grimmer, Hohmann &

[3] See Extended Introduction 1.3 for further discussion of personality disorder in adolescence
[4] See Extended Introduction 1.4 for further discussion of stigma surrounding personality disorder diagnoses

Poustka, 2014; Courvoisie, Labellarte & Riddle, 2001). Concerns include the reliability of such diagnoses in an adolescent population, and similarly the danger of labelling features of normal adolescent development (e.g. fluctuating moods). Despite some similarities however, there is markedly more concern surrounding personality disorder diagnoses both within the literature and clinical practice. Furthermore, some concerns appear unique to personality disorder, such as the impact of such a diagnosis on adolescents' self-concept.

To date, qualitative research in the area of personality disorders in adolescence is limited. What little research there is focuses on the experiences of professionals working with adolescents said to meet the criteria for BPD. Only one study has specifically explored the way in which personality disorders in adolescence are talked about by professionals (Koehne et al., 2013). This research focuses specifically on how the BPD diagnosis is communicated to adolescents, and suggests that the clinicians interviewed used a range of discursive and social strategies to resist and undermine the diagnosis. It also highlighted, alongside other studies, the use of 'hedges' or qualifying terms such as 'emerging' by clinicians to soften and offset the permanency of the BPD diagnosis (Baverstock & Wright, 2015; Koehne et al., 2013). Hedges are described by Brown and Levinson (1987) as words or phrases used to modify an individual's agreement and commitment with a statement, in an attempt to reduce conflict or make the phrase or term more acceptable to the listener.

Emerging personality disorder

In recent years the term 'emerging personality disorder' has been used increasingly in clinical practice (NICE, 2009). Without the guidance of a definition, it appears anecdotally to be used by professionals to refer to an adolescent who has begun to show features that map on to adult personality disorder criteria, in particular BPD.

The NICE guidelines for BPD (NICE, 2009) acknowledge the use of the term by clinicians and researchers, and state that its use 'most likely stems from concerns about whether or not it is possible to make the diagnosis in adolescents and/or concerns about the negative effects of labelling' (p.349). However the authors note that they choose not to use such descriptors in the guidelines, instead advocating the use of the phrase 'young person with BPD'. Despite this, 'emerging personality

disorder' appears to be a well-established term in adolescents' services. The introduction of an 'emerging personality disorder project' within CAMHS at Somerset Partnership NHS Trust (Knight, Gordon, Habberfield, Fawkes, & Yeandle, 2018), for example, is an illustration of how the use of the term extends to official use, not just a colloquialism or turn of phrase within clinical teams. Likewise, service guidelines have been published with specific reference to services working with 'young people with emerging personality disorder' (Royal College of Psychiatry, 2011).

Perhaps the most obvious example of this is the recent introduction of routine outcome measures within CAMHS teams which have seen the use of emerging personality disorder as a 'problem descriptor' – described briefly as 'severe relationship difficulties – emerging personality disorder' (CAMHS Current View, CAMHS Payment by Results Project, 2013). When used, the measure involves clinicians needing to consider the appropriateness of this descriptor for each of their cases. The use of the term in such official contexts has formed a large part of the motivation for the proposed study.

There is limited research examining the use of the term 'emerging personality disorder'. Many studies investigating BPD in adolescents reference the use of the term within CAMHS, and at times use both BPD and 'emerging personality disorder' interchangeably (Adshead, Brodrick, Preston, & Deshpande, 2012; Koehne et al., 2013). Despite acknowledgement that the term is used by professionals and researchers (e.g., NICE, 2009; Royal College of Psychiatrists, 2011), there is no clear definition of this construct, or guidance and consensus about when it should or should not be used. Some researchers have suggested that the continued use of 'emerging personality disorder' stems from uncertainty surrounding the diagnostic validity in an adolescent population (NICE, 2009), whilst others advocate for a distinct separation between adolescent and adult personality disorder labels (Cohen, Crawford, Johnson & Kasen, 2005).

Summary and rationale

Existing literature suggests that clinicians are constructing 'emerging personality disorder' as a new way to talk about a group of clients (NICE, 2009; Koehne et al., 2013). This study therefore aimed to explore the way in which 'emerging personality disorder' is talked about (and 'talked into being') amongst clinicians in reference to

the adolescents they work with. Whilst limited existing research has explored how clinicians negotiate talk around BPD in adolescence, there has been no investigation into how clinicians talk about 'emerging personality disorder' specifically. Research to date has failed to capture how clinicians conceptualise and use this term in their work with adolescents.[5]

The motivation for the proposed study lies in a concern that 'emerging personality disorder' as a construct is emerging itself as a new diagnostic category. With the concern that some mental health diagnoses creep into diagnostic manuals before they are scientifically examined as valid diagnoses, it is important to interrogate the construct at this early stage in its use.

This study therefore takes a discursive approach to explore the ways in which clinicians working within a CAMH service talk about and make sense of 'emerging personality disorder' in their work. This approach, grounded in social constructionism, views language not as a means of accessing 'reality' but the means through which that 'reality' is constructed and managed within social interaction.

Methods

Design

This study explored how clinicians working with adolescents constructed 'emerging personality disorder' and the functions of these accounts. Discourse analysis was therefore considered the most appropriate analytic framework. The data were analysed from transcripts from ten interviews with clinicians working within community CAMHs teams in the United Kingdom.[6]

Assuming a social constructionist epistemology, personality disorder is seen as a category constructed through language in the context of medical, social and historical influences (Burr, 2003). Additionally, this constructionist stance rejects the notion of a single 'truth' or 'reality' in favour of multiple realities or truths.[7] We hope that by focusing on the language around 'emerging personality disorder', we can further understand the way in which professionals construct this concept, and the

[5] See Extended Introduction 2.0 for further discussion of current literature
[6] See Extended Method 2.2 for further discussion of methodology
[7] See Extended Method 2.1 for further discussion of epistemology

function such terminology serves to those who use it. In much of the literature, 'personality disorder' is viewed in positivist terms, as something that an individual 'has' and 'experiences', the symptoms of which allow it to be measured and viewed by others. However, this view is not one shared by all clinicians and researchers, despite its dominance within the literature. A constructionist framework therefore appears important in order to add to the discourse surrounding personality disorder.

Procedure

Clinicians from across the multidisciplinary teams (MDTs) who worked directly with adolescents were invited to participate. Participants were recruited from different teams and professional backgrounds to explore a range of positions and discourses available to individuals. A mixed sampling strategy was devised with a purposive element to ensure the sample included clinicians from a range of professional backgrounds.

Information about the research was sent to potential participants by email through existing service mailing lists, and they were invited to contact the primary researcher if they wished to take part. They were sent a copy of the participant information sheet, the details of which participants were then reminded of prior to consenting to take part.[8]

Participants

Initially, eleven participants expressed an interest in taking part in the research and were invited to attend a one-off interview with the primary researcher. One participant was excluded when it became apparent that they did not meet the inclusion criteria, leaving a total sample of ten participants. This sample size was consistent with previous research in which discursive approaches have been used to explore professionals' constructions of mental health difficulties and diagnoses (Harper, 1995; Madill, Gough, Lawton, & Stratton, 2005; Lofgren, Hewitt & das Nair, 2015). Sample size in discursive research is not viewed as fundamental to the success of the study. Of greater importance is the depth of the analysis as opposed to the amount of data there is to analyse (Potter & Wetherell, 1987).

[8] See Extended Method 2.4 for further discussion of the procedure

To protect the confidentiality and identity of the small number of participants, demographic information is described for the sample as a whole (as recommended by Stevens and Harper, 2007). The sample consisted of seven women and three men from different professional backgrounds: psychiatry, clinical psychology, social work, family therapy, art therapy, and mental health nursing. They worked across six different community teams within the service, which varied in terms of their remit and geographical location.

Ethical considerations

Approval was granted by the Health Research Authority (reference 17/LO/0637) and the Faculty of Medicine and Health Sciences Research Ethics Committee (reference 29-1704) at the University of Nottingham. Consent was gained from participants and included permission to record the interviews and use verbatim quotes within the final written dissemination of the research findings. To ensure the anonymity of such quotes, and of the participants in general, each participant was allocated a number. Any information that may identify them was removed from the transcript (e.g., reference to specific NHS Trusts).[9]

Data collection

Interviews were considered the most appropriate framework for gathering data firstly because they enabled us to purposely question all participants about the same topic. Secondly, given that talk about personality disorder in adolescence is reported to happen behind closed doors (Baverstock & Wright, 2015) it was felt unlikely that such natural instances of discourse could be recorded without significant ethical and practical issues.[10]

The semi-structured interview schedule (Appendix D) included broad questions aimed at situating the participant in the context of their work (e.g., 'Can you tell me about your current role?'), in addition to questions aimed to capture talk around the use of personality disorder constructs in reference to adolescents (e.g., 'What do you make of the use of personality disorder diagnoses with adolescents?'). The interview schedule was tested with the first participant, before being reviewed by the research

[9] See Extended Method 2.4.8 for further discussion of ethical considerations
[10] See Extended Method 2.4.1 for further discussion of the use of interviews

team and amended where necessary, with the aim of the schedule enabling talk around the topic.[11]

Interviews were conducted at the participants' place of work. They lasted between 30 and 75 minutes and were recorded using a digital dictation device. Transcription of the recordings was outsourced, therefore during analysis the recordings were listened to while the transcripts were read to increase familiarity with the data. Key sections of the interview were then transcribed using a Jeffersonian-lite style of transcription (Rapley, 2007; Appendix F) in order to retain linguistic and paralinguistic features of the text.[12]

Analytic approach

Discourse analysis can be broadly defined as a 'theoretical way of understanding the nature of discourse and the nature of psychological phenomena' (Billig, 1997; 43). By its very nature, it is not a protocol driven method of analysing data, and various approaches to conducting discursive research have developed over time.

The analysis presented here draws on two key approaches: the principles of discursive psychology (Potter & Wetherell, 1987) and Foucauldian discourse analysis (Willig, 2008). Whilst both concern themselves with the ways in which language is used to construct a version of reality, discursive psychology has a focus on the language and linguistic practice within an interaction or local context, whereas Foucauldian discourse analysis attends to the wider discourses available to speakers that allow and limit their positions and ways of talking. Wetherell (1998) advocates combining approaches to analysis, stating that doing so allows a focus on both the micro and macro features of the discourse (Alvesson & Karreman, 2000). This was considered particularly relevant for aims of this research in that a combined approach incorporated a focus on the features of the talk within the interview setting (e.g., how clinicians negotiated talk around emerging personality disorder), whilst considering the wider institutional, cultural and societal discourses that clinicians draw upon in their talk.[13]

[11] See Extended Method 2.4.4-6 for further discussion of the interview schedule and process
[12] See Extended Method 2.4.7 for further discussion of transcription
[13] See Extended Method 2.3 for further discussion of the methodological approach

The guidelines for conducting the analysis were informed by Potter and Wetherell (1987) and Parker (1992). To begin with, transcripts were read and re-read several times to gain familiarity with the data. While re-reading the material, broad patterns or themes in language use in the data that related to the research question were noted down. A list of questions, drawn from previous discursive research was used to interrogate each transcript. The different ways in which 'emerging personality disorder' was talked about, the discursive strategies used by clinicians, and the range of positions made available through the talk were all key considerations. Sections of the material were gathered together into discursive themes and transferred into data files, a process Potter and Wetherell (1987) refer to as 'coding'. Once coded, these files then formed the basis for further reading and analysis, guided by the questions posed by Potter and Wetherell (1987): 'why am I reading this passage in this way [and] what features produce this reading?' (p.168).

Quality issues

Our epistemological position has implications for the evaluation of quality of the research, as traditional criteria of validity and reliability are not suitable (Antaki, Billig, Edwards & Potter, 2003). Quality however remains important, and qualitative researchers have argued that studies should be evaluated in terms of the consistency and logic of their methodology, epistemology and assumptions (Madill, Jordan, & Shirley, 2000). In line with this, this study aimed to meet the quality criteria detailed in the work by Madill et al. (2000) for discursive research. Specifically, the study was considered in terms of its internal coherence, deviant case analysis, trustworthiness, and openness to reader evaluation. In addition, as suggested by Hayes and Oppenheim (1997), an audit trail was kept throughout the research process. This was intended to further aid transparency, particularly in reference to the process of analysis.[14]

[14] See Extended Method 2.4.8 for further discussion of quality issues

Analysis and discussion

Overview

In constructing their accounts of 'emerging personality disorder', clinicians began by working up constructions of the broader concept of personality disorder. Firstly, personality disorder was constructed as a condition of adulthood, a construction that served to separate 'emerging personality disorder' from the adult diagnosis, and conceptualise it as a way of talking about personality disorder in adolescence. Secondly, personality disorders were constructed as lifelong, stigmatised diagnoses, with negative consequences for the individual. Clinicians drew on these constructions to justify a discourse of concern for the adolescents they work with, and in doing so were positioned as moral guardians with a role of protecting adolescents from the effects of a diagnosis. However, this concern conflicted with a need to name or talk about the difficulties adolescents presented with, an ideological dilemma highlighted in clinicians' hesitation in using 'adult' personality disorder terminology with adolescents, and their search for an alternative explanation.[15]

'Personality disorder is an adult condition'

Throughout accounts, age was constructed as pivotal in enabling or prohibiting a diagnosis of personality disorder. Personality disorders were talked about by most as conditions of adulthood, and clinicians drew upon discourses around personality development and used a range of rhetorical devices to justify their arguments.

Extract 1:

> **I:** *Where do you think that's come from?*
>
> **C1:** *The idea of emerging [personality]*
>
> **I:** [*yeah*]

[15] Extracts from the interviews are used throughout the analysis to illustrate the arguments presented, and support reader evaluation (Potter, 1996a). Within the extracts, the codes are used to refer to the interviewer (I) and the clinicians who participated in the study (C1, C2, etc.).

C1: *Yeah (.) yeah ((sighs)) there's almost like a rule of (.) not a rule of thumb but a kind of rule of practice or kind of <<working practice>> I think (0.2) well personality disorder is an adult condition, it's almost like a blanket rule (.) um so if you're seventeen and eleven months you can't have a personality disorder, but if you're eighteen and a half, formally you can have that personality disorder.*

In the above extract, the clinician introduces the idea of personality disorder as an 'adult condition', presenting this as 'rule', embedded in their practice and the culture of the team. To the listener, this evokes a sense of consensus or corroboration between professionals, which is effective in depicting the account as factual, and positioning the speaker as reliable (Potter & Wetherall, 1987). The use of an extreme case example (Pomerantz, 1986) adds weight to the account, in presenting a very stark and clear 'cut-off' between childhood and adulthood, and as such, between being 'unable' and subsequently 'able' to have a personality disorder. The use of the word '*formally'* again strengthens the veracity of the account, however at the same time is suggestive that despite these rules, there may be occasions where an individual is *informally* said to have a personality disorder. The impact of this rule or working practice on the decisions that clinicians make is depicted in the extract below:

Extract 2:

I: *What (0.2) what's your understanding of emerging personality disorder?*

C3: *I hear it used sometimes (0.2) u::um (.) I wouldn't really use it myself. I think what I understand by it is as soon as this person's eighteen they're going to get a personality disorder. I don't think I've heard it used in a way that suggests there's another option ((laughter))*

I: *Okay*

C3: *It's almost like it is (.) well it's emerging, not like there's a possibility*

I: *So more definite?*

C3: *Yeah I think it (.) it's a bit like 'I would give you a diagnosis but you're not eighteen so I can't'*

Again in this extract, the age of 18 is referenced as a point at which the use of a personality disorder diagnosis is deemed acceptable or allowable. Through using the words '*would'* and '*can't'* the speaker alludes to a situation in which a diagnosis may be warranted or felt justified, but clinicians are bound by the age-related rules or service norms, and therefore *unable* to apply it. Here, the construction of personality disorder as an *adult condition* functions to position 'emerging personality disorder' as a way in which clinicians are *able* to talk about personality disorder before the age of eighteen. Interestingly within this account, the clinician manages issues of interest and stake by beginning with a disclaimer: '*I wouldn't really use it myself'*. This serves as stake inoculation, a discursive strategy used to downplay or manage their perceived interest in a particular argument (Potter, 1996). By using this, the clinician effectively puts across a particular account of 'emerging personality disorder' whilst maintaining their position as someone who doesn't use the term.

Personality disorders as lifelong, stigmatised conditions

Most clinicians made reference to the lasting and negative impact that a diagnosis of personality disorder could have for an individual, and in doing so, constructed personality disorders as lifelong, stigmatised diagnoses. In several accounts, the diagnosis was talked about as an *endpoint*, and opportunities for hope or change were minimised. This is particularly evident in the extract below:

Extract 4:

C2: *So the idea of (.) of (.) of a mental health diagnosis, it is a social construct (0.8) and it's only <u>useful</u> if it's actually going to be helpful to the person who's on the <u>receiving</u> end of that diagnosis. And I know we're going to talk about personality disorder……*

I: *((laughs))*

C2 *Which (.) which tends to be the sort of (.) the equivalent of when you you've crashed your car and the insurance company say it's a <u>write-off</u>, because it's not actually offering much in the way of <<repair>> when you get*

that (.) that kind of diagnosis, unlike if (.) if you've got say a psychotic illness, well we know we've got lots of different medications we can try .hhh and we can actually also give you u:::um cognitive or (.) or psychodynamic um psychotherapy approaches to managing your symptoms, to understanding your symptoms, recognising that these are symptoms and they're not real and being able to cope with (.) daily life going down the shops and stuff.

The use of such an evocative metaphor: *'a write-off'* to describe a diagnosis of personality disorder paints a vivid image for the listener and depicts the diagnosis as lacking in hope or chance of recovery. It is also suggestive of a certain finality and irreversibility, therefore also drawing into question options for treatment. Indeed, this idea is expanded upon by the clinician in their comparison of personality disorder with other psychiatric diagnoses. Referring to personality disorder as '*that kind of diagnosis'* suggests a distinction from other psychiatric diagnoses, such as the example provided of '*a psychotic illness'*. The speaker provides a list of possible treatments for a psychotic illness, setting up a contrast that further constructs personality disorder as untreatable.

The construction of personality disorder as lifelong was consistent throughout many accounts, and in some, this was used to justify a discourse of concern surrounding the use of personality disorder diagnoses with adolescents:

Extracts 5, 6 & 7:

C9: *But (0.2) I suppose (.) I'm not comfortable with the labelling of personality disorder because it's a lifelong thing, and it says that they're disordered. Which is not a helpful (.) I don't think it's a helpful um (.) way to <u>manage</u> their difficulties.*

C6: *I mean it has very, a connotation that's very fixed and (0.4) um (0.4) if I compare it to other diagnostic labels (0.8) in my experience it=it=it <<feels>> (0.2) u:::m (0.8) yes it has a <u>permanency</u> that's quite (0.2) unhelpful?*

C7 *Um (.) I think I'm going on personal experience because I have a friend as an adult that is (.) um diagnosed and her experience has been really just <u>awful</u>, so she felt very much stigma from everybody; her family, friends (.) um (0.2) work, so I (.) I think that from my experience of her receiving that I feel*

like that could be common for adolescents experiencing (.) if they were to be diagnosed.

Here, the clinicians again construct personality disorder diagnoses as *lifelong* and *stigmatised*, a construction which functions to justify their discomfort with using the label, and construction of it being unhelpful. In extract 6, the clinician's emphasis of '*permanency'* draws attention to this particular word and paints a picture for the listener of a diagnosis that lasts forever. A discourse of concern for the individual also permeates the accounts as clinicians introduce the potential stigma that faces those receiving a diagnosis. In both extract 6 and 7, the speakers draw on personal experience to justify their concern for the individual receiving a diagnosis. In extract 6 this is achieved through reference to the clinician's '*experience'* and feelings, and in extract 7 through the use of a case example (Edwards & Potter, 1992). Constructing their accounts in such a way creates the impression of a perceptual experience that is factual and free from bias. In doing so, the speakers are positioned as reasonable and open to challenge. If challenged, these arguments are then protected as the speaker could argue if it was not for their *personal experiences* that suggest otherwise, they may consider the diagnosis useful.

Clinicians as moral guardians

Constructions of personality disorder as an adult diagnosis with lifelong consequences served to justify clinicians' concern around the use of personality disorder terminology with adolescents. Within these discourses, clinicians were positioned as moral guardians, whose role is to protect adolescents from the effects of diagnosis, and hold hope for their recovery:

Extracts 8, 9, 10 & 11:

C6: *'I think it's about protecting adolescents as well, isn't it, and if you give them a concept of (.) um (.) being disordered, you have a personality disorder, there's something within you or about you (.) um (.) that creates all these difficulties in relationships and um (.) yeah, I wonder what message that gives. I might (0.2) yeah, I think I'd like to not reinforce those ideas and for probably adolescents who hold lots of those ideas about themselves anyway (.) um (.) so I wonder if having a different message (.) um (.) might be really important.'*

C4: *'So I think to keep that diagnosis away from adolescents, is…for me is the right thing to do (0.2) because otherwise you are (.) you know (.) you :again you're being seen as a bit reductionist I think (.) um (.) but equally I think in terms of (.) um (.) you know obviously personality disorder is considered untreatable in mental health…'*

C2: *'We as mental health professionals have a <u>really massive</u> responsibility not to start setting up self-fulfilling prophecies a:::and (0.2) um (0.2) as somebody who comes from a psycho-dynamic psychotherapy training background and has done some systemic psychotherapy training (0.4) one of the things that (.) I don't like in my own practice is that I deal with a sort of <u>Hegelian metanarrative</u>, that somehow I'm sitting here with all the knowledge and my patient is sitting there without the knowledge and I'll periodically hand down some <u><<wise thing>></u>.'*

C10: '*so if I'm seeing someone at fourteen I wouldn't give that diagnosis 'cos there's another four years until that time's necessary and there's four years of potential repair for them until they're eighteen'*

Evident within these accounts is the way that clinicians assume a position of power, from which they are able to make decisions that impact on the lives of their young clients. Diagnosis is talked about as a *choice* for clinicians, and each of them negotiate the factors that impact on this choice in their accounts. Concerns over the impact of the diagnosis were used to justify the decision to withhold it. In extract 9, Clinician 4 talks about withholding diagnosis as '*the right thing to do'*, which serves to construct this decision as one that is moral and ethical. In this light, the clinicians themselves are positioned as guardians of a moral code, suggesting to the listener that they have a duty and responsibility to protect their clients.

Stigma was often constructed as the most concerning consequence of diagnosis. Extract 8 exemplifies this, in which the clinician justifies a need to protect adolescents by constructing personality disorder as inherently self-stigmatising. Using the phrase '*if you give them a concept of being disordered'* again positions the clinicians as powerful and as responsible not only for diagnosis, but for its effects on the adolescent. Within this discourse, the diagnosis itself is also attributed power to impact on the identity of an adolescent, and the act of giving an adolescent a

diagnosis may contribute to rather than alleviate their difficulties. This is emphasised by Clinician 2 in their use of the term *'self-fulfilling prophecies'* (extract 10), which constructs the diagnosis itself as capable of setting an adolescent on a particular trajectory towards then meeting the criteria for that very diagnosis.

In constructing these accounts, clinicians position themselves as reflective, considerate practitioners, and distance themselves from the position of someone who through their diagnostic practice, stigmatises their young clients. Clinician 2 also makes use of category entitlement, a discursive strategy that serves to position their account as reliable and factual based on the assumption that '*as somebody who comes from a psycho-dynamic psychotherapy training background and has done some systemic psychotherapy training'*, they have certain relevant knowledge or skills (Edwards & Potter, 1992).

Negotiating a more hopeful alternative

The discourse of concern surrounding the use of personality disorder diagnoses, and the way in which, within this, clinicians were positioned as moral guardians conflicted with a need to talk about adolescents' difficulties and communicate these both to colleagues and their clients. Within their accounts, having worked up constructions of personality disorder as an adult diagnosis with lifelong, stigmatising consequences, all clinicians began to negotiate and construct an alternative way of talking about the difficulties they associated with personality disorder, that they were able to reconcile with their position as moral guardians.

For some, 'emerging personality disorder' served this function, and was constructed as a way of talking about personality disorder in adolescence, while maintaining hope for their recovery:

Extracts 11 & 12:

> **C10:** *And (.) and diagnostic criteria. Established practice has been that you don't have a personality disorder until your personality's fully formed. I don't believe personality is fully formed at eighteen (.) far from it:it's still very much a work in progress (0.4) um but I think it* [emerging personality disorder] *allows a degree of hopefulness, potential for recovery.*

C9: *I would say that the borderline stuff is more kind of fixed, whereas the emerging stuff can change and it's (.) you know (.) it doesn't necessarily mean that that's going to be forever (.).*

Here the clinicians construct 'emerging personality disorder' as flexible and transient, and its potential temporary nature is emphasised. This construction contrasts directly with the broader constructions of personality as a lifelong condition that were discussed previously and serves to distance 'emerging personality disorder' from other personality disorder labels in this way. The use of contrasts such as this is suggested to be powerful in presenting an account as factual, as it seemingly combines ideas from different viewpoints (Edwards & Potter, 1992). For the clinicians, this construction serves to manage a conflict, between remaining hopeful and mindful of the impact of a diagnosis of personality disorder, whilst naming and talking about the difficulties of the adolescent.

Within other accounts however, 'emerging personality disorder' was likened to other personality disorder terminology, in that it was talked about as restricting or limiting hope for the adolescent. Within these accounts, clinicians negotiated alternative ways of talking about the difficulties adolescents presented with, and through doing so, were able to negotiate the same conflict in a different way. Many clinicians presented alternative explanations for adolescents' difficulties, drawing on discourses of trauma. The extract below exemplifies how an alternative explanation was constructed:

Extract 13:

C8: *I like (.) I prefer (.) um to think about it in terms of trauma or whatever it is that's kind of started that catalogue of development off. Does that make sense?*

I: *Yeah*

C8: **>>***Personality disorder<< to me (.) it sounds to me like you're not (.) you're not (.) you've done something wrong (.) you're not accepted. So I like to say that (.) you know (.) you have got personality traits that can sometimes (.) as we all have (.) can get us into hot water and there are some of them that*

we need to maybe manage a little differently perhaps. So yes, It's got to be recognised, but I think we could think about a better way of saying it I guess

I: *Okay, [so]*

C8: *[So] I would say trauma based (.) mmm (.) difficulties:::anxieties, whatever is presenting at that time*

I: *Instead of using emerging personality disorder*

C8: *Yes, 'cos it does sound very personal, direct (.) that that person's kind of already been set up to fail when they come into services almost.*

In the above extract, the clinician highlights the dilemma between the difficulties of the adolescent being '*recognised'* and the need for a '*better way of saying it'*, due to the potential stigmatising impact of personality disorder diagnoses. They then construct '*trauma'* as an alternative way of talking about the same difficulties as others label 'emerging personality disorder' and in doing so, construct trauma as the origin or basis for these difficulties. Interestingly, the alternative account is constructed with vagueness and tentativeness, evident in the use of words such as '*or whatever'*, '*perhaps', 'I guess'.* The use of these qualifiers serves to position the speaker as thoughtful and open-minded. These, alongside the question posed to the interviewer '*does that make sense?'* serve to portray their alternative construction as a loose hypothesis that is open to challenge. Interestingly, this contrasts with the certainty with which the clinician rejects the use of personality disorder terminology, which was said with marked certainty.

General Discussion

Summary of findings

This research has explored the ways in which clinicians, from a range of professional backgrounds, conceptualised 'emerging personality disorder'. Clinicians' talk within interviews offers a way of examining the current 'truths' about 'emerging personality disorder' and the positions available to clinicians within the varying discourses (Parker, 1998). The findings suggest that 'emerging personality disorder' sits at the heart of a conflict for clinicians, between a need to protect adolescents from the

effects of a personality disorder diagnosis, and the need to talk about and put a name to their difficulties. Within their accounts, clinicians drew on various discourses of the broader personality disorder concept that influenced their constructions of 'emerging personality disorder' and its use. Whilst for some clinicians, 'emerging personality disorder' functioned as a more hopeful and flexible alternative to an 'adult' personality disorder diagnosis, others negotiated alternative descriptions that provided distance from personality disorder terminology. Throughout their accounts, clinicians used a range of different rhetorical strategies to construct their accounts, consistent with the observations of Potter & Wetherell (1987). These strategies were commonly used by clinicians to construct their accounts as factual and manage issues such as accountability, consistent with previous discursive research conducted with clinicians (e.g. Lofgren, Hewitt & das Nair, 2015).

Constructing 'emerging personality disorder'

The construction of personality disorder as an 'adult condition' is interesting given calls by some researchers for BPD to be conceptualised as a 'unitary construct' across the lifespan (Chanen & McCutcheon, 2013; Chanen, 2015). Here, the separation between child and adulthood, and the pivotal role of age in determining the acceptability of personality disorder diagnoses clearly contrasted with the view of a unitary construct. For some, age justified caution in using any personality disorder terminology with adolescents, whilst for others it led to the use of 'emerging personality disorder' for this particular client group. Some researchers have suggested that ambiguity surrounding the validity of personality disorder diagnoses in adolescence contributes to the continued use of 'emerging personality disorder' (NICE, 2009). Indeed, in this study, discourses pertaining to the acceptability of personality disorder diagnoses within adolescence were central to accounts of 'emerging personality disorder'. However, the separation between 'emerging personality disorder' and *adult* personality disorder diagnoses also enabled clinicians to remain hopeful on behalf of their adolescent clients, suggesting that for them, there is more at stake than simply arguments regarding validity. The authors of the Children in the Community Study recommended a differentiation between child and adult personality disorder in order to avoid premature labelling and the carrying of stigma into adulthood (Cohen, Crawford, Johnson & Kasen, 2005). It may be that

‘emerging personality disorder’ for this group of clinicians is serving as such a distinction.

For others, concern regarding the stigmatising impact of a personality disorder label was constructed as a key justification for rejecting ‘emerging personality disorder’ and drawing on alternative explanations of adolescents’ distress. This discourse was consistent with findings in previous literature that concerns about stigma are key to understanding clinicians’ reluctance to use personality disorder terminology (Baverstock & Wright, 2015; Kernberg, Weiner, & Bardenstein, 2000; NICE, 2009). The rejection of this particular narrative for adolescents could also be seen as a wider rejection of empiricist accounts of mental health (Harper, 1995), in favour of alternative discourses that emphasised the role of past trauma or relational experiences in the development of the difficulties. Discourses pertaining to trauma as an explanation for the ‘symptoms’ related to a diagnosis of BPD are evident within existing literature. Some researchers and clinicians have argued that the ‘symptoms’ of BPD can be better explained in the context of adaptive responses to early trauma (e.g. Warner & Wilkins, 2003), and that this conceptualisation of individuals’ distress has been argued to locate the disorder within the individual, as opposed to in the context of its social causes (Shaw & Proctor, 2008). Within this study, some clinicians drew on these discourses to offer an alternative account of the distress adolescents presented with, rejecting discourses of ‘emerging personality disorder’.

Within accounts, clinicians largely positioned themselves as holding power that enabled them to make choices around the diagnostic language used with their clients and draw upon or reject diagnostic discourses. Power has been argued to be inherent within the practice of psychiatric diagnosis (Pilgrim, 2013; Roberts, 2005), and many clinicians openly named their powerful position, and the potential negative impact that their decisions could have on the identity of the young people they work with. Salient across accounts was the position of ‘moral guardian’ that clinicians assumed, and the associated responsibility to protect the adolescents they worked with from harm. Similar discourses of moral duty or concern have been highlighted in previous discursive research with clinicians, both in the context of their conceptualisations of mental health (Lofgren, Hewitt & das Nair, 2015) and of the process of psychological formulation (Stone, 2014). This suggests that these discourses may not be unique to this particular context or subject matter, but

perhaps are available to clinicians within the context of the broader mental health system.

Implications for practice

The ways in which clinicians conceptualise distress and disorder have implications for how adolescents understand their own difficulties. Crowe (2000) argues that the ways in which services frame the behaviour of the service user shapes how they understand the parameters of 'normal' and 'abnormal' and therefore what they are required to do to change. Clinicians varied in the ways in which they conceptualised the distress young people presented with. The same presenting difficulties were given the label 'emerging personality disorder' by some, whereas others rejected and negotiated diagnostic discourses in favour of descriptions grounded in discourses of trauma. Arguably, each of these conceptualisations will have implications for the adolescent's own interpretation and understanding of themselves. Conceptualising their difficulties as a response to trauma, for example, may serve to position adolescents as victims, which in itself may invoke a range of negative attributes (Lamb, 1999). Clinicians may benefit from a space to reflect on the different ways of talking about adolescents' difficulties. The aim of such a space would be for clinicians to consider how these different conceptualisations impact individuals' understandings of themselves, and furthermore to consider how the power implicit in the clinician-client relationship may be more optimally managed, in order to co-create an understanding of the adolescent's experiences that makes sense for the individual. Clinical psychologists arguably occupy a beneficial position within CAMHs teams and have the skills to facilitate opportunities for reflection. It may also be that through supervision or reflective practice sessions, they are able to support clinicians to consider the impact of their varied constructions on how adolescents are positioned and how they understand themselves.

Limitations

Discourse analysis offers a way in which to explore how meaning is constructed by clinicians in their work through language and discourse. Talk in this context is viewed as constitutive of experience and action but shaped by the social context and issues of stake and interest (Potter & Wetherell, 1987). The use of interview data has been

argued to be ‘artificial’ and likely to impact on the ecological validity of the findings (Potter & Hepburn, 2005). Given the contested nature of the topic, participants may have been conscious of how they were being perceived in constructing their accounts, and the presence of an interviewer may have influenced the ways in which clinicians negotiated their constructions of ‘emerging personality disorder’.

However, others have argued that in an interview context, speakers are restricted by the number of discursive resources at their disposal and will (re)produce routinized discourses in other similar settings (Griffin, 2007; Wetherell, 2007). Furthermore, interviews served to focus participants on a particular topic, and allow an exploration of various aspects of their talk in relation to ‘emerging personality disorder’. Further studies may consider how to overcome practical barriers to the collection of naturally occurring talk and explore how clinicians present and negotiate constructions of ‘emerging personality disorder’ in clinical settings.

7906 words excluding references

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EXTENDED PAPER

Part One : Extended background

1:1 Section introduction

This thesis focuses on CAMHS clinicians' constructions of 'emerging personality disorder'. In order to contextualise the study and its findings, this section offers an overview of the literature considered relevant to the research. Firstly, the concept of personality disorder will be explored, including a review of recent literature offering a critique of the concept. The relevance of personality disorders within adolescence will then be discussed, with consideration of the recent increase in literature surrounding the application of the BPD diagnosis to adolescents. Thirdly, critical views on psychiatric diagnosis will be considered, including a review of literature surrounding the stigma associated with personality disorder diagnoses, and a discussion of Foucault's theory and its application to the practice of diagnosis. Finally, the methodological limitations of previous research will be reviewed and used to contextualise and justify the present study.

1:2 The concept of personality disorder

Diagnostic manuals, namely the DSM (APA, 2013) and ICD (WHO, 2008), outline the diagnostic criteria for nine and 11 different variations of personality disorder respectively. Both differ slightly in the language and labels used to define these disorders but are united in characterising personality disorder as the presence of abnormal or maladaptive traits which result in ongoing distress and dysfunction. Subcategories common to both systems are; paranoid, schizoid, histrionic, borderline (emotionally unstable), anxious (avoidant) and antisocial (dissocial), dependent, anakanistic (obsessive-compulsive) and personality disorder unspecified. In addition, the DSM describes a further two categories: narcissistic and schizotypal personality disorders.

Concerns about the personality disorder concept have been well documented in the literature, and the diagnosis has in the past attracted the label 'diagnosis of exclusion' due in part to concerns around its treatability (National Institute for Mental Health in England (NIMHE), 2003). As a concept, is it said by some to be unhelpful

and stigmatising (NIMHE, 2003), and has been criticised for a lack of reliability and aetiological specificity (Pilgrim & Rogers, 2009).

With ongoing debate surrounding the usefulness of personality disorder diagnosis, the recent introduction of the DSM 5 (APA, 2013) saw clinicians challenging the categorical model of personality disorders. Clinicians criticised the arbitrary approach to diagnosis and the notion of personality disorder either being present or not (Krueger, Hopwood, Wright, & Markon, 2014; Skodol, 2014). An alternative dimensional approach was proposed in which the level of impairment in functioning and the severity of the pathological personality traits would be seen on a scale. The dimensional model did not replace the existing categorical model however it was included in the section 'emerging measures and models'.

The stability of traits over time is considered key within the criteria for personality disorder diagnoses. However, there is increasing evidence that challenges this assumption (Morey & Hopwood, 2013; Skodol, 2012). A number of longitudinal studies have been conducted in which changes in personality disorder traits were measured over time (see Morey & Hopewood, 2013, for a review). Although the results highlighted some stability in personality traits, they also showed variation in the level and rate of change in personality disorder symptoms (Lenzenweger, 2006), a natural decline in traits (Pukrop, Krischer, & Cohen, 2005) and high levels of remission in symptoms (Gunderson et al., 2011; Zanarini, Frankenburg, Hennen, Reich, & Silk, 2006). These results draw into question the stability over time of the traits considered key to a diagnosis of personality disorder.

Prevalence

Historically, studies attempting to investigate the epidemiology of personality disorders have been criticised for their use of biased samples and inconsistent methods of assessing the 'presence' of personality disorder traits (Lenzenweger, 2008). More recently, attempts have been made to measure the prevalence of personality disorders in non-clinical populations. The Longitudinal Study of Personality Disorders (LSPD) (Lenzenweger, 2006) sampled a nonclinical university population and used a two-stage approach to the assessment of personality disorder (Lenzenweger, Loranger, Korfine, & Neff, 1997), reporting an 11.01% prevalence of 'any personality disorder'. Likewise, estimated prevalence of 'any personality

disorder' in a Norwegian sample was reported to be 13.4% (Torgersen, Kringlen, & Cramer, 2001) and in a weighted UK sample 4.4% (Coid, Yang, Tyrer, Roberts & Ullrich, 2006).

Aetiology

There is further debate surrounding the aetiology of personality disorders, and the literature is arguably inconsistent and contradictory (Bourne, 2011; Cloninger & Svrakic, 2008). This perhaps relates to the various conceptualisations of personality disorder, which are varied in their assumptions and theoretical foundations (Livesley, 2001). There is increasing evidence highlighting the role of childhood trauma in the development of difficulties associated with personality disorder (in particular BPD). In a review, Chanen & Kaess (2012) concluded that there are strong associations between childhood trauma and BPD. However, the relationship between the two is complex and multifactorial. Trauma is conceptualised in the literature in different ways, including consideration of a single type of trauma (such as sexual abuse), and trauma as an accumulation of events. Furthermore, there is a lack of specificity in the relationship between childhood trauma and BPD (Ball & Links, 2009).

The upcoming publication of the ICD-11 (WHO, in press) has triggered a wider debate with regards to the relationship between BPD and trauma. Within proposals for the new guidelines, a diagnosis of 'complex PTSD' has been proposed, the 'symptoms' of which have striking similarities to those conceptualised within the BPD diagnostic category (Mosquera & Steele, 2017). Concerns with regards to the overlap between the two led some researchers to investigate whether empirically, complex PTSD has validity in its own right, arguing that it is clearly distinguishable from BPD (Cloitre, Garvert, Weiss, Carlson, & Bryant, 2014). Meanwhile, others have argued that given debate regarding the differentiation between the two, complex PTSD could be utilised by clinicians to decrease stigma and provide a trauma informed approach to BPD (Kulkarni, 2017). These arguments rest on the assumption that trauma plays a key role in the development of BPD.

Attachment is also commonly linked to the development of personality disorder traits, with a specific focus on BPD (Fonagy, 2000; Levy, Meehan, Weber, Reynoso, & Clarkin, 2005). Within attachment theory, it is hypothesised that poor attachment relationships with primary caregivers are mirrored in future relationships, and impact

on the individual's concepts of the self, others and relationships (Bowlby, 1982; Tackett, Balsis, Oltmanns, & Krueger, 2009). Fonagy (2000) suggested that an insecure attachment relationship arising from an unresponsive, neglecting or abusive caregiver may lead to fragmented and incoherent internal working models. These internal working models are hypothesised to lead to an array of difficulties that are said to be conceptualised by the BPD diagnosis, for example difficulties within interpersonal relationships, fear of being abandoned and difficulties with mentalisation (Fonagy & Luyten, 2009; Levy, 2005). The relationship between attachment style and 'symptoms' of personality disorder is supported by reported correlations between attachment insecurity and personality disorder diagnoses (See Lorenzini & Fonagy, 2013 for a review).

The associations between various factors and subsequent diagnosis of BPD have led researchers to suggest that there are multiple pathways to the difficulties encompassed by the BPD label (Widom, Czaja, & Paris, 2009). Some have argued that the personality disorder construct itself can serve to obscure or detract from aetiological factors, for example through encouraging a focus on the intrapsychic as opposed to on the social and historical aspects of personality disorder (Bourne, 2011; Shaw & Proctor, 2005). Additionally, personality disorder diagnoses have been criticised alongside other psychiatric diagnoses for merely describing a particular presentation as opposed to *explaining* it (Pilgrim & Rogers, 2009).

1.3 Personality disorder in adolescence

Within diagnostic manuals, there is agreement that personality 'dysfunction' has its onset in adolescence and early adulthood. However, there is debate as to whether this dysfunction could be seen as pervasive and persistent during this developmental stage. Key to this debate are views of personality development, and the stability of so called dysfunctional personality traits in the adolescent period.

The adolescent personality

Descriptions of the adolescent personality often emphasise fluidity and change (Bleiberg, 1994; Meekings & O'Brien, 2004). Often said to be a period in which individuals develop their identity, instability in sense of self and self-concept have been observed in adolescent populations (Cole et al., 2001; Savin-Williams, Demo &

Waterman, 1982). Furthermore, meta-analysis has suggested that across the board in adolescence, personality traits are less stable than at any point thereafter (Roberts & DelVecchio, 2000). It is perhaps this changing picture of personality in adolescence that creates difficulty in distinguishing the criteria for personality disorder from signs of typical adolescent development (Miller, Muehlenkamp, & Jacobson, 2008).

Of course, the measurement and tracking of personality development is complex, and very much related to the ways in which personality and personality traits are constructed and conceptualised. Key frameworks of personality typology make reference to a series of universal personality traits, for example the Big Five, or Five-Factor framework (John & Srivasta, 1999; McCrae & Costa, 1999) which as the name suggests, posits five key traits that make up an individual's personality. Studies applying this conceptualisation of personality to adolescent populations have demonstrated that traits are subject to development and change within this period, and indeed into adulthood (Branje, van Lieshout, & Gerris, 2007; McCrae et al., 2002). Such change is arguably contrasting with the descriptions of personality disorder traits as pervasive and persistent.

Personality disorder traits in adolescence

Given the fluctuations associated with adolescent personality, there are clear challenges in establishing a diagnosis contingent on the stability of problematic personality traits. Research exploring personality disorder traits in adolescence has reported variable levels of stability. Several studies using non-clinical community samples have reported relative stability in personality disorder traits *during* adolescence, but then a natural decline as individuals mature from adolescence into adulthood (Bornovalova, Hicks, Iacono, & McGue, 2009; Johnson, Smailes, Cohen, Brown, & Bernstein, 2000). Indeed Johnson et al. (2000) reported as much as a 28% decline in the presence of personality disorder traits from adolescence to adulthood. Other studies have reported low diagnostic stability of BPD *within* adolescence (Bondurant, Greenfield, & Tse, 2004; Miller et al., 2008). Within clinical populations, one study investigating the stability of BPD symptoms in adolescent inpatients reported a significant decrease in symptoms over time (Grilo et al., 2001), whilst

another reported that BPD symptoms did not significantly decrease over time (Chanen et al., 2004).

A recent systematic review considering the diagnostic stability of personality disorders in adolescence concluded that at best, studies with child and adolescent population indicate moderate levels of diagnostic stability, with a range of 14-40% (Winsper et al., 2015). Arguably this brings into question whether adolescents may receive a diagnosis of personality disorder in adolescence that then becomes irrelevant as they mature into adulthood.

Malleability of personality traits – an argument for early intervention

The exploration of stability of personality disorder traits in adolescence has served both to encourage caution around diagnosis (Silk, 2008) and support an argument for early intervention (Chanen & McCutcheon, 2013). Some authors argue that without the early identification and treatment of difficulties associated with personality disorder, individuals will experience more chronic difficulties in later life (Kaess, Brunner, & Chanen, 2014).

Several trials of therapeutic intervention aimed at reducing 'symptoms' of BPD in adolescence have been reported in the literature. Treatments have included Cognitive Analytic Therapy (CAT) (Chanen et al., 2008), Emotion Regulation Training (ERT) (Schuppert et al., 2009), Mentalisation-Based Treatment for Adolescents (MBT-A) (Rossouw & Fonagy, 2012) and Dialectical Behaviour Therapy for adolescents (DBT-A) (Tormoen et al., 2014). These trials reported favourable outcomes in comparison to treatment as usual (good clinical care), showing improvements on a range of outcome measures including those measuring BPD features (Chanen, 2015). However, with personality disorder traits arguably declining as adolescents mature into adulthood, it is difficult to determine the extent to which improvements in symptoms are due to the treatment, or in part attributable to natural changes in adolescent personality development.

1.4 Stigma surrounding personality disorder diagnoses

Whilst the stability of the personality disorder diagnoses in adolescence is a key concern, authors have also questioned whether the diagnosis would 'stick' over time, despite an individual no longer meeting the full criteria for the disorder (Silk, 2008).

These concerns are not unique to adolescence, with personality disorder being referred to as ‘a very sticky label’ by adult service users, that carries stigma both within and outside of mental health services (NIMHE, 2003).

In comparison to other psychiatric diagnoses, individuals with a personality disorder diagnosis are thought to experience greater stigma (Catthoor et al., 2015; Magallón-Neri et al., 2014). Research suggests that individuals can be viewed as difficult rather than unwell, and that members of the public are less likely to think that they need professional help in comparison to individuals with other psychiatric diagnoses (Furnham, Lee, & Kolzeev, 2015). Within services, stigma is reported to be greater (Bonnington & Rose, 2014), with research highlighting negative attitudes and behaviours of professionals towards individuals with a diagnosis of personality disorder (Bodner et al., 2015; Prasko et al., 2016; Sansone & Sansone, 2013). Although efforts have been made to combat stigma amongst professionals, certainly within the UK (NIMHE, 2003), individuals with a diagnosis continue to report exclusion from or discrimination in their treatment by professionals (Aviram, Brodsky, & Stanley, 2006; Lawn & McMahon, 2015; Martin & Thomas, 2015).

Although far less research has focused on self-stigma, studies report that in accepting the public stereotypes about mental health difficulties, and about personality disorder specifically, self-stigma can lead to problems with self-esteem, depression and identity (Sheehan, Nieweglowski & Corrigan, 2016). Studies focusing on self-stigma associated with BPD report that individuals may experience shame about their diagnosis, and stigma may impact on their willingness to access services (Lawn & McMahon, 2015). Amongst various conceptualisations of self-stigma, Link (2001) proposes that being linked to stereotypes and ‘labelled’ (for example through psychiatric diagnosis) may impact on an individual’s self-esteem and self-efficacy, as those attitudes, stereotypes and potential prejudices can become personally relevant (see also Link et al., 1989; Corrigan & Lundin, 2001). Although self-stigma is experienced by individuals with a range of psychiatric diagnoses, there are some factors specific to BPD that could be connected with higher levels of self-stigma. Firstly, individuals with a diagnosis of BPD are said to expect and perceive social rejection stronger than the general population (Winter, Koplin & Lis, 2015). They are also said to show negative and unstable evaluations of themselves and others when compared to individuals without a diagnosis (Winter, Koplin, Schmahl, Bohus & Lis,

2016; Korn, La Rosée, Heekeren & Roepke, 2016). These factors are hypothesised to contribute to individuals' experiences of self-stigma, and the heightened self-stigma reported in individuals with a diagnosis of BPD (Grambal et al., 2016).

1.5 Diagnosis and clinical psychology

Diagnostic systems are based on the assumption that through accurate measurement and assessment, it is possible to identify the presence of a disorder or condition. As a result of psychiatry occupying a dominant position within mental health services, research is often based on the assumption that through observing patterns and features of individuals' experiences, it is possible to identify underlying pathology. However, the diagnostic frameworks have been criticised for being flawed, having limited reliability and validity, and failing to address the complexity and personal experience of mental health difficulties (Bentall, 2004; Boyle, 2002; Johnstone, 2008; BPS, 2000; 2011).

The Division of Clinical Psychology (DCP) as a professional body has over recent years vocalised concerns about the pervasiveness of diagnostic systems in mental health services. The debate surrounding diagnostic systems was further fuelled by the release of the latest version of the DSM (DSM 5; APA 2015), which was marked by many professionals speaking up about the difficulties in the system (see Johnstone & Boyle, 2018 for a summary). Very recently, the DCP have published the Power Threat Meaning Framework, aimed at providing an alternative framework to understanding mental health difficulties away from traditional diagnostic systems (Johnstone & Boyle, 2018). This paper calls for a 'paradigm shift' in the way that mental health difficulties are conceptualised, and criticises psychiatric diagnosis both for its conceptual flaws, and for the potential impact it has on service users.

Clinical psychologists arguably sit in a powerful position within teams, from which they may be able to bring alternative frameworks of meaning to colleagues and clients. Psychological formulation is often viewed as an alternative way in which to understand an individual's presentation, without the need for a label (DCP, 2011).

1.6 Diagnosis and Foucault

However distress and disorder is conceptualised by services will impact on how service users understand their own difficulties. Diagnostic systems are based on an

inherent assumption that diagnoses reflect real entities or disorders that are universal across culture, society and history. However, many authors have argued that diagnoses can be viewed through a social constructionist lens, as discursive constructions that are embedded in an exchange of power and are underpinned by cultural values and assumptions (e.g. Boyle, 2002). It has been argued that diagnostic systems construct what is considered to be 'abnormal' behaviour, and therefore by doing so, also construct what is 'normal', affording professionals the power to position individuals as sick (Frances, 2013). The act of diagnosing mental illness inherently positions professionals in a powerful, expert position, and it has been argued to provide a framework for legitimising power and control within society.

Foucault (1967) wrote about madness not as due to an underlying biomedical disorder, but as the reification of psychiatric discourse. In relation to current diagnostic practice, Foucauldian theory provides a framework for exploring the ways in which professional discourses are shaped by knowledge and power (Foucault, 1972). In their position within teams, professionals are naturally situated within a number of discourses, which serve to afford them certain positions.

1.7 Current literature

This section is intended to provide an overview of the current literature exploring the experience and attitudes of professionals in relation to the use of personality disorder diagnoses with adolescents. Research in this area is limited, and far outweighed by studies aiming to further diagnosis and treatment for personality disorder in the adolescent population.

Two studies employed a survey methodology to explore the willingness of professionals to use personality disorder diagnoses within an adolescent population. Of 367 psychologists working with adolescents, Laurenssen, Hutsebaut, Feenstra, Van Busschbach, & Luyten (2013) reported that 57.8% acknowledged the existence of personality disorder in adolescents, but 8.7% would diagnose it in this population. Psychologists reportedly cited two key reasons for not utilising the diagnosis, firstly the belief that personality problems in adolescence are transient, and secondly the belief that diagnostic manuals did not allow diagnosis in that particular age group. In a similar vein, Griffiths (2011) surveyed a group of 52 psychiatrists, 37% of which felt that a diagnosis of BPD was valid for an adolescent population. Whilst these

findings indicate an uncertainty amongst professionals in relation to the use of personality disorder diagnoses with adolescents, their use of survey data inherently restricts their findings. Surveys offer participants a limited range of responses and prescribe the descriptive categories and constructions available to participants. They give very little insight into the complexities surrounding the terminology and of the influences on professionals' opinions.

More recently, there have been a handful of studies exploring the experiences and perspectives of professionals working with adolescents who have been given a personality disorder diagnosis. Each of these has used qualitative methodologies to analyse interviews and focus groups with professionals working within CAMHs services in the UK. Reiss & Gannon, (2015) interviewed nurses working with adolescents who had received a diagnosis of either personality disorder or emerging personality disorder. Interestingly the authors assumed these both to be separate diagnostic categories, evident from the way in which they were used within the article. The authors reported a series of key themes in the accounts of nurses, including their individual emotional responses to working with adolescents described as having personality disorders, the tensions evident within the wider team, and the lack of diagnostic clarity leading to uncertainty around treatment.

Baverstock & Wright (2015) used thematic analysis to analyse a series of focus groups with CAMHS professionals of varying disciplines. Of the themes reported, several related to the frustrations and difficulties working with adolescents with a diagnosis of BPD. Professionals also spoke about their uncertainty in relation to the diagnosis, its utility and the service's lack of recognition of it, encapsulated in a theme entitled 'the elephant in the staff room'.

Finally, Koehne, Hamilton, Sands, & Humphreys (2013) used a discursive methodology to explore how diagnoses of BPD are shared with adolescents within an Australian CAMHS service. Their focus was on the diagnostic practices of the team, and more broadly on how clinicians talked about BPD. Koehne et al. (2013) discussed ways in which clinicians resisted the BPD diagnosis. Clinicians discouraged disclosure of the diagnosis to the adolescent, and if naming BPD, would use hedges to soften the diagnosis and would reframe the diagnosis with adolescents. Interestingly within this study, the authors used the terms 'emerging

BPD' and 'BPD' interchangeably, and referred to 'a diagnosis of emerging BPD' in the aims of their study.

Within all of these studies, the qualitative methodologies used allowed for a more detailed exploration of the attitudes and experiences of staff in relation to the personality disorder diagnosis. Salient across all of the studies discussed so far is the uncertainty and concern regarding the use of the diagnosis with adolescents. In two of the three qualitative papers, there is also a pattern whereby professionals experience adolescents diagnosed with a personality disorder as difficult or more challenging than other adolescents, a theme that mirrors much of the adult literature (e,g, Crawford et al., 2010).

The methods used in exploring the views of professionals on the use of personality disorder diagnoses with adolescents have for the most part assumed a realist epistemology. Whilst attitudes have been explored, how professionals understand, construct and negotiate the personality disorder concept has been neglected. Koehne et al. (2013) attempted to address this gap in the literature, by taking an approach to analysis that allowed for the nuances of language to be considered. This was the first study to consider how professionals negotiate and construct the meaning of BPD in adolescence, and how in practice, they talk to adolescents about the diagnosis. However, the focus of this research was on the diagnostic practices of the team, and how specifically the BPD diagnosis was communicated with adolescents, in an Australian service in which the diagnosis was used. In more recent years there has been increasing use of 'emerging personality disorder' in services in the UK, and as described earlier, in increasingly official contexts. Anecdotally, it appears that 'emerging personality disorder' is emerging as a diagnostic term in its own right.

Part Two: Extended methodology

2:1 Section introduction

This section firstly outlines the epistemological stance taken in this research, before exploring two key approaches to discourse analysis: firstly, discursive psychology (Potter & Wetherell, 1987), and secondly Foucauldian discourse analysis (Foucault, 1979). An argument is then put forward for an eclectic

approach to analysis, combining the two approaches. An overview of the procedure including recruitment, data collection and analysis will be outlined, and ethical considerations addressed. Finally, a discussion of how to assess quality in discursive research will be outlined.

2:2 Epistemology

The research is informed by social constructionism, which assumes that our perceptions of knowledge and reality are constructed through experience and language, and are mediated by social, cultural and historical factors (Willig, 2001). Whilst traditional positivism deems there to be a single reality or truth, which can be accessed through individual experience, social constructionism rejects this notion, instead suggesting that there are multiple realities or truths, which are constructed through subjective experiences.

In applying a social constructionist framework to research, a key implication of this epistemology is that a particular phenomenon is likely to be constructed and experienced differently by different people. People's experiences are therefore not seen as a window through which to view and measure a single phenomenon, which is a stable and unitary construct, but the means through which that phenomenon is constructed for them. Furthermore, these constructions are seen as context-dependent (Gilbert & Mulkay, 1984), with factors that could influence the production of knowledge including the constructions and cultural meaning systems of both the participant and the researcher (Pidgeon & Henwood, 1997).

2:3 Methodology

The research question was thought to best be addressed by a qualitative approach, as this is said to provide thick, rich descriptions that are useful for exploratory research (Willig, 2008). As such, a number of methodologies were considered in the process of designing the study in addition to Discourse Analysis (DA), namely Interpretative Phenomenological Analysis, Grounded Theory and Conversation Analysis.

Interpretative Phenomenological Analysis (IPA) as a methodology focuses on exploring individuals' subjective or lived experience of a phenomenon (Smith,

2008). Grounded epistemologically in theories of phenomenology (i.e., existence and experience) and hermeneutics (referring to interpretation), it gives primacy to the meaning that individuals ascribe to their experiences, which is then made sense of by the researcher (Larkin & Thompson, 2011). Although IPA has been used to explore how clinicians make sense of complex clinical presentations like personality disorder (Donnison, Thompson, & Turpin, 2009), I was interested in how clinicians *constructed* their accounts of 'emerging personality disorder', as opposed to individuals' subjective experiences of the construct.

Grounded Theory (GT), much like DA, posits that meaning is negotiated and understood through social processes (Blumer, 1986, Dey, 1999; Jeon, 2004). The aim of GT is to explore these social processes and develop an explanatory theory that is grounded in the data (Starks & Brown Trinidad, 2007). With various different approaches to GT, a constructivist approach (Charmaz, 2005) was considered, in particular as it allows for the researcher's interaction and involvement with the development of meaning (Cho & Lee, 2014). However, as the aims of this research were not to generate a new theory, GT was not considered an appropriate methodology.

Conversation Analysis (CA), although similar to DA in its epistemology and focus on language, is concerned with the micro features of conversation. Analysis focuses on the organisation, design and content of talk, and the *action* of the talk is seen within the context of that specific interaction. CA was thought to restrict analysis to too technical a level for the purposes of this research, which aimed to situate the talk within its wider context (Sacks, Schegloff, & Jefferson, 1974).

2.3.1 Discursive Psychology

Discursive psychology (DP) is a particular method of DA that concerns itself with the construction, through language, of psychological phenomena. Viewing language as a medium for the creation of meaning, it focuses on how psychological constructs are produced and negotiated in moment to moment interactions (Alvesson & Karreman, 2000). DP is inherently social constructionist in its epistemological orientation, and therefore rejects the notion

of a single ‘truth’ in relation to a concept, favouring instead the exploration of the various ways in which a concept can be constructed (Gillies, 1999).

Key to the DP approach is the assumption that language is action-oriented, in that it is active, constitutive and performative (Potter & Wetherell, 1987). Focused on the effects of language, DP is concerned with how language is used to perform a particular function or serve a particular interest within a given context. The context itself is also considered key, in that discourse rarely appears in isolation, but within a social or interactional setting. Individuals’ accounts are often made in relation to other possible alternative accounts, and are therefore constructed to manage the risks of them being undermined (Edwards, 1997). The ways in which accounts are constructed to manage a speaker’s stake and interest are considered key to analysis (Willig, 2008).

The epistemological position of DP, alongside the focus it takes on context, means that as an approach, it does not concern itself with broad patterns or discourses, but the discursive practices within the context in which they are (re)produced (Willig, 2008).

2.3.2 Foucauldian discourse analysis

Foucauldian discourse analysis (FDA) shares many similarities with DP in that it views language as action-oriented, functional and constitutive (Foucault, 1972). Both approaches are concerned with exploring how language constructs reality. However, where FDA differs from DP is in the scale of its focus. DP very much remains within the local context of the talk, and how in that particular context and situation, the talk functions. Alvesson and Karreman (2000) refer to this as a ‘micro-discourse approach’ (p.1133). In contrast, FDA is concerned with how language functions within a broader context, situating talk within its social and cultural context (Alvesson and Karreman, 2000).

FDA assumes that through language, meanings are constructed which are to an extent, durable and standardised (Parker, 1992). Referred to as ‘discourses’, these meanings are powerful in that they can both facilitate and limit available ways of talking within a given context (Willig, 2013). They also have the power to enable and restrict the possible ‘subject positions’ available to individuals

within a particular discourse, and therefore the possible roles that an individual is able to claim for themselves (Davies & Harre, 1990; Willig, 2008).

2.3.3 Combining approaches

By focusing on talk at a 'micro-level', it could be argued that DP neglects to examine the social and institutional practices that influence the discourses and positions available to speakers, potentially leading to a reductionist account (Parker, 1992). Likewise, by taking a broader approach, FDA could be criticised for neglecting the discursive and linguistic detail within accounts, for example how individuals utilise particular discursive strategies to manage accountability within their accounts (Alvesson & Karreman, 2000).

Arguably, the shortcomings of each approach do not render the two methods incompatible (Wetherell, 1998; Wilig, 2008). Indeed, Madill and Gough (Madill & Gough, 2008) argue that an eclectic approach combining both FDA and DP is necessary within the realm of critical psychology. Furthermore, Wetherell (1998) suggests that for a fuller analysis it is necessary to draw on FDA to consider talk at a 'macro-level', whilst utilising DP to recognise at a 'micro-level' the discursive practices employed by the speakers. An eclectic approach has been used successfully in previous research (Malson & Ussher, 1996; Wetherell & Edley, 1999) and indeed in relation to research exploring constructions of personality disorder terminology (O'Key, 2014). In terms of this research, combining approaches allows for the exploration of existing discourses, and culturally available ways about talking about constructs such as personality and mental distress, whilst allowing a focus also on how these are 'emergent and locally constructed' (Alvesson & Karreman, 2000, p.1134).

2.4 Methods

The following sections outline the details of the methods used in this study, including the decision to collect data through semi-structured interviews, the recruitment aims and procedure, the participant sample and materials used.

2.4.1 The use of interviews

There are various schools of thought within the field of discourse analysis when it comes to the use of interviews as a means of collecting data. Authors often distinguish between 'naturally occurring talk', defined by Potter (1997) as talk that is 'produced entirely independently of the actions of the researcher' (p.148), and the more 'contrived' and 'artificial' talk that has been 'got up' by the researcher, most commonly by means of interview questions. Although naturally occurring data is favoured by some (Potter & Hepburn, 2005), views on what constitutes such a phenomenon vary. Speer (2002) offers an overview of the debate, and urges caution when defining such terms as 'natural' and 'contrived' rigidly. Indeed many influential discursive studies have utilised data collected from interviews (Wetherell & Potter, 1992; Wooffitt, 1992), and are seen to have rich findings from such data.

Of course, 'naturally occurring' data in the context of this study would have given fascinating insight into clinicians' talk around emerging personality disorder. However there were many ethical and practical boundaries surrounding the collection of such data. Talk is reported to happen informally, 'behind closed doors', between colleagues and 'backstage' from formal forums such as meetings and case discussions (Baverstock and Wright, 2015; Koehne, 2012). Indeed, Koehne (2012) suggested that the presence of certain team members or professions in one particular CAMHS service prevented open discussion of such topics, pushing these conversations further 'backstage'. In light of these observations, it may have been that such natural instances of discourse could not be recorded. The contentious nature of the topic was also considered a barrier to data collection methods such as focus groups, as it was thought that participants might not have felt comfortable discussing the topic in such an open forum.

In light of this, interviews were considered to be the most practical method of collecting data. They were considered to provide participants with a safe and confidential space to discuss the topic of interest that was sensitive to the potential complexities and variation in the participants' accounts. However this data will not be viewed as a substitute for that collected in a naturally occurring

context, but seen as ‘a source of evidence about the constructional work on the part of the informant’ (Hammersley, 2003, p.120). Wetherell (2007) posits that there are repeated patterns of content, structure and function within people’s talk. The discursive interests, investments and socio-cultural conventions are arguably suggestive of collective conventions and shared knowledge (Hammersley, 2008). Therefore, it was suggested that within the frame of a semi-structured interview, the questions would elicit talk around ‘emerging personality disorder’ that is comparable with other occasions in which participants engaged in conversations about that same topic (e.g. during supervision, in informal case discussions).

2.4.1 Recruitment

The project was interested broadly in the use of personality disorder concepts in mental health services for adolescents. More specifically, I was interested in how the term ‘emerging personality disorder’ was talked about by professionals working with adolescents within CAMHs. I aimed therefore to recruit ‘CAMHs clinicians’ – a term commonly used within services to refer to members of staff from any professional background who work clinically with adolescents.

The research aimed to recruit clinicians from different professional backgrounds that typify the multidisciplinary teams (MDTs) within CAMHs services. The aim of recruiting from different professions was in order to capture a breadth of perspectives and explore the different positions and discourses available to clinicians. The inclusion criteria were kept broad and inclusive, to aid recruitment of a varied sample. Two key inclusion criteria were:

- Participant(s) must be currently working within the CAMHS service.
- Participant(s) must hold a role in which they have direct contact with service users.

Sample size in discursive research is not viewed as fundamental to the success of the study unlike some other methodologies. Indeed, it is argued that too large a sample size may render analysis unmanageable, as many linguistic patterns can be identified from a small piece of talk (Potter & Wetherell, 1987). Of greater concern is the depth of analysis carried out (Seymour-Smith, 2008).

Previous research using discursive approaches to explore professionals' constructions of mental health difficulties and diagnoses has used sample sizes of between five and fifteen participants (Harper, 1995; Madill, Gough, Lawton, & Stratton, 2005; Koehne et al., 2012; Lofgren, Hewitt & das Nair, 2015), so a sample size of ten clinicians was considered appropriate.

2.4.2 Recruitment procedure

Approaching potential participants

An email containing a short overview of the project was sent to potential participants using team mailing lists within the service, inviting them to respond if they were interested in taking part (see Appendix B). Attached to this email was a participant information sheet which contained further details about the aims of the research, what would be involved should they choose to participate and how the interview data would be used (see Appendix C). Those who responded to the email were then screened for their suitability for the project, and invited to arrange to meet with the primary researcher. Participants were given an opportunity to ask any questions about the research.

Sampling

A two-stage sampling strategy was devised to enable the recruitment of clinicians from different teams and professional backgrounds. Initially, information about the study was sent to all clinicians within the service, with those interested invited to contact the primary researcher for more information. To prevent this leading to a homogenous or limited sample, a maximum of two clinicians from any one profession or team were then invited to interview. It was planned that this would operate on a 'first come, first served' basis, in that participants would only be turned away should there already be two participants from their team or profession.

In practice, the purposive element to the sampling strategy was not required, as by chance, the clinicians who expressed an interest in taking part varied sufficiently in terms of their teams and professions.

2.4.3 Sample

Eleven clinicians initially agreed to take part in the research and arranged interviews with the primary researcher. On meeting with one participant, it became apparent that there had been a misunderstanding in previous communication, and they did not meet one of the recruitment criteria. Ten clinicians made up the final sample. The range of professional backgrounds and teams was considered sufficiently varied that the research was unlikely to highlight discourses unique to a single team or profession.

2.4.4 Interview preparation

On meeting with the primary researcher, participants were given the opportunity to read through the information sheet again, and to ask any questions. They were then given a consent form (Appendix C) which outlined key ethical information, including their right to withdraw from the study, the anonymity of their responses and the potential risks of participation. This was given to the participants to sign prior to the start of the interview, and was the only item containing personally identifiable information. The consent forms were then stored in a locked cabinet following the interviews. Finally, participants were reminded of the interview process and equipment being used to record the interviews.

2.4.5 Interview schedule

The interview schedule (Appendix D) was developed through supervision and a consideration, with existing literature in mind, of areas that may elicit talk relevant to the research question. It began with questions that aimed to gain background information about the participants (e.g. what their role was in the team they worked in). These questions served to situate the participant sample (Elliott, Fischer & Rennie, 1999) and build rapport. Following this, questions were intentionally kept broad and open in order to allow participants to introduce relevant topics and to an extent, guide the interview (Cameron, 2001).

2.4.6 Pilot interview

The interview schedule was piloted with one interview which was then transcribed and reviewed with one of the research supervisors. The primary aim of the pilot interview was to examine whether the schedule achieved its aim of eliciting talk relating to the research aims, but in addition it provided a valuable opportunity for feedback on my interviewing style. On reviewing the interview, it was agreed that the interview schedule was able to capture talk in a manner relevant to the aims of the research. However, there were times during the interview in which by not prompting or asking a follow up question, I enabled the participant to expand on detail that was not relevant to the research question and missed opportunities to explore specific points the participant had made. This led there to be large chunks of the transcript that were not relevant to the analysis. To enable a larger amount of the interview time to be spent talking about key topics, we discussed the use of prompts and follow up questions that would elicit talk relevant to the research, whilst minimising the extent to which I was closing down possible avenues of talk.

2.4.7 Transcription

There is some debate surrounding the level of transcription used in discourse analytic studies. Some retain a high level of detail as is used in conversation analysis (Potter & Hepburn, 2005), whilst others favour a lighter approach (e.g. Lofgren, Hewitt, & das Nair, 2015). In this study, the lighter approach was taken, and interviews were transcribed using a simplified form of Jeffersonian transcription notation (Rapley, 2007; Appendix F), which allowed for an adaption to the amount of detail required, without impacting on the clarity (Kitzinger & Frith, 2001; Willig, 2008).

I transcribed the pilot interview myself, which allowed me to engage in the process of transcribing and familiarise myself with the transcription conventions. Following this, the remaining nine interviews were outsourced to a transcription firm where they were transcribed verbatim. On return of the transcripts, I took time to familiarise myself with the interviews, listening to them while reading the transcripts and adding in the additional transcription detail. The process of transcription was viewed as part of the analytic process, as it is argued that the

transcriptions themselves are inherently selective and interpretative due to the researcher choosing what aspects to highlight and what features to note down (Edwards, 2007).

2.4.8 Analytic process

The focus of the analysis was on the language used by clinicians when talking about the topic of 'emerging personality disorder' in adolescence. Specifically, the aims were to consider the varied ways in which clinicians organised their talk, the varied constructions of 'emerging personality disorder' and the discourses and discursive strategies they drew upon within their accounts (Horton-Salway, 2001). A list of questions was drawn up prior to the analysis stage in order to inform reading of the data (see Appendix G). The guidelines for conducting the analysis were informed by Potter and Wetherell (1987) and Parker (1992) and the following stages describe the process undertaken in further detail:

> **Stage 1:** Following each interview, the transcripts were read and re-read while listening to the interview recording. The aim of this was to gain familiarity with the data and to add further detail to the verbatim transcriptions. During this, broad patterns and themes in the talk that were related to the research question were noted down.
>
> **Stage 2:** Sections of each transcript that were felt to be relevant to the research question were highlighted, and these sections formed the 'data corpus'. At this stage, any relevant data was included to ensure valuable extracts were not lost this early in the analytic process. The data corpus was read and re-read, the reading guided by the list of questions (Appendix G). At this point, patterns across the data and both similarities and differences within clinicians' talk were drawn out and sections of data relating to these patterns were collected together into data files. These formed the initial discursive themes. If one extract appeared relevant to more than one theme, it was copied to both data files to again ensure relevant data was not excluded.

Stage 3: These data files were then the main focus of further analysis. Attention was given to each in turn as well as the pattern of themes as a whole. These were also mapped out visually to aid consideration of the links between the different themes. During this process some themes were considered very closely linked and were subsequently combined whilst others were omitted due to them being redundant to the aims of the research.

Stage 4: From each theme, extracts were chosen that were thought to best illustrate that particular theme. The themes were organised and structured into a draft analysis section in a way that would guide the reader through a coherent narrative.

2.4.9 Ethical considerations

A number of codes of ethical practice were drawn upon throughout the design and execution of the research. The British Psychological Society 'Code of Human Research Ethics' guidelines (BPS, 2014) were adhered to, alongside the UK Policy Framework for Health and Social Care Research (Health and Research Authority, 2017) and the Health and Care Professions Council (HCPC) 'Standards of Conduct, Performance and Ethics' (HCPC, 2016). The study was not thought to cause harm to participants, and care was taken to ensure they were informed as to what their participation would involve through the information sheet (see Appendix C). Participants were able to withdraw at any time prior to or during the interview, and withdraw their data from the study without giving a reason for up to one week following the interview. They were made aware of this in the information sheet and consent form, paper copies of which were provided again at the start of the interview (see Appendix C). No participants requested their data to be withdrawn.

Care has been taken to ensure the anonymity of participants. The transcriber signed a confidentiality agreement (see Appendix E) binding them by the terms of agreement in addition to the Data Protection Act (1998)[16]. Transcripts were anonymised by allocating each participant a number, and removing any

[16] At the time of data collection, this was the most up to date version of the Data Protection Act.

identifiable information (e.g. names and places of work). Records that included names (e.g. consent forms) were stored in a lockable file case only accessible by the primary researcher. In line with the University of Nottingham Code of Research Conduct and Research Ethics, study documents will be held for seven years before being destroyed.

2.4.10 Quality

As mentioned previously, the traditional measures of validity and reliability are considered contradictory to the epistemological assumptions of the present study. Subsequently these established standards are unable to be used to evaluate the quality of the research. Various frameworks for evaluating qualitative research have been developed (Willig, 2008) with no one particular unified approach. This perhaps relates to the diverse qualitative methodologies, and the need to take into account the particular aims and epistemological underpinnings of each piece of research.

For the purposes of assessing the quality of this research, a number of key markers of quality were considered, guided by the work of Madill, Jordan & Shirley (2000).

Internal coherence

Coherence was not considered in relation to the individual clinicians' accounts of emerging personality disorder, as it would be expected that as socially constructed accounts these may be diverse and unique to the individual and context. However internal coherence relates to the way in which the analysis is presented, and to what extent it 'hangs together' (Madill et al., 2000; p.13). Care was taken to present a coherent narrative through the analysis section of the paper. The claims made were embedded in the extracts of data provided and the process of reaching the analytic conclusions was described in detail.

Deviant case analysis

Deviant case analysis refers to the seeking out of material which challenges the analytical claims or theory (Potter & Hepburn, 2005). Analysis should explain both the typical and atypical or exceptions to the rule, and it is argued that analysing deviant cases demonstrates the coherence of the study (Potter &

Wetherell, 1987). It was hoped that recruiting clinicians with varying professional backgrounds and roles would enable variety in accounts, and encourage possible contradictory accounts that would enable testing and qualifying of the analysis presented. I considered writing a separate 'deviant case analysis' section, however chose instead to incorporate the varied accounts presented by clinicians into the various themes of the analysis. I felt that this would allow for a more coherent reading of the analysis, and integrate contradictory accounts as opposed to offering them as an afterthought. This was particularly key in considering the alternative ways that clinicians talked about the same difficulties, and the similarities and differences between these accounts.

Openness of the analysis to reader evaluation

A key question posed by Madill et al. (2000) in relation to this particular criterion is 'has the study contributed to the readers' understanding of the phenomenon?' (p.13). Although readers are likely to differ in their opinion and level of agreement with the findings it is essential that the analysis is transparent and open, to allow readers to develop their own interpretations. The process of analysis has been explained in detail to provide the reader with an account of how the presented findings were grounded in the data. Furthermore, extracts were included in the text, integrated into each discussion point with the aim of demonstrating a clear link between the analytic claims and the data.

Reflexivity was also considered key throughout the writing of this paper. I did not attempt to 'neutralise' my own stance, but instead put forward my own epistemology, assumptions and biases for the reader to evaluate for themselves. The inclusion of a reflexive section also allowed me to openly discuss the ways in which my perspective may have impacted on the analytic process, and I have taken care to integrate various decision making processes throughout the paper. As recommended by Hayes and Oppenheim (1997), an audit trail was kept throughout the research process, intended to aid transparency and account for the decisions made.

Part Three: Extended analysis

3:1 Section introduction

The aim of this section is to outline some of the constructions and resources clinicians used in talking about 'emerging personality disorder'. These are not intended to provide an exhaustive list of the constructions and positions available to clinicians but are presented as salient themes within the data. In line with the constructionist epistemology on which this discourse analysis rests, this analysis is not presented as the only possible reading of the data. Another researcher may well produce a different analysis of the same data, and likewise, if I were to approach the data again, I may see different themes within the data.

The analysis is split into two sections which characterise clinicians' talk in different ways:

Section 3.2: This section explores key themes in how clinicians negotiate talk around 'emerging personality disorder', and the tensions evident in their accounts. These themes are in addition to those presented in the journal paper, and offer some further context to clinicians' talk.

Section 3.3: This section expands on parts of the analysis presented in the journal paper, with specific reference to how clinicians constructed a 'need to name' adolescents' difficulties, and how they constructed alternatives to 'emerging personality disorder'.

3.2: Tensions in clinicians' talk

This section explores the ways in which clinicians negotiated the tensions around talking about personality disorders in adolescence. It provides an overview of the cautious nature of clinicians' talk and the conflicting constructions of 'emerging personality disorder'. These were both salient features of clinicians' talk throughout the interviews, something that was striking from an analytic perspective.

A cautious basis for talk around personality disorders

Throughout the interviews, talk around personality disorder in adolescence was negotiated with obvious caution, evident both in the content and features of clinicians' talk. Although in light of the contentious nature of the topic, this was to an extent expected, the degree to which caution permeated the accounts of all clinicians was striking.

Many clinicians spoke directly about the need for 'care' and 'caution' in using personality disorder terminology in relation to their work, and often stated their reluctance to use such language early in the interview discussions:

Extract 14:

> **C1**: '*and I'm very careful about personality disorder language. I'm more careful with PD (0.2) language than I am with say (0.4) kind of anxiety or low mood. Very cautious with that really.'*
>
> **I:** *So it sounds like there's a decision about what language you use in different situations?*
>
> **C1:** *Yes*
>
> **I:** *And particularly so with certain diagnostic categories (.) more (.) more so than others?*
>
> **C1:** *Yeah definitely. Definitely. You know (.) you're right as well, not just PD I guess (.) bipolar and the more serious kind of (.) when people start talking about children in those terms, I'm very careful about how I manage that narrative and that dialogue.*

Here, the clinician draws a contrast between different psychiatric diagnoses, constructing personality disorder as a *'more serious kind of'* disorder. Categorising diagnoses in such a way allows the clinician to construct a need for greater caution around personality disorder language than might be required for comparatively 'less serious' disorders (e.g. anxiety). The emphasis on '*children'* serves to draw the listener's attention to what is being constructed as a further justification for exercising caution.

This reluctance was also evident in the tentativeness within clinicians' talk. Many employed the use of 'hedges', a semantic strategy used to modify the degree of membership with a statement (Brown & Levinson, 1987). Clinicians frequently used hedges such as '*traits of*', '*sort of*' and '*so-called'* to preface the term 'emerging personality disorder' and other personality disorder terminology, perhaps to soften or lessen its impact, and to signal uncertainty in relation to the 'truth' of the concept (Prince, 1985). Interestingly, although many of the clinicians shed doubt on the use of diagnostic categories and labels more broadly, hedges rarely preceded other diagnostic terms during the interviews, appearing solely in relation to personality disorder terminology.

The need for caution expressed by clinicians was further emphasised through contrasting descriptions of other clinicians using the term 'emerging personality disorder' in a more careless manner. Others were described as '*banging a label on*' (C4), '*throwing it out there'* (C5) and saying '*oh he's PD, she's PD'* (C3), descriptions which constructed others as somewhat reckless and lacking in thought. The use of extreme case examples depicts an opposite extreme to the way in which they approached talk around personality disorders, then allowing clinicians to distance themselves from this position, and strengthen their argument for caution (Pomerantz, 1986). Potter and Wetherell (1987) described how such rhetorical devices can be used to undermine alternative descriptions that may pose a threat to their position or argument. It is also common for such strategies to be used when there is a particularly sensitive or contentious issue (Horton-Salway, 2001).

Conflicting constructions of 'emerging personality disorder'

'Emerging personality disorder' was constructed by clinicians in varying ways, both within and between accounts. This variation highlighted the range of meanings accessible to clinicians, but also demonstrated a degree of uncertainty surrounding 'emerging personality disorder' as a concept.

Most often, it was talked about as a label or description, as opposed to an objective entity, and clinicians alluded to a social constructionist ideology:

Extracts 15, 16 & 17

> **C1**: '*…so it's more of the challenging kids I think who are (0.4) who are given that label'*
>
> **C2**: '*I think that the emerging personality disorder phrase (0.4) has not been used more than (0.2) four or five times (.) with patients who (0.2) who've been on my caseload.'*
>
> **C5**: '*I've always struggled with it as a (0.2) description'*

By referring to it as a 'label', 'phrase' or 'description', clinicians were able to distance themselves from constructions of it as an observable, measurable entity. In doing so, this afforded them the option of opting in or out of its use, or indeed using it within different contexts for different purposes. Again, this framed the use of 'emerging personality disorder' as a *choice* and positioned clinicians as powerful individuals, responsible for making decisions that impacted on their clients.

In contrast, although clinicians tended not to describe 'emerging personality disorder' explicitly as a 'real thing', many drew on diagnostic discourses in constructing their accounts, and used concepts aligned with a disease model of mental health. For example many made reference to 'symptoms' and 'traits' of emerging personality disorder, and likened these to the diagnostic criteria for personality disorders. This highlighted the impact of existing powerful discourses such as psychiatry, and demonstrates how these are maintained within local contexts, and reproduced within individuals' talk (Hall, 2001).

Often, there was a tension in clinicians' accounts between the different constructions, as they shifted from talking about it as a 'label' or 'description' to listing symptoms or features of the 'disorder'. The subtlety of these shifts can be observed in the following extract:

Extract 18:

> ***I****: what are your thoughts about it [personality disorder] in the context of younger people?*

***C2**: Well we tend only to use the term <u>emerging</u> personality disorder, it's (.) certainly in the teams that I work in u::::um*

***I**: What's meant by that do you think?*

***C2**: It means (.) u::m (0.4) looks a bit like it might turn into*

***I**: Okay*

***C2**: ((laughs))*

***C2**: The symptom clusters are really similar to the symptoms clusters as if this person was twenty-three and they walked into this room (0.2) we'd have said >>personality disorder<<.*

Here the clinician begins by referring to 'emerging personality disorder' as a '*term'* that is '*used'* by clinicians. This invokes the assumption of 'emerging personality disorder' as a linguistic tool or phrase that clinicians may employ in their work. It also alludes to an element of choice in its use. However they then go on to conceptualise the same construct through talking about '*symptom clusters'*, a phrase associated with psychiatric and diagnostic discourses, and one that invokes an assumption that 'emerging personality disorder' is an underlying disorder that has observable and measurable symptoms. The shift between social constructionist and realist constructions allows the clinician a degree of space in their account to manoeuvre between different constructions of 'emerging personality disorder' depending on what they want to achieve.

Noteworthy within this particular extract is how the speaker uses 'we' in response to the interviewer asking 'what are *your* thoughts?'. This 'joint production' was a feature common to clinicians' accounts, in particular in response to this question. By using 'we' as opposed to 'I', the speaker here successfully avoids giving their individual view. It may also be that through presenting an account as jointly produced, they manage the risk of their individual views being discredited by the interviewer (Horton-Salway, 2001). This particular discursive strategy is termed 'stake-innoculation' (Potter, 1996).

3.3: Constructing 'emerging personality disorder' as useful or otherwise

This section serves as an extension of the analysis presented in the journal paper. Firstly, how clinicians construct a 'need to name' adolescents' difficulties will be further explored, and how clinicians negotiate the dilemma between 'emerging personality disorder' being potentially useful, and of it being inherently stigmatising. Secondly, a discussion of the various discourses that staff constructed as *alternatives* to using 'emerging personality disorder' is presented.

A need to put a name to the difficulties

This section further explores the conflict presented in clinicians' accounts between constructions of personality disorder diagnoses as inherently stigmatising, and a need to talk about and put a name to the difficulties that adolescents presented with. Commonly, clinicians constructed the transition to Adult Mental Health services as the key rationale for putting a name to these difficulties, doing so by framing diagnostic language as a common language between professionals:

Extract 21:

> **C1:** *But we <u>need</u> to recognise kind of what the issues <u>are</u>, what we commonly call them in this (.) in this (.) in that instance like in seven months time or something, you know. Um (0.2) so maybe it's borne out of <u>necessity</u> and it might also be qualified criteria of course as well so to get into Adult Services, I would imagine the thresholds are quite high….*
>
> ***I:*** *Hm*
>
> ***C1:*** *Um (.) so if you can go in and say 'I have emerging personality disorder' it might be a lot more effective in terms of accessing help than saying 'I really struggle with my inter-personal relationships', those types of things really. Or I struggle with self-harm, all those types of ideas …*

Here the clinician constructs and negotiates the aforementioned dilemma: having previously advocated against the use of personality disorder diagnoses with adolescents, they then construct an opposing need to name the difficulties faced by the adolescent. Here, this need is talked about as a '*necessity'* and

framed within the context of the transition between services and a need to consider *'what we commonly call'* the key issues. Framing this as a necessity positions the clinician as lacking in personal agency, constrained by the restricted options available to them, and thus positions the decision to use diagnostic language as outside of their control or influence. For this clinician, this is an effective way of managing stake and accountability within that interaction.

The clinician then goes on to construct 'emerging personality disorder' as part of a common language between professionals that is more effective in eliciting help than a description of the key difficulties faced by the adolescent. This comparison works to construct 'emerging personality disorder' as a useful tool for clinicians within the specific context of entering a new service. Although not discussed directly, throughout this account and others, the clinician alludes to a difference in language between child and adult services, and the need for clinicians to bridge the gap between these around the transition.

Whilst Clinician 1 constructed a need to name adolescents' difficulties through highlighting the benefits of doing so, another clinician drew on the dangers of *not* naming them to build up a similar construction:

Extract 22:

> **C3:** *We had some feedback from someone who (.) um (.) had turned eighteen. Quite some time after they turned eighteen they'd been diagnosed with a personality disorder (.) um (.) and they actually were quite unhappy that the (.) the idea of personality disorder had never been raised while they were in CAMHS and they actually said (.) you know (.) 'I've been in CAMHS for like several years (.) um (.) and all that time really struggled to understand what was going on for me, what was wrong with me' (.) um (0.2) and no-one had explored any explanations with them.*

In the above extract, Clinician 3 makes use of an extreme case example to highlight the dangers of *not* naming an adolescent's difficulties, and not talking about personality disorder. By emphasising that the adolescent was '*quite unhappy'* that personality disorder had not been talked about in CAMHS, the

clinician draws attention to their emotive response. Presenting the views of the adolescent in this way strengthens the clinician's argument as they draw on a representative of the people at the very heart of clinicians' conflict. This is also an example of active voicing, a rhetorical device aid to increase the perceived factuality of an account (Wooffitt, 1992). By quoting their adolescent client, the clinician's account appears more convincing than if they had merely made their point in their own words.

In both of these examples, the discursive strategies employed by clinicians may serve to manage issues of personal accountability (Horton-Salway, 2001). Underlying each of the accounts is an alternative construction of 'emerging personality disorder' as helpful, which for these clinicians conflicts with the discourses drawn upon in other areas of their interviews. By justifying the use of 'emerging personality disorder' by constructing a 'need' to name the difficulties, whether due to service expectations, or client feedback, the clinicians effectively reduce the discomfort they may experience in association with the alternative construction. They also inoculate themselves against potential accusations of not fulfilling their roles as 'moral guardians' (Potter, 1996).

Searching for an alternative – emotional dysregulation

Whilst some clinicians explored the potential uses for 'emerging personality disorder' within their clinical work, others resisted any personality disorder language altogether, and constructed alternative explanations for the adolescent's difficulties. In the journal paper, examples of how clinicians constructed these alternatives are given, and the following discussion highlights further ways in which clinicians presented alternatives.

Several clinicians presented a preference for descriptive accounts of adolescents' difficulties, in which they named the key behaviours or features of their experiences. 'Emotional dysregulation' was presented within several accounts as an alternative way of talking about the same difficulties, whilst avoiding personality disorder terminology:

Extract 23:

I: *Hm. Okay, and that's a phrase* [emerging personality disorder] *that is used within the teams from what you've been saying (0.2) do you use that kind of term?*

C8: *We tend to use (.) um (.) emotional dysregulation*

I: *Hm*

C8: *And I think we <<prefer that>>*

I: *Okay*

C8: *because that's more of a (0.2) the <u>turmoil</u> that the adolescent's experiencing that sits better with me <<rather than>> the emerging personality side of things (.) although I know that term's interchangeable for people.*

I: *Okay. So sometimes those two terms are used to mean the same thing?*

C8: *You see that in letters as well*

I: *Okay*

C8: *(.) they'll (.) they'll start off saying emergency (.) emerging personality disorder and then it's dysregulation of emotion (.) so it (.) and the two follow each other. do you know what I mean?*

I: *Yeah. And why do you think it is? Or why is it that you maybe prefer (.) um (.) emotional dysregulation?*

C8: *'Cos it says how it is for the adolescent*

I: *Okay*

C8: *you know (0.2) the professional label bit doesn't always sit (.) sit <u>well</u> with me. It's about need again. What do they want? What do they need support with?*

Here, Clinician 8 constructs 'emotional dysregulation' as a preferable alternative to 'emerging personality disorder'. Interestingly, the two are presented as equal and '*interchangeable'* in their meaning, suggesting that clinicians choose to use an alternative not based on a difference in opinion about the presenting difficulties, but on the language used to describe them. Emotional dysregulation is then constructed as a more *descriptive* alternative that is perhaps more representative of the adolescent's experiences: '*it says how it is for the adolescent'.* In stating '*the professional label bit doesn't always sit well with*

me', 'emotional dysregulation' is also constructed as a less formal, and perhaps a more 'common sense' understanding of an adolescent's difficulties. Through the use of rhetorical questions such as '*what do they want?', 'what do they need support with?',* the clinician is positioned as reflective and considerate of the needs of the adolescents.

In other accounts however, the use of 'emotional dysregulation' in place of 'emerging personality disorder' was constructed as reason for caution around using the phrase:

Extract 24:

> ***C5:*** *I mean I used to historically use emotional dysregulation. I'm really mindful now that it actually means something different to other people…*
>
> ***I:*** *Hm*
>
> ***C5:*** *and it's actually used frequently instead of emerging PD*
>
> ***I:*** *Okay. So that's a phrase that's become….*
>
> ***C5:*** *Yeah*
>
> ***I:*** *sort of associated*
>
> ***C5:*** *they say 'they're emotionally dysregulated' and you can hear by the tone {laughs} that they're (.) and you're thinking (.) well that used to be just a description.*
>
> ***I:*** *Okay. So actually the meaning that's attached to that phrase has sort of changed over time?*
>
> ***C5*** *And … and I was drawn to it because a colleague of mine said 'Oh, I don't really like to use that phrase anymore' because it has the connotation (.) it's used in the same conversations as (.) um (.) emerging PD.*

In the above extract, the clinician describes a shift in their perspective on and use of the phrase 'emotional dysregulation': '*I used to historically use emotional dysregulation'.* They attribute this shift to the changing use of the phrase, and its association by other clinicians with 'emerging personality disorder'. The phrase '*that used to be just a description'* suggests that 'emotional dysregulation' is now *more* than a description and has taken on new meaning. Its association

with ‘emerging personality disorder’ is constructed as reason to execute caution around the use of ‘emotional dysregulation’. This is an interesting account, in that it paints a picture to the listener of a contagion within the language used. For some clinicians, resistance to personality disorder diagnoses with this age group not only extends to ‘emerging personality disorder’, but to a description or phrase that has become synonymous with it.

It was common for clinicians to draw on behavioural descriptors throughout the interviews. In addition to emotional dysregulation, clinicians often cited self-harm, aggression and impulsive behaviour as key difficulties faced by adolescents. Providing a descriptive account as opposed to a diagnostic label was put forward by several clinicians as preferable and more appropriate for their adolescent clients. It may be that behavioural descriptions are viewed as more temporary and transient, allowing room for change.

Attachment as an explanation for distress

Several clinicians presented adolescents’ distress as a consequence of difficulties in early relationships, drawing on discourses of attachment. For some these accounts served to explain the behaviours conceptualised as ‘emerging personality disorder’, and for other provided an alternative framework to the use of diagnostic terminology. In the extract below, Clinician 6 constructs ‘emerging personality disorder’ as a product of an individual’s early experiences in relationships. The section of talk selected follows a discussion about the different diagnostic terms used within the service:

Extract 25:

C6: *Um (.) I wonder if they do feel different to each other actually (.) um (.) and whether there’s more acceptance of using depression or OCD (.) um (.) but there’s something about emerging personality disorder. I don’t know if that’s a personal thing for me though*

I: *Okay*

C6: *Yeah. Um (.) so I think if somebody's talking about emerging personality disorder then I would prefer to think about (.) well I would talk about what that means; I might talk about attachment?, I might talk about their experiences and (.) um (.) yeah, the sort of personal history (.) um (.) and how safe they've been in relationships and how responsive close adults have been to their needs. And I think as a system, potentially we sometimes feed into that if we have an individual formulation and an individual approach to therapeutic work (.) um (.) then that can reinforce the idea that actually these problems lie within the child and I think then that can persist (.) um (.) and sometimes we do >>lots and lots<< of therapeutic work to build a child's resources, but actually if (.) um (.) there's still (0.2) I don't know, maybe emotionally abusive or invalidating environments, then (.) um (.) they continue to present with very similar difficulties in terms of relationships and emotional regulation.*

Here, the clinician builds up a construction of the difficulties associated with 'emerging personality disorder' as environmental, and associated with past relationship experiences. A lack of safety and responsiveness from caregivers is constructed as key in the development of current difficulties with relationships and emotional regulation. This particular construction positions adolescents as victims, damaged by these experiences, and shifts responsibility for behaviours away from the adolescent themselves. This position however also offers little in the way of agency for the adolescent, as the victim position is often associated with other stigmatising attributes (e.g. weakness). This is further emphasised through the use of a case example (Pomerantz, 1986) in which treatment is constructed as futile if completed without changes being made to the environment and harmful relationships.

In the following extract, a range of difficulties within relationships are attributed to an adolescent's past experiences, with '*a very troubled upbringing'* being held to account for the current 'chaos' that the young person presents with. Here, blame is attributed to the adolescent's early relationships through *'a lack of*

attachment' being constructed as having a direct impact on current '*risky'* behaviour:

Extract 26:

I: *Yeah. Okay. And what sort of (.) sort of difficulties tend to lead to that phrase to be used?*

C7: *Yeah. Well I'm just thinking of one that I'm working with currently and she's <<just very chaotic>> (.) um (.) she's had a very troubled upbringing. There was a real lack of attachment with her and her mum (.) um (.) so her behaviour is very risky. She's pushing and pulling with her friendships; they don't (.) she doesn't maintain friendships. She doesn't maintain her family relationships very well (.) um (.) there's a lot of sexualised behaviour (.) um (.) just (.) just very hard to work with actually – the young person. She can be absolutely fantastic one minute and then the next minute she (.) she's just so chaotic that you (.) you just can't have a conversation with her. A lot of self-harm. So it's those kind of things that people go 'Well, there's a lot of emerging PD traits'.*

Within some accounts, attachment based explanations were constructed as more helpful for the adolescent than the use of the 'emerging personality disorder' label:

Extract 27:

I: *And are there times when that language* [emerging personality disorder] *is used with the young person? or with their family, that you've come across?*

C5: *Um (.) well I've had young people who've come with the diagnosis so (.) I've been working with them and will say 'what do you understand about that?'. They really struggle.*

I: *Okay*

C5: *So they haven't had any formulation around early attachment. They haven't any kind of understanding of relational issues o:::or*

in terms of <u>experiences</u> that have been helpful and unhelpful and how they have shaped how they (.) um (.) self-soothe or regulate their own emotions. Yes, they've <<<u>really struggled>></u>.

Again in this extract, the clinician constructs the difficulties associated with 'emerging personality disorder' as a result of past relational experiences. Such experiences are constructed as powerful in shaping how adolescents cope with challenging emotions. Within this extract, the clinician also argues that a 'diagnosis' of 'emerging personality disorder' falls short of facilitating understanding for the adolescent, emphasised through the repetition of '*they really struggle'.* Although not said directly, a formulation based approach is constructed as more useful for the adolescents' understanding of their own experiences.

'Emerging personality disorder' – a label for complexity

Within their accounts, several clinicians constructed 'emerging personality disorder' as a label that is used for individuals whose presentation is complex, and puzzling to professionals. Within this, clinicians emphasised the presence of *multiple* problems, and the resistance of those problems to the usual treatments offered within the service. This discourse was powerful in the way in which it positioned clinicians and clients alike:

Extract 25:

I *Hm. So you were saying that emerging personality disorder tends to be what's {used more within the team}*

C2 *{That's (0.2) that's} (.)yeah.*

I *What (.) what kind of context is that normally used in, that phrase?*

C2 *Um (.) where there are <<<u>multiple problems>></u> (0.2) u:::um (.) so where you could (.) you could have u:::um (0.2) somebody could end up with (0.1) with a (.) a sort of portmanteau o:::of <<different diagnosis>> (.) um (0.2) or (.) or, you know, comorbidity affecting their life (.) um (.) and that can therefore um (0.2) for example with people who (0.2) u:::um have an inclination um (.) to (.) um (0.3) to*

depression, people that ha::ave an inclination to (.) um (.) being socially isolated who don't have .hhh a neuro developmental disorder like ASD (.) um (.) and who (0.3) can (.) can actually not respond to various treatments to the degree that (.) that they look stuck (.) um it might be thought of as an >>emerging personality disorder<<.

There are several aspects to this account that serve to construct 'emerging personality disorder' as a way of labelling complexity. Firstly, the clinician introduces the presence of *'multiple problems',* both through the emphasis on this phrase, and the examples framed as a *'portmanteau of different diagnoses'*. They then list various different presenting difficulties, repeating the message of there being '*multiple problems'* for the adolescent. Lists are a commonly used discursive device that capture attention and typically convey generality (Jefferson, 1990). In making use of a three part list, *'being socially isolated, 'who don't have a neurodevelopmental disorder like ASD'* and *'who can actually not respond to various treatments'*, the clinician is able to build a persuasive account of the complexity associated with 'emerging personality disorder'. By positioning 'emerging personality disorder' at the end of a list of alternatives that have already been explored, the clinician also alludes to 'emerging personality disorder' as a last resort for clinicians when faced with complexity.

Likewise, in the extract below, complexity is emphasised through descriptions of adolescents who present a challenge to clinicians:

Extract 26:

I: *And what sort of context is that used in? When have you come across it?* [emerging personality disorder]

C3 *I mean (.) I (.) I think that (.) um it's frequently used about adolescents who are very difficult to work with and are not responding well to therapy (.) um and you know (0.2) and I'm not saying that doesn't have validity, but I think that it, it's (.) it's very comfortable, isn't it, when you're struggling with complexity to have a nice, neat package to parcel something up with and say 'Oh well, I can't deal with that because it's this'*

Here, the use of 'emerging personality disorder' is again constructed as a label for this complexity, but as seen in other accounts, doubt is cast on its validity, with the clinician arguing that such a label may be used to excuse or justify the difficulties faced by clinicians working with the array of difficulties the young person presents with. In constructing this particular account, the clinician makes use of a disclaimer: *'I'm not saying that it doesn't have validity but..'* in which they deny that they are questioning the validity of the construct, but are about to say something that could be heard as such (Billig et al., 1988). This is another example of how clinicians managed issues of accountability within their accounts, and employed discursive strategies to manage their positions within the discourses they constructed.

Clinician 1 also constructs 'misuse' of 'emerging personality disorder', and the use of the term as a label for complexity:

Extract 27:

I: *What do you make of the use of personality disorder diagnoses with young people?*

C1: *With <u>young</u> people?*

I: *Yes, with young people*

C1: *Okay. You might have to drag me back on this one if I go off ((laughs))*

I: *((laughs))*

C1: *(0.8) ((Sighs)). I think it can be misused (.) um (0.2) ok how can it be misused? I think sometimes it can be misused (.) I need to think really carefully how I phrase things (.) I've known some clinicians misuse it.*

I: *Okay*

C1: *I think sometimes it's been misused when a (.) when they have <u>struggled</u> to work alongside an individual child if you like and (.)*

> *I've heard some colleagues say things like 'oh that's definitely an emerging personality disorder' where if you unpick it there's a lot more behind it if you like (.) um (.) so that's one worry for emerging personality disorder is that people misuse it and I think it's also used very colloquially really, because of course there's about eight or nine different types of PD, but I think people speak very broadly when they say an emerging PD, what does that mean? What type of PD are people talking about? Um (0.2) so yeah (.) I think it can be misused.*

In the above extract, the clinician again depicts an account of 'emerging personality disorder' being used to label complexity. Here the complexity is alluded to through the notion of a clinician having '*struggled'* to work with an adolescent. The notion of there being '*a lot more behind'* a label of 'emerging personality disorder' implies that the phrase may simplify, minimise or perhaps mask the complexities of the adolescent's difficulties, and that clinicians may use this particular conceptualisation of the difficulties to explain or justify their struggles. Once again, this particular account is presented through a case example, and reference to how 'other clinicians' negotiate and make use of 'emerging personality disorder'.

In presenting accounts of 'emerging personality disorder' as a label for complexity, clinicians manage their own stake and accountability in a number of ways. Most striking is their use of the passive voice in constructing their accounts. Phrases such as '*it might be thought of as' (*Extract 25*);* '*it's frequently used about'* (Extract 26) and '*I think it can be misused'* (Extract 27) appear to serve the rhetorical function of shifting attention away from the speaker and their own actions, and towards the actions of others (in this instance, other clinicians). The use of the passive voice has been argued to help portray accounts as objective and credible (Hobbs, 2003), and in these accounts allows clinicians to present a particular construction of 'emerging personality disorder' whilst distancing themselves from these constructions, instead presenting them as observations of practice within their teams.

Part Four: Extended general discussion

4.1 Summary of analysis

This study was primarily concerned with how clinicians working in CAMHS talked about 'emerging personality disorder', and how they construct this particular concept in the context of their work with adolescents. The findings suggest that clinicians drew on a number of discourses in order to construct their accounts, and 'emerging personality disorder' was conceptualised in various ways.

Key to constructions of 'emerging personality disorder' were broader discourses surrounding the use of personality disorder diagnoses within mental health services. Some of the tensions within clinicians' accounts as to 'what personality disorder is' are not necessarily unique to the particular adolescent population, but perhaps reflective of wider tensions and variability amongst conceptualisations of a contested construct. Accounts alluding to personality disorder as *lifelong,* for example, could be viewed in the context of historical understandings of personality disorders as untreatable (NIMHE, 2003). Likewise, tensions within accounts as to the nature of the 'emerging personality disorder' construct were reflective of those identified in previous research exploring clinicians' discourses of BPD. O'Key (2014) highlighted tension within accounts of staff on an inpatient mental health unit around BPD as a construct, with their conceptualisations varying between BPD as a social construct and BPD as an underlying disorder. Here, the varied constructions of 'emerging personality disorder' and the conflict both within and between clinicians' accounts as to the object status of 'emerging personality disorder' reflect similarities to these previous findings.

In line with previous discursive research, clinicians employed a range of rhetorical devices to negotiate tension within their accounts and manage their professional accountability. Personality disorder terminology was approached with caution, and clinicians made use of hedges to remain tentative in their accounts. Often positioned as 'moral guardians', with a responsibility for protecting adolescents, clinicians employed a range of devices to distance themselves from alternative positions and protect their accounts from potential

criticism. When discussing potentially contentious subjects, stake inoculation was useful in shifting accountability away from the clinicians, enabling them to remain in the position of a reflective and considerate practitioner. Finally, clinicians made use of extreme case examples and contrasts to present their accounts as factual. The use of such discursive strategies is consistent with previous discursive research, and suggests that regardless of the topic of conversation, clinicians rely on particular rhetorical devices to 'get things done' in their talk. In the past, research has outlined how clinicians make use of discursive strategies to manage threats to the credibility of their argument (Harper, 1995; 1999b), negotiate dilemmas in their talk (Lofgren, Hewitt & das Nair, 2015; Stone, 2014), and manage their accountability (Robertson, Paterson, Lauder, Fenton & Gavin, 2010). Goodman (2008) argues that whilst findings from discursive research are limited in terms of their generalisability, the use of discursive devices and the rhetorical effects achieved by these can be generalised across interactional settings. Indeed, the findings from this research contribute to the growing discursive literature and add further examples of the ways in which professionals make use of discursive devices within their talk.

4.2 Stigma

Clinicians oriented to constructions of personality disorder diagnoses as inherently stigmatising and expressed concern for the consequences of a diagnosis on the adolescent's sense of self. The association between pathology and self-concept (personality) has been argued to be key in understanding why personality disorder as a concept is viewed as so stigmatising (NIMHE, 2003). Personality as a construct has become a primary way in which we understand ourselves and others (Stainton-Rogers et al., 1995), with ideas such as personality traits now part of a dominant discourse, embedded in society and in institutional practices (Harper, 1995). It has been argued that in this respect, giving an individual a diagnosis of personality disorder is therefore a judgement of their character (Bourne, 2011). Here, clinicians' accounts were reflective of these arguments. Clinicians emphasised both the permanency associated with

personality traits and indeed, a diagnosis of personality disorder, emphasising concern for the adolescents' self-concept throughout.

The link constructed by clinicians between receiving a personality disorder label and individuals' self-concept is consistent with certain theoretical models of self-stigma. Link (2001) proposes that being linked to stereotypes and 'labelled' (for example through psychiatric diagnosis) may impact on an individual's self-esteem and self-efficacy through key stereotypes and attributes becoming personally relevant. Here, clinicians constructed discourses of concern around assumptions of personality disorder diagnoses as inherently stigmatising, and suggested that the label itself was sufficient to impact negatively on an adolescent's self-concept.

Clinicians' preference for behavioural descriptions as alternatives to 'emerging personality disorder' could be seen as a preference for those descriptions that do not label the adolescent as a whole, but an aspect of their experience or behaviour. A common sense understanding of behaviour suggests it is temporary and changeable, which contrasts with that of personality, which is viewed as fixed. Making use of these descriptions may have allowed clinicians room to manoeuvre around the threat of stigma and manage the conflict within their accounts between protecting the adolescent and putting a name to their difficulties.

4.4 The search for an alternative

Although many clinicians constructed *age* as pivotal in whether or not personality disorder was acceptable or applicable, concern with the personality disorder label is not unique to clinicians working with an adolescent population. Over the years various alternatives names for 'personality disorder' have been put forward, including those that emphasise the aetiological role of trauma (e.g. Herman, Perry, & Van der Kolk, 1989). The equivalence, for example, constructed in several accounts between 'emotional dysregulation' and 'emerging personality disorder' is reminiscent of the suggestion by Linehan (Linehan, 1993) that borderline personality disorder should be better entitled 'emotional dysregulation disorder'.

Likewise, previous research has often referenced hesitance amongst CAMHS clinicians to make use of personality disorder diagnoses with their adolescent clients (e.g. Laurenssen et al., 2013). Koehne (2013) commented on the tendency for clinicians to avoid or 'rebrand' BPD in their conversations with adolescents, in order to 'soften' the diagnosis. This rebranding included the use of hedges such as 'emerging'. Here, reluctance and hesitance around personality disorder terminology was salient across clinicians' accounts. Particularly striking was the absence of formal diagnostic terms such as BPD, and the use of hedges to preface 'emerging personality disorder', to soften an 'already softened' diagnosis. In a similar way, some clinicians spoke about avoiding terms that had become associated with 'emerging personality disorder', distancing themselves further from the use of personality disorder diagnoses in an adolescent population. This is interesting in the context of the growing literature around personality disorder in adolescence, and the calls by some researchers to stop modifying formal diagnostic terms (Chanen, 2015). For some clinicians, it appeared that as the use of personality disorder terminology became more widespread, their efforts to achieve distance from these conceptualisations became even greater.

4.5 Subject positions and identities

Throughout their interviews, clinicians employed various discursive devices to manage their own accountability. The use of hedges and caution in their talk enabled clinicians to distance themselves from seemingly less desirable positions (e.g. as a clinician who stigmatises their young clients through the use of 'emerging personality disorder'). Additionally, they used the passive voice and reflection to present alternative accounts of 'emerging personality disorder' as factual, objective and considerate. On the whole, clinicians spent a great deal of time within their talk managing their own position. However, the positions assumed within the discourses constructed also had an impact on the subject positions available to others. 'Other clinicians' were often referred to as the ones who made use of 'emerging personality disorder', and were often positioned as reckless and thoughtless individuals. The positions made available by the discourses appeared at points to dichotomise clinicians and

their practice. Arguably this could have consequences for teams, for individuals' willingness to be open and share their views on the use of 'emerging personality disorder', and for collaborative efforts in supporting adolescents.

Likewise, the position of 'moral guardian' adopted by clinicians within their accounts has implications for how their adolescent clients are positioned. The notion of guardianship and a responsibility to protect their clients may position adolescents as vulnerable and in need of protection. Similarly, discourses that emphasised the role of invalidating environments or past experiences in the development of presenting difficulties may also position adolescents as victims of their past trauma. Previous discursive research has shown how different identities and subject positions are built in the process of building a psychosocial explanation of an individual's distress (Horton-Salway, 2001). The notion of individuals as vulnerable is argued to lead to the construction of a victim identity. The positioning of service users as victims has been described within previous discursive research with professionals (O'Key, 2015; Farrow & O'Brien, 2005), suggesting that in dominant discourses within mental health services service users may have limited positions available to them

4.6 Implications for practice

Although there are epistemological challenges associated with applying the research findings from discursive studies to other contexts, the meso-level approach taken to analysis within this study arguably enables tentative suggestions to be made beyond the context of the interviews. The ways of talking about 'emerging personality disorder' presented here will be affected by broader organisational discourses (e.g. personality disorder, diagnosis) which will influence the ways of talking that are available to clinicians (Parker, 1998). Wetherell (2007) argues that everyday talk is not 'chaotic and arbitary' but is often 'highly ordered' (p.677), meaning that to an extent, findings are able to be generalised and patterns in talk across research studies noted. However, in keeping with the epistemological framework, generalised claims about the 'subjective reality' will not be made (Alvesson & Karreman, 2000). A number of implications will be discussed here, both for clinicians and for researchers:

Implications for clinicians

Previous research considering the application of personality disorder diagnoses to an adolescent population has often cited a need for clinicians to receive further training and information with regards to personality disorder in adolescence (Chanen, Sharp & Hoffman, 2017). It is proposed that this training will effect change in clinicians' discomfort with the label and 'mistaken beliefs'. Here, however, suggestions have been made with regards to the implications of clinicians' constructions of 'emerging personality disorder' for their adolescent clients. It was suggested that clinicians should be offered space to reflect on the ways in which they construct adolescents' difficulties, and the impact of these constructions on the adolescents' understandings of themselves. The assumption that providing space for reflection and dialogue is consistent with social constructionist ideas, and is informed by the work of Paulo Freire. Freire (1995) argues that education should be conversational, and that it should be a collaborative process of meaning making, as opposed to a delivery of knowledge. A dialogic approach to supporting clinicians' reflection and learning may serve to elicit assumptions and values that inform the decisions that clinicians make within their work. It was suggested that Clinical Psychologists positioned within multidisciplinary CAMHS teams are well placed to offer opportunities for reflection and learning.

Implications for researchers

From a theoretical perspective, this research offers a valuable contribution to the growing literature concerning the use of personality disorder diagnoses with adolescents. To my knowledge, it is the first study to specifically consider 'emerging personality disorder' as a construct, and offer insight into how the term is used by clinicians within the context of their work within a large CAMH service. The findings suggest that staff orient to various discourses relating to 'emerging personality disorder', and are conflicted in terms of the constructed 'usefulness' of it as a term. On a theoretical level, the findings highlight key discourses relevant to clinicians' constructions of 'emerging personality disorder', and the dilemmas that clinicians face in negotiating conflicting discourses. In light of the tensions and complexities presented in clinicians'

accounts, care should be taken when recommending that clinicians simply 'stop' using modified diagnostic terminology, as this risks minimising the dilemmas faced by clinicians within their work.

Furthermore, the research contributes novel findings to existing DA literature, by showing how clinicians employ a range of discursive devices to present their accounts of 'emerging personality disorder' as factual and to manage issues of stake and accountability. In addition, the findings offer a unique insight into the process of objects being 'talked into being', by examining a relatively recent and evolving construct.

Part Five: Reflexive section

5.1 Section introduction

In traditional positivist research, neutrality is favoured, and studies are designed in ways that prevent influence and bias from the researcher. However, in taking a social constructionist perspective, the researcher is viewed as an active agent in the production of knowledge. Analysis of the data is not free from the influence of the personal and theoretical biases of the researcher, and the relationship between these and the content of the research must therefore be considered reflexively (Potter & Wetherell, 1987).

The aim of this section is to describe, explain and reflect on the various decisions made during the process of conducting this research. The reflections are informed by a reflective log kept throughout the research process. It is hoped that this process makes explicit my own personal and theoretical biases, and encourages readers to evaluate the claims made throughout the study with these in mind.

5.2 Research topic and question

My initial interest and motivation for exploring 'emerging personality disorder' stemmed from a number of experiences of working in services with adolescents. I often heard the term used in informal discussions between clinicians and witnessed debates (and arguments) within team meetings about

its appropriateness. I was struck by the controversy that the use of the term caused within teams, and the strong positions that clinicians held in relation to its use.

Referring to the literature, I observed the varied use of 'emerging personality disorder'. In some papers, authors argued strongly *against* its use on account of it being '*misleading'* and '*implying discontinuity with BPD as it's seen in older patients*' (Chanen, 2015, p. 781). In others, it was used freely, constructed as a diagnostic label in its own right.

The growing use of the term in the literature, in professional documents and anecdotally in teams sparked an interest in how over time, seemingly new objects can be 'talked into being'. This research presented a unique opportunity to consider how this talk is done and how 'emerging personality disorder' is 'under construction'.

5.2 My own position

In terms of my own conceptualisations of personality disorder and 'emerging personality disorder', I began the research with a sceptical view of their usefulness and like many of the clinicians I interviewed, constructed stigma as a key concern in relation to the use of 'emerging personality disorder' with adolescents

Through designing this study, I had the opportunity to meet with two members of the University's Service User and Carer Advisory Panel, both of whom had been given a diagnosis of personality disorder during their time in services. Having open discussions with both David and Lee[17] without any particular agenda or aim, I was struck by their individual accounts of receiving a diagnosis of personality disorder. These experiences challenged some of the taken for granted 'truths' I had drawn upon in constructing my own accounts of personality disorder. Below is an extract taken from my reflective diary that depicts this:

[17] Pseudonyms have been used

Reflective diary extract 1:

> *Something key that I took away from our discussion was David's description of how the diagnosis had helped him. He described how when someone tells you that you have 'a mental health problem' or uses words such as 'anxiety', these are broad terms that are used to describe a whole range of different difficulties and experiences. David, an avid googler described how if you search the web for one of these terms, what you get back is completely overwhelming and the sheer quantity of it is too much to take in. Diagnosis, regardless of what type, narrows your search field so to speak. It has helped David to research, understand and connect with others experiencing the same collection of difficulties. Having never appreciated quite how helpful this aspect may be, it made me reflect on how often as psychologists, we can perhaps be less direct or certain in the way that we describe people's difficulties. Whilst usually this is done with the best intentions, I can imagine how at times a diagnosis may also be unhelpful should an individual wish to do their own research and learning around their experiences.*

Within the interviews, I did not share my own views on the topic, or indeed on anything else. The interviews were treated as a conversation, and both myself and the participant responsible for the construction of meaning.

5.3 A note on language

In employing a methodology centred around language and discourse, I have been particularly conscious throughout the process of my own language use. Within this write up, 'emerging personality disorder' has always been presented within inverted commas. This is firstly to highlight 'emerging personality disorder' as the object of talk both within the interviews, and within this paper. Secondly, I felt this represented the uncertain and contested nature of the construct. Likewise, I have often found myself referring to 'emerging personality disorder' as a phrase or term, which I feel is indicative of my own conceptualisations of it as a construct.

In a similar vein, I initially felt uncomfortable with the phrasing used in many discursive studies surrounding subject positions and discursive devices. The notion that individuals may 'position themselves' or 'use' a particular device implies a certain intentionality. I was conscious of how phrases such as these may be perceived by the clinicians themselves, and to begin with I noticed myself adjusting the phrasing to manage this potential issue. This in itself I found an interesting observation, and the opportunity to observe how I 'get things done' in interactions.

5.4 Recruitment

There were times, as I am sure there are in many doctoral projects, where I worried about many of the practical aspects of the research. I found myself wondering 'what if they *don't* talk about 'emerging personality disorder' in this service? What if no one is willing to take part?' To aid recruitment I met with a team of team and service managers, hoping to secure their approval for recruitment within their teams. This in itself offered insight into the subject, and reassured me that the questions I was asking were of relevance:

Reflective diary extract 2:

> *For the most part they remained quiet, although I noticed a shared raising of eyebrows by some when I said the words 'emerging personality disorder'. One individual was more vocal than others and what she said intrigued me. She was quick to dismiss my claim that 'emerging personality disorder' was a 'new' term. 'It's been around for years' she says, looking round to see one or two others nodding in agreement. However, she then also went on to tell me very firmly that 'we don't diagnose it in CAMHS'. I held back at this point from questioning whether she was speaking on behalf of all clinicians within the service. What this did though, is reassure me that the project I was proposing was most certainly relevant. The term was clearly familiar to this group of professionals, and the topic of diagnosis is clearly one which elicits people's viewpoints. I remained intrigued how the term 'emerging personality disorder' is indeed used and referred to, and what purpose it is serving for these staff.*

Subsequent recruitment was remarkably straight-forward. Clinicians appeared keen to participate in the research for which I was very grateful. One key learning experience from the recruitment process was to be clear around the inclusion criteria, and in how these are communicated to potential participants. I feel I did not make this as clear as I could have done, leading to one clinician being excluded from the study. In future, I will ensure the inclusion criteria are detailed clearly on the participant information sheet, and I ask key questions directly to potential participants prior to the recruitment process progressing.

5.5 Interviews

The means of collecting talk data was considered carefully, and the debate relating to the use of interview data is discussed elsewhere. In conducting the interviews, I was initially conscious of not wanting to 'lead' clinicians' talk and considered the language I used within the interview questions. However, I was struck by the way in which many clinicians, given the opportunity to discuss their work, naturally began to discuss topics I had considered relevant to the research. Several corrected my broad use of 'personality disorder', for example saying 'we only tend to use *emerging personality disorder* in teams here' (Clinician 2), which provided a very natural way in to relevant discussions. Often, clinicians guided their own way through the questions I had prepared, and needed little prompting in terms of the direction of conversation.

In the context of the interviews, I was aware that my role as a trainee clinical psychologist may have impacted on the positions adopted by participants, and the particular ways in which they constructed 'emerging personality disorder'. Some participants may have, for example, assumed, based on my role, that I had a different view to them on the topic, although I would argue that for clinicians in several roles, I likely held a similar epistemological position. It may also be, however, that my role as a researcher was more prominent for participants, and the impact of my clinical role had less of an impact.

5.6 Expectations

Whilst to an extent, I expected clinicians to be hesitant in their talk around the topic, the extent to which this was the case came as a surprise to me. A

particular striking memory is one of my first interviews, in which the clinician asked a series of very specific questions about the anonymity of the data. Underlying their questions was a concern that other clinicians within the service would 'find out' about their views on such as 'contentious topic'. It struck me that despite the assured anonymity, clinicians were likely to negotiate the interviews with particular care for their position and accountability.

I was also expecting greater use of 'typical' personality disorder diagnostic terms, such as BPD. Instead, I found that BPD and other personality disorder diagnoses were very rarely named within the interviews, with clinicians for the most part referring either to 'emerging personality disorder' or personality disorder more broadly. This, I hope, is captured within the analysis sections in this paper, and for me demonstrates further the avoidance of what clinicians constructed as 'adult' labels.

5.7 Analysis

During the various stages of analysis, I often found 'letting go' of data challenging. Keen not to do a disservice to the clinicians who had given their time to be interviewed, I found the task of 'choosing' which themes to present to be particularly difficult. I reflected on my role as a researcher, and how through selecting sections of data for analysis, by default that meant I also discarded data. However, through the process of reading and rereading the transcripts, I began to see how certain discourses were particularly central within clinicians' accounts, and that through focusing on these, other aspects of the data were not 'neglected' or 'discarded' as such, but could be seen within the context of the most salient discourses.

5.7 Future directions

Although there are limits to the generalisability of the analysis presented here, it can be argued that the ways of talking about 'emerging personality disorder' are likely to be reproduced in other contexts (e.g. within MDT meetings). It would be of benefit to explore which aspects of these ways of talking are stable across different contexts (i.e. outside of a research interview). Likewise, analysis of naturally occurring talk could highlight the key discursive resources drawn upon

in these contexts. Although there are clear practical barriers to the collection of naturally occurring data, it would add value to consider how to address these.

Throughout the process of data collection and analysis, I was often intrigued by particular areas of clinicians' talk that were slightly outside the remit of the project. Particularly interesting was the varied ways in which clinicians constructed diagnosis within their accounts, and how diagnostic practice was talked about in the context of a range of different presenting difficulties. I remain interested in how these discourses are negotiated, both between professionals and within consultations with children and their families. To me, this would be a worthwhile area for exploration in future discursive research.

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APPENDICES

Appendix A: Ethical approval documents

NHS
Health Research Authority

Professor Roshan dasNair
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02 May 2017

Dear Professor dasNair

Letter of HRA Approval

Study title:	**How do clinicians talk about 'emerging personality disorder' in young people? A discursive psychological exploration.**
IRAS project ID:	**220634**
Protocol number:	**17013**
REC reference:	**17/LO/0637**
Sponsor	**University of Nottingham**

I am pleased to confirm that **HRA Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications noted in this letter.

Participation of NHS Organisations in England

The sponsor should now provide a copy of this letter to all participating NHS organisations in England.

Appendix B provides important information for sponsors and participating NHS organisations in England for arranging and confirming capacity and capability. **Please read *Appendix B* carefully**, in particular the following sections:

- *Participating NHS organisations in England* – this clarifies the types of participating organisations in the study and whether or not all organisations will be undertaking the same activities
- *Confirmation of capacity and capability* - this confirms whether or not each type of participating NHS organisation in England is expected to give formal confirmation of capacity and capability. Where formal confirmation is not expected, the section also provides details on the time limit given to participating organisations to opt out of the study, or request additional time, before their participation is assumed.
- *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* - this provides detail on the form of agreement to be used in the study to confirm capacity and capability, where applicable.

Further information on funding, HR processes, and compliance with HRA criteria and standards is also provided.

It is critical that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details and further information about working with the research management function for each organisation can be accessed from www.hra.nhs.uk/hra-approval.

Appendices

The HRA Approval letter contains the following appendices:

- A – List of documents reviewed during HRA assessment
- B – Summary of HRA assessment

After HRA Approval

The attached document *"After HRA Approval – guidance for sponsors and investigators"* gives detailed guidance on reporting expectations for studies with HRA Approval, including:

- Working with organisations hosting the research
- Registration of Research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics and is updated in the light of changes in reporting expectations or procedures.

Scope

HRA Approval provides an approval for research involving patients or staff in NHS organisations in England.

If your study involves NHS organisations in other countries in the UK, please contact the relevant national coordinating functions for support and advice. Further information can be found at http://www.hra.nhs.uk/resources/applying-for-reviews/nhs-hsc-rd-review/.

If there are participating non-NHS organisations, local agreement should be obtained in accordance with the procedures of the local participating non-NHS organisation.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/.

HRA Training

We are pleased to welcome researchers and research management staff at our training days – see details at http://www.hra.nhs.uk/hra-training/

Your IRAS project ID is **220634**. Please quote this on all correspondence.

IRAS project ID	220634

Yours sincerely

Gemma Oakes
Assessor

Email: hra.approval@nhs.net

Copy to: *Miss Hannah Little, University of Nottingham [Student]*
msxhgl@nottingham.ac.uk
Ms Angela Shone, University of Nottingham [Sponsor Contact]
sponsor@nottingham.ac.uk

[redacted]

The University of Nottingham
UNITED KINGDOM · CHINA · MALAYSIA

Research, Enterprise and Graduate Services
University of Nottingham
King's Meadow Campus
Lenton Lane Nottingham
NG7 2NR

Our reference: RGS 17013
IRAS Project ID: 220634

0115 8467906
sponsor@nottingham.ac.uk

Health Research Authority
Research Ethics Committee

Professor Roshan das Nair
Professor of Clinical Psychology & Neuropsychology
C22, Institute of Mental Health
Jubilee Campus
University of Nottingham
NH8 1BB

27 March 2017

Dear Sir or Madam,

Sponsorship Statement

Re: How do clinicians talk about 'Emerging personality disorder' in young people? A discursive psychological exploration

I can confirm that this research proposal has been discussed with the Chief Investigator and agreement to sponsor the research is in place.

An appropriate process of scientific critique has demonstrated that this research proposal is worthwhile and of high scientific quality.*

Any necessary indemnity or insurance arrangements will be in place before this research starts. Arrangements will be in place before the study starts for the research team to access resources and support to deliver the research as proposed.

Arrangements to allocate responsibilities for the management, monitoring and reporting of the research will be in place before the research starts.

The duties of sponsors set out in the NHS Research Governance Framework for Health and Social Care will be undertaken in relation to this research.**

* Not applicable to student research (except doctoral research).
** Not applicable to research outside the scope of the Research Governance Framework.

Yours faithfully

Angela Shone
Head of Research Governance
University of Nottingham

world-changing research
from The University of Nottingham

E-mail: FMHS-ResearchEthics@nottingham.ac.uk

Faculty of Medicine and Health Sciences

Research Ethics Committee
C/o Faculty PVC Office
School of Medicine Education Centre
B Floor, Medical School
Queen's Medical Centre Campus
Nottingham University Hospitals
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NG7 2UH

7th June 2017

Hannah Little
Trainee Clinical Psychologist
Doctorate in Clinical Psychology Student
c/o Professor Roshan das Nair
Professor of Clinical Psychology & Neuropsychology
C22, Institute of Mental Health
University of Nottingham
Jubilee Campus
Nottingham NG8 1BB

Dear Ms Little

Ethics Reference No: 29-1704 – **please always quote** **IRAS Project ID:** 220634 **Sponsor reference:** 17013	
Study Title: how do clinicians talk about 'emerging personality disorder' in young people? A discursive psychological exploration. **Short Title:** Talking about 'emerging personality disorder' in young people.	
Chief Investigator/Supervisor: Professor Roshan das Nair, Professor of Clinical Psychology & Neuropsychology, Institute of Mental Health, Division of Psychiatry & Applied Psychology.	
Lead Investigators/student: Hannah Little, Trainee Clinical Psychologist, studying for the Doctorate in Clinical Psychology, Division of Psychiatry & Applied Psychology.	
Other Key Investigators: Dr Anna Tickle, Academic Tutor, Doctorate in Clinical Psychology, Division of Psychiatry & Applied Psychology.	
Type of Study: Trent Doctorate in Clinical Psychology student project, qualitative	
Proposed Start Date: 03/2017	**Proposed End Date:** 30/06/2017 12 mths
No of Subjects: 10-15	**Age:** 18+years
School: Medicine	

Thank you for submitting the above application which was considered by the Committee at its meeting on 24 April 2017 and the following documents were received:

Emerging personality disorder in adolescents:

- IRAS Full Set of Project Data v1.0, 23.03.17
- Evidence of Sponsor Letter dated 27 March 2017
- Protocol v1.0, 23.03.17
- Recruitment email final v1.0, 23.03.17
- Participant Information Sheet –Final version 1.0: 23/03/2017
- Consent form –Final 1.0: 23/03/17
- Interview Schedule Final version 1.0: 23/03/2017

These have been reviewed and are satisfactory and the study has been given a favourable opinion.

A favourable opinion is given on the understanding that the conditions set out below are followed:

1. You should follow the protocol agreed and inform the Committee of any changes using a notification of amendment form (please request a form).

2. You must notify the Chair of any serious or unexpected event.

3. This study is approved for the period of active recruitment requested. The Committee also provides a further 5 year approval for any necessary work to be performed on the study which may arise in the process of publication and peer review.

4. An End of Project Progress Report is completed and returned when the study has finished (Please request a form).

Yours sincerely

pp Lamagdani

Professor Ravi Mahajan
Chair, Faculty of Medicine & Health Sciences Research Ethics Committee

Appendix B: Recruitment email

Dear colleague,

We are inviting CAMHS clinicians to participate in a research project about 'personality disorder' in adolescents. This research is being carried out by Hannah Little, a Trainee Clinical Psychologist from the University of Nottingham in collaboration with the Trust. We are looking for clinicians from any professional background and team and participation would involve a one off semi-structured interview at a time convenient to you which would last about an hour.

The project has been given appropriate ethical approval both from the Health Research Authority and the University of Nottingham. Any personal information will be kept confidential and interview data will be anonymised.

More information about the project can be found in the attached Participant Information Sheet, or by emailing Hannah at msxhgl@nottingham.ac.uk or speaking to [redacted].[18]

If you are interested in taking part, please contact Hannah by email using the above address.

Many thanks

[18] Details of the service removed for purposes of anonymity.

Appendix C: Participant forms



Organisation logo removed for purposes of anonymity

CONSENT FORM

Final version 1.0: 23/03/17

Title of Study: Emerging personality disorder in adolescents

IRAS Project ID: 220634

Name of Researchers: Hannah Little, Anna Tickle, Roshan dasNair

Name of Participant:

		Please initial box
1.	I confirm that I have read and understand the information sheet version number 1 dated 02/02/2017 for the above study and have had the opportunity to ask questions.	☐
2.	I understand that my participation is voluntary and that I am free to withdraw at one week from the date of the interview without needing to justify my decision and without penalty. I understand that should I withdraw after this time point, then the information collected so far cannot be erased and that this information may still be used in the project analysis.	☐
3.	I understand that authorised individuals from the University of Nottingham, the research group and regulatory authorities may look at the data collected in the study where it is relevant to my taking part in this study. I give permission for these individuals to have access to and to collect, store, analyse and publish information obtained from my participation in this study. I understand that my personal details will be kept confidential	☐
4.	I understand that the interview will be recorded and that anonymous direct quotes from the interview may be used in the study reports.	☐
5.	I agree to take part in the above study.	☐

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Name of Person taking consent	Date	Signature

Organisation logo removed for purposes of anonymity

Participant Information Sheet
Draft version 2.0: Final version 1.0: 02/02/17

IRAS Project ID: 220634

Title of Study: Emerging personality disorder in adolescents

Name of Researcher(s): Hannah Little, Dr Roshan das Nair and Dr Anna Tickle

We would like to invite you to take part in our research study. This information sheet details the purpose of the study and what would be involved should you choose to participate. Please take time to read the information carefully and consider whether you would like to participate in this research.

What is the purpose of the study?

The aim of the current study is to explore how professionals working in Child and Adolescent Mental Health Services (CAMHS) talk about personality disorders in adolescents.

What will be involved?

Participation in the research will involve taking part in a semi-structured interview with the study co-ordinator Hannah Little. Participation in the study is voluntary and hopefully you will find the process interesting.

Do I have to take part?

No, participation in the study is entirely voluntary. We will describe the study and go through this information sheet with you. If you agree to take part, we will then ask you to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. This would not affect your legal rights.

What will happen to me if I take part?

Participation in the study will involve being interviewed by the study co-ordinator, organised at a time convenient for you. The interview is likely to last between 40 and 60 minutes. During the interview you will be asked a series of questions; you have the right to refuse to respond to any question that is asked of you.

At the interview we will go through this information sheet and consent form with you and we will be able to answer any further questions you might have about the study.

What will happen with the information I give during the study?

The interview will be recorded on a digital audio-recorder, so the interview can later be transcribed. The digital recordings will be stored in a locked filing cabinet until they can be transcribed, at which point the recording will be erased. The transcriptions will be anonymised using a coding system so that you will not be identifiable from the typed notes.

Quotations from the interview may be used in the final version of the current research and may be submitted for publication in scientific journals. However no one will be able to link the data you provide to you, and only the study co-ordinator will have access to the audio recordings and transcripts before they are anonymised.

Will my taking part in the study be kept confidential?

We will follow ethical and legal practice and all information about you will be handled in confidence.

If you join the study, some parts of the data collected for the study will be looked at by authorised persons from the University of Nottingham who are organising the research. They may also be looked at by authorised people to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a research participant and we will do our best to meet this duty.

All information which is collected about you during the course of the research will be kept **strictly confidential**, stored in a secure and locked office, and on a password protected database. Any information about you which leaves the site of the interview will have your name removed (anonymised) and a unique code will be used so that you cannot be recognised from it.

Your personal data (e.g. email) will be kept for a maximum of three months after the end of the study so that we are able to contact you about the findings of the study (unless you advise us that you do not wish to be contacted). All other data (research data) will be kept securely for 7 years. After this time your data will be disposed of securely. During this time all precautions will be taken by all those involved to maintain your confidentiality, only members of the research team will have access to your personal data.

Although what you say in the interview is confidential, should you disclose anything to us which we feel puts you or anyone else at any risk, we may feel it necessary to report this to the appropriate persons.

What will happen if I don't want to carry on with the study?

Your participation is voluntary and you may wish to withdraw from the study at any time without needing to explain why up to one week after the date of the interview. You have the right to ask that any data you have supplied to that point be withdrawn and destroyed.

What if there is a problem?

We hope that given the nature of the questions, the study is unlikely to cause distress to participants. However if you do have a concern about any part of the study or if you experience distress as a result of participation, please contact the research supervisors for this project Dr Roshan das Nair or Dr Anna Tickle (contact details below).

Who is organising and funding the research?

This research is being organised and funded by the University of Nottingham. All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by the University of Nottingham Research Ethics Committee and by the Research and Development department in Nottinghamshire Healthcare NHS Foundation Trust.

How do I get involved?

If you are interested in taking part in this study please contact the study co-ordinator using the details provided below. We will be happy to answer any further questions should you have any.

Further information and contact details

Hannah Little
I-WHO,
University of Nottingham International House,
Jubilee Campus,
Wollaton Road Nottingham.
NG8 1BB
msxhgl@nottingham.ac.uk

Professor Roshan dasNair
C22, Institute of Mental Health
Jubilee Campus
University of Nottingham
Nottingham NG8 1BB
roshan.nair1@nottingham.ac.uk

Dr Anna Tickle
Division of Psychiatry and Applied Psychology
University of Nottingham
YANG Fujia Building, B Floor
Jubilee Campus, Wollaton Road
Nottingham
NG8 1BB
anna.tickle@nottingham.ac.uk

Appendix D: Interview schedule

Interview Schedule
Final version 1.0: 23/03/2017

IRAS Project ID: 220634

Title of Study: Emerging personality disorder in adolescents

Name of Researcher(s): Hannah Little, Dr Roshan das Nair and Dr Anna Tickle

Please note that this is intended as a guide for the interviewer, and not a strict list of questions to be asked.

Introduction

- Go through and sign consent form
- Cover confidentiality
- What will happen in the interview?
- Do you have any questions?

Context and setting

1) Can you tell me about your current role?

   Prompts:
   - What team do you work in?
   - How long have you worked in this role?
   - What are your main responsibilities within the team?
   - Can you describe the nature of your work with adolescents?

Focus on the clients

2) Can you describe the clients you work with in clinical practice?

   Prompts:
   - What sort of difficulties lead adolescents to be referred to the service?
   - Do you use diagnostic categories to describe adolescents's difficulties?
   - What are your thoughts on diagnosis?

Personality disorder

3) What do you make of the use of personality disorder diagnoses with adolescents?

Prompts:

- Is this a term you use in this service?
- In what situations do you use it?
- What situations do others you work with use it in?
- How do you feel about the use of these diagnoses with adolescents?
- What are the different views within the team about using personality disorder diagnoses with adolescents?
-

Emerging personality disorder

4) What's your understanding of 'emerging personality disorder?'

Prompts:

- How would you describe emerging personality disorder?
- What does it mean if that phrase is used in reference to a adolescent?
- Where do you think the term has come from?
- Where have you heard the phrase before?
- What do you think has influenced how you understand the phrase?
- How is an 'emerging personality disorder' different from borderline personality disorder?

Emerging personality disorder in relation to clinical work

5) How is the term 'emerging personality disorder' used within your team?
    - In what context is the term used?
    - Can you recall a time when the term was used to describe a adolescent's difficulties?
    - In what context was it discussed?
    - Can you tell me more about what was talked about?
    - Were the discussions shared with the adolescent and their family?

Appendix E: Transcription confidentiality agreement

UNIVERSITY OF LINCOLN

Data Protection Act 1998 Confidentiality Agreement for Transcribers

This Agreement is made as of _____ (Date), by and between the University of Lincoln, with principal offices at Brayford Pool Lincoln LN6 7TS (the University) and _____ with principal offices at _____, (the Transcriber).

The Transcriber has been appointed by the University of Lincoln to transcribe audiotapes/audio files and documentation resulting from research undertaken by _____ which will involve the disclosure to the Transcriber of personal data held by the University. Accordingly the Transcriber is required to deal with any such information in accordance with the terms of this Agreement and the Data Protection Act 1998.

The Transcriber undertakes to respect and preserve the confidentiality of personal data. Accordingly, for an indefinite period after the date of this Agreement the Contractor shall:

- maintain the personal data in strict confidence and shall not disclose any of the personal data to any third party;
- restrict access to employees, agents or sub-contractors who need such access for the purposes of the contract (and then only if the employee, agent or subcontractor is bound by conditions of confidentiality no less strict than those set out in this agreement, which the Transcriber shall enforce at the University's request);
- ensure that its employees, agents or sub-contractors are aware of and comply with the Data Protection Act 1998; and
- not authorise any sub-contractor to have access to the personal data without obtaining the University's prior written consent to the appointment of such sub-contractor and entering into a written agreement with the subcontractor including conditions of confidentiality no less strict than those set out in this agreement, which the Transcriber shall enforce at the University's request.

The Transcriber agrees to indemnify and keep indemnified and defend at its own expense the University against all costs, claims, damages or expenses incurred by the University or for which the University may become liable due to any failure by the Transcriber, its employees, agents or sub-contractors to comply with any of its obligations under this Agreement.

For the avoidance of doubt, the confidentiality imposed on the Transcriber by this Agreement shall continue in full force and effect after the expiry or termination of any contract to supply services.

The restrictions contained in this Agreement shall cease to apply to any information which may come into the public domain otherwise than through unauthorised disclosure by the Transcriber.

This Agreement shall be governed by and construed in accordance with the laws of England and the parties hereby submit to the exclusive jurisdiction of the English courts.

Signed for and on behalf of _____

Signed: ..... Name: .....

Title: ..... Date: .....

Signed for and on behalf of the University of Lincoln

Signed: ..... Name: .....

Title: ..... Date: .....

Appendix F: Transcription conventions

(.) A full stop inside brackets denotes a micro pause, a notable pause but of no significant length.

(0.2) A number inside brackets denotes a timed pause. This is a pause long enough to time and subsequently show in transcription.

[Square brackets denote a point where overlapping speech occurs.

> < Arrows surrounding talk like these show that the pace of the speech has quickened

< > Arrows in this direction show that the pace of the speech has slowed down

( ) Where there is space between brackets denotes that the words spoken here were too unclear to transcribe

(( )) Where double brackets appear with a description inserted denotes some contextual information where no symbol of representation was available.

Under When a word or part of a word is underlines it denotes a raise in volume or emphasis

↑ When an upward arrow appears it means there is a rise in intonation

↓ When a downward arrow appears it means there is a drop in intonation

→ An arrow like this denotes a particular sentence of interest to the analyst

CAPITALS where capital letters appear it denotes that something was said loudly or even shouted

Hum(h)our When a bracketed 'h' appears it means that there was laughter within the talk

= The equal sign represents latched speech, a continuation of talk

:: Colons appear to represent elongated speech, a stretched sound

Appendix G: Questions to ask of the text

Questions originating from discursive psychology

- Why am I reading this passage in this way? (Potter & Wetherell, 1987)
- What features produce this reading? (Potter & Wetherell, 1987)
- What are the patterns in the text? (Potter & Wetherell, 1987)
- What variations are there in the text? (Potter & Wetherell, 1987)
- What rhetorical strategies and devices are used? (Edwards & Potter, 1992)
- What problems might these function to manage? (Potter & Wetherell, 1987)
- What is not said that might have been? (Potter & Wetherell, 1987)

Questions originating from FDA

- What metaphors are being used?
- What positions/roles are the speakers taking? What are the implications of these roles? (Parker, 1999)
- How do these discourses reflect, reword or reject broader cultural/social discourses? (Parker, 1999).

Appendix H: Author guidelines for Journal of Child and Adolescent Clinical Psychology

For guidelines, please see:

https://www.tandfonline.com/action/authorSubmission?journalCode=hcap20&page=instructions