An exploration of the experiences of CAMHS nurses who work with adolescents with the label emerging personality disorder

Thesis submitted in part fulfilment of the degree of
Doctorate in Clinical Psychology
(DClinPsy)
University of Leicester
By
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Declaration

I confirm that this thesis is an original piece of work as part-fulfilment of the degree of Doctorate in Clinical Psychology (DClinPsy). It has not been submitted for any other academic award.
An exploration of the experiences of CAMHS nurses who work with adolescents with the label emerging personality disorder

Sarah Cross

Thesis Abstract

The literature review aimed to systematically review social cognitive abilities in young people with borderline personality disorder (BPD) features. Three electronic databases were searched and ten met the inclusion criteria. Through the quality appraisal, the studies were found to be weak overall. Across the studies, social cognition was assessed using various measures. The participants included both nonclinical and clinical populations. All studies rated BPD features through standardised, reliable measures. Findings were mixed. Studies demonstrated that individuals with BPD features had certain social cognitive deficits but the deficit findings differed across the papers. Further research is required to clarify the social cognitive abilities in young people with BPD features.

The aims of the research were to explore inpatient CAMHS staff experiences of young people with a label of emerging personality disorder. An IPA methodology was employed and six inpatient CAMHS nursing staff were interviewed. Three superordinate themes and nine subthemes were found across the data that enabled convergence and divergence within their accounts. Findings are discussed with reference to psychological theory and past research findings. The clinical implications and future research recommendations are discussed. The critical appraisal is then presented.
Acknowledgements

I would like to first and foremost thank the six participants who took the time out of their busy day to speak to me about their experiences. I would like to also thank my research supervisor, Dr Steve Allan, for the support and guidance he offered me throughout. Further appreciation must go to my field supervisor* for her enthusiasm for my project and for the support given, especially with regards to recruitment.

I am so grateful for my amazing friends, who have all been so patient with me over this period. Thanks goes to my wonderful parents and sister for all the love, much needed distractions and support offered throughout this research.

Finally, I would like to give a very special thank you to my husband. He has been my absolute rock throughout this process.

* Name not presented to protect anonymity of unit.
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Part 1: Literature Review

Reviewing social cognition in young people with a borderline personality disorder label

(Guidelines to authors for targeted journal can be found in Appendix A)
Abstract

**Introduction:** Borderline personality disorder (BPD) is a diagnosis that is being used with increasing frequency across a younger population. Interpersonal difficulties are often one of the central features for this population, with little known of the mechanism for this. Social cognitive abilities have been suggested as a potential explanation for the interpersonal difficulties. The current review aimed to explore social cognitive abilities in young people with BPD features.

**Method:** A systematic review of the literature relating to social cognition for young people with BPD features was conducted using three electronic databases (PsychInfo, Medline and Cinahl). Ten studies were reviewed and quality appraised.

**Results:** Social cognition was measured using various methodologies. Populations were clinical and nonclinical samples. The review demonstrated that young people with BPD features might have different social cognitive abilities. However, there was a paucity of evidence for this and the quality of the reviewed studies was weak.

**Conclusion:** Young people with BPD features appeared to have potential social cognitive deficits. However, considerable variation between participant populations and social cognition measures, along with the studies’ overall weak methodological quality, limit the conclusions that can be made. Further research is required to establish the social cognitive abilities in young people with BPD features.
1 Introduction

There has been growing interest in the area of the label borderline personality disorder (BPD) in young people, with the development of varying specific interventions for this population. Interpersonal difficulties are often one of the central features of these interventions and are frequently viewed as the 'symptom' that endures after others have decreased (e.g. Gunderson, 2001). There is little known about the underlying mechanism for these difficulties, with various theories including attachment (Agrawal et al., 2004), biopsychosocial (Linehan, 1993) or as a process of understanding self and others (social cognition). Social cognition findings within the adult BPD literature have been mixed. The current review focused specifically on social cognition within young people in order to help identify the aetiological interpersonal factors to BPD.

1.1 Borderline personality disorder

BPD is a contentious diagnosis. Symptoms regarded as part of a personality disorder are perceived to be enduring and chronic and therefore pose a challenge to the biologically informed healthcare system (National Collaborating Centre for Mental Health, 2009). The reliability and validity of the DSM and ICD diagnostic criteria have been criticised, along with the construct itself (Tyrer, 1999). However, applying the diagnostic criteria to the general adult population, there is an estimated prevalence rate of 1% to 6% (Grant et al., 2008; Lenzenweger et al., 2007). Prevalence rates show 20% of all adult psychiatric inpatients and 15% of all adult outpatients meet the criteria for this diagnosis (Gunderson, 2006). Although BPD can be diagnosed in individuals before the age of 18, it is not recommended by the ICD-10 in individuals before the age of 17 (World Health Organization, 1992). Professionals find it challenging to distinguish between the BPD symptoms and typical adolescent behaviour; BPD is therefore a controversial label for this age group (Aguirre, 2014). However, research has indicated that when the diagnostic criteria is applied, 3% of adolescents (Bernstein et al., 1993), 3% of community young adults (mean age 24) (Moran et al., 2006) and 22% of outpatients aged 15 to 24 year olds (Chanen et al., 2008) meet the criteria for symptoms conceptualised as BPD.

The symptom clusters that are recognised as BPD include affective dysregulation, impulsivity and interpersonal difficulties (Sanislow et al., 2002), with growing evidence of the relationship between these (e.g. Herr et al., 2013). Disturbed relationship patterns have been suggested as a phenotype for individuals with BPD and are seen as a discriminator for this diagnosis (see
Gunderson, 2007). Social cognition has been identified as one of the reasons for this interpersonal difficulty (Domes et al., 2009).

**1.2 Social cognition**

Broadly, social cognition incorporates the cognitive processes used in understanding the social world (Beer & Ochsner, 2006). The processes used to perceive other people include both nonverbal and verbal cues, and categorise these cues to extract psychological meaning. Further to this initial assessment, context or past experiences influence the processing of the social cue.

Social cognition encompasses many different areas, including the concept of theory of mind (ToM), social perspective coordination (SPC) or mentalization. ToM, SPC and mentalization are similar concepts, with mentalization more closely linked to attachment theory. All of these can be defined as the ability to infer the mental states of oneself and others based on their behaviour (Baron-Cohen et al., 1985; Premack & Woodruff, 1978; Selman et al., 1986). Mentalization is further defined in levels: undermentalizing (reflecting an insufficient mental state reasoning); no mentalizing (demonstrating a lack of mental state reasoning); or hypermentalizing (referring to an over interpretation of mental state reasoning). Social cognition can be divided into two separate but interlinked aspects, cognitive and affective empathy. Cognitive empathy refers to the capacity to take the perspective of another and infer mental states (Baron-Cohen & Wheelwright, 2004). Affective empathy is defined as an individual’s response to another’s emotional state (Eisenberg & Miller, 1987).

The overall development of social cognition arises from the caregiver’s ability to recognise their child’s state of mind and providing feedback to the infant about this, thus enabling the child to make sense of their own behaviours, thoughts and feelings and comprehend other peoples’ (Steele et al., 2002). The ability to understand others’ emotional states is thus based on the premise that during development, a caregiver has been able to recognise, label and validate emotions that are displayed by the child. These skills begin developing in childhood and continue to improve during adolescence and early adulthood, reaching maturation in adulthood (Choudhury et al., 2006).

Within mental health research, social cognitive deficits have been related to many different diagnoses, including ‘social anxiety disorders’ (Tibi-Elhanany & Shamay-Tsoory, 2011), ‘depression’ (Weightman et al., 2014) and ‘PTSD’ (Sharp et al., 2012). BPD often has comorbid diagnoses, including those stated above (Zimmerman & Mattia, 1999) and the interpersonal
difficulties present for these individuals suggest a potential social cognitive deficit.

1.3 Developmental perspectives of social cognition and personality disorder

There is a growing body of research showing that individuals with a diagnosis of BPD have come from abusive backgrounds, from emotional neglect and abuse (Fonagy & Luyten, 2009), to childhood trauma (Chanen & Kaess, 2012). Difficulties with social cognition, specifically understanding and processing emotions, could be a possible consequence of this early maltreatment. In order to survive, babies are biologically predetermined to form attachments with their caregivers. They display certain behaviours that encourage care and responsiveness and create an attachment, called social releasers, e.g. crying. Internal working models develop through the initial attachment, creating a cognitive framework comprising of mental representations for understanding the world, self and others. Emotion perception develops through these reciprocal processes, assigning attention to significant emotional cues and receiving feedback (Leist & Dadds, 2009).

Within an abusive relationship, this reciprocal process is often inconsistent and there is unpredictability for the emotional consequence of their behaviour (Dadds & Salmon, 2003). Research has supported this theory, showing that maltreated children show deficits in emotion recognition, from heightened sensitivity to threatening emotional cues to misinterpretation of emotionally neutral expressions (Pears & Fisher, 2005; Pollak & Tolley-Schell, 2003). With an early abusive background social cognition could be compromised, e.g. perceiving neutral stimuli as threatening. Interpreting others’ behaviour and the detection and recognition of emotion are key components in nonverbal communication and social interaction (Unoka et al., 2011).

1.4 Assessing social cognition

Due to the lack of theoretical framework for social cognition (Brizio et al., 2015), there is no single method for measuring the construct. Most commonly it has been measured by assessing a participant’s ability to recognise and attend to emotion through static pictures; attribute characteristics to characters in film; or to display general ToM in vignettes. Common measures are ‘Reading the Minds Eye Test’ (Baron-Cohen et al., 2001), ‘Visual Dot Probe’ test (Bradley et al., 1998), emotion recognition tasks, ‘Movie for the Assessment of Social Cognition’ (Dziobek et al., 2006) and face rating tasks. These measures have predominantly been applied in child and adult research. When social cognition has been reviewed in adolescence, it has mainly focused
on it from a neuroscientific perspective in nonclinical populations (e.g. Pfeifer & Blakemore, 2012). To the knowledge of the author, reviews on social cognition in young people with the label BPD have yet to be completed. Reviews in the adult BPD diagnosis area have been undertaken and are discussed below.

1.5 Previous reviews of social cognition in adults labelled with BPD

1.5.1 Static pictures

In a review by Domes et al. (2009) it was concluded that there were only subtle impairments in individuals diagnosed with BPD’s ability to label emotions. These individuals did show a bias towards negative emotions, labelling facial expressions as more aggressive, malevolent and generally more negative than ‘non-BPD’ individuals, particularly when there was a time limit. In a more recent review, Lazarus et al. (2014) concluded that studies examining individuals with BPD diagnosis abilities to understand and interpret the mental states of others were mixed. There was some evidence to support that those with ‘BPD features’ may be less likely to understand other peoples’ mental states across varying contexts. Those with a BPD diagnosis were found to be less accurate in recognising both neutral and negative facial expressions (Levine et al., 1997) and less accurate in recognising and discriminating between negative emotions (Bland et al., 2004; Unoka et al., 2011). Furthermore, studies have found that those with a BPD diagnosis are more likely to interpret neutral expressions as negative (Dyck et al., 2009).

However, other studies showed that individuals with a BPD label were able to understand and respond to social cues no differently than nonclinical controls (New et al., 2012). Two studies examining individuals’ abilities to interpret mental states from pictures of only the eye area demonstrated that individuals with a BPD label had a more accurate perception of mental states (Fertuck et al., 2009; Scott et al., 2011). Examining the conditions separately showed that individuals with a BPD label were superior on perceiving positive and neutral stimuli, but not on the negative stimuli. These studies did not suggest a deficit in perceiving mental states of others when just focusing on the eye area of a picture and showed a potential increased accuracy for particular stimuli.

1.5.2 Film

In the review conducted by Lazarus et al. (2014), the findings were also mixed for studies using
film clips with different characters. In one of these studies, individuals with a BPD diagnosis had a higher likelihood than controls to categorise others on an extreme end of the qualities continuum in situations that involved rejection or abandonment (Veen & Arntz, 2000). Contrary to these findings, Sieswerda et al. (2013) found no evidence of this extreme categorisation. However, both studies did find that those with a BPD label had a higher tendency to rate the characters as more negative than nonclinical controls (Sieswerda et al., 2013) and people with a cluster C personality disorder label (Veen & Arntz, 2000).

### 1.5.3 Vignettes

Studies specifically focusing on investigating theory of mind (ToM) in individuals with a BPD label have also been mixed. A study examining ToM in relation to characters’ thoughts, intentions and feelings in standardised stories of varying interpersonal behaviours found no evidence of ToM deficits in those diagnosed with BPD (Arntz et al., 2009). However, two other studies did find evidence of ToM deficits, with lower efficacy than controls on cognitive understanding of social “faux pas” (Harari et al., 2010) and poorer recognition of emotions, thoughts and intentions of characters interacting in various social contexts (Preißler et al., 2010).

### 1.6 Social cognition and adolescence

The literature on social cognition in adolescence is limited (Brizio et al., 2015). Research in this area has found that nonclinical adolescents find it harder than adults to understand others’ thoughts and feelings (Bosco et al., 2014). Research on the relationship between attachment and social cognition has shown that a secure attachment style is related to attending to positive social feedback (Cassidy et al., 2003) and insecurely attached adolescents perceive others in a negative manner (Zimmermann, 1999). Prospective longitudinal studies have shown insecure attachment in infancy and adolescence precipitate what the diagnostic model classify as BPD symptoms in adulthood (e.g. Fonagy et al., 1996). Social cognition has been identified as one of the most likely underlying mechanisms by which attachment may affect the development of BPD symptoms (Sharp et al., 2011). In previous reviews, the focus has been on adults with a BPD diagnosis when the probability of extraneous variables impacting on social cognition abilities is greater.

### 1.7 Review aims and rationale

As it has been outlined above, social cognition is a growing area of research within the adult
BPD diagnosis literature. The evidence has been mixed, with some results suggesting that there was heightened social cognitive ability, and other results either showing no difference or a decreased social cognitive ability. Research within adolescent social cognition is limited. To the knowledge of the author, no literature reviews have been undertaken on social cognition and youths with a BPD label. The aetiological and maintenance factors for what the diagnostic model call BPD symptoms are unclear. Investigating social cognition in youths with BPD features may contribute to the understanding of these factors associated with this diagnosis.

As the social cognition literature is still in its infancy, with minimal studies focusing on adolescence per se, a more inclusive view was taken to include a broader range of ages, until early adulthood. The current review therefore aimed to synthesize the information on interpersonal abilities in young people with ‘borderline personality features’.

More specifically, the aim was to systematically review the evidence on social cognition in individuals’ aged 12 to 24 to answer the following questions:

1) Are there differences in social cognition between those labelled with BPD and comparison groups and are there any differences within ‘BP features’?
2) Do young people with ‘BP features’ pay particular attention to and recognise emotions and how sensitive are they at detecting emotions?
3) Is there a relationship between the subjective emotional valence of individuals with BPD features and social cognition?

2 Methodology

2.1 Development of search terms

Search terms and selection criteria were developed with reference to the review questions and with the consideration of theoretical and empirical literature on social cognition. This was informed by a scoping review that aimed to assess the breadth of the literature. Search terms and selection criteria are described below, before a description of database searches and details of the quality appraisal.

2.2 Search strategy

A computerised search was undertaken on the 14th August 2015 on Psychinfo, Cinahl and Medline using the search terms (borderline personality OR borderline feature* OR borderline
trait* OR borderline pathology) AND (emotion recognition OR mentaliz* OR facial expression OR social cognition). The source type was limited to ‘all journals’, four different age categories (adolescent, adolescence, young adult, young adulthood) and English language. The results from the databases were collated and duplicates removed.

2.3 Inclusion criteria

There were a number of inclusion criteria set for this review, including: (a) quantitative methodology (social cognition measured in a numerical format); (b) focused on social cognition of individuals with borderline personality features; (c) participants were between the ages of 12 and 24 (research has demonstrated brain maturation in frontal lobes occurs until 24, e.g. Sowell et al., 2003; 65% of individuals who receive the BPD diagnosis present with ‘features’ by the of age 25, Gunderson & Links, 2008); (d) included a borderline personality disorder assessment or diagnosis and addressed one of the three questions of this review.

2.4 Exclusion criteria

There were a number of exclusion criteria set for this review, including (a) qualitative design, (b) articles that were not available in the English language.

2.5 Study selection

Figure 1 displays the search results and selection process. As can be seen, the initial search revealed 614 articles, reduced by the limiters described in Section 2.3 and 2.4 above to 140 articles. After duplicates were removed there were 101 articles remaining, titles and abstracts were scanned for relevance. Articles that were clearly not focused on social cognition or borderline personality disorder, were reviews or evaluated treatment efficacy were excluded. Full texts were retrieved for the remaining 45 articles and ten were included in this review.
2.6 Data extraction

Detailed data from the ten reviewed articles were extracted using a form (Appendix B). Column headings for data extraction were based on the Cochrane Public Health Group guidance (Cochrane Public Health, 2011). The data extraction table was used to summarise key features (study characteristics, participant characteristics and results) and assess the quality (assessment tools/measures, sample size and controls) of each article. Internal and external
validity were considered for the extracted data. Each study was given an ID code from 1 to 10.

2.7 Quality assessment

Methodological quality of the ten selected studies was assessed using an adapted quality appraisal checklist (Appendix C, Downs & Black, 1998). The original tool outlines 27 set criteria to ensure rigorous, scientific reporting of empirical research. These criteria are divided into five domains that assess: the overall quality of the study (ten items); external validity (three items); study bias (seven items); confounding and selection bias (six items) and power of the study (one item). Domains one to four are scored on a zero or one basis (note: some items can be given an 'unable to determine' (UTD)). Domain five is scored one to five. A higher overall score in a domain denotes stronger quality. Additional prompts and a dictionary are available to guide the researcher in scoring. Questions 4, 8, 9, 13 to 15, 19, 23, 24 and 26 were omitted due to being intervention-based. This tool was developed for non-randomised quantitative studies, making it suitable for the current review. This tool has demonstrated good construct validity and inter-rater reliability (Downs & Black, 1998). Studies were marked against these criteria to assess the quality of each paper (see Appendix D).

2.7.1 Data synthesis

Due to the heterogeneity of the studies, a meta-analysis was not possible. A narrative explanation was developed from the collected data, reviewing the studies general summaries, key findings relevant to this review and methodological quality of the studies.

3 Results

3.1 Overview

Of the ten reviewed studies, nine articles employed a non-randomised design and one used a correlational design. The nine studies that applied a non-randomised design used different comparison groups. Two used a nonclinical population, using the BPD measure to divide the group into levels of ‘disorder features’ and two studies used participants with non-BPD psychiatric diagnoses. The remaining five studies compared psychiatric diagnoses with nonclinical participants, two of which had three participant groups (BPD, other non-BPD psychiatric diagnosis and nonclinical). The remaining study used nonclinical students as
participants. The nonclinical participants were recruited through advertisements in local educational establishments and various community areas. A summary of the key characteristics for all the ten studies can be found in Appendices E and F. The studies were each given an ID code that can be found in Appendices E and F.

The specified aims and objectives of this review directed the summary. Findings of the studies are grouped by: participants and control groups; specific elements of social cognition; and the relationship between social cognition and emotional valence. Quality of the studies is then summarised.

### 3.2 Comparisons of social cognition between control groups

**General social cognition ability between those diagnosed with a BPD label and other psychiatric diagnoses**

Two studies investigated differences in social cognition between psychiatric diagnoses through examining cognitive empathy (6, 7). Both of these studies found that young people with BPD showed deficits in social cognition. These studies differed on the deficit finding. Study 7 found that BPD individuals had lower social cognitive abilities and Study 6 found that BPD was significantly associated with excessive, inaccurate social cognition abilities.

**General social cognition ability between psychiatric diagnoses and nonclinical controls**

Five out of the ten studies (1-5) included nonclinical controls compared to those with BPD characteristics. All five studies found either no deficit in social cognition or deficits only for the detection of specific emotions; however, these studies differed on which emotions individuals with BPD were shown to have difficulties with (see Section 3.3).

**General social cognition ability between people with different borderline ‘personality features’**

Three studies examined social cognition across various levels of BPD features. With two of the studies (9, 10) there was no significant difference between individuals with high BP features and low BP features on neutral facial expression. However, one study (8) found that individuals with high BP features interpreted neutral stimuli as more negative than those with low BP features. Study 10 found that individuals in the high BPD group were more accurate for negative stimuli than those in the low group. Study 9 found that individuals in the high BPD group showed a significantly lower ability to accurately identify negative stimuli than the low group.

Overall, the findings were mixed when reviewing social cognition across papers. The studies
that recruited individuals with a psychiatric label or from a nonclinical area showed that young people with borderline personality features demonstrated a deficit in social cognitive abilities. The studies that compared nonclinical to clinical found that individuals with a BPD label either showed no deficit or a deficit only for specific emotions. These reviewed studies suggested that young people with BPD features might have social cognition deficits, which suggested that they might find it difficult to infer others’ emotions.

### 3.3 Specific elements of social cognition: Attention; recognition; and sensitivity to emotions

Five studies investigated young individuals’ attention to emotional faces and specific emotional accuracy. Three studies investigated BP association with attention toward emotional facial expression. Two of these studies found an attentional bias toward negative facial stimuli (1, 2). Specifically Study 2 found that young individuals showed an attentional bias toward fearful faces. However, Study 3 showed no attentional bias toward negative facial stimuli. Two papers (4, 5) examined individuals’ sensitivity to emotional facial stimuli through showing emotional expression in various stages. These papers both found that individuals with BP features were slower and therefore less sensitive to detecting facial expressions; however neither paper found that they had an overall deficit in recognising fully expressed emotion. There was a difference in the emotions that individuals were less sensitive to. Study 4 found that individuals with BP features were less sensitive to ‘anger’ and ‘happiness’; however, Study 5 found they were less sensitive to ‘fear’ and disgust’. These studies suggested that young people with BPD features might have an attentional bias toward negative emotional expression and lower sensitivity to facial expressions. Thus suggesting that young people with BPD features might pay greater attention to ‘negative’ emotions and find it harder to understand subtle facial expressions.

### 3.4 Relationship between social cognition and emotional valence

Out of the six studies that examined the relationship between social cognition and participants’ emotions, four explored pre-emotional state. Two of these (3, 6) found there was a significant association between the social cognition task and the participants’ emotional state prior to the experiment. Hypermentalizing was found to be significantly associated with internalizing problems (depressed/anxious, depressed/withdrawn, somatic complaints) and an association was found between negative mood and an attentional bias toward negative facial expression. Two studies did not find a significant association between emotion and the social cognition task (2, 10). Two out of the six studies examined the subjective emotional response to the social
cognition task (7, 5) and did not find a significant group difference between the comparison groups. One study (7) found that vignettes designed to reflect abandonment, mistrust/abuse and deprivation elicited significantly more negative emotions in both participant groups as compared to vignettes designed to be more neutral (vignettes reflective of ‘conflicts of interest’). These studies suggested that a young person's social cognitive abilities might be affected by the emotions they are feeling. It is suggested that an individual with 'BPD features' might have an attentional bias toward negative emotions when in a negative mood.

3.5 Study quality

A number of methodological limitations are noted that affected the internal and external validity in the ten reviewed studies. Appendix D gives an overview of the study quality characteristics as measured by the quality appraisal tool. This tool demonstrated that all of the studies had limited external validity. The overall study quality was strongest for Studies 4, 8 and 10, with a perfect score of seven. Scores on the first four categories were given a rating of one for each question. The last category measuring power is based on a scale of one to five, with five indicating power to detect difference. Overall, studies were underpowered. The study quality is discussed in more detail in Section 3.6.

3.6 Samples

3.6.1 Sample size

The studies reviewed varied in the sample size, which may have biased the results and affected the ability to detect significant differences. None of the studies reported power calculations in their studies. Eight of the studies were considered underpowered for at least one of the statistical calculations they conducted (1-5, 7, 9-10), thus increasing the chance of Type II errors.

3.6.2 Recruitment, response rates and demographics

Further sources of bias were the recruitment procedures, response rates and demographics. Seven of the studies recruited the clinical participants from psychiatric services, of which three consisted of outpatient services (2, 5, 7), one solely included an inpatient service (6) and four included a combination (1-4). Three of these studies (2, 5, 7) recruited from a BPD-specific service (HYPE) that is designed to treat early BPD symptoms and one study recruited from a
tertiary mental health inpatient service, when no prior treatment had been effective (6). Therefore, the variability in treatment prior to the study makes it difficult to compare findings. None of the studies reported response rates and thus it is difficult to ascertain the generalisability of the findings.

All of the studies reported gender and three of the studies reported on ethnicity (4, 8, 10). The samples were predominantly female and had a mixture of Native European, Hispanic, African-American, Asian and Caucasian. The remaining studies gave no ethnicity details thus limiting the ability to assess generalisability. The majority of the studies used mainly or exclusively female participants, limiting the generalisability to males with a BPD diagnosis.

3.7 Measurements

3.7.1 BPD Criteria

All studies used well-validated and reliable measures for BPD criteria. The studies with clinical participants used semi-structured interviews conducted by trained professionals to measure the number of BPD criteria. Studies with nonclinical participants involved administration of self-report measures to quantify the number of BPD criteria. However, the reliance on self-report measures is not desirable due to the impact of denial or social desirability on responses.

3.7.2 Social Cognition measures

A range of valid and reliable measures were used across the ten studies covering a range of constructs. The majority of studies (1-5, 8-10) measured social cognition through a photographic image of a human face. These studies varied in how they presented these faces, i.e. completely static or changing; and within these categories there was variation of measurement (emotion recognition, disengagement, trait appraisal). Using photographs does not allow for the dynamic portrayal of emotional expression and thus limits its ecological validity. The two studies that did not use photographs (6, 7) could reflect a more ecologically valid measurement for social cognition, mirroring social interaction. Furthermore, due to the range of measures used, it is difficult to compare the findings across studies.

3.8 Control of potentially confounding variables

Studies that do not control or eliminate confounding variables, risk the internal validity of the study. Confounding variables can be controlled in various ways.
Random allocation is the ideal if using comparison groups, as operationally the groups should be similar. When this is not possible, an alternative to randomization is matching. The heterogeneity of BPD as a construct is vast, therefore in order to reduce confounding variables it is important to match control groups to generate valid conclusions. Of the studies that used a comparison group, eight studies stated there was no significant difference on demographics between comparison groups (1-5, 7, 9-10) on factors such as gender, age and socioeconomic status.

Number and type of BPD criteria are an important factor to consider within studies, as it could be a potential confounding variable. The studies varied in how many participants met full diagnostic BPD criteria (five or more symptoms), ranging from 23% to 90%. None of the reviewed studies stated the criteria that were met. Furthermore, it was not stated how long BPD features had been present and the majority of studies did not state treatment duration. It was therefore not possible to assess the BPD criteria that might be most associated with social cognition.

All studies with clinical participants had a minimum of one other diagnosis alongside the BPD criteria. The diagnoses ranged from 27% to 80% for mood disorders, 11% to 63% for anxiety disorders and 18% to 48% for PTSD. These diagnoses have been associated with social cognitive deficits. It is therefore difficult to associate any significant findings with the BPD features per se, when other diagnostic features were not controlled for. However, comorbidity in BPD is high (e.g. Grant et al., 2008) and this could increase the external validity of the findings.

Gender is an important factor to consider as a potential confounder. It has been found that females are generally more accurate in emotion recognition tasks than males (McClure, 2000). It could therefore be possible that the higher proportion of females in the studies may have biased the results.

4 Discussion

The aim of the current review was to explore the empirical literature on social cognitive abilities in adolescents and young adults with BPD features. The review focused on experimental designs and ten studies met the inclusion criteria. Social cognition was measured through static pictures, film and vignettes, employing both clinical and nonclinical participants.
4.1 Differences in social cognition between young people with BPD features and controls

In order to compare social cognitive abilities, experimental conditions were grouped into studies that compared people with BPD features to people in other diagnostic categories, studies that compared individuals with a BPD label to nonclinical controls and studies comparing social cognitive abilities across BPD features in nonclinical participants. The studies indicated an altered social cognitive ability in young people with BPD symptoms. However, when specific areas of social cognition were considered the evidence was variable with some studies suggesting an overall deficit and other studies suggesting that only certain emotions were affected. These findings were similar to previous literature reviews on adults with BPD by Domes et al. (2009) and Lazarus et al. (2014). These previous reviews found that there were general impairments in social cognitive abilities, showing mixed abilities in understanding and interpreting others’ mental states.

4.2 Relationship between BPD features and attention, recognition and sensitivity to emotions

When considering attention and sensitivity to emotional expression, the studies yielded conflicting results. Three studies found young people with BP features were more attentive and sensitive to specific negative emotions compared to positive or neutral expression. Two reported the opposite findings, with less sensitivity to specific emotions. One paper found that there was no association between BP features and attention to facial emotions. Previous literature reviews have also reported mixed results in this area. Domes et al. (2009) found that adults diagnosed with BPD showed a bias toward negative emotions; whereas Lazarus et al. (2014) reported mixed findings depending on the methodology used. When studies used photographs of the eye area, participants were superior on their perception of positive and neutral mental states. In previous studies that used vignettes and characters, adults diagnosed with BPD were shown to have overall poorer recognition of emotions. The previous literature reviews that were focused on adults seem to conflict with the current review’s findings. Specifically within the current review, there was no significant difference found for those youths labelled with BPD at perceiving positive or neutral emotions. The current review does not show an overall poorer recognition, but specific emotion recognition differences.
4.3 Relationship between subjective emotional valence and social cognition

Findings relevant to subjective emotional valence and social cognition were also mixed. There were four studies that investigated participants’ pre-emotional valence and social cognitive abilities. Two of these found that there was a significant difference between mood and task orientation, whilst the remaining two found no significant difference. Two further studies investigated participants’ emotional response to the social cognition tasks. Neither of these found a significant difference between the groups’ emotional responses to the tasks.

Overall the findings were mixed. Social cognitive abilities appeared to be affected in youths with BPD features, with some evidence suggesting that there is a heightened sensitivity to negative stimuli that may be associated with negative mood and a potential avoidance of negative stimuli whilst in a positive mood.

4.4 Overall quality of review studies

One possible cause of variation in results from the current review is the heterogeneity of the population investigated. Comparison is difficult due to the diagnostic inconsistencies across the reviewed studies. All of the studies used a BPD measure, however none of the studies stated which BPD symptoms were present. The BPD labelled participants consisted of both clinical and nonclinical populations. The clinical participants had varying durations and severity of BPD features, with some studies including ‘sub threshold’; the nonclinical participants had ‘high’ compared to ‘low’ features. The clinical participants had a range of comorbid diagnoses, including diagnoses that are related to deficits in cognitive empathy in BPD (Preißler et al., 2010). Furthermore, none of the studies assessed for childhood maltreatment, which has been found to impact on an individual’s ability to detect emotions from social information (Koizumi & Takagishi, 2014). The heterogeneity of the participants may have led to the differences in the results. It is difficult to ascertain whether certain BPD features, duration, severity, aetiology or comorbidities predict the different social cognitive abilities found in the studies.

There were a disproportionate number of female participants in the reviewed studies. Prevalence estimates have been varied for adult BPD populations, with female to male rates within one study suggesting a ratio of 4:1 (Muscari, 2005). However, more recent data has suggested there are no differences in prevalence by gender (Sansone & Sansone, 2011). The samples used in the reviews may not accurately reflect the prevalence of the BPD label across
genders, with three studies explicitly excluding males. The failure to include male participants presents a potential selection bias and prevents exploration of potential gender differences in the BPD label. Research has typically demonstrated a female superiority in nonclinical populations for social cognition tasks (Geary, 2010).

The symptoms consistent with the BPD label commonly have its onset in adolescence or early adulthood (Chanen et al., 2008). However, the difference in social cognitive ability between adolescence and early adulthood is likely to be a confounding factor. Thomas et al. (2001) found that adults demonstrate greater amygdala activation to fearful facial expressions, whereas children showed greater amygdala activation to neutral faces. Differences in emotion processing showed greater activation of the amygdala, orbitofrontal cortex and anterior cingulate cortex for adolescents when compared to adults viewing fearful emotional expression (Monk et al., 2003). It was further shown that adults were more able to modulate activity based on attention demands and adolescents were more able to modulate activity based on emotional demands. The reviewed articles all used a sample age-range from 12 to 24 and the mixed results may reflect a variation in participants’ brain development.

Inconsistencies in results may also reflect variation in the social cognitive measures employed across the reviewed studies. All of the studies used faces or scenarios that were unfamiliar to participants. The use of facial emotional stimuli does not examine social interactions or social context effects. Therefore the ability to extrapolate findings directly to social situations is difficult. One study used a measure (6) that more closely resembled the demands of everyday life and found that youths with BPD features were significantly more likely to over-interpret the social signs. This variation in measures made it difficult to synthesise results and appears to reflect the diversity of social cognition research.

4.5 Strengths and limitations of the current review

Strengths of the current review were that it was systematically conducted and provided a detailed quality appraisal. A limitation of the review was the heterogeneity of the participants and the methodologies employed. Social cognition lacks a unitary theoretical framework (Brizio et al., 2015), making the operationalization of terms difficult. Due to the methodological variety, it was difficult to compare results potentially leading to the inconsistent conclusions. As a consequence synthesising results and drawing any firm conclusions was difficult.

The current review employed the diagnostic label BPD and therefore focussed on papers that
privileged the medical model's understanding of distress. The BPD label is a term commonly used in research, as it is quantifiable and the global standards set in the DSM and ICD increases its use as common language. However, the DCP states that the DSM and ICD classification systems for functional psychiatric diagnoses have significant conceptual and empirical limitations (The British Psychological Society, 2013). It is unclear how adequate the diagnoses actually are in capturing the experiences of people labelled with a personality disorder (Ramon et al., 2001). Comparisons of the DSM and ICD personality disorder classification systems have demonstrated that there is little convergence between the criteria when applied to this group of people (Zimmerman, 1994). The BPD label used within this review obscures the boundaries between the young person’s individual and contextual factors. Therefore primarily focussing on ‘BPD features’ and ‘diagnosis’ reflects a lack of consideration for other aspects that might impact on the young person’s social cognitive abilities.

4.6 Future research
The current review highlighted the growing field of social cognition research in young people with the label of BPD. However, results were unclear with variation in participants and methodologies employed leading to inconsistent results. It is probable that several processes contributed to these inconsistencies, however investigating this was beyond the remit of the current review. Although limited, there does appear to be evidence that social cognition is affected in young people with the label of BPD. Additional research is required to clarify the relationship between social cognition and BPD features in young people and demonstrate the processes and contexts underlying any effects on interpersonal difficulties.

The current reviewed studies mainly employed either static pictures or film. Research comparing interactive, dynamic stimuli (e.g. using the MASC) with more passive stimuli (e.g. RMET) would potentially assist in demonstrating the social cognitive skills of youths with BPD features more accurately. A more longitudinal approach would also be useful to further evaluate any changes in social cognitive abilities. This could be helpful in ascertaining any effects of social cognition on interpersonal functioning and whether social cognition is the underlying mechanism for the difficulties present. Further investigation could also aid in the extrapolation of aetiological factors.

None of the current reviewed studies differentiated between BPD features. The different BPD traits could explain the variation in results. Comparing and controlling for different BP features would allow for an exploration of specific symptoms associated with social cognition. Studies
using clinical populations to investigate any BP association with social cognition would allow for a more valid representation of this population than nonclinical samples. This could assist in deciding the psychological intervention that would be most beneficial for the individual.

4.7 Clinical implications

Overall, the reviewed studies suggested that social cognition might be affected in youths with BPD features. Psychological interventions that improve social cognition have the potential to impact on interpersonal difficulties that are characteristic of BPD. However, it is difficult to draw firm conclusions regarding the relationship between social cognition and emotion as only a minority of studies investigated the association between the two.

Mentalization-based therapy (MBT) and Dialectical Behaviour Therapy (DBT) are current interventions that have been adapted for adolescents with a BPD diagnosis, which include interpersonal aspects. Treatment effectiveness has yielded mixed results (Biskin, 2013). These interventions may improve their efficacy by considering the social cognitive aspects of adolescents with a BPD diagnosis. The potential heightened sensitivity to negative stimuli that might be associated with negative mood and a potential avoidance of negative stimuli whilst in a positive mood might be interlinked in a cycle that maintains BPD features. Therapeutic interventions aimed at influencing these attentional processes could be a beneficial addition to already established BPD therapies. Mindfulness (which is present in DBT) might enhance youths’ abilities to become more aware of these processes and help with social cognitive deficits.

Furthermore, the potential sensitivity to negative stimuli illustrates the importance of self-awareness in staff working within this area. This indicates an area that could benefit in staff training and highlights the need for staff reflection in areas that work with youths.

4.8 Conclusion

This review has demonstrated that there is inconsistent information regarding social cognitive abilities in youths with BPD features. Overall, the research on social cognition is complex, but has the potential to provide valuable insight into the interpersonal difficulties of those with symptoms reflective of a BPD label. Irregular perception and understanding of social signals might contribute to the unstable interpersonal relationships and emotional lability features associated with BPD. Further research is required to establish explanations for the variability in the social cognitive abilities of youths labelled with BPD.
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Society.


Part 2: Research Report

An exploration of the experiences of CAMHS nurses who work with adolescents with the label *emerging* personality disorder
Abstract

**Introduction:** Child and adolescent mental health services (CAMHS) are increasingly using *emerging* as a descriptive term for young people displaying symptoms of borderline personality disorder. In adults these features often result in staff experiencing these service-users as difficult to interact with. For adolescents, staff-relationships are an important feature of being an inpatient. The experiences staff have might impact on the formation of these relationships. The current study aimed to explore CAMHS staffs experiences of working with those labelled with emerging personality disorder.

**Method:** Interpretative phenomenological analysis was employed to explore the experiences of inpatient CAMHS staff of working with young people labelled with emerging personality disorder. Semi-structured interviews were conducted with six staff members from the nursing team.

**Results:** Three super-ordinate themes were generated from analysis: ‘Clouding Everything’, ‘Push/Pull’ and ‘Containing the Self’. Nine subthemes illustrated the convergence and divergence within participants' accounts.

**Conclusion:** The concepts of getting ‘clouding everything’ and ‘push/pull’, precipitated emotional and relationship conflicts of working with young people labelled with emerging personality disorder. Nurses were required to find ways to contain the self in the work and enhance the relationship. Discussion of the links between participants’ experiences, theories and past research illuminated clinical implications that could aid staffs’ experiences of working with these young people.
1 Introduction

Emerging personality disorder is a term used in adolescence mental health. It refers to symptoms that mirror the behaviours and difficult relational patterns present in adults diagnosed with borderline personality disorder (BPD). In adults these symptoms result in the formation of intense relationships with staff (National Collaborating Centre for Mental Health (UK), 2009) and staff can experience such adults as difficult to interact and empathise with (Stuart & Laraia, 2005). On CAMHS inpatient units, it has been reported that staff may have similar experiences with adolescents (Reiss & Gannon, 2015). With the importance of feeling socially connected for adolescents (Hall-Lande et al., 2007), the staff relationships for inpatient adolescents are important. The experiences of inpatient staff of such relationships may impact on the nature of the relationships that they form with the young people (Harder et al., 2012).

Given the known difficulties of staff working with adults diagnosed with BPD (e.g. James & Cowman, 2007) it was deemed important to explore the experiences of inpatient CAMHS staff who are working with adolescents who present with a similar diagnosis and who have a similar range of symptoms and styles of relating. The study therefore aimed to explore CAMHS staffs experiences of working with those labelled with emerging BPD and how these experiences may impact on their emotions and interactions with the inpatient adolescents and their ability to develop a therapeutic rapport.

1.1 Current understanding of personality disorder in adults

The Diagnostic and Statistical Manual of Mental Disorders-V (DSM-V) specifies four key features common to all personality disorders (PD). A person must demonstrate significant and enduring difficulties, which cause functional impairment and/or subjective distress (American Psychiatric Association, 2013). The DSM-V added a hybrid model (Section III) as an overall measure of the severity of personality dysfunction. There have been a number of different theories regarding the development of PD, including theories from: a neurological position (Schore, 1996); temperament (Paris, 2007); a biopsychosocial perspective (Linehan, 1993; Fonagy & Luyten, 2009); and attachment theory (Duggan, 2006). However, each of these theories have highlighted the complex interaction of biology and environment as being important in the development of personality disorder.
1.1.1 Perspectives on diagnosis in the adult population

There are marked differences of opinion about the utility of a BPD diagnosis. Gunderson and Links (2008) argued that the diagnosis of BPD is clinically useful as it helps mental health professionals be aware of the difficulties a service user with BPD might experience. This awareness means they can select evidence-based interventions and strategies that are available to pre-empt or manage these difficulties. Others, such as Griffiths (2011), have argued that it is invalidating to suggest there is something fundamentally wrong with an individual's personality and doing so may lead to discrimination and stigma against those with this diagnosis.

Research within adult mental health services has shown that behaviour seems to be conceptualised as part of BPD when it is ‘challenging’, ‘unmanageable’ or ‘untreatable’. Explorations of mental health nursing attitudes have indicated that nurses find patients with a BPD diagnosis particularly difficult to care for and can have extremely negative attitudes towards them (Bowers et al., 2000; Deans & Meocevic, 2006; James & Cowman, 2007). Such research has demonstrated that there is a negative narrative that surrounds the BPD diagnosis in the adult population. However, similar research has been limited to one study of staff working with adolescent populations (Reiss & Gannon, 2015).

1.2 Diagnosing borderline personality disorder in adolescence

There is a debate about the appropriateness of a BPD diagnosis in adolescence (e.g. Meijer et al., 1998). Although it is believed that personality is still being formed in adolescence (Chanen et al., 2009), BPD is being increasingly viewed as a life-span developmental disorder (Tackett et al., 2009). The prevalence, reliability and validity of diagnosing BPD in adolescence have been found to be comparable to those found in adulthood (Muller et al., 2008). Adolescent borderline personality symptoms have been found to continue into adulthood, continuing to fulfil a greater number of BPD criteria and general impairment 20 years later (Winograd et al., 2008).

The DSM-V permits a diagnosis of BPD in adolescents when maladaptive traits have been present for at least one year, are persistent and all encompassing and are unlikely to be limited to a developmental stage or due to an Axis 1 disorder. However, the diagnosis is not recommended by the ICD-10 in individuals under 17 years of age (World Health Organization, 1992). Qualifying terms, such as ‘possible’ or ‘emerging’ are therefore often used to describe the difficulties rather than making a formal diagnosis of personality disorder (National Collaborating Centre for Mental Health, 2009).
1.3 Mental health staff working with adolescent service users with emerging BPD

1.3.1 Psychiatrists’ view of personality disorder in adolescence

A questionnaire survey was used to investigate the views of CAMHS psychiatrists on the diagnosis of BPD in adolescence (Griffiths, 2011). Significantly fewer psychiatrists considered BPD a valid diagnosis for adolescent populations. The majority of respondents’ comments were negative and viewed the diagnosis as stigmatizing, marginalizing, increased the symptoms and led to therapeutic pessimism. Those respondents who viewed the diagnosis more neutrally stated they would often offer formulations, followed by descriptions of emerging personality disorder, rather than presenting the label in a categorical diagnostic format. Although the respondents stated there was negativity linked to the diagnosis of BPD, it was not clear how the psychiatrists had reached this conclusion. There was no exploration of their interactions with the adolescents or why they believed the diagnosis led to therapeutic pessimism. Furthermore, only psychiatrists’ views on the BPD diagnosis were explored. The research did not explore ward staffs’ beliefs about this diagnosis and nor did it explore the experience of adolescents who received this diagnosis.

1.3.2 CAMHS clinicians explanations of emerging BPD to adolescents

Koehne (2010) examined whether clinicians spoke to adolescent patients about their diagnosis of emerging BPD and how that discussion was framed. Discourse analysis was carried out on 23 clinician and eight adolescent interviews across community and inpatient settings. Findings indicated that practices of disclosure to adolescents were highly context dependent, with community staff talking about BPD in a ‘careful and cautious’ manner and inpatient clinicians discouraged from discussing the diagnosis. Stigma and service rejection were discussed by both inpatient and community staff as concerns related to this diagnostic label, with an advocacy for using the descriptors ‘emerging’ and ‘traits’ to maintain hopefulness. There was no exploration behind staffs’ meaning of these descriptors and how the descriptors increased hopefulness for staff working with these adolescents. The research did not explore staffs’ experience of working with these adolescents or the emotional impact of this work. The research showed that the interaction style of inpatient staff was more cautious but there was no exploration of inpatient staffs’ experiences that may have led to this difference.
1.4 Inpatient staff experiences

The few studies that have directly examined the subjective experiences of inpatient staff in the context of BPD have primarily been limited to the context of adult mental health (AMH) (Abel, 2012). The centrality of staff relationships to clients is enhanced in inpatient environments due to limited family contact and restricted community access (Dennis & Leach, 2007). For adolescents on an inpatient unit, the way staff experience these young people becomes important as the intensity of interactions increases. Therefore, this is an important area for research to explore. Furthermore, research (Zegers et al., 2006) has indicated that less securely attached adolescents have poorer attachment relationships with inpatient staff than secure adolescents. Insecure attachment style has been suggested as a central feature of BPD (Agrawal et al., 2004) and could therefore further impact on staff experience of adolescents with emerging BPD. Thus the increased intensity of inpatient staff relationships with adolescents, along with the insecure attachment style often present in BPD, may lead to the possibility of difficult CAMHS staff experiences of adolescents with this label.

Reiss and Gannon (2015) investigated inpatient nurses’ experiences of adolescents labelled with emerging PD. Interpretative Phenomenological Analysis (IPA) was employed to evaluate how nurses experienced the demands of working with this patient-group. This study found that nurses experienced these adolescents as emotionally demanding and felt a greater need for support. However, the brevity of the interviews (12 to 26 minutes) may not have enabled staff members to fully explore their experiences in the area of emerging personality disorder. Furthermore, one of the researchers was a staff member of the service and may have influenced the participants’ responses.

1.5 Rationale

Quantitative research to-date has largely focussed on attitudes of staff working with adults diagnosed with BPD (e.g. Deans & Meocevic, 2006) and treatment difficulties (Hjalmarrson et al., 2008). The importance of staff-patient relationships in AMH secure inpatient contexts has also been highlighted as an important area for exploration due to the challenging behaviour often experienced in this context (Abel, 2012). Specific research conducted on inpatient staff experiences of BPD has mainly been limited to those working in adult services and these studies have found that staff attitudes tend to be ‘negative’.

Referrals to inpatient CAMHS services are increasing and a known proportion of the adolescents
referred have a label of emerging PD (CAMHS Tier 4 Report Steering Group, 2014). Exploration of staff experiences and the emotional impact of this work have been limited to one inpatient CAMHS study (Reiss & Gannon, 2015) and become progressively important with the increasing referrals to Tier 4 CAMHS. Staff experience of these adolescents may impact on therapeutic rapport. Poorer relationship development has been associated with adolescents who have negative expectations of care and a general high level of interpersonal problems (e.g. Eltz et al., 1995). This is important as adolescents who experience high emotional and social support from staff show a decrease in externalising behaviours (Zegers, 2007). This suggests a clear clinical demand for an understanding of CAMHS inpatient staff experiences of emerging PD. Understanding CAMHS staff experiences could highlight staff needs and allow support to be offered.

Additionally, given that one of the diagnostic criteria for BPD relates to sufferers being more sensitive to rejection (American Psychiatric Association, 2000), negative attitudes from staff may have possible implications for adolescents’ behaviour and their sense of self. This could have a negative impact on the adolescents’ experience with mental health services. In light of this, it is important to explore staffs’ experiences of working with adolescents with the label emerging PD. This study's exploration of staff experiences of adolescents who are labelled with an emerging PD would be a unique contribution to this area.

### 1.6 Aims

The study aimed to explore CAMHS nurses’ experiences and the emotional impact of working with adolescents labelled with emerging PD, how the emotional aspect may impact on staffs’ ability to develop a therapeutic rapport and their interaction with the adolescents.

In line with the overall aim, the main research questions were:

1. What are the experiences and emotional impact of CAMHS nurses working with inpatient adolescents labelled with emerging PD?
2. What are staff’s experiences of interacting with these young people?
3. What are staffs’ experiences of and ability to build a therapeutic relationship?
4. How do CAMHS staff believe they enhance the therapeutic rapport?

There were two subsidiary questions also addressed:

1. What beliefs do staff hold about the emerging BPD label in adolescence?
2. Would more in-depth understanding of the meaning of the behaviour help?
2 Methodology

2.1 Design
In line with the research aims, a qualitative approach was adopted. As the main purpose of this research was to describe and interpret the subjective experiences and personal narratives of ward-based staff, interpretative phenomenological analysis (IPA) was indicated. IPA's three underpinning theoretical perspectives (phenomenology, hermeneutics and idiography) enabled the researcher to explore the distinct experiences of staff in an inpatient setting (Langdridge, 2007).

The IPA methodology combines “empathic hermeneutics with questioning hermeneutics” (Smith & Osborn, 2008, p. 53), suggesting that interpretation of individuals’ subjective experience is an interpretative process. An IPA approach was most appropriate as it is used on data to extract themes by the researcher, whilst allowing for participant’s direct expertise in an experience to be explored (Smith & Osborn, 2008). IPA further allows for detailed analysis of the lived experiences of participants, focusing on the meanings they ascribe to the personal perceptions of events in their lives (Smith & Osborn, 2008).

According to IPA, this process allows the possibility to know something of the participants’ experiential truth. Furthermore, IPA has been suggested as an especially suited methodology for healthcare due to the affiliation with biopsychosocial theories (Smith, 2004).

2.2 Epistemological position of the researcher
A critical realist position was taken for conducting this research (Appendix G).

2.3 Research context
The research was undertaken within a CAMHS Tier 4 inpatient unit, developed to provide a secure hospital environment for adolescents aged 12 to 18 presenting with mental health difficulties. Adolescents come from a range of geographical locations and from various socioeconomic backgrounds. The team is multi-disciplinary and includes clinical psychologists, nurses (registered and unregistered), occupational therapists, psychiatrists and speech and language therapists.
This unit is separated over two wards; a general adolescent unit and an assessment unit. The rationale for completing the study in one unit was based on the homogenous population required for IPA. Both wards were mixed gender units. On this unit, the term emerging personality disorder was used to represent an individual with characteristics consistent with BPD or emotionally unstable personality disorder.

### 2.4 Participants

#### 2.4.1 Sample Size

It is suggested that small samples are used for IPA research due to the length of time taken for case-by-case analysis (Smith & Osborn, 2008). The thorough and detailed accounts of individual experiences that IPA is interested in can only be achieved through small sample numbers (Smith & Eatough, 2006). In line with these recommendations, a sample size of six to eight participants was aimed for and six recruited.

#### 2.4.2 Inclusion/Exclusion Criteria

A purposive sampling method was undertaken in line with IPA. Participants were recruited to reflect a homogenous sample. Individuals were eligible to participate if they had worked on the unit for a minimum of six months and were in a ‘frontline’ clinical position. These criteria were specified to ensure staff had regular contact with adolescents labelled with emerging personality disorder. Staff members were required to work in the inpatient setting, as research is limited in this area and the experience and emotional impact may differ between community and inpatient staff. Staff who did not work in a clinical position were excluded to maintain homogeneity. Due to the potential challenge to homogeneity, along with lack of funding for translation, participants whose first language was not English were further excluded.

#### 2.4.3 Final Sample

Demographic details are limited to those that do not impact on the anonymity of the participants. The final sample comprised of six female participants. Four participants were in the 18 to 30 age-category and two participants were in the 31 to 40 age-category. The overall duration staff had worked on the unit ranged from one to 12 years; all staff were permanent members of the team, with varied levels of CAMHS experience. Qualified staff were a combination of mental health and paediatric nurses.
2.5 Materials

2.5.1 Demographic questionnaire & semi-structured interview

A self-report questionnaire (Appendix H) was used to collect contextual information for the qualitative data gathered in the face-to-face semi-structured interviews (Smith & Osborn, 2003). This included information on occupation, duration of work in CAMHS, any training on personality disorder and years since training or qualifying (for registered nurses).

A semi-structured interview was designed to guide the interview (Appendix I). Written consent was obtained immediately before each interview commenced (Appendix J). In order to orientate the participant to the research, the aims of the study were introduced. Questions began broadly and became more specific to assist in rapport. To ensure the participants led the interviews, the interview schedule was used as a guide as opposed to a rigid structure. Prompts were used for clarification and to elicit further information. The questions on the interview schedule were scanned through at the end of each interview to ensure all pertinent topic areas were covered.

2.6 Procedure

2.6.1 Ethical considerations

University staff and a service-user reference group undertook a peer review procedure. Ethical approval for the research was sought and gained from the University Ethics Committee. Approval was granted from the local NHS Research and Development department via the Independent Research Application System (IRAS) (see Appendix K).

Interview topics had the potential to cause upset in participants due to the sensitive nature of discussing experiences of working with emerging personality disorder. Participants were reminded of their right to withdraw from the study up to the point when their data was anonymised and that this withdrawal would not affect them. Participants were informed that there would be the opportunity to discuss the interview process, including any concerns, during de-briefing, and that if required they could receive support from the CAMHS team. It was highlighted to participants that any disclosures made during the interview that raised concerns regarding the safety of them or others would necessitate a break in confidentiality by the researcher and the appropriate procedures followed for safeguarding. Throughout each interview, the participant was monitored for distress levels and offered immediate support by the researcher if they felt it was required.
University regulations and NHS guidelines were followed to maintain confidentiality of the storage of information.

2.6.2 Recruitment

Potential participants were contacted through the clinical psychologist on the unit. The clinical psychologist emailed an initial contact letter and information sheet (Appendix L) to all Tier 4 ward-based CAMHS staff. Posters (Appendix M) were also distributed in staff areas. Potential participants were invited to make contact with the lead researcher or field supervisor. The researcher emailed participants with information about the study and gave the opportunity for queries to be answered. Participants opted in to the study and interviews were arranged at suitable times and locations. There were seven individuals who met inclusion criteria and expressed an interest in being interviewed. Six of these were interviewed due to one participant withdrawing consent.

2.6.3 Interviews

It is recommended that an interview schedule is used as a guide to allow the participant to shape the topic (Smith et al., 2009). Furthermore, a key component of an interview schedule is that it allows trust and rapport to be built with the participants to enable them to feel comfortable disclosing personal information (Reinharz, 1992). Funnelling questions from general to specific allowed a gentle introduction to the main topic area and aided in rapport building (Kvale & Brinkmann, 2009). A semi-structured interview schedule (Appendix I) was therefore employed to allow for responsive question adaptations depending on the topic areas discussed by each participant. This was to ensure the understanding of the phenomenon was not biased by the researcher’s understanding of the area and facilitated participants’ accounts of their own lived experiences (Smith et al., 2009).

All six interviews took place in an office not connected to the main patient ward area. Prior to commencing the interview, the researcher ensured participants had read and understood the information sheet and answered any questions. Participants completed a demographic questionnaire. Permission to audio record the interview was requested and all participants consented.

Following the interview, participants were given the opportunity to ask questions and explore
any issues or concerns raised during the interview with the researcher. A written reflection of the interview was made at the end of each interview. Interviews ranged from 40 minutes to 67 minutes (average length 51 minutes).

2.7 Analysis

After each interview, the audio-recordings were transcribed verbatim. A professional transcription service was used to transcribe three of the recordings. Anonymisation of data occurred during the transcription process. All transcriptions were checked against the recordings of the interview for accuracy and to ensure familiarity with the data.

From the transcripts an IPA approach was used to analyse the data, which included several stages. Analysis began with a case-by-case detailed examination to follow the idiographic approach of looking at particular examples, leading to a more general categorisation of themes (Smith et al., 1995). Each individual case was read a number of times, noting areas of interest, initial thoughts and tentative interpretations. Each transcript was then revisited in order to document emergent theme titles. Following individual analyses of cases, clustering of themes and exploration of the possible links between participant’s experiences was reviewed to create superordinate and subordinate themes (Ritchie et al., 2003). To ensure transparency, further process analysis details are provided in Appendix N. The initial coding and clustering of themes are represented for one participant as an example (Appendix O).

2.8 Quality issues

2.8.1 Quality

Qualitative research is concerned with issues around coherence, credibility and transparency as opposed to reliability or generalisability (Yardley, 2000). Certain strategies were undertaken to ensure the quality of the current research was protected. Theme development was discussed in supervision and repeatedly related back to the data. A qualitative analysis support group was arranged and guidance sought from researchers applying IPA methodology. Independent reviewers were used from this group to ensure quality. Details of the process were kept throughout (Appendix O).
2.8.2 Reflexivity

The emphasis within IPA is that the research process is interactive and dynamic, with a critical role being the interpretations made by the researcher (Smith & Osborn, 2003). Therefore, a fundamental component of the research process is reflexivity. Reflections on the process were kept throughout the progression of the research (please see Appendix P for a full chronology of research process). This process was further aided by utilising the quality checks (see above) to ensure appraisal of assumptions and conclusions.

3 Results

Following the detailed analysis of each individual case, a cross review of all the cases resulted in the development of three super-ordinate themes. These super-ordinate themes were comprised of less frequent subordinate themes that were developed through an iterative process of identifying connections across cases (Smith et al., 2009). IPA does not comprise a prescriptive formatting method (Smith et al., 2009) although it is important to feature the dynamic overlap of themes (Figure 2).

The first super-ordinate theme is called ‘Clouding Everything’ and considers the challenges and conflicts the nurses felt when trying to understand the young person separate from the label. The second super-ordinate theme entitled ‘Push/Pull’ aims to encapsulate the impact of internal and external conflicts arising from having to directly manage the interpersonal and intrapersonal challenges. Respondents’ subsequent ability to manage and protect their selves from the arising frustrations is explored within the third super-ordinate theme called ‘Containing the Self’. Subordinate themes are considered in relation to the over-arching themes within sections 3.1 to 3.3 below.

3.1 Clouding Everything

This super-ordinate theme aimed to encapsulate the nurses’ ability to understand the young person with the label emerging personality disorder. The theme demonstrates the difficulties the nurses experienced with labelling the young person and the conflict that can be created from doing so. The feelings of uncertainty when working with these young people led to limited feelings of safety and a need to be alert.
3.1.1 Barriers and conflict

Participants clearly spoke about their ambivalence towards the label. There was a conflict between appearing to need a label in order to access support or to aid understanding and not really understanding what the term meant or feeling that it could exacerbate symptoms.

I think umm for some people that are given that label, it has been good for them because then they know this is what's wrong with me, like I've been going through all of this, now I know and can get treatment for it but on the opposite side, I don't think it's very good because it labels you and some people can't cope with that label so it can kind of makes you more ill in a way.... Like 'emerging' what is that, it's a bit ambiguous...um does that mean that I'm getting it and does it stop or like what does it mean? (Julia)

There was a further sense by some participants that the label would be 'with you for the rest of your life' (Jane), whereas others were clear that adolescents were 'not always necessarily going to have this diagnosis' (Jodie). The conflicting nature of these statements reflects the conflict of working with these young people. Jodie particularly appeared to dislike the term emerging personality disorder, stating that seeing it 'as an attachment disorder is more beneficial than PD'.
Figure 2: Super-ordinate and subthemes
With attachment, the problem is between people and needs to be worked on within the family; just saying PD makes the person feel like it's their problem. With personality disorder it seems to say there is something inherently wrong with your personality, leading to stigma. (Jodie)

There was a fear that once a young person was labelled with emerging personality disorder, they would need to offer an explanation of the diagnosis. This fear appeared to arise from the conflicting desire to ‘illuminate a shadow’.

I do feel that sometimes it’s maybe a bit scary for other people to try and explain without putting a negative sort of spin on it I suppose. Because when you look at the symptomatology it is quite, quite hard to put a nice light on it because a lot of the behaviours that comes out as part of that, they’re not socially acceptable. (Jessica)

The label seemed to trigger further conflicting reactions within the team. The nurses spoke about not feeling heard by the wider multidisciplinary team.

The younger they are the less people want to label them with that... as a nursing team, um we’re saying you know if that’s what they have, just let them have that so they can get the right treatment at the right time, let’s stop faffing about with all these other things that they may or may not have... the odd person that’s been diagnosed straight away, that’s what you’ve got and we’ve been able to work with them a lot better and a lot quicker. (Janet)

Jacky’s account highlighted the attraction of using the term emerging, drawing comparison between the full diagnosis and its use as a descriptive term.

I think it can be really helpful, um, and then I think it has both contexts. I think emerging means that, I think it means people avoid the actual official label that everybody has the negative view around. I think in terms of, um, professional-wise, I think it’s, the emerging sense is pointless... But I do wonder whether that gives people a bit more hope, I don’t know. (Jacky)

3.1.2 Feeling unsafe and uncertain

The awareness of the symptoms associated with emerging personality disorder led to
feelings of uncertainty and a lack of safety.

Quite on guard, if that makes sense? Quite, because I know about the unpredictability and I said that unpredictability is going to make you feel anxious anyway, it would make you feel anxious and on guard (Julia)

Julia also spoke about how this unpredictability triggered feelings of anxiety and the inherent challenges associated with not knowing how an individual was going to react to a situation.

People with emerging personality disorder are so unpredictable, the unpredictability, it does make you a little bit anxious. Because it is so unpredictable, you don’t really know what the situation is going to be and how to respond to it (Julia)

The disbelief of and a desire to not reinforce symptoms in a young person that might ‘have’ an emerging personality disorder perpetuated the feeling of uncertainty. 

She came in with apparent hallucinations…could have been learnt…imitating other patients with like eating problems but we didn’t like feed into it and then she got diagnosed with emerging BPD (Julia)

The feelings of uncertainty were echoed in staffs’ beliefs about the longevity of the label and symptoms. Jessica believed it would ‘always be a part of them’. Whereas Jacky stated that ‘it doesn’t mean that all these experiences were there and set for life’. Jessica referred to the ‘cyclical’ nature of the symptoms leading to inherent challenges with predicting risks. Her use of the word ‘cyclical’ further denoted the sense of a never-ending cycle that made the sense of wellbeing more uncertain.

With someone with emotional dysregulation problems, um, you tend to see more sort of cyclical, um, patterns of presentation, um so a young person might be experiencing voices and then they may more onto sort of a lower, a lower state overall. They might self-harm, might restrict their food. Um might go through periods where they’re so um anxious that all they want to do is run away and get away from what they’re feeling which obviously presents itself as risk in terms of absconsion… so it makes their, their pattern of risk I would say harder to predict sometimes. (Jessica)
The unpredictability felt from the uncertain behavioural cycles appeared to compound feeling unsafe. Janet spoke about the unknown risks associated with the young people and fearing that the risks would continue to escalate.

*On a shifty basis you’d have like a massive list of all the things that she’d done that were major risky, um and we were like just expressing our concerns, you know like this poor girl is going to do something really really extreme soon, really risky soon if you don’t get her out of here, so yeah it’s hard (Janet)*

The way these cycles were perceived by staff varied, with some seeing these cycles as a due to ‘boredom’ or ‘attention-seeking’ and others seeing it as more of a direct communication method about their distress. Jane’s laugh appeared to display her discomfort with the notion of attention seeking.

*But people get frustrated and people do use the like attention seeking to explain what’s going on (laughs), but yeah, you can, you can see people. It’s often like a similar thing over and over again. Which I think can be quite frustrating as well. (Jane)*

In order to manage the feelings of uncertainty and risk, staff spoke about being alert to possible risks within the environment. Julia stated that they would carry out these checks in a way that was not obvious to the young person and appeared to reassure that this would not look different.

*It’s just being aware of your surroundings because we like check the garden every day for things like sharps, so if we were like in the garden, we’d be checking but in a very subtle way, you wouldn’t be doing it obviously because that could then be a trigger, think then, well that’s because of me, like they could feel that you’re accusing them… It doesn’t look different cos that would be, I wouldn’t say unprofessional, but it wouldn’t be very nice for the young people… you treat that person as well as you treat everyone else, the same, but you’ve got it in yourself that you know and you talk yourself through it. (Julia)*

The emotional impact of feeling unsafe and uncertain within the environment often precipitated staff feeling uncertain in their professional practice.
So I think it can be quite confusing, it can make you question yourself quite a lot and question your practice quite a lot as well (Jacky)

3.1.3 Visibility of the young person

The conflict between noticing the young person behind the label and simply noticing the risk featured strongly throughout. This notion continued into having a ‘gut feeling’ versus a ‘professional’ knowing that the young person was going to do something challenging or that they ‘had’ an emerging personality disorder.

You just can’t see them cos they’re clouded by everything that you’re having to deal with. Like the melee of presentation of symptoms (Jessica)

Jessica’s statement represents that it is sometimes difficult to get to know the person behind the behaviour. Her use of the word ‘clouded’ suggested that there was more of the person to ‘see’ but the symptoms of emerging personality disorder present strongly and makes it difficult to get behind that. Jane’s statement about staffs’ tolerance toward behaviour similarly conveyed the challenges inherent with trying to get to know the young person.

I think people are a lot more tolerant of someone self-harming who doesn’t have the emerging personality disorder label (Jane)

Being in an inpatient culture that used the label ‘PD’ to describe behaviour without further explanation appeared to reinforce the difficulties associated with understanding what the label was referring to and created more tension between staff.

Being in inpatient CAMHS was hearing people use the word PD and not knowing what that meant. Uh and describing people’s behaviour as very PD (Jacky)

Managing the unknown nature of the label was the intrinsic feature of a gut feeling that a young person ‘had’ a personality disorder. Janet, Jessica, Jodie and Jane made reference to a feeling and knowing that this is what a young person ‘has’.

I’m finding it hard to answer the question, how do you ‘know’ [that they’ve got emerging personality disorder]? Um people do that self-harming when they've got emerging personality disorder but also people do that when they don’t... and, um, it depends, the way the function of self-harm I
Julia further stated that this ‘gut feeling’ and the objectivity of emerging personality disorder symptoms are used to help manage the impulsivity.

You get it with most patients but with emerging personality disorder, well I get it myself anyway, I get more of a gut feeling and I think that’s because I know about the impulsivity as opposed to someone who’s come in with depression, if that makes sense? (Julia)

Staff not understanding the young person's behaviour was associated with the belief that this led to further difficulties for the young person. Jessica referred to ‘because they’re not getting their needs met is escalating’ and Julia’s sense that ‘they need treatment but they think they’re fine’ show the conflict between staff and the young person. Jacky believed that the distress felt by the young person can go unnoticed, further creating division between the young person and staff.

Um, but I think what can happen is that the distress that the young person is experiencing can get missed within that sometimes. (Jacky)

In contrast to this was staffs’ desire to understand and get to know the young person beyond the label, symptoms and risk. Julia referred to wanting to ‘get to know a person first’ before reading through their notes as this could alter your perception of who they are and push you away from getting to know them as a person.

Not reading through her notes and getting to know her for that one shift umm it makes me more, uhh, objective...if you read that they've done horrific things, you might well get a bit intimidated and not then get to know them better (Julia)

There was a sense that understanding the young person and their context was key to helping the young person on their therapeutic journey and to managing their own emotions. Jessica, Janet, Jodie and Jacky referred to thinking about what the young person had gone through in their life in order to help them with their own frustration. They also spoke about trying to see the young person in a balanced way, noticing the positive attributes, along with the risks and challenges. Jacky spoke about the juxtaposition between wanting to see the young person’s background to aid
understanding and the complexities that understanding can lead to.

So for me I always think about them as a traumatised young person that probably needs more compassion than others. Um, which might be unfair. As equally unfair as, um, saying that they’re EPDs. So for me there’s definitely a view that, yeah, this young person’s traumatised. Young person that has been through some damaging times and that’s, yeah, I might, I could possibly end up becoming over-compassionate at times I think, which can be very frustrating for others I’m sure (laughs)... I definitely look at the positives around what that young person’s got, which I think is really good for the young person but I think when your team are getting frustrated with that young person that’s not what they want to hear at those moments. So I think that’s what I mean about being over-compassionate. (Jacky)

Summary
The superordinate theme, ‘Clouding Everything’ captured staffs’ difficulties in trying to separate the young person’s individuality from the diagnostic criteria. The subordinate themes demonstrated the multifaceted aspects of the vacillation the nursing staff experienced when considering the use of the label and trying to notice the young person.

3.2 Push/Pull
This super-ordinate theme aimed to encapsulate the push/pull nature of working within an inpatient environment with adolescents labelled with emerging personality disorder. The push/pull conflict led to frustration within individual staff members, across the team and appeared to be echoed in the adolescent inpatients.

3.2.1 Boundaries and splitting
For most participants a sense of struggling to maintain boundaries as the young people labelled with emerging personality disorder pushed against them was reflected in participants’ descriptions of interactions with them.

I think with emerging personality disorder it’s just more explicit, they do it [pushing boundaries] more and even when staff stick completely to the boundaries, they’ll try and push, which other patients don’t as much.
Participants spoke about managing this pushing of boundaries to ensure team splitting was not encountered. Julia spoke about ‘making sure that the whole team are aware of what’s going on’ with Janet drawing attention to having a boundary between information for the team to be aware of versus limiting the young person’s knowledge. The ‘them and us’ mentality appeared to be a somewhat protective factor for team splitting.

As much as possible we try and play that down, as we’ve found the more you make an issue, the worse the symptoms get... so like we have something on the back of the kitchen door, but it’s locked away but we can all see it. (Julia)

There appeared to be fear that the young people would push the boundary with staff and this may lead to the young person misinterpreting their relationship with staff. Jodie stated the need to be ‘really boundaried with them, making sure there’s that clear line and that they’re not thinking you’re their friend’. This illustrates the anxiety of the attachment issues with the label emerging personality disorder. Jacky further illuminated this by explaining the need for stability and ‘some security there for them and for you, so you know that you have your one-to-one at this point’. However, Jacky also stated that the need to be flexible with boundaries was needed at times. This further reinforces the push/pull nature of the experience of working with young people with the label of emerging personality disorder. It is difficult to ascertain and explain at what point to maintain a boundary versus flexibility.

...but I think actually sometimes you have to break boundaries and bend boundaries and be flexible. But it’s difficult to explain that to people, I think that comes with experience as to knowing how something feels and how it fits and I don’t know that you can verbalise how that is, so much as to, yeah when you’re new and less experienced and so you need those boundaries to help you more so. (Jacky)

The frustration that arises from creating a boundary with a young person and the split that can occur with a team not maintaining the boundary was prominent within participants’ narratives.
Um so you might work and that person might agree a point of care for them when they're in crisis but other people will say but we don't do that here and that's not the rules and so won't always work to that model and it can end up with them going wow, I don’t want to do this but it’s on the care plan, so I will. And some members of the team may flatly refuse to work in that way. (Jessica)

These splits can further occur between staff and family. Jane referred to an experience whereby the young person had stated that her family did not want to see her at Christmas.

This girl said that her mum wasn’t coming to see her at Christmas, didn’t want to, so the whole team ended up becoming angry at the mother, there was this like split against her, what a ‘terrible mother’ We then later found out that the mum had offered and the young person had told her not to come. I felt hoodlumed. (Jane)

3.2.2 Interactional Conflict

Most participants referred to a sense of trying to maintain rapport with the young person within the push/pull relationship.

There’s a classic quote isn’t there? ‘I hate you, please don’t leave me’ [laughs]. Generally um, that’s, that wrapped up in one [laughs] really. Um, yeah. (Jessica)

Julia stated the variability within the therapeutic relationships, stating ‘one day they’ll talk to you like you’re their friend and the next they won’t even say hello’. This appeared to lead to difficulties with knowing how to interact with the young person, further perpetuating the feeling of unpredictability of working with these young people. Jacky connected this uncertainty with the young person’s sensitivity toward others’ feelings.

Um, I think sometimes reading the young person and getting the signals right and whether you’re getting the interaction right can be hard. You don’t know that they’ll always tell you. Um, I don’t think they’d want to upset, sometimes they wouldn’t want to upset you, in order to do that. (Jacky)
Jacky further went on to refer to the innate interactional difficulties with these young people and indicated that there are challenges when an interaction does go wrong.

It’s more about actually their- how much they can tolerate both your personality and how much they actually can’t tolerate of your personality I think. I think it’s more difficult to get that right than it is for other young people. Or more obvious when you get it wrong. (Jacky)

Jessica and Julia both conveyed a sense of feeling pushed into an interaction by the young person. Jessica stated ‘they’re very demanding, they’re very tiring sometimes’ and Julia referred to the young person ‘trying to engage you in that type of conversation again where it’s a bit like argumentative’. Ensuring individual rapport building with the young person appeared to at times conflict with the need to ensure team stability.

Sometimes it can make you feel really good, that you’re the person that they want to help. Um, sometimes it can make you feel really bad that you’re the person that they want to deal with it, but you know you’ve got a team that can deal with it just as well and that they’re getting annoyed that you are, or you start worrying that they might get annoyed. (Jodie)

All participants discussed interactional conflict within the progression of treatment. Prominent in Jane’s account was the difficulties associated with experiencing a young person as not engaging and a sense of feeling helpless.

They don’t want to do it [treatment]. So what else have we got? We’re, we’re, we’re a bit lost then. So that’s, that’s actually being a failure again. (Jane)

This feeling of helplessness was reflected in the team due to the inpatient environment being incorrect for the young people and the non-linear progression of their symptoms.

Like with one person in particular, she’d make like 10 steps forward and then she’s just do something to jeopardise her leave and then it would be taken away again and it was just seeing that forward and backwards constantly, it’s really hard but also another massive massive frustration that as a staff group there was nothing we could to help because this wasn’t the place for them. (Janet)
Some participants suggested team interactional conflict. Jessica referred to fellow team members using the word ‘behaviour’ in a derogatory manner.

> I hate it when people say it’s behaviour...cos everything’s behaviour. Um me going to the shop and buying milk is behaviour, like as if it’s their fault. (Jessica)

### 3.2.3 Values Conflict

A sense of working with young people labelled with emerging personality disorder seemed to be at conflict with the inherent values of being a nurse. Julia's account spoke about feeling 'helpless, you feel like you tried your best but that's not good enough'. This seemed to lead to a desire to retract from the young person.

> I guess it's a nursing thing, like you get into nursing to look after people and care for people and make them, help them get better and when you feel like you can't do that it's like [trails off] I think sometimes you can put that on the person and really it's kind of, it's more you and your own response to it, isn't it? You probably don't want to spend as much time with them because you know, how you might come away feeling at the other end of it. Whereas the people who have different kinds of illnesses, it might seem like they appreciate what you're doing more for them. (Jane)

The feeling of helplessness often appeared to lead to a sense of ‘doubting yourself’ and ‘frustration’ (Julia). A particular frustration for Jane was that the ability to help might be restricted due to the young person’s difficulties.

> I think sometimes these kids with emerging personality disorder don't realize that's what we're here for, some of them think it is just a job but I think in this kind of field, you need to want to help otherwise that frustration can just take over and therefore it's about having that motivation to help someone and then keeping that, I suppose. (Jane)

Jodie, Jane and Janet all spoke about needing to be flexible with how you nurse. Jane's account illuminated feelings of balance between active engagement in practical nursing duties and limiting possible "reinforcing consequences" of spending time with the young people.

> You have to help someone if they've done something to hurt themselves
and we're very, you know, kind of go and give you support and you spend time with them. Um, which is difficult because at the same time you don’t want to encourage the behaviour. (Jane)

The difficult balance between creating a therapeutic space and over dependence was highlighted. This seemed to reflect a desire to be able to be a nurse in the situation and yet not create difficulties within the relationship.

I find it very hard to fine tune being a stable base and being there for someone and them not becoming overly dependent on me... because it’s not useful for them... um, because I’m a nurse you want to help fix things, no matter what it is...make sure that you’re regular but that they’re not feeling rejected. (Jessica)

The push/pull was further highlighted between nursing and MDT values. Janet highlighted that the MDT would try to offer an explanation of behaviour, not understanding that the nurses wanted practical ways to manage situations.

Then the nurses saying right well this is how we have to deal with it right, neither of you [medical or speech and language therapy] are making much sense so we need to be more practical in a way, um so it’s all well and good someone telling me why they’re doing it but you need to make a management plan for that. (Janet)

Summary
‘Push/Pull’ reflected the impact that resulted from managing the interpersonal and intrapersonal challenges of working within an inpatient environment that uses the label emerging personality disorder. This superordinate theme demonstrated the frustrations nurses experienced due to managing relationships with the young people, the team and their selves.

3.3 Containing the Self
The third theme is concerned with how participants protected themselves when working in an inpatient environment. It refers to the professional aspects of managing emotions and interactions with young people labelled with emerging personality disorder. Staff utilised various coping mechanisms to contain themselves within their
work.

3.3.1 Internal management and understanding

This theme reflects participants’ ability for reflexivity, internal supervision and understanding their own limitations. Julia spoke about the young people being in 'a very vulnerable situation' and that reflecting on the young person’s life helped her to care.

*Keep calm, keep patient, remind yourself of why you’re there, what helps me is to remind myself of the trauma that this person’s been through, think about how lucky you are and what they’ve been through* (*Julia*)

Janet and Jessica drew specific attention to their own personal attributes, believing that these personally help them to manage the nature of the work. Jessica stated that she’s ‘always been the sort of person’ who understands you cannot push someone to change or fix them and Janet's comment that ‘I am quite calm in intense situations’ denoted a certain amount of acceptance within the experiences. Jodie continued with this through her depiction that the emotion will be with you but you are required to contain that whilst you are at work.

*The frustration, everyone’s going to get frustrated at times but it’s about dealing with your frustration in your own time* (*Jodie*)

Jessica illustrates the strain of the job requirements and illuminates the loneliness of this through her use of a singular pronoun. Her strong use of 'consumed' was interpreted as showing the overwhelming nature of the work and the need to maintain balance.
Your job might to maintain them for 6 months, so that they're well enough to get to that placement that you're actually waiting for, um and I think sometimes, um, you need to make sure that you're getting space as well. Um or you can almost become as consumed as maybe the family did, um and, and as tired as the family did. And then you won't respond in a way that's appropriate for what they need.... Decide I’ll meet you 3 times a week at these times...whereas outside of those times I’ll spend positive time with them, we won’t focus on hard topics. And that just isn’t for them, it’s a way of showing them that I want to meet with them when they’re being happy and when they’re sad, um but also it’s because I need room, um to process. (Jessica)

3.3.2 External support

Alongside feeling personally responsible for an individual and containing situations individually, were the notions that there was a team and supervisor who were supportive. All participants highlighted the importance of having a team who were readily available ‘to reflect what you think’ (Julia) and ‘having a really supportive team’ (Jodie). Jessica further emphasised the importance of a team in order to help with refining nursing abilities.

You know you can talk to someone. It helps me feel supported and it helps me to identify where I've gone wrong, not wrong necessarily but how I could have improved the situation because we've always got room to improve. (Jessica)

This minimisation appeared to continue with Janet stating 'just like chatting’ and within Jane’s account ‘we’re really good at being very insistent and just keep going’. These both illustrate the importance of being part of a team and having external support around you in order to manage the job. Janet and Jane further talked about the importance of feeling unified within the process; ‘we could talk about it as a whole, which was really good’(Janet).

And it probably helps that we're a team of people and if you were one person, maybe this was your child and you had to keep going by yourself, that would be very hard. (Jane)

Further to utilising the whole team as a support mechanism, participants spoke about
the need for supervision. Julia’s reflection that supervision ‘gives me that time to like breathe’ shows the restrictive feeling of being on the unit. The emotional impact of working with the young people is normalised by stating ‘it’s just a normal reaction to get upset’ (Janet). The need to access supervision ‘on a regular basis’ (Jodie) to consider ‘the psychological reasons behind their behaviour’ was discussed.

3.3.3 Holding onto positives

This final theme portrays participants’ experiences of noticing, reflecting on and keeping hold of positive experiences that they have encountered. For Julia, considering how the small initial steps ‘can lead to bigger things’ enabled her to feel enjoyment when working with these young people.

I quite enjoy working with someone with emerging personality disorder because of seeing how when they do move on, how nice it is to see, even when, I mean that happens with everyone, but because of their symptoms it’s even nicer... Because of the initial level of risk, getting them to see that they can control this, I mean yeah there might still be a level of self-harm but not at the same level. (Julia)

Jessica and Janet conveyed how understanding an individual’s inner emotional world and the early experiences could assist them in managing their emotions. Using specific techniques with the young people that showed ‘we know you were struggling’ (Janet) enabled them to hold onto the protective factors.

Found that it’s extremely rewarding, um... I think once you understand that someone feels, can feel so deeply one end or the other throughout the day and don’t take that personally but see it more as, um, a direct result of what’s going on inside, even though you can’t see it all the time, or try and think of it as how they may have been trying to get their needs met or saying I’m distressed. (Jessica)

Jodie’s description of thinking about their journey as collaborative benefitted her in feeling like she was making a difference and acting as a positive influence.

But being able to mmm like go through that journey with them to hopefully see them get better. It’s nice to see them overcome their issues. There have been those success stories... They’ll ring back to just update us
and that’s nice, that’s probably like the best part. (Jodie)

Jane’s experience of reflecting on her interactions with these young people appeared to enable her to hold onto a sense of wellbeing. Through positively comparing her own abilities with other staffs allowed her to feel like she was making a difference. She appeared to derive a sense of empowerment from this reflection.

Sometimes I feel like I’m not really doing anything very helpful but then when I think that perhaps other people might respond to that and you think, well actually what I’m doing is definitely better than that response. (Jane)

Summary
‘Containing the Self’ showed the importance nurses placed on their internal and external resources and how they experienced these as beneficial to their work with the young people. Reflecting on their positive experiences of the young person allowed nurses to maintain rapport and increase their capacity for this work. This superordinate theme demonstrated that nurses needed to defend themselves when working in the inpatient environment with young people labelled with emerging personality disorder.

4 Discussion

4.1 Summary of research findings

The current study generated three super-ordinate themes (Clouding Everything; Push/Pull; and Containing the Self) that clarified the emotional impact of working with young people labelled with emerging personality disorder. The themes highlighted the difficulties witnessed within the relationship between the CAMHS nurse and young person. The themes further revealed ways that CAMHS nurses acted to enhance the relationship.

4.2 Theoretical connections

The processes within IPA require the application of psychological theory in the examination and illumination of themes (Smith, 2004). The emergent themes are discussed in relation to previous research and psychological theory. This part is separated into subsections that reflect the study’s overall main aims and objectives: the
emotional impact; the therapeutic relationship; and enhancing the relationship.

4.2.1 Emotional impact of working with young people with a label of emerging personality disorder

**Feeling helpless and frustrated**

Participants’ dominant negative emotional experiences of helplessness and frustration have been reported in both the adult literature (e.g. Abel, 2012) and the study in CAMHS (Reiss & Gannon, 2015). Abel (2012) found that nurses often felt difficult, challenging emotions when working with adults diagnosed with ‘PD’, feeling that they could not give ‘hope’ or do anything to help. This was reflected in the helpless feeling of the current study’s participants. The cycle described by participants in ‘Feeling Unsafe and Uncertain’ reflected the perpetuating nature of unpredictability and anxiety that precipitated a sense of helplessness and frustration within the nurses. Frustration was also found in Reiss and Gannon’s (2015) study. It was concluded that this frustration was due to the conflicting positive and negative emotions induced through working with the young people. This was mirrored in the overarching ‘Push/Pull’ theme where participants spoke about feeling a conflict between their emotions due to the interactional difficulties with the young people.

**Intrapersonal and team processes**

An important perspective illuminated by the current study was that the level of frustration might not simply be a reflection of the direct work with these young people. The importance of shared values within teamwork (McCallin, 2001) suggested the team disagreement might be a further source of frustration. A felt sense of support from colleagues is an important protective factor for burnout (Melchior et al., 1997) and could be at risk with the conflicting values.

The current study suggested that frustration was induced by a conflict between a desire to help and the nurses’ perceived ability to help due to the dynamic nature of the young person’s engagement and disengagement. This was highlighted within ‘Values Conflict’. It has been suggested that due to the innate relational difficulties within the BPD diagnosis, it can make engagement difficult and thus can make it difficult for clinicians to feel like effective helpers (Orygen, 2015). Participants’ descriptions of a desire to engage
and help the young person conflicted with the disengagement of the young person. Pines (2000) found that nurses enter the profession to help individuals who are unwell with the underlying belief that they could help. The contrast of working with young people with issues reflective of a diagnosis of 'PD' might act in contrast to this aspiration. This was reflected in participants’ descriptions of the interactional process that occurred between the nurse, young person and team that precipitated the feelings of frustration.

**Issues around labelling**

The subordinate theme ‘Feeling Unsafe and Uncertain’ reflected the difficulties that the participants felt when working with young people with a label of emerging personality disorder. There was conflict over the 'emerging' label. Participants felt an ambiguity over the term and a fear that symptoms might be exaggerated by using it, mixed with the pressure that it was necessary for intervention. This appeared to reinforce nurses' anxieties and frustrations. This conflict is reflected in the BPD literature; with some studies demonstrating that the label is necessary to access evidence-based treatments (Gunderson & Links, 2008) contrasted against the stigma of the term BPD (Griffiths, 2011). The current study demonstrated that nurses might experience both of these aspects in an ambivalent struggle, which impacted on their emotions when working with these young people.

4.2.2  *Developing a therapeutic relationship*

**Attachment Style**

It has been suggested that working with service users with a BPD label demonstrate qualities of attachment relationships (Adshead, 1998). Bland and Rossen (2005) suggested that when working with these individuals there could be a transfer of the strong emotional conflicts witnessed within the parental relationship to the nursing relationship. The nurse might be put into the position of attachment figure that re-enacts difficult early experiences. The link between insecure attachment style and personality disorder (e.g. Duggan, 2006) suggested that the environment may be stimulating attachment behaviours that might be difficult for nurses to manage.

Participants’ accounts of the ‘Push/Pull’ nature within the therapeutic relationship reflect the links with insecure attachment style noted in the literature. The potentially conflicting nature between a young person's desire to be supported and helped is juxtaposed against the withdrawal witnessed by participants, supported by qualitative
studies carried out with adult populations (Drapeau & Perry, 2004). The ‘Push/Pull’ feel could be viewed as a reflection of service-users fear of establishing a relationship, their sensitivity to rejection and negative beliefs about oneself and others (Boldero et al., 2009). The dynamic between young person as passive recipient of help and the active treater role of nurse, resulted in the participants experiencing a range of disharmonious self-responses. The psychological impact of participants continued sense of being in a ‘Push/Pull’ relationship precipitated and perpetuated a vulnerable internal world of conflicted identities; nurse as helper and feeling helpless. Through the current study it has been demonstrated that CAMHS inpatient nurses might find interactions difficult with this client group. This difficulty might be due to the insecure attachment style present for many with the label of emerging personality disorder.

**The impact of negative beliefs**

The evoked feelings of working with individuals with a BPD label have been linked to negative beliefs that might impact on the therapeutic relationship development (Orygen, 2015). Participants’ accounts highlighted a complex interactional process when considering the label of emerging personality disorder that appeared to influence the therapeutic rapport. Using the term ‘PD’ to describe behaviour acted as a barrier to understanding the young person and created difficulties with the relationship. Participants’ conceptualisation of the diagnosis acting as a barrier concurred with Griffiths’ (2011) findings that using the BPD diagnosis in CAMHS led to therapeutic pessimism and increased stigmatization. Therapeutic pessimism and resulting stigma might be due to the helplessness felt when working with these service-users. Furthermore, Aviram et al. (2006) found that the stigma could lead to nurses distancing from individuals with BPD. Participants’ descriptions of being aware of their surroundings and ensuring that an unprofessional relationship was not formed could reflect a certain distancing. The link between high vigilance for social stimuli and BPD (Linehan, 1995) could result in the young person being more aware of this than the nursing staff believed and could impact the therapeutic rapport.

**Meaning taken from behaviour**

Maintaining personal boundaries is an important aspect in managing the effects of both the introjections and projections from client-work (Menzies-Lyth, 1979). A breach of boundaries can lead to staff acting upon the projections, therefore endangering their abilities to consider the projections as a form of communication. This was noted in
‘Visibility of the Young Person’ where participants highlighted the importance of considering behaviour as a method of communication. It was noted that when behaviour was not viewed as communication, it was spoken about in unhelpful ways, such as referring to it as ‘manipulative’. Considering behaviour through this lens could endanger the relationship, causing further distancing from the young person. Issues reflected in the themes ‘Boundaries and Splitting’ and ‘Interactional Conflict’ demonstrated the challenges of developing and maintaining relationships with these service-users. Research has shown that adults diagnosed with BPD have intense relationships with staff (National Collaborating Centre for Mental Health, 2009) and that they are difficult to interact and empathise with (Stuart & Laraia, 2005).

4.2.3 Enhancing the relationship

The label
Using the term ‘emerging’ increased a sense of hope for staff, which has been reflected in past research (Koehne, 2010). This might protect against a certain amount of stigma and enable a rapport to be fostered. Rather than viewing the label as a lifelong trajectory, those who viewed ‘emerging’ personality disorder as a difficulty that could be treated remained more hopeful. Furthermore, research has noted that when an individual is viewed as a label, past experiences, such as trauma, can be unnoticed as a factor in the distress (Campbell, 2008). Therefore not considering the descriptive term ‘emerging’ could inhibit the ability to build rapport.

Increased understanding
The understanding of the individual as someone who might have had a traumatic background enabled participants to have a more compassionate view of the young person. This was highlighted within the theme ‘Clouding Everything’, which illustrated that increased understanding assisted staff in developing and maintaining rapport. Veysey (2014) suggested that adults with a BPD diagnosis found staff most helpful when there was a therapeutic connection reflective of a gained understanding of the service-users’ behaviour. This is reinforced by Linehan’s (1993) statement that there is a strong correlation between ‘liking’ this patient group and helping them.
**Positive Reflections**

Staff spoke about the importance of reflecting on positive interactions with the young people to ensure rapport was maintained. This might help in the facilitation of secure attachment development (Rutter, 1998) by allowing staff to develop a therapeutic relationship with the young person. Furthermore, this could help to decrease the stigma of this label (Aviram et al., 2006). *Holding onto Positives* might increase positive interactions, aid a shift in attributions of the individual’s behaviour and therefore potentially help to decrease the stigma associated with this label.

### 4.3 Clinical implications

The generated themes highlighted that participants found it challenging to work with these young people. In particular, participants found it difficult to separate the young person from the label and manage the frustrations that arose from the work. The nurses’ experiences highlighted a number of ways that working with the young people could be improved. Participants’ experiences particularly highlighted the importance of supervision, team communication and positive interactions when working with this population. These aspects appeared to make nursing staff feel supported and more understanding of service-users.

#### 4.3.1 Supervision

The superordinate themes highlighted that staff at times found their experience of the young person impacted on their ability to be therapeutic. It was highlighted within ‘Push/Pull’ that at times staff experienced a desire to withdraw from the young person. Considering the applicability of the DBT technique *opposite to emotion action* would be helpful for staff when thinking about the relationship with the young person, as this would indicate proximity as an intervention. The superordinate theme, ‘Containing the Self’ particularly highlighted that a supervisory space provided time to consider the young person’s background, along with time to discuss the staff/adolescent relationships.

Nurses’ feelings of personal helplessness and directionality over their input highlighted the need to discuss the importance of the therapeutic relationship (e.g. Shirk & Karver, 2003). Gallop (2002) stated that regular supervision was important to enhance staffs’ view of service-users. Research within adult’s diagnosed with a PD label has emphasised
the value of supervision for support and altering attitudes (Bland et al., 2004). The current research showed that it is likely this would be equally important when working with the adolescent population. A suggested recommendation for CAMHS inpatient units using emerging personality disorder would therefore be to ensure supervision was offered regularly to nursing staff. It would be beneficial for this supervision to include discussions around relational dynamics, increasing self-awareness and considering the emotional impact of the work. Therefore, implementing a formalised time within supervision that would allow nurses to reflect on their experiences is a suggested recommendation.

4.3.2 Training and team formulation

Within the superordinate themes, staff discussed the conflict and difficulties with the emerging personality disorder label and the resulting conflict between team members. The differences across staffs’ views appeared to heighten frustration levels and impacted on nurses’ experiences of working with the young people. Training has been suggested as a way of demonstrating the early experiences component in people with a PD label’s development to be more person-centred (Bowers et al., 2000) and thus could align viewpoints between staff. Highlighting developmental stages within training packages would further enable nurses to contextualise the young person and take a more person-centred approach. The increased understanding would enable nurses to manage the experience of working with young people with the emerging personality disorder label more effectively.

The idea of ‘team formulation’ (Johnstone, 2013) could further aid communication between the wider MDT and nursing staff. Whilst allowing staff to understand the individual, team formulation assists staff in making problems seem more understandable (Summers, 2006). Therefore team formulation could further increase understanding of the young person, which could heighten staffs’ sense of helpfulness. Furthermore, increasing staff awareness about the young person’s experiences through formulation could help manage staff frustration levels and explore potential barriers that might impact on staff experiences of the adolescent. Increasing staff awareness about the young person’s experiences may help manage the staff frustration and explore potential barriers that may impact on staff experiences of the young person. Therefore, a suggested recommendation for CAMHS inpatient units that use the label emerging personality disorder is to use a combination of training and team formulation to help with the conflict and frustration that nurses might experience in this area.
4.3.3 Positive interactions

Frustration appeared to be perpetuated by the conflicting nature of nurse as helper and feeling helpless. Participants described a desire to engage and help the young person but frequently felt at a loss to do so. Nurses highlighted the importance of reflecting on the positive interactions with young people to enhance rapport and feel helpful. Promoting social interaction is one of the primary roles for a nurse on an inpatient unit (Basavanthappa, 2007). This is part of creating an environment that affects behavioural changes and improves the psychological health and functioning of the individual (milieu therapy (Skinner, 1979)). The relationship formed between staff and service-users have been shown to be beneficial on a number of levels, from modelling to developing self-esteem (Rose, 2002). Rutter (1998) highlighted the importance of creating a secure attachment through proximity, responsiveness and a facilitating environment, which he called ‘active reciprocal interaction’. Adshead (1998) considered the application of this within an inpatient environment and suggested the importance of therapeutic activities in fostering a secure attachment style.

Enhancing ward-based activities by utilising influential nurses to interact with the young people could promote a more person-centred approach and thus help the nurses see the individual separate from the label. Combining an increased understanding of the young person and creating more positive interactions could therefore help to modify nursing staffs’ attitudes. Therefore a suggested recommendation for inpatient units using emerging personality disorder as a label would be to create opportunities for engagement through activities.

4.4 Strengths and limitations

The current study has contributed to an increased understanding of CAMHS nurses’ experiences of working with young people with a label of emerging personality disorder and contributed a unique insight into the frustration nurses might feel. This study has highlighted that frustration might arise out of conflict within professional values. It demonstrated that when team members viewed personality disorder differently to each other, this emotionally impacted the individual staff member. Furthermore, the values conflict between the nurses’ desire to help and the ambivalent presentation of the young person created further frustration and helplessness for the staff member.
There has been a paucity of research exploring the experiences of teams working with adolescents. Employing an IPA approach allowed for a deeper exploration of nurses' lived experiences with young people with a label of emerging personality disorder. The IPA criteria for a robust study include: subscribing to its underpinning theoretical principles; being sufficiently transparent to the reader; and presenting the analysis in a way that is coherent, plausible and interesting (Smith, 2011). The current study has attempted to achieve these criteria through maintaining a focus on making interpretations based on individual’s experiences and connecting these to psychological theory and research.

The sample size is within the range recommended for IPA (Smith et al., 2009) and supports the homogeneity required for an IPA study. This allowed for the depth of understanding but caution must be taken when considering the generalisability of the results. The findings reflect the experiences of nursing staff within a single CAMHS inpatient unit with a high staff to patient ratio and a robust psychology service that aids understanding of service user difficulties, along with available treatment. Therefore, it is important not to over-interpret their experiences as being indicative of all CAMHS inpatient nursing staff. Furthermore, all participants were female. Research has indicated that male nurses may view their role from more of a medical perspective than female nurses (Dassen et al., 1990; Holmqvist, 2000). Consequently male nurses might have a different experience to female nursing staff.

### 4.5 Recommendations for future research

The findings are based on female participants’ experiences from a single CAMHS inpatient unit and it would be beneficial to conduct further research with both genders in other inpatient settings. Conducting research with community CAMHS staff could help to differentiate innate inpatient experiences from the challenges occurred with this population.

This study was limited to nursing staff whose experience might differ to other mental health clinicians working with young people labelled with emerging personality disorder. Although research with CAMHS psychiatrists (Griffiths, 2011) has demonstrated that therapeutic pessimism is not limited to nursing staff, further exploration with other MDT members would be beneficial.
The findings indicated that language is an important factor when considering the use of the label and the challenges associated with these service-users. The belief held by clinicians about the BPD label and the individual signify a chronicity and intractability about the difficulties (Orygen, 2015). Discourse analysis would aid exploration of the way the diagnostic linguistics communicate to clinicians, making this methodology a valuable addition to this area.

4.6 Conclusion

In exploring the experiences of CAMHS nurses working with young people labelled with ‘emerging personality disorder’, the current study revealed the multifaceted psychological and emotional impact of this work. There was a complex interplay between the presentation of the young person and the label competing against the nurses’ desire to help and frustration over dynamics. The struggle that nurses felt trying to understand the young person and go ‘Clouding Everything’ conflicted against the ‘Push/Pull’ nature of the relationship. The desire that the participants felt to create a therapeutic rapport assisted them in managing their emotions and the dynamics. Participants actively engaged in methods that would protect these aspects. The findings of the current study highlighted the importance of self-awareness, team working and support when working with these young people. Having supervision and team discussions, along with reflections on positives aided understanding and helped participants work in this area.
5 References


Part 3: Critical Appraisal
1 Introduction

The aim of this paper is to offer a critical appraisal and reflection on the experience of conducting the research and the areas of personal, professional development through the process. A reflexive diary was kept throughout in order to help facilitate this reflection and forms the basis of this section. The first part focuses on the research process and includes: my decision to explore emerging personality disorder; epistemological position; choosing a methodology; accessing CAMHS; recruitment; conducting semi-structured interviews; and analysis. The second explores my overall personal and professional development through this research journey.

1.1 Research process

1.1.1 Decision to explore emerging personality disorder

My personal motivation for the project was an interest in CAMHS and the concept of personality disorder. I had worked with adult inpatient populations and first been introduced to the idea of something called a personality disorder (PD) when I worked in a prison and then further in a specialist PD unit. I was intrigued by the feelings that seemed to arise so readily from working with this clientele. As my understanding of PD grew and seeing the links with trauma and attachment, I began to wonder how and if this label was used in CAMHS.

I decided to contact a friend who had worked in CAMHS for over ten years to seek their advice. She told me that PD was not used as a formal diagnosis due to age but that emerging personality disorder was used as a way of describing what could be going on. She said that this label was reflective of a borderline personality disorder (BPD) diagnosis and was used with reasonable regularity within CAMHS inpatient units. Through conversation, it appeared that the experiences CAMHS staff had were similar to the experiences felt by staff working in adult services. Reflecting on the importance of social circles for adolescents, my interest in CAMHS staff experiences with this population increased. I considered the question, if AMH inpatient staff experiences were mirrored by CAMHS inpatient staff experiences, this would surely affect staffs' abilities to develop therapeutic relationships?
1.1.2 Epistemological Position

Teaching was increasingly from a critical psychology position and was making me question the very foundation of how I viewed the world and particularly mental wellbeing. I was somewhat drawn by the social constructionist stance that difficulties are constructed within a culture and context and that knowledge is formed on this understanding (Walker, 2006); that the way we think about ‘things’ create what we consider nature. I reflected on what I believed about the world and recognised that I believed reality is subjective. However, I also held firm that there was the possibility of ‘knowing’ reality in a more objective way. This led me to appreciate that my ontological and epistemological positions were somewhat conflicted. I believed that distress exists in an objective sense but our knowledge does not converge with this actual part yet. My resulting realisation was that I was a critical realist (Robson, 2002), believing that there was something that mental health services called ‘PD’ to reflect real human distress.

1.1.3 Choosing a methodology

My reflections on epistemological position, led me to consider various methodologies. The main two considerations were between discourse analysis (DA) and Interpretative Phenomenological Analysis (IPA). The DA concerns with the role of language in the description of how experience converges with the interaction with environment (Gee, 2005) appealed to my ontological position. I considered how language appeared to create and add to the experiences of mental health staff working with adult populations. In some respects language appeared to play a vital role in the creation of the reality and this intrigued me; how would CAMHS nurses use language to describe their experiences? I considered my particular interests, which were about how individuals ascribe meaning to their experiences. IPA developed to allow for rigorous exploration of idiographic subjective experiences and social cognitions (Smith, 2004), which appealed to my desire to understand the experiences and thoughts of CAMHS staff. I was interested in the meanings that staff took from their interactions with young people and what this meant to them. The difference between DA and IPA was that IPA assures that through interpretation it could become possible to access a staff member’s inner cognitive world (Smith et al., 1999). My decision to use IPA was thus chosen as it was most closely aligned with the overall research aims and objectives, as well as my
1.1.4 Accessing CAMHS

I had originally believed that the term ‘emerging’ PD was used widely across all CAMHS but soon realised that this was not the case. It was necessary to contact numerous CAMHS psychologists to discuss the use of this label with their staff groups and about gaining access to the team. This resulted in varying meetings across various sites to secure support from a psychologist whose team employed this term and was willing to allow me access. I eventually found a psychologist who could assist me. She explained that the term was used with reasonable frequency in the inpatient unit and she would be willing to discuss my research with the other leads in the service to consider access. Discussions took place over a couple more weeks before I was informed that they would be willing to support me in my research. It was decided that the psychologist would be my field supervisor and be my point of contact for recruitment. This process illustrated to me the importance of conducting research in an area that is known to you. I was trying to gain access to CAMHS in a geographical area I had not worked and with people I did not know. This made the process somewhat slow. It has further shown me the significance of communicating and asking for contacts. Furthermore, I have learnt the importance of ensuring the frequency of a variable is not simply based on one person’s experience.

1.1.5 Recruitment

I was reliant on my field supervisor for the recruitment of my participants. She had agreed that she would forward on initial contact emails to all ward-based staff and put posters up in staff areas. Staffs’ initial interest was strong, with three people contacting me immediately after learning about the research. However, interest then dwindled and six weeks later I decided to arrange a meeting with my field supervisor to consider ways forward. She agreed to continually discuss the research in team meetings and re-send emails to staff. I managed to recruit one more person following this. Due to shift patterns, one of the initial potential participants was unable to commit. I therefore had recruited three people in a three-month period. I considered that this recruitment rate would not be sufficient and therefore met with my field supervisor again to discuss
options. We agreed that it would be beneficial for me to meet staff to discuss my research and we arranged a date for an informal meeting with them. Within this meeting, I recruited three further staff members, which gave me a total of six participants. On reflection, I believe attending appropriate clinical meetings and personally introducing the research prior to emailing ward-based staff would have aided recruitment. I believe that this shows the importance of knowing people in the area and the importance of visibility when conducting research.

1.1.6 Conducting semi-structured interviews

Prior to clinical training, I had been involved in semi-structured interviews for qualitative research. I believe this helped me to feel reasonably at ease with the interviewing process. Furthermore, I felt that my clinical experiences helped me to create a good rapport with my participants. Yet, at times, my desire to validate and reassure, blurred the boundary between therapist and research roles (Birch & Miller, 2000). Some of the participants stated they found the open-ended, emotionally based questions difficult to understand and answer, stating they were “too abstract”. This appeared to be particularly true of a couple of participants whose anxiety was higher. Previous research (e.g. Jeffcote, 2005) has found that this could reflect the participant’s discomfort at being the subject of research. Furthermore, a divergence of experience might have been influenced by mutual defences (Holloway & Jefferson, 2000) that made it more difficult to access emotions. On several occasions, participants chose to continue talking after the audio-recorder had been switched off. This made it difficult to capture some of the richer descriptions of experiences that were then revealed.

Power dynamics might have further influenced participants’ abilities to be reflective. Although qualitative research proposes to decrease the power differential to encourage disclosure and validity (Karnieli-Miller et al., 2009), this is not always possible due to various factors, including educational and professional background (Anyan, 2013). Although, I deliberately took a less powerful role within the interview allowing participants to shape the interview, they might have nevertheless perceived me as possessing more power than them (Hoffman, 2007). This was demonstrated particularly in one interview whereby she repeatedly stated that she did not know how to answer questions. According to Lukes (1974) there are three dimensions of power within qualitative research. The second form, deterrence power, involves the interviewee
rejecting particular categories of questions that inhibit the interviewer from continuing with questions from those kinds. On reflection, more time could have been allocated to framing the research and discussing any concerns prior to interview. Furthermore, ensuring that participants were aware they would be required to discuss their experiences in an organic way, might have aided disclosure.

Conducting research within the hospital grounds might have meant that participants were in ‘work-mode’. Research has demonstrated that nurses are able to conduct themselves in numerous manners dependent on the context (Bolton, 2001), which might have affected their ability to answer in a completely transparent way. On reflection, I think conducting the interviews away from the hospital and preferably on a rest day may have decreased defences and allowed for a more explorative investigation of their experiences. However, this might have led to further difficulties with recruitment.

1.1.7 Analysis

Listening to interviews repeatedly and checking against transcripts for accuracy prior to analysis was important in minimising any potential threats to the integrity of the data (Easton et al., 2000). Whilst listening to the audio-recordings, I annotated the transcripts. This increased my ‘immersion’ in the data, allowing me to consider how participants’ spoken words might contribute to ‘meaning’ interpretations (Corden & Sainsbury, 2006), consequently maximizing the quality and consistency of data analysis.

Analysing the transcripts was more time-consuming than initially anticipated. The richness of the data and the compressed timeframe of the DClinPsy left me at times feeling overwhelmed and frustrated. IPA’s flexible guidelines (Eatough & Smith, 2006) were challenging for me as an IPA novice trying to find my individual style of working and remain mindful of my research aims. I continually felt that I was reducing each participant’s experiences into small parts, losing their individual meaning. I became acutely aware of this when developing the overall themes across datasets. Through an iterative process with the transcripts and the central quotes for each participant, I tried to minimise losing the individual. I aimed to do this through formulating each central concept in maintenance cycles, reflecting back to individual participant’s themes and quotes. Using research supervision and a qualitative support group allowed me to
develop confidence in my analysis and interpretations.

I reflected on my previous experiences, along with how I was positioned socially and emotionally compared to participants (Mauhtner & Doucet, 2003). As someone who has worked with adults labelled with BPD, some aspects of participants’ accounts resonated with me. Furthermore, as I had historically worked as part of a nursing team I was aware that I might predicate analysis on experiences that fit with accounts from previous colleagues. The all female sample, along with my experiences led me to consider how my gender and professional identity could impact on my relationship with the data. Carefully considering the interplay between my multiple social locations and past experience during data analysis was important in this process (Mauthner & Doucet, 2003). Drawing upon the qualitative support group and supervision assisted me in balancing my interpretations with the reality of the data.

1.2 Reflections on personal and professional development

1.2.1 Clinical work

During data collection, I had a CAMHS inpatient placement. I noticed that my position on personality disorder changed from believing that there was something called personality disorder to believing that the young person’s presentation was more trauma-based or systemically activated. I noticed a correlation between staff feeling less contained due to for example service changes and an increase in adolescents being described as having ‘personality difficulties’ and displaying more ‘challenging behaviour’. This made me reflect on my conceptualisation of other people’s experiences and my own. I began to consider what I meant by ‘wellbeing’ and ‘mental illness’, arriving at a contextually based view of both. I believe that this is an important reference point for me within clinical psychology. Data analysis also demonstrated to me the multiple layers of an individual’s experience, which has reinforced the need to illustrate this in psychological formulation.

My passion for team working and increasing psychological knowledge in MDT members has developed through the research process. My now heightened awareness of nurses’ experiences gives me a deeper understanding of their emotions, abilities and concerns. I feel that it is important that nurses are aware of their ability to provide a therapeutic experience for individuals separate from individual talking therapy. Increasing the
nurses’ understanding of their vital role in helping service users feel contained and validating their emotions is an important aspect psychology can add to a team. I believe that offering a reflective space and recognising the importance of psychology’s visibility within a team are important aspects taken from this process.

1.2.2 Research development

My knowledge has been developed through carrying out this research. I have learnt about the process and how to conduct a piece of robust research from proposal through to execution. My understanding of the importance of research supervision and how to use it to its greatest effect has developed. Learning these new skills will enable me to continue in my development as a researcher and integrate this role when I am qualified. Furthermore, using this as a template, I feel that I would be able to support others in conducting their own research.

1.2.3 Self-care

My personal management and organisation abilities have increased through this process. I have developed skills in balancing multiple conflicting demands, which I believe are invaluable in my future career. I have learnt the importance of self-care, which is not only vital for myself as a clinician but also in modeling to clients and colleagues. My understanding of the importance of supervision in facilitating this self-care ability has developed throughout conducting the research. I have learnt throughout that research is created through an ongoing reciprocal process with others and to understand that a balance must be achieved.

1.3 Final reflections

Through the research project, I have had the opportunity to experience and learn about myself as a clinician, a researcher and as a person. I found my view of wellbeing altered from not particularly considering context to believing that wellbeing is interconnected with the context that an individual is within; the two cannot be separated. I believe this knowledge is increasingly important in today’s healthcare system and hope to use this within my future role as a clinician.
2 References


Appendices
Appendix A: Guidelines for clinical psychology review

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DESCRIPTION

Clinical Psychology Review publishes substantive reviews of topics germane to clinical psychology. Papers cover diverse issues including: psychopathology, psychotherapy, behavior therapy, cognition and cognitive therapies, behavioral medicine, community mental health, assessment, and child development. Papers should be cutting edge and advance the science and/or practice of clinical psychology.

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## Appendix B: Data extraction form

<table>
<thead>
<tr>
<th>Title:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Author (1st only):</td>
</tr>
<tr>
<td>Publication Date:</td>
</tr>
<tr>
<td>Journal:</td>
</tr>
<tr>
<td>Volume:</td>
</tr>
<tr>
<td>Keywords/Definitions:</td>
</tr>
<tr>
<td>Aims:</td>
</tr>
<tr>
<td>Sampling/Participants: <em>(total number of participants? Age range, who was studied, how was the sample recruited? Response rate?)</em></td>
</tr>
<tr>
<td>Study type/Design: <em>(randomised allocation? Is a control group used?)</em></td>
</tr>
<tr>
<td>Measures: <em>(What measurements are used? Are measures validated? At what time points are measures completed? Self report or clinician rated?)</em></td>
</tr>
<tr>
<td>Analysis: <em>(What statistical methods were used? Was power calculated? Intention-to-treat?)</em></td>
</tr>
<tr>
<td>Findings:</td>
</tr>
<tr>
<td>Controls/Validity/Reliability:</td>
</tr>
<tr>
<td>Conclusions: <em>(What do the findings mean? Generalisability? Implications &amp; Recommendations?)</em></td>
</tr>
<tr>
<td>Additional Comments:</td>
</tr>
</tbody>
</table>
Appendix C: Quality appraisal tool

Appendix 2: Downs and Black checklist for non-randomized studies

<table>
<thead>
<tr>
<th>ALL CRITERIA</th>
<th>DESCRIPTION OF CRITERIA (with additional explanation as required, determined by consensus of raters)</th>
<th>POSSIBLE ANSWERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Is the hypothesis/aim/objective of the study clearly described? Must be explicit</td>
<td>Yes/No</td>
</tr>
<tr>
<td>2</td>
<td>Are the main outcomes to be measured clearly described in the Introduction or Methods section? If the main outcomes are first mentioned in the Results section, the question should be answered no. All primary outcomes should be described for YES.</td>
<td>Yes/No</td>
</tr>
<tr>
<td>3</td>
<td>Are the characteristics of the patients included in the study clearly described? In cohort studies and trials, inclusion and/or exclusion criteria should be given. In case-control studies, a case-definition and the source for controls should be given. Single case studies must state source of patient</td>
<td>Yes/No</td>
</tr>
<tr>
<td>4</td>
<td>Are the interventions of Interest clearly described? Treatments and placebo (where relevant) that are to be compared should be clearly described.</td>
<td>Yes/No</td>
</tr>
<tr>
<td>5</td>
<td>Are the distributions of principal confounders in each group of subjects to be compared clearly described? A list of principal confounders is provided. YES = age, severity</td>
<td>Yes/No</td>
</tr>
<tr>
<td>6</td>
<td>Are the main findings of the study clearly described? Simple outcome data (including denominators and numbers) should be reported for all major findings so that the reader can check the major analyses and conclusions.</td>
<td>Yes/No</td>
</tr>
<tr>
<td>7</td>
<td>Does the study provide estimates of the random variability in the data for the main outcomes? In non-normally distributed data the inter-quartile range of results should be reported. In normally distributed data the standard error, standard deviation or confidence intervals should be reported.</td>
<td>Yes/No</td>
</tr>
<tr>
<td>8</td>
<td>Have all important adverse events that may be a consequence of the intervention been reported? This should be answered yes if the study demonstrates that there was a comprehensive attempt to measure adverse events (COMPLICATIONS BUT NOT AN INCREASE IN PAIN).</td>
<td>Yes/No</td>
</tr>
<tr>
<td>9</td>
<td>Have the characteristics of patients lost to follow-up been described? If not explicit = NO; RETROSPECTIVE = YES if not described = UTD; If not explicit no numbers agreeing to participate = NO. Needs to be explained within methods section.</td>
<td>Yes/No</td>
</tr>
<tr>
<td>10</td>
<td>Have actual probability values been reported (e.g. 0.035 rather than &lt;0.05) for the main outcomes except where the probability value is less than 0.001?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>11</td>
<td>Were the subjects asked to participate in the study representative of the entire population from which they were recruited? The study must identify the source population for patients and describe how the patients were selected.</td>
<td>Yes/No/UTD</td>
</tr>
<tr>
<td>12</td>
<td>Were those subjects who were prepared to participate representative of the entire population from which they were recruited? The proportion of those asked who agreed should be stated.</td>
<td>Yes/No/UTD</td>
</tr>
<tr>
<td>13</td>
<td>Were the staff, places, and facilities where the patients were treated, representative of the treatment the majority of patients receive? For the question to be answered yes the study should demonstrate that the intervention was representative of that in use in the source population. Must state type of hospital and country for YES.</td>
<td>Yes/No/UTD</td>
</tr>
<tr>
<td>14</td>
<td>Was an attempt made to blind study subjects to the intervention they have received? For studies where the patients would have no way of knowing which intervention they received, this should be answered yes. Retrospective, single group = NO; UTD if = 1 group and blinding not explicitly stated.</td>
<td>Yes/No/UTD</td>
</tr>
<tr>
<td>15</td>
<td>Was an attempt made to blind those measuring the main outcomes of the intervention? Must be explicit</td>
<td>Yes/No/UTD</td>
</tr>
<tr>
<td>16</td>
<td>If any of the results of the study were based on &quot;data dredging&quot;, was this made clear? Any analyses that had not been planned at the outset of the study should be clearly indicated. Retrospective = NO. Prospective = YES.</td>
<td>Yes/No/UTD</td>
</tr>
<tr>
<td>17</td>
<td>In trials and cohort studies, do the analyses adjust for different lengths of follow-up of patients, or in case-control studies, is the time period between the intervention and outcome the same for cases and controls? Where follow-up was the same for all study patients the answer should be yes. Studies where differences in follow-up are ignored should be answered no. Acceptable range 1 yr follow-up = 1 month each way; 2 years follow-up = 2 months; 3 years follow-up = 3 months . . . 10 years follow-up = 10 months.</td>
<td>Yes/No/UTD</td>
</tr>
<tr>
<td>18</td>
<td>Were the statistical tests used to assess the main outcomes appropriate? The statistical techniques used must be appropriate to the data. If no tests done, but would have been appropriate to do = NO.</td>
<td>Yes/No/UTD</td>
</tr>
<tr>
<td>19</td>
<td>Was compliance with the Intervention/s reliable? Where there was non-compliance with the allocated treatment or where there was contamination of one group, the question should be answered no. Surgical studies will be YES unless procedure not completed.</td>
<td>Yes/No/UTD</td>
</tr>
<tr>
<td>20</td>
<td>Were the main outcome measures used accurate (valid and reliable)? Where outcome measures are clearly</td>
<td>Yes/No/UTD</td>
</tr>
<tr>
<td>21</td>
<td>Were the patients in different intervention groups (trials and cohort studies) or were the cases and controls (case-control studies) recruited from the same population? Patients for all comparison groups should be selected from the same hospital. The question should be answered UTD for cohort and case control studies where there is no information concerning the source of patients.</td>
<td>Yes/No/UTD</td>
</tr>
<tr>
<td>22</td>
<td>Were study subjects in different intervention groups (trials and cohort studies) or were the cases and controls (case-control studies) recruited over the same time? For a study which does not specify the time period over which patients were recruited, the question should be answered as UTD. Surgical studies must be &gt;10 years for YES, &gt;50 years for NO.</td>
<td>Yes/No/UTD</td>
</tr>
<tr>
<td>23</td>
<td>Were study subjects randomised to intervention groups? Studies which state that subjects were randomised should be answered yes except where method of randomisation would not ensure random allocation.</td>
<td>Yes/No/UTD</td>
</tr>
<tr>
<td>24</td>
<td>Was the randomised intervention assignment concealed from both patients and health care staff until recruitment was complete and irreversible? All non-randomised studies should be answered no. If assignment was concealed from patients but not from staff, it should be answered no.</td>
<td>Yes/No/UTD</td>
</tr>
<tr>
<td>25</td>
<td>Was there adequate adjustment for confounding in the analyses from which the main findings were drawn? In nonrandomised studies if the effect of the main confounders was not investigated or no adjustment was made in the final analyses the question should be answered as no. If no significant difference between groups shown then YES.</td>
<td>Yes/No/UTD</td>
</tr>
<tr>
<td>26</td>
<td>Were losses of patients to follow-up taken into account? If the numbers of patients lost to follow-up are not reported = unable to determine.</td>
<td>Yes/No/UTD</td>
</tr>
<tr>
<td>27</td>
<td>Did the study have sufficient power to detect a clinically important effect where the probability value for a difference being due to chance &lt;5%. Sample sizes have been calculated to detect a difference of 4% and 5%.</td>
<td>1-5</td>
</tr>
</tbody>
</table>
## Appendix D: Study quality characteristics

<table>
<thead>
<tr>
<th>Reference</th>
<th>Study Quality (score out of 7)</th>
<th>External Validity (score out of 2)</th>
<th>Study bias (score out of 4)</th>
<th>Confounding &amp; selection bias (score out of 3)</th>
<th>Power of the study (1 question scored out of 5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Von Ceumern-Lindenstjerna et al. (2010)</td>
<td>4</td>
<td>1</td>
<td>3</td>
<td>1x UTD*</td>
<td>1x UTD</td>
</tr>
<tr>
<td>Jovev et al. (2012)</td>
<td>6</td>
<td>UTD</td>
<td>3</td>
<td>1x UTD</td>
<td>1x UTD</td>
</tr>
<tr>
<td>Von Ceumern-Lindenstjerna et al. (2010)</td>
<td>5</td>
<td>UTD</td>
<td>3</td>
<td>1x UTD</td>
<td>1x UTD</td>
</tr>
<tr>
<td>Robin et al. (2012)</td>
<td>7</td>
<td>UTD</td>
<td>3</td>
<td>1x UTD</td>
<td>1x UTD</td>
</tr>
<tr>
<td>Jovev et al. (2011)</td>
<td>5</td>
<td>UTD</td>
<td>3</td>
<td>1x UTD</td>
<td>1x UTD</td>
</tr>
<tr>
<td>Sharp et al. (2011)</td>
<td>6</td>
<td>1x UTD</td>
<td>3</td>
<td>1x UTD</td>
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<tr>
<td>Jennings et al. (2012)</td>
<td>5</td>
<td>UTD</td>
<td>3</td>
<td>1x UTD</td>
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<tr>
<td>Miano et al. (2013)</td>
<td>7</td>
<td>1x UTD</td>
<td>3</td>
<td>1x UTD</td>
<td></td>
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<tr>
<td>Fossati et al. (2014)</td>
<td>6</td>
<td>1x UTD</td>
<td>3</td>
<td>1x UTD</td>
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</tr>
<tr>
<td>Scott et al. (2011)</td>
<td>7</td>
<td>1x UTD</td>
<td>3</td>
<td>1x UTD</td>
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</table>

* UTD = Unable to determine
### Appendix E: Summary of key characteristics of review studies

<table>
<thead>
<tr>
<th>ID, author &amp; date</th>
<th>Title</th>
<th>Aims related to this review</th>
<th>Design</th>
<th>Sampling</th>
<th>Age (mean)</th>
<th>Gender</th>
<th>Ethnicity</th>
<th>Exclusion criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) von Ceumern-Lindenstjerna, Brunner, Parzer, Mundt, Fiedler &amp; Resch (2010)</td>
<td>Initial orienting to emotional faces in female adolescents with borderline personality disorder</td>
<td>To assess female adolescents with BPD's initial orienting to negative and positive emotional faces</td>
<td>Non randomized control</td>
<td>30 BPD adolescent females 29 with mixed diagnoses (no cluster B PD) 29 nonclinical (school)</td>
<td>BPD group 16.13 years</td>
<td>All Female (F)</td>
<td>Not stated</td>
<td>Substance misuse, psychosis, pervasive developmental disorder, significant neurological disease, IQ&lt;85</td>
</tr>
<tr>
<td>2) Jovev, Green, Chanen, Cotton, Coltheart &amp; Jackson (2012)</td>
<td>Attentional processes and responding to affective faces in youth with borderline personality features</td>
<td>To examine attentional biases for emotional faces in youths with borderline personality features</td>
<td>Non randomized control</td>
<td>21 outpatients 3+ BPD criteria 20 nonclinical community</td>
<td>BPD group 18.9 years</td>
<td>BPD 18F, 3 Males (M)</td>
<td>Not stated</td>
<td>Intellectual disability, psychosis</td>
</tr>
<tr>
<td>3) von Ceumern-Lindenstjerna, Brunner, Parzer, Mundt, Fiedler &amp; Resch (2010)</td>
<td>Attentional bias in later stages of emotional processing in female adolescents with borderline personality disorder</td>
<td>To investigate if BPD adolescents display attentional maintenance abnormalities when viewing emotional faces</td>
<td>Non randomized control</td>
<td>30 BPD adolescent females 29 mixed diagnoses (no cluster B PD) 20 nonclinical (school)</td>
<td>BPD 16.13</td>
<td>All F</td>
<td>Not stated</td>
<td>Psychosis, pervasive developmental disorder, substance misuse, IQ&lt;85</td>
</tr>
</tbody>
</table>
### Appendix E: Continued

<table>
<thead>
<tr>
<th>ID, author &amp; date</th>
<th>Title</th>
<th>Aims related to this review</th>
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<th>Gender</th>
<th>Ethnicity</th>
<th>Exclusion criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>4) Robin, Pham-Scottez, Curt, Dugre-Le Bigre, Spernza, Sapinho, Corcos, Berthoz &amp; Kedia (2012)</td>
<td>Decreased sensitivity to facial emotions in adolescents with borderline personality disorder</td>
<td>Investigate adolescents with BPD's sensitivity to facial emotions</td>
<td>Non randomized control</td>
<td>European network of adolescents with BPD: 22 inpatients and 22 outpatients 22 matched community (school)</td>
<td>BPD 16.9</td>
<td>All F</td>
<td>Native European</td>
<td>Schizophrenia, any chronic or life-threatening illness</td>
</tr>
<tr>
<td>5) Jovev, Chanen, Green, Cotton, Proffitt, Coltheart &amp; Jackson (2011)</td>
<td>Emotional sensitivity in youth with borderline personality pathology</td>
<td>To explore emotional sensitivity in BP youths</td>
<td>Non randomized control</td>
<td>21 outpatients recruited from HYPE clinic (early intervention program for BPD) 20 nonclinical</td>
<td>BPD 18.9</td>
<td>BPD 18F, 3M</td>
<td>Not stated</td>
<td>Intellectual disability, psychosis, significant medical illness</td>
</tr>
<tr>
<td>6) Sharp, Pane, Ha, Venta, Patel, Sturek &amp; Fonagy (2011)</td>
<td>Theory of mind and emotion regulation difficulties in adolescents with borderline traits</td>
<td>To examine mentalizing in adolescents with BP traits</td>
<td>Non randomized control</td>
<td>111 inpatient adolescents 23% met criteria for BPD (n=24)</td>
<td>15.5</td>
<td>62F 49M</td>
<td>Not stated</td>
<td>Active psychosis, IQ&lt;70, ASD, non-English speaking</td>
</tr>
<tr>
<td>ID, author &amp; date</td>
<td>Title</td>
<td>Aims related to this review</td>
<td>Design</td>
<td>Sampling</td>
<td>Age (mean)</td>
<td>Gender</td>
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</tr>
<tr>
<td>7) Jennings, Hulbert, Jackson &amp; Chanen (2012)</td>
<td>Social perspective coordination in youth with borderline personality pathology</td>
<td>To investigate social perspective coordination in first-presentation youth BPD</td>
<td>Non randomized control</td>
<td>Mental health service for youth patients BPD n=30 MDD n=30 Major depressive disorder n=30</td>
<td>BPD 19.42 BPD 24F, 6M MDD 19.88 MDD 22F, 8M</td>
<td>BPD 24F, 6M MDD 22F, 8M</td>
<td>Not stated</td>
<td>Non-English speaking, intellectual disability, psychosis</td>
</tr>
<tr>
<td>8) Miano, Fertuck, Arntz &amp; Stanley (2013)</td>
<td>Rejection sensitivity is a mediator between borderline personality disorder features and facial trust appraisal</td>
<td>To evaluate the relationship between BPD features and facial trait appraisal</td>
<td>Correlation No control</td>
<td>95 non clinical undergraduate students participating for course credit</td>
<td>19.8 66F 29M</td>
<td>46.3% Hispanic, 21.1% African/American, 15.8% Caucasian, 8.4% Asian</td>
<td>Not stated</td>
<td>Not stated</td>
</tr>
<tr>
<td>9) Fossati, Feeney, Maffei &amp; Borroni (2014)</td>
<td>Thinking about feelings: Affective state mentalization, attachment styles and borderline personality disorder features among Italian nonclinical adolescents</td>
<td>To test the hypothesis that BPD individuals have mentalization deficits</td>
<td>Non randomized control</td>
<td>Public high school High BPD (n=29), average BPD (n=31) &amp; low BPD (n=31) features</td>
<td>16.7 High 16F 13M</td>
<td>High 16F 13M</td>
<td>Not stated</td>
<td>Not stated</td>
</tr>
<tr>
<td>ID, author &amp; date</td>
<td>Title</td>
<td>Aims related to this review</td>
<td>Design</td>
<td>Sampling</td>
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</tr>
<tr>
<td>10) Scott, Levy, Adams &amp; Stevenson (2011)</td>
<td>Mental state decoding abilities in young adults with borderline personality disorder traits</td>
<td>To examine the accuracy of mental state decoding, response time &amp; biases in individuals with high number of BPD traits</td>
<td>Non randomized control</td>
<td>Psychology students from a university High n=38 Low n=46</td>
<td>High-BPD 19.63 Low-BPD group 18.85</td>
<td>High 25F, 13M Low 31F, 15M</td>
<td>High group 86.8% Caucasian, 13.2% Other Low group 78.3% Caucasian, 21.7% Other</td>
<td>Statistical outliers (2.58 SD above or below average)</td>
</tr>
</tbody>
</table>
# Appendix F: Measures, results and critique

<table>
<thead>
<tr>
<th>ID &amp; author</th>
<th>BPD assessment</th>
<th>Social cognition measure</th>
<th>Comparison group</th>
<th>Key results</th>
<th>Critique</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) von Ceumern-Lindenstjerna et al</td>
<td>German version of the structured clinical interview for DSM-IV Axis II Personality disorders</td>
<td>Visual dot probe task using emotional faces</td>
<td>Matched on age and intellectual abilities</td>
<td>Statistically significant group differences with orienting to negative emotional faces No sig difference between BPD &amp; comorbid in orienting toward negative faces No sig difference between groups orienting toward positive emotional faces Controlled for significantly different variables (overall psychosocial functioning, general extent of psychopathology, depression &amp; social anxiety</td>
<td>No power calculation Use of psychotropic medication stated (5 BPD; 3 mixed) No significant difference between BPD and control All female Reliable &amp; validated measures inter-rater reliability tested by blinded professional through random selection of 10 audiotapes No control task used to compare attention to faces Unclear recruitment process 2 comparison groups Comorbidity (range of axis 1 = 1-6 for BPD; range 1-3 for mixed)</td>
</tr>
<tr>
<td>2) Jovev et al.</td>
<td>Diagnostic Interview for DSM-IV Personality Disorders</td>
<td>Dot probe task</td>
<td>Matched on age &amp; gender</td>
<td>BPD group significantly slower on all facial expressions (neutral, angry, happy &amp; fearful) for 500ms trial Significantly faster in response to congruent as opposed to incongruent fearful expressions in 30ms trial</td>
<td>No power calculation HYPE recruitment procedure unclear Matched comparison group Reliable &amp; validated measures Initial phone screening for non-clinical &amp; then self-report Trial order randomised for each P No control task used to compare attention to faces All clinical Ps had a comorbid mood and/or anxiety disorder</td>
</tr>
<tr>
<td>ID &amp; author</td>
<td>BPD assessment</td>
<td>Social cognition measure</td>
<td>Comparison group</td>
<td>Key results</td>
<td>Critique</td>
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</tbody>
</table>
| 3) von Ceumern-Lindenstjerna et al | German version of the structured clinical interview for DSM-IV Axis II Personality disorders | Visual dot probe paradigm           | Matched on age and intellectual abilities                                        | No significant group difference regarding positive or negative emotional stimuli attention  
Influence of current mood on attentional bias – BPD adolescents displayed a significantly greater avoidance of negative emotional stimuli when rating their mood more positively and when in a neutral or negative mood displayed a significantly greater focus on negative emotional stimuli  
BPD group had a higher extent of depressive symptoms & social anxiety  
No significant difference regarding positive or negative emotional stimuli | No power calculation  
Consecutively recruited from inpt/outpt (n=unknown) – confirmed BPD diagnosis=included; non-clinical adverts in public schools (number unknown)  
Other psychiatric/non-clinical matched by age & IQ  
Reliable & validated measures – inter-rater reliability tested by professional through random selection of 10 audiotapes  
Experimenters blind to group assignment  
2 comparison groups  
No control task used to compare attention to faces  
All female  
Ecological validity – dynamic facial recognition |
| 4) Robin et al.             | Structured interview for DSM-IV Personality Disorders                          | Emotion recognition tasks           | Matched on age, socioeconomic status & gender                                    | No significant difference between groups when facial expression morphed to 100%  
BPD required the face to be closer to full expression to be able to accurately identify all the emotions. This difference was significant overall. | No power calculation; All female  
Recruited through European network  
No clinical comparison group  
Interviews cby trained professional  
Reliable/validated measures  
Control task to check for low-level attention & psychomotor abilities  
Treatment not clearly stated (most of Ps medicated)  
Ecological validity – dynamic facial recognition |
### Appendix F: Continued

<table>
<thead>
<tr>
<th>ID &amp; author</th>
<th>BPD assessment</th>
<th>Social cognition measure</th>
<th>Comparison group</th>
<th>Key results</th>
<th>Critique</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>5) Jovev et al.</strong></td>
<td>Diagnostic Interview for DSM-IV Personality Disorders</td>
<td>The Face Morph Task</td>
<td>No significant difference between groups on age or gender</td>
<td>Happy emotion was identified earlier &amp; angry identified later across both groups</td>
<td>No power calculation&lt;br&gt;Reliable/validated measures&lt;br&gt;Recruitment procedure unclear – HYPE outpt within 1st month of initial therapy contact &amp; never received BPD-specific treatment, 67% on medication; non-clinical = local community&lt;br&gt;Comorbidity of mood and/or anxiety disorders&lt;br&gt;No control task used to compare attention to faces&lt;br&gt;High level of education in control group</td>
</tr>
<tr>
<td><strong>6) Sharp et al.</strong></td>
<td>Semi structured clinical interview using the Diagnostic Interview Schedule for Children Borderline Personality Features Scale for Children – self-report scale</td>
<td>Movie for the Assessment of Social Cognition</td>
<td>Not stated</td>
<td>Borderline traits were statistically significantly negatively correlated with the total ToM Excessive ToM (hypermentalizing) significantly correlated with BPD features, gender, internalizing &amp; externalizing problems Adolescents meeting criteria for BPD had significantly higher hypermentalizing scores compared to non-BPD</td>
<td>No power calculation&lt;br&gt;Reliable/validated measures&lt;br&gt;Recruitment procedure clear – all inpts approached on day of admission (84% participated)&lt;br&gt;Assessments conducted by trained professionals – BPD initially diagnosed through self-report&lt;br&gt;Diagnosis information not stated&lt;br&gt;Treatment information not stated, av. length of stay = 5 to 7 weeks&lt;br&gt;No control task</td>
</tr>
</tbody>
</table>
### Appendix F: Continued

<table>
<thead>
<tr>
<th>ID &amp; author</th>
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<th>Social cognition measure</th>
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<th>Key results</th>
<th>Critique</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>7) Jennings et al.</strong></td>
<td>3 or more BPD symptoms measured by SCID II</td>
<td>Interpersonal Negotiation Strategies Interview (INS) Negative emotional valence of vignettes</td>
<td>No significant difference between groups on age</td>
<td>BPD Ps responded to INS vignettes with significantly lower social perspective coordination (SPC) BPD vignettes elicited significantly higher negative emotions than neutral vignettes. No significant difference between SPC scores in neutral vs BPD vignette</td>
<td>No power calculation Reliable/validated measures Recruitment procedure unclear – HYPE / OYH mental health outpt services, no recruitment process stated Comorbidity present in both groups, incl MDD in BPD group Social cognitive ability measured across neutral &amp; emotion-specific vignettes Main author conducted all interviews &amp; scored vignette measures – no inter-rater reliability conducted Small effect size between groups indicate possible Type I error</td>
</tr>
<tr>
<td><strong>8) Miano et al.</strong></td>
<td>SCID II screener for PD – self report questionnaire</td>
<td>Face rating task Face appraisal ratings on 17 dimensions</td>
<td>No comparison group</td>
<td>High BPD features significantly more likely to appraise a neutral face as untrustworthy No significant correlation between BPD features and other face appraisals (extraverted, dull, physically unattractive)</td>
<td>No power calculation Reliable/validated measures Self-report BPD measure Recruitment procedure unclear – undergrads participated for course credit – generalizability to clinical samples is questionable</td>
</tr>
<tr>
<td>ID &amp; author</td>
<td>BPD assessment</td>
<td>Social cognition measure</td>
<td>Comparison group</td>
<td>Key results</td>
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<tr>
<td>9) Fossati et al.</td>
<td>Borderline Personality Inventory</td>
<td>Reading in the Minds Eye Test (RMET)</td>
<td>No significant difference between groups on age or gender</td>
<td>High BPD group compared to 2 other groups scored significantly lower on the RMET for correct responses</td>
<td>No power calculation</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>Mean score significantly higher in females than in males</td>
<td>Recruitment process – public high school</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>Not correlated with age</td>
<td>Professional administering RMET was blinded to BPI scores</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Levels of anxiety &amp; depression not measured</td>
</tr>
<tr>
<td>10) Scott et al.</td>
<td>Modified version of the McLean Screening Instrument for BPD</td>
<td>RMET</td>
<td>No significant difference between groups on ethnicity or gender</td>
<td>Response time did not differ between groups on valence</td>
<td>No power calculation</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Within group analysis demonstrated Ps responded significantly faster &amp; more accurately for negative than neutral</td>
<td>Recruitment procedure (homogenous sample) - generalizability to clinical samples is questionable</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>No difference in accuracy when combined but high BPD significantly more accurate for negative stimuli</td>
<td>Although RMET is validated – used own classification of stimuli into 3 valence categories</td>
</tr>
</tbody>
</table>
Appendix G: Statement of epistemological position

A critical realist position was taken when conducting this research, thus integrating the realist ontological position of the researcher with relativist epistemology. The critical realist position states that reality is observable, complex and has multiple perspectives, whilst acknowledging the subjectivity of the observations and theorisations of researchers. IPA’s assumption that through interpretation of participant’s descriptions the subjective truths that impact on enduring their world, beliefs and actions can be illuminated; making IPA coherent with critical realism.
Appendix H: Self-report questionnaire

Job Title ______________________________________

Duration within this role _________________________

Duration on this unit _____________________________

Have you worked anywhere else?
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

Do you currently work full or part time _____________

Are you a permanent, temporary, fixed term, bank? _____________________________

Age group (please circle)  18 to 30    31 to 40    41 to 50    51 to 60    60+

Gender (please circle)  Male/Female

Ethnicity (please state) __________________________

Any specific personality disorder training? ________________________________________
Appendix I: Interview schedule

INTRODUCTIONS
Researcher introduces self:

Reminder of what the study is about:

You may recall I recently sent you an information sheet of what the study is about. The study is to explore your experiences of working with adolescents with personality difficulties. Did you have any questions you wanted to ask me before we begin?

Obtaining consent:

Before we start would you mind signing a consent form, which states you have agreed to participate in the study?
(Offer consent form for signature)

State the interview will be recorded:

To enable me to capture all the information during the interview would you mind if the interview is recorded?
(Turn digital recorder on)

Note Taking: I may need to take some notes during the interview, I hope that is ok?

Explanation of confidentiality:

Any data that is collected today will remain entirely confidential to the research team. Where we use data in analysis and reporting, it will be anonymous.

Check participant is happy to continue:

Do you have any questions so far?
Are you happy for me to continue?

Introduction questions:

Do you have any questions about the information sheet?
Could you tell me about the unit?
Could you give me a brief history of your experience of working with adolescents professionally?

Thoughts/feelings about personality disorder:

In general, what do you think about the term personality disorder?
In general, what is your understanding of the term personality disorder?
Prompts: How do you understand it? What makes you think an individual has a personality disorder? What attributes do they show?
In general, do you think having a diagnosis of personality disorder affects treatment at all?
   Prompts: In what way? How do you feel about this?

Working with adolescents in CAMHS:

When working with adolescents generally, what do you enjoy?
What do you find more difficult?
Could you describe a difficult interaction that you have had with an adolescent?
   Prompts: What was it about that interaction that made it difficult? What support did you have after that interaction?

Working with adolescents with personality difficulties:

How do you understand an adolescent with the label personality disorder or difficulties?
What have you noticed about adolescents that are diagnosed with personality difficulties?
   Prompts: Is that different to adolescents who have other diagnoses?
How do you interact with these adolescents?
   Prompts: Tell me more. In what way? Is there anything different about your interaction style with an adolescent with this difficulty compared to another difficulty? What leads to this difference? How is it different? What does it look like?
Can I ask you to describe your last interaction with a young person labelled with a personality disorder?
   Prompts: How do you understand that interaction? How did you feel? What did it make you think about them? Yourself?
Can you describe your best experience with someone labelled with personality disorder?
Can you describe your worst experience with someone labelled with personality disorder?
What are some of the challenges and constraints you’ve experienced when trying to interact with these adolescents?

Is there anything else you would like to tell me?
Do you have any questions for me?

Many thanks for taking part in this study.

End of Interview
Appendix J: Consent form

Participant Consent Form

An exploration of the experiences of staff who work with adolescents with personality difficulties

Sarah Cross, Trainee Clinical Psychologist, University of Leicester

Please Initial Box

1. I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions.

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving reason.

3. I agree to take part in the above study.

4. I agree to the interview being audio recorded

5. I agree to the use of anonymised quotes in publications

________________________________________  ______________________  ______________________
Name of Participant                      Date                           Signature

________________________________________  ______________________  ______________________
Name of Researcher                      Date                           Signature
Appendix K: Correspondence with ethics and R&D

University of Leicester

To: SARAH CROSS

Subject: Ethical Application Ref: st313-cdf2

(Please quote this ref on all correspondence)

15/03/2015 22:08:18

Psychology

Project Title: An exploration of the experiences and attitudes of staff who work with adolescents with emerging personality disorder

Thank you for submitting your application which has been considered.

This study has been given ethical approval, subject to any conditions quoted in the attached notes.

Any significant departure from the programme of research as outlined in the application for research ethics approval (such as changes in methodological approach, large delays in commencement of research, additional forms of data collection or major expansions in sample size) must be reported to your Departmental Research Ethics Officer.

Approval is given on the understanding that the University Research Ethics Code of Practice and other research ethics guidelines and protocols will be complied with

http://www2.le.ac.uk/institution/committees/research-ethics/code-of-practice

http://www.le.ac.uk/safety/
Research and Development Office

Direct Line: 
Email: 

Our Ref: TM/SP/R&D Approval

20 May 2015

Miss S Cross
Trainee Clinical Psychologist
School of Psychology (Clinical Section)
University of Leicester
104 Regent Road
Leicester
LE1 7LT

Dear Miss Cross

Re: 

R&D Approval

Project Title: An exploration of the experiences and attitudes of staff who work with adolescents with emerging personality disorder

Thank you for complying with the University’s Research Ethics Committee (GATEC) process to seek R&D approval. It is noted that under current UK Health Departments’ Governance Arrangements for Research Ethics Committees (GATEC) this project does not require NHS Research Ethics Committee approval as it involves NHS staff recruited as research participants by virtue of their professional role.

Approval of the study is subject to the following conditions:

1. That you inform the R&D Office of any significant protocol amendments, sending copies of correspondence with the University of Leicester’s Research Ethics Committee and also sending us copies of your annual progress and safety reports (if applicable).
2. That you notify the R&D Office and the Governance Support Unit of any adverse events arising from this piece of research.
3. That you provide the R&D Office with interim reports as requested by the R&D Office and a final report of your research.
4. That you conduct the research in conformity with the Research Governance Framework and with clinical trial legislation where applicable.
5. That you provide recruitment data when requested.

Yours sincerely

Head of Research, Development and Innovation
Appendix L: Initial contact letter and information sheet

Date

Dear

Re: An exploration of the experiences of staff who work with adolescents with emerging personality disorder

I would like to invite you to participate in my research for my Doctorate in Clinical Psychology Thesis. I am a Trainee Clinical Psychologist at the University of Leicester who is interested in learning about your experiences of working with adolescents with personality difficulties. There has been a lot of focus on staff working with adults with a diagnosis of personality disorder and it would be great to give a voice to CAMHS staff working within this area.

If you decide you would like to take part, you will be asked to participate in a one-to-one interview on a day and time convenient for you.

The attached information sheet provides more details of the project. Your involvement in this research is entirely voluntary. If you are interested in the research then I would like to hear from you.

I would be really grateful if you could spare the time to participate and contribute to this research. Interviews will be taking place from June 2015 and should take no more than 1 1/2 hours of your time.

This research is supervised by Dr XXX, Consultant Clinical Psychologist at XXXX and Dr S. Allan, Clinical Psychologist at the University of Leicester.

Many thanks for your cooperation

Sarah Cross
Trainee Clinical Psychologist
University of Leicester
Appendix L: Continued

Participant Information Sheet

An exploration of the experiences of staff who work with adolescents with emerging personality disorder

Please take some time to read this information sheet before deciding whether or not you would like to take part in this study. Please discuss it with anyone you wish. If you would like to take part or would like clarification or further information please contact me using the contact details below.

Purpose of Study
This is a study about your experience of working with adolescents with personality difficulties. The aim is to build an understanding of the impact on ward staff, of working with this population and it could potentially identify particular support that may need to be provided.

Who can take part?
Any ward based CAMHS staff at XXXXX. Participation is completely voluntary.

What is involved in taking part?
If you decide to take part, a suitable time will be arranged for an hour-long face-to-face interview to take place. You will be asked open questions and encouraged to give as much detail as you can. If at any time you do not feel comfortable, you are able to withdraw without any impact on yourself or your job. Information given up to the point of withdrawal will be destroyed.

What are the possible benefits of taking part?
While participating staff may not benefit individually from the study, we hope that our study findings will highlight the needs of staff and the support that CAMHS staff require when working with this patient-group. There is also the potential for our findings to benefit all patients receiving mental health care.

What are the possible disadvantages/risks of taking part?
It is not thought that there are any specific risks or disadvantages to taking part in the study, but interviews can pick up on sensitive issues for participants. Support will be signposted if required.

Will my taking part in the study be kept confidential?
The interviews will be transcribed, anonymised and used for analysis. Any answers you give will only be used for the purposes of this study and will be kept confidential. Any quotes taken from your interview transcript will be coded to maintain your anonymity. Completed
transcriptions will be kept in a locked filing cabinet and on password protected computer files. Only the research team will have access to the information. The data will be kept for five years after which it will be destroyed. The only exception to this strict confidentiality is if something is said that causes the researcher concern about you or the patients in your care. This will be discussed first with you before it is taken to XXXXX, the clinical supervisor for the study.

**What will happen to the results?**

This research is being completed as part of my training in Clinical Psychology and the results of the study will be written up in a doctoral thesis format. The results may also be written up and published in scientific journals and may be presented at academic conferences. The results will not be presented in any way that could allow the identification of individual people who have taken part. If you wish to know the results of the study, they can be sent to you.

**What if something goes wrong?**

If you wish to complain or have any concerns about how you were approached during this study, you can contact Dr XXXXX or Dr Allan at the University of Leicester.

**What happens now?**

If you would like to take part please email Sarah Cross on the below email address or write your name and contact details on a piece of paper and place it in the box provided, I will be in contact soon.

Thank you for taking the time to consider your participation in the study.

If you have any questions about the study or would like to take part, please contact: XXXXX

For any concerns about the study contact: XXXXX or XXXXX on XXXXX.
Appendix M: Recruitment poster

**Tier 4 CAMHS Ward Staff**

**I need you...**

...to take part in an exciting research project looking at your experiences of working with adolescents with personality difficulties

If you would like to help me learn about your experience, I would love to hear from you!

I am a Trainee Clinical Psychologist seeking to interview 8 staff members who spend the majority of their time on the inpatient units (CSWs, registered nurses, occupational therapists) who have worked for a minimum of six months at XXXXX.

Please don’t miss out on having your voice heard!

Taking part in this research will involve being interviewed on a one-to-one basis for about one hour. Your participation is completely voluntary and your responses will be kept confidential.

To take part please contact Sarah Cross by:

email on XXXXX

Or

Write down your name and the best way of contacting you on a piece of paper and placing it in the research box and I’ll be in touch

*I look forward to hearing from you!*
In order to actively engage with data and facilitate entering each participant’s world, individual transcripts were read on several occasions and analysed separately.

**Initial coding:** Initial thoughts were noted in margins highlighting aspects of interest or significance. Different levels (descriptive, linguistic & conceptual) were commented on.

**Emergent themes & phrases:** Capturing the essential qualities of participant’s narrative through transforming initial coding.

**Connections between emergent themes & clustering:** Listing emergent themes and exploring for links by mapping ways that the themes clustered. Labels were given to clusters to describe the conceptual characteristics of the tentative themes.

A diagram was produced that illustrated each higher order theme and sub-themes within it. Data extracts were used to illuminate themes.

**Higher level abstraction:** Convergent & divergent patterns were explored by comparing & contrasting clusters from each participant’s data. Themes were re-labelled & re-configured to synthesise data.

Three super-ordinate & nine subthemes were identified that captured & organised the majority of the data. A narrative, interpretive account of themes was offered in the write-up of the results, developing interpretations in a continued process.
Appendix O: Initial coding and clustering example for Julia
### Appendix O Continued: Example of Julia's themes

<table>
<thead>
<tr>
<th>Cluster/super-ordinate theme</th>
<th>Theme/subthemes</th>
<th>Page number</th>
<th>Quote</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Containing the Self</strong></td>
<td>Connection</td>
<td>4</td>
<td>&quot;...it's nice to see them overcome their issues. There have been those success stories... they'll ring back to just update us and that's nice, that's probably like the best part.&quot;</td>
</tr>
<tr>
<td></td>
<td>Part of a team</td>
<td>4</td>
<td>&quot;Having a team, having experienced members of staff and also having new members of staff...having that team to be able to go back to and reflect on what you've seen and like heard and get their opinion on it&quot;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>16</td>
<td>&quot;having a team around you, that really helps, having a really supportive team&quot;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>24</td>
<td>&quot;I see myself as part of the team and to help them through their diagnosis and hopefully to recover&quot;</td>
</tr>
<tr>
<td><strong>Reflection</strong></td>
<td></td>
<td>4</td>
<td>&quot;having a team to reflect what you think&quot;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>16</td>
<td>&quot;It helps me feel supported and it helps me to identify where I've gone wrong, not wrong necessarily but how I could have improved the situation because we've always got room to improve&quot;</td>
</tr>
<tr>
<td><strong>Hope</strong></td>
<td></td>
<td>11</td>
<td>&quot;they're going through certain struggles, but they can lead a normal life with the right help... I think on this unit and with the right help they can lead a normal successful life...I just think with emerging as they're younger umm they may have different ways of seeing themselves cos they're still developing so they're more likely to be influenced in a good way by services&quot;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>17</td>
<td>&quot;I think anyway that they can lead a normal kind of life with some help&quot;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>22</td>
<td>&quot;to know that they can actually live a life after here and not just have to live in hospital for the rest of their lives.&quot;</td>
</tr>
<tr>
<td><strong>Self-awareness</strong></td>
<td></td>
<td>16</td>
<td>&quot;Keep calm, keep patient, remind yourself of why you're there, what helps me is to remind myself of the trauma that this person's been through, think about how lucky you are and what they've been through&quot;</td>
</tr>
</tbody>
</table>
Appendix O Continued: Visual map of themes for Julia

CLOUDING EVERYTHING

Seeing the individual
Uncertainty
Changeability

Protecting rapport
Perception of diagnosis

Pros/cons of the label
Staff emotions
Delicate balance

Boundaries
Helplessness

PUSH/PULL

PUSH/PULL

CONTAINING THE SELF

Connection
Reflection
Self-awareness

Part of a team
Hope
## Appendix P: Chronology of research process

<table>
<thead>
<tr>
<th>Activity</th>
<th>Timeline Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultation with research supervisor</td>
<td>February 2014</td>
</tr>
<tr>
<td>Developing research proposal</td>
<td>April to June 2014</td>
</tr>
<tr>
<td>Internal peer review at the University of Leicester</td>
<td>June to November 2014</td>
</tr>
<tr>
<td>Service User Reference Group (SURG) review</td>
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</tr>
<tr>
<td>Preparation of application for University ethics and R&amp;D</td>
<td></td>
</tr>
<tr>
<td>University ethics application</td>
<td>December 2014</td>
</tr>
<tr>
<td>R&amp;D application</td>
<td></td>
</tr>
<tr>
<td>University ethical approval</td>
<td>January to May 2015</td>
</tr>
<tr>
<td>R&amp;D approval</td>
<td></td>
</tr>
<tr>
<td>Recruitment and interviewing participants</td>
<td>June 2015 to January 2016</td>
</tr>
<tr>
<td>Interview transcription</td>
<td></td>
</tr>
<tr>
<td>Analysis</td>
<td>January to March 2016</td>
</tr>
<tr>
<td>Write up period</td>
<td>January to April 2016</td>
</tr>
<tr>
<td>Submission of thesis to University of Leicester</td>
<td>April 2016</td>
</tr>
<tr>
<td>Viva preparation</td>
<td>June to July 2016</td>
</tr>
<tr>
<td>Dissemination of findings</td>
<td>July to September 2016</td>
</tr>
<tr>
<td>Preparation for poster presentation and publication paper</td>
<td></td>
</tr>
</tbody>
</table>