

**A Look 'Behind the Curtains' at Personality Disorder and Mental Health Social Work: Perspectives and Expectations of Service users and Practitioners**

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*For my Mother, Father & Debbie,  
each of whom have contributed in their own way*

*“Any intelligent fool can make things bigger, more complex, and more violent.  
It takes a touch of genius – and a lot of courage – to move in the opposite direction”*

*Einstein, cited in Glover, 2012, p.31*

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Τελικά, ευχαριστώ το νίσι της Ικαριάς

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## **Abstract**

This research project aims to explore service user and mental health social workers' (MHSW) perspectives and experiences of practice in the area of personality disorder. It seeks to answer three research questions: how service users and MHSWs understand personality disorder, how they understand MHSW practice and how practice in this area might be better informed.

The study's attention to the experiences and perspectives of both groups sets the research within the interpretivist paradigm and relies on a relativist ontology, subjectivist epistemology and inductive, qualitative methodology. The involvement of both groups means that this project makes an original contribution to MHSW research and practice. Constructivist grounded theory (CGT) has been used to generate a conceptual, theoretical analysis.

The research was divided into two phases. Phase 1 involved ten semi-structured interviews with ten service users from a community service for people with personality disorder. This data was analysed before Phase 2 began, comprising twelve semi-structured interviews with twelve MHSWs from three regions of England. NVivo 7 was used to analyse the data in and across case. The analysis identified participants' understanding of personality disorder, mental health social work practice and how this practice might be better informed. The analysis was supplemented by documentary analysis of policies relevant to personality disorder and MHSW.

The findings suggest that traumatic experience impacts on the lens through which the person views self and others. Distress can be overwhelming, lead to extreme and unsafe behaviours, which reinforce disconnection from self and others. In supporting a relationship between personality disorder and traumatic experience, this study suggests the relevance of mental health social work (MHSW) to personality disorder. The findings suggest that more humane, empathic responses are required. Practice founded on understanding the impact of traumatic experience and the ways in which the individual might be trying to cope with their distress. The findings reveal the importance of MHSWs' relational skills and interventions that offer practical support, encouragement and effective liaison with others. Through more caring, protective bonds and broad social supports MHSW might empower individuals' response to traumatic experience. The findings raise implications for MHSW and mental health professionals more generally.

The findings also indicate that practice would be better informed by greater knowledge and understanding of the person and the diagnosis; the provision of feedback to the person; modelling; greater transparency and consistency; support for the person's social and family network, and more

practical support. This project makes an original contribution to knowledge about personality disorder and to MHSW knowledge and practice in this area.

**Key words: personality disorder; mental health social work; service users, trauma**

## Introduction

This study aims to explore MHSW practice from the perspective of both service users with personality disorder and MHSWs. It seeks answers to three research questions; how service users with personality disorder and MHSWs understand personality disorder, how they understand MHSW practice in this area and finally how they think MHSW practice in this area might be better informed.

These questions emerged from my own experience as a qualified MHSW in social work teams, community mental health services and most recently a forensic, medium-secure service for people with personality disorder. It was while working on a community mental health team in the late 1990s that I first became aware of how we, as mental health professionals, can stigmatize people with personality disorder and effectively deny them access to support and treatment. My observations of colleagues' reactions to people with personality disorder made me question how we understand the diagnosis. If we understood the nature of the distress, surely we wouldn't respond so negatively to the person? When I then moved to a forensic, medium-secure service I heard many narratives from patients about how they had previously been excluded from mental health services and how, if they had gained access, had invariably been miss-diagnosed and received treatment inappropriate to their needs. A number recalled how they had gone on to commit criminal offences to secure help for their mental health problems. While such experiences fitted with my previous observations, they did not seem just and led me to conclude that people with personality disorder face significant risk of stigma, discrimination and exclusion. As a member of a profession committed to challenging stigma and discrimination, I was convinced that I would find social work research and literature examining the plight of people with personality disorder. However, while I found an extensive range of psychiatric and psychological literature I was, disappointed by the relative absence of specific social work literature in this area.

My research questions therefore emerged from these experiences. From my observations about how people with personality disorder can be excluded from mental health services, despite experiencing distress which can be extreme and overwhelming. Secondly, from the apparent lack of specific social work research in this area, despite the prevalence of personality disorder in both primary and secondary settings (Newton-Howes et al., 2010). MHSWs work with people with personality disorder and yet the relative absence of specific social work research suggests that social work is potentially operating in "an educational vacuum" in this area (Keys & Lambert, 2002, p.4). Finally, from my interest in how understanding influences behaviour. I am motivated by a hope that different understandings of personality disorder, through the inclusion of service user and MHSW research participants, might lead to different, more positive responses to the person. I have been committed to

service user involvement and the development of practice through collaboration between service users and practitioners for many years (Beresford & Croft, 2001; Ramon, Warrener & Beresford, 2004). Involving both service user and MHSW participants in a project, in an under researched area for social work, seemed an ideal opportunity to better inform practice through collaboration, albeit in a virtual sense. Consequently, this interest and commitment influenced the design of the project, particularly the decision to ask service users for their ideas about how practice might be better informed and to put these ideas to MHSW participants in the second phase of the research.

This thesis reports on the execution of the research project as well as on the findings which answer the questions as to how service users and MHSWs understand personality disorder, MHSW practice and how practice might be better informed. Chapter One considers the psychiatric, psychological and social perspectives on personality disorder, reviewing the very limited body of specific social work research and literature in this area (Burton, 1990; Irvine, 1996; Titus, 2004). It offers a critique of the ways in which personality disorder is understood and suggests that its complexity can challenge mental health professionals' understanding of the diagnosis. It considers the relevance of traumatic experience, particularly trauma in childhood, to understanding personality disorder. Given this the chapter suggests that a multi-dimensional conceptualisation of, and response, to personality disorder is required; one which balances both the form and content of distress and embraces the diagnoses relationship to early trauma. This study will therefore delineate MHSWs' contribution to a more holistic response to the person with personality disorder and MHSWs' unique contribution to multidisciplinary mental health services.

Chapter Two justifies the study's interpretivist, relativist and subjectivist paradigmatic assumptions. It accounts for its theoretical foundations, qualitative and constructivist methodology and my use of a multiple case study framework. It reveals how CGT fitted on ontological and epistemological grounds and allowed for the inclusion of my interpretive frame developed over many years as an MHSW working with people with personality disorder. It offers a rationale as to why I chose to employ active, semi-structured interviews and documentary sources. The chapter will also detail the extent of ethical review, suggesting this as one component of the study's authenticity (Guba & Lincoln, 1989). A summary of the research in action concludes this chapter. Chapter 3 sets out those findings pertinent to my research questions. Data will be displayed in two separate sections in the order in which the research was undertaken. The first section will set the findings from Phase 1- interviews with service users. The second section the findings from Phase 2- interviews with MHSWs. Each category will be supported by a diagram, with a narrative explanation, to aid communication of my interpretations of the data.

Chapter Four synthesises the key findings in relation to the wider literature and summarises the emerging theory in both words and diagrammatic form. The theory will suggest that personality disorder can be related to early traumatic experience which impacts on the lens through which the person views self, others and the world around. Distress can be overwhelming, lead to chaos, extreme and unsafe behaviours and ultimately disconnection. Consequently it suggests that there is a need to recognise our commonality as human beings, especially as we are all at risk of damaging and traumatic experiences. It suggests that MHSWs are expert at working with the person in their social context, particularly with its emphasis on both the relational and the social. Through MHSWs understanding the person and personality disorder, use of self and active interest in the person and the provision of broad social supports MHSW has the potential to empower more constructive responses to trauma and therefore promote connection and/or re-connection with self, others and the world around.

The thesis is drawn to a conclusion in Chapter 5. This chapter summarises the methodology, findings and synthesises the emerging theory before stating the study's limitations, its original contribution to knowledge and methodology, ideas for future research and the implications for practice.

## **Chapter 1: Literature review**

This chapter reflects how my research questions informed my approach to the literature. It will first summarise this approach, followed by a review of certain key perspectives on personality disorder in order to contextualise the service user and MHSW's understandings of personality disorder and practice, to come. The chapter will consider the diagnosis from the psychiatric, psychological, social and service user perspectives. It will then define trauma, consider the relationship between personality disorder and posttraumatic stress disorder (PTSD) before moving on to define humane response, with reference to the relevant literature. The chapter will set out the seminal literature on trauma and then critique the specific MHSW literature which considers personality disorder (Burton, 1990; Irvine, 1996; Titus, 2004) and MHSW practice. Through a consideration of the relevant literature the chapter will suggest that traumatic experience is very relevant to understanding the complexities of personality disorder and as such it can inform both MHSW's response to the person with personality disorder and the profession's contribution to multi-disciplinary mental health services' in this area. Accepting the significance of trauma and allowing for the policy context, I suggest that MHSWs' professional value base, its commitment to the person, the social and the relational means that it has relevance in this area. The chapter concludes by summarising how the specific MHSW research and literature informed the methodology for this project. The next section will summarise my approach to the literature.

### ***1.1. Searching the literature***

Given the need to contextualise service user and MHSWs' understandings of personality disorder within wider disciplinary perspectives and the seminal literature on personality disorder search strategies for this project had to be broad but also methodical and systematic. It was necessary to search widely for literature about personality disorder but also systematically to maximise opportunities to discover any specific MHSW literature. Consequently electronic and manual searches were conducted; electronic databases, library searches for specific literature, searches of the literature and policy from relevant organisations and of newspaper databases for events of relevance to personality disorder and MHSW. Databases were chosen for their relevance to personality disorder and for their relevance to mental health and social work. In the early years of the study, Psych INFO, Pub Med, ASSIA, CAREDATA and Social Care Online were searched regularly for literature on personality disorder and MHSW. However, at times the search was obstructed by the structure of the database itself. An entry in my research diary reveals my frustration with CAREDATA, which had a field for severe mental illness and schizophrenia but none for personality disorder (J. Warrener, unpublished work, February 17, 2005). Consequently searching this particular database was extremely time-consuming, as many hits had to be trawled for any relevance to personality disorder. A range of databases have been used and searched over time, but

as electronic media have become increasingly powerful it has become more possible to access the literature directly from engines such as the British Library's *Explore*.

My research questions also demanded a systematic and specific approach to the literature. In the early years of the study, I utilised key word combinations such as "personality disorder social work"; "personality disorder stigma" and "personality disorder risk" to capture as much literature as possible and maximise the opportunity to discover literature relevant to both personality disorder and MHSW. However, I had difficulties in finding literature relevant to both subjects, confirming Keys & Lambert's (2002) early finding that specific social work research and literature on personality disorder is minimal. While I discovered a relevant undergraduate dissertation in early 2005 (Titus, 2004), an example of a search on January 31 2007 highlights the scarcity of literature relevant to MHSW *and* personality disorder. The database was Psych INFO, and the key words "personality disorder AND mental health social work" failed to generate any results. A second search on "social work AND personality disorder" generated 50 hits, although many of these were relevant to the 'social', 'anti-social' and 'work' rather than social work *and* personality disorder. Consequently, only one was relevant to the research aims because it included service users and social workers amongst its professional participants (Stalker, Ferguson & Barclay, 2005). A subsequent search of CINAL and Psych INFO using the same key words identified Irvine (1996), which led to Burton's (1990) paper.

The literature on personality disorder reveals the significant influence of psychiatric, psychoanalytic and psychological perspectives. It also reveals significant differences about the nature of the diagnosis, which, some suggest, continue to run like "fault lines" (Tyrer, 2000, p.6) through this area of psychiatric practice. The following sections will review key perspectives on personality disorder and suggest that none represent a 'gold standard' (Trull, 2005, p.279) but alternatives, which raise debate and, when taken together, can fashion personality disorder as a complex and contested diagnosis. However, a review of these alternatives might suggest a way of moving beyond the polarized debates which tend to surround personality disorder (Bowers, 2002), to open the space for additional voices and ultimately a multidimensional conceptualisation which balances the form and content of personality related distress.

### **1.2. A psychiatric perspective**

Diagnosis, as an explanatory framework for distress, is fundamental to psychiatry (Bracken & Thomas, 2005). Jaspers (1963) determined that form is universal and related to happenings within the individual and separate from content which is related to the social and cultural context. Causal explanations for universal phenomena can be discovered through technical idioms, neuroscience and a framework of psychopathology (Bracken & Thomas, 2005). There are currently two established frameworks of psychiatric classification and diagnosis: the Diagnostic and Statistical Manual of Mental Disorders

(American Psychiatric Association, 1994) (APA) (DSM IV) and the tenth International Classification of Diseases (World Health Organisation, 1992) (WHO) (ICD 10). Both systems have similarities as well as quite different characteristics. The differences appear to stem from the ways in which they conceptualise mental disorder. ICD 10 suggests that mental disorder is not an exact term and supports this stance by including personality disorder in the same domain as other mental disorders (WHO, 1992). Despite stating that there is “no assumption that each category of mental disorder is a completely discrete entity” (APA, 1994, p. xxx.i) DSM IV sets out five different axes of mental disorder, with personality disorder assigned to Axis II (APA, 1980) and grouped into clusters A, B and C. Its separate axis appears to contradict the claim that there is no assumption of discrete disease entities.

While revisions of DSM IV and ICD 10 are anticipated (APA, 2012; WHO, 2012) these current classifications of personality disorder differ significantly. ICD 10 defines personality disorder as an ingrained and “severe disturbance in the character logical condition and behavioural tendencies of the individual, usually involving several areas of the personality and nearly always associated with considerable and personal disruption” (WHO, 1992, p.202). Nine different types of personality disorder are identified: paranoid; schizoid; dissociation; emotionally unstable; histrionic; anankastic: anxious, avoidant and dependent. With little guidance on needs, risk and the measurement of change (Willmot & Gordon, 2011) DSM IV defines personality disorder as:

An enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual’s culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time and leads to distress or impairment.

APA, 1994, p. 685

There are three separate clusters: A, odd and eccentric (paranoid; schizoid and schizotypal); B, dramatic, emotional or erratic (anti-social personality disorder; borderline personality disorder; histrionic; narcissistic) and C, anxious or fearful (avoidant, dependent and obsessive compulsive). While ICD 10 emphasises the depth and severity of nine different types; DSM IV, emphasises the long-term and persistent nature of ten different types.

Differences in these classifications alone are suggestive of personality disorder’s status as a complex and contested diagnosis (Pidd & Feigenbaum, 2007) . However, its prevalence in community, in-patient and prison populations (Coid, Yang, Tyrer, Roberts & Ullrich, 2006; Newton-Howes et al., 2010) demands that it is effectively understood. Estimates of prevalence in community samples vary from between 5-

12% (Coid et al., 2006; Newton- Howes et al., 2010) and 10-13% (NIMHE, 2003; Winship & Hardy, 2007). The estimates may vary, but it is to be twice as prevalent as schizophrenia (WHO, 2012).

While both systems aim to standardise the classification of mental disorder their increasingly narrow diagnostic criteria (Jablensky, 2005) tend to encourage **heterogeneity** and comorbidity (Jablensky & Kendell, 2002) which raises subsequent questions about the reliability of criteria and framework (Blackburn, 1988; Bowers, 2002; Rutter, 1987). Prioritising form over content means that these systems can fail to account for the variety of ways in which individuals are positioned in social life (Parker, Georrgaca, Harper, McLaughlin & Stowell-Smith, 2006). Nor do they ask why the individual is “exhibiting signs of acute distress” (Castillo, 2003, p.16). Critique such as this suggests the value of alternative perspectives on personality disorder. While the range of alternatives can complicate the picture, it seems that no one perspective alone can explain the diagnoses complexity. Consequently the next section will review the psychological perspective. It will begin with this perspective’s critique of the psychiatric classification before considering the value of a dimensional approach to understanding the diagnosis (McCrae &Costa, 2003).

### **1.3. A psychological perspective**

While assessment and diagnosis are fundamental to psychiatry, with priority accorded to form over content, a psychological perspective seeks to explore and explain individual subjectivity and as such generally recognises the broader dimensions of a person’s reality (Bracken & Thomas, 2005). For example, while psychology tends to explain personality disorder in terms of maladaptive personality traits, it suggests these explanations are insufficient alone, as environmental and social factors can mean that the person still develops functional self and interpersonal systems (Ro, Stringer & Clark, 2012). It is the extent of personality dysfunction and its impact on the self-system, relationships with others and society in general which is important (Livesley, 1998). Although the inclusion of personality disorder in the DSM furthered research, understanding and treatment of the diagnosis (Ro, Stringer & Clark, 2012), Livesley, Schroeder, Jackson & Jang, (1994) argue it is inadequate for assessing the core dysfunction of personality disorder.

As knowledge about personality disorder has developed so has the critique of the classification both within psychiatry and from other disciplines (Clark, 2009; Rutter, 1987). In the context of psychiatry’s aims to standardize and homogenize the diagnosis questions have been raised about personality disorder’s evident heterogeneity and consequent co-morbidity (Ro et al. 2012). Is co-morbidity a consequence of narrow diagnostic criteria or a reflection of personality disorder’s dynamic nature (Bateman & Fonagy, 2006)? Moreover, Eaton, Krueger, South, Simms & Clark (2011) have questioned the robustness of the diagnostic categories as they apply both in clinical settings and within the DSM

itself (APA, 1994). As already suggested the psychological perspective views personality disorder as a maladaptive variant of normal personality and as such can be understood by the same set of traits which define normal personality (Ro et al., 2012). From this perspective personality and psychopathology are inherently related (Samuel & Widiger, 2008).

Allport (1937) argued that personality both 'is' something and 'does' something. Research has generally tended to concentrate more on the former rather than the latter (Trull, 2005). However, more recently attention has focused on what personality does, how it 'serves to adapt individuals to their situations' (Ro et al., 2012, p.48). If we consider what personality does it follows that we must also consider its dysfunction (ibid). While further research on the dysfunction of personality disorder is required, the Five Factor Model (FFM), derived from the five fundamental domains of personality: extraversion, agreeableness, conscientiousness, neuroticism and openness, is one of the principal dimensional models of personality disorder assessment (Ashton & Lee, 2001; Widiger, 2002). FFM assesses personality structure, traits including the maladaptive and associated social and occupational distress (Widiger, 2002). Assessing whether distress is at a clinically significant level is key (Widiger & Lowe, 2007), i.e. whether it impairs the person's relationship with self, others and wider society (Ro et al., 2012). Therefore, the assessment of normal and maladaptive personality recognises the role social and environmental factors can play in both managing maladaptive traits or indeed triggering distress and impairment (Widiger & Lowe, 2008).

It is argued that the dimensional approach to personality disorder avoids the aforementioned limitations of the categorical classification (ibid). However, psychologists acknowledge that the assessment of core personality disorder dysfunction is difficult and that the approach can appear cumbersome and less user friendly (Trull, 2005). If psychopathology is related to normal personality it is not possible to characterize behaviour, thoughts and feelings as different in kind, only in degree. Without empirically devised cut-offs to identify significant trait elevations it becomes harder to define a person as personality disordered (ibid). Despite such limitations evidence suggests that a dimensional approach to personality disorder is favoured by clinicians (Bernstein, Iscan & Maser, 2007). It appears that the assessment of personality strengths, deficits and the recognition of social and environmental factors in adaptive and maladaptive relationships with self and others balance both the form and content of personality related distress. Such an approach furthers the debate and informs questions about the possible reasons for behaviour, and whether maladaptive traits, distress and impairment are a consequence of destructive social experience (Erikson, 1968). The next section, in its review of the social perspective and the relationship between distress, context, power and powerlessness adds to this debate.

#### **1.4. A social perspective**

The significance of distress for relationships with self, others and wider society has been noted above (Ro et al., 2012). A social perspective considers the significance of the social, and relationships within this, as both a consequence and contributor to mental distress. While defining a 'social model' is difficult, some have articulated its relevance (Beresford, 2002), or at least intersecting social perspectives (Tew, 2005; 2002), for understanding distress and mental disorder. Health and illness are known to be multifactorial (Duggan, 2002), related to the person's social context, position and experience of power and powerlessness (Duggan, 2002; Plumb, 2005). While the social model of mental distress is perhaps not theoretically cohesive (Beresford, 2005), Ramon (1985) suggests that it focuses on the "contribution of the social dimension to the phenomenon of mental distress" (p.14), and moreover on the ways in which the person might come to define and understand their position in society, particularly in relation to the powerful. Power differentials, both individual and structural are highlighted with emphasis on the internalization of negative attributes of difference and the impact of this on personal agency and self-esteem. Silenced, the person is not only at greater risk of abuse and victimisation, but is forced to struggle with society's expectations from a vulnerable position and with a more susceptible conception of self. Tew (2005) argues that this can force the person to establish personal distress patterns, i.e. combinations 'of rigid, destructive or ineffective feelings, thoughts and behaviours' (p.81), which while possibly protective impact the person's relationship with self, others and society in general. This appears to resonate with personality disorder, particularly given the diagnoses complexity and apparent relationship to the social context (Castillo et al., 2001; Castillo, 2003; Fallon, 2003; Miller, 1994; Nehls, 1999; Stalker et al., 2005).

MHSWs support for the social model might easily be assumed. However, despite some apparent connections, MHSW has appeared reluctant to support it (Tew, 2002) and indeed has yet to embrace the opportunities afforded by the recovery paradigm (Tew et al., 2012). This reluctance might be explained by the contraction of the profession in mental health services (Social Care Institute of Excellence, 2008) (SCIE) and the priority accorded to its former statutory powers (Wilson & Daly, 2007). It's contracted or more diffused role may mean that MHSW has been reluctant to commit to the theoretical development of the social model for fear of further marginalisation or diffusion. However, the extension of statutory powers to other disciplines (UK DoH, 2007) means that MHSW now needs to reemphasise its connections with its professional value base, the social model (Duggan, 2002), and make a theoretical contribution to its development. It may then be in a position to articulate its unique contribution to service users and multi-disciplinary mental health services more clearly.

Social workers need to be informed and proactively responsible to the challenges and opportunities that come with organisational and structural change as outlined above (The College of Social Work, 2012) (TCSW). The Standards of Proficiency (Health and Care Professions Council, 2012) (SOPs) (HCPC) set clear expectations about social workers' safe and effective practice from the beginning of their careers. These threshold standards, map onto the Professional Capabilities Framework (TCSW, 2012) (PCF), which supports social workers through every stage of their career (TCS, 2012). Safe and effective social work practice is founded on knowledge of social work theory and methods and that of the other disciplines to ensure evidence informed responses to complex situations. It involves knowing the limitations of the role and communicating effectively with members of the inter-professional network. Understanding the multi-dimensional nature of human existence and the impact of different experiences, discrimination and strengths to engage, build and maintain effective relationships with service users and carers is fundamental to the SOPs and consequently to safe and effective social work practice (HCPC, 2012).

As such the SOPs, through the importance they attach to knowledge, understanding, partnerships and the impact of social structures support a paradigm for MHSW practice in the area of personality disorder. They provide MHSW with a rationale for its contribution to the debate about personality disorder and the need to support people with the diagnosis more productively. MHSW's priority to context and the experience of distress connects with the social perspective to complement the psychiatric and psychological perspectives on personality disorder. The next section will set out another important voice, the service user perspective, .too much information in one sentence; the information on trauma can come later.

### ***1.5. A service user perspective on personality disorder***

The service user perspective appears to resonate with a social model/perspective (Beresford, 2005; Duggan, 2005; Plumb, 2005; Ramon, 1985; Tew, 2005). This literature (Castillo et al., 2001; Castillo, 2003; Fallon, 2003; Stalker et al., 2005) demonstrates the complexity of personality disorder, its relationship to the social context, the importance and intensity of distress patterns and how service users and mental health professionals understand both diagnosis and distress patterns quite differently (Horn, Johnstone & Brooke, 2007; Miller, 1994; Ramon et al., 2001; Stalker et al., 2005).

In the psychiatric diagnostic model, personality disorder is understood as a heterogeneous entity (Bateman & Fonagy, 2004). However, Miller's (1994) research reveals striking similarities in service users' narratives of their experiences of personality disorder. Where individuals with BPD have been

classified as experiencing identity disturbance and an impaired sense of self (APA, 1994), Miller (1994) found that participants expressed a core identity:

Common to all the patients was a view of themselves as estranged from others and inadequate in the face of perceived social standards. Rather than having an impaired sense of self, they seemed to have a sense of themselves as impaired. (p.1216)

Reflecting Tew's (2005) 'hot potato', this is suggestive of the power of internalised, negative attributes of difference and the difficulty of struggling with these in the face of social expectations. Fallon (2003) too reports a commonality of experience, with all participants verbalising "... feelings of despair, hopelessness and depression" (p.396). Participants' social interaction and behaviour were affected by "strong paranoid ideas" (Fallon, 2003, p.396) that could result in strategies to manage the sense of "... themselves as impaired" (Miller, 1994, p.1217). Miller (1994) and Nehls (1999) suggest self-harm and suicidal behaviours as two such strategies, both constant features of service users' lives and consequences of extreme and chronic distress. Nehls (1999) argues that such behaviours are not attempts at manipulation but behaviours which they cannot control; as one participant suggests; "Suicide attempts ... to me that's a sign of depression, and maybe they (providers) see it as being a manipulator ... I don't think mine have ever been manipulative. They have always been to me serious attempts" (p.289). Such clarity about the relationship between chronic distress and self-harming behaviour underlines the importance of understanding the person's behaviour in its past and present context, rather than focus on the negative attribute over and above the person (Aviram et al., 2006).

As well as different understandings of self-harming and suicidal behaviours this body of work (Castillo et al., 2001; Castillo, 2003, Fallon, 2003; Miller, 1994; Nehls, 1999 Stalker et al., 2005) also indicates how service users and mental health professionals understand the diagnosis differently. Stalker et al. (2005) found that while professional participants evidenced greater certainty about their understanding of the diagnosis, consensus amongst them was lacking. Although the majority named personality disorder as a psychiatric condition, others perceived it as a form of social deviance or rule-breaking. Interestingly, a minority of professional participants understood it as "difficulty coping with day to day life, rather than the presence of a particular disorder" (Stalker et al., 2005, p.364). Service users stressed the complex and varied nature of personality disorder and articulated different levels of understanding. Some service user participants reported that they had very little understanding of it, while others reported that it was a "fixed condition, set in stone" (Stalker et al., 2005), meaning that there was something "fundamentally 'wrong' with them as a person" (p.363). These findings highlight the diagnoses complexity and suggest the importance of understanding the reasons for the person's distress pattern, particularly in the face of

evidence which suggests a relationship with early traumatic experience. Over 80% of participants in Castillo's (2003) study had experienced some form of trauma in childhood.

The service user perspective has informed this study both for what it says about service users, and mental health professionals' understandings of personality disorder, but also for what it says about the importance of understanding the relationship between distress, context, power and powerlessness. It is important to try and understand the reasons for why people are as they are, particularly how early destructive social experiences can lead to personality disorder in later life. This is supported by certain psychiatric and seminal psychological literature which suggests that early trauma impacts on personality organisation throughout the life course and is therefore a factor in the development of what we know as personality disorder (Ball & Link, 2009; Erikson, 1968). The following section will consider this literature after first offering a definition of trauma.

### **1.6. Trauma**

Firstly, it is important to offer a definition of trauma. Lee (2006) differentiates between chronic and acute trauma, defined as traumatic accidents and single episodes of harm and/or injury which threaten the person's physical integrity (APA, 2000). Chronic childhood trauma can be defined as "a repeated pattern of damaging interactions between parent(s) and child that becomes typical of the relationship" (Kairys & Johnson, 2002, p.1). Rates of chronic emotional abuse and neglect, physical abuse and neglect and sexual abuse (Lee, 2006) have been found to be increasing in some countries (Breckenridge & James, 2010). Evidence also suggests that trauma, particularly in childhood, figures in the experience of many people living with mental health problems (Read, Goodman, Morrison, Ross & Aderhold, 2004) and impacts on their psychosocial functioning as adults (Davidson, Shannon, Mulholland & Campbell, 2009).

Evidence, from within psychiatry, suggests a clear association between childhood traumatic experience and the development of symptoms associated with personality disorder (Lanius, Vermetten & Pain, 2010) or the diagnosis itself (Ball & Links, 2009; Briere & Hodges, 2010). Zanarini (2000) estimates the association between childhood sexual abuse and Borderline Personality Disorder (APA, 1994) (BDP) as between 40 and 70%. Moreover, there is an evident relationship between the severity of abuse and the severity of symptoms, particularly in disorders such as BPD (Zanarini, Yong & Frankenburg, 2002). Symptoms or consequences can include deliberate self-harm, suicidal thoughts and behaviours (Lee, 2006), acute vulnerability and severe emotional distress, including hateful thoughts and emotions that may be projected onto others.

The relationship between early childhood trauma and personality disorder is also supported by seminal psychological literature which suggests that early trauma, occurring before either identity and personality organisation are established, significantly effects adult personality (Erikson, 1968; Bowlby, 1973; Wilson, 2006). Erikson (1968) theorized that personality forms as a continuous, stage like process, throughout the life course. He argued that early trauma impacts on this process of ontogenesis, particularly upon identity, ego strength and the person's ability to 'master' threats, unusual stress and/or reactive memories (Wilson, 2006). Any attack on the ego strength, the 'guardian of meaningful experiences' (Erikson, 1968, p.148) compromises the person's ability to cope with the developing self and leads to a state of traumaontogenesis or a post-traumatic state (ibid). It is suggested that early trauma '... has long-term consequences for adaptive behaviour, proneness to psychiatric illness, expectable problems in motivation, cognitive development, memory, and information-processing systems' (Wilson, 2006, p.90).

However, Erikson (1968) offered hope by suggesting that the effects of early trauma were not necessarily permanent or pathological and that identity could be positively supported through a combination of resilience, strength and integrity. These qualities can help to enable 'trust in one-self and carefully selected others' (Wilson, 2006, p.103) to challenge the person's distress or maladaptive strategies and promote more constructive responses to trauma. Not only does this suggest the importance of relationships, but also the importance of relational qualities to encourage the traumatized person's faith in others. Moreover, a more positive sense of identity can support more stable relationships with self and others (Erikson, 1968). There is a need therefore to understand the consequences of traumatic experience in the context of the person's whole life, in order to support their recovery (Bracken, 2002).

Despite the evident importance of early traumatic experience and the development of traumaontogenesis (Erikson, 1968; Ball & Links, 2009) questions remain about whether childhood trauma is actually a cause of personality disorder (Paris, 1998). These questions centre on the lack of longitudinal evidence and a lack of specificity, in that childhood trauma is not necessarily specific to personality disorders, and not all of those with a diagnosis of personality disorder have experienced childhood trauma (Graybar & Boutilier, 2002; Zanarini, 2000). However, evidence suggests that trauma can lead to the development of distress patterns or maladaptive relationships by which the person endeavours to cope with the consequences of their experience. Early trauma therefore appears a compelling explanation for the development of personality disorder which might in turn help to reshape mental health professionals' understandings and responses to person and diagnosis (Briere & Hodges, 2010). However, while trauma is clearly recognised in the classification of post-traumatic stress disorder

it is omitted as an aetiological factor for personality disorder (APA, 1994, 2012; WHO, 1992). Research indicates clear differences between the consequences of personality disorder and those of PTSD (Burr, 2010). Given this the next section will consider both diagnoses and summarise the differences between them.

### **1.7. PTSD and Personality disorder**

While PTSD is classified on the one hand as an anxiety disorder (APA, 2000) and on the other as a neurotic stress-related or somatoform, disorder (WHO, 1992), both classifications highlight the threatening and stressful nature of traumatic experiences that cause the person to feel fear, helplessness and/or horror. The impacts of such experiences cause the person to either constantly relive the experience through recurrent and intrusive thoughts or to avoid any association with it whatsoever. Both classifications highlight the hyper arousal associated with PTSD including irritability and outbursts of anger. Traumatic experience can be both acute and chronic (Lee, 2006; WHO, 1992). The symptoms can be similar to those of personality disorder. Given the significance of trauma and the similarity of its consequences to those of some personality disorders and PTSD, it is not surprising that there have been calls to subsume some of the former into the latter, i.e. BPD into PTSD (Burr, 2010).

While there is evidence of significant comorbidity (Limberg, Barnow, Freyberger & Hamm, 2011), research suggests that personality disorder and PTSD are qualitatively different diagnoses (Wingenfeld et al., 2011). Whereas sexual abuse in childhood and adulthood have been found to be associated with “all aspects of measured pathology” (Wingenfeld et al., 2011, p.650), emotional and sexual abuse in childhood have been found to be associated with BPD (Wingenfeld et al., 2011). Physical abuse and violence in adulthood have been found to be predictors of PTSD. On-going stress is significant to both personality disorder and PTSD, although once again, qualitative differences are highlighted, with stress exacerbating difficulties in social relationships in personality disorder and associated more with stressful memories in PTSD (Wingenfeld et al., 2011). Stigma further differentiates personality disorder from PTSD, given the latter’s long association with the military (Shay, 2002), which seemingly retains high levels of social support (Kings Military Health Research Unit, 2012).

While they are two qualitatively different diagnoses, the comorbidity of personality disorder and PTSD hold significant implications for service users and for mental health professionals trying to understand and work with the person. Limberg et al. (2011) found that PTSD co-occurred with BPD in 32% of people sampled. Burr (2010) suggests that while people with a diagnosis of both personality disorder and PTSD may engage in more non-suicidal acts, this does not mean that they are at any less of a risk of serious or lethal self-injury. The frequency of non-suicidal acts should not be taken for granted by mental health professionals. Stress, particularly recent stress, has been found to exacerbate the risk and vulnerability

of those with both BPD and PTSD diagnoses (Burr, 2010). Indeed some have suggested that it is “the intersection of crises and traumatic life events that create the most severe vulnerabilities” (Breckenridge & James, 2010) and the risk of re-victimisation (Burr, 2010). Mental health professionals, including MHSWs, need to be clear about the differences between personality disorder and PTSD and to understand how added stress can exacerbate risk and vulnerability in the person with PTSD and personality disorder.

While the associations between childhood trauma and personality disorder are contested (Ball & Links, 2009; Johnson, Cohen & Brown, 1999), this research project suggests that early trauma impacts on identity and personality organisation and therefore helps to explain how people develop distress patterns, commonly associated with personality disorder, as adults (Erikson, 1968; Tew, 2005). This project defines childhood trauma as patterned and damaging interactions between parent and/or care giver. Damaging interactions are defined as long-term, emotional, physical abuse and/or neglect and sexual abuse. Drawing on the relevant literature this project suggests that it is possible to empower more constructive responses to trauma, from which the person may garner a more positive, consistent identity and greater stability in their relationships with self and others (Erikson, 1968; Winnicott, 1973). The project acknowledges that trauma is not specific to personality disorder, and suggests the need to differentiate between kinds of traumatic experience and their impact on the person. A brief review of the relationship between trauma, personality disorder and PTSD indicates how different traumatic experiences can translate into different forms of distress, and responses to stress, in adulthood. It is also necessary to understand the impact of having both personality disorder and PTSD.

It appears that appreciating both the form *and* content of distress is important to understanding personality disorder. Human existence is multi-dimensional, comprised of different relationships and experiences of self, others and society in general. Recognising the impact of trauma and consequent maladaptive relationships or distress patterns could ‘reconfigure clinical understanding of many personality disorder presentations’ (Briere & Hodges, 2010, p.213). Trauma and its consequences need to be modelled in ways which reflect the multi-dimensional nature of human experience. The different disciplinary perspectives, within mental health services are reflective of this reality, although given that distress is always embodied, en-cultured and temporal a call has been made for contextual issues to come ‘centre stage’ (Bracken & Thomas, 2005, p.107). This study supports post psychiatry’s call (ibid). Its consideration of service user and MHSW’s perspectives adds to evidence about the experience of personality disorder, particularly its relationship to early traumatic experience and past and present contexts. While it complements the psychiatric and psychological perspectives this study adds weight to the argument that a reformulation of personality disorder is required, to one that recognises early

traumatic experience as a compelling explanation (Castillo, 2003; Briere & Hodges, 2010). Such recognition may enable more humane and empathic responses to the person. The next section will define the meaning of humane response in the context of this study and with reference to the relevant literature and the SOPs (HCPC, 2012).

### **1.8. Humane, empathic response**

While the impact of trauma is most significant for relationships with self and others, the capacity of human beings to rejuvenate and 'to repair what was hurt' should not be overlooked (Winnicott, 1973, cited in Lanius, et al., 2010). Erikson (1968) highlights the importance of the traumatized person learning to rebuild their sense of safety and self-esteem, through firstly reclaiming those aspects of identity and ego injured by trauma and secondly, restoring those not disrupted by traumatic memory, affects and perceptual processes. Supporting resilience and strengths appears central to repairing what was hurt (Winnicott, 1973). Re-establishing trust, safety and self-esteem requires the support of others, who can 'safeguard vulnerability and serve as foils against self-destruction, exploitation or the regressive withdrawal into helplessness' (Wilson, 2006, p.103). The emphasis is on human courage, commonality, empathy, strengths and resilience. This study suggests these features as a platform for more humane, empathic responses to people with personality disorder.

While traumatic experience can encourage hatred and resentment both to others and self, there is a commonality in experience as we can all recognise experiences we wish had never occurred (Simon, 2012, p.x). As such, we should perhaps appreciate the trauma survivor's courage for battling, often alone, in the face of overwhelming adversity. Courage is often context dependent. Reframing the person as a courageous survivor might trigger curiosity about the context in which their courage became necessary. Social workers need to understand how diversity characterises and shapes human existence and the formation of identity (TCSW, 2012). They also have a role in challenging discrimination and inequality (TCSW, 2012). A more humane response to the person with personality disorder starts from this basis while recognising that rejuvenation and life-long learning is possible (Saleeby, 2009; Ryan, Ramon, Greacen, 2012). Secondly it involves recognising our commonality as human beings in that we all face a risk of destructive experiences which can shape lives. Both are important foundations for more humane and empathic responses to the person.

While debate exists about whether empathy is an innate or learned response, it has been defined as the 'act of perceiving, understanding, experiencing and responding to the emotional state and ideas of another person' (Barker, 2003, p.141). This fits with social work's responsibility to recognise the fundamental principles of human rights and equality (TCSW, 2012). Empathy involves translating an emotional response to the person into words (Vinton & Harrington, 1994). This requires *thought* which

some have argued is critical to practitioner empathy (Lamm, Batson & Decety, 2007). Empathic, professional responses should involve affective sharing between practitioner and person, awareness of self and person- so that the practitioner can untangle their own feelings- and a perceptual flexibility which enables the practitioner to move between the person's perspective and their own (Decety & Lamm, 2006). Evidence suggests that thoughtful, empathic responses can inhibit anti-social behaviour in young people (Eisenberg, Spinard & Sadovsky, 2005), aggression towards others (Weisner & Silbereisen, 2003), promote healthy personal development (Hoffman, 2001) and more effective outcomes (Forrester, Kershaw, Moss & Hughes, 2008) and thereby support equality and human rights (TCSW, 2012).

Given the significance of these findings this study suggests that more empathic responses to the person could promote more effective processes and outcomes for people with personality disorder. Evidence suggests that responses to personality disorder can be unhelpful and stigmatizing (NIMHE, 2003; Wright et al., 2007). Allport (1954) argues that in the face of perceived stigma people can develop defensive, and even maladaptive, traits. Dismissive, stigmatized responses would therefore appear to compound the person's difficulties, whereas empathic responses can support strengths and resilience (Crisp & McCave, 2007). Indeed assets, resources and strengths are '... crucial in achieving resilience.... They facilitate the competence/capability that enables resistance to adversity and underlies the process of adaption' (Windle, 2011, p.157). Inclusive strategies and collaborative relationships which encourage a sense of safety and consistency are important to resilience (Scourfield, Roen & McDermott, 2008; Russell, 2010). Such relationships can help foster continuity and stability in conceptions of self and others, the core of the 'self-structure strengthens and solidifies' (Wilson, 2006, p.103).

It is evident that the SOPs (HCPC, 2012) support a new professionalism (Brandon, 1993) in the area of personality disorder. They charge MHSWs to recognise and understand the impact of culture and life experience and how this may include oppression, marginalisation and alienation (HCPC, 2012). Within this MHSW should recognise the fundamental principles of human rights and work alongside people to offer support *and* protection (HCPC, 2012). Working alongside people involves working with their own knowledge, strengths and perspectives including that on their risks and needs. MHSW has a responsibility to listen to service users, to communicate effectively with them and within the inter-professional network (HCPC, 2012). However, such a shift requires change in how and what professionals learn about the diagnosis. A "transformative learning platform is required" (Glover, 2012, p.16), one which ensures that professionals understand the impact of trauma on lived experience and the importance of skills and knowledge that puts the person first (Brandon, 1993). Professionals need to learn to suspend disbelief at service users' narratives (Saleeby, 2009), and instead be prepared to alter

their perspectives on the basis of these narratives (Glover, 2012). A reliance on specialist interventions will need to incorporate value for social interventions (McNicoll, 2013) particularly broad, social supports which evidence suggests service users prefer (Ikkos, McQueen & St John, 2011). This study suggests the importance of more humane, empathic responses to people with personality disorder, underpinned by the Standards of Proficiency (HCPC, 2012). Such responses are founded on the appreciation of humans' capacity for rejuvenation and recognition of service users' courage in the face of adversity. Empathy, as a thoughtful process, involving both emotional and cognitive mechanisms is crucial to such responses and in turn promotes resilience and more constructive responses to destructive social experience.

This section completes the definition of key terms and perspectives relevant to the diagnosis. A brief review of the seminal literature on personality disorder will be provided before moving on to consider the specific MHSW research.

### **1.9. *The seminal literature***

While any identification of seminal works on personality disorder might be charged with subjectivity, they have much relevance for this study, particularly for what they reveal about the ambiguity of personality disorder. The works of Pinel (1801) and Prichard (1837) were crucial to the early identification of the diagnosis and the attempt to separate abnormal features of personality from traditional symptoms of mental illness (Prichard, 1837). The rise of the medical model, with its need to identify causal mechanisms rather than merely describe classifications or signs, led to a number of revisions of the latter's concept of "moral insanity" (Prichard, 1837, cited in Tyrer, 2000, p.4). Schneider's (1923) influential revision, the psychopathic personality, was defined as "abnormal personalities who suffer through their personalities or through whose abnormalities society suffers" (Schneider, 1927, cited in Tyrer, p.6). Schneider challenged earlier attempts to distinguish abnormal features of personality disorder from traditional symptoms of mental illness, stressing continuity with mental state disorders (Livesley, 2003). Whereas Cleckley (1941) argued that psychopathy was a distinct illness of the most profound deficit, Jasper's work (1946) placed personality disorder on a continuum with mental state disorders rather than as a distinct nosological entity (Livesley, 2003).

With the publication of DSM II (APA, 1968), the psychoanalytic approach continued to dominate this key psychiatric classification with the focus on a particular criterion of personality disorder. Knight (1953), building on Stern's (1938) earlier work, defined a form which, he argued, was on the borderline with schizophrenia. Kernberg (1967) revised this early construct, defining BPD as a broad form of psychopathology characterised by primitive defences, identity diffusion and lapses in reality testing.

Crucially Grinker (1968) argued that BPD could be reliably assessed using discriminating criteria. While Grinker's work was influential in the inclusion of personality disorder and BPD in DSM III (APA, 1980), questions remained about its precise nature (Gunderson, 2009). The seminal literature helps to contextualise and explain why current debates about personality disorder appear so contested. The chapter will now summarise and critique the MHSW literature specific to personality disorder, which was crucial to my aim of exploring how MHSWs understand both diagnosis and practice in this area (Burton, 1990; Irvine, 1996 & Titus, 2004).

### ***1.10. The MHSW literature on personality disorder and MHSW***

I will consider this literature chronologically, starting with Burton (1990), which is actually a case analysis, rather than a piece of empirical research. However, it offers an MHSW perspective on personality disorder and so is included in this review. Burton (1990) analyses her approach to working with one person with personality disorder. Attention is focused more on practice than on understanding the nature of the distress, although she does describe the person's social isolation and her difficulties with social and family relationships. Burton (1990) contextualises her work with this person by confirming that little attention is paid to personality disorder in social work training, or to what kind of social work intervention might be appropriate. Understandably, she suggests that social workers feel ill-equipped to work with personality disorder and can often feel frustrated by the work. She acknowledges the failure of her initial casework approach as she explains her switch to more goal-orientated support in key areas: housing, support with practical tasks and liaison with others. Burton stresses the importance of total consistency in her relationship as a mechanism for building trust, encouraging discussion about the person's relationships with others and positive reinforcement of appropriate behaviour. She concludes by suggesting that in her experience, social work intervention can be effective and can encourage positive change in the person.

Irvine's (1996) paper evolved out of concerns about the increasing number of personality disorder referrals to a community social work team. It was thought that these individuals took up a lot of social work time with little apparent improvement. Irvine (1996) reviewed the case files of 30 people with personality disorder and found that all but three were allocated to social workers working in community mental health teams. A questionnaire was then completed by each social worker. Irvine aimed to examine the social work role and find out what kind of work was being undertaken. She hoped that the research would contribute to a clearer team policy on personality disorder, although it is not clear what direction, if any, this team policy would take. Like Burton, (1990) Irvine (1996) was concerned to understand social work practice in this area. She suggests disadvantaged childhood and loss as reasons for personality disorder; while she does not consider the specific ways in which childhoods might be

disadvantaged, she does suggest that personality disorder often involves poor relationships with others. Indeed, two thirds of the case files sampled detailed social isolation, with the vast majority not utilising community resources (Irvine, 1996). Irvine's attention is on understanding the work that social workers do in this area rather than on how the diagnosis itself is understood.

Again with some similarities to Burton (1990), many of Irvine's (1996) sample detailed difficulties with housing, particularly with maintaining an independent tenancy. A lack of suitable, supported housing for people with personality disorder induced people to accept independent tenancies that they then found difficult to sustain. Consequently, Irvine found that liaison, investigation, assessment and the provision of information and advice were general social work activities. Social workers were also engaged with problem-solving, counselling and mobilizing resources (Irvine, 1996). Like Burton, Irvine finds that a consistent relationship is important and can contain some of the person's more unpredictable behaviours. Importantly, she stresses the importance of longer-term relationships. Both Burton and Irvine therefore stress the importance of consistent relationships and social work support for the person's housing needs and their liaison role. Irvine's attention to the challenges involved in working with personality disorder distinguishes the two papers. Social workers reported the challenge of clients' constant crises and their unrealistic expectations of social workers (Irvine, 1996). Interestingly, some also reported that other agencies held unrealistic expectations of them, and that these two sets of expectations contributed to their own sense of isolation in this area. They stressed the importance of support from colleagues and of supervision when working with the person with personality disorder (Irvine, 1996). Irvine concludes by stressing the importance of the relationship between person and worker, the importance of consistency and, like Burton (1990), suggests that social workers engage in useful work in this area, although it is difficult to say how effective it is because the "... notion of social work 'effectiveness' per se is elusive" (Irvine, 1996, p.137).

The main aim of Titus' (2004) undergraduate dissertation is to identify the challenges for MHSW working with personality disorder. My interpretation of the study is that Titus' secondary aim was to investigate how participants understood personality disorder, with perhaps less attention devoted to the nature of the social work role. Titus (2004) states that her research is "underpinned by a Foucauldian (postmodern) framework" (p.2) and that it involved six interviews with MHSWs. These interviews were "aimed at uncovering how discourse, knowledge and power might be manifest in practice and expressed in: 'attitudes'; 'language' and conceptualisations of personality disorder and related issues" (Titus, 2004; p.3). Supporting Burton (1990), Titus suggests that MHSW knowledge of personality disorder is lacking. She appears to explicate a social model on personality disorder arguing that a social model connects the

experience of trauma, distress and discrimination, and argues that a more confident, pro-active MHSW approach is required in this area.

Careful reading is required to identify Titus' findings, as they and the discussion are combined in one chapter. In the context of raising questions about the usefulness of classification and diagnostic criteria she suggests that personality disorder is a discursive construction applied to people when their behaviour becomes problematic. While professionals can construct behaviour they perceive as difficult or problematic in negative ways (Markham, 2003), to conceive of personality disorder solely as a discursive construction can understate the person's experience of distress. Titus identifies three challenges for social work; the need to embrace the concept of client competence and overcome MHSWs' professional anxiety to develop greater confidence in its skill-base in this area; to embrace a critically reflective space to interrogate the impact of macro and micro influences on professional practice; and finally, to promote a social model and to reflect on how "gendered symbolic and material arrangements of personality disorder might impact on interactions and responses" (Titus, 2004,p.58). While Titus identifies these challenges, it was perhaps beyond the scope of her dissertation to identify how MHSW might begin to overcome them. Nevertheless her work and that of Burton and Irvine offer insight into how social workers understand personality disorder and how practice in this area can be conceptualized. For this reason I will now summarise how this literature further informed my study both in terms of content and design.

### ***1.11. The contribution of the specific MHSW literature on personality disorder***

This literature relates directly to my research questions and so this study has been informed by both its findings and its apparent limitations (Burton, 1990; Irvine, 1996; Titus, 2004). While all three point to how personality disorder is understood and related to childhood disadvantage and loss (Irvine, 1996), social isolation and difficulties in relationships (Burton, 1990) and trauma and discrimination (Titus, 2004) it is evident that Burton and Irvine's priority is more to understand MHSW practice in this area. Titus (2004) attends to the diagnosis as a discursive construction but pays little attention to how MHSWs understand and report the experience of distress. The research does contribute to knowledge about the nature of MHSW practice in this area, as it points to the importance of MHSW support with specific issues, i.e. housing and liaison (Burton, 1990; Irvine, 1996), practical support (Burton, 1990), the provision of information and advice (Irvine, 1996) and a consistent relationship between MHSW and person (Burton, 1990), which for Irvine (1996) should also be long-term. Titus (2004) builds on Irvine's initial identification of the challenges to MHSW, advocating for a more proactive, critically reflective and confident approach. While the above research informs MHSW knowledge and practice, my project is also informed by two of its crucial omissions.

Firstly, there is a lack of attention to the relationship between understanding and behaviour (Weber, 1949). How are MHSW's attitudes and responses to the person with personality disorder affected by their understanding and interpretation of the diagnosis? Consequently, this project explores how MHSWs understand the diagnosis *and* practice. Secondly, Irvine, (1996) and Titus (2004) only include MHSWs as participants. The inclusion of both service users and MHSWs in this project will generate different understandings and contribute to a more rounded appreciation of both personality disorder and practice. Furthermore, change and transformation can come from dialogue and interaction (Gergen & Gergen, 2003). The inclusion of both sets of participants in this project, if only in a virtual sense, may stimulate greater collaboration between practitioners and service users and help realise better informed practice in this area. The specific MHSW literature's support for the service user perspective on personality disorder indicates that this may be possible.

While the MHSW literature does tend to focus more on the nature of MHSW practice, it proposes reasons for personality disorder and discusses its consequences and the nature of the experience. Burton (1990) and Irvine (1996) suggest that the diagnosis is related to disadvantaged childhoods and loss, which contributes to poor relationships with others and social isolation in adulthood. Titus (2004) stresses the importance of connecting trauma, distress and discrimination in a social model of personality disorder. It therefore complements literature which associates personality disorder with a commonality of experience, a relationship to past trauma and estrangement and isolation (Castillo et al., 2001; Castillo, 2003, Fallon, 2003; Irvine, 1996; Miller, 1994; Nehls, 1999 Stalker et al., 2005). While the service-user perspective attends to the experience of distress and contextualises extreme forms of behaviour, the body of literature as a whole (Burton, 1990; Castillo et al., 2001; Castillo, 2003, Fallon, 2003; Irvine, 1996; Miller, 1994; Nehls, 1999 Stalker et al., 2005; Titus; 2004) suggests the importance of setting personality disorder and the person's experience within both their past and their present contexts. It therefore offers knowledge to complement that which accords greater priority to the form of personality related distress. An integrated conceptualization of personality disorder, with trauma at its core, which balances knowledge of both its form and content, would reflect the multi-disciplinary composition of mental health services, and might help to reconfigure professional responses to the diagnosis. Appreciating the significance of trauma for identity, personality organisation and distress patterns would encourage understanding, empathy and the resilience of people with the diagnosis. A greater clarity of understanding might also help to challenge some of the negative consequences of personality disorder's current status as a complex, contested diagnosis (NIMHE, 2003). The following sections will build on the historical ambiguities within the seminal literature to suggest that the current conceptualization of the diagnosis hold significant implications for practice, particularly in relation to stigma and risk.

### **1.12. Personality disorder; ambiguous and contested**

The complexity of personality disorder rests in part on questions as to whether the diagnosis sits on a continuum with other mental state disorders (WHO, 1992) or occupies a separate domain (APA, 1994). However, it is situated in a model founded on assumptions that “disease” is related to underlying abnormalities in the body and can be treated (Ingleby, 1982; Wade & Halligan, 2004). Applied to abnormalities in the mind or brain, mental disorder is defined as a “disease condition” (Horovitz, 2002, p.x) from which biological causes can be identified and prognosis and treatment defined. While it is possible that some forms of mental disorder may fit the demands of the disease model, questions have been raised about the fit of personality disorder (Pilgrim, 2001), which has led to more than one supplementary explanation for the disorder.

Blackburn 1988, (cited in Pilgrim, 2001, p. 255) suggests that personality disorder signals “... role failure and/or rule breaking”. Anti-social personality disorder (ASPD) (APA, 1994) might therefore be defined as the medicalization of the inability to comply with the increasingly uncompromising demands of Western society. ASPD is a tautology, given that anti-social behaviour defines abnormality and abnormality is inferred from anti-social behaviour (Wootton, 1959, cited in Prins, 1996, p.60). Furthermore, discrepancies across gender add weight to the argument that the diagnosis is no more than a codification of moral judgements (Pilgrim, 2001). The ascription of certain diagnoses, in particular of BPD and ASPD, represents a gender discourse that “... shapes how we experience and understand ourselves as men and women” (Cohn, 1995, p. 132). While some dispute the gender weighting of the BPD diagnosis to women (Coid et al., 2006), it is evident that BPD is more frequently ascribed to women than men (Becker, 1997). Interestingly women are more likely to express their emotional distress in ways that indicate a need for support and to engage in help-seeking behaviour (Paris, 2009). Men are more likely to express their distress through substance misuse and offending behaviour and less likely to engage in help-seeking behaviour (Paris, 2008). It is therefore not surprising that more men than women are diagnosed with ASPD (Robins & Regier, 1981).

The diagnosis’ complexity is further accentuated by its variability across time and place (Zanarini, Frankenburg, Hennen, Reich & Silk, 2005) and the significance of positive social factors in remission (Bateman & Fonagy, 2006) and recovery. Cultural expectations in Western societies appear increasingly focused on uncompromising individualism with consequent social isolation (Paris, 2009). Personal and community support have been found to be important factors in minimising self-destructive behaviours (Linehan, 1993). The increasing absence of such support in Western societies appears to contextualise an increasing prevalence of certain externalising forms of distress such as BPD (Millon, 1993). The relationship between the absence of support and the increasing prevalence of certain forms of

personality disorder appears more significant when they are considered in relation to the low rates of personality disorder in traditional and more socially-cohesive communities (Hwu, Yeh & Change, 1989; Lerner, 1958).

The differences within and between disciplinary perspectives adds to the diagnoses complexity and the challenges for all mental health professionals. Such challenges are not helped by the ambivalent policy context which frames mental health services. The next section will summarise this policy context before moving on to suggest that both this and the complexity associated with personality disorder can mean that professional responses to the person often fail to match expectations that the professional will extend "... a genuine offer to help" (Ramon, 1985, p.24). Perceptions of the stigma and risk that surround personality disorder (NIMHE, 2003) are considered specifically.

### ***1.13. An ambivalent policy context***

Mental health professionals are expected to reflect an awareness of the person's vulnerability and offer the protection of a bond infused with caring attitudes (Downie, 2011, pp. 23-35), perhaps irrespective of the challenges and complexities associated with the nature of their distress. However, professionalism is set in an ambivalent and contradictory policy context that aims to empower service users on the one hand, but reinforces public safety agendas and service rationing on the other (UK DoH, 2005a, 2005b, 1999, 1990, 1983, amended 2007). Individuals' vulnerability requires compulsory treatment (UK DoH, 1983 amended 2007) and safeguarding (UK DoH, 2011) at times, but the ambivalence of policy can translate to professionals, raise role anxiety (Titus, 2004) and limit attempts to understand the reasons for distress and the probability of its connection with the social situation.

Ambivalence in mental health policy needs to be considered alongside recent neo-liberal intentions to "roll back" and "roll out" the state (Newman, 2011, p.93). New Labour, in particular, aimed to establish a new contract between citizen and state based on the acquisition of rights with responsibility to secure economic competitiveness and safe and responsible communities (Jordon, 2001). The Third Way (Giddens, 1999) had significant implications for public services, as it extended the marketisation implemented by the previous Conservative governments (UK DoH, 1990a). In the context of progressive deinstitutionalisation (Campbell & Davidson, 2012), mental health services have increasingly prioritised public safety (Ryan & Morgan, 2004), surveillance and control over and above engaging the person in a therapeutic relationship to promote recovery, meaning and purpose (Ryan, Ramon & Greacen, 2012). The Care Programme Approach (CPA), first established in 1990 (UK DoH, 1990b), was broadened and integrated with community care arrangements (UK DoH, 1990; 2008) to ensure integrated monitoring and care planning for individuals with complex needs presenting significant risk. The social work role

was increasingly proscribed within strict parameters of risk, management and control (Jordon, 2001; UK DoH, 1998b), all of which raise significant ethical dilemmas for mental health social workers (Campbell, Brophy, Healy, O'Brien, 2006).

The reform of the MHA (1983) was initiated in this ideological and organisational context (UK DoH, 1999a). Reform was needed, given the existing legislation's stipulation that any application for detention had to consider the "treatability test": whether admission was likely to alleviate or prevent deterioration in the condition (UK DoH, 1983). This, together with the omission of personality disorder as a classification separate from the definitions of mental disorder (UK DoH, 1983), had a significant effect on access to treatment for personality disorder (Lewis & Appleby, 1988). The existing provisions were brought into further question by Michael Stone's conviction for the murder of Lyn and Megan Russell (BBC, 2010; UK DoH, 2000). Despite doubts about reliability it was proposed that those with a "diagnosis" of Dangerous & Severe Personality Disorder (DSPD) could be detained indefinitely to protect the public. Any such detention could be based on the risk of *likely*, rather than *actual* harm (UK DoH, 1999b, 2000). While the government recognised that protective custody would infringe individual rights (Rozenberg, 2001), the rights of the individual had to be balanced against the rights of the public at risk of future harm. Controversy reigned against a backdrop of opinion that as a diagnosis DSPD was "conceptually problematic" (Sarkar, 2002, p.6) and that the proposals were "unethical, unsafe and unworkable" (Shooter, 2002, cited in Moncrieff, 2003, p.9).

Proposals for preventative detention, although eventually dropped (UK DoH, 2004b), reinforced the association between risk, dangerousness, the un-treatability of personality disorder (Castillo, 2010) and the stigma attached to the diagnosis (Lewis & Appleby, 1988). It contradicted not only New Labour's intentions to promote access to mental health services by broadening the definitions of disorder and treatment (UK DoH, 1999a; 2002) but also specific and radical policy guidance to challenge the exclusion surrounding personality disorder (NIMHE, 2003) conceived to implement the National Services Framework for Mental Health (NSF) (UK DoH, 1999) in relation to personality disorder and address the implications of the broader definitions of mental disorder and treatment (UK DoH, 2002). This guidance built on an earlier scoping study identifying significant weaknesses in service arrangements and profound antipathy of staff towards people with personality disorder (Duggan, 2001). Its objectives were threefold; to assist those with personality disorder to access services; to ensure that offenders receive appropriate forensic care; and to ensure that professionals receive appropriate training and continuing professional development opportunities in relation to personality disorder (NIMHE, 2003b). The latter will be considered later in this chapter (Duggan, 2007). While the "management" (NIMHE, 2003, p.6) of personality disorder remained a priority, this policy sought to develop good practice

through specialist multi-disciplinary teams and specialist day patient services and moreover to encourage optimism about the effectiveness of therapeutic interventions (Bateman & Tyrer, 2002). The inclusion of service users' perspectives was important to the achievement of these objectives (NIMHE, 2003).

Service-user involvement meant that the policy confirmed that personality disorder is a very 'sticky label' (NIMHE, 2003, p.20) which professionals do not like and fail to understand. Service users reported that peoples' experience of mental health services is largely "inadequate" and "negative" (p.20), which in turn precludes further engagement. Service users argued there was a need for greater therapeutic optimism, greater professional skill in the handling of therapeutic relationships and greater awareness of the impact of service withdrawal on recovery (Castillo, 2010). They suggested that there is a need for a "shared experience between patient and professional" (NIMHE, 2003, p.21) and for the professional to be in touch with the person's distress but not overwhelmed by it. The policy gives detailed guidance on team strategies and individual and personal aptitudes required for working with personality disorder (NIMHE, 2003). Despite these laudable intentions, recent evidence suggests that services for people with personality disorder remain inadequate and unable to meet their needs (Tetley et al., 2012). It is quite possible that the success of 'Personality Disorder; No Longer a Diagnosis of Exclusion' (NIMHE, 2003) was limited from the outset by the decision to implement it as guidance rather than as a strategy document (NIMHE, 2003).

This review of recent policy and legislation reveals certain contradictions. On the one hand there is a preoccupation with public safety and the management of risk (Ryan & Morgan, 2004) and on the other, the intention to promote access and involvement and to challenge exclusion (UK DoH, 2000, 2001; NIMHE, 2003). These contradictions are to be seen in the light of policy which sought to "modernise" mental health services and social services (UK, DoH, 1998a, 1998b) to balance public safety with more patient-centred care. However, it seems that priority has been accorded to safety, given the introduction of Community Treatment Orders (CTOs) (UK Department of Health, 2007). CTOs permit a person to remain in the community when they may lack capacity and present a risk to others under certain conditions (MIND, 2007). Their introduction has been particularly contentious, with many questions raised about their contested nature and dependence on contested concepts and efficacy (Campbell et al., 2006).

CTOs appear to be largely associated with mental illness. Malik & Hussain (2009) found, in an audit of CTO applications, that 66% were for people with schizophrenia and 6% for bi-polar disorder, with only 1% for those with personality disorder. While application to personality disorder is minimal, questions remain about how MHSWs can work to meet need, empower recovery and manage risk in this area,

especially in the face of doubts about the efficacy of pharmacological treatment (Feurino & Silk, 2011). Campbell et al. (2006) suggest that MHSW needs to develop its resources, particularly skills which help to engage and sustain relationships with individuals who may be reasonably unwilling to engage with authority figures and more coercive forms of practice. This is particularly pertinent as services which prioritise safety can actually make the person more reluctant to engage at a time of crisis (Ryan & Morgan, 2004) and can therefore exacerbate risk to self and others. The development of relational skills in the area of personality disorder may help MHSWs to balance the expectations of “safety” and empowerment and, ultimately, help to realise evidence calling for a shared experience between person and professional (NIMHE, 2003). The findings of this research project are therefore relevant to practice, including its more coercive forms (Campbell & Davidson, 2009). If policy and practice are to minimise risk and promote recovery, there is a need for therapeutic relationships that emphasise dialogue, learning and connection (Glover, 2012, pp.15-36).

Furthermore, while policy asserts the need to close the equality gap and improve access to mental health services and therapies (UK DoH, 2009; 2010), these objectives are set in an increasingly privatised economy of care (Pemberton, 2012; UK DoH, 2012) and at a time of severe fiscal and service retrenchment (Taylor-Gooby, 2012). Empowerment through an increase in market “choice” continues the top-down consumerist, neo-liberal premise of recent policy (Beresford & Croft, 2001) and acts to prevent the acquisition of political, social and civil rights (Marshall, 1987). It is apparent that a policy commitment to service entitlement (Miliband, 2012) would do more to empower the citizen with mental health problems than the rhetorical “choice” found in clinical commissioning (UK DoH, 2012). Empowerment approaches that assert the importance of choice without addressing structural inequalities are conceptually problematic, especially at a time of economic crisis, fiscal restraint and service retrenchment (Taylor-Gooby, 2012).

The government’s national strategy for mental health (UK DoH, 2010) needs to be viewed in the wider context of fiscal restraint and structural inequality (Institute for Fiscal Studies, 2010). While the strategy prioritises early intervention, service integration, personalisation and recovery, encouraging Local Authorities to review their use of eligibility criteria (Community Care, 2012), it is hard to see how these objectives can be achieved when spending on mental health services has declined for the first time since 2001 (UK DoH, 2012). A strategy that emphasises outcomes and commissioning (UK DoH, 2010) over and above process and resourcing is unlikely to achieve its objective of empowering people with mental disorder (UK DoH, 2010). Integrated support and treatment is surely risked by the trend of withdrawing MHSWs from community mental health services (Community Care, 2011). Despite its laudable aims, the government’s mental health strategy appears conceptually and practically flawed.

This brief review indicates how, in recent years, mental health policy (NIMHE, 2003; UK ODPM, 2004; UK DoH, 2007, 2010) has attempted to cover both safety *and* the inclusion of people with mental disorder, including personality disorder. Top-down policy formulation and implementation make these objectives irreconcilable, and indeed implementation in recent years has prioritised safety over and above inclusion, empowerment and recovery. Current resourcing constraints suggest that this priority will continue to dominate. However, it is evident that a focus on strengths promotes recovery and greater collaboration between person and professional in all areas, including risk assessment and management (Boardman & Shepherd, 2012). While this would require cultural change and the opening up of minds and organisations to service-user evaluations, the facilitation of training and shared decision making, it would not require costly, specialist interventions. Evidence suggests that innovative practice is possible. A recent evaluation of the eleven pilot community projects for personality disorder set up by the Cabinet Office in 2005 has revealed that all eleven projects are continuing to evidence quality, innovation, productivity and prevention (Personality Disorder, 2011). Innovation is particularly strong, so much so that these projects have established themselves as an innovation network (Personality Disorder, 2011). Commissioned by the Cabinet Office with a brief to coordinate the implementation of policy across all government departments, these pilot projects demonstrate how it is possible to work effectively with personality disorder. A commitment to change at the structural, cultural and individual levels is essential. This research project suggests that MHSW too should embrace such a commitment to change in relation to personality disorder, which in turn might aid the realisation of earlier policy objectives, particularly collaborative practice between service users and mental health professionals (NIMHE, 2003). This thesis may contribute to such collaborative developments. However, the complexities associated with personality disorder, set within an ambivalent, contradictory and resource led policy context appears to contribute to the stigma and discrimination which continues to surround the diagnosis within mental health services (NIMHE, 2003; Furnham & Wineslaus, 2012).

#### **1.14. Stigma**

It is apparent that both person and diagnosis have a particular stigma (Lewis & Appleby, 1988; NIMHE, 2003; Stalker et al., 2005) that diminishes the individual, denies their humanity and reinforces perceptions that personality disorder is “difficult” (Hinshelwood, 1999). In the light of the above information it is understandable that professionals perceive the diagnosis as complex and the person as a challenge to their personal and professional esteem (Bowers, 2002). Evidence suggests that professionals can feel overwhelmed (Hinshelwood, 1999) and unskilled, and therefore seek distance (Aviram et al., 2006). As NIMHE, (2003) acknowledges:

... people with personality disorder are treated at the margins – through A&E, through inappropriate admissions to acute inpatient wards ... Many clinicians and mental health practitioners are reluctant to work with personality disorder because they believe that they have neither the skills, training or resources to provide an adequate service, and because they feel there is nothing the mental health services can offer. (p.5)

Despite attempts to develop knowledge and understanding about personality disorder (UK DoH & Ministry of Justice, 2007); recent research indicates that the stigma persists (Taylor, 2011). Mason, Hall, Caulfield & Melling (2010) found that members of a key discipline continue to hold negative perceptions of people with personality disorder, especially with regard to the management of behaviour. Moreover, as suggested earlier in this chapter, it is possible that stigma further differentiates personality disorder from PTSD. Symptoms of “shell shock” or PTSD (APA, 1980) have long been associated with the military (Shay, 2002). Recent research indicates how citizens remain highly supportive of military personnel, even if they disagree with their particular mission (Kings Military Research Centre, 2012). Strong social support is a factor in reducing the stigma and discrimination faced by returning military personnel experiencing PTSD (Avkst-Margetic, Toic, Furjan, Boban & Margetic, 2009). Attitudes towards people with personality disorder are less positive (NIMHE, 2003), and therefore negative evaluations and the attribution of responsibility are critical to the operationalisation of stigma in this area.

Stigma is defined by deeply discrediting attitudes that discriminate between the person’s actual identity and their assumed identity (Goffman, 1990). Stigmatizing labels (Scheff, 1996) are applied when there is an attribution of responsibility for the discredited characteristic (Aviram et al., 2006) and/or when the person is considered violent or dangerous (Angeyer & Matschinger, 2003). The person can internalise these discrediting labels to generate a self-fulfilling prophesy that completes “... a cycle of mutual mistrust with no positive exit in sight” (Ramon, Castillo & Morant, 2001, p.12). The attribution of responsibility appears common to attitudes that surround personality disorder. The person is often seen as responsible for their behaviour as if it is something that they can control, and so they are seen as not ill, but trying to manipulate (Breeze & Repper, 1998; Lewis & Appleby, 1988). Mental health professionals are not necessarily immune to such attitudes that position person and diagnosis outside of the “sick role” (Beales, 2001) Breeze & Repper, 1998; Parsons, 1951). The privileges of the patient role are therefore not granted (Parsons, 1972). While the reality of the experience of living and working with personality disorder should not be underestimated (Horovitz, 2002), a number of factors combine to constitute the diagnosis as a stigmatizing force (Wright et al., 2007). Not least of which is the assumption of direct correlations between mental disorder, personality disorder, violence and

dangerousness (Nash, 2006; Stark, Patterson & Devlin, 2004). I critique this correlation in the next section.

### **1.15. Risk & Dangerousness**

Negative labels are generally associated with the attribution of responsibility, violence and dangerousness (Angeyer & Matschinger, 2003). It is evident that personality disorder is associated with the attribution of responsibility (Breeze & Repper, 1998) and with violence and dangerousness (Markham, 2003). This correlation is set in a wider context, in that the general public and mental health professionals correlate mental disorder with violence and dangerousness (Nash, 2006; Stark, e al. 2004). However, the evidence that supports this correlation is contested (Vinestock, 1996) and perhaps not necessarily surprising given the absence of features, known to inhibit anti-social behaviour, in those with a diagnosis of psychopathy (Hare, 2003).

While it is clear that the empirical evidence has grown since the mid-1990s, Pilgrim & Rogers (2003) argue that this does not necessarily mean that firm conclusions can be drawn. Empirical evidence appears fraught with methodological limitations (Monahan & Steadman, 1983) that have led some to conclude that any "... link between mental disorder and dangerousness appears more like an artefact of research methodology and not an empirical finding" (Corbett & Westwood, 2005, p.124). Corbett & Westwood's critique is supported by data that suggests that between 1992 and 1997 only 3% of homicides were committed by someone known to the psychiatric services (Nash, 2006). Tew (2002) argues therefore that these "correlations" are the products of individualised risk assessments and assumptions that people are "intrinsically dangerous due to their illness" (p.144). While legitimate questions have been asked about this apparent correlation, this is not to say that there is no correlation between some forms of personality disorder, violence (Hare, 2003) and high risk behaviours (Pidd & Feigenbaum, 2007).

Hare (2003) suggests that correlations between psychopathy and violence are hardly surprising, given that factors known to inhibit anti-social behaviour are assumed to be absent in those with a diagnosis of psychopathy. Furthermore, Pidd & Feigenbaum, (2007) argue that people with personality disorder face a significant risk of suicide and/or accidental death, as many "... are prone to dangerous or impulsive behaviours or lead chaotic lifestyles ..." (p.8). It is quite possible that those experiencing mental disorder, including personality disorder, are more a risk to self than to others (Nash, 2006). While negative labels are associated with violence and dangerousness, legitimate questions have been raised about the correlations between mental disorder, personality disorder and dangerousness (Nash, 2006). Are these correlations the result of methodological limitations and intrinsic assumptions that the person

will be violent? Or are they once again a consequence of the tendency to abstract the behaviour from the context in which it occurs, rather than try to understand how the social context makes this risk behaviour unique (Nash, 2006)?

Castillo (2003) found that risk behaviour corresponds to key personal factors such as “unresolved and unassimilated trauma” (p.18). Indeed Ramon et al. (2001) suggest that research participants with a diagnosis of personality disorder in a participative research project, presented as “... lonely and unhappy people, rather than angry ... irresponsible or callous” (p.10). Furthermore, risk behaviour has been found to correlate to the misuse of drugs and alcohol (Steadman et al., 1998). The person’s socio-economic context has considerable significance. People with a history of involvement with mental health services are more likely to live in areas of concentrated poverty (Silver, Mulvey & Monahan, 1999) and are therefore at a higher statistical risk of perpetrating violence on others, especially if under the influence of substances (Steadman et al., 1998) or as victims of violence (Pilgrim & Rogers, 2003). It is apparent therefore that the presence of “violence-inducing social forces” (Hiday, 1995, p.127) needs to be accounted for.

The previous sections have considered how the complexities associated with personality disorder induce unhelpful consequences for service users and pose significant challenges for mental health professionals including MHSWs. The next section will illustrate how such distant relationships can escalate the risk of a more fatal outcome (Watts & Morgan, 1994) for the person with personality disorder.

### **1.16. Risking alienation**

The reality of living with personality disorder should not be dismissed, and nor should the challenges facing the professional. Indeed, these challenges underline the need to understand the diagnosis as fully as possible. The mental health professional can encounter an individual struggling to contain their emotions, a range of interprofessional and attachment difficulties (Pidd & Feigenbaum, 2007) and a lack of cooperation (Koekkoek, van Meijel & Hutschemaekers, 2006). The professional’s personal and professional self-esteem can be challenged, leaving them feeling deskilled and helpless to affect change (Bowers, 2002). It is therefore understandable that they might lose focus on the person and engage in polarised responses (Breeze & Repper, 1998; Wright et al., 2007). Watts & Morgan (1994) define some of the complex behaviours associated with personality disorder as “pathological care-eliciting behaviour” (p.11) with which the person aims to bring the carer closer and/or try to cope with their distress. Miller (1994) found that service-user participants described trying “something, anything” (p.1217) to cope. Distant and/or controlling responses that come from pathological care-eliciting behaviour, however, need to be contextualised by mental health professionals’ expectations that they

are “therapeutic tools”, with aspirations to “heal all, know all and love all” (Watts & Morgan, 1994, p.12).

The use of self is crucial to the development of the therapeutic relationship (Cutcliffe & Goward, 2001; Livesley, 2003). However, care-eliciting behaviour challenges the identity and expectations of the mental health professional, especially in disorders where recovery is slow (Main, 1957). The projection associated with personality disorder (Bateman & Fonagy, 2006) can lead to the professional’s actual or felt rejection (Watts & Morgan, 1994), which in turn can affect their esteem and expectations and encourage a defensive attitude against the person. Wright (et al., 2007) argue that the professional’s need to defend him/herself has been legitimated in practice in this area “... with large elements of the therapeutic encounter ... devoted to efforts to protect oneself from the perceived maligned effects of the other’s personality and behaviour” (p.242). Moreover, these defences can escalate the risk of the person self-harming (Watts & Morgan, 1994).

Watts & Morgan (1994) suggest that professional defences against the “difficult” person are founded on malice and aversion (Maltzberger & Buie 1974), which encourage the professional to abandon or seek distance from the person (Hinshelwood, 1999). However, these responses are ultimately counter-productive for both, as they set in train a process of malignant alienation:

... a progressive deterioration in their relationships with others, including loss of sympathy and support from members of staff, who tended to construe these patients’ behaviour as provocative, unreasonable or over dependent. In some instances an element of deliberately assumed disability was invoked.

Morgan, 1979, cited in Watts & Morgan, 1994, p.11

Relationships without hope, humanity or empathy, which distance the individual and encourage the internalisation of negative labels and emotions, ultimately escalate the risk of a fatal outcome for the person (Watts & Morgan, 1994). However, a trauma centred, multi-factorial conceptualisation of personality related distress, reflecting the nature of human existence would encourage a more holistic approach to understanding and supporting people with personality disorder. People are products of their ‘genetic, biological, relational, social and cultural environments (Everett & Gallop, 2001, p.19). All of these factors influence the impact and consequences of early trauma. The multidisciplinary nature of modern mental health services means that structures exist to connect these perspectives in a holistic approach to the person with personality disorder. However, their continued attachment to form over

content (Bracken & Thomas, 2005) and recurrent questions about whether trauma is an aetiological factor for personality disorder (Balls & Link, 2009) impede this objective. This study in its attention to the social dimension of personality related distress will delineate MHSWs potential contribution to the support of people with personality disorder and the profession's wider contribution to the multi-disciplinary context of modern mental health services. This chapter will now briefly consider MHSWs place in the aforementioned context before moving on to consider the efficacy of current treatments for personality disorder.

### ***1.17. The multi-disciplinary context***

A reformulation of personality disorder requires effective dialogue between all stakeholders in order that respective understandings can be explored and questioned (Bracken & Thomas, 2004). The likelihood of such a dialogue is dependent on the efficacy of structural and individual relationships, including those within multi-disciplinary mental health services. While regional differences are evident, MHSW operates in an increasingly integrated and multi-disciplinary context (UK DoH, 1990; UK DoH, 1990b, 2008; DoH, 1998; DoH, 2006). Efficient integrated mental health services are known to be effective (Borrill et al., 1996) in that they can avoid duplication and promote flexible, holistic assessment and support. However, for MHSW they present threats as well as opportunities (Dickens, 2010). Integrated mental health services can offer social workers new opportunities to practice skills in new and different ways (Dickens, 2010). However, they can also threaten social workers' professional control, induce role conflict, stress and threaten job satisfaction (Carpenter, Schneider, Brandon & Wooff, 2003; Frost, Robinson & Anning, 2005). The challenges involved in working with personality disorder are significant enough without being further undermined by stress and dissatisfaction. Furthermore, an optimal MHSW contribution would enhance holistic assessment and appropriate service provision for people with personality disorder. Given the significance of both factors this section will consider why MHSW occupies a more marginal position within the multi-disciplinary context (Murphey & McDonald, 2004) before suggesting the value of specific research, knowledge and training to optimise MHSW's contribution to the support of people with personality disorder.

MHSW and social work in general has been shaped by the threats and opportunities attached to both professionalization and bureaucratization (Beresford & Croft, 2001; Dustin, 2006; Dickens, 2010). Indeed its very status as a profession has been ambiguous. While social work has long been committed to the best interests of 'clients' (Mayer & Timms, 1970), only relatively recently was its governing body and code of conduct established (UK DoH, 2000; General Social Care Council, 2002). The demise of the latter in 2012 is indicative of the extent of political antipathy towards professional social work (Dickens, 2010). Social work has also been criticised for not developing a distinct body of knowledge and for lacking

control over its work (ibid). Moreover, its liminal position on the threshold of physically, morally and socially 'dirty work', with less opportunity and power to delegate this work, can diminish its professional status (Hughes, 1958; Warner & Gabe, 2004).

While recent amendments to mental health legislation are catalysts for change (UK DoH, 2007) MHSW is often positioned in contexts characterised by medical dominance (Murphey & McDonald, 2004). Medical power and authority are reinforced by the 'science' of evidence based practice, the 'conscientious, explicit and judicious use of the best available evidence to make decisions about the best care of clients' (Sackett & Rosenberg, 1996, p.2). MHSWs' focus on the multi-dimensional nature of human existence and consequent competing responsibilities can put it 'at odds with the uni-dimensional focus of EPB' (Murphey & McDonald, 2004, p.131; Bailey & Liyange, 2012). However, MHSW is informed by evidence, from a range of disciplinary perspectives. Nonetheless, the perception that social work is not *evidence based* can further undermine its professional status (ibid).

Evidence suggests that social work's professional and positional ambiguity, as outlined above, can mean that social workers are less satisfied in their work (Onyett, Pillinger & Muijen, 1997). While the relationship between satisfaction, stress and role conflict is not necessarily a linear one, job satisfaction can correlate with levels of stress and role conflict (Bailey & Liyange, 2012). Carpenter et al. (2003) found that MHSWs were less positive about team functioning and experienced more stress and role conflict. This challenges the need for MHSW to be 'clear and confident about the expertise it has developed' in multi-disciplinary mental health teams (GSCC, 2008, para 41). Support and supervision is required to secure a confident social work contribution (Carpenter et al., 2003). Research which delineates MHSW's potential contribution to personality disorder may stimulate MHSW interest about the diagnosis and the appropriate skills and attitudes to inspire professional confidence in this area.

Structures to enhance professional MHSW knowledge about personality disorder exist. The Knowledge Understanding Framework (KUF) spans general and forensic mental health services, is open to all professionals and aims 'to support improved practice' among staff who work with personality disorder occasionally, regularly and as part of their main caseload (Duggan, 2007, p.26). It accounts for the essential capabilities which emphasise recovery and balance needs *with* strengths and safety *with* positive risk taking (NIMHE, 2004). Initial awareness training is supported by opportunities at undergraduate and postgraduate levels to ensure that good practice is sustained. Duggan (2007) argues that developing the knowledge, attitudes and skills of staff working with personality disorder is required for justice and economic reasons. Certain personality disorders are associated with high economic burden (Rendu, Moran, Patel, Knapp & Mann, 2002; Aviram et al., 2006; Soeteman; Hakkarart-van-Roijjen, Verheul & Busschbach, 2008). This evidence supports the need to further knowledge about personality

disorder to promote individual and community resilience (Duggan, 2007). While barriers remain, service and learning structures exist to promote more effective, holistic responses to people with personality disorder. Therapeutic optimism is also increasing. This chapter will now consider the treatment of personality disorder, before suggesting the value of the post psychiatry paradigm for understanding the diagnosis and optimising the MHSW contribution to a holistic, multi-disciplinary response.

### ***1.18. Therapeutic approaches and the value of post psychiatry***

Increasing attention to personality disorder has spurred an increase in ‘both clinical and research interest in treatments’ (Duggan, Huband, Smailagic, Ferriter & Adams, 2007, p.118). Therapeutic advances and intervention are now framed by guidelines for BPD and ASPD (National Institute for Clinical Excellence, 2009) (NICE). These guidelines aim to ‘improve health care’ and are intended for ‘professionals responsible for treating patients in the NHS’ (Tyrer & Duggan, 2007, p.109). While many health care disciplines were consulted in their development they stress the importance of the relationship, inclusion, collaboration, strengths and the centrality of a multi-disciplinary approach (NICE, 2009). While acknowledging an ‘absence of any high quality evidence’ (p.24) they articulate clear expectations about the psychological and drug treatment of personality disorder. High or best quality, evidence is provided by Meta analyses of good RCTS, which are not appropriate or feasible for personality disorder (Tyrer & Duggan, 2007). However, evidence for certain personality disorders i.e. BPD and ASPD is increasing. Dialectical Behaviour Therapy (Linehan, 1993) (DBT), Cognitive Behavioural Therapy (Davidson, Norrie & Tyrer, 2006) (CBT) and Mentalization Based Therapy (Bateman & Fonagy, 2001) (MBT) are among those interventions found to be effective (Duggan et al., 2007).

DBT is a structured therapy for BPD, concerned with how past and present contexts can maintain behaviours. It is based on the dialectic, the inter-relatedness of two seemingly opposing entities and therefore appreciates the variability of human existence and that change, acceptance and synthesis can evolve from ‘opposition’ (Swales, Heard & Williams, 2000). This is born out in the importance attached to the therapeutic relationship, where therapist and person ‘reciprocally influence each other’ (p.9). The focus is on enhancing the person’s capabilities and motivation, with specific strategies to address post-traumatic memories, developing trust and validation (Linehan, 1993). The empirical evidence is promising (ibid). DBT has been found to result in fewer inpatient days; less anger, fewer suicidal acts and better social adjustment days at follow up (Linehan, Heard & Armstrong, 1993). Moreover, evidence suggests that DBT adapts to the British context and other areas of intervention, i.e. adolescents (Miller, Rathus, Linehan, Wetzler & Leigh, 1997).

Cognitive behavioural approaches underpin the guidelines on ASPD (NICE, 2009). CBT is bio-social and based on the assumption that 'patients with personality disorder are characterised by dysfunction in thinking, emotional regulation, and behaviour that arose in childhood and has been maintained into adulthood' (Davidson, 2008, p.117). Its focus therefore is on the person's core beliefs and how these lead to maladaptive strategies of coping, avoidance or compensation. Attention is paid to helping the person understand how their past relates to their current problems. Change is achieved through supporting, practising and strengthening new and more adaptive beliefs to increase pro-social behaviour (ibid). While evidence is somewhat limited CBT has been shown to lead to more positive outcomes for those with BPD and avoidant personality disorder (Davidson, Norrie & Tyrer, 2006; Emmelkamp et al., 2006). MBT (Bateman, Ryle, Fonagy & Kerr, 2007), also attends to the person's past experiences, but with a focus on attachment. It sees harsh, inconsistent care together with biological vulnerability as significant factors in the origins of BPD. The focus is on the person's early development and its relationship to therapeutic change. MBT has been found to lead to substantial improvements in self-reported and clinically significant problems, including suicide attempts (Bateman & Fonagy, 2009).

While there is a need to develop quality evidence about the effectiveness of interventions for all of the personality disorders, what is available suggests that structured treatments can improve outcomes for certain personality disorders (Bateman & Fonagy, 2009). DBT, CBT and MBT have been offered as examples of effective interventions which fortunately are founded on principles aligned with social work, with the strengths approach and the recovery focus (Rapp and Goscha, 2012). The importance of the relationship between person and professional, the meaning of past and present contexts, the person's capabilities and motivation (together with the professional's motivation), validation and pro-social behaviour are all concepts which have meaning for MHSWs (Scott, 1989; Ramon, 2005; Ryan, Dowden, Healy & Renouf, 2005; Saleeby, 2009; Cherry, 2010). Furthermore, such treatments are contextualised by guidance emphasising the importance of a person centred approach, inclusion and collaboration (NICE, 2009). This would appear to support a specific contribution from MHSW to the support of people with personality disorder.

A combination of factors encourages optimism about the possibility of more effective responses to people with personality disorder. The widening of the definition of mental disorder and treatment offers people with the diagnosis the opportunity of treatment (UK DoH, 2007). Evidence of the effectiveness of certain treatments encourages therapeutic optimism (Bateman & Fonagy, 2009). Multi-disciplinary mental health services exist to enhance integrated assessment and support. While MHSW has occupied a somewhat marginal position within such services the extension of the Responsible Clinician role, to other disciplines, means that medicine is no longer the only lead discipline (UK DoH, 2007). MHSWs are

taking the lead and moreover developing innovative, evidence based interventions articulating the value of MHSW to multi-disciplinary mental health services (McNicoll, 2013). Furthermore, opportunities to develop the knowledge and skills of all mental health professionals working with personality disorder exist (Duggan, 2007). All of these factors, combined, encourage hope for the future of living and working with personality disorder. However, evidence continues to suggest that services could do more to meet the needs of people with personality disorder (Tetley et al., 2012).

It is apparent that services continue to accord greater priority to the form of distress, without a reciprocal balance to content (Bracken & Thomas, 2012). Placing greater emphasis on the meaning and significance of distress for the person would re-dress the balance (ibid, p.133). Post psychiatry appreciates the need to consider the form *and* content of distress, valuing all the different disciplinary knowledge bases, without any taking precedence over another. It therefore supports a multi-dimensional conceptualisation of disorder and the value of an effective multi-disciplinary response to it. Moreover, post psychiatry is founded on reciprocity between person and professional (Bracken & Thomas, 2005). This anchors the person's perspective at the centre of the therapeutic relationship, pinning services on the knowledge of experts by experience (James, 2007). These key tenets of post psychiatry offer hope for a more balanced, integrated and inclusive approach to all the mental disorders, including personality disorder. Attention to reciprocity in content and design, valuing knowledge about personality disorder including service users' expert knowledge means that this study connects with the post psychiatry paradigm. Through its exploration of service user and MHSW perspectives this study reflects the importance of a holistic understanding of personality disorder and furthermore articulate MHSWs' contribution to this within multi-disciplinary mental health services.

### **1.19. Conclusion**

My research questions framed my approach to the literature, both the wider literature on personality disorder and that specific to MHSW. My critique of the wider, disciplinary, literature outlines the diagnoses inherent complexities and the challenges these pose for the mental health professional. It is apparent that one perspective cannot adequately explain the multidimensional nature of personality disorder. However, while there is considerable psychiatric and psychological literature in this area there is a relative absence of that from MHSW, despite connections with traditional areas of social work endeavour and the importance it attaches to the social and the relational.

The small body of specific MHSW literature (Burton, 1990; Irvine, 1996; Titus, 2004) however, does suggest the importance of a consistent relationship and points to personality disorder as a consequence of childhood disadvantage, loss and trauma leading to difficulties in relationships and social isolation in adulthood. This research project is informed by these findings as well as by some apparent omissions.

The inclusion of service-user and MHSW participants maximises this study's potential to transform practice in this area as it establishes the project as a site of virtual interaction. The project attends to the relationship between interpretation and action, particularly in relation to how understandings of the disorder influence the professional response to the person.

Moreover, certain seminal work (Erikson, 1968) complements both the MHSW literature and that which offers service users' perspectives on personality disorder. My review of the latter highlights the diagnoses complexity, the depth of distress and a commonality of experience centred on despair and estrangement. It reveals the importance of understanding and engaging with the person and calls for more humane, empathic responses based on appreciating the person in their past and present contexts (Castillo, 2003). Extreme and unsafe behaviours need to be understood as ways in which the person may be trying to cope with their chronic distress. Understanding personality disorder as a response to past experiences, specifically traumatic ones, calls for a multidimensional conceptualization of the diagnosis which balances both the form and content of the person's distress. This study will contribute to such a conceptualisation and suggests ways in which MHSW might contribute to an effective, holistic response to empower the person's response to trauma.

The following chapter sets the study's context and considers how the project's focus on understanding participants' perspectives and experiences necessitates an interpretivist approach with a relativist, subjectivist and qualitative methodology. It considers the use of a grounded theory approach (GT) (Glaser & Strauss, 1968; Charmaz, 2006) in a case-study (Yin, 2003) framework. It sets out methods, sampling and ethical requirements and indicates the research's validity and the importance of reflexivity. It will also account for the research in action. This chosen methodology enables the research to get as close as possible to the participants' understandings of personality disorder, MHSW practice, and how the latter might be better informed.

## **Chapter 2: Methodology**

This grounded theory study seeks to answer three questions: how service user and MHSW participants understand personality disorder, how they understand MHSW practice in this area and finally how participants think MHSW practice, in this area, might be better informed. This chapter describes my methodological approach and justifies the decisions made in order to answer these questions. My approach had to accommodate my experiences as a MHSW who had worked closely with people with personality disorder for a number of years. This meant that I inevitably came to the research project with a particular view of diagnosis, person and MHSW. I was well versed in the challenges that both diagnosis and person can present. However, my commitment to respecting the person and trying to understand the reasons for their behaviour was rarely impaired by these challenges. In fact, as a MHSW, I believed I had a professional obligation to try to understand, especially in the face of colleagues dismissing both person and distress out of hand. To me this contradicted the profession's commitment to challenging discrimination and promoting social justice. My methodology had to accommodate this interpretive frame and of course be appropriate to the nature of my research questions.

This chapter will initially set the study's context before defining the meaning of "paradigm", "ontology" and "epistemology", considering all three from both the realist and the interpretivist perspective. The chapter will then begin to focus on the study's underpinning philosophical and theoretical ideas, the methodology and the choice of methods. Within this I will account for my position in the research and how my chosen methodology and strategies helped me account for my position and subsequent biases. This is followed by an account of the research in action that describes the application of these methods and justifies my decisions to employ them. The section also summarises how the initial and secondary analysis were conducted and how the substantive theory was generated. The chapter concludes with a consideration of some of the realities of ethical requirements.

### ***2.1. The Study's Context***

The study stretched across four different sites in four regions of England. All of the service user participants in Phase 1 were recruited from a voluntary service in the South East. Phase 2 participants were recruited from three regions of England. Eight MHSWs were recruited from an NHS Trust in the east of England, two from a Local Authority in the north-west and two from an NHS Trust in the north-east. I did not collect specific biographic data from any of the research participants. At the time I was concerned that this might be too intrusive. However, as my knowledge of how biographies impact on experiences and perspectives, has developed, I can see that it would have been useful and relevant to collect more detailed biographical data from all participants. I will now offer a little more information about each site.

The 10 service users were recruited from an innovative, voluntary sector service for people with personality disorder. Anyone who lives in the service's catchment area with a confirmed diagnosis of personality disorder can refer themselves. The service also accepts referrals from other agencies. It has a high level of service-user involvement across its range of therapeutic and social interventions, including involvement in the service's management and programme of research. The service is staffed by project workers and includes those skilled in working with people with personality disorder, counsellors, DBT facilitators, substance misuse specialists and trained social workers. The service offers innovative recovery approaches and works to promote positive engagement with employment, permitted work, education and the wider community. It has a far-reaching research tradition and is committed to participatory approaches and promoting the knowledge of experts by experience through publication and training, including the facilitation of training for mental health professionals. All of the interviews took place at the service's premises. Eight of the ten service users were women. Only one participant was from a BME community, one of the males was of Asian British origin. This perhaps reflects the local population and a gender and cultural weighting in the diagnosis of personality disorder (Paris, 2009).

Recruitment of MHSW participants for Phase 2 began with eight MHSWs from community mental health teams in one city and four towns in a county in the east of England. Community mental health services in the county are fully integrated and organised across eight localities. The teams are multi-disciplinary, serve the local areas and provide home-based assessment and treatment to those over 18 with severe mental illness. The eight MHSW's were based in four of the integrated community mental health teams. All but two worked with service users with a range of mental health problems, including the more functional forms of mental disorder. However, their participation in this study may indicate their interest in personality disorder. Two of the MHSWs were based in the county's sole multi-disciplinary, community team for people with personality disorder. Of the eight, three were male and five female. Seven were of white British heritage; one male was of Jewish heritage.

The two MHSWs, one male and one female, recruited from the Local Authority in the north-west were based in integrated teams in a Foundation Trust although the Local Authority retained contractual responsibility for social work staff. The Authority's Training Officer gave permission for the study and helped to identify potential participants. Her approval and that of the University's Faculty Research Ethics Committee (FREC) meant that both interviews could be conducted on Local Authority property on the same day. One of the MHSWs was based in a community "complex care and treatment" team and the other in a secure mental health service. Finally, I interviewed two MHSWs who were based in an integrated NHS Foundation Trust in a unitary authority in the north-east of England. Mental health

services in this area are fully integrated. The NHS Foundation Trust provides a range of community and in-patient mental health services for people over the age of 18. Both MHSWs were part of a community forensic team, led by a qualified social worker. Although based in the in-patient unit the team served the hospital and the community, retaining involvement with patients after they returned home. Both MHSWs were female; one was of Asian British origin. As this Trust was fully integrated, additional NHS R&D approval was sought and gained. Both interviews took place at the MHSWs' NHS base with the full support of the team manager.

This short summary highlights the study's context and to some extent its diversity, which I suggest adds breadth and depth to the exploration of participants, particularly MHSW participants, understanding of personality disorder and MHSW practice. The sections to follow are in the order set out in the diagram on p.51 (Figure 2.1). This diagram reflects how my methodological decisions were informed by the 'how' related nature of my research questions, which positioned the study within the interpretivist paradigm, sharing a relativist ontology and subjectivist epistemology. The study required a theoretical outline appropriate to these paradigmatic, ontological and epistemological assumptions. The diagram shows how these assumptions informed my decision to employ a postmodern, constructivist and critical theoretical framework and qualitative, constructivist methodology. Figure 2.1 also sets out how a multiple case study method was integral to the methodology. This method helped me to cope with the complexities of a project with two samples, conducted at different points in time and generating large amounts of data. The multiple case study method framed my in-case and cross case analysis, which in turn helped me to generate a conceptual and theoretical analysis. The diagram reflects how the study's paradigmatic and methodological assumptions informed my choice of methods. It also indicates how ethical review was integral to the study across both phases and indeed how this forms part of the study's authenticity. The diagram reveals how this chapter will conclude with an account of the research in action.

**Figure 2.1. Paradigm, Theory, Methodology & Methods**



**2.2. Research Paradigms**

A paradigm is an interconnected world-view underlying the theories and methodology of a particular subject. A paradigm incorporates and connects three elements: ontology – the nature of reality and being; epistemology – the theory of knowledge, especially with regard to its scope, methods and validity; and methodology – the best way of acquiring knowledge in ways appropriate to the paradigm (Denzin & Lincoln, 1994; Oxford Dictionary, 2010). Ontology, epistemology and methodology are

conceptualised differently according to whether the established realist or alternative, interpretivist paradigm is used (Denzin & Lincoln, 2008).

### ***The dominant realist paradigm***

The established paradigm rests on an ontological assumption that an independent reality exists and moreover, that it is possible to capture it (Edley, 2001). This realist ontology is supported by an objectivist epistemology through which, adherents of the paradigm suggest, it is possible to establish “truth” through experimental and quantitative methodologies (Denzin & Lincoln, 2008). The knower is distinct and separate from the verifiable knowledge claim (Polkinghorne, 1989). While the established paradigm is relevant for acquiring knowledge of the physical world, in my view it is inappropriate for generating knowledge of the social world (Polkinghorne, 1989), which consists of the meaning-making activities of unique individuals (Guba & Lincoln, 2008). The exploration of meaning requires the knower to be as close as possible to these unique experiences, thoughts and interpretations, rather than distinct and separate from them (Salner, 1989). The knowledge derived from such exploration requires alternative ways of judging validity (Guba & Lincoln, 2008).

As this study seeks to understand the meanings that participants attach to personality disorder and MHSW practice, the established paradigm appears inappropriate as it would not facilitate the exploration of meaning. Given that the aim was to explore participants’ different meanings rather than to establish the “truth” about personality disorder or MHSW I positioned this project within the alternative, interpretivist paradigm, which recognises the relative nature of social reality (Arnd-Caddigan & Pozzuto, 2006) and is underpinned by a subjective epistemology and hermeneutical or dialectical methodologies (Denzin & Lincoln, 2008). The next section sets out this paradigm and further justifies my use of it as I sought answers to my research questions.

### ***The alternative: the interpretivist paradigm***

The interpretivist paradigm rests on a relativist ontological assumption that reality is shaped or constructed (Denzin & Lincoln, 2008). Far from being independent, reality and being are taken as “mind dependent”, constructed by individuals in their relationships and interactions at both the macro and the micro level (Arnd-Caddigan & Pozzuto, 2006, p.429). Its subjectivist epistemology values human experience as a source of knowledge (D’Cruz & Jones, 2004). Such knowledge is best acquired through hermeneutical or dialectical methodologies that help the knower to get close to lived experience, which in turn may transform the setting or relationship (Gergen, 2000).

This paradigm was appropriate to my research questions for a number of reasons. Firstly, its relativist ontological underpinnings prioritise the participants’ different experiences and meanings. Secondly, its

subjectivist epistemology supports the knower's need to get as close as possible to participants' unique experiences and interpretations (Guba & Lincoln, 2008). Thirdly, its underpinning hermeneutical and dialectical methodologies (Guba and Lincoln, 2008) offer the best way to explore participants' meanings of personality disorder and MHSW in an original research project. The originality of a project including service users and MHSWs in an under-researched area (Keys & Lambert, 2002), calls for an inductive and dialectical approach (Denzin & Lincoln, 2008). A fitting paradigm is important, as without the appropriate ontological, epistemological and methodological underpinnings the project will have little meaning (Guba & Lincoln, 2008).

As this project seeks to generate knowledge about the meanings that participants attach to personality disorder and MHSW, it is appropriately positioned in the interpretivist paradigm. I now set out my chosen theoretical framework for the research before moving on to consider its methodology in more detail.

### **2.3. Theoretical framework**

The complex nature of personality disorder, its consequences for the person and challenges for the mental health professional led me to frame the research with postmodern, critical and constructivist theories. Guba & Lincoln (2008) argue that it is possible to utilise elements of different paradigms, especially if those paradigms "share axiomatic elements that are similar, or that resonate strongly between them" (p.266) as interpretivist, postmodern, critical theory and constructivist do (Guba & Lincoln, 2008). Kondrat (1992) argues that knowledge should reflect the broader social context rather than the particular interests that can come to dominate and subjugate through authoritative constructions (Foucault, 1980 cited in Gergen & Gergen, 2003). Critical theory, while diverse, suggests some commonality around the transformation of relationships and institutions through interaction and dialogue (Cresswell, 1998).

Knowledge about personality disorder is contested and reflects particular interests (Winship & Hardy, 2007). While differences in and between perspectives may serve to establish "truths" about the diagnosis and the person, certain truths can come to play a part in constructing the diagnosis and the person negatively (UK NIMHE, 2003). Mental health professionals are not immune from stigmatising people with the diagnosis (Markham, 2003), compounding the construction of person and diagnosis as Other (Wright et al., 2007) and risking alienation and fatal consequences for the person (Watts & Morgan, 1994). The reality of such dominant, negative constructions of personality disorder underlines the importance of a project that values participants' experiences and perspectives as sources of knowledge (D'Cruz & Jones, 2004). As it was not my intention to establish truths about personality disorder and MHSW, but explore different ways of knowing, postmodern theories set an appropriate

frame for the research (Fawcett & Featherstone, 1999, pp.5-24). As such the project may contribute in a small way to a more rounded understanding of personality disorder and MHSW.

The project explores participants' perspectives on how MHSW practice in the area of personality disorder might be better informed. Given my personal commitment to involvement and the collaborative development of practice it was not enough to rely only on the ideas of one sample. The inclusion of service users and MHSWs as participants in the research establishes the project as a site of virtual interaction about how practice might be better informed. Service users were asked for their ideas and MHSWs for their responses to these ideas, and this data was then analysed. Critical theory, with its suggestion of transformation through the interaction and interpretation of meaning (Creswell, 1998), was therefore an appropriate addition to the project's theoretical framework.

The project draws on theories that have relativist, subjectivist and transformative assumptions in common (ibid). It seeks to explore participants' understandings of personality disorder, practice and how practice might be better informed. These questions led me to employ the framework as described above. The methodology also had to be appropriate to the project's paradigmatic assumptions. The next sections detail and justify the use of a qualitative, inductive methodology framed by a case-study approach. It begins with a summary of quantitative and qualitative approaches and justifies the decision to employ the latter rather than the former.

## **2.4. Methodology**

### ***Quantitative methodology***

Quantitative deductive methodology is strongly associated with the dominant, realist paradigm. The primary concern is to generate knowledge to aid explanation, prediction, standardisation and control of the studied phenomena (Alvesson & Skoldberg, 2000; Denzin & Lincoln, 2008). The emphasis is upon objectivity and value neutrality and the measurement and analysis of causal relationships. As Flick (2002) suggests, quantitative methodologies have been utilised to isolate "causes and effects ... operationalising theoretical relations and measuring and quantifying phenomena" (p.3). Adherents suggest that good science comes from objective procedures, which allow generalisations. However, remote, deductive, empirical approaches that start from the researcher's ideas about the central focus of an investigation are unlikely to capture respondents' perspectives (Alvesson & Skoldberg, 2000; Denzin & Lincoln, 2008). The methodology needs to be appropriate to the nature of the research questions and in line with the paradigmatic assumptions that underpin the investigation. While a realist, objectivist and quantitative methodology would be relevant for generating knowledge about the

physical world, it is inappropriate for generating knowledge about an increasingly complex social world fraught with “rapid social change ... and diversification” (Flick, 2002, p.2).

A quantitative methodology was not seen as the best way of acquiring knowledge about participants’ understandings of personality disorder and MHSW, because it does not fit the assumptions of the alternative paradigm (Denzin & Lincoln, 2008). It would not enable an inductive exploration of participants’ unique meanings, as it is founded on a deductive premise that asserts the primacy of the researcher’s ideas about the central focus of the investigation. Data collection in this project starts from the participants’ perspectives rather than from my own preconceived ideas about personality disorder and MHSW. Furthermore, remote quantitative methods such as questionnaires and experiments would not have helped me to get as close as possible to the participants’ perspectives. The intention was to explore the uniqueness of all the different perspectives rather than attempting to standardise one particular truth about personality disorder or MHSW. For these reasons a quantitative methodology was rejected. The next section considers and justifies my decision to employ a qualitative methodology.

### ***Qualitative methodology***

Qualitative, inductive methodologies are strongly associated with the alternative paradigm, although “positivist and post-positivist traditions linger like long shadows over the qualitative research project” (Denzin & Lincoln, 2008, p.14). Qualitative methodologies emphasise processes and meanings that are not measured or investigated by experiment. As such they form a “broad umbrella” (Fosse, Harvey, McDott & Davidson, 2002, p.1) to understand and explain unique human experience, behaviour and interaction. Underpinned by relativist ontological and subjectivist epistemological assumptions, they stress the “intimate relationship between researcher and what is studied” (Denzin & Lincoln, 2008, p.14). This is not to suggest that qualitative methodologies are superior to quantitative approaches: they are simply different and more appropriate for investigating the social world. In general it is argued that quantitative methodologies produce hard science, qualitative ones, merely soft scholarship (Carey, 1989, p.99). Such demarcated battle lines (Denzin & Lincoln, 2008) can tend to oversimplify the contested nature of qualitative research (Mantzoukas, 2004) and obscure its controversial past and its involvement in the “colonial project” (Denzin & Lincoln, 2008, p.2) and the colonisation of indigenous people as Other (Tuhiwai Smith, 1999).

While qualitative research is contested and has a somewhat controversial history (Denzin & Lincoln, 2008), there are points of commonality in the family of qualitative approaches (Ebbs, 1996), three of which I deemed relevant for this project. Firstly, qualitative approaches remain focused on understanding the Other (Denzin & Lincoln, 2000, pp.1-30). This is relevant to this study because it seeks

to understand personality disorder, which is clearly defined as Other (Wright et al., 2007). Moreover, it can help in understanding both samples' constructions of each other as the Other (ibid.). As my interview schedule asks MHSWs to respond to the ideas of service users, encouraging interaction, it might be possible to begin to challenge unhelpful "us" and "them" constructions (Foucault, 1979; Pecheux, 1982, cited in Mills, 1997). Secondly, qualitative methodologies are inductive (Padgett, 1998) in that they start from the participants' perspectives. This was relevant for this project, as while the research questions evolved out of my experience as an MHSW, the data collection started from the perspectives of service users and MHSWs. Moreover, there is little research on personality disorder and (Keys & Lambert, 2002), and an inductive, qualitative approach is particularly pertinent for generating in-depth understanding of areas that are not well understood (Fosse, Harvey, McDott & Davidson, 2002).

Initially I had hoped to employ a more participatory methodology (Denzin & Lincoln, 2008), perhaps with participants engaged in the design and doing of the research (Shera & Wells, 1999). This would have helped to establish the project as a co-production, enabling those best placed to study their own experience, the participants, to do just that (Freire, 1970). However, following discussion with my then supervisor I decided that a more participatory methodology was not feasible in terms of recruiting participants, even if I could recruit them, and my capacity to manage a more participatory project. Consequently, levels of participation in this project have been restricted to member checking of transcripts. This decision, taken with some regret, means that this project is typical of a qualitative approach where "the researcher is an instrument of data collection who gathers words or pictures, analyses them inductively, focuses on the meaning of participants and describes a process that is expressive and persuasive in language" (Creswell, 1998, p.14).

I employed a qualitative methodology in this project because it was appropriate to my research questions and the assumptions of the alternative paradigm (Denzin & Lincoln, 2008). Its inductive nature would enable me to get as close as possible to participants' meanings. Given the originality of the project, the data generation and analysis would need to be inductive and to aid the development of a theory for practice. However, what marks it as original – the inclusion of service users and MHSWs – also makes it complex, timely and potentially unwieldy. The following sections justify and consider my decision to employ a grounded theory approach (Glaser & Strauss, 1967) in a case-study framework (Yin, 2003).

## **2.5. A Grounded Theory Study: or is it?**

As this project was both original and addressed an under-researched area, it was important for me to utilise an approach that could generate a conceptual analysis and substantive theory such as grounded theory (GT) and constructivist grounded theory (CGT) (Charmaz, 2006; 2008).

GT (Glaser & Strauss, 1967) is both a method and the product of inquiry. As a method it is flexible, enabling the researcher “to focus their data collection and to build inductive middle-range theories through successive levels of data analysis and conceptual development” (Charmaz, 2008, p.204). Constant comparative method and simultaneous data collection/analysis (Glaser & Strauss, 1967) (CCM) aid the analysis of processes and the researcher’s proximity to the studied world (Glaser, 2002). Initially I decided to employ GT to enable the generation of a theory relevant to personality disorder and MHSW practice. The simultaneous data collection and analysis would enable me to get as close as possible to participants’ unique meanings and thereby ensure the research product – the grounded theory – was relevant to the data, personality disorder and MHSW practice (Glaser & Strauss, 1967).

While not underestimating the importance of GT to the establishment of qualitative research in its own right (Charmaz, 2008), I began to question whether it was an appropriate approach for this project. GT in its original form has been criticised for its realist and objectivist leanings (Charmaz, 2008, p.204). Mills, Bonner and Francis (2006) argue that it is founded on an ontological assumption that an independent reality is apprehendable. In its original form it assumes an objectivist epistemology, emphasising logical, analytical and comparative methodologies (Charmaz, 2008). While Strauss’ (1987) independent work places greater emphasis on meaning, action and process, this is not always maintained. In later work he returns to positivist methodologies and the advancement of verification techniques (Strauss & Corbin, 1990, 1998), leading to the conclusion that in general, GT draws upon “objectivist assumptions founded in positivism” (Charmaz, 2008, p.205).

This critique informed my decision not to incorporate GT in my methodological approach. Its realist ontological assumptions did not fit my relativist, interpretivist view that the social world is mind-dependent (Arnd-Caddigan & Pozzuto, 2006), and its objectivist epistemology suggests that the researcher needs to jettison their frame of reference, remain remote from respondents and passive in interviews (Glaser, 2002). I have acknowledged my own frame of reference earlier in this chapter. I recognised that it would be extremely difficult for me to jettison this completely, even if I wanted to, as it had evolved over many years of working as a MHSW. Furthermore I was concerned that a passive and remote stance would not help me get as close as possible to participants’ unique meanings and interpretations. I continued to search and read about GT, and by chance came across a reference to CGT (Charmaz, 2000, pp.509-537). CGT shares GT’s interest in processes, adheres similarly to CCM and

concurrent data collection and analysis and shares GT's inductive theory-building capabilities. However, CGT "does not subscribe to the objectivist, positivist assumptions of its earlier formulations" (Charmaz, 2008, p.206). CGT prioritises the studied world rather than the methods for studying it and is consequently founded on more relativist ontological assumptions and on how "reality" is constructed. It does not assume that this reality is waiting to be captured, nor does it assume that the researcher approaches the studied world without an "interpretive frame of reference" (ibid, p.206). CGT assumes a subjectivist, reflexive epistemology. The researcher is much more present in this approach in terms of collecting data and of his/her voice in reporting the research (Mills, et al., 2006). However, proximity to the studied world requires a reflexive approach to help explain how participants understand their world and their position in it (Finlay, 2002). The researcher's central position in relation to the "collection, selection and interpretation of data" (Finlay, 2002, p.531) requires a commitment to reflexive processes that help the interrogation of bias.

I decided to employ CGT as part of my methodological approach. I would still be able to explore participants' meanings and build a theory relevant to personality disorder and MHSW. However, crucial ontological and epistemological differences between GT and CGT made the latter a more appropriate choice for this project. CGT fits the project's relativist ontological assumptions, prioritising the studied world, recognising that it is mind-dependent (Arnd-Caddigan, & Pozzuto, 2006). Secondly, its subjectivist epistemology helps the researcher to get as close as possible to the studied world, recognising that the researcher brings her or his own frame of reference to the research, plays a part in the construction of interpretations and takes a position in the reporting of research (Charmaz, 2008). Familiarity aids intimacy and a depth of understanding (Oakley, 1981). However, I should not impose on the participants. CGT's reflexive approach was important in this study because it helped me to explore and understand the participants' meanings and negotiate my proximity to these unique meanings together with my own interpretations of personality disorder and MHSW. I will detail my reflexive strategies later in this chapter.

The originality of the project, in an under-researched area, called for an inductive, reflexive approach appropriate to the relativist and subjectivist assumptions of the alternative paradigm in which this project is set. A defining feature of its originality – the inclusion of service users and MHSWs – meant that the project was potentially very unwieldy. Consequently it was important to frame the project in a way that would not only aid exploration and understanding but also help me to manage a complex and potentially unwieldy, time-consuming project. Below, I set out the case study framework and further justify my decision to employ this methodological device (Yin, 2003).

## **2.6. Case-study framework**

As I suggest personality disorder is both complex and related to the social context a case-study frame for this project was relevant. Yin (2003) suggests that case studies help us to “...understand complex social phenomena” (p.2) where the boundaries between context and phenomena are permeable. Creswell (1998) defines the case study as an “exploration of a ‘bounded system’ or a case or multiple cases over time through detailed in depth data collection” (p.61). The case study differs from ethnography – the study of a cultural system (Creswell, 1998) – in that while a case may share elements in common, it is not necessarily representative of a culture or way of life (Creswell, 1998). Case studies can be singular or multiple, with the latter possibly a more robust design (Yin, 2003). While somewhat contested in constructivist research (Stake, 1995), the triangulation of method is important to the case study as it relies on “multiple sources of evidence, with data needing to converge in a triangulating fashion” (Yin, 2003, p.14). Yin (2003) suggests six different sources of evidence for the case study: interviews, documentary sources, observation (including participant observation), archival records and physical artefacts (Yin, 2003). Next, I will justify my use of a multiple case-study framework for this research project.

I decided to employ a case-study frame because it would help me deal with a complex subject, where boundaries are not particularly clear. There were also other reasons. Firstly, it helped to bounder service users and MHSWs as separate cases in the same project. This led me to generate a greater scope and depth of analysis, as it gave me strict parameters for an in-case analysis and a cross-case analysis (Yin, 2003), thereby maximising the potential for both similar and contrasting results (Henwood & Pidgeon, 1992). This analysis might also be defined as embedded, in that it focuses on that which helps to answer the questions of how participants understood personality disorder, MHSW practice and ideas about how the latter might be better informed. A case-study frame therefore helped me to focus on my research questions. Secondly, it offered me a straightforward way of triangulating method through documentary analysis. For these reasons a multiple case-study frame has been important in this project; it fits the underpinning assumptions, contributes to a deeper understanding of personality disorder and MHSW and helped me to negotiate some of the complexities inherent in the project. My decisions on methods had to be appropriate to the nature of the research questions and the ontological and epistemological assumptions of the paradigm in which the research is positioned. The next section defines the chosen methods – semi-structured interviews and documentary sources – and justifies their use in this project.

## **2.7. Methods**

### ***Interviewing***

Given the study's subjectivist epistemology it would be important for me to employ methods which would enable me to get close to the participants' unique meanings and interpretations. I decided therefore to employ face-to-face interviews. Face-to-face interviews are perhaps one of the more contested research methods, given the differentiation between structured, semi-structured and unstructured interview schedules (Collins, 1998). Semi-structured interviews are defined by their flexibility and the preparation required; as Denscombe (2003) suggests, "the interviewer is prepared to be flexible in terms of the order in which the topics are considered, and perhaps more significantly, to let the interviewee develop ideas and speak more widely on the issues raised by the researcher" (p.167).

Differences in the positions that researchers occupy in research interviews are a source of the method's contested nature. Some favour distance, passivity and objectivity (Glaser & Strauss, 1967); others, intimacy, activity and partnership (Holstein & Gubrium, 2004, chapter 8). The latter suggest that the research interview is far from neutral; it is a site where researcher and participant engage in "meaning-making" (p.149). Both participant and researcher have a part to play, with the researcher positioned as the "traveller", asking "... questions that lead the subjects to tell their own stories of their lived world" (Kvale, 1996, p.4). Such active research interviews (Holstein & Gubrium, 2004) balance the "how" of the interview process with the "what" of lived experience. However, all forms of face-to-face interviews have been critiqued as some of the weaker research methods, limited by their potential for unconscious, conscious and re-call bias (Diefenbach, 2009). Bias, 'a form of systematic error' (Sica, 2009) affects all research, even that which employs 'objective' methods to counter it. While a qualitative researcher may refute claims of objectivity, they have to be aware of, and account for, bias in the design and methods of their research. Interview participants and researcher can unconsciously influence the interview situation by following rules 'about how one should normally express oneself on particular topics' (Alvesson, 2003, p.169). Moreover, participants' unwillingness to step outside of these rules can induce conscious bias and lead to "official accounts" (Bourdieu, 1977, p.37). Unconscious and conscious bias can be compounded by the 'snapshot' nature of interviews (Deem, 2001), particularly as the researcher is often asking the interviewee to re-call events that have passed (Diefenbach, 2009).

While some question the validity of active, collaborative interviews (Holstein & Gubrium, 1995) which appear to risk the researcher's over-involvement (Rubin & Rubin, 1995), it is possible that my decision to employ a more active style, constructing the interview as a site of social interaction, helped to counter bias because the data mirrors 'what people regard as their conscious thoughts in a social setting' (Diefenbach, 2009, p.881). Accepting the subjectivity implicit in the interview situation, recognising the

Hawthorne effect, the influence of the researcher on participants and the process of research (Kisely & Kendall, 2011) can help the researcher to manage unconscious and conscious bias. However, acceptance is insufficient as a sole strategy; the researcher needs to devise ways of accounting for their influence on the research. I will describe my strategies to account for bias in the interview situation later in this chapter. Below I explain my reasons for employing a more active interviewing method.

I employed active semi-structured interviews in this project for a number of reasons. Firstly, they were most helpful in answering my research questions as they fit the project's interpretivist, relativist and subjectivist assumptions. They allowed me to get as close as possible to participants' meanings in a sensitive way. Secondly, their collaborative nature fitted symbolically with the project's interactive qualities and its aim of inspiring greater collaboration between service users and practitioners. Thirdly, and more practically the flexibility they offered was important as I had no way of knowing how participants would respond to the questions I would ask. It was quite possible that they would pre-empt later questions in answer to others. Furthermore, interviews with service-user participants might touch on sensitive areas (Lee, 1999). A flexible semi-structured format would help me to negotiate such sensitivities. My final reason relates to my concerns about participants' lack of participation in the design and process of the project, compounded by their lack of participation in the construction of the topic guide. I believed that active, semi-structured interviews might compensate a little for this lack of participation. I was responsible for the design of both topic guides (Appendix 2 & 4). Both asked similar questions, although were worded appropriately to the Phase of the research. The first question explored how participants understood personality disorder. Subsequent questions asked about their contact with MHSWs/service users. Prompts asked participants to consider the nature of this experience, what activities were undertaken, positives, negatives and what perceptions appeared inherent in this experience. The final question differed across Phases of the research. Service users were asked for their ideas about how MHSW practice might be better informed. After analysis this data became a series of questions at the end of MHSWs' interviews. For example, "service users suggested that practice would be better informed by the MHSW knowing more about the person and personality disorder, what is your view on this"? In some ways the MHSW topic guide was informed by service users, but both guides were designed by me (Appendices 2 & 4).

The challenges in recruiting participants for both phases of the study meant that it was not possible for me to pilot either topic guide. I decided that to try and identify other participants to pilot the guide risked further delay, if not me giving up on the project completely. It became a question of what was feasible and what would help me realise the answers to my research questions. My use of active interviews helped me to compensate for some of these limitations. The more reciprocal nature of active

interviewing made the interviews more like a usual conversation than a site of information extraction. While the structure of the project failed to maximise participation, at least my style of interviewing might empower the participant in the process. A short illustrative extract of my interaction with participants is included in Appendix 5 to balance the “*how*” of the interview process with the “*what*” of lived experience.

Semi-structured, active interviews enabled me to get close to participants’ understandings of personality disorder and practice in a flexible, sensitive way and to prioritise these understandings in the interview situation. While this method requires specific strategies to account for bias I would suggest its appropriateness for my chosen paradigm, its transparency about my own position as the researcher within interviews constructed as flexible, social situations helped me to manage unconscious, conscious and recall bias. Reliance on only one method, however, can delimit the GT product (Charmaz, 2008). Below I discuss my use of documentary sources, its usefulness in generating a more rounded understanding of personality disorder and MHSW and as another method for managing bias.

### ***Documentary sources***

In part my decision to employ documentary sources was related to my decision to frame the research with a multiple case study method. Case studies rely on more than one source of evidence (Yin, 2003), which can include documentary sources. My use of a case study frame and documentary sources within this, helped allay my early concerns that an overreliance on one method, interviews, would raise questions about the study’s triangulation of method and its account for bias. I had discussed my concerns about the former with my then principal supervisor. While I had initially thought about holding a focus group with participants after the interviews, difficulties in recruitment soon led me to conclude that this idea would not be feasible. Documentary sources however, offered me a practicable way of triangulating method and a method to help account for bias (Diefenbach, 2009).

Documentary sources can be defined as “textual content that is not generated by researchers” (Miller & Alvarado, 2004, p. 349). Guba & Lincoln (1981) distinguish between records and documents, defining the latter as “any written material other than a record that was not prepared specifically in response to some request from the investigator” (p.228), e.g., letters and policy documents. Writing in 1997, Appleton and Cowley suggest that relatively little information exists about the process of documentary analysis. The use of documentary sources remains under-represented in qualitative research (Miller & Alvarado, 2005), despite their potential to make a distinctive contribution.

Documentary sources can enhance understanding of a subject. They speak of the wider context (Smith, 1984) as they draw on and connect with other documents (Atkinson & Coffey, 1997). They also reveal

the organisation of social life (Prior, 2003). Documents are actively produced, exchanged and consumed and relate to a particular context at a particular time, and therefore are not necessarily “transparent or consistent representations of social reality” (Atkinson & Coffey, 1997, p. 47). This raises questions about their validity as a method as documents are context specific with particular aims and functions. For example policy as one form of documentary evidence (Guba & Lincoln, 1981), offers information about the wider social context. However, social policy has been defined as “... complex ... and created in [an] environment of competing forces...” (Spurgeon, 2000, cited in Adams, 2002, p.191). Active construction can mean that policy is a rich but complex source of documentary data, limited by its own particular aims, functions and consequent biases. However, social policy documents are readily available sources of data that can be inexpensively and unobtrusively collected (Appleton & Cowley, 1997).

Miller & Alvarado (2005) suggest that researchers address the distinctive features of documentary sources in three main ways, through:

- Strategies of document selection, i.e. random or purposeful
- Consideration of the social exchange of documents
- Consideration of the socially-produced nature of documents, i.e. source criticism (p.349).

Howell & Prevenier (2001) suggest that researchers need to make sense of the socially-produced nature of documents through source criticism that is both external and internal. External source criticism is concerned with the where, when and by whom a source was created (Miller & Alvarado, 2005). Internal source criticism establishes how a source can inform understanding “by considering the intentions and abilities of the document’s producers” (Miller & Alvarado, 2005, p.350). Miller & Alvarado suggest two forms of analytic strategy: content and context. The former regards documentary sources as “independent containers of fixed evidence about the social world” (ibid, p.35), while the latter sees the source as embedded in the social context in which it is produced and used (Atkinson, Coffey, Delamont, Lofland & Lofland, 2001). Source criticism is less important to context analysis (Miller & Alvarado, 2005), as the latter is more concerned with the socially-situated nature of both documents and meanings.

My awareness of source criticism and my knowledge of the context in which the majority of the policies were produced, the New Labour era, helped me to manage bias within the function of this method. I was able therefore to generate additional information about personality disorder (UK Department of Health & Social Security, 1974, 1975; UK DoH, 1983, 2003; UK DoH & Home Office, 1992) and social work (UK DoH, 1998, 1999, 2006, 2007). At first glance this method (Prior, 2003) might appear to contradict the project’s inductive nature. However, the above policies offered rich sources of

information about both the subjects and the wider context. It was important that my selection of the policies was purposeful and comprehensive (Miller & Alvarado, 2005) and not random. Although qualitatively rich, more recent policy specific to personality disorder and MHSW is not particularly extensive, and consequently I included all of the policies published in the last 14 years. My approach also had to be methodical. Initially I familiarised myself with the content of each policy, keeping my mind organised and yet “open for unexpected clues” (Stake, 1995, p.68) and biases. I took particular note of the language used to represent personality disorder, the person and MHSW. I then developed criteria for a thorough analysis of these policies appropriate to my research questions and the project’s underpinning assumptions. The documents were analysed for their underlying assumptions and contradictions in relation to personality disorder and MHSW. I was not as concerned with the realities of their production and the intentions behind them as with the socially-situated meanings in them (Miller & Alvarado, 2005).

The use of documentary sources fitted the project’s relativist, subjectivist and inductive nature. They have been important to the management of bias in the function and method of the research, triangulation and the exploration of understandings of personality disorder and MHSW practice. My selection of policies was purposeful and comprehensive. The context analysis focused on the context of the documents and the situated meanings in them. In the next section of this chapter I consider the sampling of service user and MHSW participants, before moving on to consider ethical obligations and then issues of validity and reliability in the interpretative approach.

## **2.8. *Sampling choices***

The nature of my research questions and the paradigmatic assumptions on which the project is based meant that random or representative sampling strategies (Patton, 2002) were inappropriate for this project. Furthermore, I would not be able to pre-identify a sampling frame given the hard-to-reach nature of service users and MHSWs, with their respective diversity. I did not know what I might find (Denzin & Lincoln, 2008). However, to counter bias in selection I ensured as far as I possibly could that my sample reflected the characteristics of service users with personality disorder and MHSWs (Sica, 2006).

I therefore decided to employ a qualitative and purposeful strategy, particularly as all of the participants in this study, might, for different reasons, be defined as hard to reach (Lee, 1999) and/or vulnerable (INVOLVE, 2004). I decided to sample service users and MHSWs separately: from different organisational and regional contexts and at different times, rather than sample both groups from the same setting. I will explain my rationale for this particular decision towards the end of this section.

My general reading about sampling strategies with hard to reach populations led me to employ outcropping. Outcropping is a method for sampling a rare or deviant population where the researcher finds "...some site in which its members congregate and to study them there" (Lee, 1999, p.69). While outcropping risks the researcher depending on just one site and possibly a restricted, homogeneous sample (Lee, 1999), it enables the researcher to get close to hard-to-reach and perhaps even vulnerable participants (Involve, 2004). The process of sampling is perhaps just as important as the ultimate outcome. Engaging potentially vulnerable participants in research necessitates an element of criterion sampling (Creswell, 1998) through the establishment of inclusion and exclusion criteria. Depending on the knowledge and attributes of the researcher (Brady, 2006), opportunistic sampling may be required in situations where it is difficult to engage the gatekeepers of a particular site. All of these elements were important in my sampling strategy as I shall now reveal.

Firstly, a purposeful sampling strategy fitted the project's underpinning paradigmatic assumptions. It helped me to identify service user and MHSW participants and get as close to their knowledge and unique meanings of personality disorder and MHSW. Secondly, outcropping was useful to identify service-user participants, who could be hard to reach; I anticipated that the nature of the disorder and the stigma surrounding it (NIMHE, 2003) would make it very difficult to identify them. Thirdly, an element of criterion sampling was also necessary, given participants' potential vulnerability and the need to establish criteria for inclusion and exclusion. In Phase one this was developed in consultation with the facilitator of the organisation. It stipulated that service users who had been detained under the Mental Health Act (UK DoH, 1983) (MHA), those who had been voluntary patients in the previous six months and those who had had a crisis-related respite break in the previous six weeks would be excluded from participating in the research.

I thought initially that I would employ a similar purposeful, outcropping strategy in Phase 2 of the research. However, I was thwarted in this by the difficulties of engaging a national social work organisation. While an element of criterion sampling was retained through a simple inclusion and exclusion criteria, which included social workers with experience of working with personality disorder and excluded those who did not, sampling became increasingly opportunistic. However, this more opportunistic sampling, which depended more on my knowledge of local and national organisations, ensured that the research project continued. Sampling continued until the saturation point was reached for both populations (Schutt, 2004, p. 299).

I drew service user and MHSW participants from different sites rather than recruit both from the same site. I decided to do this for two, possibly interrelated, reasons. Firstly, I was concerned about an increased risk of conflict of interests and confidentiality breaches if service users and MHSWs came from

the same organisation. For example if a service user participant identified a MHSW during the course of the interview, while I would be able to erase the name from the tape, I would inevitably remember the MHSW's name. This would be problematic if the same MHSW were recruited to Phase 2. While I would employ my reflexive strategies, I was concerned that memory of the service user's account and my consequent unconscious or even conscious bias towards that MHSW's account of personality disorder and practice would influence the interview and my consequent data analysis. If interviews with service user and MHSW participants were separated by site, region and time the risk of this happening was negligible and this would therefore help me guard against the risk of bias on my part. Secondly, I was acutely aware of how participants might perceive me, as a former MHSW. I was concerned that service users might perceive me as biased towards MHSW, as part of the 'problem' so to speak. I believed that the risk of this would increase if I recruited participants from the same site, especially if MHSWs or other mental health professionals were gatekeeping my access to service users. I hoped that by approaching a self-contained site, independently, the risk of being perceived as biased towards MHSW would be reduced. For this reason I decided to recruit service users separately from MHSWs and indeed mental health services.

While my sampling strategy enabled me to get close to participants with experience and knowledge of personality disorder I am conscious that its purposefulness drew participants with a specific interest in personality disorder and with something specific to say. However, their interest and contribution would have been mediated by their knowledge of me as an ex-MHSW. Service users may have felt freer in their expression because I was more independent and no longer part of the 'problem', MHSWs slightly less free because as a social worker, whether currently practicing or not, my qualification and experience meant they may have felt wary of being judged by me. It is evident to me that my sampling strategy and my influence on every stage of the research process has had an impact on findings and consequently also on the emerging theory. My reflexive strategies have been crucial to this project and as such they will be described later in this chapter. The following section will describe my consideration of ethical requirements.

### ***2.9. Ethical requirements***

My attention to ethical issues and requirements was vital in this project given that it involves human participants, some of whom might be defined as vulnerable. I was guided in this by the Research Governance Framework (UK DoH, 2005c) which outlines principles of good governance and other key organisations of relevance (Social Research Association, 2003) (SRA). The DoH (2005) framework is grounded in general principles of protecting the dignity, rights, safety and well-being of participants. Researchers are required to be transparent about the risks involved in participating in research (UK DoH,

2005c). Standards endeavour to ensure that research is of benefit to the public and instils confidence in its methods and findings. Scrutiny of a project's commitment to protecting participants from harm, identification and beneficence (Christians, 2000) is another way of instilling public confidence in research. The researcher must ensure that the participant is protected from harm, from breaches in confidentiality and identification. Such protection and respect for privacy and autonomy can encourage beneficence and the well-being of participants in the research process (Holloway & Walker, 2000). This project has adhered to the appropriate standards of governance, levels of scrutiny and to a commitment to protect participants' dignity, rights, safety and well-being. I sought to encourage participants' well-being. How researchers value participants' contributions to research is a somewhat contentious topic (Grady, 2005) and raises ethical dilemmas for the researcher. Payment can coerce people to participate (Wertheimer & Miller, 2008), obscure risk, impair judgement and encourage misrepresentation (Grady, 2005). I reflect on my experience of some of these dilemmas towards the end of this section.

This project has complied with the University of Hertfordshire's Faculty of Health and Human Sciences Research Ethics Committee (FREC), the NHS Ethics Committee and the appropriate Research & Development (R&D) Departments and has been subject to four separate ethical reviews. Phase 1 was approved by FREC in September 2006. An application to FREC was appropriate as I accessed participants through a non NHS, voluntary organisation. Phase 2 was approved by FREC in April 2008; however, difficulties in engaging gatekeepers forced me to take a more opportunistic approach and capitalise on my knowledge of local, integrated NHS services. In order to interview social work staff employed by the NHS or based on NHS property I had to apply for NHS ethical and R&D approval (UK DoH, 2005c). Phase 2 was approved by the NHS Ethics Committee in May 2009 and gained R&D approval in September of the same year. Opportunities to extend the MHSW sample to a local authority site in the northwest of England in November 2010 and a second NHS site in the northeast led to further requests for approval. Approval for the Local Authority was gained from the Association of Assistant Directors of Social Services (AADSS) by September 2010. R&D approval for the second NHS site was gained in December 2010. My adherence to the University and NHS standards and the scrutiny that this project has been subject to justifies confidence in the project and findings.

This project has been conducted in ways that protect participants from harm, breach of confidentiality and identification. Protection from harm was particularly pertinent in Phase 1, given the potential vulnerability of participants. The inclusion and exclusion criterion as previously described was an integral part of protecting potential participants from harm. Furthermore, at FREC's request I devised, with the facilitator, an agreement about what would happen should a service user become distressed during the

interview. I give an example of how the agreement framed my interaction with one participant later in this chapter.

Participants' confidentiality was protected via a participant index using initials, numbers and the date the interview took place. This index was used to label NVivo 7 and audio tapes and the files. All names were removed from the tapes prior to transcription. Laptops and programmes were password-protected. Any paper transcripts were kept in a locked filing cabinet in a locked office at the University. I have protected the identities of individuals and organisations as I have written up the research. This can conflict with the emphasis in qualitative research on "thick description" (Lincoln & Guba, 1985), as it may be possible to identify participants if the data is described too "thickly". I have left some quotations out of the findings chapter and will do the same in any future publication if I think the participant could be identified or distressed by their inclusion.

By working in ways that comply with ethical standards (UK DoH, 2005) based on general ethical principles, I have sought to respect individual participant's privacy and autonomy (Christians, 2000). The provision of a participant information sheet was important to ensure that every potential participant was aware of what the research was about and what their participation would entail. It was therefore vital to establishing participants' consent. In Phase 1, participants were initially given an information sheet by the Facilitator of the service. When they expressed an interest the Facilitator told them when I would be available. At these meetings I introduced myself and then first checked that they were still interested in the project. I then summarised my experience as a MHSW, why I'd started the project and what I hoped it would achieve. I then asked if they had had the opportunity to read the leaflet they had been given (Appendix 1). If they hadn't I went through each part very carefully with the person, checking if they understood or had any questions about any part of the leaflet. If the person told me they had read it I asked them what they had thought of it. I hoped this would give me an indication of whether they had read it and were not merely trying to please me. Even so I asked if they wouldn't mind us just taking another look together. When we'd reviewed the participant information carefully, I asked again if they had any questions and whether they wanted time to think about their participation. All of the participants told me there and then that they wanted to participate. While I checked that they were sure I was careful not to labour this. I didn't want them to feel patronised and risk losing their interest. At this point I'd make another appointment to return for the interview. I reminded them that if they changed their mind at any time, including during the interview itself, they only had to tell me (or let the facilitator know) and they would be withdrawn from the study. I took a Participant Information leaflet with me when I returned for the interview. I highlighted key aspects, asked again if they had any

questions before proceeding to explain the consent form and finally asking if they were ready to sign. Two consent forms were signed, one was left with the participant and I took the other for my records.

Gaining MHSWs' consent began from them receiving a participant information sheet (Appendix 3) from a team mail shot by their respective Team Manager. All of the participants contacted me in due course, initially by e-mail, and at this point we arranged a telephone call to talk about the research and what it would entail in more detail. During these calls I was invariably conscious of the MHSWs' time pressures, so maintained a focus on the information sheet itself, using this as my guide to ensure I covered all the essential information. I asked if they had any questions and whether they wanted time to decide whether or not to participate. Again no one asked for this. I was careful to tell them that if they did change their mind they only needed to contact me and they would be withdrawn from the study immediately. I again had a Participant Information leaflet with me when I arrived for the interview and went through this again, reminding the MHSW about what the research was about and what it would entail. I again asked if they had any questions before moving towards explaining and signing the consent form.

Throughout this process I was conscious of my duty of care to the participants and of the need to respect their privacy and autonomy. I was particularly careful to ensure all participants understood what the research was about, what it would entail and how the results would be disseminated. I was particularly conscious of service users' vulnerability and so I think took more time with them to explain and double check their understanding of the project and what it would entail. I hoped that by paying such close attention all participants, but particularly those from Phase 1, would derive some benefit from being asked to contribute to the development of practice in an under-researched area (Keys & Lambert, 2002).

However, I struggled to decide how to demonstrate the value of each participant's contribution. I hoped that the return of transcripts for member checking and the provision of an executive summary and/or meetings to feedback on findings would show the participants that I valued their efforts, but questioned whether this was sufficient. I was especially concerned that some service-user participants had had to pay to travel to meet me for the interview. Payments to research participants raise ethical concerns (Grady, 2005). While I was aware of the issues, I felt it was ethical to value the service-user participants' and the facilitator's contribution in a concrete way. I expected that many of the participants were on a low income, and any service, whether voluntary or statutory, always needs extra resources. However, I did not want to coerce or influence anyone's participation unduly. I decided, in consultation with my then supervisor, to make a donation of £10 for every participant. We agreed that I would only inform them of this at the end of the interview. In this way I hoped to minimise any undue influence on

participants. I made a donation of £100 to the service once all of the interviews had been completed. MHSW participants will receive an executive summary of the research, its findings and conclusions. I hoped this would show my appreciation of all their contributions.

This research project has complied with the appropriate ethical standards and been subject to scrutiny on four separate occasions. It has sought to protect participants from harm, breaches of confidentiality and identification. The privacy and autonomy of the participants was respected at all times. Through attention to all these elements the project sought to encourage beneficence and the well-being of all participants. Such governance and scrutiny will hopefully inspire confidence in the project and its findings. The next section details validity and reliability in an interpretative approach.

### **2.10. *Validity and reliability in an interpretative approach***

Validity poses a question that must be asked of all research (Guba & Lincoln, 1985): are the "...findings sufficiently authentic that I may trust myself in acting on their implications?" (p.271). It could be argued that this question must be asked more forcefully of research involving service-user participants with a diagnosis of personality disorder, who have a reputation for ambiguous and partial accounts (Allen & Whitson, 2004). However, any such questions need to be asked in ways appropriate to the paradigm. As this project rests on relativist ontology, an alternative conception of validity is appropriate. The project seeks to explore participants' different meanings of personality disorder and MHSW. Moreover, its subjectivist epistemology recognises the researcher's need to get as close as possible to the subject of study and the complex interplay between researcher and participant (Rice & Ezzy, 2000), and so this project needs to be evaluated in ways appropriate to its relativist, subjectivist and inductive assumptions. The evaluation should consider the validity of the method, interpretation (Guba & Lincoln, 1985), project and theory (Dey, 2010).

There are several criteria to choose from (Guba & Lincoln, 1985; Charmaz, 2008). In the course of this research I have considered Guba & Lincoln's (1985) criterion of trustworthiness and Charmaz's (2008) criteria of credibility, originality, resonance and usefulness. While I appreciate the importance of credibility, transferability, dependability and confirmability in research (Guba & Lincoln, 1985) I became concerned that these represent parallel criteria. I wanted to choose a criterion that would be both appropriate and useful in its own right. In later work Guba & Lincoln (1989) propose authenticity criteria: fairness and ontological, educative, catalytic and tactical authenticity. These address more than just method, as the authors (ibid, p.245) suggest, "Outcome, product, and negotiation criteria are equally important in judging a given inquiry". I now justify why I judged these criteria appropriate for evaluating this project.

Fairness is defined as a “quality of balance” (Guba & Lincoln, 2008, p.274) whereby the views and constructions of all participants are included in the text. Any omission is unfair and marginalises the participants and their perspectives. Fairness is appropriate to evaluating a research project about personality disorder, given evidence suggesting that people with personality disorder face marginalisation and indeed unfairness in their contact with mental health services (NIMHE, 2003). The project’s existence is in itself an attempt to help redress the balance (Castillo, 2003; Nehls, 1998, 1999). Attention to accessing and sampling service-user participants in this study, using robust inclusion and exclusion criteria, helped to ensure that they would inform the authenticity of the research, were not coerced and had the capacity to give their consent. This all helped to ensure that their accounts were as authentic as those of any other participants, including MHSWs. The inclusion of service-user and MHSW participants offered a fair and authentic interpretation of personality disorder from both perspectives. Fairness was also addressed by my efforts to ensure that every participant’s voice was represented in the work, and that their stories were represented in a fair and balanced way.

Ontological authenticity is defined as a level of awareness shown by research participants during the course of the research: the degree to which participants have “improved, matured, expanded, and elaborated, in that they now possess more information and have become more sophisticated in its use” (Guba & Lincoln, 2008, p.248). Such differences are characterised by statements which suggest that the research has thrown new light on the subject or on the participants’ way of thinking about the subject. Ontological authenticity draws attention to our dependency on social reality (Arnd-Caddigan & Pozzuto, 2006, p.429) and therefore fits the relativist underpinnings of this project and the ways in which meaning is negotiated. Furthermore, it indicates the validity of method choice and selection and it highlights how semi-structured active interviews (Holstein & Gubrium, 2004) lead the participant and researcher into meaning-making work. In his response to my question about the importance of setting the person and their distress in the social context, KS<sup>1</sup> reflects, incorporates new information, and begins to establish a different interpretation. Similarly, S2<sup>2</sup> reflects on how her past behaviour may have been interpreted by others. This example is just one indication of how service-user participants were able to consider, reflect and perhaps think differently about their experiences during the interview. These examples, among others, illustrate a counter-response to questions about the “reliability” of the testimony of research participants with mental disorder, as they suggest that the service-user participants were as capable as MHSW participants of absorbing and reflecting on new information.

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<sup>1</sup>*“Oh ok, no I don’t do that quite ... perhaps I do, but I haven’t thought of it like that. Yeah, yeah, ok that’s useful”*

<sup>2</sup>*“And actually I felt bad because I went to get a knife out of the drawer but I think ... I don’t know whether they thought, well, I was going to get a knife to hurt them and that was a knife to hurt myself”*

Both examples indicate that the choice and application of method was appropriate to the ontological, epistemological and methodological assumptions of this project.

Educative authenticity is defined as the extent to which respondents' understanding of the construction of others is enhanced. Guba & Lincoln (1989) suggest that stakeholders in particular should have the opportunity to be confronted with the constructions of others very unlike themselves. This project reflects educative authenticity, in that MHSWs were asked to respond to service users' ideas about how practice might be more informed. The findings indicate the degree to which MHSWs "... come to appreciate (apprehend, discern, understand)– not necessarily like or agree with – the constructions that are made by others and to understand how those constructions are rooted in the different value systems of those others" (Guba & Lincoln, 1986, cited in Guba & Lincoln, 1989, pp. 248-249). An example of educative authenticity can be found in RT's (4-05-10) response to service users' ideas about how MHSWs need to understand the person and the diagnosis. RT's initial response seems to doubt that MHSWs need to understand the diagnosis, but then she thinks again and says:

*Yeah, I can understand that because it has been used as quite a denigrating term, and yet if you've actually been diagnosed you might not feel it's the stigma – you might just be relieved that somebody's sort of given a name to this chaos that you're caught up in, and so they can have very positive feelings about it, so yeah, I can understand that.*

It is possible that this research project has the potential to enhance service users' understanding of mental health professionals, especially MHSWs. I remain in contact with the facilitator of the voluntary organisation the site and intend to offer to report the findings to service users. The project may also influence stakeholders' understanding more widely. Dissemination of the findings in newsletters, mental health publications and peer-reviewed journals and as presentations at conferences would increase opportunities for stakeholders to be confronted with somewhat different constructions of personality disorder, service users and MHSW. There is therefore a relationship between educative and catalytic authenticity.

Catalytic authenticity is the extent to which action is stimulated by the research process (Guba & Lincoln, 1989). My intention to feed back the findings to all participants suggests the research's potential for catalytic authenticity. Feedback to service-user participants might also stimulate change in their thinking about MHSWs and their practice. Wider dissemination of findings would enhance educative authenticity and stimulate action to understand personality disorder, the relevance of a social perspective and the potential of MHSW in this area. Tactical authenticity suggests that stimulation to act

is not enough; it is the degree to which respondents are empowered to act that is important (ibid). It is evident that this research project cannot claim any tactical authenticity; it might be possible, however, to ask MHSW participants who respond to my request for feedback on the executive summary of findings for their views about the possibility of thinking and working differently with personality disorder in their organisations. In the wider setting, it might also be possible to ask a similar question in any evaluation of a conference/workshop presentation on the findings of this project. Evaluations of this kind would help to inform my future research in this area.

The authenticity criteria have has been extremely helpful in the evaluation of this project. However, the project has generated a GT, which needs to be evaluated. While Glaser & Strauss (1967) initially propose that a GT should fit and be workable, relevant and capable of being modified, Charmaz (2008) argues that many GT studies utilise only one criterion of evaluation: saturation. Saturation is defined as data adequacy achieved by collecting data until no new data is found (Morse, 1995). It is necessary, however, to evidence the GT's interpretative validity (Christians, 2000) as well as its adequacy. Dey (2010) suggests that the value of a GT needs to be assessed in relation to its face validity: "the degree to which the concepts we use are meaningful ways of interpreting the data we investigate" (p.177). There is also the question of the GT's consistency with established knowledge in the field – its construct validity (ibid). Charmaz (2008) suggests that "a strong combination of originality and credibility increases resonance, usefulness and the subsequent value of the contribution" (p.231), e.g. of the GT.

The simultaneous data collection and analysis helped me to assess the adequacy of the data. I was able to define when the data was saturated in both phases. I highlight these points in my example of category building in Appendix 4. I also suggest that face validity (Dey, 2010) is enhanced because the study has been led completely by the data. Findings have been generated through the application of CCM (Glaser & Strauss, 1967) with in-case and cross-case analysis (Yin, 2003) enabling the balanced consideration of both similarities and differences in the data (Guba & Lincoln, 1989). Moreover, the theory, which suggests more positive ways of thinking about and working with people with personality disorder, corresponds with existing literature that emphasises the importance of pro-social approaches (Cherry, 2005), suggesting that this project extends current ideas, concepts and practices (Charmaz, 2008, p.231). The GT meets the demand for originality with credible links between data, argument, analysis (Charmaz, 2008) and the existing literature.

I selected the authenticity criteria (Guba & Lincoln, 1989) as an appropriate way of evaluating this project as it fits the nature of its research questions and underpinning assumptions. This project evidences fairness and ontological, educative and catalytic authenticity. The data reached saturation. Moreover, the theory, with face and construct validity, is original and makes credible links between the

data, the argument, the analysis and the existing literature. In both process and outcome, therefore, this project answers the question of whether its findings are authentic enough to be relied upon. (Guba & Lincoln, 1985). The project's findings are sufficiently authentic for me to "trust myself to act on their implications" (p.271). The next section considers another important component of its authenticity: reflexivity.

### **2.11. Reflexivity**

Reflexivity seeks to appreciate how individuals understand the world and their position in it (Finlay, 2002). It also helps the researcher to negotiate his or her proximity to participants' meanings and the complexities in the research relationship, including bias. There were a number of reasons for why I needed to adopt a reflexive approach in this study. Firstly, I have my own interpretive frame as described earlier in this chapter. My experiences influenced the development of the research questions, the design of the project, my commitment to it and the lens through which I would view it and research participants. Consequently, reflexive strategies would help me guard against bias in the design and method of the research. Secondly, I was aware of my status as a former MHSW and how this might influence participants' view of me, their decisions about whether to participate and their responses to my questions if they did. I have already summarised my reflexive awareness of these issues and how this was key to recruiting service user and MHSWs at different times, from different organisational and regional contexts. I would suggest that this helped me to better manage participants' bias towards me. Finally, the project's subjectivist epistemology and inductive methodology would draw me close to participants' meanings. I needed strategies to help me negotiate this proximity, to help ensure that I did not over interpret the data or a particular part of it. For all of these reasons it was essential that I utilise strategies to enhance my reflexive awareness and help me interrogate and account for bias (Finlay, 2002).

### **2.12 Bias and the value of reflexivity**

Reflexivity helped me to manage any particular tendency or inclination preventing me from an unprejudiced consideration of my research questions, participants and data. The emphasis is on 'manage' as bias is difficult to eliminate from the design and method of any study (Sica, 2006). It is possible that the inclusion of both service users and MHSWs in this study helped me to manage any bias towards one perspective over another. However, as qualitative research is often charged with being 'biased by implicit assumptions' (Diefenbach, 2009, p.876) it was important for me to develop strategies to negotiate bias and moreover, to be transparent about these in the write-up of the research. So a reflexive approach has enabled me to understand participants' meanings, negotiate power differentials

and reflect on any bias or impartiality. Strategies were both general and specific to particular stages of the research.

I employed my research diary, in both notebook and electronic form, as a general strategy to enhance my awareness of how participants appreciated their position within the wider world and within this research project. This diary gave me the space to reflect on the content of each interview and participants' interpretations and reporting of others' interpretations (Charmaz, 2006), and my own interpretations (Arnd-Caddigan & Pozzuto, 2006). This helped me to reflect on the interaction between the participants and myself and how understandings might relate to the wider context. Important in this was an interrogation of whether I was seeing the "realities" I wanted to find. For example, in his interview A1 (20-06-07) appeared completely at ease using diagnostic language to describe his understanding of personality disorder. I reflected on how this could represent an internalisation and acceptance of a powerful discourse. Given the negative associations connected to personality disorder (NIMHE, 2003), I doubted that A1 could have adopted them for positive gain and wondered if he was perhaps so used to being described in these ways that he had come to accept them uncritically. However, as I have some sympathy for the view that the psychiatric discourse on personality disorder can invalidate the identities of individuals, it was important to interrogate my interpretation. Was I looking for what I wanted to find? Using my diary, I reflected on other possible interpretations for A1's apparent acceptance of such language, as his attempt to retrieve some power by adopting the language of a powerful discourse.

The limitations of my chosen methods (Sica, 2006) meant I was particularly aware of the need to interrogate my own interpretations. Audio-recordings and full transcripts of each interview acted as a check on my interpretations as they allowed me to revisit the data whenever I wanted to check on their authenticity. However, my diary was a singular strategy which while useful did not allow me to test my interpretations with others. Consequently, as the data analysis progressed I needed to develop specific and more testing strategies, which I will detail later in this chapter. My diary did allow me however, to reflect on my own skills and experience as a MHSW and in turn what this meant for my future professional practice. I held a particular view of myself as a practitioner who had always tried to engage with service users and worked hard to understand their perspective. Part of my interview with S2 (24-07-07) strongly challenged this view of myself. S2 was talking about how she wished her current MHSW would talk to her rather than "... [letting] me talk, talk and talk, then, whenever I say anything I'm upset about or anything, all she says is, 'Right. Right. Right. Right.' And that drives me absolutely potty. And I told her, and she still does that". As S2 described her MHSW I remembered how I had used "right" a lot to show that I was listening to what service users were telling me. I assumed that they would

understand that I was showing that I was listening and would be okay with it. Later I reflected in my diary with some horror that my use of “right” might have inspired such a reaction in the people I worked with. My diary gave me the space to think this through, and I realised how easy it is to assume that our behaviour and language are understood by the person we are communicating with. I resolved that in future it might be better to question, at least myself, rather than just assume.

A reflexive approach runs throughout this study, it complements my attention to the research design, ethical issues and validity. It is an important component of the project’s authenticity and helped to generate understanding, negotiate power differentials and interrogate interpretations and bias; it is also an important part of the project’s embedded “goodness” (Tobin & Begley, 2004). The appropriate application of methods is another indicator of authenticity, as it helps account for bias within the function of the method and to respond appropriately to dilemmas and challenges in the research itself. I now consider the research in action and how this needed to be appropriate and fit the nature of the research questions and underpinning paradigmatic assumptions. I pay particular attention to the process of obtaining a purposeful sample via outcropping (Lee, 1999) as well as data collection, initial and secondary analysis, and of attending to key ethical requirements.

### **2.13.        *Research in action***

How I went about “doing” this research project had to fit the nature of my research questions, paradigmatic assumptions and theoretical framework. For example, the data collection is framed by the underpinning postmodern, critical and constructivist theories. Data analysis then authenticates this theoretical framework (Titus, 2004). Similarly, the samples are framed by outcropping and a purposeful approach. Moreover, my honesty, reflexivity, discipline and rigour in the transparent write up of this research informs the reader of my paradigmatic and theoretical assumptions and therefore helps me to account for bias (Diefenbach, 2009). The next section summarises how I obtained a purposeful sample (Denscombe, 2003) through outcropping (Lee, 1999).

### **2.14.        *Reality of sampling: Phase 1***

While I had decided that outcropping would be an appropriate strategy as participants were hard to reach, especially service-user participants who can also be defined as vulnerable (INVOLVE, 2004), I was concerned that I could become dependent on one research site (Lee, 1999) and that consequently there would be a bias in selection (Diefenbach, 2009). However, these concerns had to be balanced with practicalities in that my resources were limited; I restricted my search for sites to the south, southeast and east of England. Nonetheless I did try to maximise my sample and identified three community support services for personality disorder in the east and southeast and made contact with the

facilitators of all three, receiving a reply from one. This was the facilitator who would ultimately support the project and help me to recruit the ten participants I required. As I received no response from the other two facilitators I had to tolerate the risks associated with outcropping (Lee, 1993) if I were to have a chance of starting the research.

The purposeful sampling strategy aimed to select the most “appropriate information sources to explain meanings” (Rice & Ezzy, 2000, p.726) and reveal a depth of information about personality disorder and MHSW (Denscombe, 2003). Inclusion and exclusion criteria helped to identify the most appropriate potential service-users and protect them from harm. I decided that a sample of ten participants would be adequate and enable data saturation (Glaser & Strauss, 1967) and at the same time be manageable for me as a lone, part-time student researcher (Ritchie, Lewis & Elam, 2003). However, I completely underestimated the amount of data generated by “only” ten interviews per sample. After gaining ethical approval, I concentrated on how I might publicise the research and recruit service-user participants. Next, I summarise both tasks to reveal the importance of the facilitator and my associated dilemmas.

Initially I had intended to hold an information meeting for potential participants, despite warnings from the facilitator that it might be both practically and emotionally difficult for them to come together as a group. I went ahead, only to reflect on my disappointment when no service users were able to make the time and day I suggested. I rethought my strategy in discussion with my then principal supervisor and decided to take the less formal approach of just being at the service on one or two specified days. The facilitator agreed, and we decided that she would identify potential participants who met the inclusion/exclusion criteria, introduce the research to them and let them know when I would be available to tell them more. I reflected on the advantages and disadvantages of this strategy. The facilitator was effectively identifying the sample, and I questioned whether this might unduly influence potential participants and increase the risk of selection bias, in that their expression of interest in the project was directly related to their desire to please the facilitator. Then again, the facilitator had a depth of knowledge about each individual and would be able to match the criteria to potential participants with as little intrusion as possible (Social Research Association, 2003). My doubts were exacerbated when, on my first visit to the site, six service users expressed an interest in participating. Did their interest relate to a desire to please the facilitator (Rice & Ezzy, 2000)? I was very conscious of my dependency on the facilitator and her importance in identifying the sample. I was also conscious of literature that suggests that recruitment might revolve around personal choices (Ritchie et al., 2003) and result in a homogeneous sample (Holtslander & Duggleby, 2009). It became clear, however that any homogeneity in the sample is a consequence of patterns in diagnosis rather than the personal choices of the facilitator. Moreover, without her support the research might never have begun.

However, I remain conscious that service user participation may have been driven by an unconscious or conscious desire to please the facilitator. Moreover, the context of their perspective as service users utilising a voluntary service will have influenced their contributions particularly about service type and professionals from voluntary and statutory services respectively. Some participants do talk very positively of voluntary service staff but any bias here is offset by positive contributions about MHSW and in particular about what MHSW attitudes and support are or could be particularly effective. While interview data offers only a snap shot I did try and extend the interviews over a period of time. The majority were undertaken in June and July of 2007, with two taking place in January 2008. I would suggest that by spreading the interviews over a longer period of time I extended the range of the sample which in turn helped me to account for bias (Diefenbach, 2009). Below I describe the nature of this site and sample.

### **2.15. Nature of site and sample**

Ultimately ten service-user participants were recruited, of whom eight were women of white British origin. I do not know how many people refused to participate nor for what reasons. Consequently, it is not possible to say how this affected the research. However, I have learnt and in future research would want to know the reasons for non-participation as this might inform the design of a project. For example, people may have chosen not to participate because of this project's less participatory design. I do not know if this was the case, but knowledge of the reasons would cause me to think again about the design of a project. While it is possible that the sample was influenced by participant availability, facilitator choice and a desire to please her, the sample reflects the gender and racial bias in diagnosis. Participants tended to describe their diagnosis as either BPD or personality disorder. While a contested diagnosis (Coid et al., 2006), BPD is applied more frequently to women (Becker, 1997) than to men. One of the two male participants was of dual white British/Indian heritage, reflecting the weighting of the diagnosis towards white, western industrialised societies (Linehan, 1993) and perhaps a lack of cross-cultural prevalence studies (Paris, 2008).

While appropriate to the research questions and the project's underpinning paradigmatic assumptions, the outcropping strategy risked selection bias, staked my dependency on one site and facilitator and on a restricted, homogenous sample. However, there were no alternatives, as despite attempts to extend the sampling frame I had failed to identify any other possible sites and had not received a response from the other facilitators I had identified. While I cannot describe the sample as diverse, its homogeneity might be as much the result of the construction and application of the diagnosis as of the facilitator's choices. Moreover, outcropping, purposeful sampling and the facilitator's knowledge and support

meant that my exploration of service-user understandings of personality disorder and MHSW could begin. The next section details the sampling and recruitment of participants for phase 2 of the research.

### **2.16.           *Sampling: Phase 2***

Despite concerns about dependency and selection bias I envisaged using outcropping (Lee, 1999) as the strategy for sampling and recruiting MHSWs in Phase 2. I saw MHSWs as a hard-to-reach group, as I anticipated that it would be difficult to gain the necessary approval to interview them in statutory settings. I made contact with a national social work organisation in February 2008. While early contacts were supportive, contact with the Southern Regional organisers lapsed after I had given them more information about the project. I realised by the summer of 2008 that if phase 2 was to start I would have to rethink my outcropping strategy. My sampling strategy, while still purposeful (Denscombe, 2003), would now have to be more opportunistic (Creswell, 1998) utilising my knowledge of organisations and personnel. Insider support (ibid) would be crucial to the identification and recruitment of eight of the twelve MHSWs. NHS ethical approval and R&D approval were granted by September 2009 and I received my honorary research contract with the East of England Trust in December 2009.

Despite attention to ethical standards, the scrutiny of ethics and R&D committees and the award of an Honorary Research contract, I was soon as dependent on the agency insider for support as I had been on the facilitator in Phase 1. I struggled to get the cooperation of senior gatekeepers necessary to publicise the research. It was not until late February 2010 that, with insider support, I managed to get the research publicised on the agency's internal intranet, although this did not lead to any expressions of interest. Worried that I might not be able to recruit, and empowered by my research contract, I decided to publicise the research myself and to extend the search for alternative sites. Firstly, I identified every community mental health team (CMHT) and team manager in the Trust and sent my research information directly to them. Ultimately I identified eight MHSWs and recruited from this more proactive contact. Secondly, I sent my research information to other social care leads in different trusts in the South East and Eastern Regions and to the AADSS. My call for MHSW participants was also published on the Social Psychiatry Network, Social Care Institute for Excellence and Mental Health in Higher Education websites. This led to the recruitment of two additional sites, one in the northwest of England and one in the northeast, adding to the research's authenticity (Lincoln & Guba, 1989) but with implications for the length of phase 2.

While the sampling strategy in Phase 2 became more opportunistic and reliant on my own professional and personal resources, I would suggest that it's extended time frame and different organisational contexts again helped me to counter the snapshot nature of semi-structured interviews (Diefenbach, 2009). Opportunity came from initial adversity, therefore, as I was ultimately able to recruit from more

than one site and region of England. While not seeking to generalise or stake representative claims, greater regional diversity adds depth to the sample and consequently to the exploration of MHSW understandings of personality disorder and practice. However, I have to acknowledge that the nature of the non-random sample means that the research probably only attracted MHSWs interested in personality disorder. This is possibly why the findings from phase 2 of this project are more positively orientated towards working with people with personality disorder and are therefore not representative of social work practitioners more generally. Participants' may also have been consciously or unconsciously motivated by a desire to please me as an ex-MHSW. With this in mind it is interesting to note that MHSWs tend to report the negative practice of others, rather than state it as their own. Below I describe the nature of these sites and sample.

### **2.17. Nature of sites and sample**

I recruited eight MHSWs from the Eastern Region NHS Trust, two from a local authority in northwest England and two MHSWs from another NHS trust in northeast England. The intention had been to recruit ten MHSWs. As with Phase 1, I believed that ten interviews would generate adequate data, be manageable and balance the sample in Phase 1. Ultimately I recruited twelve 12 MHSWs for Phase 2. While this was a little over what I expected, I could not resist the opportunity to gather more data, extend the time frame and generate a more regionally diverse sample. Of the twelve, six worked in community mental health teams (CMHT), three in specialist services for mental disordered offenders (MDOs) and two in a service for people with personality disorder, and one managed a CMHT while continuing to practice as an MHSW. The sample comprised eight women and four men, reflecting the greater number of women in the profession (Dewane, 2008; UK DoH, 2007). Only one participant was of BME origin. This reflects the underrepresentation of BME staff in the personal social services. National data from 2006 reveals that only 10% of staff originates from BME populations, with 81% coming from the white British population (UK DoH, 2007).

My sampling choices were appropriate to the nature of the research questions and paradigmatic assumptions. The risks associated with outcropping and the realities of engaging influential gatekeepers are highlighted above. Despite attention to the standards for ethical research, extensive scrutiny and the award of an honorary research contract, the sampling was more opportunistic than that in Phase 1 and reliant on my professional and personal resources. However, it is evident now that opportunities came out of the initial adversity. The sample has a longer duration, greater regional and organisational diversity than expected. The next section summarises the data generation and my use of semi-structured active interviews (Holstein & Gubrium, 2004).

## **2.18.        *Generating and managing data***

### ***Phase 1 & 2***

My choice of semi-structured active interviews (Holstein & Gubrium, 2004, pp.140-162) fitted with the nature of the research questions and the project's interpretivist, inductive and CGT approach. They enabled proximity to participants' unique experiences and were flexible and sensitive to different interview situations. The interactive and collaborative style helped to negotiate some of the power differentials in the research and interview scenarios. While semi-structured, active interviews are limited to claims of bias and represent only snapshots in time, their flexibility and construction as a social situation, together with the opportunities I had to extend both samples over time, helped me to manage bias within the selection and generation of data. Below, I summarise the interview timelines, the simultaneous generation and analysis of data and my use of NVivo 7 (QSR International) in the management of large amounts of data.

Interviews in Phase 1 took place between June 2007 and February 2008. Familiarising myself with the data as I collected it by listening to the tapes, reading the transcripts and making notes about specific points, including tone of voice, hesitancy and contradictions all helped me account for bias. Moreover, simultaneous collection and analysis of data ensured that the data collection was informed by analysis and vice versa. For example, the interview with F (20-06-07) was my first service-user interview. F mentioned the importance of getting feedback from the MHSW. I made a note of this in my notebook. In the second interview A also mentioned how her MHSW gives her feedback and how important this is to her. I then asked a summarising question of A; "So feedback seems quite important?" A duly elaborated, and from then on I asked a question about feedback in all the remaining interviews.

The first eight interviews in Phase 2 took place between March and December 2010. Again I familiarised myself with the data, analysing it as I generated it and ensuring that the data collection was informed by the analysis. I completed two further interviews in the NW of England in Nov 2010 and the final two in the NE of England in September 2011. While this was difficult in relation to maintaining the momentum achieved between March and December 2010, the gaps between the first eight interviews and the last four extended the time frame and gave me the opportunity to focus some of the later questions around the emerging findings. For example, the importance of involving service users in MHSW training about personality disorder emerged from the first eight interviews and I was easily able to incorporate a question on this in the last four interviews. However, there were difficulties associated with the timeline. I had to sustain my motivation over a long period of time as data generation ran from June 2007 through to September 2011. Moreover, I had underestimated the complexity and size of the project and the amount of data that I would generate from ten, let alone twelve, interviews. Ten

service-user transcripts totalled 572 KB, and the twelve MHSW transcripts, 717 KB. The need to manage all of the data safely, effectively and in one place (Charmaz, 2010; Richards & Richards, 1994) was a significant factor in the decision to use NVivo 7 (QSR International), which also helped me to approach the data systematically. It was vital to the management and analysis of data.

### **2.19. Initial analysis**

My analysis of the data was led by my research questions and framed by the project's paradigmatic assumptions and theoretical framework. An inductive analysis starts with the data rather than the preconceptions of the researcher. An embedded, thematic analysis concentrates on patterns or themes as they relate to specific aspects of the case or data (Yin, 2003; Braun & Clarke, 2006). This was compatible with my constructivist approach; as themes are a consequence of the researcher's interpretation and do not just emerge from the data passively (Braun & Clarke, 2006). CGT (Charmaz, 2008) requires active initial coding, where each piece of data is summarised, categorised and accounted for (Charmaz, 2006). The "most significant or frequent initial codes" (ibid, p.43) are then used to sort, synthesise and organise the data appropriate to the research questions. CCM (Glaser & Strauss, 1967) is crucial to both initial and focused coding (Charmaz, 2006), as it enables the researcher to interrogate the similarities and differences both in and across case and within the same interview at different points in time. CCM is not necessarily a linear progression through the data. The researcher, led by the data, needs to travel back and forth within it, following new leads as they emerge (ibid).

An inductive, embedded and thematic analysis was very important in this research project. I was interested in participants' understandings of personality disorder and MHSW, and how practice might be better informed. It was important therefore that the analysis focused on their ways of understanding personality disorder and MHSW practice, the language they used to convey meaning and the nature of the virtual "interaction" about how practice might be better informed. In-case and cross-case analysis enabled a depth of understanding appropriate to the project's originality and the need to generate a fitting and relevant theory (Charmaz, 2006). The cross-case analysis was vital to the secondary analysis and sensitising data (Charmaz, 2006).

The project's originality meant that it was important to generate a conceptual theoretical analysis. Following discussion with my new supervisor in March 2011, I returned to reanalyse the whole data set. To begin with I selected one transcript from each phase of the research: the interviews with F (20-06-07) and BB (1-12-10). F's interview generated 65 initial codes. I took care to use active rather than passive descriptors for these codes in order to reflect the constructivist underpinnings of the research (Charmaz, 2010), e.g. 'All consuming, setting me apart from the mainstream'. I followed the same process with BB's interview, which generated 53 initial codes. I then returned to F's interview to focus the 65 initial

codes to facilitate sorting and synthesising the remaining service-user data in line with my research questions. I generated 11 focused codes from F's and 16 from BB's interview. I then employed my reflexive strategies on these codes, as described earlier in this chapter, to help me sensitize the data and remain open to different meanings, interpretations and to remember the importance of differences as well as similarities.

I then began to analyse the remaining data using these focused codes. CCM ensured that I got as close as possible to participants' meanings. I compared and contrasted each in-case interview with the previous one. I simultaneously coded service-user and MHSW interviews until all 22 interviews were completed. This helped me to get close to both similar and different meanings across case, identifying patterns and categories as they emerged. As I progressed with the initial analysis it was necessary to refocus the categories at times, as on more than one occasion I felt that the analysis was becoming unwieldy. At such times the case-study framework enabled me to maintain a structured approach. NVivo 7 also helped me to maintain a systematic approach and, through the memo function, interrogate assumptions and contradictions in the data. I used Word documents to make notes and build a narrative about the data, possible sensitising ideas, the existing literature and the emerging theory. While initial coding can appear to fracture the data, my cross-case analysis (Creswell, 1998; Charmaz, 2006) and extensive use of memos (Glaser & Strauss, 1967; Charmaz, 2010) was preparing me for the secondary analysis and for reassembling the data around the core "It resists singular explanation" category (Creswell, 1998).

As a lone researcher I did not have the luxury of a second coder to check my interpretations and guard against bias. My research diary was useful, but I needed a means of testing my interpretations against others. Consequently I often sought out a colleague as a source of peer debriefing (Kisely & Kendall, 2011), who had recently completed his Ph.D. to share data extracts with and ask for his interpretations. For example we had a long conversation about the particular extract from A1's (20-06-07) interview mentioned earlier in this chapter. This conversation helped me to test out my interpretations and make links with the theories underpinning this study and the wider social structure. We agreed in this case that A's description of himself later in the interview as "a nutter" confirmed my initial interpretation that an internalization of a powerful discourse was indeed apparent in this extract. This is an example of similar debriefings which helped me to test out my interpretations and helped me to enhance my awareness and interrogate my own particular biases and frame of reference.

I was also aware of a need to check my interpretations of the data more generally. My supervision team and another colleague, independent of my research team and expert in personality disorder, were important sources of support and critical reflection. For example on one occasion I shared my analysis

of two transcripts with my team. These interviews were taken from the beginning and near the end of Phase 1. I received written and verbal feedback on my interpretations. This feedback confirmed my original interpretations and suggested alternatives. For example, an alternative to the association I had made between experiences similar to psychosis and 'magical thinking' was proposed by a suggestion that children can engage in magical thinking. My supervisor therefore questioned whether it was appropriate to label this data in this way. I returned to the data to check my interpretation. While I retained the use of magical thinking as a descriptor of experiences like psychosis her intervention meant that I interrogated my interpretations and possible biases. I found such interventions offering alternatives and references to relevant literature particularly helpful- as this meant that not only were my interpretations challenged in the immediate but continued to be as I read the literature suggested by colleagues. For example, the work of Hinshelwood (1999) was suggested by my colleague expert in personality disorder, as another way of explaining professional distance to the person with personality disorder. I valued this as I had not encountered his work previously and it helped me to understand professional behaviours as a consequence perhaps of feeling overwhelmed and helpless rather than a more deliberate defensiveness.

The initial data analysis was led by my research questions and was appropriate to the project's underpinning assumptions. The simultaneous collection and analysis of data and embedded in-case and cross-case thematic analysis helped to generate a close and in-depth appreciation of participants' understandings of personality disorder and MHSW. Line-by-line active coding was appropriate to the CGT (Charmaz, 2006) approach and my reflexive strategies helped me manage the potential for bias. The focused coding helped me to sort and synthesise large amounts of data. NVivo 7 supported the constant comparative method (Glaser & Strauss, 1967) essential to both in-case and cross-case analysis and the identification of similarities and differences in the data. CCM and memos were crucial to the more focused analysis, the reassembling of the data around the core category, and the emergence of a fitting and relevant theory for practice. The following section summarises how I sensitised the emergent theory in relation to the existing literature.

## **2.20. Secondary analysis**

A secondary analysis was important to this project for two reasons. Firstly, its originality demanded a more conceptual analysis. Secondly, sensitising the findings to the wider literature helped me account for bias by 'checking' my interpretations with the established literature (Diefenbach, 2009). Focused coding, enabled me to sort large amounts of data (Charmaz, 2006) and drive the more conceptual analysis, as it helped me to specify properties and dimensions (Strauss & Corbin, 1998) and the relationships between these and other categories. This is essential to generating a relevant, inductive theory, as is sensitising the categories with the existing literature. Glaser (1978) suggests the "6Cs", a theoretical coding family comprised of causes, contexts, contingencies, consequences, covariances and conditions to sensitise the data. Charmaz (2006), however, argues that such families or matrixes are not necessary as the researcher can simply follow leads in the data, zigzagging between these leads and the existing literature to generate an inductive, conceptual analysis relevant to the subject of study and related areas.

I felt more comfortable with immersing myself in the data and following the leads it presented, rather than use a theoretical coding family. By reading and rereading and constantly asking myself "when, where, why, who and how" (Strauss & Corbin, 1998, p.125), I began to see connections in the data. This was important, as I was committed to generating a theory inductively from the data. Identification of the core "It resists singular explanation" category, for example, came from reading and rereading Category 2 "Understanding the response to personality disorder". Properties in this category explain the largely negative responses of mental health professionals, including MHSWs, as consequences of the complex and contested nature of personality disorder and MHSWs' limited understanding of the diagnosis.

I asked myself what might limit understanding. Data in category 3 suggests that no one perspective can explain personality disorder. What are the consequences of this? Data in categories 4 & 5 suggest that service users and MHSWs can hold negative views of each other, which can lead to a negative and potentially alienating dynamic between them. However, I was also alert to different constructions, and found that some service users and MHSWs suggested that a more positive dynamic is possible. Positive properties such as "reliability and solidity" and "being positive with the person" relate to understanding personality disorder as a response to traumatic experience (category 1). Hope and reliability are important in a world of chaos and disconnection induced by trauma (Bussey & Wise, 2007). Once I had defined and identified the relationships between the categories I then needed to sensitise each category in relation to the existing literature and conceptual ideas.

I made a list of the underpinning assumptions in each category and what I needed to do to sensitise each category. For example my core category, “It resists singular explanation”, questions the classification of personality disorder. I had to return to current definitions of personality disorder and the function of classification and categorisation. Again I asked many questions of the data and what it was suggesting, i.e. why do we categorise? How does this relate to my data? I then zigzagged between the data and the existing literature as I had between interview and analysis when conducting the interviews (Charmaz, 2006; Glaser & Strauss, 1967). Memos helped me to formulate a narrative that reassembled the data to generate a relevant and fitting theory. As I sensitised the data and wrote my memos, I became aware of how certain aspects of the theory might be relevant to other areas of social work practice (Charmaz, 2006; Glaser & Strauss, 1967). For example the importance of understanding, feedback, modelling, transparency and consistency, practical support and supporting family and social networks resonates with many areas of social work practice besides MHSW and personality disorder (Trotter, 2004). The theory therefore may have both generic and specific (substantive) value (Charmaz, 2006).

My analysis of the data fitted the aims of the research and its underpinning ontological, epistemological and methodological assumptions. My approach was systematic and I had strategies to help me account for bias; I applied CCM appropriately in the initial and focused coding. Focused coding helped me to sort and synthesise large amounts of data and drive the secondary analysis. By following leads in the data, listing the underpinning assumptions in each category and zigzagging between these and the existing literature I generated a theory relevant to MHSW and social work more generally which may encourage MHSWs to think and work differently with people with personality disorder and induce more positive, supportive outcomes for the person with personality disorder.

### **2.21. *The realities of ethical requirements***

I have already set out this project’s compliance with ethical standards (UK DoH, 2005c) and scrutiny earlier in this chapter. I sought to protect participants from harm and to promote their rights, dignity, safety and well-being. This was achieved despite the excessive bureaucratic requirements, which at times appeared somewhat unnecessary and contradictory. Accessing MHSWs, who could not be defined as vulnerable (INVOLVE, 2004), in NHS settings proved more challenging than accessing service users from a voluntary agency who might be defined as vulnerable. Moreover, I could not help but wonder whether the ethics and R&D requirements might actually discourage interested MHSWs from participating. Some alterations to my documentation were required by the committees during the course of the review of Phase 2. These requests duplicated effort at times. For example, the NHS Ethics Committee asked me to insert a disclaimer about the disclosure of malpractice on the participant

information sheet. I did this, only for the R&D Committee to request that this disclaimer be changed and written more clearly. While I could see the reason for the disclaimer, as the researcher I was worried that specifying it so starkly could put MHSWs off participating. I will never know if it did. It certainly seemed to have an impact on KS (1-06-10), who, laughing, framed one of his responses with: "... so this is where you report me".

However, these concerns of mine have to be balanced with the reality that certain requirements have been helpful and none more so than the FRECs suggestion that I enter into a written, signed agreement with the facilitator about what would happen should a service user become distressed during the interview. When this was first suggested I saw it as another procedural requirement, my thoughts already clouded by the bureaucratic nature of the review process. However, as ethical approval was clearly dependent on establishing such an agreement, I drafted one in consultation with the facilitator. As the interviews would take place in the organisation it was possible to stipulate that if a participant became distressed I would ask them if they would like support from a member of staff at the service. If they did, I would find the nominated person who would support them and discuss whether they wanted to continue. Thankfully I did not need to call a member of staff during any of the service-user interviews, although I saw the value of the agreement when one participant became overwhelmed and asked "... to think ... can you?" and pointed at the tape recorder (S2 24-07-07) for me to turn it off, which I did. The participant took her time and gathered her thoughts and told me when I could turn it back on. I checked that she wanted to continue, and she did. Having an agreement that detailed how I would act in a situation such as this, as well as one in which the participant could request support from a member of staff, did not in itself change the way I responded, but it was reassuring to know that I had prepared as much as I could to protect the participants from harm.

The reality of the ethical review process seemed unnecessarily bureaucratic and at times contradictory. It was harder to obtain approval to interview MHSWs employed by the NHS or based on NHS property than it was to interview service users in a non NHS, voluntary setting who might be defined as vulnerable. The requirements of the different committees were also contradictory, duplicating effort and time. However, standards and scrutiny are necessary and can enhance a project's ability to protect participants from harm and promote their well-being, and therefore encourage confidence in the process and findings of research.

## **2.22.            *Research in action; summary***

This section on research in action has shown that I conducted the research in ways appropriate to its relativist, subjectivist and inductive underpinnings. While the research questions situate the project appropriately in the interpretivist paradigm, this does not mean that carrying out the research was

dilemma-free. Purposeful sampling through outcropping (Lee, 1999) gave me access to hard-to-reach participants but raised questions about selection bias, my dependency on the site and the nature of the sample. Moreover, outcropping did not work in Phase 2. It is possible that opportunistic sampling extended the time-frame and culminated in greater regional diversity than would have been obtained from outcropping southern branches of a national social work organisation. Obtaining ethical and R&D approval meant that I could begin to publicise the research and recruit participants. However, the extent of scrutiny to which this project has been subject raised dilemmas that caused me to doubt the usefulness of the review process. More positively, reporting on the “doing” of the research authenticates my chosen methods and helps account for the function of bias within both semi-structured, active interviews and documentary sources. Constructing the interview as a site of social interaction, separate sampling frames, my knowledge about the source of the majority of documents and my specific reflexive strategies helped me to account for bias and my influence on the research process. The use of active semi-structured interviews (Holstein & Gubrium, 2004) and a CGT method in and across case helped to generate knowledge about the participants’ different ways of knowing, highlighting particular language use and ideas about how practice might be more informed. The methods were therefore appropriate to the nature of the research questions, the paradigmatic assumptions and the theories that informed the research design.

### **2.23. Conclusion**

This research project explores how participants’ understand personality disorder, MHSW and how practice might be better informed. It was essential that the research design was appropriate to these “how”-related questions. The project is set in the interpretivist paradigm and rests on relativist ontology, a subjectivist epistemology and an inductive, qualitative methodology. The originality of involving service-user and MHSW participants in such an under-researched area demanded a CGT (Charmaz, 2008) approach that could generate a conceptual and theoretical analysis. A case-study framework (Yin, 2003) helped me to manage the complexities of the project and framed embedded in-case and cross-case analysis of data collected from 22 semi-structured active interviews. Analysis of policies on personality disorder and social work over the last 14 years aided the exploration of meaning and triangulated the method (Yin, 2003). Ethical requirements were fundamental to the project throughout. My attention to ethical research standards (UK DoH, 2005c) together with the scrutiny to which this project has been subject enables confidence in the research and its findings. Ethical issues are an important component of the research’s authenticity. The research, across both phases, evidences fairness, ontological, educative and potential for catalytic authenticity (Guba & Lincoln, 1989). This also helps to counter doubts about involving service users, especially those with a reputation for partial accounts and distorted thinking and the reliability of their accounts (Allen & Whitson, 2011). The ethical

requirements, authenticity and a reflexive and transparent approach (Lather, 1991) in the process and reporting of the research indicate that the project's "goodness" (Tobin & Begley, 2004) is embedded rather than tokenistic. This project should inspire confidence in both process and outcome, promoting alternative understandings of personality disorder, MHSW and practice. Chapter 3 will present the study's findings, with the findings from interviews with service users presented first and findings from the MHSW interviews following in section two.

## Chapter 3: Findings

This chapter presents the findings that answer the research questions asking how the participants understand personality disorder and MHSW practice, and their ideas about how practice in this area might be better informed. The chapter reflects the research's ontological, epistemological and theoretical assumptions, highlighting participants' experiences and ways of knowing personality disorder and MHSW. Emphasis is given to the participants' language and interpretation of meaning. The order of categories reflects the emerging theory, beginning with the Core Category (Category 1: "It resists singular explanation"). The data will be presented in two separate sections, with data from the interviews with service users coming first, that from interviews with MHSWs second. Attention is paid to the differences in participants' meanings, particularly their respective constructions of each other, which have implications for practice. The presentation of different and similar findings across cases indicate the authenticity of the research (Guba & Lincoln, 1989) and its potential for offering alternative ways of thinking about and working with personality disorder.

There are two appendices to this chapter. The first is an illustrative extract of my interaction with participants in Phase 1 (Appendix 5). In a constructivist project such as this it is important to reveal the "how" of meaning creation and the "what" of lived experience (Holstein & Gubrium, 2004). CGT (Charmaz, 2006) requires a partnership between participant and researcher. The illustrative extract reveals how I worked with participants' differences, yielded control (Mills et al., 2006) and aimed to work in partnership with participants to generate meaning. The extract also points to my reflexive approach. The second appendix is an example of how I constructed a category in phase 2 of the research (Appendix 7), revealing my interaction with the data and how I followed leads back and forth amongst the data to generate an inductive appreciation of MHSWs' understanding of personality disorder (Category 2.1).

This chapter illustrates my craftsmanship (Kvale, 1996) as a researcher and conveys the integrity and legitimacy of the findings and the goodness of the research itself (Tobin & Beggley, 2004). I address fairness and ontological and educative authenticity (Guba & Lincoln, 1989). I have chosen direct quotations for their capacity to reveal a depth of understanding about personality disorder and MHSW and to indicate the quality of my interaction with participants and demonstrate how close I got to their meaning. The chapter concludes with the suggestion that the emergent theory has some catalytic authenticity (Guba & Lincoln, 1989), as it proposes that different constructions of personality disorder and MHSW are possible (Gergen, 2002; Kvale, 1996). In this chapter I present my interpretations of the how and what of lived experience (Holstein & Gubrium, 2004), rather than ready answers. Readers will compose their own "interpretations of the data" (Manning, 1997, p.110).

# Section 1; Interviews with service users

## 3.1. Research question 1: how participants understand personality disorder

Table 3.1: The relevant categories

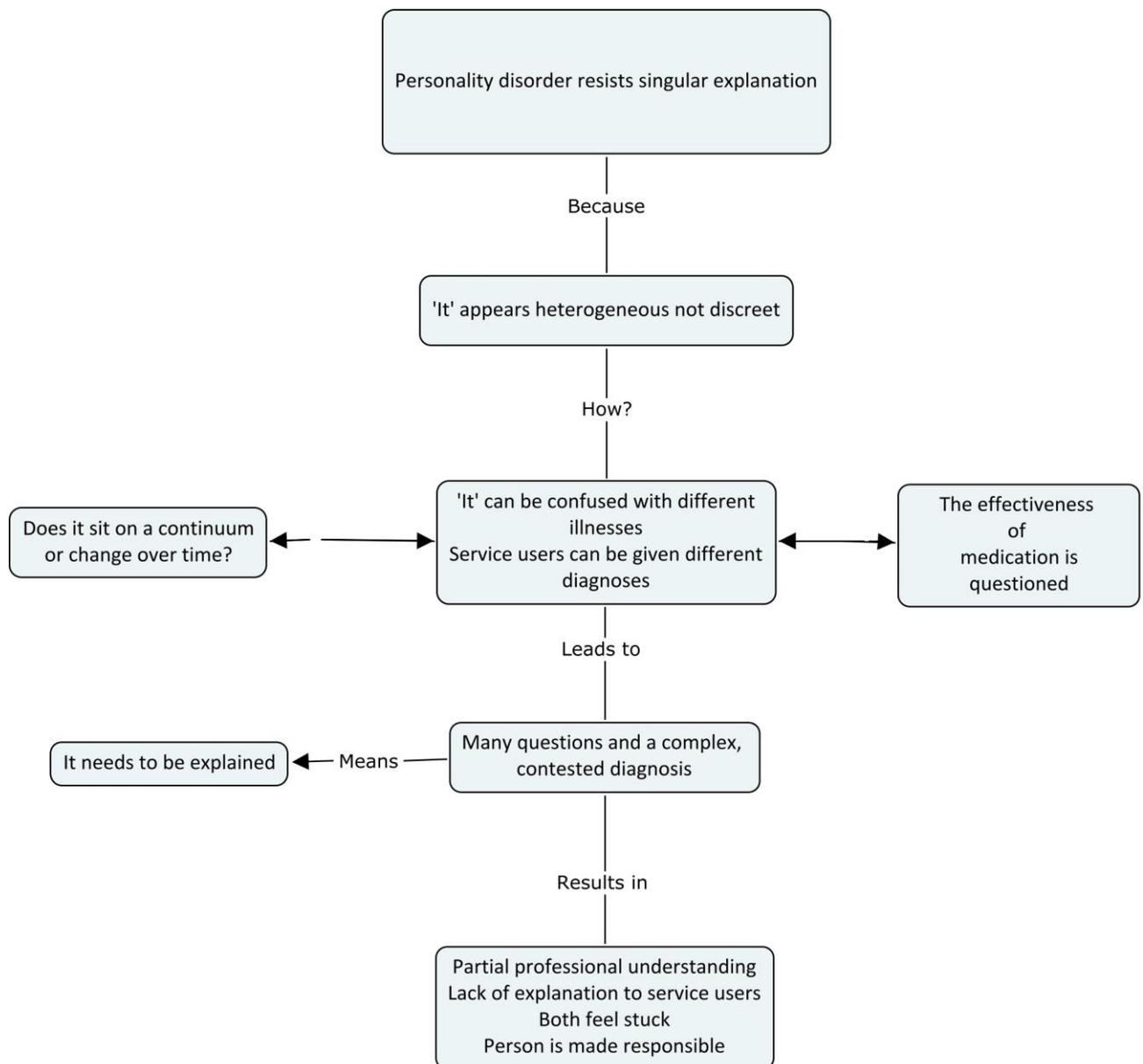
Category 1	“It resists singular explanation”
Category 2	Understanding the response to personality disorder
Category 3	Perceptions of the Other; service users on MHSWs
Category 4	Understanding personality disorder as a response to trauma

These findings highlight service user participants’ experiences and ways of knowing personality disorder and MHSW. The presentation of the findings reflects the emerging theory and so starts with the core category, “It resists singular explanation”. The data suggests that too heavy a reliance on one approach can limit knowledge and inadvertently encourage stereotypical and stigmatised responses to the person, as revealed in category 2. Category 3 indicates how such responses can lead both service users and MHSWs to hold negative constructions of each other. Category 4 reveals participants’ understanding of personality disorder as a response to trauma. The participants referred to both each other and the diagnosis at times in anonymous terms, i.e. “they” and “it”. These terms have been retained to maintain a proximity to the data.

### Category 1: “It resists singular explanation”

The findings of this project suggested that the ways in which personality disorder is understood have implications for how the person is perceived and received by MHSWs and by mental health services more generally. Figure 3.1, “It resists singular explanation” (p.92), captures this theme and reflects suggestions that the diagnosis is heterogeneous rather than discrete, can be confused with different illnesses which in turn raises questions about whether the diagnosis sits on a continuum or changes over time. The diagram reflects data which suggests that the complexities of the disorder can ultimately limit understanding of a multifaceted phenomenon and induce negative responses from mental health professionals, including MHSWs. Some service users described how they had been diagnosed with a few different illnesses.

**Figure 3.1: “It resists singular explanation”**



Service users suggested that because personality disorder is not understood, when faced with the diagnosis, mental health professionals and MHSWs do not know what to do and cannot explain it.

***I’ve been named with a few different illnesses***

M (27-06-07) described her different diagnoses before acquiring one of personality disorder:

*“Because I’ve been named with quite a few illnesses – schizophrenia, bipolar, all different things, but in the end they come up with personality disorder”.*

Two participants, A1 and L, currently have more than one diagnosis of personality disorder, as L (24-07-07) described:

*“I’ve got the borderline personality disorder – there are thirteen or something different ones. I have about four or five different ones”.*

### **They can’t give you any medication**

L (27-06-07) suggested that

*“...because they can’t give you any medication specifically for it – I’m not bi-polar, where they can stabilise your mood. They can’t give you anything...”*

The data indicates therefore how personality disorder defies singular explanation and how too heavy a reliance on one approach can limit understanding and lead to confusion. Service users suggested that because mental health professionals, including MHSWs, do not understand the diagnosis they therefore cannot explain it and do not know what to do about it.

### **Confusion stems from a lack of understanding**

Eight service users (M, S1, A, S L, H, A1 & F) suggested that the confusion surrounding personality disorder stems from a lack of professional understanding. They did not mean that they understand the diagnosis better than professionals – they simply questioned the extent of professional understanding. S1 asserted quite clearly that personality disorder is not understood:

*“...they said, “What’s your diagnosis?” And you said “PD.” And they said, “What’s that?” “Personality disorder.” And they said, “Right. Okay. What’s that”?*

This lack of understanding showed itself in a particular way for A (20-06-07):

*“If they had more understanding they wouldn’t be like that, would they, so they can’t have had that understanding in the first place otherwise they wouldn’t behave like that anyway”.*

Some service users described how they have never received an explanation of the diagnosis, suggesting that this can also be a consequence of limited understanding.

### **If professionals don’t understand, they can’t explain**

Eight participants (M, S1, A, S, L, H, A1, F) suggested that the diagnosis is given when *“they don’t know what’s wrong”* and so can’t explain. M (27-06-07) elaborated:

*“It can be various illnesses for each person, different illnesses, but when the doctors don’t know what it is that’s actually wrong with them; they use “personality disorder”.*

Nine participants had not received a meaningful explanation of personality disorder, and five (S, S2, S1, A, C) of these had received no explanation at all. S (27-06-07) was given a diagnosis of BPD in hospital, but no one explained it to her:

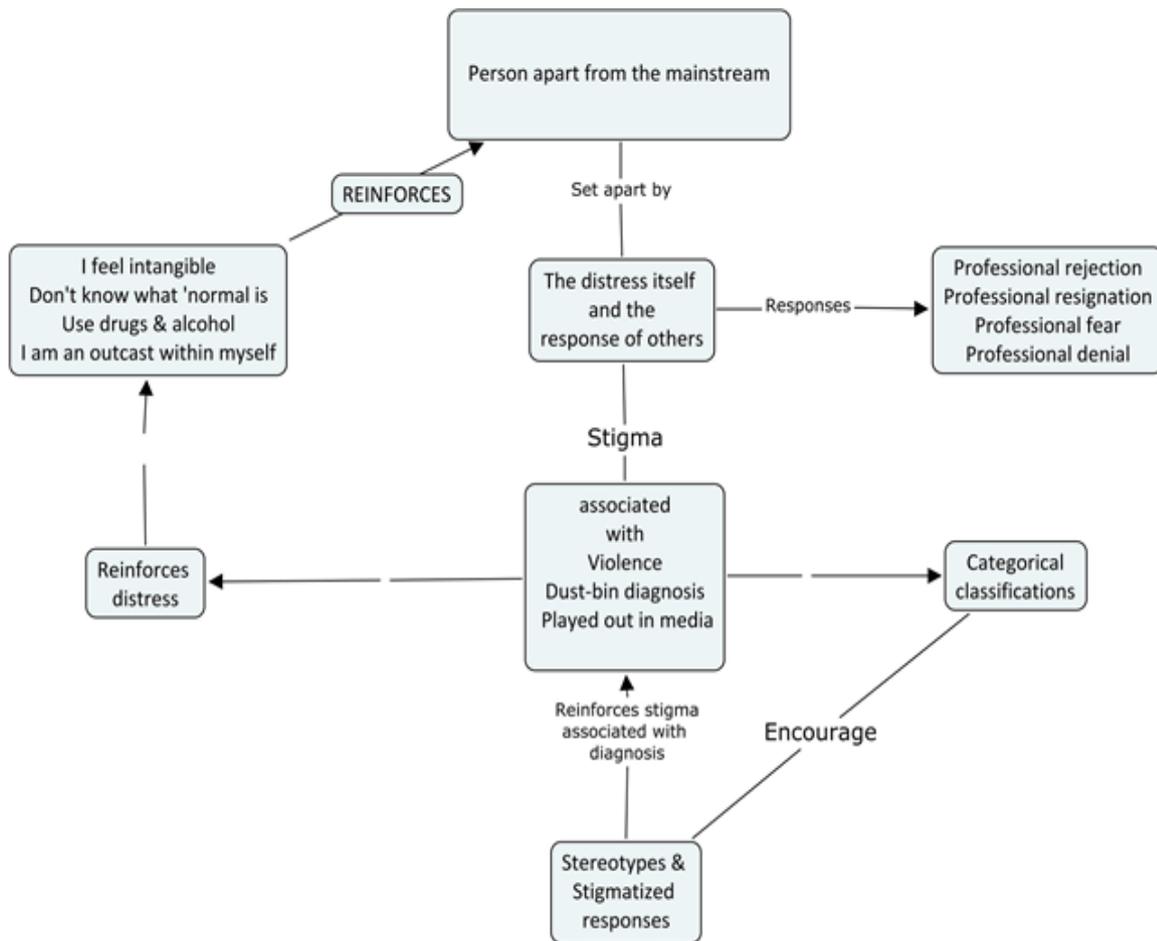
*“No, they didn’t tell me anything. I only learnt from here really”.*

The findings in this category raise questions about the categorical classification of personality disorder, suggesting that its complexity defies singular explanation and too heavy a reliance on one perspective can limit understanding, with consequences for service users. Service users may never receive a meaningful explanation of their condition, despite the need for one. Some service users described their inability to explain their own distress, further underlining the need for a meaningful explanation. The next category describes how service users can be distanced by mental health services and professionals, including MHSWs and those negative responses can compound the person’s sense of difference and apartness.

### ***Category 2: Understanding the response to personality disorder***

This project has found that service users with personality disorder can be ignored by professionals and mental health services. Figure 3.2, on p.95, reflect data which suggests how the person is set apart from the mainstream, both by the nature of the distress itself and by the responses of others. The stigma associated with personality disorder contributes to negative stereotypes and legitimizes professional distance. The diagram reflects how negative, professional responses can reinforce distress, exclusion and the sense of the person’s apartness from the mainstream.

**Figure 3.2: Understanding a response to personality disorder**



Such responses appear governed by rejection, resignation, fear and denial and contribute to the particular stigma surrounding personality disorder, associated with violence and its status as a “dustbin diagnosis” (Beresford, 2005) that does not indicate “what it is or what has gone on for that individual” (Tallis, 2006, p.222). Such responses only add to the person’s distress, their sense of apartness and their construction as other.

The data that follows first describe some service users’ sense of apartness and experience of being “dissed” and “ignored”. Service user views of stigma are considered before the section moves on to reflect participants’ constructions of MHSW as the Other.

***Distress and the label set me apart***

Two participants (F & A) felt that both the distress and the label set them apart from the mainstream. F (20-06-07) described how her thoughts, feelings and behaviour are:

*“...not kind of mainstream, they diverge from how most other people in general society behave and respond, particularly to stress”.*

She does not appear “*tangible*”. A (20-06-07), too, has felt apart and not able to think “*about a normal day in the life actually*”. A does not “*know what a family is supposed to be, so I don’t know that one*”. A’s coping mechanisms, “*drugs and things*”, compounds her sense of apartness.

Two participants (S1 & C) described how the label and associated assumptions about additional sources of stigma (minority ethnicity) can set them apart. C’s background, too, sets him apart:

*“Because I’m Asian, the thing is I’ve not come across one personality disorder at the moment who’s black or Asian, and that makes me look an outcast in society in a way, or an outcast in myself...”* (09-01-08)

Distress can set the person apart from the mainstream, and this can be intensified by experiences of being “*dissed*” and ignored by mental health services and professionals, including MHSWs. It is apparent therefore that a combination of distress and negative responses from mental health professionals can contribute to the person’s felt and actual apartness from the mainstream.

### ***Personality disorder can lead to being “dissed” and “ignored”***

“Dissed” means being shown disrespect or being disconnected from another party, in the sense of being cut off (Urban Dictionary, 2012). Five service users (A, F, S2, S, H) described their experiences of mental health professionals’, including MHSWs’, responses to them. F (20-06-07) described how once she’d acquired a diagnosis of borderline personality disorder, her psychiatrist’s response changed,

*... the psychiatrist who had been so kind to me a year before when it was depression and psychosis and anxiety – the same psychiatrist – he told me there was nothing they could do for me and that I was taking a bed that someone with schizophrenia could have.*

This accords with the views of nine MHSW participants who suggested that personality disorder is not seen as the business of mental health services.

### ***Stigma***

Seven service users (A, S, S1, A1, C, S2, H) mentioned stigma. Three suggested that there is a particular stigma surrounding the diagnosis which is associated with the assumption that the person will be violent or display “*unrational behaviour*” (C, 09-01-08):

*“People on the outside think that people with personality disorder tend to be violent and we sort of ... get walked over or ignored because we’ve been given that label”.* (S, 27-06-07)

A1 (20-06-07) described how for some, personality disorder and violence appear to go together:

*A couple of times with taxi drivers and that, they said “where are you going?” When you said “X”, they said, “What’s that?” And you said “Oh it’s for personality disorders”, and they said [respondent is inaudible] ... “They’re all axe people there”.*

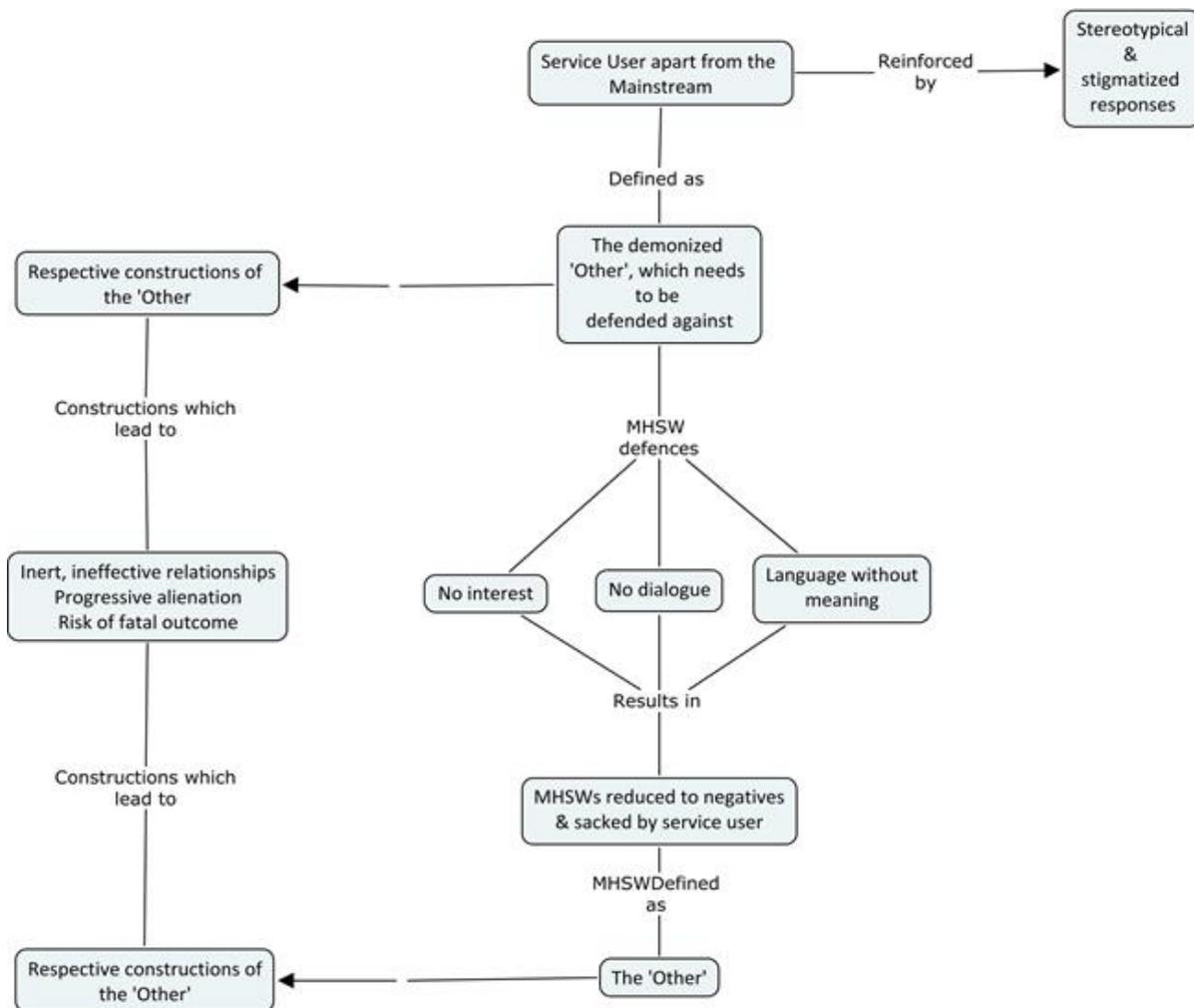
A1 suggested that this type of association results from the portrayal of personality disorder in the media.

These findings indicate that the diagnosis can be perceived as a “dustbin diagnosis” (Beresford, 2005) and the person associated with assumptions of violence and, as C (09-01-08) suggested, “unrational behaviour”. It is possible that the stigma reinforces the person’s sense of being different from the “mainstream”. Some service users saw their relationships with MHSWs as distant, lacking in dialogue, investment and interest. The data indicates that such deficits can lead to the construction of the MHSWs as Other (Wright et al., 2007), a construction that holds implications for practice.

### ***Category 3: Perceptions of the Other; Service users on MHSWs***

Differences are evident in the roles and perceptions of service users and MHSWs, even though both groups share a commonality as human beings (Wright et al., 2007). Figure 3.3 reflects data suggesting the person can feel apart from the mainstream and how stereotypical and stigmatised responses can reinforce this sense of apartness and construct them as the Other, to be defended against. The diagram reflects the particular MHSW defences to emerge from this study and reflects how such responses can lead service users to form negative constructions of MHSWs and ultimately ‘sack’ them. The diagram therefore suggests that respective negative constructions of each other can lead to inert, ineffective relationships and the increased risk of a fatal outcome for the person with personality disorder.

**Figure 3.3: Perceptions of the Other: service users on MHSWs**



The following sections present the relevant data here, beginning with service users’ interpretation of MHSWs’ defensive behaviours; no interest, little dialogue or meaning.

***Lack of interest, dialogue and meaning***

Four participants (F, S1, H, A) described how the MHSW lacked interest in them:

*“And what’s the point in being in a profession if actually all you’re going to do is fuck all? Come round my house for ... I think the longest was about eleven minutes she was round the house...”*  
(S1, 10-07-07)

Interestingly, by questioning the MHSW’s professionalism S1’s comment highlights the importance of the caring attitudes and protective bonds that recognise the person’s vulnerability (Downie, 2011, pp.23-35). Two service users (C & H) suggested that MHSWs can appear interested only in the “now and

*present*” (C), or the *“then and there”* (H, 09-01-08). It is possible that a focus on surface considerations (Parton, 2008) obstructs MHSW knowledge of the person and the development of professional caring and protective bonds. Focusing on the here and now leads to lack of knowledge of the person and stereotypical responses. Some service users suggested that MHSWs’ lack of interest is matched with an absence of dialogue.

### ***An absence of dialogue***

Five participants (S1, F, A1, C, S2) described an absence of dialogue in direct communication (defined as face-to-face communication in groups and one-to-one) with MHSWs and mental health professionals and in indirect communication (i.e. not explaining before they refer the person to another professional or MHSW). S2 described how conversation can be one-way:

*...and some will just not say anything at all. It’s very difficult because I just feel that if they said something back to me ... The lady I have now ... all she seems to do is let me talk, talk and talk, then whenever I say anything I’m upset about or anything, all she says is, “Right. Right. Right. Right.” And that drives me absolutely potty.*

Some service users described how when MHSWs do engage with them they can talk in language that has little meaning for them.

### ***Language with little meaning***

Four participants (F, A, A1, H) said that MHSWs speak in language that has little meaning for them:

*“[Whenever the MHSW] came round it was like we were two people speaking a different language”. (F, 20-06-07)*

H (09-01-08) described how the MHSW would *“talk down”* to her, so she would comply just *“...for that visit and then go back to my old ways when she’d gone”*.

The findings indicate that such defences on the part of the MHSW can contribute to negative constructions of them as not to be trusted, with implications for MHSW practice.

### ***They lie or try to fob you off – basically they are not to be trusted***

Some service users (A, S1, C, M, S2, S) found that MHSWs can *“lie”*, *“try to fob you off”* (M), *“trip you up”* (C) and appear threatening (S).

It is perhaps not surprising that deficits in interest, dialogue and language lead to more negative constructions, and as three service users described, can lead the service user to “sack” the professional as C (09-01-08) related:

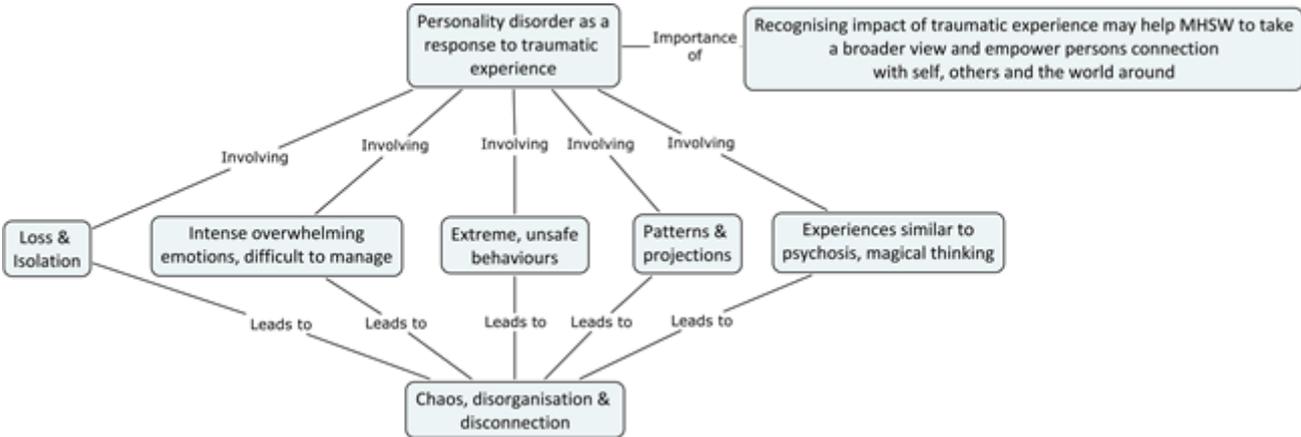
*... she was that pathetic and laid back and there was no way forward with it so I had to throw in the towel. There was no way because she wouldn't come up with inspiring ideas of how I was going to move on.*

Interpretation of some service users’ descriptions of MHSWs’ responses suggests that MHSWs may feel the need to defend themselves against the person with personality disorder. Distant responses can contribute to the person’s sense of apartness and alienation (Watts & Morgan, 1994) and to negative constructions representing the MHSW as Other, with implications for MHSW practice in this area.

**Category 4: Understanding personality disorder as a response to trauma**

Figure 3.5 reflects the data about how participants appeared to understand personality disorder as a response to traumatic experience that involves loss, isolation, overwhelming emotions, intense reactions, patterns and projections and experiences similar to psychosis. All of these consequences can disconnect the person from self and others and lead to chaos and disorganisation. Given this both data and diagram suggest the need for MHSWs to understand the impact and consequences of traumatic experience and work in ways to empower more constructive responses and more positive connections.

**Figure 3.4: Understanding personality disorder as a response to trauma**



This research project highlights the importance of recognising chronic childhood trauma, which can damage the relationship between child and caregiver causing unusually strong emotions and physiological changes with the potential to affect the individual’s functioning throughout the life course (Erikson, 1968). Trauma can be repetitive or experienced “in multiple forms simultaneously” (Bussey &

Wise, 2007, p.4) and can lead to chaos, disorganisation and disconnection (Knafo, 2004). The findings of this project therefore support a small body of existing work (Castillo, Allen & Coxhead, 2001; Castillo, 2003; Fallon, 2003; Stalker et al., 2005) that indicates a relationship between personality disorder and traumatic experience, asserting the importance of empowering a more constructive response focused on supporting the person's reconnection with self, others and the world around them.

### ***Difficult and traumatic experiences past and present***

Five participants suggested that personality disorder relates to difficult and traumatic experiences. F (20-06-07) described learning to live with *"...just being really traumatised, and I actually learned to live with that, that was it"*.

A, S, C & H asserted a relationship to earlier trauma:

*I find it a very self-destructive part of my life. It is a part of my life where something has happened and it's like some shock therapy, something has happened way, way back that has now affected me in adulthood.* (H, 09-01-10)

One service user, A1, made a connection between past experiences as *"an ex-military man"* and Post Traumatic Stress Disorder (PTSD). Some service users described their lived experience of losing their children to Social Services.

### ***Loss & isolation***

Four service users (M, A, S2, S1) connected personality disorder with loss. Five participants (A1, S2, M, C, H) described how they felt or have felt isolated at times. C (09-01-08) described how he was personally very isolated. His life was so chaotic and *"out of control ... you know.... But no one really knew me"*. For some, isolation is more practical, as S2 (24-07-07) described: *"you tend to isolate yourself in your house"*.

Three (M, A, S2) described how they lost their children to Social Services.

### ***Intense and overwhelming emotions***

The data indicates that service users experience unusually strong emotions (Bussey & Wise, 2007). Five participants (A, S2, C, A1 & S) described their emotional distress. Three suggested that this can be difficult to manage.

The intensity can lead the person to express their distress in unconventional ways, as C (09-01-08) explained:

*It's how you deal with it. You generally become emotionally in turmoil, you become ....you don't know how to deal with your own emotions. You don't know how to express them in a way that is conventionally okay, for it to be acceptable.*

L “becomes a bit more impulsive” and does things to “the extreme”. It is apparent that extreme behaviours, such as self-harm, can help the person to cope with the intensity of the distress. Data from Phase 1 indicates how behaviours associated with such overwhelming distress can appear ambiguous.

### ***Risky behaviours; extreme and potentially unsafe***

Five service users described particularly risky behaviours; two (A & S2) described situations where others clearly felt at risk from them, as S2 suggested in her description of how two MHSWs may have thought she was about to use a knife on them, when she had intended to hurt herself. Three service users described less ambiguous scenarios of “wanting to kill someone”, of having a “helluva temper” and of having been a “bully” in the past, in trouble with the police, charged with criminal damage and serving time in prison. Comparing his behaviour with other people his age, C suggests that the intention behind the behaviour of someone with personality disorder can put them at risk,

*The problem with people with PD is if they go out and get drunk, it's because they are going out to block something out or... I don't know... to put themselves in a vulnerable situation*

These findings reveal that individuals can experience unusually strong emotions which can lead to extreme and unsafe behaviour.

### ***Projecting thoughts and fears***

F & A described how for them, personality disorder means responding to patterns established earlier in their lives:

*...because of this weird idea that I had from childhood that I've done something wrong ... I do know what it is, I don't deny I know what it is that I've done. So I kind of projected that on to the social worker and the psychiatrist that some magical way I ought to know what it all means. (F, 20-06-07)*

C (09-01-08) also described how he can project his thoughts and fears on to others,

*“I constantly had in my mind – and I think it’s a trait of PD – thinking they are going to harm me, they’re gonna ... and that was going through my head”.*

The findings also suggest that the person with personality disorder can experience symptoms similar to psychosis or, as F (20-06-07) said, periods of *“magical thinking”*.

**Magical thinking**

F, A, M, S1, C & H described experiences similar to psychosis. A described how terrifying these experiences can be. M (27-06-07) described how she hears *“voices and see – I call her Lady of the Moon”*. C related an experience just after the death of Princess Diana:

*One time I was delusional, when the late Lady Diana sadly died, I idolised her in a way, I idolised her to a point that it became delusional behaviour and I thought Earl Spencer was my brother when he made that speech at the funeral.*

**3.4. Research question 2: How service users understand MHSW practice**

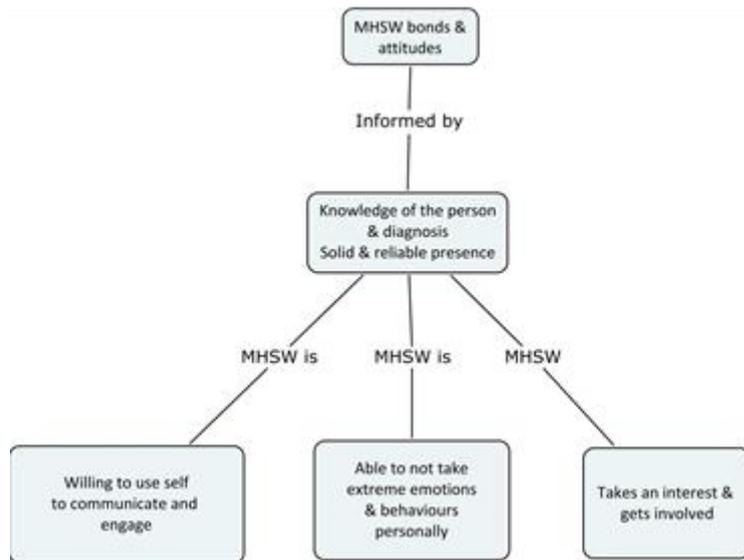
**Table 3.2: The relevant categories**

Category 5	Understanding practice; attitudes and bonds
Category 6	Understanding practice; support
Category 7	Service users’ perspectives; perceptions of MHSW can also hinder

**Category 5: Understanding practice; attitudes and bonds**

Figure 3.5 reflects data that indicates the importance of MHSW bonds and attitudes founded on knowledge of the person and their diagnosis. The diagram reflects the importance of the MHSW being a solid and reliable presence, willing to use self to communicate and engage who takes an interest in the person, gets involved and is able not to take the person’s extreme emotions and behaviours personally.

**Figure 3.5: Understanding practice: attitudes & bonds**



**MHSW needs to know quite a lot about the person**

The data from Phase 1 indicates how MHSW knowledge may need to incorporate the person’s current and past contexts. Five service users (S, A, H, F, S2) indicate how the MHSW’s willingness to “get the person” can help in building trust and support. S (27-06-07) tells how “...because I’ve been working with [a social work student] quite closely, she knows me”. As A said, when the MHSW knows her well “they help me more”.

MHSW should recognise how the person may have known Social Services or social work agencies for many years. Two service users (M & A) described how Social Services have always been there:

*“A family has always been Social Services, so in a way my relationship with the staff here is kind of family, if you look at the way my parents have always been the Social Services”. (A, 20-06-07)*

These findings resonate with those of Irvine (1996), who reports that 48% of service users with a diagnosis of personality disorder had been in contact with social services/social workers for most of their lives.

However, one service user questioned whether long-term involvement with professionals is always helpful:

*“They’ve perhaps always got a hold over you and will always have that for the rest of your life ... I’m not quite sure, you’re not in control of the life you lead. (S2, 24-07-07)*

### **....& the diagnosis**

Two service users (L & H) found that the MHSW's knowledge of the diagnosis complemented their knowledge of the person and vice versa. L (24-07-07) said that her MHSW:

*"...has known me for quite a while now and she does understand personality disorder. So she can deal with it. Whenever I say something outrageous or I've done something, she goes, "Oh, that doesn't shock me!" [Laughs].*

Knowledge and understanding are therefore important and it is possible that knowledge of the person and the diagnosis is self-perpetuating. Knowledge and understanding that generates the confidence and trust of service users may contribute to greater MHSW knowledge about the person and the impact on them of the diagnosis, and may also support the solid and reliable MHSW presence that some service users' value.

### **MHSW; Solid & Reliable**

Six participants (F, A, M, S1, L, & S2) suggested the importance of the MHSW as a solid and reliable presence. F (20-06-07) may mean this symbolically and in stark contrast to her less-than *"tangible"* self:

*"...somebody in the real world in my flat, giving a bit more reality to my flat, because, yes, I had friends, but not any who were doing something solid in the world".*

Some service users expressed the importance of such a presence in more pragmatic terms:

*"Yes, I just phone her up. If she's not in the office then they say she's not in the office and they leave a message for her to get in contact with me and she always does". (A1, 20-06-07)*

The importance for service users of a solid and reliable presence in a world that is otherwise chaotic and unpredictable (Bussey & Wise, 2007) is not surprising. Knowledge, understanding and presence are not enough, however. They need to be deployed through bonds that promote connections with the self, others and the world around. Some service users emphasise the importance of the MHSW's use of and active engagement with self and of not taking the person's attitudes or extremer or unsafe behaviours personally.

### **Bonds based on the use of self, respect & listening**

Eight participants (M, L, A, A1, S, S1, S2, H) emphasise the importance of MHSWs' use of self, respect and listening to facilitate communication. For M (27-06-7), how the MHSW *"comes across"* is more important than what they do. L (24-07-07) said,

*“I think they’ve got to come across ... For me, personally, the biggest thing is I’ve got to be able to communicate with them so they can’t do anything ...”*

Three participants (A, A1, S2) described how the MHSW used the self to engage. S2 described her current MHSW as *“an extremely nice lady and very sort of ... gosh, how can I explain it? I mean, they are always very calm when they speak to you...”*

Interestingly some service-user participants also stressed the importance of the MHSWs’ active engagement.

### ***Getting involved and taking an interest***

Six participants in total (S1, C, L, M, S2, L) clearly valued MHSWs who took an interest in them and “went the extra mile”. S1 (10-07-07) said,

*....if she was going to do something, she’d do it that day. And if she was with me ... she’d be on the phone with me. She got on the phone in my house, making that phone call, get it done there and then.*

One service user could not draw on such experience but suggested that things might have been different if she’d:

*“...had a stronger social worker and one that connected with me and understood my needs and wants...”*(H, 09-01-08)

MHSWs’ more active engagement would need to be supported by an ability to not take attitudes or ambiguous behaviour personally.

### ***Not taking it personally***

Three service users (L, A, S2) referred to this specifically; not taking ‘it’ personally can encourage safety, trust and therefore support, as A described:

*... she didn’t take it personally and it actually must have been good because I felt safe afterwards when I got to know her, to say what I thought, whereas before I would never have said what I actually thought.*

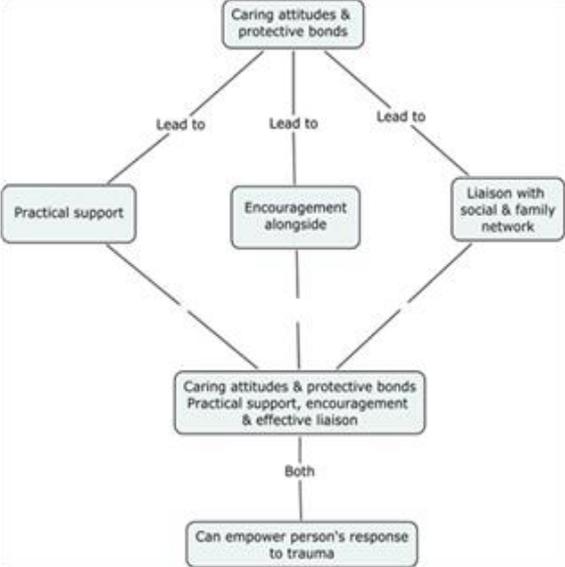
Bonds founded on knowledge of the person and the diagnosis, a solid and reliable MHSW presence, the MHSW’s use of self, interest and an ability not to allow him or herself to be affected personally are

important in his/her ability to support the service user. The next section reviews the value attached to practical support, working alongside the individual and the MHSW's effective liaison with the person's social, family and professional networks.

**Category 6: Understanding practice; types of support**

Findings from this research highlight the importance of practical support and encouragement for the person with personality disorder and an emphasis on the MHSWs' effective liaison with others, although service users tended to prioritise liaison with their family and social network, and MHSWs with professional colleagues. Figure 3.6 below reflects the data which suggests such broad social supports and more empathic, protective bonds can combine to encourage the person's more constructive response to trauma, through connection or re-connection with self and others.

**Figure 3.6: Attitudes and support to empower the person's response to trauma**



**Practical and working alongside the person**

Eight participants (F, A, A1, L, H, S, M, C) referred to the importance of practical support and of being encouraged to do something. Five (F, A, A1, L, H) defined practical support in relation to housing, benefit advice and help in getting out of the house. A (20-06-07) described how the implications of this have stayed with her:

*“But yes, she helped me and she’s actually helped me in a way that’s stayed with me to this day really, helped me to go out because I refused to go outside my front door, because I was agoraphobic”.*

While service users highlighted the importance of practical support in general, only three (A, M & L) included support with welfare benefits in this.

Some service users valued having an MHSW alongside them, being there and encouraging them.

### ***Working alongside the person***

Four service users (S, M, H, S2) emphasise the importance of having someone alongside them. M (27-06-07) elaborated on how the MHSW always seemed to be *“there ... to encourage me to get out and do things”*. Four participants (F, L, A & H) highlighted how the MHSW can help them to develop themselves and look forward, as someone who encourages them who they can learn from even when they are not physically present.

All participants see the importance of the MHSW’s liaison role, but service users appear to focus more on MHSW’s liaison with their network.

### ***Supporting the person’s network***

Six service users described the MHSWs liaison role positively. Three (C, H & F) were not so positive, highlighting an apparent lack of MHSW purpose. C (9-01-08) hints at how his MHSW’s liaison with the police was not so effective:

*“They liaise with the police – well, liaise – ... try to make them understand I had a mental health problem”.*

Three service users (A1, L, M), however, described how the MHSW’s liaison can be positive and promote their contact with others.

A1 (20-06-07) described how his worker *“has been helpful all the way through”*, helping him to receive direct payments and support from occupational therapy. L (24-07-07) described how the allocated MHSW communicates between her and her psychiatrist: *‘She won’t just go off and do it; she’ll let me know’*. L knows that the MHSW will speak to the psychiatrist even if she herself does not want an appointment: *“She’d leave it. She’d just explain”*.

The data reveals the importance of practical support with the MHSW alongside the individual and liaising with social, family and professional networks. More positive constructions of practice call for the recognition of the person’s humanity (Wright et al., 2007) and the impact of their experiences on their perceptions, emotions and actions. However, is apparent that service user perceptions of MHSWs can also hinder practice. This data will be described in the next section.

### ***Category 7; Service user's perspectives, perceptions of MHSWs can hinder engagement***

It is apparent that service users' perceptions of MHSWs can hinder the latter's ability to get to know and work with the person. Some service-user participants perceived MHSWs as threatening and frightening. S (27-06-07) explained:

*...I've always been a bit scared of social workers because I have had a childhood experience of social worker ... so that's sort of ... I've started putting my barriers up now ... I see them as a bit of a threat.*

Service users can be uncertain about who MHSWs are and what they do. This is perhaps exemplified by A & A1 (20-06-07) who blurred MHSW with CPN, as A1 did when asked whether there was an MHSW in the team that he can access:

*"Yeah, my CPN. She is part of the outreach team",* he then moves on to tell me that he saw her as a *"mixture of the two"*.

While three other participants clearly distinguished MHSW from CPN, they remained uncertain about who they were and what they did. S (27-06-07) said:

*"...I don't really know what [the MHSW] was supposed to do anyway. I'm still not quite sure what social workers are supposed to do".*

The data also suggests that notes and note-taking can be a feature of the more negative perceptions of MHSW. Three participants (S1, A, H) described how MHSWs' notes can encourage uncertainty and suspicion in service users. S1 (10-07-07) said that notes are what *"they think, not what I think. And there's the difference"*. The data suggests that there is a need for MHSWs to explain why they need to take notes and to involve the person in discussion about this.

It is apparent that the notes can be seen to represent a professional construction of the person that does not match the person's sense of themselves. This "data double" (Haggerty & Ericson, 2000) not only reinforces a negative construction of the person but can also contribute to a negative construction of the MHSW, which in turn hinders the latter's ability to work with the person. The data from Phase 1 indicates that MHSWs need to be aware of how they can be perceived as threatening and "scary", how service users can be uncertain about who they are and what they do and how their notes can raise suspicions and barriers to the MHSWs ability to work with the person. This data offers valuable insights into added hindrances over and above the agency processes highlighted in Phase 2, which need to be overcome if the MHSW is to empower the person's response to trauma.

The data from Phase 1 indicates the importance of knowledge, understanding and presence in practice. The latter may support more constructive bonds to inform MHSW practice in this area in general and in response to extreme and unsafe behaviours. The findings also highlight the importance of practical support, working alongside the service user and effective liaison to complement the relationship, and which together may promote the person’s connection with the self, others and the world around them. However, more constructive practice will require recognition of both the person’s humanity and organisational support for the MHSW to enable reflection, creativity and time to get to know and understand the person. I now consider the findings that suggest how practice might be better informed as represented in Figure 3.7 p.111.

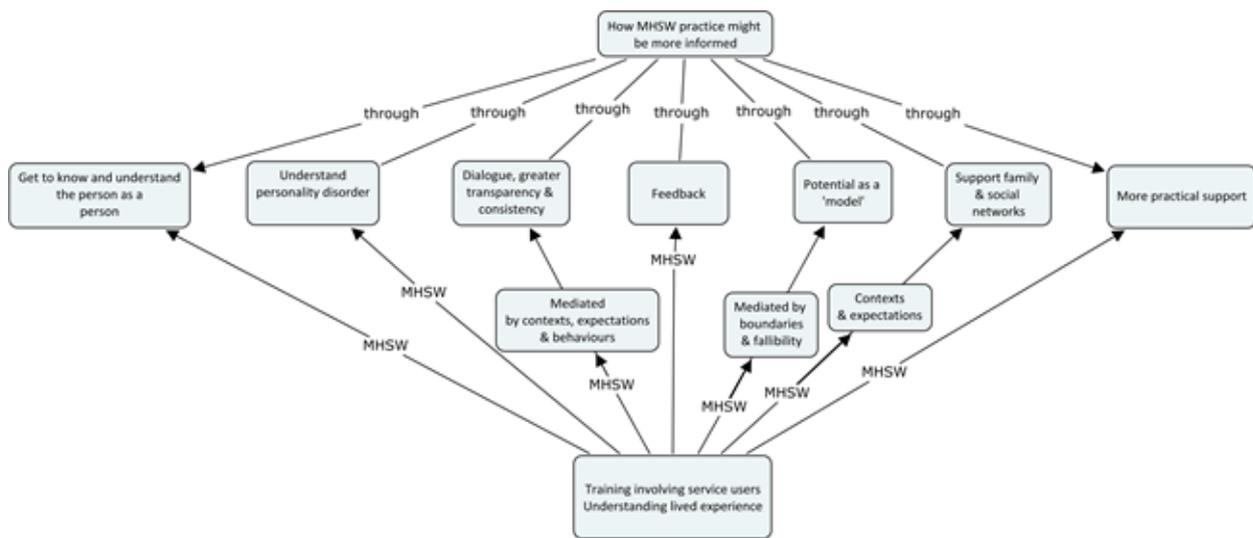
**3.5. Research question 3: Service user ideas about how practice might be better informed**

**Table 3.3: The relevant categories**

Category 8	Understand the person and diagnosis
Category 9	Feedback
Category 10	Modelling
Category 11	Transparency & consistency
Category 12	Supporting the person’s social and family network
Category 13	Practical support

Service users’ ideas about how practice might be better informed will be presented in this section. MHSWs responses to these ideas will follow, in the same order as above, in the second section of this chapter. Figure 3.7 represents the data from both phases of the research suggesting that practice might be better informed by understanding the person and the diagnosis, feedback, modelling, transparency and consistency, support for family and social network and more practical support. The diagram reflects certain mediators identified by MHSWs, i.e. how greater transparency and consistency may be mediated by context, expectations and behaviours; modelling mediated by boundaries and fallibility and support for the family and social network by contexts and expectations. The diagram suggests how one factor identified by MHSWs might help to better inform practice in this area: training involving service users as co-facilitators.

**Figure 3.7: How practice might be better informed**



**Category 8; Understand the person and diagnosis**

Service users suggested that practice would be better informed if MHSWs understood both the diagnosis and the person. Three service users emphasised the importance of the MHSW understanding the person, five (A1, S2, H, C, M) emphasised the importance of the MHSW’s understanding the diagnosis.

**Understand the person**

Three service users (S1, L, H) emphasised that MHSWs need to understand the person more.

*I think they have got to be in tune with that person, they have got to get to know that person’s needs and what that person needs to move on, not just push them to one side. Understand that person’s needs because personality disorder comes under a very broad umbrella and everybody has got a different personality part of their disorder, and you’ve got to know that person before you can help that person and support that person. And that’s what I think is the most important part that a social worker or a CPN or a place like the X needs to do, is to get to know that person before they can offer the support that they need. (H, 09-01-08)*

**Understand the diagnosis better**

A1 (20-06-07) said that MHSW would be improved by “more understanding”, crucially of “what you’re going through”. H (09-01-08) suggested that MHSWs need to understand personality disorder better;

*I think when mental health social workers do their training they should do more training on personality disorder ... so they've got more understanding of the diagnosis, because I don't think social workers fully understand personality disorders... ....if the social worker doesn't understand your diagnosis then they're no good to you.*

The findings of this project suggest that MHSW practice might be better informed by understanding the person and the diagnosis; seeing the person, appreciating their life history and actively engaging with them rather than dismissing them. Rapport is important and can facilitate the MHSW's understanding of what the person "is going through" (A1, 20-06-07), what the diagnosis means to the person and how it impacts on them. Through understanding and getting to know the person, their experiences and their experience of distress, it may be possible to avoid categorical and stereotypical responses and encourage a more humane attitude towards them. Participants also suggested that MHSW practice might be better informed through the provision of feedback.

### ***Category 9: Feedback***

Feedback is defined as both positive and constructively critical, including on what the MHSW has or has not been able to do. Some service-user participants suggested that feedback can help them to "self-develop" (A, 20-06-10). Two service users (C & H) felt that practice could be informed by more dialogue between service users and MHSWs in general.

### ***More feedback and dialogue- individual & collective***

Five participants (A, S2, C, H, L) thought that MHSWs could be improved through the provision of more feedback and dialogue with service users in general. A (20-06-07) said that "more feedback, to have more feedback" is required. Feedback would help A to "self-develop". S2 too stressed the importance of "feedback from the person about what I have actually said or how I'm actually feeling that week".

C and H (09-01-08) suggested that practice could be better informed by dialogue with service users in general:

*...a lot of the authorities, the heavyweights of the authorities, need to be brought forward, especially social workers, especially mental health social workers. They need to be in a panel, we need to have a panel of people with mental health, with PD, to ask questions, for them to be on the spot. Not to be humiliated or to be subjected to ridicule, but to have a discussion on what they can see could improve the way they move forward.*

Some service users suggested that practice might be informed by the MHSW recognising their potential as a model of what *“it might be like to live a normal life in the real world”* (F, 20-06-07).

Data from Phase 1 indicates that the MHSW has the potential to inspire just by *“being”*.

### ***Category 10: Modelling***

#### ***MHSW; capacity to model and inspire***

Three service users (F, S1, C) suggested that the MHSW has the capacity to model and inspire service users. F (20-06-07) described how the MHSW gives a *“bit more reality”* to her flat, and how:

*...a consistent solid person who is not going to rescue you or anything or necessarily be brilliant when you are sobbing or whatever, but just that kind of giving you, if you don't have it yourself, giving you an experience of what it could be like to lead a normal life almost by example...*

C's (09-01-08) description of a negative experience suggests that things could have been more inspiring:

*I wouldn't say there's nothing in my head that has been an inspiration to me ... Yeah, I mean if they turned round and said “OK, I've got something lined up for you”, you know, “we are going to take you down to...*

Interestingly, these findings are limited to MHSWs and do not reflect how individuals further along the road to recovery can also inspire and model the possibility of recovery and leading a more *“normal life”* (F). Feedback and modelling together might help the person to move on.

### **Category 11; Transparency and consistency**

Data from Phase 1 indicates that practice would be better informed through greater transparency and consistency.

#### **Transparency and consistency**

S1, S2, L, C suggested that practice needs to be more consistent and transparent. S1 (10-07-07) considered consistency important because she is a person “*who wants to get on with my life. I do have other things to do...*”

C (09-01-08) suggested a lack of transparency on MHSW’s part at times,

*I think they were kind of... I think they a bit prejudiced in a way. I kinda think they had their own notion. Maybe they thought I was untreatable, maybe they believed in their head that I was untreatable, thats what they would have said in the ... but they didn’t say that to me.*

### **Category 12: Supporting the person’s social and family network**

Some service users identify MHSW support of their family or social network as important.

#### **Support for family and social networks**

Three participants (L, S2, M) suggested that MHSWs need to develop rapport with the person and their family and/or social network. Without such support at the appropriate time, the consequences for the person’s family can be significant. S2 (24-07-07) described how her daughter was not supported when she first became ill; consequently she now:

*....wonders whether she’ll get the same sort of problems as what her mum’s got. And that can be a worry, can’t it? For any children, I suppose, but when a mum or dad has got that, “Am I going to get that?”*

Consequently SD is seeking support with being rehoused, partly because her daughter, now an adult, struggles to return to the house in which she grew up and where her mother still lives.

### ***Category 13; Practical support***

The findings suggested that practical MHSW support should definitely be retained.

#### ***More of the practical***

Three service users (F, A, S) suggested that practice would be better informed by more practical support and by the MHSW working alongside the service user. A (20-06-10) said that *“being helped to get out in society more”* is important. F (20-06-10) made concrete suggestions about being supported:

*“... going to the supermarket, getting on a bus, any of these practical things is the issue, and they are very practical ways that the social worker could help”.*

This concludes the data from Phase 1 describing how service users understand personality disorder, MHSW practice and how practice might be better informed. The findings from Phase 2 will be described in the next section. The key points of this chapter, relating to the research question and the emerging theory will be summarised on page 151.

## Section 2; Interviews with MHSWs

### 3.1. Research question 1: how participants understand personality disorder

**Table 3.1: The relevant categories**

Category 1	“It resists singular explanation”
Category 2	Understanding the response to personality disorder
Category 3	Perceptions of the Other; MHSWs on service users
Category 4	Understanding personality disorder as a response to trauma

These findings highlight MHSWs’ experiences and ways of knowing personality disorder and MHSW. The presentation of the findings is the same as the first section and so reflects the emerging theory and starts with the core category, “It resists singular explanation”. Category 3 indicates how such negative understandings of the diagnosis can mean MHSWs hold negative constructions of service users. Category 4 reveals participants’ understanding of personality disorder as a response to trauma. Anonymous terms, i.e. “they” and “it” have again been retained to maintain a proximity to the data.

#### ***Category 1: “It resists singular explanation”***

The data in this category relates to Figure 3.1 on p.92 and so I refer you to that page for the diagram with its narrative explanation. The data reveals MHSWs’ perspectives about how personality disorder resists singular explanation and how it can be confused with other diagnoses. Some MHSWs offer explanations for this confusion. Some suggest that difficulties in understanding can mean that professionals get ‘stuck’. In spite of these difficulties some suggest that personality disorder needs to be explained to the person.

#### ***It doesn’t fit the medical notions of diagnosis and can be confused***

Two MHSWs (BS, BB) suggested that while personality disorder is situated in the medical model, it “...doesn’t sit well in the medically-driven notion of the diagnosis...” (BB, 1-12-10). BS (16-03-10) said that this is because “...it’s not something that is necessarily caused by a chemical imbalance, something biological, physiological, whatever you want to call it”.

Three MHSWs (RT, JA, LB) saw personality disorder as relating more to lived experience and how “individuals have to negotiate their way through life” (LB, 24-11-10).

Four MHSWs (BB, BS, LB, JD) suggested that personality disorder can be confused with other diagnoses:

*“...very often it’s because the people were diagnosed too late, so many patients we’ve seen have been diagnosed as having recurrent depression or similar types of depression”. (BS, 16-03-10)*

### ***Personality disorder doesn't fit treatment assumptions***

With the definition of treatment apparently restricted to medication, two MHSWs (BB, KH) suggested that personality disorder does not fit the treatment assumptions of the medical model, tablets or other drugs founded on the assumption that the doctor “...makes you better” (BB, 1-12-10).

Three MHSWs (BB, KH, SD) considered that the “drugs don't work” (BB)

Two MHSWs (BB, JA) suggested that the inefficacy of medication can add to professional fear and inefficacy. MHSWs suggested that confusion about personality disorder arises from ideas that it sits on a continuum of either personality or illness/disorder and that a number of theoretical interpretations can “shed light” or “obscure” (BB) and compound its complexity. Two MHSWs believed that personality disorder can improve over time.

### ***Its complexity makes it hard to understand***

Reflecting debate about the definitions of illness and disorder (Kendall, 2002), three MHSWs (JA, SD, JD) saw that personality disorder sitting on a continuum. JA implied that it sits between illness and disorder. JD and SD suggested a continuum of the personality:

*“We've all got personalities; we could all be seen as having a disorder because what I might think is perfectly ok, something might think, “Oh, that's a bit odd of her”. (SD, 18-05-10)*

Disorder is defined in DSM IV TR (American Psychiatric Association, 2000) as deviancy or conflict with the state symptomatic of a mental dysfunction. However, as this research suggests, it is difficult to conclude with any certainty that personality disorder is indeed a result of mental dysfunction. Tallis (2006) argues that personality disorder relates to observed behaviour and is not a testable organic dysfunction. Such debate adds to the complexities that surround the diagnosis, making it more difficult to understand and further impairing professional confidence.

Four MHSWs (BB, JA, TC, MB) suggested that the diagnosis' complexity can impair professional confidence and understanding:

*....could be a factor in why people find it difficult because it is a complex illness, so it might be some people ..... may feel conscious that they don't want to do something to make it worse, or they don't feel confident in what they're doing, so... (TC, 7-09-11)*

Two MHSWs (RT, JA) described their belief that personality disorder can be surrounded by urban myths

*“...there’s various that might turn out to be urban myths, but tend to be supported by clinical experience, that is the idea that it’s got a pathway that tends to ameliorate over time”.* (JA, 12-05-10)

Findings suggest the complexity of personality disorder and consequent confusion and partial understandings arise, with consequences for MHSWs. Some MHSWs end up *“going round in circles”* (SD, 18-05-10).

### ***“We can’t do anything about you”***

Indicating the difficulties in understanding personality disorder, two MHSWs (SD, KH) described how confusion can mean that professionals get *“stuck”* and left without any *“clear-cut answers”* (SD, 18-05-10). This can have consequences for the person, who might pick up on the professionals’ feelings of inefficacy and their tendency to make the person responsible:

*“ Feel that it’s them that’s wrong, you’re wrong, and we can’t do anything about you, it’s you as a person, that’s what it is, you know, so we try to sometimes call it something else...”* (KH, 13-04-10)

### ***Personality disorder needs to be explained (MHSW)***

Despite confusion and difficulties in understanding, two MHSWs (BS, KH) said that the diagnosis needs to be explained:

*“...unless you explain to them what that means and what can be done about it, its better you just didn’t tell them”.* (BS, 16-03-10)

This is interesting given that nine service user participants had not received a meaningful explanation of personality disorder. The data in this category reflects some of the consequences of the confusion and uncertainty surrounding personality disorder. MHSWs and mental health professionals may feel ineffective and therefore make the person responsible for their own distress. The confusion that surrounds personality disorder encourages doubt and uncertainty which in turn encourages the professional to seek distance from the person. The next category describes some of the professional responses to the person with personality disorder.

### ***Category 2: Understanding the response to personality disorder***

The data in this category reflects how the person with personality disorder can be distanced by mental health services, mental health professionals including MHSWs. The data that follows builds on data of Category 2 in the first section of this chapter and the reader is referred to Figure 3.2 on (p.95). This category reveals MHSW interpretations of why the diagnosis is not seen as the business of mental

health services. MHSWs' views of stigma are considered before the section moves on to report MHSWs' descriptions of service users as the Other. One MHSW suggested that the stigma surrounding personality disorder is no different from that which surrounds other forms of mental disorder.

### ***Personality disorder; not the business of mainstream mental health services***

KS (1-06-10) listed three types of professional response to the person with personality disorder: resignation, fear, and denial of personality disorder as a mental illness. This was supported by data from other MHSW participants.

#### ***Resignation ... heart sinks***

Reflecting S2's comments on professional resignation, four MHSWs (KS, JA, SD, LC) suggested that professionals resign themselves to the person with personality disorder:

*"Heart sinks ... yeah, generally [my] heart sinks with a smile and I can live with it; "Oh, it's that person again". (KS, 1-06-10)*

#### ***Frightened and helpless***

Three MHSWs (KS, BB, JD) felt that people with personality disorder conjure fear, helplessness and inefficacy in the professional:

*In the profession there's a bunch of different ways of responding. Most of them are to do, I think, with that sense of inefficacy that working with these people brings about in professionals. And that's the fear that that brings. (BB, 1-12-10)*

JD (24-10-11) suggested that the person can "get built up into being this big ogre to be feared", perhaps as a threat. BB asked "...what do we do with threats? We turn away from them". Fear and inefficacy can lead to denial of both the person and the disorder.

#### ***"Personality disorder is not a mental disorder..."***

KS (1-06-10) reflected:

*... that causes me a lot more concern is the old school is still around that says personality disorder is not a mental disorder and we shouldn't have them on the wards, we shouldn't be offering too much of a service to them...*

Six MHSWs (BS, KH, SD, RT, LC, JD) supported this view:

*“...there are definitely still those that think that people with personality disorder aren’t the business of mainstream mental health services and that it’s best just to keep them out as much as possible”. (BS, 16-03-10)*

LC suggested that the person becomes lost and is dismissed as a problem, a nuisance to be told to “*just go away, we’re not going to deal with this*”. Stigma was mentioned by some MHSWs as particularly associated with personality disorder.

### **Stigma**

Five (BB, TC, SD, JA, LC) reported that personality disorder carries a particular stigma, which two (JA, LC) related to the media. Others suggested it stems from the diagnosis’ second-class status. TC (07-09-11) thought that:

*...the stigma of people with personality disorder is a bit of a bit of a hindrance because they’ve always been seen as like secondary to people with like a proper mental health illness, like someone with schizophrenia or bipolar...*

However, two MHSWs (LC, BB) questioned whether a particular stigma does surround personality disorder. Possibly contradicting her earlier comment, LC (25-05-10) suggested that it is no different from that which surrounds schizophrenia:

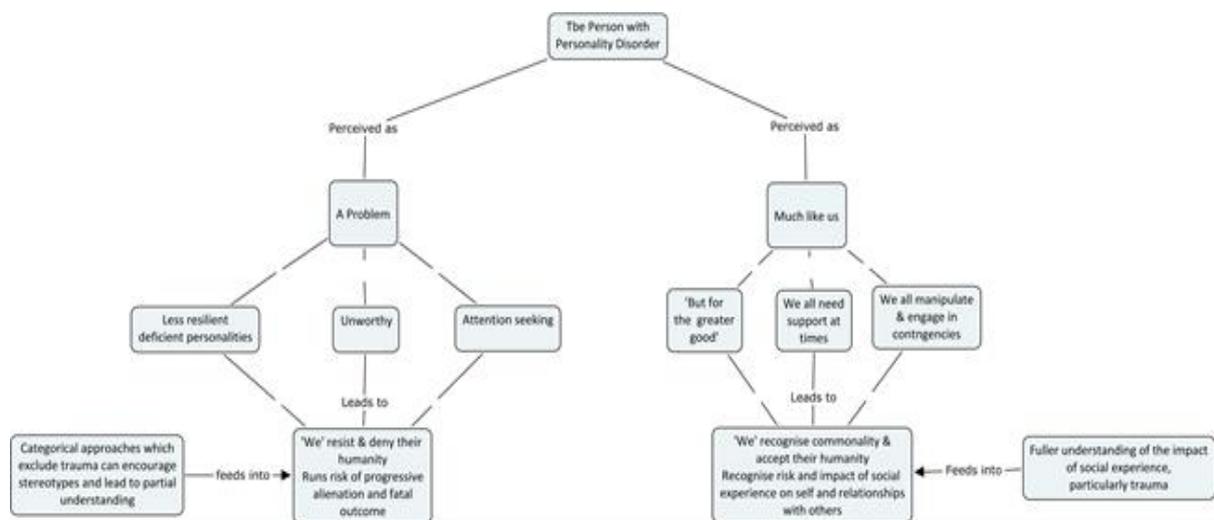
*Yeah. It’s like any labelling though, there’s issues about whether or not there is a way of saying that someone’s got schizophrenia. There’s no genetic causes, no medical tests that you can take, i.e. bloods or, to say that you’ve got schizophrenia, so it is about labelling people and how that impacts on their life really.*

While MHSW participants’ interpretations of the relationship between stigma and personality disorder are a little varied, the data indicates that there might be a particular stigma surrounding personality disorder consequent to the confusion which surrounds it. Partial understandings (Diamond et al., 2003) risk stereotypical attitudes and responses (Prentice & Miller, 2007). Stigma may also be a factor in MHSWs’ reports of professional resignation, fear and helplessness and the denial of personality disorder as a mental disorder. Category 3, below reminds us of how such responses can contribute to the construction of the person with personality disorder as Other, as a problem to be defended against.

### Category 3: Perceptions of the Other; MHSWs on service users

While this category reminds us of how the person can be perceived as markedly different, as the Other and a problem to be defended against, it also suggests ways in which they are “much like us” (BB, 1-12-10). Figure 3.4 below portrays both perspectives. The left-hand side of the diagram represents MHSW findings that the person can be perceived as a problem: less resilient than others, unworthy and attention-seeking. The right-hand side of the diagram represents MHSWs who emphasised our commonality as human beings; in that we may all experience traumas and be in need of support; as we are also all capable of manipulating others and engaging in contingencies. Indeed one MHSW suggested that it is commonality rather than difference that makes “[being] in a room with these people really difficult” (BB, 1-12-10). Understanding the impact of social experience, and particularly trauma, on the lens through which the person views the self and others encourages greater recognition of our commonality and “shared humanity” (Simon, 2007). These findings therefore reflect literature that highlights the need to understand the person in more humane and empathic ways (Little, Trauer, Rouhan & Haines, 2010; Wright et al., 2007).

Figure 3.4: Perceptions of the Other: MHSWs on service users



Below I begin with MHSWs’ reports of how the person can be seen as a problem before moving on to consider participants’ more positive constructions based on commonality rather than difference.

#### “They” are distinctly different

Two MHSWs (BS & KS) suggested ways in which the person with personality disorder is distinctly different from “us”: they are less resilient and have deficiencies in their personalities. As KS suggests,

*'...someone who's personality is not necessarily strong, it's got zones where it's more liable to fracture under particular stresses than other, where the person hasn't perhaps managed to integrate the different aspects of what make up a strong adult personality or what they have integrated is actually flawed, maybe from the result of abuse or a missing parent or other early circumstances'*

It is apparent that MHSWs may feel the need to 'defend' which can compound the person's sense of apartness and add to their construction of them as a problem, risking further alienation.

### ***The person as a problem***

Eight of the MHSWs (all but KS, RT, TC, SD) report how the person can be perceived as difficult, failed, problematic (KS), unworthy and attention-seeking (MB). JA (12-05-10) set a context for this when he described how personality disorder has always been associated with difficulty:

*"...just used to be an appellation that was attached to patients that you might otherwise call difficult".*

One MHSW suggested that defence against such difficult "problems" can be at the individual or the organisational level:

*...And I do think that the organisation has encouraged that on the one hand we don't offer them any explanation for why they are like that, and then we say to them, But you're not ill" and yet they know they are always in chaos. (LB, 24-11-10)*

Some MHSWs, however, suggested a need to recognise that the person with personality disorder views themselves and the world around them through a particular lens that can lead to extreme reactions. It is therefore necessary that the MHSW separates the person from the behaviour.

### ***Different lens, different reactions***

JD (24-11-10) described the person's lens:

*That's because he has had rejection, abuse and neglect, that's the lens that he's looking through, so will interpret people's reaction as rejection. Because of early experiences rather than "they think I'm independent and need to make my own choices". He won't be looking through that lens but through the lens of rejection and neglect.*

Four MHSWs (JA, RT, KH, JD) described how this can mean that the person develops “different ways of coping to maybe what the mainstream might do” (KH, 13-04-10). Separating extreme and unsafe behaviours from the person may be the first step in recognising commonalities rather than difference.

***“They are much like us”***

Some MHSWs saw our commonality as human beings. It might be just a matter of chance that “we” are not “them”, and as BB (1-12-10) suggested, “...but for the greater god...it could have happened to anyone of us”. “They” are perhaps not experiencing anything that we cannot or have not experienced. Moreover, we all need support at times in a pressured world and we can all engage in contingencies and manipulate others. Interestingly, one MHSW suggested a particular similarity between service users and social workers,

*I mean PD, people with PD have a bad rap in the news because they always publish the stories where somebody with PD has gone on a knife rampage, so it's the same with social workers, social workers who have done something wrong are always in the paper, you never see a social worker who has done something right in the paper... (TC, 7-09-11)*

These findings suggest why MHSWs may feel the need to defend themselves against the person with personality disorder. We are unlikely to engage readily with someone we perceive as markedly different, difficult, failed, problematic, unworthy and attention-seeking. However, the findings also suggest the importance of appreciating our uniqueness and commonalities as human beings, and to recognise the impact of the person’s experience and how this affects the lens through which they view themselves and the world around them. The importance of the lens is accentuated by findings that suggest that service user and MHSW participants understand that personality disorder is related to traumatic experience which has disconnected them from the self, others and the world around them.

These findings begin to reveal how MHSW participants understand personality disorder as something that defies a singular explanation and approach and that this can inadvertently stimulate negative responses to the person. A focus on difference can lead to negative and reciprocal constructions of the Other, and alienation with consequent implications for practice, as discussed later in this thesis. However, these findings also suggest our commonality as human beings, understanding the impact of experience on the ways in which we view ourselves and the world around us. The data indicates that this lens takes on greater significance when, as participants suggested, personality disorder can be understood as a response to traumatic experience. The next section will reveal how MHSW participants understand personality disorder as a response to trauma.

#### **Category 4: Understanding personality disorder as a response to trauma**

This data reflects MHSWs' perspectives on personality disorder as a response to trauma. Figure 3.5 is again relevant and I the reader to p.100 for both diagram and narrative explanation. Similarly this data reflects themes of traumatic past experiences, loss and isolation, distress which is overwhelming and difficult to manage, patterns and projections and magical thinking.

##### **Difficult and traumatic past experiences**

Eleven MHSWs (KH, JA, BB, RT, LC, JD, LB, TC, MB, BS, KS) connected personality disorder with difficult or traumatic past experiences, defined as childhood sexual abuse (KH 13-04-10), physical and emotional abuse (JA 12-05-10). One MHSW (JA) suggested a relationship between certain forms of abuse and certain personality disorders. LC (25-05-10) described how personality disorder:

*...seems to stem from some trauma: most of the service users I've worked with who have been given a label of personality disorder have had quite difficult childhoods: there's been abuse on some levels, both emotional and sometimes physical and sexual.*

Such experiences can lead to extreme behaviours, as JD (24-11-10) suggested,

*...often the roots of those are from early childhood experiences, traumatic childhood experiences. And it leads to them perhaps taking sort of extreme action such as threatening suicide or self-harming, responding in various sort of aggressive disproportionate ways to requests...*

One MHSW connected personality disorder with PTSD:

*"I didn't understand the impact, didn't understand either for a long, long time about the trauma aspect. I know it's part of PTSD". (KH, 13-04-10)*

Some MHSWs report that personality disorder can mean loss of the family, loneliness and isolation.

##### **Loss and isolation (MHSWs)**

Five MHSWs (BB, SD, KS, JA, TC) connected personality disorder with loss. Loss may be a constituent of personality disorder as well as a consequence. SD (18-05-10) described her understanding:

*...of somebody with personality disorder is my own perception of somebody who has missed out a big chunk of their life somehow at the very beginning ... I think something happened during their*

*life that's formed the way that they carry on to live their lives and how they cope with normal daily activities.*

JA (12-05-10) distinguishes between actual loss and the fear of it. Other MHSWs described actual loss, as here: *"She's got no family, she's basically on her own"* (TC, 07-09-11). Some MHSWs suggested ways in which they might respond to such behaviour in practice, as I describe later in this chapter. Below are MHSWs' thoughts about how the person's distress can be overwhelming and difficult to manage.

### ***Distress; overwhelming and difficult to manage (MHSWs)***

Seven MHSWs (KH, RT, LC, BB, LB, JD, JA) reported that the individual's distress can be complex, frightening and overwhelming:

*"Personality disorder for me means someone who has got very complex needs, they've got interpersonal difficulties, very impulsive, emotionally unstable, can't tolerate stress, can't tolerate relationships..."* (LB, 24-11-10)

There may be an intensity that is difficult to manage, as RT (04-05-10) suggested:

*"Personality disorder first and foremost to me means having a problem with managing your emotions, and that particular problem is large for certain people".*

Seven MHSWs (BS, KH, SD, LC, LB, TC, MB) connected personality disorder with extreme behaviours, which may be a means by which the person is trying to cope. All seven MHSWs discuss risk in this context, with some distinguishing between particular and global risk:

*I think there are always risks around the sort of enormous emotions that ... I associate with personality disorder and they're sort of global, so there are some particular risks about the person harming themselves either deliberately or accidentally and then there are whole risks to a person's whole life style and potential to grow and develop.* (RT, 4-05-10)

Three MHSWs provided examples of types of global risk and of how distress can lead to chaotic and tumultuous lifestyles involving *"drink, drugs, sex, police-type problems"* (BS, 16-03-10). One MHSW reported on how the risk to self may be greater than that to others,

*The information that even the psychopathic, drug-using, alcoholic, knife-wielding people are still more at risk from themselves than they are to other people. A very high proportion of them kill*

*themselves .... and usually hang themselves in prison or something like that ... But that actually doesn't get promulgated. (JA, 12-05-10)*

The data also suggests how the person's behaviour can be ambiguous, involving patterns, projections and experiences similar to psychosis.

### ***Patterns & Protections***

Four MHSWs (BB, JA, KS, JD) mentioned how that individuals can establish patterns of behaviour that can be "deep-rooted" (JD) and involve projection. KS described a pattern that he might help to unpack:

*...something I've had regularly over the years. Someone comes and they've said something like, "All this person did was cut me up in the car park, I got out of the car and I was screaming at them and I was shouting at them and I was furious..." So in those cases we would unpack that, look at understanding where it's come from, why they are like that.*

### ***Magical thinking***

Similarly KH, JA, KS, BS suggested that individuals can face experiences similar to psychosis. KH (13-04-07) described how:

*"Sometimes people will experience flashbacks and hallucinations as well almost, having similar sort of experiences to people who have experiences of psychosis, like hearing voices".*

The findings in this category suggest that MHSW participants also understand personality disorder as a response to traumatic experience which involves loss, isolation, overwhelming emotions, intense and risky behaviour, patterns and projections and experiences similar to psychosis. These findings underline the importance of understanding the person's social experience and its impact on the lens through which they see themselves, others and the world around them. An appreciation of our commonality as human beings and understanding the impact of experience, particularly traumatic experience, might help MHSWs to take a broader, more empathic view and empower a more constructive response to trauma. MHSWs should be capable of appreciating the impact of social experience on the person's relationship to self, others and the world around them (Keys & Lambert, 2002). I now consider MHSWs' responses relevant to the second research question, before moving on to discuss their ideas about how practice in this area might be better informed.

**3.4. Research question 2: How MHSWs understand practice**

**Table 3.2: The relevant categories**

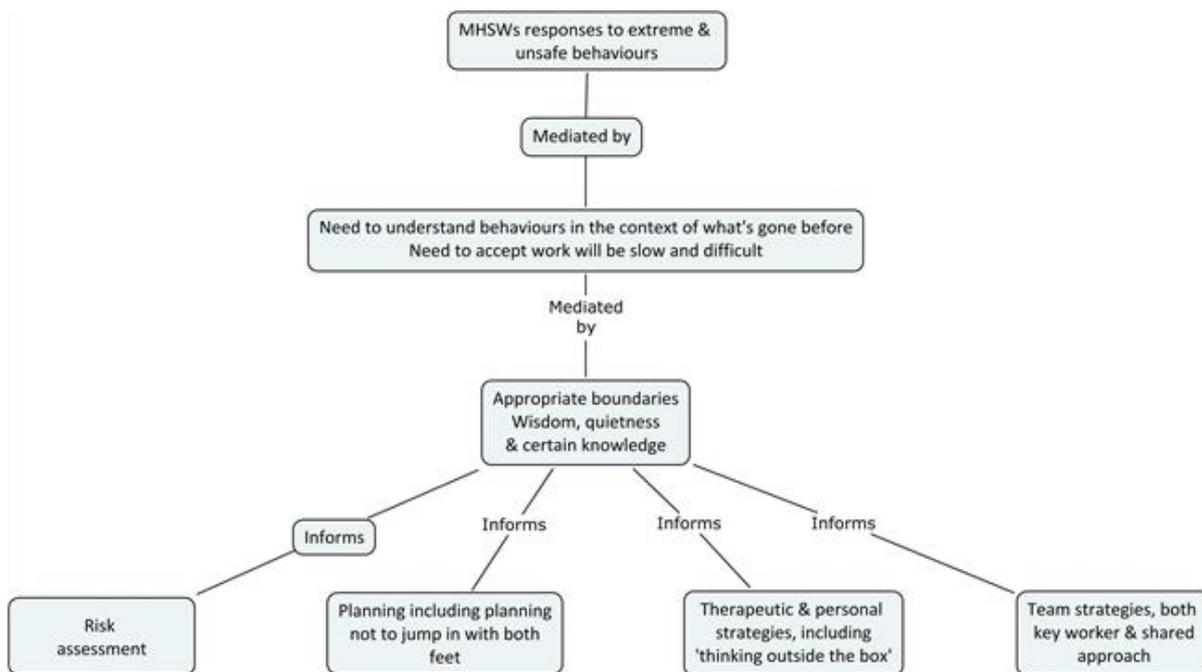
Category 5	As a response to extreme and unsafe behaviours
Category 6	Understanding practice; attitudes and bonds
Category 7	Understanding practice; support
Category 8	MHSW perspectives on what helps and hinders practice

The next section first describes MHSWs’ responses to the extreme and unsafe behaviours associated with personality disorder. This is followed by a consideration of findings that suggest that MHSWs perceive practice as a combination of attitudes, bonds and interventions that may incidentally empower the person’s response to trauma and promote connections between the person and those around them.

**Category 5: Practice as a response to extreme & unsafe behaviours**

Some service users in Phase 1 described extreme and unsafe behaviours. Data from Phase 2 offers insights into how MHSWs might respond to such behaviours through risk assessment, planning, therapeutic and personal strategies and specific team approaches. Figure 3.6, on p.128 sets out how such responses are mediated by a need to understand the person in the context of what has gone before and some acceptance by the MHSW that the work will be difficult and slow. The diagram reflects data which suggests that the MHSW’s wisdom, stability, certain knowledge together with appropriate boundaries can inform risk assessment, planning, personal and team strategies in response to the person’s extreme and unsafe behaviour.

**Figure 3.5: Responses to extreme & unsafe behaviours**



**Understanding behaviour in the context of what has gone before**

Eight MHSWs (BB, JD, KS, LB, LC, RT, TC, MB) mentioned the importance of understanding the person in the context of their experience and the need to validate and understand “*what’s made them what they are*” (TC-07-09-11). LC (25-05-10) said:

*...it’s about understanding where they’ve come from and what their life experiences have been. I think it’s really important to get a lot of history, as much as you can, in order to be able to work effectively with somebody.*

**Acceptance**

Five MHSWs (BS, JA, JD, KH, MB) implied that a degree of acceptance is required. MB says how she

*‘... accepts sometimes that they are very difficult to engage with or sometimes we’ve put a lot of work into this and just trying to change or help them to adapt their behaviours*

JA (12-05-10) explained that the work can be slow and require perseverance, and sometimes there is a need to accept that “*there is nothing more I can do*”.

### **Risk assessment**

Six MHSWs referred to risk assessment; five (JA, JD, KH, LC, SD) suggested that this can be informed by knowledge of the person, as JD (24-11-10) related:

*“...we can’t assess the risks particularly accurately because we can’t see where this person’s going and where their thought patterns are going either”.*

JA and SD described how their own personal strategies have helped with assessing and managing risk JA explained how in order to do both:

*“I [have] had to get into very close therapeutic relationships with people who were really quite dangerous and disturbed for many years. I worked out lots of little strategies that helped me engage with them...”*

One MHSW suggested that there is a need to take positive risks *“in a risk-averse culture”* (RT, 4-05-10). Some participants described the importance of plans that encourage boundaries and responsibility.

### **Planning, and planning not to “jump in with both feet”**

Having a plan that has been formulated with the person previously and sticking to it can help also the MHSW’s response to ambiguous and unsafe behaviours, as KH said:

*And also have an understanding of each of those peoples’ actual plans and actually to feel, I can say I feel quite confident to say to someone: “Well, you need to call yourself an ambulance then, don’t you?” you know...*

Three participants (JA, KH, SD) felt the importance of not *“jumping in with both feet”* (SD- 18-05-10).

JA (12-05-10) uses a *“put the kettle on”* metaphor,

*“I think it’s a sort of opposite to a manic defence ... like in a crisis, put the kettle on, sort of thing, you know”.*

The data indicates the importance of the MHSW remaining calm, being there, evidencing *“wisdom, quietness and certain knowledge”* (JA).

However, one MHSW questioned whether plans really help the person in crisis:

*...when they are at their worst, in chaos, we start referring to a care plan. And, say, when you're in chaos now you wanna go out and take your dog for a walk. And they can't hear us, they can't hear it ... So we don't validate them in any way. Because if I was really distressed about something and you told me to go for a walk [whispers] I'd want to kill you. (LB, 24-11-10)*

One participant (RT, 4-05-10) suggested that not every service involved will always “hold the contract” with the person.

Some participants (BS, JD, KH, MB) described how transparent, firm and professional boundaries need to be established with the plans. MB (7-9-11) emphasised the importance of the MHSW establishing boundaries with the person within this; JD, 24-11-10 suggested that it is important that the person understands where the boundaries lie:

*“...that people have an understanding of where the boundaries are and a lot of the message of what we are trying to drive home to them is”*

The findings also indicate how therapeutic, personal and team strategies can be utilised in response to ambiguous behaviours.

### ***Therapeutic and personal strategies***

Six MHSWs (BB, BS, JA, KS, TC, MB) referred to therapeutic approaches, and some aspect of DBT is mentioned by four of these (BB, BS, TC, MB). JA described how he has used certain assessment tools, i.e. HONOS and CORE and how he has framed his work with one person with Cognitive Behavioural Therapy (CBT), particularly using positive connotation, but then questioned whether this is always appropriate:

*But if you try to positively connote the fact that he's now been diagnosed with non-Hodgkin's lymphoma for five years and the average life expectancy of someone who is diagnosed is five years, and he's not dead yet. Is that a good sign or is that a bad sign?*

KS (1-06-10) described how he has used a number of approaches, referencing the work of Tolly in relation to his work with two service users, one of whom he mentions here:

*...simultaneously we have found an understanding with him of where that came from, and then start looking at well, how do you put this away, how do you work with that anger, how do you get*

*beyond, and him we looked at, strengthening his sense of adult self ... Eventually he began to find forgiveness for his father who had abused him.*

Two MHSWs referred to the personal strategies they employ in their response to the person. SD described how she “*thinks out of the box*”. JA described a number of personal strategies including “*paradoxical interventions*” i.e. telling someone he is the “*best catastrophic thinker*” he has ever met.

### **Team strategies**

Three MHSWs (JA, KH, LB) reflected on different individual and collective team strategies. JA (12-05-10) described how he worked in a team where the response to the person with personality disorder was channelled through one person:

*So if we got a phone call from A&E liaison saying so-and-so has turned up and they've got marks round their neck and this that and the other and blah blah blah, and we'd said tell them to ring X next time he's in ... I mean do it all through X, but X would have this other, wider team behind him, supporting the hell out of him.*

However, KH describes how her team has a duty system that can impair consistency,

*...we find ourselves sometimes in a bind here because we have a duty system, so we might be wanting to work with somebody on building up their resilience, and by saying “OK, you can give me a call but we're gonna have just ten minutes but because there's a duty worker here that person can always just come along and see somebody..*

LB described a particular approach to arranging 48/72-hour crisis admissions in her team, with the service user at the helm:

*“...we've been quite successful in that, doing 48-, 72-hour admissions, you know with them at the helm. With them taking control of those admissions, you know”*

Interestingly, the practice described by LB reflects Deegan's (2001) argument that recovery, if it is to be a truly transformative process, requires the service user to be in control of their healing. Optimism about the person's strengths and resilience might underpin more rewarding collaborations between them and the MHSW, even when responding to the person's more extreme and unsafe behaviours. More generally, the data from Phase 2 suggests that practice should be contextualised by an accepting

mindfulness that informs risk assessment, planning, therapeutic and personal and team strategies. Data from Phase 2 also suggests the importance of practice that incorporates bonds and support, promoting connection rather than alienation.

### ***Category 6: Understanding practice; attitudes and bonds***

I refer the reader to Figure 3.7 on p.104 for a diagrammatic explanation of the data in this category indicating the importance of MHSW bonds and attitudes founded on knowledge of the person and their diagnosis; the importance of the MHSW being a solid and reliable presence, willing to use self to communicate and engage, who takes an interest in the person, gets involved and is able not to take the person's extreme emotions and behaviours personally.

#### ***The MHSW needs to know the person***

BB, JA, LC, JD, MB said that the MHSW needs to know the person and that this can encourage a better-informed response, as it is not possible to work in honest and transparent ways unless *“you really know the person”* (JA):

*... asking them how this affects you, having that basic, well you would think its basic knowledge so that you can then work, so that if they are presenting in a certain way it's knowing what's happening. For a lot of our patients when their mental state deteriorates – it could be around anniversaries, significant events – ... knowing them, knowing risks to them, to other people, risks to yourself as well ...* (MB, 7-09-11)

Participants also highlighted the importance of the MHSW understanding the diagnosis and its impact on the person.

#### ***... and the diagnosis***

BS, KH & RT mentioned the importance of understanding the diagnosis and its impact on the individual. KH (13-04-10) *“totally agrees”*, as this enables the MHSW to *“actually spend some time working through how it affects them and why”*.

MHSWs also suggested the importance of respect, use of self and active interest in the person and their situation.

### ***Respect, use of self, communication and active engagement***

Four MHSWs (KS, JD, LB, BB) highlighted the importance of a relationship based on mutual respect. For KS (1-06-10):

*“... the very first thing I try to provide is a positive relationship where they experience actual stability and to a large degree, approval, and that constancy is there before anything else”.*

Three MHSWs (KH, KS, LB) described how they use their own experiences and feelings appropriately in their work. LB (24-11-10) uses her experience:

*“So I quite often, although I tend not to talk about [myself], they don’t know anything about my family, sometimes I talk about [how I might act] in situations”.*

KH (13-04-10) revealed how she uses her own feelings:

*“...what has helped me is really just that knowledge, to try and understand my own feelings about them and how I might kind of echo what they’re experiencing , and try and use that and feed it back”.*

Two MHSWs emphasised the importance of communicating and engaging. Four (LC, KH, JD, SD) stressed the importance of not dismissing the individual but actively engaging with them:

*“Once upon a time I thought dismissing it you just weren’t accepting that somebody was struggling, but now it is about, “Yes, I’m acknowledging that you’re doing it: what’s happened now that’s started the behaviour again?” (LC, 25-05-10)*

Three service users suggested the importance of MHSWs not taking ‘it’, their distress and extreme thoughts and behaviours, personally. Only one MHSW commented on this, acknowledging how she tries but how this can be very challenging,

*“... I can let a certain amount go over my head and I don’t take it personally what they’re saying”.*  
(LB 24-11-10)

This data reflects the importance of the bond. The next category reflects data which suggests that broad social supports are important to the person with personality disorder.

### ***Category 7: Understanding practice; types of support***

The data in this category is reflected in diagrammatic form on p.107. MHSWs also report on the importance of supporting the person in practical ways, working alongside the person and supporting their social and family network, although MHSWs focus more on their liaison with professional colleagues.

### ***Practical support and working alongside the person***

Eight MHSWs (KH, SD, LB, RT, KS, JA, LC, TC) referred to the importance of practical support. KH (13-04-10) said:

*“So in social work, never underestimate the power of doing something practical with somebody”.*

Only two, however, (BS & KH) included support with welfare benefits in the definition of practical support. RT, LB, & KS described how practical support can lead the MHSW to support the person in other ways. LC (25-05-10) suggested that it can help to renegotiate power in the relationship and, interestingly, was the only MHSW to suggest that it is increasingly difficult for MHSWs to offer practical support,

*“I think it’s really important, but it’s fallen by the wayside a bit because we were talking actually ... there was a time when we did an awful lot of more practical stuff than we do now”.*

The data indicates, however, that support should be alongside rather than “doing it for them” (KH, 13-04-10). Four others (KS, TC, LB, SD) agreed as KS (1-06-10) described:

*...I’ll sit with them and say “Go on, I’ll sit with you while you make the call” and as we struggle with it, it might be “OK, I’ll dial”, and they come back, come back, come back until we get something they can do and they succeed. So there’s always that push towards them being competent, but it’s always the support is there as well.*

### ***Liaising with colleagues and other professionals***

Three participants (KH, MB, TC) emphasised liaison between the person and another professional. KH (13-04-10) described how this can mean that she can:

*...go back and say, “Remember what doctor so-and-so said to you? Go and give that a try and then maybe you can call me back if things like that haven’t worked this afternoon” or something. So it’s just to reinforce and keep that door of communication wide open all the time.*

MB (&-09-11) described the frustrations that can occur in this work:

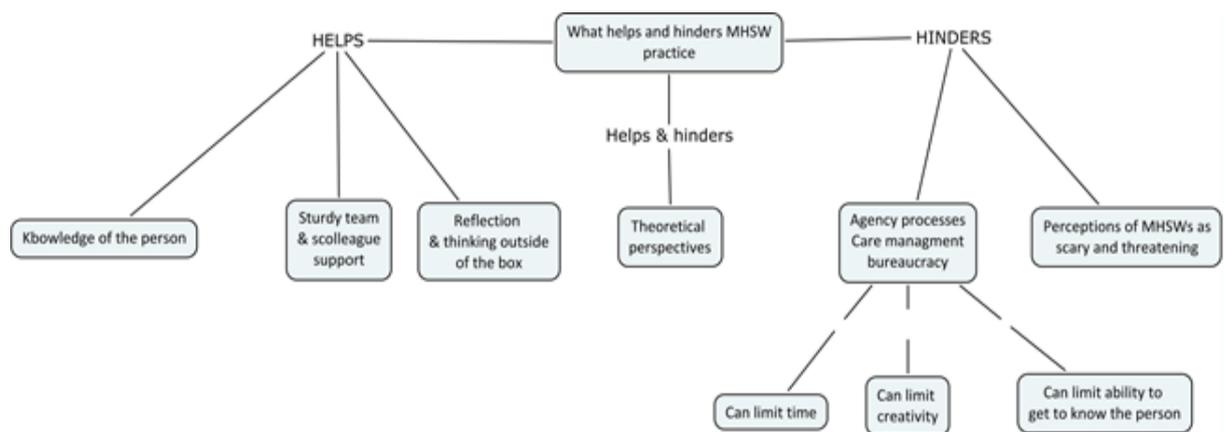
*...obviously you're relying on other agencies to do their bit and sometimes your harassing other agencies to say "Well, this person hasn't seen their children in like x amount of time" –so it can be frustrating...*

This data reveals the importance of broad social supports, which together with more empathic, protective bonds, might empower the person's more constructive responses to trauma. The next category indicates how more positive ways of relating and supporting the person with personality disorder require structural and organisational support and perhaps even change.

**Category 8: MHSWs' perspectives on what can help and hinder practice**

Figure 3.9. below reflects factors which both help and hinder practice in this area. Factors which help: knowledge of the person, the support of colleagues and a "sturdy" team, individual and collective reflection and "thinking outside of the box" (SD) are represented on the left hand side of the diagram. The numerous theoretical perspectives surrounding personality disorder it appears can both help and hinder understanding and so this is represented in the middle of the diagram. Factors which appear to hinder; agency processes, care management, bureaucracy and service users perceptions of MHSWs as scary and threatening are represented on the right hand side of the diagram.

**Figure 3.6: What can help & hinder practice**



**Theoretical perspectives**

Some MHSWs (BB, BS, JD, KS, TC, MB) described how their practice is framed by such theoretical perspectives. Two participants (BB, JA) suggested that the plethora of theoretical perspectives

surrounding personality disorder can encourage unhelpful professional attachments and different ways of responding:

*There's so many different theoretical perspectives; all of these shed some light on it from one perspective and another perspective will shed a light on it and another and each of those will shed lights on one part of the problem and obscure the other part of the problem. (BB, 1-12-10)*

JA (12-05-10) reported that professionals can become very attached to these different and competing interpretations:

*"...differing ways and interpretations of what's the best way to work for it. People actually get very attached...."*

Some participants articulate a clear sense of how agency processes can hinder their work, as indicated on the right-hand side of Figure 3.9.

### **Agency processes**

Six participants (BS, KH, SD, KS, LC, LB) described how agency processes, care management and bureaucracy can limit MHSWs' time, creativity and their ability to get to know the person. MHSWs generally focus their attention on care management and agency bureaucracy. Some participants indicated how they *"could do a lot more without [care management]"* (BS, 16-03-10), which turns MHSWs into *"glorified admin workers"* (KH, 13-04-10). Bureaucracy more generally was perceived as limiting time, curiosity and creativity and the MHSW's ability to engage in preventative work. As LB 24-11-10 explained:

*...it takes away old fashioned curiosity. You know, being curious as to why they're behaving in that way, you stop thinking about that because you just fill in your boxes, and you wonder at the end why you don't actually know anything about these people. So that's a real hindrance.*

KS evaluated the impact of *bureaucracy*

*...the biggest problem at my door, especially now, is having time. The more and more we are being drowned in paperwork the bureaucracy, the last study I did a few years ago, just a quick hand study, 60% of my time is being used up on data entry and paperwork, background phone calls and*

*letters and I feel the pressure's got even worse, more and more, myself particularly, but coming from discussion with the team, getting contact time with the patients is getting harder and harder.*

While these findings are from Phase 2, data from Phase 1 indicates that service-user perceptions can also hinder the MHSWs' ability to engage and work with the person. Some service users described feeling threatened and uncertain of who MHSWs are and what they do. It The "notes" raise particular suspicions and can make them reluctant to work with MHSWs. MHSWs therefore need to be aware of how they can be perceived by service users and how these perceptions can impair their ability to engage them. This data offers valuable insights into added hindrances over and above the agency processes highlighted by the MHSWs themselves.

The next section will consider the findings relating to the final research question, how practice might be better informed.

**3.5. Research question 3: MHSW responses to service user ideas about how practice might be better informed**

**Table 3.3: The relevant categories**

Category 9	Understand the person and diagnosis
Category 10	Feedback
Category 11	Modelling
Category 12	Transparency & consistency
Category 13	Supporting the person's social and family network
Category 14	Practical support
Category 15	MHSWs' ideas about how practice might be better informed

This section will consider MHSWs responses to service user ideas about how practice might be better informed. Please see Figure 3.10 on p.111. The data will be presented in the order of the categories above.

**Category 9: Understand the person and diagnosis**

While many of the MHSWs agree with the need to understand both person and diagnosis, priorities are different. Interestingly, the service users and the MHSWs prioritise each aspect of understanding differently. MHSW appear to attach greater priority to understanding the person, with nine expressing support for this opinion.

### ***Understand the person first and foremost***

Nine MHSWs described the importance of understanding the person first and foremost (JA, KS, SD, LC, LB, MB, BB, RT, TC).

BB (1-12-10) said:

*“Understanding the diagnosis is really a small part of working with someone. I mean you need to develop a formulation that relates directly to that person”.*

Underlining the importance of experience and its impact on personality disorder, TC (7-11-11) said,

*...it is very important to understand the person just as much as the diagnosis, because at the end of the day the diagnosis has come from what has happened to the person through their life, so you’ve got to kind of understand the bare bones of somebody to understand everything that’s gone on and what’s made them what they are.*

Three service users concurred with these MHSWs’ emphasis on understanding the person first and foremost. While no MHSWs prioritised the need to understand the diagnosis over the person, four (JD, BS, KH, RT) suggested a need for a balanced understanding of the diagnosis and the person.

### ***Understand the diagnosis and the person***

BS (16-03-10) exemplified the need for a balanced understanding in this quote,

*...that’s the two things I want to achieve in an assessment: I want to understand them and I also want to connect that with the diagnoses they’ve been given. First of all to see if it’s correct, because we do check that, because we do our own tests, you know if we think a diagnosis is wrong we do challenge it; and also to help them, to share with them my understanding of what that may mean in their context because of who they are.*

One MHSW expressed surprise at service users’ emphasis on understanding the diagnosis, but then, evidencing some educational authenticity, thought again and said,

*I can understand that because it has been used as quite a denigrating term and yet if you’ve actually been diagnosed you might not feel it’s the stigma; you might just be relieved that*

*somebody's sort of given a name to this chaos that your caught up in, and so they can have very positive feelings about it, so yeah, I can understand that.* (RT, 4-05-10)

While priorities may be different, this data indicates that MHSWs see the relevance of understanding both the person and the diagnosis. The next section will consider MHSWs' responses to the idea that practice might be better informed by feedback.

### ***Category 10: Feedback***

The data revealing MHSWs responses suggests that the context of feedback is important and that the complexities of MHSW practice would need to be considered. Some MHSW participants agreed, however, that feedback can be positive or constructively critical and can include feedback on what they themselves have not done. Four MHSWs agreed that feedback can help the person develop. One MHSW felt that greater dialogue between service users and MHSW is required.

#### ***Context and complexities in feedback***

Perhaps because it can be difficult to do, and not everyone *"likes the praise"* (KH, 13-04-10), two MHSWs suggested that feedback might be appropriately offered on a one-to-one basis, in a *"good relationship"* (JD, 24-11-10), although later in his interview JD suggested that the Care Programme Approach (CPA) review is also an appropriate vehicle for feedback.

Six MHSWs elaborated on the difficulties in giving feedback and on why *"we don't [give feedback]"* (SD). The data indicates that MHSWs might be reluctant to give feedback because *"to do it properly is quite a skill"* (BS), and as KH & KS suggested, *"you can come across as being really patronising"* (KH). Time is also a factor in both delivering the feedback and completing the task in the first place. Genuine feedback may not be possible in services based on *"rush, rush, rush"*, and if it is not genuine, service users can *"feel fobbed off and they feel that their problems are minimised"* (BS). Interestingly, one MHSW suggested that positive feedback can be deliberately *"...disingenuous because you are hoping that it will become self-reinforcing"* (JA, 12-05-10). For two MHSWs (LB, LC), giving feedback can be *"tricky"* because it depends on where the *"person is at"* (LC)

While contexts and complexities need to be considered, the data indicates that practice might be better informed by the provision of positive and constructively critical feedback, with some MHSWs agreeing that it can be a tool for helping the person to move on.

### **Definitions....positive & constructively critical**

Six participants (LB, RT, JA, SD, MB, TC) had a positive association with feedback, as LB (24-11-10) described:

*I'm just thinking about each visit as I go along. It tends to start with whether they've been going out, whatever they've been doing, blah blah blah, if they've been getting out a little bit more, if they've been going to college, they would be "Oh that's really good, that's really positive.*

However, positive feedback can be difficult for the person to hear and challenging for the MHSW to give. Three MHSWs (RT, KS, MB) suggested that feedback can also be constructively critical about the person and about their own actions, as MB explains,

*...and I will always explain, I will always say I have not been able to do it but I hope to do so, or if I've left a message .... Or if I was in the process of doing something it's about keeping them updated.*

One MHSW saw feedback as a two-way process:

*...being honest and open about the behaviour. It's ok saying "Well, I don't like that behaviour", but it's also, you have to listen to what the service user is saying in order to help them reduce the behaviour, so it's a two way thing really. (LC, 25-05-10)*

Despite these contexts and complexities, some MHSW participants concurred that feedback may inform practice and help the person to move on.

### **Help the person move on**

Five MHSWs (KH, JD, RT, SD, MB) suggested that feedback can help to normalise a situation and help the person to "feel that they are doing something right" (MB, 07-09-11). JD (24-11-10) said it is:

*"...vital that feedback is given to them on a regular basis so they do understand where they are at, you know, in terms of the process of moving on".*

The data suggests that positive and constructively critical feedback may help the person to move on. Feedback needs to be contextualised by knowledge of the person, the particular situation, where they feel they are at and the skills and confidence of the social worker. MHSWs might benefit from skills

training in the delivery of positive and constructively critical feedback. The data indicates that in the context of understanding personality disorder as a response to trauma and loss, including lost opportunity, providing feedback may promote the person's self-development and learning and therefore help them to create a more constructive response to traumatic experience. Practice may thus be informed through the provision of feedback to the person with personality disorder.

### ***Category 11: Modelling***

While data from Phase 2 supports the idea of the MHSW as a model, four MHSWs (BS, LC, JA, LB) expressed clear doubts about the appropriateness of this. Doubts are associated with the need to maintain firm boundaries, their own fallibility and how differences in lived experience can undermine the MHSW's capacity to model. However, some agreed about their capacity to model, seeing it as connected to the professional MHSW role and the MHSW's use of self. One MHSW suggested that this modelling capacity is not exclusive to the MHSW.

#### ***Doubts about the MHSW as a model***

The need for clear boundaries for some participants clouds MHSWs potential as a model, as LC (25-05-10) suggested:

*...it's quite a difficult question in some ways because it's about boundaries as well, and that's quite a big responsibility to take on; and we're there as a professional and they'd have to tell me what they want from that.*

Perhaps related to the quote from RT in the next section, two MHSWs (JA, LB) suggested that fallibility and differences in lived experience can compromise MHSW's modelling potential. Two (JA, LB) stated that there is nothing unique or "superhuman" (LB, 24-11-10) making social workers "...uniquely capable individuals living a straightforward life in a complicated world..." (JA, 12-05-07).

Some MHSWs were more positive than others about MHSWs' potential to act as models.

#### ***Potential of modelling***

Six MHSWs (KS, LB, KH, SD, JD, BB) agreed about MHSWs modelling capacity. For some modelling seems to be integral to the MHSW role, especially as MHSWs are their "own tools of the trade really, it is up to us" (SD, 18-05-10). BB (1-12-10) revealed his strong support:

*"Absolutely, I agree, I agree. Modelling and the relationship as a space to be able to try out new, different ways of relating is really important".*

KS, KH & RT elaborated on this, suggesting that modelling can aid normalisation, although RT (4-05-10) sounded a note of caution in relation to differences in experience and power:

*It's part of the normalising, I think. It's difficult, isn't it, because we're all different ages and things so I am not sure entirely, yeah, I guess everything you're doing is sort of modelling how to look at a problem for instance, and how to manage feelings and being honest about...*

JD (24-11-10) saw the capacity to model as “*not exclusive to social workers*”.

These findings indicate that MHSWs have unrecognised potential to inspire simply by being solid, reliable and professional, focused on maintaining empathic attitudes and protective bonds (Downie, 2011, pp.23-35) with vulnerable people. Maintaining an effective professional bond would not jeopardise professional boundaries or set up false expectations about the MHSW; it would simply mean that the MHSW is working and responding to the person with personality disorder as a professional (HCPC, 2012), and by so doing, offering opportunities for them to learn different ways of viewing themselves, others and the world around them. The data also indicates some MHSW support for the idea that greater transparency and consistency would inform practice in this area.

### ***Category 12; Transparency & consistency***

Data from Phase 2 indicates agreement in principle with service user ideas that greater transparency and consistency would better inform practice, however a number of MHSWs suggested that these are not ‘*simple goods*’ (BB, 1-12-10) and that both can be limited by context and expectations of self and the service user. However, some MHSWs supported the necessity for greater transparency and consistency in practice with people with personality disorder.

### ***Limits to transparency and consistency***

While two MHSWs (BB, JA) questioned whether MHSWs should aim for consistency in the inconsistent world with which service users are “*going to have to cope*” (BB, 1-12-10), others (LC, SD) suggested that context and expectations can limit the MHSW’s ability to be both consistent and transparent. LC (25-05-10) thought that consistency:

*...is quite tricky because if the social worker for example goes off sick, or leaves or is on leave, if that person is experiencing a lot of emotional stress at that time and is acting on trying to manage, it's a lot of work, you could be pulled away.*

SD (18-05-10) said that professional expectations can limit transparency:

*Yeah, yeah, well I think we do have a need to be transparent, we need to be honest, and I think quite often, yep, I put my hands up, not really honest with the person, you know sometimes I feel like saying I'm really stuck here, come on, can you help me out, because I don't want them to feel that "Oh well, if you don't know what do to, I'm the person that's suffering. What do you think I'm going to feel like if you tell me that?"*

Three MHSWs (BS, JA, LB) questioned whether the service user actually wants consistency, as JA does here:

*I would say that not every patient wants you to toe a straight line, all the time ... they want to be able to know that they are having some sort of impact on you; how do they measure that they are having an impact on you unless you change your responses or behaviours in certain circumstances? (JA, 12-05-10)*

### ***Importance of transparency and consistency with colleagues***

Interestingly, three MHSWs (SD, JD, RT) suggested the importance of transparency and consistency with colleagues, as JD said:

*"...so that we all sing from the same hymn sheet, essentially, so that the approach to this individual is consistent".*

### ***Support for greater transparency and consistency with service users***

Six MHSWs (KH, RT, LB, TC, MB, SD) express definite support for consistency and transparency. MB (7-09-11) said that to be anything else *"is not really fair"* and TC (07-09-11) agrees that it is fundamental:

*Well to be perfectly honest, it's kind of what you should be doing with everybody and anybody really, not just somebody with personality disorder, you shouldn't lie to them, you should be straight with them and keep them up to date with any information, you know, if you don't know something you tell them you don't know something but you'll try your hardest to find out the information for them. I try to always get to my appointments on time.*

One MHSW pointed out how different contexts can demand different levels of transparency:

*I think you have to be extra, extra transparent with a young person who's got a diagnosis. I was just thinking of somebody I work with, I used to have contact with the family, and recently this person mentioned to me "I expect you will be contacting the family", and I said "No, I haven't had any contact with the family for a long time, you probably know this, and I won't be contacting anybody, and if they contact me I will listen", and she believed me because she's got trust in me, but at one point she wouldn't have believed me. But I've been over-transparent really. (RT, 4-05-10)*

The data indicates that practice might be informed through greater consistency and transparency. However, it is important to recognise how different contexts and expectations, including MHSWs' perceptions of service-user expectations, can limit both in practice. In a world that can be chaotic and disorganised (Knafo, 2004), however, it is not surprising that some service users value consistency and transparency. The data indicates how MHSW practice might be able to respond to such needs and therefore help to empower the person's response to trauma.

### ***Category 13: Support for the person's social and family network***

As with the previous category, the findings from Phase 2 suggest that many MHSWs agree in principle that practice might be better informed by support for the person's family and social network, but feel that this work can be "tricky" (JA, 12-05-10) with questions about how "we facilitate that" (LC, 25-05-10). Again contexts and expectations need to be considered, as do practical and administrative issues, resources and confidentiality. Three MHSWs (SD, TC, MB) agreed about the importance of the MHSW supporting the person's social and family networks.

### ***Contexts and expectations of supporting family & social networks***

Four MHSWs (JA, SD, LB, RT) saw supporting family & social networks as very "context-dependent" (JA), and it is apparent that the contexts of this type of work are perhaps already "tricky" enough. RT, LB, & SD described how the MHSW is quite often "working in the dark" (SD) in relation to social and family networks. LB (24-11-10) suggested that involving or working with someone's family can make the MHSWs life easier on the one hand and more complicated on the other:

*"... makes my life so much easier if we can maintain family involvement. But we are often talking about parents that have been abusive"*

Contexts of practical, administrative and resource issues can also make the work tricky. JD, LB & LC suggested how these contexts can limit the MHSW's ability to support the person's contact with their family. LC asks:

*"...where do we have family meetings? Often families are working, so that would have to be in the evening. Are there members of staff who are prepared to work with you as a safety measure?"*

Some participants pointed out how differing expectations can make the work tricky. Others (RT, JA, LC, MB) suggested that it is necessary to negotiate expectations on both sides, as RT (4-05-10) described:

*"... work out how they want those relationships to be, and sometimes comment on what was healthy and what didn't feel so healthy, and enable them to reflect on what might be happening".*

JD (24-11-10) highlighted *"confidentiality issues and so forth"*, acknowledging that he got himself into *"deep water"* when trying to facilitate contact between the person and their family.

#### ***Positive support for family and social networks***

Three MHSWs (SD, TC, MB) were more positive about the MHSW supporting the person's family and social networks. One is a carer practitioner, but all three see this kind of work as fundamental in the social work role. MB (7-09-11) said that it is:

*"...quite a big role really for us because obviously we get parents who may not have seen their children or because of how they were when they were in the community they..."*

The data indicates some support for MHSW supporting the person's family and social network. While this might encourage the person to connect with others, it is evident that such work would need to take account of different contexts and expectations, including those of the MHSWs themselves and the organisation they work for. The data also indicates support for MHSWs maintaining a focus on practical support.

#### ***Category 14: Practical support***

In response to service user ideas about how practice might be better informed through practical support, some MHSWs agreed and indeed one reported that he increasingly worked with people in more practical ways.

One MHSW described how he was trying to work with individuals in practical ways:

*“...I’m no longer trying to change them, I’m trying to help them cope with what happens in their life ... now it’s more about enhancing the capabilities that are under there, that are more helpful to them”. JA (12-05-10)*

The last six categories have detailed MHSWs’ responses to service user’s ideas about how MHSW practice might be better informed. Data from Phase 2 revealed MHSWs’ own ideas about this.

### ***Category 15: MHSWs’ own ideas about how practice might be better informed***

Data from Phase 2 reveals how some MHSWs believe that they have potential in an area *“where the medical model has little purchase”* (BB, 1-12-12). Three MHSWs (RT, JA, SD) question whether personality disorder should come within the remit of the mental health services at all:

*Well I suppose really you have the diagnosis, personality disorder, I don’t know if you should be under the care of a community mental health team so, but then it’s accessing resources isn’t it? ... I just don’t think it should be under the care of mental health teams. (RT, 4-05-10)*

A majority of MHSWs suggest that in addition to more time and resources, specialised training in personality disorder is required. For some, this training should involve service users with personality disorder. Research has indicated that practitioners find such training meaningful and that it can add value (Balen, Rhodes & Ward, 2010).

### ***More meaningful training***

Eight MHSWs commented on training, three (KH, LC, SD) pointing to positive aspects of the training they have received. The five others (BB, RT, JD, SD, LB) suggested how their training might have been made more meaningful. Training is required and needs to be more focused on qualifying and post-qualifying levels, as LB (24-11-10) and SD (18-05-10) suggest:

*.. very different to when we work with schizophrenia, but we’ve never been trained to work with personality disorder. We’d have training to work with schizophrenia and bipolar disorder; there was masses of it but nothing for personality disorder. That’s why I set up this forum in our area.*  
(LB)

*“... when I was actually training to be a social worker we had no special training, you then come and work for Community Mental Health Team(CMHT) and we become jack-of-all-trades really”.*  
(SD)

The data indicates how more specialised and focused training should include people with the diagnosis. Five MHSWs (SD, LC, JD, MB, TC) suggested that training involving service users as facilitators would aid understanding, making the diagnosis more “real” for them (MB), and could make a difference, as TC (7-09-11) suggested:

*Yeah, I think it would help the service users as well, again to kind of get to know the individuals involved in their care and it might give them some hope that if they're facilitating the information, and that this group of people that they're training is actually going to pay some attention and actually going to work a bit different.*

One MHSW described how she already worked very effectively with a service-user consultant who had done “training with me” (LB, 24-11-10).

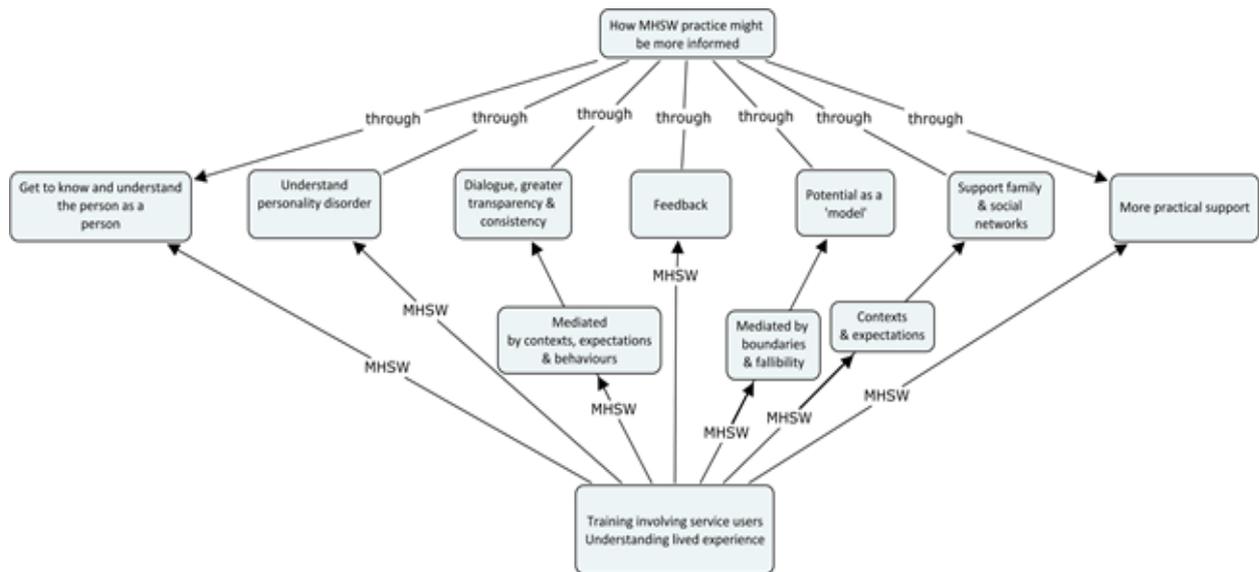
#### **Other ideas about training**

One MHSW suggested that parents/carers should be trained in supporting someone with a personality disorder. KS (1-06-10) felt that “training for social workers with a social approach” would be beneficial. LB (24-11-10) thought training should be “basic” to help MHSWs understand the impact of traumatic experience on the individual:

*... I want to start at the beginning, more basic ... The basic stuff, such as for someone with personality disorder cancelling a visit is catastrophic to them, that's when they'll self-harm because you let them down like everyone else ... training that helps practitioners to understand why people get diagnosed with personality disorder, that these people aren't born like this, that these people have had traumatic pasts. I would like training that looks at attachment, to help them understand that.*

MHSWs suggested that MHSW has potential in this area which might be enhanced with specialised training in personality disorder, possibly involving service users with the diagnosis. Service user involvement might help to make the diagnosis more “real” and support MHSWs’ understanding that service users with personality disorder may just be responding to trauma, with all the disconnection that this entails.

**Figure 3.6. How MHSW practice in this area could be better informed.**



### **3.6. Concluding summary of findings;**

#### **How practice might be better informed**

This chapter has set out the data which answers my research questions. The answer to the third question is depicted in Figure 4.11 above which reminds us of service users’ ideas how practice might be better informed through knowing and understanding the person and personality disorder; greater transparency and consistency; feedback; modelling; supporting the social and family context and more practical support. In general there is some agreement across service users and MHSWs about how these ideas might better inform practice. However, the data indicates a need for attention to the different contexts and complexities of practice, particularly in relation to transparency and consistency and supporting the person’s social and family context. However, the answer to the question of how participants understand personality disorder legitimates the importance of such features in practice. Appreciating personality disorder as a response to trauma, recognising the chaos and disconnection that trauma can cause (Bussey & Wise, 2007) would inform MHSWs’ understanding of why such types of support might be valued by the person with personality disorder.

#### **How participants understand personality disorder & MHSW practice: the emerging theory**

Findings from both phases indicate how participants understand personality disorder as a response to traumatic experience. The impact of this experience is clear: the person can experience unusually strong emotions and engage in extreme and unsafe behaviours, causing them to feel disconnected from the mainstream. MHSW practice is in part a response to such risky, potentially unsafe and ambiguous behaviour. However, the data indicates the importance of practice based on positive attitudes and

support which encourage the person, are practically orientated and promote effective liaison to support connection. This is suggestive of the emerging theory as described in detail on page 155 and 152. At its core this theory suggests that humane, empathic responses and broad social supports can empower the person's more constructive responses to their own experience. The theory suggests that MHSWs' particular skills in working with the person in their environment means the profession has a unique role to play in a more balanced and holistic response to people with personality disorder.

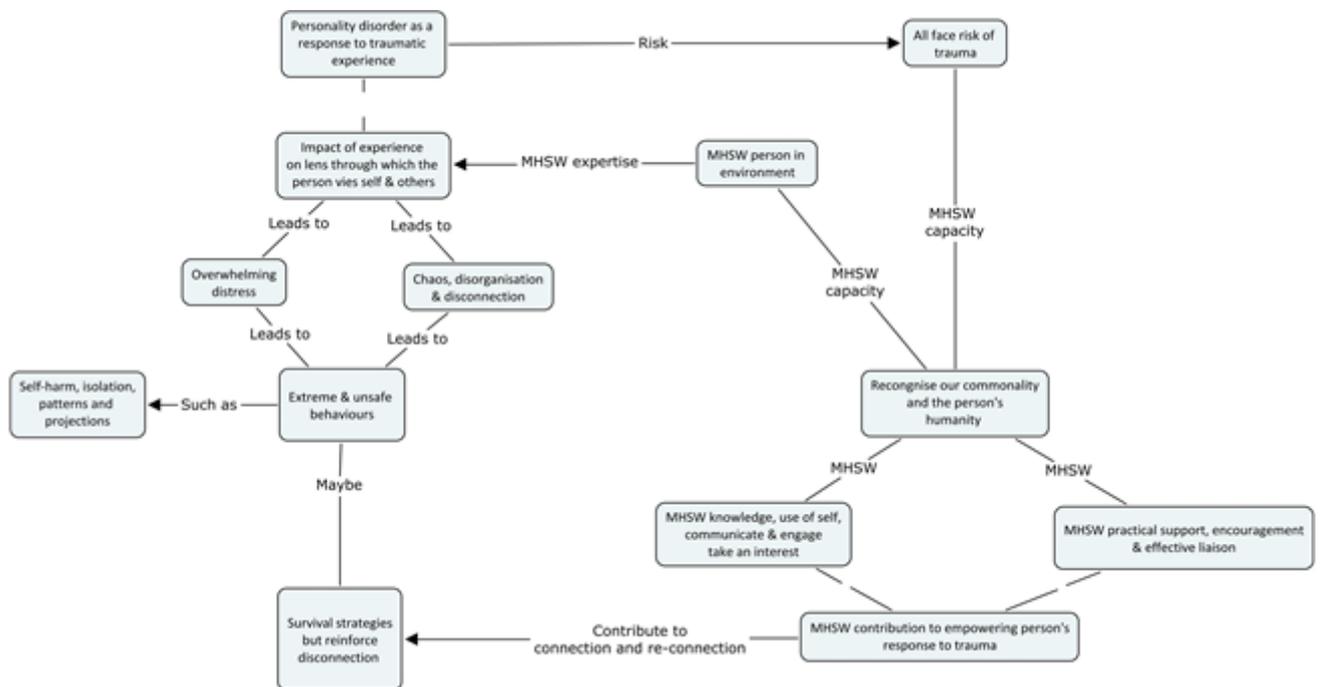
However, this theory is not without implications for MHSW and mental health professionals in general. Essentially MHSW will need to maximise its opportunities for space and critical reflection about personality disorder. The findings reveal that training in the lived experience of personality disorder, with service users as co-facilitators, would support understanding and knowledge about the relationship to trauma and the consequent importance of attitudes and support which promotes connection and re-connection with self, others and the world around. This theory, and its implications, has relevance for mental health professionals more generally, both in terms of increasing understanding and also appreciating MHSWs' unique contribution to optimising a holistic, multidisciplinary response to the person with personality disorder. The next chapter will firstly describe the theory this study has produced, it will also be set out in diagrammatic form. The chapter will then sensitise the categories relevant to this theory, starting with the core category, "'It' defies singular explanation'.

## **Chapter 4: Discussion of key categories and connections**

This chapter synthesises aspects of the categories presented in the previous chapter. The categories are discussed in the same order, highlighting the connections between them and the emerging theory. This theory has emerged from this study's focus on how participants understand personality disorder and MHSW practice. The "how" focused nature of my research questions positioned the study within the paradigmatic assumptions of the interpretivist paradigm, adhering to a relativist ontology and subjectivist epistemology. The complexity of the diagnosis, the distress and the challenges involved for mental health professionals (NIMHE, 2003) signifies the importance of exploring its different constructions and whether positive change is possible. For these reasons post-modern, critical and constructivist theories were important to this study's exploration of service users' and MHSWs' constructions of diagnosis and MHSW practice. Post-modernism framed its exploration of the various 'truths' about personality disorder. Critical theory framed its design and particularly the inclusion of service user and MHSW participants in a virtual conversation, through me the researcher, to assess whether it is possible to think differently about personality disorder. This was supported by my use of CGT and choice of methods, which fitted with the study's assumptions, took account of my interpretive framework and allowed me to get as close as possible to participants' meanings.

In answering the first two research questions this project has generated a grounded theory, represented in Figure 4.1 below, suggesting that personality disorder is related to early traumatic experience which impacts on the person throughout the life course (Erikson, 1968). Intense emotional distress can alienate the person from themselves and others and lead to extreme and unsafe behaviours. The theory suggests that humane, empathic and pro-social relationships can interrupt the cycle of malignant alienation and help manage the risk of a fatal outcome (Watts & Morgan, 1994). The theory values courage in the face of adversity, our commonality as human beings and the particular relevance of MHSWs ability to work with the person in their environment and their abilities to use self to communicate, engage and take an active interest in the person. Furthermore, broad social interventions such as practical support, encouragement and liaison with others can help MHSW to empower the person's more constructive response to traumatic experience. As such this theory suggests that MHSW has a role to play in a more balanced and holistic response to people with personality disorder through which it will articulate its unique contribution to multidisciplinary mental health services.

**Figure 4.1: How MHSW might promote connections and more positive responses to trauma**



This chapter will now set out the categories and offer a more detailed explanation of the emerging theory. It will begin with the core category, “It resists singular explanation” which suggests that one perspective alone cannot explain the complexity of personality disorder. Too heavy a reliance on one perspective can limit knowledge, empathy and encourage myths, stigma and alienation. The consequences of the latter are described in Categories two, three and four. The chapter then reveals evidence of the relationship between personality disorder and traumatic experience. Category five defines trauma and suggests the relevance of traumaontogenesis (Erikson, 1968) for understanding the person’s behaviour. It points to the omission of trauma in the current classifications of personality disorder and suggests that this can limit professional understanding and empathy. Indeed it suggests that evidence of a relationship between personality disorder and trauma underlines its heterogeneity and calls for a multi-dimensional conceptualisation of the disorder and moreover a holistic response balancing the description and classification of symptoms with the content and experience of distress (Bracken & Thomas, 2005).

Categories six, seven, eight and nine focus on the nature of MHSW practice and suggest the importance of protective and caring bonds, founded on empathy, validation and reciprocity. It suggests that the SOPs (HCPC, 2012) support such a new professionalism in this area because they commit social workers to work to the fundamental principles of human rights to support *and* protect the person. Categories eleven to sixteen describe how MHSW practice may be better informed through understanding,

feedback, modelling, and transparency, consistency, supporting the person's social and family network and practical support. Category 17 describes MHSWs' views about how practice would be better informed through specific training involving service users with personality disorder. The discussion concludes by suggesting the importance of the relationship between understanding and behaviour and in particular how understanding the relationship between personality disorder and traumatic experience calls for a multidimensional conceptualisation of the disorder with holistic, empathic responses to help repair the person's connections with self and others. The chapter suggests that through its particular skill sets MHSW has the potential to delineate a unique contribution to the support of people with personality disorder and consequently to multidisciplinary mental health services. A more detailed summary of the emerging grounded theory will conclude the chapter. It will begin with a response to the question of how participants' understand personality disorder, starting with the core category; *"It resists singular explanation"*, this chapter will then synthesise the categories relevant to all three research questions to enable a comprehensive presentation of the key findings.

***Core category: Category 1: "It resists singular explanation"***

This category has been identified as the core category because it suggests the diagnoses resistance to one explanation. Despite criticism (Jablensky & Kendall, 2002), the psychiatric diagnostic model remains the principal model in mental health services (McWilliams, 2011), constructing mental disorders as discreet disease entities (Jablensky, 1999) through categorical classification systems (APA, 2000, 2012; WHO, 1992, 2012) that aim to enrich knowledge, predict the course, the likely outcome and the response to treatment (Feinstein, 1972). The participants' responses in this project suggest that personality disorder may not fit singular explanation or such categorical assumptions. Service users described how they have been given alternative diagnoses to personality disorder, and this research has found that personality disorder can mean different things to different respondents. MHSWs suggested that personality disorder can be confused with other illnesses. S (27-06-07) described how she has had other diagnoses:

*"The thing is I've been given different diagnoses. When I came over here and also in [X] I got diagnosed with schizophrenia, which is totally wrong and also bipolar".*

BB (1-12-10) described how:

*...many people are not diagnosed with personality disorder who could be considered to be suffering with personality disorder. Many, many become depressives; many, many bipolar disorders, the big [sighs, pauses] and in fact I'm not entirely sure that they're different.*

These findings suggest that personality disorder can be comorbid and confused over time, lend support to the argument that mental disorder is “intrinsically heterogeneous” (Maj, Gaebel, Lopez-Ibor & Sartorius, 2002, p.ix), which in turn raises questions about the reliance on psychotropic medication in the treatment of personality disorders such as BPD (Horton & Lekka, 2012). No one drug is authorised for the treatment of personality disorder (NICE, 2009). While some argue that the complex and polymorphic nature of personality disorder means that different classes of drugs are often required (Stoffers et al., 2009), NICE (2009) state that drugs should not be used specifically for BPD or for individual symptoms or behaviours. Drugs that are seen as “good first line treatments” (Stoffers et al., 2009, s.339) such as second-generation anti-psychotics should not be used in the medium to long term, and sedatives should only be used cautiously in a crisis (NICE, 2009). Indeed Feurino & Silk, (2011) consider that “at best” the efficacy of any specific medication remains “uncertain and inconclusive”.

However, despite these clear guidelines and the weak evidence base for the effectiveness of psychotropic medication (Crawford et al., 2011), a reliance on medications and polymorphic prescription is evident in the treatment of personality disorder. Crawford et al. (ibid) found that 80% of their sample, of people with BDP, was prescribed psychotropic medication, with one in five prescribed three or more types. Indeed Perez-Zola (2011) suggests that this reliance on polymorphic psychotropic medication reflects mental health services’ severe difficulties in “managing” people with personality disorder and the psychiatrist’s desperate need to act in light of their deterioration or lack of improvement. While some forms of psychotherapeutic intervention have been found to be effective (Duggan et al., 2007; Feigenbaum et al., 2011; Fonagy, Roth & Higgit, 2005) it is evident that patients continue to have limited access to psychological therapies, with a high percentage only receiving relatively unstructured therapy (Horton & Lekka, 2012).

The complex and multidimensional nature of personality disorder means that no one perspective alone can explain or respond to the associated challenges. Its apparent relationship to early traumatic experience (Ball & Link, 2009) adds to the need for a way of understanding which balances the experience of distress with its form (Bracken & Thomas, 2005). Despite this, however, trauma remains absent from the revised criteria for personality disorder (American Psychiatric Association, 2000, 2012; WHO, 1992). The consequences of personality disorder’s position within such discrete systems of classification and the absence of trauma, within these classifications, are considered below.

Categories defined from criteria that allow “unambiguous assignation of phenomena to designated categories” (Dey, 2010, p.169), are fundamental to the ways in which human beings think about and organise their experience of the world (Dey, 2010). The attribute is either present or it is not. The findings of this research project question whether narrow, categorical, classifications (McWilliams,

2011) can ever capture the uniqueness and diversity of human experience (Shedler & Western, 2004). Moreover, the exclusion of trauma from both classifications of personality disorder (American Psychiatric Association, 2000, 2012; WHO, 1992) raises questions about the ability of either system to fully counter clinical experience, especially when clinicians appear to attend to individual's inner experience in their assessment of distress (Shedler & Western, 2004).

An overreliance on one explanation or method of understanding the complexities of personality disorder can limit knowledge, empathy and in turn generate myths. A common myth about personality disorder is that people get better as they get older (Out of the Fog, 2007-2013). However, the prevalence of older people with personality disorder in community settings has been estimated at 10% (Abrams & Horowitz, 1996), but research and literature on personality disorder and older people is sparse (Mordekar & Spence, 2008). It is possible that the myth that people mature out of personality disorder contributes to a lack of interest in its impact on older people. This does nothing to challenge the double burden that older people with a mental disorder carry; the stigma of older age and that of mental disorder (Graham et al., 2003). A critique of just one myth highlights how too heavy a reliance on one method of explanation can, at best generate a vacuum and at worst leads to stigmatised and negative responses.

Categorical approaches do not reflect the diversity of human experience and instead tend to reduce a person to a "fixed, underlying nature" (Haslam, Bastian, Bain & Kashima, 2006, p.64) which risks attracting stereotypical and stigmatising responses (UK NIMHE, 2003). The findings of this project suggested that professionals may draw negative inferences about the person and the diagnosis through fear or a perceived threat to their own usefulness, as BB (1-12-12) suggested:

*And that can make doctors feel these people are a threat to these doctors' sense of efficacy and that kind of thing, and can be treated as a sort of threat. And what do we do with threats? We turn away from them.*

The findings in this category question the ability of anyone model, including the psychiatric diagnostic model, to fully explain the complex and heterogeneous nature of personality disorder. They also question the reliance on psychotropic medication in the treatment of personality disorder. The absence of certain inner experience, e.g. trauma, from both systems of classification appears to limit their relevance to both lived and clinical experience. Absence can encourage myths, compromise knowledge and understanding and lead to stigmatising and negative responses (UK NIMHE, 2003). The next section considers findings that suggest that the person with personality disorder can be ignored and seen as not

part of the business of mental health services. Such stigmatising responses are a direct consequence of a failure to fully appreciate the multi-dimensional nature of personality disorder and the need for a balanced and holistic response.

### ***Category 2: Understanding responses to personality disorder***

The findings of this project suggest that as a result of the failure to fully understand and describe personality disorder, the person can be “*dissed*” and “*ignored*” by mental health professionals and researchers (Graham et al., 2003). “*Dissed*” has more than one meaning: it can mean to disrespect or put someone down with words, and it can also mean being disconnected from another party, in the sense of being cut off (Urban Dictionary, 2012). Both meanings contextualise A’s (20-06-07) use of the word here:

*It’s a pride thing. I can do it on my own. I won’t admit I need help, I’m so stubborn I suppose but also because when I’ve asked for help before I have been either ignored, or dissed, I suppose is the word for it. So I find that hard.*

Findings from Phase 2 suggest that service users can face resigned fearful responses from mental health professionals and their denial of personality disorder as a mental disorder:

*Oh, just because you hear so many people ... that there’s so much “PD” around, you know, the language that sometimes people use and then it’s, “Ah, right, we don’t have to worry about that person because they’re somebody you can’t help ... you know. (KH, 13-04-10)*

The findings of this project indicate that such responses contribute to the stigma (UK NIMHE, 2003) surrounding a diagnosis already associated with risk, violence, therapeutic pessimism (Pidd & Feigenbaum, 2007) and inertia (Wright et al., 2007). Stigma has been defined as an “attitude that is deeply discrediting in a particular interaction” (Goffman, 1963, cited in Newton-Howes, Weaver & Tyrer, 2008, p.573) that results from a discrepancy between a person’s virtual, assumed identity and their actual identity (Goffman, 1990). Categorical classifications that assume that a person’s identity is fixed allow inferences to be drawn and lend support to stereotypes and negative attitudes (Prentice & Miller, 2007; Howell, Weikum & Dyck, 2011). Howell et al. (2011) found that those who endorse fundamental beliefs are more likely to “report stigmatising attitudes towards those with mental disorders” (p.97). Moreover, the language used to describe the diagnostic criteria for certain types of personality disorder is overtly moralistic, encouraging negative moral judgements about the diagnosis and the person and suggesting that the disorder comprises amoral traits for which the person is responsible (Reimer, 2010).

Such assumptions can legitimise a response that assigns the person and the diagnosis to the dustbin (Beresford, 2005) and they are subsequently “*dissed*” and face “reduced access to mental health services” (UK Department of Health, 2010, p.58).

Negative and discrediting interactions can be internalised by the individual, adding to their already negative self-appraisal to form a negative “master status” subsuming all others (Scrambler, 2009). Data from Phase 1 describe how some participants feel reduced to a label and set apart from the mainstream, although S1 (10-07-12) showed some resistance to this:

*But the leaflet downstairs definitely does kind of describe me. And I hate that. I hate the fact that they're describing me to that and when you see doctors and you see [inaudible] and all that and they say, "What's your diagnosis?" "Personality disorder", and all the rest of them and they say, "Oh, it's you who're the one with personality disorder." "Yes".*

My findings suggested that the totalising impact of personality-related distress (Neale, Nettleton & Pickering, 2011) can be intensified by negative and stigmatising responses, which construct the person and the diagnosis as Other (Wright et al., 2007). Limitations in the definition and description and negative and stigmatising responses raise the inevitable question of why the classification has been retained (Ramon, 1986). It may function as an “effective smokescreen” (p.240) which allows the state to “manage a troublesome group of individuals” (Ramon, 1986, p.240) and psychiatry to retain its power and influence.

The findings of this research suggest that personality disorder is not adequately explained as a discrete disease entity but as a complex and diverse phenomenon it requires a multi-dimensional explanation. Categorical approaches alone will always fail to capture the meaning of personality disorder, especially if apparently relevant experiences are omitted from the diagnostic criteria (American Psychiatric Association, 2000, 2012; WHO, 1992). Such omissions limit knowledge, empathy and add to negative and stigmatising responses and therefore to the impact of the distress and the person’s sense of apartness from the mainstream (Wright et al., 2007). This project suggests that partial understanding and stigmatising responses can lead to negative constructions and inert, alienating relationships (Watts & Morgan, 1994; Wright et al., 2007) between the person and professionals, including MHSWs. The following sections consider service users and MHSWs’ reciprocal constructions of each other as Other (Wright et al., 2007).

### ***Category 3: Perceptions of the Other, Service users on MHSWs***

An appreciation of the Other requires an understanding of the ways in which ideas about self are governed by the contexts in which they are embedded (Rose, 1986; Sampson, 2003). Western economies require rational, self-contained individuals (Geertz, 1977), and those who are different or perceived as such with the dependent and seemingly less rational seen as “them” or the Other (Young, 1999). The Other must be defended against; if not the self is threatened psychologically and physically (Wright et al., 2007). A principal defence is to deny “our” commonality as human beings by denying “them” their humanity (Young, 1999). Data from Phase 1 reports how MHSWs can appear to deny the person certain humanity in that they can fail to take an interest or engage in meaningful dialogue with them and therefore risk being “sacked” by the person. H (09-01-08) asserts how her MHSW:

*...was useless, she did absolutely ... she just used to come in every so often, are you all right, blah-blah-blah, “you’ve got a psychiatrist appointment this day, alright? Goodbye!” That’s all she did. Any problems I had was dealt with from the [X], she did absolutely nothing. Then once I got established at the [X] she discharged me.*

A1 (2-06-07) reflected on the absence of any meaningful dialogue in being treated as a person with PD,

*“I used to go in there and say “I’m not getting any better”. “Well, take more pills”.*

While such mechanisms defend the MHSW against the Other they appear to contradict expectations that a professional service is delivered through a relationship that involves both a constructive bond and a caring attitude (Downie, 2011, pp.23-35) The findings of this category suggest that MHSWs’ attitudes and responses can be distant and ineffective and can fail to reflect awareness of the person’s vulnerability and how this might require the “protection of the bond” (Downie, 2011, p.25). Weak bonds do not prioritise the care of the person, nor do they facilitate good communication, empathy or respect (Stern, 2004), features of more trusting partnerships between person and professional (Borman, 2011, pp.209-221). They can lead to ineffective support and negative constructions of the MHSW and/or mental health professional. H (09-01-08) described how her MHSW made her “*feel very small sometimes*” and consequently what she said had little impact, as she would “*just do it for the visit and then go back to my old ways when she’d gone*”.

Data from Phase 1, therefore, contradicts expectations (HCPC, 2012) that social workers are able to take a broader, more considered view of the individual and their situation, as Lovatt and Gray (2008) suggest:

*...all social workers know that the very stuff they deal with – human nature – in inherently a realm of uncertainty and unpredictability ... it is an inescapable fact that good social work practice will forever rest on the ability of social workers to make sound judgements in unique situations – situations which are the complex amalgam of two individuals – the worker and a client... (pp. 1108-1109)*

While practice can contradict such expectations, the challenges of working with personality disorder should not be underestimated. The diagnosis denotes feelings of intense alienation, dysfunctional relationships, extreme emotions and risk behaviour including suicide (Adshed & Jacobs, 2008). Treatment can be difficult, slow and protracted (Main, 1957) risking staff burnout and secondary traumatic stress (Bussey & Wise, 2007). It is understandable that MHSWs feel the need to protect themselves from the person with personality disorder; indeed this in itself underlines the need for effective training and supervision (Duggan, 2007). However, defensive responses can add to the person's sense of alienation and escalate risk to themselves and possibly others (Aviram, Brodsky, & Stanley, 2006).

Interestingly, the findings of this research indicate that not only the powerful construct the Other through denial of their humanity (Young, 1999). MHSWs can be reduced to "liars", only there to "job you off" (M, 27-06-07). While these constructions reflect service users' projections about their own fallibility and unpredictability, the Category 3 findings (Findings, p.101) suggest that they stem from MHSWs' distant and dismissive responses to the person. People with personality disorder have a reputation for "distorted thinking and misleading reports" (Allen & Whitson, 2004, p.211). Mental health professionals can feel manipulated (Woollaston & Hixenbaugh, 2008) and reluctant to engage with individuals who offer impressionistic accounts of their social and family relationships (Allen & Whitson, 2004). However, recognising such accounts as responses to traumatic and invalidating experiences might encourage a more humane empathic response with opportunities to validate the person, which however should be robust enough to foster greater consistency in the person's description of their inter-personal relationship pattern (Allen & Whitson, 2004). Enabling the person to convey their story more consistently will take skill, time and effort – but it offers opportunities for validation rather than risking reciprocal constructions of the Other. This is pertinent, given literature that reports that inert, dismissive relationships can lead to alienation and risk a fatal outcome for the person (Morgan & Priest, 1984, cited in Adshed & Jacobs, 2003, p.90). The next section, while supporting the literature that suggests that the person and the diagnosis can be constructed as Other

(UK NIMHE, 2003; Wright et al., 2007), also suggests that more positive constructions and effective relationships may be possible through focusing on commonality as well as difference.

#### ***Category 4: Perceptions of the Other; MHSWs on service users***

While recent policy underplays the impact on the person of the diagnosis of personality disorder, particularly in relation to their access to services (UK Department of Health, 2009, 2010), earlier policy represents the person as the demonised Other (Wright et al., 2007), excluded from mental health services (UK NIMHE, 2003). Data from Phase 2 supports such constructions in that MHSWs report that the person can be perceived as difficult, failed, problematic and unworthy:

*...they're just seen as a problem sometimes, yeah as the problem, somebody that is really just, "it's their own fault"; it's very judgemental type thing: "Why don't they just pull themselves together?"*  
(KH, 13-04-10)

Negative attitudes towards the person and the diagnosis are evident (Cleary, Seigfried & Walter, 2002; Markham, 2003; Nehls, 1994, 1998, 1999; Stalker, Ferguson & Barclay, 2005). Hinshelwood (1999) finds that the professional can feel overwhelmed by the nature and intensity of the person's distress and can begin to evaluate them moralistically through the assignation of negative and derogatory labels. This retreat may be motivated by an understandable desire to protect themselves against the intensity of the person's distress and projection (Bateman & Fonagy, 2004; Watts & Morgan, 1994). The professional's retreat may also be motivated by a desire to protect their self-esteem as one who helps and heals, which the person with personality disorder does not always complement (Hinshelwood, 1999). Whatever the motivation, negative assumptions and attitudes appear to legitimate the professional's distance from a person who "is difficult and troubles us personally" (Hinshelwood, 1999, p.189). However, while they are self-protective, distant responses can encourage negative constructions of professionals. Reciprocal constructions by the person and the professional of each other as the Other can lead to inert, progressively alienating relationships which can prove fatal for the person (Watts & Morgan, 1994). Data from this project, however, suggested that an emphasis on the commonality of human beings encourages more positive constructions and ways of working with the person with personality disorder.

Recognition of commonality can begin to empower professional understanding of the diagnosis, the person and their behaviour. Acknowledging the relevance of diverse but damaging social experience can aid appreciation of the person's courage in the face of such adversity and how really "they" are "much like us" (BB, 1-12-10). It could be that only "chance" or "lack of opportunity" separates "them" from "us,

as BB suggested:

*“...there but for the greater god ... it could have happened to anyone of us”*

Phase 2 data highlights specific commonalities: we all face the risk of traumatic experience; we all hurt; we all need support at times in a pressured world and we can all manipulate and engage in contingencies, as BB elaborates:

*“...they are very similar; they are not suffering from any kind of thing that we are not capable of suffering with. So actually being in a room with these people is really difficult”.*

The intention here is not to minimise the impact of damaging social experience but to point out that each individual faces the risk, albeit differential, of a damaging experience in early life (Harman, 2004) that can have a profound effect on a person’s conception of self and others in adulthood (Erikson, 1968). The focus on commonality rather than difference is suggestive of literature that seeks to understand the person in different and more humane ways (Adshed, 2001; Aviram et al., 2006; Wright et al., 2007). Thinking differently about personality disorder calls for approaches that prioritise listening to the person’s subjective experience (Nehls, 1999) and reflecting on this experience and their response to it. Inquiry based on listening and reflection may help to develop trusting relationships and shared understandings about the person’s distress and the reasons for it (Bussey & Wise, 2007). Given the difficulties associated with personality disorder (Adshed & Jacobs, 2008; Main, 1957), any change will be complex and require support on many levels (Markham, 2003; UK NIMHE, 2003, 2003b; UK DoH & Ministry of Justice, 2007). However, greater awareness of the impact of destructive social experience may enable more humane, empathic responses. Such understandings may help mental health professionals, including MHSWs to take a more balanced view of the person with personality disorder, whom they might otherwise regard as a nuisance, as LC (25-05-10) reported:

*I think it’s perceived as “Oh it’s a bit of a nuisance, oh, here we go again” – you know, people go to A&E and I can’t speak of the staff there but often you will hear that they have just been ignored, or, “Just go away, we’re not going to deal with this”. It’s not actually addressed for that moment in time, an assumption has been made about that person, and if they’re presenting quite a lot of times at A&E or wherever it becomes a nuisance rather than anything else, and then the person really disappears; because the perception is there, the person is there and you’ve already made a judgement here so you know, I suspect, that the person probably doesn’t feel heard or listened to.*

It is evident that key omissions from the classifications of personality disorder (American Psychiatric Association, 2000, 2012; WHO, 1992, 2012), and particularly the omission of traumatic experience, can limit knowledge and more humane, empathic responses to the person. The inclusion of traumatic experience would enhance the relevance of the classifications, as clinicians do attend to inner experience in practice (Shedler & Western, 2004) and trauma appears to be related to the development of personality disorder in adulthood. The next section considers how participants understand personality disorder as a response to traumatic experience and then discusses features of more humane MHSW responses based on recognition of courage in the face of adversity, commonality as human beings and empathy to promote resilience and more effective outcomes for people with personality disorder.

### ***Category 5: Understanding personality disorder as a response to trauma***

Data from Phases 1 and 2 indicate how participants understand personality disorder as a response to trauma involving loss, isolation, overwhelming emotions, intense reactions, patterns and projections, with experiences similar to psychosis. A (20-06-07) said that she knows:

*“...It is from traumatic experiences in early childhood, I know that’s the trigger, or why do you have the diagnosis?”*

KH (13-04-10) described how:

*“Most of the people I’ve worked with, who have that label of personality disorder, are adult survivors of childhood abuse of some kind or another,”*

This project defines chronic childhood trauma as a repeated pattern of damaging interactions and behaviours, entailing emotional and physical abuse and/or neglect and sexual abuse (Kairys & Johnson, 2002). Evidence suggests a relationship between early trauma, mental disorder, identity and personality organisation (Erikson, 1968). Indeed multiple forms of trauma can be experienced simultaneously and in the present, traumatising the person day after day (Bussey & Wise, 2007), disconnecting them from the self, others and the world around them (Knafo, 2004), leading to a state of traumaontogenesis (Erikson, 1968). The findings indicate the importance of appreciating the impact of trauma in understanding personality disorder, the person and their behaviour. Tew (2005) suggests that extreme behaviours can be the consequence of problematic life experiences and the “internalisation or acting out of stressful social experiences that could not be resolved in other ways” (p.20). Trauma and loss are invariably related to power (Plumb, 2005) and the internalisation of negative evaluations of difference (Tew, 2005; Wright et al., 2007). Data from this project suggests that current classifications of personality disorder, which omit trauma as an etiological factor, limit empathy and therefore add to the person’s distress and

their difference from the mainstream. If relationships with professionals are distant and inert it is possible that the person will hold a “hot potato” (Tew, 2005, p.20) while trying to live up to the expectations of those around them.

Distress can be complex, frightening and overwhelming, and life chaotic and risky, as S2 (24-07-07) conveys here:

*I was really crying and crying and crying and really upset about it and things. I don't know: just different things that ... My head's like a CD at times: it whizzes round from one thing to another. I was crying and crying and crying.*

MHSWs reported how the service users' distress can be difficult to manage:

*...when somebody's saying they're going to kill themselves over and over again, you know, it's not a nuisance, it's that they really don't know how to deal with the emotions and how to express it in a way that helps them manage it and reduces the anxiety that goes with it. (LC, 25-05-10)*

Data from Phases 1 and 2 reflects literature about the content of distress and its impact on the person and the world around them. Miller (1994) found that service users diagnosed with personality disorder described their emotional pain as overwhelming and out of their control. The person is “rendered helpless by overwhelming force” (Herman, 1992, p.32) and tries to cope in whatever way they can (Miller, 1994; Breeze & Repper, 1998; Plumb, 2005; Stalker et al., 2005). Distress patterns involving extreme and risky behaviours such as self-harm can alienate and protect the person at the same time (Tew, 2005). Some assume that the person can exercise control over their behaviour, and that extreme and risky behaviours are therefore manipulative (Lewis & Appleby, 1988; Breeze & Repper, 1998). Others emphasise how extreme behaviours, although risky, “constitute both an awesome story of survival in relation to an oppressive or “unliveable” situation, and a desperate cry for help and understanding” (Tew, 2002, p.147). The latter view might inform a more balanced view of personality disorder that appreciates the context and the impact of trauma within it. Such a perspective would prioritise dialogue and reciprocity, with the professional – the MHSW – positioned as an “enlightened witness” (ibid, p.150). As such, the MHSW would need to demonstrate an interest in the person by asking questions that enable understanding (ibid) of their experiences, strengths and needs.

Data from this project suggests that personality disorder defies a singular explanation and/or approach. Indeed it suggests that its relationship to diverse social experience underlines its heterogeneity and in

turn requires a multi-dimensional conceptualisation and response. Whereas priority to the description and classification of the form of distress can limit knowledge and understanding, greater attention to the content and experience of distress (Bracken & Thomas, 2005) can promote understanding and therefore more effective outcomes through empathy for the person who is struggling with life (Miller, 1994) and with past and present traumas. It is evident that personality disorder can be understood as a response to trauma (Castillo, Allen & Coxhead, 2001; Castillo, 2003, Fallon, 2003; Stalker et al., 2005) which has had an overwhelming impact on the person, their identity and their relationships with self and others (Erikson, 1968). Appreciating personality disorder's relationship to early traumatic experiences and the consequent need for mental health professionals to recognise courage in the face of adversity, strengths, empathy, integrity and resilience may empower the person's response to their own experience.

This chapter now sensitises aspects of the data corresponding to the second research question, how participants understand MHSW practice. It is apparent that caring attitudes and positive bonds are important in general and in response to service users' unsafe and taxing behaviours.

#### ***Category 6: As a response to extreme & unsafe behaviours***

Phase 2 data complements the service users' understandings of personality disorder, emphasising overwhelming emotions, extreme behaviours and patterns and projections. In this context it is not surprising that some MHSW participants described their responses to service users' unsafe and taxing behaviours. These findings reflect those of Irvine (1996), who found that in 80% of a sample of 30 case files the person was known for unpredictable behaviour. She describes 33% of her sample as exhibiting aggressiveness and/or verbal abuse. Data from this project indicates that there is a need to try and understand such behaviours in the context of the person's experience and history. The findings highlight the importance of personal, therapeutic and team strategies as well as a need for planning, risk assessment, and acceptance that the work will be slow and difficult. It is evident that knowledge, listening and reflection are inherent to many of these responses, which might in turn indicate that "a new and better world is possible in the here and now for most BPD patients" and that there is hope for "a new satisfaction for the clinician as well" (Breiling, 2008, p.xxv1).

Highlighting the need to understand why the person behaves as they do, TC (7-09-11) says that it is important to understand "*what's made them what they are*". Responses that dismiss or reduce a person's innermost experiences to a series of negative traits can invalidate the person (Koons, 2008, pp109-133). A validating environment, however, can be created through listening and asking appropriate questions. Validation is something more than empathy, it is a means of communicating the 'wisdom, accuracy and truth' of the person's response (Swales et al., 2000). Such approaches can

highlight commonality and reinforce practice as a human encounter (Renouf & Bland, 2005), which may help to challenge the person's invalidating thoughts and behaviours. By being with the person as an enlightened witness, the MHSW can encourage responsibility and more constructive coping strategies. Furthermore, such activity with space for critical reflection might inspire MHSWs' own agency and potential to effect change (Bailey, 2002; Titus, 2004).

However, data from Phase 2 also indicates how the MHSW needs to accept the fact that working with the person will be slow and difficult. BS (16-03-10) remarks:

*It was interesting that I've answered the question in terms of all those environmental things rather than saying "Oh, it's really difficult working with those patients because they make me feel anxious or they make me feel this. I suppose perhaps I just ignore that too much. I don't know. I just take it as a given.*

BS was one of four MHSWs who suggested the relevance of DBT (Linehan, 1993) in work with personality disorder. DBT emphasises the reciprocity in seemingly opposing entities, accepts that change can evolve from such opposition and subsequently draws on philosophies emphasising the need for a "wise mind" (Koons, 2008, p.113), as progress is likely to be slow. Moreover, any progress or recovery, even when desired, can be imbued by a fear of failure on the person's part (Castillo, 2010). Recovery will need to be negotiated "as a journey of small steps" (p.139). While the person's strengths must be worked with to be developed, it is important to accept their reality at that time, an essential skill in the professional's endurance of the change process.

Castillo's (2010) concept of transitional recovery may inform the practitioner's "wise mind" (Koons, 2008). While encouraging the person to become more self-directing (Deegan, 2001), transitional recovery aims to ensure that support is on-going as the person moves forward (p.141). It supports practice as a human encounter and underlines the need for "wisdom, quietness and certain knowledge" in work with the person (JA, 12-05-10). Transitional recovery raises important implications for MHSW practice, however. The need for support to remain as part of a firm base, even if the support is used less frequently (Castillo, 2010), appears to contradict the current organisation of mental health and social work services with their focus on time-limited care management and performance indicators (UK DoH, 1998). Such priorities can obstruct the formation of longer term relationships between the person and the MHSW. It is possible that an appreciation of mindfulness (Koons, 2008) and transitional recovery (Castillo, 2010) are relevant to sustaining MHSW's involvement in order to maximise opportunities for validation and connection. The MHSW would need to be supported, but it is likely that more validating

relationships inform planning and risk assessment, two other responses to unsafe and taxing behaviours identified by some MHSWs in Phase 2.

It is unsurprising that planning is a feature of the response to unsafe and taxing behaviours, given that planning in response to risk and need has been a factor in adult social work and mental health services since the early 1990s (UK DoH, 1990, 1990b, 2008). Data from Phase 2 indicates once again the need for wisdom in a crisis and the ability to resist the temptation to “*jump in with both feet*” (SD, 18-05-10). Having the confidence to stick to the person’s crisis plan not only sustains important boundaries but also maintains a consistent and structured approach in the midst of a crisis (Titus, 2004; Bussey & Wise, 2007). However, plans need to be genuinely collaborative (Davis, 2008), otherwise, as one MHSW pointed out, they can invalidate the person at the most critical time:

*...when they are at the worst, in chaos, we start referring to a care plan and [we] say “when you’re in chaos, now you wanna go out and take your dog for a walk”. And they can’t hear us, they can’t hear it. And I just think if they had cancer and they were really, really distressed would we say that to them? So we don’t validate them in any way. Because if I was really distressed about something and you told me to go for a walk [whispers] – I’d want to kill you!* (LB, 24-11-10)

Data from Phase 2 reflects ideas about how to respond to service users’ unsafe and taxing behaviours. Trying to understand the person’s behaviour in the context of their previous experiences requires active listening and evidence of interest through appropriate questioning, and acceptance that positive change and recovery will be slow and transitional (Castillo, 2010). However, knowledge and a wise mind when addressing difficulties, limitations and strengths, including the MHSW’s own, can inform collaborative planning and the assessment of risk. More validating relationships may help to challenge invalidating thoughts and behaviour and empower the person’s response to trauma. The following sections summarise participants’ wider understandings of MHSW practice based on the latter’s attitudes and support. The first section considers the importance of MHSWs’ positive attitude and active engagement with the person; the second section discusses support that appears to aid connection, i.e. practical support, working alongside the person and liaising effectively with others.

### ***Category 7: Understanding practice; attitudes and bonds***

Professional mental health practice should evidence a protective bond and a caring attitude (Downie, 2011, pp.23-35). Positive bonds and attitudes are problematic in work with personality disorder. First, the nature of the distress itself makes interpersonal relationships difficult and taxing for others, including mental health professionals (Breeze & Repper, 1998; Koekkoek, van Meijel & Hutschemaekers,

2006). Second, the person is often lost amongst the particular stigma surrounding the diagnosis (Stalker et al., 2005; UK NIME, 2003). The findings of this project indicate how positive attitudes are important for some participants. Knowledge of the person and the diagnosis can help to empower the person to feel trust and the MHSWs' to be confident about their active engagement and communication with them. How the MHSW uses self in this is important, as L (24-07-07) from Phase 1, says:

*"I think they've got to come across ... for me personally, the biggest thing is I've got to be able to communicate with them, so they can't do anything if I can't..."*

The MHSW's knowledge and use of self is important, as KS, from Phase 2, indicates,

*...so going back to that what exactly was real about an aggressive guy in a car park for example, I talk about how I feel when I've had that and I talk about the way I've had to fight against that anger (1-06-10)*

Findings such as these reflect the literature underlining MHSW practice as a human encounter rather than a technical exercise (Renouf & Bland, 2005). In the context of recent policy initiatives that support a more generic approach to professional practice (UK DoH, 2007) findings distinguish MHSWs' knowledge and skills in understanding the person and empowering them to respond to trauma. MHSW practice is rooted in the psycho-social (Nathan & Webber, 2010; Ramon, 2005) and in understanding the person's interpretation of the world (Scott, 1998). It may span more than one conflicting duality (Ramon, 2005; Evans, 2012), but MHSWs are used to working with complexity (Renouf & Bland, 2005; Evans, 2012), all of which suggest that the MHSW has the capability to work with personality disorder, informing a multi-dimensional conceptualisation of the impact of the person's experience on how they view themselves, others and the world around them.

However, the difficulties in this cannot be underestimated. First, omissions in the principal understandings of personality disorder (American Psychiatric Association, 2000, 2012; WHO, 1992) limit appreciation of the relevance of traumatic experience to understanding the diagnosis, despite the growing body of literature that supports a direct relationship (Miller, 1994; Nehls, 1999; Castillo, 2003; Stalker et al., 2005; Wright et al., 2007). Second, the interpersonal difficulties associated with the distress (Adshed & Jacobs, 2008) mean that the professional has to endure attitudes and behaviours that can threaten their professional and personal esteem (Bowers, 2002; Cleary et al., 2002). Third, while SOPs and the PCF underline more empathic MHSWs responses to people with personality disorder the increased proceduralisation of practice (UK DoH, 1990; Carey, 2008; Evans, 2012) can restrict the opportunity to practice in accordance with the professional value base (HCPC, 2012; TCSW, 2012).

However, this project indicates that more positive bonds based on knowledge, use of self, communication and active engagement may encourage relationships more able to challenge service users' invalidating thoughts and behaviours (Koons, 2008) and promote recovery (Tew et al., 2012). It is possible therefore that pro-social practice has great relevance for MHSWs working with personality disorder.

Pro-social practice (Trotter, 2004; Cherry, 2005, 2010) fundamentally seeks to validate the person and guide them in the right direction by maintaining a caring, empathic relationship (Cherry, 2005, p.2). It is strengths-based, in that it is based on the notion that a person will develop if there is a focus on the strengths in their life (Trotter, 2004). Even the most troubled individual can utilise their inner resources positively if conditions allow (Cherry, 2005). These underpinning principles resonate with the needs of people living with personality disorder in that they reflect the extent of the distress and subsequent challenges, without ever giving up hope of the potential for rejuvenation (Winnicott, 1977). The kind of distress pattern associated with personality disorder may indeed indicate the person's courageous, capacity for survival (Tew, 2002). Pro-social practice, as its name indicates, is more than client-centred, however: it also aims to engage with the person to promote pro-social or validating (Koons, 2008) thoughts, feelings and behaviours. A positive bond based on basic courtesies and demonstrating a genuine interest in the person is at the heart of pro-social practice (Trotter, 2004). These features, in addition to the aforementioned underpinning principles, suggest the value of pro-social practice in work with people with personality disorder as findings from this research indicate the value that service users attached to the MHSW taking an interest in and actively engaging with them as a person. L (24-07-10) described how she sees her MHSW once a week:

*"...or if it's once a fortnight ... if she can't do something she'll phone me and let me know when she's done it, or if it's going to be another week".*

KH (13-04-10 suggested that there is a need for teams to

*"...actively work with people with Personality Disorders as a team, as we don't always do that very well".*

Effective and affirmative relationships are crucial to working with personality disorder (MIND, 2011) and to recovery in general (Tew et al., 2012), and yet there is a tendency to deny the *person* with personality disorder (UK NIMHE, 2003; Wright et al., 2007). Relationships which encourage the person's faith in others can help construct a more positive sense of identity and subsequently more stable relationships with self and others (Erikson, 1968). Given this MHSW has the potential to make an effective contribution to the support of, and response to, people with personality disorder because the

profession is equipped to engage positively with the person, to go the extra mile at times, as this project indicates. In their study of MHSW expertise, Ryan et al. (2005) found that MHSWs were committed to being there “for the clients” and accepted that their work could be “a lot of hard grind” (p.283). They were skilled at balancing the different perspectives of others simultaneously, often under pressure and in complex situations (Ryan et al., 2005). The question is not whether these features of practice have been identified, but why they have not been considered in relation to the person with personality disorder. While MHSW is noted for positive, empowering practice (McCrae, Murray, Huxley & Evans, 2005), it may be that personality disorder is just too taxing, too complex or just not well enough understood. However, research such as this project, which offers a social perspective on the diagnosis, may inspire MHSWs to offer more positive responses to service users (Trotter, 2004) and to affect change (Bailey, 2002; Titus, 2004). The next section suggests that more positive, pro-social relationships need to be reinforced by support that encourages the person’s connection with the self, others and the world around them.

#### ***Category 8: Understanding practice, types of support***

If personality disorder is understood as a response to trauma that induces chaos, disorganisation and disconnection (Knafo, 2004; Bussey & Wise, 2007), it is not surprising that data from Phase 1 indicates the value attached to the MHSW as a solid and reliable presence, as M (27-06-10) shows here:

*Oh yes, I could phone up at any time and if they weren’t there they would probably find someone I could talk to, or they’ll say “She’ll be in this afternoon, you can phone back then”, and she would come and see me. If she couldn’t see me she would send somebody else out if I was desperate.*

The value of practical support, effective liaison and having someone alongside to support them is reflected in both phases of the research. S (27-06-10) found that having the MHSW alongside her can help to keep her on track at key moments:

*Yes, I also got supported when I went to the psychiatrist’s appointment the other week as well, she sat in with me ... Yeah, if I get stuck. Because sometimes I can’t remember what I’m supposed to be saying, so she’s there to prompt me if I get stuck or if I forget something.*

While the data from Phase 2 highlights how practical support has more than one meaning for the MHSWs sampled, it highlights how such support is valued in its own right. MHSW SD (18-05-10), with an example of how she “thinks outside of the box”, described how a more practical focus has helped in the past:

*I took another gamble said “All I can offer” I said, “is my dog”. I said ‘She’ll keep you company” – and this is a girl who hadn’t left the house for a year – and “I’ll bring her round before I come to work and I’ll collect her”, and she was out on the street, my poor dog slept out; it gave her another focus ... during the day, and she exercised her, she thought she was doing something that was helping me, but she was getting out.*

These findings are supported by research that indicates that service users can prefer broader, less technical, social support to specialist “professional” interventions (Ikkos et al, 2011). MHSW is particularly suited to responding to such broader preferences, given that some have suggested that its function in mental health is to help clients cope with day-to-day tasks and to influence the “social and physical environments to be more responsive to meeting their needs” (Rovinelli Heller & Gittan, 2011, p14). There is a focus on the person in their environment and support with services to meet “common needs” (Newhill & Korr, 2004, p.303). Indeed, research indicates that service users value the practical help offered by social workers (Lishman, 2009). Practical support, employed as part of a pro-social response, has been found to be an indicator of more positive outcomes for clients in child-protection settings (Trotter, 2004).

It is surprising that no more than three service users and two MHSWs mentioned the importance of the social worker supporting welfare and benefit claims, despite the association of social work with welfare rights (Bateman, 2005). Its modernisation has driven social services into increasingly limited parameters (Jordon, 2001) while support for benefit advice is being located in agencies outside social work (Evans & Millar, 2005; Parton, 2009). It is possible that these findings reflect the dispersal of the social work role in this area to children’s centres (Parton, 2009) and personal advisors (Evans & Millar, 2005). Understanding personality disorder as a response to trauma that induces chaos and disconnection (Knafo, 2004) underscores the need for broader social support that assists the person in meaningful ways and may encourage their connection with others and the world around them. Positive, pro-social relationships, coupled with broader social supports are invaluable in work with people who have experienced trauma. As Herman (1992) states, the strongest antidote to traumatic experience is a “feeling of connection to others – a sense of belonging, the discovery that one is not alone” (p.215).

This project finds that practice consists of both attitude and support. Phase 2 data reveals that practice responds to the unsafe and taxing behaviour of services users. A commitment to trying to understand why the person is “as they are”, a certain MHSW mindfulness and acceptance that the work is difficult and recovery transitional (Castillo, 2010) are important in response to such behaviours. Collaborative

planning, risk assessment and validation can come from the MHSW trying to understand the person's behaviour. More generally, it is also important for the MHSW to take an interest in the person by getting to know them, taking an interest in their perspective and engaging in dialogue in language that they understand. While the stigma (Wright et al., 2007) and the more procedural nature of current practice (Carey, 2008) may challenge MHSWs' inclination and opportunity to demonstrate such an interest, this research finds that through actively engaging with the person, MHSWs will contribute more positively to the support of people with personality disorder. Moreover, this reaffirms the importance of validating and pro-social relationships as a process to help challenge service users' invalidating thoughts and behaviours. The data also suggests the relevance of particular areas of MHSW expertise such as practical support, working alongside the individual and liaising with others, all of which highlight the relevance of MHSWs' focus on working with the person in their own environment.

It is apparent, however, that the stigma and therapeutic challenges surrounding personality disorder continue to inspire negativity and dissatisfaction among mental health professionals (Bourke & Grenyer, 2010). Trust is crucial to the therapeutic relationship (Bateman & Fonagy, 2004; Langley & Klopper, 2005) and its absence risks inertia and progressive alienation that can ultimately compound isolation and the risk of a fatal outcome (Watts & Morgan, 1994). However, this research suggests that different ways of thinking about and working with personality disorder are possible. Understanding the impact of traumatic experience and the lens through which the person views self, others and the world around them highlights the need for validating relationships which also allow opportunities to challenge their more invalidating thoughts and behaviours. The development of a reciprocal working alliance is the most important aspect of engaging the person in services so that they may cope better with their distress (Bateman & Fonagy, 2004). MHSW is particularly suited to working in more validating, pro-social ways, helping to empower the person in their response to traumatic experience. This project suggests that by working in more active and pro-social ways, MHSWs may contribute to better outcomes for the person and may therefore inspire its own agency and unique contribution to mental health services.

To realise its potential MHSW will require space to question, to be critical, to think creatively and generate theory (Houston, Skehill, Pinkerton & Campbell, 2005) about both diagnosis and person. Aligned with the profession's commitment to social justice (Humphries, 2008), this may inspire MHSW to exercise its political power (Carey, 2008) and professional discretion (Evans, 2012) to facilitate a more robust and reflective response to the person with personality disorder. Data from this project suggests that practice would need to be supported to enable such a space. The next section considers the data from Phase 2 that questions the direction of recent policy relevant to social work (UK DoH, 1998, 2006).

### ***Category 9: MHSWs' perspectives on what can help and hinder practice***

MHSW participants identified what helps and hinders them in their work with personality disorder. Some described how knowing the person, support from colleagues and a robust team with space for critical reflection and “*thinking outside of the box*” (SD, 18-05-10) helps to sustain them in their work. Some MHSWs identified service users’ “*constant and fluctuating crises*” (BB, 1-12-10) as a significant “*hindrance*”, even if this is taken as a “*given*” (BS, 16-03-10). The work is emotionally draining, and both the person and the MHSW can become “*stuck*” (KS, 1-06-10). In their responses about whether the plethora of theoretical perspectives surrounding the diagnosis helps or hinders them, some MHSWs clearly framed their practice in theoretical perspectives while others questioned their usefulness, suggesting that they can both illuminate and obscure, and can encourage risky professional attachments that can “*split*” the team, as JA (12-05-10) described;

*I mean the development of splitting, which is very real, but intriguingly, one of the things that I sort of stumbled across was actually when discussing splitting and the best way to work with people with personality diagnosis. I discovered that you can get splitting in the team just discussing personality disorder.*

The data identifies agency processes that impact on MHSWs’ time, creativity and ability to get to know the person as significant hindrances:

*It definitely is because we spend a lot of time on that wretched computer, instead of when I first started social work it was a lot of preventative work and I actually did things with people that you’d say is a support worker job, but I felt very useful when I was going shopping with somebody; we were talking at the same time in the car, we were budgeting as we were building up a rapport, and I did an awful lot. But I haven’t got any time to do any of that anymore. (SD, 18-05-10)*

SD was talking from her own experience and questioning how the work she does with people has changed. While MHSW’s position in the “*psy complex*” (Rose, 1990) and its attachment to the former Approved Social Worker role (UK DoH, 1983; Rappaport, 2005) raises questions about the SD’s connection between MHSW and “*preventative work*”, social work policy and practice has changed since the early 1990s. Emerging as it did from the failings of social work’s in the 1970s (Parton, 2008), the privatisation and marketisation of public services (UK DoH, 1990, 1998, 2006) heralded greater efficiency, effectiveness and choice for service users (Le Grand, 1993). While some have suggested that

these changes have required new social work skills (Dustin, 2006) Lymberry & Postle (2010) argue that it is more that the role and purpose of social work have changed. Social workers have not necessarily lost their traditional interpersonal and negotiating skills (Dustin, 2006), but they are now forced to employ them less often, in different ways and for a different purpose. The purpose is now to ration services to “ensure that local authorities can manage cash-limited budgets” (Lymberry & Postle, 2010, p.2504) through assessment, planning, care management and the use of information technology (Parton, 2008). The literature indicates the impact of such changes on social work. Samuel (2005) found that over 50% of social care professionals said that they spent more than 60% of their time on administrative work rather than in direct client contact. Relevant knowledge is no longer about what is practical and helps to give meaning to behaviour (Barclay, 1982; Howe, 1996) but concerned with what aids “the gathering, assessing, monitoring and exchange of information” (Parton, 2008, p.260).

Frustration with such changes may encourage idealisation of the social work of the past, but it is evident that the data from Phase 2 reflects some of the consequences of this shift from the social to the informational in social work (Parton, 2008). LB (24-07-10) described how it is not just a matter of having less time but also of having to compress a narrative into a database:

*I never have enough time to do any of the paper work. I mean I would like to do, I can't do a formulation, not a psychological one. What our electronic system isn't set up for [is] good histories ... where you can start at, you know. Social workers used to do good old-fashioned psychosocial histories. There's no place for that unless you get psychological formulation; there's no place for that. So that's quite deskilling for social workers. But if we had a history written down, that started from there and maybe said "At age five, mother was an alcoholic" ... how has that impacted on the child; but we don't have anything like that so that doesn't help. (LB-24-11-10)*

LB's comment does not suggest that managerialism and marketisation are further MHSW defences against the person with personality disorder but rather that both have had a significant impact on the ability to practice in line with professional values (Evans, 2012). Evans (ibid, p.2) argues that while the proceduralisation of practice may have reduced practitioner's discretion it has not eliminated it. The findings of this project suggest that there are good reasons for MHSW to exercise its political power (Carey, 2004) and professional discretion for greater recognition of the social and, the relational and explanations of why people behave as they do. This is particularly relevant for people with personality disorder, not only because it may encourage more proactive engagement and better outcomes but also because people with personality disorder are at risk of being categorised twice over. In services

orientated to information and procedures, relevant knowledge relates to the fields in the database (Hayles, 1999). Such reductionist, categorical approaches (Dey, 2010) marginalise explanation, with significant implications for a person's identity, creating virtual realities where the information on the screen can become more important than the actual person (Hayles, 1999). In effect, a data double can be constructed that takes on a life of its own (Haggerty & Ericson, 2000). It is apparent that obligatory reliance on technology can indirectly hinder MHSWs' work with the person. Data from Category 10 reflects how some service users perceive MHSWs and social workers in general as frightening and threatening, and for some this is related to their tendency to take notes. With some relevance to Hayles (1999) and virtual realities, S1 (10-07-07) asserted how an MHSW had read about her:

*"...in the notes and she thought she knew me because of the notes. The notes are bollocks: the notes are what they think, not what I think. And there's a difference".*

The impact of the data double is particularly concerning if the person's uniqueness and humanity is already concealed by a psychiatric diagnosis such as personality disorder (Stalker et al., 2005). The exercise of discretion may enable the MHSW to both resist the power of such virtual realities and offer knowledge to generate more in-depth understanding.

The findings of this project reflect literature that suggests that the marketisation and formalisation of social work practice has resulted in more bureaucracy and less effective services. Professional discretion, knowledge of the social situation and the subject have all become more marginal, is it really appropriate to respond to spontaneous human need through complex and bureaucratic agency procedures (Carey, 2008)? This project underlines the continuing importance of the subject, the social and the relational in practice (Philp, 1979; Saleeby, 1997; Ferguson, 2003; Taylor, 2006) and reasserts the importance of professional discretion. The findings highlight the importance of relationships that validate the person and offer opportunities to challenge invalidating thoughts and behaviours. Space to reflect and think critically about personality disorder is required if the MHSW is to engage pro-socially (Cherry, 2005). While this research highlights how agency processes can hinder the MHSW's work with personality disorder, more positively it reaffirms the need to prioritise meaning over operationality (Parton, 2008, p.264).

The following sections sensitise the data that corresponds to the third and final research question: how participants envisage better-informed MHSW practice in this area. It is increasingly apparent that the uniqueness of human nature, coupled with the complexity and unpredictability of personality disorder, calls for practice informed by the relationship (Ruch, 2005) rather than managerial, technological and reductionist approaches (Carey, 2004, 2008). More collaborative relationships can generate enhanced

understandings of the person (Ruch, 2005) and promote self-direction and new beginnings (Deegan, 2001) for the person. The following sections consider participants' ideas about how MHSW practice may become better informed through greater understanding of the person and the diagnosis, the provision of feedback, modelling, greater transparency and consistency, supporting the person's family and social network and, for some, more practical support. The data again indicates the value of the relational, which is not surprising given that connection to self and others can be the strongest antidote to trauma (Herman, 1992).

### ***Category 10: Understand the person and diagnosis***

Some service users suggested that practice may be better informed through greater understanding of the person and the diagnosis. Understanding is contextualised by knowledge of the person and the MHSW's interest and commitment to looking "*behind the curtains*" (A, 20-06-07). The emphasis placed on the person and the diagnosis was a little unexpected, however. While the diagnosis itself seemed to have little meaning for many of the service users sampled, some suggested that the MHSW needs to understand it first and foremost. C felt (09-01-08) that personality disorder needs to be understood specifically,

*You can't put it all in one. You have got to separate it. You have got to look at, you know ... this person has been diagnosed with this, so let's deal with it, let's get more understanding about it and what ways we can move forward*

Three service users prioritised understanding the person first and foremost. The value that some service users attach to MHSWs' understanding of the diagnosis may reflect a loss of actual identity (Goffman, 1959) in that their understanding of self can only be garnered through the diagnosis (Haslem et al., 2006). It is possible therefore that confidence in the professional becomes ever more needed. In a world of trauma, loss and disconnection (Bussey & Wise, 2007), someone solid, reliable and confidence-inspiring can be very important. Faith in their understanding of the diagnosis may enable confidence in the MHSW's ability to engage with the nature of their distress. If practice is based on perceptions (Luborsky, 1984) and attitudes (Downie, 2011, pp.23-35) as well as interventions, a confident, credible MHSW may be important.

MHSWs' responses to the idea of understanding the person and the diagnosis were also unexpected. While the data reflects agreement with the need to understand both, seven MHSWs prioritised understanding the person first and foremost; BB (1-12-10) saw the diagnosis as "*...just a sort of a pointer at some of the directions that you ought to be looking in*", and considered the way in which the distress

impacts on the person important. These findings contradict research suggesting that MHSW has abandoned its commitment to the person in the face of marketised and proceduralised services (Specht & Courtney, 1993). While the findings may reflect MHSWs' commitment to the "person first" narratives of the service user movement and the importance of the person defining their own identity (Rovinelli-Heller & Gittan, 2011, p.6), they also reflect MHSWs' uneasy relationship with the systems for classifying mental disorder (Farone, 2002). A survey of 1,200 master's-qualified MHSWs ranked knowledge of DSM IV as the lowest source of knowledge that is "important for practice" (Newhill & Korr, 2004, p.300). It is possible therefore that many of the MHSWs sampled for this project agree that "diagnoses are important for social work only as far as questions about how the person lives with the diagnosis/es, how the diagnosis/es changes their world, or how the medication influences their everyday life" (Kvaternik & Grebenc, 2009, p.518). Collaboration and dialogue are key ingredients of such work (ibid).

However, three MHSWs found some value in the diagnosis itself. JD (24-11-10) thought it very important to understand:

*...the different types of personality disorders a lot in terms of the ICD 10 categorisations help as well ... and knowledge of the range of personality disorder. And I think the diagnosis is going to be an increasing feature of mental health services in future...*

The comments of these three MHSWs reflect the literature that suggests that MHSWs can think more positively about the systems of classifying mental disorders. Classifications, criteria and diagnoses can provide a common language (Rovinelli-Heller & Gittan, 2011), and indeed 50% of one sample of MHSWs said that they would continue to use DSM IV criteria even if not required to do so (Fraser, Westhuis, Daley & Philips, 2009).

Data in this category found some agreement across participants in phases 1 and 2 that MHSW may be better informed through greater understanding of the person and the diagnosis. The value that both groups attach to each, however, is somewhat different. Some service users prioritised the MHSW's understanding of the diagnosis over and above the person, which may reflect the need for confidence in the professional. As with earlier findings, this highlights the importance of meaningful structures in lives that can be chaotic, disorganised and disconnected (Bussey & Wise, 2007). MHSWs' agreement and priority to understanding the person may reflect the ambivalent relationship between social work and the psychiatric classification systems, but there may be hope for the retention of MHSWs' commitment to the person. A commitment to understanding the person first and foremost may promote safer relationships based on dialogue (Borman, 2011, pp. 209-221) and may therefore help to realise MHSWs'

contribution in the area of personality disorder. The data indicates therefore that practice may be better informed through greater understanding of the person and the diagnosis. Some service users suggested that practice could be better informed with the use of feedback from their MHSW.

### ***Category 11: Feedback***

The data indicates the importance of feedback from the MHSW to the person, including about what the MHSW has or has not done on the person's behalf. Feedback can be positive or constructively critical. For some service users, feedback was a means through which they might learn, and two suggested that there should be much greater dialogue between service users and MHSWs in general, as H (09-01-08) said:

*"...social workers should come to a place like this to talk to service users so that they can understand where we are coming from, because personality disorder comes from a traumatic past and social workers don't understand that"*

All ten MHSWs mentioned feedback. Some saw it as part of good practice, related to honesty, openness and perhaps "modern" or "new" professionalism (Brandon, 1993; Stern, 2004). Some found it difficult to do well as it "*depends on where the person is at*", with some also questioning whether there is enough time for it. A number, however, agreed that feedback can help the person move on and can help to validate and challenge invalidating thoughts, feelings and behaviours. KH, from Phase 2, questioned how service users will "know" how they've moved on without it,

*...how else are people going to know, because you can't remember sometimes how you were feeling a week ago and what was going on, so unless the person that's working alongside you in these things actually can sometimes say, "Well actually I recall a week ago, and things were very different, and look what you've done – do you think that's been helpful?" and sort of help that person reflect; if you don't give that feedback, they've got nothing to go on.*

Research from other disciplines highlights the importance of feedback for learning (Westberg & Jason, 2001) and personal growth, especially when "trying to make changes in long established ways of functioning" (p.13). People who have endured early traumatic experiences may never or rarely have had the opportunity to integrate constructive verbal and non-verbal feedback on their thoughts, feelings and behaviours from parents or caregivers. Without feedback, invalidating thoughts, feelings and behaviours can become established and opportunities to validate the person can be lost (Westberg & Jason, 2001). Patterns of behaviour may serve to protect the individual but can also alienate them. Feedback as a

feature of effective relationships (Wood, Englander-Golden, Golden & Pillai, 2010) can contribute positively to the person's motivation, levels of social support and coping skills (Wood et al., 2010), to their personal recovery and their "becoming new" (Deegan, 2001, p.18; Castillo, 2010).

Some service users and MHSWs suggested that feedback from the MHSW on what the MHSW has or has not been able to do was important as it can enhance transparency and clarity in the relationship about purpose and expectations. While feedback may hold positive possibilities, some MHSWs said that it can be difficult to do well, which indicates a need for training in this for MHSWs. Providing constructively critical feedback is certainly complex and can involve risk, but as Westberg & Jason (2001) suggest, "...if [it is] presented constructively and ... conveys our genuine desire to be helpful, negative feedback can actually deepen, not diminish our relationships..." (p.23). Data from Phase 2 indicates how feedback can be dependent on context and on "*where the person is at*", as "*not everyone likes the praise*" (KH, 13-04-10). The data emphasising the importance of feedback and dialogue, however, reflects the wider theoretical literature which suggested that meaningful dialogue is essential if dominant discourses are to be resisted (Foucault, 1969). Dialogue at the individual and collective level may help to challenge the discourse surrounding personality disorder (UK NIMHE, 2003; Wright et al., 2007) and aid a restorative response to trauma (Everstein & Everstein, 1993).

It is interesting that some Phase 1 data highlight the MHSWs importance as a model of what it might be like to live in the world, understanding and feeling comfortable in it (F, 20-06-07). Westberg & Jason (2001) suggest that one's ability to reflect on and assimilate feedback is in part dependent on the availability of role models. The next section considers data that suggests the usefulness of pro-social modelling (Trotter, 2004) to inform MHSWs' practice in their work with personality disorder (Trotter, 2004).

### ***Category 12: Modelling***

Pro-social modelling (Trotter, 2004) as a feature of pro-social practice (Cherry, 2005, 2010) has been seen to be effective in many fields where the client is involuntary or hard to engage. It has been particularly effective in encouraging validating, pro-social thoughts and behaviours in work with offenders and in child-protection settings (Trotter, 2004). Openness and clarity about roles, expectations and boundaries is a feature of pro-social modelling (ibid), as it is of feedback (Cherry, 2005). Cherry (ibid) suggests that, the worker should take every opportunity to model pro-social behaviour through an empathic relationship based on partnership, and engage in pro-social feedback to reinforce validating thoughts and behaviours and challenge those invalidating ones. There is the issue of who defines what "pro-social" behaviour is, but data from this project indicates that pro-social modelling may have relevance in working with personality disorder. Service users expressed different ideas about how

MHSW practice may be better informed, but the three who suggested the importance of a model to inspire personal recovery (Castillo, 2010) implied that this can be achieved by simply being, offering:

*“A ... sense of ... they are very much somebody who is in the world, understands the world, is comfortable in the world; they are a consistent presence”.* (F, 20-06-07)

Some of the data from Phase 2 also suggests that MHSWs hold a certain potential for modelling, as social work involves the use of self (Arnd-Caddigan & Pozzuto, 2008). One MHSW, KH (13-04-10) described modelling as:

*“...one of the ways in which a social worker can work with people is just really to be there, role modelling, something like that...”*

Feedback and modelling can encourage the person to direct their own recovery (Deegan, 2001). The MHSW needs to conceive of recovery as transitional, an on-going process (Castillo, 2010) requiring negotiation. Some MHSWs pointed out certain complexities in the modelling role, questioning whether MHSWs can and should act as a model of *“what it’s like to be a normal person in the real world”* (F, 20-06-07). MHSWs are fallible, and power differentials endure in a relationship that must exist within firm boundaries. Cherry (2005) reflects on exactly this type of professional concern, reasserting the importance of the professional making use of every opportunity to model pro-social behaviour, including when mistakes occur, which offer the opportunity to model acknowledging the mistake and apologising to the person. This may involve risk for some mental health professionals as it calls for a different way of thinking: not *“I can’t apologise because this person will manipulate it”*, but *“I’ve made a mistake; this person is a person and as such deserves an apology. We may both learn from their reaction to my apology”*. Indeed, such modelling, highlighting caring attitudes and bonds, can restate professionalism (Downie, 2011, pp.23-35) rather than underlining boundaries and raising false expectations.

Pro-social feedback and modelling (Trotter, 2004; Cherry, 2005, 2010) is relevant for MHSWs working with personality disorder because it commits to troubled individuals without ever giving up hope of positive change and rejuvenation. Its stress on validation through a strengths based, empathic relationship suggests a means by which the multiple losses and disconnection associated with personality disorder may begin to be repaired (Winnicott, 1973). The particular features of feedback and modelling offer opportunities for service users who have lost or never had the opportunity to assimilate positive and constructive verbal feedback from models, parents or caregivers. Pro-social practice depends on openness about boundaries and expectations in both pro-social feedback and modelling (Cherry, 2005). It is interesting that some service users suggested that MHSW practice could

be better informed by greater transparency and consistency. The next section considers this idea and MHSWs' responses to it.

### ***Category 13: Transparency and consistency***

While it is argued that people with personality disorder invoke an inconsistent response from mental health professionals (Bateman & Fonagy, 2004), some of the service users sampled for this project felt that transparency and consistency were important and that both would inform practice better, as S1 (10-07-07) made clear:

*"People not being truthful with me. Yes, like other social workers and CPNs not being truthful with me. They'll tell you one thing and the doctor another thing. That's not right. Yes consistency for me is a big thing"*

The idea that transparency and consistency are important reflects expectations that above all else mental health professionals will maintain appropriate relations and be honest (Bhugra, 2008). Transparency and consistency are particularly important when working with someone who has experienced trauma. Whether the consequences of the traumatic experience are defined as deficits (Livesley, 2005) or losses of the gravest kind (Estroff, 1987), it is evident that the person's conception of self and ability to engage in relationships can be profoundly affected (Erikson, 1968). In a world that is chaotic, disorganised and unpredictable the importance of consistency and transparency should not be underestimated. The therapeutic stance should prioritise clarity about roles, responsibilities and expectations in order to promote a collaborative understanding between the person and the professional (Livesley, 2005). Mutuality and collaboration may help to strengthen the person's response to trauma (Bussey & Wise, 2007), and ultimately their recovery.

Data from Phase 2 however, indicates a somewhat mixed response to the idea that greater transparency and consistency might inform MHSW practice. While four MHSWs expressed unambiguous support, some pointed out the complexities of both and that neither should be regarded as *"simple goods"* (BB, 1-12-10) in that they can be limited by context and the expectations of the service user and the self. In relation to the latter, SD (18-05-10) says:

*...Yep, I put my hands up, we're not really honest with the person, you know, sometimes I feel like saying "I'm really stuck here, come on, can you help me out?" because I don't want them to feel*

*that “Oh well if you don’t know what to do, I’m the person that’s suffering. What do you think I’m going to feel if you tell me that?”*

Current ways of thinking about the person with personality disorder and expectations surrounding the contract between person and professional (Gough, 1936; Haslam et al., 2006) may serve to restrict opportunities for collaboration and a more empowered response to trauma. While the type of disclosure SD imagines here may be perceived as a threat to professional credibility, such honesty may actually promote dialogue and understanding about the person’s experience, needs and strengths (Glicksen, 2004). Dialogue-based partnerships can encourage the reformulation of problems and bring about positive change (Livesley, 2000). Furthermore, while people with personality disorder ultimately have to cope with the inconsistencies of others and the world around them, as two MHSWs suggest, supportive relationships that promote consistency and transparency may be a mechanism through which they can learn to cope (Livesley, 2000).

The findings suggest that greater transparency and consistency would inform MHSW practice. MHSWs may be more able to empower the person’s response to trauma through opportunities to learn different expectation of self and others (Livesley, 2000). It is evident, however, that the contexts of mental health services together with the expectations of the service user and the MHSW can make transparency and consistency “tricky” (LC, 25-05-10) to operationalise in practice. This project, which reaffirms a relationship between trauma and personality disorder and underlines the importance of safety and reconnection (Herman, 1992), suggests that knowledge, pro-social feedback and modelling infused with greater transparency and consistency are reflective of an approach that aims to:

...engage the client in an empathic relationship within which they actively reinforce personal behaviour and attitudes and discourage anti-social behaviour ... It also includes many of the other behaviours that make it possible for us to live together in society, such as being polite, being respectful, being punctual, apologising for mistakes and so on. (Cherry, 2005, p.2)

Through such an approach the MHSW may empower the person to respond better to trauma. Transparency and consistency may also inform MHSWs’ work supporting the person’s family and social network.

#### **Category 14: Supporting the person's social and family network**

Some participants in Phase 1 suggested that practice would be better informed by the MHSW being more accessible to the person's social and family network. One service user, L (24-07-07) saw this as an indicator of trust:

*Not just have the rapport with that person: the other places they get their support from – then build up rapport with that place. They know that when you're speaking to them, the other people they get support from, whether it's the family, friends or places like the [the voluntary organisation] that you trust them enough to actually then be speaking to them as well*

Some MHSWs expressed definite support for the idea that they should work with the person's social and family networks. JD (24-11-10) said that MHSW:

*...play a crucial role in terms of maintaining those family relationships, because quite often someone with a personality disorder may reject those closest to them ... so I think it's important to have that, to be that link and to maintain that contact and to have that relationship and that transparency with the family members as much as with the service user*

These findings reflect social work's tradition of working with the person in their environment (Rovinelli-Heller & Gittan, 2011). It is also important to recognise the impact of secondary traumatic stress on those close to the traumatised person (Bussey & Wise, 2007); support may be needed for those who care for the person in their own right (UK DoH, 2004a). While there was agreement on this, some MHSWs once again highlighted the complexities of working with the person's social and family networks. Concerns were raised about the time and resources such work requires, which conflicts with systems of administration, and the complexity of family dynamics and expectations. More than one MHSW suggested that family dynamics can mean that the MHSW is "working in the dark":

*I just feel and sometimes I get to the bottom of what happened there, sometimes I do ... Families have secrets they don't want us to know about. Sometimes I'm working in the dark really, I don't know the key, and I don't get in there (SD, 18-05-10)*

The complexity of MHSWs' task is evident, as is the need to balance more than one perspective in the same context (Scott, 1989; Renouf & Bland, 2005; Ryan et al., 2005). However, the findings reaffirm the need for an empathic relationship that conveys genuine interest in the person and their lived experience

(Cherry, 2010; Nathan & Webber, 2010) through the MHSW asking the right questions. Empowering the person's more constructive response to trauma is not possible in an environment of secrecy and avoidance (Bussey & Wise, 2007). The enormity of the task at times cannot be underestimated; the work is very dependent on context and the MHSW would need to be supported in this work. However, such work may inform practice and MHSW's contribution in this area as well as supporting the person's connection or reconnection with others (Herman, 1992).

### ***Category 15: Practical support***

The value that participants attached to practical support has been addressed in the discussion of Category 8. It is interesting to note, however, that two service users suggested that practice may be better informed through the provision of more practical support. A (20-06-07) requested more on the "practical side" and S (27-06-07) suggested that MHSW should continue to "help with practical stuff like housing ... maybe if they can start helping with housing". These findings support the literature that finds that service users with mental health problems want practical as well as emotional support from social workers (Beresford, 2012). MHSWs agreed that practical support informs practice; one suggested that he was working in increasingly practical ways with people (JA, 12-05-10). The data reflects the literature that conveys how working with the person in their own environment can help to negotiate power differentials by illuminating a horizontal power-together approach rather than vertical power-over (Tew, 2006). Home visits and direct or support worker's practical support can promote the cooperative use of power and shared understandings from which more collaborative relationships may come about (Wilson & Daly, 2007). However, one MHSW cautioned that MHSW's ability to support the person in more practical ways has "fallen by the wayside":

*... a bit because we were talking actually talk about a lot, there was a time when we did an awful lot of more practical stuff than we do now, we lost our professional assistant last year, he hasn't been replaced and often he took on a lot of these sort of areas where you just go out for a coffee or go to somebody's home and work with them because you know what's happening, you need to go into the environment. It's their home so there is a power, you're on their territory and it's about being able to work on that level, but that's getting quite hard to do at the moment (LC, 25-05-10)*

It is possible that LC's comment reflects a value disparity in medically-dominated mental health services (Tew, 1999, 2005). While both physical and mental health are determined by a multitude of factors (Duggan, 2002; UK DoH, 1999), mental health services continue to prioritise the description and classification of the form or symptoms of distress over how it is experienced by the person (Bracken &

Thomas, 2005). This is despite knowledge that empathic and pro-social relationships (Trotter, 2004; Cheery, 2005) can validate the person and thereby promote their own control of their recovery (Deegan, 2001).

As well as responding to service users' ideas, MHSWs expressed their own ideas about how practice may be better informed, as I discuss in the next section.

### ***Category 16: MHSWs' ideas about how practice could be better informed***

Data from Phase 2 suggested the relevance of MHSWs working with personality disorder, as MHSW is related to social, anti-discriminatory practice and works with people "in the world" (BS, 16-03-10). Two social workers suggested that the profession needs to "step up to the plate" in an area where the "medical model has little purchase" (BB, 12-1-10). The research findings suggest that knowledge-based humane relationships featuring feedback, modelling, transparency and consistency can promote learning and possibly more positive outcomes for service users (Cherry, 2005). The data substantiates a need for specialised training in personality disorder (Bowers, 2002; UK NIMHE, 2003; Duggan, 2007) with five MHSWs suggesting that this should involve service users:

*...really good training would be quite good for social workers, and quality training, because sometimes it's not been good, not necessarily with the personality disorder but with other aspects, and I think actually service users being part of the training would be really good, to actually hear from them what it's like. (LC, 25-05-10)*

LC recounted a previous experience of service-user involvement in training:

*"...to hear her story and to hear how she manages – it was incredibly helpful, so I think those sort of trainings would be good"*

These findings reflect calls for further education in this area (Bateman & Fonagy, 2004; Cleary, Siegfried & Walter, 2002), an interest in the service-user perspective and the importance of understanding their lived experience and knowledge (Beresford, 2005; Nathan & Webber, 2010). Knowledge "based on direct experience of policy and provision from the receiving end" (Beresford, 2005, p.40) is an important source of expertise (Lester & Glasby, 2001). User involvement is meaningful because students remember the person's narrative (Repper & Breeze, 2007) and because it highlights our commonality and shared humanity (Simon, 2007, p.320). Balen, Rhodes & Ward (2010) found that qualifying students, including social work students, evaluated such training positively because it added value (p.416), helping them to understand the person's lived experience; and while a post-course evaluation of training for qualified

mental health professionals involving service users with personality disorder showed a drop in interest towards clients, it also revealed increased in understanding and skills and decreased pessimism and frustration (Castillo, 2011).

The involvement of service users as facilitators may add value to the training of mental health professionals; there is, however a need to consider the impact of the involvement on the service users themselves, which may carry the risk of negative impact as the person, recalls and utilises their personal experience to train others. However, Castillo (ibid) reports that the service user facilitator felt empowered by the achievement, seeing her views valued and generating her respect for professionals as they examined their own work ethics and values and challenged their previous perceptions. While care needs to be taken in the planning of service-user facilitated training to ensure that confidentiality is not compromised by the attendance of service users and professionals from the same geographical area (ibid), this evaluation indicates how service-user involvement can increase the understanding and knowledge of personality disorder and begin to change attitudes and perceptions. User involvement is a particularly pertinent resource with which to challenge the stigma and exclusion that surrounds the diagnosis (UK NIMHE, 2003) and leads to the mutual construction of the person and the professional as the Other (Wright et al., 2007).

Practice sensitive to the knowledge and experience of service users may also encourage professional optimism, as such knowledge can "...challenge traditional assumptions and highlight key priorities that users would like to see addressed" (Lester & Glasby, 2001, p.166). This is particularly relevant to the plight of people with personality disorder (UK NIMHE, 2003) facing therapeutic pessimism and inertia (Wright et al., 2007). These findings raise a question about how far MHSW accepts medical notions of mental illness (Beresford, 2005), as these particular participants showed a positive interest in what the service user with personality disorder can contribute to the training and knowledge base of MHSW. The findings highlight the value of a social perspective on the diagnosis and a pro-social approach to the person. It is important, therefore, for training to reflect a social approach to both (Houston, Skehill, Pinkerton & Campbell, 2005) the understanding and the enhancement of MHSW skills. An MHSW reflected on the content of any future training:

*I would offer, not that complex, I think – and this is where within our services we get it wrong – because often its psychologists that say "I'll do the training". And they offer very dry training, very academic training, and it doesn't explain, it doesn't help a care coordinator to actually start to have some empathy with these people or even begin to like them. And that's what I want to do, and I want to start at the beginning, more basic, because psychologists really don't get that we*

*really do need the basic stuff. The basic stuff, such as for someone with personality disorder, cancelling a visit is catastrophic to them, that's when they'll self-harm because you let them down like everyone else ... training to help practitioners to understand why people get diagnosed with personality disorder, that these people aren't born like this, that these people have had traumatic pasts. I would like training that looks at attachment to help them understand that. (LB, 24-11-10)*

#### **4.2. Conclusion**

This chapter has synthesised the categories relevant to my research questions: how participants understand personality disorder, MHSW practice and how practice might be better informed. The theory emerging from this study suggests that personality disorder is related to early traumatic experience which impacts on identity, personality organisation and distress throughout the life course (Erikson, 1968) colouring the person's relationships with self, others and the world around. Emotional distress can be intense, overwhelming and difficult to manage and include experiences similar to psychosis, patterns and projections, loss and isolation. Indeed trauma can induce a world of chaos and disconnection and consequently lead the person to engage in extreme and unsafe behaviours to cope with the intensity of their distress. While these behaviours may be survival strategies this theory suggests that they can reinforce the person's isolation and disconnection. A means of interrupting these defensive and maladaptive traits or behaviours, constituted in part by the stigma surrounding personality disorder (NIMHE, 2003), is required. This theory suggests that humane, empathic and pro-social responses have a part to play in disrupting behaviours which if unchecked can lead to malignant alienation and risk a fatal outcome for the person (Watts & Morgan, 1994).

Humane, empathic responses value human courage and indeed appreciate how we all face the risk of traumatic experience. They appreciate our commonality as human beings, exercise thought and feeling to connect the person with their past and present contexts. The theory suggests a particular role for MHSW given its expertise in working with the person in their environment, often with complexity and a need to balance different and at times competing perspectives (Ryan et al., 2005; Rovinelli Heller & Gittan, 2011). Data suggests the importance of protective, caring attitudes and broad social supports. Particularly MHSWs' ability to understand the person and diagnosis, their use of self to communicate, engage and to take an active interest in the person. Social supports, such as practical assistance, encouragement and liaison with others, can combine to help repair the person's connections with self and others and consequently empower the person's more constructive response to traumatic experience. Through its focus on the social and the relational this theory suggests a means by which

MHSW might contribute to a holistic response to people with personality disorder and by so doing articulate its unique contribution to multidisciplinary mental health services.

The next chapter concludes this thesis by summarising its aims, findings and methodology, and discusses the project's limitations and its original contribution to social work knowledge.

## **Chapter 5: Conclusion**

### **5.1. *Reasons for the study***

This study was undertaken for professional and personal reasons. With respect to the former, personality disorder is prevalent in in-patient and community settings (Bateman & Fonagy, 2004; Norton, 1996; Winship & Hardy, 2007), and more prevalent still in prison/forensic populations (Winship & Hardy, 2007), and remains a phenomenon with many doubts concerning diagnosis, prognosis and interventions. MHSWs work with people who have personality disorder, and yet personality disorder remains under-researched in MHSW and social work more generally (Keys & Lambert, 2002). MHSW research such as this could make a significant contribution to social work knowledge and practice. With regard to the more personal reasons for this research, as a practicing MHSW I have witnessed the consequences of the stigma and discrimination which surrounds it (NIMHE, 2003). Secondly, I was disappointed by the relative lack of specific MHSW research in this area and the questions this raises for the nature of MHSW knowledge and practice in this area. Finally, my interest and commitment to service user involvement and the development of practice through collaboration led me to include both service users and MHSWs research participants. Indeed this underlines the project's original contribution to knowledge. While I underestimated the time and energy needed for a project involving service users and MHSWs, I have been and remain committed to investigating MHSW practice from both perspectives.

### **5.2. *Research questions***

The research investigates how the service-user and MHSW participants understand personality disorder and MHSW practice and how practice in this area might be better informed.

### **5.3. *Short summary of methodology***

The "how"-related nature (Creswell, 1998) of the research questions set the project in the interpretivist paradigm with relativist ontology, a subjectivist epistemology and a qualitative methodology. The originality of involving service users and MHSWs in a consideration of personality disorder and practice meant that a grounded theory approach was vital, as it enabled a conceptual analysis and the development of a relevant theory for practice (Glaser & Strauss, 1967). My use of GT had to fit the research's underpinning assumptions. Constructivist GT (CGT) (Charmaz, 2006, 2010) was chosen as the appropriate approach as it shares GT's commitment to a constant comparative method, concurrent data collection, analysis and inductive theory building, but is founded on relativist ontological and subjectivist assumptions. CGT does not assume that the researcher approaches the studied world without an

“interpretive frame of reference” (Charmaz, 2008, p.206), and encourages the researcher to get as close to the world studied as possible.

Involving service user and MHSW participants defines the project’s originality but it also created a complex and timely project. A case-study framework (Yin, 2003) helped to manage the complexities of a project in which the boundaries between contexts and phenomena were somewhat ambiguous (Yin, 2003). The multiple case-study structure helped to frame service users and MHSWs as separate cases in the same project. A greater depth of analysis was achieved through both in-case and cross-case analysis, maximising the opportunity for similar and contrasting results. Case-study research calls for more than one source of evidence and therefore the triangulation of methods is important (Yin, 2003). Interviews were the primary source of evidence for this project. Twenty-two interviews were supported by an analysis of documentary evidence that enhanced understanding of personality disorder, MHSW and importantly triangulated method in this study (Yin, 2003). I undertook a documentary analysis of policies that were purposively selected and analysed for socially-situated meanings and underlying assumptions about the diagnosis and MHSW. This use of documentary sources was appropriate to the research’s ontological and epistemological assumptions and helped to generate a fuller understanding of personality disorder and MHSW. The sampling and research methods were also appropriate to the research questions and the study’s underlying assumptions.

The study required a sampling strategy that would enable access to respondents who could contribute information about personality disorder and MHSW (Patton, 2002). The sampling strategy was purposeful (Denscombe, 2003). However, service users with personality disorder might be defined as hard to reach (Lee, 1993) and vulnerable. Outcropping (Lee, 1993) was important to the overall strategy, in that a site was selected and the interviews were conducted there. Outcropping risks the researcher’s dependency on the site but helps to enable research with hard-to-reach participants (Lee, 1993). While MHSWs might not be defined as vulnerable, experience in this project suggests that they can be hard to reach. My original idea to adopt a purposeful out-cropping strategy in phase 2 failed due to difficulties in engaging gatekeepers in a national social work organisation. Sampling in phase 2 became more opportunistic and more dependent on my knowledge and connections within local agencies and my willingness to advertise the research more widely and follow up initial leads. The sampling was therefore purposeful and involved outcropping (Lee, 1999), criteria (Creswell, 1998) and opportunity (Brady, 2006), all of which fitted with the research’s aim of exploring participants’ understandings of personality disorder and MHSW practice from interpretivist, relativist and subjectivist perspectives.

The sampling strategies identified service users and MHSWs who would help me to answer the research questions. While these were small samples of ten service users and twelve MHSWs, they were congruent

with a qualitative approach (Trotter, 2012). The intention was to identify participants who might offer rich information to enable me to explore how personality disorder and MHSW are understood. The focus was on process and exploration rather than prediction, standardisation or the explanation of causal relationships (Alvesson & Skoldberg, 2000). However, the purposeful nature of my sampling strategy risked a bias in selection, attracted participants with a specific interest in personality disorder who may, for a number of reasons, have been motivated by a conscious or unconscious desire to please me. It was important therefore for me to account for such biases in the process of the research. I refer the reader to sections 2.11 and 2.12 for the account of this. My reflexive strategies helped me to negotiate bias in the doing and writing up of the research and were crucial to the successful completion of this project which seeks to explore meanings participants attach to personality disorder and MHSW practice rather than generalise

The nature of the research questions and the underlying ontological and epistemological assumptions also informed the decision to employ active semi-structured interviews (Holstein & Gubrium, 2004, pp.140-162), which prioritise the interaction between researcher and participant and are flexible and sensitive to different interview situations (Holstein & Gubrium, 2004). A flexible method (Grafanki, 1996) was important for a number of reasons, not least because I had no way of knowing how participants might respond to the questions I asked. Furthermore, active interviews, in which the researcher as “traveller” (Kvale, 1996) asks questions that enable participants to tell their stories, would help to generate in-depth understanding of personality disorder and MHSW. While semi-structured interviews may be limited by their snap shot nature and potential for conscious, unconscious and recall bias, they were appropriate to my paradigmatic assumptions. The data generated by these interviews was analysed using NVivo 7 and took the form of an embedded analysis (Yin, 2003) focusing on specific aspects of the case rather than the entire case (Yin, 2003): i.e. the participants’ understanding of personality disorder, the nature of MHSW practice, and how such practice might be better informed.

NVivo 7 enabled effective management of the data from the 22 interviews in one programme (Richards & Richards, 1994). The data analysis focused on constantly comparing and contrasting the emerging themes in and across case (Creswell, 1998; Glaser & Strauss, 1967). The cross-case analysis was extremely important to the secondary, more conceptual analysis (Creswell, 1998), as it enabled rigorous questioning of the underlying assumptions and a rendering of the data (Dey, 2010) from which it has been possible to generate a relevant and fitting theory (Charmaz, 2006). However, it was necessary to evaluate the authenticity of the findings appropriately (Guba & Lincoln, 1989). Their validity and authenticity are revealed by their fairness and the inclusion of different experiences and responses. The ontological, educative and catalytic authenticity of the research (Guba & Lincoln, 1989) is also

highlighted. Its validity is evidenced by the extent of the ethical review and demonstration of my continued ethical awareness throughout the project (Mauthner, Birch, Jessop & Miller, 2002). The research is reported in ways that emphasise transparency, critical subjectivity (Lincoln & Guba, 1985) and reflexivity, especially in relation to my position and respective biases.

This project has explored participants' understandings of personality disorder, MHSW practice and how this practice might be better informed. It is set in the interpretivist paradigm and rests on relativist, subjectivist and qualitative assumptions. The methodology helped to ensure that the study makes an original and meaningful contribution to social work knowledge and practice in the area of personality disorder.

#### **5.4. Summary of findings**

This section summarises the findings that answer the research questions, beginning with those that relate to my first research question of how participants understand personality disorder. First, the findings suggest that the participants see personality disorder as something equivocal rather than discrete, meaning different things to different people:

*"Oh yes, I think like any other condition, it presents differently to each individual because everybody's unique. Just as we are, everybody with a diagnosis of personality disorder is unique"*  
(JD, MHSW, 24-11-10)

The data suggests that personality disorder defies singular explanation and indeed that too heavy a reliance on one perspective and approach can limit knowledge and empathy and inadvertently contribute to the stigma and discrimination surrounding the person and the diagnosis. As L (24-07-07) said, "... it's not just that you have it. It's what you are". Phase 1 findings suggest that the person can be "dissed", ignored and perceived as difficult, failed, problematic and unworthy (Breeze & Repper, 1998). Phase 2 findings suggest that personality disorder is not seen as the business of mental health services, leading mental health professionals to seek distance from the person (Lewis & Appleby, 1988; Markham, 2003; Watts & Morgan, 1994). While service users and MHSWs offer different explanations for these responses, the outcome for the person is the same; they can be left distanced and alienated. The findings suggest that this adds to their established negative self-image, feeds increasingly inert professional relationships and service-user and MHSWs mutual construction of each other as Other (Wright et al., 2007), and risks malignant alienation (Watts & Morgan, 1994).

The findings also suggest that both groups of participants understand personality disorder as a response to trauma involving loss, isolation, overwhelming emotions and intense reactions, patterns and projections, including experiences similar to psychosis. The distress can be frightening and

overwhelming and can lead to extreme and unsafe behaviour, inducing risk for the person and those around them. Phase 2 data indicates how the person's distress can be difficult to manage and can challenge the MHSW's professional and personal esteem. These findings raise further questions about the classification of personality disorder, particularly the omission of trauma as an etiological factor (APA, 2000, 2012; WHO, 1992). This study suggests that such a crucial omission can compromise understanding still further. Moreover, it suggests that recognition of the relationship between trauma and personality disorder (Castillo, 2003; Miller, 1994; Nehls, 1999; Stalker et al., 2005) is essential if more humane, empathic responses to the person are to be realised.

Data relevant to my second research question, how participants understand MHSW practice, suggests that practice does not always reflect awareness of the person's vulnerability or the need for the "protection of the bond" with the professional (Downie, 2011, p.25). Certain professional defences such as lack of dialogue, interest and active engagement with the person can impair the quality and effectiveness of MHSW practice. They reinforce distance, add to the person's negative construction of the MHSW and consequently risk the service user "sacking" them. While the latter can be interpreted as an act of petulance or manipulation, this research suggests that it is an indicator of the person's alienation, and in turn escalates risk (Watts & Morgan, 1994).

However, the data suggests that positive conceptions of practice are possible. This research finds that the key to this lies in understanding personality disorder as a response to trauma and recognising our commonality as human beings. While the risk of experiencing some forms of trauma may be differential, we all face risk, as trauma is not exclusive; we all hurt, we all need support at times in a pressured world and we can all manipulate and engage in contingencies. Understanding personality disorder as a response to trauma and appreciating commonality as well as difference could encourage more humane and empathic responses to the person. The findings of this project also suggest that MHSW practice can be a response to service users', at times, extreme thoughts, feelings and behaviours. The data highlights the need to understand this in the context of the person's past experience, and for the MHSW to take an active interest by asking the right questions and generate knowledge to inform risk assessment and planning. It also highlights the importance of practice that evidences understanding of the person's vulnerability, reflects an empathic, protective bond and recognises the importance of broad, social supports.

This research suggests the importance of bonds based on the MHSW's use of self, knowledge of the service user, interest in service user's perspective and actively engages the service user in a dialogue in language that they understand. The findings reaffirm the importance of broad social supports, the MHSW's effective liaison with others, encouragement, working alongside the service user and practical

support. Practice founded on positive and pro-social attitudes and support may encourage connection which, as Herman (1992) suggests, is the greatest antidote to trauma. By actively engaging with the individual and asking the right questions, the MHSW can create a relationship through which they can validate the person as well as creating space in which to challenge their invalidating thoughts and behaviour.

While seeking to understand and encourage more positive responses in the person, this research does not underestimate the personal and professional challenges of working with traumatised individuals. Indeed it suggests ways in which the MHSW might sustain their involvement with the person despite the personal and professional challenges. Knowledge of the person, active interest, engagement and a certain mindfulness (Koons, 2008, pp.109-133), including acceptance of the challenges and the transitional nature of any recovery (Castillo, 2010), can inform the relationship as well as more specific responses to extreme and unsafe behaviours, i.e. planning, risk assessment and team and personal strategies. The findings of this project highlight the relationship between trauma and personality disorder, and stress the importance of practice that encourages connection rather than alienation and is active and pro-social (Cherry, 2005).

The final research question sought to understand participants' ideas about how MHSW practice might be better informed. The service users were asked for their ideas about this and then the MHSW participants were asked to respond to these ideas. The phase 1 findings suggest that practice might be better informed by greater understanding of the person and the diagnosis, with feedback, modelling, greater transparency and consistency, support for the person's social and family networks and more practical support. The findings from phase 2 reveal some MHSW agreement, at least in principle, to a number of these ideas, although some stressed the importance of recognising the complexities and contexts of practice. I now summarise each idea and MHSWs' responses in turn.

The phase 1 findings suggest that MHSWs may be better informed by greater knowledge of the person and diagnosis. As A (20-06-07) suggested: *"There is a need to look behind the curtains"*. Phase 2 data finds some agreement with this idea, although the majority of MHSWs prioritised understanding the person over the diagnosis. While these findings may reflect MHSWs' ambivalent relationship to the classification systems (American Psychiatric Association, 2000; WHO, 1992), they appear to reflect their on-going commitment to the person. Some service users suggested that more feedback would inform MHSW practice, as it would promote the person's capacity to self-develop. As A suggested:

*"... more feedback, to have more feedback. Then I would know what to change and what areas to look into. I love learning, so yes, feedback I think"*

All the MHSW participants commented on the provision of feedback, including feedback about what the MHSW has or has not been able to do for service user or on their behalf. A number agreed that feedback is part of good practice. However, for some feedback can take time and can be difficult to do well, identifying a possible resource and training need for MHSWs. Feedback is related to the availability of constructive role models (Cherry, 2005). Some service users suggested that modelling would also better inform practice. While some MHSWs agreed, others were more reticent, suggesting that MHSWs are not infallible and that differences in lived experiences and power can compromise the capacity to model, and moreover, that the relationship must be framed within firm boundaries. However, if delivered in transparent and consistent ways feedback and modelling can help to restate a professional, therapeutic stance rather than undermine it (Cherry, 2005). Mediated by the need for appropriate boundaries, the findings of this research suggest that pro-social feedback and modelling (Cherry, 2005, 2010) might be a way for MHSWs to promote validating thoughts, feelings and behaviour and discourage service users' invalidating thoughts, feeling and behaviours. Service users also identified the importance of transparency and consistency in practice and suggested that practice would be better informed with more of both.

The MHSWs' response to the need for greater transparency and consistency was mixed, with some expressing definite support and others pointing out that neither transparency nor consistency are "*simple goods*" (BB, 1-12-10), as both are mediated by context, expectations and behaviours. While context and expectations must be acknowledged, the findings of this project suggest that transparency and consistency are important both in general and as features of pro-social practice. Understanding personality disorder as a response to trauma underlines the need for relationships that encourage confidence, trust and reconnection (Herman, 1992). Transparency and consistency are crucial in this, as both encourage dialogue from which the person gains opportunities to learn to have different expectations of themselves, of others and of the world around them (Livesley, 2000). The findings suggest that transparency and consistency are also important features of working with the person's family and social networks, which were identified by some service users as another area that would better inform practice. Some MHSWs expressed definite support for this idea, although others raised concerns about the time and resources that such work would require difficulties with the administration and different expectations between the person and family. More than one MHSW pointed out that such work is complex with the social worker often "*in the dark*" (SD, 18-05-10). However, it is evident that the MHSW is capable of working with complexity (Ryan et al., 2005), and empowering a response to trauma is undermined by secrecy and avoidance (Bussey & Wise, 2007). This research finds that the MHSW's sensitive liaison between the person and their family, where desired, may help to promote the person's connection, or reconnection, with others.

This project reflects MHSWs' responses to service users' ideas about how practice might be better informed. Some MHSWs offered their own ideas about how practice might be better informed. Some suggested that specialised training involving service users as facilitators, would inform practice. These findings reflect an interest in the service user's perspective, commitment to the value of lived experience and a need for further training. While training for mental health professionals by service user facilitators needs to be carefully planned (Castillo, 2011) it is evident that it could increase knowledge and understanding about personality disorder and reduce frustration and professional pessimism (Castillo, 2011). Any such training that considers personality disorder as a response to traumatic experience and the importance of pro-social practice might help to realise more inclusive, empathic responses.

Such responses would be based on the recognition of courage, our common humanity, empathy and an understanding of the complexity of personality disorder and its relationship to traumatic experience. More humane responses would recognise human beings' capacity for repair (Winnicott, 1973), rejuvenation (Saleeby, 2009), recovery and lifelong learning (Ryan, Ramon, Grecean, 2012). The findings of this project suggest the importance of consistent relationships, dialogue offering opportunities for validation and opportunities to challenge invalidating thoughts and behaviour. This is not without implications for the MHSW however: it calls for a different approach and for learning or relearning about the diagnosis, how to understand it and how to work with the person with the diagnosis. The phase 2 findings indicate support for dialogue, broad social support and the need for MHSW training in the lived experience of personality disorder, all of which signal that MHSW might be capable of altering its perspective on personality disorder (Glover, 2012).

This project suggests that the participants understand personality disorder as a response to trauma. It suggests that the relationship between trauma and personality disorder underscores the need for more effective, holistic responses to the person. While acknowledging that practice can be a response to extreme thoughts, feelings and behaviours, findings also indicate the importance of bonds founded on the MHSW's use of self, knowledge, interest and active engagement. It also indicates the value of broad social support such as effective liaison, working alongside the person and practical support. The demands of working with personality disorder are not underestimated; indeed the findings suggest that acceptance of the difficulties and limitations and the transitional nature of recovery might help to sustain the MHSWs' engagement with planning, risk assessment and personal and team approaches. A combination of understanding the relationship between personality disorder and trauma, bonding and support might therefore empower the person's more constructive response to trauma and their connection with self, others and the world around them. While the contexts and complexities of practice

need to be recognised, greater understanding of the person and the diagnosis, feedback, modelling, practical support, transparency and consistency would better inform practice with people with personality disorder and their family or social network. This project indicates that MHSW has a role to play in this area, as a better-informed response might realise not only a more effective responses but also MHSWs' own agency to affect positive change. While the methodology and key findings evidence the value and authenticity of the research, this research is not without limitations, which I detail briefly below.

### **5.5. *Limitations of the research***

This research project is limited in four main ways. First, there were only a small number of participants. Second, the purposeful recruitment of participants (Rice & Ezzy, 2000) may have attracted only those who are interested and have definite views on the subject. Third, the triangulation of method is somewhat restricted (Banister, Burman, Parker, Taylor & Tindall, 1994); and finally, the concentration on MHSW participants in Phase 2 prohibited the opportunity to explore the emerging theory with other mental health professionals. This section explains and justifies these limitations.

First, the size of both samples was small. While debate about the validity of qualitative methodologies and techniques has progressed, some argue that “us” and “them” positions continue to linger amongst adherents of both approaches (Trotter, 2012). The issue of sample size remains contested. However, the small sample in this project fits the aims and intention of the research: to get as close as possible to participants to explore their understandings of personality disorder and MHSW. I employed general and specific reflexive strategies to help me account for bias in the generation and analysis of data. The sampling strategy relied on acceptable qualitative techniques (Trotter, 2012); it was purposeful and deployed outcropping (Lee, 1999) and some criterion sampling (Creswell, 1998). Indeed the separate sampling of service users and MHSWs helped me to manage my influence on the research process. Moreover, the sampling continued until saturation was reached (Schutt, 2004).

Second, the size of the samples and the purposeful strategy raise questions about the generalizability of the findings and the representativeness of the participants. The intention was to explore and generate in-depth understanding of the subject. It was not my intention to generalise from the findings. Participants in phase 2 may have been drawn to the project by their interest in personality disorder. This interest, however, suggests that they were appropriate sources of rich information about personality disorder and MHSW (Miller & Alvarado, 2005). The sampling strategy aimed to identify participants who were most likely to offer information that would help to answer the research questions, rather than to identify a large number of participants representing *all* people with personality disorder and *all* MHSWs in order to generalise from the findings. However, increasing attention to the person, inclusion,

strengths and recovery in multi-disciplinary mental health services means that this study has a relevance for other disciplines, which warrants the testing of the emerging theory in future research with a representative sample of all mental health professionals.

Third, the limited triangulation of the methods needs to be set in the context of both samples being hard to reach, albeit for different reasons (Lee, 1993). Identifying and recruiting potential participants for both samples was challenging. Once potential participants were identified I did not want to impose on them any more than was absolutely necessary. I was concerned that asking them to engage with more than one method of data collection would be excessive and might jeopardise their involvement and ultimately the project. Given the originality and significance of research involving service users and MHSWs, it became a question of feasibility. Triangulation of the methods had to be balanced with the risk of not completing the research.

Finally, it is possible that in a world of increasingly generic mental health practitioners (UK DoH, 2004c, 1983 amended 2007) the focus on MHSW limits the research. However, MHSW research is needed in this under-researched area, despite the number of connections between personality disorder and traditional areas of social work endeavour (Keys & Lambert, 2002). Personality disorder is a prevalent and complex disorder (Bateman & Fonagy, 2004; Norton, 1996; Winship & Hardy, 2007) and MHSWs work with people who have personality disorder; indeed MHSW is in part conceptualised by its ability to work with complexity and with those defined as therapeutically challenging (Ryan et al., 2005). Without specific MHSW research to inform more effective practice in this area it is possible that the profession is operating in an educational and practice vacuum (Keys & Lambert, 2002). Moreover, its focus on MHSW has articulated its potential contribution to a multidimensional conceptualisation of personality disorder and a more effective, holistic response to people with diagnosis. So while its focus is uni-dimensional it is relevant to the wider context of modern, multi-disciplinary mental health services.

The originality and importance of involving service users and MHSWs in an exploration of personality disorder and MHSW practice (Keys & Lambert, 2002) justify some of the decisions taken in order to ensure that the research could be carried out. The following section summarises the project's original contribution to knowledge.

#### **5.6. *Original contribution to knowledge and methodology***

This project makes an original contribution to knowledge in three ways: it involves both service users and MHSWs; it highlights the relevance of the social and the relational in work with those with a mental disorder; and it generates a theory relevant for MHSWs understanding and working with personality disorder. There is a disproportionately small body of research into personality disorder (Winship &

Hardy, 2007) and a need to generate more knowledge about it, especially in MHSW (Keys & Lambert, 2002). My literature searches over the course of the last eight years have added weight to this argument; I discovered only three pieces of UK-based empirical research on personality disorder and MHSW (Burton, 1990; Irvine, 1996; Titus, 2004); however, these only include MHSW participants. This project including service users and MHSWs is innovative and makes an original contribution to MHSW knowledge and practice in an under-researched area (Keys & Lambert, 2002; Winship & Hardy, 2007).

Secondly, through its emphasis on the social and the relational and their contribution to a more rounded understanding and ways of working with personality disorder this project highlights the value of a social approach to personality disorder. While the contexts and complexities of practice need to be recognised, this project suggests that broad, social supports and humane and empathic bonds including feedback, modelling, transparency and consistency may empower the person in their response to trauma. The value of pro-social approaches affirm the importance of practice as a human encounter and requires space for critical thought, from which MHSW might benefit and assert its political will and discretion in resisting the further proceduralisation of practice to restate the importance of the professional relationship as a means of promoting recovery.

Third, this project makes an original contribution to knowledge as it indicates how MHSW might positively support people with personality disorder. Crucially, the project suggests that MHSW has the potential, through its commitment to the social, the person and the relational, to support people with a personality disorder "*in the world*" (BS, 16-03-10). Indeed the theory suggests that MHSW is equipped to make an active contribution to a holistic, multi-disciplinary response to people with personality disorder. MHSWs' attention to humane, empathic responses and broad social supports might help the person reconnect with self and others and empower their more effective response to trauma (Herman, 1992).

As well as making an original contribution to knowledge, this project supports a growing body of research that asserts that there is a relationship between traumatic experience and personality disorder (Castillo, Allen & Coxhead, 2001; Castillo, 2003; Fallon, 2003; Miller, 1994; Nehls, 1999; Stalker et al., 2005). Service user and MHSW participants understand personality disorder as a response to trauma. The findings of this project therefore add to the body of knowledge spanning the different domains of service-user-led research (Castillo, 2003); mental health nursing (Nehls, 1999); service users and a variety of mental health professionals (Stalker et al., 2005); practitioners from specific services for people with personality disorder (Wright et al., 2007); and MHSW. The range of these contexts in which personality disorder is understood as a response to traumatic experience adds weight to the veracity of the relationship between trauma and personality disorder, suggesting its value to a multidimensional conceptualisation of the disorder.

Research into personality disorder is necessary to understand a complex and contested diagnosis, challenge the stigma, realise earlier policy objectives (UK NIMHE, 2003) and, most importantly, improve existing practice. This study suggests that a multi-dimensional conceptualisation of personality disorder involving a meld of psychiatric, psychological and social perspectives is possible in modern, multidisciplinary mental health services. This study, in the importance it attaches to the relationship between understanding and behaviour, suggests recognition of the diagnoses relationship to early traumatic experience is vital to this. Through the originality of involving service users and MHSWs in an exploration of personality disorder and practice, it suggests the relevance of humane, empathic relationships and broad social support through which MHSWs can make a unique contribution to a more effective and holistic response to those with a personality disorder. Because of its design and what it has discovered this project makes an original contribution to knowledge and should perhaps be considered as worthy of a Ph.D.

### **5.7. Future research**

Two ideas for future research are relevant and interesting. First, a longitudinal study following service users allocated to members of multidisciplinary teams including MHSWs to investigate the nature of their professional relationships and the impact of more empathic responses and broad social interventions. Second, a project with more representative samples, a mixed methodology (Trotter, 2012) and which aims to investigate pro-social practice and its relationship to recovery for people with personality disorder. Pro-social practice (Cherry, 2005) with its attention to validation through an empathic relationship, pro-social modelling, feedback, transparency and consistency resonates with the findings of this project. Consequently, it has been a significant discovery for me which I think warrants further investigation. Cherry (2005, p.9) states that she is 'not aware' of the model, as devised by Sinclair (1971) and developed by Trotter (2004), being utilised in mental health settings despite evidence of its effectiveness in probation and child protection settings (Rex & Maltravers, 1998; Bonta & Ruge, 2004). Further research involving a more representative sample, with a mixed methodology would offer an opportunity to test the model's usefulness in mental health services particularly in the area of personality disorder. However, the commonalities and differences between service users and mental health professionals mean it would be important, in any future research of this kind, to retain a qualitative element (Denzin & Lincoln, 2008). This would help to explore the key findings of this study in greater depth. It would be possible to generalise from more representative samples (Patton, 2002) and appropriate dissemination of the findings and conclusions might achieve a greater impact on policy and practice.

While there are evident benefits attached to a larger and more representative study, the challenges are also apparent. In addition to the expected difficulties in engaging stakeholders in a future project, it is likely that identifying large samples of MHSWs and service users with personality disorder would be very challenging. My experience in this project indicates how difficult it can be to identify even small samples. Second, the research design, including the methods, would have to be appropriate. It would be important in any longitudinal study not to be too intrusive. In an investigation of any association between pro-social practices, lifelong learning and recovery the questionnaire would need to be very structured and to delineate the key features of pro-social practice, asking respondents to rate their helpfulness in their recovery. The questionnaire would include key features of recovery. Recovery, however, is a personal journey (UK DoH, 2001) and it would be difficult to capture the personal nature of recovery in a questionnaire. The mixed methodology would allow for greater qualitative exploration of any association between pro-social practice and recovery. Finally, funding such a large-scale research project would be challenging. Personality disorder is known to be complex and difficult (Bateman & Fonagy, 2006; Hinshelwood, 1999), and is more likely to encourage distance than engagement (Aviram et al., 2006). However, the high economic burdens associated with some personality disorders (Soeteman, Hakkarart-van-Roijjen, Verheul & Busschbach, 2008) might therefore encourage potential funders to consider research investigating inexpensive approaches to support and recovery.

### **5.8. *Implications for practice***

The research raises specific implications for MHSW and mental health professionals more generally. Through its attention to understanding context, the importance of humane, empathic bonds and broad social support, MHSW could make a unique contribution to people with the diagnosis. Understanding personality disorder as a response to trauma underlines the importance of practice as a humane encounter. Relationships that recognise the commonality of human beings, the impact of oppression, discrimination and alienation and the importance of respecting and promoting human rights reflect MHSWs' professional requirements and capabilities (HCPC, 2012; TCSW, 2012). These professional responsibilities are important given that the profession has appeared reluctant in the past to support the social model, strengths-based practice or, it seems, personality disorder (Keys & Lambert, 2002). Evidence suggesting that broad social support can complement therapeutic endeavour and promote the person's connection or reconnection with self, others and the world around them highlights MHSWs relevance to the individual and the multi-disciplinary context. This relevance is not without implications, however.

MHSW's specific relevance call for a shift in the profession's thinking about its identity and about personality disorder. Humane, empathic responses that recognise the transitional nature of recovery

(Castillo, 2010) challenge the profession's current priorities and ways of working (UK DoH, 1998; Carey, 2008). MHSW will need to carve a space for itself and perhaps engage in an uncomfortable dialogue (Houston et al., 2005) about its priorities if it is to accept the relevance of a social perspective on personality disorder and make a more positive contribution to supporting people with the diagnosis. However, catalysts for change within the multi-disciplinary context support a new, MHSW professionalism in this area. Legislative change (UK DoH, 2007) and an increasing emphasis on person centred approaches, inclusion and strengths in policy and practice (NICE, 2009; Duggan, 2007) suggests that MHSW should have confidence that its unique contribution will be received positively by multidisciplinary colleagues. Moreover, this very context suggests the relevance of this theory for other disciplines particularly given evidence of personality disorder's relationship to trauma and the efficacy of treatment approaches which emphasise the un-predictability of human existence, the importance of connecting past and present contexts and the value of a therapeutic relationship to strengthen new adaptive strategies (Swales et al., 2000; Davidson et al., 2006; Bateman et al., 2007). While this theory is inevitably orientated towards the social, it complements clinical and therapeutic interventions which help the person to cope more effectively with the consequences of their distress. However, this raises more general implications about the way personality disorder is understood.

This study suggests the importance of balancing the form and content of personality related distress to formulate a multi-dimensional conceptualisation of the diagnosis, with the relationship to trauma at its core, optimising , psychological and social knowledge to understand and support the person. Services and structures exist to facilitate a more effective holistic response (UK DoH, 1998; UK DoH, 2007; Duggan, 2007). However, an increased focus on the content of distress will require change (Glover, 2012) in what and how mental health professionals, including MHSWs learn about personality disorder. The findings of this research indicate the importance of all professionals understanding its relationship to trauma, appreciating human courage and commonality and the value of empathy and broad social supports. However, in understanding personality disorder's relationship to trauma the boundaries with PTSD have to be explicit. This study suggests that while both disorders are centred on trauma and can be co-morbid they are qualitatively different diagnoses. Trauma in personality disorder is more commonly associated with childhood sexual, physical and emotional abuse the impact of which is felt more in the adult's relationship with self and others (Wigenfeld et al., 2011). This study suggests that involving service users with personality disorder in the training of all mental health professionals is crucial to increasing evidence about the experience of distress from which qualitative differences can be further evaluated. Balancing form with content, increasing mental health professionals' knowledge and understanding might kick-start an impetus for more humane, empathic responses to the person.

The theory generated by this project will enable MHSW to realise its unique contribution to the multi-disciplinary context and therefore inform a more balanced, multi-disciplinary response to personality disorder. Increased professional confidence could help MHSWs attain greater job satisfaction and consequently less role conflict and stress (Bailey & Liyange, 2012). Particular MHSW training would need to develop specific skills, i.e. the giving of both positive and constructively critical feedback, and to highlight the importance of critical thinking in sustained work with the person with personality disorder. Working with personality disorder is complex and can be emotionally and physically draining. Training that emphasises the importance of critical thinking and support for the MHSW has the potential to be an important catalyst in rejuvenating thoughts and ideas about personality disorder, the person and MHSW's contribution to the multi-disciplinary team. Understanding personality disorder as a response to traumatic experience, realising the importance of commonality, practice as a humane, empathic response and the value of broad social support can all help to promote the service user's connection with the self, others and the world around them. MHSW may delineate its specific contribution through such mechanisms but, more importantly, it can encourage more positive experiences of MHSW and more positive and supportive outcomes for service users with personality disorder.

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# Appendices

## Appendix 1; participant information Phase 1



**Researcher**

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Have you got experience  
of seeing a mental health  
social worker?



If so I would like to talk  
to you to find out your  
views

If you attend a support  
group for personality  
disorder you might be able  
to help



**Hi,**

Please read this information sheet carefully before deciding whether to take part.

**What is it all about?**  
I want to find out what service users think about mental health social work.

**Why I am asking you to take part?**  
There is very little information about what service users think about the support they receive from mental health social workers. I think it is important to ask service users for their opinion.

**Do I have to take part?**  
No you do **not** have to take part. If you do decide to take part you can change your mind at **any** time. If you decide to take part I would ask you to sign a consent form.

**What will it involve?**  
I would like to interview you, at the Haven, for about an hour. I will ask you for your thoughts about mental health social work.

The interview would be tape recorded so that I can be as accurate as possible when writing the interview up. Your name will not be used. Tape recordings and interview write-ups will be kept securely and will only be available to me and my supervisor.

**What would happen next?**  
I would write the interview up and send you a copy of this, so that you can read it and check that it is accurate.

Once I have completed the interviews with service users I will then interview mental health social workers. These social workers will **not** be based in Colchester or Essex.

At the end of the research I would be happy to send you a report showing you what I have discovered.

**What next?**  
Contact me, or let Heather know, if you want to take part.



## Appendix 2; Semi- Structured Interview Schedule Phase 1

Check consent, information, right to withdraw, if upset, reassure confidentiality. Sign consent form. Reassure re respect, value of contribution.

Warm up with general question about personality disorder, what does that term mean for them?  
Follow up on any leads.

Contact with mental health social workers? Prompt either in the past or present?

Probe: how did this contact start? Probe did you ask for social worker or did someone else suggest you see one?

Did social worker explain their role, why they were involved, what they could do?

How do you think social worker perceived you and your needs? What do you think they understood about personality disorder?

What did social worker do? Helpful? Focus on Service users definition of 'helpful'.

If 'no' why wasn't it helpful? Reasons for this?

What could the social worker done to be more helpful? Prompt; see regularly, time to talk, get to know you etc.

Any thoughts about how social work could be different for people with personality disorder?

Thank you for participating in this interview it has been very helpful for me. Are you ok? Anything you want to ask me?

Explain what happens next, any questions, etc.

If there is anything I am not sure of when I go through the transcript, would you mind me meeting up with you again for a second shorter interview?

## Appendix 3; participant information Phase 2



**Researcher**

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**Are you a mental health social worker?**



**Have you got experience of working with service users with personality disorder?**

**If so I would like to talk to you to find out more**



Hi,

Please read this information sheet carefully before deciding whether to take part.

**What is it all about?**  
I want to find out about social work practice with those who have personality disorder, interviewing both service users and social workers. I have completed interviews with service users.

**Why I am asking you to take part?**  
There is very little research which looks at both the service user and social worker, perspective.

I would now like to interview social workers. If you have experience of working with service users with personality disorder you could take part in the research if you want to.

**Do I have to take part?**  
No you do **not** have to take part. If you do take part you can change your mind at **any** time. If you decide to take part I would ask you to sign a consent form.

**What will it involve?**  
I would like to interview you, at a convenient time and place, for about an hour. I will ask you questions about your experience of working with service users with personality disorder and on themes coming from my interviews with service users.

The interview would be recorded. Names of individuals and organizations would not be used. The interview will be totally confidential, unless there are overriding reasons for me to take advice from my academic supervisor (e.g. disclosure of mal-practice)

Recordings and interview write-ups will only be available to me and my supervisor.

**What would happen next?**  
I would write the interview up and send you a copy of this, so that you can read it and check that it is accurate. At the end of the research I would be happy to send you a report showing the outcomes of the research

**What next?**  
If you would be willing to take part, or have any questions please contact me on the number / email I have given overleaf.



## Appendix 4; semi- structured interview schedule Phase 2

Check consent, information, reassure confidentiality. Sign consent form. Reassure re respect, value of contribution.

Understanding of the term personality disorder?

Contact with service users with this diagnosis? Prompt either within current or past caseloads; proportion as opposed to individuals with other mental health issues, etc.

What were your initial thoughts about working with those with such a diagnosis? Probe, perceptions of service users needs; understanding of the diagnosis? Equipped to undertake work?

What did you do? Practical? Emotional support?

What were the challenges? What helped you in your work?

Final questions will be derived from data analysis of service user perspective; Importance of

Understanding person & diagnosis

Feedback

Modeling

Transparency & Consistency

Supporting family & social network

Practical support

How do you think social work support to those with a personality disorder could be enhanced?

Thank you for participating in this interview it has been very helpful for me. Are you ok? Is there anything you want to ask me?

Explain what happens next, any questions etc.

## **Appendix 5: Illustrative extract of my interaction with the first 5 service user participants**

This project values experience as sources of knowledge and the transformative potential of interaction. Interaction is influenced by the presence of the Other, particularly when power is weighted in favour of one person. Fairness demanded that as the researcher, who had invited participants to talk about a subject I was interested in, I relinquished control of the interview to the expert participant (Ebbs, 1995; Manning, 1997). Irrespective of the anxiety this might provoke in me. The following extract illustrates how my interaction with participants had implications for the generation of meaning. The extract utilises data from Gathering the story, a Category of Phase 1 which describes how participants told their stories. The extract will start from the first interview in Phase 1, with F (20-06-07).

I had been apprehensive in this first interview - whether it was this or my commitment to being fair I am not sure, but F took control of the interview,

*“...well maybe I should tell you a bit about my experiences of mental health because that explains things a bit”*

F described her experience of mental health services chronologically, contextualising her experiences and taking responsibility for re-focusing herself at times,

*“Yes, yes. I’ll get back to the social worker later as that is the main purpose of this interview but to give the overview”*

My diary entry details how this interview generated some very valuable data. However, I reflected on F’s *control* of the interview and how this caused me to squeeze my questions around her narrative. Whilst I managed this, I questioned whether a greater depth of meaning would have been achieved if the participant had been more focused on the questions? The second participant, A (20-06-07) was more focused on the questions asked. This was possibly why A’s interview generated six new codes. However, my commitment to fairness again had implications for meaning. A possible reluctance to take control of the interview meant that I failed to clarify A’s blurring of MHSW with Community Psychiatric Nurse (CPN). This occurred on more than one occasion and means that a question mark remains over A’s exact meaning. My unwillingness to take control, whilst motivated by a genuine commitment to fairness, therefore had implications for meaning. However, is it really ever possible to establish exact meaning in complex social situations? These happenings confirmed how meaning can be very dependent on place, time and the quality of interaction - even when the participant appears more focused on the questions asked.

Implications for meaning were again apparent from the very beginning of my interview with A, the third participant in Phase 1. The interviews with F and A had been very discursive, both had talked eloquently, powerfully and movingly at times. I had not been prepared therefore for A1's more impassive style. My research diary details my concerns,

*I interviewed A1 last and I don't feel that went as well as the first two, he was very 'one wordy' and I felt inhibited from drawing any more out of him. I did try, but he was quite matter of fact. I don't feel I was able to encourage him to elaborate.*

*(J. Warrener, unpublished work, June 21, 2007).*

A1 was not influenced by my encouragement to describe his understanding more fully. I left the interview feeling I had wasted an opportunity. However, when I reviewed the interview in the following days and weeks I realised that the data held greater depth than I originally thought. Depth was added to some codes and new codes relating to stigma, associations with violence, risk of violence and defining features of mental health professionals as *they*, were generated. I had not seen the significance of these meanings during the interview. I found this fascinating, as it revealed how meaning is not just found in more discursive styles but in the succinct and perhaps even in absence. Time to reflect on A1's interview was important to the meaning I gleaned.

By the time of the fourth interview with M I had listened to the recordings of the three completed interviews a number of times and clearly felt more confident about interviewing and the interview schedule. I felt that my more confident presence had had a positive influence on M's ability to express her-self. I was pleased with this interview as this diary entry shows,

*I felt more confident and aware of the interview questions/areas than the previous week. M was quite forthcoming and thoughtful. It feels as if I am managing to get all the questions/areas in to the interview that I need to*

*(J. Warrener, unpublished work, June 27, 2007).*

M was talking of her past experience of MHSW. I questioned how the lapse in time might impact on her interpretations of her experiences? Her descriptions certainly didn't suggest rose tinted glasses- but had her interpretations of somewhat negative experiences become more fixed over time? I would never know, but it was important to take the context of M's experiences into account. The next interview with

S (27-06-07) had a similar temporal dimension. S talked about her past, largely negative, experiences of MHSW. However, S also had some very recent contact with student social workers- describing them as “*absolutely wonderful*”. As S elaborated further on the students’ positive qualities, I could not help but wonder how the proximity of the encounter might influence her interpretations. Would these change with time and any further contact with MHSWs? The interviews with both M and S forced me to consider how meaning might be influenced by time and its passing.

I have used these first 5 interviews to illustrate how interaction and meaning generation differed across the interviews. My commitment to fairness, the participants focus on the question and way of telling their story all raised implications for meaning. It was apparent that time and its passing also had implications for my interpretation of participants’ descriptions. Similarly, having time to reflect on the data, as with A1’s, meant that a greater depth of meaning was generated. The co-construction of meaning required a relinquishing of control but also a purposeful confidence on my part. Without the presence of both meaning could be inhibited rather than full. The experience of conducting the interviews in this project has helped me to realise that whilst interviews can be defined as a purposeful conversation on a subject raised by the researcher (Denscombe, 2003), the meaning they generate can never be taken for granted. Furthermore, there is always a need to be prepared for the nature of the interaction on the day.

## Appendix 6: MHSW understandings of personality disorder (N vivo 7)

### Initial Free Nodes for MHSW understandings of personality disorder

#### **Name: Personality disorder means big**

<Documents\Interview BB - 1.12.10> - § 2 references coded [0.42% Coverage]

Reference 1 - 0.26% Coverage

**understand the term personality disorder. What it means to you?**

(Pause) well that's a big question

Reference 2 - 0.16% Coverage

I mean, it's just a big flummox between what the diagnosis is

#### **Name: Personality disorder means theory**

<Documents\Interview BB - 1.12.10> - § 13 references coded [10.31% Coverage]

Reference 1 - 0.21% Coverage

(Pause) because there are so many theoretical stand points to, to the beginning...

Reference 2 - 0.76% Coverage

There's so many different theoretical perspectives; all of these perspectives shed some light on it from one perspective and another perspective will shed a light on it and another and each of those will shed lights and, on one part of the problem and obscure the other part of the problem

Reference 3 - 0.71% Coverage

We work with DBP and one of the principles in DBT is that you act as a consultant to the client so the client does things and you as the, act as the consultant to help them do those things so it's quite an empowering approach .... recovery based... and all that kind of thing

Reference 4 - 0.72% Coverage

#### **Name: Personality disorder meaning changes**

<Documents\Interview BB - 1.12.10> - § 2 references coded [1.04% Coverage]

Reference 1 - 0.28% Coverage

I don't think I understand it on a day to day basis in any way that could be sort of stated (pause) briefly.

Reference 2 - 0.76% Coverage

There's so many different theoretical perspectives; all of these perspectives shed some light on it from one perspective and another perspective will shed a light on it and another and each of those will shed lights and, on one part of the problem and obscure the other part of the problem

There is a principle where in that, that, the point at which that principle falls apart and erm, if set out within DBT this idea of a dialectical between one thing and another, so if you hold one principle then the opposite principle will also have to be held at some point.

#### Reference 5 - 1.98% Coverage

So the opposite principle to that would be if this, if, if not, if this thing that they're doing, they're doing... if they truly can not do it and we truly we believe that they don't have the ability to do it and them not being able to do it doing it would be like a real impact on their health and well being then that's the point that we would step in. But if it were a real impact on their health and well being and they were able to do it we'd still be a consultant to them. If erm, and if they weren't, really weren't able to do it, but really we didn't think it would be a massive impact on their health and well being we still wouldn't let them do it-we still wouldn't do it for them. We'd still let them suffer the consequences of them not doing it.

#### Reference 6 - 1.65% Coverage

**Yeah Ok. So it's that, it's those principles that inform all of your work...**

Yeah. Like this guy he's just called up about, erm, he needs, we've been talking about, he needs, rather than going to the bank and organising things for him and getting an IVA, we've been

### **Name: Personality disorder- meaning is contested**

<Documents\Interview BB - 1.12.10> - § 4 references coded [2.22% Coverage]

#### Reference 1 - 0.76% Coverage

There's so many different theoretical perspectives; all of these perspectives shed some light on it from one perspective and another perspective will shed a light on it and another and each of those will shed lights and, on one part of the problem and obscure the other part of the problem

#### Reference 2 - 0.35% Coverage

Yes it is contested. It's still quite a new diagnosis, I think it was erm, I think it only appeared in the DSM in like the 1980's...

#### Reference 3 - 0.73% Coverage

and also there are going to be some people at the CMHT team who present as themselves in this particular way and the medical model is going to shine a light up for them and so you're going to have competing ideas as to whether this is bipolar or borderline personality disorder.

#### Reference 4 - 0.40% Coverage

You know so its a bit of a, those social and sort of more complex understanding than the medical model they are, they're marginalized within the thing

### **Name: Personality disorder means complexity**

<Documents\Interview BB - 1.12.10> - § 2 references coded [0.66% Coverage]

#### Reference 1 - 0.40% Coverage

Yeah, oh I think it's much too complex to, to, well there have been entire books written about it and to sort of ask the question how I understand it.

#### Reference 2 - 0.26% Coverage

**but many of the, the social workers that I've interviewed...**

Have all recognised the complexity?

### **Name: Personality disorder- a new diagnosis**

<Documents\Interview BB - 1.12.10> - § 2 references coded [0.41% Coverage]

Reference 1 - 0.29% Coverage

It's still quite a new diagnosis, I think it was erm, I think it only appeared in the DSM in like the 1980's...

Reference 2 - 0.12% Coverage

So it's quite a new diagnosis erm, (pause)...

### **Name: Personality disorder means balancing**

<Documents\Interview BB - 1.12.10> - § 4 references coded [4.11% Coverage]

Reference 1 - 0.88% Coverage

You've got a, a knife edge to ride in that if this person really.... We work with DBP and one of the principles in DBT is that you act as a consultant to the client so the client does things and you as the, act as the consultant to help them do those things so it's quite an empowering approach .... recovery based... and all that kind of thing

Reference 2 - 0.72% Coverage

There is a principle where in that, that, the point at which that principle falls apart and erm, if set out within DBT this idea of a dialectical between one thing and another, so if you hold one principle then the opposite principle will also have to be held at some point.

Reference 3 - 1.98% Coverage

So the opposite principle to that would be if this, if, if not, if this thing that they're doing, they're doing.... if they truly can not do it and we truly we believe that they don't have the ability to do it and them not being able to do it doing it would be like a real impact on their health and well being then that's the point that we would step in. But if it were a real impact on their health and well being and they were able to do it we'd still be a consultant to them. If erm, and if they weren't, really weren't able to do it, but really we didn't think it would be a massive impact on their health and well being we still wouldn't let them do it-we still wouldn't do it for them. We'd still let them suffer the consequences of them not doing it.

Reference 4 - 0.53% Coverage

And it, it's not like we can just say alright then, just carry on doing it until you kill yourself because at some point we, then you, and then you're constantly between the devil and the deep blue sea

### **Name: Personality disorder means grey, not black and white**

<Documents\Interview BB - 1.12.10> - § 2 references coded [0.89% Coverage]

Reference 1 - 0.75% Coverage

when you see things in black and white because you see things in black and white and you see that contradiction then you say well they can go out, they are not agoraphobic. You know and its true they're not agoraphobic in that sense but their capabilities are dependent on their emotions

Reference 2 - 0.14% Coverage

I think turning it on its head is a way out of this.

**Name: Personality disorder means- not understanding**

<Documents\Interview BB - 1.12.10> - § 4 references coded [1.13% Coverage]

Reference 1 - 0.18% Coverage

Well I think outside people don't understand what the diagnosis is.

Reference 2 - 0.08% Coverage

between what the diagnosis is

Reference 3 - 0.36% Coverage

people don't really know what it is, it's not had the same sort of scare tactics that schizophrenia has had so outside of the profession

Reference 4 - 0.51% Coverage

But within the profession there's a bunch of different ways of responding most of them are to do, I think with that sense of inefficacy that working with these people brings about in professionals

## **Name: Tree Nodes\MHSW understandings of personality disorder**

### **Name: Difficult & traumatic past experiences**

<Documents\Interview BB - 1.12.10> - § 2 references coded [1.45% Coverage]

#### **Reference 1 - 0.39% Coverage**

or otherwise something has happened in their development that have, that have shaped their characters to be the way in which they are then and there

#### **Reference 2 - 1.06% Coverage**

the specific parts of the specific abuse and how that made this person feels and how that and how that and how that then impacts upon their lives. So, so you, you were naturally gregarious and your father would, would hit you and humiliate you and take your trousers and pants down at sixteen. In order to ..... actually every time there is this pattern of grandiosity and humiliation and that humiliation

<Documents\Interview JA - 12.05.10> - § 1 reference coded [0.34% Coverage]

#### **Reference 1 - 0.34% Coverage**

he fulfilled all the diagnostic criteria for borderline personality disorder in spades, he had all the history, he had all the aetiology and all the background. He'd been to every care home in erm, Hertfordshire, he came from a violent and dysfunctional family, he'd been raped and abused by his mother's, by, sort of, well by his mother's violent boyfriends,

<Documents\Interview JD - 24.11.10 v1> - § 1 reference coded [1.28% Coverage]

#### **Reference 1 - 1.28% Coverage**

Erm, in terms of erm, they have extreme maladaptive ways of responding to situations and often the roots of those are from early childhood experiences, traumatic childhood experiences. And it leads to them perhaps taking sort of extreme action such as erm, threatening suicide or erm, self harming, erm, responding in various sort of erm, aggressive disproportionate ways to requests and erm, it may involve erm, responses from the criminal justice system when they get into trouble in that regard.

<Documents\Interview KH 13.04.10> - § 5 references coded [3.84% Coverage]

#### **Reference 1 - 2.09% Coverage**

it's people who have had sort of tough early lives in particular erm, often end up demonstrating certain types of behaviour, maybe developing different ways of coping to maybe what the mainstream might do so that might typically mean that they experience feelings of self harm or suicide as a reaction to things that have happened to them like erm, often it's sort of accompanied by feelings or worries about being abandoned erm, sometimes people will experience flashbacks and hallucinations as well almost, having that similar sort of experiences to people who have experiences of psychosis like hearing voices, having really overwhelming thoughts and feelings and they basically, sometimes seem to respond to things that people might view are quite trivial, upsetting maybe, but not off the wall...

#### **Reference 2 - 0.60% Coverage**

really, really, really prejudiced against people with Personality Disorder, at the end of the day those people sometimes, really, really, do sometimes need...not all the time, sometimes you've got to run with the risk, haven't you?

Reference 3 - 0.52% Coverage

they're just seen as a problem sometimes yeah and the problem, somebody that's really just, 'it's their own fault', it's very judgemental type thing, 'why don't they just pull themselves together',

Reference 4 - 0.30% Coverage

who have that label of Personality Disorder sort of are adult survivors of childhood abuse of some kind or another,

Reference 5 - 0.33% Coverage

I didn't understand the impact, didn't understand either for a long, long time about the trauma aspect I know it's part of PTSD,

<Documents\Interview KS - 01.06.10> - § 2 references coded [4.06% Coverage]

Reference 1 - 0.98% Coverage

I haven't done a lot of psychotherapy training of the difference when the damage happens at different ages and obviously those who suffer damage at around two can present quite a few borderline psychotic features.

Reference 2 - 3.08% Coverage

One particular patient who was very badly abused as a child erm, is carrying absolute rage and he's got a forensic history for quite brutal assault on someone and major problems with these sorts of anguishes and simultaneously we have found an understanding with him of where that came from and then start looking at well, how do you put this away, how do you work with that anger, erm, how do you get beyond and him we looked at erm, strengthening his sense of adult self and he was one of the two people who were able to work with Tolly and eventually he began to find forgiveness for his father who had abused him. That took a year to get to anywhere near that point.

<Documents\Interview LB - 24.11.10 v1> - § 1 reference coded [0.24% Coverage]

Reference 1 - 0.24% Coverage

Erm, in my opinion it, personality disorder develops because of early childhood trauma, abuse, neglect, something like that.

<Documents\Interview LC - 25.05.10> - § 1 reference coded [1.19% Coverage]

Reference 1 - 1.19% Coverage

It seems to, it seems to stem from some trauma, most of the service users I've worked with who have been given a label of Personality Disorder have had quite difficult childhoods, there's been abuse on some levels both emotional and sometimes physical and sexual, so it seems to be a common factor.

<Documents\Interview RT - 04.05.10> - § 1 reference coded [1.15% Coverage]

Reference 1 - 1.15% Coverage

it might be to do with having experienced difficult experiences early in their life or it might be erm, that they have interpreted some difficult experiences or have been very sensitive to particular experiences which another person might not think are too difficult but have been for them.

<Documents\Interview TC . 07.09.11> - § 1 reference coded [2.03% Coverage]

Reference 1 - 2.03% Coverage

I understand it is that erm, an individual has had some form of trauma in their early childhood and they have not been able to develop erm, the appropriate coping strategies and erm, appropriate behaviour that people call 'normal', erm, and they use alternatives that they've picked up along the way from abuse or certain kind of people in their lives and they haven't had the structure of generally, people with Personality Disorder haven't had the structure of, of family they've even been abused or erm something traumatic has happened to them, so that's kind of it really.

### **Name: Problems in managing emotions**

<Documents\Interview BB - 1.12.10> - § 1 reference coded [0.23% Coverage]

Reference 1 - 0.23% Coverage

their constant fluctuating and experience of constant, unrelenting crisis and grief.

<Documents\Interview BS - 16.03.10> - § 1 reference coded [0.25% Coverage]

Reference 1 - 0.25% Coverage

there wasn't any kind of chaos and drink, drugs, sex, police type of problems,

<Documents\Interview JA - 12.05.10> - § 5 references coded [0.71% Coverage]

Reference 1 - 0.02% Coverage

it was a real handful

Reference 2 - 0.15% Coverage

I'm no longer trying to change them, I'm trying to help them cope with what happens in their life. Erm, and that's easier than trying to help them change.

Reference 3 - 0.14% Coverage

Erm, and you get the same thing when you sit alongside a PD and you put up all their wailing and their suicidality and this that and the other.

Reference 4 - 0.25% Coverage

this woman she'd phone up to say I've got a ligature round my neck, I've got a ligature round my next, I'm going to kill myself now if you don't get round here now. I'm going oh f- aaaah, I'm like aaaah aaaah, aaaah, aaaah! Scream down the phone at this poor woman

Reference 5 - 0.15% Coverage

And erm, it was just, you know, they traumatise and can traumatise staff quite easily and so the system protects itself by getting into a... 'oh... hum....'

<Documents\Interview JD - 24.11.10 v1> - § 1 reference coded [1.28% Coverage]

Reference 1 - 1.28% Coverage

Erm, in terms of erm, they have extreme maladaptive ways of responding to situations and often the roots of those are from early childhood experiences, traumatic childhood experiences. And it leads to them perhaps taking sort of extreme action such as erm, threatening suicide or erm, self harming, erm, responding in various sort of

erm, aggressive disproportionate ways to requests and erm, it may involve erm, responses from the criminal justice system when they get into trouble in that regard.

<Documents\Interview LB - 24.11.10 v1> - § 2 references coded [1.40% Coverage]

Reference 1 - 0.76% Coverage

Personality disorder for me means someone who has got very complex needs, erm, they've got interpersonal difficulties, very impulsive, emotionally unstable, can't tolerate stress, can't tolerate relationships, erm, often its what is significant is self harming, suicidal ideation, a lot of acting out, reacting rather than...they seem to show a marked ability to think in a given situation.

Reference 2 - 0.64% Coverage

in order to get a diagnosis of personality disorder we're talking about something that has been sustained over a few years, you know numerous admissions to A&E, erm, interpersonal conflict, ongoing relationship difficulties as I've said and sort of consistent self harm in one way or another, yeah so that's my understanding.

<Documents\Interview LC - 25.05.10> - § 2 references coded [1.15% Coverage]

Reference 1 - 0.46% Coverage

and it's about control, because often people don't feel in control and that's the only way they can gather control.

Reference 2 - 0.69% Coverage

I just wonder if that's something, for some people if that's the only way they can retain some control in what is an out of control life that they are in, yeah it's chaotic.

<Documents\Interview RT - 04.05.10> - § 2 references coded [2.12% Coverage]

Reference 1 - 0.71% Coverage

Erm, Personality Disorder first and foremost to me means, (pause) erm having a problem with managing your emotions and erm, that that particular problem is large for certain people

Reference 2 - 1.41% Coverage

I think there are always risks around the sort of enormous emotions that get erm, that I associate with Personality Disorder and they're sort of global erm, so there are some particular risks about a person harming themselves either deliberately or accidentally and then there are whole risks to a person's whole life style and potential to grow and develop.

<Documents\Interview TC . 07.09.11> - § 1 reference coded [2.03% Coverage]

Reference 1 - 2.03% Coverage

I understand it is that erm, an individual has had some form of trauma in their early childhood and they have not been able to develop erm, the appropriate coping strategies and erm, appropriate behaviour that people call 'normal', erm, and they use alternatives that they've picked up along the way from abuse or certain kind of people in their lives and they haven't had the structure of generally, people with Personality Disorder haven't had the structure of, of family they've even been abused or erm something traumatic has happened to them, so that's kind of it really.

## **Name: Different or more extreme ways of coping**

<Documents\Interview BB - 1.12.10> - § 5 references coded [3.24% Coverage]

### **Reference 1 - 0.88% Coverage**

You know and its true they're not agoraphobic in that sense but their capabilities are dependent on their emotions, much as you and I are. You know one day, one day we might be able to cope with something and another day and we might have just experienced a death, a grief so we don't come to work because we really can't cope with it.

### **Reference 2 - 1.24% Coverage**

if someone feels really unsafe and communicates their sense of lack of safety or tries to cope with their sense of safety if they feel they are going to commit suicide and they feel unsafe about that so they cut themselves to get by. Erm, things like, as a professional you own anxieties about the growing risks that at some point you're going to start thinking well, you know this person needs to be kept safe and so you might be thinking about a CAT team or a hospital.

### **Reference 3 - 0.38% Coverage**

So all the time you feel like you're being selfish in deciding that, it's, I can no longer tolerate this risk so you end up taking on more risk.

### **Reference 4 - 0.24% Coverage**

I think it's our job to help them to be able to cope with feeling uncomfortable because...

### **Reference 5 - 0.51% Coverage**

Because I mean, these are often people who, as I've said before with .....(inaudible) interpersonal skills and an inability to cope with their emotions, in regard to interpersonal relationships.

<Documents\Interview JA - 12.05.10> - § 1 reference coded [0.12% Coverage]

### **Reference 1 - 0.12% Coverage**

he has been diagnosed erm with a personality disorder. Erm, but because erm, he doesn't have a repetitive acts of self harm,

<Documents\Interview KH 13.04.10> - § 3 references coded [1.91% Coverage]

### **Reference 1 - 0.79% Coverage**

maybe developing different ways of coping to maybe what the mainstream might do so that might typically mean that they experience feelings of self harm or suicide as a reaction to things that have happened to them like erm, often it's sort of accompanied by feelings or worries about being abandoned erm,

### **Reference 2 - 0.60% Coverage**

really, really, really prejudiced against people with Personality Disorder, at the end of the day those people sometimes, really, really, do sometimes need...not all the time, sometimes you've got to run with the risk, haven't you?

### **Reference 3 - 0.52% Coverage**

they're just seen as a problem sometimes yeah and the problem, somebody that's really just, 'it's their own fault', it's very judgemental type thing, 'why don't they just pull themselves together',

<Documents\Interview KS - 01.06.10> - § 1 reference coded [1.75% Coverage]

Reference 1 - 1.75% Coverage

one of the things I am always very worried about, erm, I've had people who've have killed themselves in the past, that too late in life they gain insight into how much damage they've done to their life. Now the moment, when instead of externalising the blame on everyone around them they realise erm, and it is one of the high risks obviously....for people taking their own lives...

<Documents\Interview LB - 24.11.10 v1> - § 3 references coded [1.61% Coverage]

Reference 1 - 0.34% Coverage

often its what is significant is self harming, suicidal ideation, a lot of acting out, reacting rather than...they seem to show a marked ability to think in a given situation.

Reference 2 - 0.61% Coverage

But it tends to be erm, in order to get a diagnosis of personality disorder we're talking about something that has been sustained over a few years, you know numerous admissions to A&E, erm, interpersonal conflict, ongoing relationship difficulties as I've said and sort of consistent self harm in one way or another,

Reference 3 - 0.65% Coverage

well I say it to all of them that I believe, I believe that they're reacting normally to an abnormal situation. And I, I always say to them, you know, was I in your circumstances that's how I would probably react. You're not abnormal it's just your circum-this situation that you've found yourself in. And you know you were very young.

<Documents\Interview LC - 25.05.10> - § 1 reference coded [0.69% Coverage]

Reference 1 - 0.69% Coverage

I just wonder if that's something, for some people if that's the only way they can retain some control in what is an out of control life that they are in, yeah it's chaotic.

<Documents\Interview RT - 04.05.10> - § 3 references coded [2.36% Coverage]

Reference 1 - 0.71% Coverage

Erm, Personality Disorder first and foremost to me means, (pause) erm having a problem with managing your emotions and erm, that that particular problem is large for certain people

Reference 2 - 1.41% Coverage

I think there are always risks around the sort of enormous emotions that get erm, that I associate with Personality Disorder and they're sort of global erm, so there are some particular risks about a person harming themselves either deliberately or accidentally and then there are whole risks to a person's whole life style and potential to grow and develop.

Reference 3 - 0.24% Coverage

...and you have to take risks with people for them to grown up.

<Documents\Interview SD - 18.05.10> - § 5 references coded [4.38% Coverage]

Reference 1 - 0.47% Coverage

but to meet someone that's a little bit erm, the way they deal with life that is not the norm if there is a norm, of how other people cope.

Reference 2 - 0.71% Coverage

We've all got personalities, we could all be seen as having a disorder because what I might think is perfectly ok, something might think, oh that's a bit odd of her to think like that or deal with it in that way.

Reference 3 - 0.71% Coverage

if I can brave the risk to give them 12/24 hours because sometimes they come up with a solution themselves not always jump in with both feet and try to, sometimes you have to because they do put themselves at risk.

Reference 4 - 2.16% Coverage

They will phone us up in what they perceive as a crisis, which is I always say that is brilliant, you've actually picked the phone up and that is part of maybe because you are talking to me now and having spent 10 minutes or quarter of an hour on the phone it's calmed things down so that you don't have to go and self-harm because self-harm can actually be about who, I've got a girl who could exercise herself to it and her knee joints and ankle bones, she will walk miles, she is driven by this, so it's not just the self-harm with erm other ways, like tattoos because that's painful so she'll go and do that erm, there's other ways of self-harming.

Reference 5 - 0.34% Coverage

out of all people I have learnt they can carry out risks, so I do know that they are very risky people

<Documents\Interview TC . 07.09.11> - § 2 references coded [4.01% Coverage]

Reference 1 - 2.03% Coverage

I understand it is that erm, an individual has had some form of trauma in their early childhood and they have not been able to develop erm, the appropriate coping strategies and erm, appropriate behaviour that people call 'normal', erm, and they use alternatives that they've picked up along the way from abuse or certain kind of people in their lives and they haven't had the structure of generally, people with Personality Disorder haven't had the structure of, of family they've even been abused or erm something traumatic has happened to them, so that's kind of it really.

Reference 2 - 1.98% Coverage

Well instead of being able to talk to somebody they might not feel that they are able to talk to somebody that they take it out on themselves, they self-harm, I know of a lady that ligatures, who self-harms and overdoses erm, so she finds that's her coping strategy rather than being able to actually talk to somebody because she doesn't feel she can trust anybody erm, other coping strategies is basically to be anti-social and maybe cause harm to other people or quite a few people with PD do have quite a colourful police record because of things that they.

<Documents\Interview with MB\_070911> - § 1 reference coded [1.33% Coverage]

Reference 1 - 1.33% Coverage

so understanding, say for example Borderline Personality Disorder to Emotionally Unstable Personality Disorder where somebody might self-harm, it's understanding that that is like a symptom it's associated with the diagnosis and understanding why a person does that, again I suppose it comes back to having the experience of staff rather

than people just coming into a job, what they might is that 'oh person self-harms' but they probably don't realise that that's how they cope, because of their diagnoses, that's how they cope,

### **Name: Magical thinking**

<Documents\Interview BS - 16.03.10> - § 3 references coded [1.83% Coverage]

Reference 1 - 0.57% Coverage

so what I say to others is that it's not mental illness per say it's not a, it's not something that is necessarily caused by a chemical imbalance something biological, physiological,

Reference 2 - 0.73% Coverage

schizo-typal personality disorder and I would guess that with that there's a even stronger genetic component and that is much more strongly associated perhaps with the, the margins where personality disorder and mental illness meet.

Reference 3 - 0.54% Coverage

my first job, qualified job as a social worker was in a medium secure unit where virtually everybody probably had a PD to some degree in addition to a psychotic illness er,

<Documents\Interview JA - 12.05.10> - § 5 references coded [0.62% Coverage]

Reference 1 - 0.14% Coverage

the patients who ended up chronically engaged with mental health services erm, were people that normally had both an axis one and axis two diagnosis.

Reference 2 - 0.15% Coverage

But if you ended up chronically engaged with someone with either of those diagnoses it usually meant that they also had an axis two diagnosis as well..

Reference 3 - 0.06% Coverage

Borderline-ish, erm, but with all sorts of other features.

Reference 4 - 0.15% Coverage

Erm, and she strayed often into the erm, depressed, anxious and paranoid sort of side of things but she could also be very sort of effervescent and out there.

Reference 5 - 0.12% Coverage

Because one of the things that was, she was being medicated erm, for various anti-depressants and anti-psychotics and erm,

<Documents\Interview KH 13.04.10> - § 1 reference coded [0.48% Coverage]

Reference 1 - 0.48% Coverage

sometimes people will experience flashbacks and hallucinations as well almost, having that similar sort of experiences to people who have experiences of psychosis like hearing voices,

<Documents\Interview KS - 01.06.10> - § 2 references coded [1.39% Coverage]

#### Reference 1 - 0.43% Coverage

those who suffer damage at around two can present quite a few borderline psychotic features.

#### Reference 2 - 0.97% Coverage

we have so many people who have Personality Disorder and, erm, chap I've got at the moment, quite severe schizophrenia but underlining that is really a very disturbed person, erm, (pause) certainly a third.

### **Name: Loss & Isolation**

<Documents\Interview BB - 1.12.10> - § 1 reference coded [0.34% Coverage]

#### Reference 1 - 0.34% Coverage

Because the, the, basically people with personality disorder, people much like us who have had a lack of opportunity or otherwise

<Documents\Interview JA - 12.05.10> - § 8 references coded [1.82% Coverage]

#### Reference 1 - 0.13% Coverage

I was seeing who might been diagnosed with a personality disorder were completely alone and didn't have close family or friends...

#### Reference 2 - 0.52% Coverage

...he was an only child erm, of a family who, his mother was severely epileptic so he missed out on lots of early schooling and this that and the other because he used to stay at home and look after his mother, who he used to fit, proper fits sort of all the time. As a consequence to that he missed out on a lot of schooling and became, became or is dyslexic. And also he had terrible self esteem problems, because every time he did go to school he would get a lot of ribbing you know, well where have you been for three weeks bla bla bla...

#### Reference 3 - 0.34% Coverage

He erm, so he grew up thinking he was stupid and ugly and unwanted. Erm, his mother did eventually kill herself after... I don't know how many years, when he was eighteen erm, she committed suicide after, on her tenth attempt, obviously the nine previous ones, you know, it was the erm. His father then turned out to be a homosexual rapist and then he died.

#### Reference 4 - 0.05% Coverage

you know my shitty life and everyone's abandoned me.

#### Reference 5 - 0.11% Coverage

they turned him down he said don't you realise I've got fear of abandonment and loss, its part of my condition

#### Reference 6 - 0.12% Coverage

And here you are abandoning me already, you're injecting me, it's the worst thing you can do to someone with my condition.

#### Reference 7 - 0.34% Coverage

he fulfilled all the diagnostic criteria for borderline personality disorder in spades, he had all the history, he had all the aetiology and all the background. He'd been to every care home in erm, Hertfordshire, he came from a violent and dysfunctional family, he'd been raped and abused by his mother's, by, sort of, well by his mother's violent boyfriends,

Reference 8 - 0.21% Coverage

Whether it's the most common one well you know I think the fear of abandonment and loss erm, and feeling like you've been abandoned and loss even if you haven't ..... its the fear of it that they specify not the actuality of it.

<Documents\Interview JD - 24.11.10 v1> - § 1 reference coded [0.84% Coverage]

Reference 1 - 0.84% Coverage

Well I think that yeah, we play a crucial role in terms of sort of erm, maintaining those family relationships because quite often someone with a personality disorder may reject those closest to them. And you know the family have gone through trauma of, of, of feeling rejected and having those really difficult relationships.

<Documents\Interview KH 13.04.10> - § 1 reference coded [0.37% Coverage]

Reference 1 - 0.37% Coverage

as a reaction to things that have happened to them like erm, often it's sort of accompanied by feelings or worries about being abandoned erm,

<Documents\Interview KS - 01.06.10> - § 1 reference coded [1.78% Coverage]

Reference 1 - 1.78% Coverage

someone who's personality is not necessarily strong, it's got zones where it's more liable to fracture under particular stresses than other, where the person hasn't perhaps managed to integrate the different aspects of what make up a strong adult personality or what they have integrated is actually flawed, maybe from the result of abuse or a missing parent or other early circumstances.

<Documents\Interview LB - 24.11.10 v1> - § 1 reference coded [0.71% Coverage]

Reference 1 - 0.71% Coverage

I feel fairly careful on progress because if, if we talk too much about progress because of their difficulties and fears of abandonment they tend to think I'm going to walk away and (sighs) I find it really, really difficult because you either don't engage that well at the beginning so you can walk away more easily but then you don't actually make any difference.

<Documents\Interview SD - 18.05.10> - § 1 reference coded [0.55% Coverage]

Reference 1 - 0.55% Coverage

my understand of somebody with Personality Disorder is my own erm, perception is somebody who has missed out a big chunk of their life somehow at the very beginning,

<Documents\Interview TC . 07.09.11> - § 3 references coded [2.84% Coverage]

Reference 1 - 2.03% Coverage

I understand it is that erm, an individual has had some form of trauma in their early childhood and they have not been able to develop erm, the appropriate coping strategies and erm, appropriate behaviour that people call 'normal', erm, and they use alternatives that they've picked up along the way from abuse or certain kind of people in their

lives and they haven't had the structure of generally, people with Personality Disorder haven't had the structure of, of family they've even been abused or erm something traumatic has happened to them, so that's kind of it really.

**Reference 2 - 0.45% Coverage**

She's got no family, she's basically on her own, she came out of prison and she got moved to an area that she doesn't know erm,

**Reference 3 - 0.36% Coverage**

Some people can't have and some people aren't able to have family ties or they don't have family ties

**<Documents\Interview with MB\_070911> - § 3 references coded [1.08% Coverage]**

**Reference 1 - 0.25% Coverage**

I've got a patient whose never mothered her children, you know never had that, and lacks confidence

**Reference 2 - 0.48% Coverage**

so that's a difficult one because sometimes the parents or the family, not just the parents but the family they've probably gone through so much with the patient in terms of their frustrations

**Reference 3 - 0.34% Coverage**

some patients have nobody, absolutely nobody or some patients that far away from their homes, because they might be from a different area

**Name: Patterns & projections**

**<Documents\Interview BB - 1.12.10> - § 2 references coded [1.87% Coverage]**

**Reference 1 - 1.06% Coverage**

the specific parts of the specific abuse and how that made this person feels and how that and how that and how that then impacts upon their lives. So, so you, you were naturally gregarious and your father would, would hit you and humiliate you and take your trousers and pants down at sixteen. In order to ..... actually every time there is this pattern of grandiosity and humiliation and that humiliation

**Reference 2 - 0.81% Coverage**

And so, this, so you draw out, you draw out this pattern, this understanding, this formulation of the person otherwise, otherwise to understand it as a diagnosis that you just right so, so you're you and oh you've got this diagnosis, so I understand you because I've attached this diagnosis, not at all, no.

**<Documents\Interview JA - 12.05.10> - § 1 reference coded [0.36% Coverage]**

**Reference 1 - 0.36% Coverage**

from this idea that personality disorder is the failure of learning, it's almost a learning disability, learnt the wrong ways to relate to things through various experiences and the way your mind works, you've learnt to try and

manipulated the world but you've learnt the bad ways of doing it and so if you just learn the good way. So really what we actually need to be is taught,

<Documents\Interview JD - 24.11.10 v1> - § 1 reference coded [0.80% Coverage]

Reference 1 - 0.80% Coverage

And I think some of his perceptions are quite deep rooted at the age the of erm, he's 56 so I think if there is a lot of erm, there are a lot of assumptions that'll be quite deep rooted in there and it will all be under the surface but nevertheless I think erm, the consistency of the approach is so important.

<Documents\Interview KS - 01.06.10> - § 3 references coded [6.44% Coverage]

Reference 1 - 2.10% Coverage

but erm, something I've had regularly over the years, someone comes and they've said something like erm, 'all this person did was cut me up in the car park, I got out of the car and I was screaming at them and I was shouting at them and I was furious. I then had a really bad week because erm, I was so angry with them or I felt so bad at what I did', so in those cases we would unpack that look at understanding where it's come from, why they are like that.

Reference 2 - 3.08% Coverage

One particular patient who was very badly abused as a child erm, is carrying absolute rage and he's got a forensic history for quite brutal assault on someone and major problems with these sorts of anguishes and simultaneously we have found an understanding with him of where that came from and then start looking at well, how do you put this away, how do you work with that anger, erm, how do you get beyond and him we looked at erm, strengthening his sense of adult self and he was one of the two people who were able to work with Tolly and eventually he began to find forgiveness for his father who had abused him. That took a year to get to anywhere near that point.

Reference 3 - 1.26% Coverage

I find it easier to work with males rather than with females, the whole modelling thing and where I avoid young females because as a fifty-x year old male, you know, a 24 year old female is very hard to work with...

Yeah sure.

...and you get caught in the Father roles

<Documents\Interview LB - 24.11.10 v1> - § 1 reference coded [0.69% Coverage]

Reference 1 - 0.69% Coverage

But it tends to be erm, in order to get a diagnosis of personality disorder we're talking about something that has been sustained over a few years, you know numerous admissions to A&E, erm, interpersonal conflict, ongoing relationship difficulties as I've said and sort of consistent self harm in one way or another, yeah so that's my understanding.

## **Appendix 7; MHSW understandings of personality disorder (narrative, constructing the category)**

Kvale (1996) suggests that craftsmanship and the credibility of the researcher are decisive in whether others come to rely on research findings or not. The authenticity of research findings is not just a question of the appropriate use of method (Slaner, 1989 cited in Kvale, 1989) but also what the researcher brings to the research both experientially and ethically. Appendix 7 will summarise my CGT approach and hopefully evidence my craftsmanship as a researcher. It will reveal how I interacted with the data, generating an inductive appreciation of MHSW participants understanding of personality disorder. It will reveal therefore how I resisted imposing my experience and preconceptions of personality disorder and MHSW on the data.

The analysis of the MHSW data began with the last MHSW interview of 2010, that with BB (1-12-10-). This interview generated 13 initial codes and 2 memos ('Personality disorder is a psychological diagnosis' and 'Personality disorder is complicated') which conveyed BB's meaning of personality disorder. The latter was comprised of the 8 codes below,

**Personality disorder means big;** *"Could you start by telling me how you understand personality disorder. What it means to you?" (JW)*

(Pause) *"Well that's a big question". (BB)*

**Personality disorder means theory;** *"There's so many different theoretical perspectives; all of these perspectives shed some light on it from one perspective and another perspective will shed a light on it and another and each of those will shed lights and, on one part of the problem and obscure the other part of the problem".*

**Personality disorder meaning changes;** *"I don't think I understand it on a day to day basis in any way that could be sort of stated (pause) briefly".*

**Personality disorder meaning is contested;** *"Yes it is contested. It's still quite a new diagnosis; I think it was, I think it only appeared in the DSM in like the 1980's..."*

**Personality disorder means complexity;** *"Yeah, oh I think it's much too complex to, to, well there have been entire books written about it and to sort of ask the question how I understand it".*

**Personality disorder is a new diagnosis;** *"it's still quite a new diagnosis, I think it was I think it only appeared in the DSM in like the 1980's..."*

**Personality disorder means balancing;** “... you’ve got a, a knife edge to ride in that if this person really....”

**Personality disorder means grey not black or white;** “when you see things in black and white because you see things in black and white and you see that contradiction then you say well they can go out, they are not agoraphobic”.

1 initial code (*Personality disorder means not understanding*) appeared to relate to *Personality disorder is complicated*, but at that point I left this code to stand alone. I also left 3 other codes: *Personality disorder contributing factors*, *Constant crises* and *Poor interpersonal skills*, out of the two aforementioned memos. I will now concentrate on how *Personality disorder contributing factors* and *Constant Crises* were incorporated into the memo to form *MHSW understandings of personality disorder*, Category 1 of Phase 2.

BS’s (16-03-10) interview added depth and provided specific detail for *Personality disorder means constant crises*. BS also described how individuals’ lives can be characterised by “*chaos and drink, drugs, sex, police type of problems*”. KH (13-04-10) was the first woman MHSW I interviewed. I was interested in how she appeared more expressive as perhaps in her answer to my first question, “*how do you understand personality disorder?*” (JW)

*... it’s people who have had sort of tough early lives in particular , often end up demonstrating certain types of behaviour, maybe developing different ways of coping to maybe what the mainstream might do so that might typically mean that they experience feelings of self -harm or suicide as a reaction to things that have happened to them like , often it’s sort of accompanied by feelings or worries about being abandoned , sometimes people will experience flashbacks and hallucinations as well almost, having that similar sort of experiences to people who have experiences of psychosis like hearing voices, having really overwhelming thoughts and feelings and they basically, sometimes seem to respond to things that people might view are quite trivial, upsetting maybe, but not off the wall...*

KH appeared much more focused on the issues that people present with. Her references to “*tough early lives*” and later suggestions that most of the people “*...who have that label of Personality Disorder sort of are adult survivors of childhood abuse of some kind or another,*” contributed depth to *Personality disorder contributing factors*. KH also makes a connection between personality disorder and PTSD as A1

(20-06-07) had. I was interested in her suggestion that behaviours different from the “mainstream” can be ways for the individual to cope with the overwhelming nature of their distress. The parallels with F & A’s data were quite remarkable. KH was the first MHSW to suggest that extreme behaviours could be coping mechanisms. This data, together with a slightly more oblique reference to “coping” (BB- 1-12-10) formed a new initial code- *Different or more extreme ways of coping*. Both their references to risk, in this context, were also included within this code. KH was also the first MHSW to suggest that people with personality disorder might share similarities with those who “have experiences of psychosis like hearing voices”, generating a new code, *Magical thinking*. At the end of KH’s interview I had five initial codes that were beginning to denote these MHSWs’ understandings of personality disorder; *Personality disorder contributing factors*; *Personality disorder means constant crisis*; *Different or more extreme ways of coping* and *Personality disorder means poor interpersonal skills* and *Magical thinking*. I focused these codes, changing the name of the memo from *Personality disorder is complicated* to *Content of distress*.

The third interview, RT’s (4-05-10) added depth to 3 properties; *Personality disorder contributing factor*, *Different or more extreme ways of coping* and *Personality disorder means constant crises*. It also helped me to delineate relationships between the properties more clearly. RT described how personality disorder is to “do with having experienced difficult experiences early in their life” and how this can lead to people having a “*problem with managing your emotions and, that that particular problem is large for certain people and* “. RT also suggests how individuals may try to cope in more extreme ways- which can involve risk. I could see the relationships between “*difficult experiences*”, problems in managing overwhelming emotions and how this might involve extreme responses. I added the relevant data to *Personality disorder contributing factors* and compared the relevant data that I had already coded in *Personality disorder means constant crisis*. It became clear that the name of this code should change and I used RT’s words to rename this property to *Problems in managing emotions*. This, I felt, reflected the emotional challenges faced by the person, which could be overwhelming. If emotions were overwhelming, we might expect extreme responses. RT’s data also added depth to the *Different or more extreme ways of coping* property as she distinguished between particular and global risks;

*I think there are always risks around the sort of enormous emotions that get , that I associate with Personality Disorder and they’re sort of global , so there are some particular risks about a person harming themselves either deliberately or accidentally and then there are whole risks to a person’s whole life style and potential to grow and develop.*

RT’s distinction was important as it underlined how “*difficult*” early experiences and the associated emotions can impact on the person’s overall potential to grow and develop. Whilst I was finding the

analysis fascinating it was not without doubt and anxiety on my part. Whilst I now had five properties within Content of distress, (*Personality disorder contributing factors; Problems in managing emotions; Different or more extreme ways of coping; Personality disorder means poor interpersonal skills and Magical thinking*) I was struggling with the data sets overall and feeling quite overwhelmed myself.

SD's interview (18-05-10) caused me to return to the data I had already coded. SD described how personality disorder can mean loss,

*"... somebody who has missed out a big chunk of their life somehow at the very beginning..."*

SD caused me to re-visit the MHSW transcripts I had analysed to that point. I discovered that BB (1-12-10) refers to *"lack of opportunity"*. KH describes how individuals can fear being abandoned, implying a fear of the loss of someone. RT did not refer to loss. Consequently, I formed a new property *"loss"*. Analysis of SD's interview added depth to the *Different or more extreme ways of coping* property, through her suggestion that risk is implicit in behaviours which are *"not the norm"*. Crucially SD broadened the definition of self-harming behaviours through this description,

*self-harm can actually be about who, I've got a girl who could exercise herself to it and her knee joints and ankle bones, she will walk miles, she is driven by this, so it's not just the self-harm with other ways, like tattoos because that's painful so she'll go and do that , there's other ways of self-harming.*

This category, the *Content of distress*, now had six properties; *Personality disorder contributing factors; Problems in managing emotions; Different or more extreme ways of coping; Personality disorder means poor interpersonal skills; Magical thinking and Loss.*

The analysis of LC's interview (25-05-10) did not generate any new codes relevant to this category, but added depth to 3 properties; *Problems in managing emotions; Different or more extreme ways of coping and Personality disorder contributing factors*. I had never been happy with the name for this last property as it had seemed too general, but I had decided to keep it until the data suggested otherwise. At that point its name reflected the general nature of the data within it. With the exception of one specific reference to *"childhood abuse"* (KH), MHSWs, up to that point had referred generally to *"abuse"* (BB) or *"tough early lives"* (KH) or *"difficult experiences early in life"* (RT). LC was the first to refer specifically to trauma, in the context of *"abuse on some levels both emotional and sometimes physical and sexual"*. I attached a note to remind me of LC's use of the word trauma. I had perhaps begun to think about the need to generate a more specific name for this property as I had done with the

corresponding category in Phase 1. My analysis of KS's (01-06-10) interview, confirmed the need to generate a more specific name.

KS not only referred specifically to trauma, but suggested that the person's age at the time had implications for the kind of distress experienced as an adult,

*"...when the damage happens at different ages and obviously those who suffer damage at around two can present quite a few borderline psychotic features".*

His specificity encouraged me to re-name the property from 'Personality disorder contributing factors' to *Difficult and traumatic past experiences*. This was similar to the corresponding property within the corresponding category in Phase 1 but with an emphasis on past experiences rather than past and present. I also compared a segment of data from KS's interview with that in BB's describing how the MHSW needed to draw out the *"person's pattern"*. KS described how behaviours or ways of responding can be patterned and how this can then be projected on to others or him,

*"...you know, a 24 year old female is very hard to work with.....and you get caught in the Father roles especially if there's a faulty Father thing, it can be, a lot of transparency projection".*

This with BB's (01-12-10) formed a new property of this category, *Patterns and projections*. There were similarities across case as some service users had suggested how their behaviour could be governed by *"patterns"* established in the past (F & A- 20-06-07 & C 09-01-8). KS's interview meant that one property was named more specifically, a new property was generated and greater depth was added to the *Loss, Magical Thinking* and *Different or more extreme ways of coping*. The *Content of distress* category was now formed of 7 properties, *Difficult and traumatic past experiences; Loss; Problems in managing emotions; Different or more extreme ways of coping; Patterns and projections* and *Magical thinking and Personality disorder means poor interpersonal skills*. I had not generated any more data for the latter since my analysis of BB's interview. Whilst I retained the property, I suspected that it might become redundant.

Next I analysed JA's interview, the longest MHSW interview at 2.5 hours. This interview did not generate any new codes relevant to this category but added depth to 5 properties, *Difficult and traumatic past experiences, Patterns & Projections, Magical Thinking, Problems in managing emotions* and *Loss*. The latter was particularly interesting as with echoes of KH, JA suggested that loss and abandonment can be feared as well as actual,

*"...feeling like you've been abandoned and loss even if you haven't ..... it's the fear of it that they specify not the actuality of it"*

The next interview with JD (24-11-10) was the first of two in the North West of England. This interview helped me to feel confident that the data was becoming sufficient. JD's interview did not generate any new codes but added depth to the *Patterns and projections* property and also crystallised the connection between traumatic experience and extreme reactions as can be seen here,

*...often the roots of those are from early childhood experiences, traumatic childhood experiences. And it leads to them perhaps taking sort of extreme action such as, threatening suicide or, self-harming, responding in various sort of, aggressive disproportionate ways to requests.*

JD did introduce a different perspective on loss-as he was the only MHSW to consider the loss experienced by the person's family, suggesting the family can "lose" also,

*"...quite often someone with a personality disorder may reject those closest to them. And you know the family have gone through trauma of, of, of feeling rejected and having those really difficult relationships".*

My second interview on the 24-11-10, with LB, did not generate any new codes but added depth to 3 properties; *Loss*, now called *Loss & Isolation, Problems managing emotions* and *Difficult and traumatic past experiences*. LB offered a different perspective on *Different or more extreme ways of coping* when she suggests that the person's response is *normal*, it is their situation which is not,

*I do tend to say to them, well I say it to all of them that I believe; I believe that they're reacting normally to an abnormal situation. And I always say to them, you know, if I was in your circumstance, that's how I would probably react. You're not abnormal it's just your circumstances- this situation that you've found yourself in. And you know you were very young.*

More generally it was becoming apparent to me that my data was reaching sufficiency. Simultaneous coding across case had enhanced my awareness of the similarities and differences between service user and MHSW data. I was aware of the similarities across service user and MHSW understandings of personality disorder. I decided therefore to take the same name and re-name *Content of distress* to *MHSW understandings of personality disorder*.

Whilst my data appeared adequate, an opportunity arose for me to conduct two further MHSW interviews (TC & MB) in the North East of England. I conducted these interviews on the 7-09-11 and they helped me to decide that my data was saturated. Neither generated any new codes relevant to this

category, or any others. Both interviews added depth to 3 properties; *Difficult and traumatic past experiences*, *Loss & Isolation* and *Different or more extreme ways of coping*. Similarly to JA, JD & LB's interviews neither did they generate any data relevant to the *Personality disorder means poor interpersonal skills* property. My earlier suspicions that it would be a redundant property were therefore confirmed. Category 1-MHSW *understandings of personality disorder*, was therefore comprised of 6 properties, *Difficult and traumatic past experiences*, *Problems managing emotions*, *Different or more extreme ways of coping*, *Loss & Isolation*, *Magical thinking* and *Patterns and projections*.

This example offers some insight into the complexities of the analytic task. It reveals how I immersed myself in the data, allowed myself to be led by it, travelling back and forth in order to generate an inductive appreciation of MHSWs' understanding of personality disorder. It was not a linear process, progression often meant that I had to revisit the data I had already coded to check my interpretations or to seek out connections that I may have missed. Fairness meant that I had to look for and include participants' different constructions within the analysis. The example reveals my uncertainties, feeling overwhelmed at times and how I used focused coding and my research diary to cope with these difficulties.