

An action research study concerning how
clinicians formulate treatment choices for
people with personality disorder: using
hermeneutic and IPA methods.

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Section 2: Abstract

Background: Personality Disorder treatment is a contentious subject in health care. Despite available research concerning the diagnosis itself and also available treatments, there is little research regarding treatment thresholds or defining how treatment decisions can be formulated. This problem has been identified by clinicians, patients, supervisors and specific organisations, particularly linked to recent healthcare changes associated with austerity measures.

Research Question: How can mental health care staff use a formulated decision process concerning therapeutic interventions for people with PD, when considering the recent service changes and rationalisation of available treatments?

Methods: An Action Research study has been conducted over a four year period, using predominantly qualitative methods including: a hermeneutic literature review (n=144 papers), patient questionnaires (n=15) and Interpretive Phenomenological Analysis (IPA) of clinician and supervisor semi-structured interviews (n=10).

Results: Difficulties have been found when making decisions with people who either do not accept their diagnosis and/or do not accept the current evidence-based treatments for personality disorder. Other challenges have been identified regarding the patient/clinician relationship, the level of distress the patient presents with, and also the clinician view concerning the individual, the diagnosis, and the available treatments. The IPA produced five super-ordinate themes related to decision-making regarding treatment choices for people with personality disorder, including: difficulties with boundary management, diagnostic stigma, a focus upon time, metacognitive ability, and the potential for iatrogenic harm.

Conclusions: Multiple factors require consideration when examining treatment choices for people with a personality disorder, concerning the patient's individual symptom profile, needs, attitude towards treatments; the clinician's profession, attitudes, opinions, and wellness on the day of the assessment, and also the treatments available within the locality. A diagram has been presented summarising these formulation factors. Recommendations have been made based upon the results, analysis, synthesis and discussion sections, indicating potential practice changes and areas for future research.

Declaration of Interests:

There are no interests to declare in this study. The information contained in this study and presented in this thesis are the sole responsibility of the author. The copyright of this thesis is assigned to the author, and no quotations or extracts from this should be published without the author's consent.

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Completing a professional doctorate alongside full-time work is a very challenging experience; work, home life events and other hurdles get in the way. I would not have been able to complete this research without the significant support I have gained from my family, colleagues and my academic supervisors.

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List of Abbreviations

ANP – Advanced Nurse Practitioner
APD - Antisocial Personality Disorder
AR – Action Research
ASD – Autistic Spectrum Disorder
BAD – Bipolar Affective Disorder
BPD – Borderline Personality Disorder
CAMHS – Child and Adolescent Mental Health Services
CBT – Cognitive Behavioural Therapy
CMHT – Community Mental Health Team
CRHT – Crisis Resolution and Home Treatment
DBT – Dialectical Behaviour Therapy
DoH – Department of Health
DSPD – Dangerous and Severe Personality Disorder
DPD – Dependant Personality Disorder
EBP – Evidence Based Practice
HCA – Health Care Assistant
IPA – Interpretative Phenomenological Analysis
IQ - Intelligence Quotient
MCA – Mental Capacity Act
MDT – Multi-Disciplinary Team
MHA – Mental Health Act
MH – Mental Health
MI – Motivational Interviewing
NHS – National Health Service
NIMHE – National Institute for Mental Health in England
NSF – National Service Framework
OPMH – Older Peoples Mental Health
OT – Occupational Therapist
PbR – Payment by Results
PD – Personality Disorder
R&D – Research and Development
SD – Standard Deviation
TCG – Treatment Choices Grid
QALY - Quality-Adjusted Life Years
QOL – Quality of Life
WHO – World Health Organisation

Interview Transcripts

Within the Analysis and Discussion Section, interview transcript excerpts are provided, the abbreviation's used to reference each quote will be (T,P,L): T = meaning Transcript Number, P = meaning Page Number and L = indicating the Line Number.

Section 1: Introduction

1.1 Introduction and Motivation for undertaking this Research

Professions¹ working with people who have Personality Disorders² (PD) have to make very difficult decisions within a frequently challenging therapeutic and changing clinical context. This research was developed in order to critically understand and develop a process for how professionals can be empowered and supported with making treatment decisions when they are working with patients³ who have a PD.

The initial ideas for this innovative research evolved from actual experience of the challenges posed in both practice and supervision in this area of practice. It was evident in the context of locality teams⁴ that many of the clinicians were struggling with the Treatment Choice Encounter⁵. In order to provide the context for this research, a synthesis is developed within this Section. This synthesis brings together a coherent analysis of these personal experiences within UK research on Personality Disorder. This Section also provides an outline description of how the overall thesis is developed and presented. Finally, in order to conclude this chapter, the research aims and the specific research question are specified.

1 - The use of the term "Professionals" within this research pertains to any member of health and social care staff whose role is to provide initial assessments and treatment decisions with people with a Personality Disorder. For example, Professionals who may fulfil these roles include: Psychiatrists, Psychotherapists, Nurses, Social Workers, or Occupational Therapists.

2 – The use of the term Personality Disorder relates to people who fulfil the diagnostic criteria for the term Personality Disorder (PD), either as defined by the International Classification of Diseases 10th Revision (ICD-10), or the Diagnostic and Statistical Manual of Mental Disorders (DSM) (Appendix6). It is recognised that there are multiple subtypes of PD, the generic term PD will be used, however where specific subtypes are required, these will be specified.

3 – The term "patient" will be used within this research to collectively refer to people who use mental health services. Other terms in the literature may include: service user, client, or patient, however within the author's employing organisation, users of the service have opted for the term patient when surveyed, and therefore this term will be used in respect of this.

4 – The use of the term 'Teams' in this thesis relates to the specialist mental health, National Health Service (NHS) teams, that have been formed in the author's locality to deliver services for people with PD which may be the primary or co-morbid non-psychotic mental health disorder.

5 - The 'Treatment Choice Encounter' is defined as an encounter where a person with PD is engaged to discuss treatment choices. This is typically when they are first referred to specialist or secondary care mental health services, however it may pertain to a review of their treatment. In the service in which the author works, this encounter can be conducted by a number of professionals, including nurses, psychiatrists, psychologists, psychotherapists and/or occupational therapists.

1.2 Thesis structure outline

This thesis is structured within eleven sections. Each of these sections develop the central arguments cohesively within the thesis. This structure provides a clear flow that demonstrates critically how the research questions have been addressed and answered in a data driven unique form.

Section One provides a brief introduction to the study area and research question. Section Two provides a comprehensive literature review, using a hermeneutic method of analysing and exploring published research contributing to this empirical study. Section Three explores the ontological, epistemological, methodological, and strategic approaches taken to gather information to answer the research question. Section Four reveals how, in conducting the research, practice changed, and a need emerged to develop a clinical heuristic that served the purpose of both re-engaging participants and stakeholders, and also structuring clinical interviews conducted in participant research.

Section Five explores the participant study component, results of which are analysed within Section Six. Findings from the participant research are compared and contrasted with results from the literature review in Section Seven, to generate new information regarding formulating treatment decisions. Section Eight concludes the research, combined with a personal reflection regarding the author's experience, leading to the dissemination strategy provided in Section Nine. Sections Ten and Eleven provide references and appendices for the thesis.

1.3 Rationale for the focus of this enquiry.

In current England and Wales NHS services, there are significant ongoing changes taking place within mental health care delivery. There are also enhanced expectations about worker productivity within this change context (DoH, 2014a,b; 2011a,b,c,d, & 2009). The government introduced measures such as '*New Ways of Working*' (DoH, 2007), in part to economically utilise existing resources to support development of specialist services.

In many parts of the country, changes included moving away from generic community teams, with the creation of specialist Community Mental Health Treatment teams (e.g.: Psychosis or PD teams). This has meant that for many clinicians, their team context and caseloads have changed beyond all recognition. Thresholds for service provision within specialist services have also increased, with payments per treatment being evaluated (Monitor, 2014). Thus the overall strategic approach is aimed at the development of targeted specialised 'cluster' services, that it is envisaged will improve both effectiveness and efficiency. These aims, whilst many would consider them to be laudable, have been criticised. These criticisms mainly concern the impact on the clinicians delivering the services, such as potentially causing a negative impact on clinician wellbeing due to compassion fatigue from continuously working with patients with one set of symptoms (Schefer et al, 2007).

The study presented here took place in the context of the above implementation of "New Ways of Working". The locality services were subjected to a series of strategic organisational changes, the psychiatrist out-patients clinics and psychological

therapy provision were integrated into community mental health treatment teams. Significant changes were also made to the form in which treatment and therapeutic interventions were delivered. This included a departure from primarily 1:1 patient sessions in a clinic-based setting, to increased group-based interventions. Additionally, psychological therapy staff became increasingly involved with team training, consultation, and supervision, for other (non-psychotherapeutically trained) multi-disciplinary team (MDT) members. The overall aim of these service changes was to try and deliver a more cost-effective service that is better able to cope with increased demand, with a more flexible and responsive workforce.

Authorship and Agency

This research has been approached from a Social Constructivist perspective, using an Action Research (AR) methodology. This enabled a 'bottom-up' approach, critically exploring and understanding the Treatment Choice Encounter from different perspectives. The following section describes the agency context and summarises the clinician, supervisor, and patient factors that influenced how the focus was constructed and how the case for change was created.

Clinical context

The study has been conducted as a research project associated with the author's post as a Consultant Psychotherapist and Advanced Nurse Consultant within an NHS trust. This post incorporates direct patient interaction, providing clinical supervision, clinical teaching, and service development with several service teams. Each team is comprised of multiple professionals, adults may be referred to the team

if they have a diagnosis or traits of PD, and often they present with comorbid mental health problems.

The study was initially supported by the author's practice agency in respect of two aspects of their role. The first aspect concerned the delivery of brief psychotherapeutic training aimed at increasing the skills of the therapeutic workforce, the second concerned work conducted regarding trauma processing, after certain specific locality incidents related to self-harm and violence. Analysis of feedback from these two work strands prompted staff reflection and author curiosity in regards to the individual and systemic effects of incidents, and training concerning treatment choice, expanded upon in the following sections.

Research Progress

In 2012, the author conducted a pilot study, which delivered Cognitive Behavioural Therapy (CBT) education sessions to 179 staff members. This study enabled targeted CBT interventions to be delivered at different levels by a variety of staff, dependent upon patient need. This also enabled the increase of group level intervention, and subsequently decreased the demand for 1:1 CBT intervention delivered by a qualified psychotherapist. This mandate was necessary to enhance the skills of the existing workforce, prevent the development of increased waiting lists for 1:1 psychotherapeutic intervention, and make the most economic use of the scarce resource of registered psychotherapists.

The study generated positive results in terms of staff feeling their knowledge and skills were increased, however it also revealed personal anxiety and traumatic

experiences connected with both their experience with service users who have a diagnosis of PD, and in terms of their redefined roles and changed way of working. The synthesis of training feedback combined with practice supervision data uncovered a need to (1) explore the effects of occupational trauma in this context; (2) explore how clinicians make treatment choices with people with PD, and; (3) develop a consistent approach to psychotherapeutic supervision of staff working where there may be value judgements connected with access to specialist treatments.

To explore these themes further, the author conducted literature reviews concerning Occupational Trauma, which was published (Graham, 2012) and triangulated with a literature analysis regarding formulating treatment for PD. In researching this, the author discovered a gap in the research, in that there are currently no specific methods or tools to assist treatment choices for this patient group, and that although it is acknowledged that traumatic experiences can affect clinicians in different ways, there is no current multi-professional research which focuses upon the Treatment Choice Encounter. This disconnect is why this research provides an original contribution to the body of knowledge.

As a part of the ongoing practice Action Research process, the author then conducted informal exploratory work with key locality professionals, to understand the problem better from their perspectives. Collaborative exploration enabled a shift for the author, from a researcher and reflective practitioner to a less detached and subjective position, understanding how the different beliefs and experiences of

clinicians influence their thoughts, feelings, and behaviours, within their specific environmental context (Schunk and Bursuck, 2016:55).

Professional's perspectives and experiences:

Through supervision and clinical discussion, four core themes were identified as influencing decision-making: firstly, through service reconfiguration: instead of being referred to three services (out-patient psychiatry, psychotherapy, and Community Mental Health Teams), patients are now referred to a care-coordinator, who can then access the team resources. Care coordinators (typically junior staff) stated that they struggled when deciding when to request additional input (i.e. psychotherapy).

Secondly, through observation within supervision sessions, the author and other practice supervisors identified that there are many value-laden statements attached to PD patients, including: "deserving", "manipulating", and "attention-seeking". These value judgements appear to influence objective decision-making, and can be connected to transference processes related to the patient's psychological defence mechanisms (Gedo, 2011; Dodwell, 2008).

Thirdly, feedback showed that the patient's mood and responses to formal mood ratings is often highly changeable. Clinicians suggested that they are often left unsure about whether to refer the person into the more intensive and costly therapeutic interventions that are available, due to the scarce resource, and doubts about whether it would be helpful to the patient.

Finally, a service framework issue theme was raised, concerning treatment teams, crisis teams, and in-patient staff, who all provide components of care for PD patients. The issue concerns the lack of a whole-system cohesiveness, which often leads to 'splitting' and disagreements in teams and across services. This type of difficulty resulting from service configuration is not unique to this locality or patient group, and is one reason for piloting the current NHS Vanguard Sites, which focus upon the need for multiple care providers working to one single model (NHS England, 2015).

The synthesis of these four themes suggested a need to critically understand how decision-making happens and is supported, when working with PD patients. Thus the views of supervisors were sought within the clinical practice area.

Supervisor experiences:

Locality professional leads consist of: psychiatrists, nurses, psychologists, psychotherapists, and managers, the author's role is to provide specialist consultation with certain patients, and supervise these leads. Evidence from locality meetings, education sessions, and supervision sessions, showed that supervisors and senior clinicians are often not consulted by junior clinicians unless an incident has occurred, and they state that clinicians are often vague in what treatment they prefer.

Therapists explained that although some referrals for group and 1:1 intervention are appropriate, other patients are ill-prepared for therapy, or unwilling to engage in talking-treatments, resulting in a disappointing therapy session for the patient, and an inappropriate resource use. Therapists reflected that this is often due to service

reconfiguration, resulting in non-therapists making treatment decisions. This raised issues in clinician's understanding of what they refer patients for, and how to prepare patients for certain treatments.

In collating and critically analysing this supervisor feedback with the literature review findings and feedback from clinicians, it was identified that neither current published research or practice knowledge provided adequate descriptors of personal experiences in the Treatment Choice Encounter. This supports the need to better understand decision-making processes, and to develop a structure to aid decision-making, not only for referral to different professionals in the team, but also for team supervision.

Patient experiences:

Locality data obtained through patient discussion forums and informally raised concerns suggested that PD patients are often unsure about why certain treatments were offered, not offered, or why specifically requested help was refused. Patients explained that they have felt confused about treatment, certain patients requested specific talking therapies or medication, and some rejected both treatments, requesting quicker, more practical help (i.e. housing applications).

Themes raised by patients in clinical practice were compared by the author to feedback available in more public forums, in order to critically understand whether the issues are unique to the locality due to service configuration, or common for people with a PD diagnosis. Exploration revealed that locality patient feedback is echoed in online blogs and treatment feedback comments made upon websites

including NHS Choices, (NHS Choices, 2015a), and social media blogs, and personal experiences published on websites such as Emergence (Emergence, 2016), and through twitter chat from patients discussing their experience of PD treatment. This informed how the research was shaped, as it suggested that relational aspects are also core to the personal interaction, rather than just the configuration of services.

Difficulties raised in asking the question

It was ethically important to be reflective and sensitive to the effects that simply asking the question had upon the researcher and other clinicians (Berger, 2015). People's perceptions of their own practice, treatment decisions, and formulated decision-making, change through the process of enquiry, independently of whether any other outcomes are generated by the research. These impacts of "process" are fully congruent with the core tenets of AR. They will thus be commented upon throughout this thesis, to demonstrate reflection and the reflexive process.

In asking the question about how treatment choices are made with PD patients, a degree of instability was witnessed with locality professionals and other decision-makers, who started questioning their own actions. In response to this phenomenon, to attempt to stabilise clinicians and investigate what may help them, work was conducted with locality teams to develop a basic decision-making grid as a potential practice solution, discussed in Section Four.

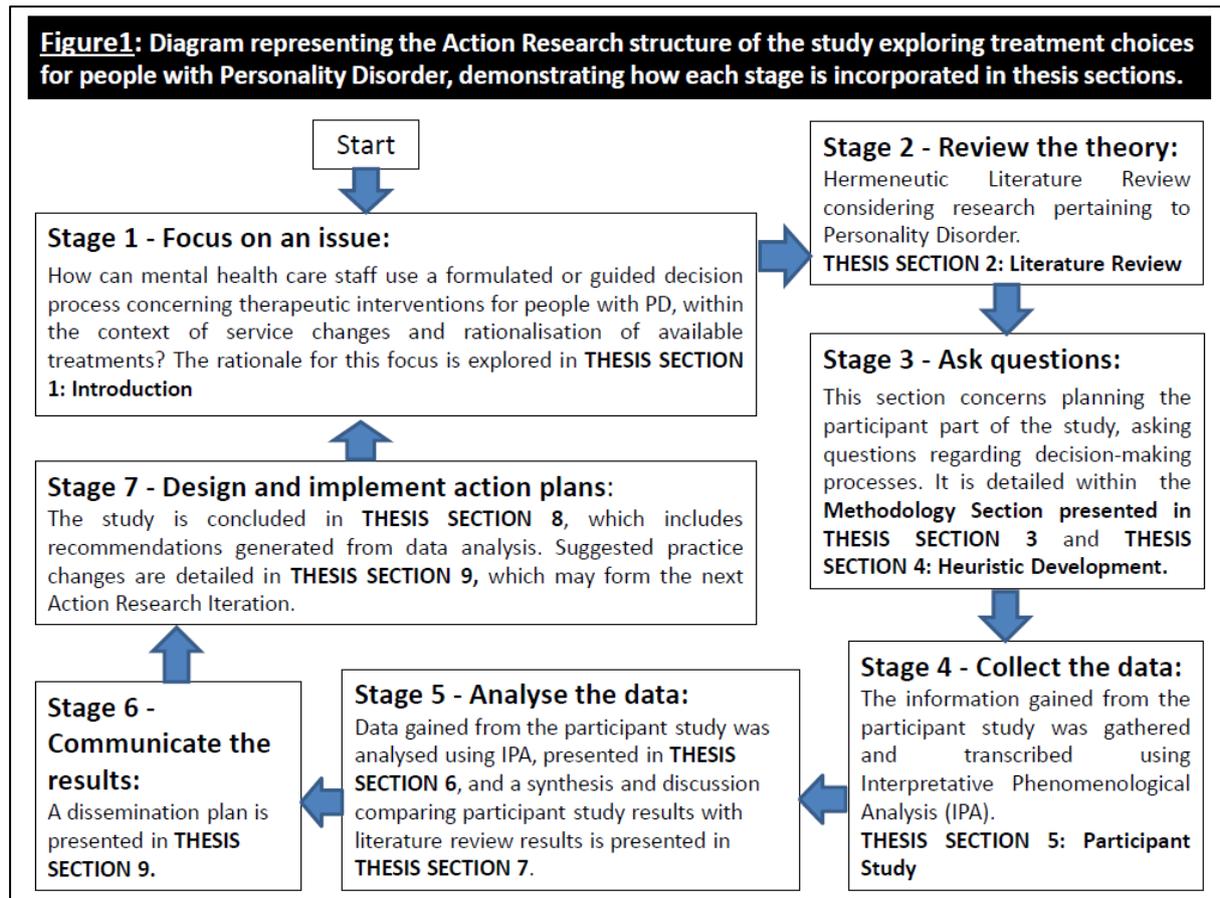
Summary

The focus of the research was identified after critical analysis of a training evaluation, contextualised through reflective information provided by clinicians in clinical supervision. The author's curiosity about the subject, due to their previous research and clinical role, was influential in the study design. Exploration of published research, and clinician, supervisor, and patient experience, revealed some of their constructed realities and cultural narratives concerning the uncertainty of the Treatment Choice Encounter and treatment selection process. Literature review evidenced that this is an unexplored aspect of clinical practice warranting research exploration, whilst being ethically sensitive to the potential impact this may have in generating increased anxiety and uncertainty with more practice reflection and potentially practice changes.

1.4 Research Question and Aims

When all information is considered from Section 1.3, the current AR focus is to explore variables affecting consistent clinical decision-making concerning treatment choices for people with PD. The subject is approached from a CBT perspective, exploring how clinical decisions are made and articulated in practice.

The study is presented, and thesis structured, using the 7 stages of an AR cycle (McNiff and Whitehead, 2006), presented in Figure 1. This demonstrates how the methodological approach answered the research question posed:



In AR, several subordinate iterations of a research cycle may underpin one problem. Within this thesis, three subordinate iterations are used to explore the focused issue: i) literature review, ii) grid development, and iii) field study. These three iterations enable the full AR study represented in Figure 1 to be achieved.

Research Question: How can mental health care staff use a pre-formulated guided decision process in the selection of therapeutic interventions for people with PD, within the context of rationalisation and service change?

Purpose: To conduct an AR study in one NHS Mental Health Service site, using a newly developed 'Treatment Choices Grid' for patients, clinicians, and supervisors, then explore clinician's experiences of making treatment decisions using the grid.

Aims and Objectives:

- (1) To conduct a critical literature review, exploring variables and support strategies for the decision-making process for people with PD.
- (2) To use the newly developed heuristic: the 'Treatment Choices Grid', to focus practice exploration of the decision-making phenomena.
- (3) To use semi-structured interviews, analysed through an Interpretative Phenomenological Analysis (IPA) framework, to gain a better understanding of the difficulties clinicians face when making treatment choice decisions with PD patients, and identify support strategies that may assist the process.
- (4) To make practice recommendations considering the research results, which will then form the next AR practice cycle.

Section One Summary

When considering: 'why this subject, and why now?', the above section provides a rationale concerning the need to focus upon how clinicians are supported to make treatment decisions with PD patients.

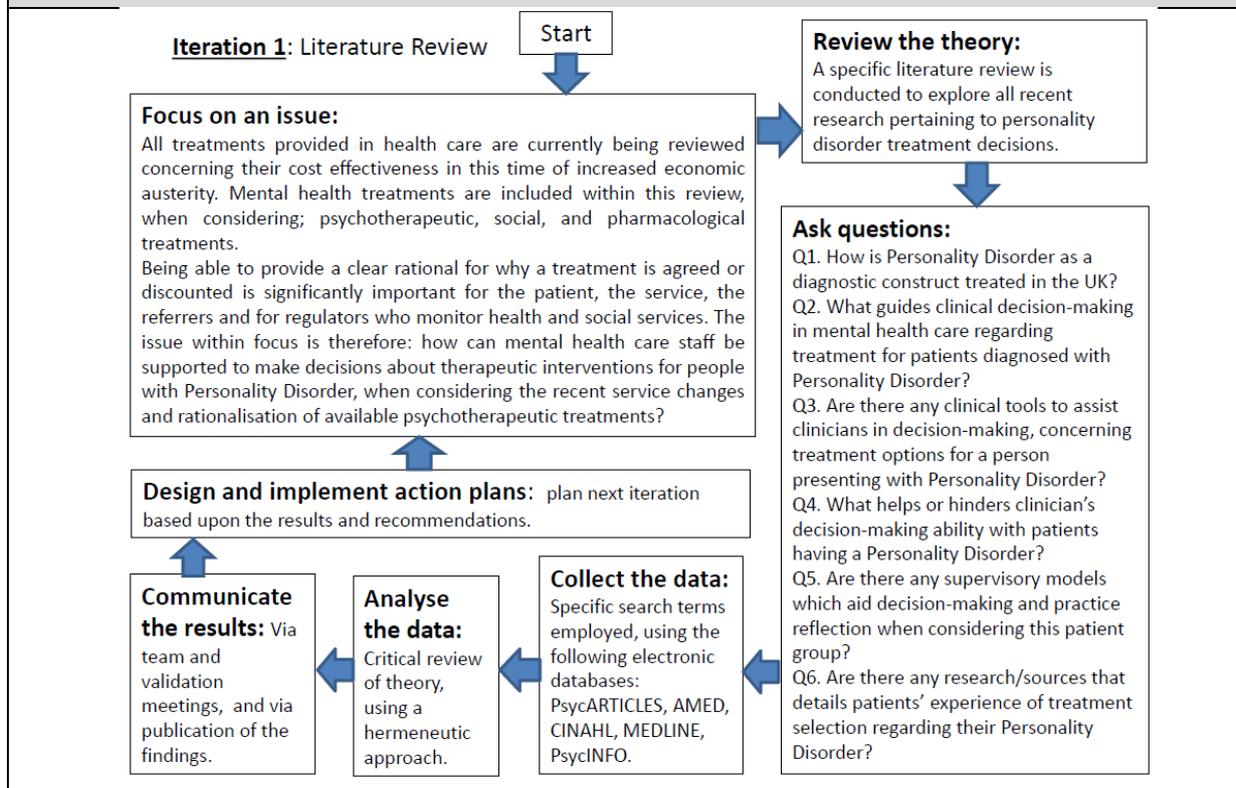
Waterman (1998) identifies three types of validity as essential when reflecting upon the purpose and outcomes of action research: dialectical validity, critical validity, and reflexive validity. The above section highlights how, in terms of 'dialectical validity', a disconnect exists between current practice evidence, and available research related to treatment choices. Considering 'critical validity', patient, clinician, and supervisor perspectives provide an insight into potentially emancipating elements of the research regarding improvement of patient and provider experiences, which require phenomenological exploration.

Lastly, in terms of 'reflexive validity', the author, as a researcher, clinician, and supervisor, has identified a need to approach the research considering the different perspectives, mindful of their own sense of personal agency. The next section focuses upon a literature review, providing an in-depth understanding of the current research concerning the research question.

Section 2: Literature Review

Within the previous section, the research project has been introduced, defining the overall research question, aims, and objectives. An in-depth literature review is presented within this section, concerning treatment choices for people with PD. This section will concern subordinate AR cycle 1 (Figure 2), providing a critical analysis of current theory, using a hermeneutic approach to the concept of literature review.

Figure 2: Subordinate Action Research Cycle 1: Literature Review within the study exploring treatment choices for people with Personality Disorder.



Defining literature review parameters is challenging for two reasons: firstly, due to complex dynamics surrounding PD diagnosis, and secondly due to the vast amount of research conducted into variables influencing clinical decision-making.

To contextualise and focus the review, specific questions are asked of the literature sourced, and hermeneutic explorations were conducted, to critically analyse sources found, and link back to the overall research question.

2.1: Theory review: Questions posed

The scope of the literature will be specific to review questions posed, which link in to the overall research question:

Literature Review Questions

Q1. How is PD as a diagnostic construct interpreted?

Q2. What guides clinical decision-making in mental health care regarding treatment for patients diagnosed with PD?

Q3. Are there any clinical tools or heuristics to assist in decision-making concerning treatment options for a person presenting with PD?

Q4. What helps or hinders clinician's decision-making ability with PD patients?

Q5. Are there any supervisory models which aid decision-making and practice reflection, when considering this patient group?

Q6. Are there any research/sources detailing patient's experience of treatment selection regarding their PD?

2.2: Scope of the literature

Information was accepted from the following sources: research databases, primary/secondary research studies, books, professional narratives, and clinical opinions.

A literature search was conducted, using these electronic databases: PsycARTICLES, AMED, CINAHL, MEDLINE, PsycINFO. Search terms employed for the analysis are displayed in Figure 3:

Figure 3: Literature Search Terms used within the study exploring treatment choices for people with Personality Disorder.	
<ul style="list-style-type: none"> • Personality Disorder& Treatment Choices • Personality Disorder & Treatment Thresholds • Personality Disorder & Treatment Suitability • Personality Disorder & Treatment Selection • Personality Disorder & Treatment Decisions • Personality Disorder & Treatment Engagement 	<ul style="list-style-type: none"> • Personality Disorder& Treatment Exclusion • Personality Disorder& Treatment Inclusion • Personality Disorder & Clinical Decision Making • Personality Disorder& Treatment & Clinical Judgement • Personality Disorder & Supervision & decision making

2.3: Inclusion/exclusion criteria:

Clear parameters were set concerning inclusion and exclusion criteria for the literature review, aiding readers to understand potential bias, enabling repeatability should readers wish to check the review. Criteria set were:

- Date inclusion: the date range was 2003-2015, as it captures data pertaining to the most recent treatment, from when ‘*Not a diagnosis of exclusion*’ (DoH, 2003) was published. However, when searching the literature, other pertinent studies referenced were sourced and included.
- No restrictions were set concerning country of publication, all pieces had to be in English. With non-UK sources, country of origin is specified, as although the results may apply to the population in focus, the context of the UK health agenda would make generalisability of non-UK studies questionable.

- The study generated both qualitative and quantitative research sources, also sources deriving from professional opinions. All of these were included in the review, due to the Constructivist approach taken.
- Sources generated were limited to: mental health care and PD, as defined in the introduction.
- Literature that primarily focused upon children was not included.
- A search completion date was set for: 1/05/2015, as pertinent⁶ studies may be published after this time, and should this be the case, the literature review outcome could be altered.

A summary of study characteristics is presented in Appendix1. For consistency in data analysis and exploration, the data extraction and review tool by Benton and Cormack (2004) was applied to all research sourced, enabling identification of potential strengths and weaknesses.

In any literature review, there is a degree of subjectivity in the analysis performed (Bowling, 1997:389), however the above framework was used to minimise result variability if the analysis were repeated.

2.4: Literature Review Method

Hermeneutics is the theory of interpretation derived from the works of Schleiermacher, Heidegger, and Gadamer (Smith et al, 2009:54). The rationale for this choice of method is explained within Section three.

⁶ The term 'Pertinent' refers to any studies that predate the stated range, but include information relevant to the research questions, specifically if they refer to making treatment choices with adults with a Personality Disorder.

2.5: Ethical Issues of the Literature Review

This part of the study does not concern human participants, however certain ethical considerations must be adhered to in any literature review (Vergnes et al, 2010). The following ethical considerations were made:

- The researcher's philosophical approach to data interpretation is presented, allowing readers to understand any potential bias (Girden, 2001) – (See Section 3).
- The researcher declares a personal bias connected with her role as a mental health nurse and psychotherapist. This bias is declared, as it will affect the literature reviewed and may influence the perception of treatment cited.
- This study is not funded, therefore has no sponsorship implications.
- Respecting the literature, analysing each source with a balanced critique so as not to skew findings (McLeod, 1998).
- Searching a wide range of sources to answer questions posed, rather than a narrow range selected to adhere to the researcher's viewpoint (Barker, 1994).
- All sources are accurately referenced, enabling repeatability (Lewis and Barnes, 1997)
- No plagiarism (Scanlan, 2006).
- Full results are presented (Welsh and Dickson, 2005).

2.6: Study selection process

A search was conducted, search findings were refined using the restriction criteria set. The refinement process is detailed in Figures 4&5:

Figure 4: Diagrammatic representation of the literature review search refinement within the study exploring treatment choices for people with Personality Disorder.

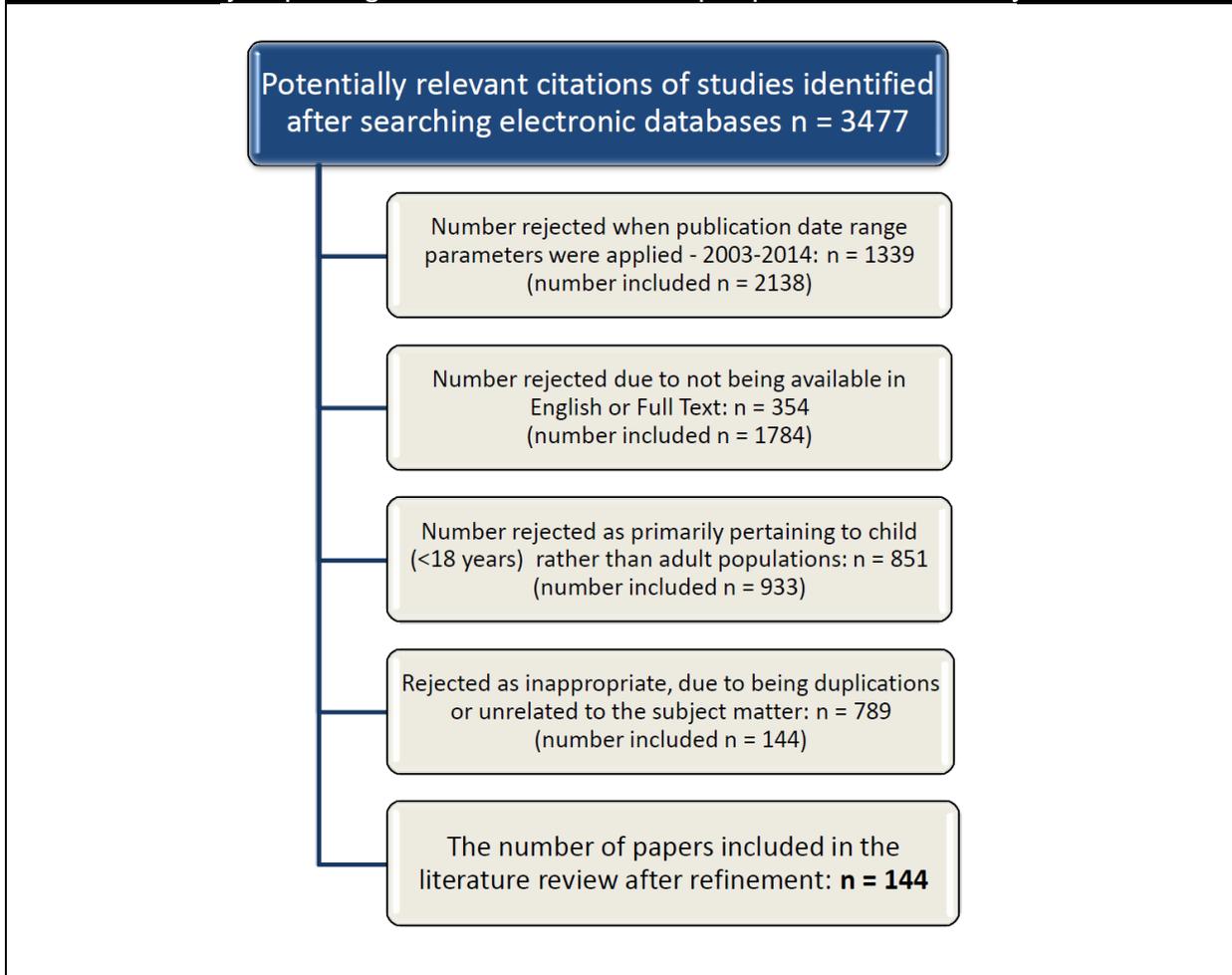


Figure 5: Literature Review Breakdown incorporating inclusion/exclusion criteria within the study exploring treatment choices for people with Personality Disorder.

Search Terms	Total number generated	Number after the pre-set selection criteria was applied, and duplications removed
Personality Disorder & Treatment Choices	505	49
Personality Disorder & Treatment Thresholds	31	6
Personality Disorder & Treatment Suitability	47	13
Personality Disorder & Treatment Selection	332	15
Personality Disorder & Treatment Decisions	580	4
Personality Disorder & Treatment Engagement	271	15
Personality Disorder & Treatment Exclusion	83	1
Personality Disorder & Treatment Inclusion	153	0
Personality Disorder & Clinical Decision Making	367	10
Personality Disorder & Treatment & Clinical Judgement	737	4
Personality Disorder & Supervision & Decision Making	371	27
Total	3477	144

2.7: Study Demographics

The appendices provide study demographics for research, including a table concerning journal sources (Appendix 2). This demonstrates that information was gained from a wide range of journals; the age range of the literature (Appendix 3); country of origin (Appendix 4); and PD type focused upon by the paper (Appendix 5). These appendices will be referred to from within the subsequent literature review discussion.

2.8: Literature Review Findings

The literature review findings are presented using the six questions posed in Section 2.1. Q1 commences by providing a historical overview related to the diagnostic construct itself, identifying moral, social, cultural, and legal factors that influenced the definition of the disorder itself, and impacted upon the notion of treatability.

Q1: How is PD as a diagnostic construct treated?

History & Diagnostic Categorisation

The psychiatric construct of having a disordered personality as a part of mental health problems dates back thousands of years, with 3,000 year-old records describing symptomatology (Antoniadis et al, 2012). The two current main diagnostic coding systems used are DSM and ICD (Reed, 2010), the ICD criteria being the main criteria used in the UK, however the DSM is also used in some areas. The diagnostic systems differ slightly, the DSM has 10 subcategories of PD, the ICD has 8, (Appendix 7).

The diagnostic conceptualisation and categorisation of PD in relation to other mental health disorders differs slightly between ICD and DSM. Since the 3rd DSM in 1980, PD is placed on a separate axis from other mental health problems, due to the disorder's course and likelihood of comorbidity (Krueger et al, 2010), whilst the ICD-10 retains PD in the main rubric of mental disorder categorisation (Moran, 2007).

ICD-10 and DSM PD classifications are currently debated due to conceptual complexity, with proposals that a hybridized, multi-dimensional model may be more suitable for PD categorisation. The introduction of DSM-5 (APA, 2013) has changed PD conceptualisation, but recommended further research. PD classification changes are likely to be expanded further in ICD-11, which will impact on UK treatment choices, and the overall research question posed concerning formulated treatment choice.

The new DSM-5 conceptualisation provides two specific PD criteria: impairment of personality functioning (i.e. interpersonal functioning and identity), and one or more pathological personality traits (i.e. detachment and empathy). This model proposes that personality pathology cannot be defined by trait elevation alone. This important differentiation should reduce the number of people meeting PD diagnostic criteria, however people previously diagnosed may no longer meet criteria.

Theories concerning PD aetiology appear to remain stable, however amorphous and changing diagnostic definitions are intrinsically linked with difficulties diagnosing PD, resulting in devalued validity of PD diagnosis itself, discussed in the next section.

Major Mental Illness or Not?

Although the defining characteristics of PD as a concept are still debated (reflected above), what is no longer debatable is that PD is now one of the most recognised mental disorders. The inclusion of PD as a major and enduring mental illness has changed the focus of the research conducted, and also the notion of its 'treatability'. Most studies that focus upon generic 'major mental illness' therefore include PD, however some researchers still exclude people with PD (i.e. Martin et al 2012). In terms of answering Q1, the author proposes that it is conceptually important as, if there is a right to provide a diagnostic label, there is a corresponding responsibility to treat. This research focuses upon the full range of PD diagnosis.

Pickersgill (2012) suggests that PD diagnostic labels are particularly controversial when associated with criminal or antisocial behaviour, posing a medical, political, and public concern, specifically focused upon constructs of Antisocial PD (APD) or Psychopathy. Categorising this particular set of traits is ethically debated in terms of treatability (Eastman et al, 2006). As a consequence, there have been alterations in mental health law, prompting policy changes and reformulated care provision for people with PD (Pilgrim, 2007). All of these factors influence PD treatment choice.

Despite the multiple PD categories, two specific PD categories have received a specific focus by researchers and policy makers. These are Borderline Personality Disorder (BPD) and Antisocial PD (APD). This focus has led to increasing service recognition of these categories; however other categories which arguably may require more treatment resources (i.e. Dependant Personality Disorder) do not currently have treatment guidelines (Bornstein, 2005). This polarised research focus

is reflected by the literature sourced in this review, which primarily concentrated on APD or BPD, or referenced PD as a generic category, without specifying the PD type. The more significant association with risk to self and/or others, requiring mental health service intervention, appears to be one of the main reasons that PD guidance/legislation is particularly focused on BPD and APD (Budge et al, 2012).

How do diagnostic labels influence attitudes and treatment decisions?

It can be argued that mental health diagnosis are socially constructed, meaning that social and cultural opinions on what is normal and abnormal are core to conceptualisation of PD. Descriptions of disorder can take one of two forms, i) the prototype view, meaning mental representation of a concept is gained by a list of defining and separating features (i.e. ICD-10 criteria), or ii) through taxonomies, which often consist of hierarchically-connected structures (i.e. the multi-axial system used by the DSM) (South et al, 2013).

There are strengths and limitations to either type of description and organisation, central to Q1. One difficulty with the prototypal view of PD conceptualisation, like other mental health problems including anxiety, is that symptoms are subjectively rated and 'norm-governed' (i.e. what is impulse control?), and therefore influenced by factors other than diagnostic symptoms, including emotionally-laden factors connected with race, gender, and socio-economic status, which influence clinician decision-making.

Several examples of this difficulty were found in the literature review. For brevity, just the topic of gender will be provided as an example: when considering PD, some

research states gender stereotypes significantly impact upon diagnosis (Jørgensen et al 2009). BPD is diagnosed more in females than males, debated in the literature concerning whether it is a gender-specific 'illness', or whether there is gender bias due to societal expectations and cultural 'norms' (Grant et al, 2008). Additional research found that in violent criminals, PD is diagnosed more in women than men, because violence is contrary to female stereotypes (Liebman et al, 2013). Research also suggests specific cultural 'norms' governing the provision of a diagnosis, specific to western societies (Leichsenring et al, 2011; Nysæter et al, 2008).

Considering the taxonomic conceptualisation of PD used in DSM, one strength is that diagnosis is not seen as merely a list of symptoms (as with prototypal categorisations), instead it is accepted that PD patients may present differently dependent upon issues in the other axis (i.e. homelessness, or IQ level). This is important when formulating, as research links allocation of diagnosis with value-laden treatment decisions, with clinicians categorising or clustering symptoms, including: "*things I refer out*", "*diagnosis I like or dislike*" and "*things I treat*" (Flanagan et al, 2007).

Whether prototype or taxonomical categorisations are used, criticisms concern the categorical approach to PD. Moray et al (2014) state that criticism surrounds: heterogeneity of symptoms; temporal instability of PD diagnosis, and complications raised by co-occurrence of PD, suggesting: "*arbitrary diagnostic thresholds in polythetic criterion sets, with little or no empirical basis*". Categorisation is important when considering treatment choice, and other diagnostic models were considered in the debate (i.e. Personality Trait model, Krueger et al 2010; Five-Factor Model,

Piedmont et al, 2009). The APA rejected proposals for model change in PD conceptualisation, however placed suggestions in DSM-5 Section 3, as “*constructs requiring further study*”.

Ongoing research debates (Rottman et al, 2009; Widiger et al, 2011; Mullins-Sweatt et al 2012) parallel the research locality clinical practice debates defined in Section 1. Various research tools are defined as useful when diagnosing PD (i.e. SCID-5-PD, First et al, 2016), however due to the ongoing changes proposed in terms of diagnostic construction, this results in a lack of a single validated test for PD. In practice, PD diagnostic testing remains subjective, meaning that, dependent upon whether traits are recognised, or a full diagnosis is provided, this affects the person’s right to access a particular treatment. This matter is core to the overall research question, and is expanded upon in the following section.

Diagnosis or traits

A point identified through literature reviewed affecting PD conceptualisation, is linked with notions of diagnostic and treatment thresholds, underpinned by concepts of; disease, dysfunction, and disability. Clark and Ro (2014) explain that it is conceptually important that ‘functioning’ and ‘traits’ are distinguished, as a person may have ‘extreme traits’, but this may not necessarily be pathological. This represents an empirical challenge to clinicians selecting treatments, because the constructs conceptually interact and overlap. They additionally introduce a further debate concerning whether, for a PD diagnosis, it merely requires symptoms to be present, or whether these must be accompanied by a degree of disability or distress, to warrant treatment?

The question of assessing levels of distress and disability is complex. The ICD-10 distinguishes “disease” from disability, considering disability as a consequence of disease. This influences clinical decision-making, meaning that disability does not influence the diagnosis of the disease itself, which is solely based on dysfunction.

When considering Q1, PD diagnoses are considered differently from other diagnosis, for example physical health problems. Physical health diagnoses have clearer distinctions between intrinsic factors of the disorder, and extrinsic consequences of the disability (i.e. arthritis is not defined by restriction of movement, that is a consequence that affects treatment). This is therefore a contentious difference between mental and physical health problem conceptualisation and treatment allocation, considering whether psycho-social impairment should be included as part of the PD diagnosis, or as a consequence of PD. DSM-5 does not include the clinical significance criterion, prompting the opportunity and challenge of separating and measuring levels of functioning and disability.

Personality Development

European and USA epidemiological studies estimate that the prevalence of PD is between 4%-13% of the adult population (Coid, 2006; Lenzenweger, 2008; Samuels, 2011). PD aetiology is closely connected to unstable attachment patterns in childhood (Eagle, 2006), and most commonly linked to trauma and/or abuse (Kanninen, 2003). Chaikin et al (2004) explain that early life abuse of any kind predisposes a person to physical health problems, other mental health problems, financial and occupational problems, and impaired interpersonal functioning (Chard, 2005; Owen, 2011).

Kruger et al (2010) explain that a personality profile of any person may find traits of dysfunction, the debate surrounds the degree of intensity and number of facets that would warrant a diagnostic pathology. This is particularly important when considering the research question as, when assessing a distressed person (i.e. one who has recently experienced trauma), or a person with diagnostic comorbidity (i.e. severe depression), symptom assessment may be skewed by transient difficulties the person experiences, potentially exacerbating underlying traits.

When considering the research focus, the research in this section is influential, as it is not the diagnostic traits that are most important regarding treatment choice for a PD patient, but contextual variables which may adjust the presentation of these traits; this is often termed the “*big picture*” of personality variation (Clark, 2007), which is significant when considering treatment formulation.

This “*big picture*” focus means that two people with PD could have few overlapping personality features, providing diagnostic heterogeneity, posing conceptual conundrums, obviated by use of multidimensional models of personality. Practically, this would mean that diagnosis would not be defined by potentially dichotomous variables (i.e. above/below diagnostic thresholds), instead assessed in multiple dimensions, related to trait extremities rather than traits themselves. Difficulties include the notion of objectivity, when not only symptom-nature is clinician rated, but also degree and/or severity, which cannot be adjudicated with value-free objective judgements. It is a matter of societal and professional opinion whether the diagnosis is made, and in terms of the nature of the presentation, whether a treatment is provided.

Certain clinicians suggest that “*Global Assessment of Functioning*” from Axis-V of the DSM be used to justify clinical judgements regarding diagnostic and treatment thresholds (Mullins-Sweatt et al 2012), linking back to the point about whether ‘disability’ or ‘distress’ must be present alongside the PD symptoms criteria, in order for the diagnosis to be recognised and treated. DSM-5 preparations debated the need for a “paradigm-shift” in relation to PD, however this debate was not concluded, but there is opportunity to now empirically research this, to influence future diagnostic changes, which will influence treatment choice (Skodol et al, 2013).

Semantics, Linguistics, and Negative Perceptions

Patients with PD have long been researched as eliciting more negative emotional responses (i.e. disdain, frustration) than other mental health disorders (Markham et al, 2003). This negative perception is changing, with the improvements in symptomatic prognosis being increasingly recognised (Zanarini et al, 2003) and the gradual shift in terminology associated with PD to focus upon ‘trauma related difficulties’, improving hope (Smith et al, 2016).

Stigma is highly linked with terminology/language and is particularly important when considering PD conceptual construction. There are many different terms used in the literature when referring to PD, which are important to explore, to understand the conceptual context of the disorder, including exploration about which behaviours attract different responses concerning treatment, core to this research.

One example concerns Bowers (2003a), who identifies social "boundaries" (deriving from ‘respect’) that a “normal” person (one without a PD) would not cross, or if they

did, would evoke guilt. Bowers (2003a) represents the PD patient as a Machiavellian schemer (Machiavelli and Bull, 2003:64), echoed in other papers which use the term 'psychopathy', and explores a particular set of traits or symptoms within the PD spectrum. Other key words from seminal texts used to describe PD are: "*general unreliability and untrustworthiness*" (Cleckley, 1982:338), "*ingenious misrepresentations*", "*apparent repentance in order to escape consequences*" (Hare, 1991:27), these types of viewpoints affect treatment choices.

The stigma associated with PD was recognised in the UK approximately 10-15 years ago, and had significant implication upon its conceptualisation in healthcare, the criminal justice system, and wider society. Arguably, the two main shifts were: the introduction of "*Not a Diagnosis of Exclusion*" (DoH, 2003), and the shift in health policy with the introduction of the concept of 'Dangerous and Severe Personality Disorder' (DSPD) (Straw, 1999). DSPD patients are defined as severely PD, from whom the public must be protected, emphasising that although these patients only represent a small proportion of people with PD diagnosis, the label influences the way that generic PD is conceptually perceived, due to notions of 'collective identity' (Frick et al, 2014).

DSPD as a concept appeared from Whitehall, rather than a medical diagnostic manual (Pickersgill, 2012). It altered the notion of state responsibility, risk regulation, and 'treatability', advancing certain recommendations from the Fallon Report related to PD treatment (Bartlett, 2003); and was revisited after the Bradley Report (Ruszczynski, 2010). In terms of indeterminate confinement and specified treatment in the UK, units were built either in special hospitals or prison hospitals, where

people with DSPD could receive treatment (DoH, 1999), the UK was not alone in this approach (de Boer et al, 2008).

This movement not only affected the image of PD, but also provoked mixed responses from mental health professionals concerning 'treatability' of PD, prompting a review of the Mental Health Act (MHA) (DoH, 1983&2007) (Glover-Thomas,2006). The '*treatability*' test in the MHA was reviewed and revised to an '*appropriate treatment test*', which impacts upon treatment decisions made by clinicians. Positively, this shift prompted research into pharmacological and psychotherapeutic treatments for people with PD (Wilson et al, 2014). Specific studies found that: psychotherapeutic techniques evidenced for BPD may not be transferable to other parts of the PD spectrum (Crawford, 2007), and that insight and acceptance of the diagnosis has a significant part to play in regards to whether treatment is accepted (Bartlett, 2003). However, no research currently identifies how clinicians can be supported with treatment decisions.

Levels of 'dangerousness' and 'risk management' obligations

Associated with treatability, research also provided a heightened focus upon levels of 'dangerousness' posed by people with PD (DoH, 2000a&b, 2004a&b, 2006a&b), which affects treatment and risk management decisions. Stigma and antipathy associated with PD diagnosis affects both professional and social opinions (NIMHE 2003a&b). This links back to the notion of treatability, suggestions made by the MHA review emphasised the necessity to '*remove obstacles to practitioners*', and challenge the false presumption that PD or certain PD diagnosis are 'untreatable' (DoH, 2006b).

Despite this recommendation, levels of disapproval still remain about the revisions made to law and policy (Prins, 2007). The USA followed UK PD treatment guidelines, but there is still bias in the way that PD is responded to. One example, sourced from research, showed a higher likelihood of defendants being found “*Not Guilty by Reason of Insanity*” with a diagnosis of psychosis, compared with a diagnosis of PD (Neal et al, 2014), meaning that there is no consistent global legal definition of PD, this affects public perceptions and approaches in healthcare settings.

The literature links the issue of risk back to the stigmatised terminology associated with PD. The most commonly associated term with PD in the literature is ‘psychopathy’, as a symptom, a disorder, and also used interchangeably with the term PD in some literature. This association affects conceptualisation of PD.

The term ‘psychopath’ is considered a derogatory term used in popular culture and fiction, typically associated with displays of egocentricity, deceitfulness, and externalisation of blame (Donahue et al, 2004). Eden (2006) emphasises that “*few disorders elicit such a visceral reaction*” from health professionals as psychopathy. He suggests influences for this are the connections of ‘psychopathy’ and PD with high-profile criminals, including Ted Bundy, Charles Manson, and Charles Bronson, linking this to negative public opinion and perceptions of ‘untreatability’. A Google search was conducted using the term ‘psychopath’, Figure 6 shows the 3 images identified, emphasising that stigma is still present:

Figure 6 - images gained using the search term 'Psychopath' (date: 10.1.14).		
Image removed for copyright reasons	Image removed for copyright reasons	Image removed for copyright reasons
Character: Jack Torrance Reference: The Shining (1980) Directed by Stanley Kubrick [Film]. USA: Warner Brothers.	Character: Patrick Bateman Reference: American Psycho (2000) Directed by Mary Harron [Film] USA: Lions Gate Films.	Character: Hannibal Lecter Reference: Silence of the Lambs (1991) Directed by Jonathan Demme [Film]. USA: Orion Pictures Corporation.

Cleckley (1964:14), differentiated psychopathy from PD, stating that psychopathy is not merely a 'PD', but a "*constructed dissimulation of a personality*". Evans (2011) suggests that one reason why professionals and others are repelled by APD patients is because APD is interchangeably used with 'psychopathy', and due to the often callous things that patients do. He explained that APD patients have a typical history of abuse, meaning that they adopt a position of defensiveness to protect themselves: "*idealisation of the self as predator, and a denigration of the other as prey*". The stigma associated with APD affects the whole concept of PD.

The 'challenging'/'difficult' patient

The concept of "difficult patient" in UK literature is repeatedly applied to people with a PD (Friedman, 2008). In the literature, it is a theme raised in in-patient, community, and A&E settings. The "difficulty" is often associated with behaviours associated with PD diagnosis, such as self-harm, drug/alcohol misuse, and threatening behaviour (Bland et al 2007; Westwood et al 2010; Woollaston and Hixenbaugh 2008).

The label of "difficult patient" is problematic for patients, staff, and organisations; it affects judgements concerning treatment allocation and the relational encounter. Research demonstrates that both mental and physical health providers feel ill-equipped to effectively treat or assess PD individuals (Kopala-Sibley et al, 2012).

This occasionally prompts unsympathetic attitudes (Lequesne, 2004), and a default to stereotypical labels concerning lack of treatability and dangerousness, which can then warrant denial of treatment (Schulze, 2007), or minimisation of threats (i.e. self-harm), which then poses risks to patient safety (James et al, 2007). Higher stress and burnout is also evident in staff working long-term with these patients (Bowers, 2002).

Stigma and treatability

'Personality Disorder: no longer a diagnosis of exclusion' was introduced to highlight stigma and focus treatment (DoH, 2003). However, Duggan et al (2007) describe how boundary issues in mainstream services (i.e.: rules applied to intoxication) make PD engagement for treatment difficult, and prompt certain reasons for exclusion related to behaviours that may be associated with PD, rather than the diagnosis of PD itself.

These rules in themselves are understandable considering safety, but when considering certain symptoms of PD (i.e.: affect instability, boundary management issues, (Kopala-Sibley et al, 2012)), the question must be posed that: does including PD treatment within mainstream services still result in excluding them, due to the service parameters in place?

Magnavita et al, (2003) emphasise a significant need for public and professional education regarding PD, to reduce stigma when accessing health and social care treatment, as despite receiving a diagnosis, most patients worldwide will receive no

treatment (Reed,2011). It is estimated that dependent upon the disorder, the gap between diagnosis and treatment is between 32%-78% (Kohn et al, 2004).

In the UK, two treatment guidelines are published by the National Institute for Health and Care Excellence (NICE) concerning PD: BPD and APD (NICE,2009a&b). No other guidance is published for any of the 6 other PD diagnostic categories recognised in the ICD-10. UK treatment for PD is via three treatments: supportive talking treatments, social support, and medication for comorbid mental health problems, with targeted specific forms of these interventions, dependent upon PD-type (i.e. DBT for BPD). There is also guidance regarding hospitalisation as a treatment for PD.

The current NICE Guidance for PD is considered as limited by the researcher, not only due to its focus upon two subcategories rather than the whole range of Personality Disorder, but also due to its lack of focus upon guiding how decisions are made for treatment.

Recent UK mental health care reform

The shift of many health thresholds changed following current UK austerity measures. Rather than PD-specific, this issue now concerns how society views illness generally. The NHS has undergone radical transformation since the early 1990's, certain papers suggest that the way reforms have been translated and implemented may have compromised core NHS principles of universality, public accountability, solidarity, and comprehensiveness (Mandelstram, 2007). Chiesa (2008) suggests that the changes are fundamentally introducing a business mentality

within the NHS, resulting in a publically owned system being replaced by a healthcare marketplace, with legal contracts and external regulation replacing public accountability.

The impact of this in terms of treatment provision and conceptualisation of illnesses such as PD, is that there are often differences in opinion between commissioner, provider, and patient, regarding 'best treatment', and whether resources are commissioned at different thresholds, connected with the diagnostic debates discussed.

Due to austerity measures, increased demand, and lengthy waiting times, threshold changes concerning treatment provision for PD were introduced. Clarke et al (2013), identify this as a problem for patients, as their receptiveness and preparedness for treatment may change within the timescales that they have to wait, which in some cases can be several years.

Q1 Conclusion

The discussion outlined in Q1 demonstrates that the concept of PD is dynamic and complex, with changing diagnostic and legal criteria. PD is a collective description of phenomena with subordinate diagnostic categories that vary significantly in their individual presentations, complicating both assessment and treatment choice, when considering the overall research question:

How can mental health care staff use a pre formulated guided decision process in the selection of therapeutic interventions for people with PD, within the context of rationalisation and service change?

Risk behaviours associated with certain PDs attract stigma which affects the Treatment Choice Encounter and subsequent treatment decisions, as risks posed are often generalised over the whole PD spectrum. The answer to Q1 provides a context to anchor debates concerning assessment and clinical decision-making, these debates are funnelled and explored further in Q2 when specifically exploring treatment choice.

Q2: What guides clinical decision-making in mental health care regarding treatment for PD patients?

Social and cultural themes raised in Q1 concerning development of PD diagnostic constructs link to notions and obligations to make decisions about treatability for patients.

Clinical Decision-Making

Clinical decision-making in healthcare is well-researched. For Q2, reference is made to certain clinical decision-making strategies; however this will not be the sole focus. Instead, a micro-focus concerns what guides clinical decision-making in relation to treatment for PD patients, linked to the Research Question.

The literature search did not generate a specific model or framework for decision-making for treatment with PD patients, however multiple themes were identified regarding the decision-making process, and dynamics that influence this. Themes are explored under three headings: evidence bases for decision-making, risk factors, and factors pertaining to the therapeutic relationship:

Evidence for decision-making: does research and policy guide decision-making?

Research typically guides treatment selection in healthcare. There are treatments suggested for certain PD types (NICE, 2009a&b), however there is a paucity of decision-making frameworks for these.

One difficulty concerns the underpinning research-base regarding talking treatments, where there is a lack of 'clinically syntonically' studies involving tasks intrinsically linked to clinical practice (Castonguay, 2013). Constantino et al (2012), suggest that despite research exploring common/pantheoretical treatments, factors such as patient's treatment expectations have more influence upon efficacy of the treatment than the model used. This type of research implies that decision-making for treatment is complex, as it must consider treatment, patient variables, and therapeutic relationships.

Cukrowicz et al (2005) suggest that the heterogeneous symptom profiles PD patients may present with means treatment choice varies dependent upon the person's individual characteristics, implying that you can have a standard model, but internal variables need adjusting to the idiosyncratic need. This study additionally reinforces the need to treat patients in a timely manner, otherwise they are highly likely to discontinue interventions if they do not perceive immediate gains, due to their difficulties regarding toleration of frustration and maintaining motivation.

Changeable Idiosyncratic Symptoms

Another difficulty is anchored to the varied symptoms PD patients present with, meaning that it is difficult to have a 'one size fits all' approach (Ebner-Priemer et al, 2009). Smith (2009:56) suggests that interacting relational and bio-psychosocial factors presented by a person with PD complicates treatment selection for them, introducing the question concerning: '*what requires treatment?*', and recommends use of a rhetorical/hermeneutic model for PD, which considers the complexity of a person's presentation, and what constitutes '*normal*' for them. This is contextually

important, as many people live with symptoms of disorders without accessing treatment. This adds another dimension to the question of treatment choice: if the aim is not cure, then what is “*good enough*”?

Polarised evidence-base

Another issue raised by the review is that despite the range of PD diagnosis, research tends to be polarised, mainly focusing upon BPD and APD (Crawford, 2007; Krueger et al, 2010). What is useful for a person with APD may be unhelpful for a person with Avoidant PD. This is not a new challenge for mental disorder policy, it was evident in the development of research into Anxiety Disorders, meaning that there is one policy guiding practice, with 6 subcategories for the separate anxiety disorders (NICE, 2014a). The author of this thesis suggests that future PD treatment policy take a similar approach; one PD framework, with 8 treatment strands for the separate PD diagnosis.

Clinician factors

Much of the literature discussed clinical factors when assessing and treating people with PD. Flores et al (2014) explored how clinicians make treatment decisions, finding that they do so by recognition of symptomatology, matching this to the range of treatments provided. This appears a simple process, however they found that different treatment decisions are made dependent upon different factors, (i.e. the stress in the therapeutic encounter, the clinician's experience and knowledge-base, and the range of available treatments and waiting lists), rather than necessarily all of the treatments that national policy recommend.

Although generic research for clinical decision-making will not be fully explored due to the focus of the research question, certain related concepts are discussed in brief: reliance upon representational heuristics in diagnostic treatment decisions (Maj, 2011; Westen, 2012), and reliance upon prototypical theory based on causative factors (outlined in Q1).

PD treatment decisions are complex (Magnavita et al, 2010), requiring specialist knowledge, rather than the ability to fit a person into the available treatments. Magnavita highlights the current dearth of empirical evidence upon which clinicians can base clinical decisions about PD treatment, further complicated with the vast range of recommended treatment options, all having different implications for both patient and provider (Stone, 2009).

A final point regarding evidence-based psychotherapeutic interventions concerns the notion of what the research describes as the '*Dodo Bird verdict*' (Luborsky et al, 2002). It refers to Lewis Carroll's '*Alice's Adventures in Wonderland*' character, and suggests that all PD-focused psychotherapies have a similar efficacy, "*no matter what model or theoretical stance they are derived from*", implying that they all have a similar outcome for the patient (Beutler et al, 2012). This supports the need for further research, but suggests a requirement to target patient and clinician variables, rather than the treatment modality itself.

The notion of 'Scientist-Practitioner'

The notion of 'scientist-practitioner' underpins the formulated approaches to PD patient treatment, as patient needs are not clearly covered by a single health/social policy. Scientist-practitioners use their knowledge of different policy guidance,

research, local resources, and patient factors, to make treatment decisions. The challenge for clinicians is to warrant how they discriminate between available options (Castonguay, 2013).

Krueger et al (2010) explain that it is the “*inconvenient truth*” that many PD patients do not precisely compare with subjects in PD research, explaining that in the zeitgeist of Evidence-Based Practice (EBP) this is problematic to the “*scientist-practitioner*”. Dozois (2013) explained that the DSM-5 review triggered an impetus for diagnostic guidance to focus upon the widening scientist-practitioner gap. They explained that there are opportunities and barriers when considering empirically supported treatments, firstly to question what constitutes best ‘evidence’, and secondly, highlighting that, at times, clinicians do not offer EBP due to the opinions they hold about the evidence (Hunsley, 2007; Kazdin, 2008; Shafran et al, 2009), or attitudes towards EBP concepts (Baker et al, 2008).

One argument against EBP is that it detracts from individualised case formulation (ideographic), which is advocated for PD (NICE, 2009a&b), leaning towards group approaches of treatment (nomothetic). This type of research approach and evidence-based prescribed intervention is typically an approach used for medication trials.

What this means in practice is that the scientist-practitioner can always identify some elements of a patient presentation that may/may not respond to a certain treatment (i.e.: psychotherapy and, or medication). It is ultimately the clinician’s choice, why they either offer or withhold a certain treatment.

The question of who is assessing for treatment?

Flores et al (2014) found that individual clinician decision-making is often anchored in personal and professional experience of what works for '*this type of person in practice*'. This means that the same patient presenting to two different clinicians may receive different treatments dependent upon the clinician's intuition, reliant on the clinician's personal cognitive heuristic, rather than necessarily the patient's individual needs or evidence-base.

Local mental health team configuration comprises of nurses, doctors, occupational therapists, psychotherapists, etc, any of whom may conduct Treatment Choice Encounters. These clinicians have different levels of qualification, and differing knowledge bases concerning the treatments NICE guidance proposes, therefore it is easy to understand where differences occur, potentially resulting in a lack of continuity for both patient and team regarding treatment provision.

Magnavita et al (2010) emphasise the importance of an MDT when making treatment decisions pertaining to PD. She explains that single clinicians may become "stuck" with such complex disorders, specifically where a risk/benefit analysis is required, regarding whether to offer treatment.

The literature not only details the assessor as a treatment choice variable, but highlights assessment time as an additional factor for consideration. Yates et al (2013) advocate extended assessment for PD patients, suggesting this improves treatment outcomes, as one encounter may not accurately represent the patient. This poses difficulties concerning cost and service configuration regarding '*Payment*

by Results' (PbR) (DoH, 2011e), which suggests 1-2 assessments only, before transfer for treatment.

The notion of 'Expert Patient'

The notion of 'expert patient' is not new, and now high on UK health agendas, specifically concerning people with longer-term conditions, including PD (NHS Choices, 2015b). Castonguay (2013) explains that a difficulty in decision-making may be; what one patient may feel is effective, may not be when considering the research. Patient choice is a large factor concerning treatment efficacy in PD, however there are other factors: the perceived challenge of treatment, the degree of belief a person has in the treatment, and the 'placebo-effect' of purely being engaged with care services (Lambert, 2005).

Cook (2004) researched problems concerning PD treatment choices, finding that clinicians may select treatment choices that are less anxiety-provoking for them and the patient, which may not be evidence-based. A challenge when analysing decision-making is to understand whether there is no specific evidence-base for this patient's unique presentation, or whether their decision is based upon avoidance of distressing encounters.

Goodman et al, (2014) suggest that clinicians must balance knowledge of treatments with the patient's perception of what may help them, to make collaborative decisions. Hershenberg et al (2012) expand, suggesting clinicians must overcome patient barriers connected to their previous health encounters, encouraging realistic treatment expectations and choices. This could be conducted via a formulated

approach, attempting to understand the problem “*as the patient sees it*”, including attitudes, values, and preferences (Spring, 2007).

Magidson et al (2012) suggest there may be narcissistic struggles in some PD encounters, manifesting in patients undervaluing clinician's knowledge and role (Dimaggio et al, 2006). In these situations, patients present as experts, only agreeing with clinicians who agree with their own perception of treatments (Kernberg,2009). This can cause difficulty if the patient's perception of problems/treatment conflicts with organisational provisions.

Rofe (2010) suggests that PD patients are often preoccupied with circumstances or behaviours associated with current distress (i.e. relationship breakdown), rather than the triggers that caused them to have difficulty problem-solving. They then seek a ‘quick-fix’, rather than develop longer-term coping strategies. Rose (2007) explains that this may be linked to impulse control issues, a core component of PD.

A final issue raised in this section concerns patients mandated to attend for treatment (i.e. detained under the MHA). Difficulties are encountered, as patients have not necessarily chosen to access treatment, instead it has been imposed.

Manchak et al (2014) explain that threats of incarceration (i.e.: in hospital or prison) can alter patient's engagement either positively or negatively, meaning they are either more likely to attend for treatment than those not mandated, or when attending, the person adopts treatment-interfering behaviours which ignore, attack, blame, or control clinician's interpreting them, as another agent of control. The

treatment that can be offered for patients exhibiting problematic behaviours is limited, as most treatment evidenced for PD relies upon 'informed consent' from patients regarding participation (Norton et al, 2005; Rudd et al 2009).

The notion of 'prescribed' treatments: which treatment, and why?

Prescribed treatment may be compulsory (i.e. Court mandated), or link to treatments prescribed by a clinician. The notion of 'prescribing' treatments may conflict with a collaborative approach. This is further complicated, as PD patients tend to present with relatively polymorphous co-morbidity (i.e. PD patients simultaneously meeting criteria for several other mental health disorders) (Krueger et al, 2010). This poses questions for prescribing clinicians concerning what treatment is offered, for which disorder, and why?

Levine et al (2006) discuss the complications of clinician autonomy and prescribed treatments, explaining that multi-professional debates can occur between psychiatrists and psychologists or psychotherapists, due to their different theoretical standpoints, raising a further question: whose right is it to prescribe a particular treatment?

There is a simple answer for certain treatments (i.e. medications require legally registered prescribers), however it is not simple when considering 'prescription' of social support, or 'talking-treatments', where any team member may 'prescribe' these treatments, potentially conflicting with other team member's views.

A further dynamic concerns the cost of prescribed treatment. Cost varies considerably when considering different treatments (i.e. medication may cost pence per dose, however talking therapy could cost several hundred pounds per session). Conflict may additionally arise if patients express a wish to have a treatment that is not provided due to high cost. Multiple recent media healthcare controversies concern access to high-cost treatments, (Osley, 2014), and 'postcode-lotteries' (Chiesa, 2008), which impact upon treatment provision in times of austerity.

This issue is not new: Paul (1969:44) asked the question: "*What treatment, by whom, is most effective for this individual with that specific problem, under which sets of circumstances, and how does this come about?*", but research supporting clinicians is sparse. Nelson-Gray (2003) suggests that understanding how clinicians process and interpret assessment data to inform clinical judgements remains one of the least-researched topics in psychiatry and psychotherapy. This is one of the core rationales for conducting this study.

Stiles et al (2008) suggests an added factor concerning: 'dose and effect', which explores the intensity of input, and the potential longevity of treatment. As described above, this can be a problem with PD patients, who may perceive that treatment needs to continue when they get to the point of discharge, due to childhood attachment difficulties, linking back to notions of what is 'enough' and in whose perspective: the patient, clinician, or organisation.

Risk factors

Risk assessment and management factors are central to PD treatment regimes, therefore when considering treatment choices, risk management must be a core

feature. The potential for the person to cause harm to others was discussed in Q1, therefore will not be repeated here. However, concerns surround the potential for PD treatments to cause patient harm, which affects decision-making regarding treatment.

Castonguay et al (2010) suggest that psychotherapy can be harmful to certain PD patients, detailing that if "*therapists are honest*", they will admit that they have potentially harmed certain patients. The harm referenced is: the patient not making progress in treatment, or mentally declining due to the process of treatment (Shimokawa et al, 2010). There is a sparse amount of research in this area, as authors suggest that clinicians are not always as reflective as they may be, related to professional ethical guidance, whose first principle is 'to do no harm' (NMC, 2015; BABCP, 2010).

Castonguay et al (2010) suggest that it may not be the psychotherapy itself that causes harm, but lack of skill in some 'therapists', or lack of engagement in some patients. Adversely, research also suggests that denial of psychotherapeutic intervention may equally cause iatrogenic harm to patients with PD and related conditions (Brand et al, 2014). Assessing clinicians must have knowledge of all potential costs and benefits of treatment sessions.

This raises a further difficulty, concerning who makes treatment decisions, and are they informed on all factors influencing a person's ability to engage in talking treatments. Within the research, various formulation structures are presented (Goodman et al, 2014; Clarkin et al, 2006:139; Bateman et al, 2004; Young et al,

2003), but no specific PD formulation model prompting specific treatment selection is identified. The model sources are tools used in psychotherapeutic treatment, rather than something prompting selection of psychotherapeutic treatment over, for example: medication.

Heilbron et al (2010) identify the paucity of research concerning how clinicians make decisions, specifically relating to whether or not to allocate a talking treatment. Dimidjian et al (2010) propose five complications concerning risk and the notion of treatment choice: (1) treatment may have harmful and beneficial effects, (2) there may be different perspectives on treatment outcome, (3) the nature of PD patient's presentation may change, (4) a treatment can be universally harmful in its effects, dependent upon the person's co-morbid characteristics, (5) a treatment may have harmful side-effects.

With many therapeutic strategies, people often have to either face past trauma or address distress, potentially causing discomfort for the patient; this will subside and is an unfortunate side-effect of certain treatments (i.e.: CBT for PTSD). However, the risk that a person may disengage, as they feel the treatment is temporarily harmful for them, is higher in PD patients (Pascual-Leone, 2009).

The therapeutic relationship

Factors connected to therapeutic relationships were one of the most highlighted areas found within the review concerning treatment decision-making processes. This is linked to a core PD symptom concerning relationship difficulties (Kopala-Sibley et al, 2012). Patient and clinician variables are focused upon more intensely in Q3 & 6,

however in the remainder of this section, an overview of specific relationship variables is presented:

Clinician's authenticity

Chatziandreou, Tsani, Lamnidis et al (2005) suggest that authenticity is the skill that a clinician has, to interact and understand the patient as a unique person, whilst creating an environment fostering support and encouraging progress. They list authenticity as the most important factor in engaging PD patients, over any particular therapy model or technique. Clarke et al (2013) emphasise that this is connected to the clinician's honesty and realism within Treatment Choice Encounters.

Clinician's explanation/formulation of difficulties

Formulating therapeutic treatment decisions is researched as complex, and linked to the clinician delivering the session (Lane and Corrie, 2012:128). This may be because certain clinicians are trained in different formulation techniques; i.e. medical formulation is not typically as collaborative as psychotherapy/psychology formulations.

Within the research reviewed, information concerning formulated approaches is confined to psychology/psychotherapy literature. This is an important practice consideration, as initial consultations are conducted by a range of different professionals, rarely a psychologist or psychiatrist. Hunsley et al (2005) explain a formulated approach to difficulties aids integration of the patient's perspective with the clinician's perspective, emphasising that PD patients specifically benefit from

either written or visual formulation structures, as they are often unable to fully recall what was discussed in-session.

Müller (2011) explains that traditional case-formulation models are in written narrative form, tailored dependent upon which model of therapy is used, however advocating diagrammatic representations as opposed to narrative, as many people have a better memory for diagrammatic cues, and diagrams can link complex interacting/interrelation variables which may maintain problems.

Empathy

Angus et al (2007) suggest that empathy and therapeutic alliance are key factors in engagement and treatment. This implies that decision-making is relationship-dependent, considering the patient's relationship with services, and the clinician's relationship with the patient. Awareness of the difference these factors make when a person presents with a PD (i.e. rather than a broken leg), is an important aspect when considering what guides clinical decision-making (Smith, 2015).

Bennett et al (2006) emphasize that empathy and clinical alliance are central to balanced decision-making, however highlight that if difficulties are present in either the patient/therapist's affective state within the session, then decision-making may be altered.

Early writers emphasise the need for empathy when engaging patients with psychological problems (e.g.: Rogers, 1951). Empathetic ruptures can occur due to counter-transferential and/or transferential dynamics within the therapeutic encounter

(Bennett et al, 2006). Rogers' (1951;1957) viewpoint contrasted with writers such as Skinner, due to his concentration on a person's self-actualising potential, suggesting that the clinician's approach in the therapeutic encounter changes the interaction itself (Rogers and Skinner, 1956). This is particularly important in the Treatment Choice Encounter, as a clinician's approach may influence engagement or disengagement (Morris, et al, 1974).

Goldfried et al (2005) advocate Rogers' theory for people with PD, however Lazarus (2007) criticises Rogers' simplification of the core premise of the therapeutic encounter, stating that patient's needs are diverse. He suggests that some patients may respond well to a warm empathetic relationship, however some prefer a 'business' relationship. This balance between empathy and directedness is a key theme in literature concerning provision of intervention for PD.

Magidson et al (2012) explain that some personality profiles present as more challenging in therapeutic encounters than others, patients may display arrogance, be patronising, and occasionally malicious, in Treatment Choice Encounters, to influence the clinician's decision-making. McMurrin (2012) suggests that patients with antisocial or narcissistic beliefs anchored in early-life experience of powerlessness, may develop compensatory behavioural strategies of relational aggression and intimidation, complicating empathetic formulation and balanced decision-making.

Ruszczynski (2010) reinforces this, explaining that different PDs can prompt clinician emotions influencing treatment selection, including feeling frightened, disgusted, corrupted, abused, or seduced, which may mean that they allocate a treatment

influenced by this, or feel complete empathetic rejection towards the patient. DPD is differentiated in the research from other PDs, Kopala-Sibley et al (2012) explain that DPD patients are characterised by feelings of weakness and fear of abandonment, which may trigger treatment prolongation, and/or a sense of duty to provide care in clinicians.

Knowledge and perception of treatments

The research reviewed generated a number of different treatments (e.g. DBT) for PD (Berrino et al, 2011). However, results failed to identify when treatments should be initiated and with who, complicating decision-making. Chard et al (2005) emphasize the need for psycho-education concerning treatment-choices, however the pace of education and clinician's ability to understand and adapt information must be monitored (Hershenberg et al, 2012).

Ulvenes et al (2014) suggest that clinicians will hold beliefs and personal bias about which different treatments work, and this will influence their decision-making. This bias is important, because it may not consider variables required to ensure the treatment is appropriate for the patient. Magnavita et al (2003) suggest that clinician's beliefs about different treatments must be regularly explored in supervision, as otherwise the patient could be allocated "*the same as usual*", rather than something appropriate for their new presenting need.

Patients presenting with multiple comorbidities

Leichsenring et al (2011) highlight the importance of recognizing that the presence of a PD makes a person highly susceptible to other potentially more transient mental

disorders. There have been instances where people with PD have not been provided treatment for other physical health and mental health disorders, due to clinicians misdirecting treatment, attributing all symptoms to the presence of a PD diagnosis (Krueger et al, 2010; Gregory et al, 2006).

A further difficulty is that research and UK policy often only guides intervention for single-diagnostic presentations (Cukrowicz et al, 2005). Evidence which presumes that treatments for common mental health problems (i.e. depression) may be ineffective if the person has a PD, mean some treatments are excluded by clinicians (McMurrin et al, 2010), despite research demonstrating the presence of PD not interfering with treatment efficacy (Weertman et al, 2005). If the facilitating clinician has seen non-adherence or poor treatment efficacy before, they may block this treatment for the patient unnecessarily (Kelly et al, 2007).

Chaikin et al (2004) recognize this, stating that presence of a PD may obscure the presentation of the other mental health issue, meaning that patients present as typically disordered in multiple aspects of their life. It is therefore not only a problem for the decision-maker to decipher which problem requires treatment, but further complicated by the presence of information either disclosed or withheld in-session by the patient.

When is enough, enough?

The concept of 'enough', is linked with the notions of 'recovery' and 'cure'. Bryan et al (2012) explain that there is limited research concerning this question, specifically when considering treatment termination for people with PD, as much recovery-

focused research pertains to treatment of psychosis. This poses an additional challenge for clinicians assessing patients who have had multiple treatments, yet still feel they need more. Warner (2010) suggests that this is one of the reasons prompting development of the “Recovery” model in mental health care, which focuses upon patients maintaining or rebuilding satisfying lives, accepting the presence of a mental illness, rather than necessarily attempting to remove it, or be ‘cured’.

Clinicians must encourage a sense of ‘optimism’ in patients, enabling them to self-manage their residual symptoms, and integrate them as a part of their being (Repper and Perkins, 2003:12). Unfortunately, no specific guidance was found in the literature review concerning how clinicians may be supported to operationalise this with PD patients, and also how the concept of “enough” is measured (Gudjonsson et al, 2011).

A final and underpinning theme identified in the review concerns the concept of motivation. Valbak et al (2003) asked: “*how you make the 'unsuitable for treatment', suitable?*” when considering PD, suggesting that motivation work, and work concerning realistic expectations, should be the focus. Younggren (2011) explained that treatment choices in this sense are ethically fraught, and the reality is that some patients are kept in treatment who should be discharged, resulting in damaging consequences, and correspondingly, some patients are discharged rather than ‘allowed’ treatment, because it is felt to be non-productive or clinically inappropriate.

Increasing efficacy by targeting resources

The '*New Horizons*' document (DoH, 2010) was published to encourage everyone, including other government departments, to engage with mental health concerns. It placed a greater emphasis upon evaluating interventions and increasing innovations, and also focused upon reducing costs, in line with the current financial climate of austerity. PD services are included within the '*New Horizon*' focus; there is an emphasis upon increasing the research base underpinning the rationale for services with differing levels of cost.

Costs do not merely relate to community treatments provided, but also high-cost long-term placements, and high-cost short-term services (i.e.: PICUs). Both of these are nationally and locally in focus as part of austerity measures, and are a core part of treatment pathways for PD.

Hunsley (2003) suggests that a common framework is required to estimate the personal and societal cost of an illness or disease, considering both direct costs of treating the disorder, and also indirect costs of not treating the disorder. Indirect costs do not just imply wider demand on public health costs (i.e. repeated crisis contacts, criminal justice contacts), but also include 'loss' costs (i.e. loss of productivity through unemployment).

BPD is named specifically as one of the most problematic disorders in this sense, due to high levels of A&E and GP use, erratic attendance, non-adherence, and/or abuse of prescribed medications, meaning that the debilitating part of the illness that often prompts the chaotic nature can mean that the illness may not be able to be

analysed in the framework of other debilitating illnesses, where chaotic disengagement may not be a central feature.

Evidence shows that not only is BPD treatable (Moran, 2007), but following successful treatment, the chaotic nature of the person is reduced, and therefore the wider use of public services is reduced, and the person's personal productivity increases (Mendelberg, 2014). The issue of cost is therefore not only about the direct cost of treatment at this time, however needs to consider future costs if proactive interventions are not provided (i.e. high-cost placements).

Q2 Conclusion

The discussion presented in Q2 builds upon Q1, demonstrating that not only is the concept of PD assessment complex, diagnostic features mean there is a higher likelihood of conflict or turbulence in therapeutic encounters. Q2 also emphasises that there may be difficulties within decision-making processes when considering PD treatment choices, due to the multiple co-morbidities people present with, the gap between research and practice, and increasing cost pressures placed upon health services. Q3 expands upon this, exploring whether there are any frameworks which may assist decision-making in this complicated therapeutic encounter.

Q3. Are there any clinical tools⁴ or heuristics to assist clinicians to make decisions concerning which treatment should be selected for PD patients?

Although several algorithms were found in the literature review, these only related to treatment direction after the initial decision-making process takes place, rather than addressing issues regarding initial suitability for treatment. Despite this, certain themes were raised connected to this question, either related to treatment selection in mental health generally, or specific aspects explored below.

Decision-Making

Widiger et al (2010) suggest that PD is a diagnosis at the forefront of a psychiatric paradigm-shift, associated with the DSM reclassification. Mental health problems are currently considered as qualitatively different from physical health disorders generally (Regier et al, 2009), as in physical health disorders, there is more often an expectation of a cure, whereas with PD, as discussed in Q2 regarding the “Recovery model” principles, a cure is not always possible, however symptom education and reduction is. This affects decision-making with PD, and may also suggest that models for decision-making developed for physical conditions which had an endpoint ‘cure’, are irrelevant when aiding decision-making for PD.

4- The term ‘Tools’ is used to describe any clinical guidelines or frameworks that clinicians use in the Treatment Choice Encounter. Examples of tools include: algorithms, care pathways, formulation models, and decision-making frameworks. In this thesis, the use of the word ‘tool’ does not apply to a person who makes the decision.

Millon et al (1993) extensively researched PD, providing evidence that the reason clinical decisions are difficult is that the disorder itself affects internal and external systems. Magnavita et al (2003) explained that in understanding this, when assessing a person with PD for treatment, biological factors, intrapersonal factors, interpersonal factors, and social factors, all contribute to treatment choice. Zeldow (2009) suggests decision-making is complicated, due to treatments not being well-defined (i.e. social care parameters changing with the introduction of the Care Act 2014). Therefore, Hollon (2006) explains that peculiarities of human experience inevitably lead to individualised clinical '*judgements*' concerning decision-making.

Schön (1983) proposed two models of decision-making in professional practice: the "instrumental problem-solver", who applies their own knowledge and applied science to real-world patient encounters, and the "reflective practitioner" who addresses indeterminate real-life problems that are not typically amenable to the application of technical rationality. Schon (1983:89) provides 3 reasons for uncertainty in clinical decision-making: (1) uncertainty about 'what is going on?', meaning the clinician must act, (2) what questions within the encounter would add value to the decision-making progress?, and (3) the uniqueness of each encounter, meaning that no researched formula could provide a direct guide for clinicians to define the actual outcome of the treatment session. This builds on the work of Meehl (1954:46): "*When Shall We Use Our Heads Instead of the Formula?*"

Van Manen et al (2008) propose various considerations when decision-making: treatment efficacy, non-evidence-based factors (i.e: treatment availability), personal experience, and personal belief in treatment models, suggesting that these possibly

lead to inefficient use of available resources and treatment selection, which may be ineffective, and potentially harmful. They explain that there are some emerging thoughts about clinical decision models for PD, however they are in their infancy.

Ma et al (2008) researched nurse's decision-making in Taiwan regarding PD treatments. They found 5 themes: *"(a) shifting from the 'honeymoon' to 'chaos' stage, (b) nurse's expectations for positive vs. negative outcomes, (c) practicing routine vs. individualised nursing care, (d) adequate or inadequate support from healthcare team members, and (e) differences in care outcomes (satisfactory experiences, and superficial relationships)"*.

Extrapolating from these themes, they developed a conceptual framework concerning a 'two-stage care process', suggesting that nurses develop positive coaching skills, rather than 'give up' on their patients, to motivate them to engage in treatment, whilst monitoring their own beliefs about whether their personal expectations of potential treatment outcomes are influencing their decision-making. Key themes concerning: 'caring less' and 'keeping a distance' to avoid anticipated 'treatment failure' were important. This study does not give a framework for decision-making regarding treatment choice for PD, but does reinforce that attitudes towards patient outcomes are central to decision-making processes.

In practice, there is often an initial need to make certain immediate treatment decisions with PD patients (typically linked with risk), then a need to make longer-term treatment decisions. Short-term or immediate treatments often have clear frameworks for decision-making (i.e. treatment following self-harm), however longer-

term treatment decisions are typically the most complicated, with the least research in terms of decision-making (NICE, 2011).

Jasper et al (2014) discussed decision-making where there is uncertainty, testing three heuristics concerning: treatment availability, representativeness, and anchoring heuristics based upon personal experience. The use of a heuristic approach may be proposed as beneficial when considering PD treatment choices, as it would provide an anchor (or reference point), and enable increased consistency.

Motivation and Psycho-education

Patient motivation is a recurrent theme in the literature, assisting in treatment selection (Clarke et al, 2012), and also as a treatment technique required for the person (Motivational Interviewing (MI)). Angus et al (2009) suggest that until a relationship is built, it is difficult to assess motivation, as there are relational dynamics that interfere with motivational processing. Westra (2004) explained that in therapeutic approaches such as CBT, it is not uncommon to use MI techniques to enhance engagement and manage treatment resistance, pre-treatment.

McMurren (2012) emphasizes that pre-treatment preparation significantly reduces non-adherence, particularly when making referrals for talking-treatments. A question therefore must be posed concerning whether the first treatment that should be selected concerning PD patients is MI? If so, is this then considered as treatment or pre-treatment?

Three potential pre-treatment strategies are presented in the research as options: open-ended groups (Birtle et al 2007), MI techniques, and a 'patient-buddy system' (Chiesa et al 2003). Simonsen et al (2014) suggest that the heterogeneity of PD must be accounted for when decision-making, disagreements between theorists is one factor to consider, and also differences between clustered symptoms defining disorders, linked with the patient's environmental, relational, and resilience factors.

Clinically relevant tools

Despite the problem of not finding a model specifically focused upon treatment selection for PD patients, research generated results for certain tools which may be potentially helpful when making choices with people with PD, briefly outlined below:

Barry (2007) suggests the Clinical Evaluation of Risk and Functioning Scale—Revised (CERF-R) model to aid clinical decision-making, he does not state that it is for PD specifically, instead states it is for all mental health problems. He suggests that the mental health diagnosis 'is irrelevant to some extent' concerning treatment allocation, arguing that it is the degree of risk and functional impairment attached to a person's presentation which influences whether health and social services allocate treatment resources. Beutler et al (2012) also support the assessment of functional impairment when considering treatment allocation, advocating use of the Systematic Treatment Selection Clinician Rating Form (STS-CRF) rather than the CERF-R model.

Although no specific PD tools were found, Pulleyblank et al (2013) presented a case for treatment decisions in psychosis, which may aid in the development of a PD

treatment selection tool. They explored the conditions considered 'useful' in making a decision to treat or not, finding that 'decision curve analysis' is a framework whereby inclusion of certain assessment tools may be useful in guiding clinical decision-making. The difficulty with this model is that treatment choices may only be made by people trained to use and interpret the tools, however the positives are that they are useful in outlining potential benefits and harms resulting from a treatment.

Choice between treatments

Beutler et al (2012) explain that a natural tension is present with clinicians concerning their preference for particular therapeutic models when making treatment choices, and that this tension will influence the particular intervention they select, and preferences between talking treatments (i.e. Dynamic or CBT).

Krueger et al (2010) explain that the value placed on different treatments by both patients and clinicians influences decision-making, when there is conflict between either what diagnosis or presenting symptom requires treatment. Larsson et al (2009) explain that techniques for PD treatments are often similar, though known by different terms, dependent upon which school the treatment derived from. Lazarus (2007) identifies manualised treatments that are evidence-based for PD; however there are divergent opinions about the sustainable effect of these treatments. Salkovskis (2002) usefully summarises conflicts between different schools of thought, suggesting that clinicians must recognise the need to individualise treatment approaches, whilst being responsive to clinical science, using empirically supported approaches, without becoming fixated upon a single theory.

Medication vs psychotherapy

Boswell et al (2010) explored what influenced clinician's approaches to patients within sessions, finding that patient's 'comfort zones', and their willingness to flex boundaries of these, was a strong factor affecting treatment selection. This is linked to respecting patient choice, but serves as a way of understanding why those who would not move from their comfort zone were not allocated an active treatment requiring participation (such as CBT).

This is important, as the patient may want something that is more collaborative, however may need something that they have to work at. This proposes a potential heading for this section as: "who knows what is good for them?" This is a difficult point when considering 'expert patients', patient choice, and patient collaboration. An example may be why some patients buy illegal diazepam, rather than use problem-solving treatments. Clarke et al (2012) explained that patient and clinician assertiveness and negotiation are significant factors in the Treatment Choice Encounter.

Engagement skills as a tool

Some clinicians have a difficulty working with people with PD, due to the nature of patient symptoms. Castonguay et al (2010) explain that due to past encounters, some clinician's approaches are linked with poor outcomes concerning engagement and treatment choices, due to: hostile control in-session, pre-set agendas due to knowledge of the patient's history (demonstrated by hostile separation in-session, ignoring or neglecting the patient's point of view), and conveying contradictory information that may be confusing for the patient, all of which can lead to toxic

therapeutic encounters. Each factor influences clinician's decision-making, and the patient's willingness to engage with any treatment offered. It also influences ways in which patients engage, if they return to services in the future.

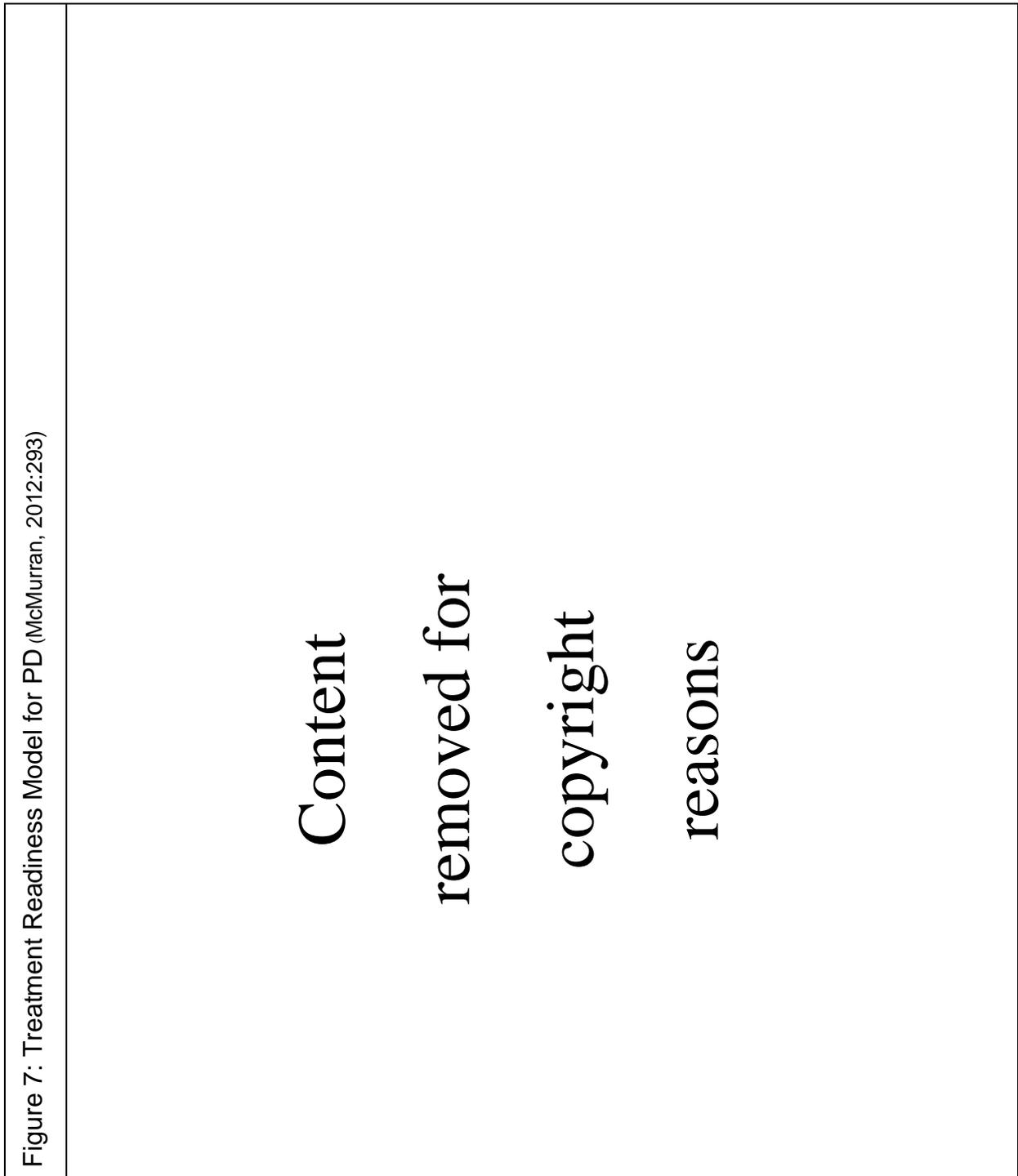
Constantino et al (2012) suggest clinicians must assess patient's prognostic outcome beliefs informally through discussion, prior to treatment selection. They suggest some outcome measures which can achieve this (i.e. The Credibility/Expectancy Questionnaire, (Devilly et al 2000) and the Milwaukee Psychotherapy Expectations Questionnaire (MPEQ) (Norberg et al., 2011)). These are not decision-making models, but models where clinicians assess factors influencing clinical decision-making. Defife et al (2011) also support this approach, suggesting it fosters collaborative goal-formation, positive yet realistic expectations of treatments, and engenders role preparation prior to allocating expensive treatment resources.

Assessment of patient readiness

Harakas (2013) identifies three key concepts in terms of readiness as motivation, resistance, and efficacy, particularly when considering talking-treatments. In contrast, psychodynamic and humanistic approaches may consider motivation as part of the therapeutic process. Additionally, research suggests that ambivalence is a core part of the unconscious conflict analysed by psychoanalytic and psychodynamic therapies, whereas humanistic approaches assume all have motivation, as long as the therapeutic environment and relationship is geared to remove barriers to engagement. Motivational enhancement, solution-focused interventions, executive

coaching, and goal setting, are all strategies which may be considered pre-therapy, to reduce resistance in people with PD.

In the literature review, a model was sourced concerning analysis of a person's readiness to engage, presented in Figure7:



McMurrin (2012) emphasises the need for respect, mutuality, and consideration when assessing PD patients, emphasising that barriers to engagement must be a central focus of the Treatment Choice Encounter. This model is helpful when considering what may aid the clinician to assess readiness, however fails to address the research question concerning how clinicians can be supported to make decisions.

Q3 Conclusion

Q3 revealed that although several algorithms were found in the literature review, these only related to treatment direction after the initial decision-making process rather than addressing issues regarding initial suitability for treatment, and selection of appropriate treatment choices for people with PD, which is core to the focus of this research. The literature has however revealed several components pertaining to the therapeutic relationship, and the complexities affecting this encounter, which may be useful when considering how people can be supported in the decision-making process. Q4 expands upon this, exploring clinician factors in the Treatment Choice Encounter.

Q4: What helps or hinders clinician's clinical decision-making ability with PD patients?

Q1, 2, and 3 have all detailed factors raised within the literature reviewed that help or hinder clinician's decision-making. This section refines this, identifying pertinent clinician factors.

Empathetic engagement

Angus and Kagan (2009) suggest that empathetic engagement significantly impacts upon patient engagement with the treatment planning process, stating it is particularly problematic for PD patients, because their predominantly negative experiences of early relationships affect how they engage with current service providers.

The experience of disclosing feelings of understanding and acceptance for a person with PD may form a part of a new corrective interpersonal experience (Castonguay, 2005). Clinician modelling via empathy and understanding is extremely important when making treatment choices, as it models for the patient, and attempts to build upon their capacity to emotionally regulate, self-soothe, and relationally interact (Elliott et al, 2004:47).

Linked with this concept is therapeutic alliance. Falkenström et al (2013) identify conflict among authors about the extent to which the therapeutic alliance affects treatment outcomes. Bordin (1979) felt that the alliance in itself may be curative, rather than a pre-therapy task.

The therapeutic alliance as a concept could be proposed as a more complex consideration with PD patients, due to the frequent relational difficulties encountered. Gadassi et al (2014) focused on social proximity, specifically where there were affective components of the patient's presentation. They found that if social reactions are positive and signal rewards (i.e. safety), then they are often responded to positively. However, if they are threatening and signal danger or punishment, this will engender avoidance tactics. Others authors reinforce this notion (Gilbert et al, 2008; Kashdan et al 2010).

When analysing this phenomena in the light of the research question, clinicians must be aware of the impact of empathic engagement on the therapeutic alliance, as it shows that it is not just what they say, but also how they present themselves and their information, that impacts upon the decision-making process.

Working with insight and resistance

Baiden et al (2013) conducted research regarding a person's willingness to engage in treatment or treatment selection, and found that insight into diagnosis and mental health problems was one of the largest variables concerning engagement.

Castonguay et al (2011) suggest that MI may assist in improving insight, and reducing ambivalence (which often sustains sub-therapeutic engagement in treatment for people with PD). They suggest that MI encourages a 'no blame approach', explores a person's motivation to change, and reduces the potential for the clinician's transference and counter-transference interfering behaviours, as described earlier.

Baiden et al (2013) discuss the shift in mental health care over the past 50 years, aimed at empowering patients to make treatment choices, explaining the many positives to this, however there are also challenges. Beutler et al (2012) expand, explaining that low levels of patient resistance, and high distress with low impairment, are collectively the best combination a person can present with to gain the most from a session, explaining that this should correspond to a comparable match of clinician factors, including high directedness with low session intensity, for the optimum engagement in a Treatment Choice Encounter.

Rationalisation and adherence

Treatment rationalisation is a contentious area in healthcare, linked with austerity measures. Corrigan et al (2014) explain that much world-health research focuses upon the cost implications (personally and financially) concerning non-adherence, and the impact upon the allocation of different treatments. They produced a table highlighting adherence across different diagnosis:

Figure 8: Table extract concerning adherence rates for various illnesses (Corrigan et al 2014)

Table 1
Rates of Failing to Adhere to Different Treatments for Various Illnesses

Illness	Treatment or procedure	Failure to adhere	Citations
Mental illness Schizophrenia	Medications	50-74%	Gilmer et al., 2004; Kessler, et al., 2001; Lehman et al., 1998; Lieberman et al., 2005; Narrow et al., 1993; Stroup & Appelbaum, 2006
Schizophrenia Bipolar disorder General mental illness Co-occurring mental illness and substance abuse Other illnesses or disabilities	Psychosocial treatments Medication or psychosocial treatments Psychosocial treatments 12-step programs	~50% 25% 22.4% 75-85%	Dixon et al., 2010; Lehman et al., 1998 McCarthy et al., 2007 Olson et al., 2009 Terra et al., 2006
Cancer Heart, Lung, & Blood Childhood Asthma	Medication Medication Medication Doctors visits	50% 12-28% 43% 60%	Partridge et al., 2003 Fung et al., 2007 Celano et al., 2010

This chart does not individualise PD as a diagnosis, but requires consideration, as it demonstrates that if there are comparable adherence rates for very different disorders (i.e. schizophrenia, cancer), taking this into account, the question then must be raised concerning: why is a similar model not adopted for PD?

Many health decisions concern the impact of cost/benefit analysis on treatment allocation. There can be harm in commencing a treatment which is then not adhered to or suddenly discontinued, whether that is medication or talking-treatment (Russell et al 2007). Cook et al (2014) explain that when allocating treatment, clinicians must consider the potential of adherence by the patient, as sometimes there is more risk in starting and stopping than completely withholding a treatment.

In terms of hindrance factors, Harakas (2013) explains that a patient's motivation to engage can change, from amotivation and unwillingness, to personal commitment. McMurrin et al (2010) explain that different personality types are associated with non-completion, having a Dependant PD diagnosis was connected with non-completion in one study sourced but not another, but having a diagnosis of Avoidant PD was more connected to treatment completion.

Traits of narcissism and impulsivity were connected to non-completion, independent of the specific PD diagnosis. For people with any diagnosis of PD, the following trait variables had an effect regarding treatment completion: people who completed were rated as less depressed or had no mood disorder, non-completers also had fewer suicide attempts, and lower levels of interpersonal distress. Finally, non-completion was compared to being in the 'pre-contemplation' stage of change, linked with lower

levels of persistence, higher levels of avoidance, and poor relational and social problem-solving skills. Co-occurring problems shown to reduce treatment completion and engagement include: psychoactive substance misuse, and the presence of aggressive behaviours.

Clinician 'wellness'.

Barnett et al (2007) identify 'clinician wellness' as a central component in health treatment decisions and ethically balanced patient assessment and care. They expand, explaining that professionals accessing training and supervision 'insulate' themselves from 'destructive effects' that may be encountered.

This research identifies that in clinical practice, there is a need to explore the vulnerability of workers who support decision-making, who may not have access to this type of training or supervision.

Bowers (2003a) explains that contact with people with PD can affect clinicians, causing them to adopt 'interpretational schema' towards certain types of behaviours such as manipulation, both inside and outside of work, it can be displayed as cynicism. This can result in a reduced capacity for compassion and a reduced ability to care. Barnett et al, (2007) explain that indicators of personal risk factors may include: increased frustration, impatience, decreased motivation, and increased fatigue.

Liebman et al (2013) describe other variables connected to wellness that are researched as affecting treatment choices and any therapeutic encounter: clinician's

age, training level, experience level, ability to recognise and manage transference and counter-transference, degree of burnout, attitude towards mental illness/wellness, and attitudes held toward the diagnosis of PD.

Clinician directedness as a theme

Directedness is raised in several papers, however with different recommendations. Chatziandreu et al (2005) explain that one problem evoking a negative response from patients in-session is the thought that the clinician has a pre-set agenda or outcome in mind, it is researched as prompting feelings in the patient that they are: not understood, that the clinician is there just to “get the job done”, and also feelings that the clinician is dishonest, all of these variables can then affect the patient's future engagement with services.

Conversely, Goodman et al (2014) emphasise that optimal treatment occurs when clinicians are empathetic, yet gently challenging of patient's implicit emotional-regulatory expectations. Directedness must therefore be considered as a variable, concerning the overall research question posed: *what helps or hinders decision-making*, which requires more consideration/research, specifically when considering the points made in Q2&3 regarding collaboration.

Financial and resource pressures

Connected with the degree of directedness, balanced against patient choice, is an added component concerning financial and resource pressures for the clinician. This is not only an awareness of wider NHS pressures, but also the micro-pressures within the service in which they work. They will be aware of the waiting times for

particular treatments, however they also need to be aware of the wider cost implication, if people with PD are left untreated (Leichsenring et al, 2010).

Cost pressures come into focus particularly when considering psychotherapeutic intervention. Beutler and Forrester (2014) explain that difficulties occur when evaluating the efficacy of certain psychotherapeutic techniques. They explain that sometimes the time required for the healing process within therapy does not meet expectations of fund-holders and commissioners, who expect certain results within short timeframes, which they feel is not possible with the most complex mental health patients.

Barry et al (2007) expand, explaining that insufficient support for complex patients can result in 'unwanted outcomes', including exacerbation of risk. Berrino et al (2011) explain that this is particularly important for PD patients, as cost-saving by denying treatment in one health sphere can often result in the patient overusing other health services, such as A&E, in-patient mental health, and crisis services. In contrast, we do know that for people with PD who engage in treatment, their overall healthcare cost is reduced (Cedereke et al, 2005; Brown et al 2005; Tyrer et al 2003).

The funding discussion is presented in papers sourced from both inside and outside the UK. The reason to make this point is that different countries such as the USA and Canada have insurance-funded access to treatments, rather than an NHS (Mendelberg, 2014). Chiesa et al (2009) suggest that often less costly interventions are opted for in the first instance, even though this may lead to treatment failure and

a need to opt for the costly intervention on top of the initial outlay, arguments are made for considering longer-term health benefits rather than shorter-term costs, to treat the severe and “treatment refractory” end of the PD spectrum. Clarke et al (2013) agree with Chiesa (2008) regarding treatment delays due to waiting lists and funding issues.

Mendelberg (2014) highlights that market forces and cost considerations have penetrated the clinical encounter, which has prompted criticism that a Treatment Choice Encounter may feel “factory-like” and driven by bureaucratization, potentially eroding person-centred care and clinician's independence.

This phenomena is central to this research question, however little evidence was found concerning how a practical rather than idealistic outcome for Treatment Choices Sessions may be achieved in a sensitive manner.

Clinician belief in or understanding of treatment

Within the literature reviewed, a recurrent theme revolved around clinician belief in the treatment. This may be because, in PD, there are so many different treatments (specifically talking treatments) which may be beneficial, or it may be reflective of the fact that certain treatments are under-researched.

Functional impairments that often accompany PD require joint health and social care provision, some interventions may concern stress reduction by focusing upon relapse triggers (i.e. debt, loss of employment etc.), and for these interventions, there can be equal treatment efficacy compared with medication and psychotherapy,

however they lie outside the realm of what are researched as interventions in the literature review (Beutler and Forrester, 2014). Bornstein (2005) suggests that especially with people with PD, the most effective treatment packages are not sole interventions, but combined bio-psycho-social treatment strategies.

This links into one of the clear challenges clinicians face, of linking EBP into treatment choices for people with PD. How do they translate an evidence-base for what they know works (i.e. social care and occupational support), when the NICE guidance etc focuses upon other treatments such as DBT? Cook et al (2004) explain that empirically supported treatments often do not consider individual patient's symptoms and current problems.

Mendelberg (2014) suggests that clinicians, concerned regarding limitations to treatment and restrictions on 'paid for' services, are in a paradoxical predicament, potentially feeling that the treatment that would be best for the patient may be unavailable.

Presence of manipulation/manipulative behaviours

Bowers (2003a) states "*social behaviour is doubly ambiguous with respect to judgements of manipulation*", suggesting a moral component, where people make decisions with patients who have a PD based on the presumption of deception and a globalised response to it, rather than a contextualised theme. In a second paper, Bowers (2003b) suggests that the presence of manipulation is integral to PD patient's interpersonal style and the disorder itself, emphasising that if rejection is the

response, it will result in therapeutic failure and potential discrimination against treatment provided to others.

Evans (2011) and Naso (2006) suggest that clinicians working solely with APD and/or Narcissistic PD can have their capacity to decision-make interfered with by the mental states and behaviours of the patients, particularly if the patients use intimidation or manipulative tactics.

The presence of self-harm

As with manipulation, the presence of self-harming behaviour, particularly in response to decision-making that conflicts with the patient's belief system, can result in staff members feeling bullied or coerced into making different decisions. Chaikin et al (2004) build upon this, suggesting that self-harming in this way is typically anchored in past trauma, leading to ethical dilemmas for the clinician regarding treatment provision. Principles of beneficence, non-maleficence, and autonomy are considered, specifically when making judgements about whether and when to intervene, considering patient's risks and clinician's duty (Royal College of Psychiatrists, 2008).

Brown et al (2012) explain that engaging with people with a disorganised attachment style, as in PD, can lead to significant problems for clinicians concerning 'boundary management', suggesting that clinicians must consider risks, strengths, resilience, and resources for recovery, when they are decision-making about treatment, resilience here is a core term repeated in several papers, with a caution against

commencing in-depth work if resilience is low, due to the likelihood of increased risk associated with an increased sense the person is 'losing control'.

This research demonstrates that resilience is a separate theme from the PD pathology, which should be considered in treatment decisions. Some PD patients will never need long-term therapy, as it would be too risky and self-destructive, however some do, and it is how clinicians define this that is one of the core components of this research. Clinicians must evaluate whether therapy or certain treatments would be tolerated by the patient, to improve functionality without compromising resilience, particularly when considering trauma exposure work. Living a 'split-existence' is advocated by some (Brown et al, 2012), as this enables a person to compartmentalise their distress, and still conduct everyday life (i.e. work etc).

Q4. Summary

Q4 has outlined several clinician factors which influence the Treatment Choice Encounter with a patient with Personality Disorder. These factors include the clinician's ability to:- empathetically engage; build therapeutic alliance; assess the level of insight, resistance and motivation for treatment; and conduct a cost/benefit analysis considering treatment adherence and treatment rationalisation in this financial climate. This is central to analysing the decision-making phenomena. Q5 explores potential supervisory models, and Q6 explores patient variables.

Q5: Are there any supervisory models which aid decision-making and practice reflection?

A significant amount of literature focuses upon providing supervision for people who work intensively or psychotherapeutically with PD patients, however this is mostly focused upon 'in-treatment' issues only, rather than decision-making for treatment, e.g:

- Magnavita et al (2010) explain that without adequate supervision, clinicians may be at risk when treating people with PD, because of the increased risk to self and others.
- Perseus et al (2007) suggest that clinicians who are not supported with supervision are more likely to burn out and become emotionally exhausted by the demands put on them by their patients.
- Ruszczynski (2010) explained that this may lead to dislike of the patient and any patient representing this group, in turn leading to negative patient experience and unbalanced decision-making.
- Hershenberg et al (2012) emphasise that supervision sessions should be where learning and reflection can occur. When working with people with PD, group supervision is essential, for a team model for consistent approaches to be provided, which gives stable and boundaried support for people with PD.

In the research reviewed, there were no PD supervision models which focused upon how to support therapeutic decision-making for all MDT members. Instead, research generally supports the need to develop training and supervision models for all clinicians working with people who have a PD (Castonguay et al, 2010). This would be a useful and important area for future research.

Q6: Are there any research/sources that detail patients' experience of treatment selection regarding their PD?

The research generated information pertaining to patient experience of treatment selection, however much of this was presented from a service/clinician perspective, rather than detailing patient's actual responses. As accounts are described by the clinician, bias may be present due to misinterpretation (Lilliengren et al 2005). Additionally, those few which were gained from patient perspectives typically used retrospective analysis, which can create difficulties, as there will be a filtered biographical reflection on retrospectively recalled events (Ebner-Priemer et al, 2009).

The following themes were raised concerning patient experiences of treatment selection:

Meta-cognitive ability

Bandura (2006) reflected that a patient's meta-cognitive ability to engage in reflection, analysing their feelings, behaviours, and actions, is a core part of 'personal agency'. This ability is posited to be a core requirement in regards to treatment selection, specifically concerning talking therapy approaches, as it is central to engagement and ability to change (Williams et al, 2007). There is substantial research linking the concept of meta-cognitive ability with the ability to adaptively problem-solve and have insight into problems, for PD patients.

Fertuck et al (2009) explain that PD patients often predict abandonment in Treatment Choice Encounters, affecting how they engage. This may mean that they

inappropriately interact on an interpersonal level (Clarkin et al, 2006:143), have altered judgements concerning what they feel may/may not help (Linehan, 1999:18), and become hyper-alert to emotional expressions demonstrated by clinicians (Flury et al, 2008).

Does the patient know best?

Certain PD patients can accept control over their treatments, however research has identified that some struggle, and present with misguided treatment requests for a variety of reasons. The first researched reason is that certain patients are seeking treatment for a different disorder, rejecting their PD diagnosis (Antoniadis et al, 2012; Paris et al, 2007; Benvenuti et al, 2005). The second reason sourced was that, if accepting the PD diagnosis, some patients request treatments that may be evidence-based, but could cause iatrogenic harm due to their personal circumstances (Brand et al, 2014)

Diagnostic stigma

Pickersgill (2012) highlights the long history of PD diagnostic stigma expressed within tabloid media and health research (elaborated upon in Q1). In the literature review for this research, one way in which this was demonstrated was via an influential paper entitled: "*Personality Disorder: The patients psychiatrists dislike*" (Lewis and Appleby, 1988). It is also clear that many services in the 1990's and early 2000's were focused more upon psychosis as a 'real' and 'enduring' mental illness, meaning PD services were very limited (Snowden et al, 2003), increasing stigma through marginalisation and lack of health priority.

The literature reviewed demonstrated that although stigma is reducing (Aguirre, 2016), and people's diagnosis are connected more compassionately to a complex trauma spectrum (Feliu-Soler et al, 2016), there is still discrimination (Guy et al, 2008).

Heilbron et al (2010) explain that social 'norms' and 'values' are changing in relation to PD, enhancing stigma reduction. However, despite this, Liebman et al (2013) explain that clinicians experience difficulty admitting any negative attitudes towards people with PD, as they feel '*unsafe*' in doing so, making this a difficult area to explore, even through the supervisory process, echoed in the process issues witnessed when planning this research.

Quinn et al (2009) explain that stigma is a socially constructed phenomenon, finding that with stigmatised concealed illnesses, (i.e. PD, rather than physical deformity), shame can often be a central component affecting the treatment selection process, as the person's experience may become "unspeakable" (Moses, 2009). This is similar to other concealable stigmas such as: HIV, rape victims, and other mental illnesses (Pachankis, 2007). Anticipated stigma refers to the degree in which people feel that they will be stigmatised by others if they disclose their difficulties, and what a person feels about the negative stereotypes attached to their diagnosis (discussed in Q1).

In contrast, Moran (2007) explains that care must be taken when analysing diagnostic stigma, to ensure that the person has a PD, and is not misdiagnosed. He

explains that the following mistakes have been made when behaviour is out of character for the patient:

- Affective disorders can be mistaken for Dependant PD,
- Histrionic PD can be mistaken for hypomania,
- Anxious PD can be difficult to separate from a disorder on the anxiety spectrum.
- Dependant PD can be difficult to separate,
- Paranoid and Schizoid PD can be mistaken for a psychotic illness or delusional disorder,
- Acute personality changes may present as part of an organic illness, rather than being a part of a PD.

Treatment beliefs

Patients have different treatment beliefs, affected by different factors (i.e. faith, personal values, health beliefs, family influence), this can also be linked with notions of personal stigma discussed previously. The literature review identified that a person's treatment beliefs will affect their engagement in the Treatment Choices Encounter, and their subsequent adherence to treatment. Defife et al (2012) explain that part of any treatment choice is engendering faith in that treatment, by the provision of psycho-education, and the explicit explanation of the degree of patient participation required for treatment success.

One issue concerning PD patient's beliefs about treatment is connected to intolerance of heightened affect, and difficulty in longer-term planning. Friedman

(2008) explains that it is understandable for a PD treatment process to progress by “*one step forward-half a step backward*”.

Green et al (2004) explain that if patients are asked to choose between treatments with delayed or uncertain outcomes, patients often discount the value of these outcomes on the basis of the expected time, which poses a problem in terms of informed treatment choice.

This is a core difficulty for people with PD, when the treatments are uncertain and unspecific in terms of benefit, however the issue is primarily linked to the clinical decision-making part of treatment. McMurrin et al (2010) explain that decision-making may be complicated further if “*practitioners are seeking inherent deficits in the patient as explanations for treatment non-completion, rather than factors concerning the service and the patient's opinions of the service*”.

Insight

Insight is another factor linked to PD patient's low tolerance to stress and high likelihood of disengagement. Baiden et al (2013) researched in-patient psychiatric settings, focusing upon self-discharge against medical advice, and found that people with a diagnosis of PD do this with higher frequency than people with other mental health problems, due to lack of insight into their treatment needs. This research focused upon an in-patient setting, however similar levels of disengagement from treatment are found in papers concerning community treatment (Brook et al, 2006; Tyrer et al 2003; Karterud et al 2003), indicating that insight and disengagement are important when considering treatment choice.

Clarke et al (2013) found that patient factors concerning treatment disengagement included: personal protective factors rejecting close treatment relationships, fears about personal safety, prompted by therapy raising difficult emotions, lack of trust in clinicians related to patient's past abusive relationships, and factors pertaining to an inability to attend/engage with appointments (i.e. homelessness). They also found therapy barriers concerning overuse of prescribed medication to numb emotions, or illicit substance/alcohol misuse, and slowed cognitive processing associated with this, and finally, service barriers including lack of access and inconsistency with certain treatments, and long waiting times between treatment decisions and commencement.

Patient distress levels

Many papers cited patient distress levels as central to treatment decisions. Beutler et al (2012) explain that distress has motivational properties which affect treatment engagement, as well as treatment apathy, suggesting that research has typically not included distress as a key factor in the type of treatment or interventions provided for people with mental health problems.

Cook et al (2004) explained; patients are often excluded from certain treatments due to the presence of suicidal behaviour, substance misuse, and differing neurological difficulties. This exclusion affects the research which considers treatment efficacy for people with PD, which then poses a challenge for clinicians making treatment choices for real-life patients, who typically present with co-morbidities excluding them from research trials, meaning that a further challenge is posed to clinicians: what about when there is little evidence to guide practice decisions?

Gadassi et al (2014) found that distress levels are predominantly higher in people with PD than the general population; Kopala-Sibley et al (2012) explain that this affects clinical encounters. Levy et al (2006) explain that distressed people with a PD often find difficulty in mentalising during appointments, however, McMurrin et al (2010) suggest that distress is considered as a motivator for engaging in treatment, as patients often wish to 'treatment-seek' to reduce distress. When considering the PD categories, this means: Anxious, Dependent, Anankastic, and Histrionic, whereas treatment-rejecting personality types are typically: Dissocial, Paranoid, and Schizoid.

In terms of distress, some patients may demonstrate their stress by taking a "one-up" position. Owen (2011) connects this type of behaviour with the 'treatment rejecting' personality types. The way these patients are likely to interact is that they approach then recoil, they dominate then submit.

Patient symptom profiles

Beutler et al (2012) suggest PD patients can be divided into two symptom profiles: 'externalisers' and 'internalisers', suggesting that 'internalisers' respond better to insight-orientated treatments rather than behaviourally-orientated ones, and are more responsive to treatment than 'externalisers'. This is interesting when examining treatment choices, as within the PD spectrum, there are certain personality types associated with internalised responses (i.e. Obsessive-Compulsive), and others who tend to be more externalised (i.e. Antisocial/Borderline) showing the highest prevalence for treatment, but also the most likely to disengage.

Correspondingly, Bornstein (2005) explains that dependency is often as problematic as treatment disengagement, stating that dependant traits are associated with cooperativeness and compliance. They explain that dependency can be a preferable factor at the start of treatment, but becomes more problematic at discharge.

Widiger et al (2010) highlight the different constellations of symptoms observed with different PDs, meaning that standardising treatment choice is difficult. Kopala-Sibley et al (2012) explain that despite the core features, symptom profiles vary, meaning different treatments may be more efficient. This, combined with the shame or embarrassment associated with treatment-seeking, may mean that treatment selection is difficult (Owen, 2011). The difficulty with varied symptom profiles is associated with construct validity (Teglasi et al, 2012), linked with diagnostic debates presented in Q1, and also linked with the overall research question concerning treatment choice.

Responses to rejection

Bowers (2003b) suggests that PD patient's demands and perceptions of increased levels of care is often difficult for clinicians. Castonguay et al (2010) explain that difficulties are associated with fluctuating patient motivation and 'split states', meaning patient presentation varies, anchored to the relationship that they are in. This factor needs consideration in Treatment Choice Encounters, as it differs from other treatment choices for disorders that have a greater degree of stability in symptoms (whether this is: stable-severe, or stable-well).

Discharge often evokes feelings of rejection. PD patients often experience autonomic hyperarousal if they perceive rejection and abandonment in the encounter (Kopala-Sibley et al, 2012). Friedman (2008) explains that discharge plans for people with PD often fail to incorporate potential decompensating factors, which then may result in re-referral due to relapse shortly post-discharge. They explain that issues that may be linked with this include: denial, resistance, divergent opinions concerning care needs, and indifference regarding crisis plans or follow-up arrangements. Other research connects perceived rejection as related to clinician 'aloofness', which can result in reduced confidence in delivering information to emotionally aroused people (Goodman et al, 2014).

Transference and Countertransference

Transfereential responses are well-researched when considering therapeutic treatments for people with PD, but lack research regarding the Treatment Choice Encounter. Chaikin et al (2004) state that PD patient's capacity for trust is often damaged, due to early-life abuse. In therapeutic relationships, patients are often vigilant concerning the reoccurrence of trauma generated from relationships where there is a power imbalance (i.e. healthcare relationships). This can then result in the patient consciously or unconsciously behaving in a way that either rejects the clinician, (because of anticipation of threat), or pressures the clinician to re-enact the early life trauma in some way.

Either behaviour will affect the Treatment Choice Encounter, due to potential confusion or disconnectedness as a reaction from the clinician (Chatziandreou et al,

2005), or potentially negative counter-transferential patient reactions (Friedman, 2008; Liebman et al, 2013).

Patient's perception of treatment

Constantino et al (2012) explain that patient's 'outcome expectations' are important, representing the person's 'prognostic beliefs' about personal resilience, treatment efficacy, and personal efficacy, which may mean a pessimistically low or unrealistically high expectation of treatment. Therefore, if clinicians commence encounters with an inflexible pre-set criteria which does not assess these factors, the patient may feel rejected and demoralised, and so have a greater likelihood of disengagement with any treatment offered (Perseius et al, 2007).

Disengagement of PDs from treatment has further knock-on consequences, including: more frequent emergency attendance, increased amounts of in-patient use (Karterud et al, 2003), and overall higher treatment costs (Webb and McMurrin, 2009). DeFife et al (2011) suggest that negative expectations after an initial Treatment Choice Encounter will affect a patient's choice to return for treatment, and future treatment efficacy.

Gudjonsson et al (2011) suggest that a key factor in the recovery process is engendering a sense of empowerment and control in the patient, whilst assessing levels of optimism, and exploring the person's capacity to engage in treatment. Lilliengren et al (2005) suggest that the patient's perspective on what works concerning treatment choices is evidently missing from research.

The study by Lilliengren et al (2005) took a grounded approach to exploring patient's feelings about selecting talking treatments, generating the following thematic results:

- (1) talking about oneself rather than others,
- (2) talking being difficult,
- (3) having a 'special' place and a 'special' relationship,
- (4) new relational experiences,
- (5) exploring together,
- (6) expanded self-awareness,
- (7) self-knowledge is not always enough,
- (8) something was missing,
- (9) experiencing mismatch.

Although the Treatment Choices Encounter is not necessarily a therapy session, all of these issues are helpful to understand in terms of potential patient feelings within the encounter. The study also revealed that the patient wanted the clinician to adopt the role of the 'expert' in regards to all treatments, to trust the clinician, and also be guided into what may benefit them and make them 'feel well', which may contradict other previous research pertaining to 'expert patients'.

Psychological reluctance and resistance

Therapeutic reluctance and resistance was a theme that arose pertaining to treatment choices. Goldfried et al (2005) identify that some patients have a higher 'locus of control' than others, and clinicians should adjust their position and approach to respond to this, even though they may be reviewing other patients with the same

diagnosis. They explain that when selecting treatments, some patients may wish to be advised what to do, and some not, and this may change within sessions with the same individual, due to the nature of altering affective states often observed in PD. Harakas (2013) discusses resistance, when examining people with PD. He explains that it is a obstructive phenomenon in the change process, and may mean that treatment is not possible. He adds that there is a related concept of reactance, which can decrease the effect of behavioural change.

Q6 conclusion

Findings for Q6 explore specific patient factors that can affect the Treatment Choice Encounter. Much research focused upon patient's relationships generally or whilst involved with specific talking treatments. This demonstrates that there is a paucity of research for PD treatments in other fields such as social, nursing, or medical care.

There is also insufficient literature published from a patient's perspective in terms of being assessed, receiving treatment, and exiting treatment (Dimaggio et al, 2006). Within the research found, for those pieces which did focus upon patient experience, it has been from a perceived perspective rather than first-person perspective. The literature review has identified this as a research gap for future study.

Patient thought processes, symptom profile, values, insight, and treatment beliefs, all impact upon the therapeutic encounter. To support clinicians to make decisions, it is therefore essential that clinicians are not only aware of potential effects, but also pitfalls of counter-transferential responses, and ways of overcoming certain negative factors.

2.9: Literature review conclusion

A significant amount of literature was reviewed and analysed to explore the research question. Unfortunately, little pertained directly to making treatment choices for people with PD, meaning that the research question cannot be fully answered by a literature review alone, justifying the need for an additional field study as a part of this project.

The literature sourced for the review came primarily from psychology and psychotherapy literature (Appendix 2), and was generally derived from clinician opinion, lacking the patient voice.

This research analysis was useful in exploring the 6 questions posed, however due to the origins of the research sources, cannot be considered as representative for treatment in the locality researched. The predominant clinicians are not psychotherapists or psychologists, however work in a way which is psychologically informed. Because no research could be found which studied a sample representative of the research locality make-up, the result's cross-applicability must be questioned.

In terms of the specific questions posed for the review, interesting insights were obtained regarding: the effect of history and stigma on treatment choices, therapeutic relationships, patient factors, and clinician factors, however no model was sourced concerning decision-making, and no supervision framework was obtained which adequately supported the decision-making process.

In summary, the following issues are raised by the literature review concerning the overall research question:

- PD as a diagnostic construct has a changing nature, making it difficult to define prevalence rates, and therefore also treatment rates.
- There is a separation of the diagnosis from other mental health problems, despite its comorbidity, which makes it exclusive, and appears to devalue it.
- The notions pertaining to treatability have been debated for a number of years, which means that there is exclusion.
- APD and BPD are the main PD diagnosis that are focused upon or treated in the literature, meaning that there is insufficient research to support the treatment of other PD diagnosis.
- People can present with traits, or full PD diagnosis, complicating whether they are eligible for a treatment or not.
- Aetiology linked to trauma appears to be a major factor and unchanged in terms of the rest of the diagnostic debates, however the transient nature of the intense distress is often representative of a person seeking treatment, resulting in patients often demanding to focus upon immediate stressors and requesting others to solve things for them, conflicting with service wishes to focus upon longer-term/'bigger picture' solutions.
- The presence of distress or disability is most important in terms of treatment choice, rather than just identifying the symptoms required to fulfil the diagnosis to justify treatment.
- Terminology surrounding the diagnostic label evokes stigma, particularly when considering the commonly associated and interchangeable terms used

for PD in the literature (i.e. "psychopath"). This is reinforced in research and popular media, meaning that empathy for PD is difficult, as exclusion is reinforced, and clinicians in patient encounters must be mindful of this.

- PD is often symbolically recognised by antisocial behaviours (i.e. violence or self-harm), which can evoke fear and exclusion. These risks can be distracting in Treatment Choice Encounters, and influence decision-making.
- The available research is considered as incomplete, as people with this diagnosis often have multiple co-morbidities in clinical practice (i.e. alcohol misuse), but people with co-morbidities are typically excluded from research trials, meaning that applicability of the results may be questioned.
- Standardised approaches or decision-making structures are difficult for people with PD, linked to their variable symptom presentations.
- Clinician factors significantly affect decisions that are made, which must be considered in the therapeutic encounter (i.e. Clinician wellness, directedness, belief in and knowledge concerning particular treatments, clinician's authenticity, ability to clinically formulate).
- Patient symptoms may vary dependent upon their reaction to the clinician conducting the encounter, linked to early attachment patterns and reinforced relational difficulties, meaning it may take more than one session to formulate treatment choices, which is at odds with the current UK payment system.
- The notion of 'expert patient' is significantly reinforced in all aspects of care, people's viewpoints must be considered in the Treatment Choice Encounter. Unfortunately, due to PD patient's difficulties with power-relations, their ability to be an 'expert' when they are significantly distressed may be limited. They

will often request immediate solutions, which then helps them regulate their affect, otherwise impulse control is destabilised.

- The question of treatment prescription is raised in several pieces, with certain prescribed treatments (i.e. medications), having clear definitions in who may prescribe, however with other treatments (i.e. talking treatments), the prescriber's remit and roles are less clearly defined, causing problems.
- There are risks associated with either prescribing or withholding treatment, this is not fully researched, which then impacts upon defensible decision-making.
- Treatment termination, notions of recovery, and treatment thresholds, are difficult to define, meaning discharge and dependency are major issues which influence treatment decisions.
- Many tools have been identified for use when a person has been accepted for treatment for PD, or to assess patient readiness, but no structures or tools have been used to define how a person is accepted for treatment, or what thresholds or symptoms make them more suitable for treatment than others, however certain tools were identified which may be adaptable.
- The decision-making process for acceptance into treatment is subjective, and subject to influence by many factors (i.e.: clinician bias, and reflectivity).
- Patient motivation is a factor when considering treatment choices, however the importance of psychoeducation for PD does not seem to be as appropriately emphasised as it is with other mental health disorders.
- There is a lack of a structure to support specific treatment selection. There are disagreements between whether different treatments have different levels of treatment efficacy or not.

- The ability to empathise and empathetically engage with people who have a PD is difficult, and reciprocally, the ability of the PD patient to empathise is researched as challenging, and influential concerning decision-making.
- Insight and resistance are often challenging factors affecting the Treatment Choices Encounter.
- Cost and treatment rationalisation must also be considered when contemplating adherence and possibility of successful treatment outcomes.
- Research cost considerations often take a narrow view (i.e. 'what the cost of providing this treatment means for the team?' - Rather than 'does it reduce the cost for the wider health and social care system?'), this micro-focus often prompts 'revolving-door' patients, which is why new health 'Vanguard Sites' are having to consider more of the wider effects than segregated services do.
- Treatment beliefs held by the patient affect treatment choice, as does insight, distress levels, responses to rejection, countertransference and transference, reluctance, and resistance.

The literature review informs phenomenological analysis by enabling a presentation of current knowledge regarding the treatment choice encounter. However, it also identifies research gaps concerning the phenomena of making treatment decisions. In the following section, a methodology plan is presented, concerning data from the practice setting, which helps to further answer the research question posed.

Section 3: Methodology

3.1 Introduction to the Research Design

In this chapter, the methods used and overall strategy for exploring the research question will be described and critically considered. Within the description, analysis of different approaches will provide a rationale concerning why specific approaches were chosen, within the context of this study and its aims.

3.2 Methodology Background

Cohen et al (2011) suggest that there is no 'blueprint' for research planning; instead they suggest governance for research design must be made through the notion of 'fitness for purpose'. To analyse this research design for 'fitness for purpose', it is important to revisit the research question:

How can mental health care staff use a pre formulated guided decision process in the selection of therapeutic interventions for people with PD, within the context of rationalisation and service change?

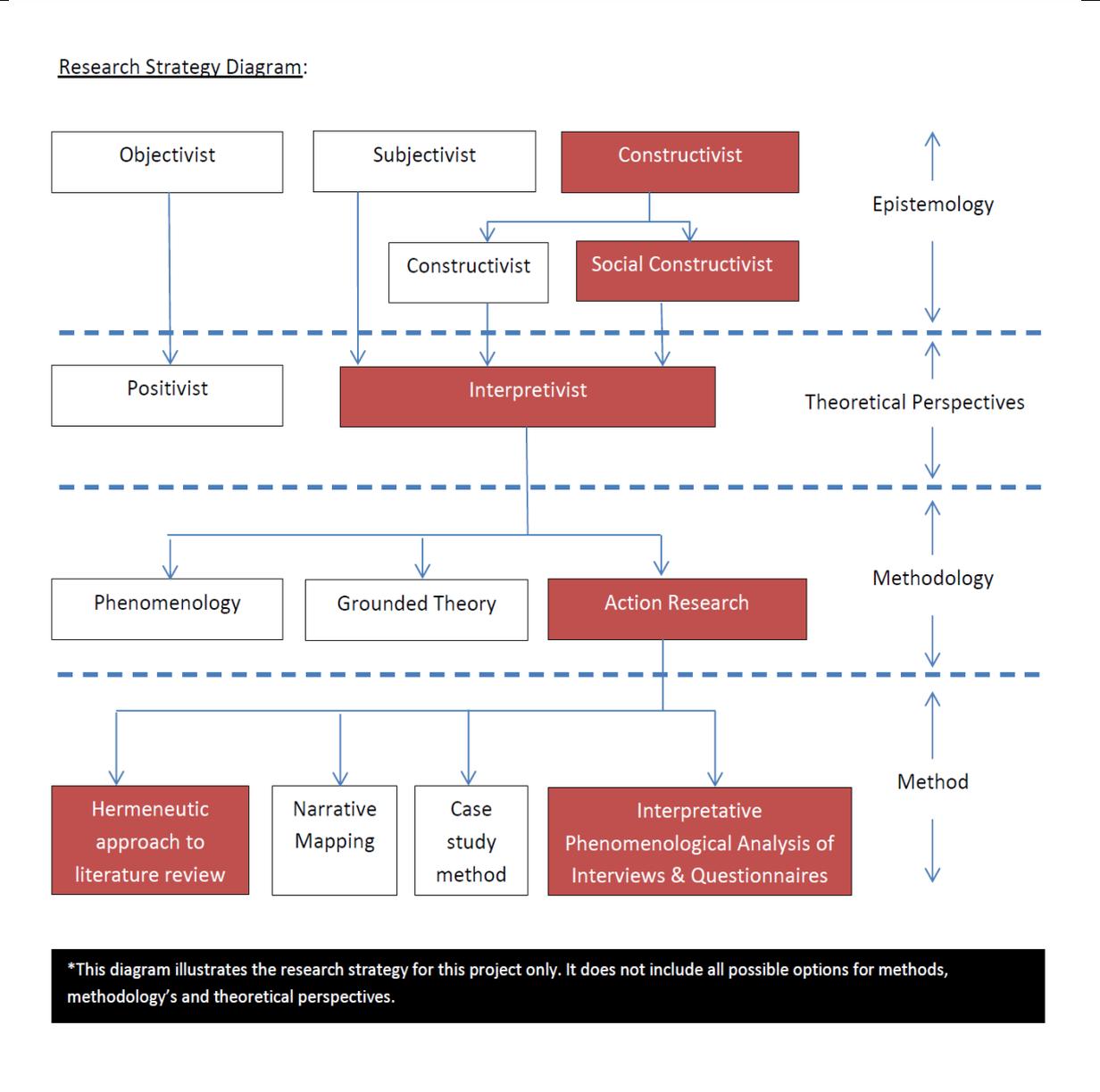
Creswell (2014:15) suggests that research approaches are procedures spanning broad assumptions to detailed methods concerning methodologies for data collection, analysis, and interpretation. Informing the research design has been the philosophical standpoint from which this researcher has approached the problem, the method proposed and methodology governs this selection, the theory underpinning the methodology, and an analysis of the epistemology that underpins the theoretical perspective (Crotty, 1998:54).

To answer the research question posed, a robust design capable of fulfilling the research aim and objectives follows. The research aims were described in Section 1 along with the overall Action Research staged plan (Figure 1).

3.3 Research Strategy

A diagrammatic representation of the overall research strategy for this study is presented below in figure 9:

Figure 9: Research Strategy Diagram concerning the research study exploring treatment choices for people with Personality Disorder.



A good research strategy transforms the research questions and aims into a credible, legitimate, and practicable plan which can be operationalised (Dawson, 2009:110). When planning research, Cohen et al (2011) identify two phases: the '*divergent*' phase, and the '*convergent*' phase. The divergent phase opens up a range of options facing the researcher; this was considered in the literature review stage of this thesis. The convergent stage analyses the options for researching a phenomena, understanding which are compatible, desirable, practical, realistic, or even unachievable. This strategy is the anchor in achieving research justification. The research strategy chosen not only guides the methodology selected, but also the approach taken towards research ethics.

When considering a research strategy such as this, this researcher takes into account four important philosophical assumptions within social science: epistemology, different theoretical perspectives, methodology, and method (Burrell and Morgan, 1979). There are many philosophical stand-points and approaches applicable to health and social research, however only a brief account of methodological approaches relevant to this research study is presented in the following sections, to define the researcher's approach and the related important concepts.

3.3.1 Epistemology

Epistemology concerns theories of 'knowledge' (Turri, 2014:24). It underpins how knowledge generation processes are understood, and specifically how the person as subject of research is theorised (Hollway, 2008). Objectivism, Constructionism,

Subjectivism, (and their variants) are considered as three core epistemological stand-points within psychotherapeutic research (Crotty, 1998:56).

The standpoints identify this researcher's perception of 'human nature', and therefore the relationship between humans and their environment (Cook, 2009:6). This is of particular importance when considering the research question, as it focuses upon the support provided for an interactional dynamic between clinician and patient in the Treatment Choice Encounter. The interaction between individual philosophical viewpoints defines the researcher's subjective interpretation of reality (Danvers, 1995).

Explicit declaration of viewpoints and approaches enables readers to understand potential subjective bias, constitutes a core part of ethical research, and may influence a researcher's methodological preference, associated with their view of the world (Gray, 2004:24). This study is approached from a Constructivist perspective. Brief discussions concerning the Objectivist's perspective (Appendix 7) and the Subjectivist's perspective (Appendix 8) are provided, but do not form the core part of this study, therefore only the Constructivist perspective is considered and synthesised below:

3.3.1.1 Constructivism

When considering the research question, aims, and objectives, this approach is more compatible, realistic, and practicable, in terms of problem analysis. The justification of utilising a Constructivist approach is on the basis that the research focuses on analysing existing influences concerning treatment selection with PD

patients, examining different possible aids to treatment selection, which may assist the patient journey and care provider's ability to make consistent evidence-based decisions.

Constructivism is described as more closely aligned to Subjectivism than Objectivism, as it also often adopts an Interpretivist approach. However, rather than placing value solely on an individual's subjective meaning, Constructivists construct meaning and value by analysing the researched subject's interaction with the world (Gray, 2004:16). The origins of Constructivism are cited back to Greek philosophers such as Heraclitus and Protagoras, more recently it has become a legitimate research approach in the psychotherapeutic research arena, since the work of Piaget (Phillips, 1995).

Constructivism has two main sub-paradigms: i) Constructivism and ii) Social Constructionism. Constructivists focus upon individual meaning-making processes, assuming a personal and private component to the process, whereas Social Constructivists examine the relationships among people, rejecting isolated individualism, prizing a more shared psychological meaning (Twomey-Fosnot, 2005:4).

A Social Constructivist approach is the most suitable for this study, on the basis that the research question explores the interaction between clinicians, supervisors, and patients, and the interaction within and between the opinions of all, rather than solely being concerned with a deep understanding of one perspective.

Glaserfeld (1995:17), detailed two principles which encapsulate a Constructivist approach: firstly, that the purpose of human constructions is not representational, but adaptive, and secondly, that knowledge is actively constructed, rather than passively received. This means that the Constructivist approach takes the view that people are '*active meaning-makers*', who formulate their experiential world "*for the sake of survival, rather than to represent ontological reality*" (Raskin, 2011:224). Constructivists typically accommodate and assimilate new knowledge connected to their research experience in order to reframe their perception of reality, and advance their knowledge base (Wadsworth, 2004:46).

There are a number of criticisms of the Constructivist approach, such as an overly subjective researcher perspective (bias), with the researcher's own assumptions and construction of events affecting the outcome of the research. This is critical, as it views Constructivists as '*dangerous*', because they deny external realities, meaning that an antirealist ('anything goes') perspective may be adopted, contradicting any '*essentialist truth*' claims (Gill, 1996). Guston (2001:93) challenges this, suggesting that '*serviceable truths*' are possible, which satisfy scientific testing without compromising individual viewpoints.

Supporters of the Constructivist viewpoint argue strongly that Social Constructivists accept the reality that society provides a structure to conduct research within, however view the lack of restraint that Constructivist theory provides as liberating, meaning that researchers can understand and reveal new realities within the dynamic of a social world. In this sense, arguments concern the conceptualisation of how Constructivism is perceived. Raskin (2011:224) suggests that it should be

conceived as an epistemological theory as opposed to an ontological theory, meaning that it is concerned with "*What people can know and how they know it*", rather than how something existed and its nature or being.

3.3.2 Theoretical perspectives

As explained above, Interpretivism is a philosophical stance that informs a methodology, and provides a logical context for the research process.

Interpretivism is a theoretical perspective linked to Social Constructivism, because Constructivists argue that '*truth and meaning do not exist in an external world, but are created by the subject's interaction with the world*' (Gray, 2014:20). Aligned with this, the researcher considers that, for the research question concerning the phenomena of treatment choice to be understood, individual perceptions and constructed meanings for reality must also be explored, to generate a collective understanding of the phenomena, or bring together opposing realities, which means the complexities of the phenomena can be revealed.

The researcher considers the adoption of an interpretivist approach as essential, as the literature review demonstrated, there are multiple different opinions about why Treatment Choice Encounters are difficult with PD patients, but there is a polarised research base for decision-making, primarily restricted to psychology/psychotherapy encounters. Understanding why this may be, by exploring practitioner's viewpoints, allows the participant interpretations to be revealed, enabling co-constructed results which contribute essential new insights into the phenomena, aligned with social constructivist principles.

3.3.3 Selecting a Methodology

Interpretivism is a major anti-positivist stance, and commonly draws upon different theoretical perspectives of inquiry, such as: symbolic interactionism, phenomenology, and hermeneutics. It typically draws upon situational-specific, historical, and culturally derived interpretations of the social world (Crotty, 1998:72).

Due to the Social Constructivist nature of the study, a hermeneutical approach was taken regarding the literature review. This is because constructivists view knowledge as created not discovered, meaning that when conducting a literature review, the information from all sources is analysed, interpreted, and in so generates a different outcome as a whole rather than individual parts, hermeneutic approaches embody this, rejecting positivist standpoints, allowing an in-depth search for meaning within literature reviews.

The literature review generated insufficient knowledge to answer the research question asked, and lacked depth regarding clinician's perspectives in the NHS. When considering the AR Methodology used, this then identified a need to consider a further AR iteration, asking questions of clinicians in practice, rather than gaining information from written sources. An IPA Method was selected, as this method has origins in hermeneutics, and is researched to enable exploration of people's experiences of a given phenomenon, in this study: how treatment decisions are made with people who have PD.

3.3.4 Methodology

'Methodology' is a set of methods, rules, and principles for regulating an approach, which in reality governs the relationship between the researcher and what is being researched, concerned with the principles and procedures of the research inquiry itself (Creswell, 2013:22). It justifies the plan of action behind a particular method used, associated with the desired outcome generated by the research question. The issue in focus is significantly complex, developed from previous research in this practice setting, detailed in Section 1.

There are many different types of methodologies, some of which are more allied with Social Constructivist Interpretative paradigms, including Phenomenological Research, Grounded Theory, and AR. An AR approach is taken for this study. The argument for this approach is that the aim of the study is to analyse a practice issue, and change an element of practice in response to the results generated. This decision was not only selected by the researcher, but also the validation group who were consulted as part of this research.

Three reasons are provided regarding the choice of an AR methodology. Firstly, AR is described as 'responsive' in order to achieve the 'action', the issue is practice generated and problematic for clinicians, patients, and supervisors, therefore requires actions to analyse. Secondly, AR is emergent, meaning that potential answers and results are not available for 'testing', this is the case with the problem focussed upon in the study. And finally it is 'not impersonal' (Brydon-Miller, Greenwood and Maguire, 2003), meaning that the researcher and all others involved

in the research process have respected opinions, enabling a socially constructed outcome.

Reason et al (2014) identified the importance of moving beyond grand narratives to understanding micro-perspectives that may influence local practice, enabled by AR. Tacit knowledge is the embodied know-how that is the foundation of action in practice, this is different from knowing what should happen based in theory regarding a certain situation. This is key to the research question posed; NICE guidance describes treatments for PD, but it is clinicians in practice who make the decision about whether to or not to provide treatment.

The research question posed can therefore only be partially answered by conducting the literature review (Section 2), the remainder of the question requires discussion with people who currently 'know how', or conduct the Treatment Choice Encounter. In conducting this research and analysing the outcome, practice development can occur, which is a reason why an AR methodology was selected.

Action Research

McNiff et al (2006) suggest that AR is a powerful tool to facilitate change at a local level, developed by Lewin (Lewin, 1946). Cohen et al (2011) expand, explaining that AR methodology is not restrictive, and is beneficial in a variety of areas, for example: teaching methods, learning strategies, evaluative procedures, for analysis of values and attitudes, management, and administration. This research focuses upon the practice procedure of selecting treatments, and requires analysis of values and attitudes from the patient, clinician, and organisation, which may influence the

outcome of this encounter. AR enables participant research, which explores personal and social perspectives to understand the different values and attitudes which influence the decision-making process.

To gather clinician opinion, various methods exist that may be used within AR methodology. Participatory research of this kind has a double objective; firstly to produce knowledge and action directly useful to a group of people, and secondly to empower people through the research process, where research participants construct and use their own knowledge to change practice, making improvements for clinician, service, and patient (Coghlan et al, 2014:54).

AR as a methodology does not mean that a specific method is prescribed, in the same way as it is not selected from a specific epistemology. The method required within the AR process must be phenomenological, to focus upon the subject matter and participatory research methods.

3.3.5 Methods

Various methods were considered when developing the research strategy for this study associated with the Interpretivist paradigm, including narrative analysis, use of focus groups, and clinician interviews. The method selected was clinician interviews, analysed using an IPA framework, on balance it is the best method for providing an insight into individual clinician's interpretations of the Treatment Choice Encounter, whilst allowing exploration of variables influencing the encounter.

IPA can be considered as either a methodology in its own right, or a method used to analyse transcripts within another methodology, such as AR (Biggerstaff et al, 2008). As a method, IPA typically has five goals: (1) to generate qualitative data concerning lived experiences, (2) to employ IPA to the qualitative data, (3) identify key themes within and across different data sources, (4) interpret and describe the lived experience, and (5) provide recommendations for change, maintenance, or discontinuation of a phenomena, based upon research results (Cooper et al, 2012). These five goals are consistent with the research aims of this study, and justify why IPA is the method rather than the methodology, as the results of the IPA will constitute a part of answering the AR question, rather than the whole. It is also consistent with the Social Constructivist approach, as it enables the interpretation of multiple personal perspectives, incorporating results generated from a shared reality of the focused issue.

A research study which has elements of both quantitative and qualitative data gathering and analysis is considered as a 'mixed-methods' study (Venkatesh et al, 2013). Despite the majority of this study employing qualitative analysis, it does employ aspects of quantitative analysis, and therefore is considered as mixed methods. When considering complex human phenomena, Doyle et al (2016) stated that the use of mixed-methods allows a deeper and broader understanding. Creswell (2014:2) expands, explaining that through the collective strength analysis, a better understanding is gained of the researched problem than with either type of data alone.

3.3.5.1 IPA approach

Smith et al (2014:63) provide an IPA framework which was employed for this research (Appendix 9). They emphasise that this approach involves detailed exploration of the participant's lived experience and account of an encounter, rather than feeling the need to produce an objective statement of the event itself. The use of IPA in this study is justified, as it enables the 'Treatment Choice Encounter' to be fully explored from a clinician perspective.

Within the IPA process, the researcher has an active role, in a two-stage (or double-hermeneutic) interpretive process: the participant is trying to make sense of their world; the researcher is trying to make sense of the participant's 'making sense' of their world (West, 2013). IPA is therefore proposed as being intellectually connected to hermeneutics and theories of interpretation (Tomkins et al, 2010), which is why it is linked in this research strategy. IPA may combine different interpretative stances, such as empathic hermeneutics with questioning hermeneutics. The way in which interviews were designed and data gathered are expanded upon in Section 4 in order to understand the complexities of asking the specific research question.

3.3.5.2 Questionnaires

The second method used within the AR process is data gathering through patient questionnaires. The questionnaires will enable patient data to be obtained regarding the Treatment Choices Encounter, which will help enhance support strategies provided for clinicians in the decision-making process.

The reason that questionnaires are used to gain patient data, rather than using the interview format that is used with clinicians and supervisors, is that firstly, the patient information is more unique concerning their individual encounter, rather than providing examples of multiple encounters, which is the case for clinicians, and secondly, because of the 'effect' an interview may have in influencing patient's expression of their thoughts. It is accepted that interviews may be intimidating for some participants, and may therefore be subject to more bias than anonymised questionnaires (Kitzinger, 1995). As is the nature of AR, the researcher clinically works in the area where the research was conducted, and therefore would influence an interview more than a questionnaire.

Lastly, consideration was made regarding gaining support for interviews, similar to the ones planned with clinicians and supervisors, with patients, using an interviewer that is either a peer support worker or external from the practice area. Although this was considered as an option, it was decided that this would alter the data gained, as there is a strength connected with the Constructivist and Interpretivist epistemologies that may be compromised by an external researcher.

3.4 Ethical Considerations

Ethical principles are central to any research and practice-based study, the main two ethical principles are beneficence and non-maleficence (NMC, 2015; BABCP, 2010). There are multiple areas to consider when drawing attention to and expressing the ethics of this study, therefore the ethical considerations are presented under separate headings below:

3.4.1 Consent

Consent was required within each stage of the research process:

Patient Feedback Questionnaires

Each patient who entered treatment was provided with a questionnaire to complete (Appendix 30). Completion of this questionnaire was voluntary, the questionnaire contained a summary outlining the research being conducted. A stamped addressed envelope was provided for returning the questionnaire; no patient identifying data was contained within the questionnaire, to ensure anonymous feedback for the patient.

Clinician and Supervisor Interviews

Written consent was obtained from each person participating within the semi-structured interview process. A consent form was devised, to ensure participants were aware of study aims and objectives and consent and confidentiality issues pertaining to the study (Appendix 31).

Validation Groups

Minutes were taken at each validation group, detailing a summary of discussions. It was appreciated that attendance at the validation group was voluntary, and therefore attendance varied. Consent to participate in this group was discussed at the start of each group.

3.4.2 Deception

All semi-structured interview questions were provided to the interviewees in advance of their interview, enabling transparency for all participants. This study does not use deception; therefore there are no considerations in this area.

3.4.3 Debriefing

There was not considered to be a need to provide a specific debrief within this study, due to the nature of the investigation. As this is an AR study, debrief was provided on an ongoing basis through the validation groups. The study outcomes were available to all participants following study completion.

If clinicians or supervisors had required support due to any issues raised by participating in the research, the service managers agreed to provide this. Should patients have required support or advice due to the research study, the NHS Trust Patient Advice and Liaison Service agreed to provide this support.

3.4.4 Withdrawal from the investigation

Once the anonymous patient questionnaires were received, they could not be withdrawn from the study. This was made clear within each participant letter. Following each semi-structured interview, transcription took place. After participant validation concerning accuracy, the transcript was provided with a study number, meaning it was anonymised, and candidates were unable to withdraw from the investigation. This was specified in each participant consent letter.

3.4.5 Confidentiality

Confidentiality issues concern: the organisation, the patient, and the interviewees. All information gained within the research will become public, due to the intention to disseminate findings within teams post-study, to publish findings within peer-reviewed academic journals, and also present findings at relevant conferences.

Questionnaires (Appendix 30): The questionnaires were structured so that they had no identifying information upon them, ensuring confidentiality. Participants could either choose to hand-deliver or post them back, and were provided with a stamped addressed envelope to do so. Participants who had literacy difficulties could choose to answer the questions when read by the clinician.

Audiotaped Interviews: prior to consenting to the interview, it was made explicit that the interview content would be used for research purposes. Interviewees were requested to complete a demographic questionnaire prior to the interview (Appendix 32). Completion of this form was optional, and it was separated from the interview transcripts once they were anonymised. Audiotaped sessions were securely encrypted as per NHS Trust policy, conforming with terms of confidentiality.

Interview Transcripts: With regard to confidentiality, the following precautions were taken:

- Removal of subject identity from final transcript. Each transcript was referred to by number only.
- It was recognised that due to the small number of clinicians and supervisors in the NHS Trust sites involved, anonymity could not be fully

assured, however the right to withdraw was explicitly stated, until the point the transcript was anonymised.

- Basic data is kept identified by a number/code, which ensures anonymization, all notes will be kept for a period of 5 years after the study is completed, then destroyed.
- Secure storage of transcription data was assured.

3.4.6 Protection of participants

All questionnaires had to remain anonymous, therefore participants were fully protected. Written consent was obtained from each person participating within the interview part of the research, the consent form was designed to ensure participants are protected by being aware of their rights, study aims and objectives, and consent and confidentiality issues pertaining to the study.

3.4.7 Giving advice

Advice letters (Appendix 33) were prepared for this research project, and provided to each interviewee who agreed to participate. The letter provided a brief study rationale, and consent and confidentiality information, including the right to withdraw from the study, with boundaries about when the right to withdraw would be removed.

3.4.8 Data protection

Data protection issues considered in this study include: anonymity of research participants, described in the consent and confidentiality sections above. All questionnaires and audiotapes were securely encrypted using NHS Trust approved software, data is securely locked in Trust filing cabinets. Once transcriptions were

validated by participants, the encrypted files were destroyed. Transcriptions will be kept securely for 5 years after the study is completed, then destroyed.

3.5 Ethics approval

Ethics approval for this study was gained from:

- The UK National Health Service Ethics Committee
- The University of Derby Ethics Committee
- Regional Research and Development Committee

Approval letters are provided in Appendix 34, 35 & 36. The reason that it is important to gain approval is to adhere to policy and also to provide an external analysis of the study structure which checks the ethical validity of approaches to protect all.

3.6 Subjects and Sampling

Patient Questionnaire: Questionnaires (Appendix 30) were provided to all patients with a diagnosis of PD, attending sessions over a 4-month period. The number of questionnaires supplied was recorded by clinicians. Research suggests that approximately 50% response rate is typical for a paper questionnaire in regards to health intervention (Care Quality Commission, 2014). This was the target for the response rate for this study. All results are presented and the actual response rate clarified when obtained, to enable the reader to considering the representativeness of the data collected.

Clinician and Supervisor Interviews: Smith et al (2014:56) suggest that IPA researchers should attempt to source a purposeful homogenous sample. He also suggests that a sample size of between 5-10 participants is typical for an IPA study. A distinctive factor of IPA is its commitment to a detailed interpretative account of the cases included, and many researchers recognise that this can only realistically be conducted on a small scale. The social constructivist perspective the research question is approached from means there is a need to explore sufficient individual perspectives to enable examination of all perspectives required in order to generate results that prize individuality whilst exposing collective experiences.

Hefferon et al (2011) emphasise that a '*less is more*' approach must be applied to IPA sample size, suggesting that the depth of analysis may be compromised if researchers attempt to include too many participants, they suggest 3-6 participants for an Masters level study, and no more than 10 participants for a Doctorate study such as this. In support of this, West (2013) argues that detailed IPA analysis is demanding, with each one-hour interview being expected to require approximately 40 hours of analysis to provide rich analysis and understanding of each participant experience.

The predicted sample size in the study for the semi-structured clinician interviews was 6-8 interviews. It was anticipated that this sample size would allow the gathering of data which was rich and detailed enough to answer the research question. Each clinician may work with 30 (or more) people with PD, which provides perspective upon up to 240 cases. The minimum number of interviewees was set at 4, and a maximum number was set at 15, interviews would continue until saturation was

reached. Saturation in this context means that the collection of any new data does not shed any more light on the issue researched (Guest, Bunce and Johnson, 2006). A theoretical sampling was used, due to the specific nature of the phenomena under investigation and the small number of team workers with this patient group.

For the supervisor-clinician interviews, a theoretical sampling method was also used, and the target number of interviews was set at 3-4. This is representative of 40% of actual employed supervisees across the teams involved in the research.

3.7 Researcher Influence

The researcher declares an interest in this particular area, having a background in mental health nursing, and qualification and practice as a psychotherapist. The researcher currently works as a Consultant Psychotherapist and Advanced Nurse Consultant within the NHS service in which the research was conducted.

The researcher interest and service position is declared, as it may influence the interviewee's participation due to their relationship with the researcher. Some researchers may consider this as a problem, however as this research is being approached from a constructivist perspective, it is accepted that any researcher will have an influence upon the research conducted. An independent researcher was considered in regards to conducting the semi-structured interviews; however it was considered that being known to the participants may instill trust and honesty on questioning, due to the pre-existing relationship, more than with a researcher unknown to participants. Within the AR process, it is accepted that the researcher is

a planner, leader, catalyst, facilitator, teacher, designer, listener, observer, and synthesizer (McNiff et al, 2006).

After all interviews were transcribed and analysed, coding was reviewed in depth by a researcher who had not been involved in the interview process. The second researcher received the transcripts after anonymization. After discussions, the results were taken to a validation group of stakeholders for further discussion and reflection.

3.8 Payments or rewards/incentives

No payments or rewards were provided for the interviews or questionnaires. Interviews were conducted within scheduled work time, which was paid by the NHS Trust. Team Leaders and the Operational Directors have agreed to this research.

3.9 Study validity and credibility

Evaluation of qualitative research is difficult due to the nature of the research, there are many variations, rather than one true perspective on reality. However it is necessary to make judgements, but the difficulty is that because there are many different types of qualitative approach, it is difficult to set criteria.

Yardley (2014:243) presents a framework for demonstrating validity in qualitative research applied to this research study. This framework formed the basis of strategy included within the above sections regarding ethics, methodology, data analysis, and collection. The framework is considered again at the end of the thesis, in the strengths and limitations section.

3.10 - Section 3 - Conclusion

Within this chapter, the research strategy and ethical considerations for this project have been described and analysed, providing rationales for the choice of method and methodology employed, these are summarised diagrammatically at the start of the section in Figure 9.

When planning the IPA study, clinical practice difficulties were encountered, which affected the study method. The next section focuses upon how the method was refined, and tools developed to 'funnel' the questioning.

Section 4: Heuristic Development

4.1 Introduction

The literature review demonstrated how the concept of making treatment decisions with PD patients is complicated, and clarified that there also a gap in the current national treatment guidance for Personality Disorder (NICE 2009a,b) concerning how the decision to treat is made. Associated with both of these points are specific process issues that were encountered in practice when planning the research, explored below:

4.2 Locality AR Progression

Considering local service reformation, a practice-based AR initiative (CBT Skills Sessions) was introduced to increase therapeutic skills of clinicians. This was at the same time as the locality shifted from a discipline-specific model, to an MDT model.

The AR study evaluated the effects of CBT Skills Sessions; clinicians and supervisors repeatedly commented that a practice challenge arising from service reformation concerned 'how' clinicians are supported to make treatment choices, and 'why' people were allocated/not allocated certain therapeutic interventions, forming the basis of this research.

This generated a '*bottom-up*' rather than '*top-down*' (Burns, 2007:39) problem on which to focus a new AR iteration, prompting this research study. This issue was not anticipated in the original research, however through wider exploration in the evaluation phase, this proved to be an important issue not only for clinicians

delivering the newly formed service, but also GP's referring into the service, and a theme raised in patient feedback and complaints.

4.3 Understanding the issue

The literature review presented in Section 4 provided evidence that that the Treatment Choice Encounter is under-researched, but complicated, and has systemic variables that influence outcomes, rather than merely specific factors focused on one clinician or supervisor. From an AR perspective, there was therefore a need to explore this issue further with participants, in order to construct the knowledge that is missing from current published literature.

Additional to knowledge exploration, the literature review also generated a need to define current thresholds and decision-making processes. The participant research design was not purely generated by the researcher, but was decided upon after consultation with stakeholders through validation groups.

4.4 Options for exploration and IPA interview design

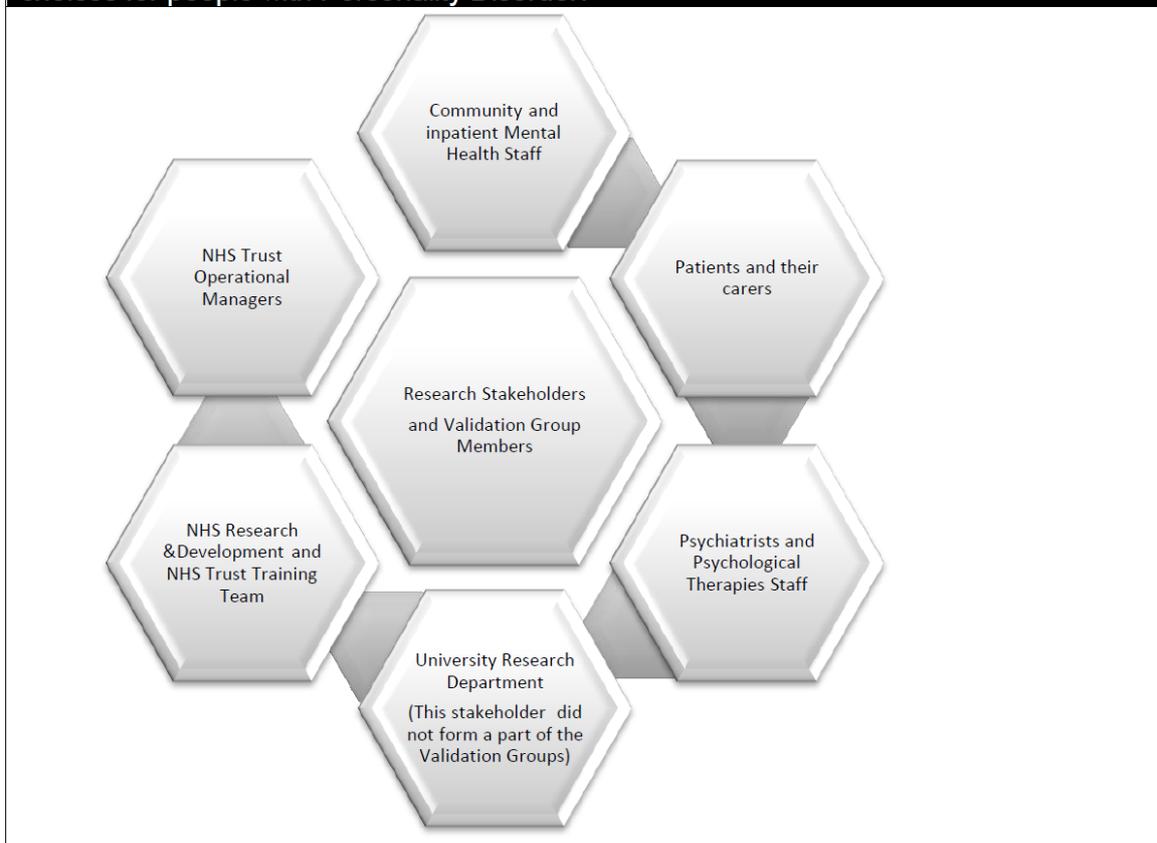
In practice, meetings with stakeholders (Figure 10) in validation groups suggested that semi-structured interviews with clinicians could be a helpful way of exploring the difficulty. This method was favoured in the validation group process, however there were specific issues regarding who would be sampled, and what questions would be asked.

The validation groups explored the fact that there are now clinicians of different disciplines conducting Treatment Choice Encounters. When the literature review

outcomes were explored, validation group members expressed the need to both collect information from a multi-professional sample (identified as a gap in the literature review), and gain perspectives concerning different types of treatment decisions, not only psychological interventions (which was the core focus of the majority of literature review findings).

The validation group supported the use of semi-structured interviews in a 1:1 setting, as they stated that with other methods (i.e. group settings), unique perspectives may not be as strongly represented, and it was also identified that certain clinicians may feel intimidated when talking in front of colleagues who make the same decisions, but either have less or more experience/qualifications than themselves.

Figure 10: Stakeholder Diagram concerning the research study exploring treatment choices for people with Personality Disorder.



4.5 Heuristics

A heuristic is either a physical tool or a mental short-cut, which aids in the decision-making process (Crowley et al, 2013). UK mental health examples of written or diagrammatic heuristics include algorithms for NICE guidance or 'rules of thumb', which people reference when making choices, and decision-making trees. It is argued that people use either cognitive heuristics or heuristic tools in healthcare as a core part of almost all decision-making processes (Gigerenzer et al, 2011). The need to consider individual decision-maker's heuristic processes was considered as central by the validation group, to answer the research question.

Payne et al (2008:571) explain the reasoning behind heuristic use in stressful healthcare encounters:

"Human information processing and prospect theories suggest that people have limited cognitive capacity. Consequently, people rely on cognitive heuristics to reduce complex input data to manageable dimensions. The management of data is especially important within the Treatment Choice Encounter. Clinicians process a great deal of information, often under conditions of uncertainty and stress" (Payne et al, 2008:571).

The use of cognitive heuristics has strengths and weaknesses. A positive example of cognitive heuristics is associated with a rapid, exemplar-based non-analytical model of decision-making and expert reasoning (Norman et al, 2007; Lago 2008). However, a disadvantage (termed "heuristic biases") may include misallocation of resources in healthcare, and in some cases, medical errors (Croskerry, 2003; Kempainen et al,

2003), and this can produce bias (Tversky et al, 1974). Crowley et al (2013) researched heuristic bias, and detail eight biases which occur in decision-making: *anchoring, availability, confirmation bias, gambler's fallacy, representativeness, overconfidence, and under-confidence.*

As the topic of clinical decision-making progressed in locality teams and validation groups, mixed responses were obtained. The consensus reached was that the research would be helpful in a step towards more support for clinicians. However, anxiety was also expressed about being 'judged' as a part of the decision-making process.

Once raised, this process issue was analysed by the researcher, and in order to progress, it was considered that a basic heuristic using common variables for treatment decisions would be created, to reduce clinician anxiety, and provide a platform for practice exploration, as a part of the research method. Validation groups and clinical teams supported this methodological addition, and participants for the interview process increased.

A reason for developing a written heuristic is that it should encourage people to follow a certain way of reasoning when considering treatment choices, which may be similar or different to their own internal cognitive heuristic that has been developed over their practice years.

There are arguments about whether heuristic use should be or can be altered (Eva et al, 2005), these arguments propose that attempts to 'de-bias' human judgments

produced mixed-results (Koriat and Bjork 2006; McKenzie, 2006). However, arguments for the use of heuristic diagrams claim that they are produced for the purpose of helping the user to understand the problem, and scientifically consider different outcomes (Chamiso, 2011).

Although clinicians may be able to articulate rational decision-making and treatment allocation outside of the patient encounter, research and anecdotal practice data provided through the validation groups demonstrated that emotive patient encounters may trigger so-called 'irrational' psychology in decision-making. Research emphasises that this should not be under-estimated, and can account for an increased use of resources, and may be indicative of staff who feel under strain (Hozo et al, 2008).

When making treatment decisions, locality clinical teams agreed upon the following fixed main variables: the person, available treatment provision, the diagnosis, and the degree of engagement with services.

4.5.1 Heuristics Outcomes

The fact that a person has a PD diagnosis does not automatically make them eligible for a specialist service, in the same way that having a diagnosis of Diabetes would not automatically necessitate being under the care of an Endocrinologist. As a part of the research method, it was therefore accepted that ethical treatment allocation is achieved by efficient resource allocation. In healthcare, this means '*professional responsibility for stewardship of finite societal healthcare resources*' (Brett et al, 2012), with the concept of efficiency including "*parsimony (conceptual efficiency)*,

speed (temporal efficiency), and cost-effectiveness (financial efficiency)" (Newman-Toker et al, 2013).

Validation groups and staff consultation agreed that current treatment decisions are not solely governed by cost, there is also an alteration and refinement of treatments offered that may trigger dependency, relevant to research into the 'Recovery' focused agenda, and the focus on self-management in mental health care (Williams et al, 2012). These themes derive from notions of long-term conditions management in physical health care (i.e.: Diabetes management).

In the researched practice area, the teams analysed manage the 'gateway' to specialist treatments (i.e. residential therapy packages), and also provide crisis support to associated services, including housing and benefits agencies. Prior to the AR, there was no schedule or tool to aid their decision-making, and therefore, clinical judgement was based upon individual's knowledge of local procedures, available resources, team discussion, and their own subjective cognitive heuristic concerning treatment choice. Clinician and supervisor feedback in the stakeholder consultation identified that a diagrammatic heuristic, or heuristic device to aid consistent clinician decision-making, would be beneficial.

4.5.2 'Treatment Choices Grid' Development

In response to clinician, supervisor, and patient concerns, and identified research gaps and paucity of direction within NICE Guidance (2009a&b), a heuristic grid format solution was developed as a potential practice solution, The rationale was that such approaches are used successfully in family and systems therapy (Sevigny

et al, 2014). The grid format is a basic heuristic, it does not provide an actual outcome, instead it focuses clinicians toward formulating the patient's unique problems, their understanding and acceptance of these problems, and also their willingness to engage in treatment. When working with PD patients, it is essential that engagement is assessed, otherwise intervention is focused upon risk management only, which is not considered a core treatment (Hamilton, 2010:181).

As part of the AR process, the researcher worked with locality clinical leads to develop a 'Treatment Choices Grid' for clinicians working with PD patients, to aid clinical decision-making, and also provide 4 different areas to focus the semi-structured interview upon. The Treatment Choices Grid focuses upon both the patients' perception of their diagnosis, and treatment.

The Treatment Choices Grid is underpinned by evidence-based Motivational Interviewing (Romano and Peters, 2015) principles, it incorporates NICE Guidance treatment recommendations (NICE, 2009a,b) and also specific treatments that are provided within the locality. The Treatment Choices Grid was agreed with locality clinicians and through the validation group, which consisted of patient and carer representatives as well as professionals. No changes have been made to the Treatment Choices Grid in the duration of this study, however in post-study research it's efficacy is to be evaluated.

There are three versions of the same grid: (1) for direct discussion with patients (Figure 11), (2) for clinician guidance (Figure 12), and (3) for supervisor guidance (Figure 13):

Figure 11: 'Treatment Choices Grid' – Patient Version

Service User 'Treatment Choices' Grid	I understand and accept my diagnosis	I struggle to understand my diagnosis and how it applies to my problems
I accept that talking about my problems may help me overcome them	<p>Evidence-based guidance details a number of different 'talking therapies' that may be beneficial for you.</p> <p>Most therapies are provided in a group forum or via therapy courses. This enables you to develop skills to overcome some of the difficulties that you face, as well as to meet people who have similar difficulties to yourself, with whom you can share your experience.</p> <p>Your worker is able to provide you with information concerning each of these interventions. Should you wish to access these types of treatments, an appointment will be made with a therapist, to explore which option may be most suitable for you.</p>	<p>Suggested interventions that may help you:</p> <ul style="list-style-type: none"> • The provision of written information and discussion with you and your family about your diagnosis. • Therapeutic work focused upon how your difficulties/ problems may be linked to the symptoms of your diagnosis. • A review by your team psychiatrist considering your single or multiple diagnosis. • A discussion concerning how your symptoms may affect your ability to relate to others.
I do not accept that talking about my problems may help me overcome them	<p>Research suggests that many people who have experienced trauma and/or mental health difficulties may find it difficult to talk about their problems.</p> <p>For people who find that talking about problems is difficult, there are two different types of interventions that may be helpful: (1) practical support and activity scheduling, and (2) medication management. However, medication may not be suitable for all, and there are strict guidelines concerning prescriptions that your worker can share with you.</p> <p>We would like to work with you to provide the services listed above, and also explore reasons why talking about your difficulties is hard for you.</p>	<p>Your initial assessment has shown that you may benefit from the intervention that this team provides.</p> <p>We would like to work with you to explore your problems further, considering the issues that you have experienced leading to your referral to mental health services.</p> <p>Should you wish to discharge yourself from this service, we would request that you attend a meeting with us so that we can develop a support plan with you, should you require help in the future.</p>

Figure 12: 'Treatment Choices Grid' – Clinician Version

Clinician Treatment Choices Grid	The person accepts they have a Personality Disorder diagnosis	The person <u>does not</u> accept they have a Personality Disorder diagnosis
<p>The person accepts that talking about the problem may help</p> <p style="text-align: center;">Distress Tolerance</p> <p style="text-align: center;">+ -</p>	<p style="text-align: center;">- Emotional Recognition +</p> <p style="text-align: center;">CBT or EMDR</p> <p style="text-align: center;">Brief Dynamic Psychotherapy, CAT, or Mentalisation-based therapy</p> <p style="text-align: center;">Psycho-education Skills Group</p> <p style="text-align: center;">DBT Skills Group</p>	<p style="writing-mode: vertical-rl; transform: rotate(180deg);">Psycho-education re: diagnosis and treatments</p> <p>This person is likely to be focused upon the fact they do not feel that they have the correct diagnosis (i.e. they may feel they have a different diagnosis e.g. Bipolar Affective Disorder, rather than Personality Disorder).</p> <p>Therapeutic engagement is likely to be problematic, due to the person's rejection of the diagnosis and subsequent rejection of the appropriate treatment plan. Sensitive diagnostic psycho-education and idiosyncratic formulation is necessary prior to being referred into any therapy group.</p>
The person does not accept that talking may help	<p style="text-align: center;">Psycho-education re: diagnosis and evidence-based treatments</p> <p>This person is likely to be either:</p> <ul style="list-style-type: none"> • Medication-focused in regards to a 'cure'. • They are likely to reject the fact they have control over their behaviour, and minimise the benefits of therapies. • Their trauma may be so unspeakable they fear entering a group or speaking about issues (i.e. significant abuse, incest, domestic violence) <p>Care coordination and crisis plans are essential for this person, as well as engagement focused interaction.</p>	<p>This person rejects the fact they either have a mental health problem, or that it can be treated.</p> <p>These service users are likely to have future contact with services at times of crisis. Therefore a contingency plan with the Access Team would be beneficial for risk management and conditional re-entry into services. This may need to involve the police, substance misuse services, and/or A&E.</p> <p>All attempts to engage the service user must be made, however if they chose to discharge themselves, the disengagement policy must be followed.</p>

Figure 13: ‘Treatment Choices Grid’ – Supervisor Version

Supervisors Grid	The person accepts they have a Personality Disorder diagnosis	The person <u>does not</u> accept they have a Personality Disorder diagnosis
	- Emotional Recognition +	
The person accepts that talking about the problem may help	<p>Clinical supervision may be useful if the service user is in this section, focussing on:</p> <ul style="list-style-type: none"> • Planning the journey through the service (i.e. skills group, leading to 1:1 CBT, with medication review, ending with WRAP group, all based upon an idiosyncratic formulation). • Supervision may also assist with the development of structured goals with the client, and evaluation of client progress, either by evidence-based rating scales or subjective monitoring. • Formulation and or re-formulation with either progress, equilibrium, or symptom worsening, to jointly develop a treatment plan, discharge plan, and / or crisis plan. 	<p>Clinical supervision should focus upon:</p> <ul style="list-style-type: none"> • Diagnostic-focused formulation. • The provision of literature relevant to the diagnosis and evidence-based treatments . • Supervision from the Psychiatrist may be helpful if the service user is in this quadrant, as they may be focused upon challenging their diagnosis. • There are likely to be significant process issues (i.e. defences such as: splitting, projection). These service users are the most likely to complain, request second opinions, and constantly challenge the clinician, team, and provider. This must take focus in supervision, to protect the clinician from burnout and ensure continued compassion for the service user.
The person does not accept that talking may help	<p>Supervision for this quadrant may focus on:</p> <ul style="list-style-type: none"> • Improving psychological mindedness. • Motivational Interviewing (MI) principles. • If the ‘unspeakable’ trauma is what is blocking progression, supervision may focus upon shame as a driver/ maintenance factor, avoidant behaviour, and psychological defence mechanisms that the service user may use (i.e. dissociation). • There are likely to be risks requiring management (i.e self-harm), supervision should allow the clinician to be supported due to exposure to the trauma narrative and service user’s distress. <p>Group or individual therapy/ treatment may never be progressed to. This is not to be seen as a service or clinician failure, and recovery must be service user driven.</p>	<p>Psychotherapy and/or Psychiatrist supervision for service users identified as in this quadrant is likely to be either when the service user is in the crisis, or in the acute mental health setting.</p> <p>Supervision should be focused upon evaluating all available treatments and resources, and ensuring all have been exhausted if discharge is being considered, or in certain cases transfer to another service.</p> <p>Contribution should be provided to discharge plans and crisis plans/ crisis team liaison.</p>

A grid format is utilised, as it provides consistency but is not too complicated, it provides a visual aid within Treatment Choice Encounters, and encourages a formulated approach to treatment choice.

4.5.3 Influences concerning ‘Treatment Choices Grid’ (TCG) Development

Many different factors influenced the development of the TCG tool. These factors include feedback from stakeholders and validation groups, literature review findings, utilising concepts from CBT formulation techniques (Grant et al, 2010), MI change cycles (William et al, 2012), and Systemic Therapy (Hedges, 2005). The TCG does not dictate patient treatments, but is suggested for use as a heuristic for problem-solving when engaging PD patients.

4.5.4 Originality and Copyright

The TCG uses a format similar to other heuristics and MI approaches utilised within physical and mental health care. It is a format that has also been used with people with psychosis (Romano and Peters, 2015). The grids are also influenced by MI grid tools used with people with substance misuse difficulties (Ezzame et al 2015:207), however as far as the author is aware, this is the first of its type specifically structured for use with PD patients.

The concept of intellectual property pertains to both personal property and real property (Copyright, Designs and Patents Act, 1988). In terms of originality, for a piece of work to be considered as original, it does not have to be new or innovative, copyright is more concerned about the manner by which it is created. The TCG draws upon works from several fields of mental health, and it uses a grid format similar to other practice tools, however its application and design are unique, and originate from the author, therefore the work is considered to be an 'original, literary work', subject to copyright.

4.6 Why introduce a heuristic?

The impact of discussing the phenomena of treatment decisions changed the way that locality clinicians viewed their decision-making. Their apprehension about whether their choices were 'right' was highlighted via locality meetings and clinical supervision. Therefore, parallel to the research proposal being designed, the researcher conducted stakeholder engagement to explore different factors which may aid consistent decision-making, the result of which was the development of the TCG.

The TCG has influenced this research, as it not only enabled people to focus upon areas that will influence clinical decision-making and treatment choices, but also provided assistance when considering Treatment Choice Encounters. This in itself contributes to the AR process and design of the semi-structured interviews, as it focuses the way people decision-make with PD patients.

Schleiermacher (1998) suggests that IPA concerns understanding the person being researched, as well as the phenomena itself, this point is key to this research, as the practitioner's variables (i.e training, attitude, belief system, experience) inform the encounter as much as the patient's presentation. Using a heuristic such as the TCG allows focused and funnelled questioning, to explore both the phenomena of making treatment decisions, and the clinician's individual perceptions of the encounter and choice itself, and assist patient questionnaires to be focused upon the decision-making process, rather than the clinician. The literature review identified a lack of guidance for decision making, the TCG is considered a potential clinical heuristic that may aid clinicians to explore decision making.

4.7 Bracketing and Interpretation

Husserl originally discussed the concept of 'bracketing' in the Interpretivist phenomenological method (Zahavi, 2003). He explained that researchers should consider the consequences of their own predisposed opinions, and 'bracket' these off when conducting research. This is an important point when considering the researcher's role in this study.

As a psychotherapist, diagnostician, and prescriber, the researcher has training in decision-making concerning treatment choices, therefore has a preconceived idea concerning the 'right' and the 'wrong' way to make treatment choices with PD patients. The researcher's viewpoints have influenced the development of the heuristic to enable others to make consistent treatment choices. The researcher's viewpoints also shape the interview structure and interpretation of the transcriptions.

The predisposed notions and subjectivity that the researcher brings is not a negative issue, but a part of the overall process in Constructivist research, which uses Interpretivist theoretical stand-points. Merleau-Ponty (1962) suggests that true bracketing is not possible, as there is an 'embodied' nature of the researcher's relationship with the world, meaning that the researcher's point of view will influence, suggesting that empathising with other's experiences is the closest that a person can get, as achieving a shared reality would be impossible, because of each person's subjective uniqueness. Gadamer (1990) suggests that one's preconceptions can hinder the interpretative process, therefore emphasises that openness is required in IPA research, preferably with a researcher's preconceptions concerning the phenomena identified in advance, otherwise to be identified as the engagement/research process continues.

Due to the issues associated with the researcher's potential bias for particular outcomes and interpretations, to attempt to minimise the effect upon the research, bracketing was used in the study, providing their own viewpoint regarding the Treatment Choice Encounter, answering the semi-structured research questions, prior to conducting any of the research interviews. In addition, validation groups are

used throughout the research process, to enable analysis of any potential bias that the researcher may bring, to enhance transparency of the research process, and increase credibility. Lastly, a second researcher has checked all transcripts, which also helps identify any potential difficulties concerning bias and bracketing.

Gadamer (1990) explores the dialogue between something old (previously held perceptions of the phenomena) and something new (the transcript or new information brought through the validation group), emphasising that Interpretivist research does not aim for researcher neutrality (as would be considered in quantitative research), but instead an appropriation of the researcher's "*fore-meanings and prejudices*".

4.8 Interview and Questionnaire Design

The study focus is upon using the TCG in a 'funneling' technique, to discover clinician's viewpoints upon what influences the Treatment Choice Encounter, by analysing their experience of working with different PD patients to answer the original research question, the aim is not to test a hypothesis or to test whether the heuristic (TCG) is successful in practice.

The introduction of the heuristic enables focus for the interview and questionnaire design when considering the Treatment Choice Encounter. The TCG consists of four quadrants, which underpin the 'funneling' process concerning the semi-structured interview design. Validation groups (consisting of clinicians, carers, patients, and supervisors) have co-produced and assisted in further refinement of interview schedules for clinicians and questionnaires for patients.

No significant changes were made by the validation groups to the concepts of the TCG, however suggestions were made regarding colour schemes, design, and language.

4.9 IPA Analysis

In this research, IPA is utilised as a method, rather than methodology. This is because it is only one component of the AR study, the other components being a hermeneutic literature review, validation groups, and patient questionnaires. It is not uncommon for several related methods to be used to contribute to an AR process.

In an overall Constructivist study, using interpretative analysis is posited to offer a viewpoint about the semi-structured interview transcript (which the participant may not be able to). In terms of using IPA, it means that a detailed and systematic analysis can be applied to multiple transcripts, generating idiosyncrasies, and also making connections between transcript themes, themes in the literature review, and themes raised through patient feedback. In this way, subjectivity of each participant and research piece is preserved, also allowing an inter-subjective dimension, to expose thematic dialogue emerging between practice data and psychotherapeutic theory/research.

Smith et al (2009:28) suggest that a Constructivist process concerns analysing the dynamic relationship between the "*part and the whole; to understand the whole, you look at the parts*". They reflect that this Interpretivist notion is not without critics, due to its "*inherent circularity*", however suggest that it describes a non-linear dynamic hermeneutic cycle effectively.

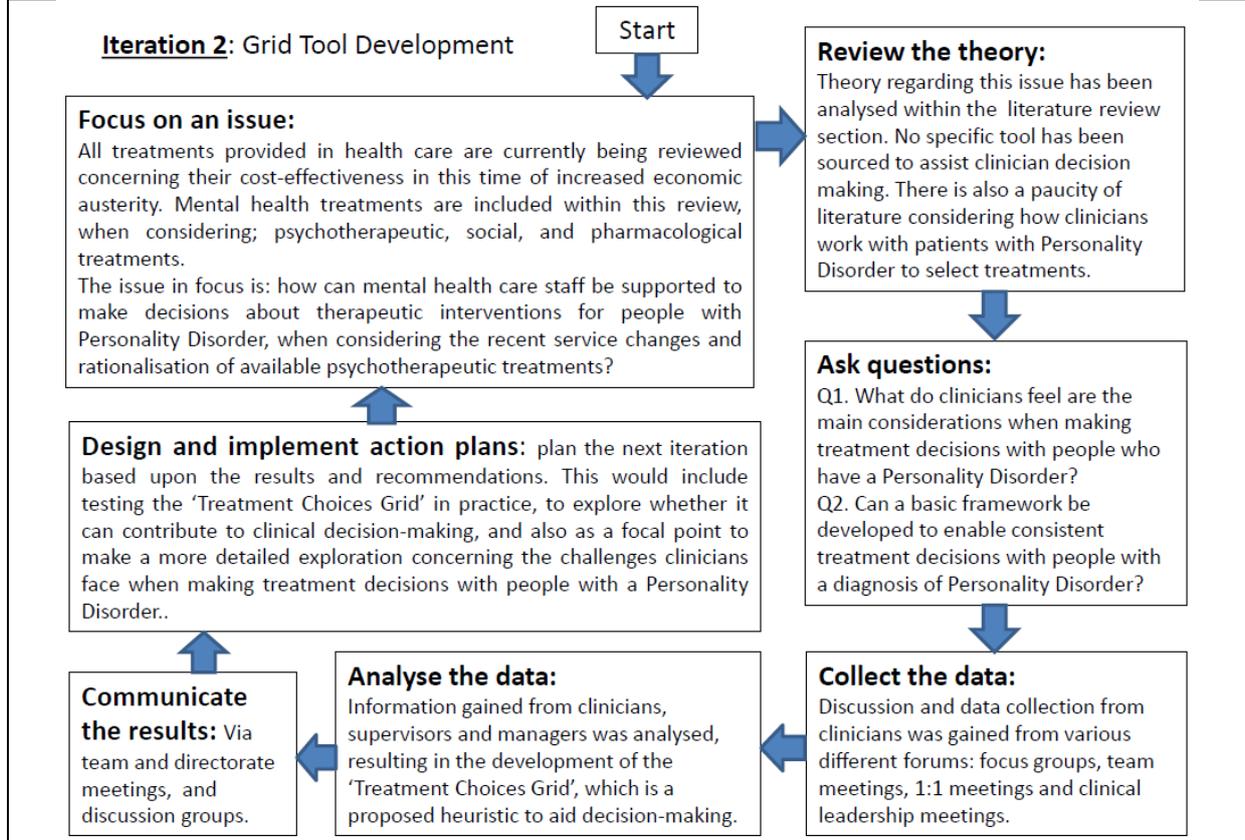
4.10 - Section 4 - Conclusion

In commencing this research and asking the research question, process issues were raised which impacted upon clinical practice. These specifically related to clinician's anxiety about being researched, which then affected sampling.

As part of the AR process, it was necessary for the researcher to take action with stakeholders, validation groups, and clinicians, to stabilise the anxiety and support practice progression, whilst continuing to research the phenomena. The TCG was therefore developed, which is a clinical heuristic encouraging a formulated approach to treatment decisions. This tool has been positively received, and through its separation into quadrants, allows questions to be formed based upon each quadrant, to structure the semi-structured interviews and patient questionnaires.

The above section gives an insight into overcoming a research process issue, which has provided a valuable contribution to the structure of the method and practicality of data collection, summarised in Figure 14:

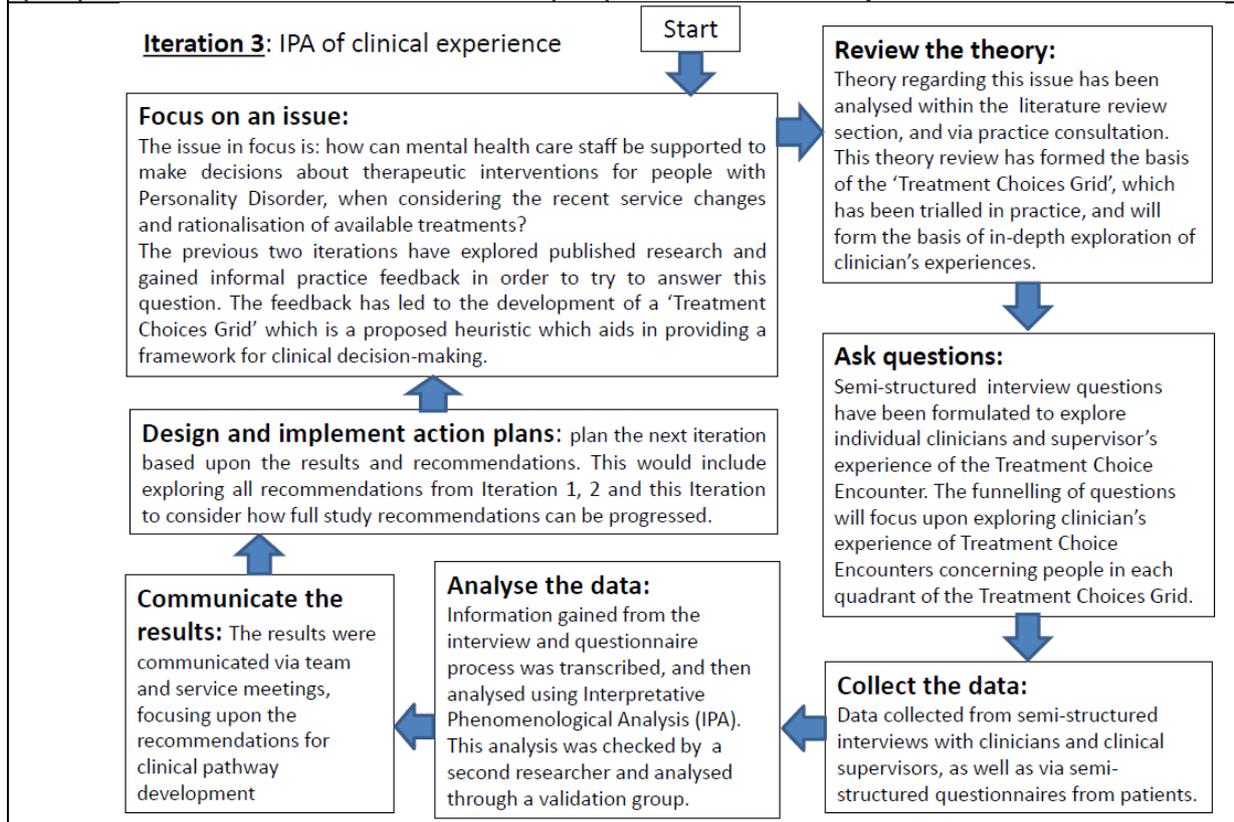
Figure14: Subordinate AR Cycle 2: Treatment Choices Grid Development within the study exploring treatment choices for people with Personality Disorder.



Section 5: Participant Study Results

In this section, a breakdown of the data collected is presented, reflecting upon the methodology section from the previous chapter. The achievements and difficulties of data collection is also reflected upon, in order to provide transparency for readers.

Figure 15: Subordinate Action Research Cycle 3: Participant Study to explore how people make treatment decisions for people with Personality Disorder.



5.1 Results Sample

The results data is presented under three headings: results of the interviews, analysed through an IPA process, patient questionnaire data, and results generated by the validation groups and other validation forums.

5.1.1 Interviews

A predicted sample size concerning clinician interviews was set between 6-8, the final number of interviews gained was 6. For the supervisor interviews, the target number was set at 3-4, the number achieved was 4. This provided a total of 10 interviews which could be analysed.

Participant information

Interview information was gained from demographic information sheets (Appendix 32), all participants agreed to complete these sheets. Demographic information is presented in the appendix section, summarised below in Figure 16:

Figure 16: Appendix summary regarding participant information gained from the study exploring how people make treatment choices for people with Personality Disorder.

Participant information	Appendix Number
Interviewee professions	10
Interviewee age range	11
Interviewee gender	12
Interviewee's first language	13
Interviewee qualifications	14
Number of years interviewee has worked in mental health care	15
Number of hours interviewee currently works	16
Number of patients on interviewee's current caseload	17
Different clinical diagnoses interviewee currently works with	18

These participant factors are briefly discussed below, to provide context for the results obtained:

Multi-professional representativeness

All interview participants had a core profession (Appendix 10). The reason for including the professional breakdown in the results was that there needs to be an accurate representation of professionals that constitute a typical multi-professional team. The results gained demonstrate a representative sample, rather than a uni-professional sample, which was typical for the research in the literature review.

Age Range

Age range was gathered to explore whether people interviewed were representative of the team. The age range of participants (Appendix 11) was slightly older than the average of the teams surveyed, whose mean average age is 43.

Gender

Within the teams that were researched, there is a gender distribution of approximately 75% female and 25% male professionals (Appendix 12). This result means that the research sample has a slight over-representation of males than is actually present in the teams.

Language

The reason why people's first language was recorded (Appendix 13) is linked to the methods used. Within IPA research, analysis of language and metaphor form a major part of the analysis process. Research demonstrates that metaphor use and phrasing can be different for people whose first language is not English, when interviews are conducted in English, as is the case with this research. In the transcripts, where meaning was unclear, verification was sought verbally within the

interview, and also after the interview was transcribed for people to not lose the context of the interview.

Qualifications

All research participants were qualified professionals, with a core qualification at either Diploma level or above. Several participants listed more than one qualification (Appendix 14), demonstrating evidence of significant post-graduate qualification. The participants had a higher level of post-graduate qualification than is average in the locality teams.

Years working in mental health care

Age is not necessarily representative of number of years worked in mental health care (i.e. a person may have qualified at 45 years old). In the sample (Appendix 15), there is a wide standard deviation (SD) of between 8.5 – 36 years (SD = 27.5 years), with a mean value of 20 years' experience.

This result shows that all professionals interviewed started in mental health care at a younger age, and demonstrates a significant amount of experience within the group as a whole to draw upon in terms of answering the research question. This is considered as more positive in terms of validity than if the average length of experience was 5 years, as this may mean that practitioners are providing opinions based upon very little personal experience.

PD Patients on current caseload

It is important to explain the number of patients that participants work with at the current time, as it helps contextualise the information which interviewees have provided. This also helps contextualise whether examples are provided from working with only a few, or with many, PD patients.

One participant did not include their current caseload on the demographic information sheet, and therefore this must be considered as incomplete. There is a large standard deviation ($SD = 685$) concerning caseloads (presented in Appendix 17), as some participants work in a clinic setting and some in a care-coordinator role. Due to this, the mean caseload is not considered as representative. However, when reflecting upon the rich data that participants bring, the fact that as a group they can draw upon their experiences with 1289 patients, adds value to the results gained.

Comorbid diagnosis

People with PD rarely present to mental health services because they have one problem, as indicated by literature review. Therefore it was important to consider with participants, whether the patients that they worked with have a sole diagnosis of PD, or other mental health comorbidities. All participants have people with comorbid mental health problems on their caseload (Appendix 18).

Interview information

Interview information is presented in Appendix 19. This demonstrates that just under 10 hours of data was collected through interview, generating 6514 lines of text to

analyse with IPA. The interviews varied in their timing, however all interviewees answered all questions.

Supervisor interviews lasted on average longer than clinician interviews by several minutes, as the interviewees were more expansive in their answers. Five out of six clinician interviews had similar timescales; however one person was more expansive. Three out of four supervisor interviews had similar timescales; however one supervisor lasted significantly longer.

Interview Validation

The interview data was transcribed, and a copy of the transcription was sent to the interviewee for checking and validation. All interviewees confirmed in writing that this was an accurate representation of their interview and opinions.

5.1.2. Patient Questionnaires

Patient questionnaires were included in the research to gain information about their experience of the Treatment Choice Encounter, and the TCG that had been introduced to help structure the encounter.

No sample size was set for the questionnaires; however an aim of a 50% response rate was set over a period of 4 months. This data collection was difficult. The response rate was low, only n=15 questionnaires were received out of a potential 62 PD patients who were referred in the time period set. This resulted in a response rate of approximately 24%.

Of 15 questionnaires received, demographic information was obtained pertaining to all patients, including: Gender (Appendix 20), Age (Appendix 21), Diagnosis (Appendix 22), and previous mental health service experience (Appendix 23).

This demographic information demonstrated that 20% of respondents were male and 80% female, spanning an age range of between 18-60 years old. Over 50% of responders indicated that they had a secondary mental health diagnosis other than PD, which is reflective of the literature review findings, and only 20% patients were new to mental health services.

Quantitative data was gathered through the questionnaires concerning patient's opinion regarding use of the TCG (Appendix 24), which indicated that the majority of respondents found the TCG useful in understanding why treatments were/were not selected. Although this is a very limited number of respondents, this may be useful data for a future study concerning testing the validity of the TCG in clinical practice.

In terms of qualitative data, only 60% people who returned the questionnaires chose to provide narrative feedback. The responses provided were very brief where completed, and are detailed in Appendix 25, 26 & 27.

This low response rate and incomplete data meant that this part of the research was considered as lacking. The reasons for the low response rate were explored with both stakeholders and validation groups, with consideration about whether a return to ethics board was required.

5.1.3. Validation Groups

Five validation groups were held during the study, each group having three core members who attended to review progress, and 14 other members who attended one or more groups. The validation groups consisted of stakeholders listed in Figure 10, and conducted at the following stages:

- (1) Commencement of the research, to devise the plan.
- (2) Prior to ethics board application.
- (3) After the literature review was completed.
- (4) To discuss the research sample, when patient data issues were identified.
- (5) To discuss final results and recommendations.

Discussions in the validation groups are incorporated into the following sections.

5.2 Difficulties encountered in gathering results

The following difficulties were encountered when gathering the results for the field study component of this research:

- Recruitment of interview participants was initially difficult. This eased after development of the TCG, and after stakeholder group presentations were provided to explore the research aims and objectives. This is an important finding, as validation groups supported the fact that recruitment difficulties were connected with two themes: high workloads, meaning that prioritising non-patient time (i.e. for the research interview) was difficult, and secondly the

fear of criticism in terms of decision-making processes. These themes will be explored in the results and discussion sections as a key finding.

- Difficulties in gaining feedback via patient questionnaires. After one month of data collection, no patient feedback questionnaires were returned. This was considered as abnormal, therefore meetings were held with locality teams to discuss research progress, and an additional validation group was requested to explore this issue and potential solutions. The following themes were raised:
 - Clinicians felt unconfident to provide PD patients with a questionnaire which they feel may reflect badly upon their clinical practice.
 - Certain clinicians stated that they felt uncomfortable in providing the patient questionnaire, when the encounter had been problematic, or if the person did not accept their diagnosis.
 - Clinicians explained that some patients refused the questionnaire, because they felt that they 'already feedback about services'.
 - Certain clinicians stated that they have not used the TCG with patients, but found it more helpful in peer-supervision, individual case reflection, or when discussing referrals with GPs. Supervision and reflection were expected uses for the TCG, but its use as a communication tool with GP's was unexpected.
 - Some clinicians stated that they saw patients place the questionnaires in the bin when they left the building.

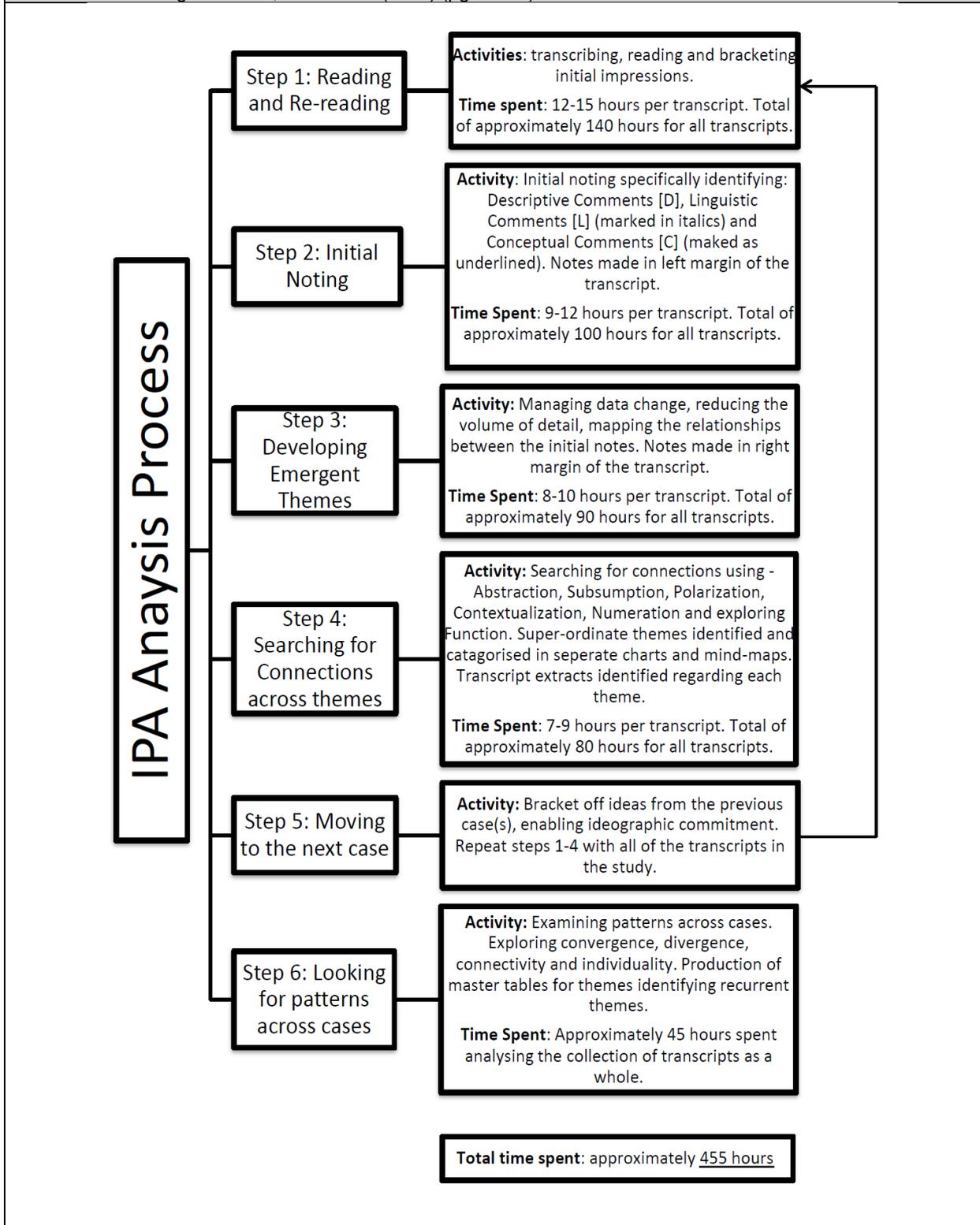
Although it was felt to be a problem that insufficient patient feedback was gained, the themes above are interesting results in themselves. A return to ethics board with the aim of conducting a semi-structured discussion group to gain patient feedback was considered by the validation group, however it was reflected to the researcher that significant emphasis had been placed upon gaining patient feedback, but that this is slightly at odds with the research question, concerning how clinicians formulate treatment decisions. The validation group suggested that the above themes provide rich information to the study concerning the Treatment Choice Encounters. The research method was therefore not changed, data collection was completed, which gained n=15 responses.

A further difficulty was encountered concerning equipment failure, specifically the recording equipment, meaning the last interview was delayed by 2 months. Also the illness of the second researcher, further delaying transcript analysis by 4 weeks.

5.3 Data Analysis

This Chapter expands upon the methodology described in the previous section, by detailing how the IPA method was used in terms of data analysis. The method of transcription analysis concerning the IPA follows the process defined by Smith et al (2009). Figure17 details the data analysis process, including the actual time spent conducting the analysis:

Figure 17: Diagram concerning the process for the transcript analysis for the IPA study concerning treatment choices for people with Personality Disorder.
Using the Smith, et al Model (2009) (pg79-107)



5.4 The Transcription Process

5.4.1 Step 1 – Reading, transcribing, and re-reading

The interviews were transcribed in full by the researcher. This was important for the first stage of the IPA process, as it enabled the researcher to fully hear the interview, and transcribe to examine the detail and immerse self in the process.

Whilst conducting the transcription, the vast amount of data gathered was intimidating and overwhelming. However, as the process continued, this anxiety reduced, as in the transcription process itself, clear themes emerged and were repeated throughout each text.

A problem and learning point for the interviewer was that transcribing of scripts began prior to the final two interviews, it was therefore more difficult to 'bracket-off' the researcher's own thoughts on emerging themes, and so not influence the final two interviews.

After transcription, the interviews were sent to each candidate for validation, prior to being anonymised and included in the study. No candidate withdrew their script, and all provided feedback upon the interview process. Only one candidate asked that three items were altered in the transcript, one was a spelling error, and she wanted two statements to be adjusted, as she felt her phraseology meant that they could have been "taken out of context".

In terms of the AR process and practice change, the process of interviewee transcript validation was powerful. The interviewees reflected that the process

helped them consider their own values and attitudes, and how this affected the Treatment Choice Encounters. One interviewee additionally reflected that it had helped her examine how she conveyed things, and her significant use of metaphoric speech and symbolism, which she aimed to reduce, as she felt that her “meaning could be misinterpreted”. The process also appeared to have an additional affect concerning increasing case discussions regarding treatments in clinical teams, this was reflected by the validation group.

5.4.2 Step 2 – Initial Noting

The aim of the initial noting section was to read through and list all initial impressions concerning the script itself, and the messages that the interviewee is conveying. The reason for this was that selective bias may be generated by the researcher’s perceptions, and although this may form part of the end result, it is important that this can be bracketed off, to not detract from the micro-analysis of the script itself.

The next step concerned analysing the transcript in detail, making descriptive notes, commenting upon the language used, and beginning to highlight potential themes. This was a very time-consuming process, and significantly added to the word count for each script, this process is detailed as the Left Hermeneutic Analysis (Example transcript is provided in Appendix 37).

This initial analysis enabled the researcher to examine each interviewee's statements in detail, and analyse the meaning and context of interviewee's opinions. Each transcript revealed that as the interviewee appeared more relaxed in the interview itself, their interaction was less formal, and their answers were more

expansive. This was evident in the number of words that they provided in answer to questions, and the type of language used.

The way interviewees referenced their experiences in the first, second, and third person, was of interest concerning the ownership they took for the views they expressed. Additionally, the interaction with the researcher changed at different stages of the interview process. Some interviewees spoke directly to the researcher instead of answering questions, and some sought reassurance from the researcher concerning the answers they provided. This demonstrated a degree of vulnerability and uncertainty in discussing the research questions themselves.

5.4.3 Step 3 – Developing Emergent Themes

This stage involved re-reading the transcripts and all of the right hermeneutic notes, to generate themes, and distil the wording of each theme into specific concepts, detailed as the Right Hermeneutic Analysis (Appendix 37).

5.4.4 Step 4 – Searching for connections across themes

After the complete transcript was analysed via the Left and Right hermeneutic Analysis, the whole transcript was further analysed in terms of thematic generation and connection. Smith et al (2009) suggest specific ways of interpreting patterns in themes raised, by: Abstraction, Subsumption, Polarization, Contextualisation, Numeration, and analysis of function. All of these processes were examined in order to produce independent Super-ordinate themes for each transcript.

5.4.5 Step 5 – Moving to the next case

The aim of the IPA research is to both prize the subjectivity of each interviewee's perspective, and also examine connected themes between the different encounters. The concepts of subjectivity and collective themes are given equal importance in this research, adhering to the principles of Constructivism and Interpretivism.

To minimise potential contamination of each transcript analysis, 5 days was left between conducting IPA Steps 1-4 on each case. This delay was important to bracket off themes from each script, allowing individual analysis.

5.4.6 Step 6 – Looking for patterns across cases

The super-ordinate themes from each of the 10 transcripts were then analysed to generate superordinate themes for the entire analysis. This process was both challenging and time-consuming, and required re-wording and also contextualising the answers that each interviewee provided.

What was clear, was that even though a distinct set of clinicians and clinician/supervisors had been recruited for the study, with anticipation that the supervisors would hold more specific opinions about what may help clinicians, surprisingly, the clinician/supervisors demonstrated similar levels of vulnerability and difficulty in the Treatment Choice Encounter as the clinicians. They additionally spent a significant time exploring their individual experience as a decision-maker rather than a supervisor. For these reasons, although the original intention was to separate clinician and clinician/supervisor responses, the analysis and discussion section will

be presented as a collective response, with indications where individual variation was identified.

5.5 Section Summary

Within this section, results are presented concerning the sample interviewed for the IPA study, the patient questionnaire data, and the use of validation groups. This section is presented in brief, as the main analysis of the themes generated by the results is to be presented in narrative format in Section 6.

Section 6: Results and Analysis

6.1 - Introduction

Within this chapter, results obtained through interviews with clinicians and clinician/supervisors, and also through patient questionnaires, will be analysed to answer the overall research question:

How can mental health care staff use a pre formulated guided decision process in the selection of therapeutic interventions for people with PD, within the context of rationalisation and service change?

Excerpts from interviews and questionnaires will be presented, to gain an understanding of the lived experience of the Treatment Choice Encounter, this is important, as it is something identified as absent from current research concerning UK PD treatment.

Within this section, variations between clinician's experiences of this encounter will be explored, specific results will be identified that either are consistent, reinforce, or differ from existing knowledge. In this way, results from the interviews will provide an original contribution to the body of knowledge regarding PD. Comments will be provided, exploring how results generated impact upon practice, exploring how this research may inform future practice change, when considering how the research question above may be answered.

This chapter will conclude by providing an evaluation of the study conducted, reflecting upon strengths and weaknesses of the methodological approach, learning points, and considerations for change, should the research be repeated.

6.2 Super-ordinate Themes

To explore the research question, super-ordinate themes were generated from all 10 transcripts, presented in Figure18. Each theme is analysed and discussed in the following sections:

Figure18 - Master table of themes (Super-ordinate &Category Theme) within the study exploring treatment choices for people with Personality Disorder.

Super-ordinate Theme – A: Difficulties with Boundary Management

Category Theme A1: Boundaries between patient and clinician
 Category Theme A2: Conflict concerning multiple clinician roles.
 Category Theme A3: Personal and professional role boundaries.
 Category Theme A4: Organisational Resource Management.
 Category Theme A5: Consistency in managing difficulty

Super-ordinate Theme – B: Diagnostic Stigma

Category Theme B1: Patient Stigma: Perception of 'self'.
 Category Theme B2: Clinician Stigma: Perception of 'other'
 Category Theme B3: The impact of media representation
 Category Theme B4: The impact of feeling 'disconnected' / different
 Category Theme B5: Conflict – 'wanting Bipolar Affective Disorder'

Super-ordinate Theme – C: Focus on time.

Category Theme C1: Orientation and direction
 Category Theme C2: Engagement time
 Category Theme C3: Length of time in services
 Category Theme C4: Movement, 'stuckness', and wasted time
 Category Theme C5: End point - Recovery rather than cure

Super-ordinate Theme – D: Metacognitive Abilities

Category Theme D1: Clinician's in-session meta-cognitive ability
 Category Theme D2: Patient's meta-cognitive ability
 Category Theme D3: The organisation's ability to think about the person
 Category Theme D4: The impact of Cognitive Dissonance
 Category Theme D5: The impact of vacillation: idealisation and denigration

Super-ordinate Theme – E: The potential for iatrogenic harm

Category Theme E1: Passivity as opposed to active engagement
 Category Theme E2: Chaotic lifestyle factors fuelling difficulties
 Category Theme E3: 'Doing for' -creating dependence
 Category Theme E4: Medication as an avoidant strategy
 Category Theme E5: Risk and personal responsibility

Appendix 38 provides a breakdown concerning which transcripts supported each theme. This not only allows a clear view about whether themes are representative of the whole sample, but also allows identification of individual variations, discussed below. The breakdown is not included in the main text, as the qualitative IPA approach does not seek to draw conclusions concerning the quantity of people who identified each theme, instead it is to contextualise, and demonstrate coherence and transparency.

6.2.1 Superordinate Theme A: Difficulties with Boundary Management

The need for 'consistent boundary management' in Treatment Choice Encounters was a theme raised within all transcripts. The definition of 'boundary' here is: the physical and psychological limits of the relationship inside and outside of the encounter.

Within the description of this theme, clinicians described the impact of boundary management at various different levels with: patients, organisations, and other workers. This finding combines and builds upon other findings in the literature review pertaining to Q2, Q4, and Q6, partially discussed by Brown et al (2012).

The lived experience of boundary management issues from the clinician perspective in the Treatment Choices Encounter fall within 5 sub-categories. Each category was prioritised to a lesser or greater extent (Appendix38). The numerical value is not intended to demonstrate which variable is more important than another, as this cannot be extrapolated from this type of research, however it shows that by virtue of

repetition, each specific clinician places value upon a particular boundary management issue.

A1: Boundaries between patient and clinician

The primary boundary theme identified concerned the clinician/patient relationship:

Interviewee1(Clinician): “*We obviously have to be flexible and boundaried at the same time, so it is obviously difficult. You know, we are here to offer a service, and we can offer what we can offer, and you know, that’s all well and good, but sometimes it’s not what they want” (T:1,P:9,L:395-401)*

In the above extract, the interviewee encapsulates the struggle with boundary management, demonstrating that boundaries are not easily defined, with need for ‘flexibility’, implying boundary movement.

The interviewee uses ‘*obviously*’, which would indicate a generalisation that ‘everyone’ may feel boundary management is difficult. This is then followed by two uses of ‘*you know*’, suggesting a degree of reassurance-seeking and checking-out from the clinician/researcher. This sense of vulnerability triggers existential questioning in each interviewee, and is linked to the factors triggering the TCG development.

The boundary discussed by interviewee1 concerns patients expecting something different from what services can offer, also experienced by several other interviewees, provoking internal conflict in the clinician holding the boundary:

Interviewee 10(Clinician/Supervisor): “*if you have a client who has never, ever been given any boundaries, then they’re going to kind of, somehow create that system for themselves as much as they can, so that’s when professionals start acting in ways that they wouldn’t normally act. So, you might have a set of clinicians who are amazing parents; they go home and - ‘mummy, can I have ice-cream, -no you have to eat your greens first and then we will think about pudding’... you know, but when it comes to work they suddenly find themselves incapable of setting a boundary.” (T:10,P:21,L:975-985)*

Interviewee10 echoes the boundary difficulty, and compares the clinician role to a parental role. The statement that the patient will 'create' a system in the encounter suggests a power-struggle, resulting in clinician's vulnerability potentiating effects on boundary management: '*act in ways they would not normally act*', rendering them '*incapable*'. This is considered as an interpersonal dynamic between the patient/clinician, but it additionally links with an intra-personal boundary dynamic; the struggle between 'clinician-role' and 'personal-role' (that of a parent).

Intrapersonal struggles connected with counter-transferential and transference issues were raised in the literature review by multiple researchers (i.e: Lieberman et al 2013, Friedman, 2008). However, the literature review research derives from encounters in psychotherapeutic programmes, rather than a Treatment Choice Encounter, meaning that results of this research may add to the body of knowledge. Intrapersonal variables will be expanded upon, under subordinate theme A3.

Interviewee8(Clinician/Supervisor): "*usually the Borderline Personality Disorders, they can befriend the therapists [term used for all clinicians, not discipline-specific]. So we need to keep the boundaries between the between the therapist and the patient. We have to make the relationship positive, but we have to keep within our boundaries, just like Personality Disorder patients in the high-secure units, when they try to help nurses to dispense the medication, they try to convince the nurses that they are fully responsible"* (T:8,P:6-7,L:299-309)

Interviewee8 reinforces the needs for boundaries, providing a specific example of potential boundary violations. Rather than a 'parental role', interviewee8 suggests another 'personal-role' (friendship) which then affects the Treatment Choice Encounter. As framed in the literature review by Hare (1991) and Cleckley (1982), boundary challenges regarding personal/professional role-conflicts are framed as having a sinister intention, emphasising how professional roles must not stray into

personal roles, due to the potential of sinister consequences, this theme is echoed throughout several transcripts.

Other interviewees provided specific contextual examples concerning the impact of boundary violations connected with roles and responsibilities. Interviewee6 describes a patient enacting behaviour in the knowledge that it will receive a specific response:

Interviewee6(Clinician): *“He sends lots of texts saying that he is going to kill himself, and the services have then to respond. .. each time that the client sends a text then the worker is rushing out, and this is not making any change for the client, it just means that he keeps feeling the need to do that”* (T:6,P:4,L:185-194)

Boundary violations are not only described as problematic to the patient's health and well-being, but also impact upon clinician well-being:

Interviewee10(Clinician/Supervisor): *“And the ‘rescuing thing’ also puts on pressure on the staff because they don’t end up making any progress with these people, so they end up feeling like they’re not doing their job properly, and that they are failures”* (T:10,P:6,L:277-281)

Building upon the theme of role variation, the next section explores conflicts raised in the transcripts regarding how the different roles a professional encompasses affect Treatment Choice Encounters.

A2: Conflict of multiple clinician roles.

Each transcript identified role conflict as a ‘difficulty’ and a ‘struggle’. There is little research pertaining to the issue of ‘role-conflict’, the majority of research presented utilised experiences from a uni-professional perspective (i.e. medical), indicating a paucity of systemic research regarding PD treatment choice. The multi-professional experience captured by this study explores perspectives of clinicians from different disciplines making the same choice:

Interviewee2(Clinician): *“I think sometimes, if I have my OT hat on, I find it difficult.”*
(T:2,P:11,L:513-514)

Certain clinicians discussed role-struggles metaphorically, i.e.: Interviewee2 using the term ‘hats’. Figure19 below demonstrates the different professional ‘roles’ listed throughout all transcripts, that each clinician feels they are expected to adopt within changing models of health and social care.

Figure 19: Roles identified in interview transcripts which may result in boundary conflicts when making treatment choices with people who have a Personality Disorder.



Various examples of role-conflict are provided in the transcripts; however the boundary issue between Resource Manager and Negotiator triggers most internal struggles regarding decision-making for all interviewees, explored further in subordinate theme A4.

An additional theme raised by several interviewees concerned how the 'gate-keeper' role is influenced by past experience of treatment efficacy, and how this impacts upon treatment selection:

Interviewee3(Clinician): *"I have seen people who have had longer-term therapy for years and years, and I am not convinced that it has done that much good, as they have still been in the system."* (T:3,P:3,L:140-144)

Flores et al (2014) raise the issue of clinician experience affecting treatment choices in the literature review, acknowledging that these factors affect clinical encounters. Interviewee3 provides a description concerning his lived experience, his judgement is that 'long-term therapy' was not beneficial, arguing this with the fact that patients are "still in the system".

Interviewee 3 is not the only interviewee to raise these types of opinions concerning treatments such as talking therapy and medications. The results of this study therefore reinforce Flores et al (2014) findings, however also highlight a need to explore contextual factors concerning value-judgements that underpin perceptions based on past experience. This research therefore contributes to the body of knowledge by asking: must treatment efficacy always result in immediate discharge? If someone receives effective treatment, does this mean they will never re-enter services?

Interviewee 8 elaborates, demonstrating that not only 'value judgements' and internal 'role-conflicts' influence treatment choices, but also variations in professional training which prompt 'different' boundary management issues:

Interviewee8(Clinician/Supervisor): *“Some people are reluctant, because there is usually some hidden agenda because of the way each discipline have been trained. Whether they are social workers or nurses, or they are doctors or OTs, each discipline unfortunately have been trained in a different way to formulate their decisions. And then there is the power-struggle between the MDT members. And then the different members of the team might say different things.”* (T:8,P:3,L:120-129)

The issue of inter-professional conflict was highlighted in the literature review by writers including Levine et al (2006), who asked “*who has the right to prescribe a certain treatment?*” Rather than experiencing this as a “right”, what the interviewees suggest is that in reality, multiple members of the MDT are in a position of making treatment choices with patients, however not only is it often a difficult in-session issue to navigate, but there are outside-session variables that then influence the treatment choice itself.

Interviewee 3 expands, concerning 'power-struggles', focusing upon not only role-conflict in terms of decision-making, but also hierarchies of roles and treatments:

Interviewee3(Clinician): *“I think that there is some treatment that is seen more important than others. Psychology has always been seen as the top echelon of treatment that you could receive. But actually, it depends how you look at it. If you are a bloke stood there in crisis and you need a social worker who is going to help you, going to do something practical to alleviate your current distress, that’s probably more valid than psychology. The majority of our treatment is risk-management and crisis management. I think that’s why I struggle with the direction of travel, that we are going to turn everybody into mini-therapists”* (T:3.,P:8,L:372-387)

The literature review explained that certain power-struggles have been researched concerning treatment selection (i.e.: Ulvenes et al, 2014), however that differs from the interaction between the clinical hierarchy of power cited by interviewee3.

This is an interesting finding when considering the current literature base for PD treatment and treatment choices. Within the literature review, 102/144 articles were from Psychology/Psychotherapy or Counselling-specific journals. This is not to say that nurses and social workers do not work with or research treatments for PD, however they are under-represented in academic research, which may contribute to the power imbalance that interviewee 3 describes.

Important results that are absent from the literature review are therefore: what treatments are provided by the majority of people who work in a PD team, and how can their voice be heard and represented? These questions are also important when considering the research question.

The data is unbalanced, as most research originates from the upper sections of both triangles, principally from psychiatrists and psychotherapists, concentrating particularly upon self-actualisation, esteem, and relationships.

However, there is little research in what treatments nursing and social care staff bring to PD care, and how they provide it, not only in terms of biological, physiological, and safety needs, but also in terms of esteem and self-actualisation. This imbalance is one reason for practice perceptions of valid or invalid treatments and power-struggles.

A3: Personal and Professional Role Boundaries.

Expanding upon subordinate theme A1, transcript information suggests that personal/professional boundary management difficulties can influence treatment choice:

Interviewee10(Clinician/Supervisor): “*because what people with PD do is they hook into the very part of you that’s vulnerable, and you don’t want them to see anything, so you shut down and you become, you know, you become very defended” (T:10,P:25-26,L:1207–1211)*

Interviewee10 builds upon the internal role-conflict described in subordinate theme A2, describing a type of role-reversal, where the PD patient attempts to impact personally, rather than use the professional as a resource, causing a boundary management issue if not adequately recognised.

Other transcripts raise similar issues concerning boundary related vulnerabilities, often described as resulting in clinicians attempting to bracket-off emotions to protect the vulnerable part of the self, which may then lead to uncompassionate responses.

This issue is demonstrated below:

Interviewee7(Clinician/Supervisor): “*So yes, as a secondary service, we are happy to say this is what you have got, you might not accept it, and be happy about it. But it is not our job to make you happy by just telling you what you want to hear. So, if you don’t accept, it is very difficult to offer you treatment for this. However this is the treatment you need whether you accept your diagnosis or not. You decide and let us know.*” (T:7,P:8,L:284-292)

A slight difference in the transcripts is that Clinician/Supervisors are more aware of (or disclose more about) potential boundary violations, than clinicians who are not also supervisors.

A4: Organisational Resource Management.

Resource reduction and its impact upon treatment choice was significant for both Clinicians and Clinician/Supervisors, supporting findings in the literature review (Leichsenring et al 2010). However, the literature review discussed general budget cuts, whilst the interviews generate an insight into the specific realities of cuts. An example of this is within the area the research was conducted, concerning the lack of access to talking treatments in IAPT services for people with a diagnosis of PD. This is an issue that has been briefly touched upon in reports such as “We Still Need To Talk” (MIND, 2013:11), however is central to themes raised within the transcripts.

Boundary issues related to treatment concern thresholds, access to resources, and capacity/demand concerns. Interviewee1 explores the secondary gain some patients experience by being in a Treatment team, which may be considered as a boundary violation, when viewed from a financial perspective:

Interviewee1(Clinician): “Quite often we will also get people come for an assessment and they sort of ask us to fill out the Benefits form. Or sort of, if we have talked about discharge with someone, they have said, well what about my Benefits.” (T:1,P:5,L:206-212)

Some interviewees suggest that this is a type of ‘malingering behaviour’, however, others state it is the lack of support for PD patients post-discharge:

Interviewee3(Clinician): “There is a difficulty in discharging these people, not just because they come back so quick, but also because there is a lack of other services to go to.” (T:3,P:6,L:273-276)

This is linked to the research underpinning the current “Parity of Esteem” agenda (NHS England, 2015b), and pertains to people with mental health difficulties being supported by all services. When comparing this rhetoric with the reality experienced by interviewees, this research demonstrates that resource management is ‘difficult’

and emotionally evocative, not only due to cost reduction, but also the lack of systemic support for people with PD:

Interviewee7(Clinician/Supervisor): “It becomes a resource issue as well, you think well, can I afford to be a bit more generous, rather than putting it all in the client's hands with as much explanation as possible? Because yes, unfortunately resources are extremely scarce, and you can't help. As cruel as that might sound”. (T:7,P:13,L:618-624)

Building on this, resource boundary issues raised within transcripts do not just concern a lack of resource, but also relate to the proportioning of resource based on current national 'cluster'-specific treatments (DoH, 2011e):

Interviewee9(Clinician/Supervisor): “I think that we do struggle to provide interventions. I think that there are resource issues. I also get concerned about the same people providing the same interventions. I suppose if you look at the NICE guidance and look at the current model, if you were setting up the team from scratch, then you wouldn't have this skill mix. And I think that this is always the case when you are trying to introduce a new service made up from an old service. You are expected to have the knowledge and understanding and skills.” (T:9,P:16,L:793-804)

Competency concerns are shared by other interviewees, anchored in service change and reformation, connected to a historical model where people were employed to only provide treatment for certain disorders (i.e. psychosis), which each interviewee remarks are distinctly different from PD.

A5: Consistency in managing difficulty

Linguistically, the terms 'difficulty' and 'struggle' appear frequently in the transcripts, displayed in Figure 20:

Figure 20: Number of times the terms: 'difficulty' and 'struggle' are used each transcript of the IPA study concerning treatment decisions for people with Personality Disorder.

Transcript Number	Number of 'difficult' references	Number of 'struggle' references
Transcript 1	N = 60	N = 4
Transcript 2	N = 24	N = 10
Transcript 3	N = 26	N = 4
Transcript 4	N = 41	N = 8
Transcript 5	N = 25	N = 0
Transcript 6	N = 24	N = 9
Transcript 7	N = 59	N = 5
Transcript 8	N = 33	N = 7
Transcript 9	N = 54	N = 10
Transcript 10	N = 69	N = 18
Total:	N = 415	N = 75

The use of the words 490 times demonstrate a consistent theme. All interviewees identified the main difficulty regarding boundary management as being a lack of systemic consistency. This parallels literature review findings, however literature review findings typically focus upon how to provide boundaries concerning the 1:1 encounter (Chiesa et al, 2009), rather than the need for systemic boundaries regarding treatment choice. This difficulty is highlighted by interviewee 6:

Interviewee 6(Clinician): "So what is needed is that people give exactly the same explanation, exactly the same message, exactly the same hand-out, if it's going to be done right... People in our team struggle to give consistent messages." (T:6,P:9,L:418-425)

Interviewee 6 suggests that patients become confused without consistent boundaries, emphasising the need for in-session and out-of-session consistency, proposing written leaflets to be given post-session. The interview transcripts support the difficulty identified within the literature review, pertaining to people with PD not

retaining messages provided in clinical encounters, defaulting to prognostic assumptions about treatments (Constantino et al, 2012).

Interviewee7 expands, explaining that boundary management issues do not just occur if the patient does not retain the information provided, but also if the peripheral services disagree:

Interviewee7(Clinician/Supervisor): “..and then they go back to their GP and then get referred back in. So, they kind of split. The split in the service is between the secondary service and the GP. But you know, what am I to do? I have done my best, what am I going to do - pin them down and give them a depot injection? Which is not going to make any difference. Or what? So it is that conflict. In the system, they split the system.” (T:7,P:8,L:395-403)

The final issue raised concerning consistent boundary management pertains to messages patients are given regarding resources. This was partly raised within the specific literature review (Mendelberg, 2014), but more recently linked with debates concerning the “7-day NHS” proposals (NHS England, 2014).

Interviewees identified two levels of service for people with PD; longer-term treatment (for people who accept their diagnosis and actively accept treatment); and short-term crisis intervention (typically prescribed for people who may not accept their diagnosis, and do not accept or adhere to formal treatments). This type of division in treatment provision is not adequately detailed in PD research, although it is recognised to an extent in NICE Guidance (2009a&b). There is a conflict between personal responsibility and service responsibility, highlighted by interviewee8:

Interviewee8(Clinician/Supervisor): “Those patients are often very challenging, to services, to carers [professionals], and they are very time-consuming to the resources... we have to make that explicit with patients, and the commissioners, and the GPs, and the Department of Health. And say; ok those patients, they disagree they have a problem, and they don't want to engage, and they are capacitous. If they are not capacitous, we go through different ways. If they are criminal, we go through legal system. If they are not capacitous, we may need to treat, if they are capacitous, we need to discharge them.” (T:8,P:11,L:536-553)

The clinician/supervisor interviewees discussed areas they felt would aid clinicians in the encounter, explaining that it is not only about the clinician/patient relationship, but also about supporting particular frameworks:

Interviewee 9 (Clinician/Supervisor): *“I suppose we talk about being consistent. Having that dialogue of being fairly strong and confident to stick to that script. And I suppose staff do benefit a lot from support with that person, and they could really do with some guidance, maybe written in policy or something about how you do manage that person.”* (T:9,P:9,L:438-444)

Interviewee 10 suggests that the TCG has been useful, not only to focus exploration, but also as a consistent boundary management tool:

Interviewee 10 (Clinician/Supervisor): *“it [TCG] makes easy sense. What I’m saying is it puts in a static Grid and um, it’s also containing, because it aids understanding on the part of the supervisor, and the supervisor has, kind of, understanding how to have a logical conversation, and it’s meant to empower the clinician”* (T:10,P:19,L:887-893)

A lack of consistency does not appear isolated to adoption of the TCG, but appears thematic in terms of boundary management when working with people with PD, reinforced by interviewees.

Boundary Management Theme Summary:

In summary, boundary management difficulties within the Treatment Choice Encounter are experienced as ‘difficult’, consistent with the literature review. Boundary issues are multi-layered, and pertain to intra-personal boundaries, interpersonal boundaries, and systemic boundaries. It is therefore suggested that either individually, or via the team, boundary breaches must be identified so that they can be managed, to result in healthy boundaried relationships for patient, clinician, and system.

Hierarchical power-struggles and a lack of research can underpin boundary management issues. There is a need to focus upon comprehensive training, to ensure treatments are selected and provided as per government guidance, rather than from personal values concerning past experiences.

When considering the findings of this Subordinate theme, three possibilities are suggested when considering the research question: (1) boundary management training at all levels, (2) assertiveness training which incorporates boundary management identification, and (3) research regarding the treatment roles of non-therapists considering specialist health and social care provision for people with PD.

6.2.2 Superordinate Theme B: Diagnostic Stigma

Evidence presented in the literature review demonstrated that there have been changes in diagnostic considerations concerning PD (Moran, 2007), and shifts in the concepts of 'treatability' (Norton et al, 2005). The literature sourced primarily focuses upon problems originating from conflicting service provider and clinician's viewpoints, then becoming a potential blocking factor. Stigma was identified by all interviewed, and is therefore a Super-ordinate theme, however the variations concerning stigma resulted in 5 sub-themes, explored below:

B1: Patient Stigma: Perception of 'self'.

The interviews provide insight into the nature of personal stigma concerning negative views that patients hold:

Interviewee 1 (Clinician): *"I mean the term Borderline actually freaks a lot of people out, 'cause they think you are just borderline... So, on the edge of having a disorder, rather than having a proper disorder". (T:1,P:4,L:146-149)*

Evocative language (i.e.: 'freaks') exemplifies many patient's reactions to the term PD being used in Treatment Choice Encounters. Interviewee1 emphasised that this happens in many cases, rather than just being a 'one-off', suggesting this is an issue to be addressed prior to making treatment choices. The terminology used by interviewee1 to describe feelings evoked in patients "*on the edge*", emphasises the anxiety present in the encounter. This is then added to a sense of invalidation, with the suggestion that some patients see PD as not being a '*proper disorder*'.

Reasons that patients may become emotionally overwhelmed concerning diagnosis varied, however the sense of personal stigma was consistent throughout each interview. Interviewee 3 attributed a lack of understanding on behalf of the patient:

Interviewee 3 (Clinician): “Well, with one lady in the review clinic, I actually sat down with her and said: this is where I think you are, where do you think you are? And it became clear that she’d been given the diagnosis, but no one had actually explained to her what the diagnosis meant.” (T:3,P:2,L:50-55).

Other interviewees agreed, however some suggested that this only applies to certain patients. With others, the problem does not concern a lack understanding, but is due to a personally held stigma concerning the disorder itself:

Interviewee 7 (Clinician/Supervisor): “They want to have a different diagnosis; they want it to be called something else”. (T:7,P:7, L:330-332)

Interviewees consistently stated that patients do not typically disagree with PD symptoms, but the PD label itself. They attribute this to the perceived ‘untreatable’ label discussed in the literature review.

90% of interviewees cited Bipolar Affective Disorder (BAD) as the label that patients most felt they should have. The frequency that BAD is mentioned indicates that it is not just an individual experience, but something frequently encountered by clinicians.

Interviewee 9 (Clinician/Supervisor): “I think 20 years ago, there were a lot of problems because there was some reluctance to diagnose Personality Disorder. Particularly in this locality, the people did tend to get diagnosed with a Bipolar disorder instead, even though they had a Personality Disorder, and that this happened because of some of the values that the doctors providing the diagnosis held, and the fact that some of the symptoms of the two disorders are similar... We had a lot of medical staff who probably shied away from saying what it probably was, and then I think we had a population of people who have been treated for the wrong condition and therefore not got better.” (T:9,P:8,L:355-370)

Interviewee 9 discusses how different levels of personal stigma have affected her experience. She contextualises her experience to her locality, however raises a point

that PD has been previously misdiagnosed. She states that diagnosticians have 'shied away' from providing the diagnosis in the past, implying unstated professional stigma surrounding the diagnosis. The issue surrounds the ability of a clinician to be able to assertively and compassionately deliver a diagnostic explanation, otherwise diagnoses are avoided and stigma reinforced. Avoidance of discussing the diagnosis is detailed by other interviewees:

Interviewee 1 (Clinician): *“Well, I will try and explain more on the symptoms, rather than focusing on the diagnosis, and then feed the diagnosis in using the ICD-10, then explain that this is what it is termed, but it is actually a group of symptoms”* (T:1,P:3,L:136-140)

Interviewee 1 introduces the need to 'feed' the diagnosis to the patient. This is interesting phraseology, as it could be interpreted to mean that the patient requires to 'ingest' the concept to make it integral to themselves, or could be suggested that the patient requires nurturing in the form of 'feeding', enabling them to progress, either way there is a sensory element to this issue, echoed linguistically in other transcripts.

When considering the effect of the introduction of the TCG, there has been an interesting finding concerning diagnosis. When considering different ways that clinicians feel patients perceive their diagnosis, there have been positive and negative encounters. Interviewee 9 provides a contextual case example:

Interviewee 9 (Clinician/Supervisor): *“And she kind of found it difficult to understand the concept of Personality Disorder, and so rejected that concept. So she's not even in pre-contemplation, it's not; 'I might think about it'. Instead it's; 'this is not me, and I will use all of my energies to disprove that'. I mean, she even printed off the diagnostic criteria for Personality Disorder, and ticked and crossed things she agreed or disagreed with, even though this was at odds with what everyone else around her knew about her behaviour.”* (T:9,P:9,L:418-429).

Feedback pertaining to the low-return rate for patient questionnaires was suggested to pertain to the difficulty certain patients have concerning the PD label. The difficulty that compounds this issue is that people who rejected the label correspondingly rejected the questionnaires, meaning a biased questionnaire response only from people who accept their diagnosis. The core question for this study does not pertain to diagnostic rejection; however transcript and questionnaire results suggest that this may be a beneficial future area of research.

B2: Clinician Stigma: Perception of 'other'

The interviews generated themes connected to 'otherness' in terms of the diagnosis of PD, and associated with diagnostic stigma held by clinicians. These are connected to the 'otherness' section raised within the literature review (i.e. Heilbron et al 2010), however interviewees provide specific evidence of how this is experienced within Treatment Choice Encounters.

The theme of 'otherness' is apparent in many transcripts, evidenced by phraseology and terminology used (i.e.: "us and them"). In the transcripts, terminology that separated and pertained to "otherness" was linked more to people with a PD who exhibit socially unacceptable behaviours, rather than all people with the diagnosis:

Interviewee 7 (Clinician/Supervisor): "So the bottom line is that, never mind how horrible what they have done might be, or how unsavoury the character might be, or how nasty they come across, just explain it to them that this is what you think. Just explain to them that this is how it has come about [PD development]." (T:7,P:12,L:578-586)

Interviewee 7 highlights how value-laden responses can be connected to socially unacceptable behaviours such as violence, which can become the focus for some clinicians. The language used shows how the focus on negative behaviour can

obscure the encounter. The notion of associating negative behaviour with a disorder is raised differently by other interviewees:

Interviewee 8 (Clinician/Supervisor): So one of the cases we were talking about - with the antisocial Personality Disorder and sexual orientation problem. It is one of the mental disorders mentioned in ICD-10, but it is not a criminal act unless they offend. This is the same, whether we are right, if we consider ourselves as normal, what's normal? Unless we conduct a criminal act then we are normal. But once we go for that, we afford to the legal system. So the public should know that, the legal system should know that, and the staff should know that." (T:8,P:8,L:374-385).

Interviewee 8 focuses upon the difficulty that he feels was brought about by changes in working practices. He discusses the notion of criminality, and then switches to discuss the perception of pathology by clinicians in the team who may be less trained regarding PD. He suggests that clinicians may be either frightened about making more proactive risk decisions for people with PD, or may have treatment choices obscured because they lack understanding about the delineation between what behaviours are treatable by mental health services, and/or those that would be considered as concerning criminal justice services. There is a paucity of research regarding the non-forensic PD community, which could be a reason why there is a lack of clear guidance for clinicians reflected by the interviewee.

Interestingly, the examples provided so far in this subsection concerned clinician/supervisor's experience of the Treatment Choice Encounter. They are more senior, but show inconsistency in how they describe their own practice standards, compared with how they reflect about their expectations from their supervisees. When considering the personal beliefs of the clinicians, it is important therefore to provide an example of a non-supervisor clinician describing their experience and perceptions of the diagnosis of the term PD:

Interviewee 6 (Clinician): *“I think because Personality Disorder is a negative name, and er, diagnosis, then most people think that they have got Bipolar. Most people that don’t accept their diagnosis, it’s because they think that they have got Bipolar. I don’t like the name Personality Disorder, if I am talking to clients, I look at it as the problems that they have rather than the label, because a lot of people think of it as negative, whatever we think.” (T:6,P:7-8,L:349-360).*

The terminology used in this excerpt is personal ('I think') and illustrates a parallel between the struggle concerning clinician’s diagnostic acceptance, and the struggles they perceive the patients are having in accepting the diagnosis. This is a further example of where avoidance is utilised to manage a difficulty.

Interviewee 5 demonstrates how there may be a difficulty for clinicians, when considering how their past experience of PD influences their own feelings within the Treatment Choice Encounter:

Interviewee 5 (Clinician): *“People’s motivation can change, and therefore they should be provided with a period to engage, rather than merely being discharged. Otherwise we are just dooming them to fail, and they turn back up anyway... usually in a sorrier state... usually angry with you, because the other service discharged them before.” (T:5,P:6,L:264-271)*

Interviewee5 articulates the experience of working with unengaged patients discharged from services. Not only does this excerpt indicate a struggle, it also suggests a division between individual clinicians and teams providing treatment for PD patients. Despite being raised as an issue by many interviewees, little evidence was found in the literature review concerning people with PD being declined services, discharged from services without treatment, or re-entering services.

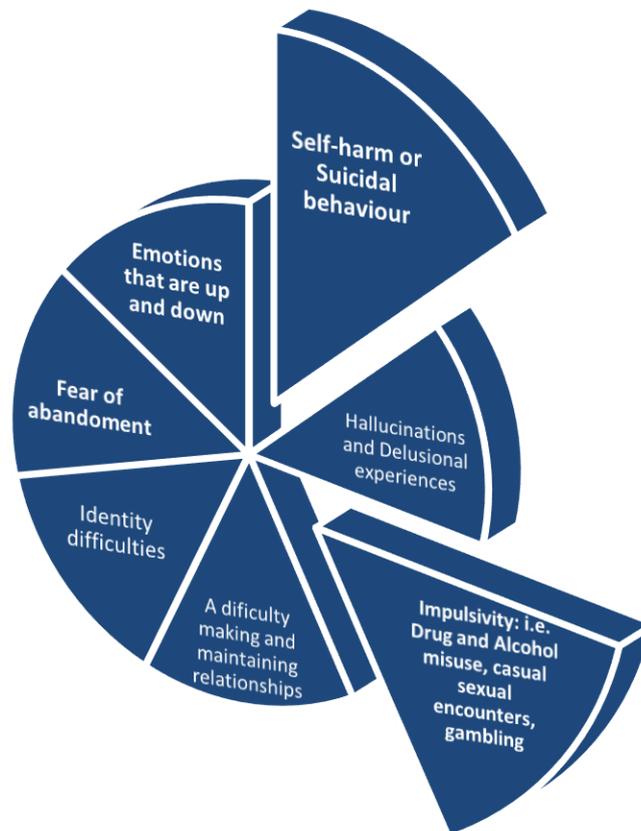
Interviewee 8 (Clinician/Supervisor): *“We as the clinicians, have not got to stick blindly to the diagnosis. And this is one of the pathologies that clinicians have got. When we say that this is an antisocial Personality Disorder, and we tell in ourselves, and we give the message to the patient that they are untreatable. Like the old-fashioned message.” (T:8,P:7,L:325-332)*

Interviewee 8 demonstrates a risk of either holding a traditional view of 'untreatability' which was raised in the literature review (DoH, 2003), or using that view to manage the impact of recent resource reduction. He discusses the need not to '*stick blindly*', which could be interpreted as needing to 'open one's eyes' to alternative ways of working together, to provide consistent treatment choices. Expanding, Interviewee9 suggests there may be a need for clinicians facilitating the encounter to anticipate, and be able to manage, different emotional responses to the diagnosis and treatment choices:

Interviewee 9 (Clinician/Supervisor): *"I had tried to put a positive spin on it [Diagnostic explanation]. I mean I have had people who have said; 'thank you, that's explained everything' and have been quite relieved, but then I have also had somebody who was actually quite sad, and said; 'that sounds really awful'"*. (T:9,P:7,L:327-335).

It is interpreted that the patient who rejects the diagnosis, like the clinician who develops prejudice, becomes over-focused upon particular anti-social symptoms of PD. This distorted focus underlies prejudice, better education and regular supervision will enable more of a balance in terms of responses. This type of response will also help build a positive profile for other agencies who provide services for certain symptoms of PD (i.e. GPs, A&E, and Police), to increase consistency, maintain boundaries, and reduce stigma. A diagrammatic presentation is provided in Figure 21 to represent how people become over-focused on certain PD symptoms.

Figure 21 - Diagram to demonstrate how over focus can be placed upon different Borderline Personality Disorder symptoms which can affect worker compassion and treatment choice.



B3: The impact of media representation

Over half of the interviewees identified a requirement for wider public health promotion to improve the public image of PD. The interviewees suggested that negative publicity impacts upon diagnostic acceptance and treatment choice, linked with the representation of certain symptoms, as discussed in the previous section:

Interviewee 8 (Clinician/Supervisor): “And we should educate the public that having a Personality Disorder does not make a bad person.” (T:8,P:8,L:371-374)

Diagnostic stigma has long been recognised as affecting a person’s likelihood to approach services for treatment, however past research has mainly focused on non-PD disorders (Crisp et al, 2000). Changes in media portrayal was also suggested to

have an influence upon other providers who serve people with PD, but are not specialist mental health clinicians:

Interviewee 5 (Clinician): *“The difficulty appears to be influenced by the person's own individual views of mental illness, but also the media. It also does not help that GPs are not clear that the symptoms may be attributed to a number of diagnosis, and they actually ask or sometimes state that you must provide a diagnosis of Bipolar”.* (T:5,P:4,L:180-186)

The discussion of media expands from considering positive media as positive health promotion, to considering the topic of inclusion and belonging, which in itself connects to the theme of ‘otherness’, discussed in subordinate theme B2. Interviewees highlighted patient's struggles concerning the lack of positive media role-models, as discussed by Interviewee 6:

Interviewee 6 (Clinician): *“I think that the media representation is quite stigmatising for people with Personality Disorder, and I think that there are a lot of problems with things on the internet... because they get a bit stuck with some of the more negative sites. I was working with a girl last week and she said – ‘when I am down I start looking at websites, which then make me more down, because they say bad things about Personality Disorder, and things like you don’t want to be mixing with people with Personality Disorder because they do this and do that, and say things like they are off their head, and that gets me more down’.”* (T:6,P:8,L:371-380)

Interviewee 2 expands, suggesting there are no positive role models for PD, therefore people often connect with celebrities with Bipolar, because there are “similar symptoms”, suggesting this provides a positive mental health anchor, however reinforces the difficulty people have concerning personal identity and diagnostic stigma:

Interviewee 2 (Clinician): *“A few [PD Patients] have said to me, it’s because celebrities have got it [Bipolar Affective Disorder].”* (T:2,P:5,L:244-245).

Interviewee 5 suggests that ‘connection’ helps people overcome their sense of ‘otherness’, and provides a sense of ‘validation’ and ‘status’:

Interviewee 3 (Clinician): “*nine times out of ten, they want to have a Bipolar Disorder. That’s what they want..... Status. Status, maybe. It’s ah... popular I think. Maybe status is not the right word. But it’s like Robbie Williams. Then they can say I am like Robbie Williams, and that gives them a status, and it kind of validates their experience.*” (T:3,P:5:L:200-211)

There were various examples in the transcripts where clinicians linked public views of PD having an impact on the Treatment Choice Encounter, which is a potential area of future research. Interviewee 10 links the lack of exploration and the lack of positive role models with a general stigma:

Interviewee 10 (Clinician/Supervisor): “*it’s never mental health and Personality Disorder, they are never prioritised in either [political] party, because they would rather deny it exists...as I say they’d rather someone else deal with it, so they can deal with all of the kinds of like normal stuff that feels comfortable.. you know, stuff. Personality Disorder is something that is very uncomfortable.*” (T:10,P:7,L:308-314)

B4: The impact of feeling ‘disconnected’/ different

In the previous two sub-sections, examples are provided concerning what stigma public, professionals, and patients can experience concerning the PD label, prompting a sense of ‘otherness’. Disconnection is described in the research connected to ‘otherness’, and it was also evident within the interviews, in that clinicians also feel a sense of isolation and ‘otherness’ in the encounter itself:

Interviewee 10 (Clinician/Supervisor): “*society needs somewhere to dump people who don’t fit into normal society, and mental health services have always been that place that they can go into. For the people that work for mental health services are like sacrificial lambs in society, who for some reason or another decide to take that particular role of holding these people*” (T:10,P:6,L:244-250)

The use of evocative words such as ‘*dump*’ suggests that this is abandonment of the patient by other services. This sense of abandonment is echoed in other transcripts, where clinicians discuss the lack of other services, and the lack of access to primary care. This theme is recognised at a National level and has current focus (NHS

England 2014), though as yet there have not been specifically-focused initiatives for PD.

Interviewee 10 describes clinicians as *“like the sacrificial lambs of society”*. The meaning of this phrase is defined by Collins (2015) as: *“someone that is surrendered or metaphorically sacrificed for the good or benefit of something else”*.

The context that interviewee 10 brings by using this phrase, suggests that in her experience, mental health services are being used as a focus for degradation and destruction by a system that is not inclusive of people with PD. This notion is echoed in other scripts, and again reinforces the need to examine the systemic influences concerning stigma affecting the Treatment Choices Encounter.

The damaging experiences pertaining to team dynamics were more cautiously discussed by each interviewee. Interviewee 8 reflects both on the negatives and positives concerning working in a team with people with PD:

Interviewee 8 (Clinician/Supervisor): “In terms of conflict, there might be a lot of different opinions, and this is what we are looking for. However, one of the problems that we have is that some of the disciplines treat the medical view like it is the medical model. And as if it is something which is a stigma, and it is not.” (T:8,P:4-5,L:186-192)

Interviewee 8 is not speaking generally, he is reflecting upon his personal experience of making treatment choices as a doctor working in an MDT. He discusses inter-disciplinary disagreements concerning diagnostic-specific treatments, that was touched upon in subordinate them B2. He also symbolically demonstrates how power-struggles concerning different discipline's perceptions of 'good' and 'bad' treatments can affect patient care and also the clinician's experience of teamwork.

Professional conflict was identified within the literature review (Beutler et al, 2012), but only in terms of specific psychotherapeutic approaches taken, rather than discipline-specific conflict. When considering decision-making processes, this is an important consideration, and is proposed to be explored further, to see whether this is a personal or team experience.

B5: Conflict: 'wanting Bipolar Affective Disorder'

Building on the theme of conflict raised above, desiring a less stigmatised diagnosis is a consistent theme in all interviews, patients wishing for a different diagnostic label, the most identified label was BAD. This appears to be both a source of difficulty when making treatment decisions, and also linked with a symptom of PD: 'identity disturbance':

Interviewee 10 (Clinician/Supervisor): *“well, one of the things talked about is Bipolar, and how a lot of people feel that they would rather have Bipolar than um... Personality Disorder.”* (T:10,P:10,L:454-456)

Interviewee 10 suggests that people have a preference in terms of diagnostic labels. The theme of preference was not only raised in the transcripts pertaining to patient's viewpoints, but also other services, specifically GPs:

Interviewee 5 (Clinician): *“Yes, so somebody came last week. The referral, for once, didn't state that they have Bipolar.”* (T:5,P:3,L:102-104)

The emphasis: “*for once*”, combined with the fact that multiple interviewees raised this fact, demonstrates a need to educate GPs and patients about the diagnosis of both PD and BAD.

Difficulties are experienced by clinicians when GPs provide a statement that people could be suffering from BAD, which influences patient expectations of a particular type of treatment; this is described by all interviewees as a source of initial conflict in the treatment encounter. The patient has been provided with different messages from people in positions of power, which have then triggered 'old behaviours' generated when feeling 'unsafe' (i.e.: anger, self-harm). This issue can have both a damaging and adversarial effect, articulated by Interviewee 9:

Interviewee 9 (Clinician/Supervisor): "as they are the ones that can cause some difficulty when working with other members of the team. We have had, sort of like, demanding second opinions. So they often think that they have other things wrong with them, like a Bipolar disorder, or OCD". (T:9,P:7,L:308-314)

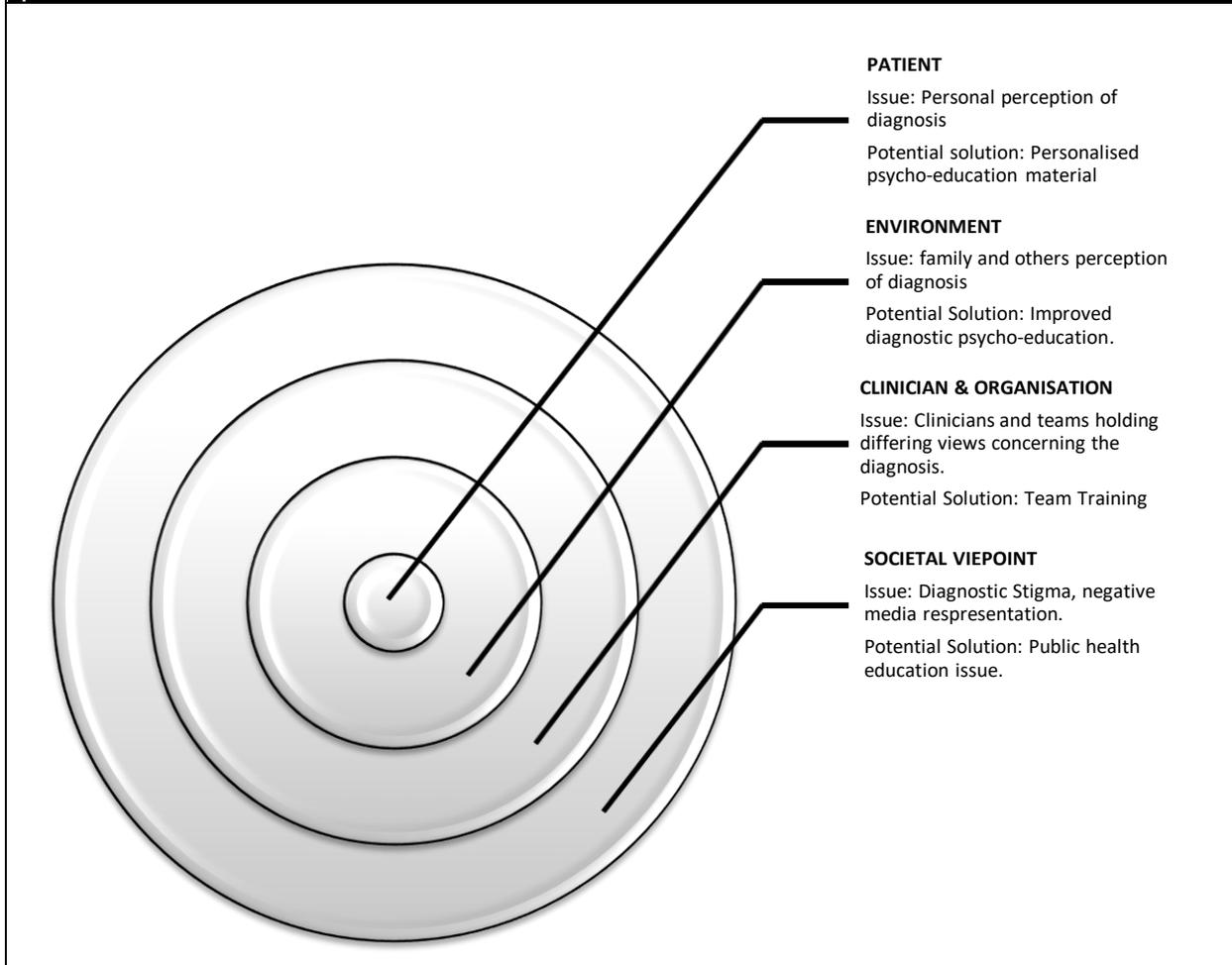
This same interviewee discusses the difficulty concerning past diagnosis, suggesting that there is a need for confidence and assertiveness in the Treatment Choice Encounter for both senior staff (diagnosticians) and junior staff members making treatment choices:

Interviewee 9 (Clinician/Supervisor): "I also think that another reason in this area is that if somebody came who was pretty astute, and they did get diagnosed with a Personality Disorder, and they came and articulated themselves well and complained about their diagnosis, it may then be changed to a Bipolar disorder, maybe a type two, so I think there is something about these patients that a part of their symptoms may be the fact that they don't accept that they conduct themselves in a particular way, which is a reason that they reject the diagnosis or confront doctors about the diagnosis." (T:9,P:8,L:380-392)

There is research available concerning both the variance between PD diagnosis and Bipolar Affective Disorder (Borda, 2016) and the diagnostic comorbidity (Álvaro et al 2016).

to an understanding of all interacting effects and what may help overcome the effects of stigma on the encounter, summarised in Figure 23:

Figure 23: Interacting diagram developed via an IPA analysis of interviews conducted concerning how treatment choices are made with Personality Disordered patients.



The interviewees emphasise the need to develop appropriate education material for patients, carers, staff, and referrers, to ease the Treatment Choice Encounter and engagement generally.

6.2.3 Superordinate Theme C: The focus on time

Resource pressures are identified as a key issue when considering treatment choice for people with PD. The key resource that interviewees focused upon above others is 'time', this is the reason that time has been used as the superordinate theme, rather than resource. This is a slight variation from the literature review findings, which tend to focus on a lack of resource and reduced cost, but do not always factor time into this resource. 5 sub-themes are identified that contextualise why appropriate use of time is important:

C1: Orientation and direction

The link with time and orientation was evident in the language people used. Clinicians described directionality and disorientation as a major factor concerning 'time-management' and 'wasted-time' for the patient and the service, as shown by the excerpt below:

Interviewee1(Clinician): 'Because a lot of people think they are sending them back and they haven't even tried. Also quite often, the people that often not attended, they will come back in two months and either the GP will send them back or the Access team, and it is more often than not then they will not come back. The crisis can often go away in the week, and the risk will reduce, so they may not need treatment, this is the nature of the Personality Disorder.'
(T:1,P:6,L:292-302)

When considering how this short paragraph described the patient journey for a person with PD, it is disorientating. The description highlights a sense of rejection and lack of support for the patient. The movement appears anchored in the fact that the patient does not fit with either service (GP or mental health), however has a need for service support. In other examples, clinicians discuss how patients can productively use time:

Interviewee 6 (Clinician): “*and this happened, and I remembered what you said in the group the other week about stop and think, and I recognised that I was on hyper-alert’. And that was great to see, someone actually getting it, and recognising what they are doing, without workers being there, and actually getting it, and putting something in to change themselves, and then coming back to the group and reflecting upon it. I think that’s great*”. (T:6,P:5-6,L:248-258)

A sense of orientation appears to be of particular importance in the Treatment Choice Encounter, as interviewees reflected upon disorientation symbolically as a negative factor, and ‘*being in the right place*’ as symbolically a positive factor in treatment choices. Interviewee 3 provides an example:

Interviewee 3 (Clinician): “*So you can say, well you are not in a place where you are able or willing to work at the moment, and we are not in a place where we can do anything therapeutic at the moment, with the beliefs and opinions that you hold about treatment.*” (T:3,P:2,L:67-73)

The introduction of the TCG meant that clinicians focused much more upon identifying ‘*where the patient is*’ – framed as a psychological rather than physical construct. This was an interesting outcome, as the TCG concept is not based upon anything that the clinicians did not already state that they knew, it primarily focuses upon diagnostic acceptance and acceptance of treatment as choice variables. However, what the interviews showed was that there can be a sense of disorientation for the clinician in the encounter, this was represented in the transcripts by repeated phrases used: “*where are they?*” “*And where am I?*” Also with repeated phrases concerning ‘*loss of direction*’, and ‘*going down the wrong road*’. Interviewee 1 describes how the TCG has been used as a type of ‘*map*’ to orientate the direction of the encounter:

Interviewee 1 (Clinician): “*I have been through the sections [in the TCG] and have asked them if they can understand where they’re at, and explained my understanding of where they’re at, and they seem to get it.*” (T:1,P:2,L:81-85)

Another point concerned 'wasted time' and disorientation, related to certain clinician's use of the TCG. It was initially implemented to focus the investigation and explore the research question, and aimed at use in the encounter itself, or in post-encounter reflection. However, 40% of interviewees reflected that they had used the TCG in different relationships, particularly with GP's and other referrers. They used the TCG to explore 'time wasted', with patients moving backwards and forwards, and also to enable referrers to consider a rationale for why they are referring a person with PD. Interviewee4 was one of these clinicians:

Interviewee 4 (Clinician): *"What we have noticed is that they are not getting back to us as much, complaining [meaning GP'S] that we have not taken them into service [meaning PD patients]. And we are not seeing a high proportion of them being re- referred, so I think that they are taking on board the message that it is not just because they have a Personality Disorder that they need treatment, but that there is a level of engagement that is needed"* (T:4,P:1-2,L:43-51)

Interviewee 4 demonstrates that having a clinical heuristic such as the TCG is helpful with referrers who have previously 'complained', and merely referred back into treatment. It is interpreted that orientation is linked with rationales for acceptance or rejection of treatments.

The transcripts provided multiple references and uses of figurative speech relating to: time, movement, and direction, summarised within the 'word-cloud' presented in Figure 24:

of motivation and engagement a patient showed. Other interviewees discussed it in the context of the amount of insight they have about their diagnosis, and how treatments may affect that diagnosis. Interviewee 1 demonstrates that this can cause a difficulty and cross-service conflict:

Interviewee 1 (Clinician): “All we can kind of do is be here if someone does want a treatment, or for when someone feels ready for a treatment. Then just pass that back to a GP, and they end up saying, ay-up, hang on a minute” (T:1,P:4,L:178-182)

Clinicians have then discussed how the use of tools such as the TCG can enable them to reflect upon the subjectivity of their perception about whether this is the ‘*right time*’ for the patient. Interviewee 5 demonstrates that there is a need to focus upon ‘*in the moment*’ problems which may be amenable to treatment:

Interviewee 5 (Clinician): “I think that historically, there has been a way in which we write the assessment; we write the person's story and we say, ok they have got a Personality Disorder, and so write that, they then go to a Treatment team. Whereas now, with the Grid, I think that the Grid helps us add to the assessment, and look at not only the symptoms, the diagnosis, and the story, but also assess the motivation to change. I think that now we sit down and we say, ok, what is it at the moment what is causing you the most distress, and can that be worked on?” (T:5,P:2,L:63-75)

Interviewee 4 builds upon this, raising another dimension about ‘right’ or ‘wrong’ time, concerning internal waiting times:

Interviewee 4 (Clinician): “We get them, they come in crisis, obviously, and they engage here, but if then we find that they are motivated, or we engage them to enhance motivation, the problem is then the time that they wait to be seen for actual treatment when they are put through to the actual Treatment teams. And so, then they may not engage, and then they might just be seen in crisis, because by the time that they get to see the Treatment team, they have disengaged again”. (T:4,P:3-4,L:139-149)

‘*Treatment readiness*’ and ‘*right time*’ are phrases that interviewees used interchangeably. In their experience, it appears to be a transient stage that people move in and out of, dependent upon their environment; their relationships, and also their perception about whether they need treatment or not. This finding raises three

issues when exploring the research question; firstly it concerns how internal waiting times for treatments affects people's treatment decisions, secondly what people perceive as valid treatment, and thirdly about whether 'time' as a healing process needs to be explored in more detail, when considering the transient nature of distress and disturbance for people with PD.

A final point raised by interviewees concerned whether 'engagement' is a treatment that can be prescribed, and if so, how long it would be prescribed for, concerning resource pressures. Interviewee8 contemplates this:

Interviewee 8 (Clinician/Supervisor): *"So they do not trust others and do not trust themselves. So if they come to the service, in the beginning they decide in themselves dynamically, unconsciously, I will prove to the whole world I am rejected. So if we allow the disengagement, we reinforce the belief, so I think a 3-month assessment period is required."* (T:8,P:8-9,L:423-430)

The impact of considering this type of intervention would appear to be centred in the experience of the clinicians interviewed, however it has a cost implication for the organisation, when considering the national payment systems.

C3: Length of time in services

The focus upon length of intervention is something undefined in the literature review. However, the question is repeatedly raised by clinicians: 'when is enough, enough?' (Bryan et al 2012). This identifies a dilemma for clinicians, supervisors, and services. When interviewees have discussed people's length of time in services, they have had different, sometimes 'value-laden' descriptions of patients:

Interviewee 7 (Clinician/Supervisor): *"...clients are not saying it, but there are alternative motives. They linger around a long time".* (T:7,P:10,L:502-504)

There is a sinister sentiment in this statement, concerning ‘*alternative motives*’ coupled with the use of the word ‘linger’ which means “*to stay in a place longer than necessary because of a reluctance to leave*” (Oxford University Press, 2015). These are phrases used by other clinicians as being anything not deemed as a social or health care treatment, but expected by some patients with PD (i.e. to apply for Benefits). The difficulty in exploring reasons for these issues is that PD patients can have a tendency to abdicate responsibility, but services aren’t always clear about what they provide in terms of “*nursing and social care*”:

Interviewee 3 (Clinician): “*In the community teams which I have worked, there have been people who have had long-term therapy and they have still walked out of the door, and they have crisis, and the therapy has had not made a significant difference.*” (T:3,P:3,L:147-151).

In this excerpt, interviewee 3 describes a difficulty arising in the Treatment Choice Encounter for people who have been in services a number of years. It raises two issues: firstly concerning dependency that may be caused by “long-term treatment”, and secondly about how clinicians who have worked in services a number of years perceive relapse, neither of these aspects were adequately covered in the literature review. This problem was expanded upon by interviewee 5:

Interviewee 5 (Clinician): “*I think the consequence of responding to people with Personality Disorder in the way that the service currently does, is quite a harsh way, and not specifically productive. I am aware of the need to ration services due to the changes, and I understand that many people with a Personality Disorder self-discontinue services, however I have assessed a number of people that have come back and have expressed dissatisfaction with the treatment teams, unhappiness with the length of wait, and also a preference not to be re-referred. Service users just say to me: ‘well what will they do different now?’. (T:5,P:6,L:276-288)*

Service refinement is an emotionally evocative theme for certain clinicians interviewed. Interviewee 5 describes frustration about the waiting times and also time restrictions put in place. The use of ‘*harsh*’, provides context to patient’s

'unhappiness' and 'dissatisfaction'. He appears to suggest that this is a difficult issue to manage in the Treatment Choice Encounter, and suggests that despite treatment limits, people return shortly after discharge, meaning they extend their treatment longer than prescribed. This links into Category Theme E, pertaining to recovery and dependency.

C4: Movement, 'stuckness' and wasted time

Time and movement are discussed under subordinate theme C1 concerning disorientating factors. However, interviewees also raised issues concerning the cost of time, considering the pace of change, 'stuckness', and the metaphorical movement through services:

Interviewee 2 (Clinician): *"Where there is a history of disengagement, we will do a bit about engagement first, to try and enable them to continue, rather than just disengage again. Because it's then not using up a space for somebody else who needs the treatment and will turn up." (T:2,P:7,L:352-357)*

Interviewee 2 stated: '*using up a space*', this emphasises the preciousness of the resource, but also places a value upon whether the person is in need of treatment, or not. This is not just linked to engagement, but also attendance factors, this is a monitored organisational cost in terms of non-attendance rates.

'Wasted time' did not only arise in the transcripts as a patient-factor, it also pertained to organisational behaviour, specifically related to internal waiting-lists:

Interviewee 1 (Clinician): *"The waiting list for the other therapies such as psychology and CBT is phenomenal, and then we end up saying the same thing in the clinic every week while they are waiting for this treatment, which is frustrating for them and also for us". (T:1,P:9,L:436-442)*

This internal wait indicates that it is a variable requiring systemic monitoring. When considering the research, little was found about problems or benefits concerning people receiving pathways of care which may have different providers (or different levels of waiting times). There are also few studies that include multiple providers of teams; typically the results are presented from one provider viewpoint: once the patient is in therapy.

Despite the difficulties described, there was a sense of compassion about the chaotic nature of a person's life, an appreciation about how 'stuckness' or 'snags' that hinder progress may occur with a diagnosis of PD:

Interviewee 7 (Clinician/Supervisor): "You have got the ones that tolerate, and the ones that hit a lot of snags. And somehow they are admitted to hospital and they do not come to therapy, and you try to get them back, and yes they are there, but because of the difficult experience they have and the experiences that trigger memories of past experiences that they have had, then what you get is that they hit lots of snags, which then affects the treatment" (T:7,P:5-6,L:245-254)

The compassionate response is caring, but impacts upon time boundaries, and precipitates a reluctance to change interventions once stability has been achieved, due to anticipated destabilisation, also demonstrated by interviewee3:

Interviewee 3 (Clinician): "Because, sometimes with people, you get stuck in a rut, and it [TCG] helps you focus where you are and where you are going. 'Cause I think sometimes you can get stuck with people sometimes."(T:3,P:1,L:38-44)

The 'stuck' sense described is linked with a lack of movement or progress towards an end goal of discharge or recovery, perceiving PD primarily as a long-term illness, rather than an illness that can be recovered from. This clinician, like others interviewed, demonstrates some contradiction within their statements, stating that they do not find it difficult to discharge people if the Treatment Choice Encounter

requires it, however then make statements (such as in the excerpt above) demonstrating difficulty in reviewing the treatment for discharge.

Within the transcripts, the lack of consistency in discharge approaches as an option in the Treatment Choice Encounter indicates that they are either not conscious of the fact that this happens with some patients, or they may feel it reflects badly on them to admit to this. This is explained by interviewee 9:

Interviewee 9 (Clinician/Supervisor): *“There are people who come along and are wasteful, non-purposeful interventions, it’s just; ‘how are you’, moaning and groaning, and the staff moaning and groaning and reflecting that back. And this is non-helpful interventions”* (T:9,P:12,L:570-575)

Interviewee 10 suggests that when patients become ‘stuck’, either reaching a treatment plateau, or due to disengagement, then a parallel process occurs where the staff become stuck:

Interviewee 10 (Clinician/Supervisor): *“So the staff feel stuck as much as the client feels stuck, and they want to pass it on. So there is a passing. There is a lot of hot potato stuff that’s goes on”.* (T:10,P:13,L:589-592)

This excerpt displays a level of discomfort deriving from ‘stuckness’, which may be anchored in time-wasting. There is an avoidance of addressing the discomfort, or evaluating treatment, resulting in movement of patients triggering patient destabilisation, then further need for treatment.

C5: End point - Recovery rather than cure?

A final theme raised concerns the impact of 'time' connected to the use of the Recovery Model in Treatment services. Over 50% of the interviewees demonstrated knowledge of the Recovery Model and supported its principles, however suggested that patients struggle with it:

Interviewee 2 (Clinician): *“A cure. They want a cure and to be on a level. It’s the instability they don’t like, and they just want to be on a level.”* (T:2,P:5,L:228-230)

The concept of 'cure' suggests that the person no longer has the disorder. Many clinicians interviewed cited this as a reason that patients longed for a different mental disorder, which they perceive would make a 'cure' more achievable:

Interviewee 8 (Clinician/Supervisor): *“Just like any other medical condition. If someone is having chronic sinusitis, we can help treating the fever but not the chronic. Therefore in Personality Disorder, we ask what are the symptoms we can treat, as cure is probably not possible. But it can be improved”.* (T:8,P:7-8,L:352-358)

Lack of acceptance of Recovery principles mean some PD patients perceive that they need services, even when recovered. All interviewees stated that this was the case; however they varied in their reasoning. Some explained that it is due to patients fearing being unable to cope alone, and some anchored reasoning to early-life trauma which triggered 'being unwell'. This second point is under-researched in relation to PD, but underpins discharge struggles:

Interviewee 1 (Clinician): *“The other thing is discharge, if you are nearing discharge there will be a crisis, or something will happen to prolong discharge”* (T:1,P:10,L:452-454)

Interviewee 1 articulates the struggle in a generalised manner, indicating that it is an occurrence in many rather than few cases. This is expanded upon by interviewee 3:

Interviewee 3 (Clinician): “*Bloody hard work. I think why they are the hardest work because they want you, and even if you get to the point where you are discharging them, they come back straight away.” (T:3,P:4,L:242-246)*

The language that interviewee 3 uses indicates a physical struggle, and also an anticipation of return. In answer to the research question posed in this study, it highlights a need for additional support for clinicians, should discharge be anticipated. Additionally, wider systemic support is required to uphold boundaries via the discharge process, detailed by Interviewee 9:

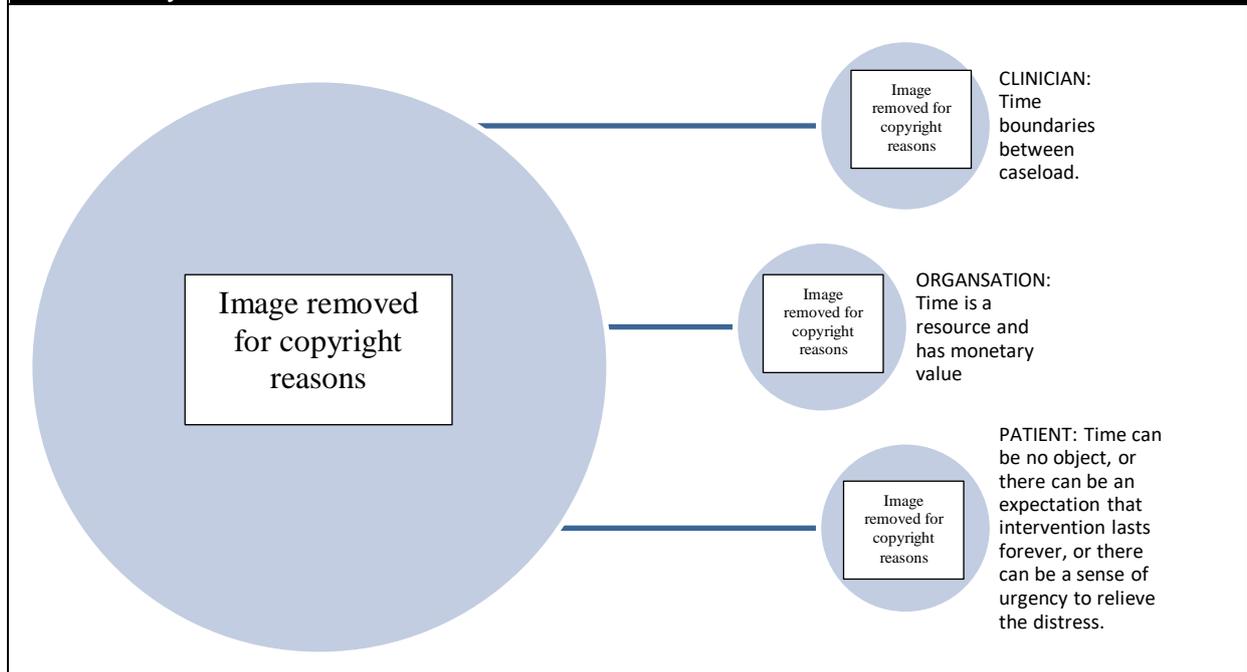
Interviewee 9 (Clinician/Supervisor): “[on discharge] *I have then sent a really nice letter saying that if you do want to come back, the door is open. I mean we don’t want those people to feel that they cannot come back, or they have to come back under the Mental Health Act, so we almost need like an ongoing care plan, or a WRAP plan with the GPs, about how they come back into services*” (T:9,P:14,L:688-695)

This excerpt suggests that re-entry must be planned for, to support discharge and also manage disengagement processes, indicating that it must be done in a compassionate way, to avoid causing disharmony, which may affect the relationship if re-engagement occurs.

Theme Summary:

The time theme has multiple aspects that can impact upon the Treatment Choice Encounter. The research question asks how clinicians can be supported to make choices, one of the ways is to understand how the different perceptions of time, time limits, and time costs, may conflict. Figure 25 provides an example of how time may be prioritised differently for those involved:

Figure 25: Conflicting time demands diagram developed through the IPA analysis of transcripts exploring the phenomena of treatment choice working with patient with a Personality Disorder



To help the clinician make the decision, there are suggestions within the subheadings above that certain types of support may be required:

- The need to orientate self and others concerning treatment choices, this can be accomplished by using a tool such as the TCG.
- The need for a clearly defined engagement phase, with time limits that are written into care pathways and also supported by payment tariffs.
- The need to support people to reflect upon stable patients, rather than just unstable patients, specifically concerning the time they have been in service.
- The need to examine systemic approaches to discharge in terms of PD, with the acknowledgement that people will struggle with relational endings.
- A greater focus upon Recovery Model principles, within all points of contact and diagnostic explanations.

6.2.4 Superordinate Theme D: Meta-cognitive ability

Metacognition relates to higher-order thinking, meaning a person is able to use higher cognitive processing concerning problem management and learning. It is a phenomena that has significant focus in CBT literature over the past 10 years, underpinning therapeutic techniques developed with patients to manage their own mental health problems, and was briefly detailed in the literature review (Bandura,2006), mainly pertaining to patient's experiences.

It is important to reflect here upon the reason for developing the TCG. In asking the research question for this study, anxiety was triggered in the staff group concerning their reasoning ability and use of procedural, declarative, and conditional knowledge, to plan, monitor, and evaluate their experience in the moment. Some clinicians began to question their decision-making ability, and their own internal cognitive heuristic for decision-making. This then caused increased anxiety, connected with meta-cognitive processing. The TCG was created to help the clinician 'think about what they needed to think about' in the treatment session.

Expanding upon this, the interviewees all discussed difficulties in terms of meta-cognitive processes, however many of them did not use this phrase to name their experience. The ability to '*think about thinking*' – or use meta-cognitive processing, was raised as problematic in different ways, explored within the 5 sub-headings below:

D1: Clinician's in-session meta-cognitive ability

Rather than patient's meta-cognitive ability being affected in the Treatment Choice Encounter (as identified in the literature review), pre-research preparation, and research interviewees, identified that it is actually clinicians who have their meta-cognitive processing affected, impacting upon treatment choice:

Interviewee 5 (Clinician): "But with Personality Disorder, it is again complicated, it may be due to self-harm, or high risk-taking behaviour, there is a lot of life events to go through, erm, you know, we need to pick through and think, alright, where is this person, so these will go to clinical discussion". (T:5,P:1-2,L:46-52)

The experience interviewee 5 describes is somewhat overwhelming and complex, and he explains the need to remove oneself from the session to 'think'. In interviews, clinician's in-session meta-cognitive ability was explored, many clinicians identified difficulties concentrating in the encounter, demonstrated by interviewees 1&3:

Interviewee 1 (Clinician): "... the chaos of the crisis, and that's when I think that you lose the direction of the treatment. Because if you just keep plodding on with something that is possibly not effective anymore, then you are going to use the Grid to take a step back, and say where am I at with this person". (T:1,P:7,L:322-328)

Interviewee 3 (Clinician): "You are not going to magically change something that it has taken somebody forty years to get to. That's about a little bit of realism, and to look at what have we got in front of us. That's what I believe in anyway, I believe very much in dealing with need rather than want" (T:3,P:3,L:167-173)

Both interviewees describe difficulty in 'thinking' in the encounter. The need to think about one's own thoughts is also central for both, for interviewee 1 this is because doing things without thinking may not be 'effective', for interviewee 3 this is because a sense of unreality occurs in the encounter, which distorts the ability to clearly think about the decision. Each interviewee identified that the Treatment Choices Grid or other such tools are helpful in-session, by enabling them to 'think' about the decisions they make:

Interviewee 1 (Clinician): *“But if you are with somebody and your mind goes blank, then you can just refer to it. Also if you try and help them see where they are, and you try and help compare them to other people to help them see where they can improve.” (T:1,P:7,L:340-345)*

All interviewees are experienced clinicians, and all describe difficulty in ‘thinking about thinking’ in this encounter. The clinicians also described the experience as emotionally evocative, which can affect the decision-making process, demonstrated by Interviewee5:

Interviewee 5 (Clinician): *“With Personality Disorder over other diagnosis, there can be an emotional aspect of decision-making. Problems can come from either clinicians feeling sorry for the service user, or feeling angry with the service user, or by feeling intimidated. The Grid helps reduce this.” (T:5,P:8,L:384-390)*

What the clinicians appear to describe is that without an anchor, their thinking is influenced by their conditioned past responses to people who have displayed similar behaviours. Over half of the interviewees also commented that this can sometimes adversely affect the encounter:

Interviewee 2 (Clinician): *“She was brought back in, but she was so much better than the previous year, so I am thinking, you know, if she had had a year where she basically has not seen anyone and she has got better, then why would we need to give her treatment now?.. So I suppose I had those ideas before I went into the appointment with her. What the Grid helped with is, because she accepted the diagnosis and also accepted talking about it and also treatments for it, she was newly diagnosed, she wanted treatments, so I brought her in. I think that previously I would have said, well, no you don’t need the interventions, but since having the Grid it made me think again”. (T:2,P:2,L:58-75)*

As a part of the research, supervisors have begun concentrating more upon people's emotional reactions to people with PD, and techniques enabling meta-cognitive processing, including managing one's own emotional reactions to certain behaviours. Interviewee6 explores not only the new intervention that has been raised through posing the research question, but also certain situations that may hinder the clinician's ability to use meta-cognitive processing:

Interviewee 6 (Clinician): “We can then explore the fact that working with these people is not just about the interventions or treatments that you give, it’s about how you feel on the day, how you react to what they do, and how others react as well, either their family or other clients. I think that this is really important in order for us to remain compassionate and not to do things that may damage people, clients and staff. I think that people with Personality Disorder remember lots of things we say, and we need to be careful about what we are saying and how we are saying it, in order to remain engaging but also boundaried”. (T:6,P:11-12,L:567-580)

The ability to think clearly and make decisions is not only linked with emotional arousal, but also the clinician's physical health state.

Interviewee 8 (Clinician/Supervisor): “This parallels with the Grid, because you may exclude some patient from treatment by using the Grid on one day that is not representing the person typically. For example, you have come to interview me today in the morning; if you come at lunch when my blood sugar is down, I might not be able to respond in the same way.” (T:8,P:14,L:689-695)

This raises an interesting point when considering how we can support clinicians to make decisions. It indicates that there may be better times of day to plan Treatment Choice Encounters, and also suggests a need to ensure staff take appropriate breaks and attend to their diet to support others.

Clinician vulnerability was a final point raised. This concerns the clinician’s ability to manage feelings evoked within themselves, and be mindful of potential transference and counter-transference responses. Interviewees 10&1 provide two different examples of ways in which the encounter may be affected due to clinician vulnerability, and the effects this can have upon meta-cognitive processing:

Interviewee 10 (Clinician/Supervisor): “[Relating to the supervisory process]It is the client sometimes who’s like; ‘give me therapy’ but it’s more the ones who just are genuinely just like they can’t cope, and they’re the ones who pull our heart strings” (T:10,P:18,L:857-860)

Interviewee 1 (Clinician): “sometimes they make me feel a bit anxious and a bit like I’m not very good at my job if they are constantly asking me questions, and I’m having to feel that I cannot give them the answers without saying that I have got to go back and look at whatever, but with the Grid in the room, then I can refer to it in the session, which helps”. (T:1,P:8,L:357-364)

These two excerpts are quite different, but pertain to the same subject; the need to support clinicians who conduct these types of encounters. Interviewee 10 proposes that clinical supervision is a positive way to regulate and monitor this process. Interviewee1 takes a different approach, which is to remove herself from the encounter, personally reflect, and use a tool such as the TCG to review the situation.

D2: Patients meta-cognitive ability

The literature review revealed the difficulty that PD patients have in terms of meta-cognitive processing (Williams et al, 2007), therefore there will not be significant focus on this concept within this section, except to say that research findings are supported. An example is provided by interviewee 6:

Interviewee 6 (Clinician): “Some people in this area think that they are dissociated, or that they can’t work on their problems. But often what is happening is that they are responding in a way because of their past experience, and their ‘detached protector’ [Schema Therapy; Young et al 2003] is taking over. What we need to do is make sure that they are aware of what this is, and that it is within their control to problem solve around this, and then they can do some work, but for some people this is not possible” (T:6,P:9,L:442-452)

Another experience described by the interviewees concerns discussing the chaos of a patient's life, and how this appears to function as a meta-cognitive avoidance strategy, demonstrated by interviewee 6:

Interviewee 6 (Clinician): “For these clients it is just too much sometimes. So you help them concentrate on one thing, rather than being chaotic and focussing upon everything and becoming overwhelmed. They just need you to help them focus on one thing, which the Grid does, and give them that bit of understanding that if they can control one thing then this is a big step for them.” (T:6,P:2,L:67-74)

When analysing this however, care must be taken that perception of lack of meta-cognitive ability is not confused with other factors, e.g. reactions to past traumatic relationships related to a disproportionate power-balance, described by interviewee7:

Interviewee 7 (Clinician/Supervisor): “Because it might be that they don’t want to talk to you because they don’t trust you. They need to tell you all these difficult things, but they need to trust you. And they need to know that you are not going to judge them on all that stuff. So they need to know that all those preconceived ideas that they have about clinicians, that needs to be completely removed over time by developing a therapeutic relationship”.(T:7,P:9,L:428-437)

The results concerning lack of meta-cognitive ability once again reinforce the need for psychoeducation material, as interviewees have experienced patients not being able to think about what was discussed in-session, post-session:

Interviewee 9 (Clinician/Supervisor): *I think people say things in the room, and then they come away and reflect-was that a criticism, that they said that I wouldn’t talk, and obviously if they had the Grid they would see that it is not a criticism, it’s just where people are”. (T:9, P:15,L:736-741)*

A lack of education does not solely constitute a part of a poor meta-cognitive ability. People are only able to think about their thoughts if they are educated enough to reason, and have alternative information to reason with. Some people have not received diagnostic psycho-education, which affects their ability to process, as demonstrated by interviewee 6:

Interviewee 6 (Clinician): “And sometimes when a client comes into service, they don’t understand. They don’t understand their diagnosis, they don’t understand what they want, and they don’t understand what treatment there is, and why his may help them. So engagement, and helping them understand what it is that they need now and what will benefit them is so important, and this is what the Grid does”. (T:6,P:4,L:159-168)

D3: The organisation's ability to think about the person

Personalised care is promoted in all aspects of mental and physical ill-health. This is difficult when there is a system that commissions a specific set of treatments, as personalisation can only then occur within the parameters of what has been set. What the literature review has shown is that services for PD have been established inside services originally designed for non-PD mental health problems. This in itself

poses a challenge for the organisation to think clearly about the individual, and it is a point clearly expressed within the interviewee's experiences.

Concerning the host organisation for the research study, like many mental health trusts, the portfolio of services is large, therefore it is a challenge to consider and respond appropriately for an individual inside such a large organisation. This links with the consistency section, as interviewee 3 describes an anonymised encounter:

Interviewee 3 (Clinician): "I don't think we've got it wrong necessarily, I think it's a challenge. A challenge for the organisation, as in the NHS. Because I believe that actually, when – say, Bill, who shouts a lot, gets to the end of his three years, and shouts a lot, and goes to the press and makes a complaint etc, and said that this has happened, and that has happened, and demands more treatment. I suspect that the NHS and we as a Trust will say - well ok, you can have more of a service. But some other somebody, not Bill, or somebody who is not as confident, when they get to discharge they will go – oh, alright then. Then it is the quiet ones that will always suffer." (T:3,P:7,L:309-323)

This description suggests that despite national guidance for treatment duration (DoH, 2011e), these will be overridden locally if required, which is in a sense personalised, however it does not indicate parity. Interviewee 3 describes people with a certain type of PD who may be able to override parts of the system, and therefore breach the boundaries, potentially causing a rift between the clinician and the organisation.

When considering organisational effects regarding the Treatment Choice Encounter, interviewees did not just discuss their own organisations, they also discussed the impact of other organisational value systems, approaches, and budget cuts:

Interviewee 6 (Clinician): ".. it is also at times about Benefits, and also about criminal justice involvement. We are getting a lot of people coming through now because the prison service and the probation service are having cutbacks like the NHS is. This is meaning that some people have put into their release that they must come to mental health services and they have a Personality Disorder. These people often don't attend, and if they do they are quite medication-focused. Often with Benzo's. I use this Grid with probation and other agencies because it helps them get why we are saying that the person won't work. I think it's difficult, because it's not just about us making treatment choices, but it is about other people's perceptions of what we do" (T:6,P:10,L:477-494)

The link interviewees have made concerning the changes in direct organisational responsibility, and allied organisation's approaches for people with PD, affects the ability of the clinician to think fully about options available and contractually obliged within the session itself. This affects the meta-cognitive processing ability of the person, and therefore the type of 'logic' that they applied to this type of encounter, highlighted below by interviewee 10:

Interviewee 10 (Clinician/Supervisor): *“and it goes through all levels, because the person with Personality Disorder themselves finds it difficult every day to apply logic to any situation... they have got so much stuff going on that... you know, the window of tolerance is so small, they have they can't think logically. Their frontal lobes are often closed to thinking logically, and that gets replicated throughout the ways of, um, social circles around them. I think it's very common that.. for any service that is managing Personality Disorder... it is surrounded by illogical thinking, you know, if you get a group of professionals together who want to talk about working with Personality Disorder ... patterns, like:- meetings get cancelled at the last minute”.* (T:10,P:6-7,L:289-303)

Interviewee 10 is not just describing the experience of the Treatment Choice Encounter here; she is explaining how she perceives that different systems consider, and behave around, planning for PD services. The last two lines suggest that the behaviour is not always a conscious one, but one that is systemic, powerful, and has 'ripple' effects that affect treatment choices.

Interviewee 3 (Clinician): *“I suppose the difficulty is, within our payment by results, this guy should only be in the service for up to three years or whatever. Actually are we doing this chap a disservice? Or actually, do we say that there are this cohort of people that will need longer-term, lower-level services such as this and actually it maintains their stability. I am not saying the service is not right..”* (T:3,P:6,L:289-300)

Interviewee 3 also discusses the impact of higher-level organisations when considering funding streams, and a reason why he perceives that a model which fits other types of mental health problems may not fit a person with PD. Both this viewpoint, and the point he makes about the funding streams, have an impact upon

the Treatment Choice Encounter. This viewpoint is to some extent reflected in the literature review, but without such personal comparisons and contextualisation.

D4: The impact of Cognitive Dissonance

Cognitive Dissonance is discomfort caused by having inconsistent thoughts, beliefs, or attitudes, concerning a certain attitudinal change or behaviour decision. It is linked with meta-cognitive processing, because it is important that we think about an issue if two conflicting viewpoints are held, otherwise this can have a confusing effect on decision-making.

Examples of cognitive dissonance and meta-cognitive dissonance were evident within the Interviews, an example is provided by interviewee 4:

Interviewee 4 (Clinician): *“I think that we have seen a switch in our attitude over the past few years. So rather than the fact we don’t want anything to do with them, we are now feeling that they are nice and we feel sorry for them, but I think it is more about being more caring, but also what is best for the client. So when you have someone with a Personality Disorder, it is important that everyone is looking at that person in the same way and saying: Are they in need of an actual mental health service treatment and engaged enough to access that treatment? Rather than just: do they feel sorry for them or not. Because sometimes, looking after people isn’t the best, and it can be damaging and make them more dependant in the long-term.”* (T:4,P:5-6,L:235-251)

The different viewpoints held by the same clinician are: feeling sorry for the patient, despite having a past view of ‘*not wanting anything to do with*’ the person with a diagnosis of PD. The effect of cognitive dissonance in this sense appears to be that people can either become overinvolved, or provide inconsistent treatment decisions, due to the conflicting feelings they experience.

The differing opinions about a similar concept are also linked by clinicians to the diagnostic debate which they have cited as central to the Treatment Choice Encounter, described by interviewee 4:

Interviewee 4 (Clinician): *“We get a phenomenal amount [of referrals] every week with symptoms of Personality Disorder, but no symptoms of Bipolar. Yet the GP refers them in for an assessment for Bipolar, and that is what they are expecting to have. For people it seems much more palatable, everybody wants Bipolar rather than a Personality Disorder, despite the fact that we as health professionals know that it’s a horrific disease, and the majority of these stars that say that they have Bipolar also may not have, and may have a Personality Disorder....It’s like we have got a guy at the moment who has got a narcissistic PD diagnosis and EUPD, his partner could have accepted if he has got Bipolar, ‘cause somehow she could have accepted that this would have in some way meant that he was not responsible for his abusive behaviour towards her. But when PD was diagnosed she left him, and she said, ‘you know, I knew it was going to be that’. His behaviour was appalling, and it shouldn’t matter what you call the mental illness, but it does, and it mattered to her and him. And that’s why she left him, she said she may have stayed if it were Bipolar.” (T:4,P:7,L:306-337)*

The inability to explore and assimilate the two opposing viewpoints is a significant sticking point for some people with PD, and services enabling the separation of these viewpoints may be a part of this, as demonstrated by interviewee 3:

Interviewee 3 (Clinician): *“But actually I think he sees coming and sitting here as actually his time that he has to talk, but that he does not want to talk about it at home. They all know that granddad or dad goes into the shed and burns himself every so often, but they don’t talk about it. And this is his place to come where he is away from home, where he can talk about it.” (T:3,P:6,L:60-72)*

Interviewee 7 suggests that there is also a problem with the fact that people with PD can hold two viewpoints - that they do/don’t want treatment at the same time, causing in-session conflict:

Interviewee 7 (Clinician/Supervisor): *“A systemic problem in that, the GP has referred them because they have got all these problems, and the GP wants you to deal with this. Then, when you see the individual, they don’t want to deal with that problem, or they do not tell you about that problem that the GP has described. They have got this Personality Disorder and the treatment is required”(T:7,P:8,L:364-371)*

Care must be taken to clarify whether the engagement issue described by interviewee 7 does concern cognitive dissonance, and is not due to another aspect of the person's symptoms, described by interviewee 9:

Interviewee 9 (Clinician/Supervisor): *“Sometimes people do actually just need time. And I think that there is a problem with this in the current service model, because there is a pressure on caseloads, and a pressure on number of appointments. So that the minute a person says that they don’t want to see you, that you need to discharge them, and I think sometimes that they just need time.”* (T:9,P:13,L:642-649)

Interviewees describe struggling to make discharge decisions in the encounter, linked with the different viewpoints they hold regarding risk management:

Interviewee 10 (Clinician/Supervisor): *“he is not responding to medication, practically he is not psychologically-minded, the clinician is like tearing her hair, out because she doesn’t know what else to do with him. She thought... she said, can you give me any ideas, and it’s disappointing, but I can’t do anything with him, because he is no way in a million years he is going, I have actually seen him on the ward, and he can’t respond, you know. He is very, very stuck, but he is of an age and situation that he presents as high-risk for completed suicide, mental health issues, so I don’t see that he is somebody that we can just discharge, because there is something about him that is quite risky”.* (T:10,P:14,L:629-642)

Interviewee 10 provides examples where cognitive dissonance affects discharge processes and clinician's perceptions of what interventions they may be providing, inside and outside of the Treatment Choice Encounter. The interviewee continues, arguing that supervisees who have a rigid viewpoint concerning what therapeutic treatments are, struggle with the concept of the role of ‘therapist’ within the team:

Interviewee 10 (Clinician/Supervisor): *“The thing is, I think they do a lot of [therapeutic] treatment, that they don’t feel like it is treatment. But if you ever say to them that they are doing treatment, they get really, really, anxious about that, because they think it’s not their role.”* (T:10,P:16,L:751-755)

Interviewee 10’s example cannot be considered as representative of the whole sample, as only her supervisor and one other clinician described this experience. Despite the lack of statistical representativeness, the experience provides rich

information when considering the movement towards therapeutic workforces and multi-professional working.

D5: The impact of vacillation: idealisation and denigration

The ability to think about treatments, while managing emotions triggered by evocative behaviours, can result in idealisation or denigration in the encounter.

Interviewee 7 provides a specific contextualised example:

Interviewee 7 (Clinician/Supervisor): *“some of the antisocial ones are quite charming. They make you feel like they are the victim. Quite often they might come to you via the criminal justice system, you know, so the client may be trying to hoodwink the system into thinking that the reason why I committed this crime is that, the reason that I have beaten my wife, or my child, or the reason that I have been looking at child pornography, is that I am not well. Or that I need the mental health label so that I can escape the criminal justice. Some of them come in that guise. A lot of them come in that guise....Erm, and so some clinicians feel sorry for them and want to take care of them, some clinicians, are just completely disgusted.” (T:7, P:12,L:576-560)*

The presenting difficulties evoke strong emotional responses, which can result in either idealisation (‘feel sorry for’), or denigration (feel ‘completely disgusted’ by) of the patient, which can affect whether a person is offered treatment or not. This factor was discussed in the literature review when considering behaviours that evoke value-laden responses (Brown et al, 2012), however the concepts of idealisation or denigration in the research primarily focus upon the behaviour being enacted on behalf of the patient, rather than the clinician (Evans, 2011). Interviewee9 also provides an insight into the potential consequences of this type of engagement:

Interviewee 9 (Clinician/Supervisor): *“staff sometimes get overwhelmed, and we know that this group of patients can be very difficult to work with. If they are in placement, or if they are ringing up saying ‘I don’t want anything to do with you’, it is quite easy to think actually, it would be easier for me to discharge, and I will get more reward out of that group that will work, that group that is less abusive, complain-y and resistive, than with this other group”.* (T:9,P:4,L:173-182)

When the interviewees did reflect upon the idealisation and denigration that they experienced from the patients, it conformed with the descriptions from the literature review. Interviewee 10 describes the potentially detrimental effects, should the clinician reciprocate and enact the role which they are expected to do, due to either the idealisation or denigration. In this example, the clinician's meta-cognitive ability to recognise the idealisation and not reciprocate, prevents the encouragement of dependency:

Interviewee 10 (Clinician/Supervisor): *“but what they do is, they go into ‘I’m stuck, I need you’, ‘you’re the answer’, ‘you’re the oracle’, and that point you get a lot of pressure...”* (T:10,P:4,L:190-193)

The interviewees that provided most of the examples of this behaviour in the Treatment Choice Encounter are clinician/supervisors, however it is also mentioned by clinicians. Another point that was not found in the literature review, but has been described by interviewees, concerns the behaviour of the current health and social care system towards people with PD. Interviewee 9 describes what appears to be a similar vacillation effect, which results in destabilisation of the patient:

Interviewee 9 (Clinician/Supervisor): *“It’s like you get all the care you need, or you’re out the service and you get nothing, because there is no primary care service for Personality Disorder. It’s like a really Borderline process in itself, all or nothing.”*(T:9,P:15,L:712-717)

A final point raised concerning this issue, pertains to the multi-professional working practices of a team; Interviewee 10 explained the danger of unilateral decision-making for people with PD:

Interviewee 10 (Clinician/Supervisor): *“it is very unhealthy for a team to leave the responsibility for deciding referrals just with the therapist in the team, or with just one worker. It has to be a team decision, you know, and because that fits in very much with the idea of the ‘Recovery Model’, and team-working. And if you leave... if you leave the therapist as the person who makes the decisions, and they remain oracle, and the expert, and the special kinda care person, a magical mystery tour, you know, that we are trying to get away from, you know, psychology used to be like that, the ivory tower.”*(T:10,P:9,L:397-408)

Category Summary

Within this section, the effects of meta-cognitive processing have been discussed in terms of the Treatment Choice Encounter. The findings from the interviews are consistent with those of the literature review, in that people with PD will often struggle with meta-cognitive processing, and subsequently display a difficulty in thinking about their thought processes, problem-solving, and also coping with boundaries within Treatment Choice Encounters. This can result in un-boundaried and sometimes aggressive interactions, consisting of either: 'ad hominem' attacks upon clinicians, or alternatively idealising clinicians.

Findings from this section that are outside of those in the literature review, are that there may be similar processes at work from the clinician and organisation which affect the encounter. A first indication of this was when the research project was initially discussed, resulting in a destabilised response from certain clinicians, prompting the development of the TCG, as a part of the AR process.

The TCG appears to have been effective in allowing research exploration of the subject matter, however it has also raised different points concerning people's meta-cognitive processing in the encounter itself. Clinicians and Supervisors have reflected on the TCG's effects, suggesting that they act as an orientating, containing, and grounding factor in the encounter, which enables a more consistent approach to treatment choice. This is summed up by interviewee 6:

Interviewee 6 (Clinician): "I use the Grid for my own reflection, not just work with the client. To see what am doing, and whether I am making a difference. Because when you are working with this client group, and it's chaotic, and chaotic, and chaotic, and you think you are going wrong at times, don't you? Whereas if you look at this Grid, and think actually no, I can see that they are struggling to understand or accept their diagnosis, so I have got to help them do this, so I am doing everything right, and it's reassuring. It's making us feel reassured as clinicians, I think". (T:6,P:7,L:306-317)

6.2.5 Superordinate Theme E: The potential for iatrogenic harm.

The literature review suggests that with people who have a PD, there is a need to consider the potential, not only for whether the available treatment will be effective, but also consider the potential negative effects of certain types of treatment (Castonguay et al, 2010). What the interviews demonstrate is a more in-depth and personal experience, recounting how experience in clinical practice can impact upon decision-making. The theme of potential iatrogenic harm is then split into five further sub-categories, explored below.

E1: Passivity as opposed to active engagement

Over half of interviewees described a passivity phenomenon in PD patients they have assessed. They particularly described these as being patients who may or may not accept their diagnosis, but reject active treatment. Interviewee 6 explained that passivity is clear in many of the patient's relationships, not just the care relationship:

Interviewee 6 (Clinician): "People who are being exploited, or other people are taking advantage, rather than them self-harming, because again it is about enabling them to take control, encouraging them not to be dependent upon their people to problem-solve for them, but instead encouraging them, and helping them to learn to develop problem-solving skills of their own" (T:6,P:5,L:219-227)

Interviewee 6 demonstrates the risk to the patient if this type of relationship is formed, she explains that passivity causes dependency on others, and a potential then for 'exploitation'. The transcripts show a level of increased effort on behalf of the clinician rather than the patient, suggesting passivity. This is demonstrated by interviewee 2:

Interviewee 2 (Clinician): "Sometimes I think that they'll come along and yes, they understand it, but I.. I don't want to say the 'cup of tea' visit, because we try not to do that. But they come along, and in the review clinic we review what we planned from the last visit, and say - this is what we planned at the last clinic review, and have you done this, this, and this. And they say, no, no, and no." (T:2,P:6,L:263-271).

The disproportionate effort is clearly frustrating for the clinicians, reflected in the violent language that they use, interviewee 2 continues:

Interviewee 2 (Clinician): *“there is also a little bit of ambivalence or being unsure. And you have to kind of work with them a bit to be sure, or give them that bit of a kick... obviously not a real kick, or that bit of a shove, to make sure that they are ready”* (T:2,P:7,L:329-334)

When this passivity was identified, the clinician struggled to consider the next stages with these patients, specifically in making the treatment choice to discharge, as described by interviewee 1:

Interviewee 1 (Clinician): *“... they say that they need more appointments, or they need to see someone more frequently, but some of them don't say why, or what they think that they would need within that other appointment. So we say ok, you are offered an appointment that you come to for an hour, but you are saying you are struggling between appointments, but you are not getting in contact with us. You can contact us by phone, and we have an emergency appointment slot every day in the clinic, which it would be possible for you to have if you contact us. But they don't do that. But then they say they need more support.”* (T:1,P:9,L:408-422)

Many interviewees describe a power-shift in the relationship, related to patient passivity, resulting in a degree of psychological control over the clinician, Interviewee8 summarises this feeling succinctly:

Interviewee 8 (Clinician/Supervisor): *“We clinicians are tools used by the patients”*. (T:8,P:8,L:366-367)

This dynamic does not appear to have been fully researched when reflecting upon literature review findings, but is a reinforced interviewee experience. Interviewee7 explains how the therapeutic relationship must be monitored for passivity, as there is a sense that the patient is trying to form a ‘friendship’ and ‘caretaker’ role, rather than a role requiring active engagement:

Interviewee 7 (Clinician/Supervisor): *“they have got a genuine problem, but they don't want to do anything about it. They are just happy to have it, and they have got a friend in you. They have got their benefits and they are being looked after. All they want is to be generally looked after, they don't want responsibility”*. (T:7,P:10,L:486-492)

Passivity-roles are linked with the overarching theme of iatrogenic harm, as they are damaging for the patient, clinician, and the wider system. In terms of the research question, focusing upon managing passivity, and being actively aware of iatrogenesis, may aid clinicians to make treatment decisions.

E2: Chaotic lifestyle factors fuelling difficulties

'Chaos' is described as an obscuring factor that fuels difficulties. The message that interviewees convey is: unlike people presenting with other disorders, people with PD have multiple issues occurring in their life at one time, all of which they feel that services must help them with. This is demonstrated by interviewee 6:

Interviewee 6 (Clinician): "It's like a jigsaw, it's not just one thing with these clients, it is like a jigsaw, and it takes them to have a lot of pieces for it to start to come together" (T:6,P:6-7,L:299-302)

The comparison to a jigsaw is a repeated theme in other transcripts, thematically this could indicate two issues: firstly that the encounter is metaphorically a 'puzzle', and secondly, that each of the pieces require focus. Interviewee 10 demonstrates how people can become distracted by certain parts of the jigsaw, or certain behaviours:

Interviewee 10 (Clinician/Supervisor): "A bit like the lady who, um, kind of cuts her genitals, it's so full-on that everyone forgets about why she did that in the first place, or you know, whether they have done something which could kind of increase that behaviour, you know, there is no thinking around that, because it's just too- you know". (T:10,P:22,L:1031-1037)

Perspectives concerning treatment choices required for people with PD appear divided in the transcripts. The majority of interviewees discuss the need for short-term crisis-type problem-solving intervention, some advocate more longer-term in-depth work. Interviewee 4 advocates short-term intervention, due to the potential dependency factors:

Interviewee 4 (Clinician): *“I believe that with these people, triage is often an intervention in its own right, because you can do a lot to sort things out and signpost and educate at this part, which is mostly what these people need.”* (T:4,P:14,L:675-680)

Some clinicians state that it is important to make a differentiation between those patients that require short-term crisis interventions, and those requiring additional support:

Interviewee 5 (Clinician): *“These people often enter services when they are extremely distressed, or require help in solving one issue, such as Benefits, or problems with the criminal justice system, or relationship problems. The service user in this bit [indicating 4th Treatment Choices Grid quadrant] may engage for a short time, however they may also discontinue their engagement after the crisis is over, and may not need services longer-term”* (T:5,P:7,L:312-322)

Enabling clinicians to consider containment, and what is required to help them to feel contained when dealing with chaos, appears to be a core part of the encounter.

Interviewee 10 details this:

Interviewee 10 (Clinician/Supervisor): *“the house is about to be repossessed... you know, and then they just couldn’t possibly cope with therapy at that point.... you know, so therapy isn’t the answer. But, the staff member feels the pressure to treat because of the person is like, ‘do something!’, ‘I can’t cope with this’, you know, it’s in some cases it’s not that the client is saying you do it, it’s like they literally can’t think straight anymore, and they are just like, please take this away from me.. They are also asking for somebody just to help them feel more contained”* (T:10,P:18,L:824-836)

E3: ‘Doing for’ - creating dependence

The third category in this subsection refers to the repeated theme of ‘doing for’ that arose in the transcripts. This theme is connected to patient and referrer expectations about what mental health services are going to ‘do for’ the patient, which does not always match the service remit. Interviewee 4 provides an example:

Interviewee 4 (Clinician): *“They ring up and say I’m referring them and you are going to do this. And if we said we are not, they would not be happy”* (T:4,P:2,L:59-61)

Another difficulty interviewees discussed related to certain clinician's need to 'do' something for the patient. This could be considered as a form of transference or projection, or it could be anchored in the clinician's vulnerability. This is demonstrated by interviewee 7:

Interviewee 7 (Clinician/Supervisor): *"So, engaging one minute and then disengaging. And the psychologist felt a bit like she had come to the end of the road. So, like she felt that she had to do something"* (T:7,P:1,L:44-47)

There is a need for the clinician to be supported, to reflect upon the balance between 'doing for' and enabling people to 'do for' themselves in the Treatment Choice Encounter, highlighted by interviewee 2:

Interviewee 2 (Clinician): *"... have got this person and she will take up a lot of time, and the family will take a lot of time up. These people often come in and just want to off-load'. They don't do anything to get better, and they don't want to do anything if it is offered, but sometimes they just want to moan"* (T:2,P:9,L:426-432)

There is a sense of difficulty in the way the interviewees discuss this issue, some describe the need to reduce dependency, yet correspondingly demonstrating encounters where they do the opposite, as highlighted by interviewee 3:

Interviewee 3 (Clinician): *"I think with this chap, he talks to me because he trusts me, he trusts that I am a nurse, and I work for the NHS, he knows that I am not in a special place. But he doesn't really want to talk to anyone else about it. I don't know, I think it might be because I ride a bike and he rides a bike. I don't know, but whatever it is he talks to me, and he doesn't want to go that deep into it, but he talks to me just enough."* (T:3,P:6,L:276-285)

When discussing the topic of 'doing for', it is linked in the transcripts to the iatrogenic concept of dependency, as described by interviewee 6:

Interviewee 6 (Clinician): *"Because especially with this client group, you can do more harm doing things that make them too dependent, than not doing anything at all"* (T:6,P:2,L:82-85)

The interviewees describe the sensitivity needed in managing this subcategory:

Interviewee 7 (Clinician/Supervisor): “So I think it had something *to do* with the clinician feeling unsure and feeling like they had to do more. The need to ‘do’ was important for the psychologist, it was the real problem. In fact she said that the client said to her that she felt that she was not doing enough for her. So she has two conflicting feelings, on one hand she feels that she is not doing enough for her, but on the other hand she feels that she is doing a lot for her”. (T:7,P:4,L:154-163)

The ways in which clinicians discuss the patient's need for help to make treatment choices:

Interviewee 6 (Clinician): “I said well, you know, we are keeping you here, we are pacifying you. We are running out when you ask us to, but this is not helping you to move forward. And this is keeping you here (demonstrated on TCG). We are not helping you deal with these urges and do something different. I said, ‘what can we do to help you with that, without running out?’ This is important, as it’s the running out that makes the person more dependent on workers, rather than feeling that they are able to cope with whatever the problem is that they are encountering” (T:6,P:4-5,L:197-210)

E4: Medication as an avoidant strategy

The literature review demonstrates that medication can be a treatment intervention for people with PD (Beutler et al, 2012), however there appears to be a disproportionately represented focus in the encounter, and the support for medication use is varied, certain medications are referred to by clinicians as ‘avoidant strategies’ rather than active treatments, highlighted by interviewee 2:

Interviewee 2 (Clinician): “Some of the people we see are quite focused on medications, and medication is not always helpful in Personality Disorder, and they need to engage, which would help them more, and they need to work towards changing themselves, which they are sometimes reluctant to do”. (T:2,P:3,L:105-111)

The issue of patient expectation is raised here, connected to the provision of medication. Unlike in the literature review, where research primarily focuses upon whether a particular medication is effective or not, when considering the transcripts, interviewees focus more on wanting medication to make problems “go away”, as described by interviewee 9:

Interviewee 9 (Clinician/Supervisor): “I think this has been a problem, and when you refer clinicians to incorporate the Personality Disorder into a narrative, and you try to put the Personality Disorder diagnosis into the psychoeducation with the patients, its frowned upon, because people become unhappy by your response, because you are not saying; ‘here’s a high dose of an SSRI and all your problems will go away’.” (T:9,P:8,L:396-404)

The difficulty with this expectation of medication is that it is unrealistic. Distress is not switched off by any psychiatric medication, however there may be a dampening effect with certain medication. The perceived medication misuse has a cross-over with substance misuse, aimed at the same type of 'numbing' effect; as described by interviewee 8:

Interviewee 8 (Clinician/Supervisor): *“Again there is the issue of expectations, say if they come with some substance misuse. They are expecting they can get whatever they want. To legalise what they are taking illegally. So we have to be aware of this” (T:8,P:10,L:479-484)*

In the transcripts, where prescribers were interviewed, they particularly highlighted difficulties with evidence, in terms of some of the medications that have been provided for people with PD, highlighted by interviewee 4:

Interviewee 4 (Clinician): *“Why they would just want a medication to cure them, which doesn't work long-term, but they don't want to engage? We should be looking at this more. And actually, we know that the prescription of Benzos is discouraged, but instead of dealing with this, what has happened is Benzo prescription has gone down, but antipsychotic prescription has just been used as a substitute. And we know that antipsychotic prescription has harmful effects and shortens people's lives.” (T:4,P:13,L:618-628)*

The issue of 'cure' is raised again here, the unrealistic view of cure is evident within the language that certain clinicians use, for example interviewee 2:

Interviewee 2 (Clinician): *“Sometimes I struggle. You know, they are not accepting it, or sometimes they are asking for treatment such as the 'magic pill' again. And, you know, they have just seen a Consultant who has reviewed their medication, then they come into me and they say 'it's not working'. But it's what their expectations are about what the medication will do. But they say that 'everything's not working'.” (T:2,P:5,L:214-222)*

Interviewee 2 appears to suggest that the wish to have medication prescribed is for it to do something 'magic', rather than what the current medications can do. This suggests an unrealistic expectation of medication that is not healthy, but sought by patients coming to Treatment Choice Encounters, linked with intolerance of distress, which is a core symptom of PD (WHO, 1992).

E5: Risk and personal responsibility

All those interviewed linked a low level of personal responsibility in a patient to the potential for a high level of dependency on a mental health service, and a subsequent struggle with boundary management and discharge process. The notion of personal responsibility for patients is not described as a static risk factor, it is instead described as fluctuating dependent upon stress levels, as demonstrated by interviewee 4:

Interviewee 4 (Clinician): "So an example would be, for Mrs Smith, every October, because it is the anniversary of her son's death, she becomes unwell and tends towards self-harm, so why don't we put that in the plan, that services should expect contact at his time, and this is the type of intervention that Mrs Smith would like, and she will not need anything after this time. And so what she does is go into the crisis bed for a few days, and then she is back out of services, not referred into a treatment team. In this way, Mrs Smith would know she had been heard, she would know she was cared for, she would know that the service is available to her, so she does not have to demonstrate her distress or risk to get it. And the crisis is averted." (T:4,P:16,L:793-808)

This suggests that the clinician role in the encounter is to understand whether what has caused the relapse is a recognisable and manageable trigger in the short-term, or whether it is something that requires a longer-term service. The ability to take responsibility for treatment is linked with risk management, as highlighted in the literature review (James et al, 2007; Dimidjian et al, 2010).

The expectation for the service to provide purely risk management interventions for people who do not wish to have active treatment is central, and connected to teams feeling over-committed, as demonstrated by interviewee 1:

Interviewee 1 (Clinician): "Sometimes they are referred in more for risk management rather than treatment. But sometimes they are referred in for treatment and they just don't want it, and that is a real difficulty for us, as we are a treatment team." (T:1,P:4,L:171-175)

The discussions concerning how risk should be managed vary in the transcripts, certain transcripts are clear about discharge processes and disengagement processes for PD patients, as described by interviewee 2:

Interviewee 2 (Clinician): *“They have not turned up for 3 appointments, we have tried ringing them, and this, and this, and this, but they have still not engaged, so we are going to discharge them, and we have a discussion with the GP about it, but if there is still concern, we will go out and do a cold call. Which is a lot more than physical services would ever do”* (T:2,P:8-9,L:397-404)

This is not a consistent view taken by all though. The variables that influence decision-making appear to be processes and legal frameworks pertaining to risk and how risk consequences are evaluated, summarised by interviewee 10:

Interviewee 10 (Clinician/Supervisor): *“and talking to the consultant psychiatrists who are the ones who usually take the responsibility. They explained that the problem for them is that when somebody commits suicide they are held up as accountable in different way to a doctor in a physical health service. So a doctor in the physical health service, you know, his patient smoking after he had been told not to, and ends up dying of the illness that, you know, the smoking-related illness, it’s not his fault; if the same thing happens in mental health services it is the consultant’s fault, and that’s what I see to be the problem”*. (T:10,P:14,L:656-668)

Over-engagement due to perceived risk management obligations has ethical difficulties in terms of iatrogenic harm. Interviewees again relate this to potential dependency and potential boundary management difficulties related to Superordinate theme 1. This is discussed by interviewee 9:

Interviewee 9 (Clinician/Supervisor): *“There is one set that we are involved with due to risk, and in some way we over-engage with them. And we intervene because we fear the risks, and we manage the risk, and put them in placements because we fear the risks. And then there is probably people that just don’t want to engage, but because there are not so many risks, we don’t put them in placements or use the Mental Health Act”*. (T:9,P:14,L:664-672)

Actual examples are provided by clinicians concerning patients who have received lengthy treatments, but due to the dependency they have developed, their contact

with services is increased, despite their risk being decreased. One example is provided by interviewee 4:

Interviewee 4 (Clinician): *“Yep, we’ve got a lady in a treatment team, went away to a specialist treatment unit, out of the area. She has mixed PD, and used to cut and harm herself. What she has done is that she doesn’t cut anymore, because the therapeutic unit has shown her how to stop this, however what she has now become is dependent on services, we have helped her to moderate one area of her life which is good, however she has nothing left, and nothing to replace it, so she is absolutely dependent upon our services now. In the team, she is going round telling people how she has improved, because of the reduction in self-harm. And yet in Crisis team we have had more positive contact, she has not been so abusive, her contact is positive, however significantly more frequent.” (T:4,P:8,L:376-393)*

Theme Summary

When considering the core principles of beneficence and non-maleficence, the concept of iatrogenic harm must take the forefront of any support provided to clinicians making treatment decisions with service users. This is a difficult subject when considering the care and treatment of people with PD, as providing any treatment could be considered as potentially disabling, if the treatment means that there is a dependency developed from the individual upon the clinician.

The issue of dependency is described in the literature review, but the impact upon service delivery, over-occupancy of mental health treatment teams, and available management strategies, is not something that is detailed or focused upon in terms of management.

The difficulty expanded upon by the interviewees concerns the fact that this is not merely a mental health service issue, but an issue for the wider health and social care system. Otherwise, if the decision to discharge is made, people can end up returning straight back, because wider non-mental health services have not agreed

to sign up to support them, and there is a wider perceived assumption, i.e. by services such as the coroner's court, where risk management decisions are scrutinised based on non-accidental death, that risk-management consequences in mental health should be evaluated differently, which processes then impact upon care delivery and treatment decisions.

The recommendation is therefore to analyse the risks that exist, and deliver more comprehensive training packages for GP's, linked with the public health need for stigma reduction, so that people with PD could be understood and supported in all systems, not just specialist mental health care.

6.2.6 Clinician results: individual variations

Within the IPA above, indication has been provided where variations between clinicians were found. For a super-ordinate theme to be identified, over half of the interviewees had to have raised the theme, however for the sub-theme, this was not always the case. To demonstrate variation, Appendix 39 is presented, this allows readers to understand the level at which each clinician supported or detailed the theme within their transcript. In providing this figure, subjective differences in results are demonstrated with wider contextual analysis, which is a core principle of IPA.

6.2.7 Clinician/Supervisor results: individual variation

When considering the presentation of the results section, the original intention was to present the clinician and clinician/supervisor results separately. This was due to the assumption by the researcher that there may be distinctly different themes raised by the different groups. This assumption was proved as false after intensive analysis, and analysis of the transcripts by the second researcher.

The reason for this is that the clinician/supervisors reflected upon many of the same issues that clinicians did. Rather than providing significant focus upon their role as a supervisor, they discussed at length their joint role of clinician. They reflected upon their struggles in the clinical encounter, and strategies they have found have helped or hindered their clinician work. This appears to indicate that the issue of making treatment choices is not something that current supervisors have the answer to, but is something that they also struggle with, and would value more research into, confirmed by all supervisors interviewed.

Despite stating that there were similar themes raised, there were a few aspects where the supervisor/clinicians differed from the clinician's transcripts, summarised below:

- The lengths of the supervisor/clinician transcripts were on average 300 lines longer than the clinicians. They were more reflective and detailed in their accounts. It is difficult to account for these differences, however it could be that due to their role, they are more experienced and comfortable in reflection, or have been involved in past research studies.
- The supervisor/clinician's contextualised their experience in different ways, evident from their transcripts; they spoke with more assertion when reflecting upon their direction as a supervisor, however with more uncertainty and vulnerability within their role as a clinician. The confidence in their statements altered, demonstrating they struggled in their clinician role, which contradicted on occasion their advice when reflecting upon their supervisor role (i.e. in decisions such as discharges). This finding appears to be linked to the difficulty in meta-cognitive processing detailed in subsection D1 above.
- The weightings for specific variables differed in the supervisor/clinician and the clinician responses, detailed in Appendix 41, this may be associated with the fact that all clinician/supervisors are also diagnosticians, and 75% are also independent prescribers.

No conclusions are drawn about whether the supervisor/clinician's experiences are more valid than the clinician's. This is associated with the research question itself, which focuses upon how people make decisions. For this reason, the clinical opinion of all interviewees are seen as valid in terms of the results, and what the interviews

have demonstrated is that each person struggles and requires assistance to make decisions, whether a supervisor/clinician or clinician, which has been summarised collectively within the super-ordinate variables discussed above.

The question was asked about what supervisor/clinicians could do to assist decision-making. The factors supervisors stated were the same as the factors that the clinicians also felt may help, these have been discussed in the superordinate themes, but also pertain to having: (1) increased access to appropriate psycho-education (in different formats), (2) consistency in supervisory advice and boundaries, (3) training in MI techniques, and (4) the ability to participate in a multi-professional system which supports decision-making.

6.2.8 Patient outcomes

The questionnaire data collected generated insufficient results. The results that were gained must also be considered as biased, as they were formed only from patients who had insight into their diagnosis and accepted that prescribed treatments may assist them. What the literature review and participant research has shown is that this does not represent the group that clinicians struggle in making treatment decisions with.

Despite the fact that the number of questionnaires generated made this quantitative result insignificant, the process issues that it raised and the discussions it generated within validation groups (which included patients and carers) was a significant result in itself, and one that was not expected.

People who reject the PD diagnosis and/or NICE Guidance recommended treatment for PD constitute an under-researched area, with little reference found in the literature. However, in practice, the interviewed clinicians, supervisors, and validation groups have found that this group is one that is most frequently in contact with acute mental health and physical health services, and the criminal justice system.

This finding is important when considering the research question, it suggests that increased psycho-education may aid a person in accepting diagnosis and treatment, but also suggests that an increased level of understanding is needed about this cohort. This increased understanding is challenging, due to the reluctance of people to engage. It was considered with the validation groups, R&D team, and university supervisors, whether, in order to answer the research question, further research was needed in this study, however as this is not the core component of the question, it was agreed that the research would not be altered, but this finding would be suggested as a post-research strand.

6.2.9 Treatment Choices Grid Outcomes

The aim of the study was not to validate the TCG, however it was appreciated that feedback would be provided which may indicate whether future research is required in terms of its efficacy and validity as a clinical tool. If testing the TCG's validity had been the focus, a different methodological approach would have been used, e.g. experiment method, this is a typical and evidence-based way of testing and validating a clinician tool.

However, an outcome of this research is that a further research study using this format is indicated for the TCG. A brief summary of the reasons for this is presented below, gathered from each different part of the research:

Clinicians and Supervisor/Clinicians: All clinicians and supervisors cited it as a tool they would use in clinical practice. However the reasons for this varied:

- Some interviewees used the TCG with patients, some did not.
- Certain interviewee's expressed that it aided in the education of referrers, and have explained that they have seen a demonstrable reduction in complaints and re-referrals since its introduction, due to the fact it provides an evidence base for treatment or discharge decisions.
- Certain interviewees have used the TCG for individual or group reflection.
- Some interviewees have used the TCG for themselves as a 'grounding' or 'containing' object, which has aided them to focus in the encounter.
- All interviewees reflected that the patient version of the TCG (Figure 11) is the only version they have used in practice, rather than the clinician or supervisor TCG (Figures 12&13).

Patients: Due to the low number of responses received, and the bias concerning the type of patient who replied, interpreting the patient questionnaire feedback must be approached with caution. However what results have demonstrated is that with those who did provide feedback, their experience of the TCG was predominantly positive:

- 86% of respondents found the TCG helpful to the session.

- 86% suggested that the use of the TCG enabled them to understand why a certain treatment had been offered to them at the time of the session.
- 86% suggested that the use of the TCG enabled them to understand why certain treatments had not been offered to them at the time of the session.
- 86% stated that by using the TCG, they understood that as their needs change, so will the treatment choices available to them.
- 79% of respondents found the wording used in the TCG easy to understand.
- 80% of respondents stated that the TCG helped structure their care plan.
- 86% of respondents would recommend that the TCG is used with other people with PD entering this service.

The narrative feedback concerning the TCG has been incorporated in the Superordinate Themes above. This is to contextualise the experience of the Treatment Choice Encounter, which has been affected by the TCG introduction. There is more information contained in the transcripts than has been presented here in terms of the TCG, however the reason for its exclusion is that it may detract from the original research question.

In summary, the introduction of the TCG appears to have been beneficial, both in progressing this research, and funnelling IPA questioning sensitively. However an outcome of the research has not been to suggest whether the TCG is a valid tool, as this would require an alternative methodological approach. If the tool is validated through this future research, then appropriate guidance would need to be provided alongside of the tool, focusing upon not only how to use the TCG, but with whom it should and should not be used.

6.2.10 Results and Analysis Summary

Within the analysis and discussion Section, the research question has been focused upon, alongside the literature review outcome, to generate findings from the interview transcripts provided by clinicians and clinician/supervisors, and the questionnaire feedback obtained from patients.

Analysis has been performed using an IPA framework, and presented in a narrative format under five superordinate themes concerning: Boundary Management, Diagnostic Stigma, Focus on Time, Meta-cognitive Processing, and the potential for Iatrogenic Harm. Each of these super-ordinate themes were cited by each supervisee, however the sub-themes contextualise the ways in which themes were explored and referenced by each individual, contextualised through transcript excerpts. This enables the reader to understand the analysis presented, and appreciate where subjective differences are generated within the collective results presented.

The analysis and discussion section has generated results which can both provide an additional insight into potential locality practice changes, and also areas for future research, this will be explored further within the synthesis and discussion section, including recommendations for practice change and future research.

Section 7: Synthesis and Discussion

7.1 Introduction

This section provides synthesis and discussion concerning how each component of the study compliment and contrast. The section will draw upon both the outcomes of the hermeneutic literature review and interviews analysed via IPA, identifying points of convergence and difference which inform the overall AR study. Aspects of the research participant's experiences which are missing in the literature will be highlighted.

This Section is presented in six sub-sections, within which the qualitative analysis presented in Section 6 above is expanded further in narrative form, as proposed by IPA researchers (Smith et al, 2009). The next three sub-sections will focus upon patient, clinician, and supervisor issues. Narratives and hypothesis are generated, relating to key similarities and differences in how clinicians formulate treatment decisions, and how this affects patient/service relationships. Subsection headings are:

- 7.2: Patient factors related to diagnostic formulation, symptom severity, comorbidity, treatability, and acceptance/perception, which are cited as contributory factors within the Treatment Choice Encounter.
- 7.3: Clinician factors, including personal and professional beliefs and perceived resource availability, which contribute to their ability to manage the Treatment Choice Encounter.
- 7.4: Supervisory factors that have been identified to support the ability to formulate consistent treatment choices and justify decisions.

The sub-sections are structured to encompass the superordinate themes identified in the IPA analysis in reference to the main research question:

How can mental health care staff use a pre formulated guided decision process in the selection of therapeutic interventions for people with PD, within the context of rationalisation and service change?

Each of the sub-sections include a discussion of the overarching issues raised, which illustrate how IPA superordinate themes are related. The two qualitative methods used within the overall methodology of AR have already initiated changes in practitioner approaches to the phenomena of treatment choice, but this section also aims to contribute towards actual practice change. The final two sub-sections presented focus upon study recommendations, and a summary of strengths and limitations.

7.2: Patient factors related to diagnostic formulation, symptom severity, comorbidity, treatability, acceptance/perception, which are cited as contributory factors within the Treatment Choice Encounter.

All of the interviews illustrate the uncertainty regarding changes in diagnostic categorisation and PD diagnosis, often viewed differently to other mental health problems, reflected in the literature review debates (Widiger et al, 2011; Rottman et al, 2009; Pilgrim, 2007) and the current NICE Guidance for PD (NICE,2009a&b). The interviewees suggest that this then confuses the Treatment Choice Encounter, as all clinicians interviewed explained that it is difficult to focus upon whether the person presenting has a PD which requires a specific treatment, or whether their PD traits mean that they may experience other mental health problems (which may or may not require treatment, i.e. depression) differently.

The majority of the clinicians and supervisors interviewed suggested that the variety of symptoms that complicate PD presentations, which differ from other mental disorders (i.e. Bipolar Affective Disorder), means that it is difficult for staff to develop structures for the Treatment Choice Encounter itself, or define whether a patient's presentation is at a sufficient threshold to require the current treatments offered. This point is consistent with the research gap identified in the current PD literature, which suggests there is lack of 'clinically syntonetic' studies that involve tasks intrinsically linked to clinical practice (Castonguay, 2013) and that a standardised or 'one size fits all' type approach is not possible for the heterogeneity of the PD patient population (Ebner-Priemer et al, 2009).

A related theme within many interview transcripts concerned the lack of appropriate diagnostic psychoeducation material for PD patients, different to other mental health problems. The majority of interviewees expressed a desire for better recovery-focussed psychoeducation, which could be used to support patients in the Treatment Choice Encounter, linked to the IPA superordinate themes of: 'focus on time' and 'boundary management'.

The research suggests that the 'Recovery' movement is expanding in mental health, particularly in the field of psychosis, however there is still insufficient literature related to non-psychotic disorders such as PD (Bryan et al, 2012), meaning patients may often focus upon the need for treatments to provide 'cure' rather than 'recovery', which all interviewed stated causes conflict in the Treatment Choice Encounter, and reinforces dependency rather than independence. Through wider reading, the

concept of *'health literacy'* connects these factors in the research, when considering treatment choices for other disorders, but is absent in the current literature for PD.

'Health Literacy' is defined by the WHO (2015) as *"the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand, and use information, in ways which promote and maintain good health"*.

Much is written about the topic in terms of physical health conditions (See figure 26 below), and the need to promote better health literacy with PD patients is consistent throughout all transcripts, however is absent in the hermeneutic literature review. Understanding the factors that promote and hinder *'health literacy'* in this patient group is an important factor in formulating treatment decisions.

Figure 26: Excerpt from the Office of Disease Prevention and Health Promotion (2015) factsheet concerning the topic of health literacy.

Health literacy is dependent on individual and systemic factors:

- Communication skills of lay persons and professionals.
- Lay and professional knowledge of health topics.
- Culture.
- Demands of the healthcare and public health systems.
- Demands of the situation/context.

Health literacy affects people's ability to:

- Navigate the healthcare system, including filling out complex forms and locating providers and services.
- Share personal information, such as health history, with providers.
- Engage in self-care and chronic-disease management.
- Understand mathematical concepts such as probability and risk.

All supervisors and most clinicians interviewed suggested that what this psychoeducation deficit means, is that if either a patient or professional is not *'literate'*, then they have difficulty contributing to formulation processes which provide a rationale for treatment decisions, causing conflict in the Treatment Choice

Encounter. Both the interviews and the literature (Spring, 2007; Hunsley et al, 2005) demonstrate that the ability to formulate complex problems, and convey what parts of PD presentation are treatable, is essential.

Most clinicians and supervisors interviewed suggested that the ability for patients to understand diagnosis and also available treatments, is complicated, firstly due to the health system's prioritisation of certain treatments, and secondly, the patient's perceptions about what treatments may be efficacious for them (i.e. psychology or medications), which may not be aligned with locality service provision.

The subject of systemic prioritisation of certain treatments reinforces interviewee experience when considering the outcome of the literature review. This is because the research sourced demonstrated significant bias in terms of publications derived from psychotherapy and psychology over other treatments (Appendix 3), despite the fact that practice guidance advocates multi-professional team working (NICE, 2009a&b), which underpins locality practice team structure. This disconnect between research and practice generates disempowerment for some professionals, which is highlighted in Section 6 (i.e. Interviewee 3: T:3.,P:8,L:372-387), and is an underpinning factor in the superordinate theme of 'boundary management'.

When considering the patient themes concerning perceived value of certain treatments, literature generated concerning 'expert patient' knowledge (Castonguay, 2013) to some extent may explain why interviewees have a difficulty with some PD patients in the Treatment Choice Encounter, again linked with the notion of 'health literacy'. This is because, whilst interviewees acknowledged that many of the

patients they encounter are 'experts' in terms of their own illness, and therefore able to contribute reciprocally in the Treatment Choice Encounter, certain patients deny that either their difficulties are due to PD, and/or they decline talking treatments, which poses a problem in terms of what treatments they feel may help.

The super-ordinate themes concerning; the potential for 'iatrogenic harm', and 'diagnostic stigma', are related to this, and are points of convergence in both the literature reviewed and the Interviewee reflections. However, an underpinning difference is that the 'stigma' described in the literature is primarily focussed upon the 'other's' (i.e. public) xenophobic perception of the diagnosis (i.e. Pickersgill, 2012; Lewis and Appleby, 1988), whereas in the interviews, clinicians explained there was little effect upon the Treatment Choice Encounter related to stigma from 'the other', instead they cited a major effect upon treatment being personal stigma held by the patient (self-stigma) concerning their PD diagnosis.

The personal stigma that certain PD patients hold, observed by interviewees, interfered with treatment choices, due to patient's preoccupation that 'something else is wrong'. This type of self-stigma was found in a few of the literature reviewed articles (Defife et al, 2012; Moses, 2009), however the literature focus explores the issue as being representative of a 'split sense of self', rather than providing information to clinicians about how to manage the phenomena in the Treatment Choice Encounter.

Many of the interviewees explained that 'self-stigma' appears to be generated from negative beliefs about PD diagnosis, and is linked to the superordinate themes

concerning: 'diagnostic stigma', 'meta-cognition' and 'focus on time'. The problems with time factors in terms of treatment decisions is detailed in the literature reviewed (McMurrin et al, 2010; Green et al, 2004).

It is difficult to evaluate the extent that time pressures affect the Treatment Choice Encounter via the literature reviewed, due to the different health systems that the research is taken from (i.e. American insurance paid health care system vs UK tax funded health system). A difference here between IPA outcome and literature review outcome is that all of the interviewees spoke from a UK health perspective, although 3 candidates had worked in other countries, however only 25 literature sources originated in the UK, in comparison to 82 from the USA (Appendix 5). Therefore, it is proposed that more specific research is required in evaluating this factor, as there may be different pressures upon the clinician and expectation from the patients in differently funded health care systems.

This cross-comparison of different health care models and subsequent effect upon treatment is something that appears to be only just emerging in the literature, and coming from UK health policy (Bell, 2015). But it is something that generates a debate about different health economies and how funding is impacting upon treatment decisions in very different ways than has been seen previously in the UK health system. It may be a way in which the difficulties that interviewees have described can be better understood, considering the current research gap. This factor is then linked with the superordinate theme of 'boundary management', concerning multiple clinician roles, which will be focused upon in section 7.3.

In summary, there are many patient factors identified within the IPA analysis and the literature review that affect the Treatment Choice Encounter. When considering the above patient-related factors, the following outcome is linked with the structure of the Treatment Choices Grid:

All interviewees suggest is that if a person accepts their PD diagnosis and talking treatments, the encounter and decision for treatment is least complicated. The only exception to this concerns certain patients who are described as 'dependant' upon mental health services, and therefore are reluctant to be discharged (i.e. Interviewee 4 - T:4,P:5-6,L:235-251). For those people who refute their diagnosis and/or refute the efficacy of talking treatments, all interviewees reflected that the Treatment Choice Encounter is problematic, and when considering the literature review results, there is little available research to support decisions concerning what to do about this. This is because most research sourced focuses either upon PD's already in treatment, receiving some form of talking therapy, or risk management.

The identification of this divergence between the literature reviewed and the practice experience is therefore significant in identifying 'outliers' (meaning differing from the 'norm' of the group), whose differences pose difficulty for clinicians in the Treatment Choice Encounter.

Services and policies are currently structured around people entering treatment who accept their diagnosis and are accepting of treatments for this. Practice data gained through the validation groups for the IPA study supported this, identifying that only 15-25% of people who enter the locality services for PD treatment could be

considered within as 'outliers', 75-85% enter treatment accepting their diagnosis and also the evidence-based treatments offered for this.

What is known about the culture of 'outlier' management in healthcare is that it is related to heightened risk and system problems (Wakeam, Hyder, Ashley, Stanley and Weissman, 2014). There was consistent feedback from all interviewees that making treatment decisions with these 'outliers' is a source of difficulty, and this is captured within the superordinate themes concerning 'boundary management', 'focus upon time' and 'potential for iatrogenic harm', specifically related to treatment thresholds. This research therefore makes an original contribution by identifying the current 'outliers' in practice in terms of PD treatment choices that lack a research base to guide treatment decisions.

7.3: Clinician factors, including personal and professional beliefs, and perceived resource availability, which contribute to their ability to manage the Treatment Choice Encounter.

All interviewees identified that 'boundary management' was a difficult theme when making treatment choices. This concerns boundaries at multiple levels, inside and outside of the encounter itself. However, boundary management was sparsely researched in the literature in regard to treatment decisions, instead it focused mainly on boundaries within a therapeutic treatment encounter (Kopala-Sibley et al, 2012). This could be considered as an area of divergence in the literature, and also from clinician training, when considering the overall research question itself.

What the literature review has provided, which the interviews did not, was indications of how boundaries can be managed in individual PD treatment sessions (Brown et

al, 2012; Duggan et al, 2007), that could then be drawn upon to consider similar strategies being used within the Treatment Choice Encounter.

Expanding upon points made in 7.2, clinician factors were identified in both interviews and literature reviewed, concerning the difficulty in 'benchmarking' treatment decisions in order to promote consistency, which is a core part of the research question posed. Slightly different perspectives have been provided concerning this phenomena by the literature review and the IPA study, however they correspond with the same difficulty in terms of treatment choice.

The literature review raised difficulties with clinicians having different viewpoints in what constitutes effective treatment for PD's, specifically focused upon different modalities of talking treatments (Beutler et al, 2012; Magnavita et al, 2010). Certain interviewees validated this factor, reflecting on clinical practice experience, however all interviewees raised difficulties with clinicians having different viewpoints in what is effective and required for PD patients across thresholds (i.e. Primary care GP's considering a PD patient requires specialist mental health care treatment, and specialist mental health services considering that they do not). Both of these factors link in with the super-ordinate themes of: 'boundary management', 'diagnostic stigma' and 'potential for iatrogenic harm'.

With PD treatment choices now being linked with commissioning (Osley,2014; DoH, 2011e; Chiesa,2008), this area will need further research, and poses a specific challenge for the 'Parity of Esteem' (NHS England, 2015b) agenda, linked with the 'Five Year Forward View (NHS England, 2014). Certain of the Interviewee data (i.e. Interviewee 7 - T:7,P:8,L:395-403) suggest that a potential reason for this is that

there may be a different level of understanding of the diagnosis between mental health services and GP's, and also a disconnect between understanding the notion of Recovery in terms of PD as opposed to other long-term conditions (i.e. diabetes), which causes inconsistency of approach between referrer and gatekeeper.

The presence of conflict between clinicians or clinical services and management of difficulty are core themes in three out of five ('boundary management', 'diagnostic stigma' and 'meta-cognitive abilities') of the super-ordinate themes. This is focused upon clinician skills, and is something that is lacking in the literature, despite there being much published research concerning the difficult behaviours that can be exhibited by people with a PD, after they have been accepted into treatment (Liebman et al, 2013).

When considering this factor, there was a difference expressed within the IPA interviews, rather than between interviewees and literature reviewed. Within three out of four of the supervisor/clinicians interviewed in one part of the transcript, they identified the need to manage boundaries and the need to support clinicians in boundary management, yet when they reflected upon their own clinical encounters, they reflected upon the difficulty they have in terms of boundary management, despite the additional knowledge and training that they have. This may suggest that, although training in boundary management may assist clinicians in the Treatment Choice Encounter, there is something about the encounter itself that has an effect upon the clinician's ability to manage boundaries with some patients (mainly the outliers identified in 7.2), despite their additional training.

The treatment choice for 'outliers' is also referenced within many of the interviewee transcripts in relation to clinician as well as patient factors. Most interviewees described a difficulty in making decisions, particularly when they were faced with a sense of 'disconnectedness' in the Treatment Choice Encounter. This was linked with both the 'diagnostic stigma' superordinate theme and also the 'meta-cognitive ability' theme, as it was described by clinicians as both the patient's ability to engage with the Treatment Choices Encounter itself, and also the connectedness or acceptance of their diagnosis and evidence-based treatments.

In this way certain interviewees reflected upon the costs and benefits of selecting or denying certain treatments in the patient encounter. The reasons provided are convergent with the literature (Castonguay et al, 2010), connected to the potential for either iatrogenic consequences (another superordinate theme) of treatment selection (Brand et al, 2014), or waste of resources (Mendelberg, 2014). This is a convergent factor, however it links to a divergence in the fact that there is little written about 'engaging the un-engaged' and where the roles and responsibilities for risk management may prompt the requirement for a mental health service, despite the patient refusing to engage with treatments, which was a problematic factor raised by all interviewees.

A recurrent use of specific linguistic terms within the entire transcripts suggested that the Treatment Choices Encounter was disorientating for the clinicians and supervisors, and this challenged their ability to 'think' about decisions, this is linked with the superordinate theme concerning 'focus upon time'. It was a subject that appeared to evoke anxiety in the interviewees when discussed, and appears to be

linked with the paucity of research regarding clinician self-doubt, which was a finding in the literature review (Barnett et al, 2007). This requires sensitive practice consideration, as it is linked with the discussion about transference, counter-transference and potential 'splitting' effects in the patient-clinician encounter, detailed in the literature review (Liebman et al 2013; Chaikin et al, 2004), and could also be considered as an underpinning factor in the need to develop the Treatment Choices Grid, detailed in Section 4.

7.4: Supervisory factors that have been identified to support the ability to formulate consistent treatment choices and justify decisions

A convergent factor between the supervisor/clinician and clinician interviews concerned the fact that they all experience the same struggles with the subordinate themes concerning 'boundary management' and 'time management'. The difference being that the supervisors were often more aware and reflective about when boundary breaches and violations were occurring in both their own and other's practices, and their meta-cognitive abilities in-session were less affected. Within the literature review, there was nothing found in terms of research comparing clinician and supervisor experiences of engaging patients with PD, however literature was found concerning the importance of supervision when working generally with people who have a PD (i.e. Magnavita et al, 2010).

Supervisor interviewees experienced conflict between their identities of both a supervisor and clinician, and provided several contradictory statements in their transcripts, which appeared to support the literature findings, which reflect the clinician vulnerability in the Treatment Choice Encounter (Bowers, 2002), however an addition that is not found in the research concerns how 'role-conflict' affects the

encounter, which is suggested as a new contribution generated from this research. This was also evident in most of the clinician interviews, however rather than the clinician/supervisor roles prompting a difference, the 'role-conflict' typically related to the gatekeeper/budget manager roles as detailed within the superordinate themes: 'boundary management' and 'metacognitive abilities'.

In the supervisor interviews a more prominent theme that was raised differently from many of the clinicians, concerned the superordinate theme of 'iatrogenic harm'. This may be because the supervisors (by nature of their role) have more active awareness of this subject, but reinforces the debate in the literature concerning PD treatability (Eastman et al, 2006; Glover-Thomas, 2006), which has continued since the publication of '*Personality Disorder: no longer a diagnosis of exclusion*' (DoH, 2003).

The convergent data from the interviews and literature review are associated with the superordinate theme of 'diagnostic stigma', which could be argued to require a better understanding connected with the current rhetoric concerning 'Parity of Esteem' (NHS England, 2015b). What the IPA study identified, that is contrary to most of the literature, is that diagnostic stigma experienced in practice affects supervised treatment choices, due to potential over-rides between systems (i.e primary care and secondary care).

In the literature, stigma is reinforced due to the lack of representativeness of PD in studies that focus upon 'major mental illness' (Krueger et al, 2010), which by omitting the PD diagnosis from the trials, reinforce a devaluation of the diagnosis when

compared to other mental illnesses (i.e. psychosis). Additionally, many PD research trials omit people with diagnostic co-morbidity, which both the research (Castonguay, 2013) and many interviewee statements suggest, means there is a disconnect between the complex patients encountered in clinical practice, and the research studies used to underpin practice policy (NICE, 2009a&b).

It could be argued that the evidence-based changes made to psychosis services has benefitted patients by reducing acuity, however due to the lack of parity provided to PD services, practice data discussed by all interviewees demonstrates that this has meant that there is a noticeable rise in caseloads of PD patients, in comparison with psychosis patients particularly in acute services, which prompts the need to re-examine parity of investment. This would then aid the clinicians in the Treatment Choice Encounter by prompting 'early intervention' and proactive rather than reactive strategies, which has been realised as effective in other mental health problems (NICE, 2014b).

A further supervising factor raised within the literature connects again to the lack of representative research for all clinicians involved in PD treatments and treatment choices, as discussed in section 7.2. The supervisors interviewed represented all different supervisor groups within the practice setting (psychiatrists, nurses, psychologist and psychotherapist), but when considering the literature review, no representative professional studies were found, which meant that supervisors specifically commented upon having a lack of research to refer to when supervising clinicians, who are commissioned to provide holistic care to patients.

In summary, supervision models for PD treatment choices are lacking in the literature, and this is linked with the lack of heterogeneity of PD symptoms, and the polarised evidence-base concerning talking treatments, as opposed to the practice provision in UK NHS teams. The variables that the interviewed supervisors appear to focus upon are: the effects on the relationship and formulating difficulties to inform the decision-making process, informed by anecdotal data such as that gained in the clinician interviews, rather than research data.

Clinicians and supervisors who were not trained psychotherapists expressed a struggle defining whether certain psychotherapeutic treatments were suitable for people with PD, due to the lack of research pertaining to treatment choice, and the lack of non-psychotherapeutic published literature concerning PD treatments.

What this study provides is an original contribution to the current UK research pertaining to PD treatment, providing a voice of many different clinicians that are in practice, making treatment decisions. The literature reviewed did not generate any such study or multi-professional sampling. This transcript data in this way is divergent from the current research base, and this research may help with convergence.

In conclusion, through the synthesis and discussion provided in sub-sections 7.2, 7.3 and 7.4, divergent and convergent factors have been identified in terms of: patient, clinician, and supervisor experiences, drawing from both the literature review findings and also the findings from the IPA study. An overriding factor for all of these appears to be the need for a joint systemic understanding when making treatment

decisions, that all clinicians (no matter what discipline) can apply in order to strengthen services for patients. The recommendations drawn from this study will be presented in the next subsection followed by the study's strengths and limitations.

7.5 Recommendations

In conducting and analysing the interviews, two results were obtained. Firstly, in participating with the study, the teams have reflected more about the decision-making process, and have made practice changes regarding support structures, policies, protocols, and working arrangements. Secondly, in terms of the data generated by the literature review, questionnaires, interviews, and validation groups, the following practice change recommendations have been suggested, to support staff to make treatment choices with PD patients:

- A bespoke package concerning 'professional boundaries training' is required to support the decision-making process. This 'boundaries training' is not only to be focused upon clinicians making treatment choices, but extended throughout the Trust up to Board level, to provide support and consistency.
- Diagnostic stigma impacts in multiple ways upon the Treatment Choice Encounter:- firstly on the patient's ability to engage in the encounter, and secondly the clinician's decision-making, and finally, there has been a wider public health issue raised concerning media representation of PD.

The recommendations in terms of stigma reduction are therefore: (1) the development of tailored diagnostic psycho-education for PD patients in multiple different formats (i.e. written, podcast), (2) the development of specific teaching packages for staff conducting treatment sessions, considering the influential variables raised in this study, (3) the need to work with wider agencies in terms of public health campaigns concerning stigma reduction for PD.

- There is an identified recommendation to review local protocols concerning time allocated to assessments for PD patients, considering the complex interpersonal dynamics that are often present in this type of encounter. It is recommended that additional time is provided.
- It is recommended that the results of the research concerning clinician's experiential narratives is published, and contributes to evaluations of PD services. This particularly relates to the current review of NICE guidance for PD, and the current revision of payment systems for different treatment tariffs.
- There is a need to analyse and revise current local team supervision structures concerning clinical decision-making for PD patients, to assist the decision-making process, enabling a multi-professional approach, and understanding the impact of role expansion on the Treatment Choice Encounters.

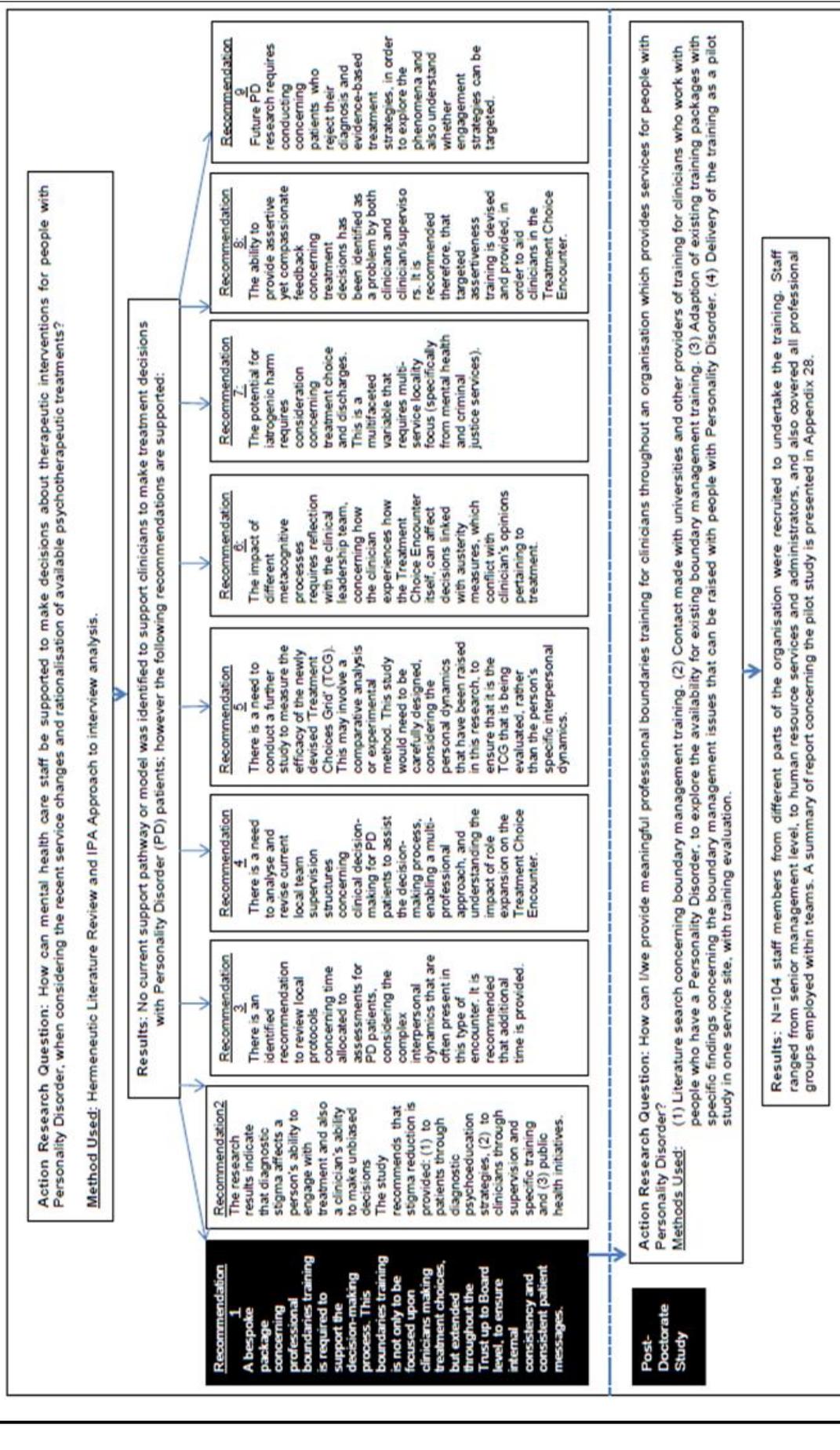
- The need to conduct a further study to measure the efficacy of the newly devised TCG. This may involve a comparative analysis or experimental method. This study would need to be carefully designed, considering the personal dynamics that have been raised in this research, to ensure that it is the TCG that is being evaluated, rather than the person's specific interpersonal dynamics.
- The impact of different metacognitive processes requires reflection within the clinical leadership team. The practitioner reflections do appear to generate new findings, concerning how the clinician experiences the Treatment Choice Encounter itself, specifically concerning decisions being made regarding austerity measures which conflict with clinician's opinions pertaining to treatment.
- Different considerations are needed concerning the potential for iatrogenic harm, when considering treatment and discharge for PD patient 'outliers'. Specific factors pertaining to this connect to the clinician experience within the encounter, and the changing expectations in terms of risk management. This is a multifaceted variable that requires multi-service locality focus (specifically from mental health and criminal justice services).
- The ability to provide assertive yet compassionate feedback concerning treatment decisions has been identified as a problem, by both clinicians and clinician/supervisors. It is recommended therefore, that targeted assertiveness training is devised and provided, in order to aid clinicians in the Treatment

Choice Encounter. This training may be delivered through supervision using clinical scenarios, building on the anonymised case examples that interviewees provided.

- Future PD research requires conducting, concerning patients who reject their diagnosis and evidence-based treatment strategies, in order to explore the phenomena, and also understand whether engagement strategies can be targeted.

The recommendations for this study will contribute to the next AR cycle focused upon in clinical practice, in order to improve services for people with PD. The recommendations are summarised in Figure 27, with an example concerning how one recommendation has been used in the next stage of the research process (Appendix 28).

Figure 27 – Recommendations concerning the research study exploring treatment choices with PD patients, with a post-doctorate research example.



7.6 Study Strengths and Limitations

Different forms of research are measured in different ways. Quantitative research is typically measured using three criteria: reliability, generalisability, and objectivity (Richie et al 2013). It would be inappropriate to use these criteria to measure this research, as although this is a mixed-methods study it predominantly uses qualitative rather than quantitative methods of data collection.

When considering this study's strengths and limitations, the Yardley (2014:243) framework will be used as an evidence-based framework for analysis:

Sensitivity to the context

The following factors relate specifically to the study sensitivity:

A literature review was conducted as a part of the study (Section 2). This has enabled analysis of relevant empirical and theoretical literature, exploring the specific social-cultural context in which the research is set. With hindsight, the literature review parameters set were too broad, however, in conducting such a broad review, this enabled research to be generated that informed the research question from an extensive perspective. Critically however, certain articles were not entirely specific to the context of the question posed.

The use of validation groups at five points within the research study ensured not only that the study design was sensitive to the context of the research question studied, but it remained so as the research progressed, with the support of locality clinicians, patients, and carers. This inclusion of patients in the validation groups is considered

to be both important in addressing the paucity of patient voice within the literature sourced for the review in Section 2, but also in terms of enhancing the authenticity and relevance of the study (Guba and Lincoln, 1989:10).

The limitations in the validation group use were that, although there were a core group of three attendees, attendance by others in the groups varied, which means that consistency of approach cannot be guaranteed.

In exploring the question from a qualitative perspective rather than hypothesis testing, patterns and themes have emerged from the lived experience of the research participants. This has enabled the emergence of the super-ordinate themes, and also the unique way in which the Treatment Choices Grid has been adapted and used by different clinicians.

A limitation of the study concerns the reduced patient questionnaire return, and the identification that, of those opinions gained, bias in terms of the sample results is likely. The low return enabled validation group analysis and clinician engagement, which generated interesting results in themselves.

Finally, study sensitivity was not only a consideration for the researcher. Ethical board approval was sought for the study, through: NHS Ethics, University Ethics Board, and R&D Team. Gaining validation and agreement from all of these panels demonstrates an ethical study proposal and sensitivity to the research context, as reviewed by independent research panels.

Commitment and rigour

The data collection and research analysis was in-depth and time-consuming (Figure 15). This demonstrates commitment to the subject matter, and rigour in exploration. The employment of a second researcher after interview transcription is an additional factor when considering the rigour of the analysis, and also is employed to ensure bracketing the researcher's own presumptions, with the findings.

At 6-monthly stages throughout the research, the literature review and research was re-visited, to explore whether new research had been published regarding the research question posed, in order to inform the study and keep it up to date.

The sample size gained was within the original parameters set, which was deemed sufficient for the question posed. The data generated was significant, which posed a difficulty in terms of analysis. It could therefore be a reflection that should the study have been repeated, fewer and more focused questions would have been posed, after considering where unrelated information was generated in this study.

Coherence and transparency

A significant proportion of the thesis has been devoted to the methodology and TCG employed to conduct the research. The reason for this is to enable transparency, and understand the coherent flow of the research direction.

Another reason for the validation groups and also the second researcher checks was to enable transparency, and to recognise the double hermeneutic produced by any IPA research, which concerns the researcher's views upon the situation changing, as

they conduct research into the situation. The validation groups and second researcher have enabled reflection upon whether the researcher's own bias was affecting interpretations of: the literature, the patient feedback issue, the transcript analysis, and also the whole study outcome.

Impact and importance

The research was primarily conducted to make a difference in clinical practice, supporting clinicians, and therefore improving patient outcomes. In conducting the research itself, a better understanding has been gained for local services, considering the literature review and current evidence-base regarding decision-making with PD patients. This literature review and dissemination into the local team assists in answering the research question set.

The outcomes have been of benefit to the teams, as even while conducting the study, it enabled focus upon the subject matter itself. There have been practical changes made whilst conducting the research, which have benefitted the clinical encounter (i.e. TCG development).

Where the research has prompted practice changes, there is now a further suggestion that research will need to be conducted, to evaluate what effect this has had upon the Treatment Choice Encounter. The dissemination of the results is summarised in Section 9, and highlights the impact and the importance of the study, in: attempting to answer the research question, reflect upon the difficulties encountered in conducting the study itself, and generating areas for future research.

A final important reflection concerned what would be done differently, should the research be repeated. The researcher reflects that the most significant unexpected factor concerned the destabilisation of teams and clinicians when the research question was asked, and sampling commenced. The impact that analysing decision-making has had is documented by research, for example exploring the Hawthorn Effect (McCambridge et al, 2014), however this usually pertains to the act of an observer or researcher, rather than posing a research question itself. In reality, this significantly affected not only clinicians/supervisor's willingness to engage in the study, but also their clinical work with patients. The positive outcome of this is that the TCG has been developed, which appears to have been a collaboratively produced stabilising factor, which requires additional testing.

Section 8: Conclusion and Personal Reflection

Within this section, a conclusion will be presented that considers all of the learning generated within this study. This will include both a summary of the research itself linked with the Action Research stages presented in figure 1. A summary of personal learning achieved by the researcher whilst conducting this process will be detailed leading on to the final chapter concerning the research dissemination strategy. This section will be presented in the first-person narrative, in order to explore personal learning generated through the research process.

When concluding research, it is important to reflect upon the research question posed, which is:

How can mental health care staff use a pre formulated guided decision process in the selection of therapeutic interventions for people with PD, within the context of rationalisation and service change?

The research question was generated out of a practice based AR project concerning increasing skills of people working in community mental health teams. The generation of data from clinicians means that it was core to the team, rather than just for myself, which generated energy for the research process, and enabled me to have the support from the teams and organisation to progress.

To plan the research, a validation group was set up, to explore potential research options and also to shape, explore, challenge, and validate findings as the research progressed. I found this both helpful yet frustrating, having never participated in or used a validation group format before. In selecting a technique new to me, I was not only required to read about facilitating the group, I also needed to motivate others to

remain focused and keep participating, despite the busy work situation. This was both challenging and rewarding for me as a researcher.

8.1: Literature Review

An initial literature review was conducted, which found no models or frameworks to support clinicians who make treatment decisions with PD patients. Due to this, search parameters were expanded and a literature review using a hermeneutic model was conducted, this generated significantly more data (n=144 research articles), some of which were directly relevant, some had less direct links to the treatment decision, and discussed more general clinical encounters with PD patients.

The literature review enabled a broader understanding of the research question posed and the complexity of the Treatment Choice Encounter. Under the headings of the 6 pre-set literature review questions, a hermeneutic enquiry was conducted and presented. This generated several core themes relating to the challenges clinicians face in the Treatment Choice Encounter itself, including:

Analysing the history of PD as a diagnostic construct, and how perceptions of trauma and associated criminality have resulted in it gaining a collective identity associated with undesirability, provided me with a better understanding of issues that have prompted personal and organisational stigma, which is to an extent sustained today.

As a clinician (psychotherapist and nurse), I am very aware of the potential relationship difficulties that can be encountered in clinical practice. However, the themes raised in the review pertaining to patient and clinician factors that may affect

the treatment outcome, but also negatively or positively impact upon the in-session relationship, challenged certain of my assumptions.

One of the main difficulties concerned the problematic evidence-base available regarding: assessment, treatment, and discharge decisions for PD. Evidence sourced was primarily researched from a psychology/psychotherapy perspective, with little published concerning medical, nursing, and social support strategies provided for PD patients, which underpins the predominant part of the workforce in UK mental health services. This enabled me to reflect about why certain clinicians may feel more informed about working with PD than others, but also caused me to contemplate upon why there is such a stark amount of research for such a complex patient group.

The literature review not only exposed areas of influence which contributed to answering the research question, but it also identified research gaps and potential solutions. One of the gaps identified was the lack of research concerning the clinician experience of the Treatment Choice Encounter, which is central to the research question, and underpins the rationale for the IPA methodology chosen.

8.2: IPA Study

In planning for the IPA, and commencing recruitment of a sample, process issues pertaining to the clinician's anxiety about having their decision-making technique and ability explored became apparent, impacting upon sampling and also support for the research. I found that people who were previously keen to provide opinions were cancelling meetings, and other clinicians began speaking about other obligations,

which meant that they could not assist further. Also, within my meetings with other supervisors, colleagues discussed how, by raising the question about how decisions are made, people had become more anxious about the everyday decisions that they make, and had started raising this more in supervision. In order to support clinicians and supervisors due to the destabilising effect of the research question, I worked with teams to develop the TCG.

Positive feedback was initially obtained when we began discussing this concept, and it seemed not only to have a stabilising influence, but also provided a focal point for exploring the experience of making treatment choices, which was less personal than asking direct questions of the clinician. I therefore reworded the interview scripts and questionnaires, to focus upon the TCG rather than clinician, and proceeded through ethics approval.

The addition of the TCG enabled me to gain a sample (n=10), which was consistent with the research protocol. All interviews were conducted, transcribed, and analysed, using the IPA framework. This is not a framework I was familiar with, therefore I spent time with other researchers, both in my organisation and also the university, who had used this method previously, to enhance my skills and confidence.

The results, analysis, and discussion sections are presented in a narrative format, generating 5 superordinate themes related to the research question. These themes concerned: Boundary Management, Diagnostic Stigma, Focus on Time, Meta-cognitive Processing, and the potential for Iatrogenic Harm. The themes were confirmed, with framing and language revised through the support of a second

researcher, who validated the findings from the transcript. This support was essential, as it not only alleviated my anxiety concerning using a new way of researching, but also in reflecting upon whether themes had been generated anchored in my own subjective opinion, or whether this accurately represented the experience of the clinicians conducting the encounter, and the supervisors providing support and clinical direction. I was pleased that very little change was made from my original super-ordinate themes, however significant time was spent on prioritising and contextualising themes.

8.3: Patient Questionnaires

Alongside of the interviews, patient questionnaires were collected. There was an issue in terms of the data collection which related partly to the literature results, and partly to the topics underpinning the TCG. In discussion with clinicians and the validation group, certain factors were generated concerning the lack of patient response. The reasons concerned the amount of questionnaires that patients gain concerning exploring and explaining their experience, and also related to personal diagnostic stigma that some patients held concerning their diagnosis.

I relied on the support of the validation group, clinical supervisors, and clinical discussions, to decide whether I should return to ethics board to explore another way of gaining data. On reflection, my preoccupation with gaining patient data to make the research complete (in my mind), biased my reasons for conducting the research. After discussion, it was clear that patient data was not required to answer the research question, and although it would be preferable to gain perspectives from all in the encounter, a result is also interpretable with a low response rate, considering

the process issues raised. I therefore agreed with the validation group not to return to ethics board to explore additional data gathering.

8.4: Recommendations

In gaining the results from the literature review, validation groups, interview data, patient questionnaires, and through reflection on the research process, nine recommendations were made concerning how mental health care staff can be supported to make treatment choice decisions with PD patients: (1) a systemic boundary management training package being delivered to all staff involved with PD services; (2) Stigma reduction strategies (with patient, clinician and through public health initiatives); (3) local protocol changes, resulting in a formalised increase in the engagement time allocated to make treatment choices; (4) Multi-professional support with decision-making; (5) a need to use a tool to focus the formulation of consistent treatment decisions (such as the TCG, however this requires further research, prior to validation). (6) Further research considering the effect of austerity measures upon clinician meta-cognitive processing when making treatment choices, (7) the need to consider indirect or iatrogenic harm that may occur with some treatments, requiring a long and short-term focus upon treatments; (8) targeted training concerning the provision of assertive yet compassionate feedback upon treatment decisions; and (9) the recommendation for future PD research, concerning patients who reject their diagnosis and evidence-based treatment strategies, yet present for help.

The outcomes of the research study are complicated, and demonstrate how there are a number of variables which require consideration in such an encounter. Figure 28 provides a concluding diagrammatic to represent the complexity of the Treatment

Choice Encounter, summarising the phenomenological analysis conducted through this research, including the recommended outcomes which may assist a clinician, from the data gained.

Section 9: Dissemination

Due to the size of this study and the different strands of the research, and the nature of the AR research process, I felt that it has been important to disseminate results as the study progresses, rather than wait until the end. Dissemination has been conducted through various methods, and further dissemination activities are planned. I have summarised the dissemination strategies below:

9.1: Practice change

Various components of the study have resulted in practice change within my organisation. This has particularly pertained to the analysis of staff support measures, the delivery of focused staff training, and the need to update clinical policies in the trust.

As a part of the doctorate research process, I have applied and been nominated for forums and networks, that have enabled me to have a wider influence upon policy and practice change. I have been nominated and elected on to the NHS Confederation's Mental Health Network Board. I have also been awarded the title of Queen's Nurse and been nominated and accepted into the Phi Mu Chapter (England) of Sigma Theta Tau International (STTI), Honour Society of Nursing, which enables me to widen my contacts concerning leadership, and attend forums to present this research and enable peer-scrutiny. My roles with the NHS Confederation, Nursing Honour Society and Queen's Nursing Institute inform clinical practice change.

9.2: Publication

I have refined the literature review conducted in the first year of the doctorate, which contributed to the generation of 'treatment choices' being the focus topic area. The paper was published:

Graham. J. (2012). Cognitive Behavioural Therapy for occupational trauma: a systematic literature review exploring the effects of occupational trauma and the existing CBT support pathways and interventions for staff working within mental healthcare, including allied professions. *The Cognitive Behaviour Therapist*. Vol 5(1): 24-45.

I am currently in the process of preparing two other papers which will be submitted for consideration for publication, concerning the findings of this research. I feel that publishing the findings of my research is important, to share the new insights that have been raised concerning engaging PD patients.

Research results have been disseminated through validation groups, and also local mental health meetings, and service user and carer forums. Each of the interviewees that participated within the research has received a letter of gratitude concerning their participation, and also a summary of the research findings and recommendations.

Certain findings have resulted in smaller practice change initiatives as a part of the Action Research process (i.e. the design and commencement of multi-level 'Professional Boundaries Training' – detailed in Appendix 28).

9.3: Conferences and Presentations

I have presented at psychotherapy, nursing, and health and social care conferences to disseminate this research at different stages. Appendix 29 details the 7 local, national, and international conference presentations at which I have presented my research, and a further two I have yet to present at, but I have had my abstract peer-reviewed and accepted.

9.4: Original Contribution

Practice reformations and refinements connected with economic reforms are affecting mental health and social care provision locally, nationally, and internationally. Specialist mental health services are providing increased group-based intervention and also training, consultation, multi-disciplinary team working, and supervision, to other (non-psychotherapeutically trained) team members, aimed at increasingly cost-effective treatment delivery. This research examines one such practice change, aimed at developing a sustainable practice initiative for clinicians working with patients with PD.

Within the literature reviewed, I have not been able to source any information to suggest that a specific model or heuristic has been developed concerning making treatment choices with PD patients. Although my work draws on a substantial body of knowledge concerning therapeutic encounters with PD patients, it focused upon the systemic and individual experience of making treatment decisions, which I have found to be lacking in the current research. I feel that my interpretation of a clinical heuristic to aid formulation, in the form of the TCG, is unique, and adds to the body of knowledge. Though it is recognised that the aim of this study is not to validate the

tool, it has been rated by stakeholders as having local clinical benefit, and so post-doctoral research will focus upon researching its efficacy and targeted use.

Finally, I feel that through my work being accepted for peer-reviewed publication and a wide range of conferences, this is indicative that my area of study is contributing to research regarding PD. With the delayed publication of the NICE Guidance for Borderline Personality Disorder, and the focus of the BABCP 2015 Spring Conference being solely devoted to expanding mental health and psychotherapeutic practice for people with Personality Disorders, I feel that my research focus is in line with contemporaneous issues being raised in my clinical practice field.

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Appendix 1: Literature Review Summary of Study Characteristics

Paper No	Author(s)	Country of origin	Year published	Study Type	Subjects	Comparison	Type of Personality Disorder Listed	Treatments Listed & Techniques	Main Findings
1	Angus & Kagan	UK	2009	Discussion Paper	None	N/A	Personality Disorder unspecified type	Integrative Psychotherapy Supervision	The identification for the need for empathetic engagement in order to improve treatment.
2	Antoniadis et al	Greece	2012	Review	Number of papers reviewed was not stated.	N/A	Borderline Personality Disorder (BPD)	Medication Treatments Psychotherapeutic Methods (various)	The review considered a comparison of BPD and Bipolar Disorder, and the identification of symptomology, causes & treatments for each
3	Baiden et al	Canada	2013	Analysis using logistic regression	811 Adolescents	No	Personality Disorder unspecified type (other diagnosis were also included)	Comprehensive Assessment Early Intervention Diagnostic and treatment psycho-education Therapeutic relationship building	The study explored patient disengagement and self-discharge from mental health services, finding that insight into difficulties was a key them in regards to treatment choice.
4	Barnett et al	USA	2007	Discussion paper	None	N/A	Not stated	Psychology Clinician Self-care	The paper describes the importance of clinician self-care when working in mental health, to prevent burnout and adverse client experiences.
5	Barry et al	USA	2007	Discussion paper	None	N/A	Personality Disorder unspecified type (other diagnosis were also included)	Individualised care plans that promote recovery and resilience.	He paper reviews the effects concerning treatments for people with severe mental illness in a climate where there is reduced budget.
6	Bennett et al	UK	2006	Task Analysis	107 enactments from 66 sessions in four good outcome cases	Yes. Compared with 35 enactments from 16 sessions in two poor outcome cases.	Borderline Personality Disorder	Psychotherapy Intervention Cognitive analytical therapy	The paper explores problems that occur in treatment for BPD patients directly related to the therapeutic relationship.
7	Benvenuti et al	Italy	2005	Comparison Study	39 BPD patients with and 21 without mood disorder	Yes	Borderline Personality Disorder	It is suggested that the assessment of mood spectrum features in BPD may be useful to inform treatment choices.	The paper investigated the relationship between lifetime mood and psychotic spectrum features in patients with BPD.
8	Berrino et al	Switzerland	2011	Comparison Study	200 participants	Yes. 100 in each group.	Borderline Personality Disorder	Cognitive and Affective support, crisis intervention, building therapeutic alliance, focus upon: rage, helplessness, deception and masochistic coping styles.	This study investigated whether crisis intervention at the General Hospital is a suitable management strategy among BPD patients referred to the emergency room for deliberate self-harm.
9	Beutler et al	USA	2012	RCT	289 Patients	Yes	Not specified.	The importance of therapeutic alliance on treatment selection and outcome. Psychotherapies (unspecified)	This study, explored what specific and what common factors determined to be related to good treatment outcomes across different modes of psychological intervention and psychotherapy.
10	Beutler et al	USA	2014	Discussion paper	None	N/A	Not specified.	The importance of therapeutic alliance and engagement.	This paper explores how different therapeutic treatments are researched, specifically using RCT's which may then miss variables which effect treatment selection and outcome.

Paper No	Author(s)	Country of origin	Year published	Study Type	Subjects	Comparison	Type of Personality Disorder Listed	Treatments Listed & Techniques	Main Findings
11	Borstein	USA	2005	Review	Not stated.	N/A	Dependant Personality Disorder	Extended assessment Blended psychotherapeutic interventions. Diagnostic Psychoeducation	The paper reviews assessments and treatments provided to dependent patients, providing recommendations for effective diagnostic, assessment, and treatment strategies in inpatient and outpatient settings.
12	Boswell et al	USA	2010	Investigation	19 therapists, 42 clients	No	Not stated.	Cognitive Behavioural therapy Interpersonal therapy The influence of the therapist client relationship	The research explored therapeutic variables which influenced treatment efficacy with different psychotherapies, with particular attention paid to the importance of clinical decision making and the complex interaction between common and unique technical factors in practice.
13	Bowers	UK	2003	Concept Analysis	Not applicable.	N/A	Personality Disorder unspecified type	Value based influences	The study explores the concept of manipulation in regards to working with people with personality disorder and explores how this effects engagement and treatment decisions and outcomes.
14	Bowers	UK	2003	Discussion Paper	Not applicable	N/A	Personality Disorder unspecified type	Cognitive Behavioural therapy Psycho-analysis Clinical supervision and reflection	This is the sister paper to concept analysis listed above in paper 13. It moves on from concept definition to
15	Brand et al	USA	2014	Survey	298 therapists and 237 patients	No	Personality Disorder unspecified type and Dissociative Identity Disorder	Psychotherapy (various types)	This study explores the potential for psychotherapeutic interventions to cause iatrogenic harm for some personality disordered patients, despite them being evidenced based treatments.
16	Brown et al	USA	2012	Narrative Analysis	20 patients	No	Personality Disorder unspecified type and complex trauma.	Psychotherapy (various types) Patient resilience Engagement Formulation	The study reveals that self-experience and identity development can become corrupted by recurrent trauma are presented. Narrative analysis reveals that adaptations to trauma are typically both pathogenic and suggestive of resilient capacities that may be mined in the service of functionality, and recovery.
17	Bryan et al	USA	2012	Literature Review	Not defined	No	Personality Disorder and specifically those patients who are suicidal.	Cognitive Behavioural therapy (CBT) Discharge preparation Clinical Judgment variables	This article reflects upon the fact that there is insufficient research regarding when, and under what conditions, treatment should be considered complete.
18	Budge et al	Norway and USA	2013	Comparative study and meta-analysis	Study 1; N = 1662 Study 2; N = 723	Yes	Personality Disorder unspecified	The need to better define evidence base for PD treatment selection. Psychotherapies (various)	The purpose of Study 1 was to examine the relative efficacy of evidence-based treatments when compared to treatment-as-usual for adults diagnosed with a personality disorder. The purpose of Study 2 was to investigate the strength of the differences between bona fide psychotherapeutic treatments for Personality Disorders.
19	Castonguay	USA	2013	Discussion Paper	Not applicable	N/A	Not stated.	The need for better evidence and explanation about therapies and their goal.	This paper takes a view about how the process of psychotherapy could be improved for people with various different types of mental health issue.
20	Castonguay et al	USA	2010	Discussion Paper	Not applicable	N/A	Not stated.	Psychotherapy (various types)	The goal of this article is to delineate training implications regarding harmful effects associated with psychotherapy.

Paper No	Author(s)	Country of origin	Year published	Study Type	Subjects	Comparison	Type of Personality Disorder Listed	Treatments Listed & Techniques	Main Findings
21	Chaikin and Prout	USA	2005	Review and reflection	Not applicable	No	Personality disorder (unspecified) and complex trauma	Psychotherapy (specific model - OPAL) Engagement Diagnostic assessment and psychoeducation	This paper explores the complexities of providing treatment for women with complex trauma histories. This paper looks at the diagnostic cross-overs, the difficulties with therapeutic relationships, and explores one psychotherapy treatment approach (OPAL).
22	Chard et al	USA	2005	Commentary	1 case	No	Personality disorder (unspecified)	Formulation Conceptualisation psychotherapy 5 factor model	The paper provides a commentary in regards to one case of a person with personality disorder examining issues in regards to assessment, engagement and also treatments.
23	Chatzandreou et al	USA	2005	Review and reflection	1 group	No	Borderline Personality Disorder	Psychoanalytic Psychotherapy The importance of supervision	The authors describe the role of a supervision group of psychotherapists within a wider therapeutic field for severely disturbed borderline patients. The group concentrates on the transference and countertransference issues.
24	Chiesa et al	UK	2009	Multi-centre study	Fourteen psychotherapy services, 1,136 patients	Yes	Personality disorder (unspecified)	psychodynamic psychotherapy	This paper explores the demographics of patient accessing psychotherapeutic treatment in the UK, including analysing the diagnostic demographics.
25	Chisesa	UK	2008	Systematic Survey	23 patients	No	Personality disorder (unspecified)	Psychotherapy Restricted treatment access Costs per treatment	The paper reviews the market-oriented changes within the NHS in the last 15 years, in regards to peoples access to psychological therapy programmes, specifically those with personality disorder.
26	Clarke et al	Australia	2012	Group analysis	34 patients	No	Personality disorder (unspecified) and anxiety disorders	CBT Attention Bias Patient variables	This paper explores why different people respond differently to the same psychological intervention. It explores potential treatment bias in regards to attention.
27	Clark	USA	2014	Survey	402 patients	No	Personality disorder (unspecified)	Accurate assessment Symptom thresholds. Patient variables.	This paper explores personality disorder traits on a continuum, it suggests that many people have traits but explores thresholds for treatments and pathology.
28	Clarke	UK	2013	Survey	23 clinicians	No	Personality disorder (unspecified)	Patient engagement Forensic mental health Treatment selection Therapeutic relationships	This paper presents a survey of how clinicians in forensic personality disorder services engage their service users in treatment.
29	Constantino et al	USA	2012	Review	Not stated	No	Multiple mental health disorders	Psychotherapy Patient expectations Patient understanding	This paper explores the difficulties in engagement with psychotherapeutic treatment specifically focussed upon patients expectation of treatments and also their understanding of different approaches and treatments.
30	Constantino et al	USA	2014	Survey	65 patients	No	Multiple mental health disorders	Patient belief/expectation Psychoeducation Psychotherapy	This paper focussed upon changing patients beliefs when they enter therapy, specifically in relation to their expected treatment outcome.
31	Cook et al	USA	2004	Review	Not applicable	No	Personality disorder (unspecified) and complex trauma	Clinician treatment selection Patient Variables Linking evidence based to clinical practice	This paper reviews the treatments that are provided to people with trauma and related disorders including personality disorder. It shows disparity in treatment provision which is not always provided in line with research base.

Paper No	Author(s)	Country of origin	Year published	Study Type	Subjects	Comparison	Type of Personality Disorder Listed	Treatments Listed & Techniques	Main Findings
32	Corrigan et al	USA	2014	Literature Review	Not applicable	No	Multiple mental health disorders	<p>Patient belief/expectation Rationality</p> <p>Psychoeducation</p> <p>Psychotherapy</p>	<p>This paper suggests that many people with psychiatric disabilities do not benefit from evidence-based practices because they often do not seek out or fully adhere to them.</p>
33	Crits-Christoph et al	USA	2005	Comment	Not applicable	No	Multiple mental health disorders	<p>Psychotherapy</p> <p>Patient expectations</p> <p>Patient understanding</p>	<p>The authors make comment upon a previous piece of published research which suggested that therapy was not effective, they suggest that the study had inadequacies to make these claims but they also discuss patient and therapist variables which may contribute to efficacy.</p>
34	Cukrowicz et al	USA	2005	Comparison study	173 patients	Yes – two groups	Personality disorder (unspecified) and anxiety and mood disorder	<p>Psychotherapy</p> <p>Evidenced based treatment choices versus clinician choice</p>	<p>This paper shows a comparison of psychotherapeutic treatments and evidenced clinician chosen treatments and evidenced based treatments and how the evidence based treatments are more efficacious.</p>
35	DeFife et al	USA	2011	Review	Not applicable	No	Multiple mental health disorders	<p>First impressions</p> <p>Therapeutic relationships</p> <p>Psychotherapy</p> <p>Patient expectations</p>	<p>The paper identifies tree therapeutic principles: fostering positive expectancies, role preparation, and collaborative goal formation. Research related to these factors is reviewed as are suggestions for implementing them into applied clinical practice during early treatment interventions.</p>
36	Dimidjian et al	USA	2010	Review	Not applicable	No	Multiple mental health disorders	<p>Clinical decision making</p> <p>Psychotherapy (different models)</p> <p>Iatrogenic effects</p> <p>Treatment Selection</p>	<p>The paper states that patients can be harmed by treatment or by the decisions that are made about those treatments. Although dramatic examples of harmful effects of psychotherapy have been reported, the full scope of the problem remains unclear.</p>
37	Donahue et al	USA	2014	Survey	91 male undergraduate students & 28 male court-mandated males	Yes	Personality disorder (unspecified)	<p>Level of antisocial traits</p> <p>Levels of engagement</p> <p>Risk assessment</p>	<p>This paper assesses the levels of psychopathic symptoms a person has and discusses this in regards to the person's ability or willingness to engage in treatment programs for their issues.</p>
38	Dozois	Canada	2013	Editorial	Not applicable	N/A	Multiple mental health disorders	<p>Psychotherapy</p> <p>Evidence based interventions versus practitioner choice</p> <p>Patient engagement</p> <p>Cost effectiveness</p> <p>Clinical decision making</p>	<p>The paper describes a task force to implement evidence-based practice in psychological treatment, to make recommendations about how psychologists can best integrate evidence into practice, and to disseminate information to consumers about evidence-based interventions. Challenges are discussed.</p>
39	Duggan et al	UK	2007	Practice Analysis	89 patients	N/A	Personality disorder (unspecified)	<p>Standardised assessment</p> <p>The need for consistent treatment decisions</p>	<p>This study focussed upon the need to offer consistent assessments to people with personality disorder who are in a forensic setting. A standard set of assessments were completed, with different levels of engagement with treatment an repeat offending behaviours.</p>
40	Dunn et al	USA	2006	Treatment Trial	45 patients with manual & face to face; 45 patients with just manual.	Yes	Personality Disorder (PD) and Eating Disorders (ED)	<p>The need to increase a patients motivation to engage</p> <p>Psychotherapy approaches</p>	<p>This paper focuses upon the treatments provided for people with ED and PD. It proposes a manualised approach and trials this with one control having a motivational face to face session and one with just the manual.</p>

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41	Eagle	USA	2006	Commentary	7 articles	Each article	Personality Disorder (none specified)	Psychotherapy Analysis of attachment patterns with care givers	This article discusses questions and issues generated by the 7 articles on the relationship between attachment theory and research, and psychotherapy and clinical assessment.
42	Ebner-Priemer et al	USA	2009	Review	Not stated	Not applicable	Borderline Personality Disorder	Ecological momentary assessment	This article evaluate treatment efficacy, but it also examines setting or context-specific relationships of symptoms or behaviours that can be identified.
43	Edens	USA	2006	Review	Not stated	Not applicable	Psychopathic personality features	Clinical decision making Influence of psychopathy Attitude and behaviours	This article reviews the empirical bases of several clinically relevant claims and assertions regarding psychopathy and concludes that many areas of research are decidedly more equivocal in their findings than is commonly perceived.
44	Evans	UK	2011	Review	Not stated	Not applicable	Anti-social Personality Disorder	Clinical Decision Making Supervision Psychotherapy	This article focusses upon the effects upon staff working with people with antisocial personality disorder.
45	Falkenström et al	Sweden	2013	Survey	646 patients	No	Not stated, all mental health problems	Therapeutic alliance Clinical Decision Making	These results indicate that alliance is not just a by-product of prior symptomatic improvements, also they point to the importance of therapists paying attention to ruptures and repair of the therapy alliance.
46	Fertuck et al	USA	2009	Control Study	55 people in two groups	Yes – 30 patients with 25 healthy individuals	Borderline Personality Disorder	Psychotherapy Treatment interfering behaviours	Mental state discrimination based on the eye region of the face is enhanced in BPD. An enhanced sensitivity to the mental states of others may be a basis for the social impairments in BPD.
47	Flanagan et al	USA	2010	Comment	Not applicable	N/A	All mental health diagnosis	Diagnostic conceptualisation Psychological therapy Treatment choices.	The paper outlines the history of studies examining how clinicians think about mental disorders and discusses current research on clinicians' natural taxonomies of mental disorders, which compares clinicians' conceptualization of mental disorders with their depiction in the DSM and the ICD.
48	Flores et al	Spain	2014	Experiment	34 participants	N/A	All mental health diagnosis	Clinical decision making Diagnosis Mental health Assessment and treatment	The paper shows that different clinicians weight symptoms differently pendant upon their experience, qualification and also personal values. This has influences in regards to diagnosis people attract and also treatment selected.
49	Frick et al	USA	2014	Review	Not applicable	N/A	Conduct problems, callous behaviour	Treatment responsiveness Trajectories Treatment interfering behaviours	The paper shows that patients with callous traits tend to respond less positively to typical interventions provided in mental health settings, they show positive responses to certain intensive interventions tailored to their cognitive characteristics.
50	Friedman	UK	2009	Review	Not applicable	N/A	Borderline Personality Disorder	Decision Making Clinical Judgements Psychotherapy Collaboration	The paper offers suggestions for enhanced in-hospital treatment, including increased collaborative decision-making, clear and realistic short- and long-term goals for patient and family, staff supervision and education.

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51	Gadassi	USA	2014	Experience-sampling study	1,200 subjects recruited via survey interviewed via telephone	Yes comparison of different diagnosis	Borderline and Avoidant personality disorders	Social differences for people with PD.	PD groups exhibited mixed affective reactions to social proximity; specifically, benefits (increased positive affect, decreased rejection, isolation, and dissociation) were interspersed with costs (increased shame for both PD groups; increased anger for BPD; increased anxiety for APD). The article explores the different reactions to pain that people with PD may have and discuss implication for assessment and treatment. This article discusses varying perspectives on the role of technique and the relationship in therapeutic change.
52	Gannon	Canada	2012	Commentary	None	N/A	Personality Disorders (unspecified type)	Treatment thresholds Medication treatments Assessment techniques	The results indicate that the recovery approach explains treatment motivation/engagement and positive social interactions above and beyond quality of life.
53	Goldfried et al	USA	2005	Review	None	N/A	All mental health diagnosis	Therapeutic relationships and the effect on treatment choices and efficacy.	The paper suggests an effective treatment model for severely disturbed BPD inpatients requires technical flexibility to make temporary use of more structured interventions that serve the treatment goal of stabilization.
54	Gudjonsson et al	UK	2011	Assessment Study	None	No	A range of mental health problems for people in secure settings	Recovery approaches Treatment Motivational approaches	A group was conducted and evaluated. Results indicate participants reported abstinence from Deliberate Self Harm during the last two months of the group.
55	Goodman et al	USA	2014	Case study	2 cases	No	Borderline Personality Disorder	Treatment choices Treatment modification Treatment modification	The paper illustrates the value of studying choice involving both delayed and probabilistic outcomes within a general discounting framework that uses similar experimental procedures & a common analytical approach.
56	Gratz et al	USA	2011	Group evaluation	23 participants	No	Borderline Personality Disorder with deliberate self-harm.	Assessment Psychotherapy Treatment efficacy	The paper suggests that factitious disorder is much more prevalent among psychiatric inpatients than is commonly recognized. Strategies to assist in the diagnosis and management this disorder are detailed.
57	Green et al	USA	2004	Review	None	No	All mental health diagnosis	Clinical Decision Making Clinical Outcomes Treatment Choices	The primary aim of the study was to evaluate the psychometric properties of the PDQ-4 ASPD and PAI ANT scales and their diagnostic efficiency relative to the SCID-II ASPD module.
58	Gregory et al	USA	2006	Case Study	6 cases	No	factitious disorder	Clinical Assessment Engagement Insight into problems	The article reviews and discusses theoretical approaches to executive coaching, the phenomena of resistance and ambivalence, the psychological theories of reactance and self-determination, and the therapeutic approach of motivational interviewing.
59	Guy et al	Sweden & USA	2008	Diagnostic Assessment study	1,345 offenders	No	Anti-social Personality Disorder	Clinical Assessment Engagement	Results also demonstrated that mean levels of psychopathic personality features tended to decrease into emerging adulthood and showed relatively modest rank-order stability across assessments with 7-year lags.
60	Harakas	USA	2013	Review	None	No	Not specified.	Motivation to engage Treatments Personal effects on efficacy	
61	Hawes et al	USA	2014	Longitudinal study	1,170 patients	No	Personality Disorders (unspecified type)	Changes in personality and levels of pathology Assessment	

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62	Heilbron et al	USA	2010	Review	None	No	Personality Traits and deliberate self-harm	Assessment Intervention Motivation to change Supervision Staff training	This paper explores the importance of a clear and consistent language for characterizing suicide-related behaviours with a particular focus on the commonly used label "suicide gesture". The historical and contemporary uses of the term are explored and clinical, research, and training implications are discussed.
63	Hershenberg et al	USA	2012	Review	None	N/A	Not stated	Link evidence to practice decision making Psychology	The paper discusses the ongoing difficulty about linking evidenced based intervention and approaches to clinical practice and ensuring clinicians follow the best evidence available.
64	Hicks et al	USA	2004	Assessment Study	96 male prisoners	Yes, 3 prison comparison	Psychopathic	Assessment Treatment choices	The paper suggests that emotionally stable psychopaths are characterized by low Stress Reaction and high Agency. Aggressive psychopaths are characterized by high Negative Emotionality, low Constraint, and low Communion. This has importance for treatment selection.
65	Howlett et al	UK	2009	Review and case study	3 cases	No	Personality disorder, trauma and Non-epileptic seizures	Treatment choices Motivational variables Treatment efficacy Psychotherapy.	The paper finds that although therapy can be effective for many people, there are some patients whom this brief outpatient psychological treatment would not help. This is particularly the case when patients reject the idea of a psychological cause completely or are unwilling to work at a psychological level.
66	Hunsley	Canada	2003	Literature Review	91 research studies	No	A variety of mental health conditions	Psychotherapy Treatment Costs Treatment decisions	The focus of this review is on costing issues associated with psychological interventions, including cost-effectiveness and cost offset (i.e., a reduction in health care costs attributable to effective intervention).
67	Hunsley & Mash	Canada	2005	Literature review	Not stated	No	Personality Disorder & anxiety and depression.	Assessment Psychology Psychotherapy Treatment choices Training and education	The paper highlights key themes emerging from the articles, including gaps in psychometric information, limited information about the utility of assessment, the discrepancy between research and current training and practice, and the need for further data on the process of clinical assessment.
68	Jasper et al	Austria	2014	Control study	355 people and 55 laboratory participants	300 online and 55 laboratory participants	Not stated	Clinical bias Clinical decision making Tools to aid choice	The paper suggests that despite much research on thinking biases such as the representativeness, availability, and anchoring heuristics, a psychometrically sound measurement instrument for assessing the degree of heuristic thinking is still missing.
69	Jenson et al	Denmark	2010	Review of re-engagement rates	130 participants	No	Personality disorder, somatoform disorder and affective disorders.	Clinical engagement Service re-entry Patient preparedness Psychotherapy	The study found that the likelihood of patients seeking treatment again within one year of discharge is high, with these types of diagnosis. The issues raised concerned treatment efficacy and discharge management.
70	Jorgenson et al	Denmark	2009	Cohort Study	108 participants	No	Borderline Personality Disorder	Clinical engagement Patient preparedness Psychotherapy	Borderline patients as a group tend to have low levels of functioning in several areas, including social functioning and underachievement in terms of education, employment.

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71	Kammen et al	Finland	2003	Cohort Study	176 participants	No	Different personality make-up and trauma	Psychological therapy Trauma Response to treatment Resilience Mentalization-based treatment	The results show that exposure to psychological torture and ill-treatment was associated with an increased level of somatic symptoms among secure-autonomous, but not insecure, persons.
72	Karterud et al	Norway	2013	Test of a clinical measure	18 therapy sessions rated by 7 different therapists.	Yes with different clinicians rating	Borderline Personality Disorder	Mentalization-based treatment	The MBT-ACS was found to be an appropriate rating measure for treatment fidelity and useful for the purposes of quality control and supervision.
73	Kelly et al	UK	2007	RCT	Problem solving treatment; n= 128, depression prevention course; n = 108, control group; n = 189.	Yes	Personality disorders (especially paranoid personality disorder)	Patient engagement Treatment selection Motivation	Study results suggest; episodes of depression in the context of personality disorder may represent a valuable opportunity to engage with patients who might otherwise resist engagement.
74	Knox et al	USA	2006	Case analysis	13 clinicians	No	Personality disorders and deliberate self-harm.	Supervision Staff training Psychotherapy Engagement	His study explored clinicians' experiences and responses to self-harm and client suicide. Supervisors are advised to normalize and process supervisees' experiences of client suicide.
75	Kopala-Sibley et al	Canada	2012	RCT	38 BPD clients compared with control group	Yes	Borderline Personality Disorder	Engagement Altered perception of treatment and need Clinical decision making	This study examined whether the personality traits of self-criticism and dependency respectively moderated the effects of perceived inferiority and emotional insecurity on negative affect during interpersonal interactions in individuals with BPD.
76	Krueger et al	USA	2010	Review	Not stated	N/A	All personality disorders	Diagnosis Assessment consistency Changing symptomology	The paper discusses the importance of constructing a comprehensive quantitative model of psychopathology based on data, an endeavour that is motivated and informed by the close conceptual and empirical parallels between personality and psychopathology.
77	Larsson et al	Sweden	2010	Review	Not stated	N/A	Not stated	Psychotherapy Different modalities Treatment differences Treatment similarities	The review discusses the range of different psychotherapies, it explore their similarities and differences. He review explores how people are offered different therapies.
78	Lazarus	USA	2007	Review	Not stated	N/A	No stated mental disorder	Psychotherapy Engagement Therapeutic relationship	The paper reviews different approaches to engagement and how engagement effects treatment selection and outcome.
79	Liebman et al	USA	2013	Survey	560 respondents	No	Borderline Personality Disorder	Impact on clinicians working with people with BPD Psychotherapy Staff self-care Treatment choices Treatment experiences	Study findings help to better understand countertransference reactions and the ways they may impact diagnostic choices and treatment decisions. The implications of these findings for facilitating better clinician-client matching, reducing clinician burnout, and improving treatment experiences for individuals with BPD are discussed.
80	Leichsenring et al	Germany	2011	Review	Not state	N/A	Borderline Personality Disorder (BPD)	Patient variables Treatment suggestions (all)	This review describes BPD, its symptoms and its different treatments.

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81	Levine et al	USA	2006	Review	None	N/A	All mental disorders	Prescribed treatment Clinical decision making	The paper discusses the implication of the change in diagnostic categories of mental health and also the perceived prescription of treatments which authors suggests impact upon clinical decision making.
82	Lewy et al	USA	2006	RCT	90 patients	Yes	Borderline Personality Disorder (BPD)	Psychotherapy Treatment compassion Treatment selection	Patients were randomized to transference-focused psychotherapy (TFP), dialectical behaviour therapy, or a modified psychodynamic supportive psychotherapy.
83	Lilliengren et al	Sweden	2005	Interview analysis via grounded research.	22 patients	No	Personality disorder (all)	Psychotherapy Treatment efficacy Engagement/ disengagement Patient experience	Nine themes were sourced from interviews conducted with patients receiving psychotherapeutic treatments for personality disorder. He outcomes provide an insight into some factors concerning patient feelings in regards to treatment.
84	Logan et al	UK & Norway	2012	Commentary	None	N/A	Personality disorder (all)	Medications Psychotherapy Treatments Engagement Risk spectrums Symptom spectrums	The paper summarises presentations at the forensic mental health conference in Norway focused upon people with personality disorder.
85	Magidson et al	USA	2012	Practice Review	None	N/A	Narcissistic personality disorder	Engagement Treatment choices Motivating to engage	This practice review highlights that these paradigms can be integrated when sharing the same ultimate goal: to improve delivery of care across medically oriented clinical settings for patients with narcissistic features.
86	Magnavita et al	USA	2003	Review	Not stated	N/A	Personality disorder (all)	Stigma and diagnosis Motivation to engage Different treatments Treatment selection	Current knowledge about personality disorders, their aetiology, and their associated features are reviewed. The common treatment modalities for these disorders, from which integrative therapies have evolved, are described.
87	Magnavita et al	USA	2010	Review	Not stated	N/A	Personality disorder (all)	Psychotherapy Clinical decision making Different treatments Treatment selection	The paper discusses the difficulty working with people who have personality disorder. It provides a review which targets relational issues which may arise on assessment and treatment.
88	Manchak et al	USA	2014	Interview study	125 mental health court participants	N/A	Serious mental illness - non-specified.	mandated treatment, therapeutic alliance, treatment alliance, interpersonal circumplex	The paper suggests that given that mandated treatment relationships involve much greater therapist control and client submission than voluntary treatment relationships, it seems important to assess this dimension as part of relationship quality in mandated treatment.
89	Marcus et al	USA	2004	Survey	309 jail and prison inmates	No	Psychopathic Personality	Assessment Diagnosis Treatment allocation	He paper explores the continuum of personality differences, exploring where traits and behaviours become pathological.
90	Martin et al	Canada	2012	Literature review	25 research studies	N/A	All mental disorders	Assessment Support Treatment choices	Results suggested some relationship between intervention effects on mental health and criminal justice reinvolvement, although future research is needed in this area, especially given the absence of mental health outcome data in many studies.

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91	McMurrin	UK	2012	Review and model presentation	None	N/A	Personality disorder (all)	Motivation to engage Treatment preparation Engagement Treatment selection Clinical decision making	A model of Readiness to Engage in Treatment for Personality Disorders is presented to guide research and assessment. Pre-therapy preparation is one potentially valuable approach to improving treatment engagement and retention, and examples of interventions are described.
92	McMurrin et al	UK	2010	Literature review	28 studies	N/A	Personality disorder (all)	Treatment selection Treatment inclusion Drop-out Therapeutic engagement	The aim of this study was to conduct a systematic review of the literature on psychosocial treatments for personality disorder to identify factors associated with treatment non-completion.
93	McRae	UK	2013	Triangulation study; interviews, notes review.	11 patients 12 nurses	yes	Anti-social Personality Disorder	Treatment provision Treatment exclusion	This study explores the needs of people with antisocial personality disorder. It discusses it in the context of Foucault's philosophical frameworks.
94	Mendelberg	USA	2014	Commentary	Not applicable	No	Various disorders	Costs of treatment Refining choices Treatment selection	The author presents a case study of an independent practice organized under the umbrella of a for-profit mental health clinic with services provided by multidisciplinary professionals and analyses its development and leadership, the obstacles encountered, and the principles underlying its success.
95	Moran et al	UK	2007	Commentary	Not applicable	No	Personality disorder (all)	Epidemiology Treatment Clinical decision making engagement	The paper presents a review of the diagnostic criteria and also all the treatment choices in the UK in regards to personality disorder.
96	Morey et al	USA	2014	Diagnostic assessment study	337 mental health clinicians	Yes - Comparison by discipline	Personality disorder (all)	Diagnostic debates Assessment differences Changes in symptom profiles	The paper uses the new diagnostic framework for personality disorder introduced by the DSM 5 and compares diagnosticians ability to use the framework and perceptions of it.
97	Moses	USA	2009	Cross-sectional study	60 adolescents	No	Serious mental illness	Stigma Treatment receptiveness Different perceptions re: mental health problems	The results support both optimistic and pessimistic interpretations regarding stigma and its effects on adolescents diagnosed and treated for mental disorders.
98	Muller	Germany	2011	Review	50 recorded therapeutic concept diagrams	Yes – different therapist use	Various disorders	Treatment Selection Psychotherapy – CBT Therapy Planning	The paper explores the implication of therapy planning in regards to treatment efficacy and treatment outcomes. The paper presents a model for CBT that may be useful.
99	Naso	USA	2006	Review	No	N/A	Personality Disorders - various	Treatment interfering behaviours Decision making	The paper suggests that not all forms of deception are alike. Unlike pathological lying or frank antisocial behaviour, moral hypocrisy reflects the deceptive pursuit of self-interest in which the individual uniquely violates his or her own moral standards.
100	Neal et al	USA	2014	Review	No	N/A	Various mental health problems	Bias Clinical Judgment Clinical decision making Assessment differences	The paper discusses the cognitive biases that cause differences in interpretation and judgment in forensic mental health care. The papers asks what it can do to reduce the negative effects of these judgements in regards to care influences.

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101	Nelson-Gray	USA	2003	Review	None	N/A	Multiple mental health disorders	Treatment utility Assessment influence upon treatment outcome	Treatment utility studies using various assessment procedures (i.e., diagnosis and functional analysis) and various disorders are described. Suggestions are made as to when elaborated assessment and/or treatment utility studies are needed.
102	Norton et al	UK	2005	Review	None	N/A	Personality Disorders - various	Treatment connection Assessment outcome Available treatments Attitude and Stigma Patient variables	This paper presents a framework for how tertiary level specialist personality disorder services might begin to connect with one another and also with secondary level services, through the formation of 'managed clinical networks'
103	Nysæter et al	Norway	2008	Review	None	N/A	Borderline Personality Disorder (BPD)	Treatment differences Treatment efficacy Psychotherapy Schema focussed therapy	The paper suggests that there are many approaches for treatment are proposed for Borderline Personality Disorder, but there is no single treatment approach that seems to be the treatment of choice. It focusses particularly on the benefits of schema focused CBT interventions.
104	Owen	UK	2011	Review	None	No	Personality Disorders and insecure attachment	Engagement Relational difficulties Treatment choices Psychotherapy	The paper presents a review concerning people with insecure attachment patterns. It discusses the difficulty that mental health clinicians will encounter when engaging and assessing these patients due to their relational conduct.
105	Pascual-Leone	Canada	2009	Session analysis	34 therapy sessions	No	Personality disorder, anxiety and mood disorders.	Fluctuation in engagement Fluctuation in insight Treatment instability Unstable relationship patterns	The purpose of this study was to examine observable moment-by-moment sequences in emotional processing as they occurred within productive sessions of experiential therapy. The outcome suggests that there is often a fluctuation on a person's ability to engage.
106	Pelissier et al	USA	2003	Analysis of group programs	1,446 men and women, from 19 programs	Yes	Antisocial Personality Disorder and substance misuse	Treatment drop-out Motivation to engage Treatment selection	The study focusses upon a range of different group programs provided for prisoners with substance misuse difficulties. It finds one of the greatest factors for drop-out is the presence of antisocial personality disorder.
107	Perseus et al	Sweden	2007	Mixed Qualitative and Quantitative analysis	22 staff members	No	Borderline Personality Disorder (BPD)	Psychotherapy Dialectical Behaviour Therapy Staff Burnout Supervision Teamwork	The result show that psychiatric health professionals experience treatment of self-harming patients as very stressful. DBT was seen as stressful in terms of learning demands, but decreased the experience of stress in the actual treatment of the patients. The teamwork and supervision were indicated as effective in reducing harm.
108	Pickersgill	UK	2012	Review	No	N/A	Personality Disorders - all	Treatability UK change in care provision Engagement Treatments (all)	This article, charts the transformation of health care provision by means of a diachronic analysis of debates and institutional shifts pertaining to both attempts to change the law, and understandings of personality disorder.
109	Pulleyblank et al	UK	2013	Meta-analysis	12 studies	Yes	Prodromal Psychosis	Clinical decision making Assessing treatment suitability	The paper suggests: for a test to be considered useful for making treatment decisions, it is necessary that making treatment decisions based on the results of the test be a preferable strategy to making treatment decisions without the test.
110	Quinn et al	USA	2009	Survey study	300 participants	Yes	Multiple mental health problems	Stigma Concealment of difficulties	The current research provides a framework for understanding how concealable stigmatized identities impact people's psychological well-being.

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111	Reed	Switzerland	2010	Commentary	None	N/A	All mental health disorders	Problems with classification Diagnostic specification Differences in symptoms	This article describes the current revision by the World Health Organization (WHO) of the International Classification of Diseases and Related Health Problems. This paper discussed the relevance of consciousness in regards to personality traits engagement and health assessment and provision of health care.
112	Roberts et al	USA	2014	Commentary	None	N/A	Personality traits	Conscious awareness Conscious influence	The paper states that patients consciously adopt neurotic disorders when confronted with intolerable levels of stress. Unawareness is created through sophisticated cognitive processes, by which patients forget their own self-involvement.
113	Rofé	Israel	2010	Commentary	None	N/A	Personality Disorder and neurosis	Patients unawareness of their symptoms	This study tested a model of the association between narcissism and compulsive consumption. They also add to growing evidence that people who are relatively narcissistic are poor self-regulators who may be at risk of developing a variety of addictive behaviours.
114	Rose	USA	2007	Survey	238 participants	No	Personality traits - Narcissism	Patients expectation Choices Influences on service provision	The paper reviews how clinicians chose to engage ad chose specific interventions and treatments for people who self-harm. It specifically focuses upon informed consent ad patient's ability to understand treatments offered.
115	Rudd et al	USA	2009	Review	None	No	Multiple disorders associated with self-harm	Informed consent Treatment compliance Treatment choice Clinical judgement	This study examined intra-individual variability in the mood and interpersonal behaviour of individuals with BPD and control participants. The findings document behavioural and affective manifestations of BPD in the context of naturally occurring interpersonal situations.
116	Russell et al	USA	2007	Comparative study	38 people with BPD 124 control group	Yes	Borderline Personality Disorder (BPD)	Relational effects on Assessment Engagement Treatment choice	The author suggests a view that in relation to recent developments in mental health services, the application of psychoanalysis might have a particularly important role to play on people with antisocial personalities.
117	Ruszczynski	UK	2010	Commentary	None	No	Antisocial Personality disorder and Psychosis	Treatability Treatment availability Psychotherapy Psychoanalysis	This article reports on a RCT allocating patients to either 4 sessions of (a) therapeutic assessment (TA) or (b) a structured goal-focused pre-treatment intervention. Short-term outcome, TA demonstrated superior ability to raise outcome expectancies and patient perceptions of progress toward treatment & higher satisfaction
118	Saeger	Netherlands	2014	RCT	74 participants	Yes	Personality Disorders - various	Pre-treatment intervention Psycho-education Patient satisfaction Patient understanding Treatment outcomes	Both meta-analyses provided promising evidence regarding the relevance of alliance rupture-repair processes to therapeutic outcome.
119	Safran et al	USA	2011	2 meta-analyses	analyses 1: n=148 analyses 2: n= 376	Yes	Various mental health disorders	Therapeutic relationship effects on engagement and treatment choices.	The findings of the paper support self-compassion as an important goal of psychotherapy and indicate that increase in the experience of activating affects and decrease in inhibitory affects seem to be worthwhile therapeutic targets when working to enhance self-compassion when working with patients who have Cluster C personality disorders.
120	Schanche et al	Norway	2011	RCT	25 patients – CBT Treatment 25 patients – Dynamic Psychotherapy	Yes	Cluster C Personality Disorders: avoidant, dependant and obsessive-compulsive	Treatment choices Psychotherapy CBT and Dynamic Therapy Engagement and self-perception	

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121	Siefert	USA	2012	Descriptive Paper	None	N/A	Borderline Personality Disorder (BPD)	Clinical supervision	The paper suggests establishing a discharge date early in treatment allows staff to immediately begin working with feelings of rejection or abandonment. At discharge, recommendations are made and criteria for future admissions are set forth.
122	Simonsen et al	USA	2014	Commentary	None	N/A	Personality Disorder - all	Psychotherapy Mentalization Motivational factors Engagement Factors	He paper comments on treatment strategies for personality disorders, analysing each of the cases and the problem of low motivation in terms of how they fit with the Level of Personality Functioning scale
123	Skeem and Cooke	USA	2010	Concept analysis	Not stated	N/A	Antisocial Personality disorder	Engagement Symptom perception Management/ Treatment	The authors believe the evidence favours viewing criminal behaviour as a correlate, not a component, of psychopathy or antisocial personality disorder.
124	Skodol et al	USA	2013	Commentary	None	N/A	Personality Disorder - all	Diagnostic debates Symptom changes	The paper reviews the changes in diagnostic criteria for personality disorder brought about by DSM – 5 and discusses the difficulty with two forms of diagnostic categorisation.
125	Smith	USA	2009	Review	None	N/A	All mental health disorders	Treatment suitability Evidence Based Practice Engagement Psychotherapy	The paper suggests that problems brought to therapy implicate fundamental questions regarding what constitutes a good life. A therapeutic response to such problems is not a technical means to change a circumscribed disorder, but an engagement with the client that has relevance to broader moral concerns.
126	Sneed et al	USA	2003	Review with 3 case examples	3 cases	No	Borderline Personality Disorder (BPD) specifically where there is deliberate self-harm.	Crisis intervention Initial contact Psychotherapy principles Dialectical behavioural therapy	The paper results stress the importance of implementing paradoxical interventions, which aim at unbalancing the patient and increasing readiness for change, in the context of validation, which aims at acceptance and restores the communicative function of emotions.
127	Snowden et al	UK	2003	Editorial	None	N/A	Personality Disorder - all	Value based judgment Exclusion Stigma Treatability Clinical decision making Treatment choices	Authors suggests that people with a personality disorder often describe themselves as 'the patients psychiatrists dislike'. They are made to feel blamed for their condition, and are met with prejudice and an unhelpful approach from professional staff, who often wrongly equate personality disorder with violence towards others.
128	South et al	USA	2013	Commentary	None	N/A	Personality Disorder – all types	Diagnostic criteria Symptoms cluster Diagnostic thresholds	The authors provide; (1) a brief review of the history of PD classification, (2) an overview and rationale for each of the five major suggested changes to PD diagnoses, (3) an outline the available evidence from behaviour genetics and interpretations of these findings.
129	Stiles et al	UK	2008	Data Analysis	9,703 patients	N/A	Mood and anxiety disorders	Treatment choices Dose/efficacy models Psychotherapy	The paper reviews data from a variety of patients entering primary are psychotherapy, it explores efficacy of interventions and also treatment thresholds.
130	Suvak et al	USA	2011	RCT	46 BPD patients 51 Control	Yes	Borderline Personality Disorder (BPD)	Knowledge of own needs Emotional encounters Psychotherapy	The paper suggests BPD patients emphasized valence more and arousing less than control participants did when using emotion terms to label their emotional reactions.

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131	Teglası et al	USA	2012	Review and single case analysis	One case	N/A	Personality traits	Construct validity Clinical judgement Clinical decision making Engagement Influences on assessment	The authors focus upon clinical judgement, they suggest: to understanding construct validity, are (a) implicit and explicit versions of personality constructs and (b) ability and personality as versions of constructs measured by performance tests presenting maximal and typical conditions, respectively.
132	Trompenaars et al	Netherlands	2006	Retrospective data analysis	593 patients	N/A	All mental health problems	Treatment decision Treatment allocation Treatment cost	The paper discusses how the concept of Quality of life (QOL) has become an important concept in research and treatment practice in mental health care.
133	Ulvnes et al	Norway	2014	RCT	50 patients with two therapeutic approaches	Yes	Cluster C Personality Disorders: avoidant, dependant and obsessive-compulsive	Therapeutic relationship Treatment efficacy Treatment continuation Patient variables in engagement and treatment perception	This article investigates whether patients' sense of self and therapists' interventions aimed at orienting patients toward affect produce an affective activation in the patient. The independent contribution of sense of self and therapist intervention, as well as sense of self's moderating effect on therapist interventions, were investigated.
134	Valbark	UK	2003	Commentary	None	No	Borderline Personality Disorder (BPD) and eating disorder	Psychotherapy CBT and Analytic Therapy Treatment choices Clinical judgement	The article discusses the treatment for people with eating disorders and personality disorder. It focusses upon those who are deemed 'not treatable' and explores reasons for this ad ways to engage people in treatment.
135	Van Manen et al	Netherlands	2008	Structured interview	27 clinicians	No	Personality Disorder – all types	Clinical decision making Clinical judgement Treatment selection Patient variables Resource allocation	The authors suggest that treatment selection in clinical practice is a poorly understood, often largely implicit decision process. This study, investigates how intake clinicians use information about patient characteristics to select psychotherapeutic treatment for patients with personality disorders.
136	Weertman et al	Netherlands	2005	multilevel analyses	398 outpatients	No	Personality Disorders and Anxiety Disorders.	Different treatments PD as an exclusion Drop-out rates Treatment suitability	People with Personality Disorders (PD) and PD-related beliefs reported higher symptom levels at outcome. However, these effects were not as strong as might be expected on the basis of prevailing clinical thought in this area. Dropout rates were not influenced by the presence of 1 or more PDs or PD-related beliefs.
137	Ma et al	China	2008	Descriptive qualitative research	15 nurses	N/A	Borderline Personality Disorder (BPD)	Clinical decision making Clinical judgement Supervision Difficulties in engagement Motivation to engage	The research raised five themes working with BPD: (a) shifting from the honeymoon to chaos stage; (b) nurses' expectations for positive vs. negative outcomes; (c) practicing routine vs. individualised nursing care; (d) adequate or inadequate support from health care team; (e) differences in care outcomes.
138	Westen et al	USA	2004	Critical review	None	N/A	None patient study	Psychotherapy Evidence based practice Treatment choice	This article provides a critical review of the assumptions and findings of studies used to establish psychotherapies as empirically supported.
139	Widiger et al	USA	2010	Review	None	N/A	Personality Disorder – all types	Treatment selection Assessment models	The paper suggests that the five-factor model compares well to personality disorder diagnostic categories with respect to all components measured.

Paper No	Author(s)	Country of origin	Year published	Study Type	Subjects	Comparison	Type of Personality Disorder Listed	Treatments Listed & Techniques	Main Findings
140	Widiger	USA	2011	Commentary	None	N/A	All Personality Disorders	Diagnostic criteria Range of symptoms Assessment	The paper discusses the changes in the diagnostic criteria for personality disorder brought about in DSM 5. T poses several criticisms to the changes in diagnostic categorization.
141	Wilson et al	UK	2014	retrospective panel study	47 patients	No	All Personality Disorders including Dangerous and Severe Personality Disorder (DSPD)	Treatability debates Engagement Motivation Treatment choices Clinical decision making	This study examines the evidence for long-term treatment for offenders in hospital who have a personality disorder. Treatment is provided within a modified therapeutic community model including accredited offending behaviour programmes.
142	Yates and Taub	USA	2003	Commentary	None	No	No specific disorder, paper focused on clinical assessment	Clinical decision making Assessment benefits Treatment selection and treatment outcome	An overview of cost-related issues is followed by practical strategies that researchers and administrators can use to measure incremental costs, incremental effectiveness, and incremental benefits of adding psychological assessments to other psychological interventions.
143	Younggren et al	USA	2011	Review	None	No	No specific disorder, paper focused on clinical, ethical and legal duties.	Clinical judgements Legal decision making Treatment choices Patient expectations	The article discusses ethical components of the therapy relationship. It states that, while the psychotherapist has the primary responsibilities when rendering treatment to a patient, the treatment alliance is actually a dynamic that changes depending upon the conduct of both the psychotherapist and the patient.
144	Zeldow	USA	2009	Commentary	None	No	No specific disorder, paper focused on how clinicians make decisions in regards to therapy choices.	Clinical judgements Clinical decision making Evidence based practice Clinical training	Although clinical psychology is characterized by its commitment to science, the author argues that clinical practice cannot rely entirely or primarily on scientific evidence and empirically supported treatments.

Appendix 2 – Table presented to demonstrate the journal source breakdown for the literature review conducted within the study exploring treatment choices for people with Personality Disorder.

Journal Title	No	Journal Title	No
Psychodynamic Psychology	1	Psychological Medicine	1
Psychoanalytic Psychotherapy	3	European Psychiatry	1
The European Journal of Psychological assessment	3	Counselling Psychology Journal: practice and research	1
Psychology and Psychotherapy: Theory, Research & Practice	2	Journal of Theoretical and Philosophical Psychology	1
Psychiatry	1	Social Work in Mental Health	1
Psychotherapy Research	2	Clinical Psychology Review	2
Personality Disorders: Theory, Research and Treatment	8	Journal of Counselling & Clinical Psychology	6
Journal of Abnormal Psychology	7	Journal of Psychotherapy Integration	10
Journal of Psychiatric and Mental Health Nursing	3	Professional Psychology: research and practice.	13
Psychotherapy	6	Psychology: Practice, Policy and Law	1
The American Journal of Psychoanalysis	1	Journal of Trauma and Dissociation	1
Journal of Counselling Psychology	2	Developmental Psychology	1
Psychiatry Research	2	British Journal of Psychiatry	1
Peace and Conflict: Journal of Peace Psychology	1	Emotion	1
Psychiatry Quarterly	1	Psychotherapy: Theory, Research, Practice and Training	9
Forensic Psychiatry and Psychology	3	American Psychologist	2
Psychological Services	1	Bipolar Disorders	1
Pain	1	Rehabilitation Psychology	1
Journal of Contemporary Psychotherapy	1	Psychology Bulletin	4
Nordic Psychology	3	Psychological Trauma: Theory, Research, Practice and Policy	1
Group Analysis	1	Canadian Psychology	2
The American Journal of Orthopsychiatry	4	Psychology of Addictive Behaviours	3
Journal of Personality & Social Psychology	1	International Journal of Forensic MH	2
Personality and Individual Differences	1	The Psychology Manager Journal	1
Psychological Assessment	11	Social Studies of Science	1
The Lancet	1	Journal of Clinical Nursing	1
		Law and Human Behaviour	2
		Psychiatric Bulletin	2

Appendix 3 - Table presented to demonstrate the age range of the literature sourced for the literature review conducted within the study exploring treatment choices for people with Personality Disorder.

Age Range	Number
Under 2 years since the publication date	N = 50
Between 2 and 5 years since the publication date	N = 41
Between 5 and 10 years since the publication date	N = 42
Older than 10 years since the publication date	N = 11

Appendix 4 - Table presented to demonstrate the diagnostic focus of the papers sourced for the literature review conducted within the study exploring treatment choices for people with Personality Disorder.

Diagnosis	Number(N)
Borderline Personality Traits/Disorder	N = 24
Narcissistic Personality Traits/Disorder	N = 2
Paranoid Personality Traits/Disorder	N = 1
Dependant Personality Traits/Disorder	N = 3
Antisocial Personality Traits/Disorder (Psychopathic)	N = 10
Avoidant Personality Traits/Disorder	N = 3
Obsessive-Compulsive Personality Traits/Disorder	N = 2
Personality Disorder (unspecified/all)	N = 58
Psychotic Disorder (including Schizophrenia)	N = 2
Mood or Affective Disorders (including depression)	N = 4
Anxiety Disorders	N = 5
Eating Disorder	N = 2
Alcohol or Illicit Substance Misuse	N = 2
Self-Harming & Suicidal Behaviours	N = 6
<i>Hypochondriacal</i> and/or somatoform disorder	N = 2
Attachment Disorder	N = 1
Trauma (including PTSD)	N = 4
Multiple mental health disorders	N = 28
Not related to any diagnosis	N = 11
*NB: the total number for this section exceeds the total number of papers reviewed (n=144) as certain papers referred to more than one diagnosis or related problem.	

Appendix 5: Table presented to demonstrate the country of origin for the papers sourced for the literature review conducted within the study exploring treatment choices for people with Personality Disorder.

Country of origin	Number
United States of America	N = 82
United Kingdom	N = 25
Canada	N = 8
Sweden	N = 4
Norway	N = 4
Netherlands	N = 4
Germany	N = 2
Denmark	N = 2
Switzerland	N = 2
China	N = 1
Greece	N = 1
Italy	N = 1
Austria	N = 1
Spain	N = 1
Finland	N = 1
Australia	N = 1
Israel	N = 1
Multicentre	N = 3

Appendix 6 – Personality Disorder Diagnostic Categorisation

DSM-IV-TR (APA, 2000;287-297)	ICD-10 (WHO, 1992;36)
<p>Personality Disorder</p> <p>Cluster A Personality Disorder 301.0 Paranoid Personality Disorder 301.20 Schizoid Personality Disorder 301.22 Schizotypal Personality Disorder</p> <p>Cluster B Personality Disorder 301.7 Antisocial Personality Disorder 301.83 Borderline Personality Disorder 301.50 Histrionic Personality Disorder 301.81 Narcissistic Personality Disorder</p> <p>Cluster C Personality Disorder 301.82 Avoidant Personality Disorder 301.6 Dependant Personality Disorder 301.4 Obsessive-Compulsive Personality Disorder</p>	<p>F60 Specific Personality Disorders</p> <p>F60.0 Paranoid Personality Disorder F60.1 Schizoid Personality Disorder F60.2 Dissocial Personality Disorder F60.3 Emotionally unstable personality disorder .30 Impulsive type .31 Borderline type F60.4 Histrionic Personality Disorder F60.5 Anankastic Personality Disorder F60.6 Anxious [avoidant] personality disorder F60.7 Dependent Personality Disorder</p>

Appendix 7 - A brief overview of Objectivism and Objectivists

Objectivists propose that 'reality' exists independent of consciousness and so can be perceived and conceptualised objectively, the aim of their research is therefore to conduct research in a way that is 'value-free' (Bryman, 2012). They often take a 'nomothetic approach' to study, meaning that they typically conduct research with large groups of people, in an attempt to produce 'generalisable' laws or principles concerning objective phenomena (Bowling, 2002).

This approach is typically conceptualised as using the positivist paradigm, where-by the hypothetico-deductive method is employed to problem conceptualisation (Popper, 2002), and problem-solving usually favours quantitative methodology (Bishop, 2002). This means that research focuses on either falsification or verification of a specified variable or hypothesis (Hume, 1978). This approach aims to quantify 'generalisable' results (Hughes, 1990b).

There are many criticisms of the objectivist and positivist stand-points. The main concerns are that it may 'over-simplify' complex health and social phenomena, and in doing so, the subjectivity of experiences which provide context and conceptual relativity may be lost (Cruickshank, 2011).

The aim of this proposed research study is to explore treatment choices and the effects the interpersonal interaction and value based judgements may have upon treatment choices, affecting care delivery and outcome. It is proposed that an objective analysis of this encounter would be difficult at this stage, as in reviewing the literature, multiple variables are cited as posing difficulty in making treatment decisions. This generates the current need to explore the contextual interaction of these variables, rather than test a hypothesis to produce a generalizable result concerning the variables, which means, at this stage in understanding the phenomena of treatment choices with people with personality disorder and objectivist, quantitative approach would not seem practical, realistic or achievable.

Appendix 8 - A brief overview of Subjectivism and Subjectivists

The origins of subjectivism are attributed to Descartes, specifically concerning his work upon 'methodological doubt' (Stroud, 2002). Subjectivists are proposed to reject the notion of objectivity and external truth, proposing that humans are unique and their subjective perceptions and experiences are of value (Hanley et al, 2001). Subjectivists are posited to take an 'ideographic approach' to research in social science, which Kant described as the tendency to 'specify' as opposed to 'generalise' in nomothetic approaches (Bowling, 2002). This means that they may use an 'interpretivist' paradigm to understand a problem by submersing themselves in the experience and subjectively translating their findings (Gray, 2004).

Subjectivists are suggested as using a 'nominalist ontology' and 'anti-positivist' epistemology, which is ontologically different from an objectivist (Burrell and Morgan, 1979). What this means is that the concept of 'objectivity' is felt not to be possible in a situation with so many variables, (Denzin, and Lincoln, 2000).

The Subjectivist epistemological stand-point has critics due to the subjective nature of research results, these critics typically prize 'generalisability', therefore place less value in subjectivity and uniqueness (Raven, 2013). Historically, UK Policy favoured research conducted from more of an objective or Positivist standpoint, meaning that subjectivists were deemed as less '*politically powerful*' (Jordan et al, 1998). However, over the past 10-15 years there has been a paradigm shift, and value placed upon subjectivist and interpretivist research has increased, evident by the inclusion of subjectivist and constructivist research within change agendas (Pope and Mays, 2006).

Subjectivists typically favour qualitative research methods, as these approaches place value upon 'contextualism' as opposed to 'generalisability'. A pure subjectivist approach to this proposed research would be difficult. This is because the treatment choices encounter exists within a structured health care system. This means that there is a non-subjective reality concerning resource allocation, policy, and procedure which governs the potential outcomes for the treatment choices encounter.

This means that the individuals within the encounter (the clinician and the patient) have the ability to subjectively affect the encounter, however are also influenced by the reality of governance frameworks. A true subjectivist may reject the fact of 'conceptual realism' (Paul et al, 2008), meaning that should the research question be explored from a solely subjectivist viewpoint, the results may be of little practice value, because they may utterly conflict with the resource provision in the current UK healthcare climate.

Appendix 9 – Semi-structured interviews as the exemplary method for IPA

Semi-structured interviews as the exemplary method for IPA (the structure is summarised from the description provided by Smith et al, 2014:55-80)

1. Construct a research question.
2. Decide upon the sample.
3. Develop semi-structured interview schedules focussed on the research question and subject matter. Consider whether a coding value is attached to each question.
4. Construct questions and prompts that encourage the participant to disclose their perception, without leading them to or from a particular response.
5. Conduct the semi-structured interviews (typically lasting approximately 1 hour).
6. Tape-record and then transcribe each interview.
7. Analyse the transcripts, looking for themes, in the first case initially. Annotation will be placed in the left hand margin concerning interesting or significant details of the participant's response. Make comment on themes, association, connections, and preliminary interpretation. Particularly exploring the use of metaphors and emotive language and references to: 'me' and 'not me'.
8. Return to the beginning of the transcript and use the right hand margin to document emergent theme titles.
9. Connect the themes raised throughout the transcript, using analytical and theoretical ordering, identifying themed clusters and subordinate themes.
10. Continue the IPA transcript analysis with the other cases.
11. Look for convergence and divergence in each case.
12. Once each case has been analysed by the interpretative process, a final table of subordinate themes is constructed.

The resulting analysis should respect both theoretical convergence and within that, individual idiosyncrasy in how that convergence is manifest, consistent with the constructivist theory.

Appendix 10 - Table presented to detail the professional background of interviewee's participating in the study exploring treatment choices for people with Personality Disorder.

Profession	Number
Psychiatrist	2
Nurse	5
Occupational Therapist	1
Nurse Consultant	1
Clinical Psychologist	1

Appendix 11 - Table presented to detail the age range of interviewee's participating in the study exploring treatment choices for people with Personality Disorder.

Age	Number
25 - 35 years old	2
36 – 45 years old	2
46 – 55 years old	5
56 – 65 years old	1
65 years old and above	0

* Please note that the mean age of the team members in the locality is 43 years old.

Appendix 12 - Table presented to detail the gender distribution of interviewee's participating in the study exploring treatment choices for people with Personality Disorder.

Gender	Number
Female	6
Male	4
Not stated	0

* Please note that the locality gender distribution 70% female 30% male at the time of the study, meaning this sample is slightly over representative in terms of males.

Appendix 13: Table presented to detail the first language of interviewee's participating in the study exploring treatment choices for people with Personality Disorder.

Language	Number
English as a first language	8
English not a first language	2

Appendix 14: Table presented to detail the qualification level of interviewee's participating in the study exploring treatment choices for people with Personality Disorder.

(**certain participants have more than one qualification, which is why the numbers detailed are above the numbers of participants interviewed)	
Qualifications	Number
Diploma	4
Batchelor's Degree	6
Master's Degree	4
Doctorate Level Qualification	3

Appendix 15 – Table presented to detail the number of years each interview participant has worked in mental health care, for interviewees participating in the study exploring treatment choices for people with Personality Disorder.

Interviewee experience in mental health care	
Interviewee	Number of Years
Interviewee 1 (clinician)	10 years
Interviewee 2 (clinician)	17 years
Interviewee 3 (clinician)	28 years
Interviewee 4 (clinician)	27 years
Interviewee 5 (clinician)	8.5 years
Interviewee 6 (clinician)	15 years
Interviewee 7 (clinician/supervisor)	27 years
Interviewee 8 (clinician/supervisor)	36 years
Interviewee 9 (clinician/supervisor)	13 years
Interviewee 10 (clinician/supervisor)	20 years
Average / Mean	20 years (averaged to the nearest year)
Total	201.5 year

Appendix 16 – Table presented to detail the number hours worked for each interview participant in the study exploring treatment choices for people with Personality Disorder.

Interviewee	Hours worked
Interviewee 1 (clinician)	37.5 Hours per week
Interviewee 2 (clinician)	37.5 Hours per week
Interviewee 3 (clinician)	37.5 Hours per week
Interviewee 4 (clinician)	37.5 Hours per week
Interviewee 5 (clinician)	37.5 Hours per week
Interviewee 6 (clinician)	37.5 Hours per week
Interviewee 7 (clinician/supervisor)	30 hours per week
Interviewee 8 (clinician/supervisor)	37.5 Hours per week
Interviewee 9 (clinician/supervisor)	37.5 Hours per week
Interviewee 10 (clinician/supervisor)	37.5 Hours per week

Appendix 17 – Table presented detailing the total patient case load size for each interview participant in the study exploring treatment choices for people with Personality Disorder.

Participant	Total number of patients on current caseload
Participant 1 (clinician)	100 patients
Participant 2 (clinician)	80 patients
Participant 3 (clinician)	30 patients
Participant 4 (clinician)	280 patients
Participant 5 (clinician)	Not stated
Participant 6 (clinician)	20 patients
Participant 7 (clinician/supervisor)	15 patients
Participant 8 (clinician/supervisor)	24 patients
Participant 9 (clinician/supervisor)	700 patients
Participant 10 (clinician/supervisor)	40 patients
Average	143 Patients (based on 9 participants as one did not state their caseload)
Total	1289 patients

(*please note that interview participants did not state what proportion of these patients had a diagnosis of Personality Disorder – they did however state their caseload predominantly consisted of people either diagnosed with PD or with traits of PD)

Appendix 18 – Table presented to detail the diagnostic range that each interview participant in the study exploring treatment choices for people with Personality Disorder works with.

Participants working with patients presented with diagnostic co-morbidities alongside of the diagnosis of Personality Disorder.	
Mental Health Problems	Number of interviewees
Personality Disorder	10
Trauma	9
Depression	10
Anxiety	10
Psychosis	7
Bipolar Affective Disorder	7

Appendix 19 – Table presented detailing transcript information for each participant in the study exploring treatment choices for people with Personality Disorder.

Participant	Interview Length	Transcript Length
Participant 1 (clinician)	49 minute 40 seconds	409 lines
Participant 2 (clinician)	51 minute 38 seconds	469 lines
Participant 3 (clinician)	54 minute 09 seconds	427 lines
Participant 4 (clinician)	66 minutes 41 seconds	728 lines
Participant 5 (clinician)	51 minute 41 seconds	364 lines
Participant 6 (clinician)	58 minute 23 seconds	595 lines
Participant 7 (clinician/supervisor)	55 minutes 27 seconds	689 lines
Participant 8 (clinician/supervisor)	63 minutes 38 seconds	600 lines
Participant 9 (clinician/supervisor)	61 minutes 35 seconds	778 lines
Participant 10 (clinician/supervisor)	79 minutes 14 seconds	1246 lines
Average	59 minutes (to the nearest minute)	630 lines (averaged to each whole line)
Total	9 hours 52 min 6 seconds	6305

Appendix 20: Table presented detailing the gender distribution of the questionnaire respondents in the study exploring treatment choices for people with Personality Disorder.

Gender	Number
Female	12
Male	3
Not stated	0

Appendix 21: Table presented detailing the age range of the questionnaire respondents in the study exploring treatment choices for people with Personality Disorder.

Age	Number
18 - 30 years old	4
31 – 40 years old	5
41 – 50 years old	5
51 – 60 years old	1
61 years old and above	0
Not stated	0

Appendix 22: Table presented detailing the diagnosis of the questionnaire respondents in the study exploring treatment choices for people with Personality Disorder.

Diagnosis	Number
Personality Disorder (Unspecified)	7
Borderline Personality Disorder	7
Bipolar Affective Disorder – Type II	1
Depression	3
Complex PTSD	2
No disorder stated	1

Appendix 23: Table presented detailing the mental health service experience of the questionnaire respondents in the study exploring treatment choices for people with Personality Disorder.

	Number
New to service	3
Previously received mental health services	11
Not stated	1

Appendix 24: Table presented detailing the outcome of the questionnaires received in the study exploring treatment choices for people with Personality Disorder.

Question	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
I found the 'treatment choices grid' helpful	1(7%)	0	1(7%)	9(60%)	4 (26%)
I understood why the specific intervention had been offered to me, at this time.	1(7%)	0	1(7%)	9(60%)	4(26%)
I understood why certain treatment was not suggested for me at this time.	1(7%)	0	1(7%)	10(66%)	3(20%)
By using the 'treatment choices grid' I understood that as my needs change so will the treatment choices available to me.	1(7%)	0	1(7%)	10(66%)	3(20%)
I found the wording used in the 'treatment choices grid' easy to understand.	1(7%)	0	2(14%)	8(53%)	4(26%)
The 'treatment choices grid' helped me to structure my care plan with my worker.	1(7%)	0	2(13%)	9(60%)	3(20%)
I would recommend that this 'treatment choices grid' is used with other people entering this service.	1(7%)	0	1(7%)	8(53%)	5(33%)

% figures provided are rounded to the nearest whole percent.

Appendix 25: Table presented detailing the outcome for Q1 upon the questionnaires received in the study exploring treatment choices for people with Personality Disorder.

Q1 - What did you most like about the 'treatment choices grid' and/or the way it was used in your session?
"it is sensible"
"I liked it because I can see how I can work towards getting help"
"easy to understand"
"I can see where I am on the grid and why I am having the groups in ICT"
"It is easy to understand and I can see where I am on the grid. I can still get help even when I can't talk to staff"
"It is very easy to understand"
"I can see how thing will work"
"Easy to understand and cross reference within the 'boxed' structure. Similar to, but better than the arrow type of grids. The clear indications of treatment choices and how/ when they would be used would be used usefully for treatment."
"Well presented and laid out. Easy to understand, helps me to understand my problems"

Appendix 26: Table presented detailing the outcome for Q2 upon the questionnaires received in the study exploring treatment choices for people with Personality Disorder.

Q2 - What did you least like about the 'treatment choices grid' and/or the way it was used in your session?
"I want to get better but I don't want to go to a unit"
"nothing"
"Nothing that I do not like"
"I liked it at the beginning of treatment"
"Rather cold and clinical in its presentation. Giving factual guidance as to treatment choices but lacking in the human touch of verbal interactions."
"If anyone has any difficulty then they can easily ask for things to be clarified, but it might be made simpler with less writing."
"I didn't like it"

Appendix 27: Table presented detailing the outcome for Q3 upon the questionnaires received in the study exploring treatment choices for people with Personality Disorder.

Q3 - Do you have any suggestions about the way in which your treatment choices could be explored with you?
"No"
"It's all explanatory"
"When I can trust people, trust is a big issue for me"
"My honest opinions about this questionnaire that the 'treatment choices' are laid out as 'belonging to me' and yet they are choices that ultimately made for me by availability of treatment at the centre I attend for such sessions. Certain treatment choices are either too expensive, not practiced at the centre or severely time limited and thus in my experience, the tantalising options for treatment as laid out within the said grid are usually just a disappointment. Before treatment choices can be explored they need to increase in availability and scope"
"It could help the staff to understand other people's problems and how to help"

Appendix 28 – Boundary management training summary report.

Professional Boundaries Training

Summary Report

Introduction:

Professional Boundaries Training has been identified as a key area which benefits any professional working within an organisation who provides services for people with Personality Disorder. However, when NHS Trusts, local Universities and Social Care Employers have been contacted, it has been a subject that is absent from many local induction and mandatory training schedules, and also professional CPD courses. This has triggered locality exploration concerning the potential to create an adapted locality training package to support all in the organisation.

In order to support the development of a whole system training package, a generic Boundary Management Session was sourced and attended produced by an independent trainer who provided consent for the training package to be used and adapted concerning the issue of systemic approaches to supporting people with Personality Disorder.

This introductory session provided a baseline package, that was then adapted by a locality trainer/researcher to focus and develop a specific Boundary Management Package for Personality Disorder Service Providers, that was not just aimed at clinicians, but different members organisations which may be involved with boundary management issues. These staff groups included: administrators, human resources departments, senior managers, and directors. The rationale for this adaption and expansion is focussed on the notion of “One Team Working”, which promotes internal consistency in working practices, as well as consistency with external providers, and is key to notions of “Board to Ward” communication and consistent working practices.

The aim and objectives of the training are:

Aim: To explore the personal and systemic impact of boundary crossing in health and social care when working with people who have a diagnosis of Personality Disorder.

Objectives:

1. To explore the types of abuse that can occur and the definition of vulnerability, and relate this to the topic of boundary violations.
2. To explore the continuum of boundary issues that may occur within a relationship with a person in a position of responsibility.
3. To explore the differences between personal and professional relationships.
4. To explore boundary issues that may occur at different levels, specifically: between patients; between patients and staff; between patients and organisations; between staff groups, and between staff members and employing or allied organisations.
5. To explore a clinical example of a boundary management challenge.
6. To explore personal and professional obligations of all staff in terms of boundary management.

The training is also anchored in research and regulation, and is specifically related to increasing whole-system working when referring to the following themes:

- The Frances Report - Mid-Staffordshire Enquiry – learning lessons regarding whole-system working.
- ‘Raising Concerns at Work’ (whistleblowing) – derived from: ‘Freedom to Speak up Review’, ‘Speaking-Up Charter’, and the ‘Enterprise and Regulatory Reform Act’.
- Building upon local initiatives focused upon the: ‘Having a difficult Conversation’ campaign introduced by Trust Nursing and Partnerships division in 2013.
- This builds upon specific research conducted pertaining to making treatment choices with people who have a Personality Disorder appreciating the local pressures, when supporting patient groups considering the 6 C’s framework.
- It provides a framework to enable the exploration of “proactive risk-management decisions”, specifically focused upon enabling safe and consistent discharge processes.
- It is also a re-enforcing strategy, to ensure all staff are aware of specific policies related to specific boundary management issues, including; Bullying and Harassment Policy, Personal Responsibility Framework, Complaints Procedures, Safeguarding and Risk Management Policies, Raising Concerns policy, and other Human Resources Policies concerning bounded working practices (i.e. Social Media Policy).

The Boundary Management Training package has been launched and 104 staff have completed the training. The course evaluation for the first attendees is presented below:

Session Attendance:

Date / Time of Session	Number of attendees	Number of feedback forms received
2 nd July 2015 – PM	18	17 (94%)
10 th July 2015 – AM	8	8 (100%)
10 th July 2015 – PM	9	9 (100%)
21 st July 2015 – AM	13	12 (92%)
21 st July 2015 – PM	2	2 (100%)
31 st July 2015 – AM	15	14 (93%)
31 st July 2015 – PM	10	10 (100%)
14 th August 2015 – AM	15	15 (100%)
14 th August 2015 – PM	7	7 (100%)
17 th August 2015 - AM	7	6 (85%)
Total:	104	100 (96%)

Multi-professional learning is considered as a core requirement for this training, in order to promote interprofessional learning and multiple system engagement. Due to this, each of the 10 sessions conducted included a wide range of professions, rather than being profession-specific. A breakdown of the different professions groups who attended the training is shown below:

Profession	Number
Lead Consultant Psychiatrist	1
Consultant Psychiatrist	1
Inpatient Nurse	6
Occupational Therapist	5

Nurse Consultant	2
Psychotherapy Lead	2
Psychotherapist	2
CPN	12
Social Worker	10
Team Manager	8
Service Manager / Modern Matron	3
MHO	14
Nursing Assistant	18
STR Worker	2
Psychotherapy Trainee	1
Human Resources	3
Assistant Director	1
Ward Sister	2
OT Assistant	1
Nurse-Led Clinic Coordinator	1
Student Nurse	1
IAPT	1
MHA Administrator	1
Secretary	3
Administrator	3
Total:	104

The gender breakdown of attendees is presented in the following table, no results are drawn from this, except to state that it is reflective of the current employment in locality teams:

Gender	Number
Female	83
Male	21

Attendee Feedback

Each attendee was provided with a feedback form to complete at the end of each training session. The response rate for completion was good, with an average of 96% feedback for the 10 sessions conducted. The feedback form consisted of 5 specific questions, which attendees could rate using a Likert Scale (1-5 – 1 being the least positive, and 5 being the most positive rating). The feedback for each question is presented below:

Question 1– Did trainers demonstrate subject knowledge, and create interest for the course subject?	
Score 5 (trainers demonstrated exceptional knowledge)	93%
Score 4	7%
Score 3	0
Score 2	0
Score 1 (trainers failed to demonstrate knowledge or generate interest)	0

Question 2 – I had opportunities to participate and ask questions?	
Score 5 (I had a good opportunity to ask questions)	96%
Score 4	4%
Score 3	0
Score 2	0
Score 1 (I was not provided with the opportunity to ask questions)	0

Question 3 – Did the training have an appropriate balance of theoretical and practical activity?	
Score 5 (There was a good balance of theory and practice activity)	82%
Score 4	17%
Score 3	0
Score 2	0
Score 1 (The training had too much of either: theory and practice activity)	0
Not rated	1%

Question 4 – Did the training content meet the stated learning outcomes?	
Score 5 (The training met all stated learning outcomes)	92%
Score 4	8%
Score 3	0
Score 2	0
Score 1 (The training provided differed from the learning outcomes set)	0

Question 5 -Was the training facilitated and presented in such a way that you can use it in your work?	
Score 5 (I can apply what I have learned to my work)	95%
Score 4	4%
Score 3	0
Score 2	0
Score 1 (I cannot apply what I have learned to my work)	0
Not Rated	1%

Alongside of the Likert ratings, attendees were requested to provide free text feedback concerning their experience of the training. A summary of the responses are provided below:

Free-text responses by attendees concerning: - their experience of the 'Professional Boundaries Training'
<p>“Very good delivery, prompted discussion and reflections”.</p> <p>“Maybe could highlight the main recommendations concerning compassion”.</p> <p>“Open and fluid feel to the session”.</p> <p>“More explanation about how Personality Disorders develop may help”.</p> <p>“Group work and case studies generated good thinking and reflections”.</p> <p>“More group work please, the discussions were very interesting and informative”.</p> <p>“It was good to talk about cases, but with some distance, making it feel safe”.</p> <p>“It was great that people could bring their personal experiences, and this was explored in a supportive way”</p> <p>“Examples were clear, and related to my workplace”.</p> <p>“Very interactive and reality-based”.</p> <p>“Excellent training, enables me to reflect”.</p> <p>“Opportunities to discuss personal experiences was helpful and supportive”.</p> <p>“This course was helpful, because I thought I was aware of my own boundaries, but this helped me reflect upon issues that I had not thought of as boundary issues in the past (i.e. providing too much time for people with Personality Disorder)”.</p> <p>“Good course, it helps me reflect upon my personal and professional responsibilities”.</p> <p>“This course makes you think more carefully about your practice, and where you may be crossing boundaries, even though you have good intentions”.</p> <p>“As a student, this has enabled me to reflect upon my practice, and prepare for qualification”.</p>

Secondly, attendees were requested to provide feedback concerning how they will use the learning from the training to influence their future practice. A summary of the responses are provided below:

Free-text responses by attendees concerning: - how they will apply the learning from the 'Professional Boundaries Training' in their future practice.
<p>“I need to consider the issue of organisational boundary issues more in my day to day practice”.</p>

“It is useful to reflect upon dynamic formulations, where we find ourselves doing things without realising it, and how we got there, something about being vigilant and self-protective”.

“Awareness of what signs to observe for before boundaries get breached”.

“In ensuring that my practice not only meets my high standards, but the standards of the organisation, and regulatory bodies”.

“Awareness about needing to be open about what decisions are being made, which could be seen by others as “crossing boundaries”.

“To use the training in clinical and managerial supervision to explore and challenge boundary management issues”.

“This has made me think clearly about boundaries”

“I will use this training when supervising others”.

“I will use this in MDT discussions, group supervision, care planning, and clinical reviews”.

“Via self-reflection, team briefings, supervision, and general work discussion”.

“Reflection on these areas will help me with my re-validation”.

“Will use the learning when conducting investigations”.

“I will be more mindful of potential boundary breaches in my clinical practice”.

“I will find it more comfortable to discuss difficult boundary issues if they arise”.

“I will use this daily in my day to day work with people with Personality Disorder”.

“Increased awareness of boundary issues that can occur between service users and also colleagues”.

“This training is very relevant to my role in HR, I will use it in all aspects of my work with different business divisions”.

“I will reflect more about boundary issues in my everyday role, and feel more confident to raise concerns if they arise”.

“I feel that I am more aware of the need to support colleagues who may be experiencing difficulties”.

“I know better how to raise concerns, and also who to approach, if I feel that there are boundary issues in my practice area”.

“Increased awareness of my own practice and how to support my colleagues”.

“I will be less worried about raising concerns, and understand that they will be taken seriously”.

“I will use this on a daily basis with service users and colleagues”.

“I will use this information in my role as a nursing assistant”.

“It enables me to understand more about potential bullying and harassment and how it can start”.

Summary and Conclusions

The adapted professional boundaries training has been well-received from all attendees. The feedback that is presented above demonstrates that the way the training has been developed and delivered appears to be beneficial for multi-professional learning and development.

Attendees have provided feedback concerning the method of delivery, they have explained that the combination of group work and case vignettes has allowed them to explore issues together, and they have explained that it has helped that senior members of the team both delivered and used self-disclosure within the training itself, as this allowed honesty and feelings of safety to explore difficult practice issue.

Due to the positive nature of the evaluation, the locality have decided to provide training sessions throughout the division, and add the training to the list of the services mandatory training requirements.

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Trust Policies:

- Bullying and Harassment Policy
- Personal Responsibility Framework
- Complaints Procedures
- Safeguarding Policy
- Risk Management Policies
- Raising Concerns Policy

Also related to other Human Resources Policies concerning boundaried working practices (i.e. Social Media Policy).

Appendix 29 – Conference presentations in dissemination strategy

<p>Type of presentation: Poster Presentation. Topic: The experience of vicarious trauma in acute mental health care. Venue: University of Derby. Conference Topic: Health and Social Care Research Date: September 2012. Status: Completed</p>	<p>Type of presentation: Oral and Poster Presentation Topic: Treatment Choices for People with Personality Disorder. Venue: COHEHRE Conference, Semmelweis University Faculty of Health Sciences, Budapest, Hungary. Conference Topic: Health and Social Care Perspectives for a Sustainable Future Date: 22nd- 24th April, 2015. Status: Presentation completed in April 2015.</p>
<p>Type of presentation: Poster Presentation and short workshop. Topic: Occupational Trauma in Mental Health Care. Venue: Regional Research Conference, Castle Park Conference Centre, Doncaster. Conference Topic: Mental Health Research Date: December 2012. Status: Completed</p>	<p>Type of presentation: Oral and Poster Presentation Topic: Splitting as a concept: supporting people with Personality Disorder in an inpatient mental health setting. Venue: Sigma Theta Tau International: Phi Mu Chapter. 2nd Biennial Nursing Scholarship Conference, Weetwood Hall Conference Centre, Leeds. Conference Topic: Caring Leadership in a Politicised Nursing Arena Date: 19th June, 2015. Status: Completed</p>
<p>Type of presentation: Oral Presentation (3 Workshops with 40-50 delegates per workshop) Topic: Advancing Mental Health Nursing Practice: New Ways of Working. Venue: Regional Health Education Conference, Cedar Court Hotel, Wakefield. Conference Topic: Advanced Practice Date: June 2013. Status: Completed</p>	<p>Type of presentation: Oral and Poster Presentation Topic: Demystifying treatment choices when working with people who have Personality Disorder. Venue: Keepmoat Stadium, Doncaster. Conference Topic: Grounded Research Date: 15th October, 2015. Status: Abstract reviewed and accepted, awaiting to present.</p>
	<p>Type of presentation: Oral Presentation and Workshop Topic: Nurse Consultancy: Targeting interventions in Mental Health Care. Venue: Healthcare Conference UK, Nurse Clinics Conference, London Conference Topic: Nurse Led Clinics Date: 19th November, 2015. Status: Abstract peer reviewed and accepted, confirmed Speaker, however yet to complete the event</p>

Appendix 30 - Patient Questionnaire used in the research study exploring treatment choices for people with Personality Disorder.

'Treatment Choices Grid' – Service User Questionnaire.
Version 1 – 26/04/2014

Service User Questionnaire – 'Treatment Choices Grid'

Thank you for agreeing to provide feedback concerning your experiences with the 'treatment choices grid' which is being piloted with this service. This pilot study is being conducted as a part of a doctoral study at the University of Derby. Judith Graham, (Advanced Nurse Practitioner) is the Lead Researcher upon this project, and will arrange to meet you should you have any questions about this study.

To ensure your confidentiality, your name or date of birth will not appear on this questionnaire. However, it is requested that you provide a small amount of information about yourself. Please mark the most appropriate answer below:

Sex: Female Male Prefer not to say

Age: Between 18-30 Between 31-40 Between 41-50 Between 51-60 61+

Mental Health Diagnosis: _____

Have you received mental health service treatment in the past: Yes No

Please could you honestly rate your experience with the use of the 'treatment choices grid' within your recent service contact, by answering the questions below:

Question	Rating				
	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
	1	2	3	4	5
I found the 'treatment choices grid' helpful					
I understood why the specific intervention had been suggested to me, at this time.					
I understood why certain treatment was not suggested for me at this time.					
By using the 'treatment choices grid' I understood that as my needs change so will the treatment choices available to me.					
I found the wording used in the 'treatment choices grid' easy to understand.					
The 'treatment choices grid' helped me to structure my care plan with my worker.					
I would recommend that this 'treatment choices grid' is used with other people entering this service.					

'Treatment Choices Grid' – Service User Questionnaire.
Version 1 – 26/04/2014

What did you most like about the 'treatment choices grid' and/or the way it was used in your session?
(Please use the box below for your answer)

What did you least like about the 'treatment choices grid' and/or the way it was used in your session?
(Please use the box below for your answer)

Do you have any suggestions about the way in which your treatment choices could be explored with you? (Please use the box below for your answer)

Your help in completing this questionnaire is very much appreciated, and your anonymity assured. This questionnaire will be used for research and development purposes to develop the way we provide services in the future. Please return this form either directly to your worker, or via the post to the Lead Researcher using the stamped addressed envelope provided.

Appendix 31 - Clinician/ Supervisor consent and confidentiality form used in the research study exploring treatment choices for people with Personality Disorder.

Covering letter for clinicians and supervisors - Treatment Choices Grid.
Version 2 – 24/06/2014

CONSENT FORM

Research Title: Demystifying intervention: enabling consistent treatment choices for people with Personality Disorder.

Name of Researcher: Judith Graham (Advanced Nurse Practitioner/ Psychotherapist)

Please initial the boxes:

- 1. I confirm that I have read and understand the information sheet dated
for the above study. I have had the opportunity to consider the information, ask questions
and have had these answered satisfactorily.
- 2. I understand that my participation is voluntary and that I am free to withdraw at any time
up until my transcription is anonymised, without giving any reason, without my occupational
or legal rights being affected.
- 3. I understand that the researcher is a student conducting the research as part of the
requirements for a doctorate study program at the University of Derby.
- 4. I understand that my interview will be digitally recorded, and I agree to have my interview
recorded.
- 5. I agree to take part in the above study.

Name of Participant: _____ Date: _____ Signature: _____

Name of Person: _____ Date: _____ Signature: _____
Taking consent

When completed: 1 for participant; 1 for researcher site file.

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Christine Boswell - Chief Executive

Madeline Keyworth - Chairman

Appendix 32 - Clinician/ Supervisor demographics form used in the research study exploring treatment choices for people with Personality Disorder.

Treatment Choices Grid – Interviewee Demographics.
Version 1 – 26/04/2014

Rotherham Doncaster and South Humber 
NHS Foundation Trust

Profession: _____

Age: (please tick) 25-35 36-45 46-55 56-65 66-75

Gender: (please tick) Male Female Not Stated

Qualifications: _____

Number of years working in mental health care: _____

Hours Worked: Full Time Part Time Other (i.e. agency): _____

Number of service users on current caseload: _____ (approximate or actual)

Service User diagnosis worked with: (Tick more than one if applicable)

- Personality Disorder
- Trauma
- Depression
- Anxiety
- Psychosis
- Bipolar Affective
- Other (please state): _____

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Christine Boswell - Chief Executive Madeleine Keyworth - Chairman

Appendix 33 - Clinician/ Supervisor advice letters used in the research study exploring treatment choices for people with Personality Disorder.

Covering letter for clinicians and supervisors - Treatment Choices Grid.
Version 2 – 24/06/2014

Rotherham Doncaster and 
South Humber
NHS Foundation Trust

Participant Information Sheet

The following information has been prepared in regards to a research study that you are asked to contribute to:

Introduction

I am undertaking a research project concerning the implementation of a newly developed 'Treatment Choices Grid' for use with people who have a diagnosis of Personality Disorder. This study concerns the provision of assessment and treatment services in regards to Specialist Mental Health Services, and I am asking you to be a participant a semi-structured interview.

Purpose of the Study

The purpose of this study is to gain the opinion of patients, staff members and clinical supervisors, considering the use of the newly developed 'Treatment Choices Grid'.

Why have I been approached?

You have been approached to provide feedback as you have either conducted an assessment appointment where you used the 'Treatment Choices Grid' with patients, or you provide supervision to staff who have used this 'Treatment Choices Grid'. The interview will aim to gather your opinion, about the usefulness and usability of this 'Treatment Choices Grid'.

Do I have to take part?

You do not have to take part in this study if you do not wish to. You are free to decline to participate in an interview and your work will not be affected. Should you choose to participate within the interview process, an appointment will be scheduled with you to meet with the Chief Investigator and a list of questions that will be explored in the interview will be sent to you.

What do I need to do?

Should you wish to participate with this 'Treatment Choices Grid' evaluation you can complete the attached consent form and return it to the Chief Investigator using the stamped addressed envelope enclosed. Once your consent form has been received you will be contacted and a mutual time will be arranged for you to be interviewed. Interviews will be held at Great Oaks Mental Health Unit within the hours of 9-5, Monday to Friday. The service manager has provided agreement for all relevant staff to participate with these interviews within their working hours. The interview will last between 60-90 minutes.

Is my information Confidential? What happens if I wish to withdraw from the study?

In terms of confidentiality and consent to participate with the study, I promise the following:

- Your identity will be protected at all times, unless you give me specific permission to name you.
- Demographic information will be requested from you, however this information will be anonymised and collated with all other interviewees.

Serving people from all walks of life

Christine Boswell - Chief Executive

Madeleine Keyworth - Chairman

Covering letter for clinicians and supervisors - Treatment Choices Grid.
Version 2 – 24/06/2014

- Your interview will be audiotaped, then transcribed. Once transcribed you will be asked if you wish to check the transcription. After this stage the audiotaped data will be destroyed and all identifying information will be removed from the transcription, which will then be allocated a number. The number reference will then be the only way your transcribed interview will be referred to in any published information, to ensure your anonymity.
- It is however recognised that due to the small size number of clinicians and supervisors working with this patient group across the Trust involved in the study, that this may mean anonymity may not be fully assured.
- All transcriptions will be destroyed, post study publication.
- Secure encryption and storage of audiotaped and transcribed information is assured, as per Trust Policy.
- Clerical assistants and co-researchers employed to check the coding of the interview transcripts will adhere to the boundaries of confidentiality specified above.
- You are free to withdraw from the study up until the point when your transcription has been agreed, anonymised and allocated a research number. After this time your transcript will not be identifiable and therefore will not be able to be removed from the study.
- If you advise me of your wish to withdraw your participation, I will destroy all data relating to you.

Results of the study

After all of the study data and feedback has been collected, a short feedback sheet will be made available which details the outcomes of this research study. You will be sent a copy of this results sheet should you wish this, you can either request it from your manager or from myself the researcher.

Who is sponsoring the study?

This study is being undertaken as a part of a Doctorate in Health and Social Care Qualification via the University of Derby.

Independent contact for support

Although it is anticipated that the interview process will not be distressing, should you become distressed at any time during the research process, the team and service managers have agreed to provide support to you, should you require this.

Ethical Approval.

This study has gained Ethical Approval via the Bradford and Leeds NHS Research Ethics Committee and also by the University of Derby Ethics Committee.

As the Chief Investigator, please feel free to ask me any further questions you have in regards to the study.

I thank you for your consideration to assist with the evaluation of this clinical tool.

With thanks,



Judith Graham
Advanced Nurse Practitioner & Cognitive Behavioural Psychotherapist
Great Oaks Mental Health Unit, Ashby High Street, Ashby, Scunthorpe, DN16 2JX
01724 382090.

Date:

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Christine Boswell - Chief Executive

Madeleine Keyworth - Chairman

Appendix 34 - Ethics Approval letter – NHS Research Ethics Committee



Health Research Authority

NRES Committee Yorkshire & The Humber - Bradford Leeds

Jarrow REC Centre
Room 002
Jarrow Business Centre
Rolling Mill Road
Jarrow
NE32 3DT

Telephone: 0191 428 3565

26 June 2014

Ms Judith Graham
Advanced Nurse Practitioner
The Mental Health Access Team
Great Oaks Mental Health Unit
Ashby High Street
Ashby, Scunthorpe
DN16 2JX

Dear Ms Graham

Study title: Demystifying intervention: enabling consistent treatment choices for people with Personality Disorder
REC reference: 14/YH/1039
IRAS project ID: 157333

Thank you for your letter received on 25 June 2014, responding to the Proportionate Review Sub-Committee's request for changes to the documentation for the above study.

The revised documentation has been reviewed and approved by the sub-committee.

We plan to publish your research summary wording for the above study on the NRES website, together with your contact details, unless you expressly withhold permission to do so. Publication will be no earlier than three months from the date of this favourable opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to withhold permission to publish, please contact the REC Manager Ms Gillian Mayer, nrescommittee.yorkandhumber-bradfordleeds@nhs.net

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a **Favourable** ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

You should notify the REC in writing once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. The REC will acknowledge receipt

and provide a final list of the approved documentation for the study, which can be made available to host organisations to facilitate their permission for the study. Failure to provide the final versions to the REC may cause delay in obtaining permissions.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations.

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database within 6 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication trees).

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to contest the need for registration they should contact Catherine Blewett (catherineblewett@nhs.net), the HRA does not, however, expect exceptions to be made. Guidance on where to register is provided within IRAS.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" above).

Approved documents

The documents reviewed and approved by the Committee are:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Indemnity letter]	1	07 June 2014
Interview schedules or topic guides for participants [Clinician Semi-Structures Interview Schedule]	1	26 April 2014
Interview schedules or topic guides for participants [Supervisor Participant Semi-Structured Interview Schedule]	1	26 April 2014
Letter from sponsor [Sponsor Letter]	1	22 May 2014
Non-validated questionnaire [Service User Questionnaire]	1	26 April 2014
Participant consent form [Clinicians & Supervisors]	2	24 June 2014
Participant information sheet (PIS) [Clinicians & Supervisors]	2	24 June 2014
Participant information sheet (PIS) [Patients]	2	24 June 2014
REC Application Form [REC_Form_09062014]		09 June 2014
Research protocol or project proposal [Research protocol]	1	16 May 2014
Response to request for further information	J Graham	(not dated)
Summary CV for Chief Investigator (CI) [Researcher CV]	1	16 May 2014
Summary CV for student [Student/CI CV]	1	07 June 2014
Summary CV for supervisor (student research) [University Supervisor CV]	1	07 June 2014

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document “After ethical review – guidance for researchers” gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

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

Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website:

<http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance>

We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details at <http://www.hra.nhs.uk/hra-training/>

14/YH/1039

Please quote this number on all correspondence

With the Committee's best wishes for the success of this project.

Yours sincerely

pp



**Dr Janet Holt
Chair**

Email: nrescommittee.yorkshireandhumber-bradfordleeds@nhs.net

Enclosures: *'After ethical review – guidance for researchers'*

Copy to: *Mrs Wendy Wood – University of Derby*

*Ms Gillian Herdman, Research Office, Rotherham Doncaster and
South Humber NHS Trust*

Appendix 35 - Ethics Approval letter – University of Derby



Approval Letter

Date: Tuesday 17 June 2014
Name: Judith Graham

Dear Judith Graham

Topic: Demystifying intervention: enabling consistent treatment choices for people with Personality Disorder.

Thank you for submitting your application to the School of Health and Social Care Research Ethics Committee.

Your study has been approved by the committee and you are able to proceed.

If any change to the study described in the application or to the supporting documentation is necessary you are required to make a resubmission to the School of Health Research Ethics Committee.

We will also require an annual review of the progress of the study and notification of completion of the study for our records.

All the best.

A handwritten signature in black ink, appearing to read "Martyn Harling".

Yours sincerely,
Martyn Harling
(Vice-Chair, School of Health and Social Care REC)

Appendix 36 - Ethics Approval letter – NHS Trust Research & Development Service

Rotherham Doncaster and 	
South Humber	
NHS Foundation Trust	
Research Governance office, based at:	
Doncaster Clinical Research Joint Research Office with NHS Doncaster and Doncaster & Bassetlaw Hospitals NHS Foundation Trust Tel: 01302 366666 Ext: 4708 Email: doncasterclinicalresearch@dbh.nhs.uk	Doncaster Royal Infirmary Armthorpe Road, Doncaster South Yorkshire DN2 5LT Tel: 01302 366666 Fax: 01302 320098 Minicom: 01302 553140 (only for people who are deaf)
21 July 2014	
<u>CONFIDENTIAL</u>	
Miss Judith Graham The Mental Health Access Team Great Oaks Mental Health Unit Ashby High Street Ashby Scunthorpe North Lincs. DN16 2JX	
Dear Miss Graham,	
Study Title: Demystifying intervention: enabling consistent treatment choices for people with Personality Disorder	
Chief Investigator: Miss Judith Graham	
Sponsor: University of Derby	
RDASH Reference: 0087/2014/NCT	
REC Reference: 14/YH/1039	
I am pleased to inform you that the above project has now been given authorisation to commence within Rotherham Doncaster and South Humber NHS Foundation Trust. For your information, the project reference is RDaSH 0087/2014/NCT . I would be grateful if you could quote this number in any further correspondence with this department.	
Permission is granted on the understanding that the study is conducted in accordance with the Research Governance Framework, ICH GCP (where applicable) and NHS Trust Policies and Procedures.	
Documentation Your authorisation has been granted based on submission of the following documentation:	
<ul style="list-style-type: none">• Study Protocol (Version 1, dated 26 April 2014)• IRAS R&D form (submission code: 157333/630725/14/896 signed by Judith Graham on 7 June 2014)• IRAS SSI form (submission code: 157333/630740/6/124/249010/302970 signed by Judith Graham on 27 June 2014)• CV of Ms Judith Graham• Academic CV of Dr Michael Townsend• CV of Wendy Wood• Participant Information Sheet and Consent Form – Clinician (Version 2 dated 24 June 2014)• Participant Information Sheet – Patient (Version 2 dated 24 June 2014)• Service User Questionnaire – Treatment Choices Grid• Treatment Choices Grid – Clinician Interview (Version 1 dated 26 April 2014)	
<small>Associate teaching hospital of the University of Sheffield Associate college of Sheffield Hallam University</small>	
<small>WPR11991a Oct 2004</small>	

- Treatment Choices Grid – Supervisor Interview (Version 1 dated 26 April 2014)
- Letter from Sponsor dated 22 May 2014
- Letter of approval from the School of Health Research Ethics Committee dated 17 June 2014
- Indemnity statement dated 11 July 2013
- Letter stating 'favourable ethical opinion' from Yorkshire & The Humber – Bradford Leeds Research Ethics Committee, dated 26 June 2014.

Permission is only granted for the activities for which a favourable opinion has been given by the Research Ethics Committee and that have been authorised by the MHRA, where applicable.

Please note that approval is limited to the dates stated on the research application form and that you are obliged to notify the Research Governance Department of any adverse events that arise during the course of the project. You are also obliged to inform us if your project deviates in any way from the original proposal / documentation you have submitted. This may result in the suspension of your project until changes have been agreed with the Trust.

The Research Sponsor, or the Chief Investigator, or the local Principal Investigator, may take appropriate urgent safety measures in order to protect research participants against any immediate hazard to their health or safety. The Research Governance office must be notified that such measures have been taken. The notification must include the reasons why the measures were taken and the plan for further action. The Research Governance office must be notified in the same timeframe as notifying the Research Ethics Committee and any other regulatory bodies.

Amendments

This approval covers the document versions stated above; any revised documents must be submitted for approval by the Research Ethics Committee and other regulatory bodies, where applicable, in accordance with guidance in the Integrated Research Application System (IRAS). If the study has been adopted onto the NIHR Portfolio, any amendments to the study must be reported to the Lead CLRN. In addition, all amendments must receive separate approval from Rotherham Doncaster and South Humber NHS Foundation Trust.

Permissions

This letter authorises you in principle to undertake research within the Trust. However, it is your responsibility to ensure that individuals appropriate to your work have no objections to your studies. This department accepts no liability for non co-operation of staff or patients.

Contracts

It is your responsibility to ensure you have sufficient indemnity to undertake this project. In addition, it is also your responsibility to ensure that letters of access / honorary contracts are in place where necessary.

Good Clinical Practice training

In accordance with ICH GCP guidelines and the UK Statutory Instruments, all key personnel involved in a Clinical Trial as part of the research team, must have completed GCP training within the last three years. It is your responsibility to ensure the research team have received this training. For information regarding upcoming GCP training courses, please contact the Research Governance team.

Auditing

I would strongly urge you to maintain an accurate and up to date site file for your documentation, as the Trust randomly audits projects to assess compliance with the relevant legal frameworks and legislation. If your study is selected, you will be notified in writing not less than two weeks prior to the required submission date of documentation. In addition, where monitoring and auditing procedures are carried out by the Sponsor, you will be required to cooperate, where appropriate.

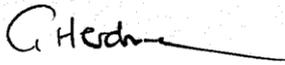
Monitoring

In order to ensure adequate monitoring of ongoing studies, the Research Governance department will send through periodic monitoring forms which require completion by the Principal Investigator or delegated individual. These will be in two formats. The first is a monthly letter requesting recruitment

information. The second form is an annual study progress report. These forms need to be completed and sent through to the Research Governance department as a condition of the approval of this study.

I would like to take this opportunity to wish you well with your project. If you have any questions, or if I can be of any further assistance to you, please do not hesitate to contact me.

Yours sincerely



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Research Management & Governance Manager

cc Mrs Wendy Wood
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Appendix 37 – Example excerpt from transcript, to demonstrate the left and right hermeneutic analysis.

Step 2: Left Hermeneutic Analysis		Step 2: Right Hermeneutic Analysis
<p>The clinician has stated that the Grid has been helpful when working with a patient where there have been '<u>difficulties</u>'. What are the difficulties? Is this a difficulty in understanding the person, or providing resource for the person, or decision-making?</p> <p>The use of the phrase '<u>at this time</u>' indicates that there is a <u>time frame where specific interventions</u> may be more relevant. Is this linked to why they have come to services now? Are there stages of intervention provided at different times? If so, is the Grid used more than once with people?</p> <p>The use of the phrase '<u>get it</u>' appears to link in with the comments above concerning <u>intra-psychic processes</u> and also <u>understanding</u>. It appears to emphasise the importance of understanding.</p> <p>The '<u>word one</u>' refers to the fact that clinicians originally asked for two versions of the service user Grid, one with words inside the boxes which guided them, and another one which is blank. The clinicians originally felt the blank one would provide more <u>flexibility in the encounter</u> whilst using the Grid as a framework.</p> <p>There is an individual reflection that the '<u>word one</u>' is better for them, but an acknowledgement that different members of the team may prefer something else. Is there therefore a need to explore the reasons different people require different types of tool? It's not a one size fits all?</p> <p>The multiple repetitions of the phrase '<u>get it</u>', appears to be emphasising the need for <u>understanding</u>. Does this mean that the patients didn't '<u>get it</u>' before? does the Grid provide <u>a framework for explanations</u> that is positive?</p> <p>Asking the patients '<u>where they're at</u>' appears to suggest that they do not know? Is there a sense of being <u>lost</u>? Or <u>confused</u>? Is there a need to stop and look? Does this need to be done prior to the decisions being made?</p> <p>The statement suggests that there is a need to look at things from two different perspectives; where the patient '<u>is at</u>', and where the clinician feels that the patient '<u>is at</u>'. This suggests that there may be a difference in the two. Does this mean that the treatment choices encounter is an intervention itself, by facilitating exploration of <u>different people's points of view</u>? Is this conducted if the Grid is not there? Again the theme of <u>clarity</u> appears to be of importance.</p>	<p>45 <i>difficulties, we have used it with. And yeah, I</i> 46 <i>would say it has <u>helped</u>.</i>"</p> <p>47 48</p> <p>49 Int: Probe: Please provide examples, has it 50 helped you look at any one treatment that you 51 provide over another?</p> <p>52 53 Clin1 – "<i>No, not really, it has helped when</i> 54 <i>looking at them all and considering what the</i> 55 <i>patient needs <u>at this time</u>".</i></p> <p>56 57</p> <p>58 Int: (Q3): In your opinion, when you have 59 worked with service users using the 'Treatment 60 Choices Grid', have they been able to 61 understand the rationale behind specific 62 treatment selection?</p> <p>63 64 Clin1 – "<i>I think so, they seem to <u>get it</u>.</i>"</p> <p>65 66</p> <p>67 Int: Probe: have any difficulties been noted?</p> <p>68 69 Clin1 – "<i>No. I have used the <u>word one</u>, and</i> 70 <i>people seem to <u>get it</u>. I know that some people</i> 71 <i>in the team have chosen to use the one without</i> 72 <i>the words on, but I prefer the word one and</i> 73 <i>people seem to <u>get it</u>.</i>"</p> <p>74 75</p> <p>76 Int: (Q4): In your opinion, do service users 77 engage with the use of the 'Treatment Choices 78 Grid' in clinical sessions?</p> <p>79 80 Clin1 – "<i>The couple that I have sat with have</i> 81 <i>really looked at it yes. I have been through the</i> 82 <i>sections and have asked them if they can</i> 83 <i><u>understand where they're at</u>, and explained <u>my</u></i> 84 <i><u>understanding</u> of where they're at, and they</i> 85 <i>seem to <u>get it</u>.</i>"</p> <p>86 87</p> <p>88 Int: (Q5): When using the Grids, what has 89 been your experience of working with people 90 who meet the criteria for the first quadrant, 91 where the service user accepts their diagnosis</p>	<p>The encounter is difficult.</p> <p>There is a need to have something to ease the difficulty.</p> <p>The patients' needs are changeable.</p> <p>The treatments decisions are within a specific time frame.</p> <p>Patient understanding is essential.</p> <p>People understanding and accepting the rationale for treatment is important.</p> <p>Some clinicians prefer one version of the Grid to another.</p> <p>It is a useful framework, but not a 'one size fits all'.</p> <p>[PHR] – 'At this time' -Time frame appears important in terms of contextualising the person's needs.</p> <p>Differences of opinions between patients and clinicians need to be addressed.</p> <p>[PHR] – 'Get it' – repeated 3 times on this page. This suggests clarity is required prior to progression to treatment. Could link to 'on board'?</p>

Appendix 38: Identification of recurrent themes within the transcripts for the IPA study concerning the phenomena of making treatment choices with PD patients.

Super-Ordinate and Category Themes	Script 1	Script 2	Script 3	Script 4	Script 5	Script 6	Script 7	Script 8	Script 9	Script 10	Present in over half the sample?
A. Boundary Management	Yes										
Boundaries between patient and clinician	Yes (n=7)	Yes (n=5)	No	Yes (n=8)	No	Yes (n=15)	Yes (n=4)	Yes (n=13)	Yes (n=3)	Yes (n=21)	Yes (total n=76)
Conflict due to multiple clinician roles.	Yes (n=9)	Yes (n=22)	Yes (n=13)	Yes (n=2)	Yes (n=3)	Yes (n=3)	Yes (n=2)	Yes (n=11)	Yes (n=9)	Yes (n=6)	Yes (total n=80)
Personal and professional role boundaries.	Yes (n=1)	Yes (n=2)	Yes (n=1)	Yes (n=8)	No	Yes (n=2)	Yes (n=3)	Yes (n=5)	Yes (n=3)	Yes (n=12)	Yes (total n=37)
Organisational Resource Management.	Yes (n=8)	Yes (n=14)	Yes (n=4)	Yes (n=4)	Yes (n=2)	Yes (n=9)	Yes (n=14)	Yes (n=15)	Yes (n=11)	Yes (n=6)	Yes (total n=87)
Consistency in managing difficulty	Yes (n=64)	Yes (n=34)	Yes (n=30)	Yes (n=49)	Yes (n=25)	Yes (n=33)	Yes (n=64)	Yes (n=40)	Yes (n=64)	Yes (n=87)	Yes (total n=490)
B. Diagnostic Stigma	Yes										
Patient Stigma: Perception of 'self'	Yes (n=2)	No	Yes (n=1)	Yes (n=2)	No	Yes (n=1)	Yes (n=2)	Yes (n=1)	Yes (n=3)	Yes (n=3)	Yes (total n=15)
Clinician Stigma: Perception of 'other'	Yes (n=2)	No	No	Yes (n=6)	Yes (n=2)	Yes (n=5)	Yes (n=1)	Yes (n=2)	Yes (n=4)	Yes (n=7)	Yes (total n=29)
The impact of media representation	No	Yes (n=3)	Yes (n=1)	Yes (n=4)	Yes (n=2)	Yes (n=3)	No	Yes (n=2)	No	Yes (n=2)	Yes (total n=17)
The impact of feeling 'disconnected' / different	No	No	Yes (n=3)	No	No	Yes (n=1)	Yes (n=3)	Yes (n=3)	Yes (n=2)	Yes (n=1)	Yes (total n=13)
Conflict – 'wanting Bipolar Affective Disorder'	Yes (n=9)	Yes (n=5)	Yes (n=3)	Yes (n=19)	Yes (n=8)	Yes (n=4)	No	No	Yes (n=10)	Yes (n=2)	Yes (total n=60)
C. Focus on time	Yes										
Orientation and direction	Yes (n=8)	Yes (n=4)	Yes (n=4)	Yes (n=2)	Yes (n=7)	Yes (n=13)	Yes (n=2)	Yes (n=5)	Yes (n=6)	Yes (n=4)	Yes (total n=55)
Engagement time	Yes (n=12)	Yes (n=18)	Yes (n=5)	Yes (n=11)	Yes (n=10)	Yes (n=14)	Yes (n=12)	Yes (n=13)	Yes (n=15)	Yes (n=5)	Yes (total n=115)
Variation in time to change	Yes (n=2)	Yes (n=2)	Yes (n=3)	Yes (n=3)	Yes (n=8)	Yes (n=4)	No	Yes (n=4)	Yes (n=7)	Yes (n=11)	Yes (total n=49)
Movement, 'stuckness', and wasted time	Yes (n=1)	Yes (n=4)	Yes (n=3)	No	No	Yes (n=2)	Yes (n=2)	No	Yes (n=4)	Yes (n=4)	Yes (total n=20)
End point - Recovery rather than cure	Yes (n=3)	Yes (n=2)	Yes (n=3)	Yes (n=2)	No	No	Yes (n=1)	Yes (n=3)	Yes (n=1)	Yes (n=2)	Yes (total n=17)
D. Metacognitive Ability	Yes										
Clinicians in-session meta-cognitive ability	Yes (n=3)	Yes (n=3)	Yes (n=4)	Yes (n=4)	Yes (n=3)	Yes (n=4)	Yes (n=2)	Yes (n=2)	Yes (n=6)	Yes (n=5)	Yes (total n=36)
Patients meta-cognitive ability	Yes (n=5)	Yes (n=8)	Yes (n=2)	Yes (n=6)	Yes (n=4)	Yes (n=3)	Yes (n=1)	Yes (n=3)	Yes (n=5)	Yes (n=7)	Yes (total n=44)
Organisation's ability to think about the person	No	No	Yes (n=1)	Yes (n=2)	No	Yes (n=1)	Yes (n=1)	Yes (n=2)	No	Yes (n=10)	Yes (total n=17)
The impact of cognitive dissonance	No	Yes (n=1)	Yes (n=2)	Yes (n=1)	Yes (n=3)	Yes (n=2)	No	No	Yes (n=3)	Yes (n=1)	Yes (total n=13)
Impact of vacillation: idealisation & denigration	No	No	No	Yes (n=3)	No	No	Yes (n=1)	No	Yes (n=2)	Yes (n=14)	No
E. The potential for iatrogenic harm	Yes										
Passivity as opposed to active engagement	Yes (n=6)	Yes (n=19)	Yes (n=2)	Yes (n=11)	Yes (n=6)	Yes (n=1)	Yes (n=12)	Yes (n=2)	No	Yes (n=5)	Yes (total n=64)
Chaotic lifestyle factors fuelling difficulties	Yes (n=1)	No	No	Yes (n=3)	Yes (n=5)	Yes (n=4)	No	Yes (n=1)	Yes (n=4)	Yes (n=4)	Yes (total n=22)
'Doing for' creating dependence	No	Yes (n=4)	Yes (n=4)	Yes (n=8)	No	Yes (n=5)	Yes (n=2)	No	Yes (n=1)	Yes (n=6)	Yes (total n=30)
Medication as an avoidant strategy	Yes (n=2)	Yes (n=3)	No	Yes (n=3)	Yes (n=1)	Yes (n=1)	Yes (n=8)	Yes (n=11)	Yes (n=12)	Yes (n=3)	Yes (total n=43)
Risk and personal responsibility	Yes (n=4)	Yes (n=1)	Yes (n=2)	Yes (n=12)	Yes (n=6)	Yes (n=3)	Yes (n=3)	Yes (n=3)	Yes (n=16)	Yes (n=13)	Yes (total n=63)