An investigation into CAMHS clinicians’ attitudes towards emerging personality disorder

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Background

- Borderline personality disorder (BPD) is the most frequently researched in adults, but little research in BPD in people under 18 (Gunderson, 2011)
- Grey area - BPD can be diagnosed in people under 18 (DSM) or BPD can’t be diagnosed in people under 18 (ICD-10)
- Currently – unclear if clinicians use the label, or what attitudes they hold about it
- Research question - what is the attitude of CAMHS clinicians towards emerging personality disorder?
Method

- Participants recruited from 3 multidisciplinary CAMHS teams.
- 6 participants – 3 Clinical Psychologists, 1 Consultant Psychiatrist, 1 Mental Health Nurse, 1 Learning Disabilities Nurse
- Semi-structured interviews covering three areas: background of the clinician, knowledge of the label, and experience of working with emerging personality disorder
- Thematic analysis (Braun & Clarke 2006)
Results

- All the participants identified with the concept of emerging personality disorder and were able to discuss it, although not all agreed with it.

- 5 overarching themes were identified, with a core theme running through many of them.
Core theme - Ambivalence

- Ran through many of the other themes
- In particular, participants struggled to reconcile the potential stigma of the label with its potential usefulness
Harnessing the power of the label

“I definitely think that if somebody gets a diagnosis, um, it becomes part of their identity. And I think it takes a lot to undo that” (Stef)

“I do find it helpful to help me to understand, to help me to work with the young people and to help me predict and anticipate what might come up in sessions” (Stef)
To Share or Not to Share

- “sh, don’t say it, I’ll think it but I won’t tell you” (Tom)

- “and that opens up the opportunity to have the conversation – what would it mean to you?” (Stef)
Emerging Personality Disorder as ‘More’

- “People aren’t as comfortable with it, as like, ok you’ve got ASD, you’ve got ADHD, people are comfortable with that. They’re not as comfortable with it” (Gabrial)

- “I think people get frightened of it” (Tom)

- “Certain staff I guess, might be thinking oh gosh, this is gonna be a difficult case, or um think about how they’re gonna work with that young person, just, and protect themselves as well, because the work can sometimes be seen as challenging” (Gwen)
Client’s Impact on the Clinician

- “It felt like everything was being thrown at this family, individual work, work through another organisation (…) family therapy, psychiatry reviewed her as well, um early intervention sort of help with the family, there was um child protection issues, so there was social workers involved quite quickly” (Gwen)

- “It felt like everybody was doing something. But the risks remained. They were becoming, risky behaviours were becoming more frequent, more impulsive, so I think people were just losing faith almost” (Gwen)

- “You can feel completely inadequate, you can feel completely lost. What the heck am I doing? You don’t know what you’re doing sometimes (laughs). You don’t know what you’re doing. And it does make you question your own ability” (Stef)
Client’s Impact on the Clinician (2)

- “I would leave sessions feeling just overwhelming emotions that didn’t fit with me (...) like I’d be driving home fuming (...) and it wasn’t until a couple of months in that I thought oh right, the common denominator is that I’ve seen this young person today” (Tom)

- “Supervision was kind of really important to realise what was mine and what was the young person’s um, feeling” (Gwen)

- “You need a lot of, I need a lot more thinking and feeling space” (Tom)
Searching for Pathways

- “There is a huge gap in terms of (...) the relevant therapy, services” (Adrian)

- “Depression, I can tell you virtually what the NICE guidelines are (...) whether you should be using medication or not, when to refer to a psychiatrist (...) whereas emerging personality disorder is a bit hotchpotch” (Gabrial)

- “The main thing that springs into my mind when I’m working with these young people is attachment theory (...) in terms of sort of intervention-wise, the models I’m most familiar with would be like DBT or, or like CAT” (Gwen)
Although many participants disliked the concept of diagnosis, still categorised their clients into groups – relates to the principle of social categorisation (Tajfel & Turner, 1979)

Participants were worried about the stigma of the label – but none of the participants expressed negative attitudes

It might not be easy to share the label – but is not sharing even worse?
Service recommendations

- Dissemination of guidelines for interventions for this client group
- Participants highlighted the need for “thinking, feeling and processing space”
- Possible training on how to share the label
- Wider service provision – this client group may need longer, more intensive support than other client groups
References

