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Guest Editorial

A brief critique of the pseudo-diagnosis 'complex emotional needs'

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Summary

'Complex emotional needs' has emerged in the UK as a label to refer to individuals given a diagnosis of a personality disorder. We argue that this name change is insufficient to address the harms associated with the personality disorder construct; rather, it risks broadening its scope, and thereby the construct's harms.

Keywords

Complex emotional needs; diagnosis and classification; patients; personality disorders; stigma and discrimination.

The term 'complex emotional needs' (sometimes abbreviated to CEN) is frequently used as an alternative label to refer to individuals who were historically given a diagnosis of a personality disorder. Despite the rapid adoption of the term (primarily within the UK), there has been a lack of scrutiny about how it is perceived by those it is applied to, or consideration of the wider implications of this language shift. Although we sympathise with the sentiment of needing to move away from the harmful implications of the personality disorder diagnosis – and associated stigma and discrimination – in this Editorial, we argue that using 'complex emotional needs' as an equivalent term for personality disorder is an insufficient and inadequate strategy to address the fundamental flaws and harms of the personality disorder construct. Instead, we argue that this risks further legitimising the personality disorder construct and broadens its scope, therefore widening the prejudice, discrimination and neglect associated with the label. We write from a lived experience perspective of being labelled with a personality disorder. We are opposed to the diagnostic construct and believe that, regardless of what it is called, the construct itself is harmful.

The use of complex emotional needs is often, but not always, specific to borderline personality disorder (BPD). In line with the move of ICD-11 to re-categorise personality disorders and remove distinct subcategories,[1] we use the term 'personality disorder' throughout this Editorial.

Personality disorder

The diagnosis of personality disorder has long been controversial. Patients, researchers and clinicians alike have argued that the diagnostic construct lacks validity and serves as a 'sophisticated insult' that is disproportionately ascribed to women and people assigned female at birth, and survivors of trauma.[2,3] The diagnosis is associated with high levels of stigma, and those given this label often experience neglect and harmful treatments and attitudes in both healthcare settings and society more broadly.[1–3]

To receive a diagnosis of a personality disorder, someone must be assessed as meeting the criteria outlined in a diagnostic manual. However, there are many instances where a psychiatrist may use a more hesitant term, instead of a formal diagnosis. For example, terms such as 'emerging personality disorder' are often used for children and young people, acknowledging that a person's personality continues to develop into early adulthood. Clinicians may use phrases such as 'BPD-traits' or 'features indicative of a personality disorder' to convey that they believe someone meets some of the criteria for a personality disorder, perhaps wanting to remain cautious about giving a formal diagnosis, or using the term *in lieu* of a thorough assessment process.

Although the use of such phrases may be intended to convey tentativeness, or to recognise the contested nature of personality disorders, the stigma and prejudice associated with the construct of personality disorders is rooted far deeper than the name. Therefore, a *de facto* diagnosis – regardless of which label or euphemism is applied – invariably attracts the same discrimination associated with the diagnosis itself. Thus, although other terms, such as complex emotional needs, may appear more 'palatable', they should not be assumed to be a safer option for the patient – indeed, the opposite may be true.

The emergence and legitimisation of the term complex emotional needs

It is difficult to ascertain when, or by whom, the term complex emotional needs was first used. However, a research team from the National Institute for Health and Care Research (NIHR) Mental Health Policy Research Unit (MHPRU) popularised the term.[4] In 2019, as part of a programme of research examining community-based 'personality disorder' service provision, the research team held a workshop with a small number of people with lived experience, researchers and clinicians. They subsequently entitled their research the 'complex emotional needs project'.[4]

This appeared to be a tentative suggestion that recognised the controversy surrounding the personality disorder construct, and was described as 'not intended to be a new diagnostic category, but adopted as a working term for the range of difficulties with which people may present to "personality disorder" services'.[4] The authors state 'we do not see this as definitively the best choice of terminology and would very much welcome more work on best ways of assessing and describing needs in this area'.[4] However, by using it in multiple papers associated with their work, it appears to have quickly gained traction and been adopted by others – without the hesitancy that was reportedly intended.

Since then, use of the term complex emotional needs has proliferated in research and across National Health Service (NHS) and third-sector mental health services in England. In describing the rationale for the choice of this term, researchers and NHS mental health staff often describe complex emotional needs as a label 'which may be more acceptable to users of mental health services'.[5] However, the claim that the term is generally preferred is

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unevidenced, as there has been no research or robust consultation conducted to consider how those who are labelled with this term perceive its use. We are not aware of any use of the term complex emotional needs beyond the UK (this may also risk causing further confusion).

Although the decision to use the term complex emotional needs by the MHPRU[4] (and other organisations) may have followed consultation or involvement of people with lived experience, preferences for language use within a specific context should not be generalised and extrapolated to services more broadly. Neither should the views of a small group be considered representative of the views of all those diagnosed with a personality disorder – in fact, this name change is categorically opposed by many. Indeed, disguising a prejudicial label in this way erases decades of survivor/lived experience grassroots activism and critique that challenges the personality disorder construct.

Furthermore, we emphasise that this name change falls short of the robust changes needed to address and challenge the root causes of the prejudice and discrimination that those labelled with a personality disorder experience. There are further risks that this is perceived as taking steps to address the stigma (without actually doing so), leading services to feel emboldened to continue without substantially addressing the issue.

Beyond an alternative to personality disorder

A concerning implication of using the term complex emotional needs is that it lacks a clear definition, which means it could be applied to an ever-growing number of people. For example, the scope of the term varies across mental health research, policy and practice.

As with other seemingly hesitant labels, such as 'traits' or 'features' of a personality disorder, and because complex emotional needs is not a formal diagnosis, it could be applied to an individual by any staff member without a diagnostic assessment. This lack of precision means the term could encompass the experiences of any individual presenting with emotional distress, functioning as a 'catch-all' diagnosis akin to neurosis. Indeed, many so-called complex emotional needs pathways do not exclusively work with patients who have a formal diagnosis of a personality disorder, but also include people who professionals consider (often in the absence of a robust diagnostic assessment) to have traits, symptoms or features of this.[6] As such, there is a risk of confusion and conflation, with the term potentially being employed more broadly to describe the experiences of large and heterogeneous groups of people – especially if it is perceived as less stigmatising than other diagnoses by mental health professionals.

Critics of the personality disorder construct argue that the construct itself lacks validity and utility.[1,2] The diagnosis has been described as being applied to patients whom psychiatrists dislike, and may be used among those who are considered to deviate from social norms and expectations, including non-heterosexual and transgender people.[7] Additionally, the diagnosis is often incorrectly and inappropriately used where the distress experienced would be better understood within the context of alternative diagnoses, such as post-traumatic stress disorder, bipolar disorder, premenstrual dysphoric disorder or neurodivergence, including autism and attention-deficit hyperactivity disorder.[8] These misdiagnoses are harmful both because they expose individuals to inappropriate (and often harmful) treatments and because they prevent patients from accessing the treatment, support and understanding they require. The new term of complex emotional needs does not address the issue of inappropriate diagnosis, misdiagnosis and poor clinical practice of applying a diagnosis without a robust assessment process (and the iatrogenic harms this causes). On the contrary, we fear that by effectively broadening the scope of the label, this language shift may worsen the prevalence of inappropriate diagnoses. Instead of creating a new pseudo-diagnosis, efforts should be focused on ensuring access to more appropriate assessment, diagnosis and support (e.g. for complex post-traumatic stress disorder and/or neurodivergence).

Complex or unmet needs?

People who are labelled with a diagnosis of a personality disorder have often experienced significant chronic trauma, abuse and unmet needs throughout their lives; therefore, the distress they experience can be considered an understandable and proportionate response to such trauma (though nonetheless devastating). In this context, we emphasise that the emotional needs of those who have experienced trauma, abuse and neglect – including emotional safety, co-regulation and a stable environment – are not greater, or more complex, than anyone else's. The distinction is not in the complexity of emotional needs, but needs that have often been chronically unmet, and that continue to be unmet by mental health services. Therefore, we are concerned that the term complex emotional needs continues to individualise the problems of distress and trauma, placing the responsibility on the individual without addressing the systemic factors that drive mental illness and trauma.

In addition to reporting poor treatment, abuse and neglect when they do access health services, those given a label of a personality disorder – and now also the even more nebulous term complex emotional needs – are often excluded from accessing services they may benefit from (or need urgently).[9] At the same time, personality disorder or complex emotional needs pathways often provide low-intensity, time-limited or group-based interventions. This presents a contradiction between emphasising the complexity of individual needs, yet failing to provide highly specialised and individualised, trauma-informed or even compassionate support for such needs.

Despite inadequate service provision to meet the needs of highly distressed and/or traumatised individuals, describing this group as having 'complex needs' positions these needs as complex from the perspective of mental health services. This is particularly troubling as it shifts the responsibility for neglectful services onto the individual; the statement becomes 'the patient's emotional needs are too complex', as opposed to recognising where the services provided are insufficient to meet a patient's needs. Therefore, we are concerned that the term complex emotional needs not only risks exposing more individuals to poor practice, exclusion and unmet need, but also allows these issues to remain unchallenged, under the guise that the needs of the patient group are inherently complex and difficult to meet.

In conclusion, robust action is needed to dismantle the construct of personality disorders, and associated harm and injustice. Meanwhile, we opt to use phrases such as 'people diagnosed with a personality disorder' (as we have throughout this Editorial). We use diagnosis as a verb, rather than a noun, to foreground diagnosis as a process which is subject to inaccuracies and biases; emphasising the distinction between having a personality disorder and being diagnosed with a personality disorder. We suggest that such phrases may have value within research and policy in this area, to facilitate discussion of patient experiences of being labelled with the diagnosis, without inadvertently legitimising it.

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