How mental health teams make sense of people who have been given a diagnosis of Borderline Personality Disorder

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ABSTRACT

Background: Stigmatising ideas about people who receive a diagnosis of Borderline Personality Disorder (BPD) are consistently demonstrated within mental health services. Existing research has predominantly focused on individual staff cognitions and actions, rather than considering stigmatisation on the grounds of BPD diagnosis as a social process, shaped by service and socio-political context.

Aims: To explore the social-psychological processes involved when mental health teams make sense of people who receive a diagnosis of BPD. To consider how contextual factors affect these processes.

Method: 3 focus groups were conducted involving 16 participants from 3 mental health teams. Constructivist Grounded Theory was used to analyse the data.

Results: The model 'Protecting the professional self' was constructed. Contrasting ideas about 'personality disorder' and 'mental illness', implicit professional and client role expectations, a culture of individual responsibility and mismatch between client need and service design meant clinicians experienced two core threats to their professional selves when working with people who receive a diagnosis of BPD. Two patterns of responding to these threats were demonstrated. 'Distancing' responses involved decontextualizing, discrediting and differentiating, and drew on culturally-dominant stigmatising ideas about 'BPD' to legitimise emotional and physical 'distancing' from clients, with a consequent reduction in felt threat. Alternative 'connecting' responses were also demonstrated, and these required resisting dominant ideas and practices.

Conclusion: Interventions should aim to reduce the experienced threat to professional self and make connecting responses more possible. This would involve changes to commissioning and service priorities, and the reconceptualisation of staff training. Furthermore, a new framework for understanding the distress known as 'BPD' is needed, which rather than reinforcing the 'distancing' processes, acknowledges our shared humanity and validates the distress as an understandable response to historical and current experience.

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1. INTRODUCTION

This chapter will start by providing a brief overview of the concept of Borderline Personality Disorder before looking at what is known about how people who receive a diagnosis of BPD have been conceptualised over time. This will be done by examining key concepts and policies which are argued to both reflect the dominant understandings at the time and shape future understanding and practice. Current service provision for people receiving a diagnosis of BPD will then be reviewed, and critiques of the concept considered.

There will then be a review and evaluation of the literature pertaining to mental health service staff beliefs about and feelings towards people who receive a diagnosis of BPD, and interventions aiming to ameliorate this. A rationale for the current study will then be presented.

1.1 Overview of the concept of ‘Borderline Personality Disorder’

‘Borderline Personality Disorder’ (BPD) is described as “a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity, beginning by early adulthood and present in a variety of contexts” in the American Psychiatric Association’s Diagnostic and Statistical Manual, fifth edition (2013, p663). For diagnostic criteria please see appendix A.

The category is considered equivalent to ‘Emotionally Unstable Personality Disorder’, which is the term used in the International Classification of Diseases-10 (ICD-10) (World Health Organization, 1992). This study will use the term Borderline Personality Disorder because it is most prevalent in research.

It is estimated that approximately 1% of the general population, 10-12% of psychiatric outpatients and 20-22% of psychiatric inpatients would meet diagnostic criteria for BPD (Ellison, Rosenstein, Morgan, & Zimmerman, 2018). Labels of BPD are comparatively more often given to women (APA, 2013), people who experience same sex attraction (Reich & Zanarini, 2008) and people who are identified as white (Byrne, Henagulph, McIvor, Ramsey, & Carson, 2014). Explanations for these differences centre the social and cultural shaping of how distress is expressed and of dominant expectations about what is ‘normal’ or considered pathological (Shaw & Proctor, 2005).

People who receive a diagnosis of BPD are also very likely to meet criteria for other psychiatric diagnoses such as mood disorders (96%), anxiety disorders (88%), PTSD (55%) (Zanarini et al., 1998), and other types of personality disorder (Grant et al., 2008). Although originally thought of as enduring, at 10 year follow up 80% of people who received a diagnosis of BPD and required hospital admission had achieved a 4-year period of ‘remission’, during which they no longer met the criteria for BPD (Zanarini, Frankenburg, Reich, & Fitzmaurice, 2012).

Research that aims to explore causal factors associated with a diagnosis of BPD has found that 92% of those diagnosed with BPD report childhood neglect (Zanarini, 2000), 80% report childhood abuse, and 70% report childhood sexual abuse (Castillo, 2000). The role of chronic invalidation in childhood (Crowell, Beauchaine, & Linehan, 2009) and disrupted and insecure attachment (Fonagy, Target, & Gergely, 2000) have also been widely demonstrated. There is also some suggestion of neurobiological differences related to brain functions such as inhibitory control and affect regulation (Lieb, Zanarini, Schmahl, Linehan, & Bohus, 2004). These may be a result of early life experiences rather than demonstrating pre-existing difference.

1.2 History of how BPD has been conceptualised

1.2.1 Personality and its disorder

The idea of personality originated in European and American societies in the late 18th Century, and is taken to mean traits within an individual that are relatively stable across time and situation, and which can shape an individual’s behaviour (Cromby, Harper, & Reavey, 2013). Perceived problematic personality traits were first understood as a psychiatric condition in the 1800s, and formally written about as ‘Morbid Personalities’ in Kraepelin’s 1904 Clinical Psychiatry textbook, where they were described as a deficit in morals and self-control, existing from childhood (Bourne, 2011).

Following this, the first psychiatric diagnostic manual was developed during World War II by psychiatrists in the American military (Bourne, 2011). It contained the concept of ‘pathological personality type’, which was used to distinguish those individuals who would receive a dishonourable discharge and lose pension rights, from those that were considered ‘insane’ and would receive an honourable discharge (Bourne, 2011). At this early stage then, there was an association between the ‘PD’ concept and judgements about morality, responsibility, and withdrawal of resources.

This army manual formed the basis of the first edition of the Diagnostic and Statistical Manual (DSM) produced by the American Psychiatric Association in 1952, in which the diagnosis of Personality Disorder first appeared (American Psychiatric Association, 1952). The concept of Borderline Personality Disorder was then introduced in the DSM-III, with similar diagnostic criteria to those used now (American Psychiatric Association, 1980). The term ‘borderline’ came from psychoanalytic theory, where it had originally described people whose difficulties were seen to be on the border of psychosis and neurosis (Bourne, 2011).

1.2.2 Policies and service provision in England and the UK

Although the diagnosis of PD entered the DSM in 1952, and BPD in 1980, providing intervention to people who received these diagnoses was not a priority in mental health services for many years (NIMHE, 2003). A diagnosis of personality disorder could result in exclusion from services, whilst the ‘real’ work was seen as helping people with ‘mental illness’. When researchers and clinicians (Ruth Gallop, 1988; Lewis & Appleby, 1988) started to highlight that prejudice towards people with a PD diagnosis existed within mental health services, and that assigning a PD diagnosis could serve to justify denying services to people that were experienced as difficult, the perceived untreatability of these labels was considered a major barrier to change. The influence of the DSM in shaping understanding is clear here, as the DSM-III placed personality disorders on ‘axis II: disorders of personality or intellect’, which categorised them as separate from ‘mental illness’ and as pervasive rather than transient disorders (Ruocco, 2005).

Some clinicians and researchers engaged in efforts to develop effective treatment for people receiving these labels, in order to challenge ideas that people could not be helped (e.g. Layden, Newman, Freeman, & Morse, 1993; Linehan, 1987). However it was only when treating ‘personality disorder’ aligned with political concerns that it became a priority.

In 1996 a high-profile murder occurred, involving someone with a diagnosis of personality disorder and a history of offending, who had been discharged from psychiatric hospital as it was not considered possible to legally detain him (Pickersgill, 2013). The government wished to respond to subsequent fears about the inadequacy of current legislation in protecting the public from such individuals and developed the concept of ‘Dangerous and Severe Personality Disorder’ (Home Office and the Department of Health, 1999). They proposed such individuals should be able to be detained indefinitely and preventatively, which represented a deviation from the criminal justice system, in which people can only be detained *after* committing an offence (Pickersgill, 2013). Amendments to the Mental Health Act (MHA) were also proposed in order to allow this to happen, and units were commissioned to detain and treat people considered to fit into this category (Pickersgill, 2013). Services for ‘personality disorder’ were brought into the public agenda, however there was a sole focus on those considered to pose high risk of harm to others. Strong links between the concept of PD, dangerousness and ‘badness’ were established.

The changes to the MHA proposed by the government aimed to broaden the definition of mental disorder to include all personality disorder, so people being detained due to this diagnosis would be required to have access to ‘appropriate treatment’ (NIMHE, 2003b). Service provision, however, remained limited and variable, with a 2002 survey revealing that only 17% of mental health trusts in England had a specialist PD service, 40% gave access to a generic service, 23% provided no service and 25% did not reply (NIMHE, 2003b). There was a need therefore to increase access to services for people with a diagnosis of PD.

The National Institute of Mental Health for England (NIMHE) produced a policy document entitled ‘Personality Disorder: No Longer a Diagnosis of Exclusion’ (NIMHE, 2003b) and a capabilities framework entitled ‘Breaking the Cycle of Rejection’ (NIMHE, 2003a). These reports gave the message that ‘personality disorder' *was* treatable, and that doing this *was* part of the business of mental health services. They highlighted that people with a primary diagnosis of PD were often "treated at the margins" and staff were likely to "prioritise the needs of other clients" because they did not conceptualise this work as their "core business" (NIMHE, 2003b, p4). It was stated that people receiving a PD diagnosis experienced a "cycle of rejection that is deeply implicated in the development of personality disorders and which is compounded by the negative and rejecting attitudes and practices of many agencies" (NIMHE, 2003a, p6).

Both documents stated that stigmatising and exclusionary practices towards people with a diagnosis of PD were a result of lack of knowledge and skills on the part of staff. The benefit of staff being taught an explanatory framework within which to understand clients' behaviour was highlighted, and funding was made available for staff training and the development of specialist personality disorder services (NIMHE, 2003b).

1.3 Current service provision in England

In 2009 NICE guidance relating to Borderline Personality Disorder was released. This was the first major clinical guideline to consider 'BPD' separately from the general category of 'PD'. With clear links to historical policies and challenges it specified that people with this diagnosis should not be excluded from services, that the therapeutic relationship should be optimistic and trusting, and should promote autonomy and choice. The guidance did not recommend specific psychological therapies, but did state that therapies of less than 3 months should not usually be offered, and specialist services should be available for people whose difficulties were considered the most complex or high risk. Medication was not recommended for BPD, although it could be prescribed for co-occurring conditions (NICE, 2009).

A recent study aiming to evaluate the availability and nature of services for people with a diagnosis of personality disorder in 2017 found that in England 84% of trusts had at least one PD service, but only 55% reported that patients had equal access to this (Dale et al., 2017). Many services excluded individuals if they were considered to be abusing substances (53%) or presenting risk to others (23%). Care was provided by multidisciplinary teams, whose composition varied widely. Within specialist services the most often offered interventions were psychoeducation, Dialectical Behaviour Therapy (DBT) and Mentalisation Based Therapy (MBT), whilst in generic services it was Cognitive Behavioural Therapy, psychoeducation and Cognitive Analytic Therapy (Dale et al., 2017). It was concluded that the nature and availability of services varied widely, resulting in a ‘postcode lottery’. Furthermore exclusion still occurred (Dale et al., 2017).

1.4 Perspectives of those receiving this label

When developing the NICE guidance (2009), a systematic review of qualitative literature pertaining to service user views of accessing services and receiving treatment was conducted (National Collaborating Centre for Mental Health, 2009). Ten studies met inclusion criteria. Six highlighted the stigma associated with the diagnosis within mental health services, including that it was associated with a lack of hope and being ‘bad’. The stigma also resulted in exclusion from services or withdrawal of help, at times when participants were often highly distressed. Four studies reported some participants finding aspects of the diagnosis useful, as it was seen to accurately describe and legitimise their difficulties and could enable a shared identity with other service users. Access to services was described as inadequate and at times intentionally limited, whilst more positive experiences were reported in specialist services (National Collaborating Centre for Mental Health, 2009).

A more recent study explored the experiences of people with a diagnosis of BPD accessing adult mental health services in England, deriving three themes (Morris, Smith, & Alwin, 2014). The first related to the experience of receiving the diagnosis, which was felt to shape subsequent experience yet often involved little information and, in some cases, expressed pessimism about the possibility of recovery. The second was entitled “non-caring care” and described services as disjointed and unreliable, sometimes providing intervention only at times of crisis. Furthermore, participants reported that once they had received a diagnosis of BPD they were seen by staff as ‘difficult’ rather than unwell or distressed. The third theme described that participants equated good care with a good therapeutic relationship, and when this occurred it was very important for participants. There was a desire for staff to be able to support clients emotionally, not just practically, and for there to a be a focus on reducing the distress underneath risky behaviours, not just the risk itself (Morris et al., 2014).

There are also people who receive a diagnosis of BPD who do not wish to receive help that is based on this construct. The survivor activist group Personality Disorder in the Bin, for example, states “we find the PD label dehumanizing and it encourages a system and society that seeks to blame us for our own reactions to distressing life circumstances” ('PD' in the Bin, 2016). Instead, they request “a human rights and social justice based approach” and “trauma-informed care that is politically and contextually aware” ('PD' in the Bin, 2016b). They state “we are asking for therapies that permit the expression of shame and rage, rather than the suppression of shame and rage. We need therapies that frame our abusers or oppressors as disordered rather than us” ('PD' in the Bin, 2016a).

1.5 Critiques of the concept

1.5.1 Reliability and validity

Concerns have been raised about inter-rater and test-retest reliability of the diagnostic category (Zanarini et al., 2000) and the high co-occurrence of other psychiatric diagnoses in those diagnosed with BPD, which could be seen to undermine the idea of the diagnosis as a distinct and valid concept (Cromby et al., 2013). Diagnostic criteria have been criticised for being based on ‘expert’ consensus and being neither empirically tested nor based on any theoretical explanatory framework (Sarkar & Duggan, 2010). Furthermore they are said to offer little explanatory power; instead circular reasoning is used to infer the existence of an individual’s personality disorder from their behaviour, with their behaviour then explained by their personality disorder (Burr, 2003). The results of follow up studies have led many to suggest that personality disorder is better described as a fluctuating state, rather than a permanent condition (Tyrer et al., 2007). Furthermore evidence that personality traits are continuously distributed across the population also led to proposals that personality disorder should be conceptualised dimensionally, rather than categorically (Fonagy, Campbell, & Bateman, 2016).

Recent changes to the way BPD is conceptualised somewhat reflect these findings. ‘Axis II’ has been removed from the DSM-V and a ‘hybrid dimensional-categorical’ model was developed to replace the existing diagnostic criteria. The DSM-V did not adopt this but included it as an ‘emerging model’ (APA, 2013). It was, however, adopted by the ICD-11 (World Health Organization, 2018). The effects of this change are not yet known, however concerns have already been raised that the new criteria are clinically unwieldy, unscientific (Fonagy et al., 2016) and may mean many more people receive a diagnosis of personality disorder (Watts, 2019).

1.5.2 Decontextualisation and subjectivity

The idea that personality traits can be objectively and neutrally assessed and compared is central to the concept of personality disorder (Cromby et al., 2013). However the diagnostic criteria represent a list of behaviours and experiences, and these are assumed to relate to underlying personality traits. The interpersonal and contextual factors affecting an individual’s behaviour are not taken into account (Cromby et al., 2013). Additionally the cultural expectations and context of an individual will affect how the behaviour is judged (Cromby et al., 2013). For example, perceived traits of competitiveness and ruthlessness will be viewed differently if the individual is male or female, and whether the context is business, sport or an intimate relationship. The diagnostic process involves making subjective judgements, for example whether an individual’s anger is ‘inappropriate’ (APA, 2013). It is not specified what an individual’s behaviour will be compared against in this decision-making, and it is proposed that this implicit ‘absent standard’ (Sampson, 1993) is in fact the heterosexual White Western male (Harper, 2011b), which is implied in diagnostic criteria, and whose experience then becomes implicitly positioned as ‘normal’. This can make typically feminine qualities such as emotionality and sensitivity, and women’s’ attempts to survive and resist gender inequality and gendered abuse, seem irrational and pathological (Shaw & Proctor, 2005).

1.5.3 Ethical

Criticisms of the diagnosis have also come from researchers, clinicians and survivors who highlight the ethical problems associated with the diagnosis. It has been described by recipients as a “horrible term for someone” (Stalker, Ferguson, & Barclay, 2010, p365), a diagnosis of rejection (Horn, Johnstone, & Brooke, 2007) and being put in the “too hard basket” (Veysey, 2011, p78). The diagnosis of BPD has been argued to not only locate the problem within the person, but to tell recipients not that they *have* a disorder, but they *are* the disorder (Shaw, 2005). This is particularly problematic given the high prevalence of childhood abuse and neglect in people receiving this diagnosis, and the consequent potential to reinforce abusive messages that these individuals are inherently pathological (Watts, 2019). Furthermore, it leads to efforts to help people so diagnosed to change their ‘personality’, whilst the social circumstances that lead to the distress are not identified as targets for intervention (Shaw & Proctor, 2005).

It is important to note that these critiques do not in any way question the reality of the distress experienced by people who receive a label of BPD, nor that it is essential to devote attention and funding to providing and improving support for these individuals. However it is questioned whether these aims are best served by being based on the concept of Borderline Personality Disorder.

Summary of background

It has been shown that the diagnosis of BPD has been associated with judgements about morality, responsibility, dangerousness and untreatability since its inception. Stigma within and exclusion from mental health services on the grounds of this diagnosis has been a long-standing problem, and people receiving this diagnosis have articulated the negative effect this has on them. This is particularly concerning given the wide-ranging critiques that cast doubt on the validity of the construct.

The literature pertaining to mental health service staff beliefs about and feelings towards people with a diagnosis of borderline personality disorder will therefore be reviewed.

1.6 Literature Review

1.6.1 Search Strategy

This systematic literature search aimed to identify how mental health staff and team beliefs about and feelings towards people who receive a diagnosis of borderline personality disorder have been researched to date.

The search criteria included three groups of terms: 1) borderline or emotionally unstable personality 2) terms referring to mental health professionals or teams, 3) terms relating to beliefs of feelings. For full search terms please see appendix B.

The search was conducted using the following databases: Academic Search Complete, PsychInfo, Psycharticles and CINAHL Plus via EBSCO, and Scopus. References from papers identified in the initial search were also reviewed for any further papers for inclusion.

The search strategy yielded 1060 records. These were screened by title, and duplicates were removed, leaving 58 papers. Papers were included if they were available in English, published in peer-reviewed journals and their participants were working in mental health services. There was no restriction on the year or country of publication. Papers were excluded if they were not empirical studies, did not address borderline personality disorder specifically, did not describe staff attitudes, or were about attitudes towards staff practice, rather than clients themselves. Abstracts were read to assess eligibility, at which point 17 further studies were excluded. The full text of the remaining 41 papers was then read, and a further 18 papers excluded, leaving 23 studies which were included in the review. For further detail of this process please see flow diagram in appendix B.

The following information was extracted from each paper: author(s), country of origin, main aim, setting, participants, design, method of analysis and main findings. These are presented in a table in appendix C. The language used in the papers was retained, for example the word ‘patient’.

1.6.2 Summary of included studies

The studies were conducted between 1989 and 2018, with 20 of the 23 having taken place since 2003. The majority were conducted in Western countries: the UK, Ireland, Canada, Australia and USA. There were also two studies from Israel and one from Taiwan. Sample sizes ranged from 4 to 710 and participants included a range of mental health professionals, but mental health nurses were the most highly researched group.

Of the 23 included studies 18 employed quantitative methods only, two used mixed methods and three used qualitative methods only. 17 used self-report questionnaires. All studies researched the attitudes of individual staff members.

Most commonly, studies compared the attitudes of staff towards BPD and other psychiatric diagnoses (ten studies), or the attitudes towards BPD of different mental health professional groups (three studies). Two studies compared attitudes across time.

In order to consider all studies within the available word count they will be grouped together based on their aims, methodology or findings, and the common themes explored. Further information about each individual study can be found in appendix C.

The term ‘attitudes’ was most commonly used in the research, and this is taken to mean “a summary evaluation of a psychological object” (Ajzen, 1985, p28).

Summary and evaluation of existing research

1.6.3 Descriptions of reported attitudes

The most common method of investigating staff attitudes were self-report questionnaires, whilst qualitative studies analysed staff talk in interviews.

Throughout the literature there were descriptions of people who received a diagnosis of BPD that appeared consistently across settings and countries and from a variety of professional groups. These included “manipulative” (Day, Hunt, Cortis-Jones, & Grenyer, 2018; Deans & Meocevic, 2006; McGrath & Dowling, 2012; Woollaston & Hixenbaugh, 2008), “difficult” (Deans & Meocevic, 2006; Markham & Trower, 2003; PD & Cowman, 2007), “splitting” (Day et al., 2018;

McGrath & Dowling, 2012; Woollaston & Hixenbaugh, 2008), “destructive” (Bourke & Grenyer, 2013; McGrath & Dowling, 2012; Woollaston & Hixenbaugh, 2008), and using “threatening behaviour” (McGrath & Dowling, 2012; Woollaston & Hixenbaugh, 2008). These descriptions appeared in qualitative studies that did not impose a pre-existing framework onto participants (Day et al., 2018; McGrath & Dowling, 2012; Woollaston & Hixenbaugh, 2008), as well as in those where participants’ agreement with existing statements was sought (Bourke & Grenyer, 2013; Deans & Meocevic, 2006; Markham & Trower, 2003).

Further descriptions were given in qualitative studies, with themes including a “destructive whirlwind” that is “dangerous” and “not genuine” (Woollaston & Hixenbaugh, 2008, p705), “preying on the vulnerable” (McGrath & Dowling, 2012, p3) and “attention-seeking” and “unwelcome” (Day et al., 2018, p314).

Generalised positive descriptions of people who receive a diagnosis of BPD did not appear, either as themes in qualitative studies or reported results in quantitative studies. There were occasional descriptions that offered less stigmatising conceptualisations, for example when participants highlighted the role of trauma in peoples’ difficulties (Stroud & Parsons, 2013). There were also instances of lower levels of agreement with statements that conveyed negative attitudes. For example, 68% of respondents in Dean and Meocevic’s (2006) study did not agree that people with a BPD diagnosis made them angry. It is not clear at what threshold low levels of agreement with a negative statement could be taken to indicate something positive.

Some questionnaires were created by the researchers for the study and their reliability and validity was not investigated (Black et al., 2011; Bodner, Cohen-Fridel, & Ianco, 2011; Cleary, Siegfried, & Walter, 2002; EL-Adl & Hassan, 2009; James & Cowman, 2007), therefore the predetermined categories available to participants may be subject to bias. For example Black et al.’s (2011) questionnaire aimed to determine clinician attitudes towards people with a diagnosis of BPD but did not include any statements that were positive about people with a diagnosis of BPD themselves, only about the available treatment for this diagnosis. Therefore staff expressing positive attitudes was precluded. Other questionnaires, such as the APDQ, had been validated and their properties investigated in previous studies (Bowers & Allan, 2006), and this methodological limitation was not present.

1.6.4 Comparisons between professions

Three studies, which took place in the USA and Israel, compared the self-report questionnaire scores for different professional groups. They reported that nurses had lower ratings of caring attitudes and treatment optimism compared with other professional groups (Black et al., 2011, sample size 706). Nurses scored lower on empathy towards BPD clients than did other professional groups (Bodner et al., 2011, sample size 57), and nurses and psychiatrists reported more negative attitudes and less empathy towards BPD clients than did psychologists and social workers (Bodner et al., 2015, sample size 710).

Three reasons were suggested for these findings. Firstly, in inpatient settings nurses have much more prolonged interaction with clients than do the other professions, which might make it more difficult for nurses to remain empathic (Bodner et al., 2015). Secondly, psychiatrists might feel more defensive and less empathic because they hold the highest levels of responsibility for safety of clients (Bodner et al., 2015). Finally, nurses have relatively little training about psychological processes compared to professions such as psychologists and social workers, leaving them feeling less able to help and with fewer frameworks to understand clients’ distress (Bodner et al., 2015).

1.6.5 Comparisons over time

Two studies compared attitudes over time. Chartonas, Kyratsous, Dracass, Lee, & Bhui (2017) attempted to repeat Lewis and Appleby’s (1988) study in which participants were asked to complete a questionnaire about their beliefs about a person in a vignette. The diagnosis associated with the person in the vignette varied between depression and PD. It was concluded that people with a diagnosis of PD were considered more difficult and less deserving of care than those with depression.

Chartonas et al. wished to see whether there had been any change in these results, given the variety of policy and practice developments since 1988. They repeated the study, using trainee rather than qualified psychiatrists, and asking about attitudes towards BPD rather than PD in general. They reported some improvement in attitudes towards BPD, although there was still a statistically significant difference in stigma compared with depression using Lewis and Appleby's (1988) questionnaire. This study might suggest therefore that attitudes towards BPD have improved during the last 20 years, but stigma specific to the diagnosis remains. However, Chartonas et al. (2017) investigated attitudes towards the diagnosis of BPD in trainee psychiatrists, whilst Lewis and Appleby (1988) used the diagnosis of PD and qualified psychiatrists. Consequently it is not possible to know whether the reported reduction in stigmatising attitudes relates to changes over time or a difference in levels of stigma associated with PD in general versus BPD specifically, or trainee versus qualified psychiatrists.

The other study to compare attitudes across time is by Day and colleagues in 2018. They compared the reported attitudes of the mental health nurses working within an inpatient service in 2000 and 2015 using a short version of the Attitudes to Personality Disorder Questionnaire (APDQ) (Bowers & Allan, 2006). They found significantly more positive APDQ scores in the 2015 sample: a mean 4-point increase. They suggested that this was due to training and increased availability of and knowledge about treatment.

They also conducted semi-structured interviews with the nurses and mapped the most frequently mentioned concepts. Their analysis of the words used in the stories told about people with a diagnosis of BPD showed a shift from words such as “deliberate”, “unwelcome”, “manipulative” and “attention-seeking” in 2000, to “splitting”, “triggered”, “behavioural” and “management plan” in 2015 (p314). They highlighted an increased focus on treatment strategies and explanatory concepts as opposed to negative descriptors. This suggests increased knowledge; however it is not known if this reflects a change in emotional attitudes or rather a new ‘professional’ language in which to talk about similar concepts e.g. ‘deliberate’ becomes ‘behavioural’.

1.6.6 Comparisons between diagnoses

Ten studies compared staff attitudes and responses towards BPD and other diagnoses. Nine of these used self-report questionnaires, sometimes in combination with vignettes in which the given diagnosis was manipulated. Comparisons were most often made with the diagnoses of depression and schizophrenia.

Nurses and therapists reported significantly more negative emotional responses towards clients with BPD than other diagnoses (Bourke & Grenyer, 2010; Fraser & Gallop, 1993). Nurses expressed much less sympathy towards clients with a diagnosis of BPD compared with depression or schizophrenia and described the experience of working together more negatively (Markham & Trower, 2003).

Clients with a diagnosis of BPD were considered more difficult to care for than those with others diagnoses (Cleary et al., 2002; McGrath & Dowling, 2012). Therapists expressed lower satisfaction and increased need for supportive supervision when working with clients with BPD as compared to depression (Bourke & Grenyer, 2013). Therapists described patients with BPD as “self-destructive” and “resistant”, compared with patients with depression, who were described with the words “respond,” “ease,” “develop,” and “attached” (Bourke & Grenyer, 2013). Similarly, clients with depression were reported as more attentive to the therapist and those with BPD as more withdrawing (Bourke & Grenyer, 2010). This suggests that judgements about clients might be related to whether interactions with them help to validate the role of the professional. This idea will be returned to later.

Other studies focused specifically on how staff reported they would respond to clients. Nurses reported significantly less willingness to help people with a diagnosis of BPD than a diagnosis of depression (Forsyth, 2007) and all professional groups considered it less justifiable to admit someone with a BPD diagnosis than depression to hospital (Bodner et al., 2015). Almost half of Black et al.’s (2011) participants reported preferring to avoid clients with a BPD diagnosis.

McGrath and Dowling (2012) used the Staff-Patient Interaction Response Scale (SPIRS) to rate the level of empathy offered by participants in response to hypothetical situations. Most responses were categorised as level 2 empathy (offering solutions, platitudes or rules) or level 1 empathy (no care). Gallop, Lancee, and Garfinkel (1989) investigated 113 nurses' reported responses to hypothetical situations with a patient described as having BPD or schizophrenia. A BPD diagnosis occasioned fewer affectively involved responses, and more responses that indicated "no care", contradiction or belittlement. The researchers hypothesized that affective involvement was avoided in order to defend against experiencing difficult feelings, and instead surface-level solutions were provided. Additionally, they proposed that patients with a BPD diagnosis may have been considered 'bad not mad' and therefore responses involving a higher level of judgement could be justified.

Limitations of the literature presented so far include that they investigate self-reported beliefs, feelings and behaviour only, and it is often assumed but not demonstrated that self-report attitudes are indicative of actual behaviour (Dickens, Lamont, & Gray, 2016). Vignette and hypothetical situation questionnaires have been argued to lack ecological validity (R Gallop et al., 1989). Anonymous questionnaires notwithstanding, social desirability bias and a desire to see oneself as a compassionate and fair professional means that stigmatising attitudes and lack of empathy may well be underreported (O'Key, 2014).

1.6.7 Observation rather than report of staff responses

There is one study that partially addresses this limitation by observing and then rating staff behaviour. There are no known other studies observing staff behaviour towards people with a diagnosis of BPD.

Fraser and Gallop (1993) explored whether patients with a diagnosis of BPD received less empathic verbal responses from nurses than did those with a different diagnosis. The researcher observed 20 inpatient nurse-led groups comprising patients with a variety of diagnoses. Heineken's (1984)

Confirmation/Disconfirmation Rating Instrument was used to rate the responses given to patients by nurses as belonging to one of seven possible categories, including confirming, disparaging and indifferent. The researcher was blind to the diagnosis of patients until after rating had been completed and excluded any instances in which patient behaviour might obviously lead to disconfirming responses irrespective of diagnosis e.g. making threats.

Nurses demonstrated fewer confirming responses to patients with a BPD diagnosis compared to those with Affective Disorder and 'Other' diagnoses. Specifically they gave more “impervious or indifferent” responses, which were described as responses that fail to acknowledge the others’ attempt to communicate. There was no significant difference between responses to patients with diagnoses of BPD and schizophrenia.

Fraser and Gallop (1993) suggest that indifferent responses may be used because the communication attempts of people with a diagnosis of BPD are seen as manipulative, or their feelings judged as “incorrect”, therefore they are not considered worthy of a confirming response. There were no suggestions given about why people with a diagnosis of schizophrenia also received less empathic responses than those with affective or ‘other’ disorders.

The studies discussed so far have demonstrated that both reported and observed attitudes towards people with a diagnosis of BPD are less empathic, more indifferent, less optimistic and involve more negative emotions than attitudes towards people with other psychiatric diagnoses. Attitudes vary somewhat between professional groups and appear to have improved somewhat over time yet remain problematic.

1.6.8 Stigmatised diagnosis or difficult behaviour?

It should be acknowledged that distressed behaviour such as self-harm and suicidality, which is associated with a diagnosis of BPD, can in itself be upsetting for staff to work with. Some researchers have argued that the stigma associated with people that receive a diagnosis of BPD is largely due to natural reactions to the difficult and ‘pathological’ behaviour of clients who receive this label (Ma, Shih, Hsiao, Shih, & Hayter, 2009; Sansone & Sansone, 2013; Woollaston & Hixenbaugh, 2008).

Studies that used vignettes as stimuli, manipulating the diagnostic label whilst keeping the description of the client's behaviour the same, aimed to investigate whether stigma was associated with the label independently of stigma associated with behaviour (Chartonas et al., 2017; Forsyth, 2007; Fraser & Gallop, 1993; Lam, Poplavskaya, Salkovskis, Hogg, & Panting, 2016; Lam, Salkovskis, & Hogg, 2015; Markham & Trower, 2003). All of these studies found stigma associated with the label, independent of behaviour.

For example, Lam et al. (2015, 2016) asked participants to complete self-report questionnaires after watching a video about a client presenting with panic. One condition added a behavioural description consistent with a diagnosis of BPD, and another further added that the client had a historical diagnosis of BPD. Participants rated clients with both a behavioural description and historical diagnosis of BPD as less likely to be motivated to engage in and to benefit from CBT for panic, more likely to harm themselves and others (Lam et al., 2015), as having more signs of personality disorder and fewer signs of putting in effort to help themselves (Lam et al., 2016) than clients with the same behavioural description but no historical diagnosis of BPD.

1.6.9 Are attitudes static?

The studies described so far assume that a person's attitudes towards a certain group of people remain relatively stable across time and situation, so can be meaningfully captured by reporting them at one point in time. However it is possible to evaluate the same object differently in different contexts, and to have more than one attitude towards the same object within the same context, for example one attitude that is implicit and habitual, and the other explicit (Ajzen, 1985).

Only one study within those reviewed acknowledged the variable nature of attitudes. Stroud and Parsons' (2013) Interpretative Phenomenological Analysis of four semi-structured interviews with CPNs found that participants' attitudes towards people with a diagnosis of BPD fluctuated between "dread" and "desire to help", resulting in shifts between "connected" and "disconnected" interactions (p247). They proposed that these fluctuations were influenced by participants' attempts to make sense of client behaviour, team culture, lack of supervision, high caseloads, a focus on paperwork and a fear of litigation.

The literature presented so far describes attitudes towards people with a diagnosis of BPD but offers relatively few ideas about their formation and maintenance. Theoretical ideas present in the reviewed research will now be considered.

Hypothesized explanations for negative attitudes

1.6.10 Attributions of control and responsibility

Markham and Trower (2003) provided 50 nurses with vignettes where the ascribed diagnosis varied, and asked them to indicate their level of agreement with statements about their perception of the causes of the client's difficult behaviour. The theoretical basis of this study was attribution theory, which posits that in order to experience a sense of control over their environment people try to determine the causes of events (Markham & Trower, 2003). The cause of events can be attributed to a person or their environment (internal or external), can be understood as controllable or uncontrollable by that person, and can be seen as stable or unstable and global or specific (Heider, 1958; Kelley, 1973). There is a proposed Fundamental Attribution Error such that, in contrast to our interpretations of our own behaviour, we are more likely to explain someone else's behaviour with reference to internal rather than external factors (Kelley, 1973). The perceived cause and controllability of a situation is then used to make inferences about the level of responsibility a person has for the situation (Weiner, 1995).

Markham and Trower (2003) found that the nurses considered patients with a diagnosis of BPD to be more in control of both the causes of their behaviour and the behaviour itself, than patients with a diagnosis of depression or schizophrenia. When participants thought patients were more in control of challenging behaviour, they were less sympathetic towards them and evaluated them negatively as a person. Attributions of intentionality and control were also evident in qualitative studies, for example “the manipulation . . . the classic thing here about trying to split the staff team . . . it seemed to be some sort of game aimed at getting control” (Woollaston & Hixenbaugh, 2008, p707).

Similarly, Forsyth (2007) used vignettes and self-report rating scales to investigate the effect of BPD diagnosis and attributions of perceived controllability and stability, on participant ratings of helping, empathy and anger. They found that participants reported significantly greater willingness to help people with a diagnosis of depression than a diagnosis of BPD, and that they were less likely to offer help and more likely to feel angry when causes of non-compliance were attributed to stable and controllable factors. They hypothesized that attributions of control are one of the central ways in which empathy is reduced and invalidating responses to clients occur, and this serves to reduce staff anxiety and sense of helplessness in the face of the client’s reported difficulties.

Markham and Trower (2003) hypothesized that ideas about controllability and people with a diagnosis of BPD are influenced by ideas about ‘mental illness’ as biologically based and extrinsic to the person and therefore out of their control, whereas with ‘personality disorder’ it is the person themselves that is seen as disordered. People with a diagnosis of BPD are less likely to be seen as ill, and those seen as ill are less likely to be held accountable for their behaviour (Markham & Trower 2003).

1.6.11 Perceived dangerousness

Markham (2003) investigated the level of social rejection demonstrated by participants towards clients with a diagnosis of BPD, schizophrenia or depression, and whether this was linked with perceptions of dangerousness. Nurses viewed patients with a BPD diagnosis as more dangerous than those with a diagnosis of schizophrenia or depression. Healthcare assistants on the other hand viewed the diagnoses of BPD and schizophrenia as similarly dangerous, both much more so than depression (Markham, 2003). In all cases increased perceived dangerousness was associated with increased desire to maintain social distance. This may be because perceived dangerousness leads to fear, and the desire to avoid the perceived threat (Corrigan, Markowitz, Watson, Rowan, & Kubiak, 2003)

Markham (2003) suggests that the association between the diagnosis of BPD and dangerousness may be due to the general category of personality disorder having been associated with ‘psychopathy’ and offending behaviour within the public and clinical domain. This was particularly the case at the time of the study, as the Department of Health and Home Office’s document introducing the idea of ‘Dangerous and Severe Personality Disorder’ had been published in 1999 (Markham, 2003).

1.6.12 Not feeling able to help

Another factor affecting attitudes towards people with a diagnosis of BPD that appeared frequently in the literature, but whose impact was not empirically investigated, was professionals feeling unable to or not believing it was possible to help. This concern was expressed most clearly in qualitative studies, for example “caring for them wastes time and money . . . our efforts would not help them change their personalities’” (Ma et al., 2009, p. 444), “they seem to shout help me help me but you can’t” and “I trained to be a nurse to actually make people better…” (Woollaston & Hixenbaugh, 2010, p.706). Only 44% of participants in Deans and Meocevic’s (2006) study stated that they knew how to care for people with a BPD diagnosis, and high levels of need for training were expressed (EL-Adl & Hassan, 2009).

Believing that clients with a BPD diagnosis could not be helped made nurses more likely to focus only on meeting clients’ basic physical and safety needs and less likely to try to provide individualised or emotional support (Ma et al., 2009). Since this is less likely to be helpful to clients, staff are less likely to feel they have helped, which may then contribute to negative attitudes towards people with a diagnosis of BPD (Woollaston & Hixenbaugh, 2008).

Attributions of globality and stability about the causes of negative behaviours are linked with this hopelessness about change (Markham & Trower, 2003). Staff are more likely to believe in the possibility of change in patients’ negative behaviours if they have a schizophrenia or depression diagnosis than if they have a BPD diagnosis (Markham & Trower, 2003). BPD has a history of being viewed as untreatable (National Institute for Mental Health for England, 2003). Indeed the defining qualities of a personality disorder include that the difficulties are considered to be both persistent (stable) and pervasive (global) (Craissati, Joseph, & Skett, 2015)(Craissati et al., 2015). It is suggested therefore that the way the diagnosis of BPD is conceptualised, and its history, make it more likely that staff will believe they are unable to help, independent of their actual experience with the client.

1.6.13 Countertransference

In contrast to theories such as attribution theory, which are centred on cognitive processes and understand attitude formation as a rational process, psychodynamic ideas applied to working with people who receive a diagnosis of BPD focus on feelings and the unconscious.

It is proposed that people who receive a diagnosis of BPD often form intense transference responses to staff (Book, Sadavoy, & Silver, 1978), meaning that in addition to responding to the staff member in the present, they may relate to staff based on templates of relationships experienced in their early life (Howard, 2017). Object relations theory proposes that people who receive a diagnosis of BPD more frequently use ‘primitive’ unconscious defence mechanisms such as splitting and projection in order to cope with the intolerable feelings they experience, and because they struggle to integrate all-good and all-bad part objects and need to keep these separate (Book et al., 1978).

Both of these mean that staff members can experience strong countertransferential feelings, for example hopelessness, anger and a desire to rescue (Book et al., 1978). These feelings can be difficult to tolerate, and without training and supervision in psychodynamic theory and practice, staff may act on these feelings without awareness, or make sense of them by concluding that the client intended to make them feel these ways (Book et al., 1978). Staff can feel under attack and thus protect themselves by shutting down the connection or interaction with the client (Fraser & Gallop, 1993). These ideas therefore present one way of understanding why working with people who receive a diagnosis of BPD can be experienced as difficult, and why staff may then respond in negative ways. Although this theory was not empirically investigated in the reviewed literature, it was drawn on as an explanatory framework in three studies (Bourke & Grenyer, 2010; Fraser & Gallop, 1993; Gallop et al., 1989).

1.7 Limitations of existing research

The reviewed research constitutes a large body of studies that demonstrate that negative staff attitudes as measured by self-report questionnaires have been consistently demonstrated across professions, countries and time. These reported attitudes have been shown to be more negative than attitudes towards other psychiatric diagnosis and they have been shown to affect both reported and observed behaviour. The label of BPD has been shown to be associated with negative attitudes independent of client behaviour, and some studies have explored putative contributory mechanisms to these attitudes, such as attributions of control and responsibility. A small number of qualitative studies have also explored the subjective experience of individual staff.

This body of research has usefully drawn attention to the issue of negative cognitive, affective and behavioural attitudes towards this group of individuals. This has led to some policy and clinical interventions aiming to ameliorate this, such as the provision of training for staff (e.g. Davies, Sampson, Beesley, Smith, & Baldwin, 2014; Herschell, Lindhiem, Kogan, Celedonia, & Stein, 2014).

Methodological limitations of individual or groups of studies have been integrated into the review above, however there are some broader conceptual limitations that should be highlighted.

The reviewed literature relies heavily on self-report questionnaires, which cannot accommodate individual staff meanings or offer nuanced understanding of why staff hold certain views. There is a sole focus on individual staff attitudes, conceptualising attitudes as stable, internal cognitive states (Willig, 2013), rather than context-dependent, socially negotiated processes (Parker & Aggleton, 2003).

The behaviour of people who receive a diagnosis of BPD is also decontextualized when it is described as manifested almost irrespective of the environment or interpersonal interactions. There is the implicit and at times explicit assumption that staff attitudes and behaviour are a response to patient behaviour, whilst the behaviour of patients is rarely conceptualised as a response to the attitudes and behaviour of staff (Kelly & May, 1982).

Much of the research also takes the position of accepting participant responses as face-value neutral representations of internal states or events (Kelly & May, 1982). This also applies to the concept of ‘BPD’, which despite wide-ranging concerns about its validity, reliability and clinical utility, was used unquestioningly in the majority of studies, as if it represents an entity that a person or group of individuals could be objectively characterised as possessing.

It is also known that the nature of the discrimination experienced in relation to a BPD diagnosis will vary depending on the other privileged or marginalised identities of that individual (Holley, Stromwall, & Bashor, 2012). The experience of inequality and disadvantage will be greater, and more nuanced, than the sum of each individual dimension of discrimination (Crenshaw, 1989). However this was not explored in the reviewed literature, with the exception of one study that investigated the effects of client ethnicity on attitudes to and rates of BPD diagnosis (Chartonas et al., 2017). Research that aims to measure generalised attitudes towards people who receive a diagnosis of BPD, without consideration of other aspects of identity, cannot take this into account. This would be particularly important given the documented higher rates of diagnosis among women and people who experience same sex attraction (Reich & Zanarini, 2008).

1.7.1 Stigma, discrimination and oppression

The limitations of the literature concerning mental health staff and team attitudes towards people who receive a diagnosis of BPD can be seen to mirror that of research into stigma and stigmatisation within other domains (Link & Phelan, 2001; Parker & Aggleton, 2003).

Stigma can be thought of as the possession, or perceived possession, of an “attribute or characteristic that conveys a social identity which is devalued in a particular context” (Crocker, Major, & Steele, 1998, p505). Link and Phelan (2001) describe stigmatisation as having four parts: the social selection and labelling of certain differences as particularly salient, the association of these differences with negative stereotypes, the separation and differentiation of these individuals (e.g. ‘us’ and ‘them’), and consequent loss of status and discrimination. Power must be exercised in order for these processes to occur. Therefore although oppressed groups could, for example, form negative stereotypes about dominant groups, stigmatisation could not occur as these groups would not have sufficient social, economic and political power for this stereotyping to have serious real life consequences for the dominant group (Link & Phelan, 2001).

However, the majority of stigma theory and stigma research adopts a social cognitive approach that focuses on only the first two parts of this conceptualisation: how categories are created and then linked to stereotyped beliefs about members of those categories (Link & Phelan, 2001). This has been criticised for focusing on how stigmatisation is enacted at an individual level, whilst the social context of beliefs and structural discrimination are less in focus (Oliver, 1990). In addition, much stigma research treats the stigmatised characteristic (e.g. a ‘personality disorder’), as if it is an inherent quality of the individual rather than a socially constructed label applied by a powerful group (Link & Phelan, 2001).

This is particularly important because the way that stigma is conceptualised then affects the nature of interventions designed. Most anti-stigma interventions have focused on achieving reported change in individual attitudes (Parker & Aggleton, 2003), and although these can demonstrate short term change, there is limited evidence that they have a lasting impact (Gronholm, Henderson, Deb, & Thornicroft, 2017). Link and Phelan (2001) state that such interventions leave the “broader context untouched and as a consequence even the very positive outcomes of an unusually successful program will erode with time” (p381).

In the case of negative staff attitudes towards ‘BPD’, staff training is by far the most commonly suggested intervention (Dickens et al., 2016), and although this has led to reported improvement in participants’ knowledge and beliefs, there is limited evidence that changes are maintained over time, or that practice change and improved outcomes are achieved (Dickens, Hallett, & Lamont, 2015).

Sayce (1998) highlights that the language used to describe an issue influences where the problem is understood to lie. The word ‘stigma’ is proposed to focus on the stigmatised individual, their self-perceptions and ability to shake off their feeling of inferiority, rendering “the act of unfair treatment invisible” (Sayce, 1998, p333). The term ‘stigmatising attitudes’ could be considered an improvement in that the focus is on those holding the attitudes, however the focus remains on individual-level cognitions and interactions.

The word ‘discrimination’ then moves away from the individual experience and encourages focus on individual, collective, and structural perpetration of discrimination, and highlights the real world impact of this (Sayce, 1998). For example, this is why it is appropriate to focus on racism (a form of discrimination) and not the ‘stigma of being black’ (Sayce, 1998). Parker and Aggleton (2003) further highlight that stigmatisation and discrimination are “social processes linked to the reproduction of inequality and exclusion” (p19). They use an oppression framework to understand these processes as a way of effecting and legitimising dominant status and power (Parker & Aggleton, 2003). An oppression framework makes apparent that when one group is oppressed and loses power, another group is privileged and given advantage in relation to that group, therefore benefitting from this process (Holley et al., 2012).

1.8 Summary and rationale

It has been shown that people who receive a diagnosis of ‘Borderline Personality Disorder’ are conceptualised in stigmatising ways by mental health professionals, and that this can occur independent of client behaviour, in the presence of the diagnostic label alone. Behaviour towards these clients is less empathic and can involve disconfirming responses and exclusion from services.

There have been attempts to ameliorate this situation through policy and staff training interventions, nonetheless stigmatising attitudes and discrimination towards people with a label of BPD persist.

Much of the existing literature has focused on measuring and identifying the need for change at the level of individual staff attitudes, whilst there is a dearth of research that considers the service and socio-political context that shapes beliefs and the change that is made possible, or the structural barriers to ‘positive’ attitudes.

This research, therefore, aims to consider mental health staff within their team, service, and socio-political context, and to explore how culturally dominant ideas, practices and structures shape the experiences and beliefs of these professionals in relation to clients with a diagnosis of BPD. It is hoped that this will provide a more contextualised and multi-level conceptualisation of some of the processes that occur when mental health staff make sense of clients with a diagnosis of BPD, and that this will allow for suggestion of contextual and multi-level intervention.

1.8.1 Research questions

1. When mental health professionals and teams make sense of people who have been given a diagnosis of BPD, what are some of the social-psychological processes involved?

2. What are the contextual factors that affect these processes?

2. METHODOLOGY

This chapter will begin by describing and justifying my epistemological and personal position and choice of method of data collection and analysis. It will then outline my procedure and participants.

2.1 Ontological and epistemological position

This research takes a critical realist position because it reflects the researcher's worldview and is consistent with the research questions, giving attention both to participants' material realities and the psychological, social and cultural contexts that shape how these are made sense of.

Ontology is concerned with what there is in the world to know, and epistemology is concerned with what can be known (Harper, 2011). The ontological and epistemological position taken in relation to a piece of research will influence the type of knowledge it aims to produce, and therefore not only the method of data collection and analysis, but entire methodological approach (Willig, 2013).

Critical realism involves a realist ontological position which posits that there is a reality that exists, independent of our knowledge of it (Pilgrim, 2014). This means, for example, that distress experienced by people who receive a diagnosis of BPD is acknowledged as a 'real' and embodied experience, as are the social and material consequences of receiving this diagnosis within current society and the psychiatric system (Pilgrim, 2014). These occur independently of the ways these experiences are understood.

However a relativist epistemological position then asserts that when the experiences are made sense of this will be influenced by personal, social and historical context and will reflect one interpretation rather than a direct reflection of 'reality' (Harper, 2011). Therefore, for example, Borderline Personality Disorder is not seen as an entity that can be objectively found within a person, but as one of many possible ways of understanding, which has been influenced by current and historical beliefs about socially-acceptable behaviour and the nature of mental illness.

Adopting a critical realist position means that participants' understanding and communication of their experiences, and then my understanding of this as a researcher, will be seen to represent one possible interpretation. It is not likely that we are always aware of the range of factors that influence our experience (Harper, 2011), therefore it will be important to critically reflect on the data and my analysis of it, asking questions about the factors that might be influencing my sense-making and that of participants (Charmaz, 2014).

2.2 Reflexivity

Reflexivity can be defined as a concern for one's positionality, how this relates to that of others, and how this affects one's 'gaze' (Cousin, 2013). In considering this the researcher is reminded that their research constitutes one possible way of seeing things and they are prompted to examine how their identity, experiences and context will have affected the research (Harper, 2011). In relation to research, both epistemological and personal reflexivity should be considered (Willig, 2013), therefore personal reflexivity will now be explored.

I identify as a White, British, middle class, cis-gendered able-bodied woman who is in my mid-thirties. Although I was not born in the UK I have lived here for most of my life. I am in the final year of training to be a clinical psychologist and worked in mental health services for 8 years prior to starting training. I also identify as Queer and as a survivor of the psychiatric system.

The first thing to reflect on is that my relationship to the research topic is twofold. I have experienced being a 'service user' within the mental health system, first without and then with a diagnosis of BPD. I have also worked in mental health services similar to those included in this study. I was motivated to conduct this research because as a professional I had experienced ways of talking and thinking about people who receive this diagnosis that had a detrimental impact on client experience and seemed almost universally present, across different settings. This was despite teams generally wishing to do their best to help clients. I therefore wanted to explore this phenomenon in more detail and try to understand the complex factors that contribute to its persistence.

Because of my experiences I hold a doubting position as to the usefulness of the diagnosis of BPD in achieving compassionate support for people so-diagnosed. The diagnosis is held as one possible explanatory hypothesis, albeit one that carries considerable power within psychiatric and related systems. This is in line with my epistemological position. Charmaz (2014) highlights that the more familiar a topic, the more it can be difficult to question what is taken for granted. Therefore I needed to give particular attention to the implicit assumptions within psychiatric ways of talking.

Another aspect of my identity to consider is that I have grown up in a Western individualistic culture and have worked in a mental health system whose focus is also on individual-level explanatory accounts. Although the clinical psychology training course I am completing emphasises ideas of social constructionism there may be the danger that I focus my analysis on the level of the individual. Charmaz (2017) argues that “methodological individualism” pervades much of qualitative research and this was something I tried to resist by prompting myself to consider the “structural contexts, power arrangements, and collective ideologies” (p35) that were also relevant to my analysis.

Charmaz (2017) also highlights the importance of considering how our privileges and positions will have affected our relationships with participants. Many aspects of my identity carry privilege, and most of those that are marginalised are invisible. As the researcher I am also in a position of relative power. During my interactions with participants I attempted to create an atmosphere in which multiple perspectives were encouraged, and no one perspective was held as being correct. I did not share my experience of having received a diagnosis of BPD with participants as I was concerned it might make it more difficult for them to feel able to speak openly, and that the associated stigma would negatively impact their perception of me.

In order to facilitate reflection on the impact of all of the above on the research process I used supervision, peer discussions and kept a reflexive journal. Further reflexivity relating to the analysis of the data can be found in the discussion.

2.3 Choice of methodology

Constructivist grounded theory is the chosen methodology because it is suited to research questions that aim to understand and conceptualise context-specific social-psychological processes. This choice will now be considered in more detail.

2.3.1 A qualitative approach

When research aims to explore the nuanced and subjective experiences of participants, the meaning they give to their experiences and the processes by which this occurs, a qualitative approach is most appropriate (Hammarberg, Kirkman, & de Lacey, 2016). Qualitative approaches are suited to research that aims to generate new understandings, rather than to test existing ones(Strauss & Corbin, 1998). Therefore qualitative methods were best placed to answer this research question.

2.3.2 Method of data collection

The chosen method of data collection for this study was focus groups, and each group consisted of members of the same team. Focus groups were chosen over individual interviews because this research holds the position that sense-making is a social process, that occurs between people and is influenced by context (Wilkinson, 2011). Within focus groups staff members are considered to not just be expressing existing ideas, but developing and negotiating ideas through interaction, adapting them to the cultural context of a team discussion (Wilkinson, 2006). In addition, existing qualitative research looking at staff understandings of people who receive a diagnosis of BPD have used individual interviews. Focus groups give valuable information about what is considered socially acceptable to express in teams, and can shed light on team culture and whether it inhibits or encourages particular ways of thinking (Kitzinger & Barbour, 2011).

It must be acknowledged that a focus group is an artificial setting and therefore discussion will differ from that which occurs routinely in teams. Nevertheless the focus groups will have many similarities with routine facilitated discussions such as reflective practice and complex case discussions. Naturalistic observation of team discussions was not permissible on ethical grounds, given that it would not be possible to know in advance which clients would be discussed and therefore clients' identifiable information would be heard without their consent.

2.3.4 Grounded Theory

Grounded Theory (GT) was chosen due to it being considered to best meet the research aims and questions. Grounded theory is suited to open-ended research questions that focus on social or social psychological processes within a particular context (Charmaz, 2015). It aims to make explicit a phenomenon that many people have experienced but not yet conceptualised (Charmaz 2015 p140), and to produce a context-specific theory which is derived from the data (Charmaz, 2014).

The identified gap in the research is *how* and *why* ways of understanding and talking about people with a diagnosis of BPD occur. Therefore, GT's focus on process, and its ability to lead to the construction of an explanatory rather than descriptive framework, were well suited to answering the research question. GT analysis enables inclusion and integration of both structure and process, so that both 'why' and 'how' a process occurs can be considered (Strauss & Corbin, 1998). It also encourages conceptualisation across multiple levels of context, for example considering the level of the individual, team, organisation and society (Strauss & Corbin, 1998). In this way it enables the development of links between participants actions and larger social processes (Charmaz, 2014) p133, which was one of the main aims of this research. Furthermore by producing a theoretical framework that considers multiple levels of context, GT can lead to recommendations that consider the multiple levels at which change could occur, which was one of the aims of this research.

2.3.5 Constructivist Grounded Theory

There are multiple versions of GT, and these share some principles and techniques but also have some fundamental differences (Charmaz, 2014). All versions involve the processes of coding, memo-writing, constant comparison and theoretical sampling, and aim to result in a theory of a social or social psychological process that is grounded in the data (Charmaz, 2014). Further explanation of these processes can be found in section 2.7.

The original version, now termed 'Glaserian' or classical Grounded Theory, takes a positivist position in which theories can be 'discovered' in the data (Glaser & Strauss, 1967), discounting the interpretative role of the researcher. In contrast, Charmaz's constructivist GT considers theories to be constructed by the researcher, who must therefore reflect on and make explicit the positions from which they have conducted the research (Charmaz, 2014). The latter position fits with my own beliefs, and (Willig, 2016) argues that Constructivist Grounded Theory is consistent with a critical realist epistemology because it aims to formulate explanatory accounts of social processes, and acknowledges that these occur within, and are influenced by, social contexts. The reasons for considering a critical realist epistemology to be important for this piece of research have already been stated. Therefore Charmaz's (2014) grounded theory was chosen.

2.3.6 Abbreviated version of GT

Willig (2016) describes that it is possible to conduct an abbreviated version of Grounded Theory, in which new data is not sought based on concurrent analysis and data collection, rather the processes of theoretical sampling and negative case analysis occur only within existing data. This means that some important aspects of GT cannot take place, for example needed further data cannot be identified and then collected to elaborate a developing theory. However, there was a requirement to agree in advance with the Health Research Authority and the participating NHS Trust's Research and Development department which teams would participate, and how much of their time would be needed, making these processes impractical. There was also limited time available for the project. Therefore the abbreviated version of GT was used.

Consequently it will not be possible to develop a fully elaborated theory that can completely explain a process and detail all relevant variables (Timonen, Foley,

& Conlon, 2018). Instead the aim will be to develop a conceptual framework that defines categories and describes the links between them (Timonen et al., 2018). The framework will still aim to be explanatory rather than descriptive, and lead to a comprehensive conceptualisation of a social psychological process (Willig, 2013). As recommended by Willig (2016) attention will be given to ensuring depth of analysis, given that the GT analysis is restricted in other ways.

2.3.7 Other approaches considered

A variety of other qualitative methods were considered before settling on Grounded Theory. The most promising alternative was discourse analysis. A Discursive Psychology approach to discourse analysis focuses on how language is used to construct a certain version of reality and achieve interpersonal goals within a specific context (Willig, 2015). Using this method would have fit with a focus on language and usefully shed light onto the functions of constructing BPD in certain ways within a mental health team context. However in conceptualising participants as agents actively employing language there would not have been a focus on the structures and powers that shape and restrict the possibilities open to participants (Willig, 2015), and the desired focus on the macro factors that impact on mental health practitioners would not have been possible. Foucauldian Discourse Analysis (FDA) would have conceptualised participants as positioned by discourse, which made available a range of possible ways of being, therefore shifting away from the individual as the location of agency (Willig, 2015). However FDA does not aim to produce a model, and it was considered that a model would provide a useful framework to guide change efforts.

2.4 Participants

The research aimed to recruit 4-6 participants from each of three teams, and for these to include people from a range of personal and professional backgrounds. It wished to explore how the BPD diagnosis was understood in comparison to other diagnoses, and how clients with a BPD diagnosis were experienced in a range of community contexts. Inclusion criteria were designed accordingly.

2.4.1 Inclusion criteria for participating teams

- Work with clients from the participating borough.
- Work with clients in the community. Inpatient settings did not meet this criterion and were excluded.
- Work both with clients that receive a diagnosis of BPD and clients that receive other diagnoses. The personality disorder service did not meet this criterion and was excluded.
- To be multidisciplinary, so participants from a range of professional backgrounds could be included. The psychotherapy service did not meet this criterion and was excluded.

2.4.2 Recruitment of teams

Based on the above criteria, I was introduced to the managers of the Single Point of Access team, the Home Treatment Team and the Community Mental Health Teams (CMHTs). They were invited to take part in the research via email and then a face to face meeting. The participant information sheet (appendix D) was presented and discussed and questions answered. All managers gave permission to recruit from within their teams and for the focus group to take place during working hours.

2.4.3 Description of participating teams

Team 1: The Single Point of Access team (SPA) who triage by telephone all referrals into the borough's mental health services and make onward referrals where appropriate. They also provide the 24-hour crisis telephone line that can be accessed by anyone within the borough. This team mostly employs nurses and social workers, and one psychiatrist.

Team 2: A Community Mental Health Team (CMHT) who support people considered to have complex or serious mental health problems that require ongoing psychiatric support and care coordination. Care coordination roles are fulfilled by nurses, social workers and occupational therapists, and there are also a small number of psychologists and psychiatrists within the team.

Team 3: Crisis Resolution Team (CRT) who provide intensive and time-limited support to individuals who are experiencing an acute mental health crisis in the community, often working from clients' homes. Nurses, social workers and support workers form the majority of the team, alongside psychiatrists and one psychologist.

2.4.4 Inclusion criteria for participating individuals

Participants were required to have experience of working clinically with people who have received a BPD diagnosis. They were not required to have a professional qualification. The aim was for each focus group to involve practitioners that represented the variety of roles found within that team.

2.4.5 Recruitment of participants

For each team I attended a team meeting to present the research, answer questions and give out the information sheet. After two weeks I returned to seek written consent from those that wished to take part (appendix E) and arrange a convenient date for the focus group. These meetings helped to build rapport with participants prior to the focus groups.

2.4.6 Description of participants

Sixteen participants were recruited. Participant demographics were collected from participants (appendix F) when gaining consent in order to give a description of the sample and indicate that participants from a variety of personal and professional backgrounds were included. In order to maintain anonymity these are described collectively rather than by individual or team.

Figure 1: Participant demographic information (n = 16)

Professional background	9 mental health nurses, 1 student nurse, 3 social workers, 1 psychiatrist, 1 support worker, 1 psychotherapist
Management role	3
Ethnicity	5 White British, 1 White Irish, 1 White Australian, 1 White North American, 3 Black African, 1 Black British, 2 British Asian, 1 Mixed Asian and White, 1 Chinese
Gender	8 female, 8 male
Age range and mean (years)	28-55, mean 40
Number of years of practice, range and mean	1-29, mean 9

2.4 Data collection

A semi-structured interview schedule was developed to guide the focus group discussion (appendix G). Initially the group was asked to discuss a client with a diagnosis of BPD that the team had worked with, to ‘warm up’ the discussion and provide the context to ask questions such as ‘how do you make sense of this individual’s difficulties?’ ‘what were the challenges?’ and ‘what went well?’ The questions then became more generalised, for example ‘what feelings tend to come up when working with people with a diagnosis of BPD?’ and ‘what do you think are some of the wider factors that influence how people with a diagnosis of BPD are thought about in services?’ In order to facilitate development of a nuanced theory the questions aimed to seek variation, for example between staff members, between clients, between services and between diagnoses.

Within grounded theory it is important to minimise the influence of existing ideas, so that novel theoretical understanding can be achieved (Charmaz, 2014). Therefore care was taken in the language used, to minimise any assumptions made, and the interview schedule was used to provide “points of departure” to open up but not constrain questions asked (Charmaz, 2006, p15). Follow up questions were adapted based on participants’ conversation. Two individuals from a user group of people who have received a diagnosis of BPD, and two members of staff in a different Community Mental Health Team within the host Trust, were asked to provide feedback on the draft interview schedule and minor changes to the language were made as a result.

One focus group took place within each of the three teams. Focus groups took place at the team base and were arranged at a time convenient to participants. They each lasted 80-90 minutes and had 3, 6 and 7 participants. A digital audio recorder was used, and observations of participants and the setting were also noted.

2.6 Ethical considerations

2.6.1 Ethical and research governance approvals

Ethical approval was obtained from the University of East London School of Psychology Research Ethics Committee (appendix H). As the study recruited staff through the NHS and carried out focus groups on NHS premises, research governance and legal compliance approval was then obtained from the Health Research Authority (appendix I). University Research Ethics Committee sponsorship was confirmed (appendix J). Research and Development approval from the host Trust was obtained and a Letter of Access issued (appendix K).

2.6.2 Participant anonymity, confidentiality and wellbeing

In order to minimise the likelihood of participants being identifiable in research products, participant profession and demographics are not included with quotes. Participants were reminded not to share identifying details of clients in order to respect their confidentiality. Ground rules including confidentiality towards other focus group members and respecting difference of opinion were agreed at the start of each group. The discussions had in the focus groups were not expected to be particularly distressing for participants, being similar to routine discussions in reflective practice. However debrief sheets containing details of sources of support were given out at the end of the focus groups (appendix L) and I remained in the room after the group in case anyone wanted to talk with me.

2.7 Data analysis

Focus group recordings were transcribed verbatim, and according to the transcription conventions in appendix M. The transcripts were read through whilst listening to recordings, using memos to note initial thoughts.

The full version of grounded theory advocates simultaneous collection and analysis of data, however this was not possible due to time constraints. However each focus group was listened to prior to the next one and initial notes were made about topics that seemed important. This enabled sensitisation to these concepts so that if they came up again I could ask elaborating questions.

2.7.1 Focus of coding

Throughout coding attention was paid to the language of both participants and researcher. In some cases ‘in vivo’ codes were used to reduce the likelihood of imposing assumptions on the data, also taking care not to assume a shared understanding of the words used (Charmaz, 2014). In order to highlight process and reduce the likelihood of assigning static labels or characteristics to individuals, gerunds were used for code names where appropriate (Charmaz, 2014). Attention was paid to the multiple layers of meaning within participant actions, for example stated intentions and implicit assumptions (Charmaz 2015). Attention was also given to interactions between participants, and field notes containing observations were coded as an additional source of information (Charmaz, 2014).

2.7.2 Phases of coding

Data analysis followed Charmaz’s (2014) method, proceeding through open, focused and theoretical coding.

Willig (2013) states that line by line coding helps to achieve the depth of analysis that is particularly important when using the abbreviated version of grounded theory, and Charmaz (2015) states that it helps the researcher to question both participant and researcher taken for granted assumptions. Therefore initial open coding assigned each line a label that described it, aiming to stay close to the data (see appendix N for an example).

During focused coding, codes that occurred frequently or seemed important during open coding were applied to further data, and codes were grouped together and integrated into higher level codes that were more conceptual and could explain larger segments of data (see appendix N for an example). Codes that had greater analytic power were raised as candidate categories (Charmaz 2014).

The third stage of coding was to further develop the properties of categories and the relationships between them. Charmaz (2015) expresses reservations about imposing a pre-existing paradigm on the data, highlighting that this moves away from a purely inductive analysis and may limit the researcher's vision. However, as a researcher who is new to grounded theory, I found Strauss and Corbin's (1998) coding paradigm helpful in facilitating development of links between categories and integrating structure (why something occurs) and process (how it occurs). I therefore used their analytical frame to code for:

- 'Phenomena': repeated patterns of action or interaction that are significant to participants and which characterise what they are doing or saying to try to manage the situation they find themselves in
- Conditions under which the phenomena occur
- Actions/interactions that characterise the phenomena
- Consequences of the phenomena

During the final stage of coding I then sought to develop a core process that related to all categories, and which could be considered the central phenomenon of the study (Strauss & Corbin, 1998). The core category should be sufficiently abstract that it could be applied to areas other than that being researched, and it should be able to encompass and explain variations in the data (Strauss & Corbin, 1998).

2.7.3 Constant comparison

Constant comparison of data from different participants, from the same participant at different points in the focus group, and of categories and subcategories took place throughout this process (Charmaz, 2014). Within a category both similarities and differences were sought to clarify the properties of the category and identify subcategories. Within grounded theory negative case analysis involves seeking examples that do not fit the developing categories, in order to further refine the properties of the category (Charmaz 2014). As I was unable to collect new data I sought negative case examples from within my data (Willig, 2013). This enabled the complexity of the data to be captured, and variation to be accounted for (Willig, 2013).

2.7.4 Memo writing and diagramming

Throughout the analytic process diagrams and memos were used to record reflections and ideas, and to justify and track decisions made during the analytic process, for example how lower order categories were integrated, and ideas about theory development (Charmaz 2015). See appendix O and P for examples. In addition to keeping a reflective log I aimed to become more aware of the assumptions I had made and things I may have missed by bringing an example of coding to supervision for discussion. Diagrams and memos illustrating ideas for the emerging theory were also considered in supervision.

2.7.5 Theoretical sampling and sufficiency

In the full version of grounded theory theoretical sampling would be used to seek out data that helps to refine and elaborate the developing theory (Charmaz, 2014). However in the abbreviated version this only takes place within the data (Willig, 2013). Grounded theory also describes the aim of reaching theoretical saturation, at which point no significant new categories or variation is apparent (Charmaz, 2014). Dey (1999) highlights the subjective nature of saturation judgements and proposes theoretical sufficiency as the standard to which many grounded theorists aspire. This was the case for this study.

2.7.6 Respondent validation

Feedback on the emerging theory was gained from my field supervisor and from one of the participating teams, and this was incorporated into the analysis where possible (see appendix Q). Unfortunately time constraints meant it was not possible to meet with each participating team at this stage.

2.8 Criteria for evaluating quality of research

There are many possible frameworks for evaluating the quality of qualitative research, some of which are generic and some of which are method-specific. As criteria are available for constructivist grounded theory, these will be used. Charmaz's (2014) criteria are credibility, originality, resonance and usefulness, and the research's performance against these criteria will be considered in the critical review.

3. ANALYSIS

This chapter will start by summarising the model that has been constructed from the analysis of the data, and then each of the model's categories and their subcategories will be described, supported by quotes from participants.

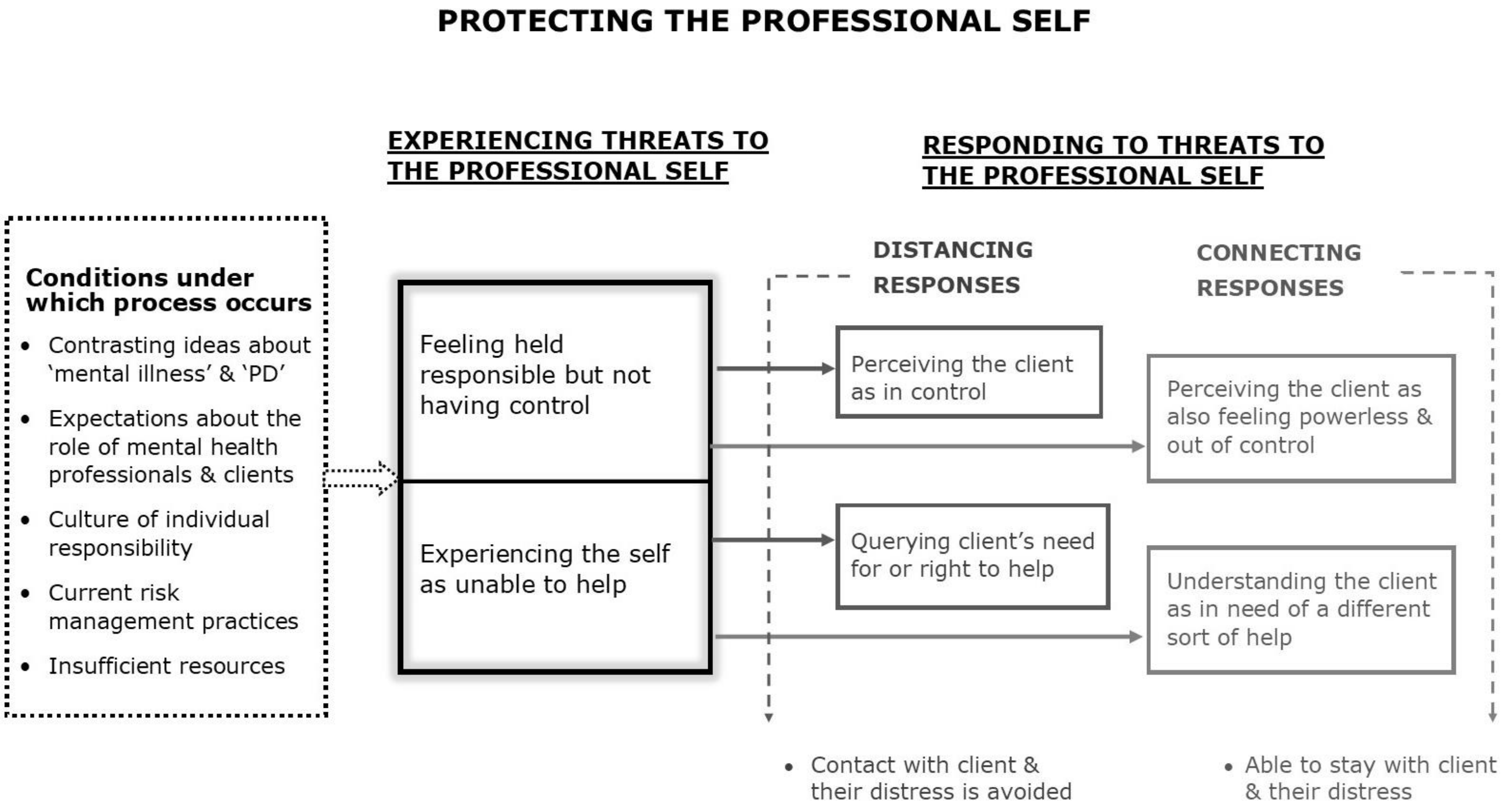
The term 'clients' will be used to refer to individuals who receive a diagnosis of BPD, with whom participants work.

3.1 'Protecting the professional self': Summary

The model is called 'Protecting the professional self' and is comprised of two core processes. These are 'Experiencing threats to the professional self' and 'Responding to threats to the professional self'. It is proposed that under the conditions described by participants, working with clients who receive a diagnosis of BPD is experienced as posing two core threats to the professional sense of self: '*Feeling held responsible but not having control*' and '*Experiencing the self as unable to help'*. Participants are proposed to draw on two different patterns of responding to these threats: '*Distancing responses'* and '*Connecting responses'*. Each of these responses serves to reduce the threat experienced to the professional self but their effect on the relationship with, and experience of the client differ.

This process is suggested to occur at multiple levels, for example at the level of individual practitioners, mental health teams, the mental health system and society. Although the majority of data relates to practitioner and team practice, where possible links have been made between practitioner experience and wider discourse and systems.

Figure 2: Diagrammatic representation of model



For clarity of understanding the two core processes of ‘Experiencing threats to professional self’ and ‘Responding to threat to the professional self’ will first be summarised, then the categories and subcategories of the proposed model will be explored in more detail.

3.1.1 Experiencing threats to the professional self

Participants reported that working with people who have received a diagnosis of BPD within their current context led to two key occurrences which were experienced as challenging and brought up difficult feelings. These were ‘Feeling held responsible but not having control’ (category **1**.1), and ‘Experiencing the self as unable to help’ (category **2**.1).

It is suggested that these phenomena were experienced as challenging because they were felt to pose threats to participants’ sense of professional self. By professional self, what is meant is staff members’ ideas about what constitutes a good mental health professional, and their desire to experience themselves as consistent with this.

Although ideas about a desirable professional self are likely to be influenced by personal values and life experiences, there appeared to be shared implicit and explicit norms that strongly influenced how mental health professionals saw themselves and their roles. These norms may be shaped by professional training programmes and policies, for example. In addition, the design of services both influences and is influenced by ideas about the type of work mental health professionals are expected to do. For example, when service design means a client will not see the same professional consistently during a crisis, this shapes and is shaped by ideas about the therapeutic relationship not being what is most useful to clients at those times.

3.1.2 Responding to threats to the professional self

First, it must be highlighted that although distancing and connecting responses are represented here as separate categories, the variety of responses of participants, services and society can be seen as falling in a variety of different positions on a continuum between these two poles. Additionally positions shifted, including within the same interaction.

Distancing responses and their consequences

Distancing responses with clients who receive a diagnosis of BPD relied upon constructing them as categorically different from staff and other client groups, and relatively homogenous as a group. This was achieved by relating to these individuals primarily by their diagnosis, for example referring to them as “PDs”. Generalisations were made about “these people” and “typical PD”, and in doing so clients’ individuality and humanity was lost. Clients were then made sense of in ways that appeared to facilitate a reduction in empathy and a disconnection from the clients’ distress (see categories **1**.1.2 and **1**.2.2). Within these conceptualisations the interpersonal, system and historical context of clients’ distress was largely absent, and client’s perspectives were often doubted.

The consequences of these conceptualisations included the avoidance of contact with clients and their distress within services, and procedures that resulted in not accepting them into services or quickly discharging them and referring elsewhere. Staff exposure to this perceived source of threat to professional self was therefore temporarily reduced. However it was reported that clients’ distress was often increased by this process and they were likely to approach services for help again, perhaps in more distressed and distressing ways, thereby resulting in a cycle of increasing distress and mistrust for both client and staff (see category **2**.2.1).

Connecting responses and their consequences

Participants also described times when they had responded to the threats that they experienced in alternative ways, which enabled connecting with rather than distancing from the client. Connecting responses were less common than distancing ones and required sustained effort on the part of participants. This was because they necessitated staying with the clients’ distress and resisting some of the ways of viewing themselves and clients that are most dominant within the cultures of teams and mental health services. This way of responding could also require more time to be spent with the client initially, and this was particularly difficult given the pressures placed on staff and services.

The second pattern of responding involved connecting with the client through identifying ways in which their behaviour is similar to one's own, taking the client's perspective seriously even when it was different to that of staff, looking at the historical and current context for their actions and formulating the challenges experienced as involving an interaction of systemic, individual and relational factors (see categories **1**.1.3 and **1**.2.3).

The consequences of these conceptualisations included staff spending more time 'being' with clients and their painful emotions and staff making use of their own emotional responses in understanding and connecting with the client. Participants stated that on some occasions clients communicated that they felt understood and less alone, and this could lead to a reduction in emotional intensity and distress. Participants reported having the experience of being able to help the client, and the dynamic shifted from being a struggle for control to a collaboration. Consequently both threats became reduced.

'Protecting the professional self': categories and subcategories

The model is presented by describing the first threat to the professional self that is proposed to be experienced (category **1**.1), followed by the two patterns of responding to that threat (categories **1**.2 and **1**,3). The second threat will then be presented (category **2**.1), followed by the two patterns of responding to that threat (categories **2**.2 and **2**,3).

The concepts of 'experiencing threats to the professional self' and 'responding to threats to the professional self', the conditions under which the processes are proposed to occur, and the consequences of the responses are woven into the descriptions of these categories (Strauss & Corbin, 1998). The conditions are also summarised in appendix Q, along with the categories with which they are proposed to interact.

Participant quotes are used to support the analysis. The participant number and team will be provided with each quote, and for clarity of reading filler words such as ‘ums’ ‘erms’ have been removed. Where words or phrases used by participants are integrated into the text they will be in quotation marks.

Figure 3: Table of categories and subcategories

Category	**Subcategory**
1.1 Experiencing threat: Feeling held responsible but not having control	**1**.1.1 Feeling held personally responsible for managing risk
	1.1.2 Feeling professionally undermined
	1.1.3 Feeling ‘pushed’ to act
1.2.Distancing response: Perceiving the client as in control	**1**.2.1 Losing touch with multiplicity of factors influencing client behaviour
	1.2.2 Inferring intentionality and losing touch with client distress
1.3.Connecting response: Perceiving the client as also feeling powerless and not in control	**1**.3.1 Seeking to understand the context of client actions
	1.3.2 Noticing shared aspects of client-professional experience
2.1.Experiencing threat: Experiencing the self as unable to help	**2**.1.1 Expecting to be able to provide solutions
	2.1.2 Facing a mismatch between client need and service provision
	2.1.3 Negotiating implicit and explicit exclusion from services
2.2.Distancing response: Querying the clients need for or right to help	**2**.2.1 Querying if client distress is performative
	2.2.2 Questioning client’s right to help

	2.2.3 Perceiving client as beyond help
2.3.Connecting response: understanding client as in need of a different sort of help	**2**.3.1 Remaining in contact with emotions
	2.3.2 Highlighting the need for system change

3.2 Category 1.1 Experiencing threat: Feeling held responsible but not having control

Participants stated that as professionals they felt they had responsibility for managing the interactions with clients and ensuring the client's safety, and if they felt they could not do this it reflected negatively on their skills and their sense of themselves as a clinician.

P11: you know, you have no control as a clinician, with your patient and it's makes you feel so powerless. All the years of training you've done just goes out the window because you …
P13: you are unable to manage the situation *(CRT)*

Clients who receive a diagnosis of BPD were felt to place additional responsibility on staff members, and participants also felt less able to influence client behaviour and the system's response. This increased the anxiety experienced.

Category **1**.1.1: Feeling held personally responsible for managing risk

Not feeling in control was described as particularly anxiety-provoking when it was combined with situations in which participants felt held personally responsible for high levels of risk.

It was felt that once a practitioner became aware of a risk, the system puts the responsibility for managing it with them as individual practitioners, and the responsibility isn't shared with the individual concerned, and not always with the team. Reference was made to a culture within the NHS and wider society that risk events such as suicide can and should be prevented by mental health professionals, and if these events aren't prevented this reflects poor or negligent practice.

P4: anyone mentions any type of risk and you've got to do something about it. You've got to stop it from happening. *(SPA)*

Some participants shared concerns that they could lose their 'PIN' (nursing registration) and cited examples of other professionals whose names had been in the media after such an event occurred.

This was a challenge experienced in relation to all client work, however it was seen as particularly difficult with clients who receive a diagnosis of BPD as they were reported to be much more likely than other clients to call services and say that they were intending to harm themselves. This was experienced as transferring the responsibility for their safety onto staff members.

P12: she's reporting it, she's calling to tell you that she's going to do it. What are you gonna do? *(CRT)*

In addition participants said that some clients who received a BPD diagnosis did not choose to share all information with staff, perhaps due to a lack of trust in services or in order to retain some sense of control within the relationship. Not having all the desired information added to participants' sense of not having control within the situation.

Category 1.1.2: Feeling professionally undermined

Participants stated that their views about what clients who receive a diagnosis of BPD needed, and the views of those clients, often differed. In these instances, clients sometimes reached out to other people or agencies for further support. When clients took such actions, it was experienced as undermining of participants' professional authority. This was particularly the case when other organisations made decisions that were counter to the team's view, and when the team needed to change their planned course of action.

P11: The plan was to discharge her and she didn't take well with that. She called a friend, the friend called the police and the police found her at home. The police then called us to say we need to ensure that you see her tomorrow, otherwise we won't leave her. So we had to make a plan with her to see her the next day.

(CRT)

Participants also described times when clients changed their mind or didn't follow participants' advice, which sometimes resulted in staff feeling professionally embarrassed.

P4: I spent an hour talking to a woman one night. I said "well when you get the home treatment team you need to talk about the things you spoke to me about". She said "I will, I will"
P1: I know what you're going to say! (laughs)
P4: Home treatment team turn up, she didn't say a bloody word!
P1: Yeah, and then you look like an idiot (laughs) (SPA)

Participant accounts indicated that they experienced some clients who received a diagnosis of BPD as breaching expected 'patient' behaviour, for example by not following professional advice. An expectation that professionals should hold control and authority meant that client actions were seen as reflecting negatively on the participants.

Category 1.1.3: Feeling 'pushed' to act

Participants stated that their decision-making autonomy could be impinged upon by both client actions and policies and procedures. Participants described occasions when individuals with a diagnosis of BPD had ideas about the help that they would find useful, and this didn't fit with participants' views or the criteria of services. Participants sometimes felt obliged to take the action that the client requested, particularly when clients stated that they would harm themselves if they weren't able to access support. This left participants feeling that their actions weren't really within their control, which led to irritation and a sense of being controlled by the client. When high levels of risk were involved participant's decision-making autonomy was further reduced by policies dictating the expected action.

P5: Even though you know that blue flashing lights and people getting their doors kicked in is going to be so unhelpful for someone's recovery, you get pushed into a position where you can't do anything else. Not because of feeling helpless or ineffective or powerless or whatever, it's simply because the way that's the world works. You'd have to justify pretty hard why you didn't take certain action on someone taking an overdose. (SPA)

3.3 Category 1.2. Distancing response: Perceiving the client as in control

Category 1 has highlighted the challenges to participants' professional identity of feeling held responsible for, yet not feeling in control of, the care of clients who receive a diagnosis of BPD. One way that this threat was responded to was by constructing clients as fully responsible for and in control of their actions and experience, and as attempting to control staff.

One function of this appeared to be that ways of viewing the client as distressed or vulnerable were closed down, and therefore they could be seen as not in need of care. Furthermore, participants could make sense of their feelings of lack of control as being because the client had "*taken*" it.

P11: because the power, the ability to control the safeness and, you know, is not in your hands because she's taken it all. (CRT)

Distancing actions could then seem warranted.

Category 1.2.1: Losing touch with multiplicity of factors influencing client behaviour

When a client was being constructed in a distancing way there appeared to be a strong focus on client behaviour, whilst the client's emotions and the interpersonal context of their actions were absent from accounts. Consequently, clients' actions were seen as "*bad behaviour*", sometimes driven by negative character traits. For example, clients behaving differently in different settings was described as "*manipulative*" and when clients behaved differently when meeting with different staff members this was described as "*splitting*" and "*inconsistent*".

When staff had contact with clients during times of crisis only, it was even more difficult to see the client's distress as contextually-related, and its cause could be seen as internal. There was also reduced opportunity to build a relationship that could provide a context within which staff could understand the distress, behaviour and intentions of clients.

When using these explanations participants appeared to be drawing on culturally dominant ways of making sense of the actions of people who receive a diagnosis of BPD. These explanatory accounts are in line with ideas about a person's difficulties being due to features of their personality and behaviour, as described by the diagnosis of personality disorder. Some participants also highlighted that their introduction to such ways of talking about people who receive a diagnosis of BPD began during their professional training, particularly on placements.

Decontextualizing participant actions appeared to mean that the variety of potential meanings of clients' behaviour were obscured. Multi-faceted perspectives were difficult to hold onto and instead there was a dominant 'single story' of clients taking deliberate action with particular goals in mind.

Category **1**.2.2: Inferring intentionality and losing touch with client distress

Aspects of clients' actions which were experienced by participants as difficult were often considered to be premeditated, deliberate and in some cases desired by the client. Perceived motivations behind behaviour were conceptualised as 'wants' rather than 'needs', and the language used was of ulterior and even dishonest motives.

P15: a secondary gain or pretence or a larger sort of … ehm … ploy to perhaps manipulate you to get you to do a specific thing that they're requiring (CRT)

Being wary of the client and being careful to keep them at a distance then seemed appropriate, and the person's own reasons for their behaviour, such as trying to cope with or communicate their distress, was absent from participant accounts. It became difficult for participants to 'see' or be curious about the distress behind clients' words or actions.

P6: Last week I received a call from a person who wanted Home Treatment Team. "I want Home Treatment Team, otherwise I'm going to kill myself." But what's the reason for referral then? (SPA)

Instead, client's actions were sometimes understood as being primarily in relation to their effect on staff, for example being intended to worry staff or raise their anxieties.

P16: to be honest I wouldn't think that it would be as a great stretch of the imagination that they would deliberately go to perhaps, you know, put themselves in harm's way, or stand next to, sort of, a bridge or whatever, in order to heighten your sense of anxiety (CRT)

Perceiving clients in this way appeared to close down collaborative ways of relating, and clients were spoken about as being in opposition to staff. When this occurred, and client distress was lost from participants' understandings, empathy for clients reduced and it became easier to distance from clients, allowing actions that reduce contact with the perceived source of threat.

3.4 Category 1.3. Connecting response: Perceiving the client as also feeling powerless and not in control

Another way of responding to the threat experienced by feeling held responsible but not having control was to construct the client as also feeling powerless and not in control of their experience. The feeling of not having control was seen by participants as being shared with the client, rather than the client having taken the control from them.

This allowed participants and clients to be seen as collaborating and coming together in the face of overwhelming emotions and uncontrollable systems.

Category 1.3.1: Seeking to understand the context of client's actions

When constructing clients in a way that supported connection, participants seemed to make efforts to think about how the clients' actions might relate to their personal history and their experience within the mental health system.

Clients' attachment relationships and experiences of trauma were sometimes drawn on to make sense of why events taking place currently might be particularly painful for clients.

P10: She intensely felt throughout "the service has let me down, no one is helping. My parents didn't look after me and then my ex-boyfriend tried to kill himself in front of me". So it's kind of the deeper meaning of being abandoned and rejection. *(CRT)*

On occasion, an understanding of clients' historical experiences of abuse of power also gave participants an appreciation that feeling powerless and not in control might feel particularly unsafe for these individuals, and that attempting to assert some control within an interaction with services might therefore be motivated by trying to stay safe.

Participants also reflected on the role that the mental health system, their service and sometimes their own actions might play in the client's distress. Participants highlighted the damaging effect of the language used to talk about people who receive a diagnosis of BPD, that services can be inconsistent in the way they respond to clients, and that often what is offered may not be sufficient for the level of distress experienced by the client. It was then considered understandable that clients might feel frustrated by and not trust the help that participants were attempting to offer.

P1: sometimes I think people phone up, and they've not been heard. You know they're not getting an effective service. I'm not going to pretend that mental health services are doing everything that they should be doing for these patients, and I can quite often see why they get really frustrated and they take their frustrations out on us. *(SPA)*

Category **1**.3.2: Noticing shared aspects of client-professional experience

In order to connect with and view themselves as alongside clients, participants reflected on ways in which their experience of clients may be similar to the clients' own experience.

P13: They feel out of control and helpless and they feel nothing is working, having tried so many things. So, in as much as we as clinicians find it difficult to *manage and deal with them, they themselves as well, they are finding it difficult to manage and come to terms with what is happening to them.* *(CRT)*

Participants highlighted that clients who receive this diagnosis often experience emotions that are intense and overwhelming, and that it is very difficult for clients to get what they need from the system. This facilitated an appreciation of the client's distress and allowed a shared challenge to be conceptualised that could be worked on collaboratively. It was then easier to maintain an empathic connection, even if clients' behaviour was experienced as being difficult to manage.

Furthermore, participants reflected that the behaviours considered to be 'personality disorder' represented an "*extreme version*" of behaviour that they identified themselves as using. Some participants described seeing themselves in the descriptions of the different personality disorder diagnoses, and acknowledged that behaviours that can be seen as pathological in one context can be adaptive and even culturally endorsed in another.

P7: You've got two [staff]. You want a day's annual leave. You think one will give it to you, you think one won't. Who do you ask? You're gonna ask the one who's gonna give it to you, yeah? But now you're splitting team. That's abhorrent behaviour. Why would you do that? But it's not, it's actually quite rational behaviour. *(CMHT)*

3.5 Category 2.1. Experiencing threat: Experiencing the self as unable to help

Participants' expectations of themselves as professionals was that they should know how to and be able to help the people they work with, and that this help would lead to noticeable change. Participants reported that this expectation was shared by clients also, however their experience was that they often felt unable to help clients who receive a BPD diagnosis. Participants were often left feeling "*helpless*", "*hopeless*" and "*deskilled*", and this could lead to avoidance of contact with these clients.

P1: he was just screaming at me like telling me you know that he needed help and he needed it now (…) it's like, chucking it all at you and then "I don't know *what I want, I don't know what I need, tell me, help me" and it's (pause), you know, it's so difficult (SPA)*

Reasons for not feeling able to help were threefold. First, there didn't appear to be discrete 'tools' that could offer solutions. Second, participants faced a mismatch between client need and what they were able to provide and third, options for onward referral were limited by implicit and explicit exclusion of clients from many services.

Category **2.**1.1: Expecting to be able to provide solutions

When participants described trying and not being able to help they often used the metaphor of "*tools*" and feeling they did not have anything suitable in the "*tool box*". This metaphor suggests an idea of helping as selecting something concrete that can offer quick resolution or alleviation of difficulties. Many individuals whose difficulties receive a diagnosis of BPD were described by participants as experiencing such an approach as invalidating or evidence of staff not understanding.

P12: you could pick any trick within the box and she will not … it won't be suitable for her … it won't work for her and (sighs) … it's really difficult (CRT)

In some instances, participants who were nurses by profession described their ability to help clients as largely being about medication, such that if this was not required they felt there was little else they could do. It appeared that the relational aspects of what can be offered to clients were often negated, and this was for multiple reasons. First, participants described seeking a sense of certainty about how to help, in order to cope with the understandable anxiety of high caseloads and high levels of client distress. Some participants felt that the medical model offered this certainty of action for other diagnoses, but BPD fell outside of this model.

P7: I think it gets very tricky to see. You know, the medical models are all very clear. If someone's psychotic you give anti-psychotic medication maybe you do a bit of psychology work to prevent relapse, blah, blah, blah. But we're talking about something that's a lot more abstract and a lot more broad and can't be defined like that and, yeah, I think it's very difficult to know what to do. (CMHT)

Second, ideas about the nature of the help that should be provided appeared to be both constituted by and reinforced by service design, where the implied assumption was that help would be offered within, for example, appointments of short duration. This conceptualisation is also in line with the need of the NHS and other public services to conserve resources through interventions being discrete and quick to have a result.

Third, feeling able to provide a solution meant there was less need for clinicians to stay with the client's distress, which participants highlighted as being a very difficult thing to do.

Category **2**.1.2: Facing a mismatch between client need and service provision

Participants expressed a lack of power within the system. They spoke about not being able to offer what they thought the client needed, both directly and in terms of referring on to other services.

Participants reported that clients often felt that nobody cared about or understood them, and there was a sense that the system re-enacted this to some extent when interventions that did not meet client needs were offered. Participants reported then being the 'face' of the system, towards which clients' anger and pain would be directed. This could be difficult to experience without feeling angry and less empathic towards the client.

Sometimes participants highlighted that they thought forming therapeutic relationships with clients could be helpful, yet felt the way services were set up made this difficult. This was usually because of limitations on the possible frequency of meetings and/or clients not seeing the same staff member(s).

P8: I know that once a month is too infrequent. It wouldn't really …
P9: Ideally you want to see someone I suppose at least once a week to have that, to build that kind of trust and meaningful relationship, and you can't do that can you *(CMHT)*

Partly this appeared to be a consequence of high caseload numbers, and also sometimes of the way that mental health services are designed. The structure of a mental health service can be seen as giving some indication of the prevailing idea of the nature of mental health problems and their treatment.

Participants highlighted that relational and emotional support was often an important aspect of what people who receive a diagnosis of BPD were seeking, but this did not correspond with service design and priorities, and client needs could not be met. It is interesting to note that these service limitations were also considered to be disadvantageous for clients who receive other diagnoses, however because participants felt that they had something else to offer these clients, such as medication or social support, this felt less problematic to them.

Participants also spoke about the effect that large caseloads, back-to-back appointments and frequent interactions with highly distressed clients had on their ability to be emotionally available to clients during the time that was available. This led to times of experiencing “compassion fatigue” and feeling unable to be their desired professional self.

P1: it’s kind of… just relentless, you know. You’re doing back to back calls with people, and there’s no respite, there’s no chance to kind of you know, catch your breath in between calls, and that can be really difficult. I think, you know, when we’re at our best we can deal with anything, but when you’ve had five calls and they’ve all been similar (…) that can be really challenging (SPA)

<u>Category **2**.1.3: Negotiating implicit and explicit exclusion from services</u>

It was expressed that further to not feeling able to offer something helpful oneself, there was a sense of helplessness about trying to navigate the system in order to get the client support.

Participants referred implicitly and explicitly to debates within mental health services about the validity of the personality disorder diagnosis and reported that people that attract a BPD label were often considered not suitable for, or to not meet the criteria for services. There was considered to be more certainty that services would and could help clients with other diagnoses.

P12: I don’t think anybody is going to sort of be “oh why did you admit this [to the ward]!” There’s psychosis and it’s evident. (CRT)

In some cases services or staff within services were reported to express blanket restrictions on people with a diagnosis of BPD accessing the service.

P10: [ward psychiatrists] tend to not to take personality disorder kind of very *clearly, saying "this is EUPD and we have no role", that sort of boundary and limitation. They say a clear message "whoever is having an assessment, encountering a known EUPD, don't admit". (CRT)*

Consequently some participants stated that they would be reticent to refer clients to these services even if they thought such a service could benefit the client, because they knew it was likely that the referral would not be accepted. Additionally, if the referral was accepted, there was concern that the client would be discharged immediately, and that this would be experienced as another rejection.

Among other services that were theoretically accessible to those with a BPD diagnosis, participants described that the range of clients that would be accepted was narrow. For example, CMHTs would often consider people either 'too complex' or 'not sufficiently complex', and psychotherapy and psychology services were often stated to exclude people who were using substances, currently self-harming or who had had a recent suicide attempt. This was reported to effectively exclude many clients who receive a BPD diagnosis, with no alternative service provision available.

P5: you have secondary services that will consistently sort of reject people because their "needs would be better met in primary care services". And then you reject all the people who you think far surpass that because they're really complex. And they're really chaotic and really risky and really difficult, and they get rejected as well. (SPA)

P7: You can't have had a suicide attempt in the last six months – on a 12-month waiting list! (CMHT)

A combination of explicit and implicit exclusion of many people with a diagnosis of BPD from services sometimes meant support would only be offered if clients were considered to be presenting a severe and immediate risk to their safety. In combination with the other factors highlighted in **2**.1.1 and **2**.1.2 this was described as often making participants feel powerless to offer something that they believed would help clients.

3.6 Category 2.2. Distancing response: Querying the client's need for or right to help

Category **2**.1 highlighted the ways in which participants often felt unable to help clients, and this threatened personal, service and cultural ideas about what mental health professionals should be able to do. Feeling unable to help or provide a solution in the face of distress was painful for participants and teams, and constructing the client in ways that either diminish the distress or emphasize the clients' responsibility for their situation facilitated coping with and disconnection from the resultant emotional discomfort.

P7: I think it's about emotional defence. It allows you to disconnect from something that is going to make you feel unpleasant. If you can belittle it, if you can write it off (…) I don't have to worry. It doesn't have to affect me. (CMHT)

Category **2**.2.1: Querying if client distress is performative

When clients had a diagnosis of BPD, doubts were expressed about whether client distress was "*genuine*" or a "*performance*".

P12: there's a sense that there's an action, a performance if you will and there's a sense that you know, there's some form of sort of manipulation as well, which then brings you back to this sense that this doesn't feel genuine (CRT)

Client difficulties were described as "*behavioural*", which implied that the clients' actions were instrumental and not driven by distress (see Category **1**.2). This was in contrast to 'mental illness', which was seen as outside of client control and responsibility, requiring professional intervention, and therefore a legitimate difficulty. In these situations, BPD's location outside of the 'mental illness' paradigm meant that clients' difficulties were doubted and not seen as the responsibility of mental health services. Furthermore, it was expressed that difficulties considered to be mental illness, such as psychosis or depression, could be "*objectively*" seen by professionals. It was felt that with the distress labelled BPD there are no "*objective*" markers, with behavioural manifestations of distress, such as self-harm, considered to be part of the client "*performing*" distress. Participants said they would therefore have to rely on clients' "*subjective view*" (P13, CRT), which was not considered a reliable source of information.

Concerns about the believability of clients' accounts was the subject of much discussion. There appeared to be two features of client presentation that further reduced estimations of client credibility. The first of these was when clients would tell staff that they were intending to hurt themselves.

P16: she's reporting it, she's calling to tell you that she's going to do it. So in a sense we see that as a performance, like she's not actually going to carry it out. (CRT)

The second was when crises occurred repeatedly, when it was even more difficult for participants to continue to stay with client distress. This was described as causing "*compassion fatigue for individual patients*" (P2, SPA) and precipitated doubts about the severity of the client's reported distress.

P12: anybody else you would be thinking "this is severe", but with these individuals you are trying to then work out exactly how severe this is, only because this is, if you like, their bread and butter. This is a daily thing for them. (CRT)

This seemed to be a particular challenge for teams involved in crisis assessment. Clients' repeated expression of suicidal intentions, whilst remaining alive, undermined their credibility. This was described as "*the boy who cried wolf*" (P8, CRT). The role of such services is to assess if suicidal (or other risk) actions will take place, which meant that clients' emotional crises might not be seen as "*real*" crises by teams unless accompanied by risk behaviour.

Examples were given of when it seemed that a mutually reinforcing cycle developed, in which clients' words and distress were not taken seriously, clients felt increasingly despairing and desperate and used the language of risk to communicate, and if this wasn't heard they might then take risky actions. If this didn't result in their death, this sequence of events made it even less likely that their expressed distress would be taken seriously next time, and therefore the chance of the client communicating in a way that services struggle to deal with was increased.

P8: they had decided there was nothing wrong with her, discharged her. We'd come out, the consultant had come out to see her, deciding there was nothing wrong with her. She'd got herself to [other hospital] they didn't want … they said "there's nothing wrong with you" and then she'd like started taking tablets right in front of the staff so they had to … like they did admit her for a bit.
(CMHT)

The combined processes, therefore, of doubting the genuineness of client distress and of their words, could result in escalation of client distress and behaviour and to the development of a climate of mutual mistrust between client and services.

Category **2**.2.2: Questioning client's right to help

Clients' right to help was queried in two ways: they were described as not helping themselves, and as demanding more than their fair share of resources.

First, when teams felt they had tried everything they could to help a client and yet the client remained highly distressed and was expressing this, the idea that they weren't helping themselves was sometimes expressed. It seemed painful for participants to stay with their own and their clients' feelings of hopelessness, helplessness, and despair, and sometimes there was a sense of irritation towards clients for not appearing to appreciate the effort teams had made. Identifying the client as not accepting help offered a way to make sense of the situation and move away from these feelings without needing to consider fundamental questions about the nature of human distress and the help that mental health services are able to offer.

P5: This is a guy that described himself as, what is it, 'so broken that nothing will ever help'. I mean (pause) is he that broken that nothing will ever help?
P2: Well, with that attitude! The point is that if you are not willing to accept help and don't think that appropriate help can be given to you then you are unlikely to find a use for it. The help-rejection is part of the ingrained continuation of that problem, that you don't continue to live in chaos if you seek solutions. (SPA)

In these situations clients were described in a variety of ways that included lacking insight, not being willing, not trying, not taking responsibility and not wanting to be helped.

P14: I think [client name] had no insight and is not prepared or ready to accept her condition or even try to receive the treatment. Which is why we're pouring the treatment on her and it's just bouncing off, because she's not ready (CRT)

Second, within a context of limited resources and professionals having a role in gatekeeping access to these, there were also occasional opinions expressed about clients "*overreacting*" to life events and seeking more than their 'fair share'. Their right to seek support was contested and comparisons were made with patients who were viewed as more deserving recipients of resources. Understanding clients in this way led to expressed anger and a perceived justification to withhold support.

P8: you don't like to see resources being wasted, you know. Especially when you see other people who really need help, but they're not asking for it. I'm going back to this woman, I'm thinking 'oh she's got a lovely flat', you know she's got everything she needs and yet she's, you know, like kind of being greedy almost, wants more, want the attention of everybody (CMHT)

Category **2**.2.3: Perceiving client as unable to be helped

The third way that clients seemed to be made sense of in relation to help was by describing the client as unable to be helped or beyond help. In these situations clients themselves would often be expressing hopelessness about the possibility of being helped and it seemed to be difficult for participants to hold onto hope when they felt they were out of ideas as to what to do.

Adjectives such as "*insatiable*" and "*never-ending*" were used to convey the perceived enormity of client need, and the perceived futility of offering support.

P12: I think that the sense is that this person is a black hole, ok. There is nothing that you can throw into it that will satiate it (CRT)

3.7 Category 2.3. Connecting response: understanding client as in need of a different sort of help

Another way of responding to the threat of not feeling able to help appeared to be to construct the client as in need of a different sort of help to that which is prioritised in mental health services, or more help than has been offered. Participants reflected that mental health services design often did not facilitate meeting the needs of those whose difficulties are conceptualised as BPD, and this reduced the threat to their professional sense of self without locating responsibility with the client.

Category **2**.3.1: Remaining in contact with emotions

Participants described how difficult it is to stay with someone's pain and not try to offer a solution. Partly this was considered to be a universal human experience, however there were felt to be additional challenges posed by the mental health professional role. Participants said that pressure on services leads to limitations on the time that practitioners are able to allocate to each client, and as described in category **2**.1.1 there was felt to be a strong expectation that professionals should *do* something to make the situation better, although participants said this was often experienced by clients as invalidating or not understanding. Some participants described occasions when they had acted counter to this impulse and been able to remain emotionally connected with the client in their distress, and this was experienced by clients as helpful.

P3: if you can manage to just listen and not jump in with any solution (…) Of the conversations I've had with her most have been disastrous but there have been a few where I've just listened, just reflected back her deep, deep despair and not minimised in any way, and it's de-escalated. She's said "thank you for listening" and she's tried to do something else that evening other than kill herself *(SPA)*

When describing such interventions participants often drew on professional frameworks such as motivational interviewing in order to justify their actions, suggesting that they were concerned about how "just listening" might be regarded by others. Similarly, some participants described times of human, rather than professional, connection with clients. Although, according to participants, these were often experienced as powerful by the client, there was a concern again about whether these actions were in line with what was expected of them as a professional.

P12: "he was sort of just telling me a little bit about some of his abuse and my eyes glazed over and he sort of looked over at me and he said "are you crying?" But do you know what was remarkable about that? I think he really got something out of that. That he could see how deeply I was affected by what he was saying. (…) that really seemed to impact him and it's always stayed with me. Just that he could see that it had elicited such a genuine response in somebody." *(CRT)*

Category **2**.3.2: Highlighting the need for system change

Participants also spoke about the ways in which they could see that it was difficult for clients to be helped because of the limitations of the mental health system, and that this did not necessarily reflect negatively on either themselves or the client. In a similar way to Category 3.2 this allowed participants to see themselves as alongside clients, trying to negotiate a shared challenge.

P4: So you're left with this whole group who are being sort of marginalised, or not looked after, or only being looked after when they demand it *(SPA)*

Such a position appeared to facilitate seeing things from the client's perspective, and clients' actions could be seen as understandable in relation to the challenges they experience in trying to access needed help.

P7: you can see why people would get frustrated because they're expressing a need, albeit maybe in a way that's not helpful, and you're saying 'here's what's gonna meet your need', but you kind of already know that it's not and then you wonder why they're getting even more upset *(CMHT)*

4. DISCUSSION

This chapter will start by relating the research findings to the research questions and existing literature. There will then be a critical review and a discussion of personal and epistemological reflexivity, before implications for practice, policy and research are discussed.

4.1 Research Question 1: When mental health professionals and teams make sense of people who have been given a diagnosis of BPD, what are some of the social-psychological processes involved?

The overarching process proposed in this study is that, within their current context, mental health practitioners and teams appear to experience working with clients who have been given a diagnosis of BPD as presenting two threats to their professional sense of self: feeling held responsible but not having control (category **1**:1) and experiencing the self as unable to help (category **2**.1). This means that their ability to meet personal, professional and societal expectations about what constitutes a good mental health practitioner feels at risk.

The default response to this sense of threat is proposed to be a 'distancing' response. This appeared to be facilitated by negative stereotypes of clients with a BPD diagnosis which construct these individuals as categorically different from staff and other clients, and as in control (category **1**.2) and not in need of help (category **2**.2). This is suggested to legitimise emotional and physical distancing from the client, the perceived source of threat.

There were also times when staff demonstrated 'connecting' responses. This appeared to be facilitated by seeking shared elements of experience and understanding client's' actions as meaningful and understandable within their context (category **1**.3), being able to stay with difficult emotions and formulating the challenges experienced as systemic in origin (category **2**.3). It is suggested that this connection also allowed the sense of threat to be reduced, as staff experienced themselves as able to be helpful and the dynamic shifted from being a struggle for control to collaboration.

4.2 Research Question 2: What are the contextual factors that affect these processes?

This study proposes that the above processes are affected by dominant societal ideas about the nature of ‘personality disorder’ and ‘mental illness’, in which ‘BPD’ is not granted the same empathy or relief from responsibility as ‘mental illness’ (categories **1**.2.1, **2**.1.1 and **2**.2.1). The mental health system appears to include implicit assumptions from the medical model, with consequent expectations that mental health professionals should be experts whose interventions provide solutions within controlled timeframes (categories **1**.1.2, **2**.1.1 and **2**.3.1). Relatedly there appear to be implicit expectations about the role of patients within this system, for example that they should noticeably benefit from intervention (categories **1**.1.1, **1**.1.2, **2**.2.1, **2**.2.2 and **2**.2.3). It is proposed that the distress and actions of people receiving a label of BPD often violate these implicit assumptions, resulting in them being constructed in negative ways.

In addition, the limitations of the current system mean it is difficult for staff to meet the implicit assumptions of the ‘good’ professional when working with clients with a diagnosis of BPD. Service design seems to make it difficult for staff to meet client need, for example with very limited time allocated for each client and expectations of back to back contacts with little time to think or process (category **2**.1.2), and implicit and explicit exclusion of these clients from services (category **2**.1.3). This is proposed to occur partly as a result of the under-resourcing of services, which puts teams under great stress, and also because this may defend against the challenge of staying with client distress.

Finally, a culture of individual responsibility affects the threat to professional self experienced by staff (category **1**.1.1) and is evident in the negative constructions of clients (category **2**.2.2).

4.3 Situating the findings in the previously reviewed literature

Having reviewed the existing empirical literature on staff ‘attitudes’ towards people with a diagnosis of BPD in the introduction, it is proposed that the idea of ‘Protecting the Professional Self’ represents a novel conceptualisation that generates further understanding of this social-psychological process. However, many of the component processes in this model are present in and supported by existing literature.

The first core threat to the professional self that is proposed in this study is feeling held responsible but not having control. It is well-documented that responsibility for high levels of risk can increase staff anxiety and defensive practice (e.g. Alexander, Klein, Gray, Dewar, & Eagles, 2000; Bohan & Doyle, 2008), however this study adds that this presents a threat to professional self when one also feels not in control (category **1**.1.1). Furthermore, this study suggests that in addition to attributing control over behaviour to individuals with a diagnosis of BPD (Forsyth, 2007; Markham & Trower, 2003) staff often experience themselves as not in control when working with clients with a BPD diagnosis. This is proposed to be due to an interaction of client, staff and service factors (categories **1**.1.2 and **1**.1.3).

The second core threat to professional self proposed in this study is experiencing the self as unable to help. It is well-documented that feeling unable to help is a common experience for staff working with people who receive a diagnosis of BPD, and that this experience negatively affects attitudes towards clients (Ma et al., 2009; Markham & Trower, 2003; Woollaston & Hixenbaugh, 2008). However, the difficulty in helping has often been previously understood to be largely due to the nature of the client's difficulties: their 'personality disorder'. This analysis, however, draws attention to the role of professional and service expectations about the nature of professional helping (category **2**.2.1), mismatch between client need and service provision (category **2**.2.2) and exclusion of clients from services (category **2**.2.3). This analysis also offers ideas about why this experience might affect attitudes towards clients.

Finally, this study proposes that ways of constructing and responding to clients, in light of these experienced threats, can be broadly seen as 'distancing' or 'connecting'. This finding is in line with Stroud and Parsons (2013) who talk about participant responses to clients with a BPD diagnosis shifting between connecting and disconnecting, depending on how they make sense of client behaviour. However this perspective is different from the majority of the literature that was previously reviewed, which viewed staff attitudes towards people with a diagnosis of BPD as singular and measurable by a questionnaire (e.g. Bourke & Grenyer, 2010; Chartonas, Kyratsous, Dracass, Lee, & Bhui, 2017; Cleary, Siegfried, & Walter, 2002). Therefore, this study advances existing conceptualisations by further exploring the factors that influence shifts in the ways that staff understand and respond to clients with a diagnosis of BPD in any given moment.

4.4 Further exploration of component social-psychological processes

Having situated the findings in the ‘staff attitudes to BPD’ literature, literature from other areas will now be drawn on in order to further explore some of this study’s findings. Efforts will be made to link the processes occurring within teams with the wider structural and discursive context.

4.4.1 Attributing personal responsibility and control

The reviewed literature theorised negative attitudes towards people receiving a BPD diagnosis to involve attributions of control, responsibility, intentionality and dangerousness. The first three of these are represented in category **1**.1.2 of this study’s findings, when clients were constructed as fully responsible for and in control of their actions and experience. Perceptions of emotional (but not physical) dangerousness are also apparent given that working with these clients is proposed to be experienced as posing threats to professional selves. Therefore this study’s findings include and support that which has been previously proposed.

However this study goes further in that it proposes that these processes serve the function of legitimising emotional and physical distancing from the client, and that this serves to reduce the felt threat to the professional self. In addition, this study highlights that culturally dominant conceptualisations will be most easily drawn on by staff when trying to make sense of a situation (Parker, 1998). It is suggested, therefore, that attributions of personal responsibility and control in the context of clients who receive a diagnosis of BPD are supported by such narratives and policies within wider mental health and social care policy, and recent changes to state welfare provision (Thomas, 2016). Personal difficulties and success are understood to be a consequence of individual actions and decisions, and the social, economic and political influences on experience are discounted (Thomas, 2016). For example, the ‘recovery’ focus of UK mental health services encourages individuals to take personal responsibility for whether they recover from their mental health difficulties, whilst the societal changes needed to support good mental health are not emphasized (Harper & Speed, 2013).

It is notable that such narratives are increasingly dominant within times of limited resources, such as current UK ‘austerity’ policies (Thomas, 2016). Professionals’ role as gatekeepers of access to limited resources becomes more prominent and an implicit hierarchy develops, based on factors including how much it is perceived that the client will benefit from the intervention, as well as moral judgements about the client (McEvoy & Richards, 2007). Patients are then compared against each other and with implicit notions of ‘real’ mental illness to determine their relative right to access the limited resources, and anger can be felt towards those who are seen as asking for more than their fair share, or who are taking away from those felt to ‘need it more’ (Breeze & Repper, 1998, and category **2**.2.2). In this way the responsibility and blame for there not being enough to ‘go around’ is located with the patients, rather than the systems of power that deprioritise such services.

4.4.2 Threats to professional self: the ‘difficult patient’

Taking the theory proposed by this study as a whole, the most striking parallels that could be found were within the ‘difficult patient’ literature.

Breeze and Repper (1998) concluded that the ‘difficult patient’ label was applied if patients challenged the “competence and control” of staff (p1301). Kelly and May (1982) concluded that a patient comes to be viewed as a ‘problem patient’ if their actions intentionally or unintentionally undermine the value of the professional’s role, for example through not giving validating feedback, or not demonstrating change. The professional’s self-esteem and professional self-image are threatened, and the patient is held responsible for this (Kelly & May, 1982; May & Kelly, 1982). Furthermore, this literature proposes that staff cope with difficult interactions with patients by avoiding and maintaining emotional distance, and that attributing difficulty to the patient in these situations gives permission to respond in these ways (Michaelsen, 2012).

The first proposed implication of the apparent similarities between the construction of the ‘difficult’ patient and the ‘BPD’ patient is that the diagnosis of BPD may function as a way to label and pathologise patients who deviate from expected behaviour (e.g. Lewis & Appleby, 1988; Sulzer, 2015). This further questions the status of this label as a legitimate psychiatric diagnosis, suggesting instead that it represents a moral judgement that designates those who breach social norms as disordered, so that social order is obscured and not questioned (Sulzer, 2015). However, it is not suggested that this means that the distress of people receiving a label of BPD is not genuine or in need of state-provided support. Rather it is argued that conceptualising this distress as a ‘personality disorder’ means the pathology is considered internal in origin, rather than a legitimate response to pathological social conditions and experiences.

Second, it is suggested that there are such similarities between this study’s findings and the cited ‘difficult patient’ literature because they both conceptualise the process of designating someone ‘difficult’ or ‘BPD’ as a social process, that occurs between patients and staff and is influenced by wider context: “difficulty cannot be considered an intrinsic property of the patient. Rather, difficulty results from the interaction of nurse factors, patient factors and situation factors” (Pottle & Marotta, 2014, p53). Conversely, the majority of the reviewed empirical literature concerning attitudes to ‘BPD’ conceptualises the category of BPD as something that objectively exists within a person, and which is the primary explanation for that person’s behaviour. Problems are then implicitly accepted as originating within the person and systemic thinking is lost.

Distancing and connecting responses: constituent processes

Looking at the summaries of distancing and connecting responses (category 3.1.2), which cut across both distancing responses (categories **1**.2 and **2**.2) and connecting responses (categories **1**.3 and **2**.3), it is proposed that there are three constituent social-psychological processes: differentiating/ seeking what is shared, decontextualising/ contextualising and discrediting/ accepting multiple valid perspectives. Each of these processes will now be explored, with particular reference to why it is that distancing responses appear to be the default, with connecting responses requiring some level of resistance to dominant discourse and practice.

4.4.3 Differentiating/seeking what is shared

The findings of this study suggest that distancing responses involved constructing people with a diagnosis of BPD as categorically different from staff, and relatively homogenous as a group.

Social Identity Theory (Tajfel, Turner, Austin & Worchel, 1979) hypothesizes that in order to construct our self-identity we categorise people into groups that we identify as the same or different from us, and we then maximise differences between groups and minimise differences within groups in order to form positive stereotypes about groups that we identify with, and negative stereotypes about those that we consider to be ‘other’ (Barter-Godfrey & Taket, 2009). In this process the other is not only constructed as different, but as inferior, and they become “objects who lack complexity, motivation, rationality and capabilities” (Krumer-Nevo & Benjamin, 2010, p695), as seen in category **1**.2.1 of this study. This process allows for undesirable parts of the self to be projected into, or conceptualised as belonging to, the ‘other’ and not oneself (Krumer-Nevo & Benjamin, 2010). In this context, this means that extremes of emotion, suffering and behaviour are seen as properties of the ‘personality disordered’ patient, and those without this label are protected from the idea that they too may at times have these experiences or behave in these ways (Wright, Haigh, & McKeown, 2007), that these clients might in some way resemble the self (Krumer-Nevo & Benjamin, 2010).

Importantly, in this context this process of differentiation is also legitimised by the psychiatric system’s creation of categories of difference and disorder (Wright et al., 2007). Staff engaging in this process are not creating these categories and inferring inferiority themselves, rather drawing on those already available in psychiatric discourse. Consequently, participants who used connecting responses had to actively resist this process by identifying elements of experience that were shared with clients, and reflecting on times when they too had behaved in ways that might be consistent with those receiving a label of BPD (category **1**.3.2).

Additionally, the process of ‘othering’ (De Beauvoir, 1949) facilitates disconnection from the distress experienced by the client. A focus on paperwork and routine task completion as key performance indicators, and the dividing up of the care of one patient into a variety of different teams, also contribute to the “alienating environment” in which connection between staff and clients is made less possible, and ‘othering’ can sustained (Mckeown, Wright, & Mercer, 2017, p452). These practices have been conceptualised as institutional defences against the overwhelming anxiety which such systems are required to contain (Lyth, 1988). Connecting responses, therefore, necessitated a willingness to stay with difficult emotions despite insufficient structural containment and support.

4.4.4 Decontextualising/contextualising

Another process that appeared to take place in distancing responses was that the actions of people with a diagnosis of BPD were talked about without attention to the emotional, interpersonal and structural context (categories **1**.2.1 and **1**.2.2). Client actions were therefore not seen as responses, but as driven by internal negative character traits or desires. It is proposed that this allows clients to be seen as responsible for, and in control of, their actions and experience, and therefore not in need of care.

Wright (2007) highlights that when interpersonal difficulties occur they are usually understood to involve an interaction between both parties, and those involved may reflect on how their actions have contributed. However this study’s data suggests that the diagnosis of BPD closes down this customary way of thinking, and in interactions between staff and those given a label of BPD, “any difficulties or breakdown in communication is always understood in terms of essential attributes to the other person i.e. his/her personality disorder” (p16). When using these explanations participants appear to be drawing on culturally dominant ways of making sense of the actions of people who receive a diagnosis of BPD, which are made available by the diagnosis of ‘personality disorder’, which proposes this disorder to be the explanatory factor of the behaviour of those so-diagnosed (Burr, 2003).

Identifying the client as the source of these difficulties protects the system and staff from needing to reflect on their relative contribution to the difficulties that are experienced in working with people with a diagnosis of BPD (Koekkoek, van Meijel, & Hutschemaekers, 2006). ‘Connecting’ responses, however, necessitated formulating the challenges experienced as involving systemic, relational and individual factors (category **2**.3.2), and including the client’s emotional, interpersonal, structural and historical context in order to make sense of client experience and actions (category **1**.3.1).

4.4.5 Discrediting/accepting multiple valid perspectives

The third process occurring in distancing responses involved doubting client accounts and distress (categories **1**.2.2 and **2**.2.1). This study proposes that constructing the client in this way can make the experience of not feeling able to help less threatening to the professional self, through understanding the client as not in need of help. Fellowes (2014) highlights that when staff construct clients in ways that dismiss, avoid or simplify their emotional distress this can be understood as a means of self-protection, and an indication that structures to support staff to contain and make sense of these emotions are not sufficiently present.

Again, this way of constructing clients is proposed to be facilitated by the diagnostic construct of BPD, which makes explicit that the emotions of those so-diagnosed are considered ‘inappropriate’ or are reactions to ‘perceived’ events (APA, 2013). Watts (2017) proposes that the dominant negative stereotypes associated with the BPD diagnosis mean that the credibility of those given a label of BPD is often reduced, in a process named testimonial injustice (Fricker, 2007). This is when the credibility that is given to a person is reduced due to negative stereotypes associated with a social group of which they are considered a part. This often occurs unconsciously, but is unjust as it is based on biased and generalised assumptions (Crichton, Carel, & Kidd, 2017). It has been suggested that all psychiatric diagnoses reduce the credibility of the diagnosed, and consequently inflate the credibility, and power, of the psychiatric professional who is in a position of ‘expert’ knowing (Crichton et al., 2017). In the case of ‘BPD’ the loss of credibility comes not from ideas of madness, but ideas of ‘attention-seeking’ and ‘manipulation’ (Watts, 2017).This process is particularly pertinent when staff and client perspectives differ, and mental health professionals have the power to have their opinion considered as ‘truth’ (Shaw, 2005).

It is proposed, therefore, that doubting the accounts of people who receive a diagnosis of BPD is culturally normative, particularly if they deviate from the professional account. Staff drawing on connecting responses did not assume that their perception of events was the ‘true’ one, rather were able to acknowledge and hold in mind multiple perspectives.

4.5 Critical Review

Charmaz’s (2014) criteria for evaluating the quality of a constructivist grounded theory study will be used as they are consistent with the study’s aims and epistemology (Willig, 2013). Please see Appendix S for further detail about the criteria.

4.5.1 Credibility

This study aimed to demonstrate credibility of analysis through inclusion of participant quotes, and example coding, memos and analytic diagrams in appendices N, O and P. Candidate categories and models were explored in memos and discussed in supervisory meetings and peer discussions to support critical reflection on the assumptions made and highlight what had been missed. During analysis, examples of variation were actively sought, and variation in participant response is a central part of the developed model. Disconfirming examples were also sought; however this was only possible from within the existing data as further data collection did not occur.

Grounded theory has traditionally recommended that the literature review be conducted after data analysis, to minimise the influence of existing research on theory development (Glaser & Strauss, 1967). However this suggestion has been the subject of debate, with many arguing that attempting to be a “theoretical virgin” is neither realistic not desirable (Dunne, 2011, p115). In this study a research proposal, which identified a gap in the literature and developed a rationale for the research, was conducted prior to commencing the project. The systematic literature search, however, and the writing of the introduction chapter, were not completed until after the analysis. Being engaged in a professional training programme and having prior experience of working in relevant fields, it would have been naïve to consider it possible to enter the research with no prior knowledge. Therefore memos, a reflexive diary and supervision were used during the analytic process to consider where ideas were coming from and ensure grounding in the data (Dunne, 2011).

Given that the study aims to explore team understandings, its credibility would be affected by biases in who agreed to participate within participating teams. Over half of participants were nurses, which could be seen as a limitation given that there was an interest in multi-disciplinary team discussions. However nurses do constitute the largest professional group in such teams (Evans et al., 2012), so this may reflect the team composition. Psychologists were present in small numbers in two participating teams, however were not present at the meetings in which the study was introduced, and did not participate in the study.

It may be that participating staff have particularly strong views on the topic or feel more comfortable than non-participants in expressing and negotiating their views in front of team members. The research-focus and recording of the focus group discussions may have limited what people felt able to say. However a variety of views, including those that might not be considered socially desirable, were expressed. This would suggest that participants felt comfortable to some extent.

The credibility of the study would have been enhanced by conducting the full version of grounded theory. This would have enabled the use of theoretical sampling to seek opportunities to test and further elaborate the properties of the emerging model (Charmaz, 2014). For example, returning to participating teams with focused questions, and including teams in inpatient settings and other geographical locations could have allowed for further exploration of the factors that influence the identified process.

4.5.2 Originality

The originality of the study has been explored in sections 4.1, 4.2 and 4.3, where it has been related to existing literature and novel insights have been highlighted. It is argued that the study provides a new conceptual understanding of the social-psychological processes involved when mental health professionals and teams make sense of people who receive a diagnosis of BPD. The study challenges the idea that the key issue behind stigmatising constructions of clients is lack of knowledge on staff's part, instead considering the functions these constructions serve and the contexts within which these processes are engaged. The theoretical, social and clinical significance of the findings are considered in section 4.7.

4.5.3 Resonance

The resonance of the study can be considered with respect to the reader and the participants. It is hoped that it has been possible to "portray the fullness of the studied experience" to the reader (Charmaz, 2014, p337), but word count restrictions and the desire to make the work easily understandable has placed some limits on this. For example, it has been necessary to edit quotations, including removing the interpersonal context in which they occurred.

In order that the study acknowledged the multiple levels of influence on the practitioner and team experience, attention was given to the effect of structure, institutional practice and discourse. As recommended by Charmaz (2014), effort has been made to highlight what is taken for granted in the focus groups and existing literature. However my own familiarity with the subject matter and psychiatric context may have meant that this has happened in ways that I have not noticed.

Feedback on the candidate theory, gained by presenting to one of the participating teams, implied a broad resonance with the model. It was considered to shed some light on the team's experience in a way that was relatively easy to understand. Participants expressed appreciation that it was not blaming towards either clients or staff, and indicated specific areas of the model that required further thought if they were to fully resonate with the team (see appendix R). For example it was suggested that it be made more explicit that connecting responses are more difficult and effortful for staff than are distancing responses. This feedback has been incorporated into the write up of the model. There is the intention to return to all three teams to discuss the study's findings. Unfortunately, it has not been possible to do this before submission of the thesis.

4.5.4 Usefulness

The usefulness of a study is affected by the perceived transferability of its findings to contexts other than that within which the research took place. All participating teams were located within one London borough, and service structure and provision vary markedly by location (Dale et al., 2017). However, the possibility for variation in conditions is included in the model, and sections 4.3 and 4.4 have highlighted that there are many resonances between this study's findings and literature from a range of settings. This would suggest that they may be applicable to and provide insights more broadly. Nevertheless, a useful extension of this study would be to explore the experiences of teams in different service and geographical locations.

The usefulness of a study also depends on the implications for research and practice that can be derived from it. Section 4.7 summarises these. Care has been taken to make the recommendations concrete and able to be applied at multiple levels, such as by frontline staff, service managers and policy makers. In order to increase the impact of this study there are plans to disseminate the findings within the host Trust, to write them up for peer review, practitioner and survivor audiences. Ultimately the usefulness of the study will be based on whether its insight and recommendations can improve the experience of clients receiving a label of BPD, as well as of staff within mental health services. Consultation with 'service user' and staff groups would further support this.

4.6 Reflexivity

In Section 2.2 I reflected on the potential influence of my personal and professional identity, experience and context on the research process. Personal and epistemological reflexivity (Willig, 2013) will now be considered from the position of having completed the study.

4.6.1 How have my beliefs, experiences and epistemological position affected the research?

Being a trainee clinical psychologist with an interest in critical psychology and social constructionist approaches I prefer to view difficulties as occurring between people and as influenced by context (Dallos & Stedmon, 2014). My personal experience of having received a diagnosis of BPD and having worked in challenging conditions in mental health services meant that I was aiming to avoid an analysis that focused on perceived individual traits or deficits, be that of staff or clients. It was important to me that the analysis considered the multiple layers of context that influence the team experience. This was in line with the chosen epistemology and methodology, and the identified gap in existing research.

Taking a critical realist epistemology meant that I took what participants said to reflect their thoughts and experience, whilst considering how these were influenced by social and cultural context. In line with realist ontology I also sought to acknowledge material challenges and consequences. If I had taken a social constructionist epistemological position I might have, for example, used discourse analysis to explore naturally occurring team discussions. This would have asked what staff were *doing* with their talk, for example justifying or disclaiming, rather than considering the talk to convey their existing beliefs and feelings about people who receive a diagnosis of BPD (Willig, 2015).

I was concerned that not adopting a social constructionist epistemology, and basing the study on the ways in which people with a diagnosis of BPD are understood, would inadvertently reify the BPD construct. However, receiving a diagnosis of BPD has very real consequences for individuals, regardless of whether the diagnostic label is in itself socially constructed. The study is about how teams make sense of people who *receive* the diagnosis of BPD, not people who ‘have’ BPD.

If I had adopted a ‘naïvely’ realist position, I might have conceptualised ‘BPD’ as an objective entity that clients had been discovered to have. This was the epistemological position adopted by some participants. Although I made active efforts to be curious about all perspectives, it is likely that I showed implicit agreement with certain viewpoints, for example by nodding my head. When views were expressed that I found to be non-compassionate I noticed that I was inclined to ask questions that would prompt consideration of alternative perspectives, or the assumptions underlying their statement. This came quite naturally as a trainee clinical psychologist, and was a topic of discussion in supervision and in my reflective diary.

4.6.2 How has the research process affected me?

I chose not to share with participants my status as a survivor of this diagnosis, partly because I thought it might limit participants’ ability to speak freely and partly due to my fear of the judgement and discomfort that might ensue. However, although I am apprehensive about the potential repercussions for my career, I have chosen to share this in the thesis. This is because I feel it is very relevant to the questions I wanted to ask and how I will have made sense of the data, and because I view being open about this aspect of my experience as a political act, given the associated stigma and discrimination.

Considering the impact of the research on me personally, I found that being immersed in the data was reminding me of the messages I had sometimes received from mental health services, leading to me feeling unable to step away from the dominant psychiatric stories about people who have received a diagnosis of BPD. I found myself doubting whether my actions were, or would be seen as ‘manipulative’, if communicating my distress was, or would be seen as, ‘attention-seeking’. This experience was a powerful reminder for me of the effect that these widely-held conceptualisations can have on people who receive a diagnosis of BPD. This reaffirmed the need for this research, and to try to somehow contribute to bringing about new understanding and change.

However, doing this research raised many dilemmas for me. One is that I believe it is vitally important that research that aims to shed light on and challenge discrimination and oppression should ensure that those with personal experience of that oppression are central to the research, to draw on their lived experience and avoid replicating oppressive power dynamics. However this also requires those individuals to put themselves in potentially painful and vulnerable positions, and the research process can in itself replicate or reactivate these painful experiences. Furthermore, it can end up placing responsibility for effecting change with those who are or have been oppressed.

I don't have a solution to this dilemma, but researchers, academic institutions and survivors of oppression need to continue to come together in the effort to create ways of conducting such research that are truly emancipatory for those involved, as well as transformational of the system.

4.7 Implications

4.7.1 Research

There is much research that would be useful to broaden and deepen the proposed theory and investigate whether insights from it are transferable to other settings. It would be valuable to explore the social-psychological processes involved in team conceptualisations of people with a BPD diagnosis in settings such as prison and probation, voluntary sector and privately-funded organisations. This would shed further light on the influence of the organisational and ideological context on these processes. Conducting similar research within different cultural contexts would also illuminate the effect of wider socio-cultural beliefs and practices.

It would also be helpful to further investigate the factors at all levels that make 'connecting' and 'distancing' responses more possible within helping professions. In addition, it would be useful to explore whether 'protecting the professional self' is a process that occurs more widely, for example with clients who receive other diagnoses. If so, it would be helpful to explore what felt threats are associated with those diagnoses and whether clients are constructed in particular ways as a response.

In terms of methodology, observation of naturally-occurring team discussions about people with a diagnosis of BPD, perhaps accompanied by subsequent individual and group interviews to prompt reflection on what had taken place, would further increase ecological validity and address the limitation of taking what is reported to occur as representative of what actually occurs. However it would also pose ethical challenges due to it not being possible to predict in advance which clients would be discussed, which constitutes access and processing of patient identifiable information without consent and requires special approval from the Confidentiality Advisory Group (Health Research Authority, 2018).

Finally, observation of naturally-occurring interactions between clients and teams, followed by reflective interviews with those involved, would allow exploration of whether and how the social-psychological processes identified in this study occur between clients and teams, and what the impact of this is on both parties and the relationship.

4.7.2 Clinical

The model suggests interventions at two points: to reduce the sense of threat to professional self that is experienced when working with clients with a diagnosis of BPD, and to make connecting rather than distancing responses more possible if threat is experienced.

Considering the first of these points, the model suggests that reducing the threat to professional self could involve broadening how ‘helping’ is understood in mental health professions. For example, Key Performance Indicators and professional training programmes could represent ‘being’ with the client when they are very distressed as just as much a core responsibility and competency as completing a risk management plan. Similarly, clients wishing to have control over the help they receive need not be a threat to professional self if professional training and mechanisms of clinical governance revised the expectation that a ‘good’ professional’s decisions prioritise ‘clinical judgement’ over client perspectives, and if it could be acknowledged in teams that the need to control access to services is often shaped by the need to ration access rather than purported clinical rationales. Other useful changes could include addressing the broader contextual factors that mean that staff are more likely to experience a sense of threat to professional self, such as unmanageable caseloads, a culture of being held personally responsible, frequent service restructuring and cuts to funding for professional training.

Considering the second of these points, interventions at all levels should be based on countering the three processes identified as supporting a distancing response: discrediting, decontextualizing and differentiating. Training, policy and service development should be explicitly based on encouraging and facilitating the opposite of these processes. This would mean, for example, that staff training that is based on understanding the ‘BPD’ category risks doing more harm than good if it suggests that people so-diagnosed are categorically different from ‘us’, that their emotions are ‘inappropriate’, their accounts to be doubted, or that their behaviour is driven by an underlying disorder rather than responses to their interpersonal, historical and social context.

Instead, some of the frameworks proposed in this research could be used to prompt reflection in supervision, team meetings, reflective practice and case discussions. For example, it might be useful to ask ‘are we feeling threatened as professionals when working with this client?’ ‘If so, why do we think this is, and what are the broader factors that might be contributing to this situation?’ ‘Does it feel like we are connecting with or distancing from the client, and why is this?’ ‘In our discussions are we taking the client’s perspective to be equally valid to our own?’ ‘What are the ways in which we can see similarities between us and the client?’

It would be important to look for commonalities between staff and clients, develop the ability to acknowledge multiple perspectives as valid and hold a not-knowing position (Anderson & Goolishian, 1992), and formulate the challenges of working with people who receive this diagnosis as related to the divergence of societal ideas, system practices and resources from client experience and needs. Increased access to forums that support such reflection and offer containment for staff that are staying with difficult emotions might make it more possible for negative stereotypes of clients not to be defensively, and make ‘connecting’ responses more possible. However these ideas would also need to be consistent with the priorities and philosophy of commissioning and policy, so that service design could accommodate these ways of working without them being considered to not meet targets, thus jeopardising funding.

Finally, it has been argued that the construct of BPD supports differentiating, discrediting and decontextualizing, and contributes to the systemic exclusion of people so-diagnosed, which in turn contributes to the professional threats of feeling unable to help and feeling held responsible but not having control. Therefore, it is questioned whether there can be meaningful change in mental health team responses to those given this diagnosis whilst peoples’ distress is still understood and treated within this framework. A new conceptualisation is required that contextualises this distress as an understandable response given the individual’s historical, societal and interpersonal context, and highlights its interpersonal, not intrapersonal nature. However, there is a risk that such a conceptualisation, if developed without a fundamental change in how the mental health system and society in general conceptualises distress and ‘disorder’, would become a euphemism for ‘BPD’, and this would be unlikely to lead to meaningful change.

Whilst this research has explored the function negative attitudes towards people with a diagnosis of BPD serve in NHS mental health teams, it is proposed that we should also consider the function that the diagnosis of BPD serves for the psychiatric system and society as a whole.

4.8 Conclusion

Stigmatising constructions of people who receive a diagnosis of BPD by mental health professionals and teams are proposed to legitimise physical and emotional distancing from the client, protect against difficult feelings and a sense of threat to professional self, and minimise the need to reflect on the complex interplay of client, practitioner and system factors that lead to these challenges.

It is proposed that these processes are shaped and reinforced by the psychiatric construct of ‘borderline personality disorder’. Consequently, if mental health staff and services are to make sense of people who receive a diagnosis of BPD in less discriminatory ways, a framework for understanding these difficulties that is built on acknowledging our shared humanity and validating distress as understandable responses to historical and current experience is needed. The structures and philosophies of mental health services would also need to change.

In the words of survivor activist group Personality Disorder in the Bin, “we do not wish to be identified as having defective personalities. We choose solidarity and humanity” (2016b).

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APPENDICES

Appendix A: DSM-V diagnostic criteria for Borderline Personality Disorder

(APA, 2013, p663)

A. A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. Frantic efforts to avoid real or imagined abandonment. Note: Do not include suicidal or self-mutilating behavior covered in Criterion 5.

2. A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.

3. Identity disturbance: markedly and persistently unstable self-image or sense of self.

4. Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). Note: Do not include suicidal or self-mutilating behavior covered in Criterion 5.

5. Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior.

6. Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).

7. Chronic feelings of emptiness. 8. Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).

9. Transient, stress-related paranoid ideation or severe dissociative symptoms.

Appendix B: Systematic literature search criteria

This systematic literature search aimed to identify how mental health staff and team ‘attitudes’ towards people who receive a diagnosis of borderline personality disorder have been researched to date.

A systematic database search was conducted in order to identify relevant papers.

The following search terms were used:

("borderline personality" OR "emotionally unstable personality") AND (staff OR clinician OR professional OR nurs* OR psychiatri* OR psychologi* OR “social work” OR “therap*” OR “healthcare assistant” OR “support work” OR "healthcare provider" OR team OR service) AND (understanding OR attitudes OR knowledge OR responses OR perspectives OR attributions OR perceptions OR reactions OR opinions OR thoughts OR feelings OR constructs OR beliefs)

Rationale for choice of search terms:

The terms ‘borderline personality’ and ‘emotionally unstable personality’, not just ‘borderline’ or ‘emotionally unstable’, were used due the latter terms having different meanings in other contexts e.g. psychoanalysis. The word ‘disorder’ was not included due to some papers using terminology such as ‘presentation’. The search terms aimed to include all possible mental health professionals, teams and services as participants, and to include a variety of words similar to ‘attitudes’ that might be used to describe the thoughts and feelings staff have towards people with a diagnosis of BPD. The list of terms was generated by use of a thesaurus and reviewing the words used in already-known papers.

The search was then conducted using the following databases: Academic Search Complete, PsychInfo, Psycharticles and CINAHL Plus via EBSCO, and Scopus. References from papers identified in the initial search were also reviewed for inclusion.

Inclusion criteria were that papers:

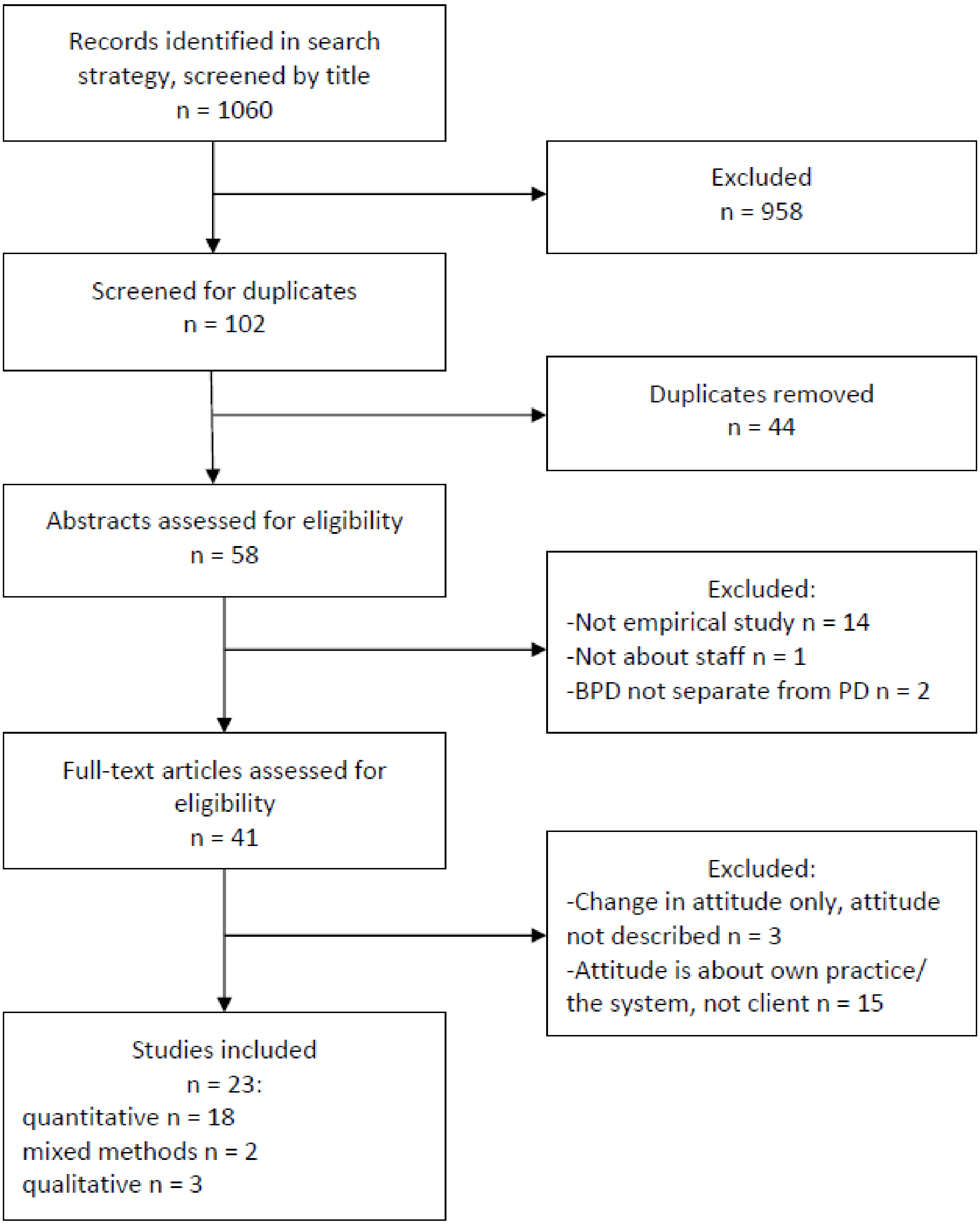
(1) were available in English
(2) were published in peer-reviewed journals
(3) had participants that were working in mental health services
(4) could be published in any year and country.

Papers were excluded if:

1. they were not empirical studies (for example opinion pieces, or systematic reviews)
2. they were not about attitudes towards borderline personality disorder specifically, but personality disorder generally.
3. their focus was a change in attitude, without adequate description of the attitude itself (e.g. evaluation of staff training)
4. they were about attitudes towards staff’s own practice with this client group, rather than clients themselves.

The search strategy yielded 1060 records, which were first screened by title, then duplicates were removed, leaving 58 papers. The abstracts of these papers were read to assess eligibility, at which point 17 studies were excluded. The full text of the remaining 41 papers was then read, and a further 18 papers were excluded, leaving 23 studies which were included. This strategy is represented below:

Flow diagram of process of identifying relevant articles



Appendix C: Table of key features of included papers

Authors	Country	Main aims	Setting	Participants	Design	Method of data analysis	Major findings
Black et al (2011)	USA	To determine attitudes towards BPD among mental health clinicians	Not reported	706 clinicians (psychiatrists, social workers, nurses, and psychologists)	Self-report questionnaire	Quantitative	Negative attitudes were consistently demonstrated. Almost half of clinicians preferred to avoid clients with BPD. Clinicians who worked with more clients with BPD in the past year had higher self-ratings of positive attitude. Nurses had lowest self-ratings of caring attitudes and treatment optimism compared to other occupations
Bodner et al (2011)	Israel	To understand and compare attitudes towards BPD of psychiatrists, psychologists and nurses	Inpatient	57 clinicians (psychiatrists, nurses and psychologists)	Self-report questionnaire	Quantitative	Psychologists endorsed fewer "antagonistic judgements" towards BPD clients than did psychiatrists and nurses. Nurses scored lowest on empathy towards BPD clients. Clients' "suicidal tendencies" were found to explain a large proportion of the negative emotions experienced by all professional groups towards BPD clients

Bodner et al (2015)	Israel	To measure cognitive and emotional attitudes towards BPD client by different professional groups	Inpatient	710 clinicians (psychiatrists, social workers, psychologists and nurses)	Self-report questionnaire	Quantitative	Nurses and psychiatrists reported more negative attitudes and less empathy towards BPD clients than psychologists and social workers. All professional groups considered it less justified to admit someone with a BPD diagnosis than a Major Depressive Disorder diagnosis. For nurses, working with more clients with BPD within the last year led to more negative attitudes reported. Nurses reported the most interest in further study to improve their skills in working with BPD, and psychiatrists the least.
Bourke and Grenyer (2010)	Australia	To examine therapists' emotional and cognitive responses to patients with BPD versus patients with major depressive disorder (MDD).	Community	20 clinical psychologists	Semi-structured interview, coded and statistically analysed	Quantitative	Therapists reported significantly more negative emotional responses towards clients with BPD than MDD. Clients with MDD were reported as more attentive to the therapist and those with BPD as more withdrawing. Therapists reported feeling less satisfied in their work with those with BPD
Bourke and Grenyer (2013)	Australia	To investigate therapists' relational patterns toward actual patients with BPD, using patients with major depressive disorder (MDD) as a comparison.	Community	20 clinical psychologists	1. Semi-structured interview (statistical content analysis) 2. self-report questionnaire	Quantitative	1. Therapists perceived patients with BPD as presenting with higher hostile, narcissistic, compliant, anxious, and sexualized dimensions of interpersonal responses than patients with MDD. 2. Therapists expressed greater emotional distress and increased need for supportive supervision when working with clients with BPD as compared to MDD.

Chartonas et al (2017)	UK	To compare the attitudes of psychiatry trainees towards BPD and depression. To examine the impact of client ethnicity on attitudes.	All services employing psychiatry trainees	73 trainee psychiatrists	Self-report questionnaire, vignette as stimulus	Quantitative	Lewis & Appleby's questionnaire showed significantly more stigma for BPD compared to depression, with the APDQ the difference fell just short of statistical significance. When results were separated by ethnicity, the latter questionnaire showed a significant difference for White British patients but not for Bangladeshi patients. Also significantly lower ratings for sense of purpose when working with clients with BPD compared to depression.
Cleary et al (2002)	Australia	To establish mental health staff experience, knowledge and attitudes about clients with a diagnosis of BPD	Inpatient & community	229 mental health clinicians	Self-report questionnaire	Quantitative	84% of staff felt that dealing with this client group was more difficult than dealing with other client groups. 66% believed that the management of clients with a diagnosis of BPD was inadequate. Reasons were shortage of services for this client group (50%), finding the clients very difficult to treat (48%), and a lack of training and/or expertise (29%).
Day et al (2018)	Australia	To compare the attitudes towards BPD of mental health staff working at the service in 2000 and 2015	Inpatient	66 mental health nurses	1. Longitudinal comparison of questionnaires 2. Concept mapping of semi-structured interviews	Mixed	1.Significantly more positive APQ score in the 2015 sample (mean 4-point increase) 2. There was a shift in the most frequently used concepts, from words such as 'deliberate' 'unwelcome' 'manipulative' and 'attention-seeking' in 2000, to 'splitting' 'triggered' 'behavioural' and 'management plan' in 2015

Deans & Meocevic (2006)	Australia	To describe the attitudes of psychiatric nurses towards individuals diagnosed with BPD	Inpatient & community	47 mental health nurses	Self-report questionnaire	Quantitative	The most commonly agreed with statements were that people with BPD are manipulative (89%), emotionally blackmailing (51%) and a nuisance (38%). 32% of respondents said people with BPD made them angry. 44% stated that they knew how to care for people with a BPD diagnosis.
El-Adl & Hassan (2009)	UK	To investigate mental health professionals experience of clients with a BPD diagnosis	Inpatient & community	185 mental health professionals (mix)	Self-report questionnaire	Quantitative	65% of respondents agreed with the statement people with a BPD diagnosis are mentally ill, 85% agreed that there was a need for training
Forsyth (2007)	UK	To identify the effect of BPD diagnosis and attributes of perceived controllability and stability, on ratings of helping, empathy and anger	Inpatient	26 mental health nurses	Self-report questionnaire, vignette as stimulus	Quantitative	Respondents reported significantly greater willingness to help people with a diagnosis of depression than BPD. Irrespective of diagnosis, respondents reported greater anger when they perceived non-compliance as both controllable and stable.

Fraser and Gallop (1993)	Canada	1. To explore whether patients with a BPD diagnosis received less empathic verbal responses from nurses than patients with other diagnoses. 2. To compare nurses' feelings towards people with a BPD diagnosis and other diagnoses	Inpatient	17 mental health nurses	Observation, rated using rating scale	Quantitative	1. Nurses demonstrated less confirming responses to patients with a BPD diagnosis compared to those with Affective Disorder and 'Other' diagnoses, but there was no significant difference between responses to patients with BPD and schizophrenia. 2. Nurses reported less positive feeling and more negative feeling towards patients with a BPD diagnosis compared to all other diagnoses.
Gallop et al (1989)	Canada	To investigate whether the label of "borderline personality disorder" compared to "schizophrenia" is sufficient to reduce staff expressed empathy towards hypothetical patients	Inpatient	113 mental health nurses	Self-report questionnaire	Quantitative	For patients with a BPD diagnosis, in comparison to patients with a schizophrenia diagnosis: Nurses were significantly less likely to give responses that demonstrate affective involvement. Nurses were significantly more likely to give responses indicating "no care". Nurses were significantly more likely to give responses that contradicted or belittled the patient.
James & Cowman (2007)	Ireland	To contribute to understanding about nurses' knowledge, experiences and attitude towards the care of clients with BPD	Inpatient & community	65 mental health nurses	Self-report questionnaire	Quantitative	80% of nurses view clients with BPD as more difficult to care for than other clients and 81% believe that the care they receive is inadequate

Lam et al (2015)	UK	To evaluate the impact of a historical diagnosis of BPD, or behavioural descriptions corresponding to BPD, on mental health professionals' judgements of a patient being assessed for treatment of panic.	Community & educational setting	265 mental health professionals (mix)	Self-report questionnaire, video as stimulus	Quantitative	A diagnostic psychiatric label of BPD produced more pessimistic views about the treatment of current panic disorder and more negative impressions of the patient. When a patient had a historical diagnosis of BPD there was therapeutic pessimism in comparison to when there was only a behavioural description corresponding to BPD: patients were rated as significantly less likely to be motivated to engage in and to benefit from CBT for panic. They were also rated as significantly more likely to harm themselves and others. These difference appear to be as a result of the diagnosis itself and not due to associated behaviours.
Lam et al (2016)	UK	To evaluate the impact of a historical diagnosis of BPD, or behavioural descriptions corresponding to BPD, on mental health professionals' judgements of a patient being assessed for treatment of panic.	Community & educational setting	265 mental health professionals (mix)	Self-report questionnaire video as stimulus	Quantitative	A historical BPD diagnosis reduced the positive characteristics clinicians were able to notice in the client currently, increased the extent to which "signs of personality disorder" were noted in the client's behaviour and reduced the perception of "signs of positive effort towards self help"

Lugboso & Aubeeluck (2017)	UK	To investigate whether nursing students have negative attitudes towards patients diagnosed with BPD. To compare first and final year students to see if education impacts this.	Educational setting	53 nursing students	Self-report questionnaire	Quantitative	Nursing students expressed optimistic feelings of enjoyment, security, acceptance, purpose and enthusiasm towards patients with BPD. There was not a significant difference between the two cohorts except for enjoyment, in which the first years scored higher.
Ma et al (2009)	Taiwan	To explore mental health nurses' perceptions of caring for patients with a diagnosis of BPD in Taiwan and the factors that contribute to positive and negative outcomes.	Inpatient	15 mental health nurses	Semi-structured individual interviews	Qualitative	Caring for patients with BPD was described as a 'honeymoon' stage followed by a 'chaos' stage. Expectations about whether patients with BPD could be helped influenced whether participants attempted to offer additional individualised care or only focused on meeting patients' basic needs. Staff having active support from team members facilitated positive outcomes for clients and a more positive experience for staff.
Markham & Trower (2003)	UK	To investigate how the label 'BPD' affected staff's perceptions and causal attributions about patients' behaviour, in comparison to other psychiatric diagnoses.	Inpatient	50 mental health nurses	Self-report questionnaires, vignettes as stimuli	Quantitative	In comparison to patients with a diagnosis of depression or schizophrenia, staff reported towards patients with a BPD diagnosis: more negative responses in general, a more negative experience of working together, attribution of causes of patients' negative behaviour as more stable and the patient as more in control of the causes of the behaviour and the behaviour itself, and less sympathy and optimism.

Markham (2003)	UK	To assess whether staff were more socially rejecting of patients with a label of BPD compared to patients with labels of either schizophrenia or depression, and to assess whether this related to perceptions of dangerousness.	Inpatient	50 mental health nurses and 21 health care assistants	Self-report questionnaire	Quantitative	RMNs expressed higher levels of social rejection towards patients with a diagnosis of BPD compared with those with diagnoses of schizophrenia or depression, and they also viewed them as more dangerous. HCAs made no distinction between patients with a label of schizophrenia or BPD, in term of social rejection or dangerousness. This difference between professional groups was that RMNs rated those with a diagnosis of schizophrenia more favourably than HCAS; ratings for BPD between the two groups were similar. There was an association between perceived dangerousness and desire to maintain social distance.
McGrath & Dowling (2012)	Ireland	1. To identify common themes from an analysis of the nurses' reported interactions with service users diagnosed with BPD. 2. To describe the level of empathy of RMNs towards service users with BPD using the Staff-Patient Interaction Rating Scale (SPIRS).	Community & residential	17 mental health nurses	Semi-structured interviews and self-report questionnaire	Mixed	1. Four themes: it was described as "challenging and difficult" to provide care, patients with BPD were described as "manipulative, destructive and threatening behaviour," and "preying on the vulnerable resulting in splitting staff and other service users," and "boundaries and structure" were considered imperative. 2. Most responses were categorised as level 2 empathy (offering solutions, platitudes or rules) or level 1 empathy (no care). For approximately half of participants when the given scenario stated it was a patient's first admission the response was more empathic than when it was stated that the patient had had multiple admissions.

Stroud & Parsons (2012)	UK	To gain a fuller understanding of how community psychiatric nurses (CPNs) make sense of the diagnosis of BPD and how their constructs of BPD impact their approach to this client group	Community	4 mental health nurses	Semi-structured interviews	Qualitative	Participants tried to make sense of client behaviour and when they had a framework to explain this they were more likely to express positive attitudes. When they did not have such a framework, participants could view clients in more pejorative terms. Participants' attitudes fluctuated between 'dread' and 'desire to help', which led to shifts between 'connected' and 'disconnected' interactions. Service factors such as high caseloads, a focus on completing documentation and fear of litigation affected participants' approach to clients.
Woollaston & Hixenbaugh (2008)	UK	To explore nurses' relationships with BPD patients from their own perspective	Inpatient, community & residential	6 mental health nurses	Semi-structured interviews	Qualitative	The core theme was: ‘Destructive Whirlwind’, which refers to the nurses perceiving patients with BPD as a powerful, dangerous, unrelenting force that leaves a trail of destruction in its wake. Participants described feeling unable to help, being idealised and demonised by clients, feelings that clients were manipulating them to meet their own agenda and were not being genuine, and that clients used threats to harm themselves or others.

Appendix D- Participant information sheet

IRAS Project ID: **243781** **21.09.18 v3**

Participant Information Sheet- Focus Group

How mental health teams make sense of people who have been given a diagnosis of Borderline Personality Disorder

University of East London
School of Psychology, Stratford Campus
Water Lane, London, E15 4LZ
[redacted]

The Principal Investigator
Name: Genevieve Wallace
Email:

Invitation and brief summary

I would like to invite you to take part in a research study that I am conducting as part of my Clinical Psychology Doctorate at the University of East London. This document aims to provide you with the information that you need to consider in deciding whether to participate in this research study.

The study aims to explore how people who have been given a diagnosis of Borderline Personality Disorder (BPD) are made sense of by mental health teams, how this affects team decision-making, and how this is influenced by factors beyond the team. The research then aims to develop a model that helps to understand these processes.

The study will involve conducting approximately three focus groups with staff members from approximately three mental health teams within [redacted] [redacted]. Any clinical staff member who has experience of working with someone with a diagnosis of BPD is eligible to take part. There will be one focus group per team, and approximately 4-6 participants in each focus group, therefore it is estimated that there will be 12-18 participants in total. The study will take place between September 2018 and September 2019.

Background to the research

Previous research has highlighted that the diagnosis of Borderline Personality Disorder (BPD) can carry a lot of stigma, including in mental health services. People with this diagnosis often report dissatisfaction with the treatment they receive, and mental health services often report challenges in working with people who receive this diagnosis.

We know that the ways we come to understand people are influenced by our interactions with others and by our professional, social, and political environment.This research aims to understand these processes in relation to how we understand people with a diagnosis of BPD. It is hoped that this will enable greater understanding and novel suggestions for ways to support mental health services in their work with individuals with a diagnosis of Borderline Personality Disorder.

What would taking part involve?
The research would involve taking part in a focus group with other members of your team. The focus group would last approximately 1.5 hours and would be audio-recorded and analysed. Discussions in the focus group will vary somewhat according to those attending and the analysis of previous data, but will include reflecting on previous experience of working with individuals with a diagnosis of Borderline Personality Disorder, talking about how people with this diagnosis are made sense of in teams, and discussing what factors may influence these ways of understanding. **Participants will be asked not to use any information that might identify particular clients e.g. avoiding the use of names.** Participants will also be asked to keep what is said in the focus group confidential.

What are the possible benefits of taking part?
Participants may find it useful to have the opportunity to reflect on this subject with colleagues. Participants will also be contributing to research that aims to improve understanding about how mental health teams can be supported in their work with people with a diagnosis of BPD.

What are the possible disadvantages and risks?
The topic of the focus groups is not highly sensitive and is considered to be similar to Reflective Practice sessions. However it is possible that participants may find the discussion upsetting, or may find it difficult to speak openly in front of colleagues. Focus groups also take part during the working day and this will take time that would otherwise be spent on clinical work.

What would happen to your data?
Focus groups will be recorded on a digital recorder and will then be transferred to an encrypted memory stick before leaving the Trust premises. The original will then be deleted from the recorder. Only the researcher, Genevieve Wallace, and a professional transcriber who has signed a confidentiality agreement will listen to the recordings, and will type them into transcripts. The transcripts will be anonymised through removal of all names and any other identifying information, and after this they will be stored in a password-protected file on a password-protected computer which may be a personal computer. These anonymised transcripts may be read by Dr David Harper, the researcher's supervisor at the University of East London, and by the examiners of Genevieve Wallace's thesis. Nobody else will have access to these transcripts. After the research has been examined the audio files will be deleted, although the transcripts will be retained for five years whilst they are used for articles or publications based on the research. Consent forms and participant contact details will be uploaded onto NHS computers, password-protected and stored separately from the anonymised data.

Excerpts from the anonymised transcripts will be included verbatim in the thesis, and in any articles written and presentations made. A summary of this research will also be shared with staff at [redacted]. All efforts will be made to ensure that no individual is identifiable. Demographic information will be collected, but this will only be used to describe the sample, and will not be linked with any quotes. Quotes will only state participant ID number and the type of team the participant worked in.

Where would the study take place?
Focus Groups will take place on Mental Health Team premises, at a time convenient to you and others wishing to participate.

Do you have to take part?
You are not obliged to take part in this study or to give a reason for your decision, and this decision will not disadvantage you in any way.

What happens next if you do want to take part?
I will return to the team approximately two weeks after the day that I introduced the study to you and gave you this information sheet, and I will ask if anyone would like to take part. I will ask for written consent from those wishing to participate, and will give a copy of the consent form as well as this information sheet to all participants to keep. I will then liaise with participants about the most convenient time for the focus group to take place.

What if you change your mind?
If you decided to take part and then wished to withdraw from the study your data could be withdrawn up to three weeks after the focus group. Your contributions would be removed from transcripts and would not be included in the analysis, however the remainder of the focus group data will be used. After the three week period your data will have been analysed and it will not be possible to remove it, although it is possible for the researcher to not use any of your quotes.

I would be very happy to answer any further questions you might have about this study; please feel free to contact me on the details above.

If you are happy to participate in this study please sign the consent form, and retain this information sheet for your reference.

If you have any questions or concerns about how the study has been conducted, please contact my supervisor:

Dr David Harper, School of Psychology, University of East London, Water Lane, London E15 4LZ. Email: [redacted]
Or
Professor Michael Seed, NHS ethics sponsor at University of East London.
Email: [redacted]

Yours sincerely,
Genevieve Wallace
21.09.2018

GDPR transparency statement

University of East London is the sponsor for this study based in the United Kingdom. We will be using information from you in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. University of East London will destroy identifiable information about you after the study has been examined, which should be by September 2019. Anonymised information will be kept for 5 years after the study has finished.

Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally-identifiable information possible.

You can find out more about how we use your information by contacting researchethics@uel.ac.uk

Appendix E- Consent form

IRAS Project ID: **243781** **17.09.18 v2**

UNIVERSITY OF EAST LONDON

Consent to participate in a research study- focus group

How mental health teams make sense of people who have been given a diagnosis of Borderline Personality Disorder

- I confirm that I have read the information sheet dated 21.09.18 (version 3) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
- I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.
- I agree to take part in the above study

Participant's Name (BLOCK CAPITALS)

……………………………………………………………………………………

Participant's Signature

……………………………………………………………………………………

Participant's work email address (for communication about the study only)

……………………………………………………………………………………

Researcher's Name (BLOCK CAPITALS)

……………………………………………………………………………………

Researcher's Signature Date:

……………………………………………………………………………………

Participant number:

Appendix F- Participant demographic information sheet

IRAS Project ID: **243781** **27.7.18 v1**

Participant demographic information sheet

The following information will only be used to describe the group of people that are included in this study. This information will *not* be linked with your name, your data or used for any other purpose.

1. **Profession**

Mental Health Nurse Social Worker Occupational Therapist

Psychiatrist Psychologist Support Worker

Other (please state) ....

2. **Management role?**

Yes No

3. **Number of years of practice**

....

4. **Gender**

Female Male Other

5. **Age**

....

6. **Ethnicity**

....

Appendix G- Interview schedule

Focus Group interview schedule

To start our discussion would someone be willing to share an example of someone they are working with or have worked with previously who has a diagnosis of Borderline Personality Disorder? Please briefly highlight the information that you consider to be important, like you would if bringing a case for discussion in a team meeting. Please **do not include any identifying information such as names.**

- What do you understand the needs of this individual to be?
- How do you make sense of this individual's difficulties?
- What are the challenges you experienced in your work with this client?
- What went well?
- How does the team as a whole respond?

- What feelings tend to come up when working with people with a diagnosis of BPD?
- Are there any exceptions to this?
- What guidance have you been given about how to best work with people with this diagnosis?
- Are there any differences between how people with a diagnosis of BPD and other diagnoses are thought about, and why?
- What are some of the ways that you have heard people with a diagnosis of BPD being described in teams?
- Where do these ideas come from?
- Has your understanding of what BPD means developed or changed at all over time?
- What do you think are some of the wider factors that influence how people with a diagnosis of BPD are thought about in services?

Closing: do you have any reflections on the focus group? Do you have any questions?

<u>General prompts</u>

- I'm really interested in what you just said, could you tell me more?
- What happened next?
- Can you describe the events that led up to…?
- What contributed to…?
- What do others think?
- Is there anyone that has a different perspective?

Appendix H- School of Psychology Research Ethics Committee review decision

School of Psychology Research Ethics Committee

NOTICE OF ETHICS REVIEW DECISION

For research involving human participants

BSc/MSc/MA/Professional Doctorates in Clinical, Counselling and Educational Psychology

REVIEWER: Kenneth Gannon

SUPERVISOR: **David Harper**

STUDENT: Genevieve Wallace

Course: Professional Doctorate in Clinical Psychology

Title of proposed study: How are people with a diagnosis of Borderline Personality Disorder made sense of in NHS multi-disciplinary mental health teams, and how does this influence decisions about their care?

DECISION OPTIONS:

1. **APPROVED:** Ethics approval for the above named research study has been granted from the date of approval (see end of this notice) to the date it is submitted for assessment/examination.

2. **APPROVED, BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES** (see Minor Amendments box below)**:** In this circumstance, re-submission of an ethics application is not required but the student must confirm with their supervisor that all minor amendments have been made before the research commences. Students are to do this by filling in the confirmation box below when all amendments have been attended to and emailing a copy of this decision notice to her/his supervisor for their records. The supervisor will then forward the student's confirmation to the School for its records.

3. **NOT APPROVED, MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED** (see Major Amendments box below)**:** In this circumstance, a revised ethics application must be submitted and approved before any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application.

DECISION ON THE ABOVE-NAMED PROPOSED RESEARCH STUDY

(Please indicate the decision according to one of the 3 options above)

APPROVED, BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES

Minor amendments required *(for reviewer)*:

Please ensure that you have formal confirmation from Trust R&D before proceeding with recruitment and data collection. The confirmation of approval should be included as an appendix in the dissertation.

Major amendments required *(for reviewer):*

Confirmation of making the above minor amendments *(for students)*:

I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data.

Student's name *(Typed name to act as signature):* Genevieve Wallace

Student number: 0809459

Date: 16.07.18

(Please submit a copy of this decision letter to your supervisor with this box completed, if minor amendments to your ethics application are required)

ASSESSMENT OF RISK TO RESEACHER *(for reviewer)*

Has an adequate risk assessment been offered in the application form?

YES

Please request resubmission with an adequate risk assessment

If the proposed research could expose the researcher to any of kind of emotional, physical or health and safety hazard? Please rate the degree of risk:

☐ HIGH

Please do not approve a high risk application and refer to the Chair of Ethics. Travel to countries/provinces/areas deemed to be high risk should not be permitted and an application not approved on this basis. If unsure please refer to the Chair of Ethics.

☐ MEDIUM (Please approve but with appropriate recommendations)

☒ LOW

Reviewer comments in relation to researcher risk (if any).

Reviewer *(Typed name to act as signature)*: Dr Kenneth Gannon

Date: 9th July 2018

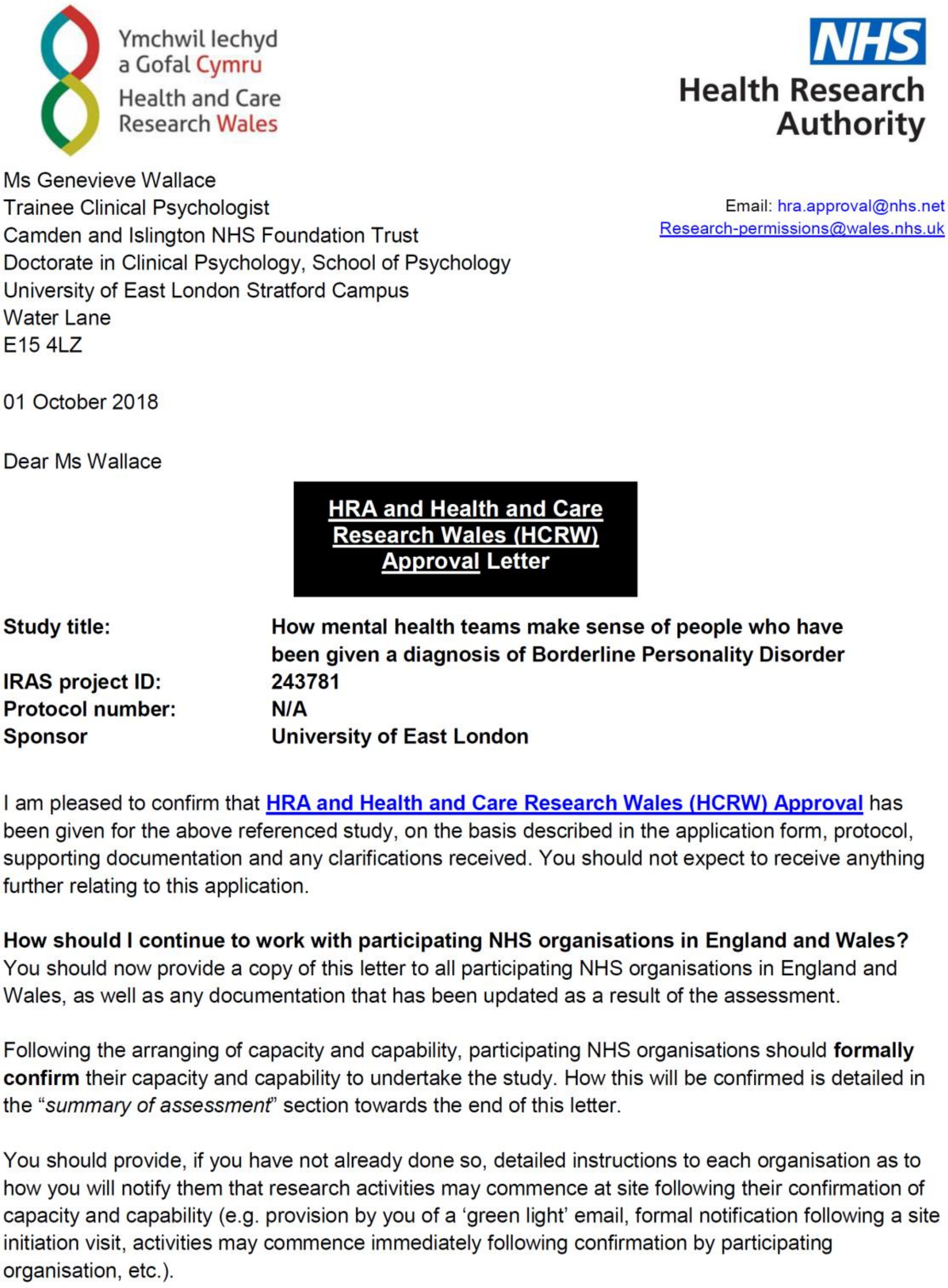
This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Research Ethics Committee

RESEARCHER PLEASE NOTE:

For the researcher and participants involved in the above named study to be covered by UEL's Insurance, prior ethics approval from the School of Psychology (acting on behalf of the UEL Research Ethics Committee), and confirmation from students where minor amendments were required, must be obtained before any research takes place.

For a copy of UELs Personal Accident & Travel Insurance Policy, please see the Ethics Folder in the Psychology Noticeboard

Appendix I- HRA approval letter



Ymchwil Iechyd
a Gofal Cymru
Health and Care
Research Wales

NHS
Health Research
Authority

Ms Genevieve Wallace
Trainee Clinical Psychologist
Camden and Islington NHS Foundation Trust
Doctorate in Clinical Psychology, School of Psychology
University of East London Stratford Campus
Water Lane
E15 4LZ

Email: hra.approval@nhs.net
Research-permissions@wales.nhs.uk

01 October 2018

Dear Ms Wallace

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title: **How mental health teams make sense of people who have been given a diagnosis of Borderline Personality Disorder**
IRAS project ID: **243781**
Protocol number: **N/A**
Sponsor **University of East London**

I am pleased to confirm that HRA and Health and Care Research Wales (HCRW) Approval has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

How should I continue to work with participating NHS organisations in England and Wales?
You should now provide a copy of this letter to all participating NHS organisations in England and Wales, as well as any documentation that has been updated as a result of the assessment.

Following the arranging of capacity and capability, participating NHS organisations should **formally confirm** their capacity and capability to undertake the study. How this will be confirmed is detailed in the "*summary of assessment*" section towards the end of this letter.

You should provide, if you have not already done so, detailed instructions to each organisation as to how you will notify them that research activities may commence at site following their confirmation of capacity and capability (e.g. provision by you of a 'green light' email, formal notification following a site initiation visit, activities may commence immediately following confirmation by participating organisation, etc.).

It is important that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details of the research management function for each organisation can be accessed here.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within the devolved administrations of Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) has been sent to the coordinating centre of each participating nation. You should work with the relevant national coordinating functions to ensure any nation specific checks are complete, and with each site so that they are able to give management permission for the study to begin.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?
HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?
The document "*After Ethical Review – guidance for sponsors and investigators*", issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

I am a participating NHS organisation in England or Wales. What should I do once I receive this letter?
You should work with the applicant and sponsor to complete any outstanding arrangements so you are able to confirm capacity and capability in line with the information provided in this letter.

The sponsor contact for this application is as follows:

Name: Michael Seed
Tel: [redacted]
Email: researchethics@uel.ac.uk

Who should I contact for further information?
Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **243781**. Please quote this on all correspondence.

Yours sincerely

Laura Greenfield
Assessor

Email: hra.approval@nhs.net

Copy to: *Michael Seed [Sponsor Contact on behalf of University of East London]*
[redacted] *[Lead NHS R&D Office Contact on behalf of* [redacted]
[redacted] *Trust]*

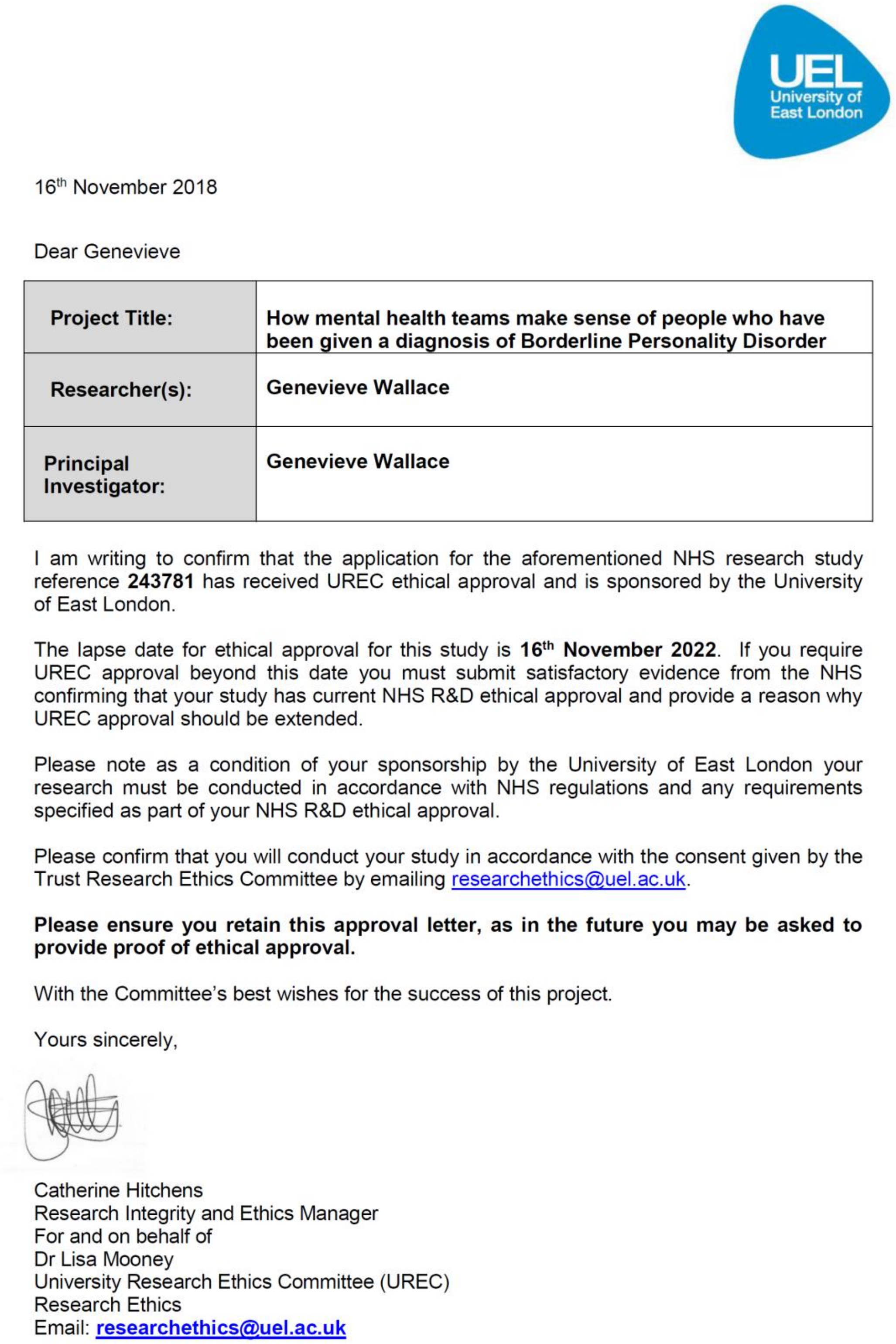
IRAS project ID	**243781**

List of Documents

The final document set assessed and approved by HRA and HCRW Approval is listed below.

Document	*Version*	*Date*
Confirmation of any other Regulatory Approvals (e.g. CAG) and all correspondence [Ethical approval from University of East London]	1	27 July 2018
Confirmation of any other Regulatory Approvals (e.g. CAG) and all correspondence [Confirmation of amendments required by UEL ethics committee]	1	27 July 2018
Covering letter on headed paper [Covering letter]	1	27 July 2018
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Certificate of sponsor's liability insurance]	1	01 August 2018
HRA Schedule of Events	1	20 September 2018
HRA Statement of Activities	1	20 September 2018
Interview schedules or topic guides for participants [Interview schedules]	1	27 July 2018
IRAS Application Form [IRAS_Form_24082018]		24 August 2018
IRAS Application Form XML file [IRAS_Form_24082018]		24 August 2018
IRAS Checklist XML [Checklist_24082018]		24 August 2018
Letter from sponsor [Research project approval letter]	1	27 July 2018
Non-validated questionnaire [Sheet to obtain participant demographic information to describe sample only]	1	27 July 2018
Other [Letter from sponsor's insurance provider confirming details of policy]	1	18 July 2018
Participant consent form [interview]	2	17 September 2018
Participant consent form [focus group]	2	17 September 2018
Participant information sheet (PIS) [Focus group]	3	21 September 2018
Participant information sheet (PIS) [Interview]	3	21 September 2018
Referee's report or other scientific critique report [Peer review of research proposal]	1	27 July 2018
Research protocol or project proposal [Research proposal 27.07.18 v1]	1	27 July 2018
Summary CV for Chief Investigator (CI) [CV Genevieve Wallace (CI)]	1	27 July 2018
Summary CV for student [CV Genevieve Wallace (student)]	1	27 July 2018
Summary CV for supervisor (student research) [CV Dr David Harper (supervisor)]	1	03 June 2018
Summary, synopsis or diagram (flowchart) of protocol in non technical language [Research summary]	1	27 July 2018

Appendix J- UREC sponsorship letter



16th November 2018

Dear Genevieve

Project Title:	**How mental health teams make sense of people who have been given a diagnosis of Borderline Personality Disorder**
Researcher(s):	**Genevieve Wallace**
Principal Investigator:	**Genevieve Wallace**

I am writing to confirm that the application for the aforementioned NHS research study reference **243781** has received UREC ethical approval and is sponsored by the University of East London.

The lapse date for ethical approval for this study is **16th November 2022**. If you require UREC approval beyond this date you must submit satisfactory evidence from the NHS confirming that your study has current NHS R&D ethical approval and provide a reason why UREC approval should be extended.

Please note as a condition of your sponsorship by the University of East London your research must be conducted in accordance with NHS regulations and any requirements specified as part of your NHS R&D ethical approval.

Please confirm that you will conduct your study in accordance with the consent given by the Trust Research Ethics Committee by emailing researchethics@uel.ac.uk.

Please ensure you retain this approval letter, as in the future you may be asked to provide proof of ethical approval.

With the Committee's best wishes for the success of this project.

Yours sincerely,

Catherine Hitchens
Research Integrity and Ethics Manager
For and on behalf of
Dr Lisa Mooney
University Research Ethics Committee (UREC)
Research Ethics
Email: **researchethics@uel.ac.uk**

Appendix K- Letter of access

noclor
RESEARCH SUPPORT

1st Floor, Bloomsbury Building
St Pancras Hospital
4St Pancras Way
London, NW1 0PE

Tel: 020 3317 3045
Fax: 020 7685 5830
Email: contact.noclor@nhs.net
www.noclor.nhs.uk

21 November 2018

Ms Genevieve Wallace
[redacted]

Dear Ms Genevieve Wallace

Employer:
Accountable to: [redacted]

As an existing NHS employee you do not require an additional honorary research contract with this NHS organisation. We are satisfied that the research activities that you will undertake in this NHS organisation are commensurate with the activities you undertake for your employer. Your employer is fully responsible for ensuring such checks as are necessary have been carried out. Your employer has confirmed in writing to this NHS organisation that the necessary pre-engagement checks are in place in accordance with the role you plan to carry out in this organisation. This confirms your right of access to conduct research through the trust(s) identified in the box below, for the purpose and under the terms and conditions set out in page 2 & page 3.

Study Title: How mental health teams make sense of people who have been given a diagnosis of Borderline Personality Disorder **R&D reference: 243781** **REC reference: REC Review Exempt**		
Letter of access duration:	**Start date: 21/11/2018**	**End date: 25/09/2019**
[redacted] - -	- - - -	
If any information on this document is altered after the date of issue, this document will be deemed INVALID		

Yours sincerely,

Mabel Saili
Research Management & Governance Manager

Page 1 of 3

NCLET010T - 3.0.0 - 23/07/15 - Letter of access for NHS employee
It is the researcher's responsibility to provide their substantive employer with a copy of this document

Appendix L- Participant debrief sheet

IRAS Project ID: **243781**

Participant Debrief Sheet- Focus Group

How mental health teams make sense of people who have been given a diagnosis of Borderline Personality Disorder

University of East London
Investigator
School of Psychology, Stratford Campus
Water Lane, London, E15 4LZ

The Principal

Name: Genevieve Wallace
Email: [redacted]

Thank you very much for taking part in this study, your time and interest is much appreciated.

Taking part in research interviews and focus groups can sometimes put us in touch with difficult feelings. If, in the course of taking part in this research, anything has come up for you that you would like to discuss further I will be available in person after the focus group, to debrief on the experience. In addition please feel free to contact me on the email address above and I will be happy to talk.

Should you want an additional or alternative source of support the Samaritans are available 24/7 on 116 123.

Best wishes,

Genevieve Wallace

Trainee Clinical Psychologist

Appendix M- Transcription conventions

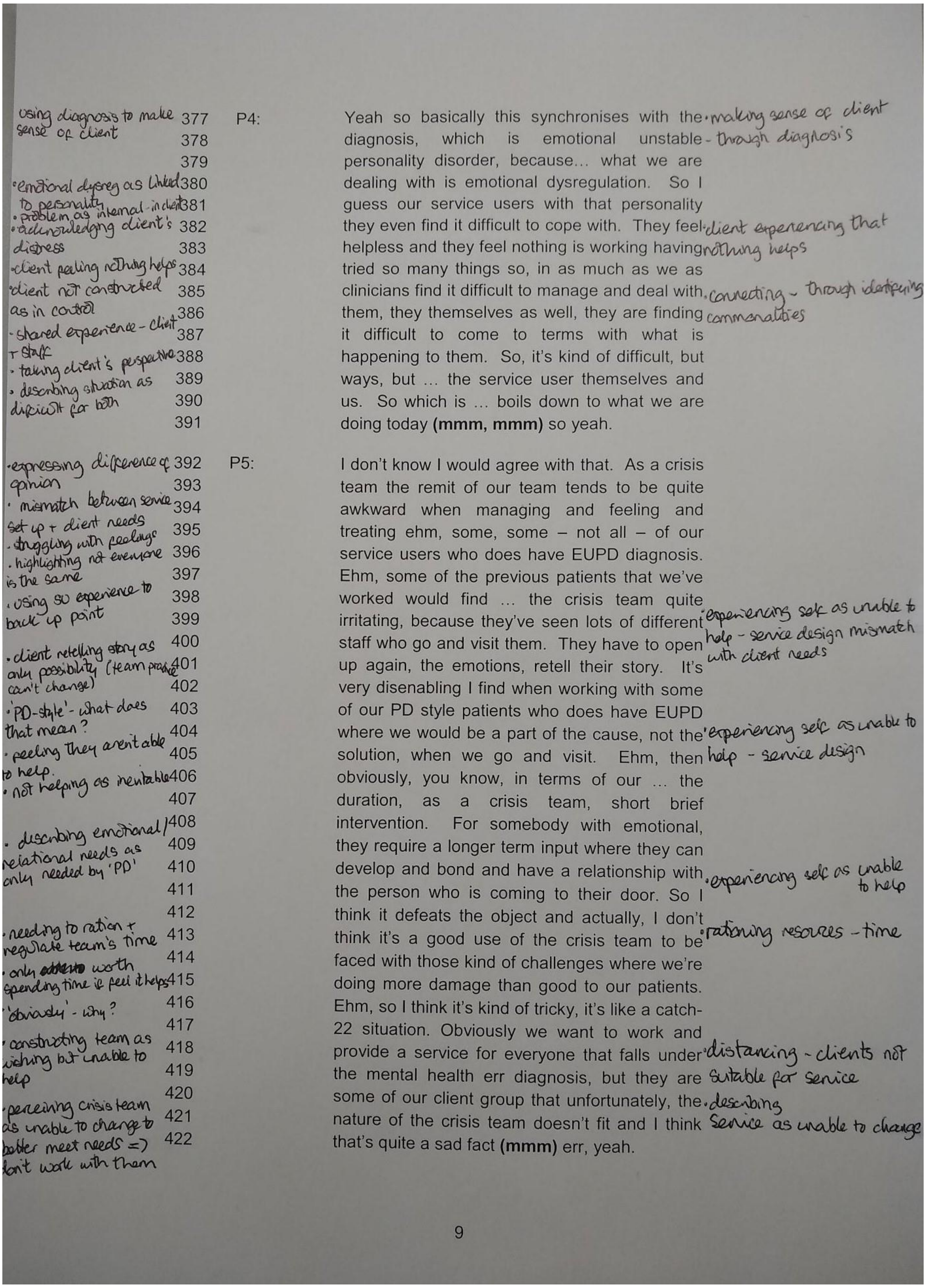
…	Participant trails off
(laughs)	Communication that is not words
[hospital]	Replacement of identifiable information with generic descriptor
(word)	Interviewer's speech

Conventions used in quotes

P1 (CRT)	Participant number and team
P1:	Participant's speech
Gen:	Interviewer's speech
Word	Indicating emphasis where this makes the meaning easier to understand
(…)	Part of extract excluded

Appendix N- Example of coding

Open coding (left margin) and focused coding (right margin) from focus group with HTT.



- using diagnosis to make sense of client
- emotional dysreg as linked to personality
- problem as internal in client
- acknowledging client's distress
- client feeling nothing helps
- client not constructed as in control
- shared experience - client + staff
- taking client's perspective
- describing situation as difficult for both

P4: Yeah so basically this synchronises with the diagnosis, which is emotional unstable personality disorder, because... what we are dealing with is emotional dysregulation. So I guess our service users with that personality they even find it difficult to cope with. They feel helpless and they feel nothing is working having tried so many things so, in as much as we as clinicians find it difficult to manage and deal with, them, they themselves as well, they are finding it difficult to come to terms with what is happening to them. So, it's kind of difficult, but ways, but ... the service user themselves and us. So which is ... boils down to what we are doing today **(mmm, mmm)** so yeah.

- making sense of client - through diagnosis
- client experiencing that nothing helps
- connecting - through identifying commonalities

- expressing difference of opinion
- mismatch between service set up + client needs
- struggling with feelings
- highlighting not everyone is the same
- using SU experience to back up point
- client retelling story as only possibility (team practice can't change)
- 'PD-style' - what does that mean?
- feeling they aren't able to help.
- not helping as inevitable
- describing emotional/relational needs as only needed by 'PD'
- needing to ration + regulate team's time
- only worth spending time if feel it helps
- 'obviously' - why?
- constructing team as wishing but unable to help
- perceiving crisis team as unable to change to better meet needs => don't work with them

P5: I don't know I would agree with that. As a crisis team the remit of our team tends to be quite awkward when managing and feeling and treating ehm, some, some – not all – of our service users who does have EUPD diagnosis. Ehm, some of the previous patients that we've worked would find ... the crisis team quite irritating, because they've seen lots of different staff who go and visit them. They have to open up again, the emotions, retell their story. It's very disenabling I find when working with some of our PD style patients who does have EUPD where we would be a part of the cause, not the solution, when we go and visit. Ehm, then obviously, you know, in terms of our ... the duration, as a crisis team, short brief intervention. For somebody with emotional, they require a longer term input where they can develop and bond and have a relationship with the person who is coming to their door. So I think it defeats the object and actually, I don't think it's a good use of the crisis team to be faced with those kind of challenges where we're doing more damage than good to our patients. Ehm, so I think it's kind of tricky, it's like a catch-22 situation. Obviously we want to work and provide a service for everyone that falls under the mental health err diagnosis, but they are some of our client group that unfortunately, the nature of the crisis team doesn't fit and I think that's quite a sad fact **(mmm)** err, yeah.

- experiencing self as unable to help - service design mismatch with client needs
- experiencing self as unable to help - service design
- experiencing self as unable to help
- rationing resources - time
- distancing - clients not suitable for service
- describing service as unable to change

Appendix O- Example memos

Memo 29th March 2019- Refining a candidate category and considering the conditions under which it occurs

I initially labelled the category as ‘evaluating client actions’ but I think this is too vague and encompasses too many categories that may in fact be distinct. I need to make the concept and title specific enough to not encompass something that is done all of the time. Why is it that the behaviour of people with a BPD diagnosis appears to be subjected to this level of scrutiny, when the behaviour of other clients is not? Also, is this process just about client actions or about the client more generally e.g. their distress and credibility of their speech too?

What process is going on here? (Question from Charmaz 2015 p70)

What are the specifics of the ‘evaluation’? It’s about:

a) Assessing motivation behind what the client is saying and doing. Is it intentional/ within full control? Secondary/personal gain?
b) Assessing the credibility of what the client says: is it genuine? Assessing the legitimacy of their claims, in these examples usually their claims re suicidality. Are they ‘true’? Can they be trusted? Or are they motivated by personal gain? True in this context means will the person carry out the action. Whether what the client says reflects high levels of distress is not the focus, it’s about their actions. There is a focus on actions/ behaviour, not on emotion. This focus is in line with that of risk assessment and crisis services criteria.
c) And the legitimacy of the distress: are they really as distressed as they say? And do they have the right to be or are they “dialling it up”/ being “greedy”? People with a BPD diagnosis don’t appear to get automatic empathy unlike other diagnoses. Their right to be distressed has to be earned.
d) Allocating responsibility for the client’s problem (are they being “difficult”/ ‘choosing’ it (“she’s looking for a war”/ “she wants to be the victim”)) or are they a ‘good’ patient, deserving of empathy (moral decision).

Staff would always be evaluating client actions, even with e.g. psychosis they would be thinking ‘is it the voices or the paranoia that’s making them do xyz’. Any risk assessment service involves appraising clients in some way. So what is different about this? Is it that with other clients what they say will mostly be taken at face value? Questions will need to be asked in order to assess risk, but there won’t be this process of second-guessing. And why is it that if staff don’t think suicide will be attempted it isn’t concluded that the client is nevertheless highly distressed, in need of support and communicating their distress? Instead many participants have talked about it as if it is being done with some sort of malicious motive e.g. to make them anxious.

"*P14: to be honest I wouldn't think that it would be as a great stretch of the imagination that they would deliberately go to perhaps, you know, put themselves in harms way or, or stand next to, sort of, a bridge or whatever, in order to heighten your sense of anxiety*"

What is going on here that this conclusion is often drawn? There seems to be a mistrust towards these clients. Where does this come from?

Under which conditions does this process develop? (Question from Charmaz 2015 p70)

This process of evaluating/mistrusting seems to develop when implicit rules about how clients should behave are broken. For example, clients behave in ways that are considered inconsistent, they ask for something that the services can't provide, they take up more time than the service has available, they present with repeated crises, they do not accept professional expertise and they may not appear to be helped by staff intervention.

Perhaps when client behaviour does not violate these implicit assumptions, client credibility is not assessed, because it can be understood within existing medical frameworks e.g. to be driven by psychosis or depression.

Action: go back through focus group transcripts and look at what implicit assumptions appear to be being violated by clients when participants start to evaluate client actions/ words/ distress.

The process also develops when there are conditions of limited time, energy, resources and empathy. This is of course almost every time. But if staff had no pressure in these respects, maybe there would be no need to assess the credibility or the right of the client to take up some of those resources.

There is also something about this process occurring when clients say something to hold staff personally responsible for the system's inadequacy, which feels horrible for staff, and then seems to result in them dismissing clients or holding clients personally responsible.

What other conditions are there that I haven't mentioned? I need to make sure I consider both macro and micro conditions (Strauss and Corbin 1998).

Memo: 19^{TH} April 2019. Exploring the properties of the category ‘feeling not in control’

“P11: you know, you have no control as a clinician, with your patient and it’s makes you feel so powerless. All the years of training you’ve done just goes out the window because you …
P13: you are unable to manage the situation”

“P4: I’ve spent an hour talking to a woman one night. I said to her “well when you get the home treatment team you need to talk about the things you spoke to me about”. She said “I will, I will”
P1: I know what you’re going to say! (laughs)
P4: Home treatment team turn up, she didn’t say a bloody word!
P1: Yeah, and then you look like an idiot (laughs)
P4: And they sort of said “there’s no… erm needs””

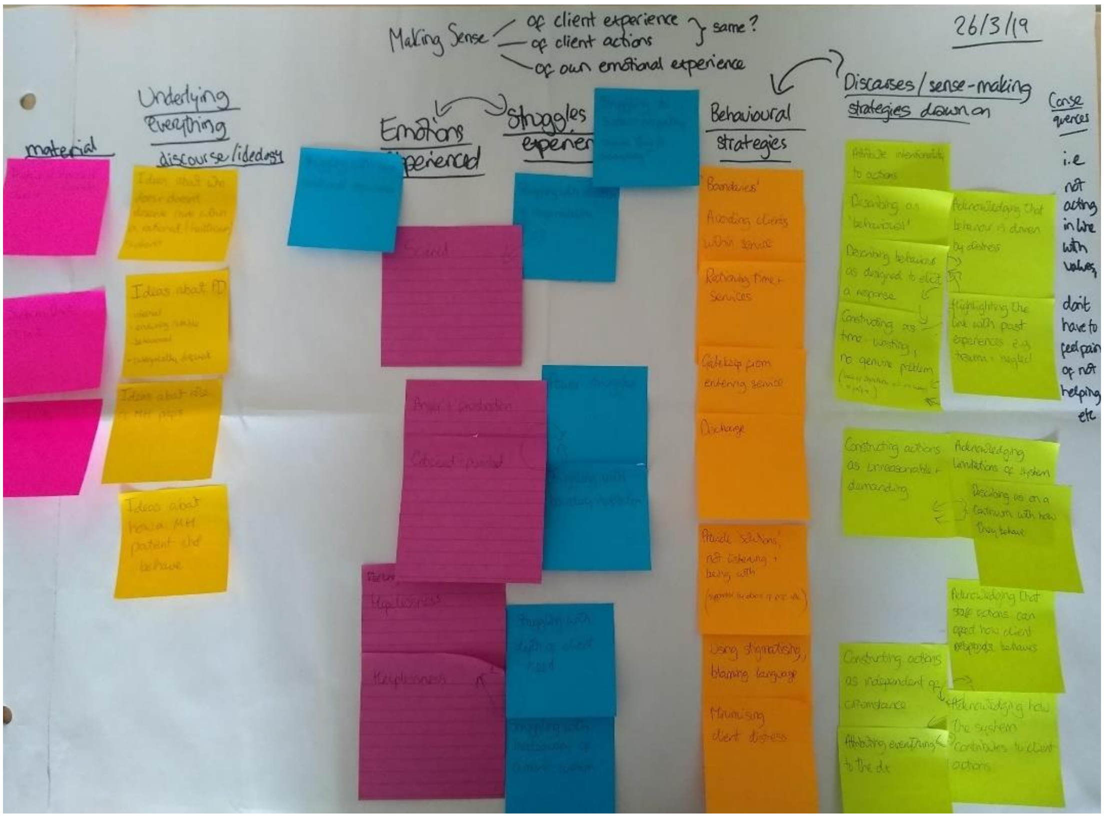
This appears to relate both to control over client behaviour and over the actions of services. Examples of things that make staff feel not in control include clients changing their mind and not following through on what was agreed with staff, clients involving other agencies or seeking help from other services, other services suggesting something different which undermines participants, clients having clear ideas of what they think will help them and not wishing to follow professional advice, clients saying that they are planning to kill themselves and staff ending up in a position of needing to take action they believe will not be helpful to the client because of risk management protocols. Also staff believing that the intervention they are offering will not be suitable for the clients’ needs, and in some cases may even be harmful, yet not having any other options. Although maybe this last one is more about being unable to help.

Not feeling in control appears to become problematic for participants when there are high levels of risk involved, and they are responsible for managing this risk. Looking through all of the examples, they all involve potential or actual threat to life, and participants needing to manage this risk. So maybe the category isn’t just about not feeling in control, but not feeling in control when also responsible for high levels of risk.

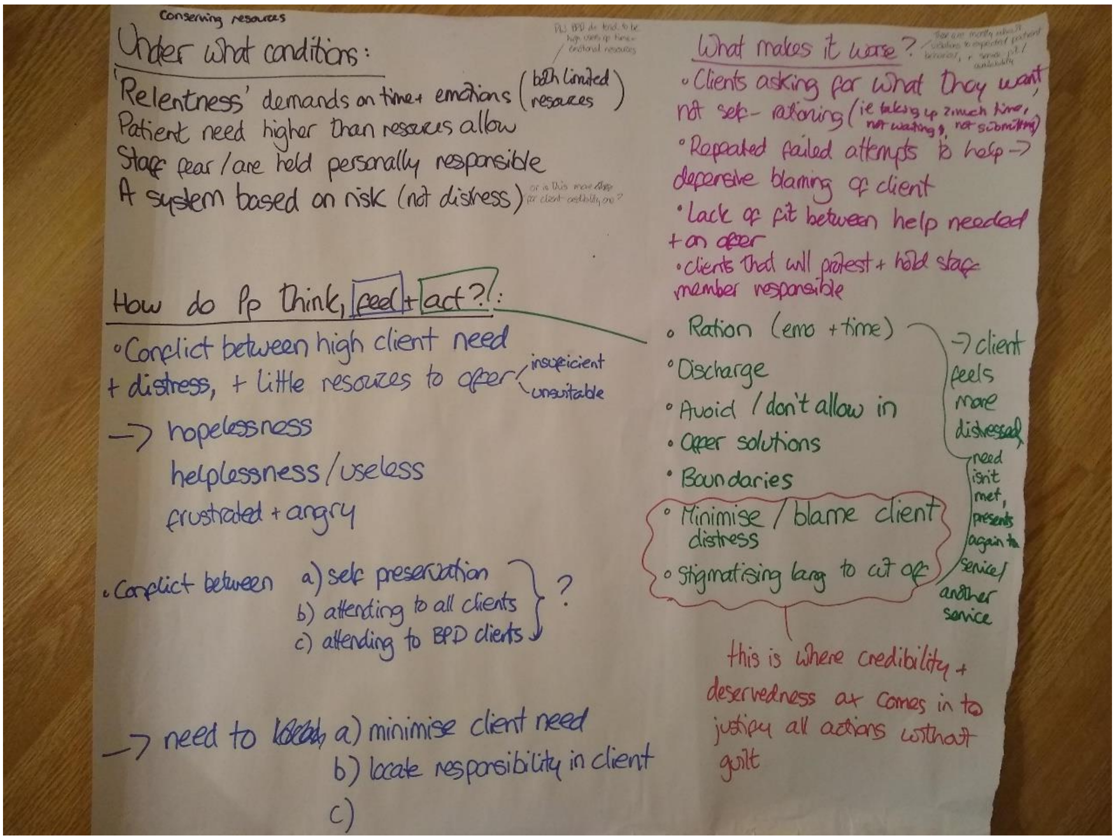
There also seems to be a connection between staff feeling out of control and attributing control to clients i.e. being more likely to explain client’s behaviour as intentional. Are ideas like ‘manipulative’ then a consequence of participants not feeling in control, and understanding the control as being with the client (rather than neither party feeling they have control)?

Appendix P- Example diagrams

Exploring relationships between and patterns in initial codes:



Exploring phenomena, the conditions in which they occur and their consequences:



Conserving resources

Under what conditions:

'Relentness' demands on time + emotions (both limited resources)
Patient need higher than resources allow
Staff fear / are held personally responsible
A system based on risk (not distress)

How do Pp think, feel + act?:

- Conflict between high client need + distress, + little resources to offer (insufficient / unsuitable)
  - → hopelessness
  - helplessness / useless
  - frustrated + angry
- Conflict between a) self preservation b) attending to all clients c) attending to BPD clients ?

→ need to ~~locate~~ a) minimise client need
b) locate responsibility in client
c)

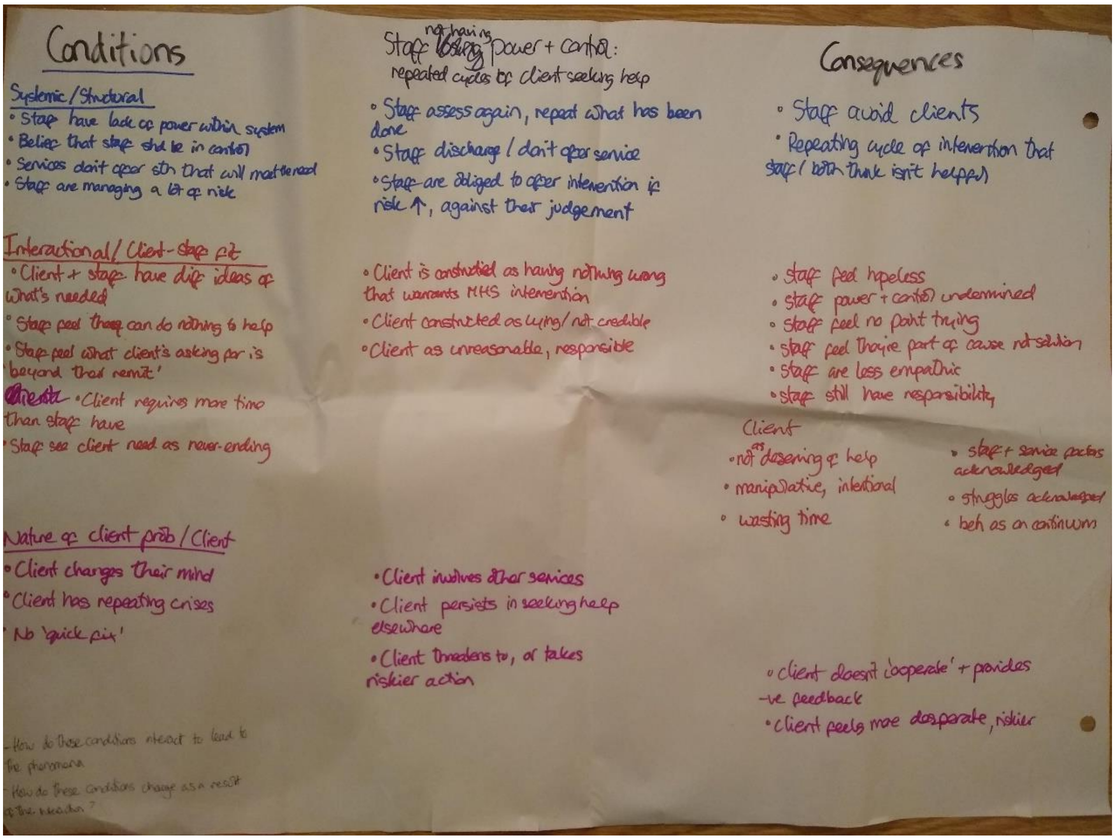
What makes it worse?

- Clients asking for what they want, not self-rationing (ie taking up 2 much time, not waiting, not submitting)
- Repeated failed attempts to help → defensive blaming of client
- Lack of fit between help needed + on offer
- clients that will protest + hold staff member responsible

- Ration (emo + time)
- Discharge
- Avoid / don't allow in
- Offer solutions
- Boundaries
- Minimise / blame client distress
- Stigmatising lang to cut off

→ client feels more distressed, need isn't met, presents again to service / another service

this is where credibility + deservedness ax comes in to justify all actions without guilt



Conditions

Systemic / Structural
- Staff have lack of power within system
- Belief that staff shd be in control
- Services don't offer sth that will meet the need
- Staff are managing a lot of risk

Interactional / Client-staff fit
- Client + staff have diff ideas of what's needed
- Staff feel they can do nothing to help
- Staff feel what client's asking for is 'beyond their remit'
- ~~Clients~~ Client requires more time than staff have
- Staff see client need as never-ending

Nature of client prob / Client
- Client changes their mind
- Client has repeating crises
- No 'quick fix'

- How do these conditions interact to lead to the phenomena
- How do these conditions change as a result of the interaction?

Staff ~~losing~~ not having power + control:
repeated cycles of client seeking help

- Staff assess again, repeat what has been done
- Staff discharge / don't offer service
- Staff are obliged to offer intervention if risk ↑, against their judgement

- Client is constructed as having nothing wrong that warrants MHS intervention
- Client constructed as lying / not credible
- Client as unreasonable, responsible

- Client involves other services
- Client persists in seeking help elsewhere
- Client threatens to, or takes riskier action

Consequences

- Staff avoid clients
- Repeating cycle of intervention that staff (both think isn't helpful)

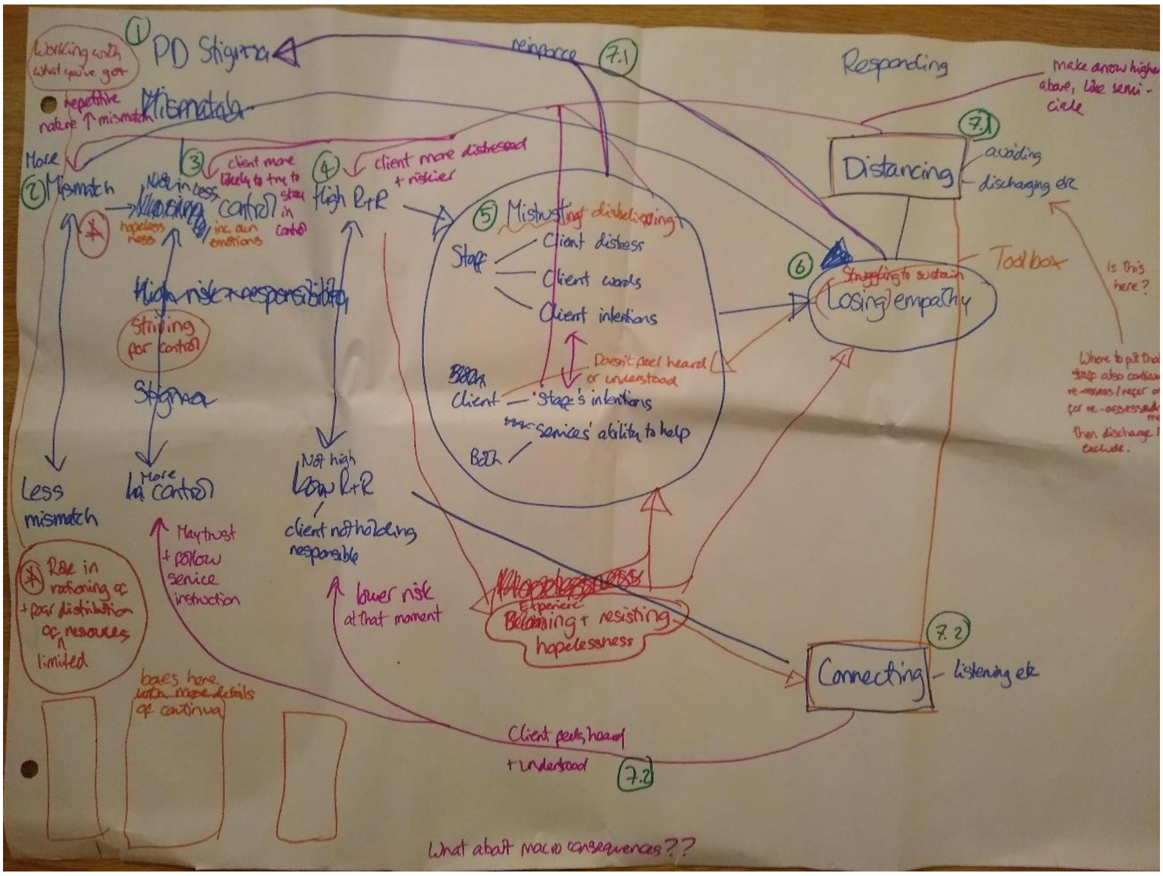
- staff feel hopeless
- staff power + control undermined
- staff feel no point trying
- staff feel they're part of cause not solution
- staff are less empathic
- staff still have responsibility

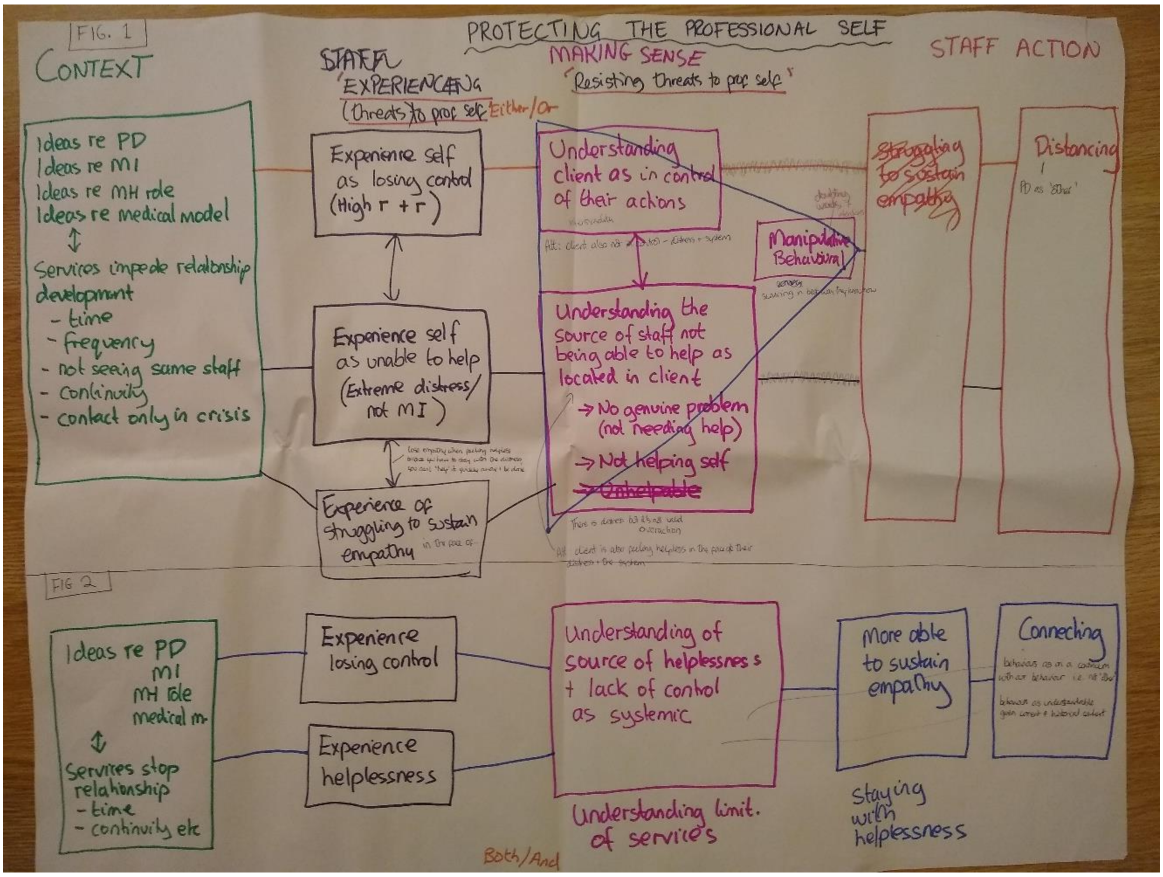
Client
- not as deserving of help
- manipulative, intentional
- wasting time

- staff + service factors acknowledged
- struggles acknowledged
- beh as on continuum

- client doesn't 'cooperate' + provides -ve feedback
- client feels more desperate, riskier

Candidate models





Appendix Q: 'Protecting the professional self': Conditions

Experiencing threats to the professional self: conditions

There were some elements of the context within which mental health teams work that appeared to be highly relevant to it being experienced as a threat to the professional self to work with clients with a diagnosis of BPD (See box in figure 2). It is beyond the scope of this thesis and of the data collected to highlight all factors, however in the table below the conditions that seemed particularly important in relation to clients with a diagnosis of BPD are highlighted, alongside the number of the categories within which they are considered to have particular interaction. The nature of the interaction has been considered within the descriptions of categories.

Figure 4: Table of conditions under which 'experiencing threats to the professional self' takes place

Element of context	Categories of interaction
0.1 Ideas about the nature of 'personality disorder'	**1**.2.1 and **2**.2.1
0.2 Ideas about the nature of 'mental illness'	**2**.1.1 and **2**.2.1
0.3 Expectations about the role of mental health professionals	**1**.1.2, **2**.2.1 and **2**.3.1
0.4 Expectations about the behaviour of patients	**1**.1.1, **1**.1.2, **2**.2.1, **2**.2.2 and **2**.2.3
0.5 A culture of individual responsibility	**1**.1.1 and **2**.2.2
0.6 Current risk management practices within the NHS	**1**.1.1 and **1**.1.3
0.7 Resources that are limited and insufficient to meet all client needs	**2**.1.1, **2**.1.2, **2**.1.3, **2**.2.2, and **2**.3.2

Responding to threats to the professional self: conditions

There were also conditions described by participants as affecting how staff and services respond when they experience a sense of threat to professional self. These factors were therefore considered to influence whether a ‘connecting’ or a ‘distancing’ response was more likely to occur. They are presented in the table below, along with the category within which they were considered. They should not be taken to represent a complete picture of the relevant conditions, and if more time was available, it would be beneficial to collect further data with this question specifically in mind.

Figure 5: Table of conditions that make connecting responses more difficult

Element of context	Categories of interaction
0.1 Client directly saying they will hurt themselves	1.1.1
0.2 Client expressing anger towards staff member personally	2.1.2
0.3 Staff interacting with client only during crisis	1.2.1
0.4 Service priorities having strong task focus	2.1.2
0.5 Frequent contact with clients expressing high levels of distress	2.1.2
0.6 Little thinking or processing time- between clients or in other forums such as supervision	2.1.2

Appendix R: Participant feedback and reflections on theory

Written verbatim, but more general reflections not related to the model/analysis not included.

General reflections after theory was presented:

- 2 kinds of threats and 2 ways of responding to them- helpful way to summarise that can be held in mind at work.
- Threat to sense of professional self- yes. We feel de-skilled. Although we have personal desire to help.
- Yes this makes sense, I experience these challenges.
- It's really important that the framework isn't blaming, of either staff or clients. So I like that it isn't.
- These two challenges are literally what a BPD diagnosis is: their symptoms. They experience themselves as unable to be helped and being held responsible but not in control. It's projective identification.

Suggested changes to theory:

- Need to not do 'good breast bad breast' by having a false dichotomy of connecting v distancing. Need to acknowledge the nuance/ continuum more.
- Threat 2 currently uses the word 'construction', but threat 1 doesn't. Look at this.
- Need to respect the effort required to connect- need to make it clear that this is the more difficult and effortful option for the staff member/ team.

Concerns about the idea of connecting responses as helpful:

- Clients might become dependent on the service if they experience connecting responses
- If we allow for that sort of behaviour from them without disconnecting surely we are feeding into that behaviour.
- Comment said to participants by a psychiatric liaison staff member elsewhere, who was involved with their client: " I don't know about you lot but we're not entertaining this. If the client wants to kill themselves don't come and tell us first. We're not feeding into that" Connecting responses to people in crisis can be perceived in this way, and what to do when others in the system have a very different way of seeing things.

Reflections on the theory and client experience:

- Client often feels out of control and someone needs to take responsibility for their safety
- Client needs to feel they're not alone with their pain
- Client feels nobody cares, nobody's helping me, and in part the system is enacting that
- Client is presenting in a way that makes us split for them (distancing and connecting)
- Asking for an ambulance doesn't mean they need one, but there is a very real distress and they do need help

Why might distancing responses occur?

- Because the clients are so worked up you may shut down and not give them what they need
- They 'turn on you' i.e. say you don't care when you end the call or try to put responsibility back with them
- You might enter the call with distancing, or it might be due to their action that the wall comes up.
- How do we manage our emotions so we don't take responsibility for them or reject them?
- There's just not enough time to connect
- Staff need training on them not being responsible for others' safety but how to communicate this to clients. "You're trying to make me responsible and I'm not responsible for your safety, but I would like to be here for you. I'd like to make a plan to help you manage this" – desired/ ideal response in this sort of situation but can be hard to do.
- Peoples' crises aren't perceived as 'real' from a safety perspective, and that's the focus of the team, therefore we just try to get them off the phone as soon as possible.
- Staff are the face of the system, they have to represent a system that is not caring and doesn't understand client needs. So they get the brunt of it. Which makes them feel so frustrated. They can't help but they want to.

Connecting v distancing: what affects staff response

- Depends on the client. Some allow for a connection, others provoke a distancing. It's not that you don't want to connect, but if you are being sworn at or it's a personal attack, that is not tolerated so that is an automatic distancing and we don't engage with them whilst they're being like that. There has got to be some level of professional boundaries. That boundary needs to be in place. Sometimes if you say this to them they'll say "sorry it's not you".

- How many calls you have taken so far that day
- Number of times you've spoken to that individual and expectations for how they'll react
- Own self-care
- Own personal lives- affects our thresholds
- Team support: if something happens and a client attempts to take their life, how much will the team have my back? Manager? The Trust? This varies hugely between and within teams. (Links to responsibility but no control theme).
- Varies a lot within same person
- Team culture- how are people with a PD diagnosis talked about in the team
- If you are pushing staff to high volume you won't get connecting responses
- We call ambulances more because we're not able to have the time to talk with people, therefore client behaviour escalates as does client dissatisfaction
- Effort required to connect
- Compassion fatigue
- Need to reflect on use of self, and this isn't something covered by most of our trainings
- It's not about training it's about resources

Recommendations/ implications:

- I hope this research would be an eye opener for senior management- I don't think they know what's going on or what we struggle with
- I hope this research will provoke some sort of change in service provision for people with a diagnosis of BPD

Appendix S: Criteria for evaluating grounded theory studies

(Charmaz, 2014, p337-338)

Credibility

- Has your research achieved intimate familiarity with the setting or topic?
- Are the data sufficient to merit your claims? Consider the range, number, and depth of observations contained in the data.
- Have you made systematic comparisons between observations and between categories?
- Do the categories cover a wide range of empirical observations?
- Are there strong logical links between the gathered data and your argument and analysis?
- Has your research provided enough evidence for your claims to allow the reader to form an independent assessment - and agree with your claims?

Originality

- Are your categories fresh? Do they offer new insights?
- Does your analysis provide a new conceptual rendering of the data?
- What is the social and theoretical significance of this work?
- How does your grounded theory challenge, extend, or refine current ideas, concepts, and practices?

Resonance

- Do the categories portray the fullness of the studied experience?
- Have you revealed both liminal and unstable taken-for-granted meanings?
- Have you drawn links between larger collectivities or institutions and individual lives, when the data so indicate?
- Does your grounded theory make sense to your participants or people who share their circumstances? Does your analysis offer them deep insights about their lives and worlds?

Usefulness

- Does your analysis offer interpretations that people can use in their everyday worlds?
- Do your analytic categories suggest any generic processes?
- If so, have you examined these generic processes for tacit implications?
- Can the analysis spark further research in other substantive areas?
- Hoe does your work contribute to knowledge? How does it contribute to making a better world?