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The attitudes of mental health nurses that support a positive therapeutic relationship: the perspective of people diagnosed with BPD

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Abstract

Introduction: The therapeutic relationship between mental health nurses and people diagnosed with borderline personality disorder (BPD) is essential to successful treatment, and nurses' attitudes are a key component of this relationship. Some nurses develop positive therapeutic relationships with people diagnosed with BPD, while others have negative emotional reactions which in turn limit their ability to develop a positive therapeutic relationship. There is a gap in the literature with respect how people diagnosed with BPD perceive the attitudes of mental health nurses that foster a positive therapeutic relationship.

Aim: To describe how people diagnosed with BPD who have experienced an improvement perceive the role of the attitudes of mental health nurses in building a positive therapeutic relationship.

Method: Qualitative descriptive design with 12 interviews; thematic content analysis.

Results: Participants identified five attitudes of mental health nurses as contributing to a positive therapeutic relationship: confidence in their ability to recover, non-judgement, humour, availability and humanity.

Discussion: Nurses' attitudes are key to the therapeutic relationship. It may be possible for nurses to improve their attitudes toward patients diagnosed with BPD through self-reflection.

Implications for Practice: Mental health nurses should incorporate methods that explore attitudes and attitudinal development of the workforce.

RELEVANCE STATEMENT

The perspective of people diagnosed with borderline personality disorder (BPD) of the attitudes of mental health nurses can reveal for nurses the role of their attitude in caring for people with a BPD diagnosis and its repercussions in the therapeutic process. These results deepen our knowledge of the therapeutic relationship with people diagnosed with BPD. Training for mental health nurses should explore attitudes and help nurses to develop self-awareness and insight. This approach could result in better nursing care for people with a BPD diagnosis.

KEYWORDS

Therapeutic relationship, borderline personality disorder, qualitative methodology

Accessible summary

What is known on the subject?

- Some nurses develop positive relationships with people diagnosed with borderline personality disorder (BPD), while others have negative emotional reactions to people diagnosed with this disorder.
- The therapeutic relationship is key in the practice of mental health nursing.
- Enhanced knowledge of BPD allows mental health nurses to develop improved self-awareness, knowledge and understanding of the individuals and insight into the therapeutic challenges, which can improve attitudes towards people with this diagnosis.

What the paper adds to existing knowledge?

- We are lacking knowledge about the perspective of people diagnosed with BPD on the attitudes of mental health nurses that facilitate a positive therapeutic relationship.
- The perspective of people with a BPD diagnosis on the therapeutic relationship offers key information about the attitudes that they credit with supporting their recovery.
- The participants—people diagnosed with BPD—perceived that the following attitudes of mental health nurses reinforced the therapeutic relationship: confidence in the person's recovery, non-judgement, sense of humour, availability and humanity.

What are the implications for practice?

- The study highlights mental health nurses' attitudes that participants perceived as having a positive effect on the therapeutic relationship.
- The recognition among people diagnosed with BPD of the constructive attitudes of mental health nurses may improve nurses' motivation to improve care for these patients.
- This study will allow mental health nurses to increase their awareness of the importance of attitude in the therapeutic relationship with people diagnosed with BPD.

INTRODUCTION AND BACKGROUND

People diagnosed with BPD suffer from a range of stigmas in the society at large and in health settings, including stigma associated with the diagnosis and self-stigma (Jones, 2012; Lawn & McMahon, 2015; Rogers &Acton, 2012; Stroud & Parsons, 2013). BPD affects 2% of the general population. This personality disorder is characterised by instability in identity and personal relationships, high impulsiveness, frequent suicidal ideation, high anxiety with emotional suffering, and problem-solving difficulties (Pack et al., 2013). This emotional suffering can produce a crisis with intense emotional turns, including spirals of anxiety and rage that can lead to self-harm. These crises can have lethal consequences (Borschmann, Henderson, Hogg, Phillips & Moran, 2012).

According to Bodner, Cohen-Fridela & Iancu (2011), the elements that lead to negative reactions in professionals working with people diagnosed with BPD are a) the risk of suicide and self-

harm, because they produce worry and discomfort among professionals; b) behaviours that can be difficult to for professionals to manage and therefore leave them feeling they have no way to help; and c) the high rate with which people diagnosed with BPD withdraw from treatment, which is frustrating for professionals. Notably, the clinical profile of the person diagnosed with BPD often presents severe functional deterioration, including unemployment, substance abuse and difficult interpersonal relationships. These factors often negatively affect people' ability to continue treatment. Keeping a person with a BPD diagnosis in treatment depends on a solid therapeutic relationship. Maintaining a motivating professional attitude can help people diagnosed with BPD (Commons Treloar & Lewis, 2008).

The therapeutic relationship is the central axis of care for people with mental disorders (Zugai, Stein-Parbury & Roche, 2015). This relationship is key to the practice of mental health nurses (Scanlon, 2006), and it depends on developing and maintaining a set of attitudinal skills (Dziopa & Ahern, 2009). It is difficult to define the therapeutic relationship and the attitudes and behaviours of the nurse that support it (Browne, Cashin & Graham, 2012). According to Dziopa & Ahern (2009), the attitudes of mental health nurses that support the therapeutic relationship with people diagnosed with a mental disorder are showing understanding and empathy, accepting individuality, giving support, being accessible, being genuine, promoting equality, showing respect, maintaining clear boundaries and having self-awareness. According to Reynolds (2009), the objectives of the therapeutic relationship are to give support through interpersonal communication that makes it possible to understand the needs and perceptions of the person and empower him or her for self-management.

For mental health nurses, building a therapeutic relationship is key for helping people diagnosed with BPD reduce their discomfort. Nonetheless, the research shows that mental health professionals often have negative attitudes toward people with a BPD diagnosis (James & Cowman, 2007). While we disavow these negative attitudes, which undermine treatment, it is essential to be familiar with this literature in order to identify areas for improvement. Some nurses see people diagnosed with BPD as difficult to treat and have negative attitudes toward them, which in turn complicates treatment (Eren & Sahin, 2016; Giannouli, Perogamvros, Berk, Svigos & Vaslamatzis, 2009). Mack & McKenzie Nesbitt (2016) observe that the negative attitude of nurses toward people diagnosed with BPD is manifested in a lack of compassion, a lack of confidence in their ability to meet therapeutic objectives, and the belief that they are attention-seeking and manipulative. Many professionals avoid caring for people diagnosed with BPD, and the therapeutic relationship often fails (Commons Treloar & Lewis, 2008). The issues of attention-seeking and manipulation are often based on misunderstandings, a lack of insight and skills, work overload and entrenched stigma relating to the diagnosis.

A contribution of our study is that instead of focusing on the obstacles to caring for people diagnosed with BPD (as many studies do), we offer a positive focus on aspects that facilitate care. Some nurses understand and empathise with people with a BPD diagnosis and manage to develop a positive therapeutic relationship with them (Dickens, Hallett, & Lamont, 2016; Dickens, Lamont & Gray, 2016). Some nurses show comprehension of the trauma experienced by people diagnosed with BPD and recognise that some health professionals make excessive use of their power over them (Holm, Bégat & Severinsson, 2009).

Understanding the difference between attitudes that do and do not facilitate the therapeutic relationships with people with a BPD diagnosis is an object of nursing research, with an important emphasis on discovering how to change the negative attitudes of some nurses (Avery & Bradshaw, 2015; Dickens, Hallett et al., 2016; Dickens, Lamont et al., 2016). One study shows that the majority of mental health nurses (both inpatient and community) were interested in receiving specific information about BPD that would help to improve their practice (James & Cowman, 2007). Some authors propose that nurses caring for people diagnosed with BPD should have access to specific training as well as supervisory sessions to help nurses to acquire skills for working with people with a BPD diagnosis (Giannouli et al., 2009; James & Cowman, 2007). A two-day Dialectical Behaviour Therapy (DBT) training workshop for nurses showed improved attitude and optimism among participants toward people diagnosed with BPD (O'Connell & Dowling, 2014). Improving nurses' attitudes has been shown to improve how they care for people diagnosed with BPD and reduce discrimination against them (Lawn & McMahon, 2015). Using theoretical knowledge to guide interventions and case supervision can have good results (Dickens, Lamont et al., 2016; O'Connell & Dowling, 2014). Understanding what causes the behaviours of people diagnosed with BPD and sharing treatment objectives with them helps community mental health nurses to have a positive attitude toward people with a BPD diagnosis (Dickens, Lamont et al., 2016).

In a different part of our overall study, we showed that people diagnosed with BPD found that learning about BPD, achieving trust with their mental health nurse and being empowered by their nurse facilitated the therapeutic relationship (Authors, 2020). In this process, the attitude of the nurse can facilitate or hinder the therapeutic relationship (Dickens, Lamont et al., 2016). In the current article, we aim to deepen our understanding of the perspective of people with a BPD diagnosis, shifting our focus to the attitudes of their mental health nurses. According to Nehls (2000), the voices of people receiving care should be carefully studied because they offer key information about the recovery process. Studying such experiences opens the path to research that moves away from paternalistic models (Nehls, 1999). There is a clear lack of data about the perspective of people diagnosed with BPD about the attitudes that foster a positive therapeutic relationship. This research makes it possible to reflect on the therapeutic relationship in clinical practice and invites nurses to

change their attitudes when necessary. Attitudes should be kept in mind in the practice of nurses who care for people diagnosed with BPD and emphasis should be placed on solidifying non-discriminatory values, increasing self-awareness and undermining unconscious bias. The aim of this study is to describe how people diagnosed with BPD who have experienced an improvement perceive the role of the attitudes of mental health nurses in building a positive therapeutic relationship.

METHODS

Design

The results reported here are part of a larger study (Authors, 2020). We used a qualitative descriptive design, an approach that is suited to arriving at a deeper understanding of practice in applied disciplines (Colorafi & Evans, 2016). This design is especially pertinent when the goal is to understand participants' perspective and experience.

Participant selection

Sampling was intentional (Morse, 2011). The population was people diagnosed with BPD who had self-reported an improvement and who were in follow-up at a public mental health centre for adults. Their treatment consisted of weekly or fortnightly individual meetings with a mental health nurse and participation in a mental health nurse-led psychotherapy group based on DBT. The nurses had received specific training about BPD based on DBT.

The inclusion criteria were having BPD as the main diagnosis, having been in follow-up with a community mental health nurse at the centre for at least two years, self-reporting an improvement compared to when treatment began, and agreeing to participate in the study. We defined potential participants as having self-reported an improvement when a) they had spontaneously told their mental health nurse that they felt better than at the beginning of treatment or b) they had responded affirmatively when asked by their mental health nurse if they felt better than at the beginning of treatment. The nurses then invited people fulfilling this criterion to participate in the study, and the names of those who agreed were passed on to the principal investigator (PI). The exclusion criteria were being in an unstable state (increased anxiety, self-harm, impulsiveness or suicidal ideation), being in follow-up with the principal investigator, and declining the invitation to participate from their mental health nurse. The PI contacted the candidates by telephone to invite them to participate. Of the 16 candidates invited (13 women and 3 men), 12 women attended the scheduled interview. One woman declined to participate. One man declined to participate and two agreed to participate but did not appear for their scheduled interview. All the participants were women, and they ranged in age from 20 to 46 (see table 1).

Data collection

The research was approved by the bioethics committee of the host university (IRB XXX). Participants received an informational document about the study before giving their informed consent. The PI conducted face-to-face, semi-structured interviews between January 2016 and December 2017. The interviews, which lasted between 30 and 55 minutes, were recorded on a tablet computer. We developed a set of interview questions relevant to the study objectives: What is important in your treatment and why? How is your relationship with your nurse? What would you recommend to a nurse who wants to get training to treat people with a BPD diagnosis? During the interview, follow-up questions were asked to encourage participants to provide additional details about their perspective. Participants' confidentiality was protected by giving them pseudonyms. The voice files and transcriptions were encrypted and stored on a computer protected with an encrypted password.

Data analysis

Braun and Clarke's (2014) approach to thematic analysis was used. Using Atlas.ti version 7, we identified meaning units (that is, segments of text) related to the research objectives and grouped them into themes. In doing so, we remained faithful to participants' expressed perspectives (Colorafi & Evans, 2016).

Phase 1: Become familiar with the data by listening to recordings, transcribing them and reading and rereading the transcripts.

Phase 2: Identify meaning units related to the research objectives. Generate codes and identify relationships among them.

Phase 3: Group codes into abstract themes. Define the parameters of each theme.

Phase 4: Identify five themes comprised of 140 meaning units, which formed the primary structure for our analysis. Devise a glossary of themes.

Phase 5: Name the five themes (Table 2).

Phase 6: Write the research report.

We completed the 'CASP checklist: 10 questions to help make sense of a qualitative research' (Critical Appraisal Skills Programme 2018).

Rigour

Credibility, transferability, dependability and confirmability ensure the trustworthiness of qualitative research (Polit & Beck, 2016). In our study, these traits were supported by the triangulation of researchers, which is the process by which researchers reflect on and discuss the data throughout the analysis phase to arrive at a consensus (Nowell, Morris, White & Moules, 2017). We also kept in mind that the PI is a nurse at the centre where the research was conducted. She did not provide nursing

care to study participants, to try to minimise the impact of her care role on the study outcomes. The PI recorded her impressions during the process of conducting the interviews and the analysis. She shared these ideas with the rest of the team and used them to reflect on the beliefs, values and personal interests that could influence the research (The University of Auckland, 2020).

RESULTS

The results are the five themes identified in the thematic analysis (see table 2).

Theme 1 - Confidence in their ability to recover

The participants reacted positively when the nurse's attitude expressed confidence that they could change and recover.

> *I always say that they've had a lot of faith in me. This is a feedback loop that makes you want to keep going, because sometimes you don't have faith in yourself. So yeah, having faith, in the sense of having confidence [in me]. Just like I say that, for me, it's been key to find confidence [in them], well, they also had confidence [in me]. The reverse as well; they had confidence in me.*
>
> *(Mónica/P4 - 4:68)*

> *When I have needed someone beside me to say, 'Hey! Hey! Are you aware of what's happening? You can get past this!' But when bad things happen to me, I stay passive and I need someone to help me see that I can change it.*
>
> *(Júlia/ P3 - 3:15)*

When nurses expressed confidence in the ability of the participants to recover, they conveyed the idea that it was worth it to keep trying.

> *That attitude of not, of not giving up. So, it's that, what I'm saying. If they're conveying to me all that good stuff, that it's worth it...it encourages me to continue fighting, right?*
>
> *(Alba/P12 - 12:51)*

> *I arrived with an incredible arrogance and I was really frustrated because behind that there was a lot of sadness, a lot of frustration about not being understood. And when you feel misunderstood you feel crazier too. Her confidence motivated me. [I thought] 'This person is here because she wants to be. She's rooting for me.*

(Mónica/P4 - 4:38)

Theme 2 - Non-judgement

This theme captures the participants' perception that the nurses did not judge them. Participants reported that it was helpful to be able to confide in the nurse without being judged. Participants were aware that they often related experiences that were difficult for others to understand, or had very negative content, or involved socially unacceptable thoughts and behaviours. Despite this, they reported that the nurse listened without judging.

> *But the peace of mind that the nurse gives me, when I come here, to tell it all, things that I can't even tell my partner. Well, it gives me everything, it gives me life, because she doesn't judge me, because it's all human. The things that humans do, by definition, we make mistakes. And I have regrets. I'm astute enough to see what I've done right and what I've done wrong. And so, I have regrets and I beat myself up about it and she tells me, 'Stop beating yourself up because that doesn't help' and that gives me a lot of peace of mind.*
>
> *(Esther/P11 - 11:33)*

> *She understands; she understands everything. There are things she doesn't agree with, but she doesn't judge you, which is very important. Because she doesn't look at you like… you know? Because there are people that you're telling them something and…well with some professionals that's happened to me, that they look at you like... and that's not right.*
>
> *(Viky/P1 - 1:35)*

This non-judgemental attitude allowed the nurse to help the patient account for her ideas and behaviours.

> *The fact that they don't judge you, that you can talk about very deep feelings, like emotions or a lot of things like… I don't know! Like sex. Or I don't know! The things you're most concerned about.*
>
> *(Anna/P2 - 2:29)*

> *Feeling listened to, and at the same time, that I can talk about everything without them saying, 'That's enough; stop talking nonsense.' Or other things that they [family] say to me at home.*
>
> *(Emma/P5 - 5:10)*

Theme 3 - Sense of humour

The participants described the importance of humour in facilitating the therapeutic relationship with their nurse. When nurses used their sense of humour, the participants reported that the nurse seemed authentic and that they felt close to the nurse and accepted and protected by him or her.

> *My confidence [in health professionals] was really broken, really weak. I started to feel confidence in the professionals, I think in that session it was total. [The nurse] said, 'Okay, come on!' and that's what made me come back; I'm talking about sense of humour.*
>
> *(Mónica/P4 - 4:135)*
>
> *Because there has to be a hook, one way or another. That's what the nurse did. She hooked me—you're not going to believe it—with her sense of humour!*
>
> *(Isabel/P8 - 8:14)*

Humour allowed participants to distance themselves from their own negative emotions and open themselves up to new perspectives. Humour also contributed to creating a sense of complicity in the therapeutic relationship.

> *A lot of times we start laughing and I laugh too, because I think, 'Look, I just told him about this and he's making fun of it, and I should laugh because it's funny.' I wasn't laughing at that moment, because for me it wasn't funny. But I see him cracking up and I think, 'No, of course. It's funny.'*
>
> *(Maria/P7 - 7:31)*

Humour and being able to laugh during visits with the nurse helped participants trust the nurse and feel that he or she is able to empathise.

Well, above all, being able to have that trust, and that empathy that she has. And I don't know, I see her more as...I wouldn't know how to explain it...she has a fun side that, in truth, that also helps, I don't know (smiling).

(Ruth/P9 – 9:20)

I also made a lot of jokes. That helped me, because she followed me, because she understood me, and that helped me, you know?

(Júlia/P3 - 3:33)

Theme 4 - Availability

The participants referred to an attitude of the nurse that reassured the participants that they would be cared for when necessary, offering them peace of mind. In addition to regular visits with their assigned mental health team, nurses offered participants the ability to call or stop by the urgent-care centre in case of a crisis.

I go to call the nurse because I'm really in bad shape, and you get an answer, right? And all very quickly. She tells me, 'Call whenever you need to, and if we're not here, go to the hospital.' I mean I've felt very taken care of.

(Laura/P10 - 10:7)

For me, it really was useful to be able to come for urgent care, when I had a problem or I wasn't doing well, I came here. When I left, I felt a lot better.

(Júlia/P3 - 3:8)

When they requested an urgent visit, they asked for a team member with whom they had a good therapeutic relationship.

Or if I have anxiety, having the possibility of coming here. I think that makes you have a little less anxiety. Because knowing you can say, 'Bah! Well, I'm really anxious, so I'm going.' Simply knowing that I can come, I think that at the level, a little bit of the anxiety goes down. Sometimes, I've come in and other times I haven't, but, well, knowing that I have [the option]; that helps me.

(Alba/P12 - 12:59)

At the visits he tells me, when we're finishing, that if I need anything, that I should stop by or call, and then, well that also helps quite a lot.

(Ruth/P9 - 9:23)

Theme 5 – Humanity

The participants highlighted the 'very human' treatment that they received from mental health nurses.

> *I don't know how to explain it. I mean, I've seen a lot of professionalism and knowledge of the disorder. Why? Because I haven't been treated like a friend could treat me; it's not that [...]. It's professionalism and competence and a very familiar treatment. It's very, very difficult because you sense a human connection and at the same time, what I have received is, 'I understand you. I have some tools to help you and we'll work on it'.*
>
> *(Anna/ P2 - 2:56)*
>
> *It's that they show a lot of empathy, comprehension, a lot of humanity… But at the same time, they're very professional. I don't know how they do it!*
>
> *(Esther/P11 - 11:38)*

Participants reported being treated as people and not as a disorder.

> Because my illness is an illness, and that's it! But they're helping me fight the symptoms of the illness. They're helping me as a person.
>
> *(Sara/P6 - 6:24)*
>
> *When I had low self-esteem… I don't know, well yeah, I felt that they treated me, well yeah, that they were keeping me in mind, that they treated you like a person […]*
>
> *(Mónica/P4 - 4:20)*

DISCUSSION

These results add to our knowledge about the perceptions of people diagnosed with BPD about the attitudes of mental health nurses that, according to participants, facilitate a positive therapeutic relationship. The first theme signals the importance for participants of the nurse's **confidence in their ability to recover**. This confidence motived them to continue working despite the difficulty of the process. This finding is in line with that of psychologists suggesting that confidence in the person's

success in recovering offers a strong therapeutic base for mental health treatments (Chugani, Seiler & Goldstein, 2017). According to people with a BPD diagnosis, confidence is the foundation for therapeutic interventions (Nehls, 1999) and they feel more supported by professionals who express confidence and treat them as people and not as a diagnosis (NICE, 2009). Confidence in the person's ability to recover is linked to hope, which, according to Tutton, Seers & Langstaff (2009), is a psychological process oriented toward the future that makes it possible to transcend health suffering and achieve an improvement. A study of people diagnosed with an eating disorder showed that nurses often felt more hope than their hospitalised patients (Stavarski, Alexander, Ortiz, & Wasser, 2019). Our study of people with a BPD diagnosis fills an important gap in this area, because we show that nurses' confidence in the recovery of our participants motivated them to keep trying to get better and supported the therapeutic relationship.

Non-judgement is the second theme that participants identified as contributing to the therapeutic relationship. The opportunity to 'tell it all', knowing that the nurse would listen without judgement enabled participants to express themselves freely and feel accepted. This is the model of a nurse that does not judge the content of the person's speech but rather responds consciously and therapeutically. The ability to withhold judgement requires nurses to have knowledge of relational dynamics when the person describes occurrences that are difficult for him or her to understand and accept. The response of the nurse consists of not reacting to the provocative stimulus and instead responding in a way that validates the emotion that led to this behaviour (Linehan, 1993). Several authors have pointed out that the mental health team needs to provide non-judgemental support to help the patient recover (McNee, Donoghue, Coppola, 2014; Mack & McKenzie Nesbitt, 2016). For some nurses, being non-judgemental in the face of behaviour that contradicts their own values, such as self-harm and suicide attempts, may be challenging. However, non-judgement is a key part of nursing ethics and nurses must be aware of the influence of their own values and beliefs (Morrissey, Doyle & Higgins, 2018). Our study adds to this area of research by showing that people diagnosed with BPD coincide with nurses in stressing the importance of non-judgement in facilitating the positive therapeutic relationship.

Our findings about the use of the **sense of humour** reveal that this attitude led participants to feel protected, accepted and calm; to be able to express their emotions authentically; and to experience closeness, trust and peace of mind with the nurse. Researchers working on the use of humour in nursing have concluded that optimism and a cheerful disposition are qualities that patients value in their nurses (Cleary, Horsfall, O'Hara-Aarons, Jackson & Hunt, 2012). There is nursing research about the effect of laughter in relieving anxiety and encouraging relaxation in people with a mental health diagnosis (Astedt-Kurki, Isola, Tammentie & Kervinen, 2001; Moore, 2008). Other research suggests that humour promotes reciprocity in the therapeutic relationship and facilitates a

more human and intimate connection (Tremayne, 2014). Our results show that the use of humour in the therapeutic relationship can have a reflexive effect, because it enables the person to decontextualise a situation and view it from a different perspective (Buxman, 1991). At the same time, research indicates that a sense of humour also allows people to preserve their dignity in the face of uncomfortable situations (Asted-Kurki et al., 2001) and that using a sense of humour tends to facilitate dialogue and allow people to show their friendliest side (Scanlon, 2006). Our results suggest that people diagnosed with BPD can benefit when their nurses express an attitude of humour in that it supports the therapeutic relationship.

The participants valued the nurse's **availability** to care for them when they needed it. Their confidence that they could get help gave them peace of mind and reinforced the therapeutic relationship. The availability or flexibility of the nurse has been recognized as an attitude supporting the therapeutic relationship with people with a diagnosis of mental illness (Dziopa & Ahern, 2009). Likewise, Lamph, Baker, Dickinson & Lovell (2020) note that a flexible approach and having more time to work with people who present personality disorder traits is necessary. In the case of people with a BPD diagnosis, the flexibility of nurses to spend time with them during a brief residential recovery-oriented programme contributed to reducing self-harm and length of hospital stay and increased their personal efficacy (Mortimer-Jones et al., 2019). Our findings extend Peplau's (1988) assertion about the importance of availability generally to the specific case of people diagnosed with BPD in the community setting. When nurses expressed their availability, our participants reported feeling that they were invested in the positive therapeutic relationship. In turn, participants were able to direct their attention to more complex objectives.

The participants identified an attitude of **humanity** in their nurses. Authors investigating the perspective of nurses have shown that specialised training in BPD based in a theoretical framework is key for helping nurses to develop more positive attitudes in nurses and avoid reactions with little therapeutic value (Dickens, Lamont, et al., 2016; Warrender, 2015). Other authors observed more human attitudes toward patients among nurses who reported wanting to help than among nurses who reported feeling fear on the job. (Dickens, Lamont, et al., 2016). Freshwater shows that the therapeutic relationship is a process that requires self-awareness and the deliberate use of humanist personal traits that can help patients (Freshwater, 2002). Our results extend these findings by showing that participants diagnosed with BPD reported that the humanity expressed by their nurses and the feeling that they were treated as people fostered a positive therapeutic relationship.

LIMITATIONS

All participants were women because none of the men invited attended the interview. The small number of men invited to participate reflects the small number of men with a BPD diagnosis cared

for at the centre. In this sense, the population was in line with epidemiological data about the diagnosis ratios for men and women at specialised mental health services (Chapman & Fleisher, 2018). Still, this limitation makes it impossible to consider gender differences in how people diagnosed with BPD perceive the factors that positively affect their therapeutic relationship with community mental health nurses.

We focused on people with a BPD diagnosis who had experienced an improvement, because we wanted to uncover attitudinal variables linked to improvement, via the therapeutic relationship. While providing rich data, this approach prevented us from learning about the perception of attitudes and the therapeutic relationship among the patients with less positive experiences. Future research should consider the perceptions of people who have not improved alongside those of people who have improved, because a comparative angle would shed light on the data.

Data collection was by self-report. Future research should compare these perspectives with those of mental health nurses and other professionals and with observational data to identify similarities and differences.

Finally, the sample was small. Therefore, the results are not representative of all people with a BPD diagnosis but rather are illustrative. This study can be a starting point, useful for comparison with future large-scale studies in other contexts, to identify best practices in caring for people diagnosed with BPD.

CONCLUSION

We identified the attitudes of mental health nurses that participants with a BPD diagnosis perceived as supporting the therapeutic relationship and their recovery. These were having confidence in the person's ability to recover, being non-judgmental, using a sense of humour, expressing availability and treating participants with humanity. Our participants perceived that the attitudes of their nurses were key to constructing a positive therapeutic relationship that helped them recover. Participants' accounts of their lived experiences are a potent source of data for research, teaching and clinical practice related to BPD. In addition to identifying these attitudes, this research has offered an opportunity for people diagnosed with BPD to collaborate in scientific research and give their opinion of the therapeutic process with their nurses, a process that could in itself have therapeutic benefits.

IMPLICATIONS FOR MENTAL HEALTH NURSING

These results offer mental health nurses the opportunity to reflect on the attitudinal factors that support the therapeutic relationship and the recovery of people diagnosed with BPD. The importance of attitude and self-reflection in mental health nurses should be a key aspect of nursing training, with

the ultimate goal of improving care for people with a BPD diagnosis or another mental health diagnosis.

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TABLES

TABLE 1. Characteristics of the participants

Participant	Age	Education level	Family situation	Employment status
Viky/P1	34	primary	lives with mother and sister	occasional work
Anna/P2	46	primary	lives with children	occasional work
Júlia/P3	40	secondary	lives with children	disability pension
Mónica/P4	42	higher	lives with partner	disability pension
Emma/P5	42	higher	lives with son	disability pension
Sara/P6	39	higher	lives alone	disability pension

Maria/P7	41	higher	lives alone	disability pension
Isabel/P8	38	higher	lives with partner and children	disability pension
Ruth/P9	20	primary	lives with parents	student
Laura/P10	26	secondary	lives with partner	stable job
Esther/P11	46	secondary	lives with partner and son	disability pension
Alba/P12	34	secondary	lives with parents	student

Table 2: Themes and meaning units

Themes	Meaning units

Confidence in the patient's ability to recover	24
Non-judgement	21
Sense of humour	18
Availability	53
Humanity	24
Total meaning units	**140**

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CASP Critical Appraisal Skills Programme

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CASP Checklist: 10 questions to help you make sense of a Qualitative research

How to use this appraisal tool: Three broad issues need to be considered when appraising a qualitative study:

- Are the results of the study valid? (Section A)
- What are the results? (Section B)
- Will the results help locally? (Section C)

The 10 questions on the following pages are designed to help you think about these issues systematically. The first two questions are screening questions and can be answered quickly. If the answer to both is "yes", it is worth proceeding with the remaining questions. There is some degree of overlap between the questions, you are asked to record a "yes", "no" or "can't tell" to most of the questions. A number of italicised prompts are given after each question. These are designed to remind you why the question is important. Record your reasons for your answers in the spaces provided.

About: These checklists were designed to be used as educational pedagogic tools, as part of a workshop setting, therefore we do not suggest a scoring system. The core CASP checklists (randomised controlled trial & systematic review) were based on JAMA 'Users' guides to the medical literature 1994 (adapted from Guyatt GH, Sackett DL, and Cook DJ), and piloted with health care practitioners.

For each new checklist, a group of experts were assembled to develop and pilot the checklist and the workshop format with which it would be used. Over the years overall adjustments have been made to the format, but a recent survey of checklist users reiterated that the basic format continues to be useful and appropriate.

Referencing: we recommend using the Harvard style citation, i.e.: *Critical Appraisal Skills Programme (2018). CASP (insert name of checklist i.e. Qualitative) Checklist. [online] Available at: URL. Accessed: Date Accessed.*

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Paper for appraisal and reference:

Section A: Are the results valid?

1. Was there a clear statement of the aims of the research?

Yes ✔ | Can't Tell | No

HINT: Consider
- what was the goal of the research
- why it was thought important
- its relevance

Comments: The aim of this study is to describe how people diagnosed with BPD who have experienced an improvement perceive the role of the attitudes of mental health nurses in building a positive therapeutic relationship.

2. Is a qualitative methodology appropriate?

Yes ✔ | Can't Tell | No

HINT: Consider
- If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants
- Is qualitative research the right methodology for addressing the research goal

Comments: An approach that is suited to arriving at a deeper understanding of practice in applied disciplines

Is it worth continuing?

3. Was the research design appropriate to address the aims of the research?

Yes ✔ | Can't Tell | No

HINT: Consider
- if the researcher has justified the research design (e.g. have they discussed how they decided which method to use)

Comments: This design is especially pertinent when the goal is to understand the perspective and experience of people.

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4. Was the recruitment strategy appropriate to the aims of the research?

Yes	✔
Can't Tell	
No	

HINT: Consider
- If the researcher has explained how the participants were selected
- If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study
- If there are any discussions around recruitment (e.g. why some people chose not to take part)

Comments: Participant sellection

5. Was the data collected in a way that addressed the research issue?

Yes	✔
Can't Tell	
No	

HINT: Consider
- If the setting for the data collection was justified
- If it is clear how data were collected (e.g. focus group, semi-structured interview etc.)
- If the researcher has justified the methods chosen
- If the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews are conducted, or did they use a topic guide)
- If methods were modified during the study. If so, has the researcher explained how and why
- If the form of data is clear (e.g. tape recordings, video material, notes etc.)
- If the researcher has discussed saturation of data

Comments: Data collection

CASP Critical Appraisal Skills Programme

6. Has the relationship between researcher and participants been adequately considered?

Yes ✔
Can't Tell
No

HINT: Consider
- If the researcher critically examined their own role, potential bias and influence during (a) formulation of the research questions (b) data collection, including sample recruitment and choice of location
- How the researcher responded to events during the study and whether they considered the implications of any changes in the research design

Comments: Rigour

Section B: What are the results?

7. Have ethical issues been taken into consideration?

Yes ✔
Can't Tell
No

HINT: Consider
- If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained
- If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study)
- If approval has been sought from the ethics committee

Comments: Data collection

CASP Critical Appraisal Skills Programme

8. Was the data analysis sufficiently rigorous?

Yes ✔
Can't Tell
No

HINT: Consider
- If there is an in-depth description of the analysis process
- If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data
- Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process
- If sufficient data are presented to support the findings
- To what extent contradictory data are taken into account
- Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation

Comments: Data collection

9. Is there a clear statement of findings?

Yes ✔
Can't Tell
No

HINT: Consider whether
- If the findings are explicit
- If there is adequate discussion of the evidence both for and against the researcher's arguments
- If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst)
- If the findings are discussed in relation to the original research question

Comments: Results

CASP Critical Appraisal Skills Programme

Section C: Will the results help locally?

10. How valuable is the research?

HINT: Consider

- If the researcher discusses the contribution the study makes to existing knowledge or understanding (e.g. do they consider the findings in relation to current practice or policy, or relevant research-based literature
- If they identify new areas where research is necessary
- If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used

Comments: Discussion