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Community Psychiatric Nurses' Experiences of Working with Clients with Borderline Personality Disorder.

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Abstract

This qualitative study explored the experiences of community psychiatric nurses who work with clients with borderline personality disorder (BPD). Ten community psychiatric nurses were interviewed. The nurses shared varied understanding of BPD. They also highlighted that specific skills are required when working with clients with BPD. However, the absence of formal clinical supervision was a particular difficulty among participants. In addition, while participants admitted to the challenges of working with these clients, they also reported on the rewards in seeing clients making progress, albeit slowly.

Key words: Borderline personality disorder, community, mental health nursing, psychiatric nursing.

Introduction

Borderline personality disorder (BPD) is a complex and severely impairing personality disorder. Those diagnosed with BPD are often overshadowed by intense emotional pain and distress (Perseus et al., 2005). Despite this, much of the literature conveys a sense of negativity towards individuals with BPD, who are regularly stereotyped by health professionals and often assumed to be manipulative and attention seeking (Fallon, 2003; Brooke & Horne, 2010). However, what clients have expressed as most useful is someone they can talk to in times of crisis (Nehls, 1999), but they often feel that they are not listened to and that their opinions are often dismissed (Rogers & Dunne, 2011).

The experiences of professionals caring for individuals with BPD have been widely explored (Nehls, 2000; Cleary et al., 2002; Koekkoek et al., 2009; Bodner et al., 2011). Studies include emergency department professionals (e.g. Treloar, 2009) and GPs and police (Little et al., 2010). While nurses are often included as part of the sample in some of these studies (Nehls, 2000; Cleary et al., 2002; Bodner et al., 2011), there is also literature available which is specific to nurses working in both acute inpatient and community settings (e.g. James and Cowman, 2007; Woollaston & Hixenbaugh, 2008; Giannouli et al., 2009; Ma et al., 2009; McGrath & Dowling, 2012). All of these studies highlight the challenges nurses face when working with this client group. Some studies also describe nurses' feelings of being demonised, manipulated and feeling threatened by clients diagnosed with BPD (Deans & Meocevic, 2006; Woollaston & Hixenbaugh, 2008; McGrath & Dowling, 2012). It is also reported that psychiatric nurses are more socially rejecting of clients with BPD than those who had a diagnosis of depression or schizophrenia (Markham, 2003) and less empathetic towards patients with BPD than those with affective disorder and 'other' diagnoses (Fraser & Gallop, 1993).

There are many assumptions as to why these negative emotions may be present. It is thought that counter-transference of emotions from client to nurse may have a role to play (Fraser & Gallop, 1993; Bland et al., 2007).

Another theory is that nurses feel that they cannot help them recover and that their 'caring' role is diminished (Bland & Rossen, 2005).

Studies exploring the experiences of community mental health nurses working with clients diagnosed with BPD are few. Webb and McMurrin (2007) surveyed nurses in a community mental health team on their attitude to patients with a personality disorder using the attitude to personality disorders questionnaire (APDQ). One ethnographic study (Forsyth, 2011) examined community psychiatric nurses' personal and professional constructions of service users diagnosed with borderline personality disorder. Finally, Stround and Parsons' study (in press), similar to this study reported here, interviewed community psychiatric nurses (n=4) and explored their experiences of working with clients diagnosed with BPD. Nurses in the study revealed that their attitudes towards clients were more positive when they had a framework to explain clients' behaviours.

Methods

The aim of this qualitative study was to explore the experiences of community psychiatric nurses who work with clients with borderline personality disorder (BPD).

An initial letter of invitation was distributed to all registered psychiatric nurses (n=15) working in one Irish adult community mental health service, which serves a catchment of 110,959. The catchment area comprises of a mixture of rural and urban areas. The adult mental health service includes three multi-disciplinary community mental health teams and one acute inpatient admission unit.

Inclusion criteria included working in adult community mental health for at least six months and having experience of working with clients with borderline personality disorder in a community mental health setting. Ten nurses (nine female and one male) responded to the letter of invitation to be interviewed. The length of time these nurses had worked in community

mental health ranged from three to fifteen years and two nurses had further education specific to BPD.

Ethical approval was granted from the health service area's research ethics committee. Informed written consent was obtained from each participant prior to being interviewed. In order to protect confidentiality, each participant was requested to choose a pseudonym.

The interview data was analysed as guided by thematic analysis framework proposed by Braun and Clarke (2006). A summary of the themes identified during data analysis was provided to each participant, along with a transcript of their interview, and each was requested to offer any comments. No participant offered any comment on their transcript or themes.

Findings

Three themes emerged in the interview data: *"Borderline Personality Disorder: a mixed bag"*; *"Positives and Challenges"*, and *"Establishing trust and managing risk"*.

"Borderline Personality Disorder: 'a mixed bag'"

Participants' understanding of the term 'borderline personality disorder' varied greatly; however the majority acknowledged that the best place to treat and care for these clients was in a community mental health setting. Participants also were of the view that BPD was an area of mental health nursing that lacked clear guidelines for reaching a diagnosis.

It was identified by all of the participants that clients with BPD usually present with a diverse combination of symptoms and issues, and many participants found it difficult to describe what BPD actually is.

'.....it's a mixture of a lot of different things'
(Diane):

'For me I think BPD is a very mixed bag, my understanding of the disorder is that it wouldn't be specific, for example, they could be, you know, they could show symptoms of depression, slight symptoms of depression, symptoms of anxiety, but maybe would fall into a bracket of maybe, have social issues, lack of coping skills and....Lack of social supports.....(Mary)

'..... destructive behaviour that they would often kind of portray on a day to day basis such as not eating and pushing others away.' (Ann)

'Well there could be self harm, you know. There's a lotthere would be say cutting, poisoning....' (Linda)

'My understanding of it is someone really that would have maladaptive coping skills or no coping skills.' (Patricia)

'Borderline personality disorder is em where people present with difficulties in coping with things... particularly relationships, they have difficulties sustaining relationships and they often get involved in relationships that might be unhealthy...maybe abusive...or have some addiction, just generally unstable....'(Kay)

Two participants clearly highlighted that people with borderline personality disorder have often experienced a traumatic childhood:

'Em more often than not there would be a history of abuse in some form in childhood...sexual or emotional maybe. Even though they usually turn up in a crisis they sometimes experience low mood or depression or anxiety. They are often suicidal.....' (Kay)

'well quite often there's a lot of childhood trauma involved , whatever that involves you know it could be neglect , quite often sexual abuse , emotional abuse would be probably one of the more common ones that I've come across. The overlying sort of feature is in my experience some horrendouschildhood trauma whether that be single or over a period of time ...' (Tom)

Participants also described the lack of clarity surrounding BPD as a diagnosis. They described the reluctance of doctors to diagnose a client with BPD and how clients often believed their diagnosis was something other than BPD.

'....another thing really is why people aren't actually diagnosed with it, but it's kind of something that's discussed as a team but it's not something that seems to be ...outlined to the person so then it prevents us from having a structured borderline personality disorder programme with them so you're trying to kind of skate around it...' (Ann)

'Well I think sometimes the whole team knows that a person has a personality disorder and the patient thinks they have depression.' (Kay)

'I think some psychiatrists are reluctant, quite rightly so to give somebody a diagnosis of borderline personality disorder. Patients, in my experience actually often find it very helpful...'. (Joan).

There was agreement that the most suitable care setting for clients with BPD is the community. However, it was also recognised by some that a short brief admission to an acute psychiatric unit may be necessary in times of crisis.

'The worst place is to end up in an acute unit . It's fine yes if there's a risk, you know as in a risk to life. But that's short very brief and then out, discharged. And be treated in the community, be it GP surgery, day hospital, whatever, you know, but that it's very structured'(Linda)

'They have no place in the acute unit, they go in there and they undo two years work and the patient sabotages any plans for discharge.....so they're there in the unit and when they come home the same issues are there and sometimes they are worse.....a crisis should be dealt with in the community.....once they know there's someone there all the time...when you work with them in the community they develop a confidence that they are being listened to'(Diane)

“Positives and Challenges”

Participants described their experiences of working with clients with BPD as both good and bad.

All participants recognised that there are positive aspects in working with these clients. The 'positives' were seen in the building of a therapeutic relationship with clients and seeing them make progress, albeit slowly.

'I wouldn't say that I dislike working with them, sometimes I enjoy it...em...part of me really enjoys the challenge of working with these people'. (Patricia)

'The good side of it is that when you do develop a relationship they're very trusting in it'. (Ann)

'It's a constant challenge but if you put in the work and encourage the client to do likewise you will see resultssometimes they are very small changes but still it's a step in the right direction.....'(Kay)

'There are positives definitely in that it can depend on the person, they can engage very well and can have a positive approach.....they

really want to recover because despite any borderline disorder they are very good people'. (Diane)

Participants also provided examples of what challenges they face in practice. These centred mostly on nurses' feelings of frustration and feeling drained because progress with these clients is very slow. They also expressed their frustration with clients engaging in 'splitting' and manipulation.

'A human being could only endure so much. You would have to make sure that you looked after yourself, 'cos they could take all your energy'. (Mary)

'I get burned very quickly from them..... that's what I find you get burnt from, progress is so slow and I often question is there progress at all? (Susan)

'because as I say they can quite often be very difficult, very draining to work with and if that was the only option you had throughout your working life ...you'd quite quickly become drained of it' (Tom).

'I tend to get frustrated after a long period of time when you've worked over a number of weeks with someone and they haven't come any further whatsoever'. (Patricia)

'Another challenge I suppose is the splitting in working with different professionals...it's just that continuous splitting all the time, em...that's very hard to work with I think, for myself'. (Ann)

Despite the challenges, the majority of the participants indicated that if they were given a choice, they would work with this client group, but not exclusively.

'I like working with them..... It's a constant challenge but if you put in the work and encourage the client to do likewise you will see resultssometimes they are very small changes but still it's a step in the right direction.....' (Kay)

'Ah... I've no problem working with them, whether I'd want to work in a specialist unit that only dealt with borderline personality disorders..... I think it's nice to have the mix'. (Joan)

"Establishing trust and managing risk"

Participants believed that certain skills were required to enable them to work effectively with these clients. These skills were underpinned by a therapeutic relationship within a structured framework that aimed to empower clients while also remaining cognisant that establishing trust was a very slow process.

'...the main thing is to get the trust and that can take ages.....I think once you are patient with them and don't expect miracles to happen in a short space of time that you will have a more positive outlook yourself'. (Kay)

'There can be no grey area with them, you have to, and of course that's all about the therapeutic relationship...they kind of respect it.....they mightn't like it and they might you know retaliate at first and all that sort of stuff.....but then you knowthey do actually respect that honesty, that truth...'. (Linda)

'I'd just encourage them to identify for themselves that 'this was a good thing you did' or 'this was a positive step in your recovery' or em 'now we can move on?'. (Irene)

The majority of the participants also acknowledged that risk assessment was an integral part of working with these clients in the community, and they had to often take risks.

'I suppose as well, being confident in your work and in your practice...I'm just thinking about risk assessment....when a client might say to you....oh I think I'll take an overdose.... or just kind of infer that that's what they might do..... But once you know that you have put everything in place and the thing is... they usually know how to source the help themselves. You can only offer them the choices and hope that they take it on board'. (Kay)

'And I know our job is about risk taking, as in we have to take the risks ...that is our job.....that sounds awful....but you know we have to assess for the risk and like you knoware they in danger or not.'(Linda)

Most participants also identified that basic education and training in relation to BPD was inadequate. They wanted more education and training, not only on BPD but also on how to manage themselves. Some participants expressed the view that clinical supervision was essential for nurses working

with these clients; however, no structured clinical supervision was in place for this group of nurses.

Discussion

The findings of this study suggest that participants' understanding of BPD as a diagnosis varies significantly. Some of the participants however, showed a very good understanding of current knowledge on BPD. A number of other studies have explored nurses' knowledge of BPD. However, all used questionnaires presenting elements of the DSM-IV (American Psychiatric Association, 1994) diagnosis of BPD as a means of measuring knowledge (Deans & Meocevic, 2006; James & Cowman, 2007; Giannouli et al., 2009), therefore comparisons with the findings reported here are difficult to make.

Some participants used the words 'attention-seeking' as part of their description; however existing literature which explores subjective experiences of BPD suggests that the terms 'attention-seeking' and 'manipulative' are derogatory in nature (Nehls, 1999; Horn et al., 2007). The participants in this study however, did not suggest or infer that clients who engage in deliberate self harm do so to purposefully seek attention.

In line with the DSM-IV (1994) diagnostic criteria, the inability of people with BPD to establish and maintain healthy relationships was found by some participants to be the defining factor in clients' presentations. This along with poor coping skills and an inability to deal effectively with difficult situations was identified by most participants to be common in people with BPD.

It was surprising that only two participants identified that there may be a history of some type of abuse in childhood. The literature suggests that it is reported in 40% to 71% of cases of borderline personality disorder (Gunderson & Berkowitz, 2003; Lieb et al., 2004); and it has been recommended that nurses need to be aware of the possibilities that their client may have been sexually abused as a child (Horsfall, 1999). Awareness of the evidence that histories of abuse can cause disturbed behaviour, may prevent negative attitudes developing (Fallon, 2003). It has also been suggested that survivors of child abuse may find it difficult to feel safe in

relationships with health professionals (Long & Smith, 1998). It is important therefore that nurses gain awareness around the impact that a history of childhood sexual abuse can have on their clients' current mental wellbeing.

An overwhelming majority of the participants agreed that the treatment environment of choice for clients with borderline personality disorder is in the community. The participants however did acknowledge that a short brief admission to an acute inpatient unit was sometimes necessary as a place of safety in times of crisis. However, some participants felt that hospital admission was counter-productive, as issues that precipitated a crisis would continue to be present on discharge. This is similar to the findings of others (Krawitz & Watson, 2000), where it is identified that while inpatient treatment has a place in the management of BPD, it can be counter-therapeutic if not delivered properly.

The findings from this study suggest that some participants had difficulties understanding why clients who were known to have BPD were never offered this information or had never been informed of this diagnosis. The literature on this topic is controversial. In one study, two of the participants were only told their diagnosis of BPD by the consultant psychiatrist when they were being recruited for a research study (Fallon, 2003). It is thought that many clinicians and researchers have found the application of the diagnosis of BPD difficult in terms of the impact that such a label has on professional attitudes and consequent provision of treatment (Common Treloar & Lewis, 2009). However, the findings reported here add to those of James and Cowman (2007) where the majority of respondents were of the opinion that not telling clients their diagnosis of BPD had a negative impact on their care. Moreover, individuals with BPD who have been given a diagnosis, report it being helpful because it provided them with a way to think about their difficulties and offered a sense of relief, often after years of not knowing what was wrong (Horn et al., 2007). A diagnosis also helped them to make sense of their feelings (Fallon, 2003). Nevertheless, the participants in Nehls' (1999) study acknowledged that while the diagnosis was helpful, the label of 'borderline' was not.

Although some participants did identify that sometimes it was difficult to see positives, all could identify enjoyable and positive aspects of their work with these clients. The positive experiences that participants described in this study were by and large connected to seeing their clients improve. A possible explanation for this finding would be that nurses working in community mental health settings have the opportunity to work with these clients when they are doing well.

In harmony with existing literature (O'Brien & Flote, 1997; Nehls, 2000; Cleary et al., 2002), it was found that the majority of the participants felt that working with this client group could lead to 'burn out'. The main causes identified for this were a sense of frustration when participants felt they were not making progress with a client. However, one participant talked about her burnout in the context of feeling manipulated by clients. Participants also agreed that a key-worker approach was the most appropriate for this client group. Many felt that working in this manner possibly would reduce the likelihood of what is described as 'splitting' or 'manipulative' behaviour from the client. It is argued however that the key-worker approach for these clients can 'create untenable levels of individual burden on individual staff members' and that a collaborative, community orientated approach would be more practical' (Winship & Hardy, 2007 p.153). However, individuals with BPD have reported that having a named key-worker was very beneficial to them as it made them feel safer in times of distress, particularly if a good trusting relationship had been formed (Fallon, 2003).

Caring for clients with BPD requires specific skills. This study found that the establishment of a therapeutic relationship was the single most important issue for participants when working with clients with BPD. However, much of the literature suggests that it is often notoriously difficult to engage with, and establish therapeutic relationships with these clients (Horsfall, 1999; Koekkoek et al., 2009; Ma et al., 2009). Nevertheless therapeutic alliance between client and therapist is paramount in the treatment of BPD (Barnicot et al., 2012). Of the various treatments for BPD, dialectical behavioural

therapy has been studied the most (Stoffers et al., 2012), and is currently considered the most effective treatment for borderline personality disorder

Being open and honest, empathetic, and having the ability to listen were the core skills that participants identified as being important in establishing a therapeutic relationship with this client-group. The qualities that facilitate sustained relationships, according to service users, are demonstrated by people who were 'calm, patient, knowledgeable, flexible, empathic and interested in them as people' (Fallon, 2003 p. 398). However, establishing professional boundaries with service users was only inferred to by some participants. This finding is noteworthy in view of the importance of professional boundaries when building up therapeutic relationships with these clients (Bender, 2005). Also important is being cognisant of the risk of malignant alienation (Watts & Morgan, 1994) where staff progressively distances themselves from clients when they feel the therapeutic relationship is overly dependent.

The skill of assessing risk was found to be an integral component when working with clients with BPD. The difficulties in assessing risk posed a dilemma for many participants. Risk assessment should be particularly cautious if the person with BPD is not well known by the community mental health care and/or there have been regular crises with suicide (NICE, 2009).

Participants expressed the view that their education and training in relation to borderline personality disorder was inadequate; a finding also reported elsewhere (Cleary et al., 2002; James & Cowman, 2007; Giannouli et al., 2009; Ma et al., 2009). Some participants identified that they had very good knowledge on 'usual' mental health issues such as depression or schizophrenia but often felt lost when it came to BPD or personality disorders in general. There was a sense of 'learning on the job' among some participants; however this practice in the absence of structured clinical supervision could be deemed inappropriate. Without clinical supervision, nurses may experience stress and burnout while patients may experience ineffective treatment (Bland & Rossen, 2005). Any absence of structured clinical supervision for psychiatric nurses is a real concern. Clinical

supervision is paramount for staff working with BPD clients in order to manage boundaries in the therapeutic relationship which is essential for clients' recovery (Moore, 2012).

Study limitations

This study was undertaken in one service provision area therefore the findings are not representative of all psychiatric nurses working with clients with BPD in the community. In addition, the sample size is small (n=10). Furthermore, nine study participants were female. A balance of male and female participants may have resulted in different findings.

Conclusion

This study adds to the increasing knowledge of community psychiatric nurses' experiences of caring for clients with a diagnosis of BPD. The nurses in this study expressed the need for more education on BPD and support through clinical supervision. The study findings reveal that while community psychiatric nurses find it challenging to work with these clients, they also report on the rewards in seeing clients making progress, albeit slowly. This latter finding is encouraging. However, the lack of structured clinical supervision for these nurses is concerning. Clinical supervision for community psychiatric nurses is essential for effective nurse-client relationships and clients' ongoing recovery.

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