THE UNIVERSITY OF HULL

Relationships Between Mental Health Staff and Those Who Have a Diagnosis of Emotionally Unstable Personality Disorder

being a Thesis submitted in partial fulfilment
of the requirements for the degree of Doctor of Clinical Psychology

in the University of Hull

by

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July 2019

Acknowledgements

First and foremost, I would like to express my deepest gratitude to Almighty God, the Most Compassionate, the Most Merciful. My success is only by you. Thank you for being with me through everything: the joyous moments, and the times of worry and hardship.

I would like to extend thanks to my participants. You have played an integral part in my research, and I hope that I have captured your voices and experiences. Thank you also to the mental health professionals who helped promote my research to potential participants.

Sincere thanks go to my academic supervisors for supporting me throughout the entire research process. To Dr Tim Alexander, your guidance and feedback have been invaluable, and your reassurance along the way is much appreciated. To Dr Philip Molyneux, your direction and extensive knowledge base helped me to apply my own knowledge and think theoretically. I would also like to thank my field supervisor, Dr Samantha Haigh, for your expertise in the field of personality disorder.

Finally, I would like to give special appreciation to my family. Thank you to my father, who raised me to work hard and to value education; I am grateful for your unwavering support and belief in me all these years. Thank you to my mother, for your thoughts and prayers. To my younger siblings, thank you for your encouragement and for continuously telling me that I would reach the finish line, even when it felt so far away. I would like to thank my lovely aunt, for your steadfast confidence in me, and for always celebrating my accomplishments. To my beloved grandmother, thank you for comforting me with all your love and prayers, especially during the times when I needed them most. And last, but certainly not least, I would like to give a special mention to my late grandfather, who sadly passed away during my first year on the Doctorate; thank you for never failing to bring a smile to my face and for always reminding me to have faith – words I treasure to this day.

Overview

This thesis portfolio comprises three parts: a systematic literature review, an empirical paper, and a corresponding set of appendices.

Part one: Systematic Literature Review

This systematic review aimed to explore the barriers and facilitators for mental health staff having compassion for people who have a diagnosis of Emotionally Unstable Personality Disorder. A systematic search was carried out resulting in eighteen studies that met the inclusion criteria and were selected for review. A narrative synthesis approach to analysis was taken which identified barriers and facilitators of compassion. Appraisal of the methodological quality of the evidence base is considered. The findings are discussed in relation to theoretical links, clinical implications, and avenues for future research.

Part two: Empirical Paper

This qualitative research explores the experiences of relationships with mental health staff from the perspective of clients diagnosed with Emotionally Unstable Personality Disorder. The study aimed to understand the process of shame and investigate repeated patterns in interactions between professional to service-user relationships and early experiences. A Thematic Analysis approach to analysis was taken due to not meeting data saturation for Grounded Theory. Three overarching themes were identified. The findings are discussed in relation to existing literature, and the implications for practice and research are reflected upon.

Part three: Appendices

This contains a set of supporting appendices for the systematic literature review and empirical paper, comprising an epistemological statement and reflective statement.

Portfolio Total Word Count: 17,864 (excluding references and appendices)

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Part Two: Empirical Paper

Part One: Systematic Literature Review

The Barriers and Facilitators for Mental Health Staff Having Compassion for People Who Have a Diagnosis of Emotionally Unstable Personality Disorder: A Systematic Literature Review

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This paper is written in the format ready for submission to the

Journal of Clinical Psychology

Please see Appendix A for the Author Guidelines

Word count: 6051 (excluding abstract, tables, figures, references and appendices)

Abstract

Context: Research has shown that Emotionally Unstable Personality Disorder (EUPD) is stigmatised, and mental health staff (MHS) hold negative views about this client group.

Objective: This systematic review aimed to identify the barriers and facilitators for MHS having compassion for the EUPD client group.

Method: The following databases were searched: PsycINFO, CINAHL Complete, and MEDLINE. Of 1167 articles, 18 studies met the inclusion criteria. Narrative synthesis was the analysis approach used.

Results: The barriers found were: (1) *Clinicians' personal responses*; (2) *Client risk and behaviour*; (3) *Lack of framework, knowledge and skills*; and (4) *Organisational issues*. The facilitators were found to be the opposite of barriers.

Conclusion: There are key barriers which impact upon the ability to provide compassionate care. Reducing barriers and implementing facilitators may enhance compassion, though change may need to begin at the organisational level. Future research could directly measure MHS compassion for the EUPD client group.

Keywords: emotionally unstable personality disorder, borderline personality disorder, compassion, mental health staff, systematic literature review

Introduction

Borderline Personality Disorder (BPD) is a type of ‘personality disorder’, and is defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychiatric Association, 2013) as being characterised by difficulties with emotion regulation, abandonment, interpersonal relationships, impulsivity, suicidal tendencies or self-harm behaviours and issues with sense of self. BPD is also known as Emotionally Unstable Personality Disorder (EUPD), as outlined in the International Classification of Diseases 10th Revision (ICD-10; World Health Organisation [WHO], 2016). Both EUPD and BPD are used interchangeably, though in the United Kingdom, the ICD-10 (WHO) is the classification used for mental health diagnoses. Therefore, for the purposes of this review the term EUPD will be used to refer to both EUPD and BPD.

Compassion is viewed as being a fundamental value of healthcare professionals (Sinclair et al., 2018). For the purpose of this review, compassion is defined as “*being open to the suffering of self and others [and] … a desire to relieve suffering*” (Gilbert, 2005, pg. 1). Gilbert (2009) describes compassion as comprising of six attributes: “sensitivity”, “sympathy”, “empathy”, “motivation” or “caring”, “distress tolerance” and “non-judgement” (p. 202-203). Providing compassionate care has been shown to positively impact upon client health outcomes (Van der Cingel, 2011).

The presence of compassion when working with the EUPD client group appears to be problematic. There is controversy around the diagnosis, for example, the adverse connotations of the label, and whether it may instead be more helpful if it were seen as a condition on the trauma spectrum (Lewis & Grenyer, 2009). The labels for EUPD are often stigmatised, and abundant research in the field indicates that mental health staff (MHS) hold negative views and experience challenges in working with this client group. Markham (2003) demonstrated that mental health nurses (MHNs) viewed clients diagnosed with EUPD as more dangerous and were more socially rejecting towards them than clients diagnosed with Schizophrenia. In support of this, other studies have shown that nurses were less empathetic towards the EUPD client group compared to other client groups (Fraser & Gallop, 2003; Gallop, Lancee & Garfinkel, 1989). If clinicians have negative perceptions about clients diagnosed with EUPD (CDw/EUPD), this will likely affect their ability to provide non-judgemental and compassionate care.

Whilst past reviews in the field have explored MHNs attitudes and experiences of working with CDw/EUPD, these reviews have investigated the perspectives of MHNs only (Dickens, Lamont & Gray, 2016; Loader, 2017; Westwood & Baker, 2010). A limitation of such reviews is that they do not capture the perspectives of other MHS who work with the client group or whether there are any differences between disciplines. Furthermore, previous reviews have focused on exploring attitudes and experiences, but have not investigated what drives these attitudes, or identified the challenges and enablers for MHS having compassion for people with this diagnosis. To our knowledge no systematic literature review has been conducted to explore the barriers and facilitators of compassion for professionals who work with this client group.

This review aims to highlight the barriers and facilitators of compassion which may help to inform practice and future research. Reducing the barriers where possible, and reinforcing the facilitators, may ultimately lead to improved care provision and compassion in MHS who work with people who have attracted the label of EUPD.

Therefore the research question for this review was:

What are the barriers and facilitators for mental health staff having compassion for people who have a diagnosis of EUPD?

Method

Search Protocol

The following databases were chosen and accessed via EBSCOhost: PsycINFO, CINAHL Complete, and MEDLINE. These databases were selected to ensure that articles relevant to the research question were identified within disciplines of Psychology, Nursing and Allied Health, and Life Sciences and Biomedicine. The databases were searched up to and including February 2019.

During the initial scoping stage, literature was examined in order to identify key terms to develop the final search strategy. The ‘compassion’ search terms were based on Gilbert’s (2009) six attributes of compassion. Final search terms were then peer-reviewed and agreed upon. The following search terms were therefore used:

(mental health staff OR clinician* OR professional* OR psychologist* OR nurs* OR psychiatrist* OR “occupational therapist*” OR “speech and language therapist*” OR “social worker*” OR “support worker*” OR therapist*)

AND

(compassion* or understand* or “positive attitude” or sensitivity or sympathy or empathy or motivation or caring or care or “distress tolerance” or “non-judgement*”)

AND

(“emotionally unstable personality disorder*” or eupd or “borderline personality disorder*” or bpd)

The limiters applied to the search were: Journal and English Language.

Inclusion and Exclusion Criteria

Table 1 below shows the inclusion criteria that were applied to the articles when being selected for review.

Table 1

Inclusion criteria for articles included in review

Inclusion criterion	**Rationale**
Participants are mental health staff	Interested in the perspectives of mental health staff, and the barriers and facilitators that they experience in having compassion for those who have a diagnosis of EUPD/BPD.
Client group are adults age 18+ with a diagnosis of EUPD/BPD Study can either have no comparator or can have other diagnoses as comparator(s), as long as adults with a diagnosis of EUPD/BPD is included as one of the client groups	Adults with a diagnosis of EUPD/BPD are the client group of interest.
Studies that explore some element of the barriers/challenges/difficulties/issues/problems/limits/obstacles/hindrances/blocks or the facilitators/motivators/enablers/help/supports/promotes/assists/aids for mental health staff in caring for those with a diagnosis of EUPD/BPD	To ensure that only relevant studies are included in the review; to ensure that the current research question is fully answered.
Articles published in a peer-reviewed academic journal	To ensure that studies included in the review are of adequate quality.

Empirical and primary research	Purpose of review is to review the findings of original research.
Uses qualitative or quantitative research methodology	To ensure that all possible barriers and facilitators to compassion are identified and explored, consistent with the current research question.

Table 2 below shows the exclusion criteria that were applied to the articles when being selected for review.

Table 2

Exclusion criteria for articles excluded from review

Exclusion criterion	**Rationale**
Participants include people who have a third person perspective on barriers or facilitators to compassion/care for mental health staff, such as service-users or family members	Interested in the perspectives of mental health staff, and the barriers and facilitators they experience in having compassion for those who have a diagnosis of EUPD/BPD.
One of the topics/diagnoses is not EUPD/BPD	EUPD/BPD is the topic/diagnosis under consideration.
Client group are children or young people	Adults with a diagnosis of EUPD/BPD are the client group of interest.
Studies that do not explore any barriers or facilitators to compassion or care for mental health staff working with people who have a diagnosis of EUPD	To ensure that only relevant studies are included in the review; to ensure that the current research question is answered.

Studies which focus only on measuring the effectiveness of a specific training or education-based programs	To ensure that only relevant studies are included in the review; research question is not measuring the effectiveness of specific interventions.
Articles published in a non-English language	Only articles published in the English language can be analysed by the researcher.
Case studies, literature reviews, discussion papers, conference proceedings, unpublished dissertations or theses, or any other secondary source	Purpose of review is to review the findings of empirical and primary research.

Article selection summary

Duplicate articles were removed. All identified articles were first screened by title and abstract to ascertain relevance to the research question. Those titles and abstracts that appeared to be irrelevant were discarded. From the abstracts that were deemed to be relevant, full-text articles were then read and assessed for eligibility, and the inclusion and exclusion criteria were applied (see Tables 1 & 2). Those full-text articles that did not meet all of the inclusion criteria, or met one or more of the exclusion criteria, were excluded. Those full-text articles that met all of the inclusion criteria, and none of the exclusion criteria, were included. This process resulted in a final sample of eighteen articles selected for review. Figure 1 below illustrates the article selection process.

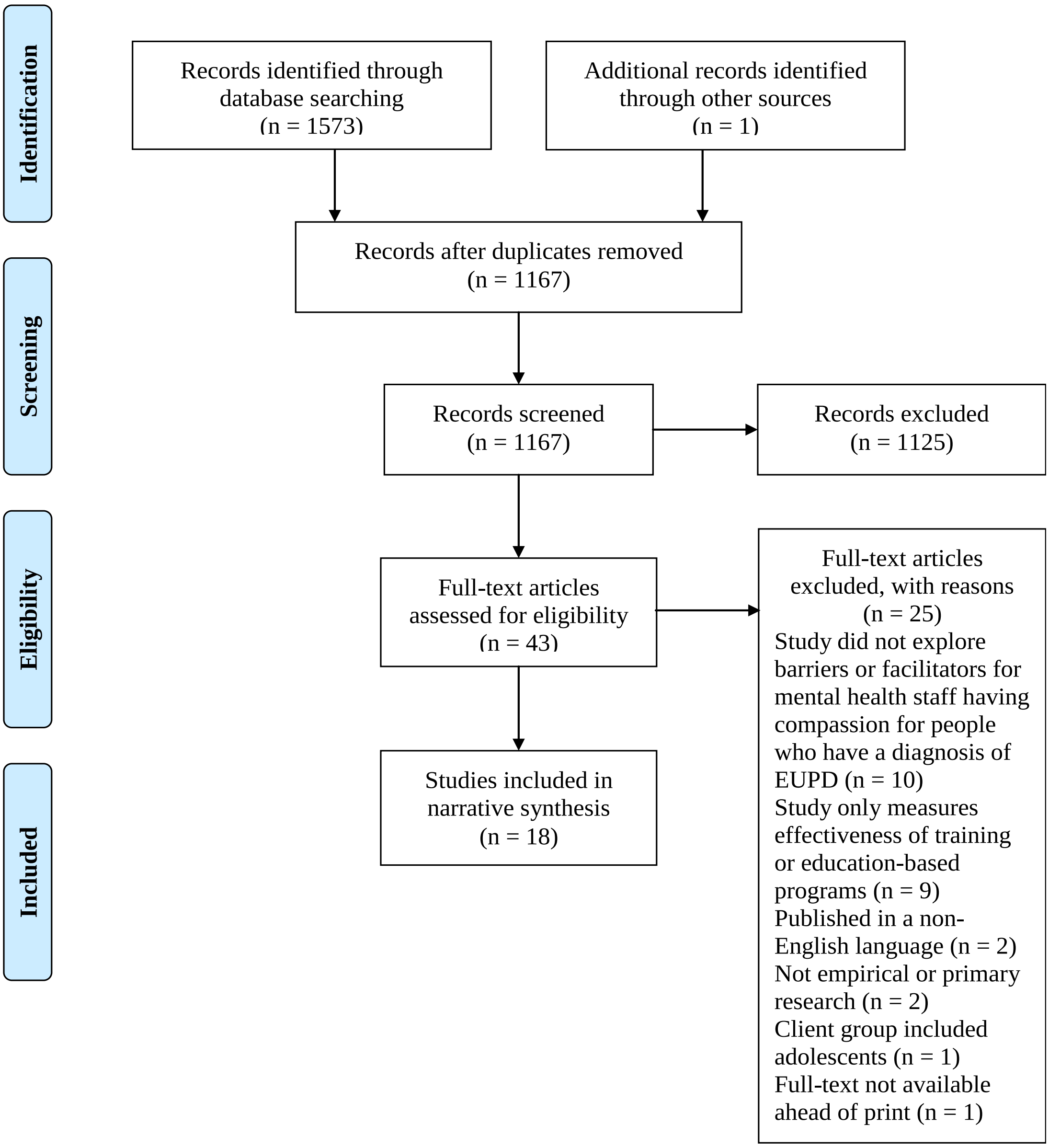

Figure 1. PRISMA flowchart illustrating the article selection process for the review, adapted from Moher, Liberati, Tetzlaff and Altman (2009).

Data Extraction

A bespoke data extraction form was created by the lead researcher for the purpose of the review (see Appendix B). Following article selection, the final sample of full-text articles were re-read, and the data extraction form was used to extract and identify key data from each study relevant to the review. The extracted key data is shown in Table 3.

Quality Assessment

Due to variation in methodology of the studies, the Mixed Methods Appraisal Tool (MMAT; Hong et al. 2018) Version 2018 was utilised to appraise methodological quality (See Appendix C). The MMAT was chosen as it comprises checklists for qualitative, quantitative and mixed methods methodology and allows for a degree of comparison across a range of studies. For each study, the most appropriate checklist(s) were selected by referring to the authors' algorithm. Qualitative and quantitative studies were rated out of a total of five criteria. Studies which used mixed methods were scored out of a total of fourteen criteria, as appraisal of this methodology requires combining together the mixed methods checklist with the most appropriate qualitative and quantitative checklists of the MMAT. Hong et al. recommend that in order to improve the quality appraisal of the studies, criteria should be assessed in more detail rather than solely relying upon an overall score. Therefore in line with this, an overall score for each study was calculated and ratings were evidenced with additional comments where appropriate when a criterion was not met. To ensure inter-rater reliability of quality assessment, four articles (2 quantitative, 1 qualitative, 1 mixed methods) were peer-reviewed by an impartial person using the same checklist. There was a high level of consistency between the raters. In the case of discrepancy, ratings were discussed and final agreement was reached. The overall quality rating assessed for each study is shown in Table 3. Studies appraised as having low methodological quality were not excluded, as the review aimed to encompass all relevant studies. The methodological strengths and limitations were instead included in the synthesis to help evaluate the quality of the evidence base.

Data Analysis

Conducting a meta-analysis was not appropriate for this review due to the heterogeneity in methodology, design and outcomes of the final sample of studies. Therefore, narrative synthesis was chosen as the approach to analysis. The central idea of narrative synthesis is to describe a story to explain findings through developing a written account (Popay et al. 2006). In accordance with the guidance by Popay et al., the following process for narrative synthesis was followed for the review. The process involved moving between different elements of synthesis. These include: systematically arranging the relevant findings from the final studies in a meaningful way in order to identify barriers and facilitators for mental health staff having compassion for people who have a diagnosis of EUPD; exploring the data to discover the relationships between the barriers and facilitators, and the similarities and differences between the findings; and assessing the strength and quality of included studies in order to determine the trustworthiness and robustness of the synthesised findings (see Table 3).

A comparison of the studies was conducted by examining country, methodology, participants, relevant findings and quality score, and the similarities and differences between studies were noted. Common themes emerged from this analysis, and relevant findings from all studies were initially grouped under various categories. This process was refined further which led to the initial categories being regrouped and merged into the overarching four barriers and three facilitators. The research findings were then written up under the relevant headings in the results of the review.

Results

Overview of included studies

The primary characteristics of the final eighteen included studies are summarised in Table 3.

Aims

The majority of studies aimed to explore the experiences and attitudes of MHS working with CDw/EUPD (n = 15). Two studies explored the impact of different client groups on staff responses. One study investigated the influences of MHNs processes of decision-making on care outcomes.

Country

The included studies were conducted across nine countries: UK (n = 5), Australia (n = 4), Ireland (n = 2), USA (n = 2), Australia & New Zealand (n = 1), China (n = 1), Israel (n = 1), Sweden (n = 1), and The Netherlands (n = 1).

Methodology

A large proportion of studies utilised qualitative methodology (n = 9), whilst other studies used quantitative (n = 6) and a small number used mixed methods (n = 3). The approaches utilised by the qualitative studies were semi-structured interviews (n = 6), in-depth interviews (n =1), unstructured interviews (n = 1), and written response to one question (n =1). The method of analysis of qualitative studies were IPA (n = 3), thematic analysis (n = 3), content analysis (n = 1), grounded theory (n = 1) and hermeneutic phenomenology (n =1). The approach used by all quantitative studies was questionnaire based, and designs included descriptive cross-sectional (n = 4) and experimental (n = 2). For the mixed methods studies, two utilised semi-structured interviews, one used focus groups, and all studies used questionnaires or scales. The method of analysis for mixed methods studies included thematic analysis and content analysis, and designs included longitudinal, descriptive cross-sectional and delphi-technique.

Settings

The mental health settings that participants were recruited from included a range of inpatient services, outpatient and community services, hospitals, institutions, centres and care units.

Sample Size and Participants

Sample sizes across all studies ranged from 4 to 706, and participant gender ranged from 33.3-100% female and 0-66.7% male, with some participants' gender not known or not identified. Four studies did not include demographic data on participant gender. The age of participants ranged from 20->50 years. Seven studies did not provide demographic data on participant age. Participant disciplines across the studies included a range of nurses, psychiatrists, psychologists, physicians, social workers, social counsellors, occupational therapists, support workers, physician assistants, registered MHS, and some were 'other' or 'unknown'. One study did not provide information on discipline. The number of years of participants' work experience varied across studies.

Table 3

Characteristics of included studies

Author(s), (Year) & (Country)	Aim(s)	Methodology, Design & Analysis	Measure(s), Scale(s), Tool(s)	Participants	Mental health setting (s)	Key relevant findings & themes		Quality assessment score
						Barriers	**Facilitators**	
Bergman and Eckerdal (2000) (Sweden)	To investigate caregivers' experiences of working with people who have a diagnosis of BPD	Qualitative In-depth interviews Grounded Theory	-	N = 29 caregivers (78% female, 22% male) Age: 30 – 62 years (M = 47 years) Discipline: 18 nurses, 5 physicians, 3 social counsellors, 3 psychologists Employment time: 0 – 25 years (M = 5.7 years, SD = 5.7 years)	Inpatient Outpatient	• Feelings of inadequacy, frustration and disappointment in caring for the client group • Limited knowledge and being unsure about decision making • Organisational pressures: large caseloads, time constraints and high levels of responsibility • Lack of a shared outlook within teams	• Having an interest in working with the client group and having hope of change helped professionals to stay motivated in caring for clients • Suggested the need for improved knowledge to promote a shared outlook between professionals • Emphasised the value of supervision for MHS in managing emotional reactions to clients • Participants expressed desire for psychology input to increase confidence in working with clients	5/5
Black et al. (2011) (USA)	To explore mental health clinicians' attitudes towards	Quantitative Descriptive Cross-sectional Self-report questionnaire	Self-report questionnaire (Shanks, Pfohl , Blum & Black, 2011)	N = 706 mental health clinicians (56.4% female, 41.4% male, 2.3% unknown) Discipline: 227 psychiatrists, 126	Nine academic centres	• Nurses were found to have the lowest caring attitudes (M = 4.46, SE = 0.08), empathy (M = 3.72, SE = 0.13) and optimism (M = 4.47, SE = 0.10) towards CDw/EUPD	• Found that MHS who had greater contact and experience with clients diagnosed with BPD self-rated greater positive attitudes (P<.001)	2/5

	people who have a diagnosis of BPD		15-items about attitudes rated on a 7-point Likert scale (1 = strongly agree to 7 = strongly disagree) Summary scales: (1) 4-item empathy; (2) 5-item optimism; (3) 14-item caring attitudes	psychiatry residents, 97 nurses, 89 psychologists, 17 nurse practitioners/physician assistants, 52 other Mean experience: 13.2 years				
Bodner, Cohen-Fridel and Iancu (2011) (Israel)	(1) To measure cognitive and emotional attitudes towards clients who have a diagnosis of BPD; (2) To compare attitudes between different disciplines	Quantitative Descriptive Cross-sectional Questionnaires	(1) Borderline patients-Cognitive Attitudes and Treatment Inventory (BCATI; Bodner et al., 2011) 47-items about cognitive attitudes comprising 3 elements of treatment, suicidality, and antagonism, rated on a 5-point Likert scale (1 = strongly disagree to 5 = strongly agree)	N = 57 clinicians (64.9% female, 35.1% male) Age: 25 – 65 years (M = 41.4 years) Exclusion criteria: < 25 years Disciplines: 25 nurses, 19 psychiatrists, 13 psychologists Experience: > 1 year	Public psychiatric institutions	• Nurses had significantly less empathy (M = 3.34, SD = 0.65) than psychiatrists (M = 3.71, SD = 0.38) and psychologists (M = 3.98, SD = 0.46) • 24.5% of the variance of clinicians' negative emotions towards the client group was explained by the risk of suicidality. • Lack of theoretical framework such as dialectical behaviour therapy (DBT)	• Found that psychologists scored significantly lower (M = 2.71, SD = 0.48) than psychiatrists (M = 3.30, SD = 0.33) and nurses (M = 3.47, SD = 0.39) on antagonistic views. • All three disciplines interested in learning about new therapy models in working with the client group	4/5

			(2) Borderline patients-Emotional Attitudes Inventory (B-EAI; Bodner et al., 2011) 20-items about emotional attitudes comprising 3 elements of negative emotions, difficulties with treatment, and empathy, rated on the same 5-point Likert scale					
Cleary, Siegfried and Walter (2002) (Australia)	(1) To conduct a baseline measurement of mental health clinicians' experience, knowledge and attitudes towards people who have a	Quantitative Descriptive Cross-sectional Questionnaire	Questionnaire (Cleary et al., 2002) 23-items comprising demographics, experience, training, objective knowledge with a binary response (agree or disagree), and subjective knowledge,	N = 229 clinicians (54% female, 46% male) Age group: 30 year or less = 55, 31–40 year = 61, 41–50 year = 73, >50 = 39 Disciplines: 141 registered nurses, 20 psychiatrists, 18 social workers, 15 psychologists, 15 psychiatry registrars, 11 enrolled nurses, 6	Inpatient Community	• Eighty percent found CDw/EUPD difficult to care for, and 84% of this group found this client group more difficult to care for than other client groups	-	3/5

	diagnosis of BPD; (2) To help inform staff training and education		confidence and difficulty treating clients diagnosed with BPD, rated on a 4-point scale	occupational therapists, 3 ‘other’ Experience: 5 years or less = 77, 6–10 years = 44, >10 years = 108				
Commons Treloar (2009) (Australia & New Zealand)	To investigate clinicians’ experiences and difficulties of working with clients diagnosed with BPD, and to explore the factors that may contribute to reported negative attitudes in the evidence base	Qualitative One question – open comments written response Thematic analysis	-	N = 140 clinicians (65.7% females, 34.3% males) Disciplines: 97 nurses, 24 allied health professionals including psychologists, social workers, and occupational therapists, 19 psychiatrists, psychiatric registrars or officers Experience: Inclusion criteria: contact with clients diagnosed with BPD over course of employment Setting: 64.3% (n = 90) of sample worked in mental health service Response rate: 73.57% (n = 103)	Three hospitals including: Emergency medicine Mental health services	• Feelings of anger, inadequacy, frustration, hopelessness and powerlessness • Negative responses and use of derogatory language • Lack of formal education about EUPD • Disagreements with colleagues about intervention options	• Frequent participant responses included wanting more specific training and education • More empathetic responses by some participants included having insight into underlying reasons for self-harm behaviour such as a way of communicating distress • Require a deeper understanding of characteristics of BPD • Emphasised need for regular clinical supervision for MHS in managing strong emotional reactions to clients	3/5
Day, Hunt, Cortis-Jones and	To compare two cohorts of mental health staffs’ attitudes	Mixed methods Semi-structured interview	(1) Demographic questionnaire (2) Items from Attitude to Personality	N = 66 (2000 sample: n = 33; 2015 sample: n = 33; both samples matched for gender	Health service: Inpatient	• Antagonistic views towards CDw/EUPD • Perceived intentionality and control over actions	• The 2015 cohort articulated greater understanding that behaviour was a way of coping with difficult circumstances and	10/14

Grenyer (2018) (Australia)	towards people with a diagnosis of BPD at a mental health service after a 15 year period	Questionnaires Longitudinal Content analysis	Disorder Questionnaire (APDQ; Bowers & Allen, 2006) 10-items of APDQ about attitudes towards people diagnosed with BPD (3) Items from Attitudes towards Deliberate Self-Harm Questionnaire (ADSHQ; McAllister, Creedy, Moyle, Farrugia, 2002) 25-items which assess attitudes towards self-harm, comprising of confidence, ability and management, empathy, and coping with protocols (4) Attitudes and Skills Questionnaire (ASQ; Krawitz, 2004)	66.7% female, 33.3% male) Mean age: 2000 sample = 37.64 years; 2015 sample = 46.21 years Discipline: MHNs Mean experience: 2000 sample = 11.04 years; 2015 sample = 17.14 years Inclusion criteria: must have had contact with three clients with a diagnosis of BPD over past 12 months) Level of education: 2000 sample had more undergraduate qualifications (n = 23) whilst 2015 sample had more postgraduate qualifications (n = 17)	Outpatient	• Limited skills and unsure about decision making	made links with client history and trauma • Higher scores on elements of the ASQ including knowledge and skills was significantly related to positive attitudes on the APDQ (rs = 0.47, p = 0.006, N = 33) • The 2015 cohort expressed interest in additional training and education on BPD

			6-items evaluating professionals' ability and desire to work with clients who have a diagnosis of BPD, covering "willingness", "optimism", "enthusiasm", "confidence", knowledge and skills (Higher scores = more positive attitude, on measures 2, 3 & 4)					
Deans and Meocevic (2006) (Australia)	To explore the attitudes of psychiatric nurses towards people diagnosed with BPD	Quantitative Descriptive Cross-sectional Questionnaire	Questionnaire (Little, 1999) 50-items about clinical description, emotional responses, concerns and management from their perspective of working with people diagnosed with BPD, rated on a 5-point Likert scale (1 =	N = 47 (72.3% females, 29.8% males) Age: 21-30 (21%), 31-40 (36%), 41-50 (23.5%), 51-60 (19.5%) Discipline: Psychiatric nurses Experience: 53% had > 15 years Settings: 53% (n = 25) of sample worked in inpatient and 47% (n = 22) worked in community	Inpatient Community	• Eighty-nine percent of nurses viewed CDw/EUPD as manipulative • Thirty-two percent of nurses reported that CDw/EUPD made them "angry" (p. 46) • Forty-four percent agreed they understood how to provide care to the client group	-	4/5

			strong agree to 5 = strongly disagree)					
Forsyth (2007) (UK)	(1) To identify any differences in MHS cognitive processes for clients diagnosed with BPD or major depressive disorder (MDD) (2) To investigate whether such processes impact clinicians' responses and helping behaviours	Quantitative 2 × 2 × 2 factorial within-subjects design Vignettes with three IVs: (1) diagnosis, (2) stability, (3) controllability Experimental	Items from empathy scale (Burns & Nolen-Hoeksema, 1992) 15-items with 3 DVs: (1) empathy, (2) anger and (3) helping behaviours towards the label BPD, rated on a 4-point Likert scale	N = 26 Mean age: 38.9 years Disciplines: 14 registered mental health staff, 9 support workers, 3 'unknown' Mean experience: 7.7 years	One NHS Trust: Four inpatient units One psychiatric intensive care unit	• Greater anger when the causes of client non-engagement with tasks were more stable and controllable • Staff were also less likely to offer help to, and had lower empathy for, CDw/EUPD as opposed to MDD. This was found to be non-significant, however a main effect was found for helping behaviours	-	4/5
Hughes, Bass, Bradley and Hirst-Winthrop (2017)	To explore clinicians' experiences of working with people with a	Qualitative Unstructured interviews Interpretative Phenomenolog	-	N = 4 clinicians Discipline: Unknown Experience: Inclusion criteria: (1) professional	One NHS Trust: Two community	• 'Splitting' behaviours of CDw/EUPD • Feelings of frustration and hopelessness due to lack of client progress	• All participants reinforced the significance of having a meaningful connection with clients which helps build warmth in the therapeutic relationship	4/5

(UK)	diagnosis of BPD, with a focus on high risk of suicide and self-harm	ical Analysis (IPA)		qualification; (2) work within the NHS trust	mental health teams	• Organisational pressures: high caseloads, time constraints, high levels of responsibility and documentation within set timeframes • Lack of clinical supervision	• All participants valued working as part of a multidisciplinary team with good communication, team support, shared responsibility and better decision-making, which helped MHS feel supported and less anxious • Clinical supervision was identified as being important for the MHS	
Koekkoek, van Meijel, Schene and Hutschemaekers (2009) (The Netherlands)	(1) To identify the difficulties that professionals experience in working with clients who have a diagnosis of severe BPD (2) To identify which problem are most urgent (3) To identify which problems are most changeable	Mixed methods Focus groups Questionnaire Four-phase Delphi technique	Questionnaire: List of problems derived from focus group (Koekkoek et al., 2009) Round 3 of Delphi procedure, 36 problems, rated for ‘urgency’ and ‘changeability’ on a 7-point Likert scale and comments were analysed. Round 4, same list, previous comments provided, re-evaluate initial scores	N = 8 professionals (50% female, 50% male) Age: 40-49 (n = 6), 50-59 (n = 2) Disciplines: 4 MHNs, 2 psychiatrists, 2 psychologists Experience: Inclusion criteria: (1) at least 3 years working with BPD; (2) under employment of a nationally recognised centre or is a nationally recognised professional	Community mental health	• Clients’ lack of progress and treatment success • Inadequate skills • Lack of organisational support • Absence of a shared outlook created conflict within team about treatment plan • Lack of opportunity for reflection and discussion	-	9/14

Ma, Shih, Hsiao, Shih and Hayter (2009) (China: Taiwan)	To discover the influences and effects of MHNs processes of decision-making on caring outcomes for clients with a diagnosis of BPD	Qualitative Semi-structured interview Content analysis	-	N = 15 (15 females) Mean age = 31.53 years Discipline: MHNs Mean experience = 5.71 years Inclusion criteria: (1) worked in mental health field for minimum of three years; (2) have provided nursing care for clients with a diagnosis of BPD within the past 12 months Settings: 46.7% (n = 8) of sample worked in acute unit and 53.3% (n = 7) worked in rehabilitation unit	Psychiatric health centre: Acute unit Rehabilitation unit	• Personal responses such as feeling “hurt”, “angry” and “hated” the client (p. 444). • Feelings of hopelessness and powerlessness • Perception that CDw/EUPD are a poor use of resources • Upholding boundaries • Organisational pressures: additional demands and responsibilities • Lack of support from team about treatment options	• Having hope and realistic expectations about clients’ outcomes influenced nurses’ approach to clients and increased their positivity and willingness to work with difficulties • Forty percent of participants reported that positive outcomes for clients was determined by team members providing emotional support to each other and developing collaborative care plans. Remaining 60% of participants described they lacked team support • Less experienced nurses reported benefitting from informal peer supervision from more experienced nurses, and felt able to be open about emotional reactions which helped them to better understand and care for clients	5/5
Markham and Trower (2003) (UK)	To explore how different labels impacts upon staff’s causal attributions about	Quantitative Questionnaire Within-subjects design IV = diagnosis Experimental	Attribution Questionnaire (Markham & Trower, 2003, based on Dagnan, Trower & Smith, 1998 and Peterson et al.,1982)	N = 48 (68.8% females, 25% males, 6.25% unknown) Mean age: 38 years Discipline: MHNs Mean experience: 12.7 years	One NHS Trust: Adult inpatient services	• Staff judged CDw/EUPD to be more in control of the cause of behaviour than those diagnosed with depression (t(47) = 77.10, p < .001) or schizophrenia (t(47) = 79.36, p < .001) • Staff judged CDw/EUPD to be more in control of the event	-	4/5

	clients' behaviour, comparing BPD, depression and schizophrenia		Six scenarios about behaviours that challenge. Response involved identifying the likely cause of behaviour, and then providing ratings for DVs = (1) Attributions (internality, stability, globality and controllability), (2) sympathy, (3) optimism and (4) experience, on 7-point Likert scales		Older adult inpatient services	than those diagnosed with depression (t(47) = 76.94, p < .001) or schizophrenia (t(47) = 79.57, p < .001) • Staff reported greater negative experiences (M = 4.6, SD = 1.2), lower sympathy (M = 21.9, SD = 5.8) and optimism (M = 18.3, SD = 5.3) in working with the EUPD client group compared to other client groups		
McGrath and Dowling (2012) (Ireland)	(1) To discover key themes in nurses' interactions with clients diagnosed with BPD; (2) To explore nurses' empathy towards clients	Mixed methods Questionnaire Semi-structured interview Thematic analysis Cross-sectional Descriptive	Staff Patient Interaction Response Scale (SPIRS; Gallop, Lancee & Garfinkel 1989) Presented with hypothetical client descriptions and statements. Participants provide written accounts in response to each	N = 17 (70.6% females, 29.4% males) Discipline: MHNs Mean experience: 15 years. Higher qualification (n = 11), masters (n = 1), training on BPD (n = 1) Inclusion criteria: (1) psychiatric nurse with minimum of 3 years of experience; (2) worked in mental health for at least 2 years; (3)	Community	• 'Challenging' to care for and perception of exaggerated feelings and behaviours in CDw/EUPD • Negative personal responses and use of derogatory language • Feelings of "mistrust", and being "drawn in" by CDw/EUPD (p. 6) • Upholding boundaries	• Only one participant's answers expressed care and empathy at level 3, and acknowledged the impact of a history of abuse	7/14

	diagnosed with BPD		client. Responses are evaluated for empathy and scored on a scale of 10 categories. The categories represent increasing empathy over 3 levels (1) no care, (2) providing solutions, (3) expressing care	worked with target client group Frequency of contact with clients diagnosed with BPD: daily contact (n = 10), 2-3 times per week (n = 4), > 5 times per month (n = 3) Settings: community residential unit (n = 11) and community service (n = 6)				
Nehls (2000) (USA)	To explore the experiences of case managers who provide care for clients with a BPD diagnosis	Qualitative Semi-structured interview IPA	-	N = 17 Discipline: Unknown Inclusion criteria: (1) case manager; (2) 6 months experience working with a client diagnosed with BPD	Community mental health centre: Rehabilitation Counselling Crisis service	• Upholding boundaries led to feelings of indifference and disconnection and were consequently detrimental to building a relationship with the client	• Feeling ‘connected’ to clients can facilitate motivation and compassion	4/5
O'Brien and Flöete (1997) (Australia)	To explore nurses’ experiences of working with “Mary Ann”, a client diagnosed of BPD	Qualitative Semi-structured interview Hermeneutic phenomenology	-	N = 6 Discipline: Nurses Inclusion criteria: (1) worked in inpatient unit; (2) involved in caring for “Mary-Ann”; (3) minimum of 12 months experience in field	Inpatient unit	• Feelings of hopelessness and powerlessness • Negative personal responses and feeling “manipulated” (p. 141) • Feelings of distrust • Nurses lacked confidence and questioned the value of their interventions	• Found that having a bond with clients aids compassion • MHS displayed feelings of compassion and demonstrated putting themselves in clients’ shoes and made links to difficult past experiences	5/5

	presenting with severe self-harm behaviours					• Disagreement between colleagues about treatment options • No safe space to discuss feelings • Feeling critical and angry towards CDw/EUPD regarding high-risk behaviour • Having boundaries and keeping distance from clients		
O’Connell and Dowling (2013) (Ireland)	To investigate community nurses’ experiences who work with clients diagnosed with BPD	Qualitative Semi-structured interview Thematic analysis	-	N = 10 (90% female, 10% male) Discipline: Psychiatric nurses Inclusion criteria: Minimum 6 months experience working in community team and have worked with clients diagnosed with BPD Experience: range = 3-15 years, BPD education (n = 2)	Community	• ‘Splitting’ behaviours of CDw/EUPD • Feelings of hopelessness and frustration due to lack of client progress • Lack of formal EUPD education • Lack of clinical supervision	• Observing clients make progress, though “slow”, helped to foster hope and optimism in professionals (p. 29) • Participants reported that specific skills supported by a framework were essential in working successfully with the client group • Highlighted that nurses should expand their understanding that current difficulties can be linked to history of abuse	2/5
Stroud and Parsons (2013) (UK)	To understand community psychiatric nurses (CPNs) views on the label “BPD” and to	Qualitative Semi-structured interview IPA	-	N = 4 (75% female, 25% male) Age range: 30-39 (n = 1), 40-49 (n = 2), 50-59 (n =1) Discipline: CPN Experience: years worked in mental health (range: 1-30),	CMHT	• CPNs who had not received specific training in EUPD had limited knowledge and no framework to work with, and these participants used more pejorative language • ‘Splitting’ behaviours of CDw/EUPD	• Feeling “connected” to clients helped professionals to view them “as a person” and hence interact in a more “human” and compassionate manner (p. 248) • Greater knowledge and DBT framework led to greater understanding and empathy	5/5

	explore how this influences their approach towards clients with this label			years worked with client group (range: 1-10) Frequency of contact with clients diagnosed with BPD: daily (n = 3), 1-2 times per week (n = 1) Inclusion criteria: (1) CPN; (2) worked in community mental health team (CMHT); (3) direct work with target client group Exclusion criteria: (1) Non-clinical role; (2) no direct work		• Feeling ‘indifferent’ and ‘disconnected’ • Absence of a formal supervision structure • Limited skills and being unsure about decision making • Perception that CDw/EUPD are a poor use of resources • Organisational pressures: large caseloads and documentation • Lack of organisational support	• Expressed desire for psychology input to increase confidence in working with clients • Regular supervision was seen as essential in working with the client group to discuss feelings and treatment options for clients	
Woollaston and Hixenbaugh (2008) (UK)	To explore relationships and interactions with clients diagnosed with BPD from the nurses’ viewpoint	Qualitative Semi-structured interview Thematic analysis	-	N = 6 (33.3% female, 66.7% male) Disciplines: Nurses Age range: 20-40 Experience: 2-17 years working at service Setting: worked in inpatient (n = 4), community (n = 1), supported tenancy scheme (n = 1)	Inpatient Community	• Participants viewed CDw/EUPD as “dangerous” and “unrelenting” (p. 705) • Feeling “sucked” in (p. 705) • Feelings of hopelessness and frustration • ‘Splitting’ behaviours of CDw/EUPD • Feelings of being ‘manipulated’ and ‘used’ • Nurses disliked that responsibility lay with them for the ‘controllable’ behaviour of CDw/EUPD • Use of time and resources	• Reported that seeing some improvement increased hope and optimism	4/5

M = Mean; SD= Standard deviation; SE = Standard error; t = t test

Quality of included studies

The quality of qualitative studies was judged to be generally good, with the exception of one study which received an overall score of 2/5. All studies used an appropriate approach to answer the proposed research question. Most studies used adequate methods of data collection, though one study did not provide information about how interviews were recorded or transcribed, and another study asked participants only one open question. One study provided a limited description of data analysis procedures. Most studies provided sufficient quotes from participants to justify the presented themes. However, two studies lacked clarity in their themes, and the design of one study resulted in a large proportion of participants providing very limited responses to the question which will have likely affected the interpretation of results. The majority of studies demonstrated coherence between data collection, analysis and interpretation of findings, though one study lacked sufficient information about methods of data collection and analysis which affected the ability to accurately judge this criterion.

The quality of quantitative studies was variable and no study met the full criteria. In terms of descriptive studies, the sampling strategies appeared to be relevant to the research question and target population. Samples were assessed as being representative of the target population for three out of four studies, with one study failing to outline inclusion and exclusion criteria, and had a mean response rate of 48% with no explanation about why non-responders chose not to participate. Three studies did not meet the criteria for appropriate measures due to not providing information about reliability and validity, and not being previously tested prior to data collection. Three studies had a response rate of below 50% yet did not describe reasons for non-response therefore there may be increased risk of non-response bias. The statistical analyses used by all studies were deemed to be appropriate to the study and research aims. In terms of the two experimental studies, one study appeared to have a representative sample, whilst it was difficult to judge the representativeness of the other study as inclusion and exclusion criteria were not outlined. Both studies utilised well-defined, appropriate measures and utilised a within-subjects design, though the findings of one study may have been influenced by a confounder resulting in potential selection bias (Forsyth, 2007).

In terms of mixed methods studies, no study met the full criteria. The rationale for using mixed methods methodology was not clearly justified across the studies. All studies appeared to integrate the qualitative and quantitative components to address the research aims. It was difficult to assess whether studies met the criterion of explaining any divergences between the results as this did not appear to be explicit in the studies.

Synthesis of findings

1. Barriers

1.1 Internal threat: clinicians' personal responses and views

A barrier to compassion and a key internal threat were clinicians' personal responses towards CDw/EUPD, and this was evident across the vast majority of studies. Studies with nurses found antagonistic (Day et al. 2018), negative and angry (Deans & Meocevic, 2006) views towards CDw/EUPD. Such responses reduced empathy and acted as a barrier to compassion. Similarly, negative responses have been found in nurses through feelings of being 'manipulated' and 'used' (O'Brien & Flöete, 1997; Woollaston & Hixenbaugh, 2008). Supporting these findings, 'splitting' behaviours of CDw/EUPD was found to be another challenge for MHS who reported feeling stressed and tested (Hughes et al. 2017; O'Connell & Dowling, 2013; Stroud & Parsons, 2013; Woollaston & Hixenbaugh). McGrath and Dowling (2012) confirmed these findings when reporting nurses' views of exaggerated feelings and behaviours in CDw/EUPD as ‘challenging’ making it difficult to care for them leading to an avoidance of interactions. Evidence of negative responses was also found in this study through the use of derogatory language. This was also found by Commons Treloar (2009) across a range of disciplines, although 30% of participants provided very limited responses.

Cleary et al. (2002) found that 80% of clinicians found CDw/EUPD difficult to care for, and 84% of this group found caring for this client group more difficult than other client groups. It is important to note that whilst the sample appeared to be representative, the questionnaire utilised was developed for the purpose of the study and thus validity and reliability were not addressed.

Ma et al. (2009) described nurses feeling negative when CDw/EUPD were in the “chaos stage” referring to distressing behaviours (p. 443). One participant described feeling “hurt and angry”, and “hated” the client and indicated that this made it difficult to care for her in a compassionate manner (p. 444). O'Brien and Flöete (1997) found that nurses experienced feeling critical towards CDw/EUPD, and moved between compassion and anger about client high-risk behaviour.

Several studies described clinicians experiencing feelings of hopelessness and powerlessness when caring for CDw/EUPD that could lead to reduced compassionate care (Koekkoek et al., 2009; Ma et al., 2009; O'Brien & Flöete, 1997; O’Connell & Dowling, 2013; Woollaston & Hixenbaugh, 2008). Furthermore, clients’ lack of progress and treatment success can cause professionals to feel hopeless, “powerless” and “demoralised”, leading to blame, anger and aggression towards the client (Koekkoek et al., p. 513). Similar negative responses were found across a range of studies in terms of CDw/EUPD being seen as a poor use of resources (Ma et al.; Stroud & Parsons, 2013; Woollaston & Hixenbaugh) and leading to feelings of inadequacy, frustration and disappointment in caring (Bergman & Eckerdal, 2000; Commons Treloar, 2009; Day et al., 2018; Hughes et al., 2017). These findings indicate clinicians' internal responses affected their ability to have compassion for CDw/EUPD and care for them.

Some studies reported on clinicians' feelings of mistrust, and being 'drawn in' by CDw/EUPD (McGrath & Dowling, 2012; O'Brien & Flöete, 1997; Woollaston & Hixenbaugh, 2008). Clinicians reported upholding boundaries and acting 'defensive' and 'guarded' to prevent becoming too 'involved' (Ma et al., 2009; McGrath & Dowling, 2012; Nehls, 2000; O'Brien & Flöete). Whilst boundaries are important, they can also result in clinicians feeling 'indifferent' and 'disconnected' and are consequently detrimental to building a relationship with the client and providing compassionate care (Nehls; O'Brien & Flöete; Stroud & Parsons, 2013).

1.2 Client threat: risk and perception of behaviour

Client risk and its impact on clinicians was found to be an inhibitor of compassion and was reported by many studies that used all types of methodology.

Some studies directly reported the difficulties for MHS working with client suicidality and self-harm. Bodner et al. (2011) found that 24.5% of the variance of clinicians' negative emotions towards the client group was explained by the risk of suicidality. Negative responses were also demonstrated by qualitative research. Woollaston and Hixenbaugh (2008) found that participants viewed CDw/EUPD as "dangerous" and "unrelenting" (p. 705). Linked to this, participants described being distressed by traumatic incidents involving CDw/EUPD, which clinicians found distressing and consequently left them feeling "angry" and "threatened" (p. 707).

Four studies reported findings about controllability, stability and intentionality of client behaviour. Two experimental studies, Forsyth (2007) and Markham and Trower (2003), explored impact of different client groups on staff responses and showed similar results. Forsyth found that staff displayed greater anger when the causes of client non-engagement with tasks were more stable and controllable. Staff were also less likely to offer help to, and had lower empathy for, CDw/EUPD as opposed to MDD. The findings were non-significant for anger and empathy, however a main effect was found for helping behaviours. In Markham and Trower's study, staff judged CDw/EUPD to be more in control of their behaviour than those diagnosed with depression or schizophrenia. Consistent with the findings of Forsyth, greater negative experiences and lower sympathy and optimism were reported by staff in working with the EUPD client group. Day et al. (2018) conducted a study to compare two cohorts of mental health nurses' attitudes towards CDw/EUPD at a mental health service after a fifteen-year period. It was found that the 2000 cohort held more negative attitudes and attributed greater intentionality and control of actions of the client group than the 2015 cohort. In Woollaston and Hixenbaugh's (2008) research it was found that nurses disliked that responsibility lay with them for the 'controllable' behaviour of CDw/EUPD, such as overdoses and suicide attempts. Therefore, the evidence indicates that there is some interaction between client behaviour and professionals' perception of clients' control over their behaviour, which in turn affects the level of empathy, optimism and willingness to help from MHS.

1.3 Lack of framework, knowledge and skills

Another identified barrier to compassion for clinicians was a lack of a conceptual framework, knowledge and skills and this was found in ten studies.

Methods of working vary in different professions, therefore the lack of a theoretical framework in some professions when working with CDw/EUPD has been shown to affect compassion. Black et al. (2011) found that discipline was significantly related to attitude, and accordingly, nurses were found to have the lowest caring attitudes, empathy and optimism towards CDw/EUPD. Bodner et al. (2011) similarly found that nurses had significantly less empathy than the psychiatrists and psychologists. Both Black et al. and Bodner et al. reflected that this finding may likely be due to nurses being on the frontline and working with clients in a state of severe distress.

Similarly, other research suggests that a lack of knowledge and framework for understanding behaviour mediate compassion. For example, Stroud and Parsons (2013) found that CPNs who had not received specific training in EUPD had limited knowledge and no framework to work with, and these participants tended to use more pejorative language when describing client behaviour. Correspondingly, O’Connell and Dowling (2013), Commons Treloar (2009) and Bodner et al. (2011) showed that a large proportion of various disciplines lacked formal education or theoretical framework for working with EUPD. Limited skills and being unsure about decision making was found to be a common challenge for many clinicians (Bergman & Eckerdal, 2000; Day et al., 2018; Koekkoek et al., 2009; Stroud & Parsons). These lack of skills and experience may also contribute to the feelings of inadequacy, hopelessness and powerlessness described earlier. In line with this, O'Brien and Flöete (1997) found that nurses lacked confidence and questioned the value of their interventions and similarly, Deans and Meocevic (2006) found that less than half the participants agreed that they understood how to provide care to the client group. The evidence suggests that a lack of framework and limited skills, knowledge and experience are barriers to providing compassionate care for this client group.

1.4 External threat: organisational and wider issues

The final identified barriers to compassion were organisational and service-related, and nine studies offered insight into this.

A number of qualitative studies found that clinicians experienced pressures of high caseloads, time constraints and high levels of responsibility (Bergman & Eckerdal, 2000; Hughes et al., 2017; Ma et al., 2009; Stroud & Parsons, 2013). Hughes et al. reported that organisational pressures, such as being required to complete clinical documentation within a set time-frame, contributed to clinician burnout. Furthermore, Stroud and Parsons and Koekkoek et al. (2009) reported that there was a lack of organisational support and the former considered the impact upon professionals' approach to CDw/EUPD. Several studies reported that there was conflict within teams and disagreement between colleagues about intervention options (Bergman and Eckerdal; Commons Treloar, 2009; Koekkoek et al.; Ma et al.; O'Brien and Flöete, 1997). The research indicates that organisational issues and additional demands may inhibit clinicians' ability to compassionately care for CDw/EUPD, who as a client group may require a high level of time and support (Woollaston & Hixenbaugh, 2008).

Five studies reported that the lack of clinical supervision and opportunities for reflection can be a barrier for clinicians having a positive outlook when working with this client group (O'Brien & Flöete, 1997; O'Connell & Dowling, 2013; Hughes et al., 2017; Koekkoek et al., 2009; Stroud & Parsons, 2013). Stroud and Parsons demonstrated that whilst some participants reported having informal conversations with co-workers, the absence of a formal supervision structure led to frustration in working with CDw/EUPD, which could be linked to the hopelessness described earlier.

2. Facilitators

2.1 Connecting with clients and having hope

One facilitator of compassion for MHS was connecting with CDw/EUPD and having hope. Eight studies reported findings on this.

Five qualitative studies demonstrated a relationship between connecting with CDw/EUPD and compassion. Stroud and Parsons (2013) reported that feeling "connected" to clients helped professionals to view them "as a person" and hence interact in a more "human" and compassionate manner (p. 248). In the same way, both Hughes et al. (2017) and O'Brien and Flöete (1997) found that participants reinforced that having a meaningful connection with CDw/EUPD helped build warmth in the therapeutic relationship. O'Brien and Flöete highlighted that a downside is that this can often create conflict with colleagues who view CDw/EUPD more unfavourably. Nehls (2000) and Bergman and Eckerdal (2000) both reported findings about MHS motivation, though in different ways. As discussed in the barriers earlier, Nehls reflected on the costs of having boundaries. The author emphasised the importance of feeling "connected" to CDw/EUPD as this can facilitate motivation and compassion (p. 16). Bergman and Eckerdal found that it was important for MHS to have an interest in working with the client group as this helped professionals to stay motivated in caring for them. The research indicates that having an interest, connecting with clients and seeing them as 'human' facilitates compassion in MHS.

Four qualitative studies reported findings about holding onto hope, having realistic expectations about outcomes, and observing clients make progress, however 'slow', helped to foster hope, optimism and positively influenced caring approaches (Bergman & Eckerdal, 2000; Ma et al., 2009; O'Connell & Dowling, 2013; Woollaston & Hixenbaugh, 2008).

2.2 Having a framework, experience, knowledge and skills

Ten studies considered the value of understanding client history, having a conceptual framework, experience, knowledge and skills.

Several studies reinforced the importance of putting themselves in clients' shoes, having insight into history and trauma and this appeared to be a key facilitator for compassion (Commons Treloar, 2009; Day et al., 2018; McGrath & Dowling, 2012; O'Brien & Flöete, 1997; O'Connell & Dowling, 2013; Stroud & Parsons, 2013). For example in contrast to CPNs who did not have a DBT framework, Stroud and Parsons found that those who did, demonstrated a greater understanding about childhood experiences, emotion dysregulation and coping behaviours and used more empathetic language. Commons Treloar and Day et al. found that some participants communicated empathetic responses and viewed self-harm behaviour as a way of coping with difficult circumstances. In further support of a framework, Bodner et al. (2011) found that psychologists scored significantly lower than psychiatrists and nurses on antagonistic views. Bodner et al. reflected that the psychology discipline may have a higher level of understanding and empathy.

Studies have shown that greater contact, experience, knowledge and skills can help improve attitudes and is essential in working successfully with the client group, and therefore facilitates compassion (Black et al., 2011; O'Connell & Dowling, 2013; Stroud & Parsons, 2013). In contrast, Woollaston and Hixenbaugh (2008) reported that nurses with greater years of experience felt more negative about the client group. Bergman and Eckerdal (2000) and Commons Treloar (2009) suggested the need for improved knowledge and training to gain a deeper understanding of the characteristics of EUPD and to promote a shared outlook between professionals. Participants in some studies expressed an interest in learning about new models or undertaking additional training and education on EUPD (Bodner et al., 2011; Commons Treloar; Day et al., 2018). Supporting this finding, participants reflected on their lack of skills and expressed a desire for psychology input to help increase their confidence in working with CDw/EUPD (Bergman & Eckerdal; Stroud & Parsons). As previously discussed, training and education may enable greater understanding and empathy towards CDw/EUPD and therefore may aid compassion.

2.3 Organisational support

The final facilitator of compassion was organisational support. Five qualitative studies addressed this facilitator.

It was highlighted previously that the absence of a formal supervision structure was frustrating for participants in working with the EUPD client group and contributed to feelings of hopelessness (Stroud & Parsons, 2013). All five studies identified the need and value of clinical supervision in managing emotional reactions to CDw/EUPD and discussing possible treatment avenues (Bergman & Eckerdal, 2000; Commons Treloar, 2009; Hughes et al., 2017; Ma et al., 2009; Stroud & Parsons). Ma et al. found that nurses found informal peer supervision helpful from more experienced nurses, and participants felt able to be open and reflect on their negative emotions about CDw/EUPD which helped them to better understand and care for their clients.

Two studies reported findings about the value of multidisciplinary team-working (Hughes et al., 2017; Ma et al., 2009). Hughes et al. found that all participants valued being part of an MDT, with good communication, shared responsibility and better decision-making, which helped MHS to feel supported and less anxious. Ma et al. found that 40% of participants reported that positive outcomes for CDw/EUPD was determined by team members providing emotional support and developing collaborative care plans.

Therefore the research suggests that organisational support in the form of regular clinical supervision and team support can help clinicians to work out difficult responses to CDw/EUPD and be more compassionate in their approach.

Discussion

Overview of findings

This review aimed to explore the barriers and facilitators for MHS having compassion for CDw/EUPD. In this review, 55.6% of studies were published in the last ten years indicating that the findings of the review may have highlighted key issues to address in the current context of adult mental health. The identified facilitators of compassion were found to be *(1) connecting with clients and having hope; (2) having a framework, experience, knowledge and skills;* and *(3) organisational support*. The identified barriers were *(1) clinicians' personal responses and views; (2) client risk and behaviour; (3) lack of framework, knowledge and skills;* and *(4) organisational issues.*

Theoretical links

From a compassion-focused perspective linking to the three emotion regulation systems (Gilbert, 2009), this review found perceived threats such as client risk, 'splitting' behaviours, and feeling 'drawn in' may trigger clinicians' threat systems. Clinicians may feel unsafe resulting in negative feelings towards clients such as anger and anxiety. In an attempt to feel safe and protect themselves, the threat system alerts clinicians to take action by upholding boundaries or being avoidant. The unintended consequence of this is the negative impact upon the therapeutic relationship as clinicians feel disconnected from clients impeding upon their ability to provide compassionate care.

Perhaps the motivation of the organisation needs to change before change can occur at the staff level. Organisational issues such as high levels of responsibilities and time-constraints can be linked to Gilbert’s (2009) drive system. Evidence suggests clinicians are constantly ‘striving’ to achieve and are under pressure to meet goals and targets. Whilst ‘drive’ can be positive and is important for motivation, if goals are not being achieved, such as lack of client progress or feeling under-skilled and inadequate, this can activate the threat system, leading to frustration, hopelessness and anger. The lack of clinical supervision and space for reflection may also cause clinicians to feel unsafe and uncontained, and suggests a need to engage their soothing, affiliative system (Gilbert, 2009).

Clinical implications

The results of the review indicate that when MHS perceived greater threat, they were less compassionate in their caring approach. An important reflection is that the facilitators of compassion were found to be the reverse of the identified barriers. This suggests that in order to facilitate compassion, there is a need for the cycle to be broken to reduce the barriers and prevent the discussed threats from continuing in the long-term. This can be achieved through the implementation of the identified facilitators which will in turn lead to more compassionate care.

The review found *lack of framework, knowledge and skills* to be barriers in providing compassionate care. This implies that if the application of conceptual frameworks, greater training and education for clinicians are not implemented, there is risk of perpetuating the pejorative discourse and lack of understanding about CDw/EUPD. This can be harmful for clients in terms of the quality of care they receive, as well as feeding into clinicians’ feelings of inadequacy and uncertainty about decision making (Bergman & Eckerdal, 2000; Day et al., 2018; Koekkoek et al., 2009; Stroud & Parsons). The review found *organisational issues* to be another barrier for MHS, therefore this suggests a need to improve organisational support such as through reviewing caseload size, levels of responsibility and opportunities for supervision. The impact of not doing so can cause clinician burnout (Hughes et al., 2017) and can contribute to hopelessness and pessimistic views about CDw/EUPD (O'Brien & Flöete, 1997; O'Connell & Dowling, 2013; Hughes et al.; Koekkoek et al.; Stroud & Parsons, 2013). The implications suggest that change at an organisational level, rather than at an individual level, may need to occur first in order to see a positive impact permeate throughout its workforce.

Relation to other reviews

A strength of the current review is that it captured the perspectives of different disciplines who care for the EUPD client group which was highlighted as an area for future research by Day et al. (2018), whereas previous reviews investigated MHNs only (Dickens et al., 2016; Loader, 2017; Westwood & Baker, 2010). Furthermore, the current review identified the challenges and enablers for MHS having compassion for people with this diagnosis. Consistent with Dickens et al., the current review found clinicians' attitudes to be a key problem and highlighted the need for frameworks, education and clinical supervision.

Appraisal of quality

The method of data collection used by Commons Treloar (2009) meant that over 30% of participants provided very limited responses. This suggests that the depth of captured data may have been compromised. Furthermore, O'Connell and Dowling (2013) did not provide sufficient information about methods of data collection and data analysis, minimising reliability and replicability. This may reduce the overall reliability of the findings of the review. Black et al. (2011) provided no participant inclusion and exclusion criteria making it difficult to assess representativeness of the sample. Furthermore, the authors reflected that the clinicians were from academic centres, which are not representative of other settings where CDw/EUPD are cared for. Some studies had a response rate of below 55% (Black et al.; Bodner et al, 2011; Cleary et al, 2002; McGrath & Dowling, 2012) therefore there may be increased risk of non-response bias, potentially skewing the results of the review. Studies which did not use pre-tested measures indicate reliability and validity are uncertain (Black et al.; Cleary et al.; Deans & Meocevic, 2006). Forsyth (2007) reported that there may have been potential selection bias in their study as participants may have compared ratings with each other, compromising the results. Day et al.'s (2018) sample did not appear to be representative and participants across the two cohorts were only matched by age. Due to the Delphi procedure employed by Koekkoek et al. (2009), ratings on a 7-point Likert scale were used rather than standardised measures. There was potential for social desirability bias in several studies due to the use of self-report measures which may affect the validity of the review.

Limitations and future research

A limitation of the review is the heterogeneity of the studies as they utilised a range of methods and measures varying in validity and reliability which made comparison of findings difficult. Nevertheless, the review identified key barriers and facilitators of compassion leading to clinical and practical implications and areas for future research.

Due to the nature of studies found, no study directly investigated compassion for the client group which may be considered a limitation of the review. Assumptions were made by the researcher that the studies were compassion-related based upon the six markers of compassion by Gilbert (2009). Therefore future research could aim to directly measure and explore MHS compassion for the EUPD client group which may help to bridge the gap in the field. Furthermore, theoretical links between the emotion regulation systems and perceived threats have been made in this review, though it may be useful to test these hypotheses further by investigating what engages clinicians’ threat system. Increasing the understanding about the triggers and threats may help to identify further solutions and mediators of compassion.

Conclusions

There are key barriers for clinicians which impact upon their ability to provide compassionate care. Reducing the barriers and implementing the facilitators by the means suggested may promote feelings of staff safeness and improve personal responses and care provision for CDw/EUPD. The findings highlighted that in order to aid compassion, perhaps change needs to occur first at an organisational level, before change can occur at the clinician level. Further research into MHS compassion for the EUPD client group is required.

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Part Two: Empirical Paper

The Experiences of Relationships with Mental Health Staff of Those Who Have a Diagnosis of Emotionally Unstable Personality Disorder

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This paper is written in the format ready for submission to the

Journal of Clinical Psychology

Please see Appendix A for the Author Guidelines

Word count: 6893 (excluding abstract, tables, figures, references and appendices)

Abstract

Objectives: Previous research has shown that clients diagnosed with EUPD (CDw/EUPD) report high levels of shame. The current study aimed to give voice to CDw/EUPD through exploring their relationships with mental health staff (MHS). The study also aimed to understand the process of shame, investigate repeated patterns in interactions, and explore helpful and unhelpful experiences.

Method: Semi-structured interviews were conducted with eight participants. A Thematic Analysis approach to data analysis was taken.

Results: Three overarching themes were identified: (1) *Judgements and Presumptions*; (2) *Humanness and Personhood*; and (3) *Feeling Safe.*

Conclusions: This study provided insight into the process of shame and demonstrated the potential for repeating unhelpful patterns. The findings suggest a need for a more ‘human’ system. It was proposed that *Judgements and Presumptions* can be overcome through *Humanness and Personhood* and safeness and understanding from MHS. Future research which explores dehumanisation of the system is required.

Keywords: emotionally unstable personality disorder, borderline personality disorder, mental health staff, relationships, shame, thematic analysis

Introduction

Borderline Personality Disorder (BPD) is characterised by difficulties with emotion regulation, abandonment, interpersonal relationships, impulsivity and sense of self (Diagnostic and Statistical Manual of Mental Disorders; American Psychiatric Association, 2013). BPD is also known as Emotionally Unstable Personality Disorder (EUPD) (International Classification of Diseases 10th Revision [ICD-10]; World Health Organisation [WHO], 2016). EUPD and BPD are used interchangeably, though the ICD-10 (WHO) is used in the United Kingdom, therefore the current study has adopted the term EUPD.

The high level of risk, due to frequent self-harm and suicidal behaviour, indicates that clients diagnosed with EUPD (CDw/EUPD) are often recurrent consumers of mental health services (Lieb, Zanarini, Schmahl, Linehan & Bohus, 2004). EUPD is believed to occur universally, however there appears to be a lack of research in non-Western parts of the world (National Collaborating Centre for Mental Health [NCCMH], 2009). An estimated 2.4% of people in England have a diagnosis of EUPD, though this may be an underestimate as the surveyed sample included only those in housing (McManus, Bebbington, Jenkins & Brugha, 2016). Coid, Yang, Tyrer, Roberts and Ullrich (2006) found that more men had a diagnosis than women in a community sample in Great Britain. Contrastingly there is a clear majority of women in services, though this may be due to willingness to seek support (Tyrer, Reed & Crawford, 2015). The prevalence of EUPD is around four times greater in general practice and primary health care settings, than in the general community and wider society (Gross et al., 2002). Shame can be a combination of anger, anxiety and disgust, and is an emotion that is linked to the sense of self (Gilbert, 2010). Though shame is often viewed as being maladaptive or abnormal, some research offers an alternative outlook. Sznycer et al. (2016) suggest that, shame, though unpleasant, has the evolutionary benefit of protection against threat of social devaluation. Shame helps humans to care about how they are valued by others and to conceal information that would otherwise evoke negative appraisals (Sznycer, Schniter, Tooby & Cosmides, 2015). This indicates that shame may be important for personal welfare and maintaining social relationships.

In recent years, shame has also been acknowledged as a key factor in vulnerability to mental health difficulties. Gilbert and Procter (2006) propose that shame has two main components. The first component is called external shame, which is related to how a person thinks they are viewed by others (Gilbert, 1997). If a person believes they are perceived unfavourably by others, they may feel in danger of being rejected and perceive the world as unsafe. Internal shame is the second component, which is connected to self-awareness and how the person views themselves (Lewis, 2003). If a person sees themselves as inadequate or undesirable, this can lead to self-criticism. Both external and internal shame can join forces to elicit shame. A person may view the external world as hostile and rejecting, and may encounter critical self-evaluations within their own internal world (Gilbert & Procter). When experiencing such shame, the person is unable to self-soothe and may become overwhelmed by their emotions and engage in avoidance or defensive behaviours in order to reduce the intensity of the emotion (Gilbert & Procter).

Linehan’s (1993) biosocial model proposes that EUPD develops due to an interaction between biological emotional vulnerability and an invalidating social environment. She suggests that CDw/EUPD may have grown up in an environment being repeatedly invalidated or criticised by parents/caregivers when expressing negative emotions. Consequently, the child learns that it is undesirable to express emotions and similarly self-invalidates, leading to feeling shame when experiencing such emotions, which continues into adulthood (Linehan). In support of this, research has shown that compared to other client groups, CDw/EUPD report significantly greater levels of shame (Rüsch et al., 2007; Scheel et al., 2014; Unoka, & Vizin, 2017). Research has shown that negative personal responses towards CDw/EUPD is a barrier for clinicians providing non-judgemental and compassionate care (Fada, Alexander & Molyneux, 2019). The label is stigmatised and CDw/EUPD are often perceived as 'manipulative' or 'difficult' by clinicians due to factors such as feeling 'used' and 'splitting' (O'Brien & Flöete, 1997; Woollaston & Hixenbaugh, 2008). Deans and Meocevic (2006) found that 32% of nurses agreed that this client group made them angry. Similarly, other research has shown that in comparison to other disciplines, nurses have less empathy towards the EUPD client group (Black et al., 2011; Bodner, Cohen-Fridel & Iancu, 2011).

A small number of studies have previously explored the perspectives of CDw/EUPD and their contact with mental health services. Veysey (2014) investigated discriminatory experiences and found that they contributed to service-users' negative self-image as they described feeling *"not as human as others"* and *"my self-worth had gone"* (Veysey, p. 26). Fallon (2003) found that six out of seven participants experienced negative responses from health professionals. Those participants who had been hospitalised reported that staff attitudes made them feel they did not deserve inpatient care. Positive aspects were also identified, such as having good relationships with key workers, as this helped with feeling safe and containing emotions. Rogers and Dunne (2011) explored inpatient experiences using a focus group. Supporting Fallon, the authors found that clinicians' negative attitudes and prejudices made participants feel unworthy.

Rationale for the current study

Despite much research in the field exploring the perspectives of mental health staff (MHS), the perspective of CDw/EUPD has received relatively little attention. Therefore, the present study may provide a valuable contribution to the field. The study aimed to explore service-users’ relationships with MHS in a variety of mental health settings, such as inpatient services, outpatient services and therapeutic communities.

Previous research has indicated that invalidating parental reactions can result in shame in childhood which progresses into adulthood (Linehan, 1993) and CDw/EUPD report elevated levels of shame. Though MHS are working in a challenging field, it is troubling that service-users may encounter hostile attitudes from the professionals who provide their care (Deans & Meocevic, 2006). Therefore, invalidating professional to service-user relationships are potentially in danger of repeating parental shaming patterns. To our knowledge no research has explored the process of shame and how it may be repeated and reinforced in the context of MHS. The present study was the first in the field which aimed to understand how relationships between MHS and service-users interact with previous and current shaming experiences.

Rogers and Dunne (2011) found lack of understanding about EUPD to be a key issue for staff. In line with this, the current study aimed to facilitate greater understanding of service-user experiences through identifying helpful and unhelpful interactions with MHS. Disseminating the findings of the study may inform training and service development, guide reflective practice and improve future care and interactions. Identifying specific unhelpful interactions with MHS may assist in preventing negative patterns from being repeated. Discovering positive interactions with MHS may encourage implementation of more helpful ways of working and help counteract shame being reinforced. The study may enhance a more psychological understanding of service-user experiences, which may facilitate greater compassion from clinicians. Ultimately, the study may help to alter the negative discourse and stigma attached to the EUPD label.

Research aims and questions

The current study aimed to give voice to CDw/EUPD through exploring their relationships with MHS. In addition, the study aimed to examine whether shame emerged in service-users' experiences, to understand the process of shame, and to investigate any repeated patterns in interactions between professional to service-user relationships and early experiences.

The research questions that the study endeavoured to answer were: (1) What are the experiences of relationships with MHS of CDw/EUPD? (2) What kinds of experiences and interactions are helpful and positive? (3) What kinds of experiences and interactions are unhelpful or shaming?

Method

Design

The study took a qualitative approach and utilised semi-structured interviews. The study employed Thematic Analysis (TA) and drew on a Grounded Theory (GT) approach. This methodology was chosen to allow an in-depth exploration of the experiences of CDw/EUPD and to understand the process of shame.

Participants and Recruitment

Eight participants were recruited from an NHS Foundation Trust and a private service. Tables 4 and 5 display participant inclusion and exclusion criteria. All participants were female and were between the ages of 18-65 years. Participants had a range of contact with various mental health settings and length of diagnosis ranged from 2-18+ years.

Table 4.

Participant inclusion criteria

Inclusion criterion	**Rationale**
Adults age 18 + with a primary diagnosis of EUPD/BPD (>6 months)	Adults with a diagnosis of EUPD/BPD are the client group of interest. Six months post diagnosis is based on clinical recommendation of field supervisor, to allow for adequate time for service-users to have experienced relationships with MHS after being diagnosed with the label EUPD.
Have capacity to give informed consent	Capacity assessed on a case-by-case basis. Participants must understand the study and what it involves, and able to make an informed decision to provide consent to take part in the research.
Must have a named key worker/care-coordinator	Key workers can be contacted by the researcher if the participant experiences emotional distress or if they require support.
English-speaker	Participants are required to understand and answer questions and talk about their experiences.

Table 5.

Participant exclusion criteria

Exclusion criterion	**Rationale**
Detained under the Mental Health Act (2007)	Due to ethical issue of capacity to give informed consent and potential for increased risk of distress.

Recently discharged from inpatient service (<3 months)	Three months post discharge is based on clinical recommendation of field supervisor. Being discharged can be highly distressing and destabilising and is usually a time of high emotion, and may be experienced as intense rejection, which could potentially bias perceptions of interactions. Three months would allow for a period of separation from the point of discharge.
Have an intellectual disability (ID) or borderline ID	Participants are required to answer questions and talk about their experiences in-depth.

Participants were identified by approaching service leads and team managers, delivering verbal presentations at team meetings, email correspondence and face-to-face meetings with professionals, and liaising with care-coordinators. It was emphasised that any client who met the criteria should have opportunity to take part in the research. Care-coordinators were provided with participant information sheets (PIS) (see Appendix D) and the topic areas of the interview schedule were shared. The role of care-coordinators was to assess eligibility and risk, and their clinical judgement helped to ensure that participants would not experience a high level of distress when taking part in the research. Those clients deemed eligible were invited to take part in the research and received PIS and consent to be contacted forms from their care-coordinator. One participant contacted the lead researcher directly to express interest in taking part. All participants were required to have a named key worker.

Procedure

The study was independently peer reviewed and received a favourable review from a University research group within the Doctorate Course in Clinical Psychology. Ethical approval was gained from an NHS Research Ethics Committee and governance approval via the NHS Health Research Authority (See Appendix E).

Those participants who agreed to take part and completed the consent to be contacted form (Appendix D) were contacted by the researcher to arrange to meet at a mutually convenient time and location. The majority of interviews were conducted at the service where the client was based so support could be sought from the care team or key worker if required. Two interviews were conducted at other locations, and it was ensured that contact details for named key workers were held prior to commencement of interviews.

Before the interview, the researcher offered further information about the study, answered any questions, discussed confidentiality agreement regarding disclosure of risk and reminded participants they should only share information with which they felt comfortable. The researcher checked the participant was still willing to participate and obtained signed informed consent to take part and permission to audio record (Appendix F). Participants answered questions in a semi-structured interview, see Appendix G for interview schedule used as a guide. Interviews lasted between thirty-five minutes to two hours and short breaks were incorporated dependent upon individual participants' wishes.

After the interview, participants were debriefed and provided with contact details for the researcher if they wished to discuss any aspect of the research process. In addition, participants were signposted and provided with a sources of support sheet which included contact details of various services (see Appendix H). Contact details for a Patient Advice and Liaison Service was detailed on the PIS if participants required confidential advice or wished to discuss concerns about care they have received. For participants who experienced distress when talking about difficult experiences, support was offered by the researcher and their key worker or care team were contacted to help them access further support. For risk considerations, guidance was sought from the field supervisor, participants were reminded of the confidentiality agreement, and key workers and care teams were notified in order to manage risk and ensure safety of the participant and others.

Data Analysis

Data saturation is a key principle in Constructivist GT methodology (Charmaz, 2006). A small number of participants did not wish to, or were not able to, answer particular questions therefore data saturation was not achieved in order to develop a complete theory about the process of shame. As a result, to answer the research questions, a TA approach was taken, due to the flexibility it allows with analysis, orientation and theoretical perspective (Braun & Clarke, 2006; see Appendix I for further detail). Interviews were transcribed and analysed by the lead researcher and recurrent patterns within and across data sets were detected (Braun & Clarke). An inductive, data-driven approach to analysis was adopted, whereby themes were developed from the data gathered as opposed to being based upon existing theories (Patton, 1990). The TA was informed by GT methodology, which used an iterative and constant comparative approach where data analysis was simultaneous with data collection (Charmaz, 2006). In this manner, initial codes were determined for each interview which guided questions of subsequent interviews. Following the guidelines of Braun and Clarke, a six stage process of analysis was undertaken in a recursive fashion, as summarised in Table 6.

Table 6.

Stages of Thematic Analysis, adapted from Braun and Clarke (2006)

Stage	Outline
1. Familiarise self with data	Transcribe interviews; immerse self in data through multiple readings of transcripts; search for patterns (themes) and note initial thoughts
2. Determine initial codes	Work systematically through each transcript; identify stimulating features which may form potential themes (See Appendix J for a worked example of data analysis); gather quotations applicable to each code
3. Collate codes into themes	Consider connections between initial codes; organise and combine codes into broader themes and subthemes; gather quotations applicable to each theme
4. Review and refine themes	Review collated codes and extracts for each theme to appraise fit; refine themes or create new themes; discard extracts that no longer fit; assess whether developed themes truly reflect overall data set; create ‘thematic map’ of themes and subthemes (See Appendix K for versions of thematic maps)
5. Define and name themes	Further refine themes; develop clear narrative of each theme; allocate concise name to each theme
6. Write-up and report	Final analysis; develop strong narrative of data; select captivating quotations to support analytic point; link analysis back to original research questions

Quality

During the design of the research, service-users were consulted to determine how the researcher could promote a safe and containing environment during interviews. Meetings were held with the researcher's field supervisor (the clinical lead of a personality disorder service) to discuss the research purpose, procedural queries, proposed interview schedule, and recruitment processes. Regular supervision meetings were held with academic supervisors to gain feedback on the development of the research, documentation, and to discuss methodological considerations. Though TA relies upon an element of researcher judgement to establish themes (Braun & Clarke, 2006), several practices in line with Elliot, Fischer and Rennie's (1999) qualitative research guidelines were followed to ensure sufficient rigour and clarity. The coding of transcript excerpts were discussed with peer researchers in qualitative research groups, the development of data analysis was discussed with research supervisors, and a reflective journal was kept by the researcher to track progress and reflections throughout the research process (See Appendix L). Furthermore, direct quotations of participants have been presented in the results to remain inductive and to demonstrate the link between original transcripts and the subsequent developed themes, thereby reducing the potential influence of the researcher's personal assumptions (Patton, 1990).

Results

The analytic process led to the development of three overarching themes: (1) *Judgements and Presumptions*; (2) *Humanness and Personhood*; and (3) *Feeling Safe*. Table 7 provides an overview of themes and subthemes, with illustrative quotes. Participants were allocated pseudonyms.

Table 7.

Overview of themes and subthemes, with illustrative quotes

Theme	Subtheme	Illustrative Quote
Judgements and Presumptions	Invalidated and criticised	*"I've had that a lot. "You're attention-seekin', you're a bed waster" and that's how mental health teams made me feel." (Cynthia)*
	"Uncared for" and "rejected"	*"I was actually quite suicidal ... "Can you ring back when you're less upset" ... I felt really rejected ... like I didn't matter ... feel ten times worse than I already did ... It makes me feel really upset. Really, not worthy." (Sharon)*
	"Blamed" and "ashamed"	*"I presumed I was a waste of space ... someone who just was a burden on people ... it added to my bucket of things that were crap about me" (Evie)*
Humanness and Personhood	Talking and listening – " … nobody's ever done that to me before. Actually sat down and just, spoke to me"	*"There's like the one thing that a lot of people will know will help is not given to them and that's just talking." (Evie)*
	"Subhuman"	*"No care, no offer of any sort of comfort or, not even sort of basic human rights" (Heather)*
	EUPD is "just one slice of the cake"	*"It makes me feel good ... it makes me feel like I'm important ... when they show an interest in things that you're doing outside of your mental health condition" (Sharon)*

Feeling Safe	“Consistency” and “continuity”	*“You know having the security of that, I’m not gonna be fobbed off after like twelve weeks” (Maggie)*
	Knowledge and experience	*“It just lessens that distress for you if they understand ... then you can make a plan forward” (Katie)*
	Reactions to the label	*“It’s a bit of a mixed blessing really ... it’s brought some relief after having years of not really understanding what was going on” (Heather)*

Theme One: Judgements and Presumptions

Theme one captures how the *Judgements and Presumptions* of others led to negative experiences such as being invalidated, criticised, rejected, blamed and shamed. Some repeated patterns were observed as such experiences were found to occur in participants’ early environment, current relationships, as well as in their interactions with MHS.

1.1 Invalidated and criticised

Participants provided a sense of how their childhood and current experiences led to feelings of being misunderstood, judged and invalidated by family members:

> “Even my own sister … “You just need to behave … don’t get into any trouble” … it’s not trouble like it’s an *illness* … again like it’s just a massive misunderstandin’ of BPD.” (Katie)

> "“[Heather’s] always been a difficult child” … that sort of has stayed with me throughout life really” (Heather)
>
> “Always belittled. In fact, my mum, even now will say … “Why do you behave like that? You’re only seekin’ attention.”” (Monica)

Similarly within mental health services, there was a sense of invalidation, prejudices and negative responses towards the EUPD label. Participants perceived MHS to have more concern for people who had “real” mental health difficulties, which led to feelings of not being as “important” as other client groups:

> “Oh, I’ve been told … “You’re wasting our time, we’ve got actual ill people to see”” (Evie)
>
> “I wasn’t as good or important as a schizophrenic” (Cynthia)

Participants discussed the impact of invalidation and judgement from MHS on self-worth:

> “It makes me really angry. But it makes me feel really stupid as well … like I’m not worthy” (Heather)

The adverse effects of clinicians perceiving EUPD as a ‘hopeless diagnosis’ were highlighted. There was a sense of clinician hopelessness contributing to comparable feelings in participants, such as losing hope and experiencing despair:

> “Being told “There’s nothing we can do for you” it’s awful and you believe that … this is a *terminal illness* … it’s like someone had pressed self-destruct button.” (Evie)
>
> ““Well I’m sorry, I don’t know how to help you” … I went out cryin’, I didn’t know what to do wi’ myself … It made me feel hopeless … I were devastated … ” (Monica)

In contrast, some participants reflected on positive experiences when MHS had more of an optimistic outlook, and this seemed to lead to a positive sense of wellbeing and self-worth:

> “It gave me this little bit of hope … “Actually maybe I do have a bit of worth in the world”” (Evie)
>
> “You are important … you are worth … they kind of believe in ya, so you have to believe in yourself as well.” (Katie)

1.2 “Uncared for” and “rejected”

There was a strong sense of not being looked after and feeling rejected in some participants’ accounts of their childhood relationships with parents and caregivers, as well as in other relationships in their life:

> "I can't ever remember being hugged or kissed or anything … I can't ever remember … I could ever go to mum … I did feel massively rejected … angry … unloved … when my marriage first broke down … I did feel unwanted, uhm, uncared for, and rejected …" (Katie)

> "My mum never met my needs … it made me feel rejected like I wasn't important … I'm not valued … it made me feel like I haven't got a voice." (Cynthia)

Similar feelings of rejection and dismissal were also reflected in participants' relationships with MHS, though in a different context. Participants talked about their experiences of being at crisis point, yet they felt they were not being taken seriously or their distress was downplayed and minimised by MHS:

> "I literally want to go throw myself off the bridge then like-like professionals can sometimes like downplay it … "Oh it's just [Katie] she's sayin' she's gonna kill herself again" … "It's your BPD"" (Katie)

Likewise, several participants discussed their experiences of utilising crisis teams when in distress or feeling suicidal. They reported that MHS would see their diagnosis on their file and the immediate response would be to use distraction techniques. Whilst a few participants acknowledged there was a rationale for utilising such techniques, on the whole participants expressed that this was not a helpful response and made them feel dismissed and not taken seriously, which in turn escalated risk and distress and also affected their future service-use:

> "They read my notes and they go "oh well just have a cup of tea or have a bath". "Oh thanks a fuckin' bunch, you know"…"I feel like cuttin' myself" "Have a cup of Horlicks" "Well thanks-fuckin'-tastic"…what's the bloody point in ringin' again? You know, that sort of thing makes me really angry, this is what fuels the abandonment" (Cynthia)
>
> "If you ring up, you're about to take tablets, and they're sayin' "Go have a cup o' tea", you don't feel taken seriously, and that just makes you feel more rejected and more lonely and so you act out even more." (Katie)
>
> "Sometimes it's good to distract a bit but when you're told to "go and take a bath" … then you're not gonna ring back later even if you're still feelin' bad. So you feel like you're dismissed … Rejection. That you're not worth their time." **(**Janet)

1.3 "Blamed" and "ashamed"

Some participants disclosed that they had experienced childhood abuse indicating a power imbalance, and this appeared to lead to disempowerment and feelings of shame, guilt, being at fault and unworthiness:

> "I used to feel ashamed of what was goin' on … and guilty and embarrassed" (Katie)
>
> "I remember … feeling ashamed … like it was my fault … I think I kinda felt like I had nowhere to turn … so I was a bit unworthy" (Sharon)

Other participants described feelings of guilt and inadequacy, beginning in childhood due to not meeting expectations that were placed upon them by parents and others. Participants further elaborated that these feelings have stayed with them throughout their life:

“It always felt like I wasn’t good enough for them” (Evie)

“I feel guilt about everything, all the time … it’s just a massive thing that just under-underpins a lot … a lot of the time I felt guilty for my existence … ” (Evie)

“I feel like a complete and utter failure.” (Heather)

Likewise, feelings of guilt and shame, were also mirrored in some participants’ interactions with MHS who made presumptions and used blaming language:

““[Evie] is uhm a disruptive influence on the ward and is … problematic in encouraging others to be disruptive” … I-I felt-I felt really ashamed to be honest … it was really hard … I cried actually when I read it.” (Evie)

“I ligatured on the bed … [staff] wouldn’t talk to me … because they were that pissed off … “ … you’ve got two children” … and she just thought it was selfish, and that made me feel ashamed.” (Katie)

Some participants reflected that deep-seated feelings of shame and worthlessness were compounded through some of their interactions with MHS. These feelings originated in participants' early experiences, and were reinforced throughout their lives:

> "A lot of the time like if I feel ashamed then I … feel guilty … it just all goes back to that thing of I don't feel like I'm a worthwhile person." (Katie)
>
> "Makin' me feel like that I was wastin' his time, that sort of tapped into all the early times, you know" (Cynthia)

Participants with many years of living with the label and who had extended contact with mental health services reinforced the incidence of repeated patterns of interactions with MHS:

> "I hope that every example I've said, you know that there's probably about a hundred more examples" (Cynthia)

Theme Two: Humanness and Personhood

The second theme *Humanness and Personhood* captures participants' positive relationships with MHS and explores what it means for CDw/EUPD to be seen as a human being, and the impact of this. Talking, listening, building trust, and taking an interest in them as a *whole person* rather than "just a mental health problem" were found to be important and helpful experiences. In a powerful counterpoint to this, examples of being treated as 'less than' human by MHS, and the effects of this, are also illustrated.

2.1 Talking and listening – " … nobody's ever done that to me before. Actually sat down and just, spoke to me"

In contrast with theme one which demonstrated that participants experienced MHS to be invalidating and rejecting towards them, this subtheme demonstrates the importance and impact of MHS taking the time to talk and listen. Participants explored the helpfulness of having a human conversation and breaking things down when in distress, as opposed to immediately being provided with generic solutions and distraction techniques:

> "We'll try and like step-by-step it like "Why do I feel like this? What led up to it? What am I actually feeling right now?" … talk through it and *then* come up with solutions … that's so much more helpful than … "oh let's have a cup of tea"" (Katie)

Following on from this, some participants highlighted how little opportunity they had been given to talk previously, and it appeared to be a major turning point for them when they were given this opportunity:

> "I know I can talk to [care-coordinator] but nobody's ever done that to me before. Actually sat down and just, spoke to me." (Monica)

Contrary to the judgements and criticisms highlighted in theme one, there appeared to be value placed upon MHS being compassionate and accepting of participants' feelings as valid and worthwhile:

> "Because she don't talk at me-at me, as though I'm stupid. She listens … and talks softly to me and reassures me" (Monica)
>
> "She oozed validation, gentleness … holdin' me in mind" (Cynthia)

Other participants reflected that having casual conversations, not necessarily what is causing the distress, can be helpful in crisis situations:

> "Sometimes just talkin' to somebody about anythin' … I find like the *best* distraction for me … not necessarily what I'm feelin' or what I'm goin' through, just y'know just talk random shit. So yeah." (Maggie)

Listening, understanding and building trust were also found to be helpful and important human elements of the therapeutic relationship with MHS:

> "Respect, listening to each other, treating each other as people, it needs to work both ways" (Evie)
>
> "Just being listened to. And accepted." (Sharon)

2.2 “Subhuman”

In contrast to the *Talking and listening* subtheme, participants explored their experiences of minimal interaction with MHS during their admissions at inpatient units. The impact of not talking and understanding can lead to *Judgements and Presumptions* as outlined in theme one, which in turn can lead to further rejection. Such feelings of being rejected, dismissed and ignored by MHS appeared to lead to “despair” and submissive behaviours. Furthermore, the strong and powerful language used by participants such as *“subhuman”*, “keepers”, “prisoner” and “ragin’” emphasises the extreme feelings of being treated in a way they perceive as *“subhuman”*, and signifies a strong disparity of power:

> “I’ve found a lot of the staff quite dismissive … you didn’t see a lot of them … I kinda left feelin’ maybe even worse than when I was there.” (Maggie)
>
> “Treated like you were subhuman … the mental health staff just don’t want … a conversation … they’re just keepers … it’s just really humiliating … I just despair … it’s almost easier to give up than try and fight it” (Heather)

Lack of human interaction also appeared to be an issue in participants’ contact with crisis services. Participants felt their telephone calls with crisis services were surface-level, checkbox exercise that lacked genuine care, concern and understanding of their distress, which they found unhelpful:

> "They're reading a list of questions off and it's just a-a sort of a checklist really but no sort of emotional- or there's no interaction, there's no sort of care behind what they're asking" (Heather)

> "I'm like really bad … tryin' not to cut and ragin' urges goin' right through me, and they want to know all the details: my name, my age, my address, my care-coordinator, my care team … " (Cynthia)

2.3 EUPD is "just one slice of the cake"

In contrast to the negative experiences illustrated in *"subhuman"*, more helpful experiences described by participants included MHS taking an interest in them as a *real* "human being", rather than viewing them as "a ball of … symptoms". Participants reflected on the positive impact of being seen as a "human being" by MHS, such as helping them to recognise that they were "not just" the EUPD and feeling "worthwhile" and "important":

> "I've got coloured hair, like talk to me about my hair … I've got sparkly shoes on, like "Do you like sparkle?" Just those things that … you're not just a mental health problem." (Evie)

> "Like speakin' to you as a person … there's a lot more to [Katie] than just BPD … The BPD is like just one slice of the cake … that helps you recognise as well that you're not just the BPD … I'm worthwhile." (Katie)

Theme Three: Feeling Safe

Theme three *Feeling Safe* reveals that participants valued (1) regular appointments and continuity with clinicians; (2) MHS knowledge, experience and understanding of their difficulties; and (3) having an understanding of the self. Participants used language such as “contained”, “security” and “sumink tangible” to demonstrate feelings of safeness. This theme appears to be linked to *Humanness and Personhood,* as understanding and safeness is connected to and dependent upon how MHS talk, communicate and treat people as humans, which in turn leads to feelings of safeness.

3.1 “Consistency” and “continuity”

“Tangible” elements such as regular appointments and block bookings helped participants feel safe in their relationships with MHS, and appeared to combat fears of rejection and abandonment, in contrast to the experiences outlined in *“Uncared for” and “rejected”*:

> “We booked all our appointments until like our diaries finished … I knew that he wasn’t gonna go away … it’s turned my life around actually, having that … consistency”.
>
> (Evie)
>
> “She gave me block bookings … which used to help, sumink tangible to hold onto to you know” (Cynthia)

Continuity with “set” staff was also found to help participants feel safe, and participants described difficulties with building trust when this was not the case, demonstrating the value of the therapeutic relationship:

> “So the continuity with set people … I know quite a lot of the staff here now so no yeah continuity and just consistence.” (Maggie)

> “If you’re passed on and on and on to different people that you don’t know, it makes it much harder to build up the trust” (Heather)

3.2 Knowledge and experience

MHS level of knowledge, interest, and understanding of EUPD was found to be important in helping participants feel “contained”, “understood” and “plan forward”. This can be linked back to and contrasted with *Invalidated and criticised* which illustrated that a misunderstanding of EUPD can result in invalidating and negative responses:

> “Since going with the BPD team and getting that specialist treatment where that-that group of people understand, I feel a lot more contained.” (Katie)

> “I always knew she had like a-an interest in personality disorder … very uhm clued up about it … I think it helps me feel understood.” (Sharon)

Age and experience of MHS were also important for some participants, as these characteristics appeared to influence how much they felt understood and respected staff:

> “She was quite a bit younger than me … I kind of felt a bit like “What do you know? You know, you’re too young”” (Sharon)

> “I tend to perform better when-when-when they’ve had more training than when they haven’t … I felt they couldn’t understand me as much. And, I respected ‘em when they had more experience” (Cynthia)

3.3 Reactions to the label

The downsides of having the EUPD label have previously been addressed in *Judgements and Presumptions,* whereas this subtheme, in contrast, explores the positive side of receiving the diagnosis. Participants viewed *Knowledge and experience* as imperative in order to feel understood by MHS, and likewise some participants expressed that it was helpful to have the label as it helped to facilitate understanding of the self:

> “Ah ok … [laughs] I’m not just crazy” (Evie)
>
> “It kinda made me understand a lot more about my behaviour and the way I reacted to things … it reassures you that it-it’s not because you-you’re broken … there is a reason for it” (Katie)

Figure 2 shows the temporal map which illustrates the themes and subthemes, and the connections between the themes. The bidirectional arrow demonstrates that *Humanness and Personhood* and *Feeling Safe* are linked and dependent upon each other. The map also shows that *Judgements and Presumptions* and negative patterns may be overcome through *Humanness and Personhood* and safeness and understanding from MHS.

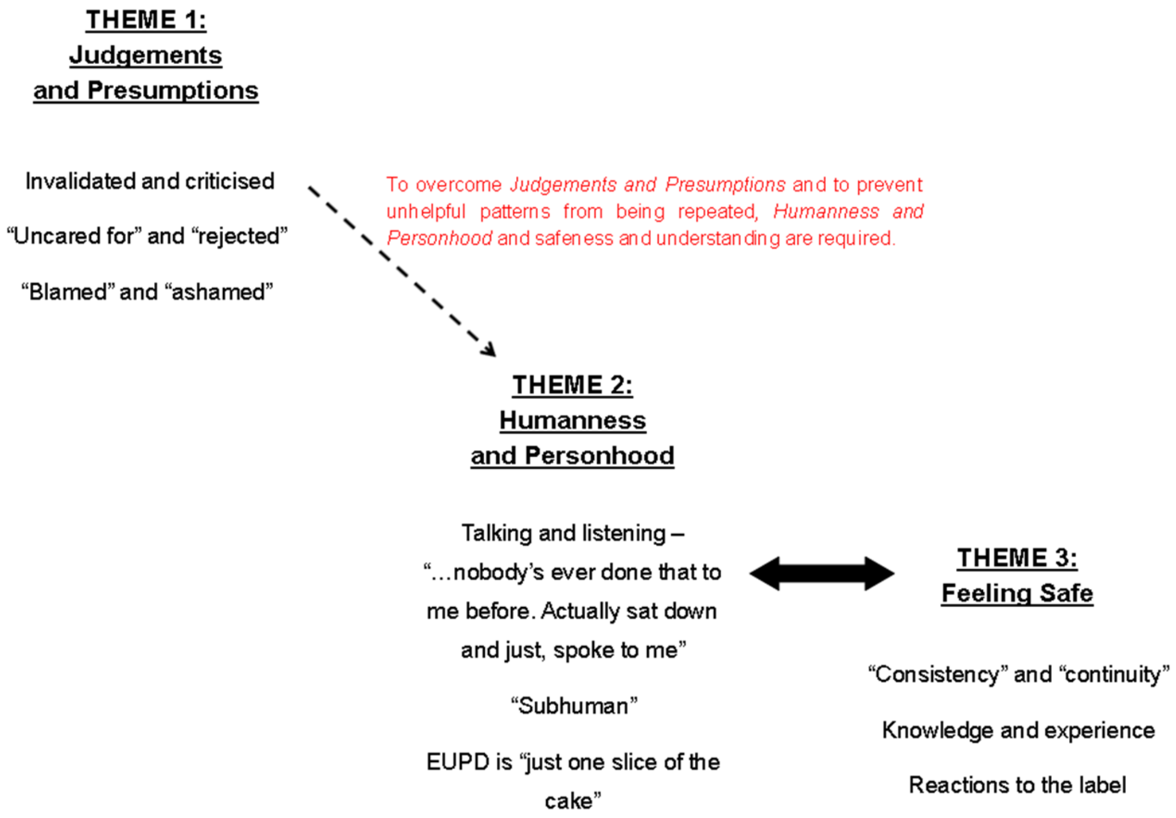

Figure 2. Temporal map of themes

Discussion

Overview of findings

The purpose of this research was to explore relationships with MHS from the perspective of CDw/EUPD. The research aimed to examine whether shame emerged in service-user experiences, to understand the development of shame, and to discover any repeated patterns in interactions. The study endeavoured to explore unhelpful or shaming experiences as well as helpful and positive experiences.

Unhelpful experiences and repeated patterns

The *Judgements and Presumptions* theme demonstrated that negative interactions and feelings were found to occur in participants' early experiences with parents/caregivers, and were mirrored in interactions with MHS. As such, being invalidated, rejected and shamed were found to be repeating patterns. The *"surviving rejection, entrapment, and invalidation"* pattern described in the Power Threat Meaning (PTM) Framework corroborates the findings of the present research (Johnstone et al. 2018, p. 224). The PTM framework outlines that issues with power such as insecure attachment, neglect and abuse in childhood, and facing core threats such as rejection, invalidation and powerlessness, can give rise to meanings such as feeling unsafe, shame, guilt, unworthy, hopeless and alienated (Johnstone et al.). The findings of the present research indicate that these feelings can be reinforced during a person's life through their interactions with others.

Negative staff responses towards CDw/EUPD were reported, consistent with existing literature (Rogers & Dunne, 2011; Veysey, 2014). It was found that participants felt less "important" than other client groups in their interactions with MHS, and Rogers and Dunne similarly reported that unhelpful comparisons were made by staff. The present study found a misunderstanding of EUPD to be unhelpful for participants, supported by Rogers and Dunne who found that the key concern was staff attitudes and lack of understanding. Consistent with Veysey, the present research also found that participants felt *"Subhuman"* and disregarded in inpatient services. Furthermore, feeling rejected, isolated or viewed negatively by MHS, led to feelings of shame, humiliation and unworthiness. These feelings resulted in behaviours such as giving up and not wanting to access further support, which supports Gilbert and Procter (2006) who reported that when experiencing shame, the person can become overwhelmed and cannot self-soothe, and thus engages in avoidant, defensive or submissive behaviours in order to cope.

Helpful and positive experiences

The *Humanness and Personhood* theme showed that participants valued being treated as a human being. Talking was one element of this, and breaking distressing situations down with a professional was found to be more helpful than being provided with solutions. This finding is consistent with Griffiths et al. (2019) who found that people with first-episode psychosis found talking therapy helpful in developing self-awareness and problem-solving, in contrast to receiving peer advice: *"And this is the psychological process, it's what helps with the understanding yourself … instead of … asking for fucking bullshit advice that doesn't fucking work." (p. 729)*. Furthermore, consistent with the findings of the present study, Griffiths et al. reinforced how therapists' probing questions and talking enabled people to make sense of their difficulties: *"[The therapist] … he'd go 'Oh, why do you think that?' and 'What makes you think that way?' (p. 727).* The present study also found MHS listening and building trust to be helpful human elements of the therapeutic relationship, supported by Gilburt, Rose, and Slade (2008): "*I was just so moved by the willingness of so many people to sit and listen" (p. 4).* The present study also found that positive relationships with MHS entailed staff taking an interest in participants as a *whole person*, consistent with other literature which found human connection and looking beyond the EUPD diagnosis to be important (Stroud & Parsons, 2013; Veysey, 2014).

The *Feeling Safe* theme demonstrated how consistency and continuity with MHS, and knowledge and experience, countered fears of rejection and abandonment and helped participants to feel safe and contained. Fallon (2007) reinforced that experienced staff helped containment of emotions and understood client behaviour. The present study found that some participants expressed a preference for MHS with greater years of experience, age, and knowledge, whereas Fada, Alexander and Molyneux (2019) found knowledge and skill to be important facilitators of compassion for MHS. The present study proposes that *Feeling Safe* is linked to *Humanness and Personhood,* as understanding and safeness is connected to and dependent upon how MHS communicate and treat people as human beings, which in turn leads to feelings of safeness.

Temporal map

Previous research has shown that CDw/EUPD report high levels of shame (Rüsch et al., 2007; Scheel et al., 2014; Unoka, & Vizin, 2017). The present study has made a valuable contribution to the field towards understanding the process of shame, has highlighted the potential for repeating unhelpful patterns, and discovered ways of counteracting this in the context of MHS. The research demonstrated that shame, guilt and unworthiness were evident in participants' experiences as a result of *Judgements and Presumptions* they had encountered, and that there was potential for these feelings to be reinforced. The temporal map is presented in Figure 2. The study illustrates connections between *Humanness and Personhood* and *Feeling Safe* as when professionals engage in a human manner through talking, listening and being compassionate, this can lead to clients feeling safe, understood and contained. Conversely, the map hypothesises that if professionals do not talk and listen, and therefore do not understand and provide safeness, this can lead to *Judgements and Presumptions* increasing the potential for invalidation, rejection and shame. Therefore, the research proposes that in order to overcome *Judgements and Presumptions* and to prevent unhelpful patterns from being repeated, there is a need for *Humanness and Personhood* and safeness and understanding from MHS.

Clinical implications

The study found *Judgements and Presumptions* to be a key issue and demonstrated a lack of understanding about clients' distress, and their histories of trauma and neglect. This suggests a need to develop a more psychological understanding which may help to prevent unhelpful patterns being repeated. Perhaps the implementation of formulation groups and trauma-informed care may aid MHS compassion and understanding. Reflective practice groups may also be helpful for clinicians to reflect and understand the impact of their interactions, for example how perceived rejection can escalate risk and distress for clients. The results showed a lack of understanding of EUPD to be unhelpful, whereas knowledge and experience were helpful. This indicates a need for greater training and education of EUPD for MHS, which may in turn help clients to feel safe and understood. There was a strong sense of participants being provided with generic distraction techniques when contacting crisis services for support. Though this may be in line with current system level guidance, participants perceived this as unhelpful and dismissing, indicating a need to implement more individualised formulation-driven approaches that identify patterns of behaviour and personalised strategies that work for the person. The findings also suggest a need for a more ‘human’ system, such as to talk and listen to the person in distress. Taking a compassionate perspective for staff, this implies that change may be required at the wider system and training level. These changes may help to improve care, de-escalate risk and distress, and prevent unhelpful patterns of relating from occurring.

Strengths and limitations

This study provided a rich exploration of relationships with MHS from the service-user perspective, and gave voice to people who have attracted a label that is highly stigmatised. Furthermore, the research has made a valuable contribution to the field. It was discovered that unhelpful patterns of relating occur, even though this may not necessarily be the professional's intention; particular ways of interacting may be linked to training, policies and system level guidance. Finally, the present research has provided insight into the process and development of shame, and discovered ways to prevent unhelpful patterns from being reinforced.

A limitation of the study was that data saturation was not fully achieved in order to develop a complete theory about the process of shame, as a small number of participants did not wish to elaborate on or answer particular questions, for example about their childhood experiences. This may be explained by Macdonald and Morley (2001) who found that clients experienced difficulty in revealing shaming experiences where there is risk of eliciting negative responses from others. Furthermore, the researcher was a mental health professional, therefore it is important to consider whether participants felt safe and contained enough to explore their experiences or whether their previous interactions with MHS limited their responses (see Appendix L).

Gatekeeping was a potential obstacle as recruitment was reliant upon professionals and services sharing the research information with eligible service-users. The majority of participants were identified by care-coordinators, therefore due to the research topic, there is potential risk that care-coordinators may have only provided the study information with whom they have a good relationship. However, this was considered during the design of the study. Presentations were delivered to staff teams to explain the purpose and value of the research. It was also highlighted that the research would not focus solely on that current relationship or service, nor did it aim to place blame on staff. This process helped to reduce the barrier and promote recruitment. Furthermore, the findings of the research demonstrate that both negative and positive experiences were captured, indicating that participants felt able to talk about a range of experiences.

Future research

Future research which explores the potential dehumanisation of MHS is required. This may involve examining the systems that professionals work within, for example, by reviewing staff training, guidance and policies. As such, identifying and reducing the barriers to compassion and intervening at the system level may assist in facilitating compassion in MHS (Fada, Alexander & Molyneux, 2019). A study which implements and evaluates the trauma-informed care model with the EUPD client group could be conducted. The impact of introducing formulation groups into teams who work with

CDw/EUPD could also be investigated. Finally, research which investigates MHS awareness of the implications of their interactions and interventions with CDw/EUPD may also be valuable.

Conclusions

This study provided insight into the process of shame, highlighted the potential for repeating unhelpful patterns, and discovered ways of counteracting this in the context of MHS. Though a full theory was not developed, the temporal map proposes that *Judgements and Presumptions* can be overcome through attributes of *Humanness and Personhood* and safeness and understanding from MHS. The findings suggest a need for a more 'human' system, which may begin with changes at a wider level. Future research may involve exploring dehumanisation of the system and the evaluation of psychological approaches to working with the EUPD client group.

Acknowledgements: The authors would like to thank the participants involved in the study.

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Part Three: Appendices

Appendix A

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Objective(s): Succinctly state the reason, aims or hypotheses of the study.
Method (or Design): Describe the sample (including size, gender and average age), setting, and research design of the study.
Results: Succinctly report the results that pertain to the expressed objective(s).
Conclusions: State the important conclusions and implications of the findings.

In addition, for systematic reviews and meta-analyses the following headings can be used, Context; Objective; Methods (data sources, data extraction); Results; Conclusion. For Clinical reviews: Context; Methods (evidence acquisition); Results (evidence synthesis); Conclusion.

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Appendix B

Bespoke Data Extraction Form

Author	
Title	
Year of publication	
Country	
Aims	
Methodology, design & analysis	
Participant characteristics	
Sample size	
Measure(s), scale(s), tool(s)	
Mental health setting(s)	
Barriers to compassion/care	
Facilitators of compassion/care	
Statistical analysis	
Main findings	
Conclusions	
Quality assessment	
Key limitations	

Appendix C

Mixed Methods Appraisal Tool

Part I: Mixed Methods Appraisal Tool (MMAT), version 2018

Category of study designs	**Methodological quality criteria**	**Responses**			
		Yes	No	Can't tell	Comments
Screening questions (for all types)	S1. Are there clear research questions?				
	S2. Do the collected data allow to address the research questions?				
	Further appraisal may not be feasible or appropriate when the answer is 'No' or 'Can't tell' to one or both screening questions.				
1. Qualitative	1.1. Is the qualitative approach appropriate to answer the research question?				
	1.2. Are the qualitative data collection methods adequate to address the research question?				
	1.3. Are the findings adequately derived from the data?				
	1.4. Is the interpretation of results sufficiently substantiated by data?				
	1.5. Is there coherence between qualitative data sources, collection, analysis and interpretation?				
2. Quantitative randomized controlled trials	2.1. Is randomization appropriately performed?				
	2.2. Are the groups comparable at baseline?				
	2.3. Are there complete outcome data?				
	2.4. Are outcome assessors blinded to the intervention provided?				
	2.5 Did the participants adhere to the assigned intervention?				
3. Quantitative non-randomized	3.1. Are the participants representative of the target population?				
	3.2. Are measurements appropriate regarding both the outcome and intervention (or exposure)?				
	3.3. Are there complete outcome data?				
	3.4. Are the confounders accounted for in the design and analysis?				
	3.5. During the study period, is the intervention administered (or exposure occurred) as intended?				
4. Quantitative descriptive	4.1. Is the sampling strategy relevant to address the research question?				
	4.2. Is the sample representative of the target population?				
	4.3. Are the measurements appropriate?				
	4.4. Is the risk of nonresponse bias low?				
	4.5. Is the statistical analysis appropriate to answer the research question?				
5. Mixed methods	5.1. Is there an adequate rationale for using a mixed methods design to address the research question?				
	5.2. Are the different components of the study effectively integrated to answer the research question?				
	5.3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted?				
	5.4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?				
	5.5. Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?				

Appendix D

Participant Information Sheet and Consent to be Contacted Form

Participant Information Sheet

UNIVERSITY OF HULL

NHS Humber Teaching NHS Foundation Trust

Title of the study: The experiences of relationships with mental health staff of those who have been diagnosed with Emotionally Unstable Personality Disorder (EUPD)

Invitation

We would like to invite you to take part in a research study which is looking at the experiences of relationships with mental health staff in those who have a diagnosis of EUPD. Before deciding if you want to take part in the study, we would like you to understand why the research is being done and what it would involve for you, if you decide to participate. We would therefore ask that you read the following information carefully before making your decision. You can also talk to others if you would like before you choose to take part. The researcher will answer any questions you may have.

What is the purpose of the study?

Little is known about the impact of relationships and interactions with mental health staff from the service-user perspective. This study aims to explore these experiences in those who have attracted the label of “EUPD”. We are also interested in developing an understanding of what service-users found helpful and unhelpful in their experiences of being treated in different settings, such as inpatient, outpatient or therapeutic communities. We hope that this study will inform training and improve care provision by supporting professionals to develop a greater appreciation of service-user experiences and difficulties.

Why have I been invited?

You have been invited to take part in this research as you have a primary diagnosis of EUPD/BPD (> 6 months) and are over the age of 18. You are also able to give informed consent and are an English-speaker. You must have a named key worker who will be able to provide support if required. Care-coordinators at the service will give this information sheet and consent to be contacted forms to people who fulfil the criteria as they may be interested in participating in the study.

Do I have to take part?

No, participation is completely voluntary. If you decide to take part you will be asked to sign a consent form to indicate that you agree to take part. You are free to withdraw from the study up to the point where the study results are analysed and written up and you do not have to give a reason for this. Your decision will not affect your care or your legal rights.

What will happen if I decide to take part?

If deemed eligible, you will be invited to take part and will receive information sheets and consent to be contacted forms from your care-coordinator. You will also be given a form to provide contact details of your named sources of support. In addition, you will be signposted and provided with contact details of various support services.

If you agree to take part, you will be contacted to arrange to meet at a mutually convenient time and location. At the interview, the researcher will offer further details of the study, answer any questions, check that you are still willing to participate, gain signed informed consent to take part. You will be asked to answer questions about your past experiences and your relationships with mental health staff in an interview that will last approximately 1-2 hours and will be audio recorded. At the end of the interview, you will be provided with contact details for the researcher, including phone number and email address, should you wish to discuss any aspect of the research process.

What are the possible disadvantages and risks of taking part?

Some people may experience emotional distress when talking about difficult experiences. If this happens to you, the researcher will offer support and contact your named worker and clinical care team to help you access further support. You will also be signposted and provided with contact details of various EUPD support services. You are able to withdraw at any time during the interview if you wish.

Participating in the study will also require 60-120 minutes of your time which may be inconvenient for you.

What are the possible benefits of taking part?

We cannot promise that you will have any direct benefits from taking part in the study. However, the interview will help you to reflect on your experiences which may be valuable as the research will give voice to people who have attracted the label of EUPD and highlight strengths and limitations within service provision. The study may also help to improve training and care provision within services.

What will happen if I decide I no longer wish to take part?

You are free to withdraw from the study before the results are analysed and the study is written-up without giving a reason. This will not affect your legal rights or the care that you receive from the service.

What if there is a problem?

If you have a concern about the study you can contact the researcher or their supervisors who will do their best to answer your questions.

Will my taking part in this study be kept confidential?

Yes, all the personal information that you provide will be kept strictly confidential. Any information that could be used to identify you will not be used in the research. The people who participate will be given a code to protect their anonymity. After the research is complete, audio recordings will be destroyed. The only time that information cannot be kept confidential is if you disclose something that suggests that you or someone else is at risk of serious harm. If this happens during the interview, the researcher will need to contact appropriate authorities to ensure that you and other people are safe.

What will happen to the results of the study?

After the study is completed, if requested, you will be provided with written feedback about the results of the study. The results will be presented in a doctoral thesis, submitted for publication in an academic journal, and may be presented at conferences. Some direct quotes from your interview may be used in the write-up. Your personal details and any identifiable data **will not** be included in the write-up.

Who is organising and funding the research?

This research is being undertaken as part of a doctoral research project in Clinical Psychology. The research is funded and regulated through the University of Hull. Some relevant sections of data collected during the study which are relevant to taking part in this research may be looked at by responsible individuals from the University of Hull or from regulatory authorities to ensure that appropriate guidance was followed by the researcher.

Who has reviewed the study?

Every stage of the study's development has been reviewed and commented upon by the Chief Investigator's academic and field supervisors. The study has also been independently peer reviewed by the research group within the Doctorate Course in Clinical Psychology at the University of Hull and has received a favourable review. Research studies are also reviewed by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and been given a favourable opinion by The Yorkshire & The Humber – Leeds West Research Ethics Committee.

Data handling and confidentiality

Humber Teaching NHS Foundation Trust is the sponsor for this study based in 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. Humber Teaching NHS Foundation Trust will keep identifiable information about you for three months after the study has finished. The identifiable information will be your name and contact details. The information collected from you at the research interview will be anonymised so it will not be possible to identify you from this.

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.

Humber Teaching NHS Foundation Trust will use your name and contact details to contact you about the research study, and make sure that relevant information about the study is recorded for your care, and to oversee the quality of the study. Individuals from Humber Teaching NHS Foundation Trust and regulatory organisations may look at your research records to check the accuracy of the research study. The only people in Humber Teaching NHS Foundation Trust who will have access to information that identifies you will be people who need to contact you to arrange the research interview or audit the data collection process. The people who may audit the data collection process will not be able to identify you and will not be able to find out your name or contact details.

You can find out more about how we use your information
https://www.hra.nhs.uk/information-about-patients/

Further information and contact details

If you have any further questions, comments or queries, please do not hesitate to contact us. Thank you for taking the time to read this information.

Yours sincerely,

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Patient Advice and Liaison Service (PALS)

If you have concerns about care you have received and require confidential advice and support, you can contact:

Complaints and PALS department
Trust Headquarters
Willerby Hill
Beverley Road
Willerby
HU10 6ED
Tel: (01482) 303930
Email: hnf-tr.pals@nhs.net

Consent To Be Contacted Form

UNIVERSITY OF HULL

NHS Humber Teaching NHS Foundation Trust

If you are interested in taking part in the study please leave your contact details and your key worker's contact details in the space provided below. You will be contacted by the researcher to arrange a meeting at a convenient place and time.

Name:

....

Address:

....

....

....

....

Telephone Number:

....

Mobile Phone Number:

....

Email address:

....

Are there any times of the day that you prefer to be contacted?

....

Named key worker:

....

Telephone Number:

....

Email address:

....

Do you have any further comments?

....

....

Signature:..

Date:..

Thank you very much for your interest!

Appendix E

Documentation of Ethical Approval

REMOVED FOR DIGITAL ARCHIVING

REMOVED FOR DIGITAL ARCHIVING

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Appendix F

Participant Consent Form

Consent Form

UNIVERSITY OF HULL

NHS
Humber Teaching
NHS Foundation Trust

Title of the study: The experiences of relationships with mental health staff of those who have been diagnosed with EUPD

Name of Researcher: Ruby Fada

Please initial boxes

1. I confirm that I have read and understand the information sheet dated 19.10.2018 (Version 1.2) for the above study. I have had the opportunity to consider the information. If I had any questions, they have been answered satisfactorily.	☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason up to the point of data analysis and transcription, without my care or legal rights being affected.	☐
3. I confirm that direct quotes from the interview may be used in future publications and understand that they will be anonymised.	☐
4. I understand that data collected during the study may be looked at by individuals from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.	☐
5. I agree to take part in the interview part of the study and understand that my interview will be audio recorded.	☐

Name of participant	Date	Signature
____________________	____________________	____________________
Name of person taking consent	Date	Signature
____________________	____________________	____________________

When completed: 1 for participant; 1 for researcher site file.

Appendix G

Semi-structured Interview Schedule

UNIVERSITY OF HULL

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Interview Schedule

1. How long have you had the EUPD diagnosis? What does this label mean to you? What were your interactions with people like prior to being given the diagnosis?
2. What was your relationship like with parents/caregivers? Who would you go to when you were feeling upset? Can you give me an example of an interaction you had with your parents as a child?
3. What settings/services have you had contact with?
4. What were your interactions with mental health staff like when you were at service X?
5. Can you give me an example of an interaction you found helpful and positive? What made this experience helpful and positive?
6. Can you give me an example of an interaction you found unhelpful? What made this experience unhelpful?
7. How did this experience make you feel?
8. How do any of these interactions in services remind you of how others in your life have treated you? How do the good/bad experiences relate to previous experiences?
9. Is there anything else you would like to add about interactions you have experienced?

Appendix H

Sources of Support Sheet

Sources of Support

You can seek support from your care-coordinator or duty cover at your mental health team during office hours

For urgent care, contact your local Crisis support service

For urgent care, contact the Mental Health Response Service (Hull) –
Tel: 01482 301701

For emotional support, you can contact Samaritans on their free helpline –
Tel: 116 123

You can also seek advice from your GP. Contact your GP practice and ask for an emergency appointment

In case of imminent risk –
Call 999 or go to your local A&E

Appendix I

Epistemological Statement

In research, it is imperative that the ontological and epistemological stances taken by the researcher are reflected upon. In doing so, the researcher can consider the influence of their lens and acknowledge the assumptions and biases which underpin the research. Ontology can be understood as the nature of being and existence (Ritchie, Lewis, Nicholls & Ormston, 2013) whereas epistemology refers to the nature of knowledge (Willig, 2013). It is thought that the epistemological position adopted by the researcher guides the selection of methodology and methods (Scotland, 2012). This statement aims to reflect upon the epistemological position and assumptions within which the empirical research of this thesis was conducted.

As demonstrated by the literature in the field from clinicians' perspectives, clients diagnosed with EUPD (CDw/EUPD) are a highly stigmatised client group. The relatively small number of studies conducted from the service-user viewpoint proposed an area worthy of further research. Therefore the present study sought to empower and give voice to this client group, and to explore the experiences of relationships with mental health staff (MHS) from their perspective. The research also intended to investigate whether shame emerges in service-user experiences and whether interactions with MHS reflect earlier experiences. Therefore, it was important to select methodology that would effectively capture the experiences of CDw/EUPD, and as such a qualitative approach was taken.

There are a several stances that can be taken by the researcher when conducting research. One such stance is the positivist stance which aims to seek and measure an objective 'truth' without the influence of researcher bias (Ponterotto, 2005). This notion conflicts with the purpose of the present research and was therefore not an appropriate position to take. An alternative position is the constructivist stance which suggests that one objective 'truth' does not exist, and there are in essence numerous realities, all of which are valid (Schwandt, 1994). This stance fits with the present research which aimed to explore the subjective experiences of relationships with MHS from the point of view of CDw/EUPD.

In regards to the type of qualitative approach taken, different methodologies were considered. The present research aimed to examine whether shame emerged in service-user experiences with MHS and to build a theory about repeated patterns in interactions. Interpretative Phenomenological Analysis (IPA) aims to 'give voice' to participants and 'make sense' of experiences (Larkin, Watts, & Clifton, 2006). However, the present study additionally intended to build an understanding about the process of shame and repeated patterns, therefore IPA was not used.

Grounded Theory (GT) was initially chosen as the approach, as this methodology fit best with the aims of the research. GT employs a systematic approach to data collection and analysis, and theories are created based upon the data gathered (Charmaz, 2014). GT takes an iterative, constant comparative method where the researcher is involved in an interactive process of alternating back and forth between data collection and analysis (Charmaz, 2006). The researcher used this method in the study by determining initial codes for each interview in turn, which subsequently guided questions and topic areas of the following interviews. Constructivist GT takes into account the subjective nature of relationships and experiences, emphasises the understanding of phenomena, whilst in addition considers the sociocultural context in which the research occurs (Charmaz, 2006). Utilising this approach, the researcher adopts a reflexive stance and reflects upon how their interpretation of the data may influence the research process and development of the emerging theory (Charmaz, 2006).

As there was not enough data to meet data saturation to develop a theory as intended, an alternative approach was taken to analysing the data. Thematic Analysis (TA) is an approach which involves detecting recurrent patterns within and across data sets (Braun & Clarke, 2006). TA offers a flexible method of engaging with the data, without being bound by particular theoretical and epistemological notions (Braun & Clarke). However, this does not signify that researchers should be unmindful of such ideas, as TA allows the researcher to determine where they place themselves on a series of continua. For example, in coding and analysis in TA, a deductive or inductive approach can be taken (Braun & Clarke). For the present study, an inductive, data-driven approach to analysis was chosen, where themes were closely linked to the data and developed from the data itself, as opposed to a deductive approach where themes are driven by existing theories (Patton, 1990). Furthermore, in regards to the theoretical perspective that can be adopted in TA, researchers can consider taking a critical realist position or a constructionist position (Braun & Clarke). The data collection and analysis of the research was informed by Constructivist GT methodology as outlined above, though the final analysis involved developing themes and subthemes in line with TA. Comparable to Constructivist GT, the TA of this research was underpinned by a constructivist perspective, which informed the way in which meaning was created. Constructivism assumes that experience and meaning are formed socially (Burr, 2015) and the present study was interested in how reality was constructed from the data gathered. In this way, the research therefore considered the cultural and social contexts within which the participants exist, rather than an emphasis upon individual accounts (Braun & Clarke).

Lastly, the personal values and professional orientation of the researcher should be considered as this may have influenced approach and motivated interest in the research area. The lead researcher was a Trainee Clinical Psychologist, female, in her twenties, of British nationality and of a minority ethnic group. Though the lead researcher did not have personal experience with EUPD, she did have an interest in the discourses and attitudes towards stigmatised groups in society. Furthermore, in the profession, a strong emphasis is placed on formulation skills and developing a shared understanding of a client's difficulties, and in a manner consistent with this, the research aimed to build a theory about the process and development of shame from the perspective of CDw/EUPD. Though efforts were made to remain neutral, it is nonetheless important for the researcher to reflect upon how her own lens and professional orientation may have impacted upon the research process.

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Appendix J

Worked Example of Data Analysis

Codes/Notes	**Transcript Excerpt** “Evie”
Feeling dismissed? Staff see label and response = utilise distraction techniques “Judgemental” Lack of education/understanding of EUPD	Evie: …and then you get into an acute psychiatric ward and it’s like “Oh, BPD, right you can just stay over there and use your distraction techniques, like use your own distress tolerance techniques” and then, that’s it, and there’s like just no-quite often, like there’s just a judgement wall, uhm so yeah as you get closer to the people who should be helping you [laughs], you actually get further away, from the help, as the, yeah, it just gets, yeah more and more judgemental and I don’t know, I’m not hundred percent sure where that comes-that comes from to be honest, some of it’s lack of education.

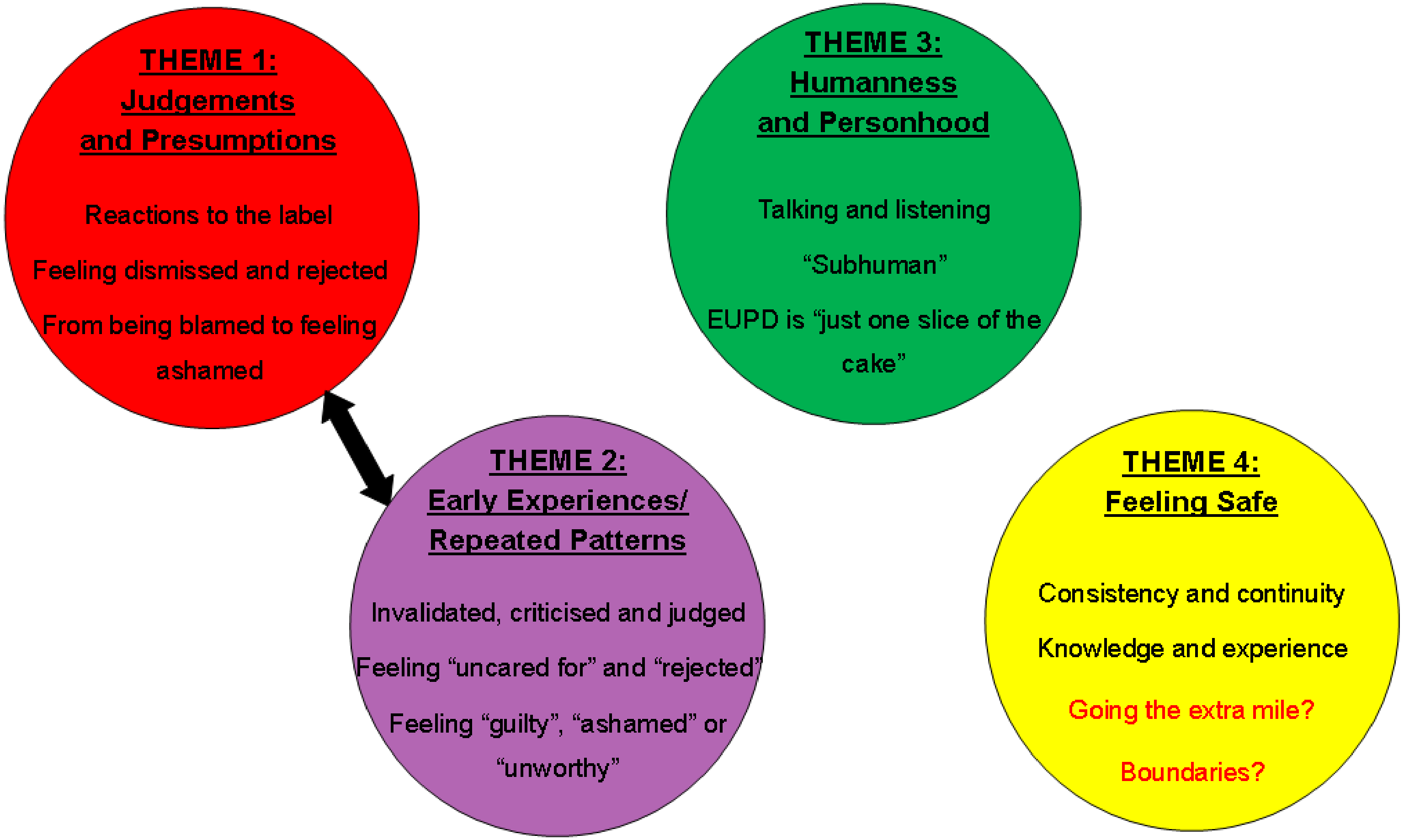
	Interviewer: You mentioned the word “judgemental” a couple of times, and I wondered what was that like for you? How could you tell that that’s what was going on there when you were in the psychiatric inpatient unit?
“Overhearing” “Going through a bad time” Staff pre-judgments and presumptions of label	Evie: Uhm, overhearing people saying stuff, behind your back, or when they think you can’t hear. Uhm I also used to work as uhm a support worker in a psychiatric ward myself and I can remember standing there uhm behind the nurses station and I was going through a bad time at the time and these colleagues didn’t know I had stitches in my legs like uhm I wasn’t very well at all but I was still functioning at work and I remember standing there next to another member of staff and there was a new admission coming in and she was like “*Sigh. It’s another one of those PD patients, brace yourselves*”, and I was stood there like I wanted the ground to swallow me up, *or* to like turn round and say, actually I have the same-same diagnosis as that person, to see what-because she just *presumed*, like, before she’d even met this person she presumed they were trouble, but she took me as a colleague that she respected and like was helpful at work or whatever and I just wondered what would happen if I turned round and said, “Actually on paper

Reputation precedes Unhelpful: Unsure of what was happening – staff did not talk to her (inpatient) Helpful: "Talking" and understanding; "no judgement" (specialist service) Barriers "glass wall"	I'm the same as that person". Uhm, so, and I-I know that like, I know more now actually, uhm about my reputation that pr-like was before me when I was in acute services a lot a couple of years ago, people used to dread me coming in, and part of that was because nobody knew what was going on, I didn't know what was going on because nobody would talk to me, uhm and it yeah it wasn't until I went to the specialist service and I just spent the whole year talking that I understood what was going on. Uhm, and, I now really noticed when I was there and there was no judgement, how much judgement there had *been* [before] and how many – just-just-just that barrier, it just felt like there was a kind of glass- like you know when you're talking in the offices about glass ceilings, you know like people can't go past a certain point, it felt like that, it felt like there was like a glass-glass wall between me and actually getting some helpful help…

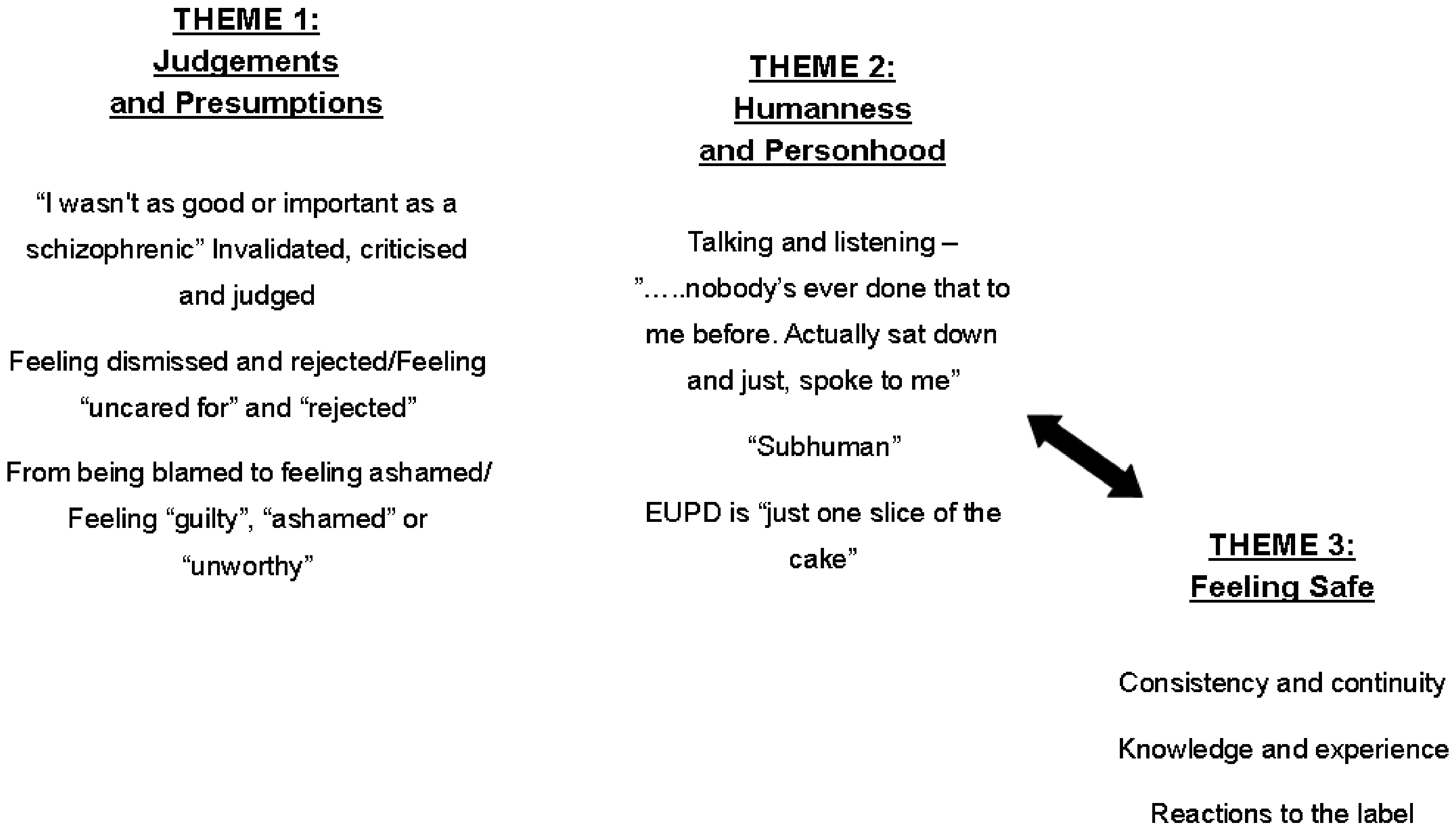
Appendix K

Versions of Thematic Maps

Thematic map version 2:



Thematic map version 3:



THEME 1:
Judgements
and Presumptions

“I wasn't as good or important as a schizophrenic” Invalidated, criticised and judged

Feeling dismissed and rejected/Feeling “uncared for” and “rejected”

From being blamed to feeling ashamed/ Feeling “guilty”, “ashamed” or “unworthy”

THEME 2:
Humanness
and Personhood

Talking and listening – ”…..nobody’s ever done that to me before. Actually sat down and just, spoke to me”

“Subhuman”

EUPD is “just one slice of the cake”

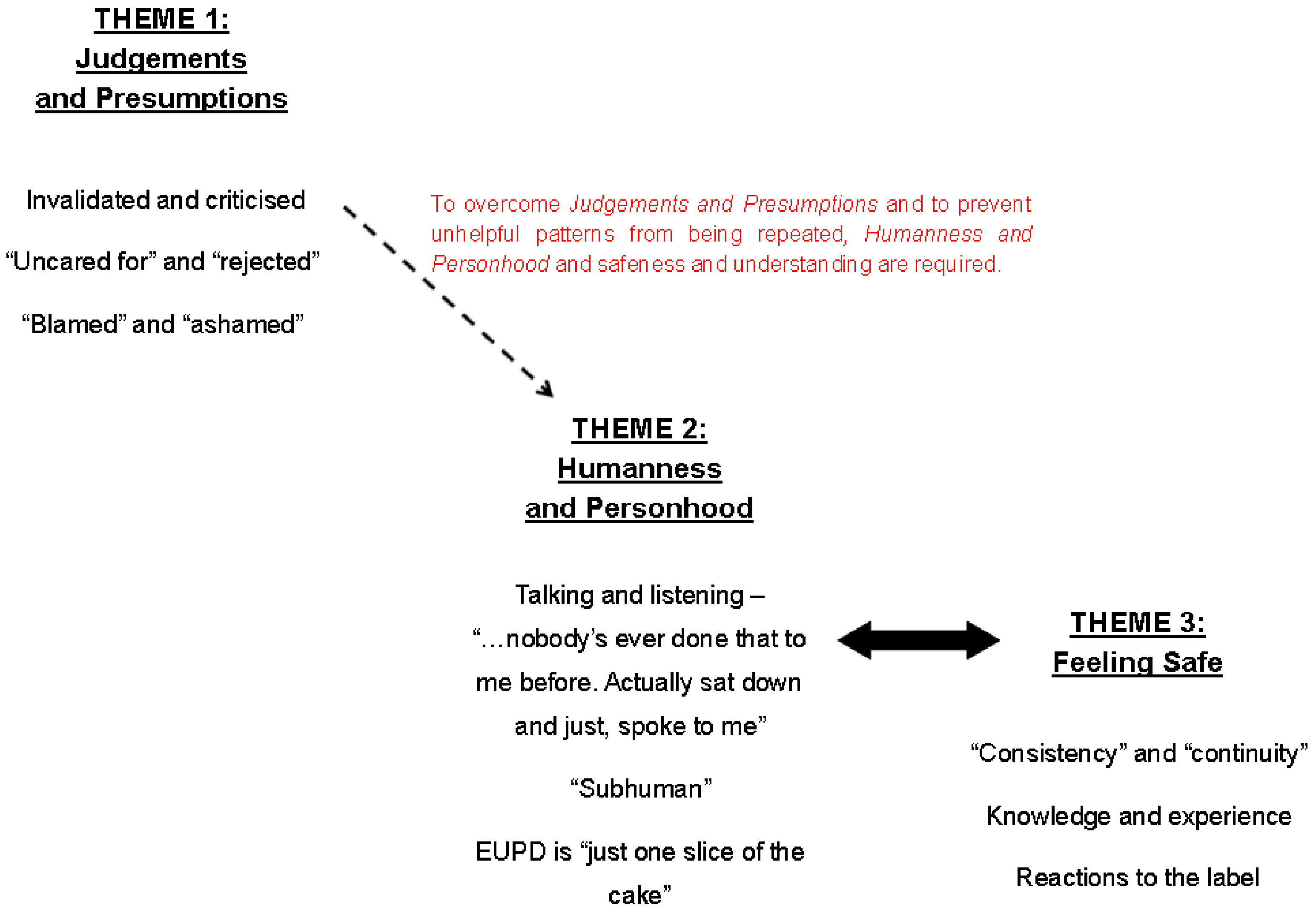
THEME 3:
Feeling Safe

Consistency and continuity

Knowledge and experience

Reactions to the label

Thematic map version 4:



THEME 1:
Judgements
and Presumptions

Invalidated and criticised

“Uncared for” and “rejected”

“Blamed” and “ashamed”

To overcome *Judgements and Presumptions* and to prevent unhelpful patterns from being repeated, *Humanness and Personhood* and safeness and understanding are required.

THEME 2:
Humanness
and Personhood

Talking and listening – “…nobody’s ever done that to me before. Actually sat down and just, spoke to me”

“Subhuman”

EUPD is “just one slice of the cake”

THEME 3:
Feeling Safe

“Consistency” and “continuity”

Knowledge and experience

Reactions to the label

Appendix L

Reflective Statement

Opening statement

I would like to begin this statement by acknowledging that developing this thesis portfolio has certainly not been without its challenges, though I truly have enjoyed conducting my research in this field. I feel a great sense of accomplishment at the finished piece of work, and that my research has achieved what it fundamentally set out to achieve, which was to give voice to a stigmatised client group. The whole research process has definitely made me ponder, and I hope that my reflections highlight my experiences, and demonstrate all I have learnt over the past three years and what I intend to take forward to the future. I sincerely look forward to reading this reflective statement back one day, to recall my growth and development throughout this entire journey.

Systematic Literature Review (SLR)

Developing a research question

Finding a research question for my SLR was no easy task. I recall initially coming up with different ideas only to find that there were not enough papers or the question was either too broad or too specific. After examining the research base and getting some new ideas, and following several discussions with my supervisors with ideas moving back and forth, we finally came up with a question which complimented my empirical research project and seemed very relevant to the current context in adult mental health.

Screening process

After deciding on the question, it was time to develop the search terms for the strategy. This was not too challenging a task and the final search terms were peer-reviewed and agreed upon. I think the most gruelling and time-consuming part of the SLR process was screening over a thousand searches. I recall at the time thinking I had somewhat underestimated how much time and effort goes into conducting an SLR. That sense of relief I felt when I had finished screening and obtained my final eighteen papers was a great feeling. Once I had my final papers, the task at hand did not seem as large as it did when I first started the process.

Analysis

Sometimes it can be tricky to find the motivation to get started with a task that seems daunting, which is what happened with the analysis. When I did manage to overcome the fear and summoned my inner warrior to get started, I did actually find it enlightening reading and analysing my final papers. The review certainly helped me to take a compassion-focused perspective for clinicians, and understand the barriers and difficulties that clinicians experience in working with the client group. It also made me think about what needs to be done in order to reduce these barriers for clinicians and improve care provision. The identified facilitators of compassion and implications of the review could perhaps be considered in future service-development to enable greater compassion in mental health staff (MHS) who work with the client group.

Empirical Paper

Designing the research

Though I had to use the terms *“Emotionally Unstable Personality Disorder”* and *“Borderline Personality Disorder”* for the purposes of research, it is important to reflect that these labels are somewhat problematic in themselves. *"Disorder"* suggests that fault lies with one's *character,* and does not encompass the influence of difficult life experiences, early trauma or distress. I think this is why the labels never felt quite right to me. Even during the design of my research I had to consider the use of these diagnostic labels carefully and think about how potential participants may perceive my research. As a result, I refrained from saying things such as "people *with* Emotionally Unstable Personality Disorder" and stating it as *fact*, but rather I preferred to use phrases such as "*people who have attracted the label of EUPD"* or *"people who have a diagnosis of EUPD"*. Perhaps the future will be brighter – the valuable findings of my empirical research, in conjunction with the move toward more trauma-informed care, may help to provide a more psychological understanding of people's distress and alleviate the stigma surrounding the label.

At the beginning stages of the research process, I remember attending the course research fair already having my own ideas about research. I had an interest in 'personality disorder', yet it was not within the expertise of the staff in the department, so I was unsure whether I would be able to conduct my research in this area. However, I was pleased when Tim and Philip agreed to co-supervise me, with the recommendation that guidance from a field supervisor with expertise in the field would be required.

What motivated my interest in this area was my awareness of the stigma around the label and the negative attitudes of some MHS towards the EUPD client group. I remember being quite taken aback when I first encountered this. I wondered: Why do MHS feel this way? Do their feelings about the client group get in the way of the care they provide? What is the impact of this on clients? How do clients who have this diagnosis experience their relationships with MHS? Do MHS play a role in the development of shame? I had all these questions that I wanted to know the answers to. So I thought, what better way to address this than conducting research which explores service-users' experiences of relationships with MHS.

Gaining ethical approval

The ethical approval process was lengthy and complex and the application was time-consuming. Once I had submitted my ethics application, I also had to wait a period of time to get a date for the Research Ethics Committee meeting which meant there was a delay in getting started with recruitment. Getting through ethics felt like a never-ending process but I remember what a great feeling it was when I finally received approval and was given the go-ahead to commence with recruitment. Looking back though, I do wish I had strived to submit my ethics application a little earlier; it certainly would have lessened the time-pressure of recruitment and writing-up the research further down the line.

Recruitment and data collection

The recruitment process was a mixed bag – both challenging and rewarding. I remember feeling so elated when my first participants came through. However, when it got to the end of January and I had recruited only two participants, I was feeling panicked that I had not recruited more by that point. Transcribing the interviews required so much time, which I was not in abundance of. However, it is important to reflect that transcribing the interviews really helped me to immerse myself in the data and generate initial ideas. For this reason, if I were to conduct qualitative research in future, though transcription requires a big time commitment, I would likely do the same again. I ended up with eight participants which I was really pleased about, so those countless weeks of transcribing audio recordings were worth it in the long run!

Perhaps something I would consider doing differently in future research is the method of recruitment. I recruited participants through mental health services and this was somewhat a barrier. I had doubts about whether my research was reaching enough people, as I was largely dependent upon professionals providing the information sheets to potential participants. I remember feeling quite hopeless at times because I was putting in so much time and effort by contacting different services, speaking with different professionals, all to no avail. I faced correspondence blocks such as emails not being replied to. I realised that I needed to adapt my approach and take more of an active role. I did this by having more face-to-face interactions with staff, delivering presentations about my research in team meetings, and building rapport. This helped to generate more interest and staff were more willing to endorse my research.

Though there were limitations of recruiting through services and professionals, such as potential gatekeeping, there were also benefits and an important rationale. Care-coordinators helped in assessing eligibility and risk, and their clinical judgement helped to ensure that participants would not become highly distressed by the interview. I also found having contact with care-coordinators helpful as it gave me a point of contact in case of participants experiencing emotional distress or making risk disclosures. This would have been much more challenging to manage had participants not been required to have a named keyworker. Weighing up the pros and cons of different methods of recruitment certainly provides food for thought for my future endeavours with research.

As a clinician myself, who is conducting research exploring relationships with MHS, it is important to reflect on whether participants were able to be frank and open about their experiences, or whether their previous experiences with MHS meant that they anticipated any judgements or responses. This is something that I found myself thinking throughout the data collection process. I wondered: What version of themselves are they portraying to me, a MHP? How did they perceive me as a MHP? Do they feel safe and contained enough to explore their experiences? Asking people to talk about their experiences, some of which may be difficult and shaming, is a big ask, so it was completely understandable why a small number of participants did not wish to answer or elaborate on particular questions, for example about their childhood experiences. Perhaps it would bring up a lot of emotion for them or worried about the response they might receive. Some participants talked about having difficulty trusting others and receiving negative past reactions from MHS to their distress, so this made sense.

I found conducting the majority of interviews to be a rewarding experience. At times, it was difficult to hear about some participants' experiences. On the other hand, it was pleasant to hear participants take an interest in my work, and tell me that they thought conducting my research in this field was valuable and how much it was needed.

Data Analysis

After transcribing the final interview, it hit me. I thought "Oh my goodness, this is it". It was time to actually sit down and make sense of the many thoughts and ideas that had arisen throughout data collection. The thought of doing this was quite intimidating yet at the same time it was exciting to uncover what my research had found. Due to the nature of my methodology, data analysis was simultaneous with data collection which meant that I had already been coding each transcript prior to the subsequent interview which really helped to elicit initial ideas about patterns that were commonly occurring. So by the time I had coded the eighth interview, I already had a pretty good idea of some of the key themes (in my head, anyway!). The difficult part was narrowing down all my ideas, putting pen to paper, going through the reams of transcripts and codes, considering all the different connections, and thinking about the best possible way of grouping themes and subthemes. Creating different versions of the thematic map really helped to visualise the findings and bring them to life. I remember looking at my final version of the thematic map and was astonished at how the huge cloud of ideas had advanced into this nice, neat map. Discussing the themes with my peers and my supervisors was helpful as it reassured me that the findings made sense and strong themes had been established. What was particularly striking was the powerful ‘human’ element that came through from the research.

Write-up

I found writing up my research to be one of the biggest challenges for a number of reasons. Firstly, I could feel myself running out of time as hand-in deadline was fast approaching, and this, together with the added pressure of balancing all the different demands of the course, was very difficult. Secondly, there were so many ideas and thoughts in my head that I had yet to get down on paper so it felt like an overwhelming mountain of a task. Breaking things down into smaller, more attainable goals really helped with this. Thirdly, whilst the research process has drawn on my strengths as a scientist-practitioner, also emerged was one of my underlying flaws. The perfectionist inside of me was really put to the test during the write-up. My fear of not producing the ‘perfect’ piece of work really pulled me down. Though my old *foe* Ms Perfect tells me she is my *friend*, (and granted, a little bit of her is good because she motivates me to work hard and aim for success), she is also the voice behind my self-criticism. A strong theme of invalidation emerged from my empirical research, and it was strange to also find myself self-invalidating. I experienced worries like “I’m not writing my best” and “Is this good enough?” and these self-doubts left me feeling quite disheartened, stuck and unsure of how to progress further. I remember discussing this with my supervisors who told me “Just do it. Write something” and “You have good ideas” but “You need the substance before you can actually do anything with it”, which really struck me. I tried to get on with the tasks at hand, and told myself I would deal with my worries later (when I had the time!). Only then, did I begin to overcome this hurdle. In hindsight, I wish I was able to conquer that fear and hand in my drafts earlier. The research process has certainly taught me that sometimes you just have to take the leap and get on with it. Once I had finished writing up my research and drawn everything together, I felt a great sense of fulfilment as I was reading through it. Tim and Philip’s feedback was also reassuring. I have to remind myself that one can never really, truly achieve perfectionism – I just have to give it my best effort and hope that it is “good enough”. It is peculiar how we are good at being kind to others, but often not so good at being kind to ourselves. Perhaps this is a lesson to hold onto moving forward: learn to be more self-compassionate.

Choice of journal

Much of the existing research in the field appears to be published in journals associated with nursing or psychiatry. I wanted my research to also be read by clinical psychologists who work in the field of adult mental health, who can share the findings of my research with their teams and help to implement the proposed implications and ideas. For this reason I chose the *Journal of Clinical Psychology*. This journal is interested in research from a psychological perspective and clinical practice, and accept both empirical research and reviews.

Closing statement and final reflections

I would like to end on a positive note and reflect on just how far I have come. Thinking back to the many moments of self-doubt, in comparison to where I am at this point, is certainly worth celebrating. I do feel that my research has made a valuable contribution to the field. My SLR and empirical research have certainly helped me to understand the experiences and difficulties from both the professional and service-user perspectives. I would like the findings to be disseminated, not only with MHS, but also with the systems and organisations within which MHS work. I hope that the research will help clinicians to have a greater psychological understanding of the client group, and ultimately reduce stigma, improve care and enhance compassion. Though completing this thesis portfolio has undeniably been a colossal task, I am glad to have conducted my research in this field, and I feel proud of the finished product.