A Qualitative Investigation of the Clinician Experience of Working with Borderline Personality Disorder

Amanda J. Commons Treloar, *Monash University*

The current research provided opportunity for 140 clinicians across emergency medicine and mental health service settings in Australia and New Zealand to make comment about their experiences in working with patients diagnosed with borderline personality disorder (BPD), in order to allow for some illustration of the difficulties found within the literature with regard to negative attitudes towards this patient group. Thematic analysis conducted on the qualitative responses revealed four key themes: 1. BPD patients generate an uncomfortable personal response in the clinicians, 2. specific characteristics of BPD that contribute to negative clinician and health service response, 3. inadequacies of the health system in addressing BPD patient needs, and 4. techniques and strategies needed to improve service provision with BPD. This investigation gives illustration to the key difficulties that clinicians have in working with patients diagnosed with BPD and suggests that interpersonal and system difficulties may have altered the provision of service that is available to this patient group.

Of recent times, much research has been conducted to examine professional attitudes towards patients with borderline personality disorder (BPD). A review of some of these studies reveals a consistent theme that the attitudes of health professionals towards patients diagnosed with this complex disorder tend to be negative and derogatory (e.g., Commons Treloar & Lewis, 2008; Bowers & Allan, 2006; Deans & Meocevic, 2006; Potter 2006). A recent quantitative study of health professionals across emergency medicine and mental health service settings however revealed that there appeared to be some discrepancies across clinicians working in these two service settings, with emergency medicine clinicians reporting more negative attitudes towards BPD patients than their mental health counterparts (p<.001) (Commons Treloar & Lewis, 2008). Furthermore, gender and discipline specific differences in attitude ratings were found, with female staff reporting a more positive attitude towards this patient group (p=.02), and examination of participant attitudes across the three occupation areas of nursing (general and psychiatric registration), allied health (psychologists, social workers, and occupational therapists), and medical fields (medical registrars and officers, and psychiatric registrars and psychiatrists) revealed a significant difference between the attitude ratings recorded (p = .04), with clinicians registered as allied health professionals demonstrated significantly more positive attitude ratings towards patients with BPD than the other two occupation areas (Commons Treloar & Lewis, 2008). Although gender, service setting, and discipline of the clinicians appears to be of some influence to the generation of more positive or more negative clinician attitudes, a more enriched illustration of the difficulties perceived by health professionals in their work with patients diagnosed with BPD, which may in fact contribute to the recorded attitude ratings of emergency medicine and mental health clinicians, was not a focus however in the current literature.

A review of the consumer literature also raises some concerns as to health professional attitudes towards patients with BPD. Many BPD patients that engage in self-harm, particularly those with repeated episodes, feel that the health professionals are not willing or interested in becoming involved in their psychotherapeutic treatment (National Collaborating Centre for Mental Health, 2004). Upon review of patient feedback, it becomes apparent that "service users describe contact with health services as often difficult, characterised by ignorance, negative attitudes and, sometimes, punitive behaviour" (National Collaborating Centre for Mental Health, 2004, p.28). Numerous studies have suggested that difficulties with clinician attitudes towards working with BPD remain constant, but until now an examination of why this may be, perhaps in regard to the limited health system resources or clinician knowledge available within the community, has not been completed. This research therefore aimed to provide the opportunity for clinicians across both emergency medicine and mental health service settings in three hospitals across Australia and New Zealand to make comment about their experiences in working with patients diagnosed with BPD, and therefore provide some illustration as to the difficulties that that may have contributed to the reported

negative clinician-patient interactions found within the current literature base.

Method

Participants

The participants in this study were 140 registered health practitioners across two Victorian health services, Ballarat Health Services (*n*=54) and Barwon Health (*n*=30), and a New Zealand health service, Nelson Marlborough District Health Board (*n*=56). The cohort included 48 males and 92 females, with 64.3% (*n*=90) of the sample working within the mental health component of the health service; the remaining participants were employed in the department of emergency medicine. The primary field of occupation of the participants was 69.3% (*n*=97) in nursing (including both general and mental health registration), 17.1% (*n*=24) were allied health (including psychology, social work, and occupational therapy), and 13.6% (*n*=19) in the medical field (medical or psychiatric registrars and officers, or psychiatrists). Mental health and emergency medicine clinicians of these health services were asked to participate if they encountered patients diagnosed with BPD in the course of their employment. All clinicians across these departments were eligible for participation in the current study if they were a registered health practitioner and no exclusion criteria were used. The response rate was 73.57% (*n* = 103), and although most of these clinicians provided at least a paragraph of comment about their experiences with BPD patients (69.90%, *n* = 72), other participants wrote very little (from a one-word description to a few sentences) (30.10%, *n* = 31).

Materials and Procedure

Following consultation with management staff, and completion of the requirements for ethical approval at the three health services, participants were provided with an explanatory statement as to the aim of the research program (to collect clinician views on working with patients diagnosed with BPD) and a consent form that was signed prior to their participation. Participants were then provided with a demographic questionnaire (including gender, service setting, primary occupation/discipline, and completion of prior training in BPD), and offered to make comment about their experiences in working with BPD. The open comment section contained only the following question, phrased in a neutral way: Please provide some comments about your experience or interest in working with patients diagnosed with Borderline Personality Disorder. Spaces for written responses were provided. Responses and completed demographic questionnaires were then returned in a sealed envelope, separate from the completed consent forms.

Research design

Responses on the open comment section were analysed using a thematic analysis procedure (Braun & Clarke, 2006). First, the data was read and re-read to carefully identify initial ideas, and then a systematic procedure of coding interesting features of the data was completed. These codes were collated into potential themes and a thematic map of the analysis was completed. A further analysis of this map refined the specifics of each theme, generating clear names for each theme that illustrate the core concept of the responses relevant to that theme. Lastly, a selection of vivid extracts was collected to illustrate the key themes generated from the analysis procedure just described. The thematic analysis was exhaustive in that 93.5% of the clinician responses were able to be allocated by the researcher to at least one theme elicited by the analysis. The remaining 6.5% of clinician responses were disregarded as they were insufficient in their content to illicit a further thematic category in its own right or allow for further elaboration of the generated four themes.

Results

As illustrated in table one below, the responses of the participants on their experiences in working with patients diagnosed with BPD were identified across the four emergent themes of: 1. BPD patients generate an uncomfortable personal response in the clinicians, 2. specific characteristics of BPD that contribute to negative clinician and health service response, 3. inadequacies of the health system in addressing BPD patient needs, and 4. techniques and strategies needed to improve service provision with BPD. The clinician responses that were associated with a large number of text units are shown in italic, with those that received few mentions are shown in plain type. The basis of this division was that at least six participant responses were represented by the themes reported in italic text, and at least three participant responses were represented by plain text.

Borderline Personality Disorder patients generate an uncomfortable personal response in the clinicians

A review of the comments provided by emergency medicine and mental health clinicians on their experiences in working with patients diagnosed with BPD revealed that many clinicians in this study experienced an uncomfortable personal response to working with this patient group. Many of the comments offered by the participant group reflected that some clinicians feel frustrated, inadequate, and challenged in direct professional contacts with BPD patients. Two typical responses were: "*I have found people with BPD to be manipulative and I wonder if... BPD is just an excuse for bad behaviour and nastiness*" and "*working with BPD can be very frustrating…can make you feel inadequate, angry and powerless*". Such responses are consistent with the literature on clinician responses to working with BPD, which suggest that negative attitudes towards working with this patient group remain in the current health system.

From the analysis of responses, the uncomfortable personal response of the clinician in direct contact with BPD patients then appears to generate a difficulty within treatment teams where conflict often arises with regard to treatment responses and options: "*In the team…potential conflict regarding management and treatment is likely to be about someone diagnosed with BPD*". Originally generated by the

Table 1. Themes identified from participant responses via thematic analysis

BPD patients generate an uncomfortable personal response in the clinicians	Characteristics of BPD that contribute to negative clinician and health service response	Inadequacies in the health system in addressing BPD patient needs	Techniques/ strategies needed to improve service provision with BPD
I feel challenged	*They are manipulative*	*Often clinicians have no experience with BPD*	*We need more training and education on this disorder*
I find them too difficult to deal with	*They show poor ways of coping*	*Some professionals refuse to treat them*	*They need regular contact to help them*
They are too frustrating	*They are chaotic*	*Once labelled BPD, they will not get an objective assessment*	Rapport can be improved with access to training
I feel inadequate	*They are time consuming*	*There is a lack of resources to help them*	Use of crisis management plans can help
They cause increased arousal and conflict in the team	*They are a waste of my time*	There is a lack of resources to help them	Limiting the number of clinicians involved can help
I am unsure how to respond	They present with habitual behaviours crisis	The health service provides inadequate care	
	They constantly present in crisis	They are neglected by mental health services	
	They have difficulty interacting appropriately	Clinicians lack understanding of the disorder	
	They are highly strung and tipped off		
	They use self harm to communciate their distress		

difficult personal response of the clinicians, this appears to be further exacerbated by the observation that many clinicians feel unsure of how to respond, thus contributing to the conflict within treatment teams. As found in the research via the demographic questionnaire, only 47.12% (n=66) of the participant sample had received any formal or targeted clinical education in the area of BPD, with only 18.00% (n=9) of emergency medicine clinicians and 63.33% (n=57) of mental health clinicians reporting knowledge derived from the completion of training in the area of BPD.

Specific characteristics of Borderline Personality Disorder that contribute to negative clinician and health service response

From the participant responses, there was an apparent theme relating to characteristics of patients with BPD that may contribute to the negative clinician and health service response found within the literature. It was felt by some of the participants that patients with BPD were manipulative, displayed poor ways of coping, were time-consuming in their contacts, and that patients with BPD were chaotic by nature of their disorder. Many clinicians indeed felt that because of these patient traits, they were a waste of clinical time and such clinicians were unable to foresee any impact of their clinical efforts with regard to treatment responsiveness.

A combination of the clinician's personal response and their view of the core traits of BPD then appeared to impact on the level of engagement and therapeutic rapport that can be established between the clinician and patient, as illustrated by the following response: "*I have found patients have difficulty interacting in an appropriate manner; they are caught up in the situational crisis and have trouble answering and responding to questions. Patients are usually highly strung and easily tipped off. I have a usual good rapport with patients and cannot with patients of this nature*". There were some responses offered by some clinicians in the study however that demonstrated some insight into the underlying causes of the difficult behavioural picture that they observe, concluding that the self harm behaviours become a means of communicating distress and that these behaviours become habitual to the patient, thus making clinical improvement arduous: "... *(they) present with intense emotional issues that are habitual patterns of behaviour that create crisis for themselves and significant others. The self harming is a means of communication to express their anxieties and conflicts*".

Inadequacies of the health system in addressing Borderline Personality Disorder patient needs

Many clinicians within the cohort also revealed concern with the current composition of the health system in its ability to meet the needs of patients with BPD. "*I have a real interest in learning about what might be helpful for these people because anecdotally I don't see them as improving in current provisions of mental health services and they are clearly a group of people who need something!*". The observation that many professionals decline service to patients with BPD, and are unable to provide an objective assessment based on the presence of BPD as a diagnosis, were supported by many clinician responses: "*Once labelled as BPD it is hard for the patient to be given an objective assessment...*". The report of declines of service or providing biased clinical assessments of patient needs, based on a patient's possible diagnosis, found within the current study was alarming. Clinician responses within this theme were also related to a concern with the knowledge base of the clinicians in the area of BPD, as well as a lack of resources to provide the level of treatment that BPD patients may require. Limited patient/staff ratios were indeed one issue identified that were related to lack of resources to enable sustained clinical attention for the patient with

BPD, both in the emergency medicine and mental health setting.

Techniques and strategies needed to improve service provision with Borderline Personality Disorder

Clinician responses on the open comment task also generated a consideration of the possible ways to improve the current difficulties with service provision observed above, providing an insight into the needs of the health professional in improving the therapeutic relationship and clinical experience in working with patients diagnosed with BPD. These included practical ideas of regular access to training and education on the disorder, using crisis management plans to assist in the consideration of clinician response to behavioural difficulties demonstrated by BPD patients, and using limited clinicians in the care of BPD patients to reduce the conflict that can occur when clinician views on treatment are various and contradictory. A typical response was: "*it is valuable if a limited number of staff are involved in the care to provide consistent boundaries*". The request of regular clinical supervision and training on BPD appears to be the most significant means suggested by which to address the uncomfortable personal response of clinicians when in direct clinical contact with this patient group, as well as enabling a more in depth understanding of the personal characteristics of patients with this disorder that appear to generate such personal responses in emergency medicine and mental health clinicians.

Discussion

The thematic data presented here demonstrates that some clinician attitudes towards patients with BPD may be negative and derogatory. This is consistent with the literature that has substantiated the presence of such attitudes towards BPD in today's health professionals (e.g., Commons Treloar & Lewis, 2008; Bowers & Allan, 2006; Deans & Meocevic, 2006; Potter 2006). The quantification of clinician attitudes as negative via such studies however may appear to be more related to a personal discomfort of the clinician, as found here, in understanding and responding to BPD patients within a clinical context. In order to address the uncomfortable personal response that is generated in the clinician upon contact with the patient with BPD, many participants were able to acknowledge that they feel unsure of how to respond to the needs of the BPD patient, and indeed requested more training and education in the area of BPD. Inadequacies and frustration were clearly identified themes; however some participants did also offer derogatory summations about this patient group: "they are manipulative" and "they are a waste of my time".

There was however also indications of frustration found within this examination towards the current health system in meeting the needs of clinicians in their work with this patient group. Such a frustration has not been a focus of the current literature, but does allow for a consideration of the underlying processes that may be connected with the usual negative or uncomfortable personal response of the clinicians when in contact with patients diagnosed with BPD. Interestingly, the negative comments offered in relation to the health system by the participants also demonstrated some compassion for the experience of the BPD patient when they come into contact with such services: "*the health service provides inadequate care*", "*they are neglected by mental health services*", and "*some professionals refuse to treat them*".

Access to training in BPD and procedural requirements in relation to standardising response to patients with BPD, including the limiting of allocated clinicians in the work with each BPD patient and the practice of using designated crisis response plans, were raised as possible means of enabling clinicians to feel more equipped to respond to the service needs of BPD patients. The lack of consistent team and organisational approaches, and indeed consistent clinician knowledge with regard to BPD, is evident from the responses found here. It has been found in the literature that access to training and education in the area of BPD can improve clinician attitude ratings (Krawitz, 2004) however it appears from the comments collected here that such training may not be readily available or accessed. In considering this suggested lack of opportunity or resource, training and supervision in the area of BPD may provide a significant area of vocational opportunity for psychologists within these services, who may be in a position to provide suitable education and supervision to other disciplines in both emergency medicine and mental health services.

The thematic data did raise preliminary questions of prejudiced views regarding prognosis of BPD, as well as actual views amongst clinicians that much more needs to be done in the management and treatment of BPD from a systemic level. Within the literature there does exist written protocols as to how to response to behavioural difficulties with BPD patients (e.g., Oldham et al., 2001; Mitchell, 2000), from both an emergency medicine and mental health service perspective, however many clinicians may not have ready access to such documents or adequate knowledge on the speciality area of working with BPD (Moran & Mason, 1996). This examination suggests that the limited resources available within current health system may be a contributing factor to the consistently reported negative clinician attitudes towards BPD within the literature, as access to ongoing clinical education and supervision, and procedural guidelines, appears to remain lacking in many health services. In depth qualitative investigation of these emergent themes would be beneficial to map these processes in more detail.

References

Bowers, L., & Allan, T. (2006). The attitudes to personality disorder questionnaire: psychometric properties and results. *Journal of Personality Disorders*, 20(3), 281-293

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology*, 3, 77-101

Commons Treloar, A. .J, & Lewis, A. J. (2008). Professional attitudes towards deliberate self-harm in patients with borderline personality disorder.

Australian and New Zealand Journal of Psychiatry, 42, 578-584

Deans, C., & Meocevic, E. (2006). Attitudes of registered psychiatric nurses towards patients diagnosed with borderline personality disorder. *Contemporary Nurse*, 21, 43-49

Krawitz, R. (2004). Borderline personality disorder: attitudinal change following training. *Australian and New Zealand Journal of Psychiatry*, 38, 554-559

Mitchell, P. (2000). *Crisis intervention and primary care: Evaluation of the national youth suicide prevention strategy: Technical report Volume 3*. Melbourne: Australian Institute of Family Studies

Moran, T., & Mason, T. (1996). Revisiting the nursing management of the psychopath. *Journal of Psychiatric and Mental Health Nursing*, 3(3), 189-194

National Collaborating Centre for Mental Health. (2004). *Self-harm: The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care. National Clinical Practice Guideline Number 16*. Leicester: The British Psychological Society.

Oldham, J. M., Gabbard, G. O., Goin, M. K., Gunderson, J., Soloff, P., Spiegel, D., Stone, M., & Phillips, K. A. (2001). Practice guidelines for the treatment of patients with borderline disorder. *The American Journal of Psychiatry*, 158(10), 1-52

Potter, N. N. (2006). What is manipulative behaviour, anyway? *Journal of Personality Disorders*, 20(2), 139-156

Acknowlegements

I wish to acknowledge Dr. Leonardo Rodriguez and Dr. Andrew Lewis for their guidance and supervision of the research area. This work was undertaken in part fulfilment of a Doctor of Philosophy in Psychological Medicine by Amanda Commons Treloar at Monash University, Melbourne, Australia.

A qualitative investigation of the clinician experience of working with borderline personality disorder

Corresponding Author:

Amanda Commons Treloar

C/O Ballan District Health & Care,
Cowie Street, Ballan,

Victoria, Australia.

mcandpt@bigpond.net.au

Ph: (03) 53681100.