Caring for People Diagnosed with Borderline Personality Disorder: A Discourse Analysis with Nurses

by

Lisa Rachel Wensink

BSN, University of British Columbia (Okanagan), 2007

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The undersigned certify that they have read, and recommend to the College of Graduate Studies for acceptance, a thesis entitled:

Caring for People Diagnosed with Borderline Personality Disorder: A Discourse Analysis with Nurses

Submitted by Lisa Wensink in partial fulfillment of the requirements of The degree of Masters of Science in Nursing.

Donna Kurtz, Faculty of Nursing
Supervisor, Professor (please print name and faculty/school above the line)

Penny Cash, School of Nursing, Federation University Australia
Supervisory Committee Member, Professor (please print name and faculty/school in the line above)

Judy Gillespie, Faculty of Social Work
Supervisory Committee Member, Professor (please print name and faculty/school in the line above)

Lynn Bosetti, Faculty of Education
University Examiner, Professor (please print name and faculty/school in the line above)
External Examiner, Professor (please print name and university in the line above)

April 5, 2016
(Date submitted to Grad Studies)
Abstract

People who are diagnosed with Borderline Personality Disorder (BPD) experience mood changes, idealization, devaluation of others, and are prone to lives that are chaotic. Clinicians who provide care for people with the diagnosis often have uncomfortable feelings such as frustration, anger and irritation. Nurses report having negative thoughts and emotions and struggle with identifying appropriate treatment options. This study used discourse analysis and the researcher’s feminist lens of her experience as a nurse on understanding the societal and medical influences on perceptions of BPD. Registered Nurses (RN’s) and Registered Psychiatric Nurses (RPN’s) working on acute in-patient mental health units in the province of British Columbia, Canada were interviewed to discover discourses underlying nursing work with people diagnosed with BPD. Four major discourses informing nurses’ practice are: Power, Safety, Biomedical, and Caring. Nurse participant recommendations for change action include: BPD education for nurses and healthcare professionals, on-going support for ethical challenges within nursing practice, and improved community resources. This study will inform changes in practice and policy for improved care and health outcomes for people diagnosed with BPD and identify areas of further inquiry for mental health nurses. This can help health care providers identify potentially discriminatory practice and illuminate possibilities for health system change.
Preface

This thesis is an original, unpublished, independent work by Lisa Wensink. Ethical approval for this study was obtained via UBC Behavioural Research Ethics Board and Interior Health Authority [certificate #H14-01183].
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My most sincere appreciation for the nurses who spent time helping me understand the challenges and successes in working with people who have BPD. Your stories resonated with me and I hope will encourage all of us working in mental health to think about this important and gratifying work in new ways.

To my Mom, your strength, kindness, and wisdom gave me the foundation to do this work.

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Richard, you are the best husband and support I could ask for. You help me stay grounded, practical, and at the same time encourage me to do more. I am a better person because of you, and always know that I am loved. What more could I ask for?
Dedication

This thesis is dedicated to the women and men who are diagnosed with BPD and have shown me how to be a better nurse.
Chapter 1

Borderline Personality Disorder (BPD) is a complex mental health condition with significant emotional, mental and physical effects. It is often referred to as an untreatable disorder. Suicide and self-harm are real and significant risks for people diagnosed with BPD, yet more evidence into effective treatments and larger scale trials for suicidality and self-harm are “badly needed” (Hawton et al., 2009, p. 2).

Health care professionals struggle with negative feelings and feel uncomfortable providing care for people diagnosed with BPD. Words used to describe this condition are: manipulative, dangerous, attention-seeking, and demanding. Such descriptors are found in literature and are used to depict people diagnosed with BPD (Deans & Meocevic, 2006; Ma, Shih, Hsiao, Shih, & Hayter, 2009; Nehls, 2000; O’Connell & Dowling, 2013). Certainly these adjectives are not an exhaustive list, nor an exclusive one to the diagnosis, but this language resonates with me as it is language heard frequently in my work in mental health nursing. Though I am reluctant to admit, these are words I have said or thought. Consideration of my actions and thoughts led me to ask the question: How do words and beliefs in mental health nursing impact nursing practice when working with people diagnosed with BPD and how do the beliefs create and reinforce the subsequent provision of care?

I developed an interest in the relationships between people diagnosed with BPD and nurses through my work in mental health. As a new nurse, I wondered why I struggled with providing effective care for the many people diagnosed with the disorder I saw on the in-patient unit. I recognized I was just one of many nurses who had difficulty with personal reactions and responses. Frequently, I noticed though I would have meaningful and affirming interactions with patients, I would also have days where I became angry, frustrated, and reacting in ways which
made me question whether I was acting professionally towards people given the diagnosis. There were times when I felt judgemental towards people with the diagnosis, seeing them as being oppositional and almost impossible to help. Strategies I used in my work seemed to make no discernable difference in patients’ mood or coping skills. Though people with other diagnoses such as schizophrenia or depression could also elicit emotional responses within me, it did not happen in the same intensity nor incidence as when working with people diagnosed with BPD. I discussed these reactions with other nurses, and found others struggling with similar discomfort. Often ethical and distressing situations were discussed in the nursing station, and they frequently seemed to revolve around patients given the diagnosis of BPD. These discussions would arise again and again, yet I found I left these talks with no better understanding of how to work well with people given the diagnosis.

Research into treatment strategies for people diagnosed with BPD offered me some understanding of the disorder and what could potentially help people, but I found little which helped me as an in-patient nurse actually work with people. The ethical struggles led me to look deeper into my own reactions, considering how I might work better with people given the diagnosis and keep my professional and personal standards as a nurse intact. The almost universal struggles nurses in my environment had in working with people diagnosed with BPD mirrored my own. I wondered what helped create situations where nurses such as myself continually questioned what effective care looked like for people diagnosed with BPD, yet I was unable to find any definitive understandings of how to best work with people.

The questions revolving around complex practice situations outlined above lends itself to research using discourse analysis. Discourse in this paper is defined as “how systems of representing knowledge and social roles are constructed and maintained in language…”
establish[ing] meaning that is related to the exercise of power” (Fischer & Freshwater, 2014, p. 198). Important to note is how discourse analysis examines power structures and relationships embedded in the context of words and beliefs. For this research, the meaning of discourse includes the views, understandings and emotions represented in the language used by nurse participants. Outlined in this thesis is the need for understanding the discourses that underpin nurses’ practice when caring for people diagnosed with BPD in hospital mental health units. During analysis the discourses that emerged were profoundly complex and layered.

Chapters in this thesis include: Chapter 1, the background, significance and purpose of the research; Chapter 2, the current literature on broader mental health discourses and a review of literature on feelings, attitudes and views of health care professionals towards people diagnosed with BPD; Chapter 3, a summary of the feminist lens that informs the researcher’s approach to methodology; Chapter 4 contains methods used in conducting the research, data collection and analysis; Chapter 5 examines findings of the study in which nurses’ shared their nursing experiences of working with people diagnosed with BPD in acute mental health environments. This chapter also examines themes and discusses the discourses uncovered and; Chapter 6 discussion how this study is relevant to health care professionals, insights for further implications such as education and policy, and recommendations for nursing work and practice.

**Borderline Personality Disorder**

Within mental health settings, the significance of Borderline Personality Disorder is highlighted by the percentage of people diagnosed with the disorder seeking service. BPD is diagnosed in 0.5 -5.9% of the general United States population and approximately 10% of the community mental health population and 25% of hospital mental health populations (Leichsenring, Leibing, Kruse, New, & Leweke, 2011). Literature is mixed on whether BPD is
primarily diagnosed in women. Gunderson (2011) reports 75% of the people diagnosed in United States clinical settings are female whereas Sansone and Sansone’s (2011) literature analysis reveals no difference in gender distribution. Sansone and Sansone and Bjorklund (2006) argue there has been a historical gender bias towards diagnosing women with BPD. In contrast, Liebman and Burnett (2013) question whether BPD is under diagnosed in men, rather than over diagnosed in women. There is the possibility of sampling bias since individuals surveyed were in hospital, where there are more women than men (Sansone & Sansone, 2011). It is unclear why significantly more women than men are diagnosed and hospitalized with the disorder, though Appignanesi (2007) suggests that depression and anxiety rates are higher in women because “women go to doctors where men go to the pub” (p. 453). She theorizes women become medicalized by the nature of their reproductive system and become accustomed to seeking medical help, whereas men self-medicate with street drugs and alcohol. This may be the case for women diagnosed with BPD, who live with mood swings, more frequently seek out medical help for the challenges, and then receive the diagnosis, and subsequently admission to hospital.

The name of the disorder comes from the 1930’s when a psychoanalyst described a set of patients who were on the borderline between psychoses and neuroses (Commons-Treloar & Lewis, 2009). Diagnosis of the disorder is defined in the most current Diagnostic and Statistical Manual, version 5 (DSM-5) of the American Psychiatric Association (APA) (2013a). Though the psychiatric language and constructs can be seen as problematic and endorsing of the biomedical discourse surrounding mental health (Crowe, 2000; Lakeman, 2013), it is the standard tool throughout North American mental health settings to quantify and qualify mental illness. The APA criteria provide a common understanding of the criteria for health care
professionals when someone is given the label of BPD. To receive the medical diagnosis of BPD, a person must have five of the following nine criteria:

- Extreme reactions to abandonment
- Pattern of intense relationships
- Distorted and unstable self-image
- Impulsive and dangerous behaviour such as unsafe sex, substance use
- Recurring suicidal behaviour and self-harm such as cutting
- Intense and changeable moods
- Chronic feelings of emptiness and boredom
- Inappropriate anger
- Stress related paranoia or dissociation

The criteria for diagnosis of BPD has not substantially changed from the DSM 4-TR. However, the APA (2013b) notes the new DSM 5 removed the ‘axis’ (used to categorize illness into segments or streams of illness) which were created to ensure personality disorders such as BPD received enough medical attention. The previous DSM 4-TR listed personality disorders in its own Axis 2 category separated from Axis 1 disorders such as bipolar disorder and schizophrenia (APA, 2000). According to the APA there is no need for artificial distinction between the different disorders, yet it is unclear whether this is due to the understanding by the APA that there is enough current research in this area. However, Goodman, Roiff, Oakes, and Paris (2012) note there remains limited options for treatment and ability to predict and prevent suicide in people diagnosed with BPD.

In the re-categorization of diagnosis, questions arise whether these categories prompted more research, or rather created a separation between mental disorders that have broader
acceptance such as depression. Additionally, Kealy and Ogrodniczuk (2010) note exclusion of disorders such as BPD from services, and question whether Axis 2 designation allowed for perceptions of people diagnosed with BPD as not truly having a mental illness and therefore resulting in less service.

Uncertainties about diagnosis continue. Crowe (2000) deconstructs the diagnosis of BPD and the “unease that surrounds diagnosis” (p. 327). She questions the idea of a ‘normal’ vs. ‘abnormal’ personality and refers to functioning of people with BPD as being a shame response to situational stressors such as abuse. Markham and Trower (2003) discuss that “the distinction between the person and the disorder is blurred” (p. 244) with resulting stigma directed towards people with the diagnosis. The person becomes the diagnosis, medicalized, and devalued. Nehls (1998) refers to being “labelled, not diagnosed” (p. 288), resulting in marginalization and poorer treatment. Commons-Treloar and Lewis (2009) highlight the challenges of diagnosing people with BPD, noting health-care providers may over-diagnose due to problems identifying both quantitative, such as the DSM, and qualitative, such as individual reactions and perceptions. Nelson (2013) suggests physicians may diagnose people with other illnesses such as bipolar or depression to avoid hopelessness assumed in diagnosis of BPD. Raven (2009) proposes diagnosis is avoided due to stigma attached, but actually acknowledging diagnosis and then helping people adapt personal functioning in a positive manner is best for patients and helps care providers remain optimistic and engaged.

The tension within diagnosis has been clear to me in my work, as I have encountered circumstances where labels of BPD have been applied to patients, which seem unnecessary or stigmatizing, yet have also encountered patients who seem to have the signs and symptoms attributed to diagnosis. For instance, the background of people diagnosed with BPD is
significant with abuse, trauma or neglect being recognized factors in developing the disorder in medical literature (Gunderson, 2011; Helgeland & Torgersen, 2004; Leib, Zanarini, Schmahl, Linehan, & Bohus, 2004; Oldham, 2005). However, Leichsenring et al. (2011) note that it is based upon self-report and questions whether or not there is a relationship to these factors and development of the disorder. Questions also remain on how and why people may develop these symptoms, but especially as noted in the literature is the idea of a complex interplay between environment and biology (Gunderson, 2011; Leichsenring et al., 2011; Linehan, 1993). If people develop ways of coping with their trauma, how is it the diagnosis becomes ingrained into the person’s personality? Do they take on the persona of the diagnosis through a social reading of that condition?

There is a real risk of suicide for people diagnosed with BPD. People diagnosed are often chronically suicidal and 60-70% attempt suicide while living with the disorder (Goodman et al., 2012). Dying by suicide is at 50 times greater rate than the general population, with mortality between 8-10% and significant functional impairments (Leichsenring et al., 2011). A study by Zanarini, Frankenburg, Bradford-Reich, and Fitzmaurice (2010) on psychosocial functioning over a 10 year period showed on-going impairment in vocational and social functioning, specifically the ability to maintain a non-abusive relationship. Zanarini et al. found that vocational functioning was impacted more than social, and hospitalization was correlated with worse function.

**Significance of Research**

Personality disorders such as BPD are complex and not easily ‘cured’. In a press release discussing treatment for BPD, Dr. Tim Kendall stated, “We have largely ignored this problem or have been too dependent upon on drug treatments that don’t work and in some cases… can be
harmful” (National Institute of Clinical Excellence [NICE], 2009a, p. 2). A biomedical approach focuses on compliance with treatment that reinforces medical dominance, (Mitchell, 2006) and fails to sufficiently treat this type of disorder. Treatments seen as most beneficial are psychotherapies, (Gunderson, 2011; Hawton et al., 2009; Leib et al. 2004; NICE, 2009b; Oldham, 2005) and therapeutic engagement by nurses or other clinicians seen as vital in providing care (Swales, Heard, & Williams, 2000; Swift, 2009). This is in contradiction to the biomedical North American approach to mental illness (Appignanesi, 2007) where medication might be considered as more valued in treatment.

The biomedical approach can be seen in my own practice, where medications are covered for people with mental disorders through a general, funded, provincial pharmaceutical coverage program called Pharmacare and Plan G (psychiatric medications not covered by Pharmacare are paid for by the government), and provided within a day or two. This prescription drug coverage is in contrast to the waiting list for free counselling at the local community mental health center which is at least 5 weeks (N. Rigby, personal communication, December 7, 2015). Also of note, psychotherapy for the diagnosis itself is not covered by the provincial health plan within the health authority.

BPD has been seen as an untreatable disorder (Swift, 2009) and clinicians working with this group often have uncomfortable feelings such as frustration, anger and irritation (Bland, Tudor, & McNeil-Whitehouse, 2007). These feelings are often difficult for health care providers and challenging to manage as a clinician. Woollaston and Hixenbaugh (2008) found in their study all the nurses interviewed endorsed feeling “personal distress” (p. 705) when nursing people diagnosed with the disorder. Numerous studies report nurses and other clinicians struggle with negative feelings towards people diagnosed with BPD (Cleary, Seigfried, & Walter, 2002;
Deans & Meocevic, 2006; James & Cowman, 2007; Liebman & Burnett, 2013; Markham, 2003; Markham & Trower, 2003; Sansone & Sansone, 2013). Understanding emotional reactions on the part of the clinician may help in preventing ‘blaming the victim’. Warner and Wilkins (2004) write of the need to avoid blaming the individual person for expression of internalized powerlessness. They point out the effect and rates of child abuse, including sexual abuse, and how this affects presentation to clinicians. Uncovering the discourses might also help in understanding the cultural influences upon the disorder which may in turn affect how nurses respond, react, think, and care for people diagnosed with the disorder. Acknowledgement and understanding may help create change in perception as negative attitudes can affect care and treatment (Black et al., 2011). For these reasons, a research study on discourses involved in care for people diagnosed with BPD may be helpful and so the research question is outlined below.

**Research Question**

This study was conducted to explore the following research question:

What are the discourses present and informing nurses working in mental health hospital units towards people diagnosed with Borderline Personality Disorder and how do these discourses inform their work with this group of people?

I work in mental health and notice how the current practices seem to marginalize people diagnosed with BPD. At the same time, I recognize that I engage in conversations and actions which reinforce this marginalization. Though I am concerned about inequalities in my workplace, I notice as I become more embedded in my professional practice work, it becomes easier to overlook or justify the inequities. By undertaking this study, I wished to create awareness of unspoken beliefs for myself and where possible with others, but also create
opportunities in challenging the biomedical structural status quo for people diagnosed with BPD.

In one way, this study has forced me to acknowledge my own taken-for-granted practices, language, and relationships hopefully increasing awareness of my own position so that I can help to create some changes in the nursing care/practice of people diagnosed with BPD.
Chapter 2: Literature Review

From the initial steps of the research study it was clear that literature addressing the discourses involved in treating people diagnosed with Borderline Personality Disorder was lacking. Considering the rates of those with the diagnosis accessing services, as mentioned earlier, it is curious that minimal research has been conducted on this patient group.

Inclusion criteria for the literature review began with peer-reviewed, international, health care literature: 1) written in English or had a translation available; 2) through the University of British Columbia library system; 3) that addressed broader discourses in attitudes of health care professionals towards people with mental illness; and 4) that was more specific to the attitudes of professionals towards people diagnosed with BPD. After reviewing the initial literature list, abstracts were screened and full reviews of articles which met the above criteria read and either included or discarded if not meeting eligibility. In total articles 35 articles were read after reviewing abstracts that met criteria.

A search was conducted to find general mental health discourses. CINAHL and Medline were searched using the search terms “mental health” and “discourse analysis” with the limiter of English only articles, 146 results were found. To narrow results, a further search term of “nurse” was added, with 17 results found; however, none met the criteria. Another search was conducted with CINAHL and Medline using the search terms “mental health”, “discourse analysis” and “attitude” with 63 results found and 5 articles relevant to the research topic and meeting the criteria.

After using search terms “discourse analysis” and “Borderline Personality Disorder” to search CINAHL, PsychINFO, and PubMed databases, results ranged from 1 article from the
PsychINFO database to 6 articles in PubMed. None of the articles found addressed the question of discourses informing nursing care of people diagnosed with BPD. Search terms were then broadened to capture more literature related to the research question. As the research focused on discourses related to caring for people with the diagnosis, the terms “care” and “Borderline Personality Disorder” were used to search the CINAHL database, with 233 results. This was too broad, so the term “experience” was added to narrow results to 33 in CINAHL and 88 in PsychINFO with several relevant peer-reviewed publications found, although as expected, many duplicate results between databases.

To gather information on background history of BPD (and thus potentially influencing discourses), CINAHL, PsychINFO, PubMed, Social Work Abstracts, and Academic Search Premier databases were searched using terms, “Borderline Personality Disorder”, and “history” and “perception”, with 24 papers found, however none were relevant to the research question. CINAHL was searched using “Borderline Personality Disorder” and “history” and “analysis” to hopefully find articles discussing the background factors and societal influences on perceptions of Borderline Personality Disorder, with only 1 relevant article out of 46 results found.

Finally, CINAHL, PsychInfo, Academic Search Premier, PubMed, and Social Work Abstracts databases were searched using terms, “Borderline Personality Disorder”, and “care” and “perception” with 36 results. These results had some duplications from earlier searches, but also resulted in some further relevant articles. No restrictions to search terms were used, other than limiting to scholarly articles.

After reviewing peer-reviewed publication abstracts, a total of 15 relevant articles were identified. Within these 15 articles, 2 were literature reviews addressing mental health nurses attitudes and perceptions towards people diagnosed with Borderline Personality Disorder. Those
articles chosen considered the attitudes and perceptions of caregivers towards people diagnosed with BPD, the majority looking at in-patient nurses. Articles which also considered other health care professionals such as physicians, social workers and psychologists were not excluded due to limited research available. For this same reason, out-patient mental health resources were not excluded.

The reference lists of the selected publications found through the previous searches were also reviewed to find suitable articles for the literature review. Through this, 7 more articles were selected to review abstracts, and of these 4 abstracts were found to be relevant to the topic, and met criteria. These articles were subsequently used in the literature review. Areas of literature reviewed included mental health discourses and literature themes on nursing care for people diagnosed with BPD.

**Mental Health Discourses**

To situate the research, some examination of broader mental health discourses are discussed here. These discourses are: biomedical, pharmaceutical, and consumer-driven care. Though not specific to BPD, an understanding of the broader discourses in mental health helps in appreciating what particular understandings inform the work with this group of people, and thus useful with data analysis. Drawn from the literature reoccurring and dominant commentaries and particular language used were grouped or clustered. These were then placed into reoccurring groups or clusters creating the discourses visible in the literature.

**Biomedical Discourse**

The biomedical discourse is prominent and a significant part of the general mental health culture. Crowe (2000) discuss the discourses involved in the construction of the DSM 4,
informing DSM 5, the ‘bible’ of psychiatry. The DSM constructs or defines what reality is, by defining one true normalcy (Crowe, 2000). This normalcy is situated in the individual and contributing factors to mental health problems (Crowe, 2000) such as poverty and culture are ignored. Disorders such as depression and schizophrenia are strictly due to chemical imbalances; the medical gaze looks at mental disorders as products of the brain, which allows professionals to objectify the illness and the person with the illness (Crowe, 2004). Roberts (2005) also discussed how this medical gaze instills a power imbalance, as patients know breaking normalcy will result in a consequence meted out by physicians and nurses. The biomedical discourse also includes the psychological discourse which sees mental illness as the person malfunctioning in their environment (Fischer & Freshwater, 2014). Lakeman (2013) regards this biomedical standardization of mental illness diagnosis as not suitable for the complexity of mental illness and suggests that the focus on diagnosis is related to insurance companies requiring a diagnosis prior to paying for treatment.

**Pharmaceutical Discourse**

   The second discourse is pharmaceutical. Foucault (2006) saw the use of medication as a method of control and discipline over patients, a way of reinforcing the power of psychiatric asylums and complicity in social norms of the day. Bracken and Thomas (2010) suggest that a post-psychiatry critical discourse requires critiquing of the pharmaceutical industry. Pharmaceutical treatment for mental illness is noted as being found almost by accident; the drugs were developed for other purposes and then discovered efficacy in treating symptoms of psychiatric illness (Lakeman, 2013). The Evidence Based Practice (EBP) discourse reinforces the continued use of medications in treating illness as medications are more easily used in randomized trials (Lakeman, 2013). Lakeman states that biological treatments such as
medication do not necessarily indicate a biological cause of disorder. Crowe (2004) also writes of diagnosis being linked with medications. To prescribe medications, a clear diagnosis must be in place (Crowe, 2004). This clearly intersects with the biomedical discourse, with the diagnosis itself a construction of that discourse, and pharmaceutical discourse reinforcing the biomedical.

**Consumer Driven Care Discourse**

Finally, the discourse on consumer driven care is present. Fischer and Freshwater (2014) discuss the empowerment and choice discourse, but raise questions on whether this can successfully be used when people with mental illness have been marginalized and segregated. The authors discuss tokenism related to this discourse in which people with illness are mentioned only as afterthoughts. Inclusion and empowerment are a noble aim, but if driving focus in the mental health care system is segregation, control, and power-over, choice is negligible and might be used to mask the underlying dominant discourses. Crowe (2000) suggests there is a discourse of productivity in mental illness, where lack of productivity (work and social functioning) is seen as a diagnostic indicator for illness. Productivity in most Western cultures is derived from “neo-liberal and rational ethos” (Crowe, 2000, p. 73) where value is placed upon profits and inequality is a natural consequence of society (Thorsen, 2010). A question might be whether the focus on productivity in our society leads those with an illness to take ownership of their care and treatment to show productivity and thus less likely to be seen as sick. Certainly, being free to decide what treatment is best without professionals dictating care is appealing on many levels, but what might be the rationale behind those in power allowing it to happen? Bracken and Thomas (2010) identify the need for a post-psychiatry discourse, in which a partnership movement is encouraged, so people with illness are supported in deciding and are involved in their care.


**Literature Themes on Nurses’ Perceptions of People Diagnosed with BPD**

Review of the literature found through the previous searches discovered limited information on nursing or health care discourses towards people diagnosed with BPD. Thus, articles that addressed views, feelings, and attitudes were considered in evaluating the need for research into this arena of mental health nursing. Indeed, there is consistently minimal research on this broader topic as noted in the literature reviews by Sansone and Sansone (2013) and an earlier review by Westwood and Baker (2010). The treatments for BPD and accompanying self-harm seen as most effective are psychotherapies such as Dialectical Behaviour Therapy (DBT) (Gunderson, 2011; Hawton et al., 2009; Leib et al., 2004; NICE, 2009b; Oldham, 2005). These types of interventions require health care staff to provide a stable, caring, trustworthy relationship (Linehan, 1993; Lynch, Chapman, Rosenthal, Kuo, & Linehan, 2006; McMain et al., 2009; Swales et al., 2000). In light of this, understanding relationships and attitudes of nursing staff are vital. There is a clear need for more literature that addresses attitudes and perceptions of nursing staff towards people diagnosed with BPD to provide groundwork for a discourse analysis in mental health nursing. What literature is available can be divided into themes: manipulation; lack of education and clinical supervision; lack of appropriate treatment. As earlier indicated, perceptions and emotions related to people diagnosed with BPD would not necessarily indicate a discourse. Thus, this literature review was categorized into themes, which informs discourse analysis, including underpinning power relationships which are discussed later in the thesis.

**Theme One: Manipulation**

Throughout the articles reviewed, the words manipulative and manipulation were consistently noted. Use of the word typically has a negative meaning which seems likely to impact nursing care towards people diagnosed with the disorder. An on-line Google search of
synonyms offers such words as: scheming, wily, calculating, artful, shrewd, and devious. Deans and Meocevic’s (2006) quantitative Australian study found patients were seen as manipulative and demanding by nurses. Another quantitative Canadian study by Gallop, Lancee, and Garfinkel (1989) revealed nurses using belittling responses which resulted in more emotional distance to hypothetical patients diagnosed with BPD, than patients diagnosed with schizophrenia. They suggest this may be due to nurses perceiving people with the BPD diagnosis as manipulative. Crowe (2004), Ma et al. (2009), McGrath and Dowling (2012), Nehls (2000), Weight and Kendal (2013), and Woollaston and Hixenbaugh (2008) all reported people diagnosed with BPD were viewed by health care providers as manipulative and threatening. O’Connell and Dowling (2013) discuss a patient who “sabotages any plans for discharge” (p. 29) and name “splitting” (p. 29), often thought of as a patient playing one nurse off another. Westwood and Baker (2010) refer to in-patient nurses viewing people diagnosed with BPD as being manipulative and even dangerous.

**Theme Two: Lack of Education and Clinical Supervision**

Several articles discussing nursing people diagnosed with Borderline Personality Disorder refer to gaps and lack of knowledge and education for people living with the disorder. An underlying discriminatory attitude may result in less attention paid to understanding and treating people. Lack of education and research may point to a devaluing of the diagnosis or people with the diagnosis. Less consideration is given to learning and treating the disorder, health care providers then find less value in working with the population. Bergman and Eckerdal (2000), in their Swedish study of caregivers’ (including nurses, physicians, psychologists, and social workers) attitudes and beliefs towards people diagnosed with BPD, identified significant system deficits including a need for better supervision of clinical staff, and increased skill base in
working with this group of patients. King (2014) encourages specialized education for nurses directed towards treatment interventions for people diagnosed with BPD. Black et al. (2011) also used education directed towards treatment and found increased optimism and hope among health care professionals, but the study did not address whether these results were long term changes in practice. Nehls (2000) suggests education on “maintain[ing] a helping relationship over time” (p. 17) could help nurses become leaders in work with people who are given the diagnosis. Ma et al. (2009) encourage a collaborative team approach to promote optimism among team members, as working alone may result in guilt and even feelings of trauma. Cleary et al. (2002) endorse education for nurses, but suggest further research on the particulars. Deans and Meocevic (2006) cite a lack of knowledge among nurses as leading to negative attitudes towards people. Regular supervision, including time to debrief on difficult experiences is regarded as critical (James & Cowman, 2007; McGrath & Dowling, 2012). Understanding the dimensions of BPD and nursing self-awareness is also highlighted by Hauck, Harrison, and Montecalvo (2013). Adequate supervision, including self-reflection, and education in appropriate treatments are identified by Woollaston and Hixenbaugh (2008) as important in nurses’ work with this population of patients.

In addition, Bodner Cohen-Fridel, and Iancu (2011) argue that education on BPD should be “mandatory” (p. 544). Liebman and Burnette (2013) reiterate the importance of relevant education and propose that novice nurses would benefit from in depth training to counteract burn out and promote self-awareness of negative reactions. In fact, without adequate knowledge it is questioned whether quality care can be provided (Deans & Meocevic, 2006; Westwood & Baker, 2010).
With in-patient nurses providing the majority of care for those diagnosed with BPD, both undergraduate nursing education in mental health and post Registered Nurse (RN) learning opportunities should include a significant amount of content directed towards care of people with BPD. Hauck et al. (2013) report higher nursing optimism about prognosis with patients than other studies, but correlate the brighter outlook with longer years of experience and on-going nursing education. However, James and Cowman (2007) reveal in their small study on nurses’ knowledge and attitudes that only 3% reported having any post-RN education on the topic of BPD.

**Theme Three: Lack of Appropriate Treatment**

Another area of concern for nurses and other caregivers is the lack of suitable treatment options. As with lack of education, poor treatment options underpin the devaluation of the diagnosis and help frame this study. Cleary et al. (2002) in their Australian quantitative study of mental health professionals including nurses, found 66% of the 516 survey participants reported inadequate management of people diagnosed with BPD. Bergman and Eckerdal (2000) identified the need for more organizational cooperation in treatment and a shared philosophy of care for those with BPD. This particular research also pointed to an overuse of medication in treating the disorder and noted a “polarization between a positivistic and a psychodynamic-cognitive approach” (Bergman & Eckerdal, 2000, p. 249). King (2014) discussed other diagnoses, such as depression being treated, while the symptoms of BPD were ignored, because of discomfort with non-pharmaceutical approaches. Black et al. (2011) write of the differences between professional designations in accepting medication as appropriate treatment. They noted psychiatrists valued treatment with medicines more than social workers and psychologists. This may be a result of psychiatrists’ role in prescribing medications. Nelson (2013) writes of the
need to move from a pharmalogical based approach to a psychodynamic (talk therapy) approach. Crowe (2004) identifies the need to move from a behavioural model which presumes a person’s personality is flawed towards a psychodynamic approach. She sees the diagnosis of BPD as constructed by the biomedical model of health care.

James and Cowman (2007) in their study of hospital and community Dublin nurses, found 81% believed care was lacking and also raised the question of why psychodynamic therapies are not available. For example, though research was conducted to explore service users’ perspective, Nehls (2000) writes of women with BPD accessing hospital care, experiencing care provision as “intentionally limited” (p. 290) due to inadequate communication with health professionals. Fraser and Gallop (1993) suggest that nurses’ impervious and indifferent attitudes may be related to feelings of incompetence in treating people with BPD. Bodner et al. (2011) also found among nurses, psychiatrists and psychologists that nurses were the least empathic of these three disciplines and also theorized that it may be due to being on the ‘front line’ of care and thus more exposed to the sometimes challenging behaviour such as suicide attempts and mood swings. In addition psychologists held less antagonistic judgements than nurses and psychiatrists which might be related to a less “authoritarian and limit-setting styles of other professions” (Bodner et al., 2011, p. 553). This could be understood to be the discourse of power which will be discussed further. Bowen (2013) studied nurses’ perceptions of good care for people diagnosed with BPD and identified realistic optimism and inclusion as important in helping people with recovery work, but noted this work orientation has not been incorporated into actual practice. Improving communication skills and positive attitude is critical in caring for people diagnosed with BPD and helps build therapeutic relationships leading to better outcomes for patients (Weight & Kendal, 2013).
Summary of Literature Review

Research on nurses’ perceptions towards people diagnosed with BPD is limited, especially in light of the prevalence and impact of the disorder on nursing practice. In itself, the scarcity of research may be indicative of less value in treating people with the diagnosis of BPD, as research requires funding and an interest by academics and health care professionals. The notion of less value can also be seen in limited educational opportunities for nurses in understanding and treating people with the diagnosis, as again spending time for educational purposes either in university or on the job, requires investment by those in power who fund education. The limited service access and treatment seem to indicate a discourse behind these scarcities, as again, more money and effort is spent on diagnoses given ‘value’. The frustration in working with people who have this diagnosis, while perceiving appropriate resources and education are not present, is evident to me in my work, and I have heard other health care providers echo similar complaints.

Common language used in articles noted in the theme of manipulation outlines the importance of language in this work. Literature reviewed here showcases some of the underlying beliefs of nurses such as seeing patients as manipulative, but also highlights the possibility of the language reflecting the broader social and medical perception of people diagnosed with the disorder. I have sometimes thought about and participated in an undercurrent of blame attached to people diagnosed with BPD in mental health work. Given the literature review and observed lack of resources, a question arises if health care workers ‘blame the victim’ for needing services nurses are unable to provide. Underpinning these multiple positions, those of blaming, lack of education, resources or taken-for-granted assumptions, it is clear tensions and ambiguities exist in the care provision for people with the medical diagnosis of BPD. It is
understandable nurses might become overwhelmed and wish to focus on other diagnoses where more resource is attached, simply to increase job satisfaction. Trying to provide service when there is an overlay of futility in people becoming ‘better’ or ‘cured’ from a biomedical perspective might be seen as a Sisyphean task. Thus, questions arise on what may influence nurses to see patients as manipulative, rather than constructing the clients lives in other ways.

The following chapter discusses the methodologies used in conducting the research.
Chapter 3: Methodologies

Researcher Position

Using feminist discourse analysis to research in-patient nurses’ attitudes, beliefs and understandings of people diagnosed with BPD requires the researcher to identify where she is positioned. Feminism is described in detail further in this chapter, but firstly researcher position as defined by Hall and Stevens (1991), and Fonow and Cook (2005) states feminist researchers must clearly explicate their situatedness. Understanding and explaining roles and researcher position ensures transparency and offers opportunity to consider awareness of participation in power dynamics and taken-for-granted beliefs. Exploring personal positioning, especially when the position is one of power, such as a researcher, creates space for other views to be seen and heard. These can be first steps in making a safer environment to explore inequities in power, both directly in the research process between the researcher and participants, but also extending to the research discussion on nurses understanding in providing care for people diagnosed with a mental illness.

Currently, I am a Team Lead for Assertive Community Treatment (ACT) program in Community Mental Health and Substance Use in Kelowna, British Columbia (BC). However, my interest in the topic developed at the hospital where I was Staff Development Educator on the in-patient mental health and substance use unit. My role was diverse, including some patient care, but mostly consisting of education and implementing policy direction within this in-patient setting. Thus, I was often in a position of evaluating care given on the unit. This led me to question some of the dominant practices within mental health care.
In the role as educator I also facilitated education on treatment options for people diagnosed with BPD directed towards nursing, social work, and occupational therapy staff on our unit. Though the education was relatively well received, I continued questioning both my own practice, but also the many taken-for-granted beliefs, practices, and ways of acting which I engaged in within my work environment and also my colleagues. Education has been helpful in opening conversations on BPD and strategies to help people, but questions remain for me about why nurses in my work environment, along with other health professionals, continue to struggle with appropriate treatment for people given the diagnosis. Ironically, within my current position as Team Lead for Assertive Community Treatment, I screen potential clients for service suitability and though some clients may have a secondary diagnosis of BPD, criteria for acceptance into the ACT program must include a primary psychotic disorder, such as schizophrenia, schizoaffective or bipolar disorder. Those with only a diagnosis of BPD are not considered good candidates for this service. Reflecting upon this, I recognize that I could well be perpetuating discriminatory practices towards people with the diagnosis of BPD by excluding them. In particular, Horvitz-Lennon, Reynolds, Wolbert, and Witherridge (2009) reviewed the use of ACT for people diagnosed with BPD and did not support the use of the program due to lack of research. Instead, they promoted the use of comprehensive Dialectical Behaviour Therapy programs to meet the need. Unfortunately, my local health authority does not offer a comprehensive DBT program. Some frustration with the current state of treatment for people diagnosed with BPD has led to an initial discussion of better ways to support those with the diagnosis.
Feminism

There has been considerable debate on what constitutes feminist epistemology and in this case the feminist approach adopted in this study. Feminist methodology is considered here using four principles: 1) reflexivity 2) emancipatory action 3) oppression and 4) status and role of women.

Feminist informed research includes reflexivity. This is the process of acknowledging position, power, and responsibility (Aranda, 2006). The researcher considers and critiques the act and meaning of research (Fonow & Cook, 2005). Dowling (2006) refers to feminist reflexivity as being a reciprocal process whereby participants share and learn from one another. Interpreted here the participants shared their understandings with me and then I found myself questioning the extent to which I too participated in the taken-for-granted practices that act, for example, to stigmatize clients diagnosed with BPD. In addition the intent of reflexivity is to also transform understanding. Problematizing practices facilitates this disposition in ways that surface tensions between for example, ways people act and the language they use. Inherent in this problematizing is the ability to illuminate the tensions, inconsistencies and contradictions in professional landscapes. Using a feminist approach creates opportunity to challenge dominant taken-for-granted beliefs, practices, social relationships, and discourses by drawing attention to oppression and relations of power. Hall and Stevens (1991) conclude one of the principles of feminist research is creating change transformation, through criticism and social action. Emancipatory action as a principle of feminist research “actively formulate[s] solutions for positive change” (Rose & Glass, 2008, p. 15).
Feminist researchers openly discuss how situatedness, social constructs, subjectivities, and the research process itself impacts the researcher and those with whom the researcher engages. Often considered an ethical concern, feminist methodology pays attention to participating in research in an ethical way (Olesen, 2011, p. 135). This not only means that the research has received ethical approval but also that it questions the way the researcher works with participants sharing understandings in a reciprocal relationship. In addition, power within these relationships is acknowledged. In this research, there were power differentials between myself and the research participants as researchers are understood to hold power related to the institutions of knowledge, and within the research team between myself and my research committee, as there are student/professor relationships. I had influence on participants in the ways in which I collected and processed the information given by participants. However, I was also influenced by the other researchers in the study, as their feedback and suggestions impacted my understandings of the research, but also whether I would succeed in my research and educational aims. Ultimately, understandings derived from this study, may impact care for people diagnosed with BPD, and thus there is a power structure impacting potential patients.

Feminist theory focuses on the experience of women’s oppression. Of particular concern in this study, Canadians who are diagnosed with mental illness are too frequently marginalized (Canada, Senate, 2006) and within the mental health setting, people diagnosed with Borderline Personality Disorder are further oppressed (Aviram, Brodsky, & Stanley, 2006; Markham, 2003; Nehls, 1998; Westwood & Baker, 2010). They are perceived by health care providers as a “chronic drain on health care resources” (Kealy & Ogrodniczuk, 2010, p. 145). In her discussion of oppression, LeBlanc (1997) claims that nurses need to consider how they categorize oppression and suggests that there must be careful consideration in any labelling process to avoid
unwittingly reinforcing a “colonizing gaze” (p. 259). Therefore, when referring to people given the label of BPD in this thesis, people are deliberately referred to as ‘diagnosed with’, rather than ‘having’ or ‘being’ BPD. Being diagnosed with a disorder by a medical professional can clearly lead to preconceptions and beliefs on what is ‘truth’ in treatment and care by health care providers. Power is clearly evident in diagnosis of BPD, as only physicians are able to diagnose. Diagnosis can easily become an oppressive label and impacting one’s identity, rather than an external finding by a physician. Understanding this position, I acknowledge how my categorization of people in this study may inadvertently reinforce power differentials potentially perpetuating the oppression patients diagnosed with BPD might experience including stigma.

A feminist approach looks at societal influences and inequities in consideration of the status and role of women (Aranda, 2006; Fonow & Cook, 2005). Psychiatric diagnosis in general, (Shaw & Proctor, 2005; Thachuk, 2011) and BPD in particular (Nehls, 1998; Sansone & Sansone, 2011; Warner & Wilkins, 2004) has been discussed in research as gendered. Given that BPD is diagnosed more frequently in women, and nurses are predominantly female, using a feminist stance is appropriate. Adopting a feminist approach meant ensuring women’s voices were heard by interviewing women during the research process and considering how those (mostly) women diagnosed with BPD fared within the mental health system. Men’s voices were also present during the interviews, though in smaller numbers than women. Thus discourses emerge from the appearances of women participants’ voices reflecting their personal/professional subjectivities. Embedded in these subjectivities are meanings. Nurses interviewed were both female and male, and though this research did not ask specifically for nurses’ thoughts on women diagnosed with BPD, frequently participants spoke of women when
referring to their work experiences. What is apparent are the multiple subjectivities conveyed in different texts which were then deconstructed to reveal the various discourses.

A common concern raised with feminist research is some positioning by feminist researchers that there is a knowable, singular truth (Aranda, 2006; Grant & Giddings, 2002). Given the intention is to explore discourses behind nurses caring for people with the diagnosis of BPD the dominant assumptions of ‘truths’ impacting care can replace singular truth claims. Using a relational ethical stance, a fuller picture of what discourses are present might provide a better understanding of potential for changes to practice. Therefore, individual situations and relationships are used to examine power imbalance and thus might work to look at issues raised (Oleson, 2011).

The next section discusses discourse analysis used in this research study.

**Discourse Analysis**

Discourse analysis is a post-modern qualitative methodology. Reality is seen as socially constructed, and how this social construction affects power relationships and oppression within society is considered carefully (Carr & Kemmis, 2005; Powers, 2001; Zeeman & Simmons, 2011). Cheek and Rudge (1994) refer to reality and knowledge being “socially relative-they pertain to specific historical and social contexts” (p. 16). To understand these contexts, written and spoken texts and communications are explored and analysed for their unspoken assumptions and beliefs (Cheek & Rudge, 1994; Lynam, 2007; Powers, 2001). This research analyzed nursing interviews about people diagnosed with BPD to understand discourses behind care provided to patients. Powers (2001) notes that discourse analysis makes no claims for generalizability, as opposed to modernistic, reductionist reasoning. Discourse analysis is meant
to create knowledge used to break down imbalances (Powers, 2001) and brings to the forefront inconsistencies between policy and practice (Lynam, 2007) as well as incongruities in practice. These are important considerations when working with marginalized people, such as those diagnosed with BPD, who may have been studied but not seen or experienced an improvement in care after being the subject of studies- a true gap in applying research to practice.

Michel Foucault (2006) examined the role of medicine, psychiatry and power. His work, described as Foucauldian, examines power relationships within discourses, such as biomedical, and how those involved position themselves (Campbell & Arnold, 2004; Stevenson, 2004). Though power structures and institutions, such as schools and hospitals, are found throughout society, Foucault (2006) saw mental health asylums as different due to the overlay of medicine and medical power. The words and language found in institutions both describe the discourse, but also inform and produce the discourse itself (Stevenson, 2004). Thus, discourse continually creates and recreates itself and in so doing, continually creates and recreates reality.

**Discourse of Resistance and Power**

Powers (2001) discusses Michel Foucault’s philosophical work on power and resistance and writes of the role of confession in the power dynamics that play out in society. Specifically, confession is used within health care settings. This setting is an arena of bio-power where according to Foucault, empirical control through the social sciences, including medicine and nursing occurs (Powers, 2001). In an area such as mental health, professional health care providers make scientific and empirical claims determining what is or is not normal mental functioning. People seeking care must reveal or confess their thought and behaviour patterns and then medical professionals determine whether these are normal, and if not, intervene to change the thought and/or behaviour patterns through treatment. People who are deemed significantly
mentally unwell may be unwillingly detained in health care facilities, observed, assessed, and treated. As an example, mental health language refers to people gaining insight into the nature of their diagnosis. Speaking, or acknowledging (or perhaps acquiescing?) the nature of their illness is seen as significant and an indication of mental healthiness. However, through the lens of Powers and Foucault, this insight might be seen as the person agreeing or maybe capitulating to the unspoken social contract of confessing to health care providers. Cheek and Rudge (1994) state that the critical question within discourse analysis must include, “whose voice dominates or emerges, and whose is silent” (p. 18). When a person disagrees with a diagnosis or is not provided an opportunity to contribute to decision-making about their mental health, this person is disqualified by professionals and silenced; once agreement within the professionals’ circles occurs the dominant discourse prevails, the person is given voice.

The medicalization of social control is evident when social ills are viewed as health issues, solved through medical interventions (Powers, 2001) in which the human body is seen as an object and space for medical professionals such as doctors and nurses to act on. People are deemed well or unwell contributing to a binary and extinguishing all other possibilities. The psychiatrist is the specialist who is able to legitimize who is normal or not by societal structures. The psychiatrist, a member of the medical profession, in fact has been given power and determines what reality is (Foucault, 2006) through texts such as the DSM. By positioning medicine as scientifically ‘proven’ and thus the ‘truth’, psychiatry creates the only truth (Foucault, 2006). Psychiatrists’ words are more powerful than any others within the mental health medical setting. As psychiatrists have the power to determine legitimate diagnoses, owning the ‘truth’, psychiatry is the only entity able to evaluate itself (Foucault, 2006).
questioning this ‘truth’ the reality is there can be no questioning of who is in authority, it is those who hold the truth.

If the biomedical discourse situates someone as unwell or abnormal it leads to further marginalization (Crowe, 2005; Thachuk, 2011; Wilkin, 2001). Power and control held by the dominant biomedical system continues stigmatizing those with mental illness or difference. Rather than bodies being part of a human being, the human form is ordered according to norms, and Powers (2001) notes women are especially vulnerable to the objectifying of bodies due to medicine’s male dominated system. If the body is objectified and social problems are medicalized, then social ills are treated within the body. Issues such as poverty become an individual’s ‘problem’ or shortcoming, and are addressed through individual medical interventions, rather than examining social inequities that might lead to poorer health. Here it is possible to appreciate the politics of liberalism with an absence of social connectedness. The diagnosis of BPD is given primarily to women, many who have experienced abuse in their past. Using Foucault’s lens, the social issue of abuse becomes a medical illness to be treated in those women’s bodies, rather than addressing the ethical and social implications of abuse (Shaw & Proctor, 2005). By focussing on the biomedical discourse with diagnosis and personal attributes, the impacts of the social determinants of health are easily ignored (Arrigo & Williams, 1999; Shaw & Proctor, 2005; Thachuk, 2011). Notably, Barker (2003), Buchanan-Barker and Barker (2008), Crowe (2005), Radden (2012), Shaw and Proctor (2005), and Wilkin (2001) all write of identity loss people experience when diagnosed, labelled, and categorized. By giving a person a diagnosis, the underlying social conditions such as abuse, poverty, and poor access to health care are minimized or ignored by the biomedical discourse placing responsibility into genetics, or poor lifestyle choices. These social conditions include female status, as women are often
marginalized as noted in feminist research and in the case of BPD, are diagnosed in women more frequently. Social change will not occur, as illness is seen as an individual responsibility. These scenarios offer opportunity for feminist examination of social injustices.

**Feminist Discourse Analysis**

Feminist discourse analysis looks to see whose interests are being served and interpreting power structures and relationships (Powers, 2001) along with the oppressiveness experienced through the language imbued in these relationships. Powers (2001) refers to the “tyranny of the discourse of caring” (p. 43) and notes that caring is seen as part of being female. Associated with this is the therapeutic relationship in which Powers comments, the patient/object is acted on by the nurse. Change occurs by the force of the nurse, questioning the actions of nurses within mental health. The discourse behind caring in mental health is one worth considering. Nurses and clients in mental health have significant power imbalances. The medical system has the authority to detain people deemed mentally unwell, with nursing observation and assessment impacting perceived readiness for discharge. Reflecting upon the unconsidered forces behind the caring, one wonders do nurses use the act of caring to elicit confessions from people who are ill, thus reinforcing the control and power of medical professionals?

**Limitations of Discourse Analysis**

Campbell and Arnold (2004) identify challenges in using a discourse analysis approach in their paper. There are limited studies in nursing research using this approach and thus limited avenues to determine appropriate applications (Campbell & Arnold, 2004). Indeed, when considering how best ‘to do’ discourse analysis, I found little information on practical methods. Rather discourse analysis could be seen as “an orientation towards research rather than a recipe
for doing it” (Campbell & Arnold, 2004, p. 31) and there are limited nursing studies using this type of methodology (Campbell & Arnold, 2004). Given that discourse analysis is post-modern and therefore pluralistic and not uniform (Stevenson, 2004), itemizing it to do research is challenging. This will be further discussed in the data analysis section of this paper.

Another challenge in discourse analysis could be avoiding an ethical stance. Emden and Sandelowski (1999) describe how post-modernism can struggle with finding meaning and goodness in research. This might be defined as the idea that there is no universal truth to be discovered, nor is there any knowledge without context. The position is appealing for the freedom it offers in knowledge generation and acceptance of differing philosophies and traditions. There is a limit however and carrying this idea further leads to challenges. For example, moral ideas are indeed contextual, the moral dilemmas encountered by ethicists and health care providers speak to considering situation and individual need, rather than handing out judgement. Powers writes that the discourse process is “narrative with moral intent” (Seidman as cited in Powers, 2001, p. 10). Yet, there is a need for careful evaluation of moral and ethical encounters and society generally agrees on some moral parameters, as without them there is great potential for relativism and moral ambiguity. Using a relational ethical stance is helpful as this position finds understanding in working with women’s subjectivities and

immersing oneself in the situation, rather than using external rules to determine right and wrong. Principles such as beneficence…are not discarded, rather the[y]…require analysis within context; application of the principles cannot occur without examining the uniqueness of each situation” (Wensink & Oelke, 2013).

Using discourse analysis with a feminist approach helps to keep ethical issues of justice and equality at the forefront, while examining social and cultural ideas which may be perpetuating
stigma on both institutional and personal levels. For instance, considering language used by nurses when referring to people diagnosed with BPD, helps uncover general mental health attitudes and beliefs, while at the same time honours the individual nurses’ understanding of what care in this area means.
Chapter 4: Methods

Data Collection

Discourse analysis requires a discursive object, such as written or oral text (Powers, 2001). For this study, semi-structured interviews with Registered Nurses and Registered Psychiatric Nurses (RPN) were conducted to analyze the discourses found when caring for people diagnosed with BPD. Academic research papers, such as those mentioned in the previous literature review, as well as any others found during the course of the thesis writing period were also used. Examining the literature both before and during analysis of the interviews helped reveal individual and larger discourses informing nursing work with people diagnosed with BPD. The discourses within the literature were then examined with the individual interviews and connected where there were common themes.

Purposeful sampling was used in this study. This sampling groups people according to the particular research question (Mack, Woodsong, MacQueen, Guest, & Namey, 2005) to meet the requirements of the research (Powers & Knapp, 2011). Interview participants were RN’s and RPN’s from two in-patient, publically funded mental health units within the interior of BC. These participants also had a minimum of 6 months of experience working in the area of mental health and cared for a person diagnosed with BPD within the previous 6 months. Exclusionary criteria were any RN’s or RPN’s who had not practiced for 6 months, or had not cared for a person diagnosed with the disorder.

A letter requesting support of the research project was sent to the unit managers via email (see Appendix A) along with an information sheet (see Appendix B) and the ethics summary. This information sheet was distributed to all the RN’s and RPN’s on the units by the unit
managers via email once ethics approval was obtained (see Appendix C). Follow up reminder emails were sent every 2 weeks to unit managers within the health organization for 2 months and asked to forward on to unit nurses to ensure all nursing staff were aware of the project until enough sample participants were obtained. As the research is qualitative discourse analysis, a large sample size was not needed.

Seven potential participants responded by email indicating interest and wished to participate. These nurses had a range of ages, practice experience, professional designations (both RN’s and RPN’s participated), and both male and female nurses were involved in the study.

Once the potential participants had indicated interest by emailing, the writer responded by email (see Appendix D) and also included the consent form (see Appendix E). The consent form was also reviewed with each participant in person prior to beginning the interview, ensuring informed consent.

Interviews were conducted from October 2014 to January 2015. They were held mostly at private meeting rooms in the health agency, with only one interview conducted at the participant’s home. Interviews took approximately 1 hour, ranging from 49 minutes to 1 hour and 9 minutes. The interviews consisted of open ended questions (see Appendix F). The interview format versus focus groups was chosen for data collection as information gathered may be seen as sensitive; it includes nurses’ beliefs and opinions on a group of patients who may provoke an emotional reaction and thus more suitable to an interview format, rather than focus group (Elmir, Jackson, Schmied, & Wilkes, 2011; Mack et al., 2005). Participants were asked about beliefs and conceptions of people with a diagnosis of BPD. This lent to using an interview process in accessing participants’ understandings of the “connections and relationships a person
sees between particular events, phenomena, and beliefs” (Mack et al., 2005, p. 30). Further, a focus group consisting of 5 to 10 nurses on one in-patient unit would be difficult to conduct given the challenges with shift work in a 24 hour facility.

The interviews were digitally recorded and transcribed verbatim by the writer, ensuring accuracy and completeness. The names of participants were kept separate from the interview transcripts. In the written transcripts participants were identified by pseudonyms of their choosing. The transcripts were kept in the researcher’s password protected computer hard drive. Once the interviews were transcribed, each interview was sent to the participant by encrypted, password protected email (see Appendix G). The password to access the transcribed word document was sent in a separate email. Participants were asked to contact the author by email or by telephone within 2 weeks of initial email if there were any discrepancies or questions about the transcript. They were also asked to write a brief reflection on the interview and return it via password protected email within two weeks if they chose to do so. One participant replied with a brief email elaborating on the interview, but other participants did not offer any more reflection. If no reply was received within the two week period, an email reminder was sent inviting a response within the next two weeks. If there was no response it was assumed that the transcript was an accurate reflection of the interview. Participants confirmed the transcripts were accurate as transcribed, though three people noted that they did not realize how often they used conversational fillers, such as ‘um’. One participant noted that he appreciated the opportunity to reflect upon practice as it had led to a request for further education on people with BPD.

Participants were informed they were free to withdraw from the study at any time and would have been sent an email thanking them for their involvement regardless of whether they
have completed the interview process (see Appendices H and I). However, no nurses withdrew from the study.

Wodak and Meyer (2009) suggest that data collection within discourse analysis is not a precise empirical phase, but rather an on-going process with theoretical sampling used to find indicators for concepts, expanding into categories and then perhaps looking for further data. Thus, an examination of the literature addressing in-patient nursing treatment of people with BPD, was also used for data collection during the research process.

**Data Analysis**

After conducting interviews, I transcribed the interviews which allowed for immersion in the data. Hole (2007) and Kjorven, Rush, and Hole (2011) suggest multiple readings of the transcript once transcription is completed, with each reading contributing to the understanding of the material. Each time I read and reread the data, I made notes and categorized the data using a highlighter. Categorizing included considering each participant’s positioning and power relationships that might be potentially impacting participants. This focus on power and social positioning distinguishes discourse analysis from a content or structural analysis. I then reviewed the data and further categorized according to analyses mentioned by Wodak and Meyer (2009):

- Kind and form of text
- Arguments used
- Intrinsic logic
- Insinuations and symbolism
- Clichés and idioms
- Actors
Scientific references and knowledge source

Validity

Ensuring validity in qualitative data and research is challenging, yet a necessary requirement for research credibility. Nursing researchers have examined this topic with several authors offering methods of establishing validity. Emden and Sandelowski (1998), Emden and Sandelowski (1999), Hall and Stevens (1991), and Lincoln, Lynham and Guba (2011) all write of the difficulty of establishing credibility in qualitative research, especially if viewing with a modern, medical gaze and offer suggestions for evaluating this methodology. Wodak and Meyer (2009) note that “rigorous ‘objectivity’” (p. 31) such as claimed by quantitative research cannot be established through discourse analysis. For example, research language and text itself creates its own discourse and is as subject to these discourses as any other knowledge. Nonetheless, the issue of validity must be addressed, despite these difficulties.

Crowe (2005) maintains that discourse analysis can be verified for interpretive rigour by asking the following questions:

- Have linkages between discourse and findings been adequately described?
- Is there adequate inclusion of verbatim text to support the findings?
- Are the linkages plausible?
- Have the linkages been described and supported adequately?
- How are the findings related to current knowledge?

After reviewing and identifying discourses identified from nurses’ interviews and comparing to existing literature, this thesis demonstrates linkages exist between the identified discourses and text. A clear drawback in establishing validity in this manner is similar to discourse itself, whereby the text reinforces the validity, creating a circular argument.
These questions relate and correlate with the criteria of quality and completeness mentioned by Wodak and Meyer (2009) and Jager and Myer (2009) in their discussions of discourse analysis. These writers describe an analysis as being sound and complete if analyzing other texts show no further new discourses. This can be open to question however, as conceivably when other texts are examined and new discourses are uncovered, these may be seen in the original research. Also worth considering is the notion of analysis as interactive work, leading to changes in understandings, or reflexivity. A feminist reflexive lens underpinning this study leads the researcher towards constant re-evaluation of the findings. This reflexive process occurred during review of dialogue individually and within the supervisory committee. Considering this, a better mechanism for establishing validity might be triangulation. Wodak and Meyer note triangulation of data analysis is helpful in determining the quality of research findings.

Nurses participating in the study were given interpretation of the discourses to establish validity through triangulation (see Appendix J). The following section discusses the validation process.

**The Journey of Reflexivity**

The interview interpretation of the interviews (see Appendix J) were sent to participants to gather feedback. Once nurses reviewed the interpretation, they were asked to respond by email with any further reflections. This process also ensured that participants were meaningfully offered opportunities to critique and challenge the researcher’s findings. No response within a 2 week period was an indication they agreed with the interpretation. Of the 7 participants, only 6 were reachable by the contact information they had provided during the data collection phase. Out of the 6 participants, 4 responded briefly in email, and all agreed with the study summaries.
Only one had any further comments, and this participant expressed appreciation of the study and stressed the importance of examining work with people diagnosed with BPD. Further feedback from participants on whether the research findings were congruent with their experiences would have been helpful in saying emphatically that the results were valid. Perhaps having a ‘debriefing’ type of review would have been helpful in truly establishing whether the meanings I discovered as a researcher were consistent with the meanings of the participants. Also, understanding how the study offered opportunity for the nurses participating to consider their practice going forward in work with people diagnosed with BPD would have been meaningful, especially considering one of the aims is creating change for nurses and patients. However, given that all reachable participants agreed with the summaries, I conclude that the results are valid within the limitations above, noting that results are not generalizable beyond this particular group of nurses, working within their particular environments at that moment in their work.

The process of analyzing the data provided opportunity to reflect upon the participants’ voices and the meaning in their words, and uncovered some discourses influencing the nurses’ work. These discourses could help inform further research, and the participants also identified areas they perceived as requiring more investigation and possible action.
Chapter 5: Findings and Discussion

In this chapter participant demographics, the summarization process, interview summaries and discourses arising from the interviews are presented. Each of the four major discourses are discussed in terms of smaller sub-discourses.

Nurse Participants

Of the 7 participants, 5 were female and 2 were male nurses. Professional designations included 3 RN’s and 4 RPN’s (Registered Psychiatric Nurse), with mental health practice ranging from approximately 1 year to 15 years. Though ages were not specifically collected or identified, there was a range of ages from early to middle 20’s to over 50 years old. All had worked in the acute adult mental health ward, though some nurses had other mental health nursing experiences in other settings, either concurrently, or in previous employment. Other employment experiences will not be specified as it might inadvertently identify participants. A summary of each participant interview provides contexts and themes demonstrating how dialogue generated into discourses.

Participants’ Texts and Theme Summaries

Using discourse analysis data from the interview was organized according to broad categories, such as kind and form of text, clichés, and idioms, interviews were summarized by pulling out main ideas identified by participants, grouping together similar ideas, and omitting duplication. Though participants were all asked specific question, naturally their responses varied from person to person. In addition, depending upon answers, additional questions were often asked to provide opportunity for the participant to clarify or expand upon their response to ensure the participant understood the questions being asked. The interview summaries cannot
include all that participants said, but during the summary process, the intent was capturing relevant material related to the research questions and discourses found through analysis. For instance, during interview analysis, most participants answered the questions on self-harm directly, and identified this as a challenging situation to manage as nurses. Nurses identified emotions such as fear, worry, and distrust surrounding the topic. However, this same question also generated responses that referred to individual nursing care practicalities in managing self-harm behaviour on the in-patient mental health unit. Both types of responses were important to include opportunities for nurses to give a broader and deeper reflection of the challenges and strategies in providing nursing care for people who self-harm.

Each discourse summary provided to interview participants included dialogue about the background of the discourses arising or mental health practice and taken-for-granted practice in general. By grouping the dialogue from participant answers to questions asked within specific contexts, such as self-harm, clusters of ideas were reflected in the language used by the participants. These language clusters or commonalities began to coalesce and provided a deeper meaning. For instance, many participants referred to ‘splitting’, a common term used to describe times when staff perceive people diagnosed with BPD are ‘playing’ or manipulating one care provider off another. Again, this type of language provides context for the reader in understanding mental health work and thus was important to include.

When there were major variations in the dialogue between different interview participants, these statements were not included in the summaries. For example Leanne, one of the participants, elaborated and spoke about issues regarding restraint in multiple ways but contextual discourses varied widely and it was not possible to describe and summarize all the ideas she brought forward. Another example about discourses and contextual relevance
surfaced when Alex spoke about recent nursing union agreements, and changes in the work environment with older experienced nurses retiring. Though some may think these variations in dialogue could add depth to the summary, they were not included as they did not add to the discourses identified or provide deeper insights into nursing practice within the aim of the study.

During analysis the complexities of distilling several themes arising from the dialogue was challenging, yet some needed to be examined further. For instance in the biomedical discourse, a subtheme centered on somaticism in BPD. This theme alone could be researched in detail, and considering the mind/body philosophical debate covered by, among others Gadow (1980), Picco, Santorro and Garrino (2009) and Priest (2000), are not within the research questions or study, nor a particularly strong theme from the participants interviews. However, significantly strong areas worth considering are outlined in the participants’ interview summaries.

**Participants Dialogue and Discourses Emerging**

A summary of each participant interview provides contexts and themes specific to each participant and further among all participants demonstrating how dialogue generated into discourses when considering power and positionality. This dialogue depicts understandings expressed as text, and discourses were chosen based on practice expertise and literature reviewed. As mentioned earlier, the names of participants are pseudonyms. The interviews are presented in alphabetical order of pseudonyms. As an aspect of the feminist methodology the participants’ voices will be threaded through the commentary to give a sense of their situatedness, understandings and points of view. Also consistent with the methodology is that the transcripts were reviewed and authenticated by participant reviewing the summaries so the ideas that appear below are those meanings conveyed during the interview process.
Alex

Alex has worked in the in-patient mental health unit for 7 years as an RPN, and saw himself as a fairly experienced nurse. He reported working with people who have been diagnosed with BPD as frustrating, challenging and hard work as a nurse.

For the first year or two, Alex assessed and listened to patients but stated he was taken “on a little path of...arguing and trying to manipulate situations.” After several months, he learned how to work with people, recognizing patterns, being genuine, and now focusses on the strengths of the person. Using a strengths-based approach helped him build a therapeutic relationship. This approach includes highlighting ways people find solutions to their problems and applauding accomplishments. Learning this way of being with patients takes time however. He now observes newer nurse graduates struggling to work effectively with people who have the diagnosis of BPD, similar to his past experiences.

Alex suggested using a strengths-based approach can also potentially present problems, such as when he needs to enforce limits or unit rules. In these situations he reframes the situation, “you just kind of have to remind them that you know, it’s not me, it’s just the rules, and why do you think you’re having a problem waiting?” Alex found that he used a strengths-based approach in nursing practice when working with people, even prior to taking a course on strength-based strategies. Initially, he learned to work with people with the diagnosis of BPD from his own life experience. “It’s your own creativity and your own humanity, really.” He found this approach helps patients build insight on where their problems may be originating. In his role as a nurse he noted, “I don’t (pause) I don’t want to tell them what they need to do, but I can reflect on what is happening.”
His life experience is complemented with nursing knowledge and expertise, care planning with the rest of the team, relating to people, recognizing that patients “hold the key” and caring. Alex recognised that caring includes gently challenging people without becoming confrontational. He described caring as inspiring hope in patients, “like a trunk of tree, you can walk up to this branch. You can always come back to the trunk. Make a new branch.” Caring is critically important as there are “revolving door” patients, and the rapport built on previous admissions will make a “difference later on.”

However, there can be issues with “staff splitting” related to caring when the patient manipulates one care provider off another, disrupting consistency in the provision of care. Alex identified consistency as important, especially if learned skills, such as Cognitive Behavioural Therapy (CBT, a form of talk therapy focussing on relationships between thoughts, emotions, and behaviours) are being reinforced by nurses on other shifts, because these techniques require practice.

Alex also discussed how “patients get sick and tired of being asked questions. I think they actually want someone to work with them” and want practical help in solving problems. He believed that there is a significant role for nursing in working with people with the diagnosis versus the approach of physicians, who may take a more pharmaceutical oriented approach.

Working with people diagnosed with BPD who self-harm is often challenging and creates ethical dilemmas for nurses. Alex said he attended “to the wounds, rather than try and fix them for them. There’s a different energy there.” His perspective on attending to emotional wounds was similar in that he avoided trying to ‘fix’ the wound. He spoke of a particular example when a patient had tried to suicide. When he found her, he talked to her, reassured her, and put her on “10 minute checks” during the night, “subtly” and with “no drama.” Alex spoke of the
responsibility he had a nurse to keep people safe but also telling this patient, “if you kill yourself don’t blame me,” after this same patient continued to cut herself on multiple admissions.

Ultimately, the team decided that further admissions would not be helpful and that “not reacting” was better. The team “didn’t give up on her, we just accepted that that’s what she’s going to do and how’s the best way to support her in the community, while she’s doing that?” He saw this as being helpful because the patient was not readmitted.

Alex described what was important for other nurses to know when working with people who have been diagnosed with BPD. He stressed the importance of “good limit setting,” listening to patients, consistency, empathy, remaining calm and quiet, reflecting back their experiences, and that “it’s never personal... don’t expect them to just warm up to you... even though you hold the keys to the door, you still mean this much [a minimal amount].”

When asked what would be helpful in continuing to work with people who have a diagnosis of BPD, Alex suggested specific unit education directly helping nurses work with people. Even though he did not identify any particular gaps in service, over and above those already existing in mental health care, he did stress the potential value of lessening these gaps though educational presentations of BPD directed towards care providers. Alex also mentioned the inability to predict choices people make after leaving the hospital which may determine their success and failure.

Anne

Anne has several years of experience as a Registered Nurse working in acute mental health. She spoke of days working with people who have been diagnosed with BPD as being “either a fabulous day or...a really difficult day” but not “an ordinary day.” She indicated she
has often worked with people with the diagnosis, as usually female nurses are paired with female patients. She did not explain why work was structured this way, but given the previously mentioned trauma and abuse many people diagnosed with BPD have endured, it may be a protective measure for the patient and nurse. Work with people diagnosed with BPD was described as “difficult” “frustrating” and “trying.” Due to the length of time she has worked in this area, Anne reported that patients tend to gravitate towards nurses, like her, who they know from previous admissions, and that “splitting” will happen with these same nurses.

Anne also spoke of the importance of consistency when working with patients who have been given the diagnosis of BPD.

_You know, a promise, saying you’re going to come in [to see] for somebody with BPD is like somebody promising, ‘I will be there at 9 o’clock.’ And then there’s the trust and all, you know, the abandonment and all that comes into play if their expectations aren’t met. Staff, as a nurse, if I say, ‘you know, I’m really busy, I’m going to have half an hour in the afternoon to spend with you.’ I’m going to make sure I do it. So anything you say you’re going to do, you have to do that._

She continued to describe the importance of consistency which helped build relationship between nurse and patient.

_I believe the, trust, because often, and if you talk to a patient, they’re, they’ve dealt with some sort of abandonments, some sort of abuse. Something. You know, they’re not born with Borderline Personality Disorder, they develop it from stuff that happens. So, if your treatment towards them isn’t built on a trusting relationship, making them feel secure,
making them feel safe; then their stay will be longer, and your day will be more difficult.

And you know, it’s just not good.

Anne spoke of honesty and being forthright about what she was and was not able to do as a nurse. Anne noted that she was more likely to do a little extra for these patients; that she would call the physician promptly, and would in fact, demonstrate more caring for people with the disorder, than those patients who are “a little more laidback.” She described “little things that you can do…little comfort things… it’s not big stuff, it’s kindness.” This caring included more time such as one-to-ones, where the nurse spends exclusive time with the person. Anne contrasted this type of individualized care for people with a diagnosis of BPD with just giving medications, as in the case of someone with schizophrenia who was becoming “ramped up” or agitated.

Anne described working with people who are engaging in self-harm, or suicidal gestures, such as cutting as “Well, initially I thought it was awful. But I guess we’re told to minimize that part.” She tried to

make it more practical. Take away from the inside and make it more practical. Like, ‘Look what’s happened here. But you know, medically, obviously, you’re going to fix them up and that. But, I talk a lot. I talk to them. You know, ‘What’s going on?’

She spoke of a patient trying to self-harm on a night shift and that the approach was “I guess just more, not so much attention around that [the self-harm], just trying to get around keeping a better eye on them without them thinking, ‘Oh, I cut myself, now I’m getting more attention.’ It’s tricky.” She also spoke of the challenge in not knowing what exactly helps people when they are self-harming as
Often you think you’ve just spent two days focussed on this patient, more so than your others, and you’ve kind of gotten nowhere. But then after a week or two, you find that maybe you got somewhere because the next time, someone else had them, and someone else had them, [sic] and finally they got better. So, somehow it was a process that got them better and it could have been a variety of nurses. You know, all bringing their perspectives and that patient took it in…. I’m not sure what makes these folks well. (laughs slightly).

Anne has learned how to work with people who are diagnosed with BPD, but she noted initially she did not know about personality disorders, and they were simply seen as the “demanding” and “needy” patients. However, she found she was able to work well with people, perhaps because when she entered nursing her perception was, “You are caring for people, you’re serving people.” After working in mental health, she started “learning about boundaries and limits and stuff like that.” She spoke of trying to balance caring acts with needing to enforce unit rules and limits, and that this was most evident during the beginning of an admission to hospital.

I will be upfront and set limits and boundaries with people with BPD but at the same time, I will do what I can to make their day better. Recognizing that it’s not me that’s making it, it’s them but still you can be supportive and kind... in my mind, every patient still has to follow the rules of the unit. OK? So, fresh air passes [time spent unaccompanied off unit] are when fresh air passes are [at set times]. Just cause you have BPD and would rather go at a different time. So I’ll stick with the unit rules. So that’s one end of the balance. Try to do what I say I’m going to do... They’ve just come in, they’re very labile, even toxic. It’s really hard.
So, it takes a lot of patience and I think at that point I’m setting more boundaries, but they’re taking more of my time... And as they’re getting better and better, you don’t really need to set those boundaries because they get it.

Anne shared how she managed working with people with a diagnosis of BPD, and described a recent situation with a co-worker who was “being called everything” and appeared “ready to quit her job” as a result. Even though Anne has worked in mental health for several years, she reported “even if it was me, I would have felt the same way, with all those years [of experience]. Because the person, if they’re that toxic and mean. That’s what makes it difficult.”

Anne identified the need to self-evaluate, to know whether after a difficult shift, if she can care for that patient again, or if someone else should, as taking turns as a team may be necessary. At times, she has needed to take time off work due to mental fatigue.

Over the years, Anne has noticed more patients are diagnosed with Post Traumatic Stress Disorder (PTSD), rather than BPD. She attributed this to a desire to avoid the stigma associated with BPD within the mental health system. She also noted that most people with the diagnosis of BPD, also have PTSD, from trauma and abuse in their background. There are also changes in how nurses work with patients who have the diagnosis. Anne has seen a shift from “not just giving meds, but also giving homework,” such as CBT and Dialectical Behaviour Therapy worksheets. These behavioural change strategies help people make connections between thoughts, emotions, and actions, along with self-regulation strategies. Anne considered teaching these skills valuable because medications may help calm, but do not “cure BPD” and “won’t make it go away always.” Teaching these skills are a way to give people choices, other ways to cope, and “putting responsibility back” onto the patient, according to Anne. There is still a role for medications at the beginning of admission, when the patient may be quite unsettled, but then
working on the skills, socialization, and building rapport, with less medication used as the therapeutic support and admission progresses.

Anne advised that nurses do not need to “take things personally” when working with people with the diagnosis of BPD. She stated that though people with the diagnosis can be “manipulative,” nurses need to build rapport with patients, while being aware of potential for manipulation. This is also in the context of self-care for the nurse, knowing that people with the diagnosis can be reactive and emotional, and differentiating between “who’s the patient and who’s the nurse” which helps nurses react less emotionally. Managing manipulation was challenging as she wanted to be liked; setting limits and boundaries assertively was “very hard.” Deferring back to unit policy and rules is helpful in these situations for Anne to maintain consistency while in relationship with the patient.

To better work with people who have been diagnosed with BPD, Anne recommended nurses becoming more knowledgeable about the variety of exercises and skills such as CBT and DBT that are available to teach people how to care for and teach patients. She wondered whether research had been done on medications most effective for people with the disorder, because she does not like to “pop pills unless necessary.” She also questioned whether lack of research and knowledge about BPD might perpetuate medication use and gaps in the system such as suitable counselling services. She also attributed these gaps to the impact of stigma

_Because it’s not a treatable diagnosis. I mean it’s treatable. But it’s not like people who have schizophrenia and go on anti-psychotics, and your symptoms often go away. Your symptoms don’t go away with that. You have to learn. So I think the common knowledge is, it’s your behaviour, control it._
Anne suggested for people diagnosed with BPD who do not “do well” in hospital, or “out there [in community]” specialized transition services would be helpful. She also questioned whether lack of research and knowledge about BPD might perpetuate medication use and gaps in the system such as suitable counselling services.

Cal

Cal is an RN who has worked in a variety of roles on the in-patient mental health ward over several years, including supporting other staff in their work. He described his work with people who have been diagnosed with BPD as “complicated” due to the “variety of symptoms.” Cal spoke of the importance of nurses maintaining a “low-reactive approach” and reiterated several times the importance of a calm demeanor, especially when patients are “testing limits...challenging you...attempting to maybe staff split, or try to have you be a part of their emotional experience.” He noted that “clear boundaries,” conciseness, and consistency were helpful. When asked if using his own presence and approach helps facilitate people’s wellness, he noted the value of “building relationship and trust...that many clients don’t have that level of trust, so it takes time, that you’re there to help them, you’re not there not to judge them.”

Cal explained caring practice for people diagnosed with BPD as based on a holistic understanding of the person including the trauma they may have been through and providing hope. He saw hope demonstrated in telling a patient, “you can get through this” and helping teach people other strategies to manage stress and symptoms which can be used outside of the hospital

With people who engage in self-harming acts, Cal spoke of making people aware of the harm they were doing to themselves. For nurses to manage patients who self-harm it is
keeping them in the moment...take safety measures...either taking the lighter away, or,
(pause), preventing people having sharps, access to sharps...Engaging them in other
activities to keep them distracted. (pause). And listening to them.

He shared how he managed such situations, by acknowledging that in his first five years
of nursing it was difficult to understand what the disorder was and how to work with people
living with the diagnosis. He noted he had “no real teaching in Borderline Personality
Disorder,” but he learned from experience, his peers, and from texts, what was effective. He has
seen situations when a person diagnosed with BPD might be “ramping up”, with poor boundaries
and if nurses are not aware of their own emotional reactions, this can inadvertently create further
turmoil for the patient.

Cal reflected on changes during his career working with people who have been diagnosed
with BPD. He noted that previously he used to administer medications “and just try to sedate
people”, though he believed that approach is not successful longer term. Physician consistency
of approach was seen as important because “you don’t want to be overmedicating in these sorts
of circumstances.” Cal finds nurses now have more awareness of the disorder.

He identified the need for nurses to have more education about strategies, but did not
identify specific techniques. The hospital environment has specific impact on people with the
diagnosis of BPD. He recognized the need for a calm and relaxed space as important and areas
where people can “decompress.”

In relation to providing the best care for people with the diagnosis, Cal recommended
looking at people holistically, with calmness and a caring, non-judgemental approach. He also
suggested community resources such as weekly counselling and DBT-type skills groups
presently offered in the community are adequate, but the major issue is several people continue
to “fall through the cracks.” He is not sure why people may not be connecting with the
resources, perhaps due to individual stage of change, or intensity of the service, something that
needs to be examined further.

**Desiree**

Desiree has worked in acute mental health as an RPN for approximately a year and saw
herself building abilities to work effectively with people. Nursing people who have been
diagnosed with Borderline Personality Disorder has been mostly positive, seeing the diversity of
what BPD can look like. However, she also mentioned negatives such as assumptions about
people and dealing with self-harming behaviour.

As Desiree reads patient histories and meets more people with the disorder, she has
developed a deeper understanding of “*hurts and pains*” experienced by this group of people.
This discovery has led to a more “*proactive*” way of nursing, and “*a better trusting relationship*”
between Desiree and her patients. She noted that recent psychiatric diploma education and work
experience was helpful in learning more effective strategies. Desiree related that reading about
the diagnosis in texts gave her an understanding of the science of diagnosis, but seeing the
person helped her understand, “*It’s just a person.*” Finding a thorough understanding of the
antecedents, and how these experiences may affect people, along with “*always assum[ing]*
*positive intent*” has helped her practice. She believed nurses are successful with this group of
patients if they “*empathize or understand them a bit better, and then in understanding them, you
are able to respond.*” She found this approach working well compared to a sterner response she
has seen in other nurses, as she has better success with a gentle demeanor.
Desiree shared that relationship building with patients was “making a commitment and following through on the commitment. And sometimes the commitments are just about showing your face and a friendly smile and a, ‘How are you this morning?’” She offers comfort to people and found people seemed more “settled” when she did this. According to Desiree people diagnosed with BPD are looking for “stability,” “consistency,” and open communication between nurse and patient. This compassion can sometimes be seen as contradictory as Desiree said “sometimes caring for somebody isn’t giving them what they want. It’s giving them what they need.” Desiree explained this through an example of a woman with the diagnosis admitted with anxiety. Desiree reinforced her expectations the woman would get out of bed and connect with others throughout the day, rather than lying in bed, worrying or relying on medications to allay anxiety. This approach worked well, though Desiree found she needed to adapt her intervention dependent upon the woman’s emotional presentation during her stay.

Desiree mentioned labelling of patients, identifying assumptions such as “attention seeking” and “manipulative.” In contrast, she preferred viewing people’s actions as “really, it’s just an action that’s signalling that there’s something else going on right? I feel it’s part of our responsibility to see it like that. Whereas it’s...always described as attention-seeking.”

Working with people who are in abusive and unhealthy relationships was one of the more difficult situations for Desiree to manage as a nurse. She shared that she felt like “throwing my hands up and (sighs)... Like there’s no way, no way you’re going to change.” However, she said, “I think that’s a good time to just step back and realize that it’s not your call to say it’s never going to change.” Desiree spoke of the challenges in caring for people who have been diagnosed with BPD. On an acute unit interactions can be brief and sporadic, with little time
spent developing a relationship. This has led to Desiree feeling there is not enough opportunity to help people gain skills.

Desiree related that nursing care for people who self-harm can leave her feeling “really intimidated...and unsettled.” Despite this, Desiree approaches patients in a “soft, caring” manner and not focussing “on the self-harm so much as what was going on at the time and what’s going on now... I try not to really focus on the actual physicality of self-harm too much.” Desiree perceived people sometimes being “almost proud” of self-harming. So she tried to pay little attention to the wound, while acknowledging what the emotional experience may be for the patient. This is sometimes difficult for her as though she can “maintain calm...it shakes me up too much.” She had difficulty understanding what might lead someone to self-harming. So she tried to see her role as

*teaching them about how to respond, rather than react, you know. So while things may never, ever, be perfect in their life and while their relationships may continue to be shattered and unhealthy, you can teach them how to respond as opposed to react by self-harm.*

Desiree spoke of wanting more group interaction and more one-on-one time with people as she continues her work. She said

*You did OK (speaker’s emphasis) for 6 people, but you didn’t do great for one. So I mean in a perfect world that would be there and I feel that would help to develop positive relationships. Where the nurse is walking in unstressed with not a ton of other obligations and responsibilities under her belt. And just talking to someone person to person, not nurse to patient. And that would be nice.*
Desiree noted developing a trusting relationship quickly is challenging and spending time in a genuine way leads to a therapeutic relationship. She believed that longer hospitalizations can build dependency and create institutionalization. She saw best care for people with the diagnosis of BPD as “short, consistent stays and then linking them to community services.” However, Desiree believed there are not enough community resources, such as DBT. She proposed this might be due to “a general discomfort...not a lot of people really enjoy working with this population.” She shared “no one comes out and says ‘I hate working with borderlines. But there’s such negative spin whenever that term is thrown out.”

On-going training of care providers and reinforcing seeing people in a human versus a diagnostic way was offered as important in providing care to people with the diagnosis of BPD. Desiree suggested this training would be best delivered by a person who understands unit culture and attitudes. This approach might help guide a discussion on nursing practice and could create a “more education-driven, more care-driven, and less assumption-driven” unit culture. Desiree also saw other areas of health care, such as emergency and medical/surgical nurses as benefiting from this type of education.

Diana

Diana is an RN, who has worked on the in-patient unit for approximately 2 ½ years. Being effective in caring for people who have been diagnosed with BPD took a significant amount of mindfulness along with self-reflection on Diana’s own reactions and responses. She saw herself as having done much of this internal work. Diana related it can be difficult, especially on a busy, acute mental health unit.
Diana has noticed “themes” related to BPD. She described the term ‘borderline’ as a “red flag” to warn other nurses of “difficult behaviour.” The term is “used as a label, rather than a diagnosis”, though she noted this can happen in mental health with many different diagnoses. Diana said, “it’s used as a label for person’s behaviour you don’t like. Only, it’s the person, not just the behaviour.” “Firm boundaries” was another flag, often in response to “attention-seeking behaviour” and the boundaries created by nurses in response can be “almost punitive.” She does not discount the need for boundaries, “especially when safety is an issue.” However, Diana believed these limits need to be set with thoughtfulness and not a “knee-jerk reaction.” Noticing when a patient might be unhealthily attaching to any nurse, and recognizing that others can help the patient are important boundary principles for Diana; “knowing that you’re (speaker’s emphasis) not the answer. They don’t need you.”

She found unconditional, consistent, positive regard, “mirroring love and acceptance” was the best approach in caring for people with a diagnosis of BPD. This was considered as a balance to promoting “a sense of empowerment”, looking different with each patient. The empowerment is promoting choices and helping people see their strengths. Diana perceived caring and building relationship as involving warmth, caring, and an “embodied gentleness,” maintaining dignity and respect. “Modelling appropriate behaviour” was offered as a way for nurses to help patients develop the needed relationship skills.

Challenges with a biomedical approach were concerning to Diana. Use of the diagnosis might promote the idea people are “not going to be changed, or there can’t be any sense of recovery or change in patterns. And I don’t think that’s true.” However, Diana identified a need for people with BPD to gain insight into their behaviour patterns and how it impacts relationships, in order for change to happen. She did not identify how that process happens.
Diana learned about personality disorders in an abnormal psychology course, but she identified much subjectivity in diagnosing BPD. Considerable human behaviour could be seen as dysfunctional, leading to judgemental attitudes. She learned some strategies from “other, more seasoned nurses.” Understanding her “own vulnerabilities and weaknesses” has been the most helpful in Diana’s work, leading to “more compassion” in her care. She sought self-awareness from “wanting to help people and my own humanity.”

Diana identified a belief among nurses that self-harm is “an attention seeking tactic” and spoke of the “desperation and franticness they [the patients] feel.” Instead of subscribing to this understanding, she tried to help people understand the emotions, while trying not to “give them positive reinforcement.” For example, “fussing too much” was not seen as helpful, but offering distraction, “a safe place, and unconditional positive regard” has worked well for Diana in the past.

Diana spoke of the “moral distress” she feels, working in an environment that offers limited time doing meaningful work with people. She saw this lack of time leading to a biomedical approach, where “we can give them an anti-depressant, and that may lift their mood and that’s a great thing. It’s a great thing. But that is not, and all research shows, that it’s not the pathway to healing.”

She further saw this biomedical approach leading to disconnection between mentally ill and mentally well people, or “othering.” Diana believed that understanding the background and circumstances of people diagnosed with BPD might help decrease stigma and judgement directed towards people with the disorder.
Diana suggested education for nurses on causes and recognizing human commonalities between nurses and patients as helpful in continuing her work with people who are diagnosed with BPD. Diana spoke of overall societal values towards mental health requiring change towards more acceptance and greater tolerance of differences.

**Helen**

Helen is an RPN who has been working in acute mental health approximately 5 years. She described her work with people who have been diagnosed with Borderline Personality Disorders as “frustrating”, “complex”, and requiring “patience and compassion.”

Helen shared frustration when working individually with people who may become overly dependent upon nurses and “needy.” She described her role as helping people become more independent and to develop coping skills in managing suicidal thoughts, gestures and self-harming behaviour. These coping skills need to be individualized and “make it something that they are comfortable with and they can take responsibility and ownership of.”

Empathy and engagement are important in Helen’s work. Identifying and acknowledging feelings such as pain, and “giving them a voice” is helpful in “small steps towards making changes.” Helen described interactions with people diagnosed with BPD requiring a very soft approach. A very passive approach to get them to engage. If you’re aggressive or assertive, they’ll back away, so you have to just keep offering it to them and hopefully at one point they will agree to engage.

This can be challenging when working with people who are emotionally volatile with “intense rage” and Helen spoke of the need for understanding of the disorder as untrained staff can lead to “actually triggering further outbursts and episodes.”
Prior to nursing, Helen had not heard of personality disorders. She shared her first clinical nursing experiences, when she learned about BPD and noticed “caring staff becoming easily frustrated” with this group of patients. “People whine about having them on their patient load” and refer to them as “a PIA, Pain-in-the-Ass.” However, after attending an ethics conference where feminist psychiatric philosopher Nancy Nyquist-Potter was speaking on ethical care of people with the diagnosis, Helen “had a long, hard look at my own practice.” She described how “we [are] blaming people who actually have no control.” This self-reflection has been important in her work with people, as she acknowledged “it is such a difficult task working with these personalities.” Helen also consulted colleagues, including the employee assistance line, which has counselling professionals who can review the situation with her. She also looks for any new research in the area of BPD.

Helen tried finding the triggers to self-harm when caring for people who may be hurting themselves. She understood people who self-harm as “looking for release. Often with our chronic cutters, they actually get a euphoria.” Understanding the rationale behind self-harm is important in developing other strategies with the patient. In her work area, nurses also teach about infection risks of open wounds, helping people understand the dangers of cutting.

Helen emphasized the importance of inter-disciplinary team collaboration when working with people who have been diagnosed with BPD. She noted there is more attention on care planning now, and nurses are attending discharge planning rounds, rather than just having the social worker and psychiatrist present, as was previous practice.

Suggestions identified on best care for people with the diagnosis were individual counselling, therapy, and support for the rest of the family. Helen spoke of having on-going crisis supports, especially in the first few months after leaving hospital, with consistent follow up
for people discharged. She discussed community resources available to people with a diagnosis of BPD, such as art, pet, group, and talking therapies, but noted that these had been cut back, and in some cases, people with the diagnosis were excluded. People diagnosed with BPD did not “meet the criteria” as “psychosis, of course is the first one that gets funding. And depression.” So she tried to offer whatever on-line resources are available and “start the process of psycho-education”, which she saw helping decrease fear, especially given that there are limited in-patient beds. Helen identified “huge gap[s] in our [geographical] area” for psycho-education with nurses. Helen spoke about a need for realignment of community resources to meet on-going needs and lack of appropriate federal and provincial funding. Finally, Helen noted there is no federal mental health policy or enough oversight on mental health outcomes, which she found surprising. There is also a lack of research into effective strategies and treatments.

While working with people who have been diagnosed with BPD, Helen suggested “an open discussion” should be conducted with care providers on what is best care, and look at this through a philosophical and ethical lens. Having clinical experts or “unit champions”, on each unit, who specialize in BPD would be helpful. Flexibility to change patient assignments if a particular nurse is struggling with a patient, especially if there is frustration due to frequent presentations, or limited success was also mentioned.

**Leanne**

Leanne has been an RPN for 6 years, holding a variety of roles within acute mental health units. She saw her role helping nurses provide consistency, “enforce boundaries” and looking for “staff burn out.” Leanne emphasized a team approach, ensuing “staff splitting” and “power struggles” are minimized. This is especially important if a patient has a history of violence or aggression.
Leanne reiterated the importance of environment and its impact on patients who have been diagnosed with BPD, especially if the patients are possibly violent. She has worked in other, more restrictive areas and finds in her current work, “we don’t necessarily have that threatening environment, it’s kind of more an open environment. And so, I find there’s a lot more reliance on empathy and communication in order to de-escalate patients or set boundaries.” Leanne believed a less restrictive environment was beneficial in working with people with the diagnosis as there are more opportunities for “creative…and individualized coping skills.”

She discussed the importance of looking at patients individually and “encouraging staff not to take it personally.” Leanne noted this can be difficult when staff have been physically hurt by patients. “Sometimes it’s not even about taking it by the day, it’s about taking by the afternoon” when working with patients who are having a difficult time managing their emotions. She promoted the idea that “it’s not about enforcing consequences, it’s about fostering positive behaviours.” At the same time she also said “it is exhausting to try and stay focussed on positive feedback for someone who is being very negative and being very needy. And maybe verbally abusive or physically aggressive.” So, she tries frequently checking in and allowing opportunities for debriefing and “venting” in a safe and non-toxic manner. Leanne saw a need for nurses to “leave work at the door” in order to recharge at home, but this is a challenge. It involves self-care and awareness of own stress levels.

She distinguished between “not asking, ‘why are you doing this?’ Asking, ‘What’s going on?’ not, ‘what’s wrong with you?’” She spoke of challenges working with people who are “very emotional” and “very intense”, but noted nurses are trained to look for underlying emotions and help patients identify them. This is important because “sometimes we’re [nurses]
the triggers” for emotional outbursts and communication is “huge” with people who have been diagnosed with BPD. This can include awareness of “accusing manners... I think we throw words around too much like attention-seeking, they’re borderline.” She said “everyone deserves” a neutral, empathetic, trauma-informed manner.

Flexibility as a nurse in working with people was emphasized as necessary, as Leanne believed “if you’re rigid I don’t think you can work with people with BPD. I think that’s just not an option for you. I think you’re just going to be in power struggles the whole time.” She spoke of the importance of consistency and setting boundaries, helping build trust between nurse and patient. At the same time nurses must acknowledge when they do not know the answer. This can be challenging for nurses because “we tend to want to have that authority.” Honesty about limitations within the care setting is important “because they’ll hold you accountable to it.” Leanne believed nurses need to communicate with the patient and not pretend to be “that go-to, every-wise, adult in their life.”

Leanne considered “degree courses” in nursing helpful in understanding the disorder and she promoted a fresh perspective on patients. “A PRN (as needed medication) is not going to help this patient” and Leanne encouraged nurses to promote other coping mechanisms and look at patients with a renewed perspective. She thought there is too much reliance on medications, resulting in patients prescribed multiple medications.

There is a role for good nutrition and exercise in helping people become well and Leanne noted that a significant proportion of people with mental health issues are seeking out alternative therapies such as naturopaths. She thought this may be because
our medication [such as anti-psychotics, and mood stabilizers] has some of the harshest side effects. Who would want to be on that forever? And the other issue is that these patients get put on these medications and they don’t get reviewed for years.

When describing why medications might be used in this manner Leanne spoke of “managing behaviour...what will sedate them...what will, we use the word, snow [refers to giving enough medication to make the patient sleep].” She also discussed how people with mental illness see multiple physicians who give multiple diagnoses which “contradict each other...they’ll [the physicians] add a new diagnosis but they can’t discredit the one that was there before... all these windows of time that are all being treated differently.” The windows of time refer to diagnoses made based on what the physician might see at a particular moment in the patient’s life, rather than a robust understanding of the entire person.

Leanne has expertise in working with people who have self-harmed and spoke of the “struggle in not re-traumatizing the patient” by “strip[ping] them in a babydoll [type of physical restraint] and...put them in a five point restraint bed” and wondered “is that necessary?” Again, there are challenges in supporting staff members to react in a calm manner, as nurses are afraid of negative consequences if a patient self-harms. Often, Leanne supported ignoring superficial self-harm attempts and redirecting patients, instead of restraining. She reflected on using restraints, “it’s not fun, it’s not... it breaks down relationships of trust between the staff and the patient, it breaks down relationships of trust between the staff and the staff.”

Leanne learned to work with people in crisis through her schooling, trial and error in practice, and having leadership on the unit supporting alternative interventions. This leadership led to a culture shift on the unit, where “empathetic staff that fostered a positive, non-trauma environment” for patients were encouraged.
A lack of resources to keep people with a diagnosis of BPD well in community was mentioned. Leanne noted hospitalization can “reinforce a lot of negative behaviour.” Yet, she described a lack of sufficient services in community, including proactive case management. Continuing education on how to work with people on boundaries and self-care as well as specific strategies such as DBT, were identified as helpful.

**Reflection on Participants’ Voices**

In summary, all the participants had variations on what was seen as important in caring for people who have been diagnosed with BPD. There was also differences in how nurses viewed resources, education, and perceptions of people with the diagnosis. A few did not see much need to increase services in community, whereas others identified significant need for increased counselling services. These variations in viewpoints could be understood from the participants’ backgrounds in practice, their taken-for-granted understandings and the various hegemonies that come to bear in terms everyday action. These positions surface through for example, significant gaps and stigma directly related to the diagnosis of BPD, as well as issues stemming from generalizations about the mental health system as a whole. Each interview gave insight and understanding into some of discourses which may be present, and will be examined in the following sections.

**Discourses Uncovered Through Participants’ Stories**

Discourses emerged during the review and analysis of interview data. These discourses were selected during data analysis as: 1) majority of participants used language reflecting these discourses; 2) current literature found during review supported and reinforced the discourses; 3) discourses which resonated with me as an RN working in mental health; 4) discourses which
reflected a fruitful area of inquiry using a feminist lens; 5) were related to the research question on nursing people diagnosed with BPD. This section discusses some themes found, but given the nature of discourse analysis, it will be not be an exhaustive list. Further data collection and analysis could provide additional discourses which would be beyond the scope of this work. Instead the focus here is to uncover the dominant discourses that exist in the textual details shared by participants. It should also be noted that each theme interacts and is combined with each other. It should be noted too that they have been separated out to enable the deconstruction of the various texts which when considered together reinforce and support each other.

Lynam (2007) describes discourse being “dynamic” (p. 55), creating space, social structures, and experience. For instance, though the discourses of power and biomedical are separated in this discussion, they are also integrally connected and help create and strengthen one another. Discourses about nurses’ reactions, ways of being with and caring for people diagnosed with BPD emerged during the review and analysis of interview data. Uncovering discourses, “how systems of representing knowledge and social roles are constructed and maintained in language… establish[ing] meaning that is related to the exercise of power” (Fischer & Freshwater, 2014, p. 198), could help in understanding the cultural influences upon the disorder of BPD and relationships, and attitudes of nurses. These discourses are implicated in how nurses respond, react, and think about people diagnosed with the disorder and are central to the study. Some of the hidden discourses reflect taken-for-granted practices and ethical positioning of one’s own nursing practice. The knowledge shared by nurse participants help illuminate ways to improve the treatment and care of people diagnosed with BPD. Discourse analysis is meant to create knowledge used to break down power imbalances (Powers, 2001) and brings to the forefront inconsistencies between policy and practice (Lynam, 2007). This is an important
consideration when working with marginalized people, such as those diagnosed with BPD the larger majority of whom are women, who may have been studied and in within these studies been objectified and their selves (including their voice) rendered invisible. Knowledge from these studies as Lyman (2007) suggests, has not translated into tangible changes in care resulting in better health or in my opinion more inclusive care considering emancipatory action from feminist methodology.

Wodak and Meyer (2009) suggest that data collection within discourse analysis is not a precise empirical phase, but rather an on-going process with theoretical sampling used to find indicators for concepts, expanding into categories and then perhaps looking for further data. Thus, an examination of the literature addressing in-patient nursing treatment of people diagnosed with BPD, was also used for the data collection during the research process. By drawing on the literature and examining the discourses, attempts were made to triangulate the information from the transcripts through a feminist lens. It is clear various tensions are apparent in the literature in comparison to the voices of the participant. Given the intention of this research is to examine the discourses implicated in nurses’ acts of caring for people diagnosed with BPD, this analysis of the discourses helped expose the dominant assumptions impacting care and the ways in which care is enacted by nurses.

Four discourses were prominent: Power, Safety, Biomedical, and Caring. As explained in the methods and in the following sections, participants’ language illuminated the importance of these selected discourses. They were chosen as being most evident and powerful during analysis, including participant’s emphasis and repetition of themes in interviews. Some of the discourses were not only themes found through the literature review, but also types of dialogue I observed as a nurse working within mental health and noticed as seeming to have underpinnings.
of power or presumption of insider knowledge, prior to conducting the research study. Consistent with a feminist lens participants spoke their truths and their positionalities and understandings were reflected in their conversations. I am critically aware that my own understandings and uptake of these discourses can, and do, affect my interaction with the participants, my understandings of what they said, and thus my analysis of their texts are implicated in the ideas presented. However, they also provide another ‘insider’ perspective in terms of meaning; what my everyday knowledge contributes to this study as a practitioner in the field. In addition, as an ‘insider’ reflecting on and looking at the data from a distance (another nurses’ contextual meaning of working with people diagnosed with BPD) there is a heightened awareness in whose interests are being served, and interpreting power structures and relationships (Powers, 2001).

**Discourse of Power**

Given the power differentials within mental health settings, particularly the authorial voice of medicine, noted in the literature review, it is unsurprising this discourse emerged. The subject of power is also at the forefront of feminist theory, especially the tenets of oppression and emancipatory action (Olesen, 2011). From a feminist lens understanding of power dynamics illuminates who may be oppressed thus examining power relationships enables a critique of structural oppression. However, the trickier question lies in how the participants take on and work with the fluidity of power within everyday practice, and whether they are cognisant of the subversion and operations of power within the health care setting. Without understanding how power differentials are working, change for either nurses or patients cannot occur. Additional interviews perhaps could have provided access into these understandings.
Common language used by participants pointing towards this theme were words such as: *rules, boundaries, limit setting, restrict, consistency, team approach, passes, seclusion, special care* (a more restrictive environment with ability to seclude and considered a high observation area), *institutionalized, and dependency*. Though not every participant used each of these words, all but one did use language referencing boundaries and limit setting, and a majority of participants used each of the other words. The extent to which there is a sense of complicity to practices stemming from this language remains questionable. A feminist lens enables these power relationships to be understood as an aspect of oppression, ethically questionable as it reduces the autonomy and identity of the clients. In addition, it excludes the very experience the clients are having, marginalizing them from the potential of quality care.

Clearly, just using these words alone do not indicate a discourse, but commonality and frequency of use of words do point to a pattern of referencing people diagnosed with BPD, and further analysis of the context of the words will help to draw out ideas and patterns of power.

Within the power discourse subcategories are: Drawing a line in the sand; Attachment and separation; Dance of containment.

**Drawing a line in the sand.** Almost all participants used the words ‘boundaries’ and ‘limit setting’ in their interviews. When asked what kind of care is best for people diagnosed with BPD, many responded as Leanne “*that you kind of have to set those boundaries*”, and explained boundaries as part of “*consequences*” and a “*team approach*” towards the person with the diagnosis. Cal spoke of nurses needing to set “*clear boundaries*” if a patient is “*challenging you*” and had “*poor boundaries.*” BPD is a complicated diagnosis and nurses struggle with best treatment for people. Nurses in this study perceived the boundaries as necessary in helping create clarity for patients within the institution. However, I wonder if these boundaries are really
limitations set in place to create more structure and that they possibly reinforce existing power structures dominant in the biomedical health care system, increasing the challenges in practice that nurses face. Perhaps setting rules and regulations for nurse-patient interactions helps nurses simplify and quantify approaches, yet if the interactions do not go as planned, the nurse is able to apply a consequence or limit onto the patient. The consequences might be overt such as increasing observation of the patient and restricting their ability to leave the unit unescorted, or covert by withdrawing or decreasing care when the nurse gives the patient less of their time and attention.

Enforcing a *line, limit, or boundary* was common language with the nurses interviewed. As a mental health nurse, interviewing these other nurses, I intuitively understood what the participants meant by this language. I have heard this type of language commonly used in different mental health settings within the community and hospital. I also notice little explanation is needed when health care workers use these terms. There seems to be an underlying common understanding, sometime spoken and sometimes unspoken, that the professional needs to be firm, strict, or even unyielding. The metaphor of drawing a line in the sand, might accurately describe the meaning. This is emphasized by Diana’s comments that using “*firm boundaries*” can be also construed as “*almost punitive*” towards patients, though she also notes when safety is of issue, boundaries are important, but they should be used in the “*right spirit.*” This theme is also evident in the literature, for example McGrath and Dowling (2012) found this talk of boundaries within nursing practice in their study on nurses’ responses to people diagnosed with BPD. Within health care settings, using boundaries with people who have the diagnosis is an accepted practice and acknowledged as being helpful in coping with the emotional volatility that may accompany the disorder (Smith, Robinson, & Segal, 2015).
Sometimes clients might request help with maintaining internal (managing emotions within self) and external (managing relations with others) boundaries (Lisa Marie, 2011).

Working with people who may be unpredictable and in some situations violent, it is understandable that nurses require some structure and guidance to have a functioning and safe team-based unit, perhaps what Diana was referring to as the “right spirit.” This might also include times when the patient requests help in the area of structure and boundaries. Yet, boundaries and rules can easily become artificial constructs of what is acceptable or not, and act as a method of controlling peoples’ behaviour, rather than ensuring safety. From a feminist lens, clearly these rules become a method of oppressing those who are vulnerable and hold less power. Treating people as individuals and justly is challenging when rules and fairness dictate that all are treated the same. This indicates the dominant philosophy that perpetuates social injustice and inequality.

The nurse reinforces this dominant hegemony in which power is nested in the greater system. For example, in these circumstances, the police, hospital security personnel, and physician, representing the legal and medical systems. This allows the nurse to maintain a therapeutic and less confrontational rapport with the patient. Alex spoke of “the doctor... send[ing] the police after” a patient, if they had not returned on time from their off unit pass. Anne said, “I just let them recognize, it’s not my decision.” Power stemming from the legal and medical systems allows the nurse to maintain control, without being perceived as controlling. Tarlier (2004) describes power differentials between nurse and patient not being well researched, perhaps because nurses tend to avoid naming power relationships or admitting to issues regarding power in these relationships. Perhaps nurses are reluctant to identify the power inherent in their position due to the caring nature of the profession. Or is this due to a general
discomfort with examining power structures in health care? Unpacking this further might be disclosed in a reinterpretation of the power phenomena. Asking questions such as, do colleagues enact practices derived from hegemonic understandings and in doing so disguise or render invisible the underpinnings of power? While boundaries and limits might be constructed as claims of safety, are they threatened to lower risk and in these instances used within the institution to avoid harm? To what extent do boundaries and limits reduce risk when a diagnosis of insanity or mental illness is used to reinforce control? Responsibilities of care provision then become positioned within a structure of control in which clients are asked to share their stories and subsequently unknowingly providing a confessional that further oppresses them. The extent to which nurses realize this remains questionable and unknowingness comprises part of the institutional culture.

Powers (2001) illuminates the use of caring as a way to exert power over patients, a subtle form of control. It might be nurses are perceived as the caring professionals, by reinforcing to patients it is the system and physicians who ‘make the rules’ yet are still enacting the system’s rules and controlling stance. Foucault (2006) spoke extensively of the medical domination and control; those with power create truth, or in this situation the truth of what limits need to be set. Rules reinforce the truth of those in power and control, in this situation, nurses, physicians, and the hospital structure. Nurses such as Diana identified unease with the power differentials, but did not identify ways to challenge the status quo. This may be because of the stratified health care system, with nurses holding less power than physicians. By acknowledging that power is fluid, nurses could reshape their understandings to better reflect and challenge mutually constitutive dilemmas that occur in practice.
The line and boundary of patient versus nursing team is clearly delineated and reinforced. Many participants spoke of needing to take a ‘team approach’ towards patients. This approach is also apparent in the APA (2001) guidelines on treatment of BPD which frequently reference boundary violations and splitting. The APA cautions treating clinicians and teams on these issues and suggests good communication to prevent violations. This stance also reinforces boundaries and limits and the power of the professional nurses. The individual patient is no match for the many nurses who are, as Leanne says, “explaining consequences as a team” which helps “avoid a one on one power struggle with someone who has a history of violence and aggression.” Moore (2012) discusses how this view may lead to inflexibility in reacting to patients’ distress. Splitting, noted as “a trap” by Alex and a form of manipulation by Anne might be seen as the opposite of a team approach, because if the nurse being praised acquiesces to the patient request, they are split off from the team and therefore the team is less effective in maintaining a united and strong front. Ultimately there is less power over the patient, however this could be constructed as the client’s resistance to the health team. This resistance of splitting the team reduces the power of each team member, fragmenting care.

Ma et al. (2009) discusses the importance of a team approach with adequate support from colleagues but saw this care in a constructive light, noting that having support “positively influenced care outcomes” (p. 446). Unit culture plays a large role in this; if the majority of nurses working on the hospital unit promote healthy, caring interactions, individual nurses could learn and adopt these practices. A team approach might create change for both nurses’ approach and patients’ treatment. Conversely, if culture endorses stigma and disregard for people with BPD, attitudes harden towards people with the diagnosis, and perhaps treatment would be less effective. Nurses who were interviewed found having healthy team dynamics was helpful to
support a team approach to care, even though they recognized discrimination by the mental health system towards those for whom they were providing care.

**Attachment and separation.** The discourse of power and limit setting is also related to separating the ‘mentally well’ nurse from the ‘mentally ill’ patient. Woollaston and Hixenbaugh (2008) referenced nurses promoting the use of boundaries and needing to be vigilant with people who have BPD, to prevent “anything being used against them [the nurses]” (p. 707). In her interview, Diana spoke of “hanging onto yourself as a nurse.” Diana found using attachment theory by validating and accepting. She also discussed “neediness and unhealthy attachment” resulted in how “professional boundaries” became so important for nurses. The boundaries help the nurse clearly delineate who is sick and needs control, the patient; and who is well, professional, and in control, the nurse.

There are often challenges for nurses working to keep their own identity and emotional well-being intact, due to high emotionality and unpredictability of people diagnosed with BPD. Nehls (2000) talks of the difficulties in boundary setting and raised ideas about whether the boundaries were for the client or clinician and the struggle clinicians have in feeling that they are the “most important person in their [clients] lives” (p. 16). Using boundaries may help the nurse to maintain professionalism while working with people who might lead a nurse such as Desiree to “feel completely rattled...and almost...a bit of distrust.” Again Woollaston and Hixenbaugh (2008) write about the challenges of working effectively with people who are perceived as manipulative, which in turn can lead to the nurses feeling mistrust towards patients and “devalued” (p. 707) in their work. These competing tensions are challenging; caring for people who are perceived to rely heavily on nurses in such an emotional way, while the nurse tries to
maintain a professional identity. Further discussion of this emotional attachment can be found later in the caring discourse.

**Dance of containment.** Restraints and special care were mentioned by several participants. Restraints are “physical, chemical or environmental measures used to control the physical or behavioural activity of a person or a portion of his/her body” (Registered Nurses Association of Ontario, 2012, p. 19). Physical restraints can include tying limbs to the bed. Chemical restraints may include medications such as benzodiazepines and anti-psychotics. (Further discussion on chemical restraint will be covered in the biomedical discourse later in this paper.) Environmental restraints can be a lockable unit or room. Participants mentioning special care were referring to a smaller unit within the larger mental health unit, which has higher staffing levels, higher observation abilities for potential self-harm and violence, and more restrictions on the patient. Both restraints and special care areas are used in mental health to manage violent or aggressive behaviour and self-harm or suicidality. Clearly any of the above mentioned restraints demonstrate the ability of the nurse and acute mental health system to control the person.

Alex spoke of needing to use seclusion when “*people have some aggression...so until you’re [the patient] ready to accept anything from us, this is what has to happen.*” Desiree shared an incident of a patient with “*more liberated levels on the unit*” who then self-harmed and wound up in special care. Use of restraint and special care are clearly examples of the power nurses have in controlling patients. By using restraint and “special care” the patient is rendered invisible despite the fact that they may be close to the nurses’ vision. One wonders if this closeness is designed to reinforce to the patient their inappropriate actions. From a feminist lens, this would render the person’s subjectivities as void. Social control is enacted within medical
settings (Powers, 2001). For example, using a medical facility to lock someone up with nurses being the de facto guards, is on the surface, a puzzling situation. Why would a building used to treat illness, also be a building that keeps people locked, restrained, and disempowered? Within mental health settings, it is clearly evident how much power and control is present on the ward, units are locked, staff are frequently behind safety glass and closed doors. Leanne stated, there is a “hanging threat in the air” regarding restraints and nurses “have the power to restrict” and “have all the tools to stop them [patients].” Bracken and Thomas (2010) describe this as the “incarceration of madness” (p. 225), in which medicine is used to justify social exclusion.

Suicidality and self-harm is almost always present during hospital admissions and that may lead nurses into reinforcing restraint, and exerting powers within the institution to keep patients safe. Grotto et al. (2014) found nurses can experience negative emotions such as anxiety and guilt when at-risk mental health patients leave hospital units without ‘permission.’ This can lead to nurses using strategies such as confinement to prevent perceived criticism from hospital administrators (Grotto et al., 2014). Lord (2007) suggests that clinicians feel a responsibility and duty of care to keep people alive, especially in a hospital setting, when people may be admitted to prevent suicide. The emphasis here is on cure – consistent with the medical discourse. Lord also describes the challenge arising when working with people who are diagnosed with BPD, and how clinicians become drawn into a dance of containment with the patient. Certainly participants spoke of seclusion and restraint being used to keep all involved safe. Why the hospital setting is seen as the most appropriate place to do this should be challenged, and whether there are accessible and promoted alternatives should be explored within the health care system for a shift forward in which inpatient centred, nurse facilitated best practices could
evolve. Further discussion of the use of restraint will also be covered in the following discourse of safety.

**Discourse of Safety**

One of the interview questions asked of all participants was how the nurses deal with and manage self-harm for people diagnosed with BPD. Self-harming behaviour is one of the diagnostic criteria for BPD, and is one of the most challenging behaviours that confront nurses working in mental health (Lindley-Starr, 2004). Bowers (2014) in analyzing safety risks such as aggression and self-harm on mental health units stressed both the physical risks involved in these situations, and also the breakdown in nurse/patient relationships. Through nurses answering this question, a safety discourse emerged. All but one participant mentioned the importance of safety. As an example, Desiree said of her work with people who self-harm, “I just kind of tell myself, it’s about safety and keeping people safe.” Reminding herself of this allows Desiree to remain calm and helps her put the actions into a frame of reference, allowing her to care for the person. Otherwise, she has challenges in working with the person in an effective manner. Lanthen, Rask, and Sunnqvist (2015) write of the need for nurses to remain calm and supportive during times of restraint when working with people who are self-harming, and how this approach is actually beneficial to the patient. However, the challenge of doing this is highlighted by Moore (2012) that staff attitudes are affected by this violence they sometimes encounter which can create a toxic environment for both staff and patients, and lead to a less safe treatment space. Staff have difficult roles in maintaining therapeutic care with people who may evoke negative feelings within them. Maintaining a professional approach is indicated by Moore as needed to provide good care to people diagnosed with personality disorders. Perhaps a focus on safety allows the nurse to detach from the situation and person and instead focus on the larger
imperative of keeping the person with mental illness safe and the duty to provide care as a nurse. This too generated tension as the nurse’s enculturated understanding for care provision move the tension away from the nurse’s personal position and in doing so undermines the nurses’ ethical location.

When the focus on safety allows nurses to categorize patients as belonging to another, unsafe, group of people, ‘othering’ of the patients becomes easier to justify oppressive nursing action. If nurses are encouraged (within the work environment) and/or required (within the unit policies) to control patients for the safety of all, it becomes easier to exclude people diagnosed with BPD. This group of people already has higher potential for oppression, as they are stigmatized within the healthcare system (Kealy & Ogrodniczuk, 2010) and largely women are diagnosed. Examination of safety through a feminist lens offers consideration of whether this discourse might be used to oppress both patients and nurses as ways to exclude and ‘other’ patients to ensure safety.

Words that pointed to a discourse of safety were: safety, rules, responsibility, environment, minimize suicide attempts, restraints, special care, liable. There is also a connection between safety and the power discourse, specifically power and restraints, which will be further examined below. Some sub-discourses within the safety discourse are: Safety and restraints vs trauma and confinement; Power as the only option; Ensuring safety through observational gaze; Safety: who is responsible?

**Safety and restraints vs trauma and confinement.** Alex discussed the need for seclusion, ensuring safety. He used the example of a physician not allowing a patient to leave the unit, leading to a crisis with subsequent seclusion for the patient. There was no differentiation on whether this safety was for patients or for staff. However, Alex and other
nurses seemed to infer that this concern of safety was for both patients and staff members. In fact, Westwood and Baker (2010) and Markham and Trower (2003) note that there may be a perception by mental health nurses that people diagnosed with BPD are more dangerous than people with other mental health diagnoses. For instance, Cal spoke about locking people in seclusion if they “aren’t in control of their emotions.” Keeping people on the unit would keep them safe from the ‘outside’ world, but would also keep the world safe from them and potentially out-of-control emotions. Seclusion within the mental health unit keeps the patient safe from any dangerous objects that they may use to cut or self-harm, but also keeps the patient from interacting with nurses who might be at risk from people who are not in control of themselves.

Leanne had the most to say regarding restraints. She spoke of difficulty in working with patients who had self-harmed along with fear nurses might experience when a patient is hurting themselves.

*When they’re self-harming...nurses are always worried what are they liable for? Like ‘someone’s self-harming, I need to stop them.’ ...The charge nurse is like, ‘Nope, I’m in charge, I’m calling it, I’m not having that on my butt, on my shift.*

There appears to be an underlying perception that if nurses do not prevent self-harm, they will be held responsible and accountable for patient actions. Nurses have power over patients, but nurses themselves are also controlled and answer to others in power. Perhaps this is why Leanne spoke of restraints being “such a go-to experience,” an indication in this environment, restraints are an automatic action. Paterson et al. (2009) describe this as “system corruption” (p. 18) when control and restraint is used to “enforce compliance” (p. 18). Leanne spoke of the intervention of restraints being more traumatizing for the patient than the actual cutting on the
body and how all involved are traumatized by these types of interventions. However, the fear of repercussions (failure to provide care; patient neglect; incompetent practice, etc.) from the broader system if a patient hurts themselves under a health care provider’s watch seems to outweigh the internal and external distress that occurs from this practice. Deuter et al. (2013) discuss the increased focus on risk assessment within mental health, especially in regards to suicide risk assessment and violence risk assessment and explain that managing and assessing risk is anxiety provoking for clinical staff. The focus on risk is unhelpful unless clinicians work together with clients to make a plan of how they will work together to deal with the risk event (Deuter et al., 2013). This appears to be in contrast to the practice of restraint described by nurses in the study, who refer to it in the context of trauma and confinement. Though restraint is clearly a way to control patients, nurses also express feeling distressed by the practice, and feel unable to counteract the systems that support and demand this practice, and as a result feel disempowered and oppressed within the system.

**Power as the only option.** The concern of safety and fear of repercussions such as reprimand within the system, or ethical or practice incompetence within the profession, may also be related to the power discourse. Intervening in restrictive ways, such as restricting a person to the unit and various methods of restraint (physical, chemical etc.) have nurses using power to control patients, in order to keep both parties safe. Moore (2012) discusses how staff who have been victims of violence in the workplace may become controlling and result in persecution, such as unfair treatment or singling out, of patients by staff. Viewing patients as needing physical control and thus, kept safe for their own good allows nurses to justify coercive and restrictive measures. Diana talked of boundaries being important “especially when safety is an issue.” Using these measures from a safety discourse also allows nurses to frame these actions as
necessary and within the standards of nursing practice, and obligation to provide care. Considering the previous discourse of power, specifically reference to rules governing patient’s movements off the unit, it may be that nurses see no other option than restricting and restraining people to keep them safe, especially when at risk or perceived risk of self-harming even though they may ultimately be unable to prevent self-harming actions.

**Ensuring safety through observational gaze.** In his interview, Alex discussed how “in the first couple years, it’s assessing. You know, you’re really ensuring safety but you don’t have the robust quality to really give back to the patient.” This may indicate that safety is not actively engaging a patient, rather it is observing and assessing. Safety is something done to the patient, rather than done for or with a patient. Alex also states that, “safety is the reason people are in hospital... medical safety, physical safety, or their psychiatric safety from killing themselves or substance use, or whatever it is.” From this perspective, do dominant biomedical structures hospitalize people in mental health care to prevent harm, rather than to become well, able to self-manage outside the institution? Nurses do not need to necessarily engage with people to keep them safe. Nurses assess to help provide diagnostic clarification and the focus, engagement and relationship is with the diagnosis, rather than the therapeutic relationship critical in working with people to help them feel better and be healthier. Further, this practice of observation solidifies and maintains a subtle form of power and control over people with mental illness (Roberts, 2005). Is observation also a type of othering in which the health care professional, in a position of power, gazes down upon the patient? It may be that the focus on observation rather than engaging patients has led to less resource allocation in treatment and more resource allocation directed towards observation and confinement. Alex spoke further about safety, assessment and
observation. He noted how continually asking people whether they “feel safe or not” gets tiresome for the patient. Alex shared

patients get sick and tired of being asked questions [regarding safety]. I think they actually want someone to work with them. And once you get in through the assessment, they’re kind of exhausted too. They’ve just told their story again. And you haven’t given them anything back, but a pill. Maybe a little bit of human encouragement but anyone could do that, you know.

Historically, there has been a lack of engagement between mental health providers and those receiving care. By increasing interactions between staff and patients, risk of adverse events such as self-harm decreased, and staff and patient satisfaction increased (Pereira & Woollastone, 2007). Deuter et al. (2013) discussed the culture of observation that is pervasive within mental health settings, and suggest that instead of just observing, engaging with patients in their plan of care and their responsibility to become well will actually decrease risk. Bowers (2014) reviewed different factors involved in safety on mental health wards and reiterated positive and timely staff interactions likely decreasing risk of self-harm and violence.

Safety: who is responsible? Finally, in the safety discourse, some nurses referred to patients being more responsible for their safety than the nurses. Alex gave an example of a particularly challenging patient who had self-harmed multiple times on his unit, and noted how he would talk with her,

‘Look, you still have the right to do what you want to do. I’m charged with keeping you safe. And I’m certainly not going to have a row of knives out for you to choose from. But if you kill yourself don’t blame me.’ Cause that’s inevitably what she would do, ‘well, it’s
your fault, you guys didn’t keep me safe.’ It’s like, ‘no, you’re responsible for you, I’m not.’

Leanne also used an example from an incident of a patient self-harming. Nurses wanted to stop the patient’s self-harm through a code (meaning a team intervention to manage a violent or aggressive patient). Leanne discussed her role in suggesting staff not engage in these actions to prevent trauma to all involved and noted that

*the patient’s going to have some superficial scratch marks on their arm and I’m OK with that because the patient’s OK with that. And they’re going to look at those, they’re the ones who are going to have to live with those scratch marks, they’re the ones who are going to feel that drop [in emotion] afterwards. And you know, they don’t feel good about those. And so, it’s kind of a consequence all in itself.*

This dichotomy is interesting, as throughout the interviews, participants spoke of safety being paramount in their nursing, especially when people were at potential of self-harm. Nurses stepping back (or withdrawing care) and allowing self-harm to occur creates tension between the power and control of the health system and the nurses’ actions. Whether it is a shift in the safety discourse, or a mechanism for nurses to release some power over patient actions, or a way for nurses to reject the idea of responsibility for someone else’s actions is unclear. Woollaston and Hixenbaugh (2008), Black et al (2011), and Markham and Trower (2003) report nurses saw people diagnosed with BPD as more in control of symptoms than people with other mental health diagnoses. However, Hauck et al., (2013) suggest nurses’ attitudes towards people who self-harm are more positive than previously thought, but the practice setting seems to play a role in approaches used in clinical environments, with different approaches used on different hospital units. There may be a possibility of nurses simply letting the self-harm ‘play out’ to see what the
patient does, for if the patients are in control of their behaviour, they have the means to stop. Alternatively patients could be resisting the dominant ideology to enact what is left of their autonomy.

There is bias towards people with the diagnosis. It may be an unconscious bias and revealed through nursing practice when nurses are less reluctant to intervene and stop self-harm. Problematizing practice within health care provision would be helpful in understanding what happens between nurses and patients who are self-harming. Workshops that support nurses’ awareness of their taken-for-granted practices and how to cope with these situation might be a starting point for practice change.

**Biomedical Discourse**

Understanding the historical and contemporary prevalence of the biomedical model within health care, it is not surprising participant interview texts surfaced references to this discourse. Naturally, there were differences between participants, but what became evident was an overall perception of seeing the biomedical approach as insufficient in caring for people with BPD. For example Diana said “you also can’t use a biomedical model with it [work with people who have BPD], I think it’s destructive and unhelpful.” Seeing this discourse as unhelpful may be a reflection on discomfort with power inherent in the model. Power and knowledge held by health care professionals can oppress patients, especially those who are already marginalized. The nurses in the study identified unease with using a biomedical model to work with people diagnosed with BPD and suggested other strategies seen as more effective. This could create opportunities to expand on action addressing inequalities, as viewed through a feminist lens.
Words which pointed to a biomedical discourse were: medications, pills, meds, assessment, sick, behaviour, logic, diagnosis, somatic. Sub-discourses identified were: Medications: interruptions in caring; Legitimizing need for care; The somatic patients; Questioning diagnosis.

**Medications: interruptions in caring.** There was an overarching concern of the participants about reliance on pharmaceuticals and their lack of efficacy in treating people. Alex referenced that “there’s not always the psychotherapeutic approach to a lot of situations and it’s always, medications, medications.” Cal, in discussing treatment with medications said, “It’s found over time that these approaches are rarely successful long-term for the patient.” Diana spoke how on her unit an embedded belief is “all we have here is medications” and are not able to offer more than this to patients. Leanne spoke at length of concerns of overuse of medications in treating BPD. *We always complain that our patients are medication seeking, yet I think that we reinforce that in hospital.* Leanne also talked about “medication stacking.”

*I’ve seen 14 year old girls come in with, 1500 mg of divalproic acid [a mood stabilizer, used to treat bipolar disorder] and Seroquel [an anti-psychotic]. Like just ridiculous amounts of medication ...then we’re throwing on Cogentin (an anti-cholinergic used to treat side effects of anti-psychotics) to help with the side effects of the medication. We’re stacking (speaker’s emphasis) these medications and people don’t want those side effects...*

Though this is a small, qualitative study, the larger question of how units have been structured in such a way that medications are seen as primary treatment for mental disorders is interesting. Foucault (2006) noted the relationship between pharmaceuticals, medicine, and power as significant. Lakeman (2013) points out pharmaceuticals are seen as evidence-based,
perhaps simply because they are easy to study quantitatively, rather than more complicated and harder to measure qualitatively based psychosocial and relational interventions which nurses in the study saw as more efficacious. Pharmaceuticals treat the symptoms within the diagnosis somatically, through the manipulation of brain chemicals, despite scientists not clearly knowing how psychiatric illnesses develop (Lakeman, 2013). In the literature review, it was evident that a pharmaceutical discourse reinforced the biomedical discourse, with diagnosis being necessary for pharmaceutical treatment (Crowe, 2004). Perhaps the biomedical system promotes need for treatment with medication, with hospitalization then justified as best practice. There are limited in-patient beds available for patients; perhaps medications validate an in-patient admission.

While working in the hospital, I saw this link being made-questions were raised if the patient was not being treated with medications while an in-patient. Zeeman and Simons (2011) explain categorization of mental illness according to the DSM, leads to medical treatment, then hospitalization and pharmaceutical treatment. Fainzang (2013) describes “biologization of phenomena labeled as illnesses” (p. 491), whereby socially constructed disease in psychiatry becomes reduced to pharmaceutical treatment through prescription medications, resulting in expectation of becoming healthy based on medication. Medications and those who prescribe them have the power, not actions of the patient.

Participants spoke of medications being used to control people’s behaviour, or as a restraint. Anne talked about medications used to calm a person and that “I’ve even seen people with BPD to get Acuphase for a reboot if they’re really, really bad. I’m not saying that’s the best thing, but sometimes they’re actually psychotic. They’re just so off the wall.” Acuphase or zuclopenthixol, is a potent anti-psychotic used to treat aggression and psychosis, with significant sedative effects lasting 2 to 3 days (Datapharm, 2015). These sedative effects might be
interpreted as ‘snowing.’ Cal referred to previous practice being to give “tons of medications and just try to sedate people.” Sedation might allow nurses to disengage relationally from patients, and perhaps is a reflection of the distance and othering highlighted in literature and participant interviews. Participants all suggested this use of medications was not particularly successful in treating people. Yet, nurses also saw a need for medications, as Anne noted “good meds’ were needed at the beginning of the admission. This may be because people are admitted in a more acutely emotional, or even psychotic state, due to symptoms of BPD. Medications might be seen as a way to safely de-escalate a person who is out of touch with reality or having emotional extremes, including anger, violence, and rage.

However, more than one participant mentioned that use of medications to manage behaviour and treat BPD has changed. Cal and Anne talked of practice shifting to less reliance on medications. They felt this was positive progress. In fact, Alex said nurses who are not effective “feed them meds…and [believe] it’s hopeless and why are they even here?” as opposed to more effective nurses who promote resiliency and hope in patients. Further research on why this shift has happened within mental health, and how this has evolved over time would be helpful.

Reliance on medications seemed uncomfortable for participants, but as noted by Leanne’s comment above, nurses may feel they have little ability to change this practice. Anne said, “The doctors order the meds they think should be ordered, but I know we [nurses] think we know what should be ordered (laughs).” Medications in hospital are given by physician’s orders and though nurses can question orders, not giving a medication is a patient safety issue that requires the nurse to admit to and formally submit an incident report and being questioned. According to the scope of nursing practice and regulation nurses on most mental health units do not prescribe, but
seem to feel hampered and unable to question whether the patient benefits from the medication. Physicians are given and hold more power within the hospital system, even the use of the term ‘physician’s orders’ is a command for nurses to carry out in caring for patients. Team approach was previously discussed in the power discourse and discussed as important for nurses. It may be that physicians are seen as outside of the team or perhaps controlling outcomes for the patient and the team, especially in the area of medications. This is an interesting contrast as NICE (2009b) recommends use of medications only when people with BPD are in crisis or to treat comorbid conditions. Silk (2015) in his commentary on pharmaceutical management of BPD states, “the role of medication is uncertain and our knowledge about the impact of any medication on the overall course of the disorder is nonexistent” (p. 525). He advocates for considerably more research on using medications with this group of patients. Yet nurses continue to feel uncomfortable questioning physicians despite expert recommendation from physician groups decrying the past and current pharmaceutical practices. Though beyond the scope of this study, it would be worthwhile to research how nurses navigate and manage situations where questioning of physician’s orders is happening and nurses are questioning taken-for-granted practices.

**Legitimizing need for care.** Several participants used language suggesting differing perceptions on symptoms of BPD which were accepted and given validity versus actions of patients which had less credence or were perceived as invalid symptoms.

Some participants referred to patients being “sick” as Anne did when talking about people first admitted to the unit. “It can be frustrating initially because they’re so sick.” Describing a person as sick gives credence to the patient and physician recommending treatment, a stay in hospital, and as indicated earlier, treatment with medications. Seeing the person as sick
also allows nurses to maintain their own professional stance. They can distance themselves from
the person, and maintain ability to work with people who may challenge nurses through conflict
or power struggles. If nurses feel discomfort from the conflict, they can see the actions as part of
an illness, rather than an attack on nursing ability to deal with conflict. Perhaps nurses are not
aware of the conflicts arising in their roles in mental health, or have not been equipped to work
with people who might be reacting against the health care system. This is an area for further
investigation; how mental health nurses manage conflict with patients, in a professional and
caring manner. Perhaps research on conflict resolution and relationship building skills would be
helpful.

Actions that were seen as unpleasant were described as behaviour, as Alex says when
talking about a patient who had self-harmed, “It just seemed to be more behaviour, more than
anything else.” The self-harm is behaviour, versus an uncontrollable symptom or sickness.
Aviram et al., (2006) discusses how the individual with BPD may be seen as the problem, rather
than having an illness. Anne discussed how “your behaviour will direct your care…If you can’t
get some control of yourself, we can’t let you go outside…So, it’s putting the onus more on them
to get well, than on us to make them well.” ‘Behaviour’ or individual action exhibited by the
patient allows and reinforces nurses’ needs and abilities to control and restrict patients until the
patient is willing to take control over their own actions. This self-control by patients is perhaps
the visible actions deemed appropriate by nurses and the system. Patients are only in control of
their situation so far as they are willing to align themselves with what the system deems as
appropriate. The patient’s ability or being given ‘privilege’ to ‘go outside’ is seen by the nurse
as in their control, but control is actually with the system, as it is the nurses who ultimately
decide where the patient will go. This theme is clearly related to the previous discussion on power and control.

**The somatic patients.** Some participants mentioned somaticism with people diagnosed with BPD. Somatization disorder as defined by Medline Plus is a “chronic condition in which a person has physical symptoms that involve more than one part of the body, but no physical cause can be found.” (para.1, 2015). Alex spoke about patients having “somatic or emotional complaints.” Leanne said, “Borderline Personality Disorders tend to be known as the somatic patients” and talked about the physical issues that these patients would bring up such as pain and gastrointestinal upset. This manifestation of physical symptoms leads people to seeking alternative therapies, Leanne said, “I think there are other ways to address that than medication or maybe certain combination of vitamins or whatever kind of supplements, they can look up for themselves through a naturopath.” Though this emerged as a smaller discourse than other biomedical themes identified here, it is of note given the separation of mind and body that happens within hospital and medical environments. People diagnosed with BPD are seen as mentally ill by the medical system and the physical issues are seen as stemming from their mind, and perhaps discounted. A real concern that must be addressed and challenged is that patient’s medical concerns continue to be dismissed due to their mental disorder, diagnosis, and the implications this has in the provision of optimal health care services (Corrigan et al., 2014; Harangozo et al., 2014; Thornicroft, Rose, & Kassam, 2007, Van den Tillart, Kurtz, & Cash, 2009). Van den Tillaart et al. (2009) describe this as “silencing of health concerns” (p. 153). Acknowledging the barriers people diagnosed with a mental illness encounter when trying to access physical medical care and challenging the power structures which discount people’s own
body knowledge is needed to provide better health care for people diagnosed with a mental illness.

**Questioning diagnosis.** During interviews, nurses discussed issues regarding diagnosis. Anne said “there’s not so much getting diagnosed with Borderline Personality. They’re starting to get diagnosed with PTSD. I’ve noticed that in the last year.” She attributes this to stigma attached to the diagnosis. Desiree learned much more from actually working with, providing nursing care to people because, “you see it and it’s like, ‘It’s just a person’, you know... and that’s how people work when things happen like this.” Being able to use descriptors from texts allowed Desiree “to maybe chart better, you know, using fancy terms” but as a nurse, ultimately she saw people as “just human.” Leanne talked about “diagnoses that contradict each other” and

you’re diagnosing someone with, PTSD, and you’re diagnosing them with ODD [Oppositional Defiant Disorder], and you’re diagnosing them with Borderline Personality Disorder and the real truth is, probably only one of those diagnoses are appropriate.

Or you’ll get, they’re ADHD, and you’re stacking these diagnoses and you’re stacking these medications. And one doctor doesn’t wanna, you know, they’ll add a new diagnosis but they can’t discredit the one that was there before.

The concerns raised by nurses interviewed seem consistent to the biomedical approach of labelling and diagnosing patients. Crowe (2008) and Lakeman (2013) highlight issues surrounding mental health diagnosis. Diagnosis may be seen as simplifying actions and behaviour and does not adequately represent a person’s entire life experiences (Crowe, 2008). If
it is difficult to determine the multiple ways people may demonstrate BPD, it may be the
diagnostic process needs clarification, or the diagnosis itself is in question. The rationale for the
DSM is quantifying and organizing mental illness, creating standardization. It may be nurses are
reluctant to quantify human behaviour in this fashion, or find the standardization problematic in
some way. Shifting from a standard diagnostic framework to more individualized assessment
and care provision would provide more just and equitable care.

Caring Discourse

Given interview questions and the topic of this thesis itself is on caring for people with
BPD, it is not surprising that a discourse of caring emerged. Watson (2003) describes caring as
conscious love energized, allowing nurses to mirror humanity back to their patients. In
interviews, participants discussed caring in different forms, such as developing relationships,
warmth, and a non-judgemental approach. Psychodynamic and relational approaches are
indicated as the best approach for people diagnosed with BPD, and the heart of these approaches
requires a deep connectedness to do the work.

Participants spoke about the need to care similarly. Alex spoke about the importance of a
thorough assessment and building a therapeutic relationship, “Getting their story is the one thing.
And I, I think maybe that’s where it starts, may be the caring. You have to hear their story and
maybe invest a bit.” All nurses spoke of needing to intervene with caring, using it as a tool to
help people become well and leave hospital. There were differing strategies and approaches, but
all seemed to point to the need to care and in fact as Desiree said, “for the most part, people
[nurses] want to do really well and they want to touch people. It’s a caring profession.”
Specific words that participants used which pointed to a caring discourse were: calm, gentle, emotions, emotional, kindness, trust, relationship, hope, comfort, acknowledge, empathy, non-judgemental, self-reflective, trauma, loss, grief, flexibility, skill-building, coping skills.

Themes within the discourses included: Caring as extension of self and identity; Situating and protecting self; Carrying emotional work.

**Caring as extension of self and identity.** Many participants spoke of needing to use themselves as care agents for people. Alex said

*If you have a life full of resilience, you can’t help but share that. So, I think we all have that resilience in our lives. If you can understand and really care. Genuinely and sincerely care and they’re not just a patient.*

Diana spoke about using a type of therapy which “allow[s] them [people diagnosed with BPD] to kind of attach to themselves through that mirroring that they’re valuable” and “bridging that gap with them and helping to look at what they do have in their life that they can see as being a strength.” When discussing the difficulties of working on a busy mental health in-patient unit Leanne said, “especially in acute, we’re constantly dealing with patients who don’t know us and we don’t know them. It’s a revolving door unit and I think sometimes all we have is our approach.” In essence, participants seemed to identify using themselves and relationship as necessary, and perhaps the most essential piece of helping people. Hartrick-Doane and Varcoe (2007) describe relational practice as context specific and a “conscious consideration of possibilities” (p. 198).

Powers (2001) challenges the notion of caring as ‘working on’ patients and suggested caring might be a way to elicit confessions from patients and reinforce the domination of the
biomedical model. Though an interesting proposition, the data did not support this particular discourse. Participants referred to caring approaches as ways in which to help people find healing and groundedness, not as a potentially coercive activity.

This use of self to care seemed difficult to quantify and when asked what caring looks like Cal said, “I don’t, sometimes it’s just a kind of way of caring and being with that person.” Anne spoke about “little caring things” like “making sure they’re fed and warm.” However, it seems that though caring might be displayed through these actions, as Anne also said, caring involves “building a relationship based on trust.” Diana talked of this type of work as “quite subtle and within the therapeutic relationship.” Wyder, Bland, Blythe, Matarasso, and Crompton (2015) discuss therapeutic relationships on mental health wards and propose using recovery principles, partnerships with patients, and decision-making based on individual choice as helpful in relationship building.

Creating this type of relationship within the confines of acute care is not easy, considering the hectic nature of hospitals and the challenges of working with people who may have significant emotional reactivity, including angry outbursts. As Alex said, “You have someone who’s constantly wanting to argue with you and is oppositional, constantly confrontational with you, you’re not going to have much satisfaction in delivering caring.” Yet, participants pointed to the need to develop caring relationships, and using their own selves to help create connections by “just really listening to the core of what people are saying.” (Desiree).

This can be difficult when working with people who are self-harming as Desiree said,
Cause it just seems like something that I just can’t relate to in any way, you know. I’ve felt anxious. I’ve felt sad. I’ve felt all those other normal human being things... So I feel that I can you know, give to people who are going through the same thing...But I’ve never experienced the thoughts of self-harm or anything like that. (speaker’s emphasis)

The challenges of helping people through these types of episodes may be related to difficulties in using self, when the nurse is not able to understand, relate, or empathize. This may be where caring becomes the challenge. If nurses see themselves as necessary in people becoming better, how to accommodate this when the nurse is truly unable to understand what the other is going through?

Porter (2015) discussed the moral distress that nurses encounter when working with people diagnosed with BPD and notes that one of the outcomes can be disengagement with the patient. This might be a reason for the difficulties and stigma noted in the literature review; not understanding or relating to a group of people may lead to frustration and then distancing between nurse and patient. Another possible reason for the moral distress may be the binary I have witnessed between caring and ‘boundaries.’ I notice at times, expression of caring emotion either by nurses or patients can simultaneously include discussion of limits and inappropriate boundaries of the nurse or patient. There is a tension between caring or wanting to care and the reinforced need to emphasize boundaries and limits.

**Situating and protecting self.** An aspect of caring that several participants mentioned was looking after themselves in order to care. This relates to use of self in caring, as nurses are using themselves to care- if they are unwell or not grounded, then the caring will not work. Cal talked about challenges when “getting emotionally involved with patients and feeling frustrated by something that’s going to show to that patient.” Anne told of needing to recognize if a patient
“trigger[s] something in me.” Diana saw knowing yourself and being self-reflective as important because “if you can learn to be compassionate with yourself, you can hopefully learn to be compassionate with others.” Self-reflection was actually a mechanism Helen used to understand and find ways in which to work with people diagnosed with BPD, “for myself it’s always about trying to understand if there is anything new that I could be doing differently and self-reflection.” Self-reflection seems to both inform and direct care for people diagnosed with BPD. McGrath and Dowling (2012) note in one circumstance, working with people diagnosed with BPD, actually helped develop self-awareness in the nurse. Perhaps nurses found through the trial and error process, evaluating self and effectiveness was necessary to provide good caring. Porter (2015) suggested that mindfulness, which involves centering oneself, may also help health care providers in their work with people with the diagnosis. There is much written in nursing literature on reflexivity and the importance of considering power and position, including authors such as Aranda (2006), Fonow and Cook, (2005), and Dowling, (2006) among many others mentioned in the feminist methodology section. It is interesting that the process of looking at taken-for-granted practice and culture in the larger arena of mental health care, may also be used individually by nurses to work with this marginalized group of patients. Using self helps patients, but can also create a richer experience for the nurse, who can then use these increased self-knowledge with other patients.

Carrying emotional work. A challenge arising within the caring discourse was working with people who are emotional and emotionally reactive. Anne talked about people diagnosed with BPD having “huge, big emotion” and this emotionality making it difficult work in caring. This emotional reactivity seemed difficult for nurses. Bodner et al. (2015) studied nurses among other professionals in interactions with people diagnosed with BPD and found nurses expressed
less empathy. They suggest awareness of emotions aroused by patients is a key first step in providing better care. Leanne also talked of patients being emotional and if the nurse is not aware “then it becomes this kind of emotional back and forth” between the nurse and patient. The challenge of working with people who are emotional is noted by Leanne, “if a patient is kind of, you know, being emotionally reactive to them, they [the nurses] just want that to stop. They don’t want that interaction, they want that interaction to stop and it’s, ‘how can I do this?’” Hartrick-Doane and Varcoe (2007) write of nurses desiring to distance themselves when unable to ‘cure’ the person especially those “they see as “unfixable”—such as people who under liberal ideology are seen as creating their own suffering, people with addictions, people in poverty” (p.199). Within the profession of nursing in which the nurse ‘does things to patients’, such as wound and personal care, stepping back and simply allowing the emotion to be expressed without ‘fixing’ it and allowing this healing for the patient is a challenge for a busy nurse.

Emotional reactivity is a challenge when working with people, but the question remains why is working with people who are emotional so challenging? After all, nursing is seen as a caring profession and within mental health, it would seem that working with emotional people would be simply a routine part of the nursing work in this field. As Leanne points out, nurses are “trained to recognize those types of underlying emotions and what to look for.” However, perhaps as Leanne said, “when we talk about borderlines there’s a lot of emotion. And emotion is very human, you know, it’s very human and we tend to carry it with us” which makes the work hard and difficult to keep personal and professional lives healthy. Leanne spoke about the need to separate work from home in order to maintain wellness as a nurse. Aviram et al. (2006) suggest distancing may be “self-protective…and defensive” (p. 251) when working with people diagnosed with BPD. However, distancing may impact the patient, if the nurse withdraws
emotionally while actually giving care to the person (Aviram et al., 2006), so nurses must be self-aware of when and how they are practicing this skill.

This is an interesting dialectic, to give good care as a nurse recognizing and connecting with people while at work, but also being able to ‘turn off’ the emotional attachment in order to carry on with a personal home life. How possible is this to do? Leanne stated that she found a way to do this. Personally, I have found strategies to manage the sometimes overwhelming emotions that come through work, but given the complexity of all types of patients and nurses, there is no easy answer to the question. Chang et al (2006) indicated ‘distancing’ may be a healthy coping mechanism for nursing stress. Distancing involves not “dwelling excessively” (Chang, 2006, p. 35) on troubling events and maintaining a positive outlook. However, the mechanism to actually distance oneself is not identified, and within my own practice, I am hard-pressed to explain how I actually ‘distance.’ Cecil and Glass (2014) examined how nurses maintain emotional composure when working within the current complex health care system. There are challenges in connecting with a patient authentically, while keeping composure in check, and self-reflexivity seems paramount in being able to navigate these complex situations (Cecil & Glass, 2014). Again, this would be an important area of research for nurses working with diverse emotions, regardless of work site, i.e. emergency, cancer care, mental health, palliative.

Extreme emotional reactivity is one of the notable symptoms of BPD. It may be that the biomedical discourse has some effect on nursing perspective of emotions. Alex spoke of IQ [Intelligence Quotient] dropping “10-15 points” when people are “upset.” He also talked of working with people who are emotional, angry, and reactive, encouraging people to think rationally which was effective as “logic is tough to blame.” The powerful biomedical discourse
may be impacting nurses’ perceptions of emotions in people with the diagnosis. If the biomedical gaze values logic and lack of emotion, seeing the world as a scientific and rational place, caring for people who are by their nature, full of emotion may create difficulties in knowing how to care and exactly how to help people with their emotions. Possibly nurses see emotion and emotional people as being less intelligent due to the biomedical discourse.
Chapter 6 Implications and Conclusion

In this concluding chapter, I discuss reflexivity within the research journey as a practitioner, in the extent to which I am complicit with cultural practices within mental health. As a nurse with expertise in this area it is difficult to raise questions about my own agency. What I have attempted here is to stand back and critically understand the tensions within the practice environment. At times I found myself unable to stand back and supporting the status quo. I acknowledge the difficulty in working in the area of mental health, while at the same time critiquing the systems that I employed under. Participants within this study also struggle with these same barriers, as even acknowledging problems within the practice environment may have implications for both employment and well-being. With the support of colleagues (supervisory team) my journey has enabled me to think differently and question the taken-for-granted practices in which I too have engaged. Using a feminist approach creates awareness of the power imbalances present within mental health care systems, and the need to bring awareness and change how people diagnosed with BPD are treated in these systems, including my own practice. This research has helped me to recognize where I participate in stigmatizing and othering of patients. I hesitate to state this will never occur again, but I believe my awareness has shifted enough to hopefully significantly decrease times where I perpetuate inequities. I hope to also draw awareness to these power imbalances in my role working within the system. There appears a dialectical relation between my conscientization (Freire, 1970) and engagement with nurse participants and supervisory team enabling me to shift my understandings and perspective. It is from this vantage point that I have been able to construct the discourses that arose from the sensitive and profound texts within the participant transcripts.
The strength of this study rests in the vivid descriptions of practice which when analyzed revealed a number of discourses that paralleled and at some instances stood at odds with the literature. I offer insights for implications within nursing practice and the broader mental health system. Specifically, the role of education, impact of effective treatment, political structure and working with emotions. Finally, suggestions for further research are identified and final reflections.

**Implications for Nurses’ in Continuing Their Work**

During data collection, participants were asked what would be helpful in continuing work with people who have been diagnosed with BPD and what other nurses should know about working with this group of people. These specific findings helped develop some of the implications below, specifically education and lack of effective treatment. Other implications such as examining power structures were discovered from the actual discourse analysis. These implications came from examination of structures within mental health work and understanding how nurses work with complicated and emotional people who have been diagnosed with BPD.

**Nurses’ Education: Necessary and Needed**

The nurses within the study unanimously pointed to the need for education and learning gaps within their work environment. Many discussed the lack of knowledge when entering into mental health work with people diagnosed with BPD. There is a dichotomy between general nursing education and specialized nursing knowledge and practice. Apparent in this study are the multiple tensions and struggles nurses experience when working with people diagnosed with BPD. Some, like Heather and Desiree, recalled learning about BPD from clinical instructors, but others such as Cal and Anne did not learn about this work until actually employed within mental
health settings. The study further reinforces a need for education that is relevant and helpful for nurses who work with people living with BPD, including knowledge on teamwork (Ma et al., 2009), debriefing strategies, (James & Cowman, 2007; McGrath & Dowling, 2012), and nursing self-awareness (Hauck et al., 2013; Woollaston & Hixenbaugh, 2008).

Ideally this education should start with a strong foundation in RN and RPN nursing programs, but also continue after employment. As Alex and Desiree suggested, this education would best be offered by people who are interested in the area, and also understand the particular nursing unit culture, when offered in the work setting. Clinical nurse leadership with strong role modelling could help newer nurses develop professionally, and promote a learning atmosphere on units (Ennis, Happell, & Reid-Searl, 2015). This might help the education be targeted towards specific learning needs, for instance stigma reduction or practical nursing strategies on working with people who self-harm. Karman, Kool, Poslawsky, and Van Meijal (2015) reviewed literature on nurses’ attitudes towards people who self-harm and found education resulted in positive nursing attitude shifts. Practical strategies would be especially useful for nurses who are with patients up to 12 hours per day, in busy work environments and many patients to care for on their units. In this study, nurses found CBT and DBT skills useful in their work, so perhaps more education directed in this area might prove fruitful. These talk therapies rely heavily on communication techniques, also specified as important by Leanne, Diana, and Heather who saw good communication skills as vital in work with patients. This might indicate education directed on specific caring communication strategies would be worthwhile, given that participants spoke to the importance of a caring approach. The focus on communication strategies should also include opportunity for nurse reflection and interaction when focussed on working with people who self-harm (Karman et al., 2015).
Gaps in Caring: Lack of Effective Treatment

Another area of need singled out by participants is the lack of effective treatment, including transition services between hospital and community resources. This was expected given the literature review which identified the theme of inadequate treatment options (Bergman & Eckerdal, 2000; Bowen, 2013; James & Cowman, 2007). Participants especially indicated a need for non-pharmacological approach to treatment with people (Alex; Anne; Cal; Diana; Leanne). As mentioned above, talk therapies such as DBT and CBT were championed. Though communication may not be immediately seen as an effective treatment, the study indicated the manner in which nurses approach patients makes a significant impact on how the nursing work unfolds. Understanding how and what communication treatment methods work would help nurses provide good care. For example, participants such as Heather and Leanne promoted short hospital stays with effective follow up in community as best for patients, and yet this was not happening in the participants’ work areas. Since BPD makes up 25% of in-patient and 10% of community mental health populations (Leichsenring et al., 2011), a systematic look at treatment options and opportunities and following through with specific action on these findings could benefit both people diagnosed with BPD and the care providers struggling to find appropriate treatment. If care is found to be fragmented and disjointed as participants indicated, a robust and effective treatment strategy would initiate changes to health care provision and result in better outcomes for patients, and decreases in expensive and often unnecessary hospital visits and health care expenditures.

Power Structures: Restraints and Risk

Through the discourse analysis several possible avenues for further research were uncovered and would benefit from further investigation.
In the section on power, there was discussion on the role nurses and the health care system have in excluding and restraining patients, in order to manage violent or aggressive behaviour. It is suggested that more study would be beneficial on this topic. In this research, nurses’ language pointed to beliefs that these interventions were necessary in keeping patients safe from hurting themselves or others. Deuter et al. (2013) and Lord (2007) discuss the increased focus on risk assessment and the obligation clinicians feel in keeping suicidal people alive while in hospital. There are many avenues for investigation within this topic. Leanne spoke of the fear nurses have regarding ‘what am I liable for?’ It seems nurses perceive an obligation to intervene with physical force, if required, to keep the patient safe, so there are no legal repercussions. How did hospitals become comfortable excluding and restraining patients, when these actions seem more suited to a prison or jail and why are people deemed ‘mentally ill’ treated in this fashion? Are these actions considered medical treatment and if they are, how has this come to be? Foucault (2006) wrote extensively on this discourse, and the relationship between the legal and medical systems, but it would be worthwhile to investigate how nurses, the participants carrying out these tasks, understand, think, and feel about ‘holding the keys’ and working within these restrictive environments. How do nurses take up these discourses and incorporate them into practice? And how do nurses understand and consider their work which may place them at risk for violence? Examining ways of decreasing fear within these stressful work environments could lead to using less restrictive methods of working with people.

These above topics also intersect with the role of the nurse in carrying out physician’s orders, especially when there may be disagreement in how the patient should be treated. This was identified in the biomedical discourse, specifically on medications. In this study many participants identified discomfort with how medications are used. As with the recommendations
for education on treatment alternatives, are nurses given opportunity to fully work with patients in therapies other than medication? How has the mental health system been created to reinforce the power relationships between nurse, physician, and patient? Both Anne and Cal reflected on the change seen in medication use, and acknowledged that medications seem to be used less often. A research avenue might be whether this a result of nurses’ influence on the health care system, or is the system influencing nursing practice? How are nurses working within these power relationships between patient, physician, and nurses? How could these dynamics be shifted by nurses to create a more equitable treatment setting? One of the reasons for this research is illuminating the power structures that may be oppressive. Use of medications, controlled by the physician in orders, might be seen as an object of oppression, which would benefit from investigation. Learning strategies and practices other than medication as a first line of treatment, would assist nurses in work against the on-going perpetuation of these oppressive environments.

**Working With Emotions**

Within the caring discourse, the discussion on managing extremes in emotion brought forth the question of how nurses manage work with people who are seen as highly emotional. This study found nurses used their presence in caring for people diagnosed with BPD, but the nurses also identified a need to separate themselves, to maintain wellness outside of the work environment. This finding has been supported in the literature by Chang et al. (2006). They raised the concept of ‘distancing’ as a healthy coping mechanism for nurses when working with high emotionality. Cecil and Glass (2014) studied the concept of emotional protection for nurses. Though this “professional face” (p. 7) may help nurses manage emotions, self-awareness and healthy nurse emotional processing is key in being able to care effectively for patients (Cecil...
& Glass, 2014). Nurses in this study spoke of how challenging it was to maintain personal emotional and professional integrity while maintaining good care in challenging circumstances such as being involved in negative emotions from patients (Alex, Anne, Desiree, Diana, Leanne). Understanding how nurses keep well when working with suicidal people who are in enough hurt to wish for death is a worthy research topic. Is the system supporting nurses with education and resources to continue this work? In this study, participants lamented the lack of time and resources to work effectively and meaningfully with people who are in significant pain, which certainly could add to nursing distress. Also, providing this caring every day, and after work is finished, needing to reconnect with one’s own personal life, without carrying home emotional turmoil is, from personal experience and the experience of study participants, not always easy. Health care pressures are not abating, and resiliency in these situations is needed for nurses doing this important work. Further studies on how to build emotional wellness and strengthening positive resiliency in nurses in mental health would help build capacity within the public health care system. This work should begin in undergraduate nursing programs and continue regularly once nurses are in the practice environment.

Emotions may be less valued by the rational and scientific gaze of the biomedical discourse, yet working with emotions is necessary for work with people who are diagnosed with BPD. If the biomedical gaze values logic and lack of emotion, seeing the world as a scientific and rational place, caring for people who are by their nature, full of emotion may create difficulties in knowing how to care and exactly how to help people with their emotions. There may be conflict for nurses who are trying to work with people, who are devalued and stigmatized because of emotional dysregulation, but also perhaps the very work is devalued, given the scientific and logical gaze. As a nurse, it would be challenging to care, using emotion, when
both the patient and the method of helping through caring is devalued. Offering opportunities for nurses to strengthen their skills in emotional work would be useful. Creating environments where nurses are encouraged and supported in helping people work with emotions would seem appropriate, rather than possibly using medications to anesthetize the feelings patients’ experience.

**Caring: Reciprocal Gifts**

This research study used a feminist lens to consider the discourses present in nurses’ work with in-patients who have the diagnosis of BPD. Through interviews, nurses identified gaps and successes in their work. This in turn, helps draw attention to specific discourses which are informing their work and what might change to promote better treatment for people diagnosed with BPD.

A discourse of power pointed to the challenges of working within health care systems which rely on nurses to enforce boundaries and rules. This may lead to alienation, separation of nurse and patient, and increased reliance on methods such as seclusion and restraint to control patients. This discourse intersected with the safety discourse, where participants discussed the need to control patients to keep them safe, while at the same time, patients were seen as responsible for keeping themselves safe. Safety was also created by observing patients, which may also reinforce the power of the observer (Roberts, 2005).

As expected the biomedical discourse impacts nursing work with people with a diagnosis of BPD in significant ways. Both nurses and patients are affected and driven by this discourse. Nurses indicated that more focus on caring and communication would result in better outcomes for patients, yet the health care system does not seem to always support these less ‘scientific’
treatments. Indeed, nurses in this study identified a general lack of effective treatment options for patients, especially community mental health counselling services.

Caring was the final discourse within this study. Of all the discourses, it is the most hopeful. Nurses spoke of use of self to create caring and healing for patients. Though these nurses may have struggled with learning how to carry out this treatment, they identified it as a successful approach in their work with people who have been diagnosed with BPD. Knowledge on how to do this work, while maintaining personal wellness can be a challenge, but is manageable and worthwhile.

Though work with people with the diagnosis of BPD is complex and frustrating, there is also hope and success. The complicated interplay between cultural, social, and professional beliefs adds to the complexity of working with people. Yet, helping people find a healthier path is immensely rewarding.

I am reminded of my first year of work as a nurse in mental health. One weekend, I had a patient diagnosed with BPD who was struggling with multiple social and emotional issues. I spent time with her and felt we had a connection, but did not think any more of it until the next time I worked, when another nurse told me there was an envelope in the staff room for me. I opened the envelope, and there was a letter and a ring made out of beads from the craft room. In the letter, this patient thanked me for my time and for ‘treating me like a person.’ I still have the ring and the letter, though I never saw her again. When I would have a particularly difficult day at work, I would take the ring out, look at it, and think, ‘this is why I do this work.’ I am sure this patient never knew that she gave me more help and courage in my career, than I ever felt I gave to her. This small and personal story reflects the impact of caring which nurses are privileged to give and receive while working with people diagnosed with BPD.
References


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Appendices

Appendix A

Request for Support from Unit Manager

______________, Manager, Acute Mental Health and Substance Use,
_________ Hospital, ______________

Dear ________,

Following up with our previous conversations regarding the proposed Mental Health research project I am writing to request a letter of support from your agency. The research team would like to submit your letter to the University of British Columbia Okanagan/Interior Health Harmonized Research Ethics Board as a supporting document.

Please see attached research proposal titled “Caring for People with Borderline Personality Disorder: A Discourse Analysis with Nurses” and the “Participant Consent Form”, for further information about the study. Major changes required by the University of British Columbia/Interior Health Harmonized Behavioral Research Ethics Board will be forwarded to you prior to initiation of the study. Any other changes to the study will be solely for editorial purposes.

Your continued input and support of the project is most appreciated. Should you have any concerns please contact me at this private and confidential phone number 1-250-862-4300 ext. 2372.

The research team plans to submit your letter of support along with the project description, participant consent form and ethics application to the Research Ethics Board at University of British Columbia Okanagan.

Regards,

Lisa Wensink, BScN, RN, Staff Development Educator, McNair Acute MH&SU, KGH

For the research team of
Donna Kurtz, PhD, RN, Associate Professor, Faculty of Nursing, University of British Columbia-Okanagan

Penny Cash, PhD, Adjunct Associate Professor, School of Nursing, Human and Social Development, University of Victoria

Judy Gillispie, PhD, Associate Professor, School of Social Work, Faculty of Health and Social Development
Appendix B

Information Sheet Distributed to Nurses

Caring for People with BPD: A Discussion with Nurses

Research Project

Who can participate?
Registered Nurses or Registered Psychiatric Nurses who have practiced for at least 6 months and have cared for someone with BPD are welcome to join the study.

Your time commitment only requires a 1 hour private and confidential interview with an additional hour to offer your thoughts on the interview, if you choose.

For more information or to join this study please contact:

Lisa Wensink
Lisa.wensink@interiorhealth.ca

Or

1-250-862-4300 ext. 2372
Appendix C

Sample Email to Managers after Obtaining Ethics Approval

Dear __________,

On __________, ethics approval for the research study, “Caring for People with Borderline Personality Disorder: A Discourse Analysis with Nurses” was obtained. The research team thanks you for your support of the project and ask that you email the attached information poster to Registered Nurses and Registered Psychiatric Nurses on your unit. I also request that the information sheet be posted in the nursing station to recruit participants.

If you should have any further questions or concerns, please feel free to contact me at 1-250-862-4300, ext. 2372, or by responding to this email.

You may also contact Donna Kurtz at 1-250-807-9627 or email address: donna.kurtz@ubc.ca.

If you have any concerns about your treatment or rights as a research participant, you may contact the Research Participant Complaint Line in the University of British Columbia Office of Research Ethics by e-mail at RSIL@ors.ubc.ca or by phone at 1-604-822-8598 (Toll Free: 1-877-822-8598) or the UBC Okanagan Research Services at 1-250-807-8832. In addition, you may also contact the Chair, Interior Health Research Ethics Board by phone at 250-870-4602 or by email to researchethics@interiorhealth.ca

Warm regards,

Lisa Wensink
Appendix D

Sample Email Response to Interest in Study Participation

Dear __________

Thank you for your interest in participating in the research study titled, “Caring for People with Borderline Personality Disorder: A Discourse Analysis with Nurses”. As discussed, we will meet at __________ on __________ at ______ to discuss the research, answer questions you may have, sign the consent form and participate in a private interview, if you agree to join the study.

In preparation for our meeting, carefully read the attached Participant Consent Form. If you have any further questions or concerns, before or after our meeting, please feel free to contact me at my private and confidential phone, 1-250-862-4300, ext. 2372, or by respond to my password protected, confidential email lisa.wensink@interiorhealth.ca.

You may also contact Dr. Donna Kurtz, UBC Okanagan School of Nursing, Principal Investigator for the study at 1-250-807-9627 or: donna.kurtz@ubc.ca.

Thank you for considering this project and looking forward to meeting you.

Warm regards,

Lisa Wensink
Appendix E

Participant Consent for Study

_Caring for People with Borderline Personality Disorder: A Discourse Analysis for Nurses_

Principal Investigator:

Dr. Donna Kurtz, Associate Professor, School of Nursing, Faculty of Health and Social Development, (1-250-807-9627; donna.kurtz@ubc.ca)

Co-Investigators:

*Lisa Wensink, RN, BSN, Master of Science in Nursing student, School of Nursing, University of British Columbia Okanagan (1-250-862-4300 ext.2372; lisa.wensink@interiorhealth.ca)

Dr. Penny Cash, Adjunct Associate Professor, School of Nursing, Human and Social Development, University of Victoria, (1-250-868-3218; pcash@uvic.ca)

Dr. Judy Gillespie, Associate Professor, School of Social Work, Faculty of Health and Social Development, (1-250-807-8745; judy.gillespie@ubc.ca)

This research study is the basis for Ms. Lisa Wensink’s master degree thesis.

Ms. Wensink will be the co-investigator referred to in this consent form.

Purpose of the Study:

The research team thanks you for your time and welcomes you to this study.

The purpose of this study is to explore Registered Nurses (RN) and Registered Psychiatric Nurses (RPN) experiences on caring for people with Borderline Personality Disorder (BPD) on an inpatient mental health unit. Since people with BPD make up 20% of acute in-patient mental health admissions, understanding nurses’ experiences caring for people who have BPD in these setting will add knowledge to inform nursing practice and provide a deeper understanding of the nature of healthcare interactions for improved health care provision and policy change. You will be one of five to ten nurses to participate and share your perspectives, experiences, thoughts, and emotions on what it means to care for someone with BPD.

Who May Participate?

To participate in this research study you will be:
a) A Registered Nurse (RN) or Registered Psychiatric Nurse (RPN) currently working in an in-patient mental health unit at Vernon Jubilee Hospital (VJH), Vernon British Columbia or Royal Inland Hospital (RIH) Kamloops British Columbia;

b) A RN and RPN with a minimum of 6 months experience working in the area of mental health;

c) A RN and RPN who has cared for a person with BPD within the previous 6 months.

d) You have indicated by phone call or email that you wish to participate in the study.

**Study Procedures:**

Your participation will involve a digitally recorded interview, review of the transcript of your interview, and the development of a written response of the transcript. This will require approximately 2 hours (1 hour for the interview and 1 hour to document your thoughts of your transcript).

**Process**

To guide discussion, questions you may be asked include:

1. Please share your experiences as a nurse caring for people who have BPD
2. Describe what you have found out about people who have BPD since you started working in mental health?
3. Tell me about what kind of care is best for people who have BPD. How do you know this?
4. What kinds of things do you think is important for other nurses to know about people with BPD?

Your interview will be conducted by Lisa Wensink, co-investigator. The interview will be digitally recorded, transcribed, encrypted and stored in a secure place, by the co-investigator. Following the transcription, the co-investigator will email you your interview transcript that will be encrypted to ensure confidentiality. To access the encrypted transcript, you will be sent a password in a separate email.

You will be invited to document your thoughts about the transcript and send this response in a password protected email to the co-investigator within two weeks. If no reply is received within a two week period, the co-investigator will send you an email reminder. If you choose not to respond to the email reminder, it will be assumed that the transcript accurate and that you do not have any further comments.

The transcripts will then be analysed for the themes and connections in ideas. This analysis will be done by the research team and may involve the use of computer programs such as NVivo.

Study findings will be presented in written and oral formats, parts of which may be selected for peer reviewed papers and conference presentations. Other knowledge translation activities may
be in the form of education sessions and policy development. The study will be used as partial completion of a Master’s thesis and possibly used later to inform the co-investigator’s doctoral studies. As this study is part of a Master’s thesis, it will be available publicly and on line.

**Potential Benefits and Risks:**

You will have the opportunity to share nursing practice experience stories. This exploration and reflection may provide a chance for you to have an increased awareness and understanding of your current practice.

Personal and emotional risks may be that you will experience emotions ranging from joy to sadness as you participate in the interview. However, this is not significantly different from your everyday nursing practice. Though some conversations may potentially be distressing, you will be encouraged to share only the information you feel comfortable sharing. Support will be offered if you become distressed during the interview and the recording will be paused until you are ready to continue the interview. Should you wish to stop the interview altogether, then the conversation will end and another meeting time arranged if desired. Should you remain distressed, you will be advised to contact the local Employee Assistance Program through Interior Health Authority (IHA) at 1-800-663-9099 or UBCO at 1-800-663-1142, or the Interior Crisis Line at 1-888-353-2273.

**Withdrawal:**

Participation is voluntary and you may choose to refuse or stop participation at any time, refuse to answer any particular question and may withdraw whenever you like without penalty, including all data collected up to the point of withdrawal If you choose to withdraw, you may either allow the data collected to remain in the study, or you may choose to withdraw your all your data.

**Confidentiality:**

Your confidentiality will be respected. You may create a pseudonym (false name), or a pseudonym will be created for you at the beginning of the project to protect your identity. From that point on, you will be referred to by your pseudonym for all written and recorded data. The key linking your real name to the pseudonym will be placed in a sealed envelope and stored in a locked filing cabinet in the principal investigator’s locked office. Only the principal investigator and co-investigators will have access to your information, and no personal information will be disclosed by the principal or co-investigators. The research team will also ask you to avoid disclosing your involvement or any information shared at the interview with team members or colleagues.

The interview will be held in a private location where you feel comfortable, such as a booked meeting room at the university, in the hospital, or in the community. All communication via email will be encrypted and password protected.
The digital audio recordings from the interviews and transcribed data will be stored on co-investigator’s hard-drive, encrypted and password protected. Upon completion of the study, digital and printed data will be transferred to the principal investigator’s office at UBCO for storage for a minimum of five years after any research publication, then destroyed. Transcripts will be shredded and hard drive information will be deleted. Information that discloses your identity will not be released without your consent unless required by law.

Remuneration/Compensation:

As a participant you will not be paid for your time or travel, and interviews will not be conducted on work time. However, refreshments will be provided during the interviews.

Contact for information about the study:

Lisa Wensink, private/confidential phone: 1-250-862-4300 ext. 2372 or email: lisa.wensink@interiorhealth.ca will be available to answer any inquiries concerning the procedures to ensure that you fully understand what is required of you. If you have any questions or desire further information with respect to this study, you may contact Dr. Donna Kurtz at 1-250-807-9627 or email address: donna.kurtz@ubc.ca

Contact for concerns about the rights of research subjects (participants):

If you have any concerns about your treatment or rights as a research participant, you may contact the Research Participant Complaint Line in the University of British Columbia Office of Research Ethics by e-mail at RSIL@ors.ubc.ca or by phone at 1-604-822-8598 (Toll Free: 1-877-822-8598) or the UBC Okanagan Research Services at 1-250-807-8832. In addition, you may also contact the Chair, Interior Health Research Ethics Board by phone at 250-870-4602 or by email to researchethics@interiorhealth.ca

Consent:

Study Title: Caring for People with Borderline Personality Disorder: A Discourse Analysis with Nurses.

Your signature below indicates that you have received a copy of this consent form for your own records.

Your signature indicates that you consent to participate in this study.

____________________________________________________
Participant Signature                                                                          Date
Appendix F

Sample Interview Questions

1) Tell me about your work as a nurse with people who have BPD

2) Can you tell me what you have found out about people who have BPD since you started working in mental health? Prompt: Where did you learn this?

3) Could you tell me what caring for people who have BPD is like?

4) People with BPD might sometimes self-harm by cutting themselves or burning, what kinds of things do you do when this happens and you are working? Prompts: How did you know what to do? Where did you find this out?

5) Tell me about what kind of care is best for people who have BPD. Prompt: How do you know this?

6) What kinds of things do you think it is important for other nurses to know about people with BPD?

7) What kinds of things would be helpful for you as you continue in your work as a nurse when working with people who have BPD? Prompts: education? Environment? Other professionals? Other nurses?
Appendix G

Email to Participants with Transcript Attached

Dear _____________

Please find attached the transcript of our interview on _____________.

I invite you to read through the transcript and contact me via email with any feedback or concern on the transcript as attached.

You are invited to write a reflection on this transcript in a password protected email. If you choose to do this, please send the password in a separate email.

If I do not hear back from you in two weeks, by ______, I will send a reminder email. Following this period of time, if you do not reply, I will assume you are satisfied interview transcript and have no further comments.

Thank you for participating in this study.

With warm regards,

Lisa Wensink.
Appendix H

Sample Email Thanking Participant for Their Interest without Completing Study

Dear __________

I would like to thank you for your interest in the research study titled, “Caring for People with Borderline Personality Disorder: A Discourse Analysis with Nurses”. Though you did not wish to/could not finish participating in this study, I greatly appreciate your time involved. Your participation is entirely voluntary and removing yourself from this study has no further impact. Thank you for considering this project.

If you should have any further questions or concerns, please feel free to contact me at 1-250-862-4300, ext. 2372, or by responding to this email.

You may also contact Donna Kurtz at 1-250-807-9627 or email address: donna.kurtz@ubc.ca.

If you have any concerns about your treatment or rights as a research participant, you may contact the Research Participant Complaint Line in the University of British Columbia Office of Research Ethics by e-mail at RSIL@ors.ubc.ca or by phone at 1-604-822-8598 (Toll Free: 1-877-822-8598) or the UBC Okanagan Research Services at 1-250-807-8832. In addition, you may also contact the Chair, Interior Health Research Ethics Board by phone at 250-870-4602 or by email to researchethics@interiorhealth.ca

Warm regards,

Lisa Wensink
Appendix I

Sample Email Thanking Participant for Their Interest upon Completing Study

Dear ________________,

I would like to thank you for your interest and participation in the research study titled, “Caring for People with Borderline Personality Disorder: A Discourse Analysis with Nurses”. I greatly appreciate your time involved in this project.

If you should have any further questions or concerns, please feel free to contact me at 1-250-862-4300, ext. 2372, or by responding to this email.

You may also contact Donna Kurtz at 1-250-807-9627 or email address: donna.kurtz@ubc.ca.

If you have any concerns about your treatment or rights as a research participant, you may contact the Research Participant Complaint Line in the University of British Columbia Office of Research Ethics by e-mail at RSIL@ors.ubc.ca or by phone at 1-604-822-8598 (Toll Free: 1-877-822-8598) or the UBC Okanagan Research Services at 1-250-807-8832. In addition, you may also contact the Chair, Interior Health Research Ethics Board by phone at 250-870-4602 or by email to researchethics@interiorhealth.ca

Warm regards,

Lisa Wensink
Appendix J

Email to Participants with Discourses (Findings) from Transcript Attached

Dear ____________

Recently you participated in the study, “Caring for People with Borderline Personality Disorder: A Discourse Analysis with Nurses.” The methodology for the study included sending participants the researcher’s interpretation of discourses from interview transcripts to participants for feedback, but this was not included in the original consent form that you signed.

This letter is to invite you to write a reflection about these discourses in an attached password protected word document. In providing your reflection feedback, you are giving consent for this additional participation. Please note there are no additional risks or benefits than those stated on the original consent form you signed previously when you joined the study.

If you choose provide feedback, please send to me in an encrypted word document and send the password in a separate email. If you have any questions or concerns, please contact me via email.

If I do not hear back from you in two weeks, by ______, I will send a reminder email. Following this period of time, if you do not reply, I will assume you are satisfied with the interpretation of discourses of your transcript and have no further comments.

Thank you for participating in this study.

With warm regards,

Lisa Wensink