Staff Support Worker Perceptions of adolescent patients diagnosed with Borderline Personality Disorder: An Interpretative Phenomenological Analysis.

A thesis submitted to London Metropolitan University in partial fulfilment of the requirements for the Professional Doctorate in Counselling Psychology

By

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Declaration: I hereby declare that the work submitted in this dissertation is fully the result of my own investigation, except where otherwise stated

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Abstract

Background: Borderline Personality Disorder (BPD) patients are considered among the most challenging groups to work with, being associated with impulsive risk-taking behaviours and difficulties engaging in the therapeutic alliance (Bender, 2005; Black, Blum, Pfohl, & Hale, 2004; Cruz & Soriano, 2014). It is apparent that many mental health professionals hold negative attitudes towards this group and report feeling underequipped to work with the challenges associated with BPD ((Bland, 2003; Cleary et al., 2002; Shanks, Pfohl, Blum & Black, 2011). It is suggested that support workers, who require little to no formal training and are considered front line staff, provide a significant portion of care to this patient group (Kenward et al., 2001). However, there is little to no research focusing on understanding their role with young BPD patients and the impact they have on therapeutic outcomes. ***Aim*****:** The following research aimed to explore the perceptions of support workers working with young BPD patients in inpatient services. It aimed to open up the discussion on what it is like to be a support worker in this environment and the challenges they may face, also hoping to enhance our understanding of any training and support needs required for effective therapeutic outcomes. This research may provide some insight into how support workers perceive their role, their attitudes towards young BPD patients, and how best to support them to achieve positive therapeutic alliances. ***Method*****:** Semi-structured interviews were conducted with six participants. The transcripts were then analysed using Interpretative Phenomenological Analysis. ***Findings*****:** Four superordinate themes emerged; Attachment, Boundaries and Ruptures; the Emotional Rollercoaster of Managing Self-harm; Co-existence of Hope and Hopelessness and Making a Difference. Eight subordinate themes, related to the initial superordinate themes, are discussed in further detail. The research highlights the challenges support workers face and the difficulty they have developing the therapeutic alliance with young BPD patients and the subsequent impact this could have on therapeutic outcomes. It suggests that the training and support needs of support workers are under emphasised and could be having an effect on the therapeutic outcomes for this patient population. This research makes implications for clinical practice bringing forwards the needs of support workers who have a front line role. Being an under-researched area, the potential for future research is plentiful.

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Glossary

Abbreviation

APA	American Psychiatric Association
BPD	Borderline Personality Disorder
BPS	British Psychological Society
CoP	Counselling Psychology
CoPs	Counselling Psychologists
CAMHS	Child and Adolescent Mental health service
DA	Discourse Analysis
DSM	Diagnostic and Statistical Manual of Mental Disorders
GT	Grounded Theory
IPA	Interpretative Phenomenological Analysis
NICE	National Institute for Health and Care Excellence
ONS	Office of National Statistics
WHO	World Health Organisation

1. Introduction

Borderline Personality Disorder (BPD) is reportedly one of the highest prevailing personality disorders presenting in mental health services (Hong, 2016; Hepper et al. 2014; Moran, 2002), and is associated with individuals experiencing impairments to their sense of self, challenges in interpersonal functioning, emotional dysregulation, disinhibition, pervasive impulsivity and suicidal ideation (APA, 2013; Grenyer et al., 2017). This diagnosis is reported in around 3% of the child and adolescent population (APA, 2013) which is a health concern due to the high rate of self-harm and suicide associated with this diagnosis (Clarking et al. 2015; Kidger et al., 2012; WHO,2014). Suicide is a leading cause of death in young people and is a risk factor when it comes to BPD patients(World Health Organization, 2014;2018). Research has implied BPD patients will attempt suicide at least once in their lifetime with many having multiple suicide attempts (APA, 2000; Paris, 2019; Paris, 2003; Soloff et al. 2000). BPD patients receive a lot of input from mental health teams from individual therapy to medication, frequently utilising inpatient mental health services. Research has shown that intervention needs remain high for BPD patients following multiple treatment interventions compared with other mental health diagnosis (Hörz et al., 2010; Zanarini et al, 2004; Zanarini et al 2003).

The issue of a BPD diagnosis in young people continues to be a complex and controversial one with the literature highlighting the negative impact of such a diagnosis, the negative attitudes associated with it and the lack of empathy for the disorder compared with other mental health diagnoses (Bodner et al., 2011, Bourke& Greyner, 2010). On the other hand, literature has highlighted the benefits of therapeutic intervention which may be more accessible with early recognition of BPD (Chanen et al., 2008; Chanen & McCutcheon, 2013; McGorry, 2013; Patel, Flisher, Hetrick & McGorry, 2007; Schuppert et al., 2009). Literature has shown that some clinicians are reluctant to diagnose this disorder in young people, believing the diagnosis will do more harm than good (Muller, 2008). While there remains a debate around the disorder what is more understood is the importance of the therapeutic alliance to therapeutic outcomes and how this seems to be being damaged by the negative attitudes held towards this group (Gunderson & Links, 2014; Goldstein, 2005).

Research has shown that educating and training staff members can reduce the negative attitudes that they hold towards BPD patients, helping them to work more effectively with the challenges this group present, build positive therapeutic alliances and empower the patients (Bowers et al., 2005; Gunderson & Links, 2014). Although this is something that has been recognised as important for the therapeutic outcomes, it seems only a small few are receiving specialist training for this. Also, it would appear that training is directed at qualified members of the staff team, such as nurses and psychologists, often overlooking the support needs of support staff who are reported as providing most of the staff-patient contact (Bowers, 2006; Kenward et al., 2001).

The following literature review will provide a rationale for the current study, which aims to develop a deeper understanding of the perceptions support workers hold towards BPD patients and on their training and support needs.

Reflexive Statement

The relationship between the research and the researcher tends to be a personal one where their assumptions and bias can influence the research which in turn can reduce its validity (Morrow, 2005; Tufford & Newman, 2010). Due to the impact a researcher can have, it is important to remain reflective to ensure there is an awareness of the researcher's direct impact on the research, promoting transparency (Donati, 2016, Finlay, 2002). Husserl (1931) suggested bracketing, which involves the researcher reflecting on their biases and assumptions in an attempt to maintain impartiality as much as possible (Yeh & Inman, 2007). This statement will attempt to outline my position in relation to the research of exploring Staff Support Worker Perceptions of adolescent patients diagnosed with Borderline Personality Disorder. This is important so that the reader can understand the positioning of the research in relation to the topic (Elliott, Fisher & Rennie, 1999).

Prior to starting my literature review, I had worked as a clinical support worker at an inpatient CAMHS hospital for three years and had completed my Psychology degree at the Open University. My experience at CAMHS inspired me to do the Counselling Psychology (CoP) doctorate and formed the foundations for my research topic. Having experienced the challenges of working with young people considered to have a BPD, and bearing witness to the negative attitudes held towards this group, I started to wonder whether this was an institutionalised way of thinking and how these attitudes continued to manifest in mental health workers. I had noticed that as a new member of staff, with little experience of mental health, I adopted the beliefs displayed by staff more qualified and experienced than me, developing an understanding of BPD based on others experiences rather than from formal education about the disorder. I was warned about the manipulative and attention-seeking behaviour of the BPD patients and that I would learn to distinguish between what was true mental health and what was ‘attention-seeking behaviours’. This made me feel uncomfortable, and although I questioned it to myself I did not speak up about my feelings. Whether this was because I was new and the power dynamics made me unable to do so, or as I knew nothing about BPD, there was a part of me that thought maybe the patients were attention-seeking. Over the coming months, I witnessed stigma towards BPD patient from their peers, who had other mental health problems, labelling them as attention-seeking. It seemed that the uniqueness of these patients was being disregarded, instead of branding them as attention-seeking. It was considered that these patients had control over their behaviours reinforcing the negative attitude towards them, as evidenced by Lewis & Appleby, (1988). As a trainee, I wanted to explore the perceptions of support workers working with this population with an aim to improve understanding about the development of these negative perceptions and to help in the fight to reduce the stigma associated with the BPD diagnosis.

Through my role as a support worker, I began to realise the increasing responsibilities that were expected of support workers but how they were overlooked when it came to educational support and supervision of their work. As a result, my assumption was that support workers were not thought of as being able to aid in the therapeutic outcomes of the patients; therefore, were not seen as needing this support. From that experience, I wanted to understand what it was like for support workers and whether or not this is something that needed to be addressed when working with BPD. Holding this view created some bitterness towards mental health professionals for what I perceived as overlooking valuable members of the team, viewing this as a missed opportunity for therapeutic support. I was interested in exploring this and to consider my assumptions that support workers found their job challenging, and that further support could be beneficial for them as well as the patients they were working with.

The way I approached the topic would have been influenced by my previous experiences, and my assumptions held about this topic. This lead to me focusing my literature review on the challenges faced by support workers and the accessibility to training and supervision. Through bracketing, I attempted to reduce the impact my assumptions were having on my search and opened the door to multiple understandings of the topic. The literature I found highlighted to me that there was a focus on qualified staff member's attitudes towards BPD with little research on support workers and their perceptions of this group. The lack of research on support workers suggested to me that perhaps they are a group that is at times overlooked, suggesting an opportunity to explore this gap in the research and contribute to it. It could potentially promote considerations for clinical practice working with BPD, looking at how counselling psychologists (CoPs), as well as other mental health professionals, can better utilise and support their team.

My interest in working with young people with BPD and my experience of being a support worker was central to my choice of research. I felt that as a counselling psychologist, not only could I offer a different level of therapeutic input, but I could also have the opportunity to support other staff working with BPD. Therefore the current research was a way to understand the individual experiences of support workers and how their role can be utilised in the therapeutic work with the BPD group.

Being aware of the effect my assumptions and bias can have on the research and the importance of being reflective (Shaw, 2010), I maintained a reflective journal throughout the research process and have been able to integrate this into the process (Appendix J).

My aim for this research is to provide a foundation of what it is like for support workers working with BPD and how CoPs can utilise their role to effectively support others working with this group. I hope that in doing this, I can create a better understanding of the perceptions held towards BPD patients and of how training could help promote a more optimistic outlook on working with young people diagnosed with BPD.

Relevance to Counselling Psychology

The following literature review shows that those categorised as having a BPD have attached to them many preconceived ideas about who they are and how they may present to mental health services. It can be argued that many of those who work with BPD patients find it difficult to see beyond these beliefs, reducing the patient's experiences to that of the collective. The British Psychology Society's (BPS) Division of CoP places an importance on empowering each patient by understanding the diversity and uniqueness of each individual. However, it appears in the literature that when someone is associated with this diagnosis, their uniqueness is reduced and they become lost in the stigma (Cooper, 2009).

With an increase in CoPs working with young people and the increase of BPD present in this age group, it is more likely that CoPs will be involved in working with young BPD patients. This means that CoPs have an opportunity to challenge how BPD patients are viewed, engaging with them to understand their unique internal worlds rather than understanding them from the diagnostic criteria (Strawbridge & Woolfe, 2010). Gaining knowledge about these preconceptions in support workers could help identify how CoPs can best support the support workers to manage the challenges they may face in their role and help them to develop a positive therapeutic alliance.

There has been a focus in the research on the attitudes of nurses and therapists towards BPD patients; however at this time, there is limited research about how support workers perceive BPD patients in young people. In conducting this research, it may enhance our understanding of what impact the negative preconceptions of BPD patients are having on the therapeutic alliance, which has been reported as central to therapeutic change. It may also inform us about the training and support needs of support workers and other health professionals working with BPD patients and how CoPs can continue to make positive changes to the mental health system.

Furthermore, this research could improve the understanding of support workers needs possibly informing the delivery of care to young BPD patients and identify possible future research. The recommendations identified from this research hope to give a voice to support workers, an underrepresented group in the literature, to encourage mental health services to understand and meet the training and support needs of their employees and continue to confront the stigma associated with this group. In doing this, it is hoped that BPD patients can be empowered rather than discouraged by the negative preconceptions attached to them.

2. Literature Review

2.1. Borderline Personality Disorder

2.1.1. The History of Borderline Personality Disorder

BPD has only been recognised as a mental health condition since the 1980s, when it was introduced to the Diagnostic and Statistical Manual of Mental Disorders (DSM) (Friedel, 2012; Schmideberg 1947), and has since been a central feature in psychological research. Although BPD was not made an official diagnosis until its recognition in the DSM, Adolph stern conceptualised the term ‘borderline’ in 1938 identifying a group of people that would fluctuate between the ‘psychotic’ and ‘neurotic’ diagnosis. However, the current conceptualisation of BPD, as found in the DSM-5 (5th ed.; DSM-5; APA, 2013), identifies a group of individuals that suffer with a severe type of personality disorder that is characterised by impairments to the sense of self, challenges in interpersonal functioning, emotional dysregulation, disinhibition, pervasive impulsivity and suicidal ideation (Cloitreetal., 2014; Grenyer et al., 2017; Trull et al., Tragesser & Robinson, 2009).

While the term borderline has been around for many years, and there has been a considerable amount of literature focused on BPD, there is little clarity about its nature. Many theories have been proposed, some arguing the importance of biological and environmental factors (Distel et al., 2008; Distel et al., 2009 ;Linehan, 1993; Perry, Calkins, Nelson, Leerkes, & Marcovitch, 2012; Vandoerden et al, 2020), and others the significance of early childhood trauma and individual temperament (Van der Kolk, 1988; Linehan, 1993; Jovev 2013; Winsper et al., 2016) however there remains no clear understanding of this disorder. As research continues to grow and our understanding of this disorder changes, attempts are being made to increase the clarity of the diagnosis and improve the guidelines for those working with BPD patients (Hofert, 2015; Menke et al., 2006; Peter et al., 2014; Sharpe & Fonagy 2015). Nevertheless, there is an ongoing debate about the relevance of a BPD diagnosis and despite a general consensus that the roots of the disorder lay in childhood there remains a controversy about the validity of such a diagnosis in the younger population (Bondurant, Greenfield & TSE, 2004; Miller, Muehlenkamp & Jacobson, 2008; Sharpe & Fonagy 2015).

While emerging research argues that a BPD diagnosis in young people is valid (Biskin et al 2011; Miller et al 2008; Sharpe & Fonagy 2015) there is an inconsistency between the two diagnostic manuals (DSM-5 and the ICD-10) with the DSM-5 allowing for a diagnosis of BPD in young people while the ICD-10 does not make the same recommendations (WHO, 1992). It has been argued that the diagnostic criteria allows for too much diversity within the diagnostic criteria reducing its clinical relevance and increasing scepticism within a child and adolescent diagnosis of BPD (Griffiths, 2011). This scepticism is reinforced due to the problematic nature of the disorder, for example there has been evidence that suggests there can be a worsening of difficulties faced by individuals once diagnosed and that there are often barriers faced when entering treatment (Griffiths, 2011). Despite the conceptual challenges brought about by the diagnosis, diagnostic labels are used to identify groups of individuals to allocate effective and evidence based treatment for specific features of mental health disorders. The diagnostic labels also allow the clinicians to learn and understand a large amount about the difficulties an individual is having. It remains important for clinicians to understand individual diversity within diagnostic labels and that although the use of labels makes assumptions and some homogeneity exists in these groups, it is important for clinicians to remain aware of the variability within individual presentation.

The uncertainty about the validity and justification of this disorder has been influenced by both past and current stigma associated with the diagnosis, and although BPD is becoming more accepted this remains a primary concern due to the impact these negative attitudes have for those considered as having a BPD (Gunderson et al., 2013). Research that has focused on BPD has stimulated change in the attitudes held towards it, moving away from a disorder that was viewed by some as untreatable and prevailing across a life span to one that is more widely accepted, justified and viewed more optimistically (NICE, 2009; National Health and Medical Research Council, 2012; Tyrer, 2009). However, it remains a complex and controversial diagnosis with many arguing against its validity.

Highlighted within the literature is the significant gender differences found within a BPD diagnosis. It has been brought to light that the diagnostic criteria for BPD, as laid out in the DSM-5, can be seen as a source of gender bias as it is seen as focusing primarily on the presentation more commonly seen in women. For example women have been found to more commonly experience BPD criterion compared to men, with the exemption of impulsivity (Boggs, Morey, & Shea, 2005; Hoertel, Peyre, Wall, Limosin, & Blanco, 2014). The core features of suicidality, emotional dysregulation and self-harming behaviours are more commonly found in women along with co-morbid disorders such as eating disorders and mood disorders (Hoertel, Peyre, Wall, Limosin, & Blanco, 2014; Sansone & Sansone, 2011). More commonly associated with a male diagnosis is aggressive and pleasure seeking behaviours and substance misuse disorder, which can often draw in a diagnosis of Anti-social personality disorder (ASPD) (Hoertel et al., 2014; Sansone & Sansone, 2011). Due to the gender biased criteria it may be that, inappropriately, women are receiving a BPD diagnosis much more than men (Braamhorst et al, 2015; Silberschmidt, Lee, Zanarini, Schulz, 2015; Shaw & Proctor, 2005).

To manage the current bias associated with a BPD diagnosis it is important to consider the implications of both cultural and social differences, for example how emotional experiences differ between cultures. This has been shown in the emotional expression seen in African-American women compared to European-American women (Durik et al., 2006). Due to the emotional expressiveness found within the African-American populations there is a possibility that this behaviour may be inappropriately pathologized leading to African-American women more commonly seen as meeting the DSM-5 criteria for BPD. With these biases in mind it is important for clinicians to consider cultural and gender differences and recognise the difference between pathological behaviours and societal and cultural norms. This demonstrates that there is a significant challenge when considering a BPD diagnosis and further research is essential to evaluate and develop an accurate diagnostic criteria. While cultural and gender bias does not have a key relevance to the purpose of this current study. Due to its focus on how support workers perceive their working role with a BPD diagnosis in young people, it is an important consideration when looking at the wider context of the BPD diagnosis.

This highlights the challenges faced by clinicians when met with the decision to diagnose since there is a debate between the damage it can cause and the helpfulness of intervention. There is also an argument that not diagnosing due to stigma may prolong any stereotypes associated with BPD, lengthening individual suffering due to misdiagnoses or having symptoms dismissed (Gunderson et al., 2013; Ruggero, Zimmerman, Chelminski & Young, 2010; Western et al., 2003).

2.1.2. The Health Concerns of Borderline Personality Disorder

Research has suggested that BPD is one of the most frequently diagnosed and presenting disorders that mental health services face and has become a central concern for many mental health professionals. The existence of

BPD has been estimated in around 11% in the general population increasing to between 19% and 53% of adolescents in a hospital setting (Balderas et al 2012; Knafo et al, 2015; Sharpe et al, 2012) and 78% of suicidal adolescents attending A&E. This is an increase since the American Psychiatric Association (APA) estimated a rate of 3.2% of young people having a BPD (APA, 2013; Grant et al., 2008; Johnson et al., 2008). It has been suggested that this is likely to be higher due to the number of individuals misdiagnosed, of which research has suggested a number of around 40% receiving a misdiagnosis, therefore perhaps increasing the true prevalence rates of BPD (Ruggero, Zimmerman, Chelminski & Young, 2010). Due to the frequency that BPD presents to services it has been suggested that it is occurring at a similar rate to other major mental health disorders such as bipolar disorder and schizophrenia (Kealy & Ogrodniczuk, 2010).

It has been suggested that individuals with BPD often experience the recurring crisis as well as episodes of severe psychological and physical harm to the self, which has been linked with multiple hospital admissions (Bland, Tudor, & Whitehouse, 2007; Nelson, 2013). This may influence the high presentation of BPD patients in hospital settings where it is estimated that 20% of the adult inpatient population present with BPD and 49% of the Child and Adolescent Mental Health Services (CAMHS) (Grilo et al., 2001; Leichsenring et al., 2011). Not only do BPD patients present in hospitals, but it is also estimated that 25-50% of prison inmates present with a BPD suggesting that those with a BPD are at risk of being convicted of a crime (Sansone & Sansone, 2009).

Although there is little research into suicide in adolescence with a BPD, it is recognised that adolescents are typically more likely to engage in impulsive behaviours compared to adults (Adriani & Laviola, 2003; Chambers et al, 2014; Cruz & Soriano, 2014; Steinberg et al., 2008) implying an increased likelihood of them engaging in risk-taking behaviour. When paired with a BPD, it may be that young people are more likely to engage in self-harm and suicidal behaviours, which remain central features of BPD (APA, 2013). This implies a concern for this group since suicide has been recognised as a leading cause of death in young people (Hedegaard et al., 2018; Kidger et al., 2012). Research has found that as many as 33% of BPD patients engage in suicidal behaviour (Ayodeji 2015; Cailhol 2015; Kongerslev 2015;), with an estimate of around 10% of adult BPD patients completing suicide (Leichsenring et al., 2011). It is expected that these numbers are much higher, however the stigma associated with suicide may cause low reporting of suicidal ideation (Hedegaard et al., 2018).

Furthermore, BPD is considered a comorbid disorder that has been associated with depression and anxiety, eating disorders and substance misuse (among other diagnoses), with some studies suggesting that many BPD patients will have comorbid mental disorders. It has also been reported that comorbidity is most commonly found in the adolescent population (Chanen, Jovev & Jackson, 2007; Kaess et al., 2013; (Schmaling & Fales, 2018; Zanarini, Frankenburg, Hennen & Reich, 2004) potentially making diagnosing a BPD in young people more challenging. Not only this, the co-morbid nature of BPD seems to increase the life-time prevalence rate of having a lifetime comorbid mental illness associated with their BPD (Bender et al., 2001 ; Gross et al., 2002; Johnson et al., 2008; Sar et al., 2011).

Due to the reported numbers of BPD presenting in services and the potential personal and societal costs this disorder has, BPD has become a public health concern. With these concerns in mind, there have been significant changes in how mental health professionals work with BPD (Choi-Kain, 2017; Muehlenkamp & Gutierrez, 2007) Nonetheless, there are still many unknowns when it comes to BPD, especially for young people. Therefore it remains an area that will benefit from further research to further develop our understanding of the disorder.

2.1.3. Attachment and Borderline Personality Disorder

Attachment theory has been used to understand the development of BPD, concerning itself with the development of personality from birth through the attachments with significant others, and linking disruption in the attachments in the early years to BPD traits (D'Andrea et al., 2012; (Dvir, 2017; Linehan, 2018; Murphy et al, 2018; Nickell et al, 2002; Sher,

Koenig, & Rustichini, 2014). When an attachment figure creates a safe and stable environment a secure base is formed where the infant can build a secure internal model of the world (Bowlby, 1973). However infants whose primary care givers are unable to provide a safe and consistent environment, and infants who experience adverse and traumatic experiences can become vulnerable to the development of insecure attachment styles (Godbout, Briere, Lussier, & Sabourin, 2014; Muller, Thornback, & Bedi, 2012; Erozkan, 2016). While no specific attachment style is confirmed as a origin for BPD, research has linked insecure attachment styles to BPD traits (Agrawal et al., 2004;Barone , 2003, Cassidy & Shaver, 2008; Fonagy et al., 2002, Holmes, 2002; Levy, 2005; Scott et al., 2013), such as emotional dysregulation, impulsivity, self-harm and suicidality (Grootens et al., 2008; Nielsen et al., 2018; Reisch, Ebner-Priemer, Tschacher, Bohus, & Linehan, 2008; Sloan et al., 2017). Insecure attachment styles have also been linked to the challenges in interpersonal functioning, a key component in the classification of BPD (Bartholomew et al, 2001; Beeney et al. 2015; Meyer et al, 2001). There is a vast amount of research on attachment theory and the links to personality disorders which can be used to inform our understanding of the challenges experienced in BPD patients.

A further link between BPD and attachment styles is an individual’s ability to mentalise, with impaired mentalisation having a link to insecure attachment styles (Fonagy & Luyten, 2009; Sharp et al., 2011; Sharp, 2014). Mentalisation is a person’s capacity to understand and predict their own and other people’s behaviour (Bateman & Fonagy, 2004; Sharp & Fonagy, 2008; Bateman & Fonagy, 2011) which is considered a key component in affect regulation and interpersonal functioning, key components of BPD (Shamay-Tsoory, Harari, Aharon-Peretz, & Levkovitz, 2010). The link between impaired mentalisation practice and

BPD has impacted the proliferation of mentalisation based treatment in NHS practice to help BPD patients develop mentalisation based skills, in a hope to reduce the impact of some of the BPD characteristics.

2.2. Adolescent Borderline Personality Disorder Diagnosis and its Challenges

2.2.1. Diagnosis of Borderline Personality Disorder in Young People

In 2004 the office of national statistics estimated that 10% of young people experienced mental health concerns (ONS, 2004). However, in 2017, this estimate raised to nearly 13%. Of those suffering from their mental health, it is estimated that 1 in 12 will engage in self-harming behaviour (McManus et al., 2016). While little research has focused on the prevalence rates of BPD in adolescents, there is research that estimates BPD is present in a high percentage of young people (Leung and Leung, 2009; Knafo et al, 2015).

In the recent years changes have been made to the diagnostic criteria of BPD heralding more careful consideration in the diagnosis of BPD in young people, and attempting to establish more acceptance of the early diagnosis (Chanen & Kaess, 2001; Hofert, 2015;). Nonetheless, it is reported that clinicians remain divided on the validity of a BPD diagnosis in young people (Biskin et al ,2011; Glenn & Klonsky, 2013; Paris, 2003; ;Sharpe & Fonagy 2015) and there remains an unresolved debate about whether or not to diagnose in this age group. This shows how important it is to continue to expand our understanding of a BPD diagnosis in young people and the impact that this diagnosis has.

Regardless of the general consensus that the roots of the BPD lay in childhood and an agreement that early recognition can be beneficial (American Psychiatric Association [APA], 2013; Chanen et al., 2004; Laporte et al., 2011; Miller et al., 2008; Paris, 2015) literature indicates clinicians continue to debate the validity of such a diagnosis before the age of 18. The evidence base for a BPD in those under the age of 18 is growing and is believed by some to be a reliable diagnosis (Chatagner, Olliac, Choquet, Botbol, & Raynaud, 2015; Greenfield et al., 2015;;Kaess, Brunner, & Chanen, 2014). Although an adolescent diagnosis is now considered justified, it is reported that barriers still remain for clinicians considering such a diagnosis in this population (Chanen & McCutcheon, 2008; Chanen & McCutcheon, 2013; Stepp, 2012). Research suggests a concern about the rapid nature of adolescent development and the tendency for adolescents to engage in impulsive behaviours (Adriani & Laviola, 2003; Chambers et al, 2014; Cruz & Soriano, 2014) which could be misinterpreted as BPD symptomology, making it difficult for clinicians to distinguish between what behaviours are part of a 'normal' adolescent development and which ones are considered a BPD symptom (Fonagy et al, 2015;Laurenssen et al., 2013; Griffiths, 2011). Clinicians have also voiced concerns about the impact the BPD label has on individuals, proving a persistent barrier for both clinicians and BPD patients (Aviram, Brodsky & Stanley, 2006; Gunderson et al., 2013; Rusch et al., 2006; Ruggero, Zimmerman, Chelminski & Young, 2010) often creating resistance to formally diagnosing a BPD (Chanen, 2013). This may impact the individual due to the possibility of a misdiagnosis which could lead to the wrong intervention and further challenges for the young person (Chanen & McCutcheon, 2013; Westen et al., 2003). This is an ongoing conflict that is affecting the way clinicians work with BPD patients.

This diagnosis is also questioned because there has been reports of a natural decline in BPD symptoms between adolescence and adulthood (Bisking et al., 2011; Johnson et al., 2000; Townsend et al, 2019; Videler, et al 2019; Zanarini et al, 2008) with many asking if there is a justification for the diagnosis when it is highly stigmatised and can cause distress to the individuals (Aviram, Brodsky & Stanley, 2006; Gunderson et al., 2013; Rüsch et al. 2006). These challenges highlight the barriers clinicians face when considering a BPD diagnosis and how to work with the individuals that fall into this group.

2.2.2. Early Diagnosis

BPD has received a lot of attention in the existing research which has led to an increased understanding of a BPD diagnosis in young people. This is reflected in the current guidelines of the ICD and DSM (APA, 2013, Tyrer, Crawford & Mulder, 2011). Regardless of the empirical support for the early recognition of BPD (Chanen et al., 2019; Chanen et al., 2017 Miller, Muehlenkamp & Jacobson, 2008) clinicians remain reluctant to diagnosis in young people. Laurenssen et al. (2013) reported that although 57.8% of psychologists thought BPD is valid in adolescence, only 8.7% reported following through with a diagnosis, with as little as 6.5% offering specialised therapeutic interventions. Clinicians continue to question the stability of BPD due to the natural reduction of symptoms in line with the typical progression of behaviour from adolescence to adulthood, and that the diagnosis may do more harm than good due to the associated stigma (Aviram, Brodsky & Stanley, 2006; Gunderson et al., 2013; Ruggero, Zimmerman, Chelminski & Young, 2010; Rüsch et al., 2006; Muller, 2008; Townsend et al, 2019; Videler, et al 2019;), resulting in a reluctance to diagnosis in this age group (Fonagy, 2015; Roberts, Caspi & Moffitt, 2001; Kealy, 2010). Research has suggested patients naturally remit from adolescence to adulthood, with some patients no longer meeting the diagnostic criteria (Bornovalova, Hicks, Lacono and McGue, 2009; Wright, 2016) however it has also been shown that young people with a BPD have a reduced quality of life, which impacts them into adulthood (Cohen, Crawford, Johnson & Kasen, 2005; Crawford et al., 2008; Livingston et al, 2010; Latalova et al, 2013; Latalova et al,2014). This shows the challenge faced by clinicians when considering a BPD diagnosis in young people; on the one hand it may be damaging to them because of the associated stigma when their symptoms may naturally decline (Chanen et al., 2007; Muller, 2008; Townsend et al, 2019; Videler, et al 2019;) however it has been suggested that a misdiagnosis can be harmful reducing access to potentially helpful intervention at a younger age (McGorry, 2013).

While there are valid reasons for the reluctance to diagnose BPD in young people, the adolescent development stage is a time where the brain is at its most malleable making it more susceptible to experience potentially increasing intervention effect (Chanen, 2015; White, 2009; Lenzenweger & Desantis Castro, 2005). This would suggest that the adolescent population are more responsive to intervention. Therefore, some would argue that it is a good time to intervene and diagnose a BPD. Research also argues that early diagnosis also increases opportunities for young people to seek help with their symptoms (Patel, Flisher, Hetrick & McGorry, 2007) which is seen as important due to the high mortality rate associated with BPD (Paris and Zweig-Frank, 2001). Research has shown that BPD patients are positively impacted by the clinical intervention (Chanen & McCutcheon, 2013; NICE, 2015), and it is likely that early intervention will reduce the negative symptoms of BPD (Correll et al, 2018;Patel, Flisher, Hetrick & McGorry, 2007; McGorry, 2013). This is supported by research that has shown positive outcomes when intervening during the adolescence years (Chanen et al., 2008; Correll et al, 2018;Schuppert et al., 2009).

Although there is considerable research that suggests a natural decline in symptoms over time, research has also shown that there is a negative impact on individuals when they are dismissed or given the wrong diagnosis (Chanen, 2015; Zanarini et al., 2001). Therefore highlighting the importance of understanding that although there may be a natural decline of symptoms, there are consequences for those who do not have the disorder recognised. On the other hand, we must recognise the consequences of receiving a diagnosis that is highly stigmatised. With all this in mind, it is important to continue to grow the body of research into the impact of the adolescent diagnosis of BPD, since there are benefits to an early diagnosis and by increasing our knowledge we can begin to tackle the implications of the associated stigma. The current study will increase our understanding of the perceptions of support workers working with BPD in young people and how they negotiate their role with a controversial diagnosis.

2.2.3. Mental Health Professionals Attitudes towards Borderline Personality Disorder

Despite one in four people experiencing mental health difficulties there remains a strong stigma associated with mental health conditions (Mental Health Foundation, 2015). This has been of particular significance when it comes to BPD which is a highly stigmatised group (Aviram, Brodsky & Stanley, 2006; Forsyth, 2007; Knaak et al., 2015; Ring & Lawn 2019). Bodner et al. (2011) found that mental health professionals held less empathy towards BPD patients, holding more negative attitudes towards them, compared with patients who had other mental health conditions (Forsyth,2007; Markham & Trower, 2003; Westwood & Baker, 2010). In addition to this, Stroud & Parson (2013) reported that mental health staff experienced feelings of 'dread' when it came to working with BPD patients, often finding their behaviour too complex to manage, describing them as "manipulative" and "frustrating". The challenging nature of this client group can lead staff to feel inadequate and helpless in their role often having negative consequences for the patient, for example, it has been reported that staff will sometimes become angry and distance themselves from these patients (Aviram et al., 2006; Black et al, 2011; Bowers, Nijman, Simpson, & Jones, 2011; Commons Treloar, 2009; Gallop, 2002).

The negative attitudes held towards this group may be influenced by a belief that BPD patients have more control over their behaviours compared to clients with other mental health diagnoses, leading to a sceptical view of BPD (Forsyth, 2007, Winship, 2010). These negative attitudes may also be reinforced due to the belief that BPD patients are less receptive to intervention and have multiple referrals to services due to high dropout rates (Bohus et al., 2004; Kvarstein, Karterud, & Pedersen, 2004; Chanen et al., 2008; De Panfilis et al, 2012; Martino, et al. 2012; Schuppert et al., 2009;). In addition to this, research reports that it can be difficult to engage patients in a therapeutic alliance (Gunderson, 2001), which is seen as central to successful therapeutic outcomes (Gunderson & Links, 2014; Hirsh, Quilty, Bagby & McMain, 2012). It is also reported that staff are left feeling helpless and inadequate which can lead to them becoming disengaged in their work (Bodner et al., 2015; Hasetings, 2005; Markham & Trower, 2003). Research has shown that working with BPD has a tendency to increase the levels of stress at work, potentially impacting the high levels of staff burnout reported in this staff group (Carrotte et al, 2019; Egan & Rees, 2003; Linehan et al., 2000; Perseius, Kaver, Ekdahl, Asberg, & Samuelsson, 2007;).

Despite there being a significant culture of negativity toward the BPD population, research has put forward that some professionals do hold more positive views, with an increase in optimism about this group (Crawford, Adedeji, Price, & Rutter, 2010; Cleary et al., 2002, James & Cowman, 2007;McHale & Felton, 2010; Karman et al., 2015). This may have come with the continuing changes to the DSM and the ICD, where BPD has become a more recognised and accepted disorder. This has encouraged the development of different therapeutic interventions, such as Mentalization-Based Treatment (MBT) (Goldstein, 2005) which is grounded in attachment theory and understanding the development of mentalization in individuals with BPD. This treatment is based on an understanding that if we can improve a person's ability to mentalize then the BPD symptoms will be alleviated (Bateman & Fonagy 2008, 2009; Fonagy, Luyten, & Allison, 2015), and Dialectical Behavioural Therapy (DBT) (Linehan, 1993), which follows a cognitive-behavioural therapeutic line of thought. DBT includes individual sessions, skills based training, phone coaching and multi-disciplinary teams. There is a focus on mindfulness strategies and change based skills. DBT has been effective at reducing emotional dysregulation (Neacsiu, Eberle, Kramer, Wiesmann, & Linehan, 2014), a core feature of BPD. Both these treatments have reported successful therapeutic outcomes (Bateman & Fonagy, 2001; Jorgensen et al., 2013).

With an enhanced understanding of the disorder, there seems to have been a shift in some of the negative beliefs about this group. Nevertheless, negative attitudes continue to be reported about this group, for example, some mental health professionals still hold the attitude that these individuals are ‘bad’ rather than mentally ill (Lam, 2015;Ross & Goldner, 2009; Servais and Saunders, 2007). It is understood that there are negative consequences of belonging to a stigmatised group, leaving individuals more vulnerable to isolation and being seen as having less worth than others (Aviram & Rosenfeld, 2002; Link et al., 2001; Livingston & Boyd, 2010; Mittal, Sullivan, Chekuri, Allee, & Corrigan, 2012; Schomerus, Matschinger, & Angermeyer, 2009). It is therefore important to consider the need for more training in this area in order to tackle the issues of stigma and the impact these are having on individuals with a BPD (Commons Treloar, 2009; Shanks, Pfohl, Blum & Black, 2011; Karman et al., 2015). It may be important for research to continue focusing on how these attitudes are impacting both the patients and the staff, and how we can support the change in attitudes towards them.

2.2.4. Impact of Negative Attitudes on Mental Health Patients

Many mental health professionals report BPD patients as challenging to work with, associating them with being violent, manipulative, threatening of suicide and refusing of therapeutic intervention (Aviram & Brodsky, 2006; Rizvi, Steffel & Carson-Wong, 2012; Ross & Goldner, 2009; Sansone & Sansone, 2013; Vivekananda, 2000)These attitudes can add additional challenges affecting the way this group are treated, for example many professionals distance themselves from these individuals (Aviram et al., 2006; Black et al., 2011; Bodner et al, 2015; Latalova et al, 2015; Tull & Gratz, 2012; Lawn et al, 2015). This could have a negative impact on clients with BPD who have been suggested to be sensitive towards real or imagined abandonment and rejection (Ayduk et al., 2008; Fallon, 2003; Lasalvia et al, 2013). Therefore the way in which BPD patients are treated

has the potential to increase the challenging behaviours displayed by these patients (Wrigley et al, 2005; Sirey et al, 2001).
Research has shown that the negative attitudes held about mental health patients have a significant impact on the likelihood that they will accept intervention and remain in therapeutic programs, with up to 78% either refusing or dropping out (Leslie, & Rosenheck, 2004). Block, Gjesfjeld and Greeno (2013) spoke with a group of adolescents about their views of therapeutic intervention in an attempt to understand their decision to accept or decline it. They showed that adolescents were concerned that they would be stigmatised and consequently would be negatively impacted. This is consistent with findings from a study conducted by Time to change (2012), who reported that 9 out of 10 young people experienced stigma associated with a mental health label. They reported that 70% of young people experienced stigma from friends, 57% from parents and 45% from romantic relationships. It was also reported that 40% experienced stigma from teachers and 47% from doctors.

Moreover, the research identified the impact this has on individuals; 54% of young people stopped hanging out with friends, 40% stopped having relationships, and 40% stopped going to school. This led to feelings of loneliness, depression and self-injury with 26% experiencing suicidal thoughts. Furthermore, 95% reported feeling that society saw them negatively and feared being bullied, which impacted their likelihood of seeking mental health advice. This research shows how negative attitudes about the mental health can impact young people and how it can be linked to the high dropout rates in treatment (Bailey, Hetrick, Rosenbaum, Purcell, & Parker, 2018; Bohus et al., 2004; Chanen et al., 2008; Schuppert et al., 2009).

Additionally, Pinfold, Astley and Hayes (2008) used online surveys to gather information about service users and carers' experiences of stigma and discrimination. The results showed that 87% of service users report mental health labels having a negative impact on their lives preventing them from doing things such as getting employment, having a relationship, getting education and engaging in leisure activities. They felt less able to discuss mental health concerns which has a negative effect on help-seeking behaviour, which in turn has a negative effect on recovery. Furthermore, the negative attitudes towards mental health had a negative impact on quality of life, resulting in family members becoming overprotective and professionals dismissing psychological symptoms. Likewise, Moses (2010) shows that nearly half of the participants experience stigma leading to the concealment of mental health problems, further impacting therapeutic outcomes.

Research shows that the negative attitudes towards BPD can impact the likelihood of clinicians diagnosing this and therefore, may be a contributing factor of the disorder being both under-recognised and underdiagnosed (Gunderson, 2008). This reduces the likelihood of early diagnosis and intervention which some research considers to be an important factor in increasing remission rates (Bisking, 2011; Ruggero, Zimmerman, Chelminski & Young, 2010; Western et al., 2003). However, while the impact of stigma remains high, many patients have reported mental health staff having a positive impact on them (Fallon, 2003). Moses (2010) showed that school staff who recognise the struggle of young people with BPD allowed for a more flexible approach to learning and had a greater understanding of the issues faced by the pupils. This allowed these individuals to cope better in school. Unfortunately, there is still a negative impact of stigma in schools with individuals feeling isolated and being disliked by staff. This could have a negative effect since individuals may not feel able to get the help they need and experience feelings of rejection that could lead to feelings of worthlessness.

From the literature, it appears that the negative effects of stigma are hindering opportunities for intervention. It is an important focus for research to begin challenging these views and further re-enforce the importance of education to challenge the negative attitudes and promote more positive behaviours in BPD patients (Karman et al., 2015).

2.3. Mental Health Professional’s Experience Working with Borderline Personality Disorder Patients

2.3.1. Staff Education and Training

BPD has historically been reported as a misunderstood diagnosis, which has had a negative impact on the therapeutic outcomes for individuals with BPD (Tyrer, 2009). The literature has implied BPD is a complex disorder which has been challenging for mental health workers working with these individuals, including the demands on resources and the dividing of mental health teams, with 76% of staff feeling that they needed specialist training when it came to working with BPD patients (Cleary et al., 2002). With access to specialist training and education staff attitudes towards BPD patients can be challenged, with research showing this can create more positive ways of responding to the challenges these patients present, and improve the therapeutic alliance between the patient and staff member (Krawitz, 2004; McGrath & Dowling, 2012). By developing an understanding of the patterns of behaviour associated with a BPD diagnosis, this can allow staff to move away from seeing the patient’s behaviour as something to be avoided or taken personally and instead respond more therapeutically towards them.

Research has shown that clinicians hold negative views about BPD, often having less empathy towards them compared to other mental health disorders. Many mental health workers view BPD patients as manipulative, attention-seeking and untreatable, often as a result of not understanding the complexity and uniqueness of each individual. Challenging these negative attitudes begins with education around the complexity of BPD and has been shown to increase the empathy held by mental health workers towards these patients, allowing a better therapeutic alliance to be created (Commons-Treloar 2009; Karman et al., 2015). Furthermore, education about BPD has been reported to have positive effects on staff attitudes (Bowers et al., 2005) and can help create an understanding of the patient's difficulties. This can create a more empathic way of interacting with this group and in turn, positively impact treatment outcomes (Bland, 2003; Commons-Treloar 2009; Elliott et al , 2018; Gleichgerrcht & Decety, 2013). Nevertheless, despite the evidence that training is important for improving attitudes and therapeutic outcomes, many mental health staff report feeling under-equipped to work with BPD patients (Bodner et al, 2015; Commons-Treloar, 2009; Loader 2017).

Furthermore, nurses have reported that working with BPD patients can leave them feeling angry and helpless due to the challenging nature of their presentation (Carrotte et al, 2019; Gallop, 2002). This can result in the negative attitudes held by staff which can lead to staff acting unprofessionally, possibly due to not knowing how to manage their own feelings of anger and frustration. For example, staff have been shown to distance themselves from BPD patients and harbour strong negative feelings towards these patients (Bland et al.,. 2007; Bourke & Greyner, 2010; Jobst et al, 2010). With the use of training and supervision staff can begin to reflect on their own feelings when it comes to working with BPD, which in turn will allow them to better understand BPD and develop more effective support for this complex group (Bodner et al, 2015; Bowers et al., 2005; Commons-Treloar, 2009; Loader 2017; Stroud & Parsons, 2013). This is supported by research that demonstrates that staff can be left feeling demoralised when working with BPD (Carrotte et al, 2019; Gallop, 2002) and feel that this is due to the lack of education and understanding of the BPD presentation (Stroud & Parsons, 2013; Weight & Kendal, 2013; Woollaston & Hixenbaugh 2008).

It is evident in the literature that access to specialist education has a positive impact on the therapeutic outcomes; nevertheless this level of training has only been available to 12-46% of mental health workers. Not only this, specialist training appears to be directed at qualified staff, often missing out the support workers who have the most contact with BPD patients and whose attitude and perceptions may impact the treatment received by BPD patients. Therefore, it is important to begin to bridge the gap in the literature and develop a better understanding of support workers perceptions of this group, since they have more client contact and less education, and understand their experiences in order to support them and the patients better.

2.3.2. Support for Staff

One of the fundamental elements for positive therapeutic outcome is the therapeutic alliance (Gunderson & Links, 2014; Hirsh, Quilty, Bagby & McMain, 2012), which has been shown to be particularly true for BPD patients (Fraser & Gallop, 1993; Hirsh, Quilty, Bagby & McMain, 2012), however due to the challenging nature of BPD it can be difficult to form such trusting relationships (Gunderson, 2001; O'Brien, 1998). It has been argued that these difficulties can be managed through the use of supervision as this facilitates the development of skills and enhances care and emotional support, both of which have been suggested to be important parts of delivering care to mental health patients (Ogren & Jonsson, 2003). Furthermore, supervision provides emotional support to those working in complex and emotive environments, helping mental health workers feel more confident and increase workers self-efficacy (Bernard & Goodyear, 2004; Vallance, 2004). Therefore, supervision can have a positive impact on the therapeutic alliance and improved therapeutic outcomes (Cashwell & Dooley, 2001; Pesut & Herman, 1999). This was supported by Bambling et al., (2006) who found that supervision had a positive effect on therapeutic outcomes and has become a recommendation for staff working with BPD to engage with clinical supervision.

Additionally, research has highlighted that mental health workers felt that supervision is needed, especially when working with BPD clients. O'Connell & Dowling (2013) highlighted that psychiatric nurses felt there was a lack of supervision when working with BPD patients and it was felt that supervision is important to increase the effectiveness of a therapeutic intervention. Furthermore, supervision was seen as an important way for staff to manage the emotional demands of working with BPD and preventing staff burn out (Bergman & Eckerdal, 2000). Nonetheless, while there is evidence to express the need for supervision for staff working with BPD, there is minimal evidence to suggest that this is being provided to meet the needs of all staff. Where supervision is provided, it would seem that there is a focus on qualified staff receiving supervision with little importance put on the needs of support workers. This is reflected in the literature that has focused on the benefits of supervision for qualified members of staff such as nurses and psychologists. However, since support workers provide much of the client contact, there could also be a benefit for them, allowing them to further develop in their role and help them to manage the challenges that come with supporting patients with BPD. This could also benefit therapeutic outcomes. Therefore this is something that could benefit from further research to understand how supervision could positively impact therapeutic outcomes by supporting staff in their role.

2.3.3. The "Support Worker"

"Support worker" is just one of many titles used to describe the role of an unqualified member of staff working in hospitals alongside qualified staff members. Others include; health care assistant, care worker and ward assistant (Thornley, 2000). The variety of titles reflects the varied roles undertaken by support workers with no clear cut description of their role (Tornley, 2000). Following the "agenda for change" support workers have increasing responsibility for tasks previously carried out by qualified nurses and are increasingly relied on due to staff shortage in the NHS (Gerrish & Griffith, 2004). Support workers are often seen as the front line in providing patient care. However, there is no formal training required to be in this role (Kenward et al., 2001). Additionally, little research has been conducted on the role support workers have in mental health settings, particularly their role in the therapeutic interventions and outcomes of BPD in young people and their perceptions of this. Therefore much of our understanding comes from the literature on the benefits of supervision and training for nurses and therapists.

Research shows that BPD patient's present to mental health services with a number of challenges and are considered the most challenging group to manage and treat (Pavlovich-Danis, 2004). Furthermore, research relates the complex and challenging situations experienced by individuals working with BPD to such individuals feeling manipulated and sometimes threatened in their work (McGrath & Dowling, 2012). This has led to mental health professionals feeling hopeless in their role and as though they cannot make a difference (Bland & Rossen, 2005), with many nurses highlighting a need for further training and education about the BPD diagnosis in order to work with these individuals more effectively (Cleary et al., 2002). It is important to consider the impact that this will have on the staff members who have little to no training about BPD since the effects may have a significant impact on them. It could be inferred from this that support workers who receive no formal training about BPD may also feel that they could benefit from training and guidance.

Research has shown that those working with BPD often feel unskilled to do so increasing the stress they experience at work (Bodner et al, 2015; Commons-Treloar, 2009; Loader 2017; Rossberg, Karterud, Pedersen, & Friis, 2007), often leading to staff burnout (Carrotte et al, 2019; Linehan et al., 2000; Perseius, Kaver, Ekdahl, Asberg, & Samuelsson, 2007). These stress levels may be linked to the high risk of self-harm and suicidal intent in BPD patients (Krawitk and Batcheler, 2006;Paris & Zweig-Frank, 2001) causing anxiety in staff around managing this high-risk group (Howe, 2013). It has been found that staff experience feelings of blame and responsibility for patient's safety which cause mental health professionals a great deal of anxiety (Krawitk & Batcheler, 2006). This is exasperated by feeling helpless in the face of BPD (Gallop, 2002; Markham & Trower, 2003) due to the nature of the presentation, subsequently reducing job satisfaction and increasing the negative attitudes held towards BPD patients (Markham & Trower,2003). Therefore, it could be argued that support workers are also being impacted by these challenges and could benefit from further training and support to empower them to make a therapeutic change (Cleary et al., 2002; Jorn & Kitchener, 2007; Robinson et al., 2008; Shanks et al., 2011)

Since this group are seen as one of the most challenging groups to work with, an increased education has been asked for from qualified staff members to further their understanding of patient presentation (Cleary et al, 2002; Stroud & Parsons, 2013; Sherin & Linehan, 1992). It would seem that support worker roles, which are identified as unskilled positions, would also benefit from educational opportunities to increase the care given to the BPD group as well as their own psychological wellbeing. Therefore, to further understand this area, the current research sets out to understand the perceptions of the support workers working with BPD in young people to better understand their perceptions and how best to support them.

2.4. Summary of Literature Review and the Gaps in our Knowledge

The above literature review highlighted the fact that BPD patients tend to make up a significant portion of inpatient and outpatient services, have reoccurring admissions and have a tendency to get in trouble with the law, with as many as 25-50% of prison inmates diagnosed with BPD (Leicsenring et al., 2011; Nelson, 2013; Sansone & Sansone, 2009). Moreover, around 10% of those diagnosed with BPD will complete suicide (Leicsenring et al., 2011). Although much of the research is conducted on the adult population, the existing literature that has focused on BPD in young people has found a higher proportion of inpatients experience BPD and that they are at a higher risk of self-harming and suicide (Grillo et al., 2001; Kidger et al., 2012). Much of the research conducted on staff attitudes towards BPD has been conducted on adults, and the experience of working with young people is likely to generate a completely different experience. This is an important shortfall in the literature and one that should be addressed so that we can start to consider the impact this client group has on the staff, but also begin to understand the perceptions of working with BPD on young people since this is going to become a more frequent encounter. This may provide new insights into the impact working with this group has on staff members whilst also addressing the working environment and any additional needs required to be met to improve the development of the therapeutic alliance with young BPD patients. In addition, research has mostly been limited to the experiences of qualified members of staff and not support workers (an unskilled position), and the impact of being front line staff with this challenging group.

Moreover, 76% of staff felt they needed more specialist training when it came to working with BPD patients (Cleary et al., 2002) with many finding the work emotionally overwhelming (Bland,2003). However, it is found that as little as 12% of staff have received specialist training and support. In addition to this, when specialist training is provided this is more often directed at the qualified staff members, not at the support worker staff. As well as this, supervision, which is considered an important aspect of client work is provided, but again with a focus on the qualified staff. Therefore, support workers are not receiving the adequate amount of supervision to support them with the challenging aspects of their work, including the emotional experiences encountered.

With this in mind, there is a need for qualitative research exploring the perception of working with BPD patients, particularity from the point of view of support workers working in the child and adolescent mental health sector. In addition, several studies have shown that staff attitudes impact the therapeutic outcomes and have a negative impact on their own wellbeing, with staff working with this group having high levels of burnout due to experiencing self-doubt and failure. Research has shown that education can change these attitudes and improve the wellbeing of staff working in this challenging environment. Nonetheless, while research shows the importance of education, supervision and support it would seem that support workers, who are considered as having little or no training for their role, are often not seen as needing supervision. In light of the fact support workers are spending much more face to face time with these challenging clients, yet are receiving little to no support, indicates the importance of understanding the perceptions of support workers around the BPD diagnosis in young people.

The following research question is suggested; **How do support workers perceive their work with adolescent patients diagnosed with BPD?** The research aims to provide a meaningful contribution to understanding the perceptions of support workers, who are under-researched in the literature, giving them a chance to voice their views on their work and in turn better understand their clinical needs when working with BPD in young people. The deeper aim is to help CoPs, who are more and more likely to come across BPD in young people, understand the needs of support workers who are delivering much of the day to day contact. Therefore, allowing CoPs to better support the support workers in their role and positively affect therapeutic outcomes.

2.5. The Relevance of the Research Topic in Counselling Psychology

Young people's mental health has become a central concern with research indicating that individuals with mental health conditions will have developed them during adolescence (Kessler et al.,2012) and that there is an increase in the number of young people receiving mental health interventions (Lin & Bratton, 2015). More specifically, around 3% of young people were estimated to have a diagnosis of BPD in 2013 (APA) with the numbers likely to increase following the changes to the DSM-5, which allows more consideration of an early diagnosis. Considering the increased likelihood of young people having a BPD diagnosis, there are many concerns around the shortfalls of therapeutic intervention and the limited amount of research conducted in this area. This can be seen as a significant gap and one where research has failed to remain current and informed about the changing nature of mental health in young people and the increased presentation of BPD in mental health services.

This is true of CoP where little research concerned with BPD in young people has been conducted and none on the impact this challenging group has on support workers working with them. It is important for CoPs to bridge this gap since we can make valuable contributions to the understanding of support workers subjective experience of working with this group and therefore develop an understanding of their professional development and training needs, again another area that has little research. The proposed research is relevant to the CoP discipline since it is focused on the individual experiences of support workers which is consistent with the principle of CoP (Strawbridge and Woolfe, 2010).

Additionally, CoPs may have the opportunity to provide supervision, something which has been found to improve therapeutic outcomes (Bernard & Goodyear, 2004; Cashwell & Dooley, 2001; Ogren & Jonsson, 2003). However, it has been shown that support workers are often overlooked and not seen as needing access to this support. Therefore, I feel it is important to understand how support workers perceive their work in order to better understand their training and support needs. This will have implications for CoPs working with a BPD as it may change the way support workers are viewed and worked with. It is important for CoPs to have this knowledge in order for them to effectively support workers with their own material as well as helping to provide successful therapeutic intervention.

With BPD clients viewed as difficult to work with (James & Cowman, 2007) and an indication that less qualified staff, support workers, have more contact with this vulnerable group, I feel it is necessary to understand what this is like for the support workers in this position. This research will look at their experiences of working with this group with the aim to understand how to support the support worker, and for psychologists to understand their perspective when it comes to collaborative working. Carrying out this research will hopefully add to the discussion and understanding of how best to support staff and patients working with BPD.

3. Methodology

The literature review highlighted the identified research gaps that directed me to my research on exploring Staff Support Worker's perceptions of adolescent patients diagnosed with Borderline Personality Disorder. An Interpretative Phenomenological Analytical (IPA) approach was used to collect and analyse the data. The following section will outline the rationale for using a qualitative approach, my epistemological position, the chosen method (IPA) and analysis.

3.1. Qualitative Design

To explore Staff Support Workers Perceptions of adolescent patients diagnosed with BPD, it was considered that a qualitative method would be the best-suited methodology for this research. There were several reasons for this; firstly the psychological literature has mostly been built up from quantitative research and for many years lacked a strong presence of qualitative research. Although recently more qualitative research is being carried out, this is still an underused method of analysis for this topic. Secondly, qualitative methodology aims to explore and understand subjective individual experiences (Willig, 2013). Therefore, qualitative research methods try and capture the complexities of subjective experiences to collect rich data with a focus on social context and what is going on individually and interpersonally (Smith, 1995). This methodology is in line with CoP principles that focus on the importance of subjectivity (BPS, 2010). These principles consider that each individual has a different experience of a set phenomenon and therefore, although there may be a common and shared reality, it is understood that each individual will experience this reality in a different way. When conducting research it is important to consider the philosophy of subjectivity and understand that there are different shades of meaning relating to individuals experiences of a phenomena. In the current research it is understood that although the participants share a common reality, working as a support worker with BPD in young people, each participant will have different experiences of relating to this.

It was decided that IPA (Smith, Flowers & Larkin, 2009) was the most suitable approach to answer the research questions, over methods such as grounded theory and discourse analysis, the reasons for this will be discussed later. The following section will discuss why IPA was the chosen methodology including the main principles of IPA; phenomenology, hermeneutics and idiography (Smith, Flowers & Larkin, 2009), and how the philosophy of IPA relates to the theory of social constructionism.

3.2. Interpretative Phenomenological Analysis

As CoPs, there is a core value in the exploration of individual subjective experiences, which is something that is seen as a focus in therapy. Therefore, the reflection of this in qualitative research increases its validity when using it to inform clinical work (Hill, 2005). IPA explores how individuals construct the meaning of their lived experiences gaining rich data that can be used to inform psychological understanding (Elliott et al., 1999; Smith, 1996; Smith & Osborn, 2003) which is in line with the aims of the current research.

By using IPA, I aimed to develop a deeper understanding of the support workers lived experiences of working with BPD in young people, attempting to achieve an insider's perspective of the phenomena (Conrad, 1987). Through the use of IPA, we become closer to the experiences of individuals, and although sweeping generalisations cannot be made, we can get a deeper understanding of a specific phenomenon.

IPA, which was developed by Smith (1996), aims to explore the subjective nature of experiences and how each individual makes sense of these (Smith & Eatough, 2007). There are three key theoretical principles in IPA; phenomenology, hermeneutics and idiography (Smith, Flowers & Larkin, 2009). IPA is rooted in phenomenological philosophy focusing on individuals' experiences aiming to capture the richness of experiences rather than to test a hypothesis. IPA is an interpretive process that moves away from the idea that there are objective truths (Smith & Osborn, 2003) instead of focusing on the importance of subjectivity and intersubjectivity, which sits within the remit of CoP. The research method also adopts a double hermeneutics approach. This focuses on the interpretative nature of IPA whereby the researcher is trying to make sense of the participant's world from the participant who is trying to make sense of their own world (Smith & Osborn, 2003). The approach recognises that by bringing hermeneutics and phenomenology together, we are able to gather data about an individual's subjective experiences and enhance our understanding of phenomena, even though this is interpretative in nature (Smith et al., 2009). The third component in IPA is its idiographic nature, meaning that this approach doesn't aim to make sweeping generalisations, instead focuses on statements that can be transferred across cases (Smith & Osborn, 2003) and then used to inform psychological knowledge. Although large generalisations cannot be made from this data, by combining several case studies and identifying common themes, we can start to understand the wider experience (Smith et al., 2009) which can then be used to inform theoretical knowledge and clinical practice.

IPA was chosen as the most appropriate methodology firstly because its exploratory nature is suited to under-researched areas as it allows a deep understanding of phenomena that little is known about (Smith et al., 2009). Secondly, the recognition of hermeneutics is important due to the focus on the researcher's interpretation in the current study (Willig, 2008). Moreover, the idiographic practice in IPA was a good fit for the study which is concerned with how each individual made sense of being a support worker working with BPD in young people.

3.3. Why Not Other Qualitative Methodologies?

The current research aimed to look at how staff support workers perceive their work with adolescent BPD patients. With these research aims in mind, a number of qualitative methods were considered including Grounded Theory (GT; Glaser & Strauss, 1967) and Discourse Analysis (DA; Foucault, 1969).

GT focuses on the development of theoretical models to understand a topic that has little known about it (Starks, Brown & Trinidad, 2007; Pidgeon, 1996; Payne, 2007) in contrast to IPA where there is a focus on the individual and subjective experiences of the participants (Holloway & Todres, 2003). Since IPA has idiographic underpinnings, this was considered more appropriate for the research question, due to the focus on individual lived experiences opposed to wanting to form a theoretical understanding of these experiences.

DA was also considered. DA focuses on the psychological components of language and dialogue and how discourse is used to construct knowledge and reality (Starks, Brown & Trinidad, 2007). It focuses on how subjectivity and meaning-making come from our use of language rather than focusing on subjective experiences which is a central focus of IPA. Therefore, DA was not deemed as a suitable research method for the current study.

I felt that IPA was most suitable for this study since understanding individual experience is central to this approach (Smith et al., 2009) which is congruent with the research aims and to the philosophy of CoP.

3.4. Epistemology and Ontology Reflexivity

CoP has moved away from a positivist approach where it was believed there is one natural unified world and subjectivity was disregarded, towards a postmodern pluralistic approach that asserts multiple truths and realities that are constructed socially. Social constructionism is linked with postmodernism, arguing that our perceptions are shaped by the contexts in which we have our experience and we share realities within these contexts, not referring to set reality as singular instead having multiple individual realities (Burr, 2003).
A critical realist perspective also underpins the current research where reality is considered as having enduring features. Nonetheless, the reality is also recognised as being fluid, considering each individual as experiencing different parts of the reality (Bhaskar, 2008). IPA is interested in understanding these different realities, assuming each is valid and can lead to a rich understanding of a phenomenon. This notion of plurality of experience is also emphasised in CoP (Strawbridge & Woolfe, 2010).

IPA embraces both critical realism and social constructionism. It assumes that there is such a thing as reality; however individual's experiences have been individually constructed and are influenced by the individual's context, and that reality is different from person to person. Using IPA in research allows a deeper understanding of what a particular experience was like for a participant, therefore allowing us to develop our understanding of phenomena (Smith, 2008). However, the nature of IPA means that the knowledge developed from the research is only relevant to specific situations and is influenced by the researcher interpreting the data (Lyons & Coyle, 2007). The current study aims to develop an understanding of what it is like for support workers working with BPD in young people.

3.5. Reflexivity

In IPA, the researchers own assumptions influence the interpretations they make of the data. Therefore, the researcher helps shape the knowledge found in the research. It is important to engage in reflexivity to understand the positioning of the researcher. To clarify this, I shall begin by describing how I developed my epistemological position.

During my early career, I worked in a CAMHS inpatient hospital where I felt the approach was largely focused on the medical model, with diagnostic labels being a large part of the intervention. This created a focus on managing the presenting symptoms as opposed to focusing on an understanding of the individual experiences of them. As I became more experienced in my work, I started to question this way of working challenging the ideas behind this positivist epistemology.

Further study, a Doctorate in CoP, helped my epistemological position change as I grew as an individual and as a counselling psychologist. During my placements, I have been able to work in a setting that works with individuality rather than reducing individual experiences into a common one. This work was aided by supervisors who have a background in CoP helping me to develop my epistemology and to consider the wider context of the client. Working with diversity was particularly important to begin to understand how different factors can affect the therapeutic alliance, understanding that a person's context is important and taking this into consideration can aid in therapy, therefore challenging a more positivistic approach. I started to pay attention to these factors in my clinical work which empowered the client during therapy. I moved away from the reductionist position paying attention to more humanistic approaches. I found that as I progressed with my training and encountered different clinical settings, I came to think that although there are fundamental truths, each individual experiences these differently since each individual will construct their reality depending on their personal experiences of which no one person's are the same. This therefore, moves my epistemological position in line with critical realism where reality is considered fluid and influenced by an individual's experiences. My epistemological position stands within critical realism that considers that an individual experiences the world differently and moves away from the idea that there is a set reality.

The use of IPA as my chosen method shows congruence between CoP values, my research model and my own epistemology.

3.6. Procedure and Data Collection

This section will discuss the procedure for recruiting participants, carrying out semi-structured interviews, ethical considerations and data collection.

3.6.1. Participant Recruitment

Purposive sampling was used to recruit a homogenous sample in line with IPA principles. Participants were recruited using a recruitment poster (Appendix A), put up on social media and common areas such as community notice boards and private agencies that provide medical staff. Potential participants then contacted the researcher and were sent the participant information sheet (Appendix B). Once returned, the eligible participants were then invited for the interview, the location of which was at the university.

Following the IPA guidelines, 6 participants were recruited for this study. The small sample size was appropriate since only a small number of participants are needed when adopting the idiographic stance of IPA (Smith & Osborn, 2008). All the participants were support workers working with young people suffering from mental health conditions; they all reported having experienced working with BPD in young people. The participant ages ranged from 25-45 years (see table 1)

Table 1 gives an overview of the participant's demographics.

Participant	Ethnicity	Age	Gender	Number of years in service
Participant 1	White British	26	Female	3
Participant 2	White British	25	Female	3
Participant 3	Asian	28	Female	4
Participant 4	Irish	45	Male	8
Participant 5	White British	27	Female	5

Participant 6	White British	32	Female	4

3.6.2. Inclusion and Exclusion Criteria

The criteria used in purposive sampling created a homogenous sample which is an IPA principle (Smith & Osborn, 2008). These criteria are as follows;

- A minimum of 2 years experiences of being a support worker at an inpatient CAMHS setting
- No longer than 3 years having not worked in an inpatient CAMHS setting as a support worker.
- Participants must have experience of working with BPD in child and adolescent patients.
- Participant needed to be English speaking since the research relies on interviews.

3.7. Ethical Considerations

Ethical approval for this study was obtained from the London Metropolitan University's Research Ethics Review Panel prior to starting the research (Appendix C). The research followed the BPD's ethical guidelines (2009) as well as London Metropolitan University's Code of Good Research Practice (2005).

Before taking part in the study, participants were given an information sheet that outlined all the details of the study, and they were then given an opportunity to ask any questions regarding the nature of the study. The participants were then asked to sign a consent form if they were happy to continue with the study (Appendix D). Participants were informed they had the right to withdraw themselves or their data from the study at any time up to six weeks after the interviews due to the start of the analysis process.

Participants were made aware of the fact all interviews are recorded and transcribed and that the data would only be used for the purpose of this study. The transcripts were anonymised by removing any personal identifying information and pseudonyms were used. The limits of confidentiality were explained to the participants verbally and also in writing on the participant information sheet.

An encrypted digital recorder was used to record the interviews for which the researcher was the only person to have access to the password needed in order to access the data. The transcribed interviews were stored on a password protected memory stick. Any written notes and paperwork such as consent were locked away and destroyed along with the recording and transcripts as soon as the thesis was finished or on withdrawal of participation.

There was potential for this study to cause distress to the participants due to the nature of the interview, the history of working in mental health and the experiences they may have had. To minimise this, the participants were fully informed about the nature of this study, their right to decline to answer any difficult questions and to withdraw from the study without giving a reason. They were reminded of this during the interview if the interview appeared to be causing any signs of distress. The participants were encouraged to seek help if there were any negative effects from taking part in the study. A distress protocol was available to be used if participants showed any signs of distress (Appendix E). Participants were debriefed following the interview as an opportunity to ask any questions and identify any distress caused by the interview (Appendix F). The researcher's supervisor was there to talk to if any issues emerged causing the researcher any distress following the interviews. It was identified that travelling to a venue, external to the university, to hold interviews could hold risk; therefore, interviews were held at the university.

Following the interviews, the participants were debriefed. The distress protocol was not needed throughout the interview process; however, each participant was provided with relevant contact detail for further support including that of the researcher as well as the researcher’s supervisor.

3.8. Semi-Structured Interviews

A semi-structured interview technique was used as the chosen method for collecting data. To assist with the interview, a semi-structured interview schedule was developed (Appendix G), directing the interview towards the research aims but still allowing the participant to freely recall their experiences. The questions were open-ended to allow the participant to freely recall their experiences and prompts were used to encourage further detail; this was in line with IPA (Smith et al., 2009). This way of collecting data tries to gain an understanding of the participant's perceptions by obtaining detailed and rich information about their own experiences (Smith, 1995).

The interviews lasted approximately 1 hour with an extra half an hour for consent and debrief. Consent, confidentiality and the distress protocol were discussed prior to the interviews and participants were debriefed and given an opportunity to ask any questions after the interview. A written debrief form was given to the participants which outlined organisations if they needed any further support.

The interviews were recorded on an encrypted digital recorder and transcribed to a password-protected memory stick. The transcription of the interviews included pauses and noises such as laughter, this allows for an accurate interpretation of the interview. Any identifiable data was removed, and pseudonyms were used. All data is destroyed on completion of the research.

3.9. Data Analysis

The process of data analysis followed the principles set out for using IPA (Smith et al., 2009). The first steps were to transcribe the interviews verbatim and then analyse each transcript separately. The first step was to closely read and re-read the transcripts several times to get a real sense of the data and to become immersed in it. Whilst I was doing this I was noting down my preliminary thoughts and observations in the margin to the left of the transcript, including keywords, phrases or details, in order to gather detailed notes from the data. From these preliminary notes and from re-reading and listening to the audio recording, I added exploratory notes and recorded these in the right-hand margin. The focus here was on descriptive, linguistic and conceptual details (Smith et al., 2009).

Following the exploratory notes, I identified emergent themes (Smith et al., 2009) based on my perception of what was being portrayed from the interview. I did this by working with my notes on the transcript rather than the transcript itself. The research aims were kept in mind while identifying emergent themes. Once identified, the themes with similar meanings were clustered together, this was done using abstraction and subsumption (Smith et al., 2009). In doing this emergent themes were ordered developing a hierarchy of themes, known as super-ordinate themes, and then within these super-ordinate themes, sub-themes are created. This was done for each interview separately, and I tried to bracket off my own motives from the analysis and the influence from other transcripts, this was aided by making notes on my own views and assumptions. The next stage was to create a table of themes for each transcript and then compare and integrate to create a master table of themes from across the interviews showing connections between the participants as a group.

4. Results and Analysis

Four superordinate themes emerged from the IPA analysis of six semi-structured interviews. The first of these were "Attachments, Boundaries and Ruptures" which discusses the participant's persistent feelings of anxiety encountered by support workers when working with BPD in young people. Secondly, "Emotional Rollercoaster of Managing Self-Harm”, considers the turbulence of emotions experienced by support workers working with BPD in young people/working with young people with BPD. The third theme, "The Co-existence of Hope and Hopelessness" explores the contradiction of belief and confidence for change while also experiencing feelings of despair and frustration in the face of persisting BPD Behaviours. The final theme "Making a Difference" looks at the rewards and achievements experienced by support workers in their role. Table 2 summarises these superordinate themes and their sub-themes, including extracts from transcripts.

Table 2: s*ummary of superordinate and sub-themes with relevant quotes*

Superordinate Themes	**Sub-themes**	**Relevant quotes**
Attachments, Boundaries and Ruptures	**Managing attachments**	*“…you might say the wrong thing, and instantly erm they no longer err view you in a positive light… “325-3266 Anna*
	Difficulty maintaining boundaries	*“…it can be really difficult to put in the boundaries…” 463-464 Amber*
	Difficulty predicting ruptures	*“…it’s almost a bit like a guessing game…” 189-190 Mary*
The emotional rollercoaster of managing self-harm	**Spectre of self-harm**	*“…something bad is going to happen… 887 Amber*
	Desensitisation to self-harm	*"…after a while, it becomes such a regular thing that you just get used to it and unfortunately you do become de-sensitized to it." 24-25 Mary*
Co-existence of hope and hopelessness.	**Powerless to effect change**	*"…nothing you say is going to impact them anymore … what's the point?" Line 476-477 Anna*
	“*They still have time to learn*”. Holding onto hope	*“…they are developing, they are finding their own personality there, what works*

		for them and what doesn't work for them." Line 394 Tyler
Making a difference	**Having a positive impact**	*"…the young person I've worked with they're all, have such, they are all so talented and have all these like hidden skills and things and it's really nice seeing them kind of develop those further....really rewarding and fun…" 23-27 Anna*

4.1.1. Superordinate Theme One: Attachments, Boundaries and Ruptures

This superordinate theme reflects the participant's thoughts and feelings towards some of the challenges experienced while working with BPD in young people. There are three sub-themes "managing attachments, "difficulty maintaining boundaries" and "difficulty predicting ruptures."

4.1.2. *Subtheme One: Managing attachments*

This sub-theme explores the issues of developing and maintaining a positive therapeutic relationship with young BPD patients. This theme was relevant to each participant discussing how their role is almost governed around these attachments.

> *"…always having to deal with that attachment issue…"* **Anna,** 199

Anna describes how, as a support worker, she is “always” working with difficult attachments, implying that it is something that is ingrained in her work and is consistently something that she needs manage in her role. There is a sense that she is constantly dealing with difficult situations and this is something that is always on her mind. Moreover, Anna implies that dealing with these attachments unfailingly comes with its “issues”, potentially complicating the work being carried out and increasing the difficulty of managing the patient’s attachments.

Sarah also talks about these ‘attachment issues’,

> *“…I might then, you know, be having a one to one with someone else and you can notice sometimes, you know they escalate or they get frustrated because you're not spending loads of time with them…”* **Sarah,** 195-199
>
> *…it is hard to kind of break away from the patient, I find myself, I will often stay late at work so that that the patient will know that I am there, that I do care…”* **Sarah,** 245- 247

Sarah describes the difficulties experienced when a therapeutic relationship has been established. She creates an image that young people can become dependent on this relationship, experiencing rejection when attention is diverted away from them. Sarah's experience seems to suggest that when there is perceived rejection there is an escalation in risk-taking behaviour. This suggests a volatile relationship, which could lead to a stressful working environment, due to the support worker’s uncertainty over how to manage these needs. Sarah’s account described feeling a lot of pressure within the relationship, possibly causing feelings of anxiety and fear around young people’s engagement in maladaptive behaviours.

The volatility of this relationship would suggest that managing attachments are complex, perhaps resulting in support workers becoming enmeshed in the maladaptive relationship pattern, in an attempt to prevent any risk-taking behaviours. This is shown by Sarah who has a tendency to stay late at work in order to satisfy the attachment needs of the patient. However, the young person may become too reliant on the support worker, if too much attention is given, and this could reinforce negative behaviours. This lack of clarity about what level of support is appropriate could lead to Sarah feeling discouraged, perhaps compromising her work and could result in her feeling guilty over not knowing how to manage these complex attachments.

Mary also experienced frustration in response to the level of need exhibited by the clients:

> *"…when someone might be becoming particularly demanding for your attention it can get quite frustrating erm and it can be difficult because you're supposed to be everywhere else…"* **Mary,** 323-326

Mary continues to suggest that it is complicated to balance the role of the support worker along with the particular attachments of BPD patients. Mary seems to feel as though she cannot always give the patient the attention they desire, perhaps feeling that she does not have enough resource to meet her patients' needs. It is possible that she feels conflicted between what she can do within her role and what she wants to be able to do.

Mary creates an image that she feels it is impossible to manage these demands since it is impossible to be 'everywhere'. Perhaps she does not feel she can effectively manage in her role, finding it difficult to cope with all the different needs of the young people, possibly leading to frustration.

4.1.3. *Subtheme Two: Difficulty maintaining boundaries*

The participants discussed how they found working with boundaries and the difficulties that they can create in their work. In particular, there was a common theme that boundaries often caused a divide and tension in the relationship.

Amber talks about boundaries and how these can be difficult to enforce once the therapeutic relationship has been established,

> *"... it can be really difficult to put in the boundaries if a child if they form an attachment with you and you have to be really careful that you do not that that you that you notice that happening and that you put a stop to it."* **Amber,** 463-467.

Amber describes how once the ‘child’ has formed an attachment with you it can be ‘really difficult’ to enforce boundaries. She talks about having to be ‘really careful’ with any attachments made with the young people, which could suggest that Amber experiences the relationship as a fragile one and one that needs to be carefully managed.

There is a sense that as a support worker you have to be boundaried in the attachment process, making sure that the attachment remains healthy. Amber talks about having to sometimes ‘put a stop to it’, suggesting that sometimes an attachment can become unhealthy. Ending such a relationship, one of strong attachment and reliance, could elicit feelings of guilt in the support workers who are trying to have a positive relationship with the young people, therefore the support workers may be left feeling like a failure because they were unable to maintain the relationship. These experiences may lead to a sense of confusion about how to manage these attachments, possibly leading to a difficulty in remaining within boundaries.

Remaining boundaries in the relationship with BPD patients could elicit a feeling of rejection for them, possibly causing difficulties in the relationship between support worker and patient. This could cause further challenges for the support worker helping BPD patients, complicating the management of boundaries. However, it is possible that the support workers feel relieved by the termination of such an intense attachment that has been experienced as all-consuming and guilt-ridden, which in turn may leave them feeling guilty and like a failure. This may lead to low job satisfaction and self-doubt.

Similarly, Mary suggests that enforcing and maintaining these boundaries can be a challenge.

> *“…when you are enforcing a boundary you’re upsetting a patient erm and not allowing them to act in ways that they may want to act and yea erm they can be quite eruptive when that happens…”* **Anna,** 424-428

> *"... you are being the bad guy almost and that's not a nice feeling...*" **Anna,** 572-573

Anna explicitly says that 'you're upsetting a patient' when you are enforcing boundaries, suggesting that enforcing boundaries is a challenge for the support workers. Since support workers are trying to make the young people's lives better, upsetting them could create a sense of failure and guilt for them.

Anna goes on to explain that it is in the best interest of the young person to set boundaries and rules, in order to keep them safe, however, her account would suggest that the same boundaries and rules can cause maladaptive behaviours, '…they can become quite eruptive…'. This could perhaps create feelings of failure in the support workers, feeling as though they are failing at helping these young people, causing them more distress.

Anna feels like the 'bad guy', which she describes as 'not a nice feeling' when setting boundaries. These feelings might make it difficult for Anna to maintain these boundaries, suggesting that it is challenging to do so for this client group.

Anna's account seems to suggest that setting boundaries could, therefore, be complicated, due to feeling uncertain of how the young person is going to react to the boundaries put in place and the possible guilt felt by the support workers.

Sarah also shows how there are challenges in maintaining boundaries, often leaving the support worker in a difficult situation.

> "*…you know again put those boundaries in and say look, I want to be able to speak to you can't really do that today it's going to have to be a different day, but making them aware that you are not ditching them you still are interested in them and you still want to help them, it's just got to be within a certain time frame, otherwise you end up staying, staying way late, ...*"**Sarah,** 328-336.

Sarah's account suggests that putting boundaries in can often end in the young person feeling a sense of rejection, therefore feeling negatively impacted by the boundaries. Sarah seems to experience the enforcement of boundaries as something that needs to be handled sensitively, possibly feeling as though enforcing these could harm the attachments that exist between the support worker and patient. There is a sense that Sarah experiences managing boundaries as a constant in her role, implying that she is 'always' reinforcing them. Furthermore, Sarah is trying to enforce boundaries in a way that does not upset the young people, perhaps warily managing boundaries due to a fear of disrupting the volatile attachment, resulting in an escalation of risk-taking behaviour. This could cause a lot of anxiety in the support worker role making it difficult to maintain boundaries.

Tyler demonstrates that boundaries have an impact on the therapeutic relationship from the outset:

> "*…making sure the patient is aware that there is that boundary to the relationship that you are a member of staff and they are patient*s." **Tyler,** 353-355

Tyler describes the act of letting the patient know from the onset that there is a divide in the relationship, working within a power dynamic, emphasising the role of 'staff' and 'patients'. He seems to highlight the importance of this distinction by saying '…making sure the patient is aware…' possibly to let the patient know the boundaries within the relationship and to understand that there is a limit to the support worker role. It is possible that setting these boundaries helps Tyler to manage the client's complex needs.

4.1.4. *Subtheme Three: Difficulty predicting ruptures*

The participants are discussing the eruptive and volatile nature of the therapeutic relationship, agreeing that there is a difficulty in managing and predicting the relationship.

> *"...a lot of mood Swings, very intense outburst of emotion (...)they can become extremely attached to people very quickly but then at the same time they can kind of end that relationship very quickly as well..."* **Anna,** 182-190

Anna's account of BPD patients becoming 'extremely attached' highlights the complex nature of her work, suggesting that the patients experience extreme emotions. She also highlights that BPD patients often experience and exhibit/act out these intense emotions, using the term "outburst", indicating an unpredictable pattern of emotional expression. This image suggests that these patients can be challenging to work with because dealing with impulsive and volatile behaviours contributes to an unstable base from which the staff must operate.

This account would suggest that individuals with BPD break off the relationship abruptly which could leave the support workers feeling they are being punished for failing at managing the attachment needs of their patients. This could lead to the support workers feeling confused and with little confidence about their abilities to do the job effectively.

Anna creates an image of a see-saw like relationship, where the patient exhibits extreme emotions of both love and hate, making it difficult to maintain the therapeutic relationship, due to its volatile nature. Perhaps Anna sees working with BPD as a constantly anxiety-provoking role, not knowing how the young person is going to respond from one moment to the next.

The volatile nature of the relationship can mean that it is difficult to predict how the patient is going to react in certain situations, therefore, making it difficult to predict any ruptures in the relationship.

> *"...they still will be self-harming constantly and having these outbursts, suddenly hating you and then loving you again, it can be really confusing if you don't understand the disorder..."* **Anna,** 340-343.

Anna’s use of the word “suddenly” implies a relationship that is associated with uncertainty and fear. The unpredictable nature of the work could mean that Anna, and other support workers, find it difficult to predict how a young person is going to behave in a given situation. The nature of this relationship represents a rollercoaster-like relationship where you can go from being loved and adored to being hated and dismissed. This is likely to leave a person feeling elated when they are being praised and then knocked down when they are projecting negative feelings on to you. This can have an impact on your self-esteem and can be damaging to an individual that is difficult to manage.

Moreover, Anna creates an image that a strong therapeutic relationship is possible to create. However, this is a volatile relationship that can erupt at any given moment and therefore support workers are likely to experience a roller-coaster of emotions from positive to negative. BPD patients have the ability to lift you up when you are in favour with them, increasing your self-esteem and making you feel great, then the next minute you can be in the line of fire or ignored completely, knocking your self-esteem.

Mary continues to explore the difficulty predicting rupture by going on to say,

> *“…they’ve suddenly turned and they do not want to talk to me ever again.”* **Mary,** 78

Her account suggests that the relationship can be unpredictable, ‘suddenly’ shifting from one extreme to another. Due to the changeable moods, and the extreme responses to situations, it can be difficult for support workers to predict behaviours, suggesting support workers are likely to experience rapid changes in their emotions. The support worker may have a sense of pride and achievement in the attachment they have formed with the patient, however when the patient shuts them out and cuts of the relationship this is likely to leave them feeling hopeless in their abilities, reducing their self-esteem and leaving them feeling abandoned. This is somewhat representative of how BPD patients experience fluctuation in emotions, feelings of emptiness and abandonment.

This changeability and difficulty in predicting ruptures are also indicated by Jade.

> *"...they could be your best friend one minute and then you have to go and do something or see someone else and they think you hate them and can take that really badly."* **Jade,** 143-145

Jade suggests that a young person can become strongly attached and dependent on the relationship with a support worker, however, this attachment can rupture easily due to sudden changes in the patient's presentation. This paints a picture of a volatile relationship, rupturing when the patient perceives rejection. Her account suggests it is difficult for the support worker to predict ruptures in the relationship, due to the unpredictability of their behaviours, possibly causing support workers to experience feelings of rejection and confusion about what they have done wrong when ruptures occur. Support workers may feel at fault if the young person then engages in risky behaviour, experiencing guilt and self-doubt and questioning their ability to effectively work with these young people.

Each participant seems to experience the difficulties that come with working with young people whose attachments are at times intense and volatile. This can be interpreted as having a negative effect on the support workers, causing them to feel apprehensive when working with this client group due to the uncertainty of how the patient will react.

4.2. Superordinate Theme Two: The Emotional Rollercoaster of Managing Self-Harm

This superordinate theme discusses the participants' experiences of self-harm by BPD patients and how the participants respond to the demands of this risky environment. It contains subthemes that go on to discuss 'the spectre of self-harm' and 'desensitisation to self-harm'. Each sub-theme is discussed in the following section.

4.2.1. *Subtheme One: Spectre of Self-Harm*

This sub-theme looks at how the participants experience the looming risk of self-harm. They argue that self-harm is something that is always imminent and is a constant worry for them.

Anna's account suggests that, while working with BPD in young people, there is a constant concern by the spectre of their clients self-harming.

> *"...say if you're, you're too busy to give them someone to one time erm during your shift they will interpret that as you no longer liking them and then they may go and self-harm or start becoming very distressed*" **Anna,** 202-206

Anna paints a picture that a young person can become distressed, with a risk of self-harm, due to a perceived abandonment. The idea that a support worker may be too busy to spend one to one time with a patient is seen as a personal attack, potentially leaving them feeling abandoned and rejected. This perceived rejection could lead to self-harming behaviour.

Perhaps Anna has a feeling of responsibility in preventing the young person becoming distressed, with a possibility that there is a sense of guilt around this if the support worker is perceived as the reason behind the self-harming behaviour.

There is a sense that the patient's interpretations of events can lead to misunderstandings which can be linked to maladaptive behaviours. This would leave a sense of fear around how the young person is going to respond and worrying about the self-harming behaviours.

Sarah experiences a high level of anxiety in her work which is evidenced by the following quote,

> *"...being constantly like every 15 minutes, like oh where are they, (...) to make sure they are just seeing that they are okay, just because you you knew what they were like and you knew they were having like a rough day or rough rough last couple of days (...) You know you look around you check you carry on you look around and you check again, like that kind of thing. So it's just a lot to hand to, it's not it's not easy, it's defiantly not..."* **Sarah,** 800-813

From Sarah's account, it appears that there is a need to be vigilant, due to the possible danger self-harming can put the young people in. Sarah is continually checking on the young person to make sure that they are safe, giving the impression that there is a sense of imminent danger. Sarah’s account would suggest that this way of working, where there is constant anxiety and need to be aware of your surroundings, is one that is very demanding and often hard to handle, whether physically or emotionally.

Sarah goes on to say,

> *“…extremely stressful, erm because you do not know when they are going to change, and obviously because of the emotional dysregulation the they are not able to control themselves in that sense because they will literally be having incidence left right and centre and then they will be completely fine like a couple of hours later because they have calmed themselves…”* **Sarah,** 148-156

This account looks further at how as a support worker you are constantly on your toes, in the sense that “*you do not know when they are going to change”.* This implies unpredictability in the role, therefore suggesting that there is no way to plan or predict how a day is going to turn out. This would mean that you always need to be prepared for something to happen.

Amber’s account refers to the ‘dread’ associated with their clients self-harming.

> *“previously done quite severe self-harm, there would be a feeling of dread of oh god they are going to self-harm at night again and we are going to end up in A&E with them and they are going to, you know there’s, you know they’re going to be bringing in blades or I suppose basing it on previous experience”* **Amber,** 753-758

This quote paints a picture of self-harming as an act that is grievous and something that induces fear in those responsible for the patient. Amber describes explicit feelings of "dread" which suggests that she anticipates the self-harming, constantly feeling afraid of the potential outcome of the patient's behaviour. This could lead to Amber being very tense at work, just waiting for the next thing to happen and “end up” in A&E.

Self-harming seems to be something that is encountered constantly in Amber's role, implying that the self-harming is something that happens constantly and is an inevitable part of the support worker role. Amber seems to have an expectation of high-risk behaviour occurring in young people with BPD.

Amber goes on to say,

> *"...work really hard to try and make sure this person isn't going to harm themselves again and then they would and I suppose it's that idea that you feel like you have done really good work with this person you feel like they have come really far (...) then they have self-harmed again and it can be quite emotional it can be quite difficult..."* **Amber**, 295-303

Support workers seem to have a difficult job keeping young people safe, and as Amber is saying, there is a sense that support workers can do everything right and still young people will engage in self-harm. There is a sense that Amber is feeling that she goes around in circles at work, explicitly stating that her work can be "*emotional*" and "*difficult*". Ambers account suggests that there is a constant fear of self-harm, since even when good progress has been made this doesn't eradicate the potential self-harming behaviour.

Amber gives a sense that the risk of self-harm is something that is always present and a very emotional experience. This could lead to a feeling that the support worker role is a debilitating one.

Sarah continues to talk about the impending nature of self-harm,

> *"...they feel really low and really erratic and turn to self-harm and take their own life and like that kind of stuff, but I think (sigh) in a nutshell, extremely stressful..."* **Sarah**, 145-149

Sarah's experience of young people with BPD goes further than self-harm and talks about them wanting to "*take their own life*". This is a very emotive part of Sarah's experience with BPD in a young person, painting a clear picture of the risk and the responsibility that this life-threatening disorder has. There is a sense of a very final act and one that implies the desperation these young people feel. The responsibility of keeping young people safe may be what Sarah is referring to when she says "*extremely stressful*".

Amber also talks about this anticipation of self-harm and how this impacts her work.

> *"…constantly checking erm taking away anything from them that could they could use to harm themselves erm and sometimes it felt really mean and sometimes it felt really strict and horrible but you had a priority and that was to make sure that they didn't do that…"* **Amber**, 316-322

Amber continues to paint a picture of high anticipation of risk-taking behaviour. She experiences a constant need for checking on the young person and taking away potentially dangerous items, due to a fear of them harming themselves. Anna describes this as something that has an impact on her, describing feelings of being "*horrible*" and "*mean*". Anna could feel as though she is being intrusive on the young person, constantly watching them and taking away their belongings, due to the high anxiety around potential risky behaviour. There is an understanding of the necessity in keeping a close eye on the young person, as a way to protect them from the risks they pose, possibly making the negative feelings Anna has more manageable for her, perceiving her actions as doing good.

Amber goes on to discuss further why there is a sense of constant alertness while working.

> *"…the most difficult thing I found was it not being able to trust them because they would hide a blade in different places or they would bring blades onto the ward erm and and it would be quite manipulative sometimes…"* **Amber**, 290-294

Amber paints a picture of constantly anticipating risk, experiencing feelings of mistrust, giving a sense of constantly being on high alert for suicidal behaviour, not trusting the young people to keep themselves safe. It is possible that Amber feels she has a responsibility for the young people's safety, perhaps leading to her constant suspicion of young people bringing blades onto the ward so that they can self-harm. Working with such a high-risk group could lead to high anxiety in the support workers, keeping their anticipation of self-harm constant.

4.2.2. *Subtheme Two: Desensitisation to Self-Harm*

This sub-theme looks at how support workers manage the constant stress of self-harming. The feelings of desensitisation can be seen as both a way to self-care, a 'protective' mechanism but also something that raises some concern. Moreover, there is a sense of shame around the desensitisation due to feeling as though they have lost the empathy towards the patients, however is seen as necessary to manage the emotional challenges this can evoke in the support workers through vicarious trauma (Figley, 1995, Sansbury et al.,2015).

There is a sense that being a support worker comes with a lot of anxiety and the way that support workers have dealt with this has shown to be by becoming desensitised to it.

> *"...building a tolerance and building erm kind of I suppose a bit of a thicker skin (...) but yea it got easier as, as you did it you kind of learnt from your own mistakes ..."* **Amber**, 32-42

Amber talks about how as you experience the self-harming more and more it is something that becomes easier to deal with and manage. Amber describes building a '*thicker skin'* which would imply she became less sensitive at work and perhaps able to manage her work better.

> *"When you first start out it does take a while to get used to. So that can be quite distressing (...) the emotional and distressing environment it can be very draining."* **Mary** 25-29

> *"...after a while it becomes such a regular thing that you just get used to it and unfortunately you do become de-sensitised to it."* **Mary**, 96-98

Mary describes that it was difficult for her to get used to the self-harming behaviour when she started out as a support worker and that it was something that she found quite distressing. She goes on to say, that after a while, it is something that she got used to as it was such a common experience in her role. Mary explains how she became de-sensitised to the self-harming behaviour, however, indicated this as something that was not necessarily a positive thing.

It could be that this desensitisation allowed Mary to manage her job more effectively, as she would not feel as troubled by the self-harming, becoming less sensitive to the situation. However, Mary seems troubled by becoming desensitised, possibly over concerns of how often this was witnessed and perhaps feeling less compassionate around self-harm.

Sarah also talks about becoming desensitised,

> *"...you almost just get used to not worrying like you, it's almost like (...) you become numb to it almost, or like you just realise that if you are going to be constantly stressing you can't do this job (...), you just kind of learn to switch off ..."* **Sarah,** 74-82

Sarah also talks about how you get used to the working environment but describes feeling '*numb',* which would indicate being deprived of feelings towards self-harming. There is a sense that reducing sensitivity and feeling towards the self-harming allows you to do the job. Sarah explained that being constantly stressed at work would mean that you wouldn't be able to do the job effectively. This then would imply that there is a practical base for becoming less emotional as a support worker.

Jade goes on to say;

> *"If you want to help you can't let everything get on top of you, like with emotions, every time someone self-harms, it happens too much. You have to not let it affect you and and over time it just become another incident, they happen so frequently."* **Jade,** 166-168

This account shows how as a support worker Jade feels you cannot let the self-harming behaviour overwhelm you, otherwise you cannot do your job effectively. It would seem that the desensitisation to the self-harming behaviour is so that she can be more effective at her job. However, it could also be to protect her emotional world to enable her to manage the challenges in her work.

4.3. Superordinate Theme Three: Co-existence of Hope and Hopelessness.

This superordinate theme explores how the participants negotiate the feelings of hopelessness, which could make their work seem like an impossible task, with the existence of hope that these young people can learn to better manage their symptoms and improve their quality of life. It contains the sub-themes ‘powerless to effect change,’ “they still have time to learn” and “holding on to hope’ which will be explored in more detail below.

4.3.1. *Subtheme One: Powerless to Effect Change*

This sub-theme refers to the participant’s experiences of feeling hopeless in the face of BPD.

> *“…you were dealing with the symptoms of things rather than the root cause of things…”* **Mary,** 177-178

Mary explains her experience of being a support worker as one where you are managing behaviours rather than getting to the cause of these behaviours. This could indicate that Mary feels hopeless in the face of working with BPD since she is not able to work with the young person to understand the reasons behind their maladaptive behaviours, only scratching the surface, which might be challenging when trying to elicit change.

Amber goes on to talk about the feelings of helplessness further,

> *“I’m not going to be able to help, there was a sense of this person is going to be in the services for the rest of their lives…maybe with their third admission and you get to the point where you just do not know what it is that we can do for the child … I do not know what what their future is going to hold and it would feel very, you would feel very helpless about it I suppose.”* **Amber,** 700-707

Amber simply states “I’m not going to be able to help", which quite clearly shows Amber’s feelings of lost confidence and hope in her ability to elicit change. This could suggest that Amber has become demoralised in her role, holding a despondent attitude towards these young people. Amber goes on to say that young people with BPD will remain in the service for "the rest of their lives". This account would suggest that Amber feels there is no hope for these young people, perhaps holding a fatalistic view on BPD patients. There is a possibility that support workers feel there is nothing that can be done, holding a view of BPD as being a helpless disorder.

Amber’s account would suggest an uncertainty, feeling unsure about the futures of the young people, perhaps feeling fearful for their futures and "helpless about it ". This uncertain and hopeless attitude could lead to Amber feeling unable to effectively carry out her work in an optimistic and positive manner. This would become problematic if this fatalistic appraisal was somehow communicated to the patient, this would perhaps leave the patient with little hope and increase the risk of self-harm and suicide.

Sarah's account seems to mirror that of Ambers, continuing to express the lack of hope around the BPD diagnosis.

> *"... there isn't much hope out there for that personality disorder, it's a long term illness and you have basically got it for life."* **Sarah,** 653-656

Here Sarah is suggesting that the feeling of hopelessness goes beyond the mental health professionals who work closely with BPD, extending into society, suggesting they see the BPD diagnosis as one with little hope. Feelings of hopelessness could impact the communication style of staff, perhaps becoming pessimistic and viewing BPD patients as a lost cause. This could transfer onto the patients who may also start to feel this way, impacting their behaviour.

When Sarah says *"it’s a long term illness”* there is a sense that this increases Sarah’s feeling of hopelessness towards it, rather than simply being a challenging disorder. In this account BPD is seen as a "life" long disorder which could mean support worker's, along with other mental health professionals, may feel as though they have an impossible job, feeling powerless to effect change.

There is a recurrent theme amongst the support worker's with Anna also suggesting that the BPD diagnosis is a hopeless one and one that cannot be changed.

> *“...just means it’s their personality, it’s who they are, that’s how they are, there isn’t anything that can do to change it..."* **Anna,** 273-275

Anna's account suggests that a BPD diagnosis is fixed and that it is ingrained in them "it's who they are". This attitude would suggest a feeling of hopelessness, trying to change something that is viewed as rigid and unchangeable. This attitude could make it difficult to work with BPD in young people since it might be felt that there is no hope and that it is just "how they are".

4.3.2. ***Subtheme Two: "They still have time to learn". Holding onto Hope***

This sub-theme describes the importance of hope in working with BPD in young people and how this hope allows support workers to carry out their work believing change can be made, despite the difficulties in the role.

The following account from Mary demonstrates her feelings of hope towards BPD in young people.

> *"I think there is so much you can teach them about building relationships and building resilience."* **Mary,** 349-351

Having "so much to teach them" suggests an image of being able to effect positive change while working with BPD in young people. Mary goes on to illustrate that there is an ability to elicit change in two areas, relationships and resilience, drawing on this illustration of being able to nurture these skill through teaching. The imagery from this quote would be one of hope, where through the use of teaching, changes can be made in those with BPD, moving away from a previously perceived hopeless and a fixed diagnosis. Perhaps holding on to this hope allows the support worker to manage the pressure in their role and continue to work in a positive manner.

Another example of BPD in young people and the ability to elicit change comes from the significance of their age and their development stages. This is described by Tyler.

> *"…they are developing, they are finding their own personality there, what works for them and what doesn't work for them"* **Tyler,** 382-384

Tyler's account suggests an important role played by the age of the young person, suggesting that there is hope, perhaps indicating the importance of an early diagnosis. Tyler's account suggests an image of a natural remission, suggesting that it is the natural development of the young people that elicits changes "they are finding their own personality". This seems to highlight the idea that these young people have not finished developing and do not yet have fully developed personalities, implying that while they are still developing there is hope for change and perhaps develop healthier coping strategies. There is a feeling that the support workers are there to guide the young people in developing their personalities and figuring out positive coping strategies.

Anna goes on to talk about the ups and downs encountered by a young person with BPD and the challenges of working with BPD in young people.

> *"...because of their ages its ... going to take them a long time to kind of figure it out ... but it's always important to keep trying with them…"* **Anna,** 484-487

> *"...feels like they have taken a million steps backwards, but it's all part of the process and that what it's like for someone with Borderline Personality disorder…"* **Anna**, 448-450

> *"…while they are young, as horrible as it is, it is the time to kind of do it, it's the time they are going to make mistakes, as long as they are progressing even if it's a little bit each time it's kind of good..."* **Anna,** 458-462

Anna sends a message here of perseverance and patience when working with BPD in young people. This image is created when Anna says "*it's always important to keep trying"*. The emphasis on this importance paints a picture of the hope, where Anna feels that perhaps there is hope and if we keep trying then we might be able to elicit positive change.

Anna accepts the difficulties faced when working with BPD in young people, however, continues to paint the picture of hope and possibility, "*taken a million steps backwards, but it's all part of the process".* The idea of taking a million steps backwards creates an image of frustration and becoming disheartened, however, Anna goes on to say how that is all *"part of the process*", contrasting the initial frustration with hope and understanding.

From Anna's account there seems to be an understanding that these clients come with many challenges and that perhaps therapeutic progress is slow, however, has the attitude that this is okay and small progress is positive progress.

In keeping with the image of hope, Jade suggests that there has been a positive development in treating BPD which could bring hope to her role as a support worker.

> *"...previously we didn't have, we didn't have the skills to actually even treat people with, technically we didn't have the DBT skills that we do now-now we have got training in dbt so now you know we are starting to run groups so we are going to help teach skills that and that's going to kind of I think help quite a lot, whereas previously it was just kind of a lot of holding or kids coming in because they were high risk and then not leaving till they are 18 because we couldn't do anything with them if that makes sense."* **Jade**, 385-398

Jade talks about how there have been changes to the way that BPD is being treated, mentioning how there has been a shift from "w*e didn't have the skills to actually even treat people"* to *"now we have got training in DBT".* From Jade's use of the word "even" it could suggest there is an attitude of despair on how little they were working with before, illustrating feelings of hopelessness. These feelings were present until they engaged in DBT training, illustrating that there is a new and exciting intervention and how this is bringing hope to the support worker role.

The contrast between feeling hopeful and feeling hopeless is illustrated here by Jade, who talks about how "*we couldn't do anything with them",* emphasising a hopeless feeling in the face of BPD compared to a focused therapeutic intervention where they will "r*un groups ", "teach skills"* and feeling as though that will "*help quite a lot".* In Jade's account, there is a clear contrast in how she feels things were done previously to how they are done in the present.

Again Sarah brings a sense that there are reasons to be hopeful when working with young people diagnosed with BPD.

> *"...you are young you can still change things, diagnosis change all the time, if anything you're in the best place for her to pick up any skills so that, you you, obviously the younger you learn something the better you are going to be at it, like languages same sort of things with skills, so there's a secured opportunity for them to really work hard and crack some of the adaptive behaviours like maladaptive behaviour..."* **Sarah,** 662-671

Sarah's account would suggest that she sees diagnoses as fluid and changeable, expressing feelings that just because a young person is diagnosed with a BPD doesn't mean that it is fixed for life. She also paints a picture that having a diagnosis when you are young means that there is a higher chance of making changes, stating that "*you are young you can still change things".* This attitude could help Sarah in her role to keep that sense of hope allowing her to see the potential to elicit change.

Sarah would suggest that young people with BPD, who have access to therapeutic intervention, have an opportunity to learn new skills and make positive changes, *"the younger you learn something the better you are going to be at it".* This again would encourage support workers to hold an optimistic attitude towards working with BPD in young people, holding on to the possibility of change and not seeing it as a fixed and hopeless disorder.

4.4. Superordinate Theme Four: Making a Difference

This superordinate them contains one sub-theme 'Having a positive impact'. This will be discussed in the following section.

4.4.1. Subtheme One: Having a Positive Impact

This subtheme looks at what it is that keeps support workers going in such a high stress and often debilitating role.

Tyler's experience of being a support worker is a positive one.

> *" It's been good, getting to do activities with the kids, taking them out, erm trying to be a positive role, male role model…"* **Tyler**, 6-8

Tyler's experience of being able to be a positive role model for young people can be seen as giving Tyler some purpose in his role, where he can start to have a positive impact. It seems to be important for Tyler to be able to do fun activities with the young people, perhaps as a way to be rewarded in his role through the young person's enjoyment, despite struggling with their BPD.

Amber goes on to talk about how she feels rewarded in her role when the young person feels a sense of achievement, which is likely to not be something they had experienced in the past.

> *"…having children kind of go up to school and achieve things at school, like getting an award for an essay that they have done or something, happy about that."* **Amber,** 662-665.

Anna discusses how her role as a support worker is one that she sees as a rewarding and enjoyable one.

> *" I find it very enjoyable working with children, errrm, seeing them you know in kind of progressing just, as people (…) they are all so talented and have all these like hidden skills and things and its really nice seeing them kind of develop those further (…) it's really rewarding and fun…"* **Anna**, 4-27

Anna finds her work enjoyable which seems to be related to a feeling of achievement and a sense of reward in her work. She describes how supporting a young person with BPD to blossom as an individual is a rewarding aspect in her role. Perhaps being able to help the young person find their hidden talents and increase their confidence is a reinforcing factor as to why support worker's stay in a role that has been described as consistently stressful.

This sense of reward in the support worker role is also experienced by Mary.

"…it was rewarding in the sense that (pause) when you put the time and the effort into trying to help someone (...) and it works then it's rewarding..." **Mary**, 12-16

"…when you have worked with someone through the period of their admission and they're in a much better place by the end of discharge erm you feel like you have contributed to that…" **Mary**, 17-20

Mary describes that when she can see her work making a difference to these young people, she feels rewarded, perhaps giving her a sense of purpose as a support worker and a reason to keep going in a role that is often seen as impossible.

Mary goes on to describe further feelings of having a sense of purpose as a support worker. This leaves her feeling as though she has been able to contribute to a young person being discharged and having had an impact on them having a better quality of life.

It seems as though support workers feel a sense of purpose and reward in their role and Sarah goes on to talk about discharge and the sense of achievement felt.

"…when they leave and they are in a better place and they have made it, and you see them, later on, move on to like much better life situations and they have got everything on track then it's it's worth it…" **Sarah**, 158-162

Sarah paints a picture that the young person has made it through a difficult journey and is now having a life which is much more positive. There is a sense that Sarah feels support workers are involved in this journey, feeling a sense of achievement when a young person is seen from admission to discharge. When

Sarah says "*it's worth it*" she is creating an image of a struggle in getting to the point of discharge and despite the difficulty, it was all worth it to see the young person much happier and more positive about their future.

5. Discussion

5.1. Overview

This study aimed to explore the perceptions of support workers working with BPD in young people giving a voice to this staff group in a hope to better understand their support needs. It also hoped to develop an understanding of what it is like to be a support worker and the challenges they face in their work. It could be used to inform CoPs about their role in supporting the support workers to positively impact therapeutic outcomes.

An interpretative phenomenological approach was used to analyse interviews from six participants, gathering rich qualitative data. The analysis resulted in four superordinate themes; Attachments, Boundaries and Ruptures, Emotional Roller-coaster of Managing Self-Harm, The Co-existence of Hope and Hopelessness and Making a Difference. There is a limited amount of literature on the experience of support workers working in mental health, with this research being the first to examine the role of support workers working with BPD in young people as part of an inpatient program. The aim was for this study to contribute to the literature on support staff and BPD in a hope to bridge the gap in our understanding of how support workers perceive patients with a BPD diagnosis. This section will explore the research findings and link them to the existing literature explored in the literature review. It will also focus on any original contributions this research has made to the literature in this field and make a suggestion for any future research.

The following section will consider these questions in more detail relating them to the current research. Further literature will also be considered when looking at the findings. Additionally, the implications for clinical practice will be discussed followed by the limitations of and future considerations for this area of research.

5.1.1. Attachments, Boundaries and Rupture

The current study has been able to provide new insight into the perceptions held towards young people with BPD from the viewpoint of support workers. This adds to the existing literature on the therapeutic alliance with young BPD patients, something that is of importance to CoP. The study found that support workers face many of the challenges highlighted in previous research that has focused on qualified staff such as nurses and therapists. They all face the demanding nature of building and maintaining a positive therapeutic alliance.

The data collected in this study broadly supports the findings from previous research that suggests BPD patients can be a challenging group to work with (Jeung & Herpertz, 2014; Lazarus, Cheavens, Festa, & Rosenthal, 2014; Skodol et al., 2002) and that building a positive therapeutic alliance can pose a particular challenge due to the nature of behaviours seen in many BPD patients (Bender, 2005; Black, Blum, Pfohl, & Hale, 2004; Pompili et al., 2005; Yeomans et al., 1994). The support workers in this study have described that building a therapeutic alliance is challenging, sometimes finding it difficult to engage the patient in the process, a process that has been identified as a central part of therapeutic intervention (Goldstein, 2005; Gunderson & Links, 2014). The development and maintenance of this relationship may be impacted by the common perception that BPD patients are emotionally dysregulated, struggle with interpersonal functioning and are impulsive (Cowen, Harrison & Burns, 2012; Grenyer et al., 2017; Gunderson, 2001). The support workers often view the attachments as too intense and something to be mitigated against and therefore boundaries are required to manage within these attachment styles. Boundaries are important to deploy when working with these challenging attachments however are often used out of fear and a defence against these attachments. Boundaries should be used to provide a safe environment for both patient and staff members so that there is a structured framework where the patient’s best interests are held(Kellogg & Young, 2006; Young et al, 2003). Where boundaries are unclear or used inappropriately both patient and staff can feel vulnerable which can have negative implications for the therapeutic alliance. For positive therapeutic outcomes it is important to work with these attachment styles and understand the patterns of difficult attachments that are communally acted out by BPD patients ,and effectively set therapeutic boundaries (Gabbard, 2005; Hruby et al, 2011; Kirchmann et al, 2012; Young et al, 2003).

A further challenge may come from the age group the support workers are engaging with since it has been suggested that it is more difficult to engage with young BPD patients (Chanen, 2015; McCutcheon, Chanen, Fraser, Drew, & Brewer, 2007).

Many of the experiences described by the participants in the current study indicate towards experiencing many ruptures in the therapeutic alliance, describing this relationship as one that can be intense and volatile often bouncing between love and hate. This perceived instability in BPD patients interpersonal functioning appears to leave the support workers feeling confused and uncertain in how to manage this relationship, with ruptures having the potential of interfering with the development of the therapeutic alliance (Cash, Hardy, Kellett, & Parry, 2013). Since research has shown that the therapeutic alliance is a fundamental part in positive therapeutic outcomes (Goldstein, 2005; Gunderson & Links, 2014; Linehan, 1993), with the therapeutic alliance impacting both the outcome and attendance of therapeutic support of BPD patients (McMain, Boritz, & Leybman, 2015; Horvath, Del Re, Fluckiger, & Symonds, 2011), it is important to attend to the therapeutic alliance to improve any therapeutic work with this client group (Gunderson & Links, 2014).

The ruptures in the therapeutic alliance are perceived by the support workers to occur when they, themselves, are not available to the patient and as a result feel BPD patients escalate their behaviour and reject the therapeutic alliance. The data gives the impression that support workers are left feeling punished resulting in feelings of self-doubt and incompetence. They also seem to experience feelings of blame for the escalation of risk-taking behaviour and distress experienced by the patients, which is something the literature suggests increases levels of anxiety in those working with BPD patients (Bender, 2005). The data implies that support workers are left feeling on edge about how patients will interpret and respond when they are not available to interact with them. It is inferred that they perceive BPD patients as jealous and can interpret staff as rejecting them when they are interacting with other patients. It may be that the BPD patient is responding to feelings of abandonment and rejection, something some have argued BPD patients have a particular sensitivity towards (Ayduk et al., 2008; Fallon, 2003). It would seem that support workers have a sense of heightened responsibility for the patient's behaviour possibly driving feelings of needing to be available exactly when required in order to prevent the escalation of self-destructive behaviours. It is indicated in the current research that support workers experience an element of fear regarding safeguarding these patients. For example, enforcing a boundary may result in the patients perceiving rejection and as a result, engage in risk-taking behaviour. This could be linked to the tendency for some support workers to go above and beyond their contracted hours to meet the perceived expectation of the patient. It is possible that support workers are trying to reduce their own anxiety, which has been linked to the safeguarding concerns of BPD patients (Krawitk & Batcheler, 2006), by crossing boundaries in order to placate the perceived challenges associated with this patient group. Consequently, this is likely to increase the support workers perception of the patients as risky and challenging.

The data collected in this study has indicated support workers sometimes perceive their role as an impossible task, finding it challenging to manage the demands and expectations associated with the patients, as well as managing the responsibilities of being a support worker. This seems to create feelings of frustration and overwhelm in the support workers, which is similar to reports in the existing literature that suggest therapists can be left feeling uncertain and overwhelmed by the unpredictable nature of BPD patients (Deans & Meocevic, 2006). The concern here is that when clinicians feel uncomfortable and unconfident in their role they have a negative impact on therapeutic engagement (Binder et al, 2011), and when we consider the extent of the research that suggests the BPD population elicit these feelings in clinicians, we can see the barriers these feelings create in treatment (Bodner, Cohen-Fridel, & Iancu, 2011; Stewart, Manion, & Davidson, 2002).

Although much of the existing literature focuses on the challenges faced by senior staff, this research suggests that the support workers are also impacted by the nature of BPD patients, creating an environment that could leave them feeling unsure on how to best negotiate the therapeutic alliance and repair any ruptures that may have occurred. Not only do support workers express the nature of their role to be challenging, they also imply that they can feel unable to make a tangible difference to the patients. This lack of perceived progress seems to leave the support workers with a sense of helplessness and reduction to their confidence in their therapeutic purpose. Although the support workers in this study have not indicated towards withdrawing from the clients, literature has suggested that staff can respond in a non-empathic way, often distancing themselves from patients (Aviram et al.,2006; Bland et al,. 2007; Commons Treloar, 2009) as a response to the challenges BPD patients bring. This is something that has a strong impact on the therapeutic alliance and is, therefore, important to prevent in therapeutic interactions. This suggests it is important for research to continue to better support the support workers who seem to struggle with this therapeutic alliance.

It is apparent from the current study that support workers perceive BPD patients as unstable, unpredictable, self-destructive and difficult to work with, which has been backed up by research that has found similar attitudes in other staff groups, such as nurses and therapists (Bodner et al.,2011; Forsyth,2007; Markham & Trower, 2003). It has been proposed that these preconceptions effect the therapeutic alliance due to the influence they have on their interactions with BPD patients (McGrath & Dowling, 2012; Shanks et al., 2011). For example, it has been shown that a therapist who becomes frustrated and angry can elicit a similar reaction in their clients due to the way they interact with them (Bland, Tudor, McNeil & Whitehouse, 2007 Dimaggio, Carcione, Salvatore, Semerari, & Nicolo, 2010). This is important for support workers to recognise since they have indicated towards becoming angry and frustrated, something research suggests is common when working with BPD patients (Deans & Meocevic, 2006) and may have an impact on the BPD patient behaviours and the therapeutic alliance. Considering literature has found skilled therapists can become stuck in unhelpful interaction patterns with BPD patients, often influenced by their own resentments and anger (Rossberg, Karterud, Pedersen, & Friis, 2007), it is reasonable to consider that support workers, who do not require formal education, may have similar experiences.

As demonstrated in this study support workers experience intense emotions and are likely to experience their role as emotionally draining (Alwin, 2006; Byrt, 2009 Kurtz, 2007). As a consequence, support workers are more likely to create a distance between themselves and the patient (Aviram et al., 2006; Bland et al,. 2007; Gallop, 2002) potentially having a negative impact on the therapeutic alliance. This may have an impact on their ability to empower the patients and instead could be giving off a message of pessimism which may be internalised by the patient. Access to training may be helpful to improve staff-patient communication by enhancing support workers abilities to manage with the demanding nature of their role and build the therapeutic alliance (Shanks et al., 2011). If training was more readily available to support workers they may be more equipped to work empathically with their patient’s, positively impacting treatment outcomes (Alligood, 2005; Bland, 2003; Commons-Treloar 2009; Townsend, 2008). This would come from an enhanced understanding of the behaviours displayed by the BPD patients, understanding their attachment styles as outcomes of difficult early life experiences and the abandonment and rejection commonly felt in those with insecure attachment styles. From this understanding support workers can then shift their negative perception towards this behaviour, from something to be avoided and taken personally, to a place of more empathy and understanding. Research has shown that low empathy levels in clinicians creates higher levels of distress in patients' negativity, impacting treatment outcomes. (Newton, 2013, Orlinsky et al, 1994) Therefore training could help support workers communicate optimism and acceptance further facilitating the therapeutic alliance and improve outcomes of therapeutic intervention (Goldstein, 2005; Newman, 2007). This level of understanding may also reduce the stress experienced by staff, by increasing their self-efficacy, which may contribute to staff burnout (Carrotte et al, 2019; Linehan et al., 2000; Perseius, Kaver, Ekdahl, Asberg, & Samuelsson, 2007).

Research has shown that BPD patients elicit intense and difficult emotions in staff, and has shown that experienced therapists can find themselves challenged by BPD patients. This suggests support workers could also have similar experiences (Gabbard & Wilkinson, 2000; Fleet & Mintz, 2013; Fox, 2011; Friedman et al., 2006). Not only could they experience similar challenges, it would appear in the literature that support and training are less available to support workers compared to other members of staff (Storey, 2000). Some approaches have emphasised the importance of supervision in the development of the therapeutic alliance (Gunderson & Links, 2014; Goldstein, 2005) and in reducing stress in staff working with BPD patients (Perseius, Ojehagen, Ekdahl, Asberg, & Samuelsson, 2003). Therefore access to supervision may be a vital component in supporting the support workers. This highlights the importance of expanding on literature that focuses on support for the support workers in this area, continuing to understand their development needs.

5.1.2. Emotional Rollercoaster of Managing Self-Harm

Suicidal behaviour has been recognised as a leading cause of death in young people (WHO, 2014), with the risk of suicide expected to increase as a consequence of engaging in self-harm behaviour (Fox & Hawton, 2004). The support workers in the current study have implied feeling as though a central part of their role is to safeguard the young people from self-damaging behaviours, behaviour which is recognised as a prominent feature of BPD presentation (Grenyer et al., 2017; Woollaston & Hixenbaugh's, 2008). Research has suggested that self-harm is one of the most complex issues faced by mental health professionals (Slee, Arensman, Garnefski & Spinhoven, 2007) highlighting the importance of the therapeutic alliance for positive therapeutic outcomes (Goldstein, 2005; Gunderson & Links, 2014; Linehan, 1993). Therefore the perceptions, from the support workers in this study, that self-harming is inescapable and that they cannot make any tangible difference, could lead to apathy towards this patient group, negatively impacting on the therapeutic alliance, something that is arguably central to therapeutic outcomes.

It would seem as though the support worker can be left feeling highly anxious and helpless when working with self-harm and suicide, often becoming overwhelmed by the nature of self-harming. This is consistent with existing literature that has shown self-harm patients can elicit intense emotions, for example, feelings of fear, in counsellors (Fleet & Mintz, 2013; Fox, 2011; Friedman et al., 2006). The support workers anxiety may be influenced by the perception that BPD patients have a tendency to self-sabotage (APA, 2013) reinforcing their need for continuous anticipation of self-harm. This perception, that self-harm is always looming, could enforce a state of high alert due to the consequences associated with risk-taking behaviour. In addition, it seems as though support workers feel that no matter what they do they cannot make a tangible difference when it comes to self-harm, possibly impacting their self-efficacy. It is widely known that working closely with BPD patients causes significant and overwhelming stress levels often resulting in burnout and high levels of emotional exhaustion (Bowers, 2000; Linehan et al., 2000). This is reflected in the support workers who seem to be finding it challenging to manage the nature of their work. It could be that they are in need of extra support to manage this, with some approaches highlighting the importance of supervision in reducing stress in staff working with BPD patients (Perseius, Ojehagen, Ekdahl, Asberg, & Samuelsson, 2003), as well as helping in the development of the therapeutic alliance (Gunderson & Links, 2014; Goldstein, 2005).

Research has shown that self-harming behaviour is often done in secret creating further challenges when it comes to safeguarding this population (Fortune, Sinclair, & Hawton, 2008; Fox & Hawton, 2004; James, 2013). This research gives the impression that support workers are left with an overwhelming sense of dread and fear around what could happen behind closed doors. As a result support workers express being constantly vigilant and on edge about the safety of these patients, due to the perception that these young people have highly dysregulated and unpredictable emotions and behaviours (Cloitreetal., 2014; Grenyer et al., 2017; Trull et al., Tragesser & Robinson, 2009). It would appear that support workers experience high levels of anxiety and overwhelm, feeling they are unable to make tangible differences to the young people in their care. The nature of self-harm and feeling as though whatever they do they cannot make tangible differences appears to leave them with self-doubt and reduced self-efficacy. It is possible that the support workers may begin to distance themselves from the patients due to these feeling, something that is evident in the literature and something that can impact the therapeutic alliance and therefore therapeutic outcomes (Aviram et al., 2006; Gallop, 2002). This highlights an opportunity for training which could help improve their ability to manage the overwhelming nature of the work and continue to build the therapeutic alliance positively impacting the therapeutic outcomes (Jorn & Kitchener, 2007; Robinson et al, 2008; Shanks et al., 2011).

It seems as though the support workers are on an emotional rollercoaster, maybe one similar to the dysregulation of emotion thought to be experienced by BPD patients (Cloitreetal., 2014; Grenyer et al., 2017; Trull et al., Tragesser & Robinson, 2009)). They seem to experience emotions from anxiety, fear, guilt and dread often leaving them overwhelmed in their role. It has been suggested by this research that over time, as a result of the emotional impact self-harm has, support workers became desensitised experiencing a sense of numbness, something that has been reported by others working with self-harm (Allen & Jones, 2002; Crawley,2004). Although this can be seen as a defence against the intense emotional experiences, helping them to better manage in their role (Bowing,2004; Hasetings, 2005; Maslach & Jackson, 1986), it has been suggested that prolonged exposure and desensitisation can lead to reduced empathy and compassion, something that is central to building the therapeutic relationship (Cole-King, Green, Gask, Hines & Platt, 2013; Bohart, Elliott, Greenberg & Watson, 2002; Sanderson, 2013; Schnur & Montgomery, 2009). It could be that support workers are yet to develop the skills needed to deal with self-harm effectively and perhaps require further training which has been found to improve confidence and ability to effectively help those who self-harm (Jorn & Kitchener, 2007; Robinson et al, 2008).

It is possible that the overwhelming environment, reduced self-efficacy and the desensitisation towards the patients can be linked to negative attitudes towards this group, (Hastings & Brown, 2002; Saunders et al., 2012), for example that they are manipulative and attention-seeking (Bland, 2003; Lewis and Appleby; 1988; Potter, 2006), which could have negative consequences on the therapeutic outcomes(Anderson, Standen, & Noon, 2003) . Not only that, these attitudes have been linked to staff feeling helpless and an increase in staff burnout (Carrotte et al, 2019; Gallop, 2002; Linehan et al., 2000; Markham & Trower, 2003; Mills & Rose, 2011). Due to such attitudes and negative preconceptions, it may be challenging for staff to work positively with this presentation. The current research has implied staff feel undertrained in dealing with young BPD patients and therefore face feeling inadequate in their role. It has been suggested in the literature that training can help staff feel equipped for working with young people who self-harm (Crawford, Geraghty, Street, & Simonoff, 2003) and increases empathy towards them (McCarthy, 2010). A reduction in negative attitudes towards young people who self-harm has also been found following training and supervision opportunities helping to increase self-efficacy (Crawford et al, 2003; Treloar and Lewis, 2008). With that in mind, understanding the perceptions of support workers ability to work with self-harming behaviours may be helpful in understanding their training and support needs, and perhaps improve their emotional wellbeing and ability to create a positive environments when working with young BPD patients (Treloar & Lewis, 2008). This is an important implication for practitioners working with BPD in young people, increasing the understanding of the emotional demands this role is having and how this can impact the development of the therapeutic alliance.

5.1.3. The Co-existence of Hope and Hopelessness

Literature has shown that the therapeutic alliance is central to therapeutic outcomes across many different therapeutic interventions (Gunderson & Links, 2014; Goldstein, 2005). It has been suggested that the development of the therapeutic alliance, with someone considered as having BPD, can be inconsistent and difficult to maintain (Gunderson, 2001), something that seems to be reflected in the experiences of the support workers in the current study. It would also seem that, where they feel unable to make tangible differences, the support workers become frustrated and less confident in their abilities to make a therapeutic change, something that may contribute to the feeling of hopelessness that appears throughout this research. They also described feeling inadequate in their role often feeling frustrated and angry, which has been experienced in other staff working closely with BPD patients (Berhman & Eckerdal, 2000). It is believed that individuals with BPD evoke intense emotions in those working closely with them (Fleet & Mintz, 2013; Fox, 2011; Friedman et al., 2006) and can often cause mental health workers to distance themselves from this group (Aviram et al.,2006; Black et al,2011; Commons Treloar, 2009; Gallop, 2002). This may impact the development of the therapeutic alliance since it has been suggested that the trust, warmth and empathy, from the mental health workers, are significant (Carr, 2010; Bedi, 2006) which may be reduced as a result of the perceptions held about them.

It would seem that support workers perceive their role as risk prevention rather than having an ability to promote therapeutic changes. They imply feeling that at times there is no therapeutic change to be made and at best things remain the same. This may contribute to, and reinforce, feelings of hopelessness which could lead to apathy towards the patients. Since literature has suggested that negative attitudes can prevent the development of the therapeutic alliance (Gunderson & Links, 2014; Goldstein, 2005), the feeling of hopelessness in the support workers may be a barrier to therapeutic change due to the impact their perceptions have on the alliance. This may be linked to the findings that the intensity of emotions experienced by mental health professionals can lead to non-empathic interactions with patients, which has been shown to reduce therapeutic outcomes (Dimaggio, Carcione, Salvatore, Semerari, & Nicolo, 2010). The challenges faced by these support workers and the negative perception held about the young BPD patients could reinforce the views that BPD is a hopeless disorder. This could impact the patient by sending messages of pessimism to them (Fallon, 2003; Stalker, Ferguson & Barclay, 2005) and end up with a self-fulfilling prophecy.

The study points toward support workers perceiving young BPD patients as revolving door patients adding the pessimistic views held by some of the support workers. As a result of the challenges associated with working with BPD patients it has been found that staff can begin to distance themselves and become less empathic towards the patients (Aviram et al.,2006; Bland et al,. 2007; Commons Treloar, 2009), possibly having a negative impact on the therapeutic alliance and increasing the challenging behaviours presenting in BPD patients. This could make the support workers feel overwhelmed and frustrated in the role, leaving them stuck in a challenging cycle of interaction, something that has been shown to affect others working with this client group (Rossberg, Karterud, Pedersen, & Friis, 2007).

Despite the overarching theme of negativity towards BPD, not only in this research but in existing literature, it has been demonstrated that the nature of negativity towards this group can be reduced and more optimistic views can be developed when specialist training is received (Bowers et al., 2005; McCarthy, 2010; McGrath & Dowling, 2012). Therefore, by providing this training to support workers, it is possible that these negative perceptions can be reduced and in turn improve therapeutic outcomes.

Some of the support workers suggested that despite the limited availability to them, training has helped develop new therapeutic skills and has brought a sense of hope about the young BPD patients they work with. Some suggest that there are more opportunities to effect positive changes. There is some understanding that although it may not feel like any change is being made, perseverance and patience is important when working with young BPD patients and there is an understanding that moving forwards then taking steps backwards is all part of the process. This more optimistic attitude is likely to produce hope in the support workers who understand that the process may be a slow one but one where tangible progress can be made. This is likely to enable a warm and empathic communication which is highlighted as being important in the development of the therapeutic alliance (Elliott et al., 2011; Horvath and Bedi, 2002), and increase feelings of acceptance.

It has been shown in the literature that access to training has the ability to improve the negative attitudes held towards stigmatised groups (Bowers et al., 2005; McCarthy, 2010; McGrath & Dowling, 2012). Therefore if support workers were more able to access this it is possible that they could further develop positive therapeutic alliances with young BPD patients, and the impact they have on therapeutic outcomes. With the correct training and support, it is likely that support workers will increase their confidence working with the challenges associated with BPD patients and possibly perceive there role as a more therapeutic one. This is consistent with research that shows training and support has a positive effect on staff and patients, showing the importance of promoting this for better therapeutic outcomes with this group (Bowers et al., 2005; Westwood & Baker, 2010).

Another factor that seemed to elicit hope in the support workers was the age of the patients. There was a sense that they felt as young people they are able to learn and develop skills more quickly, rather than in adulthood where it was perceived as more ingrained and difficult to change. This is reflective in the literature that suggests adolescent brains are more malleable and susceptible to interventions (Chanen, 2015; White, 2009; Lenzenweger & Desantis Castro, 2005). The support workers felt that they were able to help teach resilience to the young people and help to improve their quality of life.

It is important to continue trying to understand the impact the support worker role has on the therapeutic outcomes and also how best to support them in delivering this care. There seems to be an argument for further training and support, not only to impact therapeutic outcomes, but also staff wellbeing. It is important to foster a hopeful attitude when working with BPD patients to improve therapeutic outcomes.

5.1.4. **Making a Difference**

Clinicians face many challenges when working with BPD patients who have been considered as some of the most challenging groups to work with (Aviram & Brodsky, 2006; Bender, 2005; Black, Blum, Pfohl, & Hale, 2004; Rizvi, Steffel & Carson-Wong, 2012; Sansone & Sansone, 2013). As the literature has suggested staff often experience frustration, overwhelm and burnout as a result of the stressor of working in such an environment (Deans & Meocevic, 2006; Linehan et al., 2000; Perseius, Kaver, Ekdahl, Asberg, & Samuelsson, 2007). However it has been reported that there are many parts of the job that are considered pleasurable, including building positive relationships, that can result in positive affect (Galeazzi et al., 2004; Pakenham, 2005; Parveen, Morrison, and Robinson, 2011).

The support workers in the current research expressed that this patient groups is very challenging to work with however despite the challenges, anxiety and stress ingrained in their work, the support workers felt the rewarding nature of their role and feel that this kept them going during the challenging times. For example when a patient is discharged from hospital and able to progress and move forward in their lives, the support workers feel that they are part of this journey leading to a sense of reward and pride. They also felt a boost in self-efficacy and optimism. With the literature showing how optimistic staff attitudes positively impact therapeutic outcomes (Goldstein, 2005; Leslie & Rosenheck, 2004; Newman, 2007), it is important to understand and foster these feelings to continue to have a positive influence.

It seems to be important to the support workers' motivation that they can see tangible differences in those they are caring for, giving them a sense of satisfaction when they make a positive impact on a young person. The support workers in this study emphasise the importance of seeing patient achievements, such as when they are able to attend school and begin to achieve their educational goals, leaving the support workers seeing value in their work. The support workers also feel a sense of satisfaction as a result of their role in the therapeutic process, helping these patients to make positive attachments in treatment and seeing changes in the patients' presentation. The importance the support workers seem to place on their ability to be involved with change is consistent with research that suggests nurses who felt they could make a positive difference reported their work as satisfying (Shanks et al., 2011). This sense of satisfaction seems to make the challenges support workers face worthwhile and keeps them motivated in times of stress. It is suggested by this research that support workers find their role rewarding and enjoy helping the young people develop through their struggles and grow as individuals. For example the participants in this study felt that being able to support their patients in building an emotional tool kit to manage with the challenges associated with the BPD features, and seeing them develop as individuals, gave them a sense of purpose and hope for change. Therefore despite the challenges reported in this research and much of the existing literature, it would seem that the satisfaction and hopeful attitudes motivate the support workers and keep them passionate in their role.

Existing literature has proposed that optimism and empathy have a positive impact on therapeutic intervention and although the support workers in this study do show some optimism and hope for this client group, much of their experience is embedded with the negative attitudes that have been associated with this group for much of its history. It would seem that there is an opportunity for training and supervision to help empower support workers and increase positive feelings towards working with young BPD patients. This is in line with Bowers and Allan (2006) who found there were more positive attitudes if staff were provided with training and supervision. While Morgan et al. (2013) found that supervision is a predictor of satisfaction in healthcare workers. Since the current research shows that the support workers often feel ill-equipped to manage the nature of their work with young BPD patients, it is important to understand their training and support needs to increase the optimistic attitudes that are positive for therapeutic outcomes (Goldstein, 2005; Newman, 2007). This has the opportunity to reduce the feeling of frustration and anger, reported by the support workers, and instead, help them to foster the therapeutic alliance. This is likely to improve therapeutic outcomes as well as job satisfaction.

5.2. Implications for Clinical Practice

The current study has provided some new insights into support workers experiences of working with BPD in young people and it seems as though they face many of the same challenges reported by senior mental health staff. The existing literature highlights that there is an aura of negativity associated with BPD which has a negative impact on treatment outcomes. This is reaffirmed by current research suggesting that this negativity impacts the support workers directly, having an impact on their perceptions of BPD patients. Both existing and the current research highlights a preoccupation with preconceived expectations based on the clinical diagnosis, potentially reducing a patient's individuality. CoPs consider the uniqueness of individuals to be a central component in therapeutic intervention, therefore understanding that although a diagnosis may be given and can provide a clinical understanding, central to therapeutic intervention is the unique experiences of each patient. This research can continue to inform CoP about the consequence of stigma and the importance of confronting it to allow each individual to tell their unique story. Through educational and training opportunities support workers, and other mental health professionals alike, could learn to challenge their preconceptions and empower the patient by holding a more empathic understanding for them.

The participants in this research feel that there are limited training and support opportunities in their role and training is something that is expressed as being important to them. With adequate training and educational opportunities, specific to BPD, the support workers could develop a deeper understanding of what a BPD is and what this may be like for the diagnosed individual. With an enhanced understanding of the aetiology of BPD, the treatment set out in the NICE guidelines and some of the common difficulties faced by BPD patients, support workers could begin to understand their behaviours in the context of BPD, seeing their behaviour as less threatening and less of a personal failure, responding more empathically towards them and enhancing their treatment experience. Offering training to support workers would equip them will tools and interventions to manage with the daily challenges presented by this group, giving them the confidence to manage the associated risks and allowing for a greater sense of self-efficacy.

With the therapeutic alliance being held in high importance within CoP, as well as empirical evidence suggesting it is a critical part in successful therapeutic intervention, this research highlights an area of potential improvement when it comes to therapeutic alliance and treatment outcomes. This research suggests that the support workers struggle to work within a therapeutic alliance often finding themselves experiencing uncertainty and frustration, states which are incongruent to positive therapeutic alliances. Therefore, understanding the challenges support workers face cultivating these relationships can inform CoPs on the educational and support needs of this staffing group, which is especially important when we recognise these support workers are considered front line staff.

This research can be used to inform on the training and support opportunities needed by support workers to ensure they are able to carry out their job effectively. It highlights that support workers face similar challenges to senior staff however are perhaps less well equipped to deal with these challenges. Therefore this research has highlighted a need of further support in order to deliver a high standard of therapeutic care to young BPD patients. This may be something a counselling psychologist is responsible for, perhaps providing education and support opportunities through supervision. This research can inform clinical practice by highlighting the training and support needs of support workers. Therefore CoPs can continue to make positive changes to the mental health systems.

5.3. Future Research

With research into support workers working with young BPD patients being limited in the literature, there are many opportunities for further research. Since support workers are considered front line staff and with the many challenges they face, it could be beneficial to understand how the therapeutic alliance, between the support workers and BPD patients, impacts therapeutic outcomes. This could then inform how best to support the support workers to deliver the best care to BPD patients, as well as the emotional support needed by the support workers.

With an indication in the literature towards a need for supervision, it could be important for further research to focus on the impact supervision has on the wellbeing of support workers and on the development of the therapeutic alliance. This could give insights into the barriers of accessing this support and provide practical guidance on how to best manage these challenges to ensure staff have access to the required training and support.

By researching more into the experiences and needs of support workers it may open up opportunities to improve therapeutic outcomes for this group. In doing so it could highlight any educational needs that could improve staff attitudes towards this clinical group, in turn impacting on therapeutic outcomes.

Within the current and existing literature many of the difficult and challenging aspects of working with BPD patients are highlighted, however there is an opportunity to focus some research on what motivates staff to peruse and preserve in such a challenging role. With the high levels of recorded staff burn out, a focus in the aspect of the role that keeps staff motivated could help to facilitate job satisfaction and enhance continuity in clinical teams.

Additionally, investigating the perceptions of their role as a support worker could be beneficial to better understand their position in the care team and to better understand how to support them to deliver the best care and understand the clinical relevance of support workers.

5.4. Evaluation of Research Methodology

The focus of this study was to provide an in-depth exploration of support workers perceptions of BPD in young people; therefore the chosen methodology was consistent with this focus. The purpose of this study was not to make generalisations about support workers experiences, but instead, focus on how an individual experiences a specific phenomenon. This is the justification for using a small sample size to ensure an in-depth understanding of an individual’s experiences can be developed. This idiographic focus is consistent with the IPA principles. While this study can be used to further develop the understanding in this area, the results of this study should be considered within the particular context these support workers were experiencing.

Additionally, the themes derived from this study are of the direct influence of the researcher's interpretations, therefore, can only be made sense of in the current context and it must be considered that other researchers may have developed a different understanding. Nonetheless, the study adopted the double hermeneutic principles of IPA which meant it was not seen as necessary to have someone else checking the transcripts.

A strength of this study is that the researcher attempted to have a homogenous participant sample of all support workers, working in an inpatient hospital for young people with experience of working with BPD in young people. Although the participant sample included one male participant, affecting its homogeneity, it indicated an area of future research and added a different dynamic in terms of gender difference.

5.5. Reflective Statement

As I have gone on this journey through the research process I have been reflective of my own intentions and interests in this area of research. Engaging in reflection, through a reflective diary as well as personal therapy, I have developed a deeper understanding of my own assumptions about the world and how these assumptions have influenced my interest in the current study. This is an important process so that I am able to 'bracket' (Smith et al., 2009) my own preconceptions in order to reduce my influence on the research findings.

The research topic was of importance to me as it was aligned with my passions to work with young people with BPD and also my previous experiences as a support worker in this environment. My concern was around the missed opportunity to utilise the support workers working with BPD and the impact the challenges of this work was having on them. I began to think that there was a lack of understanding about the support needs of support workers and they were somewhat overlooked as a valued member of staff. For instance, there were limited training opportunities and limited supervisory support. On reflection, this was impacting staff morale with many of my colleagues becoming overwhelmed and unable to cope with the challenges we were faced with. Consequently, I felt that this was having an unjust impact on the patient's level of care with staff becoming withdrawn and unable to cope. With these feeling in mind, the research topic created an opportunity to develop an understanding of support workers perceptions of BPD in young people with an aim of understanding their professional development needs.

Having worked with BPD in young people I was aware of the impact this diagnosis has for mental health staff, who felt apprehensive when working with this group. I was aware that I had my own expectation of what it was like for support workers in this field and it is important to acknowledge this in order to understand how I am influencing the interpretation of the research. It was a challenge to bracket off my own preconceptions and I found it challenging to stay neutral. After discussing these ideas with my supervisor I was able to formulate interview questions that were neutral and were not based on my own personal curiosity or as a way of validating my own experiences. In doing this I was able to focus the interviews on the phenomena I was exploring as opposed to questions that were biased by any personal agendas.

During the interview process I was aware of how I may have been perceived by the participants: being a trainee counselling psychologist may have meant that I represented a person of higher authority and someone who may be reducing their importance as support workers. I may have also been seen as an outsider as it had been mentioned in the interviews that the support workers stick together and support one another. On the other hand this may have been a benefit for the study as they may have felt their voice was being heard by someone who wanted to understand what it was like for them. During the interviews I tried to employ a non-judgemental attitude to reduce the impact I was having in the interviews, this was in line with Rogers (1957) core principles of person-centred therapy.

Furthermore, my experiences as a support worker and my developed understanding of BPD inevitably impacted the themes I was drawn to in the analysis. However, by discussing my data with peers I was able to see that there were some common experiences arising from the data and was also able to be more neutral in response to the data, moving away from identifying themes that were important to me instead of focusing on what was in the data. I was surprised by some of the themes that emerged and had an expectation that participants would hold only negative views about BPD patients. On reflection, this was because of my experience of when I was a support worker and the environment of negativity I found myself in when it came to BPD patients. Instead, I found that all the support workers felt hopeful about therapeutic outcomes and how there was a shift in attitudes towards BPD from when I was a support worker in a similar context.

The process of this research has been one that has felt much like the roller-coaster ride described in the themes, one where there have been lots of ups and downs with a feeling of uncertainty and challenge. Nevertheless, this has been an exciting and rewarding process that has challenged me as a researcher and also influenced the way I see my role as a counselling psychologist. For example, I feel I have increased my awareness of the importance of supervision when working with BPD and how important it is to provide opportunities for staff to access support in order to improve patient therapeutic outcomes. I feel that this research has contributed to the field of CoP research and the research on BPD by highlighting the shortcomings in the treatment of staff and patients, as well as the positive changes to staff attitudes. The research also has implications for future research into supporting young people diagnosed with BPD.

6. Concluding Remarks

This study has highlighted that support workers face many of the same challenges that nurses and therapists face when working with BPD, however perhaps do not have the same access to training and supervision that is seen as important in these professions. The research has indicated that perhaps support workers could benefit from such support which could have a positive impact on the therapeutic outcomes for young BPD patients.

Support workers seem to be impacted by the same stigmatised views of BPD patients that have been present in the existing literature and has been shown to impact the development of the therapeutic alliance. Some participants revealed that they felt frustration, anger and overwhelm in their role which could impact their ability to deliver empathic care to BPD patients. Therefore this research has given some more insight into the roles of CoPs in challenging the stigma associated with BPD and facilitating a more holistic approach to the work with those considered as having BPD. CoPs could also help facilitate the clinical needs of support workers, empowering them to empower the patients.

It seems important for research to attempt to understand the impact of the support worker role in the therapeutic outcome with young BPD patients. In understanding their role, CoPs may be able to positively influence the impact they have on therapeutic interventions and therapeutic outcomes.

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8. Appendices

Appendix A: Recruitment Poster

Appendix B: Participant Information Sheet

Appendix C: Ethical Approval

Appendix D: Participant Informed Consent Form

Appendix E: Distress Protocol

Appendix F: Debriefing Information Sheet

Appendix G: Interview Schedule

Appendix H: Interview Transcript with Initial Notations

Appendix I: List of initial themes for Participant 5 (Anna)

Appendix L: Extracts from my Reflective Diary

Appendix A: Recruitment poster

CAMHS SUPPORT WORKERS

needed for research on Borderline personality disorder (BPD).

I am a Doctorate student in the Department of Counselling Psychology at the London Metropolitan University.

We are looking for volunteers to take part in a study looking at:
Staff Support Workers perceptions of working with adolescent patients diagnosed with Borderline Personality Disorder (BPD): An Interpretative Phenomenological Analysis.

As a participant in this study you would be asked to take part in an interview (30-60 minutes) about your experiences of being a support worker, Borderline Personality Disorder and CAMHS. The aim is to further develop an understanding of what it is like for support workers working with BPD, in the hope to understand their experiences to improve the working environment.

For more information about this study, or to volunteer,
please contact:

Jessica Coombes
at

JHC0048@mylondonmet.ac.uk

This study has been reviewed by and received ethical approval through the London Metropolitan University Research Ethics Board

Appendix B: Participant information sheet

Staff Support Worker Perceptions of adolescent patients diagnosed with Borderline Personality Disorder (BPD): An Interpretative Phenomenological Analysis.

Thank you for your interest in taking part in my doctoral research project. Before you decide to take part, it is important that you understand why this research is being conducted and what it will involve.

Dear reader,
My name is Jessica Coombes. I am a Trainee Counselling Psychologist carrying out this research as part of my Doctorate qualification. The research is being supervised by Dr Verity Di Mascio (Senior Lecturer).

Purpose:
I am completing this research as part of my Doctorate in Counselling Psychology at London Metropolitan University. This research will explore the experiences of Support workers, who have spent two years working in inpatient CAMHS with experience of working with borderline personality disorder (BPD) symptomology and emotional dysregulation. BPD is highly researched however, this topic a relatively under-researched area. I hope that this research will increase awareness of importance of working with young people with BPD, and hopefully inform the professional training and practice within the area.
What is expected from you:
As participant you need to fulfil the following criteria in order to be eligible to participate:

- You have worked for 2+years as a support worker in an inpatient CAMHS setting.
- You must have worked in an inpatient CAMHS setting within the last 5 years.

If you agree to take part in this study, you will be asked to read and sign a consent form. You will be asked to take part in a recorded interview that will last between 30 – 60 minutes with an extra 30 minutes to answer any questions and complete a debrief at the end of the interview. The focus of the interview will be on your experiences of working with BPD, stigma and being a support worker in CAMHS services. Part of the interview may be included in the final write-up to illustrate my findings and you can request a summary of the finding from me by informing me of your contact details.
Participation:
Participation is voluntary and you are free to refuse to answer questions and you can stop the interview at any point, without giving a reason. You are also free to withdraw yourself and your data from the study until six weeks after the interview, after which your data would be incorporated into the study. In addition, if you have any concerns or questions you can contact myself or my university.

The interview will take place at a location of your convenience, in a quiet and confidential location.

Confidentiality:

In line with the British Psychological Society's guidelines on Ethical Principles for Conduction Research with Human Participants: All of the information you provide will be kept strictly anonymous and confidential. It is important to be aware that although all attempts will be made to maintain confidentiality, there might be instances when this might need to be breached, for example if you disclose any harm coming to yourself or others, or if you reveal details of practice that raises serious ethical concerns, according to the BPS Code of Ethics & Conduct (2006).

Data and signed forms will be stored in secure locations. I may wish to publish the results of my study to inform practice. To allow for this, the anonymised transcripts of our interview will be kept for 5 years and then destroyed. Once I have written up my research, a copy of the doctoral thesis will also be placed in the London Metropolitan University library, which could be accessed by other interested researchers.

Risk:

This research focuses on your personal experiences which could be of a personal a distressing nature. Measures will be taken to minimise the potential distress and you are free to decline to answer any questions that make you feel uncomfortable. Short breaks will be offered if needed in order to process any difficulties faced. As a safeguarding measure both you and the researcher have the right to terminate the interview at any point if the interview becomes too distressing.

After the interview, you will be provided with a debriefing sheet, which will contain additional information about the study and we will have time after the interview to discuss your experience of taking part in my research. You will also be provided with information about support following the interview if unwanted distress occurs as a result of the interview including therapeutic services.

Making a complaint:

If you have any concerns about this research project then please contact my research supervisor

Dr. Verity Di Mascio
London Metropolitan University
v.dimascio@londonmet.ac.uk

If you are happy to participate in the above study or have any further questions then please email me at:

Jhc0048@londonmet.ac.uk

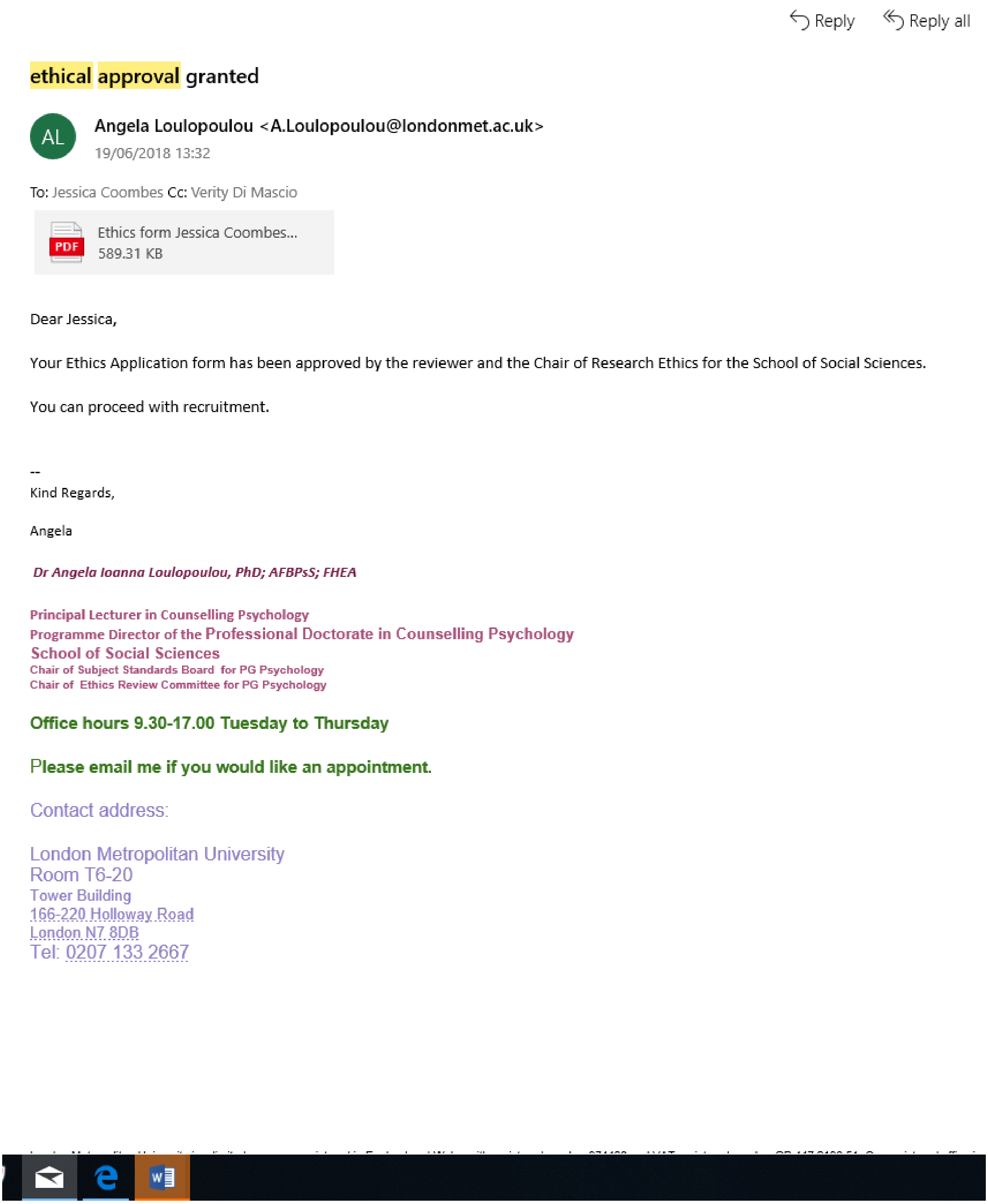
Thank you for taking the time to read this information.

Yours faithfully,

Jessica Coombes

Trainee Counselling Psychologist

Appendix C: Ethical Approval



ethical approval granted

Angela Loulopoulou <A.Loulopoulou@londonmet.ac.uk>
19/06/2018 13:32

To: Jessica Coombes Cc: Verity Di Mascio

Ethics form Jessica Coombes...
589.31 KB

Dear Jessica,

Your Ethics Application form has been approved by the reviewer and the Chair of Research Ethics for the School of Social Sciences.

You can proceed with recruitment.

--
Kind Regards,

Angela

Dr Angela Ioanna Loulopoulou, PhD; AFBPsS; FHEA

Principal Lecturer in Counselling Psychology
Programme Director of the Professional Doctorate in Counselling Psychology
School of Social Sciences
Chair of Subject Standards Board for PG Psychology
Chair of Ethics Review Committee for PG Psychology

Office hours 9.30-17.00 Tuesday to Thursday

Please email me if you would like an appointment.

Contact address:

London Metropolitan University
Room T6-20
Tower Building
166-220 Holloway Road
London N7 8DB
Tel: 0207 133 2667

Appendix D: Consent form

Study title: Staff Support Worker Perceptions of adolescent patients diagnosed with Borderline Personality Disorder (BPD): An Interpretative Phenomenological Analysis.

Researcher: Jessica Coombes, Trainee Counselling Psychologist

Thank you for considering taking part in this research. Before participation all participants are asked to sign a consent form. It is important that you understand and agree to each of the points below, please tick the boxes to indicate you have understood these. Signing this form indicates that you are willing to participate in this study and are aware of your rights as a participant.
Please ask the researcher if you need further clarification.

- ☐ I confirm that I have read and understood the Participant Information Sheet for this research and have had the opportunity to ask questions.

- ☐ I understand that my participation is voluntary and I am free to refuse to answer questions, without giving a reason. I am also free to withdraw my data entirely from the study until six weeks after the interview has taken place.

- ☐ I understand that I will be asked a series of questions about my experience and that the interview will be audiotaped for the data analysis using a Dictaphone.

- ☐ I understand that the data will be anonymised by the removal of all identifying information and that the anonymised transcripts will be used in a doctoral thesis and potentially in future publications.

- ☐ I understand that the tapes and anonymised transcripts will be kept for up to 5 years and will then be destroyed. A copy of the doctoral thesis will be kept in the London Metropolitan University library.

- ☐ I understand that my confidentiality will be maintained wherever possible, but that it might need to be mitigated if I disclose a danger of harm coming to myself or others, or if I reveal details of practice which raises serious ethical concerns, according to the BPS Code of Conduct & Ethics (2010).

- ☐ I understand that I will be provided with a debriefing sheet, which contains additional information about the study and that I will have the opportunity to discuss my experience of taking part.

- ☐ I have been given an opportunity to ask questions and if asked these questions have been answered fully.

- ☐ **I agree to participate in the research.**

___________________________ _____/_____/_____ _____________________

Name of Research Participant Date
Signature

___________________________ _____/_____/_____ _____________________

Name of Researcher Date
Signature

Please send me a summary of the research findings: YES / NO (please circle)

Address to which details should be sent:..
……………………………………………………………………….. ....

E-mail address:...

Appendix E:
Distress Protocol

The distress protocol is developed to address any harm that may be caused to participants as a result of taking part in research.

To monitor any distress that may be experienced by the participant a distress protocol has be devised to ensure the safeguarding of the participants. Although measures are taken to ensure participants do not experiences harm as a result of the study there is a possibility that distress may occur and the protocol used. Extreme distress isn't expected since the participants are provided with detailed information regarding the nature of this study prior to taking part so are made aware of any risks. They will also be told of their right to withdraw or take a break from the interview if they

Signs to look for:	Actions to take
Tearfulness Change in voice/becoming chocked Appears anxious/change in body language	Offer a break from the interview Ask if they are happy to continue Remind them of the right to terminate the interview
Uncontrolled crying Verbal or physical aggression Panic attack Intrusive thoughts Suicidal thoughts	Intervene and terminate interview Debrief participant Use relaxation Reassure participant/ maintain their safety Numbers for support organizations given Contact appropriate organization if concerned about participant's welfare.

Appendix F:
Participant Debrief

Staff Support Worker Perceptions of adolescent patients diagnosed with Borderline Personality Disorder (BPD): An Interpretative Phenomenological Analysis.

Thank you for taking part in this research . You have the right to withdraw your data any time in the next 6 weeks (date ___/___/___) please contact me via email if you wish to do so.

Making a complaint:

If you have any concerns about this research project then please contact my research supervisor

Dr Verity Di Mascio
London Metropolitan University
v.dimascio@londonmet.ac.uk

Risks:

If you feel there has been any distress caused to you as a result of participating in this study then please contact London Metropolitan University or contact any of the people listed below for further advice and support:

Jessica Coombes
Jhc0048@londonmet.ac.uk

University Address:
Professional Doctorate in Counselling Psychology
London Metropolitan University
166-220 Holloway Road
London N7 8DB

Support organisations:

Samaritans · Phone
53-55 Felsham Road, Putney SW15 1AZ
020 8789 9121
Offers a 24 hour support help-line service.

Mind
15 – 19 Broadway, London, E15 4BQ.
Tel: 0300 123 3393 / 020 8519 2122
Email: contact@mind.org.uk
Website: www.mind.org.uk

Provides a confidential helpline, face-to-face counselling, advocacy, support and befriending for a broad selection of mental health difficulties.

Appendix G: Interview Schedule

Questions:

1) Can you tell me about your experiences of being a Support worker in inpatient CAMHS
2) What is your understanding of BPD?
3) What does a diagnosis of BPD mean for you?
4) What is it like to work with BPD patients?

   Prompts:

   - How do you feel other people reacted to this diagnosis?

5) Have you experienced any difficulties working with this group of individuals?

   Prompts:

   - Can you elaborate on that?

6) Can you tell me about your experience of working in a multidisciplinary team?
7) Do you feel that having BPD had any effect on the treatment patients receive?

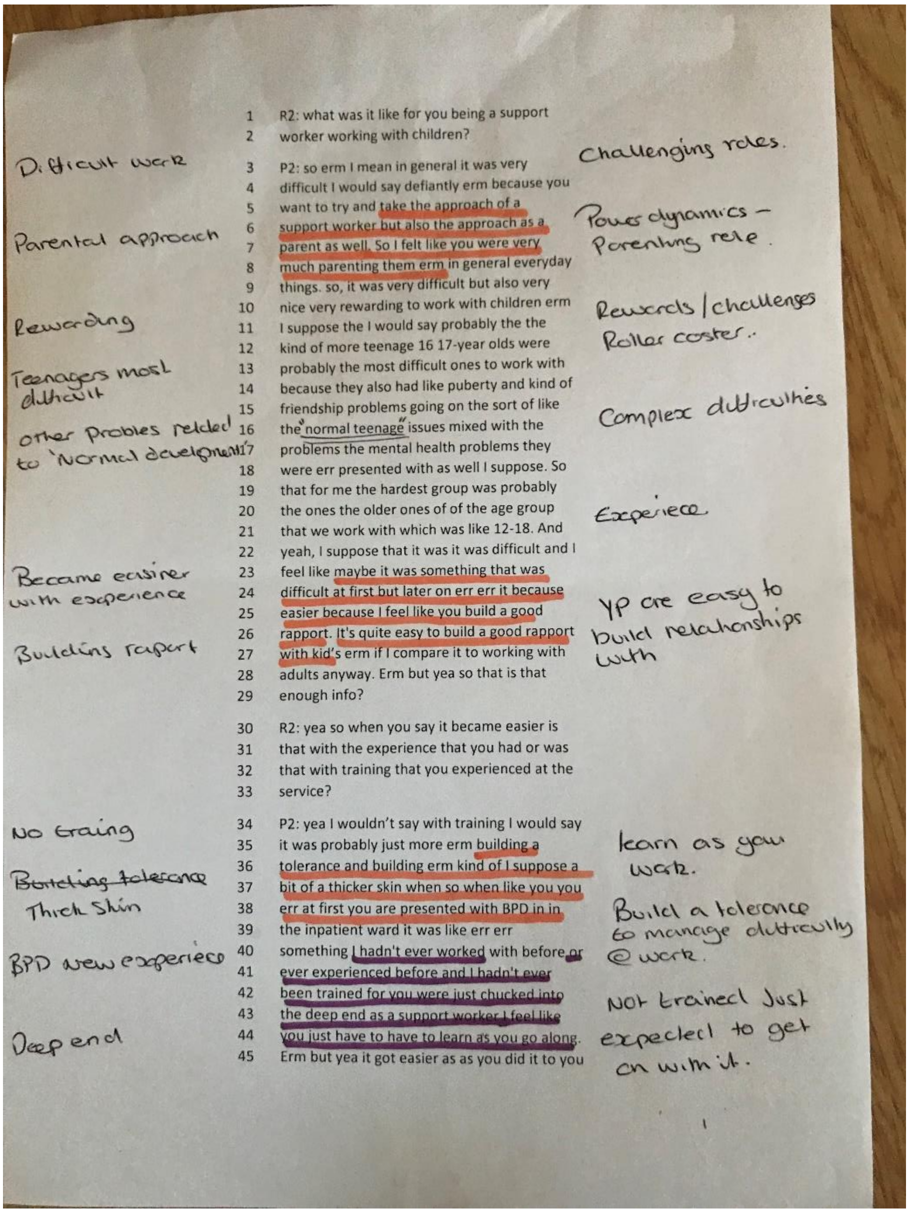
   Prompts:

   - What do you feel this effect was?
   - How does it affect treatment?

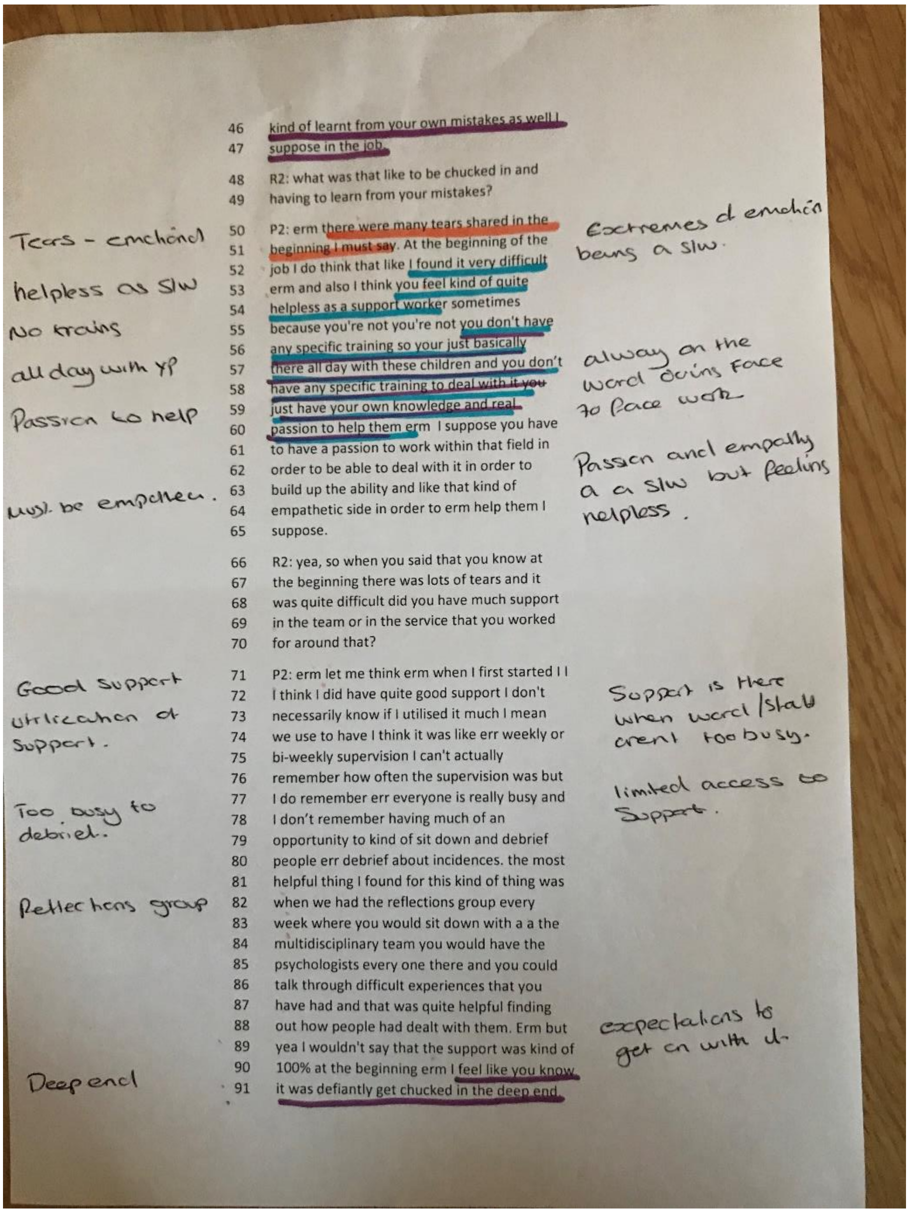
Further prompts to use:

- Can you say a little bit more about…?
- What do you mean when you say that?
- How did you respond to that?
- Can I take you back to when you said…?

Appendix H: Interview Transcript with Initial Notations



	R2: what was it like for you being a support worker working with children?	
Difficult work Parental approach Rewarding Teenagers most difficult other Probles related to 'Normal development' Became easier with experience Building rapport	P2: so erm I mean in general it was very difficult I would say defiantly erm because you want to try and take the approach of a support worker but also the approach as a parent as well. So I felt like you were very much parenting them erm in general everyday things. so, it was very difficult but also very nice very rewarding to work with children erm I suppose the I would say probably the the kind of more teenage 16 17-year olds were probably the most difficult ones to work with because they also had like puberty and kind of friendship problems going on the sort of like the "normal teenage" issues mixed with the problems the mental health problems they were err presented with as well I suppose. So that for me the hardest group was probably the ones the older ones of of the age group that we work with which was like 12-18. And yeah, I suppose that it was it was difficult and I feel like maybe it was something that was difficult at first but later on err err it because easier because I feel like you build a good rapport. It's quite easy to build a good rapport with kid's erm if I compare it to working with adults anyway. Erm but yea so that is that enough info?	Challenging roles. Power dynamics – Parenting role. Rewards/challenges Roller coster.. Complex difficulties Experience YP are easy to build relationships with
	R2: yea so when you say it became easier is that with the experience that you had or was that with training that you experienced at the service?	
No training ~~Building tolerance~~ Thick Skin BPD new experience Deep end	P2: yea I wouldn't say with training I would say it was probably just more erm building a tolerance and building erm kind of I suppose a bit of a thicker skin when so when like you you err at first you are presented with BPD in in the inpatient ward it was like err err something I hadn't ever worked with before or ever experienced before and I hadn't ever been trained for you were just chucked into the deep end as a support worker I feel like you just have to have to learn as you go along. Erm but yea it got easier as as you did it to you	learn as you work. Build a tolerance to manage difficulty @ work. Not trained Just expected to get on with it.



kind of learnt from your own mistakes as well I suppose in the job.

R2: what was that like to be chucked in and having to learn from your mistakes?

P2: erm there were many tears shared in the beginning I must say. At the beginning of the job I do think that like I found it very difficult erm and also I think you feel kind of quite helpless as a support worker sometimes because you're not you're not you don't have any specific training so your just basically there all day with these children and you don't have any specific training to deal with it you just have your own knowledge and real passion to help them erm I suppose you have to have a passion to work within that field in order to be able to deal with it in order to build up the ability and like that kind of empathetic side in order to erm help them I suppose.

Tears - emotional

helpless as S/W

No training

all day with YP

Passion to help

must be empathetic.

Extremes of emotion being a S/W.

always on the ward doing face to face work

Passion and empathy a a S/W but feeling helpless.

R2: yea, so when you said that you know at the beginning there was lots of tears and it was quite difficult did you have much support in the team or in the service that you worked for around that?

P2: erm let me think erm when I first started I I I think I did have quite good support I don't necessarily know if I utilised it much I mean we use to have I think it was like err weekly or bi-weekly supervision I can't actually remember how often the supervision was but I do remember err everyone is really busy and I don't remember having much of an opportunity to kind of sit down and debrief people err debrief about incidences. the most helpful thing I found for this kind of thing was when we had the reflections group every week where you would sit down with a a the multidisciplinary team you would have the psychologists every one there and you could talk through difficult experiences that you have had and that was quite helpful finding out how people had dealt with them. Erm but yea I wouldn't say that the support was kind of 100% at the beginning erm I feel like you know it was defiantly get chucked in the deep end.

Good support

utilisation of support.

Too busy to debrief.

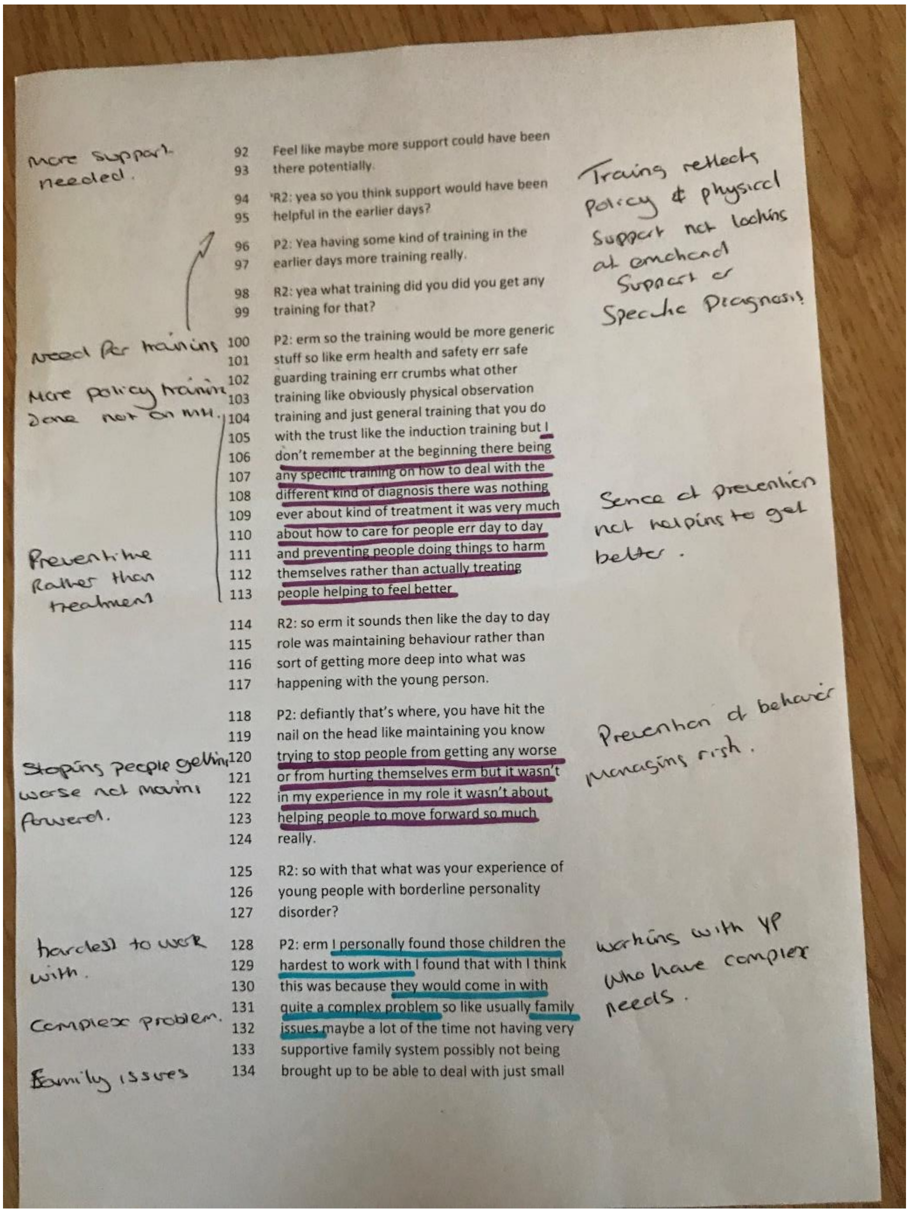
Reflections group

Deep end

Support is there when ward/staff arent too busy.

limited access to support.

expectations to get on with it.



More support needed.

Feel like maybe more support could have been there potentially.

R2: yea so you think support would have been helpful in the earlier days?

P2: Yea having some kind of training in the earlier days more training really.

R2: yea what training did you did you get any training for that?

Training reflects policy & physical support not looking at emotional support or specific diagnosis

Need for training

More policy training done not on MH.

P2: erm so the training would be more generic stuff so like erm health and safety err safe guarding training err crumbs what other training like obviously physical observation training and just general training that you do with the trust like the induction training but I don't remember at the beginning there being any specific training on how to deal with the different kind of diagnosis there was nothing ever about kind of treatment it was very much about how to care for people err day to day and preventing people doing things to harm themselves rather than actually treating people helping to feel better

Preventitive Rather than treatment

Sence of prevention not helping to get better.

R2: so erm it sounds then like the day to day role was maintaining behaviour rather than sort of getting more deep into what was happening with the young person.

P2: defiantly that's where, you have hit the nail on the head like maintaining you know trying to stop people from getting any worse or from hurting themselves erm but it wasn't in my experience in my role it wasn't about helping people to move forward so much really.

Stoping people getting worse not moving forward.

Prevention of behavior managing risk.

R2: so with that what was your experience of young people with borderline personality disorder?

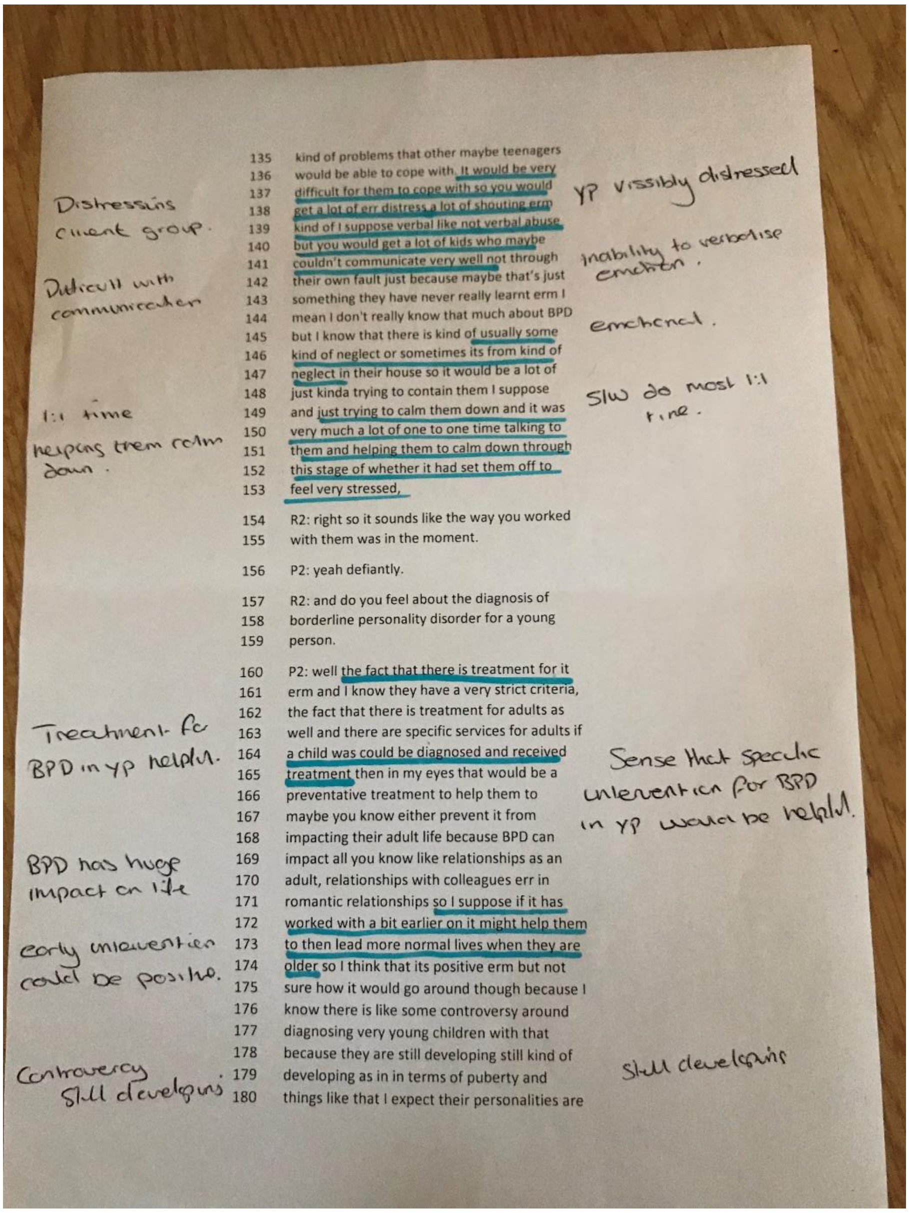
P2: erm I personally found those children the hardest to work with I found that with I think this was because they would come in with quite a complex problem so like usually family issues maybe a lot of the time not having very supportive family system possibly not being brought up to be able to deal with just small

hardest to work with.

Complex problem.

Family issues

working with YP who have complex needs.



Distressing client group.

Difficult with communication

1:1 time helping them calm down.

kind of problems that other maybe teenagers would be able to cope with. It would be very difficult for them to cope with so you would get a lot of err distress a lot of shouting erm kind of I suppose verbal like not verbal abuse but you would get a lot of kids who maybe couldn't communicate very well not through their own fault just because maybe that's just something they have never really learnt erm I mean I don't really know that much about BPD but I know that there is kind of usually some kind of neglect or sometimes its from kind of neglect in their house so it would be a lot of just kinda trying to contain them I suppose and just trying to calm them down and it was very much a lot of one to one time talking to them and helping them to calm down through this stage of whether it had set them off to feel very stressed,

YP vissibly distressed

inability to verbalise emotion.

emotional.

S/W do most 1:1 time.

R2: right so it sounds like the way you worked with them was in the moment.

P2: yeah defiantly.

R2: and do you feel about the diagnosis of borderline personality disorder for a young person.

Treatment for BPD in YP helpful.

BPD has huge impact on life

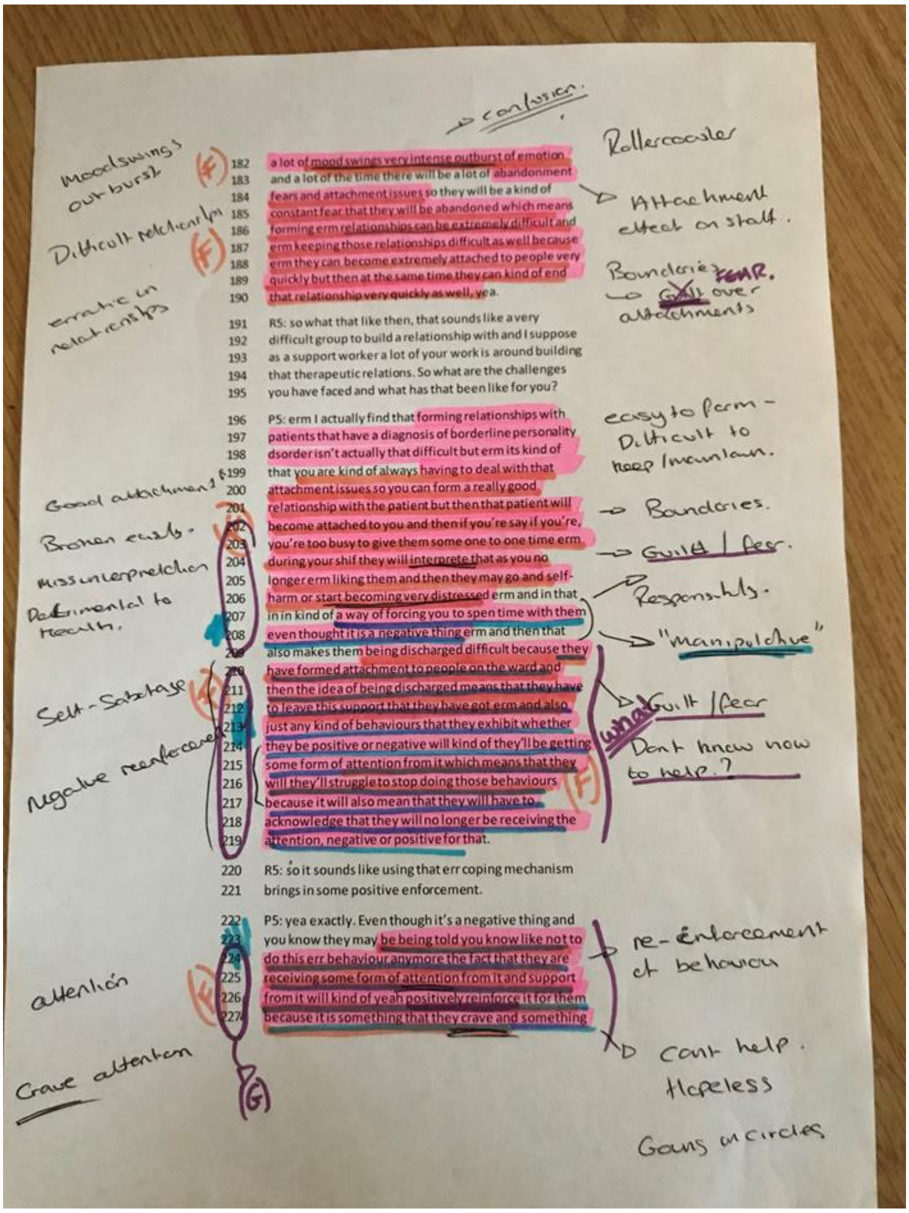
early intervention could be positive.

Controversy
Still developing

P2: well the fact that there is treatment for it erm and I know they have a very strict criteria, the fact that there is treatment for adults as well and there are specific services for adults if a child was could be diagnosed and received treatment then in my eyes that would be a preventative treatment to help them to maybe you know either prevent it from impacting their adult life because BPD can impact all you know like relationships as an adult, relationships with colleagues err in romantic relationships so I suppose if it has worked with a bit earlier on it might help them to then lead more normal lives when they are older so I think that its positive erm but not sure how it would go around though because I know there is like some controversy around diagnosing very young children with that because they are still developing still kind of developing as in in terms of puberty and things like that I expect their personalities are

Sense that specific intervention for BPD in YP would be helpful.

Still developing



→ confusion.

a lot of mood swings very intense outburst of emotion and a lot of the time there will be a lot of abandonment fears and attachment issues so they will be a kind of constant fear that they will be abandoned which means forming erm relationships can be extremely difficult and erm keeping those relationships difficult as well because erm they can become extremely attached to people very quickly but then at the same time they can kind of end that relationship very quickly as well, yea.

R5: so what that like then, that sounds like a very difficult group to build a relationship with and I suppose as a support worker a lot of your work is around building that therapeutic relations. So what are the challenges you have faced and what has that been like for you?

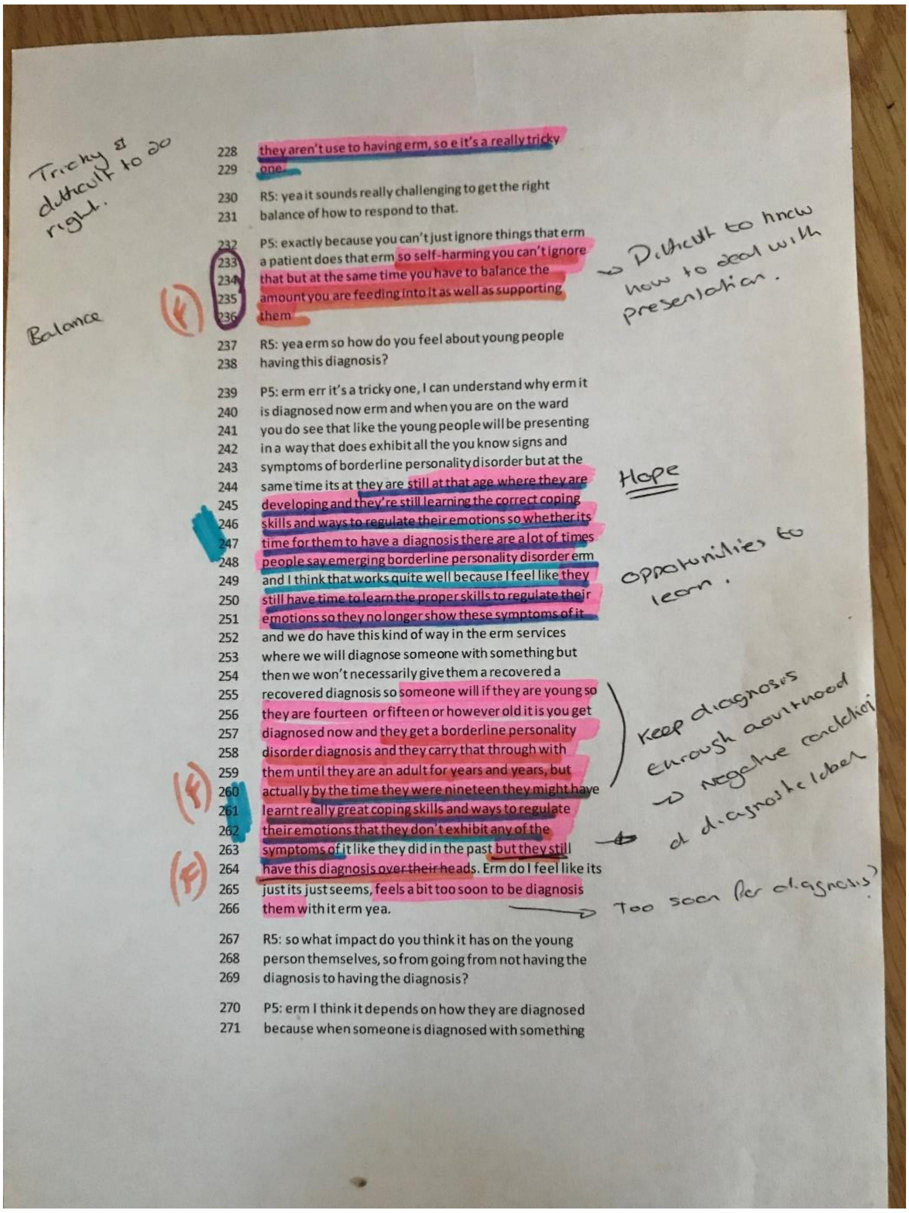
P5: erm I actually find that forming relationships with patients that have a diagnosis of borderline personality dsorder isn't actually that difficult but erm its kind of that you are kind of always having to deal with that attachment issues so you can form a really good relationship with the patient but then that patient will become attached to you and then if you're say if you're, you're too busy to give them some one to one time erm during your shif they will interprete that as you no longer erm liking them and then they may go and self-harm or start becoming very distressed erm and in that in in kind of a way of forcing you to spen time with them even thought it is a negative thing erm and then that also makes them being discharged difficult because they have formed attachment to people on the ward and then the idea of being discharged means that they have to leave this support that they have got erm and also just any kind of behaviours that they exhibit whether they be positive or negative will kind of they'll be getting some form of attention from it which means that they will they'll struggle to stop doing those behaviours because it will also mean that they will have to acknowledge that they will no longer be receiving the attention, negative or positive for that.

R5: so it sounds like using that err coping mechanism brings in some positive enforcement.

P5: yea exactly. Even though it's a negative thing and you know they may be being told you know like not to do this err behaviour anymore the fact that they are receiving some form of attention from it and support from it will kind of yeah positively reinforce it for them because it is something that they crave and something

Moodswings
outburst
(F)
Difficult relationships
(F)
erratic in
relationships
Good attachment
Broken easily.
Missinterpretation
Detrimental to
health.
Self-Sabotage
(F)
Negative reenforcement
(F)
attention
Crave attention
(G)

Rollercoaster
→ Attachment
effect on staff.
Boundaries FEAR.
→ ~~Guilt~~ over
attachments
easy to form -
Difficult to
keep/maintain.
→ Boundaries.
→ Guilt / fear.
→ Responsibility.
→ "manipulative"
→ what Guilt / fear
Dont know how
to help.?
(F)
→ re-enforcement
of behaviour
→ Cant help.
Hopeless
Going in circles



Tricky & difficult to do right.

they aren't use to having erm, so e it's a really tricky one.

R5: yea it sounds really challenging to get the right balance of how to respond to that.

P5: exactly because you can't just ignore things that erm a patient does that erm so self-harming you can't ignore that but at the same time you have to balance the amount you are feeding into it as well as supporting them

Balance

(K)

→ Difficult to know how to deal with presentation.

R5: yea erm so how do you feel about young people having this diagnosis?

P5: erm err it's a tricky one, I can understand why erm it is diagnosed now erm and when you are on the ward you do see that like the young people will be presenting in a way that does exhibit all the you know signs and symptoms of borderline personality disorder but at the same time its at they are still at that age where they are developing and they're still learning the correct coping skills and ways to regulate their emotions so whether its time for them to have a diagnosis there are a lot of times people say emerging borderline personality disorder erm and I think that works quite well because I feel like they still have time to learn the proper skills to regulate their emotions so they no longer show these symptoms of it and we do have this kind of way in the erm services where we will diagnose someone with something but then we won't necessarily give them a recovered a recovered diagnosis so someone will if they are young so they are fourteen or fifteen or however old it is you get diagnosed now and they get a borderline personality disorder diagnosis and they carry that through with them until they are an adult for years and years, but actually by the time they were nineteen they might have learnt really great coping skills and ways to regulate their emotions that they don't exhibit any of the symptoms of it like they did in the past but they still have this diagnosis over their heads. Erm do I feel like its just its just seems, feels a bit too soon to be diagnosis them with it erm yea.

Hope

Opportunities to learn.

Keep diagnosis through adulthood → negative connotation of diagnostic label

(F)

(F)

→ Too soon for diagnosis?

R5: so what impact do you think it has on the young person themselves, so from going from not having the diagnosis to having the diagnosis?

P5: erm I think it depends on how they are diagnosed because when someone is diagnosed with something

Appendix I: List of initial themes for Participant 5 (Anna)

Responsibility for safeguarding

Anxiety about DSH

Feelings of doing it wrong

Shame/guilt

Upsetting patients

Attachment challenges

Boundaries setting

Self-sabotage

Revolving door

Disheartened

Frustration

Can’t help these patients

Can’t do right, always get stuff wrong

Stuck , unable to help

Overwhelmed

Disappointment

Shame

Given up

Helpless

Circles

Patients as nasty

Manipulative

Attention seeking

Bad personally

Negative attitudes

Untrustworthy

Life-Long condition

Challenging

Enduring

Negative impact

Individual difference

Not one fit all

Lack of education

Feel good when able to help

Reassurance

Talented individuals/ potential

Opportunity for young people

Learning

Psychoeducation

Lack of understanding

Don’t know what I am doing

Support worker not priority

Deep end, no training

Learn by making mistakes

Inconsistent

learn on job

lack of training

figure out as you go

supported by team

teacher/parent role

give guidance

face to face

engagement issues

Awarding achievements

Positive feeling

Satisfaction building relationships

Acceptance

Get used to it

Detached

Switched off

Off load

Become numb

Grow thick skin

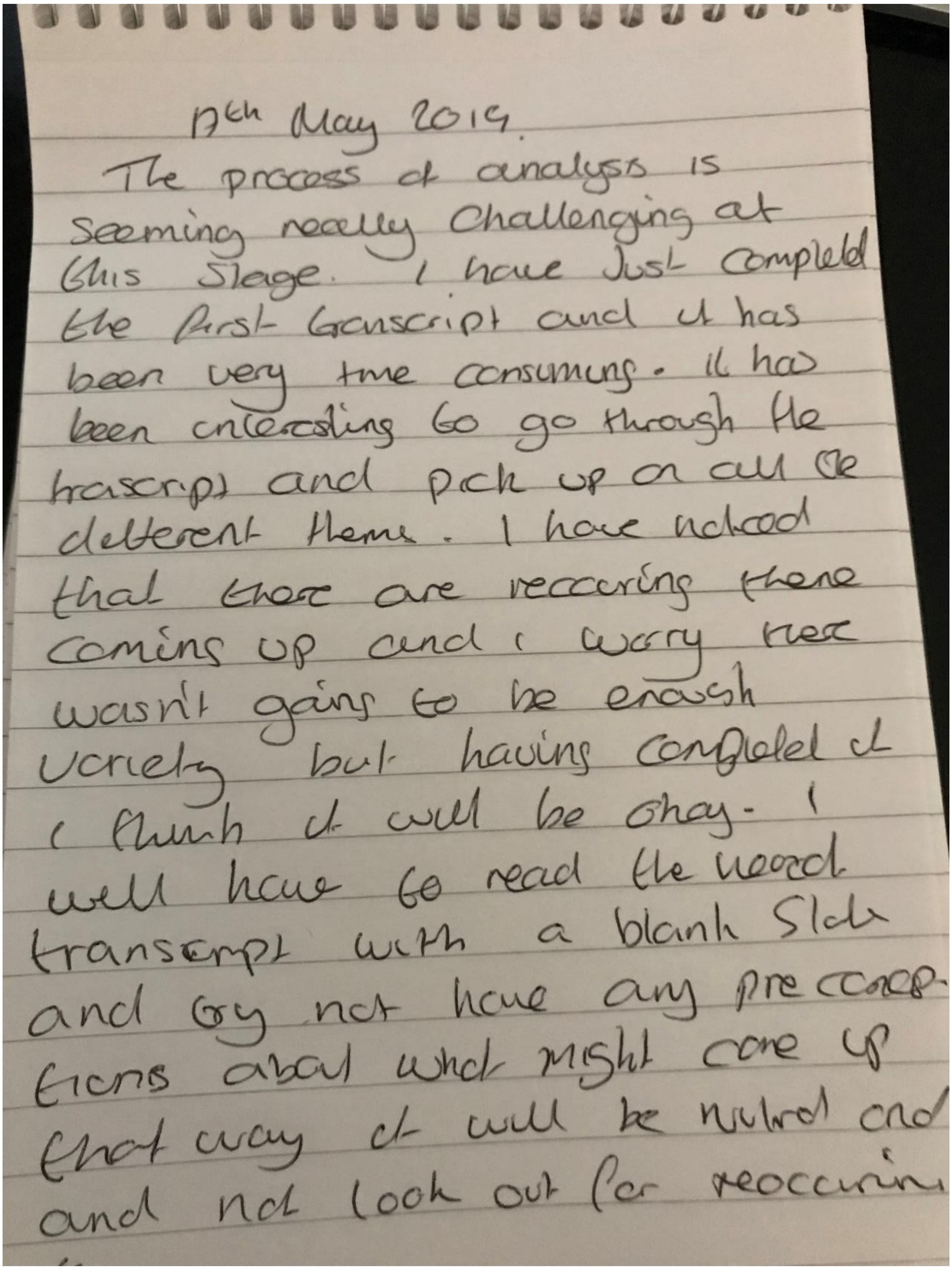
Tolerance

Toughen up

Keep going

Reflective practice

Appendix L: Extracts from my Reflective Diary



17th May 2019.

The process of analysis is seeming really challenging at this stage. I have just completed the first transcript and it has been very time consuming. It has been interesting to go through the transcript and pick up on all the different themes. I have noticed that there are reoccuring theme coming up and I worry there wasn't going to be enough variety but having completed it I think it will be okay. I will have to read the next transcript with a blank slate and try not have any preconceptions about what might come up that way it will be neutral and and not look out for reoccurin