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**Stress, burnout and the attitudes and experiences
of mental health professionals working with
clients who meet the criteria for a diagnosis of
personality disorder**

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A thesis submitted in partial fulfilment of the requirements for the
degree of Doctor of Clinical Psychology

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Declaration

This thesis was carried out under the supervision of Dr Delia Cushway, Dr Amanda Gatherer and Dr Kay Garvey who helped me to design the study and facilitated access to the participants. I carried out and transcribed all the interviews. Apart from these collaborations the thesis is my own work. Authorship of any papers arising from this work will be shared with the above. The thesis has not been submitted for a degree to any other university.

The literature review (Chapter 1) is being prepared for submission to Clinical Psychology Review. The first empirical paper (Chapter 2) is being prepared for submission to the Journal of Mental Health and the second empirical paper (Chapter 3) is being prepared for submission to the British Journal of Clinical Psychology.

Summary

The validity and use of the term personality disorder (PD), its sub-categories, and the treatment of those who may attract this type of diagnosis are controversial issues which have long been the subject of debate. In recent years, the development of a number of new treatment approaches, such as dialectical behaviour therapy for borderline personality disorder (BPD) have increased optimism and interest in this group of clients amongst the mental health community. However, despite this increased optimism, much of the research shows that the PD client group is perceived as difficult and stressful to work with. This thesis begins by reviewing the efficacy of psychological approaches to treatment for BPD (Chapter 1). Chapter 2 then explores the relationships between levels of stress, burnout and attitudes towards the PD client group amongst a group of forty mental health professionals working with this group. This study identified that lower levels of personal accomplishment and higher levels of stress at work were associated with a more negative attitude towards the PD client group. The provision of specialist training for work with this group is hypothesised as an important mediator of attitudes. The second empirical paper (Chapter 3) used Interpretative Phenomenological Analysis (IPA) to conduct a qualitative analysis of the experiences of four mental health professionals working with clients with BPD. Work with this client group was experienced as complex, demanding and emotionally and physically draining at times. The negative effects of this work appeared to be buffered by gaining formal and informal support from others, development of realistic expectations of the likely progress of client work and strong personal motivations for work with this group. Methodological issues arising from the research and the clinical implications of the findings are discussed. A reflective review of the research process is also provided (Chapter 4).

Chapter 1: Literature Review

The efficacy of psychological treatments for borderline personality disorder

**This paper has been prepared for submission to Clinical
Psychology Review
(See Appendix 17 for Instructions to Authors)**

The efficacy of psychological treatments for borderline personality disorder

Abstract

In recent years, there has been a great deal of research interest in the development and evaluation of psychological treatment approaches for clients with borderline personality disorder (BPD). This paper aims to provide a critical overview of this research. Within this literature, dialectical behaviour therapy (DBT) and psychodynamic approaches to treatment have received the most attention, but other approaches such as cognitive analytic therapy have also been discussed. The research evidence for these treatment approaches is summarised and evaluated, with the findings being discussed within the wider context of the difficulties associated with conducting research in this area. These include issues such as comorbidity and validity of the BPD diagnosis and the process of natural remission of symptomatology over time. The common elements associated with promising approaches are discussed and possible areas for further research suggested.

1.1 Introduction

The term "personality disorder" is a contentious one and there is a considerable amount of debate as to the validity of the personality disorder diagnosis, its sub-categories (e.g. Blackburn, 1998; Lewis & Appleby, 1988) and its definition. Blackburn (1993, p. 76) defines personality disorders (PD's) as psychological problems arising from personal dispositions rather than a breakdown or discontinuity in psychological functioning. The concept has more recently been defined as "an enduring pattern of personality organisation which significantly deviates from the norms of a culture, which leads to dysfunction in behaviour, emotional self regulation and relationships with others, and is a stable pattern, resistant to change" (British Psychological Society Professional Affairs Board – Forensic Section DCP, 1999, p. 2, para 1).

Probably the most common way of classifying and diagnosing personality disorders is a categorical approach, such as the classification systems contained within the Diagnostic and Statistical Manual (4th Edition) (DSM-IV, American Psychiatric Association, 1994) and the International Classification of Diseases (10th revision) (ICD-10, World Health Organisation, 1992). The range of PD's described by these classification systems is similar, with DSM-IV (Axis II) defining three clusters – Cluster A (paranoid, schizoid and schizotypal), Cluster B (borderline, antisocial, histrionic and narcissistic) and Cluster C (anxious/avoidant, dependent and anankastic). Estimates of prevalence vary but it is estimated that around 10% of the population have a diagnosable PD (Zimmerman & Coryell, 1990) and in 40% of these cases, this is severe (Norton, 1996; Tyrer & Alexander, 1988).

The purpose of this paper is to review the empirical literature in relation to one of these Personality Disorder categories – Borderline Personality Disorder (BPD). BPD is probably the most common type of PD presenting in mental health services because of its strong affective components (Coid, 1993) and the tendency towards help seeking which this client group typically demonstrates.

There has been a great deal of research interest in treatment for BPD in recent years and this paper aims to provide an overview of this. It will look at each of the major approaches to psychological treatment for BPD in turn, critically reviewing the evidence for each approach. Due to limitations in length, this paper will not discuss the theoretical underpinnings of the treatment approaches described. Furthermore, it is not designed to be an exhaustive account of every published study within the area, but will attempt to provide an overview of the research, discussing the most important and influential research findings and issues.

According to DSM-IV (APA, 1994, p. 654), in order to obtain a diagnosis of BPD a client needs to exhibit at least five of the following criteria: a pervasive pattern of mood instability, unstable and intense interpersonal relationships, impulsivity, inappropriate intense and uncontrollable anger, recurrent suicidal or parasuicidal behaviour, identity disturbance, dissociative symptoms, chronic feelings of emptiness and frantic attempts to avoid real or imagined abandonment. BPD has an estimated prevalence of up to 2% in the community, 8-11% in mental health outpatients and between 14-20% amongst inpatients (Modestin, Abrecht, Tschaggelar & Hoffman, 1997; Widiger & Frances, 1989; Widiger & Weissman, 1991). Individuals with BPD frequently have substantial psychiatric comorbidity (Fyer, Frances, Sullivan, Hurt & Clarkin, 1988; Zanarini et al, 1998), with Fyer

et al (1988) reporting that 91% of the sample had one additional diagnosis and 42% had two or more additional diagnoses with mood, anxiety and substance use disorders being the most frequent axis I disorders. Co-occurring axis II disorders have also been commonly reported, with one study identifying that only 23% of a community BPD sample did not meet the criteria for another personality disorder (Zimmerman & Coryell, 1990). Suicide attempts amongst clients with BPD have been reported in up to 73% of clients with a mean of 3.4 lifetime attempts (Soloff, Lynch & Kelly, 2000).

1.2 Dialectical Behaviour Therapy (DBT)

Developed by Marsha Linehan (1993a, 1993b), Dialectical Behaviour Therapy (DBT) is a structured, time-limited, cognitive behaviourally based therapy originally developed for outpatient treatment of chronically suicidal clients with BPD. DBT differs from other cognitive or behavioural therapies in that it focuses on acceptance and validation of behaviour as it is in the moment, pays particular attention to the therapeutic relationship and therapy interfering behaviours and has a strong focus on the importance of balancing change with acceptance (Linehan, 1993a).

The first major study which investigated the efficacy of DBT was conducted by its originator Marsha Linehan and her colleagues and reported the results of a one year trial of DBT (Linehan, Armstrong, Suarez, Allmon & Heard, 1991). Forty four female outpatients aged between 18 and 45 years who met the diagnostic criteria for BPD were assigned either to the DBT condition or to a "treatment as usual" (TAU) control condition. Results indicated that the DBT subjects were significantly more likely to begin and stay in therapy with the same therapist for the year compared with the TAU group. The DBT

subjects also had significantly fewer psychiatric inpatient days than the TAU subjects and engaged in significantly fewer parasuicidal acts. However, there were no significant differences between the groups in the number of suicide attempts, suicidal ideation, depression, hopelessness or reasons for living.

A major criticism of this study was that the favourable outcomes associated with the DBT group might have been explained by the increased amount of therapeutic contact experienced rather than the intervention itself (Hoffman, 1993). Subsequently, Linehan & Heard (1993) conducted an analysis of the possible impact of disparity in treatment hours between the two groups and concluded that the DBT group showed significantly fewer parasuicidal episodes even when individual therapy hours and telephone contacts were controlled. Disappointingly, this analysis did not take into account the hours of group treatment received by the DBT group and so it is difficult to draw a firm conclusion about the possible influence of treatment hours on outcome.

A follow-up study re-assessed the subjects at 6 and 12 months post-treatment (Linehan, Heard & Armstrong, 1993). Overall findings indicated that the DBT group were rated as being significantly improved in respect of interviewer rated global functioning and social adjustment 12 months post-treatment compared to the TAU group. However, there were no significant differences between the groups in relation to frequency, severity or the number of medically treated parasuicide episodes at 12-month follow-up. Although the findings of this follow-up study suggested some positive change associated with DBT, it is important to note that this was a naturalistic follow-up which did not control for additional treatment undertaken by subjects during the follow-up period and this may have had an influence on outcomes. An unpublished study cited in Linehan (1993a), assessed the

effects of adding DBT group skills training to non-DBT individual therapy, but there was no evidence of a beneficial effect on outcomes. This leads to the conclusion that the use of the group skills training without individual DBT therapy is probably contraindicated.

Koerner & Dimeff (2000) summarised the results of research on the efficacy of DBT, concluding that the more severely impaired DBT groups showed reductions in parasuicidal behaviour and substance misuse, and demonstrated increased treatment retention and improved global functioning at follow-up compared with TAU groups. They also concluded that less severely impaired groups may show improvements in suicidal ideation, depression and hopelessness when compared to a TAU condition which was also successful in reducing depression (Koons et al, 1998).

A more recent study reported the findings of a 12 month randomised controlled trial (RCT) of DBT which included 58 women diagnosed with BPD in the Netherlands (Verheul et al, 2003). This study compared DBT with TAU and explored whether the efficacy of DBT was modified by the baseline severity of parasuicidal behaviour. Overall findings indicated that the DBT group were significantly more likely to remain in treatment over the 12-month period and showed a greater reduction in self-mutilating behaviours and self-damaging impulsive acts than the control group. An additional finding was that the beneficial impact on the frequency of self-mutilating behaviours was stronger in participants who reported higher baseline frequencies compared with those reporting lower frequencies. This suggests that DBT may be more useful for those groups of individuals who exhibit signs of severe BPD.

This study is important for a number of reasons. Verheul et al (2003) published the first major DBT trial which did not involve Linehan and was conducted outside the USA. This supports the idea that DBT can be learned and applied outside the USA and used by clinicians who were not part of one of Linehan's research teams. Secondly, the sample size was larger than much of the previous research and included participants with substance use disorders who had commonly been excluded from past research. This inclusion of a more heterogeneous group is crucial in increasing the external validity of this study's sample and is a step forward in assessing how well DBT can be usefully applied to the wider range of complex borderline individuals who commonly exist in everyday clinical settings. Thirdly, the findings indicated that the control group actually deteriorated over the 12-month period, raising the idea that non-specialist treatments for BPD may actually be harmful for individuals rather than helpful.

Since their original studies, Linehan and her colleagues have addressed the criticism that clients with BPD and comorbid disorders such as substance use disorders were excluded from research. Linehan et al (2002) conducted a 12-month trial which compared the use of DBT for women with BPD and heroin dependency with Comprehensive Validation Therapy (derived from DBT) and a 12-step programme. The results were promising with few differences between the two groups, but DBT participants maintained their reductions in heroin use over the 4-month follow-up period, whereas the CVT group increased theirs during this period. Together with the findings of Verheul et al (2003), this study provides some initial evidence that DBT may also be useful for clients with BPD and comorbid substance use disorders.

Although initially developed as an outpatient treatment, a few studies have attempted to adapt DBT for use in inpatient settings with some evidence for success. Barley et al (1993) adapted DBT for use on an inpatient unit and reported that the parasuicide rate was significantly lower during the DBT programme than during prior periods. Although the study was uncontrolled, the parasuicide rate on another general psychiatric unit was noted to have remained constant during this time and DBT was reported to be easily accepted by both staff and patients. Bohus et al (2000) reported pre-post data for a three month inpatient DBT programme piloted on a group of 24 females with BPD. The group was followed up one month post-discharge (four months after the start of the DBT programme) and showed significant improvements in ratings of depression, dissociation, anxiety and global stress, and a highly significant decrease in the number of parasuicidal acts in comparison to the month prior to the commencement of treatment. However, although the findings of these two studies may appear promising it is important to note that neither included a control group for comparison and so it is not possible to reliably conclude that the improvements reported were attributable to the specifics of the DBT approach.

Less encouraging were the findings of Springer, Lohr, Buchtel & Silk (1996) who evaluated the effectiveness of DBT group skills training for short-term hospitalised clients with BPD. Although participants rated the experimental treatment as being more helpful than a discussion based control group, there was some evidence that parasuicidal acts may have become "contagious" with 13% of the experimental group who did not have a history of self-harm engaging in this type of behaviour whilst none of these events were recorded in the control group. The study concluded that DBT may be contraindicated in a short-term setting. However, there has been some discussion over whether the

intervention in this study actually constituted DBT due to the heterogeneous nature of the sample and short length of the intervention (Linehan, 2000).

Scheel (2000) provided a detailed critique of the empirical research on DBT, much of which has been echoed elsewhere in the research literature. One of the main criticisms of the research evidence has been that DBT groups have often been compared with unstructured "treatment as usual" and therefore its effectiveness cannot yet be compared meaningfully with other treatments (Verheul et al, 2003). As such, it is difficult to conclude whether outcome differences are due to the specific content of the DBT intervention or whether they result from the fact that DBT is a well organised psychotherapy which pays attention to therapist factors and therapy interfering behaviours (Scheel, 2000). The possible influence of a wide and complex range of other possible confounding variables has also been discussed. These include the levels of expertise, training or experience of therapists involved in DBT trials, the level and amount of clinical supervision and the number of hours of contact with clients (Turner, 2000). It has also been hypothesised that higher levels of therapist motivation in DBT conditions may have influenced outcomes (Verheul et al, 2003). Scheel (2000) suggested that this increased motivation may stem from the fact that DBT therapists tend to be implementing a new approach to therapy in an area where therapeutic nihilism has previously existed. It has also been postulated that clients allocated to DBT conditions within studies may have felt special and privileged, whilst those allocated to the control groups may have felt disappointed and that this may have influenced outcomes (Scheel, 2000).

The results of an analysis which aimed to control for between groups discrepancies in hours of therapy have already been discussed. Koerner & Dimeff (2000) also described

the promising preliminary findings of Linehan, Dimeff, Comtois & Kanter's (1998) research which attempted to control the possible influence of therapist expertise, clinical supervision and institutional prestige. The study compared DBT with treatment by experts in the community and found the DBT group showed greater reductions in suicidal behaviours, increased treatment retention and reduction in use of inpatient care/emergency services. It is disappointing, however, that no further results of this research have been reported in the literature.

Research on the efficacy of DBT to date has shown broadly promising findings. Verheul et al (2003) suggested that DBT may be an efficacious treatment for high risk behaviours in individuals with BPD because it has an explicit focus on the modification of these behaviours at the first stage of treatment and incorporates routine monitoring of the risk of these behaviours throughout the treatment programme. The prevention of therapist burnout through the supervision and consultation processes included in DBT was also felt to be a crucial factor. Levendusky (2000) also attributed DBT's popularity to its promise of a positive therapeutic experience for both the client and therapist and the way it reframes problematic behaviour more positively into emotional regulation and skill deficit issues. The emphasis on therapist support and training has also been identified as adding to DBT's appeal (Levendusky, 2000; Swenson, 2000).

However, the lack of follow-up data beyond 1 year post treatment is a concern particularly given the enduring nature of BPD (Westen, 2000). A number of areas can be highlighted for future research into DBT. The obvious area is more carefully controlled research which includes randomised groups and compares DBT to other treatment groups rather than just TAU. There is also a need for more research to include participants with

comorbid disorders in order for samples to more accurately reflect real life client groups and increase external validity (Westen, 2000). Widiger (2000) has also called for continued efforts to dismantle DBT as a treatment to attempt to identify its most effective features.

1.3 Psychodynamic approaches

Research in relation to BPD has focused on a variety of psychodynamic approaches to treatment, with both inpatient and outpatient studies being reported. This paper will discuss each of these two types of treatment in turn.

Probably one of the most publicised and quoted research programmes within this area is that of Bateman & Fonagy (1999, 2001). Bateman & Fonagy (1999) investigated the effectiveness of a day hospital based psychoanalytically oriented partial hospitalisation programme for clients with BPD. This group was compared with a control group who received standard outpatient psychiatric care. The 19 participants in the experimental group stayed in the programme for an average of 1.45 years and received an intervention composed of a combination of individual psychoanalytic psychotherapy, group psychotherapy and psychodrama based expressive therapy. Outcomes for the experimental group were promising with episodes of self harm and suicidal acts decreasing over the course of treatment whilst remaining constant in the control group. The experimental group also showed a reduction in the frequency of hospital admissions and length of inpatient stays during the last six months of treatment, compared to an increase in the control group.

A follow-up study which monitored participants' progress at 3-month intervals over an 18-month period indicated that the experimental group's gains were maintained in all areas (Bateman & Fonagy, 2001). During this 18-month period, the experimental group was offered a follow-up programme consisting of 2 hours group therapy per week which had a high attendance rate of 75%. However, although the experimental group continued to report lower levels of psychiatric symptoms across most of the follow-up period, by the end of the period there were no differences between the scores of the two groups. The reasons for this were unclear, but this finding provides some evidence for a spontaneous improvement in symptoms amongst the control group in the absence of a consistent approach to treatment.

Although the outcomes of Bateman & Fonagy's studies appear promising, there are also some areas where they may be criticised. As with much of the DBT research, the participants were a highly selected group diagnosed with BPD, with clients with substance misuse and other comorbid mental health difficulties being excluded. Whilst this is a useful way of maximising the internal validity of the study, it compromises the external validity and generalisability of the findings of the research as real life clinical populations tend to present with a complex range of comorbid difficulties. In addition, the study did not make any consideration of clients' medications which may also have influenced outcomes (Stern, 2001). The inclusion of a follow-up intervention for the experimental group during the 18-month follow-up also inhibits meaningful comparison of the outcomes of the two groups.

Other outpatient studies include that of Meares, Stevenson & Comerford (1999), who reported the outcome of a one year trial of psychodynamic psychotherapy where a group

of 30 BPD clients receiving twice weekly therapy were compared with a waiting list control group. At the end of the year's trial, 30% of the experimental group no longer met the DSM III criteria for BPD, whilst no clients in the control group changed diagnosis. More recently, Clarkin & Levy (2003) evaluated the effectiveness of manualised transference focused psychotherapy in a group of 17 participants who received twice weekly therapy over a 12-month period. The findings of this study were promising with 52.9% of participants no longer meeting the criteria for BPD at the end of the intervention. The group also showed marked reductions in emergency room visits, hospitalisations, the number of days hospitalised and an increase in global functioning. Although the authors acknowledged that the homogeneous nature of the group may limit the generalisations that can be drawn from this study, these promising findings led to the suggestion that an RCT be planned to provide a more rigorous evaluation of the treatment package.

Residential treatment has traditionally been a popular approach to psychodynamic treatment of BPD and a series of published reports have described and evaluated the treatment approaches used at the Cassel Hospital. Chiesa & Fonagy (2000) reported the results of a comparative evaluation of two different models of treatment for personality disorder. The study split the 90 participants into two groups, a one-stage group who were given 11-16 months inpatient treatment with no aftercare and a two-stage group, who had a six month inpatient stay followed by 12-18 months of outreach treatment in the community. The findings indicated that participants in the two-stage treatment group improved significantly more in terms of global adjustment and social adjustment at 12-month assessment. Although some participants in this study had diagnoses other than BPD, statistical analysis revealed that the BPD clients showed greater improvement in the two-stage programme relative to those with non-BPD diagnoses. This report was later

followed by a further 36-month follow-up of the same sample (Chiesa & Fonagy, 2003).

This indicated that participants in the two-stage group showed significantly greater improvements in self-mutilation, attempted suicide and hospital admissions compared with the one stage group, who did not improve on these dimensions when compared with the year prior to their admission to the Cassel Hospital.

Chiesa, Fonagy & Holmes (2003) reported the further comparison of these two treatment groups with a third matched sample who received standard psychiatric care in North Devon. This third group remained largely unchanged by the 24 month follow-up which provided further support for the superiority of the two-stage approach to treatment.

Chiesa & Fonagy (2003) concluded that follow-up treatment following hospitalisation was an important part of stabilising personality disorder clients back into the community and that this appeared to reduce distress and breakdowns which may lead to acute psychiatric admissions. The major weakness associated with the Cassel Hospital study was that participants were not randomly allocated to treatment conditions, with those living within Greater London being assigned to the two-stage condition and those from other areas being included in the one-stage condition. In addition to this, the third "treatment as usual" group described in Chiesa, Fonagy & Holmes' (2003) paper originated from Devon, a completely different area of the UK, which is geographically and demographically dissimilar to the London area where the Cassel Hospital is based.

Rutter & Tyrer's (2003) review of the Therapeutic Community (TC) approach to the treatment of personality disorder also provides some useful insights. Rutter & Tyrer (2003) described how the TC movement has tended to avoid formal evaluation methods, with evaluation commonly being conducted in terms of cost-effectiveness compared to

other forms of treatment utilised by individuals before and after TC treatment rather than efficacy. Rutter & Tyrer criticised Lees, Manning & Rawlings' (1999) systematic review of TCs, highlighting that this review had only identified 29 studies which had specified clear outcome measures, raw numbers before attrition and used a control of some sort.

Although this review described 8 of these 29 studies as meeting the criteria for an RCT, on closer examination, Rutter & Tyrer (2003) identified that none of the eight actually met the required criteria to fulfil this label. They concluded that there was a strong need for more rigorously controlled studies to be carried out before a reliable conclusion on the efficacy of TC treatment could be drawn.

Within the realm of psychodynamic treatments for BPD a diverse range of approaches have been implemented and evaluated. The scale of Bateman & Fonagy's (1999, 2001) studies are comparable to the initial studies which have evaluated DBT and the findings seem similarly promising, although like the DBT research the naturalistic style of follow-up and lack of ability to control for intercurrent treatment limits the power of the conclusions drawn. Again, as with the DBT literature, this treatment approach would really benefit from the inclusion of a longer-term follow-up. The conclusions of the outpatient study described by Meares et al (1999) would also be strengthened greatly by support from follow-up data extending beyond the length of the one-year intervention.

The series of studies conducted at the Cassel Hospital (Chiesa & Fonagy, 2000; Chiesa & Fonagy, 2003; Chiesa et al, 2003) identified superior outcomes for their two-stage model of treatment which consisted of an inpatient stay followed by treatment within the community. This finding provides support for the premise that in order to gain maximum benefit from treatment, this client group needs the opportunity to generalise their learned

skills and knowledge to everyday situations within real life whilst still engaged in therapy. This series of studies has made an important contribution towards research in this area, with one of the major strengths being a large sample size. These findings could be strengthened further if the issue of the lack of randomisation of participants to conditions could be addressed and as with much of the previous research a longer term follow-up programme maintained.

1.4 Other approaches to treatment

Although the majority of published empirical research studies on BPD have been within the two theoretical orientations described previously, there are also a number of other studies which merit discussion. Davidson & Tyrer (1996) reported a series of single case studies in which cognitive therapy was used to treat individuals with antisocial and borderline personality disorders. The sample included seven clients diagnosed with BPD and reported the results of three of these, who each attended ten or more individual sessions. Within this study, individuals negotiated their own treatment targets and monitored their subjective feelings towards these on a daily basis. Although there were no statistically significant changes in relation to any of the clients' treatment targets between the baseline and intervention phases, the study concluded that important clinical changes in dysfunctional behaviour and attitudes could be achieved by using short-term cognitive therapy with this client group. It is very difficult however, to compare the study outcomes to other research within this area because the outcome measures utilised were a heterogeneous set of individual targets which were rated solely by the clients themselves and were mainly measured in terms of behaviour.

More recently, Blum, Pfohl, St John, Monahan & Black (2002) described "STEPPS" – a 20 session cognitive behaviourally based group skills training programme which included a systems component and focused on the development of emotional and behavioural management skills. This intervention was designed as a brief treatment package which should necessitate little extra training for professionals and could be used to complement other treatments which individuals might be undertaking, such as individual therapy. The paper reported preliminary data gathered from 52 subjects which indicated that the group showed a significant post-treatment decrease in the symptoms associated with BPD, including a significant reduction in negative behaviours such as self-harm, suicide attempts and substance misuse. Although the data reported by this trial sounds promising, the outcome measures seem rather unclear compared with other studies such as those which have evaluated DBT and this limits any conclusions which could be drawn. A controlled trial would also be needed to increase the credibility of this approach.

One published research paper reported a naturalistic trial of time-limited Cognitive Analytic Therapy (CAT) for BPD (Ryle & Golykina, 2000). The 27 participants in this study each received 24 sessions of CAT and at post-therapy follow-up fourteen of these individuals (52%) no longer met the criteria for BPD and were judged to have improved. This group were also more likely to be in employment and in an ongoing relationship. Further analysis indicated that factors associated with poorer outcomes were greater severity of borderline psychopathology, history of self harm, history of alcohol abuse and being unemployed. The findings of this study indicate that time-limited CAT may be a promising approach to treatment for BPD. However, this was a naturalistic study which again did not include a control group and so it is difficult to draw any firm conclusions

about the effectiveness of this approach relative to other approaches or indeed no intervention at all.

1.5 Discussion

To date, there has been an absence of published meta-analytic or critical reviews of treatment approaches for BPD alone and the intention of this paper has been to begin to address this issue. The review literature which does exist has either focussed on reviewing treatment for a range of personality disorder categories or has evaluated defined approaches to treatment, such as DBT. So far, this paper has attempted to provide a critical overview of the empirical literature relating to a range of treatment approaches for BPD. The purpose of this last section is to draw together conclusions from the discussions so far and to highlight issues which will be important to future research conducted within this area.

It is clear from the literature outlined so far that there are some promising approaches to treatment of BPD clients, particularly the outpatient DBT studies, Bateman & Fonagy's (1999, 2001) partial hospitalisation studies and the research programme based at the Cassel Hospital. Scrutiny of these quite different approaches highlights a number of commonalities. Firstly, all three treatment programmes tend to be intensive. This fits with research which has shown that individuals who receive more psychotherapy, up to a point, benefit more than those who receive less (Orlinsky, Grawe & Parks, 1994).

Secondly, the DBT research and Bateman & Fonagy's research both consisted of a well organised and structured intervention. A third factor associated with the more successful approaches is the opportunity for generalisation of skills and knowledge in the

community. This was part of both the Cassel Hospital's two-stage treatment programme and is also encompassed within outpatient DBT through the use of skills training and telephone consultations between sessions as required. A final commonality between these promising treatment approaches is the prevention of therapist burnout through a strong focus on clinical supervision. The influence of this is supported by Kroll (1993), who observed that both DBT and successful psychodynamic treatments for BPD had close supervision as a common factor. Scheel (2000) suggested that the quality and quantity of supervision for DBT therapists may be an important factor in its success, and this along with the impact of the team supervision encompassed within the approach was highlighted as being important for further investigation (Turner, 2000).

Bateman & Fonagy (2000) reached a similar conclusion in their review of psychotherapeutic treatments for personality disorder. They suggested that those treatments which have been shown to be moderately effective have a range of common features, namely that they are well structured, devote effort to enhancing compliance, have a clear focus, are theoretically coherent to the client and therapist, are relatively long term, encourage a powerful attachment relationship between client and therapist and are well integrated with other services available to the client. This paper concluded that part of the benefit of successful treatment for PD clients may derive from the experience of being involved in a carefully considered, well structured and coherent interpersonal endeavour.

The review of articles for this paper also highlighted a wide range of difficulties for researchers working within this area. Again, many of these are common to researchers regardless of their theoretical orientation. One issue which needs to be considered when

planning or reviewing any empirical research within this area is that of allocation of individuals to groups based on their diagnoses. Bateman & Fonagy (2000) highlighted that reliable case identification is difficult to achieve in treatment evaluation studies which focus on PDs. This is because participants are commonly selected on the basis of diagnoses made using categorical methods such as presence of the requisite number of criteria contained in DSM-IV (APA, 1994) or ICD-10 (WHO, 1992) definitions. Bateman & Fonagy (2000) suggest that although these classification systems have face validity, there is little agreement on the traits encompassed within these categories or on whether these traits represent extremes of normal personality or are qualitatively different. Westen & Shedler (1999) also provided a detailed discussion of the weaknesses of such classification systems, describing them as lacking an empirical basis and artificially dichotomizing continuous variables. They also argued that high levels of comorbidity amongst Axis II personality disorders suggest a lack of discriminant validity. It is beyond the scope of the present paper to examine these issues in depth, but this is an important issue which consistently arises in research within this area and merits further detailed research in its own right. At the present time, these categorical approaches are probably the most commonly used means of making diagnoses and it is therefore sensible to bear these arguments in mind when assessing the validity of research findings. The issue of comorbidity of PD diagnoses and Axis I disorders amongst individuals included in these studies is also an important issue which needs to be considered when evaluating empirical data. Bateman & Fonagy (2000) concluded that this comorbidity may either exaggerate or obscure genuine treatment effects.

The outcome measures used in studies is also an issue of some debate. Leichsenring & Leibing (2003) highlighted that many studies used broad and non-specific measures of

symptom severity and functioning such as the Beck Depression Inventory, SCL-90-R and the Global Adjustment Scale. As such, the authors felt it was not possible to determine whether improvements resulted from changes to underlying personality or to improvements in Axis I psychopathology. Others have argued that studies which have attempted to measure changes in personality as outcome measures may simply be measuring changes in behaviour and symptoms rather than an underlying change in personality pathology. For example, a client with BPD may avoid intense relationships and so show fewer symptoms (Bateman & Fonagy, 2000). This again depends on how one views the PD categories – whether they are seen as an accurate measure of personality pathology which needs to be modified in order to produce a treatment effect or whether are they seen as descriptions of unhelpful styles of behaviour which can be addressed and modified using psychological therapies.

Studies which have focused on long term follow-up of BPD clients have highlighted the importance of accounting for natural remission of BPD symptoms. Paris (2002) reviewed 26 papers which assessed long term outcomes for clients with BPD. Summarising four fifteen year retrospective follow-up studies published during the 1980's, this paper highlighted that despite differences in the types of treatment, socio-demographic characteristics of clients and follow-up methodologies, all studies revealed remarkably similar results. At fifteen-year follow-up, virtually all clients' global functioning was within the range of normality, re-hospitalisation was uncommon and most clients were working and had a social network. The suicide rate in these four studies was fairly consistent at around 9% with most suicides occurring late on in the illness course, after age 30.

A 27-year follow-up of a cohort of BPD clients (Paris & Zweig-Frank, 2001; Zweig-Frank & Paris, 2002) revealed that only 8% of the sample still met the criteria for BPD, compared with 25% at 15-year follow-up. However, although there was a significant reduction in the number of participants meeting the criteria for a diagnosis of BPD, the symptoms of depression were still common, with 22% meeting the criteria for dysthymia. Although these findings need to be considered cautiously as this follow-up study had a high attrition rate over time, this is an interesting finding which points to the possibility of a strong trend towards remission of symptoms in BPD clients over time. Paris (2002) hypothesised that several mechanisms may underlie the remission process in BPD, including the tendency for impulsivity to decrease with age, increased ability to learn from experience over time and avoidance of intimacy.

Zanarini, Frankenburg, Hennen & Silk (2003) criticised treatment research within this area as neglecting the assessment of natural remission rates. Their prospective follow-up study of BPD clients also found that remission was common and increased over time, with approximately 75% of their sample experiencing a remission during the six year follow-up period and recurrences being rare. Consistent with Paris' (2002) conclusions, impulsive symptoms seemed to resolve most quickly whilst affective symptoms were the most chronic. These findings have important implications for research which incorporates long term follow-up, as if BPD is viewed as a chronic disorder which improves over time, then treatment response must be assessed within this context of natural remission.

These findings suggest that long term follow-up of this client group is crucial as the outcome of therapy may not be fully evident at discharge (Hogland, 1993), nor if follow-ups are discontinued after a few years. However, the need for long term follow-up does

create additional complications for research in an area in which follow-up is already associated with difficulties due to high rates of participant attrition and the inevitable presence of intercurrent treatment (Bateman & Fonagy, 2000).

The difficulties for research in this area outlined previously have illustrated a range of areas which may be important for those planning future research. What is really needed now is further research which directly compares the handful of promising approaches highlighted in this review. Whilst this might be challenging for the originators of these approaches, this might also go some way towards resolving some of the difficulties with identifying viable control groups which are ethically sound and acceptable to the clients involved. In addition to this, the inclusion of long-term prospective follow-ups is also important, as is the need for more research to be conducted by research groups which do not include the originators of each approach. Despite a growing number of empirical papers on treatment of BPD being published, there is still a strong predominance of only a few researchers within this area and replication of their studies by other research groups is crucial to establishing the external validity and robustness of these treatment approaches.

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Chapter 2: Empirical Paper 1

Stress, burnout and attitudes towards clients who meet the criteria for a diagnosis of personality disorder amongst mental health professionals

**This paper has been prepared for submission to the
Journal of Mental Health
(See Appendix 18 for Instructions to Authors)**

Stress, burnout and attitudes towards clients who meet the criteria for a diagnosis of personality disorder amongst mental health professionals

Abstract

Background: Much research has explored stress and burnout amongst mental health professionals and the research literature describes a consensus of opinion that clients with a personality disorder (PD) are difficult and stressful to treat. However, the relationships between these constructs have not yet been explored.

Aims: To investigate the relationships between stress, burnout, specialist training and attitudes towards PD clients amongst mental health professionals. Additionally, to explore the perceived difficulties which work with this client group raises and the coping strategies employed to cope with these.

Methods: Mental health professionals completed postal questionnaires which measured levels of stress, burnout and attitudes towards the PD client group. They also completed two short answer questions relating to the difficulties and coping strategies associated with their work.

Results: Personal accomplishment emerged as a significant predictor of attitude towards PD clients whilst overall stress levels correlated negatively with attitudes. Participants who had received specialist training for work with this client group expressed significantly more positive attitudes towards the group.

Conclusions: A tentative model of the relationships between stress, burnout, training and attitudes is outlined. Difficulties associated with this work were most commonly attributed to the characteristics and behaviour of PD clients. The implications for clinical practice are explored.

2.1 Introduction

There is now an evidence based assertion that people centred work is intrinsically stressful with a large body of research having been conducted in this area (Coffey & Coleman, 2001). Stress has been defined as "an excess of demands over the individual's ability to meet them" (Atkinson, 1988, as cited in Coffey & Coleman, 2001), suggesting that an individual's ability to cope with external pressures is dependent on both their cognitive appraisal of a situation and the coping strategies they have available to them. Therefore, stress is perceived in relation to the individual's previous experience, successes or failures in dealing with similar situations and their familiarity with the situation (Lazarus & Folkman, 1984). This transactional view helps provide some explanation for the individual differences which may occur both in the appraisal of stress and in individuals' reactions to it (Coffey & Coleman, 2001).

The term "burnout" is often used to describe the outcome of chronic stress (Cushway et al, 1996). Although there is no standard definition of this concept, much of the research literature focuses on the theoretical perspective of Maslach et al (1996), who published the most widely used measure of burnout, the Maslach Burnout Inventory (MBI). Maslach & Jackson (1986, p.1) describe burnout as "a syndrome of emotional exhaustion, depersonalisation and reduced personal accomplishment that occur among individuals who do 'people work' of some kind". Emotional exhaustion has been described as a feeling of being emotionally overextended and exhausted by one's work, whilst depersonalisation refers to the development of cold, negative attitudes towards service users. Reduced personal accomplishment meanwhile refers to a tendency to evaluate oneself negatively, particularly with regard to one's work with clients.

A good deal of research has focused on stress and burnout amongst groups of human service professionals such as mental health nurses (e.g. Carson et al, 1991; Fagin et al, 1995; Sullivan, 1993) and clinical psychologists (Cushway, 1992; Cushway et al, 1996), demonstrating that this type of work is stressful. The possible effects of burnout have also been widely discussed. Hannigan et al (2000) summarised literature on the effects of burnout, and suggested it was associated with reduced staff morale, increased absenteeism and as contributing to high rates of staff turnover. Edwards et al (2000) also suggested that the symptoms of burnout may be contagious amongst colleagues.

There is also some evidence that the presence of burnout amongst mental health workers may be associated with negative outcomes for the clients for whom they care. It has been suggested that mental health workers who are experiencing high levels of emotional exhaustion may experience difficulties in developing strong and trusting therapeutic relationships with clients and that this in turn may have a negative influence on client outcomes (Coffey, 1999). Some support for this hypothesis came from research conducted by Cronin-Stubbs & Brophy (1985) who concluded that nurses with higher levels of burnout spent less time with patients and tended to use prescribed medication to calm patients down. Coffey (1999) suggested that this may be because nurses experiencing high levels of stress were unable to emotionally support their patients and so used medication as a means of attaining control in situations where they were unable to secure this themselves. Overall, the findings of this literature indicate that the presence of high levels of stress and/or burnout do seem to have negative effects on mental health workers as individuals both inside and outside work. Whilst it is difficult to demonstrate a

causal relationship between levels of burnout and quality of client care, it seems likely that this too may suffer.

In addition to focusing on overall stress and burnout levels and the possible effects these may have, research has aimed to identify the sources of stress associated with mental health work. This work has revealed a wide variety of stressors, but amongst these client related difficulties emerge as an important factor, with clients who may display violent, aggressive or suicidal behaviour being perceived as particularly stressful to work with (Carson et al, 1991; Sullivan, 1993; Reid et al, 1999a).

One client group that seems to be widely perceived as difficult and stressful to work with is the group who meet the criteria for a diagnosis of a personality disorder (PD). The fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV, APA, 1994) describes ten personality disorder categories grouped into three clusters. It also offers a general definition of PD as "an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time and leads to distress or impairment" (APA, 1994, p.629).

Research has revealed that many professional groups such as psychiatrists (Lewis & Appleby, 1988) and nurses (Gallop et al, 1989) have negative attitudes towards working with the PD client group. Further support for this view was provided by Bowers et al's (2000) postal survey of all nurses in English high security psychiatric hospitals. Their findings revealed that most respondents felt that PD clients were a difficult group to care for with less than 10% of this sample considering the group posed 'mild' or 'no' difficulties

and less than 5% expressing any optimism about treatment. However, this study did identify that female nurses and those who worked in specialist PD units had more positive attitudes towards this client group.

It is likely that negative attitudes towards the PD client group have a negative effect on the treatment they receive. Bowers et al (2000) summarised literature which linked negative reactions by staff to suicidal behaviour in clients with borderline personality disorder (BPD) (e.g. Adler, 1973; Friedman, 1969; Gunderson, 1984). There is also some evidence from observational studies to show that nurses are likely to show reduced numbers and shorter duration of contacts with disliked patients (Hamera & O'Connell, 1981; Podrasky & Sexton, 1988). Linked to this, Morgan & Priest (1984, 1991) introduced the concept of "malignant alienation". Their analysis of unexpected deaths among psychiatric inpatients showed a significant number who committed suicide lost support from others in the last few weeks of their lives and that staff became critical of these individuals' behaviour, perceiving it as provocative, unreasonable and over-dependent.

2.2 Aims and hypotheses

1. To investigate the relationship between stress, burnout and attitudes towards PD clients amongst mental health workers who work with this group in both community and inpatient settings. Given that the existing research literature discussed has highlighted that PD clients are viewed as difficult and stressful to work with, it was hypothesised that higher levels of stress and burnout would be associated with more negative attitudes towards this client group.

2. To investigate the relationship between specialist training and attitudes towards the PD client group. It was hypothesised that mental health workers who had received specialist training for work with PD clients would have more positive attitudes towards this group than those who had not.
3. Despite the existence of a consensus of agreement that work with PD clients is difficult and stressful, little research has actually attempted to examine the reasons for these views. The study aimed to explore both the difficulties which work with this client group may raise for mental health workers and also any coping strategies employed by staff to cope with these difficulties. This part of the study was exploratory and utilised open-ended questions and as such no hypotheses were generated.

2.3 Methodology

2.3.1 Design

The study employed a one sample correlational design to investigate the relationships between stress, burnout and attitudes towards the PD client group. An independent samples, between-groups comparison was used to explore the relationship between specialist training and attitudes towards PD clients, with the presence or absence of specialist training for work with the PD client group being the between groups variable.

Data was collected from mental health professionals working within one National Health Service (NHS) Trust using a questionnaire survey distributed via the internal mail system. Each participant was asked to complete three psychometric questionnaires which were designed to measure levels of stress, levels of burnout and attitudes towards PD clients.

In addition, participants were asked to complete a questionnaire which collected a range of demographic data including details of their occupation and training. This also included two open-ended short answer questions which asked participants to identify what they found most difficult about working with PD clients and the coping strategies they used when their work was stressful.

The data collected from these two short answer questions was analysed using an adaptation of the thematic content analysis procedure described by Burnard et al (2000). Initially this process involved collating the responses to each of the questions and removing any repetition of responses to reduce the volume of the text. The responses were then clustered together under thematic headings and a discrete category heading generated for each group. The author then diverged from this method by identifying and naming a number of further sub-categories within each of the main thematic categories to allow a more detailed analysis to be undertaken. The number of items within each of the main and sub-categories were then counted and rank ordered by the frequency of occurrence and presented in a table. Although it is important to acknowledge that this method of analysis involves some degree of subjective judgement on the part of the researcher, the process does allow the researcher and reader to identify the frequency with which similar type of responses occurred along with the range of responses given.

2.3.2 Participants

The sample was recruited from staff working within the community mental health teams and mental health inpatient services of a National Health Service Trust. A total of 42 questionnaire packs were returned from the 160 distributed, a response rate of 26.3%. Of those responding to the survey, two participants were excluded from the analysis. One

participant was excluded because they did not work with PD clients and the other because only one of the four questionnaires had been completed. The final sample comprised 34 females (85%) and 6 males (15%). A breakdown of their ages is presented in Table 1:

Table 1: Ages of participants

Age range	Frequency	%
20-29 years	6	15.0
30-39 years	10	25.0
40-49 years	12	30.0
50-59 years	11	27.5
60-69 years	1	2.5

The 40 participants were drawn from a variety of occupational groups (illustrated in Table 2). Of the 40 individuals, 30 worked in a CMHT setting (75%), 4 were based in inpatient services (10%), 4 worked across both CMHT and inpatient settings (10%) and 2 worked in day hospital settings (2%). The sample was composed of 35 qualified staff (87.5%) and 5 unqualified staff (12.5%), with the mean length of time post qualification varying widely (Mean = 12.5 years, S.D. = 11.7 years, range = 0.5 – 39 years).

Table 2: Occupational background of participants

Occupational group	Frequency	%
Community Mental Health Nurse (CMHN)	11	27.5
Registered Mental Health Nurse (RMHN)	3	7.5
Forensic Community Mental Health Nurse (FCMHN)	1	2.5
Social Worker	6	15.0
Clinical Psychologist	13	32.5
Psychotherapist	1	2.5
Psychological Therapist	1	2.5
Support Worker	3	7.5
Technical Instructor	1	2.5

2.3.3 Measures

The Mental Health Professionals Stress Scale (MHPSS – Cushway et al, 1996).

The MHPSS was used as a measure of stress (see Appendix 1). This is a 42 item self-report measure composed of seven subscales which represent specific sources of stress - home-work conflict, client/patient related difficulties, organizational structure and processes, lack of resources, workload, professional self-doubt and relationships & conflicts with other professionals. All scales of the MHPSS have been demonstrated to show acceptable internal consistency with Cronbach's alphas ranging from 0.60 to 0.87 and good concurrent validity has been demonstrated, with MHPSS scores showing the predicted relationships with a range of measures including job satisfaction, psychiatric symptomatology, self-reported stress level and social support (Cushway et al, 1996). Participants were asked to rate how far each of the 42 statements applied to them on a

scale of 0 – 3 (0 = does not apply to me, 3 = does apply to me). Each individual's overall score was produced by calculating the mean of their total score on the scale, with the means of each of their seven subscale totals also being calculated.

The Maslach Burnout Inventory (MBI – Maslach et al, 1996).

The MBI is one of the most widely used measures of professional burnout, with well established reliability and validity (Maslach et al, 1996). The 22-item self-report questionnaire was used to produce scores on three separate burnout subscales measuring emotional exhaustion, depersonalisation and personal accomplishment (see Appendix 2). Participants were asked to rate how often the statements applied to them on a scale of 0 – 6 (0 = never, 6 = every day) and their scores were summed to provide the three subscale scores. In addition to this, each participant's individual subscale scores were assigned to a category of either low, moderate or high burnout in accordance with the normative data for mental health workers (presented in Table 3). A high degree of burnout was reflected by high scores on the emotional exhaustion and depersonalisation subscales and low scores on the personal accomplishment subscale.

Table 3: Normative scores for mental health workers on the MBI

Subscale	Low burnout	Moderate burnout	High burnout
Emotional Exhaustion	<13	14-20	>21
Depersonalisation	<4	5-7	>8
Personal Accomplishment	>34	33-29	<28

Attitudes to Personality Disorder Questionnaire (APDQ – Bowers et al, 2000)

Part A of the APDQ was used as a measure of global attitude towards PD clients in this study (see Appendix 3). Part B of this scale was not used as this was written for use with nurses in secure inpatient settings and so was not suitable for use with this study's more diverse sample. Part A is a 37 item self-report questionnaire composed of a series of statements which reflect both positive and negative feelings which may be experienced by those who work with PD clients. Each participant was asked to rate the frequency of their feelings towards PD clients in relation to each of the statements on a scale of 1 - 6 (1 = never, 6 = always). Global attitude scores were produced by summing each individual's scores across the 37 items, with scores on the negative items being reversed, so that a higher overall score represented a more positive attitude towards the PD client group and vice versa. Normative data for the APDQ was not available at the time of this study as it was a relatively newly developed measure. However, it demonstrated good internal consistency and showed the ability to identify predicted differences between staff who worked on specialist PD units and those who did not, with PD unit staff showing more positive attitudes (Bowers et al, 2000).

Demographic questionnaire

A demographic questionnaire to collect a range of background data on participants was created for the purposes of this study (see Appendix 4). The data collected by this measure included the age and gender of participants, work setting, occupational group, an estimate of the percentage of working time spent with personality disordered clients and any specialist training undertaken. The questionnaire also included two open ended questions which asked participants to describe the three most difficult or stressful things

about working with the PD client group and the three most helpful coping strategies utilised when their work was stressful.

2.3.4 Procedure

The study was granted ethical approval from the Local Research Ethics Committee (LREC) (see Appendix 5) and Coventry University ethics committee (see Appendix 6) and permission to conduct the study was gained from the trust Research & Development Committee (see Appendix 7). Within the CMHT settings, the questionnaire packs were distributed to individual participants by the Clinical Psychologists working with each of the teams. Within the inpatient service, the questionnaire packs were distributed by the service manager. Each questionnaire pack included an information sheet introducing the study (see Appendix 8), a copy of each of the four questionnaires and a pre-paid envelope for their return via the post. Participation in the study was anonymous.

2.4 Results

Exploratory data analysis revealed that all variables conformed to the normal distribution with the exception of the MBI depersonalisation and MHPSS home-work conflict scales. Parametric tests were employed, with the exception of analyses involving these two variables which used non-parametric tests.

2.4.1 Stress, burnout and attitudes towards the PD client group

Descriptive data relating to each of the questionnaire measures is presented in Tables 4 & 5.

Table 4: Mean scores on the questionnaire measures

Measure	Mean	St. Dev.
MHPSS overall mean	1.23	0.44
MHPSS home-work conflict	0.69	0.58
MHPSS client/patient difficulties	1.34	0.54
MHPSS organisational structure	1.34	0.69
MHPSS lack of resources	1.35	0.63
MHPSS workload	1.32	0.65
MHPSS professional self doubt	1.33	0.62
MHPSS relationships with other professionals	1.24	0.66
MBI emotional exhaustion	21.48	10.18
MBI depersonalisation	5.48	3.85
MBI personal accomplishment	33.93	7.07
APDQ total	143.70	23.56

Table 5: MBI results by burnout category

MBI subscale	MBI category	Frequency	% of sample
Emotional Exhaustion	Low	11	27.5%
	Moderate	6	15.0%
	High	23	57.5%
Depersonalisation	Low	17	42.5%
	Moderate	15	37.5%
	High	8	20%
Personal Accomplishment	Low	20	50%
	Moderate	10	25%
	High	10	25%

The MBI was the only measure used in this study which has published normative data. The data was compared to the normative scores for the mental health occupational subgroup, presented in Table 3 (Maslach et al, 1996). The mean score for emotional exhaustion was 21.48 (S.D. = 10.18), which fell just within the lower end of the high burnout category. The mean score for depersonalisation was 5.48 (S.D. = 3.85) which fell within the moderate burnout category. The mean score for personal accomplishment amongst the sample was 33.93 (S.D. = 7.07), which fell at the upper end of the low burnout category.

The relationships between the scores on the measures were explored using correlational analysis and a summary of these findings is presented in Table 6. There were strong positive correlations between the MHPSS overall mean and the MBI emotional exhaustion ($r = 0.695$; $n = 40$; $p < 0.01$) and depersonalisation scales ($r_s = 0.511$; $n = 40$; $p < 0.01$), with the personal accomplishment scale being significantly negatively correlated ($r = -0.321$; $n = 40$; $p < 0.05$). This is consistent with what was anticipated given that the underlying constructs measured by the MHPSS and MBI are similar.

Table 6: Summary of correlations between measures

	MHPSS overall mean score	MHPSS home work conflict	MHPSS client difficulties	MHPSS org. structure	MHPSS lack of resources	MHPSS workload	MHPSS prof. self-doubt	MHPSS rel'ships with other profs.	MBI emotional exhaustion	MBI depersonalisation	MBI pers. accomplishment	APDQ overall score
Years since qualification	0.026	0.089	-0.186	0.246	-0.044	0.241	0.049	-0.182	0.186	0.352*	-0.183	0.001
MHPSS overall mean score		0.783**	0.797**	0.639**	0.808**	0.571**	0.734**	0.699**	0.695**	0.511**	-0.321*	-0.333*
MHPSS home work conflict			0.610**	0.277*	0.587**	0.536**	0.536**	0.316*	0.554**	0.349*	-0.054	-0.065
MHPSS client difficulties				0.331*	0.613**	0.377**	0.734**	0.416**	0.489**	0.296*	-0.289*	-0.340*
MHPSS org. Structure					0.467**	-0.075	0.334*	0.666**	0.265*	0.487**	-0.264*	-0.210
MHPSS lack of resources						0.321*	0.627**	0.495**	0.538**	0.549**	-0.328*	-0.372**
MHPSS workload							0.252	0.233	0.588**	0.138	-0.002	-0.055
MHPSS prof. self-doubt								0.279*	0.523**	0.325*	-0.466**	-0.376**
MHPSS rel'ships with other profs.									0.447**	0.410**	-0.225	-0.210
MBI emotional exhaustion										0.538**	-0.159	-0.157
MBI depersonalisation											-0.296*	-0.564**
MBI personal accomplishment												0.569**

** Correlation is significant at the 0.01 level (1 tailed)

*Correlation is significant at the 0.05 level (1 tailed)

The MHPSS overall score and APDQ total score were negatively correlated ($r = -0.333$; $n = 40$; $p < 0.05$), confirming the hypothesis that higher levels of stress would be associated with more negative attitudes towards the PD client group in this sample. In addition to this, APDQ score was significantly negatively correlated with the MHPSS client difficulties subscale ($r = -0.340$; $n = 40$; $p < 0.05$), the MHPSS lack of resources subscale ($r = -0.372$; $n = 40$; $p < 0.01$) and the MHPSS professional self-doubt subscale ($r_s = -0.376$; $n = 40$; $p < 0.01$). This indicates that those participants who scored highly on the client difficulties, professional self-doubt and lack of resources subscales were also likely to have a more negative attitude towards PD clients.

A significant positive correlation was identified between personal accomplishment and APDQ scores ($r = 0.569$; $n = 40$; $p < 0.01$). This suggests that those with a low level of personal accomplishment were also likely to have a more negative attitude towards the PD client group. Depersonalisation scores were also found to be significantly negatively correlated with APDQ scores ($r_s = -0.564$; $n = 40$; $p < 0.01$). Given that a low score on the MBI's personal accomplishment scale reflects a high level of burnout and a high score on the depersonalisation scale represents a high level of burnout, these findings also supported the hypothesis. There was no significant relationship between emotional exhaustion and APDQ scores amongst this sample.

Given the strong correlation of personal accomplishment scores with APDQ scores, these two variables were entered into a multiple regression analysis along with MHPSS overall scores. Using the enter method, a significant model emerged ($F_{2,37} = 9.938$, $p < 0.00005$). Adjusted R square = 0.314.

Predictor variable	Beta	p
Personal accomplishment	0.516	p = 0.001

Personal accomplishment was found to predict 31.4% of the variance in APDQ scores amongst the sample, but MHPSS overall score was not a significant predictor in this model.

2.4.2 Specialist training and attitudes towards the PD client group

An independent samples t-test was employed to assess differences in APDQ totals based on whether or not participants had received specialist training to work with the PD client group. This revealed that those who had received specialist training had significantly higher scores on the APDQ ($t = 4.323$; $df = 38$; $p < 0.01$), supporting the hypothesis that individuals who had received specialist training for work with PD clients would have significantly more positive attitudes towards this client group.

The demographic questionnaire asked participants to make a subjective judgement about whether or not they felt adequately trained to work with the PD client group. Analysis using an independent samples t-test revealed that participants who did feel adequately trained for work with this client group scored significantly higher on the APDQ ($t = 2.585$; $df = 38$; $p < 0.05$). This finding indicates that subjective feelings about one's own capabilities to undertake this type of work may also be an important factor in influencing perceptions of the client group.

2.4.3 Perceived difficulties associated with working with the PD client group

Participants were asked to identify the three things which they found most difficult or stressful about working with the PD client group. A total of 117 stressors or difficulties were identified amongst the 40 participants. These were analysed using an adaptation of the thematic content analysis method used by Burnard et al (2000).

There was a strong tendency for difficulties to be attributed to a particular source, whether this be the client themselves, the participants' own feelings or the attitudes or behaviours of other colleagues with whom they worked. These three categories accounted for 74.4% of all the difficulties described by participants, with the remaining difficulties being attributed either to a lack of, or inappropriate resources (9.4%) or to the nature of the work with this client group which was not attributed to any one source (16.2%). The composition of the responses to this question are shown in Tables 7 & 8.

Table 7: Main thematic categories - sources of difficulty in work with the PD client group

Stressor	No. of statements	% of total statements
Client characteristics or behaviour	46	39.3%
Own feelings or attitudes	25	21.4%
Nature of the work – not attributed to any one source	19	16.2%
Attitudes or behaviour of other colleagues	16	13.7%
Difficulties with resources	11	9.4%

These main categories were broken down into further sub-categories:

Table 8: Sub categories – sources of difficulty in work with the PD client group

Stressor	No. of statements	% of total statements
Client characteristics or behaviour	46	39.3%
Unpredictable or impulsive behaviour	11	9.4%
Risky behaviour towards self	7	6.0%
Manipulative behaviour	5	4.3%
Behaviour that causes themselves distress	3	2.6%
Demanding behaviour	3	2.6%
Dependent/emotionally needy	3	2.6%
Blaming of others for difficulties	2	1.7%
Tendency to take polarised views of members of care team	2	1.7%
Damaging behaviour towards others	2	1.7%
Attention seeking behaviour	2	1.7%
Other	6	5.1%
Own feelings or attitudes	25	21.4%
Feelings of frustration towards client in relation to slow rate of progress	13	11.1%
Feeling used or manipulated	4	3.4%
Feeling inadequate/not knowing what to do	4	3.4%
Feeling overwhelmed or distressed by client's difficulties	3	2.6%
Feeling responsible for coping with clients alone	1	0.9%
Nature of the work – not attributed to any one source	19	16.2%
Long term work/slow pace of change	11	9.4%
Difficulties in maintaining and managing the therapeutic relationship	8	6.8%
Attitudes or behaviour of other colleagues	16	13.7%
Differences in attitudes and ways of understanding the client group	14	12.0%
Lack of consistency amongst team with regard to treatment	2	1.7%
Difficulties with resources	11	9.4%
Lack of or limited resources	4	3.4%
Time pressures	3	2.6%
Inadequate training and support	2	1.7%
Other	2	1.7%

At the attribution level, difficulties were most commonly ascribed to the characteristics and behaviour of the PD client, with the professionals' own feelings towards the client group also being an important source of difficulty and stress.

However, it could be argued that the slow rate of change demonstrated by the client group and the frustration this could provoke in participants emerged as the strongest theme, being the most popular sub-category in both the "own feelings and attitudes" and "nature of the work" categories. The next strongest theme to emerge from the analysis was the unpredictable or impulsive nature of client behaviour with the third strongest theme being difficulties provoked by differences in attitudes and ways of understanding the client group amongst colleagues.

Participants were also asked to describe the three most useful strategies that they found helpful when their work was stressful. Analysis of the 119 statements obtained is shown in Table 9. There was greater repetition of themes amongst this data set and so statements were coded into just one series of main categories.

Table 9: Main thematic categories - coping strategies used when work is stressful

Coping strategy	No. of statements	% of total statements
Gaining informal support from others at work	31	26.1%
Relaxation outside work	20	16.8%
Formal supervision arrangements at work	15	12.6%
Taking time out away from work	10	8.4%
Detaching self from work situations	6	5.0%
Moderating demands of workload	6	5.0%
Strategies to actively manage workload	4	3.4%
Self reflection at work	4	3.4%
Utilising theoretical approaches to help understand the client	4	3.4%
Having a happy home life outside work	4	3.4%
Gaining support from family and friends outside work	4	3.4%
Taking breaks/non-clinical time during the working day	3	2.5%
Involving the client in their own care	2	1.7%
Joint working	2	1.7%
Other	4	3.4%

The use of informal support at work was a particularly popular coping strategy described by the participants, with this accounting for 26.1% of all statements. Formal supervision arrangements were also commonly cited and together these two strategies composed 38.7% of all statements made. The importance of undertaking relaxing activities outside work was also a strong theme emerging from the data.

2.5 Discussion

2.5.1 Stress, burnout and attitudes towards the PD client group

The findings on the MBI amongst this sample were highly consistent with the means and standard deviations reported amongst a number of other larger samples of mental health professionals (e.g. Fagin et al, 1995; Coffey, 1999; Prosser et al, 1999; Hannigan et al, 2000). Despite efforts to recruit similar numbers of community and inpatient based staff members, the sample in the present study was composed of a high proportion of community based staff. Amongst the literature, the most similar sample for comparison was that of Prosser et al (1999), who studied members of community mental health teams and ward based staff across a similar variety of disciplines. At 21.2 (S.D. = 10.0), the mean level of emotional exhaustion amongst Prosser et al's (1999) community sample was very similar to that reported in the present study and this was also the case in relation to levels of personal accomplishment, with Prosser et al (1999) reporting a mean of 33.5 (S.D. = 6.6). Mean levels of depersonalisation were slightly higher than in the present study at 6.7 (S.D. = 5.0).

Despite the fairly high levels of burnout identified amongst sample, the data collected on coping strategies used by participants is promising. There was a good consensus about which strategies were useful, with the three most popular types accounting for 59% of all statements made. The most popular means of coping described was informal support at work. This is consistent with many other studies (e.g. Cushway & Tyler, 1996; Reid et al, 1999b; Burnard et al, 2000; Coffey, 2000). As a behavioural attempt to deal with a stressful situation, this strategy can be defined as falling within the category of active-behavioural coping (Billings & Moos, 1981). Together with active-cognitive coping

strategies, where the individual attempts to manage their appraisal of a stressful situation, these coping strategies have tended to be negatively correlated with distress in contrast with avoidance coping strategies (Cushway & Tyler, 1996). The second most commonly cited coping strategy was relaxation outside work, with formal supervision arrangements taking third place. Overall, a low frequency of avoidance coping strategies was described and although this study did not monitor whether the coping strategies described by participants were actually put into practice, this finding is a hopeful one. The focus of this paper on the relationship between stress, burnout and attitudes towards the PD client group prohibits further detailed discussion of the findings in relation to burnout. However, the consistency between the levels of burnout identified amongst this sample and those found in a range of other, larger studies provides good evidence for the validity of these findings.

Exploration of the relationship between stress, burnout and attitudes towards the PD client group identified personal accomplishment as a significant predictor of attitudes towards the PD client group, with low levels of personal accomplishment being associated with more negative attitudes. Within Maslach & Jackson's (1986, p. 1) definition of burnout, reduced personal accomplishment is described as the tendency to evaluate oneself negatively, particularly in relation to work with clients. In simple terms, this finding means that negative feelings about one's work with clients predicted negative attitudes towards the PD client group in this sample.

Although not a significant predictor of attitude, overall stress levels were also negatively correlated with APDQ scores. This provided further support for the hypothesis that higher levels of stress and burnout would be associated with more negative attitudes towards

the PD client group. In addition to this, three out of seven subscales of the MHPSS were also associated with attitudes towards the PD client group. Significant negative correlations were found between scores on the client related difficulties, professional self doubt and lack of resources subscales and the APDQ scores. This means that those individuals who perceive client contacts to be a source of stress and those who feel uncertain about their professional capabilities are likely to perceive work with the PD client group in a more negative way. The finding that perceived lack of resources was also associated with a more negative attitude may be seen as adding a further dimension. It is postulated that perceived lack of resources may be a source of anxiety which may increase the individual's feelings of being ill equipped for their work. This in turn may affect their attitude towards work with the PD client group, who are often perceived as a needy and resource intensive group.

Although these are important findings, it is important to consider that they may have a number of explanations. It could be hypothesised that working in a job which is experienced as stressful leads to the development of negative attitudes towards the clients one works with. Using this model, professional self-doubt, perceived client related difficulties and perceived lack of resources could all be viewed as interrelated forms of stress which over time lead to a reduction in an individual's personal accomplishment, affecting their attitudes towards the PD client group. This would fit with Maslach & Jackson's (1986) model of burnout, which views emotional exhaustion, reduced personal accomplishment and depersonalisation as the result of chronic stress. Alternatively, it could be hypothesised that working in a role where one is required to work with a client group which one feels negatively about increases that individual's levels of stress. This could then become a cyclical process.

2.5.2 Specialist training and attitudes towards the PD client group

There are also likely to be other mediating variables which may mediate the relationships between stress, burnout and attitudes towards this client group, such as the training undertaken by individuals. This study identified that those participants who had received specialist training and those who subjectively judged themselves as being adequately trained for work with the PD client group had significantly more positive attitudes towards the PD client group.

These are important findings because they indicate that both the provision of specialist training and subjective perceptions of proficiency for work with PD clients may have an important influence on attitudes towards this group. Considered alongside the relationships between stress, burnout and attitudes already described, the provision of specialist training may be viewed as a mediator in this relationship. It is postulated that training may reduce stress associated with professional self doubt, client related difficulties and resources by enhancing individuals' perceptions of their skills and abilities to cope, with attitudes towards PD clients being improved as a result. Whilst it is not possible to draw any firm conclusions that provision of specialist training had a causal effect on attitudes amongst this sample, this finding provides some support for the use of training as a means of promoting positive attitudes towards this group.

2.5.3 Clinical implications of the study

The relationships between stress, burnout, specialist training and attitudes towards the PD client group have important implications for those working in services which cater for this client group. The provision of specialist training and the subjective feeling of being adequately trained for work with this client group seem particularly important areas for

attention. The qualitative data collected about sources of stress and difficulty associated with work with PD clients helped to shed some light on the areas where training input might usefully be targeted.

This analysis revealed that difficulties were most commonly blamed on the characteristics and behaviour of the PD client, with unpredictable and impulsive behaviour being a particular source of stress. This fits with Markham & Trower's (2003) research which identified that nursing staff considered clients with BPD were more in control of both the causes of their behaviour and the behaviour itself compared with individuals diagnosed with depression or schizophrenia. This view may result in powerful effects, with staff showing more anger and less sympathy, optimism and help giving behaviour towards clients who are perceived to have control over their behaviour (Sharrock et al, 1990; Dagnan et al, 1998).

Markham & Trower (2003) suggested that addressing attributions of control through supervision and training may help to modify attitudes towards clients with BPD and alleviate negative experiences associated with working with this group. It has also been suggested that increased awareness of the long term consequences of the sexual and emotional abuse often suffered by clients with PD could help to prevent negative attitudes from developing amongst staff who work with this client group (Fallon, 2003; Horsfall, 1999). This approach is also recommended here. It is suggested that focusing training on increasing awareness of the relationship between a person's current behaviour and past life events may help to challenge negative attributions about the control which PD clients have over their behaviour and improve staff attitudes towards this group.

The slow rate of change demonstrated by PD clients also emerged as an important source of stress for the professionals in this study. This was also identified by Reid et al (1999a). Allied to this issue was the frustration that this slow rate of change provoked in participants, highlighting the importance of the professionals' own feelings as a source of difficulty and stress in this study. Fallon's (2003) suggested that an awareness of the likelihood of relapse amongst staff who work with this client group may prevent the development of therapeutic nihilism. It is suggested that these issues could be addressed through training and supervision.

The final major theme to emerge from the qualitative data in this study was the difficulty associated with differences in attitudes and ways of understanding the client group amongst colleagues. The importance of close collaboration and a consistent approach to treatment was highlighted in recent government guidance on the treatment of PD (NIMHE, 2003). The emergence of this as a significant source of difficulty may suggest that this is a wider issue which requires further research and the possible need to conduct a review of how teams work together to implement and manage input to the PD client group.

2.5.4 Methodological limitations and areas for future research

The size and nature of the sample included in this study imposed some limits on the degree to which the results may be generalised. Firstly, data was collected from only one NHS trust, which has had some investment in specialist services for PD and may not have been representative of other NHS trusts.

Secondly, at 40 participants, the sample was small and heavily weighted in favour of females. Bowers et al (2000) identified a trend for female nurses to be significantly more optimistic about the treatment of PD and to consider themselves better trained than their male counterparts. As such, the predominance of female participants may have led to more optimistic findings in relation to attitudes towards the PD client group than would have emerged if the gender proportions had been more equal. It would be interesting for future research to focus on a sample which has a more even gender balance in order to investigate whether possible gender differences in attitudes towards PD clients.

The reasons for the predominance of female respondents were unclear, and as records were not kept of those individuals who received questionnaire packs, data on the relative response rates for males and females could not be generated. The study may have benefited from sending personalised questionnaire packs out to participants as this would have facilitated the collection of data about the non-responders and enabled them to be followed up, increasing the return rate. However, in order to keep participation in the study completely anonymous this method of distribution was not chosen and questionnaire packs were distributed via the clinical psychologists attached to the community teams and the manager of the inpatient service.

It is also important to consider how the nature of the client group who were the subject of this study may have influenced participation. Previous research indicates that borderline personality disorder (BPD) is probably the most common type of PD presenting in mental health services (Coid, 1993) and so it is likely that many of the participants who took part in this study responded to the questionnaires with experience of working with clients with BPD in mind. Approximately 75% of this client group is female (O'Brien, 1998) and a high

frequency of sexual abuse experiences have been identified amongst this group (Horsfall, 1999). It could be hypothesised that clients with BPD provoke a more empathic response from female staff, making female staff both more likely to choose to work in this area and more likely to respond to a research project like the present study. If these hypotheses were indeed true, this may help to provide an explanation for the predominance of female participants amongst this sample.

This method of questionnaire pack distribution is also likely to have affected the composition of the sample, which included a relatively large proportion of clinical psychologists. It is predicted that this may also have had an effect on results, leading to the study identifying more positive overall attitudes towards the PD client group than it would have been found if the sample had been more balanced across the professional groups. This is hypothesised because as a profession, clinical psychology places a strong emphasis on formulation of individuals' difficulties within the context of their life histories, something which has been associated with more positive attitudes towards the PD client group. The small number of participants in this sample did not allow comparison of scores relating to stress, burnout and attitudes to be made between the different professional groups, but this is also an area on which future research could usefully focus.

An original intention of this study was to recruit participants from both community and ward based backgrounds to enable comparisons between the two groups to be drawn. However, despite an equal number of questionnaires being distributed to both groups, the response rate amongst the ward based staff was extremely low. Again, it was not possible to follow up or collect information about non-responders. This was a

disappointing outcome since previous research has demonstrated significant differences between the two groups. Community based staff have generally been shown to display higher levels of stress (e.g. Butterworth et al, 1999; Prosser et al, 1999) alongside higher levels of personal accomplishment (Fagin et al, 1995) and job satisfaction (Butterworth et al, 1999) but also lower levels of depersonalisation (Fagin et al, 1995) when compared with ward based staff. As such, it would have been interesting to compare attitudes towards the PD client group between the two groups of staff. This would be an interesting area for future research.

This study has identified a complex relationship between stress, personal accomplishment and attitudes towards the PD client group and further research is needed to help explore these relationships. It is also likely that other variables which have not yet been explored may play an important role in influencing attitudes, for example, whether or not an individual has chosen to work with PD clients. It would be interesting to explore attitudes towards the PD client group and indeed the experiences of clinicians working with this group in more depth using a qualitative approach as little work in this area has utilised qualitative methodologies. A preliminary study which has attempted to do this is described in Chapter 3.

A good deal of scope has been identified for further work in this area with there being a need to investigate these phenomena in larger and more diverse samples. The inclusion of a control group consisting of professionals who do not work with the PD client group would also be a useful addition in future research. There is also a need to further explore the relationship between specialist training and attitudes towards PD clients and how this may be mediated, using both quantitative and qualitative methods. Within the present

study the sample was too small, and the range of training undertaken too diverse to allow further exploration of the possible effects of specific types of training, but this would also be an extremely interesting area for future work.

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Chapter 3: Empirical Paper 2

The experience of working with clients with borderline personality disorder: A qualitative study

**This paper has been prepared for submission to the
British Journal of Clinical Psychology
(See Appendix 19 for Instructions to Authors)**

The experience of working with clients with borderline personality disorder:

A qualitative study

Abstract

Objectives: Clients with borderline personality disorder (BPD) are widely perceived as being difficult and stressful to work with, but little work has explored the reasons for these beliefs. This study examines the experiences of mental health professionals working with this client group in order to explore the stressors associated with their work and the processes used to cope with these.

Design: The qualitative method Interpretative Phenomenological Analysis was used.

Methods: Semi-structured interviews were used to explore the experiences of four professionals asked to describe positive and negative experiences of work with the BPD client group, the effects that their work had on them and coping strategies employed when their work was stressful.

Results: Work with this client group was described as complex, demanding and emotionally and physically draining at times. The participants described feelings of personal responsibility for the safety of clients extending outside working hours. Informal support, formal supervision and development of a shared understanding of client difficulties amongst multi-disciplinary teams were described as important aspects of effective work with this client group.

Conclusions: Work with individuals with BPD was experienced as being both stressful and rewarding. The negative effects of this work appeared to be buffered by sharing responsibility for client work and gaining support from others, development of a realistic view of the likely progress of clinical work and strong personal motivations for work with this client group. The wider clinical implications arising from these findings are discussed.

3.1 Introduction

Within World Health Organisation definitions (WHO, 1992, p. 205), borderline personality disorder (BPD) is described as a disorder of emotional instability, with the diagnostic criteria including impulsivity, chronic feelings of emptiness, recurrent threats of self harm and a tendency to become involved in intense and unstable personal relationships leading to repeated emotional crises (Fallon, 2003). Amongst the research literature, clients with BPD are perceived as being particularly challenging and stressful to work with (Gutheil, 1985; Linehan, 1993; Linehan, Cochran, Mar, Levensky & Comtois, 2000). Indeed, Cleary, Siegfried & Walters' (2002) survey of Australian mental health professionals concluded that 80% of respondents rated dealing with BPD clients as moderately or very difficult and 84% felt they were more difficult to deal with than other client groups. Markham & Trower's (2003) recent study investigated staff attitudes towards clients diagnosed with BPD compared with clients with diagnoses of schizophrenia and depression. They concluded that nursing staff were less sympathetic and optimistic about change in clients diagnosed with BPD compared with the other two groups and also rated their experience of working with the BPD group more negatively.

However, despite therapist stress in treating clients with BPD commonly being believed to be much greater than that associated with other disorders, virtually no empirical research has been carried out to test this and there has been a tendency for responsibility for these perceived difficulties to be blamed on the interpersonal characteristics of the BPD client (Linehan et al, 2000). The study described in Chapter 2 began to address this gap in the literature by collecting some qualitative data on the perceived sources of difficulty in working with clients with a personality disorder (PD) as a general group. This study identified that difficulties were most commonly attributed to the characteristics and

behaviour of the client. However, the participants' own feelings towards the group were also a major source of stress, with frustration at the slow rate of client progress emerging as a particular difficulty.

It is also true that amongst research conducted with mental health professionals, coping has been given less attention than stress (Coyle, Edwards, Hannigan, Burnard & Fothergill, 2000). When it has been investigated, it has tended to be done in a quantitative way, using psychometric questionnaires with little qualitative research having been conducted. A review of published work revealed only three qualitative reports within the area of stress and coping amongst mental health workers, two of these being generated from the same research study.

Relevant to the discussion of clients diagnosed with BPD is the work of Hopkins (2002), who reported an ethnographic study looking at the meaning of clients who had harmed themselves for nurses working on medical admissions units. Hopkins' (2002) experience was that clients who had harmed themselves were viewed as a blockage to the operation of busy admission wards, with the presence of these clients seen as challenging the efficiency of the ward and creating a sense of frustration and failure amongst the nurses. Hopkins (2002) also described how the nurses in the study struggled to understand the nature and purpose of self harming behaviour and as a result tended to avoid and resent these individuals.

Within the more general area of stress and coping amongst those involved in mental health work, Reid et al (1999a) reported a qualitative study based on a sample of 30 inpatient and community based mental health professionals from a representative cross

section of occupational backgrounds. This study explored the aspects of the professionals' work which they found enjoyable, those they found stressful and also explored how their work could be made more rewarding and less stressful, with the interview data being analysed using content analysis. A companion paper (Reid et al, 1999b) explored additional aspects of the same data, focusing on sources of support at work and coping strategies used by the participants when their work was stressful. These two papers provide some useful insights into the rewards, stressors and coping strategies discussed by a range of different professional groups working in mental health settings. However, despite the use of quotes from participants, the content analysis remained at a general, descriptive level and the detail and richness often associated with qualitative methodologies was not always apparent.

The aim of the present study is to begin to address the lack of qualitative research, by focusing on the experiences of mental health professionals who work with clients who may be diagnosed with, or meet the criteria for a diagnosis of BPD. The purpose of this is to explore the experiences of professionals who work with this client group, with a particular focus on stressors associated with their work and the processes used to cope with these.

3.2 Methodology

3.2.1 Participants

Participants were recruited from one National Health Service Trust, following approval from the Local Research Ethics Committee (LREC) (Appendix 5), Coventry University ethics committee (Appendix 6) and the trust Research & Development Committee

(Appendix 7). Both qualified and unqualified mental health workers based within the community mental health teams and mental health inpatient services were approached to take part in the study, with the initial approach being made via a flyer included in questionnaire packs distributed as part of the research project reported in Chapter 2. Individuals who were interested in taking part in this study were asked to complete their contact details on the flyer (Appendix 9) and return this to the author. These individuals were then sent a letter (Appendix 10) and a more detailed information sheet about the study (Appendix 11) and were asked to complete and return a tear off slip indicating whether they were willing to take part. Six individuals expressed an interest in taking part in the study and of these four were willing to be interviewed.

All four participants were female and described themselves as working with clients who would meet the DSM-IV (American Psychiatric Association, 1994) criteria for a diagnosis of Borderline Personality Disorder (BPD). One participant described herself as a psychotherapist, one as a counsellor, one as a clinical psychologist and one as a nurse. All four participants worked in community settings with two individuals working as part of Community Mental Health Teams (CMHT), one working as part of a dialectical behaviour therapy (DBT) service and one working in a day hospital setting. Two participants described their clinical caseloads as being solely composed of clients with BPD type difficulties with the other two making estimates of 25% and 50%. The number of years experience since qualification ranged from one year to twenty years and three participants described having undertaken specialist training for work with this client group.

All interviews were conducted by the lead researcher, a 29 year old female trainee clinical psychologist, with an interest in the areas of adult mental health and severe and enduring

mental health difficulties. The interviewer had no clinical experience of working with clients with BPD and had not undertaken any specific training in relation to working with this group other than that provided by generic clinical psychology training.

3.2.2 Data collection and analysis

The Interpretative Phenomenological Analysis (IPA) approach to data collection and analysis was used. This approach is phenomenological in that it aims to explore the personal experiences and perceptions of participants, rather than attempting to produce an objective statement about objects or events (Smith & Osborn, 2003). As is common within the IPA approach, semi-structured interviews were used to facilitate data collection; with the construction of the interview schedule being guided by the guidelines outlined by Smith (1995) (see Appendix 12). The main areas covered by the interview schedule included a description of the participants' work, views on working with this client group, the effects their work had on them as individuals and any coping strategies employed when their work was stressful. Each area was introduced by one or two general questions, which were followed by more specific prompts if the initial questions were too general or vague for a particular participant. All interviews were conducted in private rooms at the participants' places of work and lasted approximately 45 minutes each. The purpose of the interview was explained at the start of the interview and participants were asked to sign a consent form to indicate that they were happy to take part in the research (Appendix 13). The interviews were audiotaped and transcribed verbatim. A sample extract from one of the interviews is included in Appendix 14.

Consistent with the guidelines described by Smith & Osborn (2003), the first transcript was read a number of times with the left hand margin being used to make preliminary notes, which included summaries, connections, associations and other interesting or significant features of the account. The whole transcript was then re-read with the preliminary notes being transformed into tentative emerging themes which were documented in the right hand margin (see Appendix 15 for an example). These emergent themes were then listed in a chronological order before being clustered together into groups based on the connections between them to form a coherent master list of themes. The themes from this first case were then used to help orientate the analysis of the other three cases, with care being taken to identify repeating patterns and also to identify new concepts which emerged from the individual accounts as the analysis proceeded. As part of this evolving process, a number of themes which were not well represented amongst the data or which did not fit well with the emerging data were dropped. This process led to the production of a consolidated master list of themes for all transcripts. A directory of the participants' phrases which supported the master list themes was developed, including details of the location of each extract within the transcripts (see Appendix 16). This provided an overview of the supporting evidence for each theme.

In line with Smith's (2003) recommendations, an independent auditor reviewed the master list of themes and supporting evidence from the transcripts to ensure that the account produced was credible and justified in terms of the data collected. This individual had experience of using the IPA methodology, but was not involved in the study.

3.3 Results and discussion

Table 1 provides a master list of the superordinate and sub-themes emerging from the data along with the frequency with which they occurred amongst the participants.

Table 1: Master list of themes emerging from the analysis

Theme	Frequency of occurrence
1. Client complexity <ul style="list-style-type: none"> • Pervasive nature of client difficulties • Client work is demanding and unpredictable 	<p style="text-align: center;">4</p> <p style="text-align: center;">4</p>
2. Ambivalence about the use of diagnostic labels	<p style="text-align: center;">4</p>
3. Effects on self <ul style="list-style-type: none"> • Fatigue • Risk and responsibility • Self growth 	<p style="text-align: center;">4</p> <p style="text-align: center;">4</p> <p style="text-align: center;">4</p>
4. Spreading the load <ul style="list-style-type: none"> • Informal support • Formal support • Importance of professionals having a shared understanding in relation to client work 	<p style="text-align: center;">4</p> <p style="text-align: center;">4</p> <p style="text-align: center;">4</p>
5. Personal motivations for working with the client group	<p style="text-align: center;">3</p>
6. Reappraisal over time in light of experience	<p style="text-align: center;">3</p>

The six superordinate themes were felt to fall within three main groups, with the first two, client complexity and ambivalence about the use of diagnostic labels relating to the participants conceptualisations of the client group. The third theme, effects on self, described the impact that participants felt this type of work had on them. The final group

of themes consisted of spreading the load, personal motivations for working with the client group and reappraisal over time in light of experience. These emerged as a set of buffering factors which enabled participants to continue to work effectively with the BPD client group.

3.3.1 Client complexity

There was a strong tendency for participants to conceptualise the BPD client group as complex and to spontaneously compare this group with other client groups who may be seen as part of adult mental health work. Although the interview schedule included comparison with other client groups as an area for discussion, these comparisons also occurred at other points during the interviews and in a number of cases, prior to the specific prompts arising.

Pervasive nature of client difficulties

All participants perceived the client group as presenting with a complex and pervasive range of difficulties:

So they tend to be more complex I suppose, there wouldn't just on the whole be one issue, there would tend to be a range of issues that one person would be presenting with.

So I suppose it's the more complex end of counselling if you like.

Rebecca

It just kind of feels much more chronic, much more complex, in terms of being able to sort out what the issues are and grabbing hold of something, and deciding on some goals, and being able to work on that, because every week, you know, stuff's going on and it's

changing and there's so much going on at the same time...there just seems like there's so much more to take into account with everybody.

Lucy

Client work is demanding and unpredictable

Therapeutic work with this client group was perceived as being complex, demanding and unpredictable, with a lack of consistent progress. Again, comparisons were commonly drawn between work with this client group and other client groups:

If you're working with someone who has relationship difficulties or if something has a kind of fairly straightforward sound to it, you can feel that even if therapy doesn't always progress, there's some kind of thread that you can hold on to, and sometimes it feels with people with these particular difficulties as if it's hard for them to hold on to anything, so that you're jumping about, you don't know what you're going to be looking at, what the difficulties are going to be. You can't assume that there's going to be a progression from one therapy session to the next.

Anna

For three participants, a key part of managing this more demanding type of work was an increased need for a strong focus on both self reflection and the therapeutic process:

I need to pay so much attention I think to what goes on in the room. I mean I do that anyway, but I think it's probably more so with this client group.

Rebecca

The prevalence of physical, emotional and sexual abuse amongst this client group was discussed by all four participants and there was a perception that NHS services were not flexible or sensitive enough to meet their needs, with individuals being expected to "fit in" with general adult mental health services. Caroline discussed this point in relation to day services:

A lot of the clients I work with tend to be women and there often seems to be a high level of abuse in childhood...It seems to be brushed under the carpet and ignored, or you know let's focus on the here and now...we don't have a specific women's service here, people are expected just to be able to come here and they are quite excluded in the summer holidays for example, if they've got children, and you may have to sit in groups with a high ratio of men and I think that's something that stops a lot of people coming here and I think we need to be a bit more mindful about how we plan that.

Caroline

This struggle to provide an adequate service for clients with a PD within general adult services was recently recognised as part of Department of Health guidance for the development of services for people with personality disorder (NIMHE, 2003, p. 13, para 13).

3.3.2 Ambivalence about the use of diagnostic labels

Amongst the participants, there was a recognition that some clients presenting to services would have a diagnosis of BPD, whilst others would not, but may still present with similar kinds of difficulties. Lucy described her reluctance to use this term when communicating with other professionals, preferring to use alternative terminology instead:

So things like patterns of behaviour or personality styles or personality traits that kind of thing, rather than disorder. Because I think there is some stigma attached to the way people interpret the word "disorder".

Lucy

This may be seen as reflecting a reticence amongst professionals to use the diagnostic label BPD; with all participants expressing the feeling that diagnostic labels could be viewed as stigmatising. This finding echoes that of Fallon (2003), whose grounded theory study focused on the experience of mental health services for clients with BPD. This study also identified a reluctance to disclose participants' diagnoses because of the negative connotations attached to the BPD label. Indeed two of the seven participants in Fallon's (2003) study were only told their diagnosis when their consultant psychiatrist recruited them for the study. Caroline described a client she had worked with who had become upset when the term was applied to her, but also acknowledged that there were some occasions when use of the diagnostic label could be useful:

We had been working on a package for them [a client] to be discharged and they were looking at going to a therapeutic community and I'd gone through some reports with this individual...and it said in the letter that their problems were mainly of a borderline personality disorder type and they were actually quite upset by that...I think it has had a very negative image really. Staff have perceived it to be very negative, but personally I think it's quite helpful for people sometimes to have a diagnosis and it maybe helps people understand you know that it's not that they're awkward and timewasters or how they are often perceived, but they do have a condition that can be worked upon and is treatable really.

Caroline

Current research literature indicates that views on this topic amongst clients are divided. Despite the stigma and negative attitudes associated with the label, the participants in Fallon's (2003) study felt that having a diagnosis helped them to make sense of their feelings and behaviours. In contrast to this, the clients interviewed in Ramon, Castillo & Morant's (2001) study largely described the impact of a diagnosis as negative. These mixed attitudes create a difficulty for professionals when deciding whether or not to discuss diagnosis and this is an area which requires further exploration amongst the client group.

3.3.3 Effects on self

One of the strongest themes emerging from the analysis was the range of effects which work with this client group could have on the participants. This was viewed by participants as being an inevitable part of the demanding type of work in which they were involved. Although effects of the work were explored as part of the interview schedule, it was also something that participants raised spontaneously throughout the interviews.

Fatigue

There was a recognition that this type of work left the participants feeling both emotionally and physically drained at times. The increased complexity and intensity of the work also meant that participants needed to moderate the number of clients seen in the working day and take more time between sessions in order to have a break and provide enough space for reflection:

I think after a session I'm usually very tired and kind of drained and particularly if it's a difficult session, I'll feel shattered and need to have a drink and a biscuit perhaps (laughs). I reach for the chocolate...and just take some time to reflect on it really so I think it's, certainly that's a stronger reaction that I would get on the whole with most clients.

Rebecca

All four participants discussed the importance of having a fulfilling life outside work in order to counter the effects that their work could have:

I think there's something about being overwhelmed sometimes and the kind of material that people bring and the distress associated with their experiences can be beyond belief in a way. I don't mean unbelievable in the sense of not believing that happened to somebody but it's like there's a bit of me sometimes which finds it very hard to believe these things happen to human beings or other people, or that human beings could do this to other human beings. It's really heavy work, you can lose hope at times and I think that's why it's important to have good things outside, in order not to lose hope.

Anna

The importance of having a stable and enjoyable home life and having interests and hobbies outside work have also been highlighted as particularly important in a number of other studies conducted amongst mental health workers (e.g. Coyle et al, 2000) and this is an unsurprising finding. However, participants also described the effects that emotional and physical fatigue could have during the working day and this highlights the importance

of ensuring professionals are comfortable with both the size and balance of their caseloads.

Risk and responsibility

All four participants talked of a feeling of personal responsibility for the clients on their caseloads and at times experienced intrusive thoughts about clients outside of working hours. This increased sense of responsibility tended to be linked to issues of risk associated with their clients and this was described as an inevitable part of work with this client group. Anna's description provided a particularly rich illustration of the impact of working with individuals with a tendency to harm themselves:

It can be terribly anxiety provoking, I think that's the other thing, particularly if people are at very high risk of self-harm or suicide attempts. There is a dread at times if someone is finding it very hard – what haven't I done, am I going to get caught out for not having done this....waiting to be punished myself. In case something goes wrong – I'm thinking why do I do this work, saying it aloud to you (laughs).

Anna

Caroline provided a further example, whilst also describing the importance of finding effective ways to help switch off and wind down after work. This was a popular coping strategy cited by all participants:

Particularly if people have been self harming for example, that's one thing that particularly plays on my mind and I might often think at home - right when I see them tomorrow what am I going to do? It's hard to switch off sometimes, so it's very important to try and do

those things and if you are doing, you know working at the gym or something it's quite hard to think of those things as well. An hour there and work seems like a million miles away really and I'm able to relax then and focus on what I'm doing at home.

Caroline

These feelings of personal responsibility for the clients on one's caseload were also identified by Reid et al (1999a) who identified this as the most frequently cited client based stressor amongst community staff. Again, individuals described this responsibility continuing after they left work at the end of the day.

Self growth

Without exception, all participants felt their work also had positive effects on them. There was a strong focus on increasing awareness of the self and others, and this was felt to have benefits both inside and outside the workplace:

I've learnt loads, I've learnt absolutely loads about me and about the client group and you know how I operate, how they operate with me...as I said earlier, sometimes it's been absolutely awful...but it's also been great, I wouldn't have missed it really. I think it's stretched me and it's made me grow as a therapist and it's given me more confidence.

Rebecca

I think I'm a bit more, what's the word, aware. So hearing, you know people's experiences I think kind of opens my eyes a bit, so outside of work I'm much more...aware of what might be going on for people...it gives me a bit more perspective on things really, when you listen to people's experiences and [the] difficulties that they have

or a lot of people that I work with have. It just kind of gives you a bit more perspective and [I] perhaps take things for granted less than I used to. I appreciate things a bit more.

Lucy

Several of the participants became quite animated when discussing these positive effects and this was felt to be a very important part of the work for them. The self growth associated with this type of work seemed to emerge as a buffer to the other stresses and strains it could impose.

3.3.4 Spreading the load

The need to "spread the load" by gaining support and sharing responsibility in order for participants to continue to work effectively with this group was an extremely strong theme to emerge from the data.

Informal support

There was a strong consensus that informal and peer support was an extremely important part of the participants' work. Again, this appeared to act as a buffer, especially when client contact had been particularly difficult or stressful. Rebecca described the peer support system in her workplace:

I think that's useful because it gives me somewhere to spread the load if you like, you know if I've had a particularly difficult session...we have a kind of peer support system here so there's always someone I can go and talk to and offload and maybe just discuss the way forward on a quite informal basis. Of course, I have supervision too but it's nice to

be able to just do it straight away after a difficult session or you know within the week anyway.

Rebecca

However, the practical difficulties in accessing this type of support were also raised:

There are times when actually I know I have seen somebody very difficult, to have ten minutes, not even supervision, but ten minutes with somebody just saying, you know, I'm really worried or that was a dreadful session, or not even talking about them at all but can we just have a cup of coffee together. But that actually takes some of the pressure away and it's really hard to do that because we mostly work...to timetables where there's not a lot of space for that.

Anna

The emergence of informal support as a valued coping strategy was not unexpected given that this has been the most commonly cited coping strategy in a number of studies of stress and coping amongst mental health workers (e.g. Coffey, 1999; Reid et al, 1999b; Burnard et al, 2000). However, this study highlights that there may be a need to overcome difficulties in accessing this to ensure that all professionals within this area can utilise this powerful source of support.

Formal support

All participants felt that formal supervision arrangements were a crucial part of effective work with clients with BPD. Lucy described the DBT consultation group as a particularly valuable opportunity for team supervision using a shared model to understand clients'

difficulties. It was clear this helped her to feel supported in her work as well as providing an opportunity for team reflection:

It gives you space to think it through, helps you to think about what's going on and how much of it is your stuff and what it is about the thing that's going on that's tapping into your stuff, that, you know, might make you less empathic and actually I think sometimes you can think that you are being empathic until somebody listens to the tape of you working with the client and will say "that's not very empathic" (laughs) and kind of pulls you up on it, so it does make you sit up and notice those moments as well.

Lucy

In contrast, other participants felt unhappy with their formal support arrangements.

Despite being experienced in her work with this group, Anna did not feel her supervision was adequate, whilst Caroline did not receive any formal supervision and described difficulties in identifying a supervisor with the necessary expertise:

I think within the psychology department I feel very well supported. I think the difficulty is when you don't have that. I don't feel very well supported in terms of supervision. I think that's one of the things that happens to you as you get higher up – you are very busy giving supervision to lots of other people, but there's not always somebody there for me.

Anna

I don't think [I am] well supported in terms of supervision at all, I don't get clinical supervision although I have addressed it and I think that that would really improve the support dramatically... The difficulty being because I work primarily with this client group

then there's not that many people in the immediate vicinity that work in that type of work and that want to provide supervision.

Caroline

These findings highlight the need to ensure that all clinicians working with this group receive adequate supervision, regardless of their levels of experience. It also seemed important for the participants that their supervisors had specialist knowledge of work with the client group. Firth et al (1986) suggested that although respect and empathy are important elements of supervisor support, these may not be sufficient alone. They suggested that specialist expertise and an in depth understanding of the area of work were also required to enable supervisees to feel able to carry out their jobs well. The importance of regular supervision for all practitioners working with the PD client group was also highlighted in the recent Department of Health (DOH) guidance (NIMHE, 2003, p. 44, paras 124-125). This study suggests that the provision of formal supervision is essential for professionals who work with this client group. There is also a need to ensure supervisors can offer an appropriate level of expertise in order for supervision to be viewed as adequate.

Importance of professionals having a shared understanding in relation to client work

Having a consistent and shared understanding of individual client difficulties amongst members of the multi-disciplinary team emerged as an important theme in this study, with all four participants describing this as a crucial part of good team work with this client group. Lucy described the shared theoretical framework which the DBT approach provided as being highly beneficial for the effective and consistent working of her team:

In my experience working with [clients with BPD] using DBT, is really good just because I have had a sense of where I am going with people and what we are doing and what it's about and everybody is really clear about it, which makes a huge difference.

Lucy

In contrast to this, the lack of a shared framework or understanding of clients' difficulties was cited as a source of difficulties by the other three participants:

I think some of the aspects of team work can be quite difficult, umm, sort of in terms of consistency and boundaries with people. I've had difficulties at times with that, say for example you've got a care plan and you're working in a specific way with somebody and then another person may unwittingly, I don't mean deliberately, but unwittingly, maybe sabotage or go into something that you are trying to avoid in say one of the groups or in individual work and that has been difficult.

Caroline

Two of the participants described the tendency for clients with BPD to take a polarised view of the professionals involved in their care, idealising some team members whilst being hostile and critical towards others, a phenomena often referred to as "splitting" within the psychodynamic literature. Rebecca viewed this process as being potentially very damaging to team work and relationships unless it was recognised and understood by all involved:

I think [team work is useful] providing the rest of the team can understand also what's going on because I think, you know, you do get the splitting and it's like you know I'm the

awful therapist and the GP's wonderful or the you know the CPN's wonderful and I'm rubbish and I need, I can understand that and as long as the other people can as well, then that's ok. It's if they get hooked into hearing how awful I am and thinking oh yes she's not very good and reacting to that themselves then that's, that can be difficult.

Rebecca

The need for team based supervision and opportunities for case discussion were also described as an important part of effective work with this client group in the recent DOH guidance (NIMHE, 2003, p.44, para 125). This finding is echoed here, in the importance attached by participants to having others around who have a similar understanding of the way they understood and worked with clients. It was clear that participants in this sample placed a high value on having opportunities to allow them to take a coherent team approach to work with the BPD client group.

3.3.5 Personal motivations for working with the client group

Amongst this group of participants, strong personal motivations for work with this client group seemed to act as a buffering factor, which helped them to persist with their work despite there being times when it was difficult. All described their work as challenging and as an opportunity for increased self growth. However, there was evidence of other motives amongst the three participants who had made a conscious decision to work with clients with BPD, with a recognition that these clients had often had to overcome difficult experiences, both in life and in their contact with services. There was an admiration of the tenacity demonstrated by members of this client group and a sense that participants were attempting to redress the balance for their clients by trying to offer them a better experience and service than they may have previously encountered:

They're quite, as a group of people...I'm just trying to think of the word...inspiring to work with as well. When I think about a lot of the experiences and the histories of people that I work with...I enjoy working with people because they are an inspiration.

Lucy

It's a real challenge and I suppose there's something for me which isn't about enjoyment but feels more like to do with injustice. I think that often people get a very raw deal if they have a particular diagnosis, or even, not a diagnosis, but present in particularly difficult ways. It feels that so often the services that they get can be quite punitive, withholding or perhaps can act out something they have already experienced earlier in their life and then, I kind of, I don't know, I have a desire to do something a little bit different or try to.

Anna

There was no doubt that a positive attitude towards the client group was important here, both as an initial motivator in starting work with this client group and in helping the participants to persist with this work. These positive attitudes were felt to stem from participants having an understanding of some of the factors common amongst the histories of their clients, such as the experience of childhood sexual abuse. The findings of this study provide some support for the idea that increasing understanding of these issues and the effects they may have on client behaviour may be an important target for training in order to help foster more positive attitudes towards this client group amongst mental health workers (e.g. Fallon, 2003; Horsfall, 1999).

3.3.6 Reappraisal over time in light of experience

Another important buffering factor identified amongst participants was the adjustment of expectations of client progress over time. A central theme here was that participants had learned to anticipate a slower rate of progress in comparison with other adult client groups:

The longer I've done the work, in a way my expectations have changed of what the outcome is likely to be, maybe that's almost inevitable. There's something about in the beginning, where you really do hope that huge differences are going to be made. My experience is that actually small steps are very important...and sometimes there's even something I think about no change at all, but if somebody's been able to engage in a relationship in a different way, then that in itself is something sometimes that...can be a real move forward.

Anna

When I first trained and I first started working with these people I found them incredibly frustrating because they didn't seem to almost go in a nice straight line as I'd like them to. But I've learnt over time that's how people are and you've got to go with that and work with that and I find it not frustrating at all now really. I probably expect it not to go smoothly all the time and I'm much more realistic maybe about outcomes and goals that people set for themselves and that I would expect as well.

Caroline

This reappraisal of expectations of progress over time seemed a crucial factor in promoting effective work with the BPD client group amongst this sample. This too is

supported in the literature, with Reid et al (1999a) identifying that the slow nature of work and lack of immediate progress amongst clients with more severe mental health difficulties was a source of stress for the professionals in their study. The crucial difference amongst this sample was that the participants talked of reappraising their expectations of progress, so that slow and inconsistent progress did not cause them anxiety. Perhaps this finding can be attributed to the predominance of experienced and well trained individuals amongst this sample, however, this highlights the important role of having realistic expectations of progress amongst staff who work with the BPD client group. This is suggested as an important area for further education and training.

3.4 Overall discussion

This study has begun to explore the qualitative experiences of mental health professionals working with clients with BPD and IPA proved to be a valuable tool in facilitating this. Detailed reflections on the use of this methodology are described in Chapter 4.

The sample used here was small and solely composed of females working in community settings who were predominantly very positive about their work with this client group. Three out of four of the participants had also undertaken specialist training for work with this client group and had made a conscious choice to work in the area. As such, the views expressed are unlikely to be shared by all individuals who may work with this client group in other settings and may feel less positive about their experiences.

It is also likely that the way in which the study was presented to participants and the interviewer's interactions with them during the interview process had an influence on the findings. As this study progressed, the author became increasingly aware of a desire to produce a piece of research which described work with the BPD client group in a more positive and optimistic way than much of the previous published research. It is likely that these aspirations may have been communicated to participants both through the style of the study information sheet and in the direct interactions with those individuals who took part. This may have discouraged some potential participants who did not feel positive about the client group from taking part and influenced those who did take part to present their experiences in a more positive way.

Despite these limitations, the study has been able to provide a powerful insight into the experiences of the four participants involved. Participants' work with this complex group of clients was described as demanding and emotionally and physically draining, with the effects of this being countered or buffered by sharing responsibility and gaining support from others, development of a realistic view of the likely progress of their clinical work and powerful personal motivations to work with this client group. It would be useful to explore the applicability of this model further amongst a wider variety of professionals in the future.

This work has highlighted a number of areas which could be addressed in order to provide effective support for professionals who work with the BPD client group, with many of these findings being consistent with, and providing further support for the guidance provided by the Department of Health (NIMHE, 2003). The study identified a need to ensure that professionals working with the BPD group are content with the size and

balance of their caseloads in order to ensure that there is enough time during the working day for breaks between client sessions and reflection on the work conducted. There is also a need to ensure that individuals have good access to peer support in the workplace as this was viewed as a powerful means of managing stress and may also help to moderate feelings of personal responsibility for clients amongst clinicians.

Amongst this sample, a good understanding of the aetiology of PD type difficulties and realistic expectations about the rate of progress amongst BPD clients were associated with a positive and empathetic view of work with this group. Increasing knowledge in these areas amongst staff who work with this group through training and supervision may assist in promoting more positive attitudes towards the client group generally. In addition, the importance of providing adequate formal supervision for all professionals who work with this group was highlighted and the need for a coherent approach to treatment amongst multi-disciplinary teams also emerged as a strong theme. These findings are consistent with DOH guidance on the provision of services for the PD group (NIMHE, 2003) and the findings of this qualitative study provide powerful support for the implementation of this guidance from the viewpoints of professionals who are actively involved in working with the PD client group on a day to day basis.

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Chapter 4: Reflective Review

4.1 Summary and integration of the research findings

Despite much attention being paid to the area of stress and burnout amongst mental health professionals and limited research focusing on professional attitudes towards clients with a personality disorder (PD), until now the relationships between stress, burnout and attitudes towards the PD client group have not been addressed. The questionnaire based study described in Chapter 2 began to explore the relationships between these areas, along with a preliminary investigation into the perceived difficulties associated with work with this client group. Meanwhile, the qualitative study described in Chapter 3 provided a detailed exploration of the experiences of four mental health professionals working with clients with borderline personality disorder (BPD).

The study described in Chapter 2 highlighted that the provision of specialist training for individuals who work with the PD client group is extremely important, with this being viewed as a mediating factor in the relationship between stress, burnout and attitudes towards the PD client group. A number of possible ways in which training and supervision might be used to improve attitudes and reduce stress and burnout were identified, with increasing awareness of the relationships between behaviour and past life history and education about realistic rates of therapeutic progress amongst this client group being suggested as areas for input amongst staff who work with this group.

The qualitative study reported in Chapter 3 highlighted the important role of peer support, adequate formal supervision and the need for a coherent approach to treatment of this client group amongst multi-disciplinary teams. The findings of the two studies were complementary, with the participants interviewed for the qualitative study illustrating that a

good understanding of the aetiology associated with PD type difficulties and realistic expectations about therapeutic progress were associated with a positive view of work with the BPD client group. This provided further support for the recommendations discussed in Chapter 2. In addition to this, the findings of the two studies provide good support for the proposals described in the recent Department of Health guidance for the development of services for people with PD (NIMHE, 2003).

4.2 Methodological considerations and reflections

Conducting a research project which utilised both quantitative and qualitative methodologies was a challenging experience and I sometimes found it difficult to switch between the two methodologies during the writing up process as I found that producing the two papers involved quite different approaches. However, a major strength of using this combination of methodologies was that it facilitated comparison of the results of the two papers, providing greater credibility for the findings; a process referred to as triangulation (Elliott, Fischer & Rennie, 1999).

Having conducted quantitative research projects for my undergraduate and masters degrees and as part of an assistant psychologist's post I was much more familiar and comfortable with conducting and writing up this type of study. As with my past projects, a major difficulty in conducting the study reported in Chapter 2 was recruiting a large enough sample and I did not manage to recruit my target of 60 participants. On reflection, perhaps a better method of recruitment would have been to attend the appropriate team meetings and introduce the research personally before handing out questionnaire packs for individuals to take away and complete. A similar approach to this was used in Markham (2003) & Markham & Trower's (2003) studies with nursing staff and enabled the

studies to achieve a very high response rate. The ability to generalise from this study's results are limited by the size and nature of the sample. However, despite the small number of participants, the findings which emerged from this sample were strong and this emphasises the need for similar research to be conducted on a larger scale across a number of NHS trusts.

Using a qualitative methodology was a new experience for me and I chose Interpretative Phenomenological Analysis (IPA) as my approach because I felt its emphasis on exploring individual experience suited the aims of my study. There has also been a good deal written about analysis using IPA and as a relatively structured and explicit methodology it appealed to me as a novice qualitative researcher. Having now had the experience of putting this method into practice I feel that it was an appropriate and pragmatic methodology for use in this study and I would definitely consider using IPA again in future qualitative work. However, I had not anticipated quite how time consuming and challenging qualitative research could be. For practical reasons, the interviewing process was much more difficult than I had expected. Using tape recorders and dictation machines without external microphones, I found it very difficult to make good, clear recordings of the interviews and the transcription process was very time consuming. Each of the interviews was recorded using two separate dictation machines, with one being placed next to myself and one near to the participant. This approach was indispensable as it meant that I was able to pick up virtually everything that had been said despite the quality of recordings being poor at times – if one machine didn't record part of an interview clearly then the other one invariably did. It also proved extremely useful when one of my tapes became damaged during the transcribing process as it meant I had a back up copy.

On the whole I found my clinical experience of interviewing and conducting assessments helpful in conducting the interviews for this research. I feel my skills enabled me to create a good rapport with my participants and meant that I was well rehearsed in making tentative summaries of what participants had said, enabling me to check out the validity of my assumptions. However, my intuitive use of minimal encouragers during the interviews did prove problematic on a couple of occasions when to my dismay, during transcription, I found I had actually managed to obscure what a participant had said! Here again, the use of a back up recording was an invaluable resource.

In writing up this qualitative paper, I found there was a tension between keeping the quotes used to support the themes to a practical length and preserving the richness contained in the data. I am aware that in comparison to some IPA studies I have read, my quotes may seem rather long. However, I felt that it was important to provide the reader with sufficient context to enable them to make their own decisions about how well the quotes fitted with the themes. I also felt that limiting the length of many of the quotes would have reduced the paper's capacity to resonate with the reader as the participants' accounts would have lost much of their richness and vibrancy.

As a newcomer to qualitative researcher, the evolving guidelines for reviewing qualitative research produced by Elliott et al (1999) were extremely useful in helping me to think about some of the ways in which a good qualitative research study might differ from a poor one.

Although the small and relatively homogenous sample used in this study limits the generalisations which can be made from the results, the findings raised important clinical

implications which were discussed in Chapter 3. However, it is also important to consider how the characteristics of the self-selecting sample used may have influenced findings. Given the consensus of agreement about the prevalence of negative attitudes towards clients with a personality disorder (discussed in Chapter 2), I was initially surprised at the positivity expressed about work with the BPD client group amongst the participants. However, on reflection, given the finding that participants in this study had strong personal motivations for this type of work and a tendency to view themselves as advocates for the client group it is probably not surprising that these individuals volunteered to take part. It is important to bear in mind that the views of this small group of participants are probably not representative of all professionals who work with the BPD group.

Elliott et al (1999) highlighted the importance of owning one's own perspective and being explicit about how the values, interests and assumptions of the researcher may have affected their interpretation and understanding of the data. As an assistant psychologist, I worked in two separate secure units and in both these jobs had informal contact with women with BPD type difficulties who were living on the mixed gender wards where I was based. At the time, I remember feeling that these types of settings were inappropriate and counter-therapeutic for these women, given that their background histories tended to include severe emotional and sexual abuse. As a fellow woman, I also felt that I tended to empathise more strongly with these clients than my male colleagues. I strongly feel that these experiences were part of what influenced my decision to carry out my research in this area and wonder whether similar processes occurred for some of my participants, both in making a choice to work with the BPD client group and in choosing to take part in

my research project. This might help to explain why my study attracted such a predominance of female participants.

Despite having little direct experience of work with this client group as a trainee clinical psychologist, as I conducted my research I became more aware that part of my motivation for conducting this project was to try to shift the balance amongst the research literature. I realised I was keen to produce a piece of work which felt more optimistic than much previous work and did not present this client group in pejorative terms. I am sure these feelings had an effect on the way I planned and carried out this research and I am aware that I tried hard to write my study information sheets in a neutral and balanced way. This too is likely to have had an effect on the sample recruited and outcomes of the work as it meant I was perhaps more likely to attract participants who felt positively about this client group and viewed themselves as advocates for their clients.

According to Yardley (2000), it is also important to consider the socio-cultural context in which qualitative studies take place and how this may influence the outcomes of such research. In relation to the current study, the recent publication of government guidance for services for people with PD (NIMHE, 2003) and the rise in popularity of treatment approaches for BPD such as Dialectical Behaviour Therapy (DBT) may be important considerations. The mental health community now seems more optimistic about the effective treatment of PDs than ever before and with these feelings being reflected in the participants' accounts of their work, it is likely that this growing culture of optimism had an influence on this study's findings.

4.3 Personal reflections on the research process

Alongside placements and other pieces of academic coursework, I have found the process of carrying out and writing up this research extremely challenging and there have been peaks and troughs in my enthusiasm and optimism along the way. As I come to the end of the writing up process, however, I do feel that it has been a valuable experience, both in terms of generating meaningful and useful findings and in terms of what I have learned about conducting research within the NHS. There is no doubt that the research process has had far reaching effects on my personal life, with holidays, weekends and social events all having been sacrificed to some degree and my family, friends and partner all being neglected in the name of my thesis.

Although I had conducted research projects for my undergraduate and masters degrees in the past, conducting this research in a predominantly community setting within the NHS was a new and much more difficult experience for me. My previous projects had involved undergraduate students and mentally disordered offenders resident in a medium secure unit as participants, and with my research forming part of larger, established projects in both cases, these samples were much more straightforward to recruit and had not necessitated the long process of gaining approval from either NHS ethics or Research and Development committees. In conducting this research, I have learned a great deal about what it is really like to plan and conduct a research project within the NHS. I feel that the skills and knowledge I have developed as a result have provided me with a good grounding for my career ahead, which I have no doubt will involve me conducting research again in the future.

I found both the quantitative and qualitative aspects of my research interesting, but one of the things I enjoyed the most about using a qualitative methodology was that I was actually able to meet and learn something about my participants. They were all very enthusiastic about my research and this was both encouraging and motivating. I also found the data collected fascinating, and despite finding the process of analysis challenging, I would be keen to use a qualitative approach to research again in the future.

During the process of this study, I regularly met with a group of other trainees who were also using IPA as their method of analysis. My involvement within this study group was a very valuable part of the research process as this enabled me to learn a good deal about IPA as a methodology and gain objective opinions about the validity of my analysis. It also helped me to generate new ideas and interpretations which I had not previously considered and was an invaluable source of moral support.

4.4 Directions for future research

Some areas for further research have already been discussed in Chapters 2 and 3. It is clear that the complex relationships between stress, burnout, specialist training and attitudes towards the PD client group require further investigation across a more diverse range of professionals and in other NHS trusts. It would also be interesting to explore the qualitative experiences of a wider variety of mental health professionals who work with this group.

As this project has progressed, a number of other interesting ideas for future research have arisen. Linehan, Cochran, Mar, Levensky & Comtois' (2000) research investigated the phenomenon of burnout as a reciprocal experience for both therapists and clients,

concluding that the phenomenon of client burnout was similar to that experienced by therapists, in that clients could also become emotionally exhausted from the therapy and begin to depersonalise the individual they were working with. This is an extremely interesting area which has not been the subject of further research. I feel it would be beneficial to investigate this phenomenon from a client point of view using a qualitative methodology.

Throughout the process of conducting my research, I have also been conscious that the voice of the client has been missing. Some research has already been conducted within this area, such as Fallon's (2003) grounded theory study which explored the experience of mental health services for individuals with BPD. However, evidence which shows that some service users perceive research agendas and methodologies generated by professional researchers as an imposition which they feel suspicious of and alienated from means that it is increasingly important to involve service users in planning and carrying out research projects (Oliver, 1992; Beresford & Wallcraft, 1997). Ramon, Castillo & Morant (2001) carried out a qualitative study which trained people with a PD diagnosis to conduct interviews with fifty people who also had a diagnosis of PD. These interviews focused on the meaning of the PD diagnosis and participants' experiences of contact with services and Ramon et al (2001) concluded that this approach to research was both useful and viable. It seems important that future research continues to extend the use of this type of research methodology within this area in order to gain a more comprehensive picture of service users' experiences of the processes of diagnosis and treatment within the mental health system.

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Appendix 1

The Mental Health Professional Stress Scale (MHPSS)

MHPSS

SOURCES OF PRESSURE AT WORK

The following have been found to be sources of pressure at work in health care.
Please respond by circling the numbers which represent the extent to which each item applies to you
(i.e. represents a source of pressure at work for you).

		Does not apply to me		Does apply to me	
1	Too much work to do.....	0	1	2	3
2	Ending treatment with clients/patients	0	1	2	3
3	Lack of support from management.....	0	1	2	3
4	Conflict with other professionals e.g. doctor, nurse...	0	1	2	3
5	Lack of adequate staffing.....	0	1	2	3
6	Feeling inadequately skilled for dealing with emotional needs of clients/patients.....	0	1	2	3
7	Not enough time with family.....	0	1	2	3
8	Too many different things to do	0	1	2	3
9	Dealing with death or suffering.....	0	1	2	3
10	Relationship with line manager.....	0	1	2	3
11	Conflicting roles with other professionals.....	0	1	2	3
12	Lack of financial resources for training courses/workshops.....	0	1	2	3
13	Uncertainty about own capabilities.....	0	1	2	3
14	Inability to separate personal from professional role...	0	1	2	3
15	Not enough time to complete all tasks satisfactorily....	0	1	2	3
16	No change or slowness of change in clients/patients....	0	1	2	3
17	Communications and flow of information at work.....	0	1	2	3
18	Working in a multidisciplinary team.....	0	1	2	3
19	Shortage of adequate equipment/supplies.....	0	1	2	3
20	Feeling inadequately skilled for working with difficult clients/patients.....	0	1	2	3

		Does not apply to me		Does apply to me	
21	Taking work home.....	0	1	2	3
22	Too many clients/patients.....	0	1	2	3
23	Difficult and/or demanding clients or patients.....	0	1	2	3
24	Poor management and supervision.....	0	1	2	3
25	Criticism by other professional e.g. doctor, nurse.....	0	1	2	3
26	Lack of adequate cover in potentially dangerous Environment.....	0	1	2	3
27	Doubt about the efficacy of therapeutic endeavours.....	0	1	2	3
28	Relationship with spouse/partner affects work.....	0	1	2	3
29	Working too long hours.....	0	1	2	3
30	Physically threatening clients/patients.....	0	1	2	3
31	The way conflicts are resolved in the organisation.....	0	1	2	3
32	Lack of emotional support from colleagues.....	0	1	2	3
33	Inadequate clerical /technical back-up.....	0	1	2	3
34	Keeping professional/clinical skills up to date.....	0	1	2	3
35	Work emphasises feelings of emptiness and/or isolation.	0	1	2	3
36	Not enough time for recreation.....	0	1	2	3
37	Managing therapeutic relationships.....	0	1	2	3
38	Organisational structure and policies.....	0	1	2	3
39	Difficulty of working with certain colleagues.....	0	1	2	3
40	Poor physical working conditions.....	0	1	2	3
41	Fear of making a mistake over a client/patient's treatment	0	1	2	3
42	Inadequate time for friendships/social relationships.	0	1	2	3

Appendix 2

The Maslach Burnout Inventory (MBI)

MBI Human Services Survey

The purpose of this survey is to discover how various persons in the human services or helping professions view their jobs and the people with whom they work closely. Because persons in a wide variety of occupations will answer this survey, it uses the term *recipients* to refer to the people for whom you provide your service, care, treatment, or instruction. When answering this survey please think of these people as recipients of the service you provide, even though you may use another term in your work.

On the following page there are 22 statements of job-related feelings. Please read each statement carefully and decide if you ever feel this way *about your job*. If you have *never* had this feeling, write a "0" (zero) before the statement. If you have had this feeling, indicate *how often* you feel it by writing the number (from 1 to 6) that best describes how frequently you feel that way. An example is shown below.

Example:

HOW OFTEN:	0	1	2	3	4	5	6
	Never	A few times a year or less	Once a month or less	A few times a month	Once a week	A few times a week	Every day

HOW OFTEN

0 - 6

Statement:

_____ I feel depressed at work.

If you *never* feel depressed at work, you would write the number "0" (zero) under the heading "HOW OFTEN." If you *rarely* feel depressed at work (a few times a year or less), you would write the number "1." If your feelings of depression are fairly frequent (a few times a week, but not daily) you would write a "5."



Consulting Psychologists Press, Inc.

3803 E. Bayshore Road • Palo Alto, CA 94303

Published by Consulting Psychologists Press, Inc. ("CPP"), 3803 E. Bayshore Road, Palo Alto, California 94303.

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Appendix 3

Attitudes to Personality Disorder Questionnaire (APDQ)

APDQ

Now please take a moment to reflect upon your experience of working with patients with personality disorder (PD).

For the purposes of this questionnaire we would like you to think about your feelings towards PD patients overall. We realise that you may have different mixtures of feelings about different PD patients you have worked with in the past. For this questionnaire we would like to you try and average those out and tell us what your responses are in general towards PD patients as a whole.

For each response listed below please indicate the frequency of your feelings towards people with a personality disorder. Please circle your choice quickly, rather than spending a long time considering it. We want to know your honest, gut feelings.

		Never	Seldom	Occasionally	Often	Very often	Always
1	I like PD patients	1	2	3	4	5	6
2	I feel frustrated with PD patients	1	2	3	4	5	6
3	I feel drained by PD patients	1	2	3	4	5	6
4	I respect PD patients	1	2	3	4	5	6
5	I feel fondness and affection for PD patients	1	2	3	4	5	6
6	I feel vulnerable in PD patients company	1	2	3	4	5	6
7	I have a feeling of closeness with PD patients	1	2	3	4	5	6
8	I feel manipulated or used by PD patients	1	2	3	4	5	6
9	I feel uncomfortable or uneasy with PD patients	1	2	3	4	5	6
10	I feel I am wasting my time with PD patients	1	2	3	4	5	6
11	I am excited to work with PD patients	1	2	3	4	5	6
12	I feel pessimistic about PD patients	1	2	3	4	5	6

Please Turn Over

		Never	Seldom	Occasionally	Often	Very often	Always
13	I feel resigned about PD patients	1	2	3	4	5	6
14	I admire PD patients	1	2	3	4	5	6
15	I feel helpless in relation to PD patients	1	2	3	4	5	6
16	I feel frightened of PD patients	1	2	3	4	5	6
17	I feel angry towards PD patients	1	2	3	4	5	6
18	I feel provoked by PD patients behaviour	1	2	3	4	5	6
19	I enjoy spending time with PD patients	1	2	3	4	5	6
20	Interacting with PD patients makes me shudder	1	2	3	4	5	6
21	PD patients make me feel irritated	1	2	3	4	5	6
22	I feel warm and caring towards PD patients	1	2	3	4	5	6
23	I feel protective towards PD patients	1	2	3	4	5	6
24	I feel oppressed or dominated by PD patients	1	2	3	4	5	6
25	I feel that PD patients are alien, other, strange	1	2	3	4	5	6
26	I feel understanding towards PD patients	1	2	3	4	5	6
27	I feel powerless in the presence of PD patients	1	2	3	4	5	6
28	I feel happy and content in PD patients company	1	2	3	4	5	6
29	I feel cautious and careful in the presence of PD patients	1	2	3	4	5	6
30	I feel outmanoeuvred by PD patients	1	2	3	4	5	6
31	Caring for PD patients makes me feel satisfied and fulfilled	1	2	3	4	5	6
32	I feel exploited by PD patients	1	2	3	4	5	6
33	I feel patient when caring for PD patients	1	2	3	4	5	6
34	I feel able to help PD patients	1	2	3	4	5	6
35	I feel interested in PD patients	1	2	3	4	5	6
36	I feel unable to gain control of the situation with PD patients	1	2	3	4	5	6
37	I feel intolerant. I have difficulty tolerating PD patients behaviour	1	2	3	4	5	6

Appendix 4

Demographic Questionnaire

Please tell us some basic details about yourself by circling the response that applies.

1. **Age** Under 20 yrs / 20–29 yrs / 30–39 yrs / 40–49 yrs / 50–59 yrs / 60+ yrs

2. **Gender** Male / Female

3. **What setting do you work in? (e.g. inpatient unit, Community Mental Health Team etc.)**

.....

4. **Your job title and grade (if appropriate)**

.....

5. **If you are a qualified health professional (e.g. nurse, doctor, clinical psychologist, occupational therapist) how many years since you qualified?**

.....

6. **Approximately how much of your working time do you spend working with clients with personality disorders?**

None / up to 25% / 25 – 50% / 51 – 75% / 76 – 100%

7. **Approximately how many of the clients on your caseload would you consider to have personality disorder type problems?**

.....

8. **Have you received any specialist training on how to work with personality disordered clients?**

Yes / No If yes, please specify what.....

9. **Do you feel adequately trained to work with personality disordered clients?** Yes / No

10. In your opinion, what are the THREE most difficult or stressful things about working with clients with personality disorders?

1)

.....

2)

.....

3)

.....

11. Please describe the THREE most useful coping strategies that help you when you feel your work is stressful.

1)

.....

2)

.....

3)

.....

Appendix 5

Local Research Ethics Committee (LREC) approval

Warwickshire Local Research Ethics Committee

Lewes House
George Eliot Hospital
College Street
Nuneaton
Warwickshire
CV10 7DJ

2nd December 2003

Emma Cotes
22 Elkington Croft
Solihull
West Midlands
B90 4PB

Tel: 02476 865244
Fax: 02476 865058
pat.horwell@geh.nhs.uk

Dear Emma

REC Ref: 603 Study title Stress, burnout and the attitudes and experiences of mental health professionals working with clients diagnosed with or believed to have a personality disorder

The Chairman on behalf of the Warwickshire LREC has considered your response to the issues raised by the Committee at the first review of your application on 25th September, 2003 as set out in our letter dated 13th October 2003. The documents considered were as follows:

- ◆ PIS Version 2 October 2003 x 2
- ◆ R & D Management permission 25th November 2003

The Chairman, acting under delegated authority, is satisfied that your response has fulfilled the requirements of the Committee. You are therefore given approval for your research on ethical grounds providing you comply with the conditions set out below:

Conditions of approval:

- (Where approval is given before receipt of CTX) Please let the LREC have a copy of the CTX when it is available. If changes to the protocol are required by the MHRA (Medicines and Healthcare Products Regulatory Agency), the LREC approval will become void until those changes have been made and the revised protocol will need to be approved.
- You do not undertake this research in any NHS organisation until the relevant NHS management approval has been received.
- You do not deviate from, or make changes to, the protocol without the prior written approval of the LREC, except where this is necessary to eliminate immediate hazards to research participants or when the change involves only logistical or administrative aspects of the research. In such cases, the LREC should be informed within seven days of the

implementation of the change. Likewise, you should also seek the relevant NHS management approval for the amendment, or inform the NHS organisation of any logistical or administrative changes.

- You complete and return the standard progress report form to the LREC one year from the date of this letter and thereafter on an annual basis. This form should also be used to notify the Committee when your research is completed and should be sent to the REC within three months of completion. For a copy of the progress report please see www.corec.org.uk.
- If you decide to terminate this research prematurely, a progress report form should be sent to the LREC within 15 days, indicating the reason for the early termination. For a copy of the progress report please see www.corec.org.uk.
- You must advise the LREC of all Suspected Serious Adverse Reactions (SSARs) and all Suspected Unexpected Serious Adverse Reactions (SUSARs).
- You advise the LREC of any unusual or unexpected results that raise questions about the safety of the research.
- The project must be started within three years of the date of this letter.

NHS LRECs are compliant with the International Conference on Harmonisation/Good Clinical Practice (ICH GCP) Guidelines for the conduct of trials involving participation of human subjects.

Your application has been given a unique reference number, please use it on all correspondence with the LREC.

Yours sincerely



Pat Horwell
Administrator
Warwickshire Local Research Ethics Committee

Cc: [Karen Payton, NWPCT]
[Dr. A. Gatherer]
Enc: List of members present

Appendix 6

Coventry University Ethics Committee Approval

STUDENT SUBMISSION TO SCHOOL RESEARCH ETHICS COMMITTEE

1. Student's name: EMMA COTES
(BLOCK CAPITALS)

2. Course: CLINICAL PSYCHOLOGY
DOCTORATE

3. Title of project: STRESS, BURNOUT AND THE ATTITUDES AND EXPERIENCES OF MENTAL HEALTH PROFESSIONALS WORKING WITH CLIENTS DIAGNOSED WITH, OR BELIEVED TO HAVE A PERSONALITY DISORDER.

4. Summary of the project in jargon-free language and in not more than 120 words:

Sample:
MENTAL HEALTH PROFESSIONALS OF ALL TYPES

Research site:
NORTH + SOUTH WARWICKSHIRE PRIMARY CARE TRUSTS

Design (eg experimental):
STUDY HAS 2 PARTS - QUANTITATIVE QUESTIONNAIRE SURVEY & QUALITATIVE INTERVIEWS (ANALYSED USING IPA).

Methods of data collection:
QUANTITATIVE QUESTIONNAIRE SURVEY: - POSTAL SURVEY TO MENTAL HEALTH JOBS PROFS. QUESTIONNAIRE PACK CONTAINS 4 QUESTIONNAIRES (1 MEASURE OF BURNOUT, 1 MEASURE OF WORK RELATED STRESS, 1 MEASURE OF ATTITUDES TOWARDS P.D. CLIENTS, PLUS A DEMOGRAPHIC QUESTIONNAIRE). PLAN TO SEND OUT APPROX. 250 Q'NAIRE PACKS

QUALITATIVE INTERVIEWS:
MAIN METHOD OF DATA COLLECTION IS INTERVIEWS WITH INDIVIDUAL STAFF MEMBERS (N = 6 - 10). EACH INTERVIEW WILL LAST APPROX 45 MINS AND WILL FOCUS ON EXPERIENCES OF WORKING WITH THE P.D. CLIENT GROUP. THE INTERVIEWS WILL BE ANALYSED USING INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS (IPA).

Access arrangements (if applicable):
TO BE ARRANGED BY MYSELF IN CONJUNCTION WITH MY SUPERVISORS, DR DEUA CUSHWAY + DR AMANDA GATHERER.

- 5. Will the project involve patients(clients) and/or patient(client) data? Yes [] No [X]
- 6. Will any invasive procedures be employed in the research? Yes [] No [X]
- 7. Is there a risk of physical discomfort to those taking part? Yes [] No [X]
- 8. Is there a risk of psychological distress to those taking part? Yes [X] No []
- 9. Will specific individuals or institutions (other than the University) be identifiable through data published or otherwise made available? Yes [] No [X]
- 10. Is it intended to seek informed consent from each participant (or from his or her parent or guardian)? Yes [X] No []

Student's signature:
Emma Cotes

Supervisor's signature:
Deua Cushway

Date:
22/10/03

FOR COMMITTEE USE:

Immediate approval [X]
Referral to local Hospital Ethics Committee []

Referral to full School Committee []
Decision pending receipt of further information []
(specify below)

Committee Member's signature:
David Giles

Date:
27/10/03

Appendix 7

Research & Development Committee Approval

Centre for Quality and Education in Health Care
Jepson House
4 Manor Court Avenue
Nuneaton
CV11 5HX

Tel: 024 7637 4045

Fax: 024 7632 1524

Email: karen.payton@nw-pct.nhs.uk

Our ref: ecotes_internal_approval

25 November 2003

Emma Cotes
22 Elkington Croft
Solihull
West Midlands
B90 4PB

Dear Emma

Research Application: Stress, burnout and the attitudes and experiences of mental health professionals working with clients diagnosed with or believed to have a personality disorder

Thank you for your application for approval to undertake the above research.

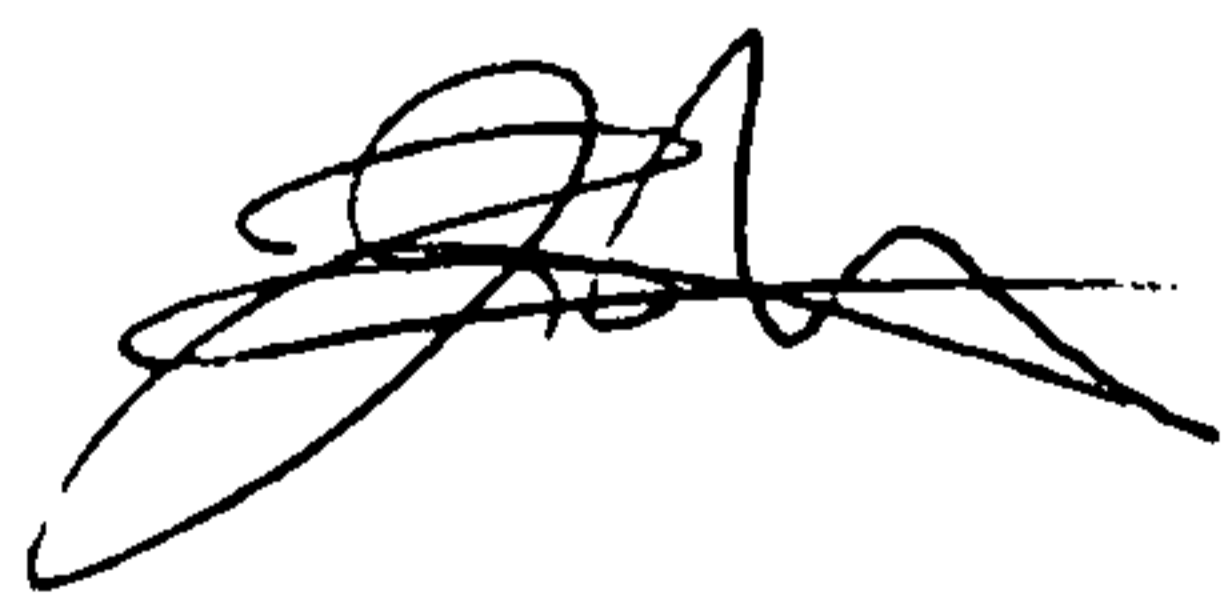
I have reviewed your application and research protocol against research governance guidelines and I am pleased to confirm that the Trust approves this application.

As we discussed, please could you let me have a copy of the covering letter which will accompany the information sheet for participants who have indicated a willingness to be interviewed.

Could you also provide me with a copy of your final report when the research is complete. I would also encourage you to publish your finished research in appropriate journals.

Good luck with this project. I look forward to seeing the outcomes of this work.

Yours sincerely



Karen Payton
Research Governance Facilitator

cc Dr Amanda Gatherer, Clinical Psychologist, The Manor
Mrs Pat Horwell, LREC Administrator, Lewes House, George Eliot Hospital

Appendix 8

Participant Information Sheet (Empirical paper 1)

Programme Director
Doctorate Course in Clinical Psychology
Dr Delia Cushway
BA (Hons) MSc PhD AFBPS CPsychol (Clin Foren)

School of Health and Social Sciences
Coventry University
Priority Street Coventry CV1 5FB
Telephone 024 7688 8328
Fax 024 7688 8300



C O V E N T R Y
U N I V E R S I T Y

Our ref

Stress, burnout and attitudes towards personality disorder in mental health professionals

My name is Emma Cotes and I am a Trainee Clinical Psychologist who is carrying out this research for my doctoral thesis. I am studying on the Clinical Psychology Doctorate run by the Universities of Coventry & Warwick.

Date

You are being invited to take part in a research study. Before you decide whether or not you wish to take part it is important for you to understand why the research is being done and what it will involve.

Please read this information sheet carefully and take time to decide whether or not you wish to take part.

What is the purpose of the study?

This is a questionnaire survey which aims to:

- Investigate levels of work related stress and burnout in professionals working within a range of mental health settings (including inpatient and outpatient settings).
- Investigate attitudes towards clients who have been diagnosed with or are believed to have a personality disorder.

Why have I been chosen?

We are interested in the views and experiences of professionals who work with clients referred to a range of mental health services. You have been asked to take part in the study because you work in a mental health setting and have direct professional contact with clients referred to mental health services. Up to 300 other professionals working within North and South Warwickshire Primary Care Trusts will also be invited to take part in this study.

Do I have to take part?

Taking part in this research is voluntary. It is up to you to decide whether or not to take part. If you do decide to take part you should keep this information sheet, complete the questionnaires and return them in the enclosed envelope. If you take part and change your mind later you are still free to withdraw at any time, without giving a reason, by contacting the study investigator.

What will happen if I decide to take part?

This is a questionnaire based survey. If you decide to take part you are asked to complete and return a set of four questionnaires which are included in this envelope. These should take approximately 30 minutes to complete.

What do I have to do?

- If you wish to take part, please complete the four questionnaires enclosed in this envelope. Two of the questionnaires ask about work related stress and one questionnaire asks about your attitudes towards individuals with a personality disorder. The fourth questionnaire asks for some background information about you, your job & training etc.
- Please do not write your name on the completed questionnaires - your responses will remain anonymous.

- When you have completed them please return them in the enclosed stamped addressed envelope.

What are the benefits of taking part?

Taking part in this survey will help to inform health service managers both locally and nationally about the true levels of stress and burnout among staff working within mental health services. Your responses will also help us to build up a picture of what types of support and training are needed by staff working in a variety of mental health settings.

Confidentiality

All the information you give will be kept confidential.

- You will be assigned a random participant number and the responses from your questionnaires will be entered on to a computer database where they will only be identified by this number.
- When the research has been completed and written up, the results will be summarised and the contributions of individual participants will not be discussed in the reports. You will not be personally identifiable in any reports written or published about the research.

LREC approval

This study has been approved by Warwickshire Local Research Ethics Committee. It has also been discussed with and approved by your local Research & Development Officer. The study is supervised by both an academic supervisor at Coventry University (Dr Delia Cushway) and by a local Clinical Psychologist (Dr Amanda Gatherer).

What will happen to the results of this study?

The estimated completion date for this research is mid 2004. The results of this study will be reported and submitted as part of the principal investigator's doctoral thesis. The results will also be submitted for publication in academic journals. Individual participants will not be identified in any reports or publications arising from this research.

If you have any questions or need any further information about the study please contact:

Emma Cotes
Trainee Clinical Psychologist
c/o Clinical Psychology Doctorate
School of Health & Social Sciences
Coventry University
Priory Street
Coventry CV1 5FB

Telephone: 024 7688 8328 Email: cotese@coventry.ac.uk

The research is being facilitated by Dr Amanda Gatherer. If you have any concerns regarding the study please contact her at:

Dr Amanda Gatherer
Psychology Department
The Manor
6 Manor Court Avenue
Nuneaton
Warwickshire CV11 5HX

Telephone: 024 7637 4434

Appendix 9

Flyer introducing qualitative research study

Would you be willing to be interviewed about your experiences working with clients diagnosed with or believed to have a personality disorder?

We are also looking for mental health professionals who would agree to be interviewed about their experiences of working with clients diagnosed with, or believed to have a personality disorder.

The interview would last approximately 45 minutes and would be arranged at a time and place convenient to you.

If you would like to find out more about this part of the research please complete your details in the spaces below. You will then be sent further information about the research which will help you to decide whether or not you would like to take part. Completing your details below does not commit you to taking part in an interview.

Please send me further information about the interview part of the research.

Name: _____

Occupation: _____

Telephone no: _____

Address where you would like the information to be sent: _____

Please return this form to Emma Cotes in the enclosed pre-paid envelope.

Appendix 10

Letter to potential participants (Empirical paper 2)

Programme Director
Doctorate Course in Clinical Psychology
Dr Delia Cushway
BA (Hons) MSc PhD AFBPS CPsychol (Clin Foren)

School of Health and Social Sciences
Coventry University
Priory Street Coventry CV1 5FB
Telephone 024 7688 8328
Fax 024 7688 8300



C O V E N T R Y
U N I V E R S I T Y

Our ref

Your ref

Dear

Date

Qualitative experiences of mental health professionals working with clients diagnosed with or believed to have a personality disorder

Thank you for expressing an interest in taking part in this research project. Please find enclosed an information sheet which will give you more details about what taking part in the study involves. Please read it carefully and consider whether or not you are willing to take part.

When you have made your decision please complete the detachable reply slip at the bottom of this letter and return it to me in the enclosed pre-paid envelope.

Thank you for taking the time to find out about this study. If you have any further queries, please contact Emma Cotes (Trainee Clinical Psychologist). Contact details are included on the enclosed information sheet.

Yours Sincerely

Emma Cotes
Trainee Clinical Psychologist

✂-----

Qualitative experiences of mental health professionals working with clients diagnosed with or believed to have a personality disorder

Please tick the appropriate statement:

I am willing to be interviewed as part of the above study

I am not willing to be interviewed as part of the above study

If you are willing to take part, please complete your details below. You will then be contacted to arrange a convenient time/place for the interview to take place.

Name _____

Telephone no _____

Email address (if appropriate) _____

Appendix 11

Participant Information Sheet (Empirical paper 2)

Programme Director
Doctorate Course in Clinical Psychology
Dr Delia Cushway
BA (Hons) MSc PhD AFBPS CPsychol (Clin Foren)

School of Health and Social Sciences
Coventry University
Priory Street Coventry CV1 5FB
Telephone 024 7688 8328
Fax 024 7688 8300



C O V E N T R Y
U N I V E R S I T Y

Our ref

Qualitative experiences of mental health professionals working with clients diagnosed with or believed to have a personality disorder

Your ref

My name is Emma Cotes and I am a Trainee Clinical Psychologist who is carrying out this research for my doctoral thesis. I am studying on the Clinical Psychology Doctorate run by the Universities of Coventry & Warwick.

You are being invited to take part in a research study. Before you decide whether or not you wish to take part it is important for you to understand why the research is being done and what it will involve.

Please read this information sheet carefully and take time to decide whether or not you wish to take part.

What is the purpose of the study?

This is an interview based study which aims to explore the qualitative experiences of mental health professionals working with clients diagnosed with, or believed to have a personality disorder. Past research has indicated that this client group is often considered difficult to work with, but the specific reasons for these feelings have not been explored in detail. For this reason a qualitative methodology has been chosen for this study. The focus of the interviews will be on your experience as a professional working with this client group and you will be encouraged to talk about both positive and negative aspects of your work.

Why have I been chosen?

We are interested in the views and experiences of all types of mental health professionals who work with clients who may be termed personality disordered. You have been asked to take part in the study because you work in a mental health setting and are likely to have direct professional contact with this client group. We are looking to interview approximately ten professionals in total.

Do I have to take part?

Taking part in this research is voluntary and it is up to you to decide whether or not to take part. If you take part and change your mind later you are still free to withdraw at any time, without giving a reason, by contacting the study investigator.

What will happen if I decide to take part?

- You will meet with the study investigator who will carry out the interview at a time and place convenient to you.
- You will have an opportunity to ask any questions you may have prior to the start of the interview and will be asked to sign a consent form when you are sure that you are happy to take part.
- The interview is likely to last approximately 45 minutes.
- It will be audio taped and transcribed by the study investigator.

What do I have to do?

- If you wish to take part, you should keep this information sheet and complete and return the reply slip to the study investigator in the enclosed envelope. The study investigator will then contact you to arrange a time and place for the interview.

What are the benefits of taking part?

The aim of the research is to find out more about the experiences and needs of staff working with clients who are diagnosed with or are believed to have a personality disorder. Taking part will help us to build up a detailed account of what this type of work entails on a day to day basis. It will also help to identify what types

of training and support staff working with this client group may need. Agreeing to take part will give you a chance to discuss and think about your experiences. The focus of the interview will be on your personal experiences and views and will be a one-off event.

What are the disadvantages of taking part?

In some cases, taking part in an interview like this one could provoke unpleasant or difficult memories. However, if you do agree to be interviewed for this study please be assured that you will not have to answer any questions or discuss any experiences if you do not feel comfortable to do so. The focus of the interviews will be on your experiences from your viewpoint and it will be up to you to decide what information you wish to discuss.

Confidentiality

All the information you give will be kept confidential.

- Your interview will be audio taped and transcribed by the study investigator.
- Your name will not be written on the tape or transcript of your interview. Each participant will be assigned a random number which will be used to identify their tape and transcript. The consent form is the only place where your name will be written and this will be stored separately from the tapes and transcripts.
- You will not be personally identifiable in any reports written or published about the research.
- The tapes and transcripts will be destroyed once the research thesis has been passed.

LREC approval

This study has been approved by Warwickshire Local Research Ethics Committee. It has also been discussed with and approved by your local Research & Development Officer. The study is supervised by both an academic supervisor at Coventry University (Dr Delia Cushway) and by a local Clinical Psychologist (Dr Amanda Gatherer).

What will happen to the results of this study?

The estimated completion date for this research is mid 2004. The results of this study will be reported and submitted as part of the principal investigators' doctoral thesis. The results are also likely to be submitted for publication in academic journals. Individual participants will not be identified in any reports or publications arising from this research.

For further information about the study please contact:

Emma Cotes
Trainee Clinical Psychologist
c/o Clinical Psychology Doctorate
School of Health & Social Sciences
Coventry University
Priory Street
Coventry CV1 5FB

Telephone: 024 7688 8328

Email: cotese@coventry.ac.uk

The research is being facilitated by Dr Amanda Gatherer. If you have any concerns regarding the study please contact her at:

Dr Amanda Gatherer
Psychology Department
The Manor
6 Manor Court Avenue
Nuneaton
Warwickshire CV11 5HX

Telephone: 024 7637 4434

Appendix 12

**Interview Schedule
(Empirical paper 2)**

Interview Schedule

Description of work

To start off with, can you tell me a bit about the job that you do?

Prompt for:

- Occupational group
- Part/full time
- Work setting
- How long have you worked in your current post?
- How long since you qualified in chosen profession?

What types of clients do you work with?

Prompt for:

- What contact do you have with clients who may be described as having a personality disorder?
- Which diagnostic categories would the clients you work with best fit into?
- Approximately how much of your clinical time do you spend working with this group?

Views on the client group and terminology

I am aware that the term personality disorder can be a contentious term. What are your opinions about the use of this term/the diagnostic categories?

Prompt for:

- Do you think this approach is helpful or unhelpful?
- Why? Why not?
- How would you tend to define/describe this group?

What are the best things about working with this group?

Prompt:

- Why?

What do you enjoy least about working with this group?

Prompt for:

- Why?
- What do you find most difficult/stressful about working with this group?
 - Why do you think this is?

How do you think work with this client group compares with work with other client groups?

Prompt for:

- How?
- What are the similarities/differences?

Have your views about working with this group changed over time at all?

Prompt for:

- How?
- Why do you think this is? (prompt for particular influences)

Did you make a conscious choice to work with this group?

Prompt:

- Why?

How easy do you find it to empathise with this group?

Prompt for:

- Why do you think this is so? (prompt for particular influences)

How do you think your attitudes towards this client group compare with those of other professionals you work closely with?

Prompt for:

- What are their views?
- Why do you think they might hold these similar/different views?
- How do you deal with differences in attitude/opinion?

Effects of your work on yourself

How do you feel your work with this client group affects you on a personal basis?

Prompt for:

- During working hours? How do you cope with this? Why is this helpful?
- Outside working hours? How do you cope with this? Why is this helpful?
- Do you feel your work with this client group affects you positively in any ways?
 - Inside work? How is this helpful?
 - Outside work? How is this helpful?

How well supported do you feel at work?

Prompt for:

- Are there any ways in which you feel this could be improved?
- How?

Do you have any ideas for how support for professionals who work with this client group could be improved more generally?

Prompt:

- How?

Finally, is there anything else that you would like to add to any of your responses?

Is there anything you have said during the course of this interview that you would prefer me to exclude from my analysis?

Appendix 13

Consent form for participants (Empirical paper 2)

Programme Director
Doctorate Course in Clinical Psychology
 Dr Delia Cushway
 BA (Hons) MSc PhD AFBPS CPsychol (Clin Foren)
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C O V E N T R Y
U N I V E R S I T Y

Centre number:
 Participant number:

Our ref

Your ref

CONSENT FORM

Qualitative experiences of mental health professionals working with clients diagnosed with or believed to have a personality disorder

Date

Please read the following statements and initial each box:

1. I confirm that I have read and understood the information sheet for the above study (dated October 2003).
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving a reason by contacting the study investigator.
3. I consent to have my interview recorded on audio tape.
4. I agree to take part in the above study.

Please print and sign your name below:

 Name of participant

 Date

 Signature

 Researcher

 Date

 Signature

Appendix 14

**Sample extract from an interview
(Empirical paper 2)**

Sample extract from an interview

- 1 Interviewer: OK, so moving on a little bit, what would you say for you are the
2 best things about working with this group of clients?
- 3 Participant: Best things...I find it, I think its quite challenging, very challenging
4 actually (laughs) and its quite stimulating because its challenging. It stretches
5 me, and I have to think a lot about we're doing and about whats going on
6 between us and those kinds of things. And the clients that I've worked with,
7 most of them, we've had sessions that have been absolutely brilliant and really
8 you know kind of, I've felt a real sense of achievement in some of the sessions
9 we've done and some of the sessions have been absolutely horrendous. So
10 its like the two sides of a coin really, which is suppose is what they're like isn't
11 it, sort of black or white and so that's my experience too, some of its great and
12 its intriguing and stimulating and interesting and challenging and its awful and
13 terrible and ooh, sometimes I think oh why do I do this?
- 14 I: What would you say would you think are the most difficult things about
15 working with this particular group of clients?
- 16 P: Umm. I think it's the kind of countertransference, you know, what I pick up
17 from them, the projections, the splitting, the way they, their anger, umm, the
18 way you know, its so volatile really, its so up and down, its so hard to know
19 really what you are going to get each time you meet.
- 20 I: Mmm hmm
- 21 P: And I know that I can end up feeling deskilled, struggling, all of those things
22 and I know I really have to kind of hold on to myself and know that I can do
23 things to get through it. So um, sometimes its really tough.
- 24 I: Mmm hmm, and it sounds like from what you're saying as well that its
25 important to pay attention to the process...
- 26 P: Oh absolutely, absolutely, yes. I think that's the most important thing really.
- 27 I: And what about working as part of a team when you're working with this
28 client group, how has that been?
- 29 P: Umm, I think that's useful because it gives me somewhere to umm spread
30 the load if you like, you know if I've had a particularly difficult session, then I
31 can, we have a kind of peer support system here so there's always someone I
32 can go and talk to and offload and maybe just discuss the way forward on a
33 quite informal basis. Of course I have supervision too but its nice to be able to
34 just do it straight away after a difficult session or you know within the week
35 anyway. Umm and in terms of kind of containing them and you know things
36 like self harm and things like that, its useful to have somebody else, you know
37 maybe like a CPN or the GP. Strictly they are not part of the team but they are
38 involved, so you can talk to them about that and find strategies for managing
39 that.
- 40 I: Umm hmm, so it sounds like its helpful to perhaps spread a bit of the
41 responsibility.....
- 42 P: Yeah, yes that's right, yeah, because I think I can get very, it can feel so
43 heavy if its just me and you know it feels, it can feel like a huge responsibility if
44 I let it. If I don't do the offloading, if I don't talk to other people and involve
45 other people, then it can get very heavy.
- 46 I: So it sounds on balance for you working as part of team is a good
47 experience when you are working with this type of client?

48 P: I think it is providing the rest of the team can understand also what's going
49 on because I think, you know, you do get the splitting and its like you know I'm
50 the awful therapist and the GPs wonderful or the you know the CPNs
51 wonderful and I'm rubbish and I need, I can understand that and as long as the
52 other people can as well, then that's ok. Its if they get hooked into hearing how
53 awful I am and thinking oh yes she's not very good and reacting to that
54 themselves then that's, that can be difficult.

55 I: Mmm hmm, ok...do you think that work with this client group differs from
56 work with other client groups in any way?

57 P: Ummm, well it differs in that its more demanding I think, its much slower
58 from my point of view its, the way that I work I suppose is very much through
59 the relationship that I would build with the client and so that's why, partly why
60 it's a lot slower and I need to pay so much attention I think to what goes on in
61 the room. I mean I do that anyway, but I think its um probably more so with
62 this client group. I try and work with the clients to look at that but sometimes
63 that's hard because they don't want to do that and its quite challenging for
64 them to do that too. So...and the boundaries, that's the other thing...I probably
65 should have said that in the question about what's difficult because they
66 always try and push the boundaries and you know they want contact between
67 sessions and then its hard to get them out of the room afterwards and things
68 like that...umm...I know that I need to be really strong on that, that's important.
69 So I suppose its just attention to detail and, and being aware and just being
70 clear about what I can offer and what I can't offer and what's ok and what isn't
71 ok...

72 I: Yeah

73 P: ...and I do that anyway its just more so (laughs).

74 I: So its kind of an extension of what you do already but perhaps you feel that
75 you need to pay a little bit more attention to those kinds of things?

76 P: Yeah, yeah

Appendix 15

**Sample interview analysis – emergent
themes in chronological order
(Empirical paper 2)**

**Sample of interview analysis – emergent themes from the right hand margin
(line numbers correspond to the interview extract at Appendix 14)**

Emergent theme (chronological order from extract)	Reference in extract (line no.)
Work is viewed as challenging	3 – 5
Importance of paying attention to the therapeutic process	5 – 6
Experiences client work as one of two extremes - likened to presentation of the client	6 – 13
Experience of countertransference in therapeutic work	16 – 17
Client work is unpredictable	17 – 19
Struggle with countertransference feelings	21 – 23
Importance of paying attention to the therapeutic process	24 – 26
Spreading the load - peer support	29 – 35
Spreading the load - between professionals	35 – 39
Struggle with burden of responsibility	42 – 45
Importance of having a shared understanding of client difficulties amongst professionals	48 – 54
Client work experienced as more demanding and slower in comparison with other client groups	57 – 58
Importance of paying attention to the therapeutic process	58 – 64
Importance of setting clear therapeutic boundaries	64 – 73

Appendix 16

**Extract from directory of
participants' phrases to support
the master list themes
(Empirical paper 2)**

Extract from directory of participants' phrases to support the master list of themes

EFFECTS ON SELF		Page/line no.
Fatigue		
Anna	I think there's something about being overwhelmed sometimes and the kind of material that people bring and the distress associated with their experiences can be beyond belief in a way, and I don't mean unbelievable in the sense of not believing that happened to somebody but its like there's a bit of me sometimes which finds it very hard to believe these things happen to human beings or other people, or that human beings could do this to other human beings. Its really heavy work.....you can lose hope at times and I think that's why its important to have good things outside, in order not to lose hope.	5.19
Anna	I think I get very tired. I get very...very emotionally tired and very drained, I guess. I mean one of things that I notice is that certainly compared to the beginning of my work, when I had recently finished training when I was seeing a lot more, more straightforward clients was that I could see five people in a day and feel ok. If I see four people in a day who've got these kind of difficulties I'm wiped out. So that for me is very different.	9.12
Anna	I Yeah, I think often its about exhaustion, I think sometimes about difficulties in relationships outside work and they can kind of intrude, so there is a need for really good supervision and really good ways of switching off, but I think however good we are at it, there are times when it doesn't work....	9.26
Lucy	Its tiring (laughs). It can be quite tiring and its obviously very demanding which I suppose is the other side of challenging (laughs). So yes...umm...and its frustrating sometimes.	4.29
Lucy	But yeah, its more of a kind of time and energy thing, its quite demanding and tiring,	5.8
Rebecca	I think after a session I'm usually very tired and kind of drained and particularly if it's a difficult session, I'll feel shattered and need to have a drink and a biscuit perhaps (laughs). I reach for the chocolate...and just take some time to reflect on it really so I think its, certainly that's a stronger reaction that I would get on the whole with most clients, but then some sessions are more difficult than others anyway, but as a general rule I'm more tired after a session....I feel drained and exhausted.	9.8
Caroline	I think it varies from day to day, if it's been a really heavy day then I can feel extremely drained and exhausted really from the work. So if I've been seeing people back to back and things are not going along as smoothly as they might that's personally very draining, but other days when things are going along pretty much as planned I don't find it stressful at all.	9.11
Caroline	Sometimes if I'm really feeling very, very stressed then I might ring somebody up and say 'could you come a little bit later?' If you've got an appointment can you come a little bit later and I'll try and go and walk somewhere out of the building and get some fresh air and a change of scenery and try and forget the last person. Clear my mind and get ready for the next person. It isn't always possible though.	9.21

Risk & Responsibility	Page/line no.
Anna	4.22
It can be terribly anxiety provoking, I think that's the other thing, particularly if people are at very high risk of self-harm or suicide attempts. There is a dread at times if someone is finding it very hard – what haven't I done, am I going to get caught out for not having done this....waiting to be punished myself. In case something goes wrong – I'm thinking why do I do this work, saying it aloud to you (laughs).	
Anna	9.17
I find there are times that I will be thinking about people at home and that's not good, I'm certainly not paid enough to do that (laughs). But its again, all the training that you do encourages you to leave your work behind and sometimes when people are very, very distressed in front of you, its incredibly difficult to do. I know people kind of "pop-up" and its really interesting in a way that this client group kind of gets inside your head and you can be watching something on television or seeing a film or something and something will then trigger and you'll think of a particular person.	
Lucy	10.16
Errm, I think with some of the people that I work with I have a greater sense of responsibility. I don't know whether that's partly a DBT thing in terms of them being able to ring at any time, at any point in the day and its my responsibility to get back to them as soon as I can, to help them with urges and give them a bit of coaching. So that feels like a responsibility, because that's less so the case with other clients on my other three days, which can be quite stressful.	
Lucy	13.20
I think a lot of the time I struggled and I would imagine other people might struggle because you feel like you're on your own with it and there's such a great sense of responsibility. I mean this might be my issues, but taking responsibility for somebody whose got so many needs in so many different areas. It can be really confusing and feel like such a huge thing to carry on your own.	
Rebecca	9.21
As far as outside work goes, on the whole its ok, if it's particularly difficult or we're at a particularly difficult stage and you know they all seem to go through this phase of "oh you're rubbish and this is not doing me any good, I don't want to be here" or you know, if they're feeling suicidal and things like that then there's...oh god what are they going to be doing when they're not here?, so sometimes inevitably that comes home with me.	
Rebecca	9.28
Occasionally it does stay with me and you know I'll be in the bath and suddenly I'm thinking oh I wonder what this persons doing? and things like that. I'm just aware of it really and I think there is a price to pay if you like.	
Caroline	10.23
...Sort of shutting your mind down a little bit. So it's not working overtime, particularly if people have been self harming for example, that's one thing that particularly plays on my mind and I might often think at home - right when I see them tomorrow what am I going to do?. It's hard to switch of sometimes, so it's very important to try and do those things and if you are doing, you know working at the gym or something it's quite hard to thing of those things as well. An hour there and works seems like a million miles away really and I'm able to relax then and focus on what I'm doing at home.	

Self growth		Page/line no.
Anna	Well it's certainly given me a different view of the world. I have certainly heard things that I didn't know about in quite the same way. I mean, you know, but you don't know and when somebody's very explicitly talking about the way their life is, you learn something quite different about how the world is.	9.8
Anna	I suppose the other bit for me is that I think I learn an awful lot more about myself by doing this kind of work..um...and that feels quite an important bit in my world as well. I don't mean to sound self-centred, but it's actually helping to make sense of things for me.	13.21
Lucy	I think I'm a bit more...whats the word...aware, so hearing, you know people's experiences I think kind of opens my eyes a bit, so outside of work I'm much more...I suppose I'm still being a psychologist aren't I? Much more aware of what might be going on for people or the kind of people that I might come across. It gives me a bit more perspective on things really, when you listen to people's experiences and difficulties that they have or a lot of people that I work with have, it just kind of gives you a, a bit more perspective and perhaps take things for granted less than I used to. I appreciate things a bit more.	11.17
Rebecca	I've learnt loads, I've learnt absolutely loads about me and about the client group and you know how I operate, how they operate with me, you know I have learnt loads, absolutely loads and as I said earlier, sometimes its been absolutely awful and I've been on my knees and felt "oh no", but its also been great, I wouldn't have missed it really. I think it's stretched me and it's made me grow as a therapist and it's given me more confidence.	11.12
Rebecca	Well personal growth and, you know, both personally and as a therapist too on a work level, you know development and understanding of the process and all of that, yeah, its worth doing (laughs).	11.20
Caroline	I think that it's made me a far more patient person, in and out of work. I used to be a lot less patient and tolerant so I think that yes definitely.	11.5

Please note: The page and line numbers stated here are those used in the analysis of the complete interviews. As such they do not correspond with those used in the extract discussed in Appendices 14 & 15.

Appendix 17

Instructions to Authors: Clinical Psychology Review

Clinical Psychology Review - Guide for Authors

SUBMISSION REQUIREMENTS: All manuscripts should be submitted to Alan S. Bellack, Department of Psychiatry, The University of Maryland at Baltimore, 737 W. Lombard St., Suite 551, Baltimore, MD 21201, USA. Submit three (3) high-quality copies of the entire manuscript; the original is not required. Allow ample margins and type double-space throughout. Papers should not exceed 50 pages (including references). One of the paper's authors should enclose a letter to the Editor, requesting review and possible publication; the letter must also state that the manuscript has not been previously published and has not been submitted elsewhere. One author's address (as well as any upcoming address change), telephone and FAX numbers, and E-mail address (if available) should be included; this individual will receive all correspondence from the Editor and Publisher.

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COMPUTER DISKS: Authors are encouraged to submit a 3.5" HD/DD computer disk to the editorial office; 5.25" HD/DD disks are acceptable if 3.5" disks are unavailable. Please observe the following criteria: (1) Send only hard copy when first submitting your paper. (2) When your paper has been refereed, revised if necessary, and accepted, send a disk containing the final version with the final hard copy. Make sure that the disk and the hardcopy match exactly (otherwise the diskette version will prevail). (3) Specify what software was used, including which release, e.g., WordPerfect 6.0a. (4) Specify what computer was used (IBM compatible PC, Apple Macintosh, etc.). (5) The article file should include all textual material (text, references, tables, figure captions, etc.) and separate illustration files, if available. (6) The file should follow the general instructions on style/arrangement and, in particular, the reference style of this journal as given in the Instructions to Contributors. (7) The file should be single-spaced and should use the wrap-around end-of-line feature, i.e., returns at the end of paragraphs only. Place two returns after every element such as title, headings, paragraphs, figure and table call-outs. (8) Keep a backup disk for reference and safety.

TITLE PAGE: The title page should list (1) the article; (2) the authors' names and affiliations at the time the work was conducted; (3) a concise running title; and (4) an unnumbered footnote giving an address for reprint requests and acknowledgements.

ABSTRACT: An abstract should be submitted that does not exceed 200 words in length. This should be typed on a separate page following the title page.

KEYWORDS: Authors should include up to six keywords with their article. Keywords should be selected from the APA list of index descriptors, unless otherwise agreed with the Editor.

STYLE AND REFERENCES: Manuscripts should be carefully prepared using the *Publication Manual of the American Psychological Association*, 5th ed., 1994, for style. The reference section must be double spaced, and all works cited must be listed. Avoid abbreviations of journal titles and incomplete information.

Reference Style for Journals: Raymond, M.J. (1964). The treatment of addiction by aversion conditioning with apomorphine. *Behaviour Research and Therapy*, 3, 287-290.

For Books: Barlow, D.H., Hayes S.C., & Nelson, R.O. (1984). *The scientist practitioner: Research and accountability in clinical and educational settings*. Elmsford, NY: Pergamon.

TABLES AND FIGURES: Do not send glossy prints, photographs or original artwork until acceptance. Copies of all tables and figures should be included with each copy of the manuscript. Upon acceptance of a manuscript for publication, original, camera-ready photographs and artwork must be submitted, unmounted and on glossy paper. Photocopies, blue ink or pencil are not acceptable. Use black india ink and type figure legends on a separate sheet. Write the article title and figure number lightly in pencil on the back of each.

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Appendix 18

Instructions to Authors: Journal of Mental Health

Journal of Mental Health – Instructions for Authors

Instructions for Authors

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*****Note to Authors:** please make sure your contact address information is clearly visible on the **outside of all packages** you are sending to Editors.***

Journal of Mental Health is an international journal adhering to the highest standards of anonymous, double-blind peer-review. The journal welcomes original contributions with relevance to mental health research from all parts of the world. Papers are accepted on the understanding that their contents have not previously been published or submitted elsewhere for publication in print or electronic form.

Manuscripts should be sent to Executive Editor, Professor Til Wykes, Department of Psychology, Institute of Psychiatry, De Crespigny Park, London, SE5 8AF, United Kingdom. Electronic submission is also welcomed using the *Journal of Mental Health* e-mail address: jmh@iop.kcl.ac.uk. It is essential that authors pay attention to the guidelines to avoid unnecessary delays in the evaluation process.

To expedite assessment, three complete copies of each manuscript should be submitted along with an electronic version on disk. The names of authors should not be displayed on figures, tables or footnotes to facilitate blind reviewing.

Manuscripts should be typed on one side of paper, double-spaced (including references), with margins of at least 2.5cm (1 inch). Good quality printouts with a font size of 12 or 10 pt are required. The first page should show the full title of the paper, a short title not exceeding 45 characters (to be used as a running title at the head of each page), the full names and affiliations of authors and the address where the work was carried out. The corresponding author should be identified, giving full postal address, telephone, fax number and email address if available. To expedite blind reviewing, no other pages in the manuscript should identify the authors. All pages should be numbered.

Abstracts . The second page should also show the title, together with a structured abstract of no more than 200 words, using the following headings: Background, Aims, Method, Results, Conclusions, Declaration of interest. The declaration of interest should acknowledge all financial support and any financial relationship that may pose a conflict of interest. Acknowledgement of individuals should be confined to those who contributed to the article's intellectual or technical content.

Keywords. Authors should include up to five key words with their article, selected from the American Psychological Association (APA) list of index descriptors, unless otherwise agreed with the editor.

Text . Follow this order when typing manuscripts: Title, Authors, Affiliations, Abstract, Key Words, Main text, Appendix, References, Figures, Tables. Footnotes should be avoided where possible. Manuscripts should not exceed 6,000 words unless previously agreed with the editor. Language should be in the style of the APA (see *Publication Manual of the American Psychological Association* , Fifth Edition, 2001).

Style and References . Manuscripts should be carefully prepared using the aforementioned *Publication Manual of the American Psychological Association* , and all references listed must be mentioned in the text. Within the text references should be indicated by the author's name and year of publication in parentheses, e.g. (Hodgson, 1992) or (Grey & Mathews 2000), or if there are more than two authors (Wykes *et al.* , 1997). Where several references are quoted consecutively, or within a single year, the order should be alphabetical within the text, e.g. (Craig, 1999; Mawson, 1992; Parry & Watts, 1989; Rachman, 1998). If more than one paper from the same author(s) a year are listed, the date should be followed by (a), (b), etc., e.g. (Marks, 1991a).

The reference list should begin on a separate page, in alphabetical order by author (showing the names of *all* authors), in the following standard forms, capitalisation and punctuation:

a) For journal articles (titles of journals should *not* be abbreviated):

Grey, S.J., Price, G. & Mathews, A. (2000). Reduction of anxiety during MR imaging: A controlled trial. *Magnetic Resonance Imaging*, 18, 351–355.

b) For books:

Powell, T.J. & Enright, S.J. (1990) *Anxiety and Stress management*. London: Routledge

c) For chapters within multi-authored books:

Hodgson, R.J. & Rollnick, S. (1989) More fun less stress: How to survive in research. In G. Parry & F. Watts (Eds.), *A Handbook of Skills and Methods in Mental Health Research* (pp. 75–89). London: Lawrence Erlbaum.

Illustrations should *not* be inserted in the text. Three copies of each should be provided separately, numbered on the back with the figure number and the title of the article. All photographs, graphs and diagrams should be referred to as 'Figures' and should be numbered consecutively in the text in Arabic numerals (e.g. Figure 3). The appropriate position of each illustration should be indicated in the text. A list of captions for the figures should be submitted on a separate page and should make interpretation possible without reference to the text. Captions should include keys to symbols. It would help ensure greater accuracy in the reproduction of figures if the values used to generate them were supplied.

Tables should be typed on separate sheets and their approximate position in the text should be indicated. Units should appear in parentheses in the column heading but not in the body of the table. Words and numerals should be repeated on successive lines; 'ditto' or 'do' should *not* be used.

Accepted papers. If the article is accepted, authors are requested to submit their final and revised version of their manuscript on disk. The disk should contain the paper saved in Microsoft Word, rich text format (RTF), or as a text or ASCII (plain) text file. The disk should be clearly labelled with the names of the author(s), title, filenames and software used. Figures should be included on the disk, in Microsoft Excel. A good quality hard copy is also required.

Proofs are supplied for checking and making essential corrections, not for general revision or alteration. Proofs should be corrected and returned within three days of receipt.

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Appendix 19

Instructions to Authors: British Journal of Clinical Psychology

British Journal of Psychology – Instructions for Authors

The Editorial Board of the British Journal of Psychology is prepared to consider for publication:

- (a) reports of empirical studies likely to further our understanding of psychology;
- (b) critical reviews of the literature;
- (c) theoretical contributions.

Papers will be evaluated by the Editorial Board and referees in terms of scientific merit, readability, and interest to a general readership.

1. Circulation

The circulation of the Journal is worldwide. Papers are invited and encouraged from authors throughout the world.

2. Length

Papers should normally be no more than 5,000 words, although the Editor retains discretion to publish papers beyond this length.

3. Reviewing

The journal operates a policy of anonymous peer review. Papers will normally be scrutinised and commented on by at least two independent expert referees (in addition to the Editor) although the Editor may process a paper at his or her discretion. The referees will not be aware of the identity of the author. All information about authorship including personal acknowledgements and institutional affiliations should be confined to the title page (and the text should be free of such clues as identifiable self-citations e.g. 'In our earlier work...').

4. Online submission process

- 1) All manuscripts must be submitted online at <http://bjp.edmgr.com>.

First-time users: click the REGISTER button from the menu and enter in your details as instructed. On successful registration, an email will be sent informing you of your user name and password. Please keep this email for future reference and proceed to LOGIN. (You do not need to re-register if your status changes e.g. author, reviewer or editor).

Registered users: click the LOGIN button from the menu and enter your user name and password for immediate access. Click 'Author Login'.

- 2) Follow the step-by-step instructions to submit your manuscript.

- 3) The submission must include the following as separate files:

- Title page consisting of manuscript title, authors' full names and affiliations, name and address for corresponding author.
- Abstract
- Full manuscript omitting authors' names and affiliations. Figures and tables can be attached separately if necessary.

- 4) If you require further help in submitting your manuscript, please consult '[Tutorial for Authors](#)' (PDF, 130Kb).

Authors can log on at any time to check the status of the manuscript.

5. Manuscript requirements

- Contributions must be typed in double spacing with wide margins and on only one side of each sheet. All sheets must be numbered.

- Tables should be typed in double spacing, each on a separate page with a self-explanatory title. Tables should be comprehensible without reference to the text. They should be placed at the end of the manuscript with their approximate locations indicated in the text.
- Figures can be included at the end of the document or attached as separate files, carefully labelled in initial capital/lower case lettering with symbols in a form consistent with text use. Unnecessary background patterns, lines and shading should be avoided. Captions should be listed on a separate sheet. The resolution of digital images must be at least 300 dpi.
- All articles should be preceded by an Abstract of between 100 and 200 words, giving a concise statement of the intention and results or conclusions of the article.
- For reference citations, please use APA style. Particular care should be taken to ensure that references are accurate and complete. Give all journal titles in full.
- SI units must be used for all measurements, rounded off to practical values if appropriate, with the Imperial equivalent in parentheses.
- In normal circumstances, effect size should be incorporated.
- Authors are requested to avoid the use of sexist language.
- Authors are responsible for acquiring written permission to publish lengthy quotations, illustrations etc for which they do not own copyright.

For Guidelines on editorial style, please consult the APA Publication Manual published by the American Psychological Association, Washington DC, USA (<http://www.apastyle.org>)

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Code of Conduct
Principles of Publishing

7. Supplementary data

Supplementary data too extensive for publication may be deposited with the British Library Document Supply Centre. Such material includes numerical data, computer programs, fuller details of case studies and experimental techniques. The material should be submitted to the Editor together with the article, for simultaneous refereeing.

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10. Checklist of requirements:

- Abstract (100-200 words)
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