Mental Health Nurses' Understanding of the Concept of Self-Management of Borderline Personality Disorder

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A Thesis submitted for the degree of
Master of Health Sciences endorsed in Nursing
at the University of Otago, Christchurch

1st September 2013

ABSTRACT

BACKGROUND

The recovery framework is held as a mainstay in mental health to guide clinical practice. One of the main concepts of the framework is self-management. Borderline personality disorder (BPD) is arguably the most stigmatized diagnosis within mental health nursing. While mental health nurses appear to have embraced the recovery framework, they have struggled to apply this framework to nursing practice for people with a diagnosis of BPD.

AIM

The objective of this study was to determine what mental health nurses understood the concept of self-management to mean in relation to a service user with a diagnosis of BPD.

METHOD

A sample of ten mental health nurses working within a large District Health Board Specialist Mental Health Services was interviewed using a semi-structured interview format. The data generated from these interviews was analysed using the general inductive approach resulting in 26 sub-themes. These sub-themes were the varying concepts that participants understood to be self-management and were organised into three over-arching themes.

RESULTS

The three resulting themes from the study were: self-management is self-responsibility; second, that self-management is self-awareness; and third, that self-management is maintaining safety.

CONCLUSION

The three themes represented the diverse understanding of self-management held by the study participants. The first and second themes, self-management is self-responsibility and self-management is increasing self-awareness, both fit with the recovery philosophy of client empowerment and required nurses to move from the paternalistic, dominant, medical model. The third theme, self-management is maintaining safety, did not fit with the recovery model. Nurses practicing with a goal of maintaining client safety as self-management, have yet to break free from the aforementioned parochial model and question the use of power employed as well as the goal of their practice. Nurses may have been unaware of the underlying beliefs and assumptions that have shaped their practice and may benefit from a reflective style of supervision. Nurses' understanding of the concept of self-management for people with a diagnosis of borderline personality disorder was embedded in their practice and influenced the roles that they and the person played in their recovery journey.

ACKNOWLEDGMENTS

always impressed by my study endeavors. My remaining sister, Chrissy Kereama, and my parents, Lionel and Adrienne Stewart, thanks for being there over the last two years. I acknowledge my family; Greg, Brynley and Brendon. At the end of the day, we made it! And finally my biggest thanks to God, who is able to do immeasurably more than all we can ask or imagine according to His power that is at work within us!

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CHAPTER 1 - INTRODUCTION

RESEARCHER - CONTEXT RELATED TO THE FORMULATION OF THE RESEARCH QUESTION

This thesis explores mental health nurses' understanding of the concept of self-management as it relates to a person with a diagnosis of Borderline personality disorder. As a mental health nurse, the most challenging and fulfilling experiences in my practice have pertained to working with people with a diagnosis of BPD. People with this diagnosis and their families have intrigued and fascinated me on personal and professional levels. No other group of people that I have worked with has evoked such a wide range of emotions in me or stretched me as a nurse. I have learnt a lot about myself as I have worked with this group of people.

As a clinical nurse specialist leading a team of nurses working with people with this diagnosis, we have known that it has been vital for the client with a diagnosis of BPD to ensure that we have been consistent in our approach and that good clinical rationale has been the foundation for our practice. Just what this approach has entailed at times has been a source of tension and conflict with the team. Nurses have held diverse viewpoints on how to work with someone with this diagnosis and I have been involved in many meetings where these viewpoints have been aired passionately and fervently. I was curious as to why nurses arrived at such different conclusions and how these various opinions and understandings had come about. I wondered if other teams of nurses experienced the diversity of understanding that our team did.

When considering a research question for my thesis I knew that I wanted to explore borderline personality disorder in a way that would reflect on and inform nursing practice and attempt to answer some of the questions I had been curious about. Exploring what mental health nurses understood of the concept of self-management seemed the perfect platform from which to do this. I believed that what mental health nurses understood about self-management could inform and impact on their practice.

The proposed significance of this work will contribute to nurses gaining understanding and mastery of promoting self-managing practices for clients with a diagnosis of borderline personality disorder. The findings will reveal what is important for providing quality client care to this group of people.

SELF-MANAGEMENT

Self-management is a multi-faceted concept that is discussed in detail in the literature review. Self-management has been increasingly popular within mental health care delivery as 'part and parcel' of the recovery philosophy. Bowen (2013) noted that while "there does seem to be a general acceptance of a recovery focus, this has not yet been translated into nursing practice for people with a diagnosis of borderline personality disorder" (p. 497) which is perhaps reflected in the different understandings nurses have of the concept of self-management. Observing how a nurse works with clients who have a diagnosis of BPD may reflect their understanding of what self-management entails.

THE STUDY CONTEXT

This study was conducted within a large District Health Board Specialist Mental Health Service in New Zealand. The participants were all registered nurses who worked in clinical settings in the community and inpatient areas. Previous practice models in New Zealand for people with a diagnosis of BPD were "reactive to service users' distress and continued to focus on risk minimization rather than the cause of the individual's distress" (Te Pou, 2007). Service users were seen in crisis and admitted to acute inpatient care services. The DHB was the first in New Zealand to have implemented a service for people with a diagnosis of BPD based on Mentalization-Based Therapy (MBT) which takes place in the community. The new service delivery model started in 2009 and was therefore relatively new when data gathering commenced. MBT will be elaborated on further in the literature review.

THESIS STRUCTURE

CHAPTER 1 describes the background context to the researcher's question for the study as well as the study context within the DHB. It briefly outlines the concept of self-management as it relates to someone with a diagnosis of BPD.

CHAPTER 2 involves the literature review process and is divided into three parts. Part one of the literature review gives an overview of borderline personality disorder, including origins of the diagnosis, stigmatisation, and how the Diagnostic and Statistical Manual of Mental Disorders V (DSM-V) (American Psychiatric Association [APA], 2013) may have contributed towards this. Alternate ways of viewing a diagnosis of BPD are reviewed followed by current treatment foci for clients with a diagnosis of BPD. Part

two of the literature review gives an overview of self-management including the history of self-management within the medical and recovery models, and consideration of the moral implications. Part three contains the systematic review concerning mental health nurses' understanding of the concept of self-management relating to a person with a diagnosis of BPD.

CHAPTER 3 considers qualitative nursing research followed by discussion about the general inductive approach which is the qualitative research method utilised by this study. Limitations of the study are explored followed by an explanation of the sample selection process and discussion regarding the data collection. The practical aspects of the data analysis strategy are explained followed by consideration of the trustworthiness of the research. Finally, ethical considerations are examined.

CHAPTER 4 reports the results of the general inductive analysis: the generation of three themes. These are self-management is self-responsibility, self-management is increasing self-awareness and self-management is maintaining safety. Within each theme a number of sub-themes were developed. The themes and sub-themes are presented with quotations to illustrate and support the analysis.

CHAPTER 5 discusses the results in context with research done on the subject previously. The information from the results is then considered in relation to the literature review. There is a critical interpretation of the results obtained. The implications of the study for future research and recommendations for mental health nursing practice are examined.

CHAPTER 2 - LITERATURE REVIEW

INTRODUCTION

Part one of the literature review gives an overview of borderline personality disorder that includes the origins of BPD, the diagnosis, and stigmatisation of BPD within the mental health setting and how the DSM-V (APA, 2013) may have contributed towards this. Alternate ways of viewing a diagnosis of BPD are then reviewed followed by current treatment foci for clients with a diagnosis of BPD.

Part two of this chapter gives an overview of self-management including the history of self-management within the medical model, followed by discussion about self-management within the recovery model in the field of mental health. Finally, moral implications of self-management are considered.

Part three consists of the systematic review regarding nurses' understanding of the concept of self-management as it relates to someone with a diagnosis of BPD.

BACKGROUND

PART 1: BORDERLINE PERSONALITY DISORDER

Brief outline of origins of BPD and introduction to the diagnosis

Pseudo neurotic schizophrenia was an early term that came from clinicians' descriptions of patients in the late 1930s and the 1940s. Patients were considered too well to be diagnosed with schizophrenia but too disturbed for classical psychoanalytical treatment (Gabbard, 2005). These patients did not appear to fit on the continuum of 'normal', 'neurotic' or 'psychotic'.

By the 1960s the term 'borderline' was coined to describe this messy syndrome that did not fit well into any existing diagnostic category (Gabbard, 2005). This group of people was labeled as suffering from a borderline group of neuroses. The term 'borderline' evolved to refer to a structure of personality organisation and BPD first appeared in the American Psychiatry Association's Diagnostic and Statistical Manual, 3rd edition (DSM-III) in 1980. BPD was the most prevalent of all personality disorders and was more prevalent than schizophrenia or bipolar disorder (McGrath & Dowling, 2012). There was a higher incidence of females to males by a 3:1 ratio in a diagnosis of BPD (Bjorklund, 2006).

Nurses recounted clients with this diagnosis as among the most challenging of clients to work with (Bland & Rossen, 2005; McGrath & Dowling, 2012; Stroud & Parsons, 2012; Ma et al., 2009; Woollaston & Hixenbaugh, 2008). There was a strong correlation in the literature between sexual and physical abuse, particularly in childhood, with BPD and self-harming behaviours (Crowe, 2004; McAllister, 2003; Stroud & Parsons, 2012; Warne & McAndrew, 2007).

Borderline personality disorder has been described in the following way:

the condition is characterized by suffering of such quality and magnitude that it cannot be clearly articulated…the sort of suffering from which suicide seems the only escape… unparalleled poverty of soul and self that leaves its possessor bereft of identity, alone, and empty…self-hating…relationships are doomed…distance is too close and too far…nothing soothes for long…when others hate them as much as they hate themselves, at least they are no longer alone. Someone finally feels what they feel. (Bjorklund, 2006a, p. 4)

A diagnosis of BPD is highly stigmatised within the mental health setting and the DSM-V (APA, 2013) has contributed to this by way of classification and description. Gabbard (2005) stated that by 1990, clear discriminating features in descriptions of the diagnosis of BPD had been identified which included manipulative suicide efforts, demandingness/entitlement and counter-transference difficulties. The term itself, 'borderline,' contributed to the growing discrimination providing connotations of 'doubtful,' 'indecisive,' and 'marginal' to the diagnosis (Gabbard, 2005).

The DSM-V recorded nine criteria for BPD that are listed in Appendix 1 (APA, 2013, p. 663). These criteria are divided into four areas:

1) Affective

2) Cognitive

3) Behavioural

4) Interpersonal.

(1) Affective criteria included mood instability, chronic feelings of emptiness and inappropriate, intense anger or difficulty controlling anger (APA, 2013, p 663). The DSM-V (APA, 2013) noted that "physical and sexual abuse, neglect, hostile conflict and early parental loss are more common in the childhood histories of those with borderline personality disorder" (p. 665) but failed to make links between this observation and the criteria listed. This failure may have contributed towards mental health nurses potentially viewing these affective symptoms as the personality of the individual rather than the nature of pathology (Aviram, Brodsky & Stanley, 2006). The person with a diagnosis of BPD may potentially be seen as the problem instead of the person being viewed as someone who was exhibiting learned coping strategies in response to previous, traumatic circumstances. The 'inappropriate, intense anger' may be viewed as a symptom of a diagnosis rather than within the context of a person's life, which had experienced sexual and/or childhood trauma. The criteria of the DSM-V did not mention any reasons for people with BPD having experienced this disorder; the criteria simply stated that one did experience impairments. Mental health nurses who viewed people with a diagnosis of BPD through the lens of the DSM-V may have tended to focus on these affective criteria rather than the circumstances in which they were learned. "People are viewed as possessing a negative attribute that is misunderstood and exaggerated, resulting in global devaluation" (Goffman as cited in Halter, 2008, p. 20). These affective attributes may be misunderstood resulting in nurses withdrawing from clients and further perpetuating feelings of emptiness, anger and abandonment. "The independent contribution of stigma associated with BPD towards…negative outcomes is subtle and difficult to determine in relation to the underlying pathology of BPD" (Aviram et al., 2006, p. 252). Nurses may

be influenced by the stigmatisation of BPD and allowed 'inappropriate anger' expressed by the client to reinforce the stigmatization. The client's anger is then not responded to therapeutically and a learning opportunity is lost. This was also an issue of counter-transference; emotional reactions that may have reflected unconscious identification with the client. Understanding counter-transference and the influence of stigmatisation were vital to working successfully with people with a diagnosis of BPD (Evans, 2007). Courage and honesty are required by nurses to address the pervasive stigmatisation associated with BPD as well as addressing counter-transference issues found within themselves.

The DSM-V (APA, 2013), in defining mental disorder, stated that the pattern of the symptoms was not what was an expected or culturally sanctioned response. It did not quantify, in terms of affect, what an expected and culturally sanctioned response to childhood sexual or physical abuse would be for the person with a diagnosis of BPD. To pathologise affect as the DSM-V has in regards to BPD was to look on the surface of the disorder. Perhaps 'inappropriate anger' and feelings of emptiness and abandonment were normal affective responses to sexual and physical abuse.

(2) Interpersonal criteria were the second group of criteria for BPD in the DSM-V (APA, 2013, p. 663). These criteria included frantic efforts to avoid real or imagined abandonment as well as patterns of unstable and intense relationships characterised by alternating between extremes of idealisation and devaluation. These responses may be

viewed as abnormal compared with the norms for society but may be viewed as normal or expected for someone who had experienced childhood trauma and/or sexual abuse. Nurses' responses to clients' frantic efforts to avoid real or imagined abandonment may have potentially included taking a self-protective or defensive stance or withdrawing emotionally in order for them to perceive that they, the nurses, were not being manipulated. This stance had the potential to result in fueling the person's feelings of abandonment, culminating in anger and verbal abuse, and reinforcing the stigmatisation of the disorder. It has been observed that "qualified nursing staff express higher levels of social rejection towards patients with a diagnosis of BPD than they do towards patients with diagnoses of schizophrenia or depression" (Markham, 2003, p. 610). The classification of BPD in the DSM-V may have encouraged nurses to focus on the diagnosis rather than seeking to understand the person's experience, having the effect of "creating a distance between those people experiencing mental distress and the rest of society" (Crowe, 2000b, p. 76).

Tredget's (2001) views on personality disorders were an example that reflected the DSM-V classification of personality disorders. The article abstract commenced with the sentence: "Personality disorders are a heterogeneous collection of conditions with common features, which may include an exaggerated self-centered nature, little regard for the feelings of others, or the regular fabrication of stories to explain the behaviour of self or others" (Tredget, 2001, p. 347). The article contained phrases from the DSM-V definition of mental disorder illustrating the dominant psychiatric discourse presented in the DSM-V.

(3) Cognitive criteria included identity disturbance, a markedly, persistent unstable self-image or sense of self and transient, stress-related paranoid ideation or severe dissociative symptoms (APA, 2013, p 663). A 'persistent, unstable self-image' may describe many people at certain points in their lives, some worthy of mental health service attention, many not. A newspaper article cited by Kutchins and Kirk (1977) stated that "the psychiatric establishment is expanding into everyday life and defining it in terms of medical conditions" (p. 36). Appropriate mental distress experienced by a person in response to a lived situation may also be constructed by psychiatry as a mental disorder. An unstable self-image and paranoid thoughts may be viewed as a legitimate or logical outcome for people who have suffered trauma in their formative years.

In the article '*Meanings of madness: a literature review*', Casey and Long (2003) stated that "psychiatric diagnosis are not objective, scientific renderings of truth, but constructions of life experiences inextricably linked to the social and political context" (p. 94). These authors argued that because of dominant cultural or biomedical explanations for mental distress, people suppressed their own meanings for the mental pain that they were experiencing. People have alternatively been encouraged to have their own narrative rather than relying on the psychiatric, biomedical model to put forward their cultural, political, gendered, class bias onto peoples' realities (Crowe, Carlyle & Farmer, 2008). The interpretation of a narrative was "dependant on both the client's and the nurse's explanatory frameworks" (Crowe et al., 2008, p. 800) with the nurse working alongside the client to help them find the best interpretative fit for their narrative. This

approach contrasted with the DSM-V approach which viewed psychiatric problems as medical problems with a biochemical cause.

(4) Behavioural criteria were forms of marked impulsivity that included recurrent suicidal behaviour, gestures, threats, or self-mutilating behaviour, along with impulsivity in at least two areas that were potentially self-damaging (e.g., reckless spending and driving, unsafe sex) (APA, 2013, p. 663). These behavioural criteria were the criteria of the diagnosis that were seen as particularly stigmatising for clients. "Once a diagnosis of BPD is made, inquiry tends to cease and staff see the disorder rather than the person with the disorder, resulting in a failure to explore the reasons behind the patient's self-harm" (Commons Treloar & Lewis, 2008, p. 579). Behaviours such as self-harming, suicidal threats, reckless self-damaging actions may by responded to negatively by nurses. "Pessimistic attitudes and reactive behavioural management strategies…act as a major barrier to effective service provision for this group of patients" (Commons Treloar & Lewis, 2008, p. 579). The DSM-V also stated that personality disorders were pervasive, inflexible and unstable over time (APA, 2013, p 645). The underlying assumption was that the person diagnosed with BPD would not make any change over time or would show no improvement in terms of mental distress.

Addressing these assumptions, Deegan (1996) stated that "many of us who have been psychiatrically labeled have received powerful messages from professionals who in effect tell us that by virtue of our diagnosis the question of our being has already been answered and our futures are already sealed" (p. 92). A further observation made by Deegan (1996) was that it was not for nurses to judge who will and will not recover.

Exploration of alternate ways of viewing a diagnosis of BPD

Alternate views of BPD other than the DSM-V classification, promoted enquiry and facilitated the clinician to look beyond the disorder to the person with the disorder. These views sought to decrease the distance between the person with the mental illness and the rest of society, and to understand the reasons for someone's presentation rather than to have pathologised it.

A strong case was made by Crowe (2004a) for people with a diagnosis of BPD to be viewed as having an overwhelming affective response of shame rather than a person who was disordered at a fundamental level of their personality. This view attempted to understand the person rather than merely assess and describe them and helped mental health clinicians react more empathetically towards people with a diagnosis of BPD. Related to the interpersonal criteria of BPD was the notion that a psychiatric diagnosis may have established and maintained "parameters of normality and abnormality in a manner that reflects particular gender biases" (Crowe, 2000a, p. 125). Consistent with that notion was the idea that "historically, and some would argue currently, the socialisation process of young children is reflective of gender stereotypes" (Nehls, 1998, p. 98) and it was also noted by Nehls (1998) that girls learn dependence, passivity and domesticity – attributes not highly valued by western society. "Women are more vulnerable to having their experiences interpreted as signs of mental disorder because of the subject positions available to them and the pervasive influence of psychiatric

discourse throughout western culture" (Crowe, 2000a, p. 127). Acknowledgement of this gender bias and accepting and validating differing subjective forms of experience was a vital consideration for mental health nurses in addressing the dominant discourse where maintenance of parameters of normality and abnormality were found.

Self-harm, which often accompanies a diagnosis of BPD, has been understood in three ways: psychodynamically, behaviourally, or socioculturally:

> Psychodynamic theories see self-harm as a form of anger turned inward, a way of showing psychic distress without talking about it, a mechanism of repressed guilt in relation to sexual conflict, behavioural theories emphasize the way the behavior is learned and becomes self-reinforcing, sociocultural theories acknowledge the importance of traumatic or damaging social experiences on particular social groups. (McAllister, 2003, p. 183)

Disorganised attachment, a component of attachment theory, "can be understood in terms of an approach-avoidance dilemma for infants for whom stressed and traumatized/ traumatizing caregivers are simultaneously a source of threat and a secure base" (Holmes, 2003, p. 524). People with a diagnosis of BPD were seen to possess disorganized attachment traits and failed to develop a robust sense of self (Bateman & Fonagy, 2004). Furthermore, "according to attachment theory, the development of self occurs in the affect regulatory context of early relationships…disorganization of the attachment system results in disorganization of self-structure" (Bateman & Fonagy, 2006, p. 11). Disorganised attachment and early inadequate parental mirroring, within which trauma played a key role, undermined the person's capacity for mentalization (Bateman &

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Fonagy, 2004). The inability to mentalize contributed to a profound disorganisation of self-structure. Mentalization will be discussed in the following section of the literature review. Disorganised attachment was "most likely to be associated with self-harming or aggressive and potentially violent behaviour later in development" (Bateman & Fonagy, 2004, p. 87). Alternative classifications of viewing the person with a diagnosis of BPD have encouraged the client, the family and the mental health professional to see the person as a human being first and foremost and not simply define the person as a disorder.

Current treatment foci for clients with BPD

Three therapeutic models were used in the treatment of BPD within New Zealand, namely Cognitive Behavioural Therapy (CBT), Dialectical Behavioural Therapy (DBT) and Mentalization Based Therapy (MBT) (http://likeminds.org.nz/files/Newsletter-archives).

The study was carried out in the first DHB in New Zealand to have implemented a service for people with a diagnosis of BPD based on MBT. The new service delivery model commenced in the community mental health teams in 2009 and was therefore relatively new at the time of this study. Previous practice models for people with a diagnosis of BPD were focused on taking responsibility for clients' safety rather than trying to address the underlying cause of the client's emotional distress (Te Pou, 2007). Clients were asked to take responsibility for their thoughts of self-harm or were admitted to an acute unit because of the perceived risk of self-harm (Te Pou, 2007). Over the last

decade there has been an increasing recognition of the significance of talking therapies for people with a diagnosis of BPD. MBT was regarded as affordable in terms of training and a good fit with clinicians' existing skills (Te Pou, 2007). The Mindsight programme consists of individual and group therapy, which generally runs for 18 to 24 months. Interventions in the Mindsight programme include fostering mentalizing and a sense of agency and choice; enhancing ability to self-regulate and strengthening self-awareness and awareness of others (Allen, 2003).

MBT is a therapy that focuses on a person's ability to mentalize as this ability is weakened in BPD and can disappear in times of emotional distress (Bateman & Fonagy, 2004). Mentalizing is the sense we have of ourselves and others as people whose behaviours originate in mental states: desires, wants, emotions, thoughts and beliefs (Allen, 2003). The focus is on the here and now, on building a sense of self, and "on the experience of another human being having the patient's mind in mind" (Bateman & Fonagy, 2004, p. 47). When mentalizing occurs, there is a sense of self-management and of being in control of and responsible for one's behaviour, rather than feeling that our behaviour just happens (Allen, 2003).

A core feature of BPD was the person's difficulty with mentalizing because of the disrupted attachment relationships they experienced at a young age (Fonagy & Bateman, 2006). When a person becomes emotionally aroused, their capacity to mentalize is diminished and they misread the minds of others (Bateman & Fonagy, 2004).

PART 2: SELF-MANAGEMENT

History of self-management within the medical model and beyond

The medical model had been the dominant concept driving mental health care delivery in New Zealand and internationally prior to the 1970s. The focus of the model was on treating the illness and addressing the deficits and symptoms of clients. Clinicians were seen as the experts, the people in charge of dealing with and managing mental illness. Patients tended to be seen as a collection of symptoms and an illness with little to say about their treatment (Koch, Jenkins & Kralik, 2004). The concept of self-management did not fit easily into the medical model and at best may be viewed as a client complying with the experts. "Close analysis of the literature revealed that a medical prescriptive approach to self-management is widespread, emphasizing adherence to directions given by health care professionals" (Koch et al., 2004, p. 485).

The term self-management was introduced by Thomas Creer in 1976 in a book about rehabilitating chronically ill children (Lorig & Holman, 2003; Sterling, von Esenwein, Tucker, Fricks, & Druss, 2010). It was mostly cited in the literature in relation to self-management of chronic physical disease and appeared in mental health literature in the last two decades. Deinstitutionalisation and social reforms in New Zealand however, saw the emergence of a new paradigm of delivering care, that of the recovery philosophy. Significantly, "nurses have helped to de-institutionalise long-term care and to reframe [it] as a socially determined construct…these movements have also reinforced the importance of self-care and self-responsibility for health" (Holmes & Gastaldo, 2002, p. 560). Self-management as a concept was observed to be of increasing significance in

nursing research as demonstrated by the inclusion of self-management, symptom management and care giving in the 2010 budget for the National Institute in Nursing Research in the United States (Polit & Beck, 2012).

Self-management within the recovery model in the field of mental health

The recovery philosophy evolved from the addiction and mental health consumer movements and one of its definitions was "a way of living a satisfying, hopeful, and contributing life even with limitations caused by the illness" (Anthony, 1993, p. 527). The recovery philosophy challenged the paternalistic, dominant truths of the biomedical model that delegated service users to the sick role, a role without voice or options regarding their treatment within the mental health system.

The recovery philosophy appeared to have many definitions and it was noted that both practitioners and policy makers struggled to understand what recovery was (Jacobson, 2001). It was observed by Davidson, O'Connell, Tondura, Styron and Kangas (2006) that although the concept had taken centre stage in guiding policy and practice, it was not clear what the term meant. In addition to recovery being a focus for policy and practice, it was also seen as a unique and subjective experience which Anthony (1993) described as a "deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles" (p. 527). Recovery was what people with disabilities did, whereas treatment, case management and rehabilitation was what other people did who wanted to help people in the recovery process (Anthony, 1993). It was noted by Bowen (2013) that while " There does seem to be a general acceptance of a recovery focus, this has not yet

translated into nursing practice for people with a diagnosis of borderline personality disorder" (p. 497).

One of the central elements of the recovery philosophy within the field of mental health was self-management. "Recovery is a person centered approach, which builds on an individual's sense of control and responsibility in the process of getting well" (Deegan, 1998, p. 11). It was contended that "self-management…allows mental health consumers to become active participants in the recovery process leading them to an overall sense of wellness" (Sterling et al., 2010, p. 134).

"Self-management is one aspect of recovery which begins to translate the heady ideas of recovery and turn them into practical tools for everyday living" (Davidson, 2005, p. 26). In their review of self-management, Wilkinson and Whitehead (2009) noted that there was an absence of a consistent definition for the term 'self-care' in the literature but that Gantz' review did find agreement on four characteristics of self-care. "Self-care was seen as: situation and culture specific, involves the capacity to act and make choices, is influenced by knowledge, skills, values, motivation, locus of control and efficacy, and focuses on aspects of health care under individual control" (Gantz as cited in Wilkinson & Whitehead, 2009, p. 1144). Self-management was demonstrated then, in a multitude of expressions in peoples' lives, situations and cultures.

Moral implications of self-management

"Any discussion about empowerment would be superficial without an understanding of power; empowerment can neither be explained nor enacted without it" (Masterson & Owen, 2006, p. 20). Three models of empowerment were identified by Masterson and Owen (2006); the first model was the consumerist model of empowerment which related to ideas of self-management, self-responsibility and personal control with the assumption that clients accepted responsibility for themselves rather than relying on mental health clinicians. The consumerist model sought to share formal power. The second model, the psychological model, was about developing power from within and assented to the feminist notion of power, that it "may be generated within individuals through facilitation of knowledge, skills and self-esteem" (Masterson & Owen, 2006, p. 26). This empowerment took place within a therapeutic relationship while the social model, the third model of empowerment "may mean creating equal opportunities through structural change, accomplished through legislative, policy, financial and organizational processes" (Masterson & Owen, 2006, p. 24).

Three main assumptions have been held about the self-management concept relating to power. First, that all service users fitted well into the concept of self-management; second, that clinicians believed in and promoted self-management as a concept, and third, that health systems were supportive of self-management. These assumptions highlighted ethical issues that surrounded the concept of self-management however Redman (2007), noted that self-management has been an evolving movement and awareness of the ethical issues and moral dilemmas have been absent in the rhetoric.

First assumption: All service users fitted into the concept of self-management

The consumerist model of empowerment assumed that clients wanted to take responsibility for themselves rather than relying on mental health clinicians. In the article 'Mental Illness and the Freedom to Refuse Treatment: Privilege or Right', Bassman (2005) promoted freedom to self-manage regardless of the consequences of the self-management practices. He stated that "psychiatric survivors say yes to assuming responsibility for violating law…[and that] the freedom to make poor choices is a privilege that is denied to the person who is labeled mentally ill" (Bassman, 2005, p. 491).

 Arguments against this model included the notion that individualistic empowerment had deflected attention from socio-structural disempowerment; and that it was wrong to imply individual pathology when the society may have contributed to the problem (Masterson & Owen, 2006). Redman (2007) raised an ethical issue of patient empowerment that was particularly pertinent to people with a diagnosis of BPD in terms of "helping patients discover and use their own innate ability to gain mastery over their disease" (p. 247). People with a diagnosis of BPD have experienced difficulty adopting concepts of self-sufficiency and independence because they have lacked a sense of self resulting in identity disturbance.   The distortions of self impacted the person's ability to assume responsibility in managing their symptoms, treatment and life style changes. Reasons why people may or may not have adopted self-management practices included a huge range of diverse attitudes towards undertaking self-management, the influence of significant others, the social context in which the self-management took place, and the timing and stage of the illness (Chapple & Rogers, 1999). This argument was echoed by

Townsend, Wyke and Hunt (1999) who contended that symptom management was something that people knew they should do. However, "the priority… given to 'identity management' was sometimes said to be at the cost of their symptom management…controlling symptoms may not always be their main priority in the face of threats to valued social roles, identities and a 'normal life'" (Townsend et al., 1999, p. 193). Self-managing symptoms was seen by people in Townsend et al.'s (1999) study as "essentially core moral work intertwined with maintaining some semblance of a coherent and positive identity" (p. 192). Symptoms experienced by the person with a diagnosis of BPD such as impulsivity, anger, shame and self-harming underscored the need for self-management but were also part of an identity that was not simply threatened but already distorted, disturbed and poorly formed.   Self-management was described as the individual's ability to believe that they had the capacity to reach a desired goal or outcome (Schmutte et al., 2008). A service user with a diagnosis of BPD observed "I did not believe I had the power to change, and the only way I could see myself getting out of the situation I was in, was for the situation to be changed by someone else, or for someone to remove or protect me from the situation" (Krawitz & Jackson, 2008, p. 19). This observation highlighted the difficulty people with a diagnosis of BPD have with translating self-management principles to their situations.

There has been a tendency for people to view health professionals as having all the responsibility for preventing and curing illness with less consideration as to what personal responsibility could have entailed (Lorig & Holman, 2003).

Second assumption: Clinicians believed in and promoted the concept of self-management

Redman (2007) explained that the empowerment movement needed to meet certain conditions to be successful, one being that all providers were to practice in an autonomy-supportive fashion. An autonomy-supportive fashion referred to "the extent to which providers elicit and acknowledge patients' perspectives, support patients' initiatives, offer choice about treatment options and provide relevant information minimizing control" (Redman, 2007, p. 248). There was potential for mismatch between what professionals and service users understood the concept of self-management to be because the health professional retained the belief that "the professional is the expert, that the health care system is the legitimate gate keeper for socially supported health care services, and that the ideal patient is both compliant and self-reliant" (Thorne, Nyhlin & Paterson, 2000, p. 303). It was noted that "self-management was interpreted narrowly as referring to compliance with medical instructions…[and that] patients' experiential self-management strategies were marginalized" (Rogers, Kennedy, Nelson & Robinson, 2005, p. 231)

Disciplinary power, an alternative to coercive and so-called expert power, was a form of power described by Foucault, that was used by nurses to influence clients productively with respect to their coping mechanisms, emotional regulation and increased self-awareness (as cited in Holmes & Gastaldo, 2002). Disciplinary power was subtly employed by nurses in a non-coercive manner together with pastoral power, which utilised confession, introspection and self-examination to assist the individual to increase

their self-awareness and therefore self-management (Holmes & Gastaldo, 2002). It was "suggested that self-regulation is a dominant form of social control… and that individuals could reach self-regulation…through pastoral care… [which] promote[s] processes of self-surveillance and self-awareness" (Holmes & Gastaldo, 2002, p. 562).

There was debate in the literature around who self-management involved. Self-management could be viewed as an action occurring without professional input which was consistent with the consumerist model or alternatively, self-management "should be seen as a continuum, with self-care managed alone at one end of the continuum and self-care shared with professionals at the other" (Chapple & Rogers, 1999, p. 447). A third view was concerned not so much as to where the care came from as to "whether the care is self-managed (i.e. ultimately within control of the individual)" (Chapple & Rogers, 1999, p. 447). Clinicians have a part to play in self-management according to Mueser et al., (2006), who noted that "recovery or living successfully with any chronic health condition requires individuals to learn how to manage their illness in collaboration with treatment providers" (p. S32). There is potential for disparity between nurses' expectations for the service user to manage and the service user's ability to manage. Treatment providers may assume to have understood what self-management meant without active collaboration with the client resulting in the false belief that clients "need to be protected from stress and live in protected settings" (Mueser et al., 2006, p. S33). Study participants in Koch et al.'s (2004) study identified three models of self-management: the medical model of self-management referred to previously, the collaborative model, and the self-agency model. The collaborative model was described

by participants as a joint effort with "input from the client being acknowledged and valued" (Koch et al., 2004, p. 488-489). The self-agency model reflected the stance that "taking control of their own lives was crucial to those who claimed to manage the self'" advocating self-determination and the importance of locating the 'self' in self-management (Koch et al., 2004. p. 489).

Third assumption: Health systems and society were supportive of self-management

Society and health delivery systems often only paid lip service to the recovery philosophy and concept of self-management and did not appear to support clinicians in their promotion of self-management. "For empowerment to occur, people with severe mental illness need a minimal level of psychiatric stability and decision-making skills, as well as an organizational culture that promotes shared decision making and provides resources required for empowerment" (Linhorst, Hamilton, Young & Eckert, 2002, p. 425). An argument presented by Redman (2005) was for complementary roles that health care professionals and patients play in successful self-management. It was noted that health systems often fell short of this and defaulted to viewing self-management as providing clients with basic information and expecting compliance; ensuring that "medical ethics remains largely paternalistic, which does not help patients to become true partners in care" (Redman, 2005, p. 366). It was also contended by Redman (2005) that "the inability to provide adequate self-management preparation [within this paternalistic culture] is one cause of moral distress amongst nurses" (p. 367). These ideas were consistent with Koch et al.'s (2004) view that medical self-management was the dominant model used where "the role of 'self' was excluded…[while] the focus was on medication compliance" (p.

490). The increasingly apparent challenge of integrating self-management into existing health care systems was described by Lorig and Holman (2003) who reported that barriers included funding, little or no structure to support self-management, as well as the fact that "the system itself does not support self-management education" (p. 5). A physician (as cited in Lorig & Holman, 2003), poignantly observed of self-management education "This is not part of our dance" (p. 5).

An erroneous assumption that health systems are supportive of self-management may be illustrated by the situation when mental health services have placed the responsibility for client safety onto nurses. Nurses may have wanted to promote self-management and self-responsibility for clients with a diagnosis of BPD but find themselves in a constrained position of practicing in a risk averse manner. "Exploration of nursing attitudes, knowledge, perceptions and readiness regarding the concept of self-care/management within a country's health care context may contribute to enhancing chronically ill individual's self-care practices" (Wilkinson & Whitehead, 2009, p. 1147).

PART THREE: SYSTEMATIC REVIEW

OBJECTIVE OF THE SYSTEMATIC REVIEW
The objective of this review was to determine what mental health nurses' understood the concept of self-management to mean in relation to a service user with a diagnosis of BPD.

CRITERIA FOR CONSIDERING STUDIES FOR THIS REVIEW

Type of studies

Any relevant studies and articles, published or unpublished, that explored the concept of self-management in relation to BPD from mental health nurses' point of view. Qualitative studies although scarce, best captured these points of view and included phenomenological, grounded theory, critical discourse, ethnographic, narrative, case, action and evaluative research studies using questionnaires, interviews and surveys. Quantitative studies were not found to be useful because they did not allow nurses to freely express their thoughts about working with people with this diagnosis. Furthermore quantitative studies had limited definitions of the topics in question rather than allowing nurses to express their own meanings. Nurses' responses in quantitative studies were also sometimes categorized in a limiting manner as being positive or negative without providing detail as to what these responses entailed.

The search was restricted to the last ten years to capture recent opinions and research. Expert opinion articles written by mental health nurses or written by other professionals about mental health nurses regarding their understanding of the concept were also accepted. Studies were restricted to the English language.

Types of participants

Participants included nurses who worked in mental health care, either an inpatient or a community setting. Nurses were either the author or objects of the articles, or the author or participants of the selected studies. The studies excluded nurses who worked in a general nursing setting.

Phenomenon of interest

Articles of interest included studies, articles, thoughts, speeches and opinions of mental health nurses about the concept of self-care as it related to the service user with a diagnosis of BPD. Articles included stated rationale as to why nurses cared for service users with a diagnosis of BPD in the manner that they did and how that rationale related to self-management.

Types of outcome measures

Understanding what self-management meant to the participants of the studies or authors of the articles/books in relation to caring for service users with a diagnosis of BPD. Secondary outcome measures included clinical rationales explaining why people with a diagnosis of BPD had been cared for in a particular way and how that related to self-management.

SEARCH STRATEGY FOR IDENTIFICATION OF STUDIES

The search strategy included the last ten years available in each database and all relevant qualitative studies and articles of expert opinion were chosen. The 'subject' search terms 'self-management', 'borderline personality disorder' and 'mental health nurse' and their equivalent words were searched for in the abstracts/titles in CINAHL. The search yielded minimal results and the terms were expanded. Expanded terms for self-management were self-care, self-efficacy, self-responsibility, autonomy, responsibility, empowerment, and coping. Expanded terms for BPD were axis II disorders, self-harm,

self-mutilation, and self-injury. The alternative term for mental health nurse was psychiatric nurse. The expanded search yielded 21 results. The other data bases, EMBASE CLASSIC, OVID, MEDLINE and PsychINFO were searched with the initial and expanded terms also utilising the 'thesaurus' function, 'exploding' and some subheadings of the thesaurus function of the search tools. Fifty-one results were netted from the other data bases. Google scholar was searched which yielded two more papers. The Cochrane Library was excluded because of its bias towards quantitative studies. Seventy-two articles were submitted to further detailed examination with reference to the inclusion and exclusion criteria previously mentioned. The four literature reviews were excluded as they contained data gathered from quantitative studies.

METHODOLOGICAL QUALITY

Seventeen articles were reviewed to critically appraise the quality of the studies using the JBI critical appraisal tool and quality assessment forms for qualitative studies (Appendices 2-3). Of the seven qualitative studies, all seven scored seven and above out of a possible ten criteria on the qualitative assessment form and six of these were retained. The researcher had determined that studies needed to contain seven or above of the possible ten criteria. One study was excluded due to lack of relevance to the research question. Studies lost points for not meeting the criteria of locating the researcher theoretically or culturally; as well as the criteria of researcher influence on the research. Eight articles were retained after using the expert opinion criteria to assess their quality. Two expert articles were excluded on the basis of one being a case study with no

analytical argument or reference to extant literature and the other for no analytical argument or peer support. Fourteen articles were retained overall (Appendix 4).

DATA EXTRACTION AND ANALYSIS/SYNTHESIS

Data extraction was accomplished using adapted data extraction tools available from JBI (Appendix 5 & 7) for the six qualitative research studies and eight expert opinion articles. The 14 studies yielded 36 sub-themes with accompanying findings (Appendix 6). The 36 sub-themes contributed to four themes.

RESULTS

Two of the studies explicitly employed descriptive and exploratory designs, one study an interpretative phenomenological stance and the last three simply mentioned qualitative study using semi-structured interviews. Of the six qualitative research articles, four focused on BPD and two were concerned with nurses' responses to self-harm. Five of the opinion articles involved BPD and three concentrated on self-harm. It was acknowledged at the outset that not all people who self-harm have a diagnosis of BPD. The articles on self-harm were included in this review due to the lack of articles concerning nurses' attitudes towards people with a diagnosis of BPD. Not all clients with a diagnosis of BPD self-harm in the sense of self-mutilating behaviours outlined in criterion five for BPD in the DSM-V (APA, 2013, p 663). The concept of self-management however can also be viewed in relation to behaviours outlined in criterion five that are potentially self-damaging such as impulsivity in spending, sex, substance abuse, reckless driving, and binge eating (DSM-V, APA, 2013, p 663). While the DSM-V

(APA, 2013) locates self-harm within criterion for BPD, there is a train of thought that self-harm ought not be seen as a symptom of a mental illness (McAllister, 2003; Rayner, Allen & Johnson, 2005; O'Donovan & Gijbels, 2006) because of the stigmatization associated with people receiving a diagnosis of BPD and people showing no other symptoms of BPD other than self-harming. There were similarities between self-harm and BPD in terms of nurses' attitudes towards issues of risk, responsibility and self-management although this was not always seen as helpful for the client because of the label of BPD (Rayner et al., 2005). While the focus of the five included articles was self-harm, all but one of the articles discussed self-harm in relation to a diagnosis of BPD.

The literature review did not yield any studies relating to mental health nurses' understanding of self-management in connection with someone with a diagnosis of BPD. Nurses' understanding of self-management had to be worked out from studies concerning nurses' attitudes to working with people with BPD and from articles written by nurses or about nurses and their perceptions of the diagnosis and nurses' attitudes towards clients with the diagnosis. How a nurse interpreted their role in helping a client to develop self-management directly reflected how the nurse conceptualised self-management. There was a lack of consistency in the literature as to what constituted self-management (Wilkinson & Whitehead, 2009).

The following four themes are associated with mental health nurses' understanding of the concept of self-management in relation to a service user with the diagnosis of BPD.

1. Self-management is the client coping in the context of historical abuse

2. Self-management is not feasible/ too difficult given the client's presentation

3. Self-management is something nurses do for clients to keep them safe.

4. Self-management is the client being responsible for themselves.

Self –management is the client coping in the context of historical abuse

This theme showed nurses who looked beyond the client's current presentation and saw the client within their context of historical abuse. This perspective allowed nurses to see the client as self-managing past trauma compared with seeing the client as indulging in risky, problematic behaviours for the sake of it.

Six sub-themes contributed towards this theme (Appendix 6).

"Nurses offered a range of explanations for self-harm …in an attempt to understand it" (O'Donovan & Gijbels, 2006, p. 190) that were suggestive of the client self-managing. Nurses "suggested it was a cry for help, a way of coping, a way to release emotion, or a way of dealing with distress" (O'Donovan & Gijbels, 2006, p. 190). Although sexual abuse was not explicitly mentioned in this article in relation to self-harm, it was argued by Pembroke that "self-harm is a sane response when people are gagged to maintain social order" (as cited in O'Donovan & Gijbels, 2006, p. 187). This alluded to non-validating, unacknowledging attitudes from society towards women who had suffered sexual abuse. The participants in the study also made references to "experiences they [patients who self-harm] had in the past" (O'Donovan & Gijbels, 2006, p. 190). Historical sexual abuse was referred to more overtly by participants in Stroud and Parson's (2012) study when they acknowledged "the importance of negative early life experiences including trauma experienced by clients with BPD" (p. 5). Despite this

acknowledgement, the participants did not view the clients' presentation within the context of historical trauma, "the link between past traumas and current difficulties could fluctuate" (Stroud & Parsons, 2012, p. 5). An example of this was a participant discussing a client noting:

"a really bad childhood into teenage [years], extremely shocking the sexual abuse. Became a drug addict who masked the feelings, not able to cope with what happened...she can be quite devious, saying one thing to you and then something different to someone else." (Stroud & Parsons, 2012, p. 5)

Another participant however, saw the client within the context of sexual abuse and noted, "the traditional view is about them being very manipulative and attention-seeking, but I have not really found that. It is just about the distress they are in you would look at it in terms of the client is trying to cope" (Stroud & Parsons, 2012, p. 6).

The strong correlation between women with a diagnosis of BPD and a history of sexual abuse was acknowledged by Warne and McAndrew (2007) where self-harm and other 'challenging behaviours' were not seen as a cluster of BPD psychiatric symptoms but rather "the expression of active defenses against psychosocial conflict that produce unbearable intra-psychic tension and pain" (p. 159). 'Active defenses' could also be viewed as a self-management strategy. It was concluded by Warne and McAndrew (2007) that "it is only when mental health nurses can embrace and acknowledge the

person in the context of their life, that the pejorative and disabling consequences of the BPD label can be eliminated" (p. 155).

It was noted by Crowe (2004b) that the shame experienced by the client with a diagnosis of BPD interfered with a sense of self and the capacity to self-reflect. Crowe (2004b) encouraged exploration, within the nurse-client relationship, of alternate positions for self-managing feelings of shame. The correspondence between people who self-harm and those who have experienced sexual abuse was also noted by McAllister (2003), that "self-harm is a way earlier trauma is repeated, communicated or symbolized [and that] self-harm is seen as a coping strategy to manage painful feelings, powerlessness intrusive memories and compulsion to the repeat the trauma" (p. 180).

While sexual abuse was not mentioned specifically in their article, Rayner et al., (2005) noted that "self-injury can be understood as a coping strategy for difficult emotions…a response to feeling helpless and unable to control life events…[and that] resilience is the reframing of distressing events to encourage survival, courage and the validation of clients' efforts at coping" (p. 17).

Self-management is not feasible/too difficult because of perceptions that clients were too hard to work with

This theme displays nurses' thoughts that clients with a diagnosis of BPD did not have the ability to self-manage but instead sabotaged their treatment. They felt that nursing efforts were fruitless because of the level of difficulty encountered in working with this group of people.

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Half of the 36 sub-themes contributed towards the second theme of self-management. Participants perceived clients with a diagnosis of BPD as unable to self-manage or cope with life and requiring professional assistance (Woollaston & Hixenbaugh, 2008). A participant observed that "caring for them just wastes time and money. I didn't want to understand what they were thinking. Our efforts would not help them change their personalities or disease at all" (Ma et al., 2009, p. 444). This view was consistent with McGrath and Dowling's (2012) observation that nurses gave up on holding out for hopeful outcomes for clients with BPD. In McGrath and Dowling's (2012) study a nurse participant viewed the client as a "totally difficult patient to manage totally self-obsessed, manipulating you people with attention seeking behavior and a lot of time they have unresolved issues and they largely take this out on everyone else" (p. 3). A similar participant reflection from Stroud and Parson's (2012) study was about a client who:

"Became a drug addict who masked feelings, not being able to cope with what happened quite a few of them don't want to change, perhaps they are scared of change but I think they are also hiding behind it it's challenging, they are so complex" (p. 5-6).

The participant's belief about the client not wanting to change was reiterated by a participant in a different study "patients are often seen as deliberately trying not to improve or sabotaging their treatment" (Bland & Rossen, 2005, p. 509). Nurses did not feel that they were able to contribute towards a client self-managing. "I don't really like working with them because I'm not able to see a result for my effort…you can't make it

better" (Woollaston & Hixenbaugh, 2008, p. 706). Similarly Thompson, Powis and Carradice (2008) noted in their study that nurse participants found patients who self-harmed difficult to work with.

"She was so badly damaged that it would be difficult for her to work constructively people [who] were just, at times, were just phenomenally difficult to work with because they're just so demanding [and] you think 'well what's the point of that?' and take it personally." (Thompson et al., 2008, p. 157)

It was observed by Warne and McAndrew (2007) that "negative attitudes and value judgments contaminate professional responses" and that clients are "generally regarded by nurses as being irritating, attention-seeking, difficult to manage and unlikely to comply with advice or treatment" (p. 157- 158). Referring to this stance, Evans (2007) stated "staff may hide behind a defensive position in which they start to moralise about the patient" (p. 218). This thought was reiterated in the following statement: "people are labeled as 'manipulative' and 'attention-seeking'…as a defense mechanism, this serves to make the nurse feel better about themselves, locating the source of difficulty with the client rather than looking at the nurses' own knowledge, attitudes or beliefs" (Rayner et al., 2005, p. 13).

Nurses' negative perceptions were a contributing factor to the breakdown of the therapeutic relationship required for developing self-management skills. "I actually withdrew from any sort of therapeutic liaisons with a client because I felt they were not

genuine" (Woollaston & Hixenbaugh, 2008, p. 707). This was consistent with McGrath and Dowling's (2012) statement that some nurses withdraw and distance themselves from clients with BPD and "would avoid providing a service user with any level of care…until it became completely necessary and they would do this at the end of the day where they knew there would be no time to explore issues in depth" (p. 37). This observation was repeated in the following statement "nurses see patients' behavior as deliberate or bad… [and] withdraw and become distant" (Bland & Rossen, 2005, p. 509). Further observation by Bland and Rossen (2005) was that many nurses were unaware of counter-transference issues which resulted in diminished therapeutic relationships. This was corroborated by Evans (2007) who noted that counter-transference issues affected the professional's perspective. Diminished therapeutic relationships decreased the opportunities for clients to develop self-management skills, "counter-transference reactions by nurses affect the patients' treatment because a therapeutic relationship no longer exists" (Bland & Rossen, 2005, p. 510). In addition to nurses not being willing to develop therapeutic relationships with clients with a diagnosis of BPD, Warne and McAndrew (2007) noted that nurses tended to be unwilling to acknowledge sexual abuse in clients. "For women who have been abused as children, this repeat experience centers on a culture that does not allow women a voice to express their abuse" (Warne & McAndrew, 2007, p. 158). Nurses may potentially view acknowledging sexual abuse as 'opening a can of worms'; belonging to the realm of psychology; or too complex a topic to acknowledge.

Self-management is something nurses do for clients to keep them safe

The third theme represented nurses' belief that clients must be able to keep themselves and others safe in order to be said that they were self-managing. Nurses therefore thought that if clients could not self-manage, then nurses needed to make judgment calls regarding the client's ability to keep themselves safe.

A quarter of the sub-themes contributed to this third theme. In their study Ma et al. (2009) found that "six nurses with more inherently negative expectations for their BPD clients decided to…focus only on basic needs and safety" (p. 444). This finding was consistent with O'Donovan and Gijbels (2006) observation that "providing a physically safe environment and preventing self-harm were the key priorities for the participants" (p. 191). The community nurses in Thompson et al.'s (2008) study did not think it was their job to prevent self-harming, but that monitoring risk was important: "I don't actually see it as my aim to stop somebody kind of self-harming, maybe we can look at reducing this and making that behavior as kind of safe as possible" (p. 156). The significance of community nurses' concern about risk was also noted by Stroud and Parsons (2012), "It's all to do with risk. That's all we are being embroiled in at the moment is risk" (p. 8). Another participant observed of her colleagues and service that "staff are very defensive in their practice and very risk adverse it is about having a service that is prepared to take well thought out positive risk and I don't think we are there yet" (Stroud & Parsons, 2012, p. 8).

Referring to inpatient nursing, Bland and Rossen (2005) observed how "trying to stop self-destructive behaviours can derail treatment efforts …nurses can become involved in

power struggles when trying to protect the client…which can lead to punitive consequences for the patient such as seclusion, forced restraint…[and] forced medications" (p. 512). This statement was reiterated by McAllister (2003) who noted "surveillance and control of the individual using restraint, seclusion or close observations may be ...difficult to defend" (p. 183). Maintaining client safety was a priority because the client was seen as not self-managing and so the nurse worked with a "strategy of prevention of self-harm…by one-to-one supervision of patients, or by close observations in conjunction with the removal of any implements that could be used for self-harm" (Edwards & Hewitt, 2011, p. 81).

Self-management is the client being responsible for themselves

In this fourth theme nurses thought that clients were responsible for their choices, behaviour, decisions and life and that when clients took up this responsibility that they were self-managing.

Nurses articulated clearly in Thompson et al.'s (2008) study, "It's about putting the responsibility back to them…you can make the choices about what therapies you wish to engage in, you're in control" (p. 156). Nurses however, "seemed to resent being made to feel responsible for behaviours which they felt patients could control…we have to remind her…that it's her responsibility" (Woollaston & Hixenbaugh, 2008, p. 707). Nurses were also seen to be "wanting to give responsibility to the client but fearing being blamed if anything untoward happened" (Thompson et al., 2008, p. 159). Fear of blame was also referred to in Stroud and Parson's (2012) study, "I think staff are so scared of things going wrong and them getting the blame and being sued it is very hard to allow clients to

have some responsibility" (p 8). Nurses found it challenging to give responsibility saying "it is difficult because you try to be open and non-judgmental and give them the opportunity to take responsibility…but they usually sabotage things" (McGrath & Dowling, 2012, p. 3). It was found by Edwards and Hewitt (2011) that when nurses' focus was not on preventing self-harm but on allowing the client to be responsible for their actions, that "patients retain control over their situation and able to continue to use a reliable means, as they see it, in order to cope with their feelings of intense distress" (p. 82). Clients' ability to take responsibility did not however take place within a vacuum. When "we ask a person diagnosed with BPD to take responsibility for her *self,* what are we asking that person to do? …our understanding of our responsibilities and how we are to 'take' them depends…on how others signal who we are (or are not) and what we are (or are not) supposed to do" (Bjorklund, 2006, p. E68).

DISCUSSION

Mental health nurses' understanding of the concept of self-management was diverse. Theme one focused on the context in which clients with a diagnosis of BPD were seen to self-manage and viewed so-called destructive behaviours, as valid, coping responses to sexual abuse. This understanding of self-management invited exploration of new self-managing skills. Theme one rebutted the idea that mental illness was concerned with the client having a disordered personality and posited the problem in society where the trauma occurred. The idea of disordered personality was more in keeping with traditional ideology in mental health services and the DSM-V (APA, 2013) which consisted of

patriarchal paternalism, seeing people with a diagnosis rather than a person within a historical context of abuse.

This understanding of self-management appeared to be in contrast with theme two. In theme two nurses exhibited moral defensiveness and described clients in negative tones because there was no conceptual framework or context within which they viewed the person. A lack of knowledge about counter-transference issues also existed, resulting in a default position of viewing the client as a disordered personality. Nurses' thoughts about clients' capacity to self-manage were almost obliterated by nurses' defense mechanisms towards clients.

Theme one viewed clients who self-injured as having "considerable insight into their behaviour" and "self-harming behaviours an attempt to regulate internal distress" (Warne & McAndrew, 2007, p. 159), and that women who self-harmed showed resilience. In theme three nurses wanted to take away client's capacity to self-manage by focusing on keeping the client safe. It was reasoned by Edwards and Hewitt (2011) that when staff took responsibility for the client by trying to protect the client from themselves, that staff "risk undermining their, perhaps fragile, self-identity…by removing patients coping mechanisms…rides roughshod over these patients' autonomy" (p. 82). Themes two and three focused on the client's presentation, behaviours and nurses' subsequent reactions. In theme one, nurses attempted to understand clients. Nurses, who focused on providing boundaries and control to maintain safety for the client, scored low on the empathy scale and were categorized as providing no care (McGrath & Dowling, 2012).

In theme four, self-management consisted of the client taking responsibility for themselves which nurses viewed in different ways. The view that clients "shouldn't be treated by the mental health team and they should 'sort themselves out' and take responsibility for their behavior" (Stroud & Parsons, 2012, p. 8) aligned itself with theme two, that self-management was too difficult/not feasible. An opposing view provided by Bjorklund (2006) noted that "it is a condition of responsibility that a person recognizes her worthiness to answer for herself, which develops in an interpersonal context as a result of others' recognition of her worth and that she has standing in a moral community that invites her answer" (p. E66). In Bjorklund's (2006) view of self-management, nurses remain actively involved with the client instead of distancing themselves from the client. The focus is on feeling responsible towards the client rather than responsible for the client (Wilkinson & Whitehead, 2009).

Nurses who wanted to work this way often found themselves operating within risk averse services or within teams that constrained them from giving responsibility to the client. Nurses consequently felt that they were going to get blamed if anything went wrong. The notion of nurses giving responsibility to clients was a complex concept with many variables.

CONCLUSION

Nurses' understanding of the concept of self-management for people with a diagnosis of BPD influenced their practice and affected the roles that they and the person played in their recovery journey. Mental health nurses' understandings of self-management were diverse and at times varied greatly from the client's concept of self-management.

IMPLICATIONS FOR PRACTICE AND RESEARCH

The articles dealt with nurses' perceptions and understandings of BPD and their experiences of working with these clients however none of the articles asked nurses about what self-management might mean for these clients. There was a gap in the literature for nurses to directly articulate their understanding of the concept of self-management as it pertained to people with a diagnosis of BPD. Having the opportunity to discuss understandings of self-management would also give occasion to the implications for practice and what is important for providing quality care for this group of clients.

An implication for practice would include clinical supervision for nurses working with people with a diagnosis of BPD in order to provide a forum for them to reflect on their practice. Nurses may benefit from clinical supervision to ascertain and clarify the underlying beliefs, values and assumptions that are the foundation for their practice. Group supervision might also be beneficial for nurses to discuss strategies for working with clients with BPD so that nursing practice is less ad hoc and more consistently intentional towards clients. Another implication for practice would be having explicit discussion regarding risk taking for clients with BPD. This discussion would take place at

MDT level and management level and would help to alleviate nurses' anxiety about them taking unnecessary responsibility for clients' behaviours and choices.

CHAPTER 3 - METHODS

INTRODUCTION

In this chapter a short background to qualitative nursing research will be considered followed by a discussion about the general inductive approach which was the qualitative research method utilised by this study. Limitations of the study will then be explored, particularly with regards to the role of the researcher. The sample selection process will be explained, followed by discussion about the data collection. The practical aspects of the data analysis strategy will be explored and then the trustworthiness of the research will be considered. Finally, ethical considerations including approval and vulnerability of participants will be examined.

QUALITATIVE RESEARCH

Positivism was the paradigm that dominated nursing research for decades (Polit & Beck, 2012; Denzin & Lincoln, 2011). Positivism (or modernism) assumed that reality existed, that there was a real world out there that could be studied and known. Quantitative research was most closely linked with positivism and was concerned with the objective and quantifiable, utilising "deductive reasoning to generate predictions that are tested in the real world" (Polit & Beck, 2012, Chapt 1, para. 59). Quantitative studies were excluded in the literature search for this study because nurses were unable to freely express their thoughts or elaborate about working with people with a diagnosis of BPD in these studies. Furthermore, quantitative studies had limited definitions of the topics

searched rather than allowing nurses' to express their own meanings. Nurses' responses in these studies were also sometimes categorized in a limiting manner as being positive or negative without providing detail as to what these responses entailed.

The constructivist paradigm on which this research was based, was a countermovement that challenged positivist thinking and assumed that reality was multiple and subjective and mentally constructed by individuals (Polit & Beck, 2012; Gerrish & Lacey, 2011). Qualitative research most closely associated with constructivism which grew out of post modern thinking that "emphasizes the value of deconstruction - taking apart old ideas and structure - and reconstruction - putting ideas and structures together in new ways" (Polit & Beck, 2012, Chapt 1, para. 55). Qualitative research has been likened to quilt making and jazz improvisation, where "many different things are going on at the same time: different voices, different perspectives, points of views, angle of vision" (Denzin & Lincoln, 2011, chapt 1, para. 33). Qualitative research methodologies emphasised there was no one interpretation, truth or meaning because of the unique perspectives each person holds within the diverse societies and cultures that they are situated (Gerrish & Lacey, 2010). The researcher was observed to use skills to "create and enact moral meaning…to move from the personal to the political, the local to the historical and the cultural" (Denzin & Lincoln, 2011, chapt 1, para. 33). Another image for qualitative research consistent with these ideas was noted to be a crystal, with multifaceted angles, each reflecting a different point of view, "embodying an energising, unruly discourse, drawing raw energy from artful science and scientific artwork" (Ellingson as cited by Denzin & Lincoln, 2011, chapt 1, para. 35).

QUALITATIVE RESEARCH AND MENTAL HEALTH NURSING

Mental health nursing belonged to the "artful science and scientific artwork" (Ellingson as cited by Denzin & Lincoln, 2011, chapt 1, para. 35), an observation with which LoBiondo-Wood and Haber (1994) similarly noted that qualitative research "combines the scientific and artistic natures of nursing to enhance understanding of the human health experience" (p. 254). Qualitative mental health research is concerned with truth as the "subjective expression of reality as perceived by the participant and shared with the researcher… truth is context-laden" (LoBiondo-Wood & Haber, 1994, p. 256).

Qualitative research methods "enable health sciences researchers to delve into questions of meaning, examine institutional and social practices and processes, identify barriers and facilitators to change, and discover the reasons for the success or failure of interventions" (Starks & Trinidad, 2007, p. 1372). These authors expounded on three methods commonly used in health science research: phenomenology, discourse analysis and grounded theory. Grounded theory has its roots in sociology and "posits that meaning is negotiated and understood through interactions with others in social processes" (Starks & Trinidad, 2007, p. 1374). The overarching philosophy of the grounded theory method is that theory is discovered by examining concepts within the data. It was noted that some qualitative analytic approaches in the literature were not aligned with any of the specific traditional models such as the three previously mentioned (Thomas, 2003). "A considerable number of authors reporting analyses of qualitative data in journal articles (where space for methodological detail is often restricted) describe a strategy that can be labeled as a 'general inductive approach' "(Thomas, 2003, p. 2). The general inductive

approach however was used in some types of qualitative analysis and was most closely aligned with grounded theory. Indeed, Thomas (2003) noted that "the outcomes of analysis may be indistinguishable from those derived from a grounded theory approach" (p. 9). It was also noted by Thomas (2006) that the "inductive approach is not as strong as some other approaches in the area of theory or model development" (p. 246). The general inductive approach was the research method adopted for this study.

GENERAL INDUCTIVE APPROACH

The general inductive approach "provides a convenient and efficient way of analysing qualitative data for many research purposes" (Thomas, 2003, p. 1). It was noted that "researchers using the general inductive approach typically limit their theory building to the presentation and description of the most important categories" (Thomas, 2006, p. 241). The general inductive approach was noted to be less complicated and more straight forward than other traditional approaches to qualitative research and there was no emphasis on learning new technical terms such as open coding or axial coding as with the grounded theory approach (Thomas, 2006). Inductive analysis commences with observation generating a hypothesis which in turn generates theory (Gerrish & Lacey, 2010). This inductive analysis is contrasted with deductive analysis which starts with theory that generated a hypothesis which culminates in observations that proved or disproved the hypothesis and/or theory (Gerrish & Lacey, 2010). "The primary purpose of the inductive approach is to allow research findings to emerge from the frequent, dominant or significant themes inherent in the raw data, without the restraints imposed by structured methodologies" (Thomas, 2003, p. 2).

There are five procedures used for inductive analysis of qualitative data described by Thomas (2003, p. 5). These five procedures were also used for this research. First, the raw data files or transcripts were prepared which was also referred to as data cleaning. The transcripts were formatted into a common format and printed with a back up of each transcript. Second, the transcripts were closely read in order for the researcher to gain familiarity and an understanding of the themes in the text. Third, sub-themes were created after identifying items of analysis or text segments. The items of analysis were derived from the research study question. Fourth, overlapping sub-themes were merged into one sub-theme and texts or items of analysis that were not relevant were discarded. There were two rules identified by Thomas (2003) that were suited for qualitative analysis that differed from quantitative analysis, namely that items of analysis may contribute towards more than one sub-theme and that "a considerable amount of text may not be relevant to the research objectives" (p. 5). Fifth, there was continued revision and refinement of sub-themes in order to generate themes. In his summary, Thomas (2003) noted that "most inductive studies report between three and eight main sub-themes in the findings" (p. 5). Any more sub-themes than this indicate that the researcher is still in the process of combining the smaller sub-themes into more encompassing sub-themes or that they may not have prioritized which sub-themes are the most significant (Thomas, 2003, p. 5).

LIMITATIONS

"Qualitative analysis is inherently subjective because the researcher is the instrument for analysis" (Starks & Trinidad, 2007, p. 1376). The researcher was aware that they were making choices about which items of analysis were deemed to be significant and were to be included as such, what themes were emerging and which items of analysis were not relevant. The role of the researcher in grounded theory and by association, the general induction approach, was for the researcher to bracket their views, which meant that the researcher needed to try to take themselves out of the process and keep an open mind with the data (Gearing, 2004). The researcher met with two supervisors regularly during the data collection and analysis, and sought to determine that the themes were genuinely present in the findings and was not part of the researcher's prior knowledge. However what may be seen as a limitation can also be seen as a strength as "the constructivist paradigm assumes that knowledge is maximised when the distance between the enquirer and those under study is minimised… [that] findings from a constructivist enquiry are the product of the interaction between the inquirer and the participants" (Polit & Beck, 2012, chapt 1, para. 57). A question could be raised however, that if another researcher studied the same constructivist research question, would they arrive at similar conclusions to those reached in this study?

The researcher was aware of the need to constantly be on guard not to self-disclose details related to their own experience of working with people with a diagnosis of BPD or to react in a particular manner that may have introduced a bias towards the interviewees' responses to the questions. The role of the researcher was to listen and ask questions to

encourage the participant to give as comprehensive a view as they are able about the topic of study (Starks & Trinidad, 2007).

The researcher was aware of two presuppositions held prior to conducting the study. The first was that self-management was a positive concept, a quality to be sought after that contributed beneficially to one's mental health. The second presupposition was that people with a diagnosis of BPD ought to be encouraged to develop self-management skills. The researcher's clinical perspective historically involved promoting choice for clients with a diagnosis of BPD, along with the therapeutic importance for clients not to be placed under the Mental Health Act. The researcher was aware that the sample size involved a small group of participants and "the generalizability of findings from constructivist inquiries is an issue of potential concern" (Polit & Beck, 2012, chapt 1, para. 71)**.**

SAMPLE

The criteria for the sample stated the interviewees were registered mental health nurses who worked with service users with a diagnosis of BPD within the last year in an inpatient, outpatient or non-governmental organisation setting in the region the study was undertaken. All sampling in qualitative research was argued by Coyne (1997) to be purposeful sampling. The grounded theory approach, which was most similar to the general inductive approach, utilised theoretical sampling, a purposive type, in order to recruit participants who had "differing experiences of the phenomenon so as to explore multiple dimensions of the social processes under study" (Starks & Trinidad, 2007, p.

1375). Theoretical sampling "is a complex form of sampling that is dictated by the data and emerging theory" (Coyne, 1997, p. 629). While it is not said that classical theoretical sampling took place in this study, there was some blurring between purposeful and theoretical sampling in selecting the last interviewee. The first nine interviewees yielded data from which appeared two clear emerging themes and one theme that was emerging although not as clearly as the other two themes. The last interviewee was selected on the basis of their probable ability to contribute to this as yet underdeveloped, emerging theme. This type of sampling was warranted in order for the sampling to "be responsive to real-world conditions and that meet the information needs of the study" (Coyne, 1997, p. 630).

The sample of 10 registered mental health nurses was therefore chosen rather than randomly selected in order to potentially obtain diversity in experience, ideas, workplace setting and gender. Reliance on mental health nurses to have responded to the invitation to participate in the study may have generated a homogenous sample which would not have been advantageous to the study. The sample was sent a letter of invitation (Appendix 10) following an initial phone call from the researcher to ascertain interest in participation. The sample, once known to the researcher, was also sent a participant information form outlining the study (Appendix 9). The sample consisted of six females and four males, five of whom worked in the community setting, the other five working in an inpatient setting within the District Health Board. Three of the nurses working in the inpatient setting worked in locked units, one of these being a forensics unit. One of the interviewees was under 30 years old and the remainder was over 40 years old. Nurses'

length of experience with Specialist Mental Health Services varied from three to 30 plus years. The sample selection process ensured that no groups of nurses were excluded or under-represented. The interviewees were given adequate time to present their viewpoints and the researcher took every caution not to have led or influenced the interviewees in any way (Gerrish & Lacey, 2010).

DATA COLLECTION

Observing nurses working with clients with a diagnosis of BPD would have been the preferred method of data collection for this study. However, the intrusive nature of this method along with ethical issues rendered it a non-viable option. The study therefore depended on semi-structured interviews as the primary data collection method. The semi-structured interviews ranged from 40 to 60 minutes for nine nurses and an hour and a half for one nurse who wished to go over the recommended guideline of one hour as they had not finished relating all that they wanted to say. The interviews took place over a three month period and were in a venue chosen by the participant, either at their place of work or at the researcher's place of work, whatever was deemed more convenient by the participant. There was some pre-interview discussion where the researcher introduced themselves, the consent forms were signed (Appendix 8), and if required, discussion was held on the information sheet. The researcher presented herself as the listener and enquirer, asking the interviewees questions to elicit not merely an answer to the question but to "encourage the participant to elaborate on the details to achieve clarity and to stay close to the lived experience" (Starks & Trinidad, 2007, p. 1375). The questions were sent to the participants prior to the interviews for them to peruse if they

wished. The questions listed below were the main questions asked but also acted as the framework from which other related pertinent questions were asked.

1. What does self-management mean to you as it pertains to clients within the mental health setting?

2. Do you feel you have a part to play in supporting clients to develop self-management skills?

3. What does self-management mean to you as it pertains to clients with a diagnosis of borderline personality disorder?

4. Do you feel you have a part to play in supporting clients with borderline personality disorder develop self-management skills?

5. What relevance does self-management have to someone with a diagnosis of borderline personality disorder?

DATA ANALYSIS STRATEGY

The final transcripts were read multiple times, systematically and thoroughly, to identify emerging items of analysis from the raw data. The 307 items of analysis were then allocated to emerging sub-themes. The transcripts yielded 75 sub-themes which were selected for three reasons. The first reason for selection was statements made by nurses about what self-management did or did not entail. For example, the following item of analysis contributed to the sub-theme 'self-harm as self-managing'.

'..if they cut they do it from a good basis, for a particular reason, they know the outcome, their challenging behaviour is probably something that they have adapted and used when they need it'.

An opposing view about what the concept self-management involved was seen in the following item of analysis which contributed to the sub-theme 'self-harm is not self-management.

 'And self-harming, where there is no control, there is no self-management.'

The second reason for selecting a sub-theme related to how nurses saw their role in relation to helping a client to develop self-management. Sub-theme 33, 'Self-management work involves sitting with risk' had the following item of analysis:

'You sit and you breathe and you wait…you sit with that risk'.

How nurses interpreted their role in helping a client to develop self-management indicated how nurses conceptualised self-management and was therefore another means to collating sub-themes. The third reason a sub-theme was selected included observations that nurses made, which on their own may have led to no specific conclusion, but when examined within the context of their other comments, was significant. An example of a sub-theme being generated in this way was sub-theme 30, 'Long journey over time'. Five of the nurses talked about self-management for someone with a diagnosis of borderline personality disorder being a long process, significant enough to generate a sub-theme. After the 75 sub-themes were elicited, they were sifted through over and over to tease out any commonalities that they had with each other. Some of the sub-themes were condensed to become one sub-theme, for example, sub-theme 24 'Pulling on their skills' was very similar to sub-theme 55 'Give opportunity to show ability' and was moved to become part of theme 55. Three clear themes were generated via analysis utilising 32 of

the original 75 sub-themes while the other 43 sub-themes were discarded. The three themes were first, that self-management was self-responsibility, second, that self-management was an increasing self-awareness and finally, that self-management was maintaining safety.

Table 1. Data analysis strategy

Initial read through text data	Identify items of analysis (text segments)	Creation of sub-themes	Reduce overlapping of sub-themes and remove sub-themes not contributing to themes	Sub-themes organised to generate themes
52 pages of transcript	307 items of analysis	75 sub-themes	26 sub-themes retained	3 themes generated

TRUSTWORTHINESS

The researcher met with two supervisors each month and submitted the transcripts, items of analysis, sub-theme and theme generation tables and documents for their examination to ensure credibility. The supervisors were able to assess the validity of the participants' views aligning with the researcher's representation of these views and were able to assess the transparency of the research process and decision trail made by the researcher in the data analysis strategy. Finally the supervisors were able to confirm that the data, findings and interpretation were clearly linked (Gerrish & Lacey, 2010). Trustworthiness was further ensured for this study by having a clear aim for the study: what mental health nurses understood the concept of self-management to mean relating to a service user with a diagnosis of BPD. The study utilised a qualitative approach using semi-structured

interviews which was the most appropriate data gathering approach to draw out mental health nurses' perceptions. An appropriate methodology, the general inductive approach, was also utilised following a transparent process. Finally a comprehensive justification of the sampling strategy was provided (Gerrish & Lacey, 2012).

ETHICAL CONSIDERATIONS

Ethical approval

Ethical approval followed a rigorous process which necessitated scrutiny and approval from the University of Otago Board of Graduate Studies in Health Sciences, the Southern B Regional Ethics Committee, the District Health Board, the Specialist Mental Health Services Senior Management Team and the Maori Consultation Committee of the University of Otago. Maori are the indigenous people or tangata whenua of New Zealand and all primary research undertaken in New Zealand is approved via Maori consultation. This is to ensure that Maori perspective is protected, provided and that the research is carried out in a culturally sensitive manner. The question sheet, participant information sheet and consent form (Appendices 8, 9 and 11) were approved by these relevant groups.

Vulnerability of participants

The study acknowledged that the participants chose to disclose private information that could place them in a vulnerable position. Many mental health nurses have experienced strong, often negative emotions when working with people with a diagnosis of borderline personality disorder. In the event that a participant had become upset, the recorder would have been switched off and the participant given time to reflect on their reaction to the

question with reassurance and support given by the researcher. The consent form and participant information sheet stated that the interview could be stopped at any time if it should appear harmful to the participant. The participant would also have been given time to decide whether or not they wanted to continue with the study. The participants were made aware of their right to withdraw from the study at any time. A signed, informed consent was obtained at the outset of the study following the participant having read and understood the participation information form which was supplied to the participants upon invitation to take part in the study. Confidentiality was assured for the participants. Interviewees were allocated letters to ensure de-identifiability, for example, Nurse A through Nurse J. To further aid confidentiality the nurse's gender was not referred to in the findings.

No participants showed overt signs of distress when being interviewed although some of the answers to the questions reflected the conflict, stress and degree of difficulty that the interviewees had experienced working with people with a diagnosis of borderline personality disorder.

One person, an administration assistant known to the researcher, was in charge of typing up the transcripts and these were carefully checked against the recordings by the researcher to ensure accuracy. The transcripts were stored in a secure location and on a secure computer accessible only by the researcher and two supervisors. The tape recordings have been destroyed and the transcripts will be destroyed upon completion of the study. The participants were offered the transcripts to review them but all declined to do so.

The interviewer was in a clinical nurse specialist position in an inpatient clinical area. Questions were raised in particular by the Board of Graduate studies in Health Sciences related to the potential conflict of interest with the researcher/practitioner roles. Discussion of these issues was raised with the researcher's academic supervisor and it was decided that the following facts deemed the potential conflict tenable. The clinical nurse specialist role was not in a position of power over any of the participants interviewed as none of the interviewees had worked with or were currently working with the researcher while the researcher had been in the clinical nurse specialist position. Those nurses with whom the researcher worked were directly excluded from the sample at the outset of the study thereby negating any potential power issues that may have occurred from such a situation. The role of clinical nurse specialist in the interviewer position may conceivably have caused some self-editing on the part of the interviewees relating perhaps to an answer to a question being perceived to be judged 'right' or 'wrong'. At the beginning of each interview therefore, the participants were assured that there were no right or wrong answers and that the essence of the study was about capturing their unique understanding of the concept of self-management. During the interview process, care was taken to ensure that a non-judgmental and respectful approach towards participants was utilised.

The participants were also informed of the ways in which the study findings could be disseminated, that the study may be accepted for publishing and that the study is part of a thesis.

SUMMARY

This chapter has considered the benefits of qualitative research which allow for different unique viewpoints, meanings and interpretations of mental health nurses to be examined in response to the study question. The general inductive approach was discussed and noted to be a research method that did not restrain findings but was constructive in having allowed themes to emerge from the data. The researcher acknowledged the limitations related to being the instrument for analysis, and the subsequent attempts to bracket their views accordingly. Sample selection was discussed followed by data analysis strategy for the three themes generated from the data. Trustworthiness of the study was considered prior to examining ethical considerations for the study.

CHAPTER 4 - RESULTS

INTRODUCTION

The general inductive analysis led to the generation of three themes. These were self-management is self-responsibility, self-management is increasing self-awareness and self-management is maintaining safety. Within each theme a number of sub-themes were developed (Table 2). The themes and sub-themes will be presented with quotations to illustrate and support the analysis.

Table 2. Themes and sub-themes

1. **Self–management is self-responsibility**	1.Self-management equating to self-responsibility
	2.Staff not being responsible for a person's choice
	3.Staff sitting with risk
	4.Staff promoting self-responsibility
	5.Staff giving opportunity to show ability
	6.Situation of not being able to give responsibility
	7.Ability for client to make own choices
	8.Self-harm as self-management
	9.Client independence
	10.Client using staff family/friends/ resources
	11.Client feeling in control
2. **Self–management is increasing self-awareness**	1.Promoting continuous self-exploration/awareness
	2.Acknowledging attachment issues
	3. Emotional regulation is central to self-management
	4.Having internal resources
	5 .Developing resilience
	6.Developing empathy for self
	7.Learning self-management involves becoming self-aware
	8.Mentalizing
3. **Self-management is maintaining safety**	1.Giving/keeping control and responsibility
	2.Self-management is something that can come and go
	3.Staff are responsible for clients' safety
	4.Providing boundaries and control
	5.Intervening when necessary
	6.Taking choice away
	7. Self harm is not self-management.

THEME ONE: SELF-MANAGEMENT IS SELF-RESPONSIBILTY

This theme contained 11 sub-themes, refer to Table 2.

In theme one, eight of the mental health nurses articulated their understanding of self-management for the service user with a diagnosis of BPD to mean that service users took responsibility for themselves.

Sub-theme 1: Self-management equating to self-responsibility

The items of analysis that contributed to this sub-theme strongly asserted that people with a diagnosis of BPD were responsible for their own choices, behaviour and life.

'A person is responsible for their own journey in life.' (Nurse E)

'Self-management for them is that they are directing their own care'. (Nurse E)

'It's about taking responsibility for being able to control parts of their life that they maybe have not had the chance to do over the years' (Nurse H)

The last item of analysis alluded to people with a diagnosis of BPD who had begun to take control over their lives. The reason for the loss of control was not specified but may be speculated to be due to other people in the community having previously taken control or clinicians and services who had seen their role as taking control over the person's life.

Sub-theme 2: Staff were not responsible for a person's choices, behaviour, life journey

Sub-theme two maintained that nurses were not responsible for the person's choices or were in a position where the nurse's will was somehow superior to the client's will.

'Somehow for me it doesn't feel right that I am suddenly responsible for this person's life when this person has chosen on many occasions to give it up.....I don't think staff should take any responsibility to be honest'. (Nurse D)

'If they choose to cut or anything like that, there's nothing I can do'. (Nurse E)

The following item of analysis was consistent with the two previous items of analysis but also highlighted the complex and difficult nature that taking this position presented to the mental health nurse.

'...not rescuing her or taking responsibility for her actions is challenging because you sometimes feel like, you can see that there is going to be a bad outcome and you want to stop that but you can't, you know'. (Nurse A)

The item of analysis demonstrated that the service user's actions were challenging for the nurse, who was required to be aware of risks if they were not going to take responsibility for a person's choices. Nurse A experienced tension from wanting to stop the client's behaviour and take responsibility for their actions yet knowing that this would not be therapeutic for the client. The nursing practice Nurse A believed was therapeutic, was for the nurse not to take responsibility for the service user's behaviour. This challenging tension generated the next sub-theme.

Sub-theme 3: Sitting with risk

The sub-theme of sitting with risk arose from the challenging conflict of nurses' belief that they were not responsible for a client's behaviour and were not going to force their will onto the client.

'But it is about I think, as clinicians, accepting that we are working with people who are very risky at times, and that we actually need to be okay with that risk, to sit there with them'. (Nurse B)

Sitting with risk at times, involved complex and challenging clients who had been in near death experiences associated with severe deliberate self harm by cutting and overdosing. The following item of analysis was what Nurse F communicated to their client about their position on not taking responsibility for them should the client commit suicide.

'If you do choose to kill yourself, that's part of my job that I have to live with and I will move on, I just have to move on, you can't leave a note saying that I was a terrible case manager, or that I failed you, I don't want to hear that stuff. I make it very clear that is part of my process'. (Nurse F)

The difficult and complex nature of 'sitting with risk' had potential for further complications when working within a system or with colleagues, who had different views on taking responsibility for a service user's choices and behaviours. This could have resulted in the clinician having to take responsibility at times when they did not feel that this was the best therapeutic option for the client. This issue was highlighted in a dilemma recounted by a nurse regarding a service user with a diagnosis of BPD who was

admitted to a locked unit. The unit policy required that the service user was placed under the Mental Health Act when people were to be admitted there.

'There is a big difference [between a locked and unlocked unit] *because now in unit X* [locked unit] *now they have to be under the Mental Health Act so we do have a couple of people who come in and are under the Act and I really struggle with that...* ' (Nurse E)

The option of nursing a service user on an open unit would have bypassed this dilemma but would generate conflict if it was decided to keep the client longer than Specialist Mental Health Service policy stated. Acute Inpatient Service protocol states that the length of crisis admissions for a client with a diagnosis of BPD is 48 hours.

'...if the clinicians change their mind then we have a bit of an issue of someone being risk averse and going 'well this person needs another 9 days or we need more to be sure' and everyone is going 'noooo, please just leave it, this is working'. (Nurse E)

Sub-theme 4: Promoting self-responsibility for clients

When nurses ascertained that they were not responsible for choices a client made, this decision appeared to correlate with nurses' desire to promote self-responsibility for clients.

'I find you have to be firm, and encourage the self-responsibility'. (Nurse A)

'You have to be firm but fair and again putting the responsibility back on the client at all times'. (Nurse I)

Both of these items of analysis noted nurses' stance of having to be firm when promoting self-responsibility for people with a diagnosis of BPD. These statements imply that people with this diagnosis have not necessarily found it easy to take responsibility for themselves and that they have perhaps wanted nurses to take responsibility for them.

Sub-theme 5: Giving clients opportunity to show ability.

This sub-theme included items of analysis that had a sense of encouraging the client to do rather than guarding the client from doing. The following item of analysis was about working with a client who was finding it hard to manage in the community.

'*You are pulling on that person's techniques and self-management skills really for a long time before they get to that point,* [of a crisis admission] *so you are helping them grow, you know, you are prolonging them from going into crisis and feeling like they can't cope anymore, but that's still progress'.* (Nurse A)

A nurse discussed their belief that a service user should have been given the opportunity to be admitted to an open unit rather than a closed unit for a crisis admission:

'*I believe that this person has a lot more ability to not act in a manner that she does and has a lot more skill. If she is given the opportunity to demonstrate some of those skills and that ability to cope, that would seem a lot better, that the results would seem better rather than putting her there.'* (Nurse E)

The item of analysis implied that when a service user was given an opportunity to show ability, they would rise to the challenge of taking responsibility but having then been

admitted to a locked unit sent the service user the message that they were not able to take responsibility and therefore could not self-manage.

Sub-theme 6: The situation of staff not being able to give responsibility

This sub-theme reiterated the conflict created for nurses when they were hindered from being able to give the service user opportunity to show ability,

'…but she is in that situation of being under the Mental Health Act and being in a restricted environment and we are wanting the least restrictive environment possible and so it kind of puts us in a situation.' (Nurse E)

In this sub-theme nurse E continued to define her own role as well as that of the client. The nurse felt that their role was to give the client responsibility and experienced conflict when they were constrained from doing so.

Sub-theme 7: Clients' ability to make own choices

The sub-theme was similar to the previous sub-theme where nurses recognised that it was therapeutic for clients to make their own choices and that they were to be enabled to do so regardless of the risk involved.

'They have a right to make their own choices and maybe stumble and learn from it'. (Nurse G)

'They are self-responsible, we don't rescue them from self-harm, that is their choice'. (Nurse I)

Some nurses viewed self-harm as a form of self-management rather than merely an activity they allowed clients the choice to perform without rescuing them.

Sub-theme 8: Self-harm is self-management

Nurses contended that self-harming was the client's way of coping, of dealing with their mental distress the best way they knew how.

'...they manage themselves the best way they know how and the way they know how for some people would be self-harm, that's how they manage themselves'. (Nurse H)

This understanding of self-management appeared to be counter-intuitive for nurses to adopt and the following item of analysis was indicative of the process that the nurse went through to have arrived at that position.

'...one client who we were trying to foster the responsibility [in] *and they were chronic self-harmers and quite severe and we had to recognise that it was part of her coping techniques.'* (Nurse A)

'...it goes against the way of nursing a lot of the time, and it goes against my core values of what I would like to do for my clients, so it is always a challenge. I think it is one of the most challenging things you have to face in mental health, it is a complete turnaround of what you would want to do'. (Nurse A)

As with sub-theme six, this understanding of self-management, also created conflict for nurses. Nurses felt strongly that self-harm was a form of self-management but found it challenging to see the outworking of that self-managing.

Sub-theme 9: Client independence.

A third role nurses saw service users performing, or an attribute they saw service users attaining to, was client independence.

'Having as much independence as possible is the answer to managing yourself I think....self-management and independence go hand in hand...' (Nurse H)

'It is hugely important, especially, you know, how they want to be independent, to be able to call on their own resources...' (Nurse A)

This sub-theme did not, however, negate the ability and role of the service user in nurses' eyes to utilise resources outside of themselves to self-manage as the above item of analysis indicated.

Sub-theme 10: Self-management is using staff/family/friends/resources/crisis admissions

In this sub-theme, nurses understood that self-management was not a solo effort but was about calling on others for assistance when needed. The act of a client seeking help showed their ability to self-manage.

'It would be mismanagement I think, not to seek help... self-management is using help...sometimes it will be taking on assistance from others.' (Nurse G)

'Self-management is using the staff member and/or family or friends and their own resources when they need to...self-management is knowing what the resources are'. (Nurse G)

One of the resources available to service users with a diagnosis of BPD in Specialist Mental Health Services mentioned previously, was a 48 hour crisis admission for which service users could self-refer.

*'So they've gone out to see her because she's made the phone call 'I'm not okay'. It's still quite self-directed for her at that point because she can say I'm fine, I've coped and I've stayed here [*open inpatient unit*] for a while and I've had a day or 2 of stable medication and I feel okay'.* (Nurse E)

Nurses recognised this ability of service users to utilise resources as self-management.

Sub-theme 11: self-management is feeling in control

Nurses understood clients to have self-managed when clients felt in control and made decisions for themselves. When staff took control over clients and made decisions for them, this resulted in nurses viewing clients as having stopped self-managing, clients were seen to have handed responsibility for themselves over to staff. The scenario mentioned in sub-theme 10 recounted the experience of a service user who had accessed a crisis admission. It continues in the following item of analysis which resulted in the client losing control of utilising the resource because clinicians had decided to have her admitted to a locked unit and placed under the Mental Health Act.

'…it feels like her ability then, is to completely unravel, 'I'm not going to take responsibility for myself, this is nothing to do with me, I have no control' and so she rages, we get that real raging stuff'. (Nurse E)

The service user had taken control of their situation by contacting services and saying that she was not feeling okay. The service user then had that control or ability to make decisions removed from them on admission to hospital by clinicians which exacerbated the crisis for them.

'part of being in control is 'I need assistance please'…they have decided to ask instead of someone taking that away from them and saying 'we'll do this and you'll do that'. That is part of self-management, so it is showing them that they have choices'. (Nurse G)

These eleven sub-themes outlined above, contributed to the first theme generated from the analysis, that self-management is self-responsibility. This was a complex theme that was observed to cause conflict for the nurse and the service user. Nurses spoke with conviction about this understanding of self-management. The idea that self-management is self-responsibility was the foundation on which nurses' work with service users rested.

THEME TWO: SELF-MANAGEMENT IS INCREASED SELF-AWARENESS

The second theme had the second largest number of items of analysis (N=40) and contains eight sub-themes. All but two of the interviewees are quoted in this theme. Twenty five percent of the items of analysis were derived from the role nurses saw

themselves performing in this theme compared with 45 percent of the items of analysis for theme one. The majority of the items were about the service users' role and how nurses defined self-management. This was the only theme to which one nurse contributed to exclusively; the items of analysis from this nurse did not contribute towards the other two themes. In this theme nurses understood self-management for the client with a diagnosis of BPD to be an increased self-awareness, gaining an understanding of the reasons why they behaved, thought and felt the way they did. Self-management then, was a process of gaining awareness of themselves, of having new thoughts about themselves.

Sub-theme 1: Promoting continuous self-exploration/awareness

This sub-theme was the first of two sub-themes that described the nurses' role in the theme 'self-management is self-awareness'. Nurses saw that they had a role to play regarding the client learning to self-manage, which involved promoting, encouraging and assisting self-exploration and self-awareness.

'I don't come in as an expert. In terms of a part to play, I see myself as having a role in terms of helping people locate their own thoughts and feelings and help them reflect on them.' (Nurse C)

'Self-management focuses on retrieving that before it disappears...to be able to get the ability to think straight back.....So my focus is a lot around getting to know your own mind and your own emotions'. (Nurse C)

Nurses saw this role as a major focus in working with people with a diagnosis of BPD.

'I guess with the work that I have done it is that continuous exploration with the person around what they find useful for managing themselves and how they feel and their emotional reactions which I feel are the biggest things that I see with borderline'. (Nurse A)

'…if we can't help someone identify and understand and work with their own internal self-management, their own emotions, then they are not going to get very far, in fact, the rest of it's just not going to work…..so if they can get an understanding on how they feel it, they can start to have that self-management around it. And so it is an insight you try and help them with'. (Nurse B)

The role was described by the nurses as helping the client to explore, identify, understand, internally self-manage, know, locate and reflect on their emotions, thoughts, reactions, and feelings; in short, enabling self-awareness, insight and self-knowledge.

Sub-theme 2: Acknowledging attachment issues

Half of the interviewees articulated that attachment issues were of significance to people with diminished self-awareness. Whether these ideas were viewed through the lens of formal attachment theory or not, they were significant because of their mention. This sub-theme was included in the generation of theme two because nurses' acknowledgement of attachment issues pointed to awareness that people with a diagnosis of BPD did have attachment issues that contributed to a decreased self-awareness and self-knowledge.

'It's all about attachment. It [attachment] is huge. The more you hear about it, the more that it starts to sink in I think and it makes a huge difference. It's everywhere in front of us all the time, in the way that we relate to each other'. (Nurse C)

Although the word 'attachment' did not appear in the following quotations, attachment issues were alluded to when concepts of neglect, abuse and trauma during childhood were mentioned.

'...some of the basic things that many lucky children are taught, or they experience that again from parents, are not learnt by children who are neglected, abused or traumatised ....the building blocks aren't there...' (Nurse D)

'They have a lack of coping skills right from day one basically, whether it be trauma, whether it be neglect, no matter what happened in life, they haven't developed those coping skills like you or I would have....' (Nurse I)

'I see it as a developmental problem, whatever has happened to them within their process of development, through trauma or through family dysfunction or through whatever kind of trauma history they have got, something happened to disrupt the development of their own internal structures'. (Nurse J)

Nurses looked beyond the challenging behaviours that people with a diagnosis of BPD presented with, and saw reasons for the presentation, reasons that included poor attachment and childhood development issues.

Sub-theme 3: Emotional regulation is central to self-management

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Nurses understood that the service user with a diagnosis of BPD was not self-managing when they were unable to regulate or understand their emotions,

'Self-management is around emotional regulation…they are in total flux with themselves, but all their emotion dysregulation, for them it is the whole inability to understand their feelings and responses' (Nurse B)

'Their emotional regulation skills are limited or non-existent'. (Nurse J)

Another item of analysis which related to emotional regulation being central to self-management was stated succinctly in the first comment of the interview: '*I suppose my focus is around emotional self-management for the client'.* (Nurse C)

This statement about self-management was stated in a similar vein in the following item of analysis: *'I think of self-management…in terms of self-soothing'.* (Nurse D)

Self-soothing was a term that appeared to have been used by these nurses synonymously with emotional regulation.

'It's almost like re-training them on how to live in life, how to self-soothe, particularly with emotional distress'. (Nurse I)

Nurses understood that the ability for clients to regulate their emotions or self-soothe, was central to being able to self-manage,

Sub-theme 4: having internal resources.

Self-management was viewed by nurses as an inner resource or ability that the client possessed.

'It [self-management]*, would be around people having internal resources'.* (Nurse A)

The following item of analysis elaborated on what internal resources may have meant for the client.

'Internal self-management…how they perceive things and think things through'. (Nurse B)

Empowerment was a word nurses used synonymously with the concept of internal resources, meaning to be enabled, or having achieved or gained some quality, thereby being equipped. The words empowerment and self-management were also used interchangeably. It was argued in the following item of analysis that empowerment or internal resources could be taken but not given to clients by nurses.

'Empowerment…can be taken away [by clinicians] *but is not something that we can give them.'* (Nurse E)

'.…we don't empower people at all, the empowerment comes from that person, their ability to self-manage their own mental illness, how they live in the world.' (Nurse E)

'I can be there with as many tools as I like but that person needs to use what works for them.…empowerment comes from the person.' (Nurse E)

The nurse was saying that empowerment or internal resources were not assets that could be given to clients by nurses but were assets that a client could choose to utilise and make

their own when exposed to them by clinicians, circumstances, family or their own reflections.

Sub-theme 5: developing resilience.

This sub-theme further defined the concept of internal resources or empowerment discussed in the previous sub-theme.

'...my focus is around emotional self-management …and the word that comes up most strongly is resilience, developing resilience.' (Nurse C)

Nurse C contended that most of their work was around assessing and developing peoples' resilience. The following quotation reflected the significance of resilience for clients.

'…they have got to develop some kind of internal structure so they have got the level of resilience to manage things that life throws at everybody.' (Nurse J)

Developing resilience was important in gaining increased self-awareness which resulted in self-management.

Sub-theme 6: developing empathy for yourself.

The development of self-empathy was consistent with the theme of self-management being viewed as increasing self-awareness. Nurses saw empathy for self as significant for emotional self-management. This sub-theme was linked to the previous sub-theme, developing resilience, in the following item of analysis:

'...key to that [emotional self-management and resilience] *is ...developing empathy for yourself...people who this affects often have very strong self critical, interior sort of self critic, so that they are constantly listening to the wrong voice, if you like, and that undermines their ability to a stable buoyancy and to have this resilience.'* (Nurse C)

Nurse C observed that promoting clients' ability to develop empathy toward themselves was challenging especially if nurses had a lack of awareness of counter-transference issues that they may be experiencing with the client. By over identifying with the client, nurses would not be able to promote self-empathy because they would not be objective enough when viewing the client's behaviour.

'....it is a very empathetic approach which kind of goes against the grain for a lot of people [nurses] *because it is not the first inclination that most people* [nurses] *have.'* (Nurse C)

Counter-transference issues experienced by nurses also emerged in the first theme, sub-theme two, when Nurse A discussed their desire to intervene and rescue a client when sensing a potentially bad outcome in a particular situation. Nurse A stated that the therapeutic intervention was to let the client take responsibility for their actions. These two similar items of analysis contributed to themes one and two underlining the significance of counter-transference issues for nurses when working with people with a diagnosis of BPD.

Another interviewee alluded to developing self-empathy. When asked for a definition of self-management, Nurse I asked for time to think. At the end of the interview when the question was asked again, their answer was ready: *'Self-love.'* (Nurse I)

The 'self-love' referred to by Nurse I was not narcissism but empathy for oneself that sought to address the issue of the 'very strong self-critical, interior sort of critic' that Nurse C referred to.

Sub-theme 7: Becoming self-aware

Clients who were observed to be 'learning self-management' were seen as possessing the ability to reflect or to become self-aware.
'…they were able to talk about it at the end, talk about what they did, what they could do next time, recognise the warning signs earlier.' (Nurse A)

'…you are able to explore that feeling with them, it's that, taking a back step and back and back and take it right back to looking at when they first felt that feeling, whatever happened in that episode. Taking it back another step to when things were ok, identifying that feeling and what changed for them. That to me is a good start to self-management…just letting them explore it.' (Nurse B)

The process of the client becoming self-aware was also referred to in the following way:

'...I guess self-management is actually a process and it's the end of a process of connecting with yourself.' (Nurse D)

The last item of analysis for this sub-theme also focused on self-awareness equating to self-management when the interviewee was asked 'So self-management – it's like something you're aiming for?

'Yes...I think if you get them to aim back to those sorts of things, then they eventually manage to do things on their own...like um, some sort of self-awareness or mindfulness.' (Nurse F)

Sub-theme 8: Mentalization

Mentalization was a concept that three of the participants acknowledged during the interviews. Additionally, four nurses mentioned the Mindsight programme which is based on the concept of mentalization, for people in the community who have a diagnosis of BPD. The programme was run in the Community Mental Health Teams within the District Health Board. In the next item of analysis the nurse used the words 'mentalization' and 'self-management' almost interchangeably.

'It's [mentalization] *the ability to notice what's happening in their own minds, to self-manage,'* (Nurse C)

'...our focus is around mentalization, that is something that we are encouraging people to do, just notice how they're feeling, wondering why they are feeling the way they are feeling and then thinking about responding to that.' (Nurse C)

These ideas were repeated in the following item of analysis:

'…mentalization, you know, how to work on, okay, this is the situation, what emerges in me, what happens for me, and you know, why does this happen for me, how will I handle it…' (Nurse I)

Mentalization was an ability or skill that nurses recognised was missing to some degree in clients with a diagnosis of BPD. It was therefore necessary for clients to learn how to mentalize in order for them to gain increased self-awareness and be self-managing.

The second theme was concerned with the client with a diagnosis of BPD being understood by nurses to self-manage when they gained an increasing awareness of themselves. Key concepts identified in this process included self-exploration, resilience, attachment, emotional regulation, internal resources, empathy and mentalization.

THEME 3: SELF-MANAGEMENT IS MAINTAINING SAFETY.

The third theme, self-management is maintaining safety, which represented nurses' belief that in order to self-manage, clients must first be able to keep themselves and others safe. Nurses' understanding of self-management in this theme obligated and necessitated nurses to make judgment calls regarding clients' ability to keep themselves safe. If the nurse judged that the client was not self-managing, was not able to keep themselves safe, then the nurse took on the role of self-managing for the client until they were able to self-manage again. This theme had the smallest number of items of analysis, twenty one, and

these contributed towards seven sub-themes. Fifteen of the items of analysis were contributed by one interviewee and four other interviewees provided the remaining six items of analysis.

Sub-theme 1: Giving/keeping control and responsibility

This sub-theme related to nurses performing a role whereby they determined when to keep control and responsibility for the client's behaviour with the nurse and when to give control and responsibility to the client. Nurses felt they could give the client control and responsibility when they deemed that the client was going to keep themselves safe. The following item of analysis demonstrated the core of this theme:

'...the fact that they are in here in a locked unit, means at the moment they can't take responsibility for themselves, we are taking responsibility for them until they take over taking responsibility for themselves. I have had disagreements with staff about that.' (Nurse J)

Nurses understood their role to include the need to determine or judge when a service user with BPD was able or unable to be responsible for themselves.

'Depending on where they are at in terms of a level of responsibility ... it is my job to kind of assess where they are at in terms of their spectrum of responsibility...' (Nurse J)

The previous item of analysis was tempered by the following item of analysis provided by the same nurse who wanted to promote choice for clients in areas other than safety.

'…I try to leave as much decision making in their court as I can, but I don't compromise on safety because I know some nurses do…'.

In two of the three statements Nurse J made, they observed themself to be at variance with some colleagues in their practice. Safety for the client was the focus for the concept of giving/keeping control and responsibility.

Sub-theme 2: Self-management being something that can come and go

The idea of self-management being something that can come and go had been alluded to in the second item of analysis of sub-theme one when a 'spectrum of responsibility' was mentioned. This 'spectrum of responsibility' was elaborated on in an item of analysis that contributed to this sub-theme:

'…it's something that's very fluid, because that patient group is so unstable themselves, their mental state can vary wildly between very responsible and able to manage self well and very irresponsible and not able to manage self well very quickly…it's a rapid shift…'

Self-management was seen by the nurse to be tenuous and something that the client moved in and out of at any given moment.

Sub-theme 3: Staff being responsible for clients' safety

This sub-theme was concerned with nurses taking over self-management and keeping the client safe from them self when the client was judged unable to self-manage and in risk of harming them self.

'…ultimately they are in hospital for safe keeping, and it's the nurse's job, big part of our inpatient role, it's not therapy, it's safe keeping…' (Nurse J)

This point was reiterated in the following item of analysis where a client had been admitted to the acute inpatient service for whose safety the nurse felt responsible for.

'…I took full responsibility for her safety because I didn't think she was prepared to...' (Nurse J)

'…but you have to do the stitch gear and stuff [referring to the safety garment the client is dressed in when put in seclusion] *because she will just hurt herself...'* (Nurse E)

In these items of analysis nurses expressed the thought that if the client was not going to keep themselves safe then the only option left to nurses in these situations was to take over that role of being responsible for the client. This sub-theme presents with many similarities and appears aligned with theme 1, sub-theme 3-sitting with risk. The difference between the two is that the nurse is willing to sit with the risk and let the client self-manage in theme 1 whereas in theme 3 the nurse is not willing to sit with the risk and takes over self-management for the client.

Sub-theme 4: providing control and boundaries.

Stitch gear and seclusion were two of the means identified that nurses utilised to provide control and boundaries to stop clients hurting themselves. They were viewed as necessities in certain situations. The following item of analysis was in response to the question 'Are there ever times on crisis admissions where you seclude or restrain them?'

'Unfortunately yes because of peoples' raging, if she is threatening staff, picks up chairs, smashes windows, if you go anywhere near her she is going to hurt you, to hit staff and be verbally abusive towards other clients.' (Nurse E)

'…the self-management thing then becomes caught up in the need to, if you like, for want of a better word, control, provide boundaries for people when they are actually becoming out of control or unable to manage their own issues, maybe loss, or anger…' (Nurse D)

If nurses perceived that clients did not have control and boundaries for themselves, nurses then reasoned that they, the nurses, needed to provide those controls and boundaries.

Sub-theme 5: intervene when necessary.

This sub-theme was consistent with sub-theme four and reiterated that intervention was something nurses did out of necessity, when the client was unable to intervene for themselves.

'... that is part of self-management, so it is showing them they have choices, maybe doing, almost taking something off their hands when necessary and dealing with that matter or conflict...and then letting them go again' (Nurse G)

The emphasis in this statement was on the nurse's role in deciding or judging when to intervene or not and this stance was echoed in the following item of analysis:

'...we were continuing to ensure that person knew that they had the responsibility but they knew we would intervene when necessary...' (Nurse A)

Again, client safety was the underlying reason for nurse judging that intervention was necessary.

Sub-theme 6: Take choice away

This sub-theme was similar to the previous sub-theme; intervene when necessary, although the action appeared more custodial in manner. The situation of a client with a diagnosis of BPD being admitted to a locked unit instead of an open unit was recounted:

'If she turned around and said I would rather not go to the locked unit, it could happen that the decision would be changed but the thought is that the person is already beyond making that decision..' (Nurse E)

'I am not giving her too much responsibility, if she …was responsible for keeping herself safe, she wouldn't be here…' (Nurse J)

Nurses noted that even if the client stated that they were feeling responsible for themselves, the final decision remained with the nurse or clinical team if their assessment of the client differed from the client's assessment of their ability to be responsible for their safety. This sub-theme is similar to theme 3, sub-theme 1 – giving /keeping control and responsibility. In sub-theme 1 there is some attempt by the nurse to give some choice based on their judgment of the client's ability to self-manage but in sub-theme 6 choice is taken away.

Sub-theme 7: Self-harm is not self-management.

This sub-theme contradicts theme 1, sub-theme 8 'self-harm is self-management'. The nurses contributing towards theme 3, sub-theme 7 held differing perspectives from the nurses contributing towards theme 1, sub-theme 7. The nurses in sub-theme 7 felt that when a client self-harmed that they were not self-managing whereas the nurses in theme 1, sub-theme 8 felt that self-harm is a form of self-management.

'And self-harming where there is no control, there is no self-management…' (Nurse D)

Self-harm was alluded to as an inability to self-manage in the following item of analysis. The nurse clearly saw their role as taking over self-managing for the client.

'...I took total charge for her safety because of her history of secreting blades and I have been involved in nasty incidents of self-harm with her when she was being specialled with blades and cutting.' (Nurse J)

'...I don't approve of it (self-harm), it is dysfunctional behaviour....I do not think it is okay, it is a dysfunctional coping strategy.' (Nurse J)

Nurses thought that clients who could not keep themselves safe were not managing and felt that it was their role to act for the client to keep them safe.

There was a greater focus on the role of the nurse in this third theme of self-management than the previous two themes. The nurses' role was initially to assess the client with regards to their ability to self-manage. If the nurse determined the client was unable to self-manage, the nurse then took over this role for the client until it was deemed that the client was able to self-manage again.

SUMMARY

The three themes and their respective sub-themes were presented in this chapter. In theme one nurses understood that self-management was concerned with the client with a diagnosis of BPD taking responsibility for themselves. They reported having experienced conflict regarding possible client risks that could occur but maintained that that clients needed to be responsible for their own safety, that this was part of self-management. Other nurses understood that for clients with a diagnosis of BPD to have

self-managed, was for clients to have experienced increasing self-awareness. Nurses felt

they had a clear role in assisting a client to self-manage by promoting opportunities for

the client to become more self-aware.   In the third theme, nurses understood self-

management to be a tenuous ability that clients possessed.   When clients with a diagnosis

of BPD were not seen to be able to keep themselves safe, nurses understood that the

clients were not self-managing and that of necessity; nurses took over this role for the

clients until clients were able to self-manage again.

CHAPTER 5 - DISCUSSION

INTRODUCTION

Analysis of the data on what mental health nurses understood self-management to mean, in relation to someone with a diagnosis of BPD, resulted in three themes. Firstly, that self-management is self-responsibility; secondly that self-management is increasing self-awareness and thirdly, that self-management is maintaining safety. The themes developed in this study were related to the four themes generated in the literature review. These historical themes were; that self-management is the client coping in the context of historical abuse; that self-management is not feasible or is too difficult given the client's presentation; that self-management is something that nurses do for clients to keep them safe; and that self-management is the client being responsible for themselves.

There was a lack of consistency in the literature as to what constituted self-management (Wilkinson & Whitehead, 2009) and this study also demonstrated diversity in descriptions of self-management for the service user with a diagnosis of BPD according to mental health nurses.

This chapter discusses the inter-relationships between the themes, and sub-themes and those generated in the literature review. Finally the discussion will look at the implications for nurses and avenues for future research.

SELF-MANAGEMENT IS SELF-RESPONSIBILITY

The theme of self-management equating to self-responsibility was the major finding in both the interviews and literature review, although variation was noted in the meanings ascribed.

In the study, self-management was understood by participants to mean that the client was responsible for directing their care, choices and their own journey in life (sub-theme 1). The focus on self-responsibility was reflected in the literature. Deegan (1996) described people with a mental health illness, herself included, as "we…can become experts in own self-care, can regain control over our lives, and can be responsible for our own individual journey of recovery" (p. 2). Participants in the Thompson et al. (2008) study noted that "There was a clear recognition that –'It's about putting the responsibility back to them', that the patient should be seen to have the ultimate responsibility for their behaviour" (p.156). This understanding of self-management being self-responsibility, however, could have the potential to confine nurses' focus to the individual. The argument was posed that self-management "shifts responsibility for health and illness back onto the individual, individualis[ing] what is essentially a social problem" (Bolaria, 1979, cited by Wilkinson & Whitehead, 2009, p. 1145). While this quote related to socio-political reforms, it was pertinent also for nurses working with people with a diagnosis of BPD, who have not sometimes viewed the client within the context of historical abuse. The literature review's first theme; self-management is understood to be the client coping in the context of historical abuse, addressed this deficit in nurses' views of self-responsibility. Self-harm and other 'challenging behaviours' were not seen as a cluster of BPD psychiatric symptoms that a person presented with, but rather "the expression of

active defenses against psychosocial conflict that can produce unbearable intra-psychic tension and pain" (Warne & McAndrew, 2007, p.159). When the nurse did not see the client within the context of historical abuse or another clinical formulation, for example, attachment theory, the focus on self-management being self-responsibility diminished nurses' sense of responsibility towards the client who were "just needing to sort themselves out and take responsibility for their behaviour" (Stroud & Parsons, 2012, p. 8). Nurses' sense of diminished responsibility had the potential for nurses to distance themselves from clients and obscure their view of what role they might have played in helping the client to self-manage by being self-responsible.

The DSM-V (APA, 2013) as argued extensively in the literature review, played a part in emphasising the concept of self-responsibility, defining mental disorder as occurring in the individual, "thus inadvertently seeming to exonerate society of any responsibility for the contextual circumstances of the individual's life" (Warne & McAndrew, 2007, p. 156).

The nurses equated self-management with being independent (sub-theme 9), having the ability to make choices (sub-theme 7) and possessing a sense of control (sub-theme 11). Although a lack of consistency in the literature about what self-management is has already been mentioned, agreement from experts was found regarding four characteristics of self-care. One characteristic involved the ability to act and make choices (Gantz as cited in Wilkinson & Whitehead, 2009, p. 1144), which corroborated the study participants' understanding of self-management. The benefits of clients making their own choices, thereby retaining control over their situation was "respecting the autonomy

of patients" and seen to be important in the literature (Edwards & Hewitt, 2011, p.82). A feature of mental health care for the mentally unwell was an "expectation that even the severely and persistently mentally ill will attempt to take responsibility for their behaviour…and rightly so" (Bjorklund, 2006, p. E57).

 The nurses thought that they were not responsible for clients' choices (sub-theme 2) but that they had a role in promoting self-responsibility (sub-theme 4) and in giving clients opportunities to show self-responsibility (sub-theme 5). Nurses felt this was not an easy position to take and disclosed that they experienced conflict at times. They felt like they wanted to take responsibility for the client in situations when they saw how a client's choice may have resulted in a bad outcome but knew that the best therapeutic intervention was to have given the client the responsibility for the choice. This view was not found in the literature. Nurses in the interviews noted that they 'had to be firm' to promote self-responsibility with clients with a diagnosis of BPD. Historically in the literature it was asserted that "girls learn dependence, passivity and domesticity" when growing up due to gender stereotypes (Nehls, 1998, p. 98). People with a diagnosis of BPD often experienced trauma in addition to a disorganised attachment style in their developing formative years compounded further by these learned gender stereotypes culminating in reluctance to engage in self-responsibility. A feminist focus advocated shifting the focus towards the larger relational crisis for the woman with a diagnosis of BPD rather than looking at individual pathology. This feminist focus was concerned with "giving clients opportunities to gain control, claim power and use their voice in less damaging ways or covert ways" (McAllister, 2003, p. 181). Participants in the Ma et al.

(2009) study were also seen to be giving opportunities to show responsibility such as a behavioural contract or keeping a mood diary. These nurses were observed to have positive personal expectations for care outcomes and were willing to work with people with this diagnosis (Ma et al., 2009). The willingness for nurses to work with people with a diagnosis of BPD indicated the importance of building a therapeutic relationship which nurses in the Ma et al. (2009) study thought was vital to predicting a good outcome despite difficulties in engagement. According to O'Donovan and Gijbel's (2006) study, maximising patient responsibility was noted by study participants to be one of the appropriate responses for nurses who were working with clients who self-harm.

Nurses were not observed to have the power to change or motivate a person to take responsibility for their choices but were noted to have significant influential power by providing opportunities for choice and signaling to people with BPD that they are worthy of the responsibility to make those choices (Deegan, 1996; Bjorklund, 2006). Dan Siegel concurred with the importance of others' presence for taking responsibility and noted that "our capacity for self-regulation depends so much upon our interactions with other people that it might well be called 'other-regulated self-regulation'" (Sykes-Wylie, 2004, p. 37). Nurse participants in my study did not articulate this view when discussing self-responsibility for the client.

The nurses viewed self-responsibility and therefore self-management occurring when clients utilised resources such as 48 hour crisis admissions, staff, family and friends (sub-theme 10). Varying views of self-management have been described in the literature. At

one end of the continuum self-care was viewed as exclusively non-professional care but another view proposed that it did not matter who provided the care so long as the care was under the control of the client (Chapple & Rogers, 1999). Self-management of this latter type was also referred to as assisted autonomy (Redman, 2005). It was this kind of self-management that the nurse participants appeared to be alluding to and one nurse noted during the interview that it would have been mismanagement for the client not to seek help. Peer support was also viewed a vital component to clients' growth and self-management along with the idea that clients needed to learn to appreciate the significance of these available supports that peers and nurses (Bowen, 2013).

The nurses understood self-management to include clients being responsible for self-harming behaviour which nurses saw as a means of coping (sub-theme 8). Nurses therefore did not see their role as trying to prevent the self-harm. Self-harm was not merely seen as a means of coping in the literature but was noted to be an appropriate response to within a society where sexual abuse is not addressed (O'Donovan & Gijbels, 2006). The idea of self-harm being a legitimate coping response for living a life where feelings of intolerable distress were experienced was corroborated in the literature (Edwards & Hewitt, 2011; O'Donovan & Gijbels, 2006; Thompson et al, 2008).

Understanding that self-harming was a means of coping did not necessarily equate to nurses giving clients the responsibility for their self-harming behaviour. The participants in O'Donovan and Gijbel's (2006) study were noted to have prioritised safety in their nursing practice and wanted to prevent incidents of self-harm. Furthermore, Thompson et al. (2008) noted that nursing staff often reacted negatively to clients when they do self-

harm. While mental health nurses in the literature recognised the defense mechanisms used by people with a diagnosis of BPD, it was only when they acknowledged the self-harming practices as a viable coping mechanism in response to abusive life experiences that the diagnosis of BPD can be better understood (Warne & McAndrews, 2007). Consistent with that view was McAllister's (2003) notion that when self-harming behaviour was seen by nurses as self-soothing, as a survival strategy, that negative attitudes were replaced by hope resulting in new perspectives and conversations between the client and nurse.

For the nurses not to take responsibility for clients, they needed to be prepared to acknowledge an element of risk in their practice if the client decided to self-harm (sub-theme 3). This stance created conflict for nurses in the study. The significance of risk related to working with clients with a diagnosis of BPD was also a common theme for community mental health nurse participants in Thompson et al.'s (2008) study and Stroud and Parson's (2009) study. Nurses in these studies did not want complaints made against them, or to be involved in litigation or lose their jobs because they had not made accurate risk assessments or 'covered themselves' adequately.   Another view expressed by a participant in Stroud and Parson's (2009) study was that health services were very risk averse to working with clients with a diagnosis of BPD and that risk taking needed to be part of nursing practice. Sitting with risk was also viewed in a literal sense by Edwards and Hewitt (2012) who proposed that nurses supervised clients self-harming. The risks for nurses who focused on preventing self-harm were seen to involve a breakdown in the

therapeutic relationship although the relationship was strengthened when nurses were present when a client self-harmed because of the concern and support shown.

Risk assessment in mental health systems was explained by Crowe and Carlyle (2003) as a means of trying to control clients and nurses behaviour for the sake of the organization rather than for the client. The nurses in the study however, appeared to be thinking of the interests of their clients and the need to be able to sit with risk rather than trying to control their behaviour. This ability to practice in uncomfortable, challenging situations showed determination to care therapeutically for clients with a diagnosis of BPD rather than appearing to protect the interests of the organization.

The nurses believed that the clients with a diagnosis of BPD were able to take responsibility for themselves and therefore self-manage. Schmutte et al. (2008) described self-management as the person's ability to believe that they have the capacity to reach a desired goal or outcome. People with a diagnosis of BPD experienced a distorted sense of self that often impacted on their ability to choose to assume responsibility. This led to a disparity between the expectations of nurses and clients of what self-responsibility and therefore self-management meant.

The nurses discussed the situation of having to admit a client to a locked unit when they would have preferred to have given responsibility and choice to the client and kept them in an open unit. The nurses felt their hands were tied because of the prevailing views of other clinicians in the team, mainly doctors, with whom they were working and that they

were therefore not able to give responsibility (sub-theme 6). An observation made in the literature is that nurses are often trapped in a position where they are wanting to give responsibility to the client and yet are facing fear of reprisal from the organization within which their practice is constrained (Warne & McAndrew, 2007; Thompson et al, 2008). This was a different type of conflict compared with the conflict mentioned by nurses in this study but still pertains to nurses feeling constrained in their practice. This notion was echoed by Bland and Rossen (2005) who noted that nurses felt victimized within an organisation whose priority is safety for the client regardless of what practice is most therapeutic for the client. This conflict was apparent when nurses practiced from an empowerment model that was at variance with the model of their team or service (Wilkinson & Whitehead, 2009). It was suggested by Wilkinson and Whitehead (2009) that more research was needed to be undertaken to understand the consequences when organisations promote self-management but do not fully support the practice of self-management and what that practice might entail. In the literature review the third assumption discussed concerning the concept of self-management was that health systems were supportive of self-management. Medical self-management was the dominant model of self-management used in health systems where the client's role is largely seen as complying with the doctor's treatment which has not resulted in clients becoming partners in their care (Koch et al, 2004, p. 490).

It was argued by Bjorklund (2006) that any discussion regarding taking responsibility must also include discussion regarding morality in clinical practice. She observed that nurses felt constrained to follow doctors' orders and give away some sense of

responsibility in their practice (Bjorklund, 2006).   Social context   was significant according to Bjorklund (2006) who noted that "our understanding of our responsibilities depends on our role and location in the social hierarchy- on whether we are visible…for 'taking responsibility' is a matter of occupying social space and being an eligible participant of a moral community" (p. E71). The previous statement referred to clients but could also have referred to mental health nurses and the social space they sense they occupy.

SELF-MANAGEMENT IS INCREASING AWARENESS

Eight nurses contributed to the second theme while two of the nurses stated that promoting self-awareness (sub-theme 12) was the major focus of their work with people who had a diagnosis of BPD. Their aim, articulated in the interviews, was to help clients to know their own minds and emotions, to be able to 'think straight', to identify, understand and work with their own internal self-management, and to gain insight. Nurses in the study did not see themselves as the expert but as having a role in terms of helping people locate their own thoughts and feelings. This view was consistent with an interviewee in Bowen's (2013) study who was "emphasizing a need for staff to actively resist taking up a role of being 'all knowing'" (p.495). Nurses in the study felt that they needed to partner and collaborate with clients regarding health education which was consistent with Thorne et al.'s (2000) thinking, that nurses were not to presume to know better than clients or be the gate keepers of knowledge. Promoting self-awareness was seen by the study participants as collaborative exploration with clients. None of the qualitative study articles contributed to this sub-theme, promoting self-awareness,

although the subject was included in three of the expert articles. Health care professionals working with people who self-harm need to be aware of the function of self-harm: a way of regulating intolerable feelings of distress (Warne & McAndrew, 2007; O'Donovan & Gijbels, 2006; Thompson et al. 2008). There has been a presumption that nurses have understood the psychological defenses that are in place for clients but nurses can be aware of these and yet blind to their own pathology (Warne & McAndrew, 2007)

The person with a diagnosis of BPD was understood by Crowe (2004) in terms of the role and impact of shame in their life. The nurses' role in this clinical formulation was to promote self-awareness for the client in relation to how they see themselves in relation to others, to help the client be explicit about what may have been implicit for them (Crowe, 2004). As the nurse worked with the client and promoted self-awareness, the client needed to be able to trust the nurse and their skills and their ability to deal with intense expressions of emotion (Crowe, 2004), which may involve the client testing the nurse's skills before exploring the feelings. There was a close relationship between a "'borderline' client's role in the social hierarchy, her social relationships, her sense of identity (which includes her values, and a sense of integrity and self-worth) and her understanding of her responsibilities" (Bjorklund, 2006, p. E71). These relationships may not be obvious to the client without the nurse promoting self-awareness.

Three of the expert articles discussed the significance of nurses having clinical supervision to deal with counter-transference issues assisting with their own self-

awareness so that they could work effectively with clients' self-awareness. It was important for nurses to realize that client-nurse relationships can replicate conflicts that each party brings from their respective parental relationships resulting in intense reactions (Bland & Rossen, 2005). Nurses' counter-transference reactions resulted in the breakdown of the therapeutic relationship affecting the clients' treatment (Bland & Rossen, 2005). Nurses were unlikely to be aware of their own counter-transference reactions and clinical supervision could aid self-awareness. "Knowledge and a deeper understanding can help nurses shift their view of the patient as deliberately bad, manipulative, and attention-seeking to a perception of the patient as one who is struggling with adaptively expressing intense, negative emotions" (Bland & Rossen, 2006, p. 512). While clinical supervision was not mentioned specifically, Warne and McAndrew (2007) noted that health care systems needed to provide a place for nurses to explore the counter-transference reactions they experience with clients. Clinical supervision assisted staff to work with clients with a diagnosis of BPD by helping them to separate themselves from the client's projections and regain the ability to reflect on underlying meanings of the clients' behaviours (Evans, 2007; Rayner et al., 2005).

Theme two of the literature review was self-management was not feasible or was too difficult given the client's presentation. Some nurses in the qualitative studies perceived that clients were unable to self-manage, that clients could not change (Woollaston et al., 2008; Ma et al., 2009; McGrath & Dowling, 201). Nurses in these studies also felt that they, the nurses, had no role to play in terms of helping a client to self-manage and found them too difficult to work with. These perceptions resulted in nurses withdrawing from

the client causing a breakdown in the therapeutic relationship. Self-management being thought of as unfeasible or too difficult may be attributed to nurses' lack of self-awareness and knowledge of counter-transference issues that they were facing (Bland & Rossen, 2005; Evans, 2007; Rayner et al,. 2005). Some nurses in the qualitative studies also lacked a conceptual framework other than the DSM-V, within which to view the client. Nurses tended to react defensively which "served to make the nurse feel better about themselves rather than looking at the nurses' own knowledge, attitudes and beliefs" (Rayner et al., 2005, p. 13).

Three nurses identified mentalizing (sub-theme 19) as a way of promoting self-awareness. While this concept may be seen to be outside of the scope of what nurses understood of self-management, these nurses viewed mentalization as synonymous with self-management noting 'It's [mentalization] the ability to notice what's happening in their own mind, to self-manage' (Nurse C). Mentalization was an ability that nurses saw was missing to some degree for clients with a diagnosis of BPD and was necessary for them to possess in order to learn to self-manage and gain increased self-awareness.

In the book written for people with a diagnosis of BPD, Krawitz and Jackson (2006) described mentalization as "the capacity to know and experience the psychological world of ourselves and, as best as we are able, the psychological world of others" (p. 68). For clients whose childhoods were filled with overwhelming emotions, mentalization skills were not acquired and these were needed for adult functioning (Krawitz & Jackson,

2006). Mentalizing was noted to be "the basis of self-awareness and a sense of identity the key to self-regulation and self-direction (http://www.menningerclinic.com)."

Mentalization was not mentioned in the literature articles but was alluded to by Woollaston and Hixenbaugh (2008), when they cited Bateman and Fonagy (2001), regarding a "psychoanalytically oriented, partial hospitalisation program found at follow-up to be more effective than treatment as usual in reducing: symptoms, self-mutilating behaviour and hospital admission rates" (p. 704). The nurses' role in mentalization required the nurse to take a curious, enquiring, validating, empathic, clarifying stance that encouraged the client to explore other interpretations surrounding events, behaviours, and thoughts that they were experiencing rather than remaining stuck with one rigid interpretation (Bateman & Fonagy, 2006).   When clients lacked the ability to mentalize they resorted to other developmentally primitive forms of subjectivity that resulted in dysregulated affect, impulsivity, relationship problems and poor identity formation (Bateman & Fonagy, 2006).

Secure attachment was seen as the single most important factor in enhancing the ability to mentalize because "we learn about our own mind from the outside in: it is through the mind of another person - ideally a secure attachment figure- that we become fully aware of our own mental states (http://www.menningerclinic.com)."   The nurses in the study acknowledged the impact of insecure attachment issues (sub-theme 13) on the clients' ability to mentalize and therefore be self-aware and self-manage. They articulated that unstable attachment styles formed in childhood were germane to understanding clients'

incapacity for self-awareness. Disorganisation of the attachment system resulting from childhood trauma and sexual abuse contributed to a disorganisation of self-structure and decreased self-awareness.

Clients' negative childhood experiences and trauma were seen by nurses to have contributed towards trust issues in relationships and symptoms of BPD (Ma et al., 2009; Stroud & Parsons, 2012). Clients with a diagnosis of BPD were also seen to have experienced intense emotional conflict in parental relationships (Bland & Rossen, 2005) and it was similarly observed by Warne and McAndrew (2007) that children were simultaneously fearing yet having a need for the parent and therefore growing up with ambivalence, resulting in trust issues in relationships. The significance of childhood sexual abuse for clients utilising mental health services was clearly acknowledged (Warne & McAndrew, 2007). Often childhood abuse and trauma was associated with strong feelings of being invalidated contributing towards a diminished self-awareness (McAllister, 2003). While Crowe (2004) did not mention abuse or trauma contributing to shame, she maintained that a person's earliest interpersonal experiences impacts on how someone senses shame.

While most nurses in the qualitative study articles acknowledged the impact of negative early life experiences on a client, acknowledgement did not necessarily translate into the nurses' ability to understand the client with their current presentation in the context of negative trauma. "The impact of childhood sexual abuse on the mental health of adults is poorly understood by mental health nurses… many mental health nurses are unprepared,

educationally and emotionally to work with people who have experienced childhood sexual abuse" (Warne & McAndrew, 2007, p. 158). Nurses' seeming unpreparedness had the potential to compound the invalidation these clients had already experienced and McAllister (2003) noted that "society expects people to recover from past trauma and get on with their life. Society needs to move towards encouraging disclosure of abuse and develop a culture of acceptance, support and tolerance for survivors" (p. 182).

The sub-theme, nurses acknowledging attachment issues, was also consistent with the first theme of the literature review; self-management is the client coping in the context of historical abuse. Attachment issues for the client with a diagnosis of BPD arose from within a context of historical abuse.

Attachment issues experienced by the client were noted in the literature to result in emotional dysregulation. In the study nurses viewed emotional regulation as vital for people with a diagnosis of BPD to self-manage (sub-theme 14) and saw emotional regulation as the focus of their work with the client. The ability to mentalize was seen by nurses in the study as the key to emotional regulation. A reason for the emotional dysregulation was noted by one of the participants in Stroud and Parson's (2012) study who thought that people grew up feeling invalidated which resulted in issues of being able to identify their own emotions. This thought was echoed by Warne and McAndrew (2007) when they noted that people used self-destructive behaviours to try to regulate distressful emotions. This statement was also consistent with Bland and Rossen's observation that self-destructive behaviours may be the client's attempts to regulate their

emotions that obstruct cognitive functioning (2005). A participant in Ma et al.'s (2009) study also made the link between emotions and cognition observing the client having experienced less distorted thinking when their emotions became more stable. Shame was noted by Crowe (2004) to be an acutely painful and powerful emotion that overwhelmed clients. The nurse was able to play a role in helping the client to be aware of their own feelings and motivations as well as those of others. (Crowe, 2004). People with a history of childhood trauma may have experienced difficulty expressing over-whelming emotions and expressed these by self-harming. Self-harm can be a way of showing internal crying (McAllister, 2003).

The DSM–V cited affective criteria as one of four criteria pertaining to a diagnosis of BPD, listing mood instability, chronic feelings of emptiness and inappropriate, intense anger or difficulty controlling anger (APA, 2013). These feelings may be observed to be inappropriate in a given situation when exhibited by the client but when viewed within the historical context of childhood abuse and trauma, they may be understood and viewed differently. As stated in the literature review, the DSM-V did not describe what a culturally sanctioned response to childhood trauma or abuse might look like. Pathologising affect was to look away from the client and look on the surface of the disorder.

The nurses in the study thought the concepts of internal resources (sub-theme 15) and empowerment were synonymous and were helpful for increasing self-awareness for clients. Self-management was thought by study participants to be possible if clients had

internal resources and were empowered. Nurses also stated that empowerment was something that came from the person and could not be given to the person by nurses. Nurses provided opportunities and tools for clients but it depended on the client to self-manage and utilise assets, thereby empowering themselves and acquiring internal resources and resilience.

In the qualitative studies, nurse participants mentioned a number of interventions they performed with the client to foster internal resources and ultimately the ability to increase self-awareness. These interventions included stress management, assertiveness training, instillation of hope, development of problem- solving skills, mind mapping, and positive reinforcement (O'Donovan & Gijbel, 2006); cognitive behavioural therapy and psychodynamic techniques (Thompson et al., 2008);   dialectal behavioural therapy (Stroud & Parsons, 2012); and keeping a mood diary or having a behavioural contract (Ma et al., 2009). These were used by individual nurses but were not used collectively by the team working with clients with a diagnosis of BPD. Other approaches in the literature included giving clients opportunities to discuss sexual abuse (Warne & McAndrew, 2007); sharing narratives and exploring alternate subject positions for managing feelings of shame (Crowe, 2003); conceptualising self-harm as a survival strategy, strengths oriented nursing, and building effective social supports and connections for the individual and their family (McAllister, 2003); signaling to people with BPD who they are (and are not) and what they are (or are not) supposed to do (Bjorklund, 2006); openly allowing clients to discuss their feelings, utilising cognitive behavioural theory combined with psychoanalytic theory (Rayner et al., 2005); and

supervising self-harm (Edwards & Hewitt, 2011). People were encouraged to use a narrative structure to make sense of what they were experiencing and to have their meaning validated (Casey & Long, 2003), although it was argued that interpretation was dependent on both the nurse and client's frameworks (Crowe, Carlyle & Farmer, 2008). The ability to mentalize was another tool noted by nurses in the study as useful for developing internal resources and resilience. This is consistent with the statement "mentalizing in psychiatric treatment is based on a growing body of evidence that points to mentalizing as the key to resilience (http://www.menningerclinic.com)." These approaches, interventions and tools were seen in the context of the recovery philosophy. Self-management was a component of the recovery philosophy which took the ideas of recovery and turned them into practical tools for everyday living (Davidson, 2005). Also relevant to self-management was the client believing that they had the capacity to reach a desired goal or outcome (Schmutte et al., 2008).

The nurse participants described that the clients' ability to develop empathy for themselves (sub-theme 17) as central for building internal resources and resilience (sub-theme 16). One participant perceived that clients with a diagnosis of BPD had a very strong interior self-critic which undermined their ability to possess self -empathy.   It was noted by Krawitz and Jackson (2008) that lack of self-empathy may have resulted from clients blaming themselves for the trauma or sexual abuse they experienced as children. Carrying blame could also have resulted in shame (Crowe, 2003). Self-blame was also viewed as a sign of concrete thinking, a common component of poor mentalization (Bateman et al., 2006). Clients with a diagnosis of BPD often engaged in black and white

thinking, where only two options seemed to be available, and the options being either all-good or all-bad. "Black and white thinking often involves us being harshly critical of ourselves. This harsh self-judgment will keep our energy for change low" (Krawitz & Jackson, 2008, p. 169). Often the abusive older adult role- modeled self-hatred towards the abused child, a life position or outlook the child adopted in the absence of other positions they have experienced (McAllister, 2003). This statement was consistent with Evan's observation that abusive and harmful relationships can be internalised to become negative learnt attitudes towards themselves and others (2007). It was important for clients to develop a way of relating to themselves with compassion and acknowledging that they were doing the best they knew with the coping mechanisms they had at the time given their abusive backgrounds (Krawitz & Jackson, 2008). Clients were encouraged to challenge old beliefs about themselves and to …and help reconstruct an image of self that is less disabling and more emotionally fulfilling" (Crowe, 2003, p. 339). These alternate subject positions could be seen to include self-empathy instead of self-blame, self-hatred and shame. It was suggested by Bjorklund (2006) that clients needed help to take pride in their small successes in order for them to develop a sense of self-worth. A sense of self-worth closely related to self-empathy, allowed for the experience of worthiness to answer for one's behaviour and therefore to take responsibility to self-manage (Bjorklund, 2006). In their argument for supervised self-harm, Edwards and Hewitt (2011) noted that care is centred on "acceptance and compassion and validation of patients' subjective experience of overwhelming distress" (p. 84). This approach may be validating for the client and result in self-empathy, reminding the client that they were self-managing the best they knew how and that their efforts at self-management were being supported. While none of

the qualitative study articles mentioned self-empathy, one participant in Stroud and Parsons (2012) study noted that clients with a diagnosis of BPD find it difficult to track their own emotions and consequently start to invalidate them, indicating a lack of self-empathy required for self-management.

The nurses perceived clients to be self-managing as they began to become more self-aware (sub-theme 18). As clients were able to reflect on situations and explore feelings and connect with themselves, nurses viewed them becoming more self-aware. 'Is it our awareness that makes the difference?' is the title of Chapter 26 in the book '*Borderline Personality Disorder'* by Krawitz and Jackson (2006, p. 151). The chapter discussed the importance of people having the capacity to monitor and take ownership of thoughts, emotions, and behaviours acknowledging that "self-reflection is a psychological skill that requires practice" (p. 151). Survivors of child abuse exhibiting violent actions were also seen by McAllister (2003), as displaying "violent innocence" (p. 181), because they lacked the self-awareness about why they felt such aggressive urges. Counter-transference reactions by nurses often resulted in lost opportunities for the client and nurse to recognise and verbalise their feelings and by so doing, gain self-awareness (Rayner et al., 2005). In a given situation a client may have the potential to feel anxious, helpless, out of control and rage causing them to resort to self-harm which in turn, may result in the nurse feeling anxious, helpless, out of control and rage, potentially causing them to withdraw from the client (Rayner et al., 2005). If the client did not express their feelings due to their emotions being too intense and the nurse did not share their feelings as they had withdrawn from the client, the client's intense emotions may be perpetuated

(Rayer et al., 2005). The potential for the nurse and client to become self-aware through this experience may be lost. The ability to reflect according to Crowe (2003) may also be impaired owing to a person being overwhelmed with feelings of shame and inferiority. The nurses in the study recognised the importance of going back and exploring feelings in situations to promote greater self-awareness and noted 'you were able to explore that feeling with them…taking…it right back to looking at when they first felt that feeling, whatever happened in that episode'. This exploration is part of mentalizing which aims to "promote awareness of one's own and other person's mental states (http://www.menningerclinic.com)."

SELF-MANAGEMENT IS MAINTAINING SAFETY

Half of the nurses in the study contributed to this theme. It had the smallest number of findings. One nurse in the study who worked in an inpatient setting, reasoned that clients who were able to keep themselves safe from harming themselves and from harming others and the environment around them, were in fact, self-managing. When clients were not able to keep themselves safe and therefore were not self-managing, the nurse was responsible for their safety (sub-theme 22).

Nurses in the study felt that a client was in hospital for safe keeping and that it was a big part of the nurse's role to keep the patient safe. It was noted by Ma et al. (2009) regarding the nurse participants in their study that nurses who have poor expectations for clients with a diagnosis of BPD tend focus only on patients' basic needs and safety. Similarly, also in an inpatient setting, participants in O'Donovan and Gijbel's (2006) study also prioritised safety and the prevention of self-harm in their practice and their

practice was noted to be strongly influenced by the structure of the acute admission environment. Community mental health nurses, according to Thompson et al.'s (2008) study, also felt responsible for the clients, and noted there was a lack of services for people who self-harm. Paradoxically nurses' need to keep people safe may have contributed towards clients experiencing less agency in their care and may have promoted more self-harm (Thompson et al., 2008). Nurse participants in Stroud and Parson's (2012) study in the community similarly felt that nursing people with a diagnosis of BPD was all to do with risk and expressed concern and anxiety about being sued and needing to have covered themselves. Staff in Stroud and Parson's (2012) study were noted to be very defensive in their practice and one participant stated that the service they worked with was not prepared to take considered risks which in turn made staff feel responsible for clients' safety. This statement was corroborated by Bland and Rossen (2005) who noted that nurses feel trapped when working in an organisation that insists on absolute safety being the benchmark for care. When staff tried to prevent clients from self-harming and engaged in power struggles with clients, their actions can be seen to derail treatment efforts (Bland & Rossen, 2005). Nursing practice that involved taking responsibility for clients' safety by utilising surveillance and close observations "may be difficult to defend without a thorough assessment of the many functions and meanings that self-harm has for the particular individual" (McAllister, 2003, p. 183). Increased surveillance and close observations had the potential for the client to become dependent on this nursing practice, which would perpetuate this unhealthy cycle of action and reaction (Evans, 2007). In their discussion advocating supervised self-harm, Edwards and Hewitt (2011) noted advantages and disadvantages for nurses taking responsibility

for clients' safety by working to prevent self-harm. Apparent advantages included nurses feeling they were fulfilling a sense of a duty or obligation to clients and were signaling to the clients that they mattered, as well as the belief that self-harm may have been preventable (Edwards & Hewitt, 2011).   Criticisms of taking responsibility included increased risks of covert self-harm and of suicide because self-harming was found to be a a means of coping for resisting suicidal urges (Edwards & Hewitt, 2011). There was also the risk of "undermining their perhaps fragile, self-integrity by preventing them from doing something they would otherwise choose to do…this strategy rides roughshod over these patients' autonomy" (Edwards & Hewitt, 2011, p. 82). A final criticism offered by Edwards and Hewitt (2011) was that nurses sent a clear message when they tried to prevent self-harm: that clients were not to be trusted, resulting in clients experiencing these measures as demeaning and paternalistic. That which was thought to be caring commitment was in fact, oppression.

In the literature review, nurses were reported at times to be unaware of the model that they practiced from and that a change of focus was required from responsible *for* clients to being responsible *to* clients (Wilkinson & Whitehead, 2009). An assumption discussed in the literature review was that clinicians believed in and promoted self-management. One of the conditions for the empowerment movement's success was that providers must practice in an autonomy-supportive fashion which referred to the extent to which nurses worked collaboratively with clients in true partnership offering choices, decreasing control and supporting clients' views. (Redman, 2007). It was suggested by Rogers et al. (2005) that self-management has been translated in a limited manner and that clients'

views and ways self-management have been marginalised. Nurses have the potential to bolster or erode clients' belief that they have capacity to reach goals and self-manage by the way they work with clients.

A 'spectrum of responsibility' was mentioned in the interview by one participant who reasoned that it was their job to assess where the client was on that spectrum. On the basis on their assessment, the nurse decided whether or not the client was able to be responsible for themselves. The questions Bjorklund (2006) asked in relation to this kind of assessment were "whose deliberation determines when that moment of severance occurs - or range of moments, if agency and responsibility admit degrees…how are these determinations made?" (p. E62). In the medical model, self-harm was seen as a symptom of a diagnosis, which, once in place, distanced nurses from seeing the client as the one who needed to develop expertise with the nurse positioned as the expert (McAllister, 2003). One way of taking responsibility and keeping control (sub-theme 20) was by removing objects from a person's possession and requesting that the patient remained in his or her nightclothes according to O'Donovan and Gijbel's (2006) study participants. Nurses in Thompson et al.'s (2008) study felt torn between wanting to give responsibility and the fear of reprisal should anything happen to the client. Nurses stated that they tried to give clients opportunities to take responsibility but that clients sabotaged these attempts instead of taking responsibility for their behaviour (McGrath & Dowling, 2012). Nurses' perception of clients sabotaging treatment is confirmed in the following view of clients' "behaviour as deliberate or bad rather than part of an illness…and patients were often seen as deliberately trying not to improve or as sabotaging their treatment" (Bland

& Rossen, 2005, p. 509). The sub-theme of giving/keeping control and responsibility was:

"particularly relevant to the 'borderline' client with deeply rooted self-hatred mistrust she and others among the oppressed and mentally ill do not meet society's notion of proper self-sufficiency or self-governance and therefore lack standing as moral agents in the moral community that would allow them to answer for their conduct," (Bjorklund, 2006, p. E66)

There were a myriad of opportunities and situations where responsibility could have been fostered or hindered, and control could have been given or kept, for clients within mental health systems. Nurses played a significant role in realising those opportunities and situations which slip by undetected if not actively sought out. By taking responsibility for clients to prevent self-harming, Edwards and Hewitt (2011) noted that this only ensures clients to lose further any sense of autonomy that they have. Good nursing care enabled the patient to have some meaningful control over their treatment according to Breeze and Repper (1998), and a necessary condition for a client to take responsibility, was for nurses to give up their need for control in working with the client. It was contended by Breeze and Repper (1998) that there are two forms of power: 'power over' which was exercising control and 'power to' which was the ability to perform effectively. Clinical supervision was suggested as a way for nurses to step back from the situation and take a realistic view of their capability to prevent the client engaging in self-destructive behaviour and suicide (Bland & Rossen, 2005).

The idea of self-management 'coming and going' (sub-theme 21) was alluded to in a comment by nurse J in the study about the 'spectrum of responsibility'. In the interview the nurse stated that a rapid shift could occur in the client's mental state resulting in their being able to self-manage one moment and not being able to self-manage the next. This idea was contested by Bjorklund (2006) when it was noted "If my client's loss of agency does not occur in a single moment, which it surely does not, and if a determination of their degree of agency and responsibility is a matter of social negotiation among the members of a moral community, how does moral responsibility exist only as an individual attribute?" (p. E62). She continued to argue that "there must be another view for agency that waxes and wanes, for responsibility that grows and develops" (Bjorklund, 2006, p. E62) and discussed the role of the nurse which signaled to the person who they were and what they were supposed to do. When the client had a sense of who they were and what they were supposed to do, they had an understanding of what taking responsibility and self-managing looked like.

In the interviews, nurses noted the necessity for providing control and boundaries (sub-theme 23) and one participant observed, 'the self-management thing becomes caught up in the need to, if you like, for want of a better word, control, provide boundaries for people becoming out of control'. Nurses mentioned stitch gear, special clothing worn by the client that could not be used by them to self-harm or commit suicide and that which was worn when a client was placed in seclusion. Also used by nurses to gain a measure of control was the use of close observations and no harm contracts (O'Donovan & Gijbels, 2006; Evans, 2007; Edwards & Hewitt, 2011), strict rules, limits and guidelines

(McGrath & Dowling, 2012), strict boundaries (Stroud & Parsons, 2012), forced restraint and forced medications (Bland & Rossen, 2005), and being placed under the Mental Health Act (Evans, 2007; Breeze & Repper, 1998). While seclusion and restraint are still widely used in New Zealand, these practices are all but obsolete in some countries such as Great Britain, Scotland and Sweden (Taxis, 2002). These health systems have noticed a reduction in seclusion and restraint and experienced change in their model of practice from control to collaboration (Taxis, 2002). A strong case was made for empowering clients by staff working collaboratively with clients involving them in treatment planning (Linhorst et al., 2002). Foucault maintained that power seemed to range from negative plays of power such as coercion and manipulation to other forms of power such as the subtle use of authority and influence (as cited in Holmes & Gastaldo, 2002). Foucault asserted that the creation of self is related to existing knowledge as well as institutionalised practices. Self is not viewed as an entity but is something that is formed by many types of power working on a person (Holmes & Gastaldo, 2002). Nurses may contribute to the creation of self and a person's ability to self-manage by the way they wielded power when working with clients, in a controlling or collaborative manner.

Nurses in the study also thought part of their role, in maintaining safety, was to intervene in a client's situation when necessary (sub-theme 24). Nurses, according to Woollaston and Hixenbaugh (2008), felt a client would deliberately create a scene where she knew nurses would have to respond. Clients with a diagnosis of BPD can try to propel others into a place where the person is experiencing an emotion on behalf of the client. (Evans, 2007). The way in which clients propel other can be quite forceful

and nurses can feel impelled into experiencing anxiety or fear for the client. (Evans, 2007). A question posed by Bjorklund (2006) challenged the judgment calls nurses make, namely, "which moment in a client's trajectory through time and space, and from reasons-responsiveness to madness and back was the moment of loss of agency?" (p. E62). This question challenged the notion that loss of agency was so sudden that it required intervention in an attempt to self-manage for the client by assuming responsibility for their safety. It was noted by Rayner et al. (2005) that the way nurses responded to forceful communications including self-harm or the threat of self-harm, had a profound impact on clients with a diagnosis of BPD.

Taking choice away (sub-theme 25) was another strategy that the nurses utilised in order to maintain client safety. The situation of a client being admitted to a locked unit instead of an open unit was recounted by a nurse participant when clients were thought to be 'beyond making the decision'. Another nurse in the interview reasoned that she did not give clients too much responsibility because if they were responsible for keeping themselves safe, they would not be in hospital. Another type of choice nurses took away from clients according to Ma et al. (2009), was not giving them the choice of hope; declining to enter into therapeutic relationships with them, providing basic cares and safety measures only, expressing beliefs that these clients would not change no matter what nursing interventions were employed and that caring for them was a waste of time and money. Taking choice away from the client often mirrored earlier situations of childhood sexual abuse resulting in mental health settings recreating trauma for clients (Warne & McAndrew, 2007). Choice was a key factor in the component of the recovery

philosophy, with choice and motivation being viewed as inseparable. "The freedom to make poor choices is a privilege that is denied to the person who is labeled mentally ill. Chronicity means always having to prove that you have the capacity to make appropriate independent choices" (Bassman, 2005, p. 491).

Nurses in the study who mostly contributed to this theme did not see self-harm as self-management (sub-theme 26) and disapproved of the practice. Interventions to prevent self-harm such as close observation, room searches, restraint and seclusion upheld nurses' beliefs that there was nothing beneficial for clients to gain from self-harm in terms of self-managing. It was observed by Bland and Rossen (2005), that nurses who did not understand why a client with a diagnosis of BPD self-harmed, felt "angry, helpless, disgusted, betrayed, and dismayed at the patient's repetition of such behaviours" (p. 511). Further common counter-transference reactions were discussed by Rayner et al. (2005) and included guilt, rescue phantasies, transgression of professional boundaries related to fear and intimidation, rage and hatred, helplessness and worthlessness and anxiety and terror.

RELATIONSHIPS BETWEEN THEMES

Each of these three themes of self-management revealed displays of different types of power wielded by nurses. It was noted by Foucault that "power is relational…power is everywhere; not because it embraces everything but because it comes from everywhere" (as cited in Holmes & Gastaldo, 2002, p. 559). Theme one, self-management is self-responsibility, demonstrated the use of disciplinary power which "trains and enhances

individuals, utilizes people's productive potential, and makes optimal use of their capacities" (Holmes & Gastaldo, 2002, p. 561). Disciplinary power promoted self-responsibility, and gave clients opportunities to show responsibility, make their own choices, be independent and feel in control enabling clients to be internally rather than externally directed (Holmes & Gastaldo, 2002). Nurses established standards and norms for clients by non coercive means. Theme two, self-management is increasing self-awareness, demonstrated what Foucault termed pastoral power, which "seeks disclosure of consciousness; it penetrates the soul and acts upon it to ultimately direct it" (as cited in Holmes & Gastaldo, 2002, p. 562). Nurses' therapeutic use of disciplinary power was based on principles of self-regulation and "individuals reach[ed] self-regulation by being involved in…pastoral care where nurses would promote processes of self-surveillance and self-awareness" (Holmes & Gastaldo, 2002, p. 562). This statement shows a connection between themes one and two. Theme three, self-management is maintaining safety, employed power to repress certain client activities, and at times required violence and coercion to achieve this. This use of power involved providing control and boundaries, taking choice away and intervening when the client was deemed not to be self-managing.

The argument for different types of power and influence utilised in the three themes of self-management appeared to be consistent with Bjorklund's (2006) view of what it meant for a client with a diagnosis of borderline personality disorder to take responsibility for themselves. Clients could self-manage by taking responsibility for themselves but this depended on the client having "a sense of worthiness to give an

account of oneself to others" (Bjorklund, 2006, p. E66). Responsibility therefore depended on the existence of others, of nurses, and the types of power that nurses chose to employ when working with clients. Nurses could use disciplinary power to give feedback regarding a client's actions as well as endorsing norms; nurses could use pastoral power to provide opportunities for self-disclosure, recognition and inclusion (Holmes & Gastaldo, 2002). Backward looking responsibility, "looking down and back, the 'view from there' is often that of the impartial judge who looks to the past to determine who among us can be held morally responsible" (Bjorklund, 2006, p. E59), was similar to nurses making judgments about who was able to self-manage at a given point in time and determining if intervention was required. This nursing approach aligned itself with theme three.

In terms of individual empowerment, theme one was viewed in the consumerist model of empowerment which was to do with self-responsibility and self-management, where power was delegated or formally shared. Theme two was viewed as consistent with psychological empowerment which involved developing power within the person (Masterson & Owen, 2006). Theme three did not appear to relate to empowerment discourse. Mental health service user activists "have seen it vital to expose and contest a mental health system that disempowers, stigmatizes, constricts choice and shapes the mental health service user role that offers no hope" and saw the recovery model as a "pathway for empowered action and a strategic necessity to legitimise mental health service users' rights, autonomy and self-direction" (Masterson & Owen, 2006, p. 29).

Themes one and two related to nurses who felt responsible to the client whereas theme three related to nurses who felt responsible for the client (Wilkinson & Whitehead, 2009). Themes one and three raised significant issues for nurses working within health systems which are risk averse in relation to allowing clients to take responsibility for themselves, and which expect nurses to shoulder this responsibility. Nurses felt constrained in their therapeutic practice and worked at times with a sense of being unsupported and in fear of ramifications if safety for clients could not be maintained.

Themes one and two challenged the DSM-V construction of the diagnosis of BPD arguing for the client to be viewed in a more empathic manner and as part of a society which contributed towards their traumatized life. Theme three appeared to endorse the DSM-V viewpoint of illness, not seeking to understand the person behind the illness or seeing them within a context of historical childhood abuse.

STRENGTHS AND LIMITATIONS OF THE STUDY

Although the project was small and limited to ten participants, the study was able to elicit different ideas that mental health nurses held about self-management at a significant time within Specialist Mental Health Services in the District Health Board. With the introduction of MBT four years ago, new ideas about what self-management involves have been explored. This study is significant in New Zealand because this was the first DHB to have employed MBT as a basis for treatment for people with a diagnosis of BPD.

This resulted in greater diversity of what mental health nurses understood self-management to mean.

Another strength of the study included balanced representation of nurses from inpatient and community settings, from male and females. A limitation was that ethnic identification was not a feature of the study.

Due to the small sample size, data relating to the significance of the therapeutic relationship in relation to self-management was inadequate to support research credibility. A larger study may have elicited further data warranting investigation in this area.

The methodology utilised for the study was effective and was a positive element of the study. The methodology allowed for mental health nurses to adequately express their understanding of self-management as it related to a person with a diagnosis of BPD. A further strength of the study was the regular monthly supervision throughout the tenure of the study. This ensured adequate reflection at each stage of the process and the occurrence of rigorous scrutiny.

The study has uncovered diverse meanings of self-management for the person with a diagnosis of BPD that shape and inform mental health nurses' clinical practice. This study has contributed towards filling a gap in the literature pertaining to this area.

CONCLUSION

Within one mental health care system, nurses' understandings of self-management were diverse, contributing towards three different concepts of self-management. These different understandings impacted significantly on the way nurses worked with clients with a diagnosis of borderline personality disorder. These diverse understandings of self-management may be seen to have varied at times with the client's concept of self-management. The first and second themes, self-management is self-responsibility and self-management is increasing self-awareness, both fit with the recovery philosophy of client empowerment and have required nurses to move from the paternalistic, dominant, medical model. The third theme, self-management is maintaining safety, does not fit with the recovery model and nurses practicing with a goal of maintaining client safety as self-management, have yet to break free from the aforementioned parochial model and question the use of power employed as well as the goal of their practice. Nurses may have been unaware of their underlying beliefs and assumptions that shaped their practice and may benefit from a reflective style of supervision. Nurses' understanding of the concept of self-management for people with a diagnosis of BPD was embedded in their practice and influenced the roles that they and the person played in their recovery journey.

IMPLICATIONS AND RECOMMENDATIONS FOR CLINICAL PRACTICE

An implication for clinical practice is an awareness that nurses in Specialist Mental Health Services in the District Health Board are at varying stages of aligning their

practice pertaining to clients with a diagnosis of BPD with the recovery philosophy. This may result in a fragmented, inconsistent approach towards this group of clients which could potentially lead to frustration for nurses who are endeavoring to implement the recovery philosophy in their practice. The findings reveal that providing quality care for this group of clients involves nurses promoting self-management in terms of self-responsibility and self-awareness. This necessitates nursing teams exploring how nursing cultures can change from a culture of control based custodial nursing to a culture of client empowerment and assisting in client self-awareness.

Three of the ten nurses interviewed were familiar with mentalizing; the focus of treatment for people with a diagnosis of BPD in the DHB. Clients with a diagnosis of BPD are therefore receiving an inconsistent approach in their care as some nurses are utilizing the MBT principles and some are not. Clinical supervision is recommended for mental health nurses to provide a forum for nurses to reflect on underlying beliefs, assumptions and use of power that underpin their practice. Group supervision may be helpful where there are differences of opinion within the nursing team to ensure a uniform, recovery-aligned direction of care.

Nursing leaders are advised to advocate for a consistent approach in practice towards clients with a diagnosis of BPD within the multi-disciplinary team. It would be beneficial for all clinicians to be familiar with the basic principles of mentalization based therapy. This would provide continuity for clients with a diagnosis of BPD within the service and

would allow nurses to have a compass for treatment that is aligned with the recovery philosophy.

IMPLICATIONS FOR FUTURE RESEARCH

Further research should investigate the impact of basic mentalization based therapy on nurses' practice. Nurses would need to be interviewed prior to and post basic mentalization training to see what effects the training has on nursing practice. Areas of focus could include how nurses feel that their practice contributes towards self-management in light of the recovery philosophy before and after the training. Nurses' confidence could also be investigated pre and post training. Recent research has looked at the impact of MBT on client outcomes and this proposed research would focus on the influence that principles of MBT have on nurses' practice.

Another area of research should study what factors contribute towards the various nursing cultures within different mental health organizations that are identified by different understandings of what self-management means for people with a diagnosis of BPD. The study should look at how change from one culture to another culture can occur for groups of nurses and how to facilitate that change.

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LIST OF TABLES

APPENDICES

Appendix 1: Diagnostic criteria for 301.83 Borderline Personality Disorder.

A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. Frantic efforts to avoid real or imagined abandonment. Note: Do not include suicidal or self-mutilating behaviour covered in criterion 5.

2. A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.

3. Identity disturbance: markedly and persistently unstable self-image or sense of self.

4. Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). Note: do not include suicidal or self-mutilating behaviour covered in criterion 5.

5. Recurrent suicidal behaviour, gestures, or threats, or self-mutilating behaviour.

6. Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).

7. Chronic feelings of emptiness

8. Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights)

9. Transient, stress-related paranoid ideation or severe dissociative symptoms.

(APA, 2013, p 663)

Appendix 2: Qualitative Assessment Form

	Criteria	Yes	No	Unclear
1)	There is congruity between the stated philosophical perspective and the research methodology.	●	●	●
2)	There is congruity between the research methodology and the research question or objectives.	●	●	●
3)	There is congruity between the research methodology and the methods used to collect data.	●	●	●
4)	There is congruity between the research methodology and the representation and analysis of data.	●	●	●
5)	There is congruity between the research methodology and the interpretation of results.	●	●	●
6)	There is a statement locating the researcher culturally or theoretically.	●	●	●
7)	The influence of the researcher on the research, and vice-versa, is addressed.	●	●	●
8)	Participants, and their voices, are adequately represented.	●	●	●
9)	The research is ethical according to current criteria or, for recent studies; there is evidence of ethical approval by an appropriate body.	●	●	●
10)	Conclusions drawn in the research report do appear to flow from the analysis, or interpretation, of the data.	●	●	●

Include

Reason

Appendix 3: JBI critical appraisal tool

1)	Is the source of the opinion clearly identified?
2)	Does the source of the opinion have standing in the field of expertise?
3)	Are the interests of patients/clients the central focus of the opinion?
4)	Is the opinion's basis in logic/experience clearly argued?
5)	Is the argument developed analytical?
6)	Is there reference to the extant literature/evidence and any incongruence with it logically defended?
7)	Is the opinion supported by peers?

Appendix 4: List of the 14 articles and studies chosen for the review

Bjorklund, P. (2006). Taking responsibility: toward an understanding of morality in practice. *Advances in Nursing Science, 29* (2) E56-E73.

Bland, A.R., & Rossen, E.K. (2005). Clinical supervision of nurses working with patients with borderline personality disorder. *Issues in Mental Health Nursing, 26*: 507-517.

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Appendix 5: Details of included qualitative studies

Author/Year	Country/ Culture	Purpose of the study	Sample size	Participants	Gender	Context	Method
Woollaston & Hixenbaugh 2008	United Kingdom English	To examine nurses perceptions of patients with BPD	6	Mental health nurses	Male and female	All members of psychiatric nursing teams working with clients with BPD	Semi structured interviews
Ma et al., 2008	Taiwan Taiwanese	To explore contributing factors and effects of mental health nurses' decision making patterns on care outcomes for patients with BPD	15	Mental health nurses	Female	Nurses in acute or rehabilitation units in psychiatric centre working with clients with BPD	Semi-structured interviews
O'Donovan & Gijbels 2006	Ireland Irish	To gain understanding of the practices of psychiatric nurses in relation to people who self-harm	8	Mental health nurses	Male and female	All had experience of working with patients who self-harm in the last 12 months	In depth semi-structured interviews
Thompson et al., 2008	United Kingdom English	Community psychiatric nurses' experience of working with people who engage in deliberate self-harm	8	Community Mental health nurses	Male and female	All from community mental health teams who work with people who self-harm	Semi-structured interviews
Stroud & Parsons 2012	UK British	Community mental health nurses' constructs of BPD	4	Community mental health nurses	Male and female	Nurses with considerable experience with BPD	Semi-structured interviews
McGrath & Dowling 2012	Ireland Irish	Nurses' responses towards service users with a diagnosis of BPD	17	Community mental health nurses	Male and female	Min 3 yrs post grad experience, working with clients with BPD	Semi-structured interviews followed by questionnaire

Appendix 6: List of qualitative/expert article findings as they pertain to self-management

Sub-themes	Findings
Woollaston, K. & Hixenbaugh, P. (2008). Destructive Whirlwind: nurse's perceptions of patients diagnosed with borderline personality disorder. *Journal of Psychiatric and Mental Health Nursing,* 15,703-709.	
Participants perceiving patients with BPD as unable to self-manage (theme 2)	'..they considered them unable to cope with life and in need of help.'p706
Participants didn't feel that they could contribute to a client self-managing (theme 2)	'I don't really like working with them because I'm not able to see a result for my effort…you can't make it better'p706
Participants' negative perceptions cause them to not develop therapeutic relationships needed for self-management.(theme 2)	'I actually withdrew from any sort of therapeutic liaisons with a client because I felt they were not genuine'p707
Patients are responsible for their own behavior (theme 4)	'…we have to remind her …that it's her responsibility' p707
Ma, Wei-Fen., Shih, Fu-Jin., Hsiao, Szu-Mei., Shih, Shaw-Nin., & Hayter, M (2009). 'Caring across the thorns'-different care outcomes for borderline personality disorder patients in Taiwan. *Journal of Clinical Nursing*, 18, 440-450.	
Participants thought clients could not self-manage and focused only on keeping clients safe (theme 3)	'Six nurses with more inherently negative expectations for their BPD patients decided to ///focus only on basic needs and safety…'p444
Participants thought self-management was impossible (theme 2)	'…caring for them just wastes time and money. I didn't want to understand what they were thinking. Our efforts would not help them change their personalities or disease at all' p444
O'Donovan A., & Gijbels H. (2006) Understanding psychiatric nursing care with non-suicidal self-harming patients in acute psychiatric admission units: the views of psychiatric nurses	
Participants' priority was to maintain safety because the client wasn't seen to be able to self-manage (theme 3)	'Providing a physically safe environment and preventing self-harm were the key priorities for the participants'p191
Participants attempt to understand self-harm as a way of coping (theme 1)	'You can only help somebody try figure out why…what experiences they have had in the past…'p190
Thompson, A.R., Powis, J., & Carradice, A. (2008). Community psychiatric nurses' experience of working with people who engage in deliberate self-harm. *International Journal of Mental Health Nursing,* 17, 153-161	
Participants found patients who self-harm difficult to engage with (theme 2)	'She was so badly damaged that it would be difficult for her to work constructively', 'you think 'well what's the point of that?' and take it personally'p157
Participants need to monitor risk because the client is not self-managing (theme 3)	'what the hell are they gonna (*sic*) bring this time?', 'be aware of a thorough risk assessment'p156

Participants thought self-management equated to client's being responsible for themselves (theme 4)	'It's about putting the responsibility back to them', '…you can make the choices about what therapies you wish to engage in, you're in control' p156, 'wanting to give responsibility to the client but fearing being blamed if anything untoward happened' p159
McGrath, B., & Dowling, M. (2012).Exploring registered nurses' responses towards service users with a diagnosis of borderline personality disorder. *Nursing Research and Practice,* doi:10.1155/2012/601918.	
Negative attitudes of participants hinder their ability to see client's capacity for self-management (theme 2)	'Totally difficult patient to manage…totally self-obsessed…manipulating you…'.'People with attention seeking behavior and a lot of time they have unresolved issues and they largely take this out on everyone else'p3
Avoid working with person with BPD because self-management is too difficult (theme 2)	'..they would avoid providing a service user with BPD any level of care…until it was completely necessary and they would do this at the end of the day where they knew that there would be no time to explore issues in depth'p3
Participants wanting to give opportunity to take responsibility (theme 4)	'You try to be open and non-judgmental and give them the opportunity to take responsibility for their actions' p3
Stroud, J., & Parsons, R. (2012). Working with borderline personality disorder: a small-scale qualitative investigation into community psychiatric nurses' constructs of borderline personality disorder. *Personality and Mental Health,* doi: 10.1002/pmh.1214.	
Participants acknowledged client's presentation in context of past history (theme 1)	'All participants acknowledged the importance of negative early life experiences including trauma experienced by clients with BPD', 'A really bad childhood. ..extremely shocking the sexual abuse', 'the traditional view is about them being very manipulative and attention seeking…I have not really found that. It is about the distress they are in…the client trying to cope'p6
Participants feel responsible for bearing risks (theme 3)	'It's all about risk. That's all we are being embroiled in at the moment is risk', 'staff are very defensive in their practice and very risk adverse…it is about having a service that is prepared to take well thought out positive risks and I don't think we are there yet'
Participants feel that clients can't self-manage (theme 2)	'Became a drug addict who masked the feelings, not being able to cope with what happened…she can be quite

	devious you know', ' quite a few of them don't want to change , perhaps they are scared of change but I think they are also hiding behind it', 'it's challenging they are so complex' p5,6
Participants feeling that client can self-manage and be self-responsible (theme 4)	'…they should sort themselves out and take responsibility for their behaviour', 'I think staff are so scared of things going wrong and them getting the blame and being sued it is very hard to allow clients to have some responsibility' p8.

Bland,A., & Rossen, E.(2005) Clinical supervision of Nurses working with patients with borderline personality disorder. *Issues in Mental Health Nursing, 26 ,*505-517.

Authors note nurses view clients negatively resulting in viewing self-management as something difficult (theme 2)	'Nurses see patient's behavior as deliberate or bad…nurses may become less empathetic, withdraw and become ...distant', '…patients are often seen as deliberately trying not to improve or as sabotaging their treatment'p509
Authors note nurses are unaware of counter transference issues resulting in diminished therapeutic relationship and self-management (theme 2)	'Counter transference reactions by nurses affect the patient's treatment because a therapeutic relationship no longer exists'p510 'Counter transference reactions …are likely to exist outside of the nurse's consciousness'p512
Nurses try to keep patients safe because they are perceived as not self-managing (theme 3)	'Nurses can become involved in power struggles when trying to protect the patient from self-destructive behaviours'p512

Warne,T., & McAndrew,S. (2007) Bordering on insanity: misnomer, reviewing the case of condemned women. *Journal of Psychiatric and Mental Health Nursing, 14,*155-162.

Negative attitudes from nurses impact on self-management opportunities (theme 2)	'…negative attitudes and value judgments contaminating professional responses'p157, 'generally regarded by ...nurses as being irritating, attention-seeking, difficult to manage and unlikely to comply with advice or treatment'p158
Authors believe self-management occurs in context of historical abuse (theme 1)	'...women who self-injure have considerable insight into their behavior…self-harming behaviours (as) an attempt to regulate internal distress' p159, '…women symbolize their unbearable traumas in a way that creates and communicates meaning'p160
Authors note that nurses' unwillingness to acknowledge sexual abuse creates re-abuse (theme 2)	'For women who have been abused as children, this repeat experience centers on a culture that does not allow women a voice to express their abuse'

Crowe, M. (2004) Never good enough-part 2: clinical implications. *Journal of Psychiatric and Mental Health Nursing, 11,*325-340.

Author sees self-management in context of historical abuse (theme 1)	'…the person has learned to cope with shame and their current mental distress, situating shame in its socio-cultural context' p335 '…helping that person to recognise and accept her or his self and develop alternative, more fulfilling subject positions' p337 'help the person make connections with what they do and how they feel' p338
McAllister, M. (2003). Multiple meanings of self-harm: A critical review. *International Journal of Mental Health Nursing, 12,*177-185.	
Nurses see clients negatively and see self-management as a difficult thing (theme 2)	'…a person with this diagnosis is often judged harshly , feared, constructed as chronic and not likely to change', 'the label distances staff from seeing the person and instead they see the disorder' p179
People who self-harm to self-manage do so in historical context of self-abuse (theme 1)	'…people who self-harm have a history of child and/or adult sexual abuse' p179'deliberate self-harm is a way earlier trauma is repeated', 'self-harm is seen as a coping strategy to manage painful feelings, powerlessness intrusive memories and compulsion to repeat the trauma' p181.
Focus on keeping client safe without exploring role of self-harm (theme 3)	'surveillance and control of the individual using restraint, seclusion or close observations may be difficult to defend'
Bjorklund, P. (2006). Taking responsibility: toward an understanding of morality in practice. *Advances in Nursing Science, 29* (2), E56-E73.	
Self-management is not a feasible option in the eyes of nurses (theme 2)	'…the borderline client … and others amongst the oppressed and mentally ill do not meet society's notion of proper self-governance and therefore lack standing as moral agents…that would allow them to answer for their moral conduct' pE66 'Responsibility thus rests not only on self-worth, but also on recognition, inclusion and opportunities for self-disclosure' pE66
Patients taking responsibility and thus self-managing (theme 4)	'…we ask a person diagnosed with BPD to take responsibility for her *self*, what are we asking that person to do? …our understanding of our responsibilities and how we are to "take" them depends …on how others signal who we are (or are not) and what we are (or are not) supposed to do' E68.

Evans, M. (2007). Being driven mad: towards understanding borderline and other disturbed states of mind through the use of counter-transference. *Psychoanalytic Psychotherapy, 21*(3), 216-232.	
Nurses distance themselves from clients hindering opportunities for client self-management.(theme 2)	'…staff may hide behind a defensive position in which they start to moralise about the patient…' p218 'The counter-transference then affects the professional's perspective' p224
Client's can't self-manage and so nurses need to manage for them by keeping them safe (theme 3)	'staff are made to feel entirely responsible for protecting the patient from themselves' p228
Rayner, G., Allen, S.L., & Johnson, M. (2005) Counter-transference and self-injury: a cognitive behavioural cycle. *Issues and Innovations In Nursing Practice, 50*(1), 12-19.	
Counter-transference increases nurses' negative thoughts and behaviours resulting in a decline in nursing care and therefore opportunities for client self-management (theme 2)	'…people are labeled as 'manipulative' and 'attention-seeking'…as a defense mechanism, this serves to make the nurse feel better about themselves, locating the source of difficulty with the client rather than looking at the nurse's own knowledge, attitudes or beliefs' p13
Self-management seen as coping within historical context of self-abuse (theme 1)	'Resilience is the reframing of distressing events to encourage survival, courage and the validation of client's efforts at coping' p13
Edwards, S.D., & Hewitt, J. (2011) Can supervising self-harm be part of ethical nursing practice? *Nursing Ethics, 18*(1), 79-87.	
Maintaining client safety is nurses' main focus because the client can't self-manage (theme 3)	'…strategy of prevention of self-harm…by one-to-one supervision of patients, or by close observation in conjunction with the removal of any implements that could be used for self-harm' p81 'risks undermining their, perhaps fragile, self-identity…by removing patients' coping mechanism…rides roughshod over these patients' autonomy' p82
Self-management is the client being responsible to cope (theme 4)	'…patients retain control over their situation and are able to continue to use a reliable means, as they see it, in order to cope with their feelings of intense distress' p82 'being with a patient during self-injury is seen as a means of strengthening the therapeutic relationship….may allow nurses to explore alternate future coping strategies with patients' p86

Appendix 7: Details of included expert opinion articles

Author/ Year	Country	Stated position	Culture	Author's conclusion	Reviewer's comments
Bland & Rossen 2005	USA	Nursing school educators	Mental health nurses working with BPD patients	Clinical nursing supervision will enhance therapeutic effectiveness and clinical outcomes	Logical argument developed with the interests of the client articulated.
Warne & McAndrew 2007	United Kingdom	Nursing Educators at post graduate level	Mental health nurses working with BPD patients	Mental health nurses need to recognize the defense mechanisms involved in working with BPD individuals	Argument developed analytically with clients' interests underlying the opinion.
Crowe 2004	New Zealand	Nursing Educator at post graduate level	Mental health nurses working with BPD clients	Nursing a BPD client involves recognizing the impact of shame on their lives	A logical discursive approach that has the interests of the client at the centre of the article
McAllister 2003	Australia	School of nursing educator	Health providers working with people who self-harm	Clinicians need to have multiple and flexible responses to clients who self-harm knowing that there are many reasons for this behaviour	This is a critical review of selected articles about self-harm that explores the content and the way the information is situated within and across discourses.
Evans 2007	United Kingdom	Psychotherapist working with mental health nurses	Mental health nurses receiving clinical supervision	Mental health nurses working with BPD people need time to reflect on their practice focusing on transference and counter-transference issues	Good logical argument with the client's interests at the centre.
Rayner et al 2005	United Kingdom	Nursing educators	Nurses working with clients who self-harm	Knowledge about counter-transference when working with people who self-injure may reduce nurses' negative thoughts and behaviours which may result in improved client care	Logical argument which is supported by peers and backed up by existing literature
Edwards & Hewitt 2011	United Kingdom	Department of Philosophy, History and Law	Ethical nursing practice for mental health nurses	Evaluates three competing responses to self-harm and makes a tentative case for supervised self-harm	The argument is logical and well presented and definitely is client focused.

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Study: Mental Health Nurses' Understanding of Self-Management relating to Borderline Personality Disorder.

- I have read and I understand the information sheet dated 19th December, 2011 for volunteers taking part in the study designed to gain mental health nurses' understanding of self-management relating to borderline personality disorder. I have had opportunity to discuss this study. I am satisfied with the answers I have been given.
- I have had the opportunity to use whanau support or a friend to help me ask questions and understand the study.
- I understand that taking part in this study is voluntary (my choice), and that I may withdraw from the study at any time, and this will in no way affect my employment.
- I understand that my participation in this study is confidential and that no material that could identify me will be used in any reports on this study.
- I understand that the interview will be stopped if it should appear harmful to me.
- I have had time to consider whether to take part in the study.
- I know who to contact if I have any questions about the study.
- I consent to my interview being audio taped
- I know that I will have the opportunity to edit the audiotape transcript

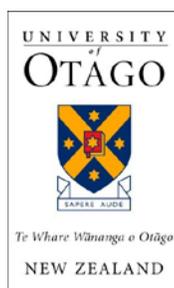I, ……………………………… (*full name)* hereby consent to take part in this study.

Date: Signature:

Full name of the researcher:

Contact phone number of the researcher:

Signature:
Date:

Study: Mental Health Nurses' Understanding of Self-Management relating to Borderline Personality Disorder

Participant Information Sheet

You are invited to take part in a study that will explore self-management relating to borderline personality disorder from the perspective of a mental health nurse. Expressions of interest should be made via the contact details below before the end of August, 2012.

Participation
Your participation is completely voluntary; you do not have to take part in this study. If you do agree to take part in the study, you are free to withdraw from the study at any time, without having to give a reason.

Who is the researcher?
My name is Karen Harrington, I am a registered nurse currently working in Seager Clinic, Rehabilitation Services in mental health. I have worked for 4 years in mental health and for 2 decades in general nursing in the CDHB, CPIT and abroad.

What if I know the researcher?
You can still participate in this study if you know the researcher. You will not be treated any differently to other participants within the study and your freely informed consent will still be required. If you feel uncomfortable knowing the researcher it would be best if you do not make contact to participate in the study.

About the study
The research is being undertaken as part of the researcher's post graduate masters study. Some Registered Nurses who work in SMHS in the CDHB have been asked to participate. The first 10-12 mental health nurses who volunteer to participate in the study will be included. Inclusion criteria include being a registered nurse working in the field of mental health and having worked with someone with a diagnosis of borderline personality disorder in the last year.

What will happen if I do take part?
If you do decide to take part then contact should be made via the details given below. The researcher will then arrange via phone or email a convenient time and place for an interview. The interview can be done at your place of work, at home or another place that is convenient. The researcher/interviewer will go through this information sheet and if you are happy to consent to take part in the study you will be asked to sign 2 copies of the consent form. You will keep one copy and the other copy is for the researcher. The interview is likely to last around one hour and will be tape recorded. There will be some pre-determined questions but flexibility to follow your responses. You do not have to answer all the questions, and you may stop the interview at any time. Following this interview no further time will be required of you. You will be given the opportunity to edit the audiotape transcript should you wish.

Will the information be kept confidential?
Yes, the information you provide will be kept confidential unless serious concerns are raised about patient safety or professional conduct. No material that could personally identify you will be used in any reports on this study. The tapes from the interviews will be stored in a safe place and your specific details will be removed when they are transcribed into a written form.

What will happen to the results of the research study?
When all the data has been gathered it will be transcribed into a written form and this will be analysed for themes and written up in a report. This will be submitted to Otago University for marking and a copy of the report will be made available via the university. The expected completion date for the study is September 2013. It is possible that the results may be used in other publications such as a nursing journal. As already stated you will not be identifiable in these reports. The data will be stored electronically with the university for a 10 year period.

Can I view the results of the study?
You may view a copy of the final report via the university. The findings are likely to be later presented. If you are interested in attending the presentation express your interest to the researcher.

What are the disadvantages of taking part?
There are very few disadvantages to taking part in the study. As already described it will take about an hour of your time. You will be asked questions on the topic of self-management relating to borderline personality disorder. If you have any queries or concerns regarding your rights as a participant in this study, you may wish to contact your professional organization.

What are the possible benefits of taking part?
There is no intended direct benefit to you from taking part in the study. The information gathered could be used to further develop nursing knowledge and understanding of the topic from mental health nurses' perspectives.

What if something goes wrong?
The risk of something going wrong is very small given the nature of the study. If you have any questions or concerns about your rights as a participant in this study you can contact an independent health and disability advocate. This is a free service provided under the Health and Disability Commissioner Act.
Telephone: (NZ wide) 0800 555 050
Free Fax: (NZ wide) 0800 2787 7678 (0800 2 SUPPORT)
Email: advocacy@hdc.org.nz

Who has approved this study?
This study has received approval from the Upper South B Regional Ethics Committee, ethics reference number: URB/12/02/011

Please feel free to contact the researcher if you have any questions about this study.

Contact details for further information:

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Would you like to participate in a study about

Mental Health Nurses' Understanding of Self-Management relating to Borderline Personality Disorder

This qualitative study is being undertaken as part of a master's study. If you are interested in taking part please make contact with the researcher via the details below.

Karen Harrington

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Appendix 11: Study Questions

1. What does self-management mean to you as it pertains to clients within the mental health setting?

2. Do you feel you have a part to play in supporting clients to develop self-management skills?

3. What does self-management mean to you as it pertains to clients with a diagnosis of borderline personality disorder?

4. Do you feel you have a part to play in supporting clients with borderline personality disorder develop self-management skills?

5. What relevance does self-management have to someone with a diagnosis of borderline personality disorder?