A qualitative exploration of the relationship between those with a diagnosis of Borderline Personality Disorder and their care coordinators: A service user perspective.

Louise Bradbury

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School of Psychology
Faculty of Health and Medical Sciences
University of Surrey
Guildford, Surrey
United Kingdom
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Abstract

Introduction: Little is known about the relationships between those diagnosed with Borderline Personality Disorder (BPD) and their care coordinators in UK community mental health settings, with the role of care coordinator poorly defined with limited guidance. The purpose of this research was to explore these relationships and interactions from the perspectives of those diagnosed with BPD.

Method: Semi-structured interviews were conducted with eight participants diagnosed with BPD in current relationships with care coordinators. The transcribed interviews were analysed using Interpretative Phenomenological Analysis (IPA).

Results: Four superordinate themes were identified: Trust, Qualities of the care coordinator, The complexity of the relationship and Developing a safe base. The first three themes are viewed as contributing to the final theme.

Discussion: Themes were discussed in the context of attachment theory with consideration that the development of secure attachments in care coordinator relationships may be therapeutically beneficial and important in recovery. The research was critiqued and future directions considered.

Implications for Practice: Whilst the generic role of care coordinator is not specifically defined as therapeutic there is potential for this relationship to be therapeutically beneficial or conversely counter-therapeutic for those diagnosed with BPD.
Acknowledgements

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Statement of Journal Choice

The ‘Journal of Psychiatric and Mental Health Nursing’ was identified as an appropriate peer-reviewed journal to which this literature review might be suitable for submission. The scope of this journal is to consider papers that advance the development of policy and practice in psychiatric and mental health nursing. Papers published in the journal are written by authors from a range of professional backgrounds, including clinical psychology. The journal aims to translate research into psychiatric nursing practice, with a particular interest in the consumer perspective. This journal seemed an appropriate choice given the statement of interest in articles considering implications for community based care. The editors cite their interest in papers relevant to the development of broader areas of healthcare such as public policy and legislation. The journal has previously published papers considering the experiences of clients with Borderline Personality Disorder and their experiences of community psychiatric services. The editors have recently produced new aims for the journal which highlight the growing importance of service user involvement and the views of experts in improving the lives of those affected by mental health problems.
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Introduction

Overview

Individuals diagnosed with Borderline Personality Disorder (BPD) constitute a significant proportion of the caseloads of care coordinators working within Community Mental Health Teams (CMHT) (Keown at al., 2002). Many clinicians do not believe they have appropriate skills or training (National Institute for Mental Health in England [NIMHE], 2003; Koekkoek, et al., 2009), identifying that this, combined with poor understanding of personality disorders, is a major barrier to confident and effective care management (NIMHE, 2003). Service users report negative experiences of general mental health services, noting unhelpful attitudes from professionals and a desire for trusting, reliable relationships, and shared understanding with their care coordinators (Haigh, 2002). Additionally, service users commonly feel rejected and dismissed by these services (Crawford et al., 2007). This may be due to the complexity and challenges of relational difficulties associated with this diagnosis, but also through the lack of clear guidance. Whilst many service users may be referred for specific therapeutic interventions commonly the care coordinator, a generic role not specifically defined as therapeutic, may be the most frequent contact and constant source of support. The National Institute for Health and Care Excellence (NICE, 2011) suggests that essential to care is the investment of professionals in building trusting, supportive, empathic and non-judgemental relationships. There is a paucity of research considering the relationships between those diagnosed with BPD and care coordinators, mostly focussed on the views of professionals. This research aims to build an understanding of these relationships and explore care coordination from the perspectives of those diagnosed with BPD.
Community Mental Health Teams (CMHT)

The estimated prevalence of personality disorders in the UK is 4.4%, with 0.7% believed to be diagnosed with BPD (Coid et al., 2006). In the UK CMHTs provide support for adults with mental health problems living in the community. Within CMHTs there is likely to be a high proportion of those with a diagnosis of personality disorder, with one study finding 52% on team caseloads and 11% diagnosed with BPD (Keown et al., 2002). Those diagnosed with BPD have been shown to have high levels of contact with services, highlighting the importance of considering these interactions (Comtois et al., 2003).

Role of the Care Coordinator

Within CMHTs the Care Programme Approach (CPA) was developed as good practice for working with those with complex mental health difficulties in the National Health Service (NHS) (Department of Health [DoH], 1990). This involves the allocation of a care coordinator, a role drawn from various professions including community psychiatric nurses and mental health social workers. This role includes coordinating referrals alongside general monitoring of mental health with NICE (2011) guidelines identifying the aim to support service users in a collaborative way, emphasising assessment of needs and care planning. DoH (2008) guidance advised that the role involves “shared listening, communicating, understanding, clarification, and organisation of diverse opinion to deliver valued, appropriate, equitable and co-ordinated care” (DoH, 2008, p.7).

It is expected that service users have regular contact with care coordinators, therefore this relationship is central to their care and wellbeing (NICE, 2011). The DoH (2008) highlighted that the quality of such relationships “is one of the most important determinants of success” (DoH, 2008, p.7). Historically this role has not been clearly defined and is subject to local interpretation and policies, with potential for wide variability in the quality and provision of
care (NICE, 2011). The DoH document *Personality Disorder: No Longer a Diagnosis of Exclusion* (NIMHE, 2003) identified that people did not always experience services as helpful. The lack of clarity surrounding the care coordinator role, negative experiences of services, and government documents suggest that the implementation of community care is variable, highlighting the need to research this area.

**Borderline Personality Disorder**

The *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) (American Psychiatric Association [APA], 2013) defines those diagnosed with BPD as experiencing impairments with interpersonal functioning relating to difficulties with empathy and intimacy (APA, 2013). Given these difficulties with maintaining relationships, interpersonal sensitivity, and preoccupations with real or imagined abandonment (APA, 2013) it is likely that relationships with clinicians would prove challenging. These difficulties have been linked to a high incidence of insecure attachment resulting from neglect or abuse from a primary caregiver (Bateman & Fonagy, 2008). As a result of attachment difficulties it has been hypothesised that individuals diagnosed with BPD struggle to tolerate being alone or alternatively being close to others (Gunderson, 1996), presenting problems for developing meaningful relationships with clinicians. Bateman and Fonagy (2008) noted that those diagnosed with BPD may swing between care seeking and angry withdrawal as a consequence of insecure attachment difficulties, however this has not been explored within the context of relationships with care coordinators.

For those diagnosed with BPD, stigma associated with the label ‘personality disorder’ presents further difficulties in engaging with services as this leads to assumptions about the individual, negative stereotypes, and discriminatory practice (Warne & McAndrew, 2007). Psychiatrists have been shown to view patients diagnosed as personality disordered as
manipulative, difficult to manage and unlikely to arouse sympathy (Lewis & Appleby, 1988). This large, longstanding study considering psychiatrists’ opinions, utilised short vignettes rather than responses to real clinical cases, but suggests that attitudes may play a significant role in developing supportive and collaborative care coordinator relationships.

**Conceptualisation of Borderline Personality Disorder**

Various explanatory models of BPD have been developed, with considerable controversy and debate surrounding the definition and classification of BPD due to the heterogeneity of those with the diagnosis (Perris, 1999; Lewis & Grenyer, 2009). Theories and conceptualisations of BPD have included Kernberg’s (1967) model of ‘borderline personality organisation’, the view of BPD as chronic Post Traumatic Stress Disorder (Herman & van der Kolk, 1987), biopsychosocial models and theories of emotional dysregulation (Linehan, 1993), disorder of attachment and fear of abandonment (Gunderson, 1996), and inability to mentalise due to early attachment difficulties (Bateman & Fonagy, 2004). Resultantly the diagnostic label of personality disorder has been broadly criticised in regards to whether this is a meaningful or well-conceptualised construct. Given the difficulties associated with the conceptualisation of BPD and diagnostic categorisation, it has been suggested that a greater focus on considering the underlying characteristics of an individual’s experience, such as regulating intense emotions might present a more helpful understanding (British Psychological Society, 2013).

**Existing Evidence Base**

Little research has focussed on the experiences of those diagnosed with BPD within CMHT settings or care coordination, with a dominant focus on inpatient care or specialist interventions. Relevant studies have considered CPA processes in the UK (Rogers & Dunne, 2013), the impact of care coordinators on engagement in Dialectical Behaviour Therapy (DBT) (Gaglia at al., 2013), case management in the USA (Nehls, 2000; Nehls, 2001), the
mental health ‘system’ in the community (Fallon, 2004; Koekkoek et al., 2010) and staff attitudes towards those diagnosed with BPD (Cleary et al., 2002; Deans & Moecevic, 2006; Black et al., 2011).

In the UK little research specifically considers the experiences of those diagnosed with BPD and their relationships with care coordinators. Existing qualitative research has identified factors important in relationships with professionals such as trust (Fallon, 2003), and collaboration, consistency and communication (Rogers & Dunne, 2013).

In the USA ‘case management’ (similar to care coordination) has been considered using Interpretative Phenomenological Analysis (IPA) (Nehls, 2001; Nehls, 2000). These studies examined the experience of clinicians, and those diagnosed with BPD in such relationships. The studies highlighted the importance of ‘being treated like a person’ and non-judgemental stance (Nehls, 2001). Whilst these findings may be relevant to care coordinator relationships in the UK, experiences may differ due to privately funded healthcare in the USA. The provision or longevity of support may not be equitable, indicating likely differences in experiences and need for replication of this study in the UK. The longevity of relationships, viewed as important in meeting the needs of clients (Nehls, 2001), may be under threat in the UK where services are likely to have been affected by financial cuts (Karanikolos et al., 2013).

Further studies have been carried out internationally, with findings again highlighting the importance of trust and difficulties with trust in relationships (Koekkoek et al., 2009; Langley & Klopper, 2005). There was also consensus that professionals lacked a coherent way of working with clients, with poor understanding of BPD (Koekkoek at al., 2009).
Rationale for the Present Study

No research specifically explored the relationships between those diagnosed with BPD and care coordinators in UK CMHTs. A dominant focus on attitudes towards BPD and mental health services in general has resulted in limited literature considering client experiences of these relationships, as well as what is perceived by this group as helpful or unhelpful styles of interaction. Existing research has also primarily been conducted outside of the UK.

Previous research has noted the importance of building on our understanding of best practice in providing ‘continuous and comprehensive services from a single caregiver’, such as a care coordinator (Nehls, 2001). Current government guidance on the care coordinator role in interactions with clients is limited, therefore it is hoped that this research will advise on more meaningful and helpful client-centred interactions. The study may inform training and guidance, repeatedly highlighted as a necessity in tackling negative attitudes and supporting those working with this complex group (Koekkoek et al., 2009; Deans & Meocevic, 2006; Cleary et al., 2002; Nehls, 2000).

The use of inductive qualitative exploratory methodology may offer a richer understanding of the processes taking place in these relationships and how they are experienced as it seeks to discover how individuals make sense of their lived experiences. Existing qualitative studies have begun to investigate processes taking place in similar relationships, therefore a more thorough understanding of the contributing factors in establishing good working relationships with care coordinators may add to our knowledge of how these might be experienced as beneficial and utilised effectively.
Research Aim

This study aims to further the understanding of relationships between those diagnosed with BPD and their care coordinators and how they make sense of these experiences.

Research Question

How do people with a diagnosis of BPD experience their relationships and interactions with their care coordinators?

Method

Methodological Rationale

The inductive, open-ended approach of Interpretative Phenomenological Analysis (IPA) allows exploration of how participants make sense of their lived experiences, particularly an individual’s perception of experiences rather than an objective view (Smith, 2008). The exploratory nature of the research question requires an in-depth approach to develop understanding of participants’ individual experiences.

In selecting an appropriate qualitative methodology it was important to consider the epistemological assumptions of potential approaches (Willig, 2001). A critical realist approach was taken as this recognises that knowledge is not objective but contextual, and that individuals hold subjective representations of reality accessible through conversation. IPA takes this approach, assuming that individuals hold relatively stable beliefs accessible through interviews and open-ended questions. The interpretative nature of analysis also takes account of the researcher’s views, and the interactions between participant and researcher. IPA infers that attempting to understand people’s relationship to the world is interpretative and seeks to comprehend how they make meaning of the situations they experience. IPA allows the research question to be answered at an idiographic level, with detailed analysis of individual
lived experiences of relationships with care coordinators. Therefore in this study, IPA furthers our understanding of these relationships by providing an in-depth perspective from the standpoint of those diagnosed with BPD. Grounded Theory (Glaser & Strauss, 1967) was not selected as this is concerned with theorising social processes rather than obtaining an individual’s perspective of experiences.

**Ethical Approval**

Ethical approval was obtained from the NHS Research Ethics Committee (Appendix A), the Research and Development Committee of the relevant NHS Trust (Appendix B) and University of Surrey Research Integrity and Governance Office (Appendix C).

**Ethical considerations**

Participants were advised that all identifying data would be removed or changed to ensure anonymity. This aimed to reassure participants that they could speak freely about their experiences without impacting on the care they received from services. This was particularly important as the study explored ongoing care participants were receiving from care coordinators.

Participants were informed before the interview that if concerns regarding their welfare were raised, local Safeguarding Adults procedures would be followed. Details of where to seek support were also provided in case of emotional distress arising. Time was allocated post interview for debriefing and discussing any concerns arising from the process.
Participants

Recruitment strategy.

The research took place within CMHTs within a large NHS mental health Trust in the south of England. A purposive sampling strategy was chosen to recruit participants diagnosed with BPD and experiences of a relationship with a care coordinator within the CMHT, for whom the research question was relevant. The aim was to recruit ten to twelve participants, with the intention of obtaining data from six to eight interviews, suggested as appropriate for an IPA study (Turpin et al., 1997).

To make the study known to suitable participants, CMHT managers were advised of the study. Where possible the researcher attended team meetings to explain the study to care coordinators able to alert potential participants to the study. Care coordinators were asked to discuss the study and provide interested potential participants with an information sheet (Appendix D). Interested participants were able to return a reply slip consenting to be contacted. The researcher’s email address was provided which some participants utilised to request further information. Posters were also displayed in CMHT waiting rooms allowing potential participants to contact the researcher directly (Appendix E).

Criteria for participation.

IPA requires a fairly homogenous sample to allow the researcher to focus on factors relevant to the research question (Dallos & Vetere, 2005), therefore participants were recruited subject to the following criteria:

- Service users at CMHTs within the same NHS Trust.

- A diagnosis of BPD (DSM-V criteria).
• At least 5 episodes of contact with the same care coordinator, including face-to-face and telephone contacts.

• Opted into the research, providing written consent.

They were not invited to participate if:

• They lacked capacity to consent to participate.

Whilst various conceptualisations of BPD exist, the DSM-V diagnosis was used for inclusion criteria to help identify suitable participants within CMHTs utilising this classification system, and to ensure the homogeneity of the sample.

Sample.

Eight participants consented to take part in the research, at which point recruitment ceased. See Appendix F for demographic details.

Procedure

Interviews were arranged with those who consented to be contacted. Information about the study was provided and a suitable time and date for the interview arranged. To ensure safety interviews were held at CMHT bases. Prior to interviews participants were given an information sheet and completed a written consent form (Appendix G) confirming their willingness to participate. Participants were reminded that their participation would not impact on the care that they received and that interviews would be anonymised. Interviews lasted between 45 and 60 minutes, were recorded on a digital voice recorder and later transcribed verbatim by the researcher.
Data collection.

A semi-structured interview schedule (Appendix H) was developed in consultation with the Service User and Carer Advisory Group at the University of Surrey. This method allowed the researcher and participant to engage in flexible dialogue with ongoing development and adaptation of the initial questions to gain an in-depth picture of the individual’s experience (Smith, 2008).

Data Analysis

The following guidelines informed the analysis of data obtained from the interviews (Smith et al., 2009):

1. Initial transcripts were read repeatedly to allow the researcher to immerse themselves in the data. Thoughts and observations were noted in the right hand margin of the transcript, including descriptive, linguistic and conceptual comments.

2. Initial comments were examined and emerging themes identified and developed for each transcript. These were described in the left hand margin to capture participants’ experiences.

3. This was repeated for all participant transcripts prior to identifying superordinate themes across all data.

4. Subsequently, emergent themes were clustered into superordinate themes according to their meanings. Thematic categories were verified by checking there was adequate data to support them. Inadequate data relating to an interpreted theme unrelated to the research topic was removed.
5. Superordinate themes were grouped into master themes according to connections or relationships between their meanings and participants’ experiences organised in order to address the research question.

**Evaluating the quality of the research.**

In evaluating qualitative research Elliot and colleagues (1999) advised of the importance of the researcher’s honesty about their own theoretical and personal orientations relevant to the study.

My interest in those diagnosed with BPD developed from working with this client group as a support worker in a CMHT and later providing group therapy in a specialist Personality Disorder Service. Anecdotally I gained some understanding of the experiences of those diagnosed with BPD with their care coordinators. Sometimes support seemed lacking and at other times invaluable in enabling progress towards recovery. As a multidisciplinary team member I experienced frustration with care coordinators and the service which they provided, whilst balancing this with my knowledge of the pressures in providing this service. From my specialist experiences, the polarised view of appropriate or severely lacking care coordination was evident and prompted my interest in considering this relationship in detail.

To account for my own interests and their potential impact on the research I kept a journal throughout the process. This was to assist me in remaining honest and transparent about my assumptions and bring this awareness to the co-construction of meaning between myself and participants during analysis. Regular discussions were held in supervision to consider my reflections further.

The guidelines of Elliot et al. (1999) were further used to ensure the quality of the research (Appendix I).

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1 I will use the first person to facilitate self-reflexivity in this section.
Results

Analysis of the data obtained from the interviews produced four overarching themes.

Table 1. Master table of superordinate and sub-themes.

<table>
<thead>
<tr>
<th>Superordinate Themes</th>
<th>Sub-themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Trust</td>
<td>- Trust in the early stages</td>
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<tr>
<td></td>
<td>- Building trust</td>
</tr>
<tr>
<td></td>
<td>- Ability to trust</td>
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<td></td>
<td>- Loss of trust</td>
</tr>
<tr>
<td></td>
<td>- Trust as a two-way process</td>
</tr>
<tr>
<td>2. Qualities of the care coordinator</td>
<td>- Suitability of allocation</td>
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<tr>
<td></td>
<td>- Judgements</td>
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<td></td>
<td>- Going beyond their role</td>
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<tr>
<td>3. The complexity of the relationship</td>
<td>- One-sided relationship</td>
</tr>
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<td></td>
<td>- Boundaries</td>
</tr>
<tr>
<td>4. Developing a safe base</td>
<td>- Feeling understood</td>
</tr>
<tr>
<td></td>
<td>- Not feeling understood</td>
</tr>
<tr>
<td></td>
<td>- Understood as an individual</td>
</tr>
<tr>
<td></td>
<td>- Enabling understanding of self</td>
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<tr>
<td></td>
<td>- Availability of care coordinator</td>
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<td></td>
<td>- Endings</td>
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</table>

The first theme, **Trust**, was described by all participants and indicated as important in the development and maintenance of their relationships with care coordinators. The second theme, **Qualities of the care coordinator**, considered the significance of being allocated the ‘right person’, the impact of feeling judged and the consideration of professionals who acted beyond their remit. In **The complexity of the relationship**, participants spoke of the unusual experience of the relationship as one-sided and how boundaries between the personal and professional were developed and maintained. Finally, **Developing a safe base**, considered the implications of feeling understood by care coordinators, the importance of feeling valued as an individual in the context of diagnostic overshadowing, perceptions of the availability of care coordinators, and the experiences and anticipation of relationships ending. Within this
theme these processes were discussed in terms of enabling a better understanding of the self. These four superordinate themes and their sub-themes will be presented in more detail, and anonymised quotations from interviews provided to exemplify the descriptions of the themes.

1. Trust

Participants described the importance of trust in relationships with care coordinators, including how trust impacted on the early development and later strengthening of relationships. Participants described the consequences of lost trust and the potential for the breakdown of relationships. The relationship with trust and ability to trust was also commented on, including the impact of personality on trust in relationships. Participants spoke of trust being two-way, highlighting the value of trust being reciprocated by care coordinators and the importance of approaching the relationship with honesty.

**Trust in the early stages.**

Participants spoke of the initial lack of trust in the early stages of relationships and how this prevented engagement with their care coordinators:

“I dunno I never thought I would trust her the way I trust her now and I always thought it would be a lot more like...well definitely to start with as well it was very like...I didn’t trust her and I probably lied to her and stuff, or I kept stuff back.”

(Anna)

Georgina similarly found that she withheld things from her care coordinator as it took time to develop trust:

“It’s taken me a long time. I didn’t just take to her, no way, I kept things in and was on my guard and wouldn’t say things, I wouldn’t trust saying things or being honest with things in that sense.”
Building trust.

Participants described building trust from the difficult early stages in relationships and the positive impact of time. For Georgina having a care coordinator for a long period of time fostered trust and the ability to talk openly:

“So at the very beginning I didn’t say very much to her, but because obviously realising that she stayed, so the longer I have had her that’s why the trust built up. Because if she had just been here for six months or they had moved me onto somebody else she wouldn’t know anything.”

For Helen, the way her care coordinator responded in situations enabled her to build trust, positioning her care coordinator as a significant person and relationship in her life:

“When I say or do things she reacts very professionally towards me but still very friendly. I suppose that built my trust up to be able to be extremely open and honest with her to the point where I think she is the person I am most honest with, and I do trust her the most out of anybody in my life.”

Whilst trust can be built it was acknowledged that this is not possible with all care coordinators:

“You want to build up trust but then it’s just human nature isn’t it, trust is built up over time and some people are just never going to be there.” (Emily)

Ability to trust.

Participants commonly described difficulties with their ability to trust others, with consequences for the development of relationships. Beth’s view of being able to trust was polarised:
“In my life I find it really hard to trust someone or really easy to trust someone.”

Anna’s relationship with her care coordinator demonstrated that it was possible to trust others despite previous experiences:

“So that has really helped me, the consistency and like having that person because I find it really hard to trust people.”

The impact of existing difficulties with relationships was sometimes indicated as a factor in being able to trust people:

“...because with personality disorder, for me anyway, I don’t know whether it’s other people, I don’t trust people. I have a big thing about trusting people, I can’t get to the point where I can trust people.” (Georgina)

Fiona’s difficulty trusting others prevented relationships from developing, resulting in a series of broken relationships with various care coordinators:

“...my care coordinators, I still went through a few of them....it was very difficult because of the personality of the way I am and trusting people, and not having that- I don’t know what you call it- rapport, with them. It just wasn’t happening and I just went from one to another to another.”

Loss of trust.

Loss of trust was often precipitated by experiences where participants felt let down by their care coordinators, leaving them feeling alone with their difficulties:

“So in terms of trusting her that was a real step back again because then I was like...I kind of felt like “oh no she’s not on my side”. (Anna)
Helen’s negative experiences with her care coordinator led her to feel that there was nobody she could trust:

“...it does affect me quite badly because it makes me feel like I don’t have anyone that I can rely on. It makes me feel like I don’t have anyone I can trust.”

Trust that had been built up over time was described as fragile and easily lost:

“Trust can be broken quickly can’t it? It takes years to earn and I think can be broken very quickly at the same time.” (Emily)

**Trust as a two-way process.**

Feeling that care coordinators reciprocated trust was equally significant:

“...they trust you to be able to stick to your word as well. Trust goes both ways I suppose.” (Emily)

In Georgina’s case, breaking trust with her care coordinator would have significant consequences for their relationship:

“I was still on Section 17 but she trusted me not to run off in the middle of the high street. I promised I wouldn’t, and I wouldn’t do that to her.”

For Emily, trust was indicated through proof and built up over time through a gradual process:

“I had to prove to them I would be trusted with X, Y and Z. And it took years, but finally you did get there in the end.”
2. Qualities of the care coordinator

Participants compared experiences with different care coordinators they had worked with and the significance of being allocated the “right person”. Being judged or conversely feeling that care coordinators took a non-judgemental stance was seen as significant in terms of how positively relationships were viewed. When care coordinators were willing to step outside of their roles, providing support during challenging times this was seen as significant.

Suitability of allocation.

Participants described needing to feel that their care coordinator was the “right person” and someone they would could build a rapport with. For many there was no choice in who they were allocated, impacting on how easy they felt it was to open up. For Georgina the consequences of being allocated a male would have been detrimental:

“So for me if I had a male, even the thought of it I couldn’t. I really couldn’t. I would really just say “then I will just be on my own”. I know I would become unwell but I really wouldn’t be able to cope with that.”

For others the experience of not getting on impacted on how well they worked together:

“I wasn’t having any other help then and I didn’t like her. I think she did do more but I didn’t like her as a person at all, but she was just really annoying and I know that wasn’t her fault really but I didn’t want to see someone that made me that annoyed.”

(Claire)

For some, being well matched with care coordinators facilitated close relationships:
“...she’s quite young so it’s quite good that we are similar in age because...I kind of get on with her. She kind of understands a bit more about what it’s like being my age and so we talk about a lot of stuff that’s relevant to young women I suppose.” (Helen)

Fiona felt that their similarities were beneficial and helped her to feel she was understood:

“Yes I’ve got a fourteen year old daughter, my care coordinator she’s got children so she can relate to me as a mother...the way I struggle with my feelings and what I struggle with my daughter and the issues that we’ve had with the social workers. You name it I’ve seen it, but she’s a mother herself and that is very very comforting.”

Judgements.

Participants spoke of the impact of feeling judged by care coordinators. For some, experiences in other relationships affected how they responded to their care coordinators:

“....because I struggle with social relationships outside, you know, I look a bit... and I think people are judging me very quickly. And if I see that person judging me before they knew me I automatically put the defence up and it doesn’t go well.” (Fiona)

Anna felt that judgement from others clouded their understanding of her difficulties:

“I feel like I’ve had to wade through so much bullshit with other people to just be like...ok...here’s the facts of my life now can we get to the things that are causing me problems. And I haven’t really had to do that with her as much, like, um...like I don’t need to be made to feel different about those things when that’s not the stuff I’m struggling with.”

Anna also experienced greater acceptance from her care coordinator than from others:
“But I think yeah acceptance in that, like when there’s been other things that other people haven’t necessarily been as accepting of, she’s been quite accepting. Like my sexuality and stuff like that.”

Fiona had mixed experiences with care coordinators:

“...I never ever felt when she took over my case that I was being judged. And I think there is nothing worse than when this happened in the past, some of them it felt like they were throwing it back in your face sometimes.”

**Going beyond their role.**

Participants spoke of some care coordinators going beyond the requirement of their role and expectations, and were particularly appreciative of support they received during difficult times.

Where care coordinators were perceived as going beyond their remit, this was spoken about with significance and appreciation:

“I said I’m dreading it, here we go again. She said right ok I’ll be back at three o’clock, I’ll sit in on the meeting with you. I said are you sure you’ve already been out. “No” she said “I’ll be back”. And she’d never met the new social worker and she did, she came out and sat with me to put her side across of how I am, what I am doing now, and I tell you what she is worth her weight in gold. That meant more to me than anything else that.” (Fiona)

Participants described care coordinators as supporting them through difficult life events, going beyond their obligations:
“...she came with me, she took me to the undertakers and she came in the room with me to see my Nan. And it was like, she didn’t have to do that... The next day on Wednesday she came to the ward, picked me up, took me to the crematorium and came into the service. She didn’t have to.” (Georgina)

For Helen it was important that her care coordinator understood what might be difficult for her and took a risk to ensure she was ok:

“...it was the first funeral I had been to of somebody that is my age. And my care coordinator actually took me out for lunch afterwards, even though we are not really supposed to, because she just wanted me to be around somebody after going to the funeral that was kind of going to make sure I was ok and just look after me and see how I was, and talk through it with me as well.”

3. The Complexity of the Relationship

Participants described the complexity of relationships with their care coordinators, describing them as “one-sided” and feeling it was unusual to be in a relationship focussed on them. This was experienced as different from other relationships. The importance of personal and professional boundaries was also highlighted, determining the differences between a relationship with a care coordinator and a friend.

One-sided relationship.

For Anna the one-sided focus was challenging in developing the relationship:

“Well it’s different because it’s all about me. With other relationships there is a lot more give or take but with her...she’s just there to help me. I get to be a bit...selfish. And that was really difficult at first because it felt really uncomfortable that I was
having a relationship with someone that was all about me. Because that is actually really unnatural isn’t it?”

For some there was conflict with being interested in their care coordinators’ lives and the impact of how this knowledge might affect their relationship:

“Partly just because I’m nosy and I want to know stuff about her. But also partly for the reason that she doesn’t want me to know about her, like if I feel I want to know what she feels about something or if I feel like she might be making some judgement on me… and if I know stuff about her then maybe I could guess what she is thinking. That is probably exactly why it is helpful for me not to know stuff about her.” (Anna)

Georgina was concerned about the impact she might have on her care coordinator:

“…they must have this mechanism where they can take on board empathy but shut down their emotions, do you know what I mean, so it doesn’t upset their life, intrude on their personal space…”

Boundaries.

Boundaries were talked about extensively by all participants. Consideration was given to what defined the relationship as different from friendship and how this distinction was maintained. This was discussed with the responsibility for maintaining boundaries lying with care coordinators.

In Beth’s experience her care coordinator demonstrated professionalism, however she felt that she could connect with them:

“I wouldn’t say like friends, it’s not like we went out…but within the constraints of four walls he was someone that I would almost relate to.”
Fiona’s more positive experiences of care coordinators were marked by feeling that the relationship was similar to close friendship:

“Well the previous ones have sort of listened but it’s like when you’ve got a really good best friend, you know. When you’ve got borderline personality disorder it’s like a best friend coordinator if that makes sense.”

The responsibility for maintaining professional boundaries was perceived as lying with care coordinators:

“...because obviously with my diagnosis it is possible to have relationships that aren’t 100% what they are supposed to be and I think that’s kind of up to the care coordinator as well to kind of lead the boundaries and where they are supposed to be.” (Beth)

There was also a sense that whilst the relationship may feel informal it was important to believe that a care coordinator would act professionally when necessary:

“...so even though I feel comfortable telling her whatever I am going to tell her I know that she is going to still do the professional thing as a care coordinator and what she needs to do for that. So we can have a chat, we can have a laugh, but once I’m gone I know that she has got to go again to do what she needs to do as a professional...” (Helen)

4. Developing a Safe Base

Feeling understood by care coordinators was viewed as important in developing relationships. Participants described how their needs were either met or not met by their care coordinators due to this understanding. Where care coordinators demonstrated good understanding, participants felt this facilitated better understanding of themselves. Lack of contact led to
fears of abandonment and damage to relationships. The perception of care coordinators as available and contactable during difficult times led to feeling supported or alternatively unsupported. The process and anticipation of relationships ending was met with mixed emotions. Taken as a whole these elements are understood as combining features consistent with a “safe base” within an attachment perspective.

**Feeling understood.**

All participants spoke of the importance of feeling understood by care coordinators. This was shown by care coordinators demonstrating understanding of their individual needs and characteristics:

“... they get to know you and I suppose the way you articulate, your behaviour I guess, I don’t know. They get to know when perhaps something is not quite right...”

*(Debbie)*

Fiona’s care coordinator’s ability to understand her needs led to her feeling optimistic about her future:

“You know all my needs are met at the moment, I know what’s wrong with me and so does my care coordinator. She knows my strengths, she knows my weaknesses and that just about sums it up. If they know your strengths and they know your weaknesses and you can work with them well then there’s no reason why you can’t improve your health.”

Beth discussed how her care coordinator built up their understanding of her over time:

“...even though they have so many people to care about they kind of pick up on bits from what you’ve told them before which you hadn’t even picked up on. It was just
like they really knew, or remembered things that didn’t seem that significant at the
time but actually were able to come back and say...“do you remember when?”.”

Georgina’s care coordinator’s understanding of her was critical at times when she was
unwell:

“...you don’t know you are unwell and the only person who is connecting with you is
my care coordinator. Because she knows me inside and out all this time and although
you see different psychiatrists- they do get to know you- but she has been the rock all
the way and she’s been the same person all the way along.”

Not feeling understood.

Participants discussed times when they had not felt understood by care coordinators. Debbie
discussed an experience where her care coordinator’s understanding of a situation was
different to her own, meaning she was unable to get the help she required:

“She felt that I was annoyed with her and I said to her “I just can’t keep still at the
moment, I’m not in a good place”. She didn’t get it because she thought it was
related to the fact that I had to wait for her to finish a phone call, and it had nothing
to do with that.”

Not feeling understood led to some participants feeling that care coordinators would be
unable to help them:

“I felt like I didn’t want to talk to them you know, if they didn’t understand me they
are never going to come up with something different, they are not going to turn my
life around.” (Fiona)

For Anna the impact of not feeling understood led to feelings of hopelessness:
“Sometimes you just feel like people aren’t listening and I get kind of frustrated, well I used to get really frustrated when people wouldn’t listen. And it was like a couple of times where I was just inconsolably crying because I just couldn’t work out what was going on, everything was so overwhelming and they didn’t seem to help, they just seemed to either sit there and do nothing...”

For Claire, feeling that her care coordinator did not understand her needs led her to question the purpose of their relationship:

“And they are supposed to help me, not be another source of stress.”

**Understood as an individual.**

Participants spoke about the importance of being viewed and understood as an individual and the impact this had on the support they received. For some their diagnosis of BPD overshadowed this.

For Anna the significance of being valued and understood as an individual related to the type of support she was offered:

“Looking back I feel that it was really good that she didn’t just go on my diagnosis, she went on me as an individual sort of thing and she was right because it was one of the things that has helped me the most.”

In Beth’s experience being viewed as a person by her care coordinator had significant positive consequences:

“I had an amazing guy where I used to live who could see me as a person and would just sit with me and have conversations that were really helpful rather than just talking about what was happening. He would be like “maybe we could try this” and
actualy be giving me things to try and do. It sounds a bit silly now but he went through an example with me and basically it changed my life. That day I stopped self-harming.”

Claire’s experience was the opposite, believing that her diagnosis negatively affected her care coordinator’s perceptions and the help she received:

“I feel like once you get a diagnosis of BPD they sort of act like you are kind of beyond their...bother. Like they don’t especially want to do anything because you are not going to be easy.”

For Claire a key motivator for discussing her experiences was to highlight the significance of this:

“I was mainly hoping that I could just put forward like the idea that it would be helpful, like having BPD...for care coordinators to know it was more helpful to be treated less as a diagnosis.”

Beth’s experience of negative attitudes and the connotations of her diagnosis affected how her difficulties were understood:

“You’d be thinking that they would be empathetic and kind of know what you are feeling. Like that they would know your diagnosis but then they would be able to see you as a person rather than just being able to see...see beyond the diagnosis and beyond the behaviour that sometimes people with BPD can display. And yeah just seeing the person who is actually struggling rather than just seeing the diagnosis.”

For Claire the attitudes towards her diagnosis led to her feel that her views were not valued or understood, leaving her feeling shamed:
“So I asked to change and then I was told by the duty person, “oh no you can’t change it’s your illness that makes you not like her”, and she made me have a meeting with her and my care coordinator and tell her to her face that I didn’t like her…it just felt like she was trying to shame me and belittle me.”

Several participants were left feeling de-individualised as a number on a caseload with little meaning or value to care coordinators:

“Sometimes I just feel as though I am a tick box and I’m being seen for the sake of being seen.” (Debbie)

“I think one of the biggest things is feeling really like a number to them. So it’s like oh I’ve got another person to fit in, and it’s just like I mean nothing to them.” (Claire)

“...we are real people, we are not just a number coming through the system and I think to hear...when my friends say about it they say we are just a figure, we are just a number in the book and they just put a line through our appointment....and that’s horrible.” (Georgina)

**Enabling understanding of self.**

Some participants described that feeling understood by their care coordinators led to them gaining an enhanced understanding of themselves:

“Someone who knows about your conditions and how to help you. Like, you know, that’s your mental health talking, that’s that talking. So helps you see that you are not maybe the way you see yourself. That it’s your mental health, and making you see that you’re not actually that person you think you are in a negative way. They just help you see a different way of dealing with things as well.” (Emily)
Debbie spoke of an experience where her care coordinator’s understanding allowed her to make discoveries about herself:

“Sometimes he was very good at linking things, making connections, where I quite often couldn’t see a connection. But he would pick up that connection and say well are you feeling anxious because last week you said this that and the other...he managed to link a lot of things actually which I never saw myself...”

Available of care coordinator.

Feeling that care coordinators would available during difficult times was significant for participants:

“...just knowing they are there on the end of a phone, or would come and see you if needed. It kind of frees you to get on in a funny way, just knowing they are there.”

(Emily)

In contrast a lack of availability was talked about when discussing negative experiences of care coordinators:

“He would only kind of step in and be there when I was in crisis which wasn’t what I needed. I kind of needed somebody about twenty-four seven.” (Helen)

Where participants were actively seeking help or support, the impact of care coordinators not responding led to them feeling unimportant and devalued:

“You know when I ring. If she didn’t pick up...obviously if she has to go out on a call I know, but if I hadn’t heard from her for like 3 or 4 days and she hadn’t returned my call, that would then leave me thinking has she got my message, or she’s got my
message and she’s not bothered and it’s like she doesn’t seem to realise the importance.” (Georgina)

Anna talked of feeling abandoned, with the consequence that her relationship with her care coordinator had to be repaired:

“I feel like she has abandoned me basically... usually if I see her and it has been ages we have a really awkward appointment where I feel like she is a kind of stranger again and we are trying to like...I dunno...trying to build a relationship again because I feel really distant from her then.”

Endings.

The experience and process of relationships ending with care coordinators was discussed by all. For Claire who was soon to be discharged from services, the loss of a care coordinator was met with conflicting emotions:

“Mixed emotions of “oh great I’ve been waiting for this for years”, but then on the flip side that “oh gosh, oh dear, panic, panic”. ”

Anna reflected on the impending end of her relationship with her care coordinator and challenges this might present her with:

“...I’ve learnt all I need from this person and they have done that so I can do the next bit of my life which doesn’t involve them sort of thing, so I am really hoping I can get to that point with my care coordinator, but...yeah it’s going to be really hard.”

Helen spoke about the significant loss of her care coordinator leaving and her lack of control over this:
“I was really gutted actually, I was very disappointed...I was really getting on with her very well, she was very helpful and I was like I have to deal with this change so I will be ok, this is going to happen and I will have to deal with it. But I didn’t think I would get anyone as good as her...”

Several participants spoke of fearing their relationships ending. For Georgina short periods of separation from her care coordinator triggered fear:

“I love when she goes on holiday because she needs it. But I worry; she knows I worry that she won’t come back.”

Helen talked of requiring constant reassurance from her care coordinator about the likelihood of leaving:

“I probably shouldn’t say this on record but I said to her you need to let me know if you buy any tickets to go abroad, you need to let me know if you have any unprotected sex...I need to know if you are going to get pregnant. I said you need to sign a contract...and I said I need to know if you put in any job applications.”

Helen suggested that she would joke about this with her care coordinator but stressed the importance of knowing what might happen:

“So I am hoping she understands that I am serious about it and that she will give me a lot of warning and a lot of support on how I am going to move onto another care coordinator.”

Claire shared similar views, wishing she had been informed in advance of her care coordinator leaving:
“...and also being communicated with...like “you’re going to have a new person, I’m going to be leaving now”. Rather than being phoned up by somebody else and saying that they’ve left. I get that they might leave in a hurry but my first one and my third one, they didn’t tell me themselves when they could have done.”

**Discussion**

**Summary of Findings**

This research intended to explore the experiences of eight individuals diagnosed with BPD with their relationships with their care coordinators from CMHTs. Analysis of the transcripts using IPA identified four superordinate themes in participants’ accounts, *Trust, Qualities of the care coordinator, The complexity of the relationship* and *Developing a safe base*. The first three themes are viewed as contributing to the final theme, *Developing a safe base*.

Trust was described as key to the establishment and maintenance of relationships with care coordinators. This developed over time and impacted on what participants felt they could share with care coordinators. The fragility of trust was discussed and easily lost through the actions of care coordinators. Key to the development of relationships was the realisation that trust could be reciprocated by the care coordinator. Theorists have proposed that disturbed early parent-child relationships and maltreatment play a role in the development of BPD, leading to difficulties with interpersonal trust (Bateman & Fonagy, 2003; Holmes, 2004). Erikson (1950) theorised that early experience of chaotic abusive attachments leads to a lack of ‘basic trust’ and those that have experienced this find it difficult to express their distress or ask for help in a constructive manner.

The findings were consistent with Langley and Klopper (2005), concurring that to facilitate trust consistency is key, and that clinicians must counter expectation by being accessible,
reliable and honest in order for clients to feel emotionally and physically safe. As in the current study, trust was viewed as key in laying down the foundations of the therapeutic relationship (Langley & Klopper, 2005). Over time the relationship may be internalized enabling clients to trust others and function more independently (Harris & Bergman, 1987). The findings were also consistent with McHale and Deatrick (2000) who found that in all healthcare relationships trust takes time to develop, exists on varying levels, and has its basis in shared intentions, mutuality and expectations.

Within the Building Trust sub-theme the professional and containing response of care coordinators was viewed as important. This links with Winnicott’s (1965) idea of the holding relationship, where a significant object (in this case care coordinator) is able to act as a ‘container’ for their client’s emotional difficulties. In this way the client is reassured that that care coordinator is there to help them when required.

The development of personality disorders has been postulated as occurring due to the failure of a nurturing early environment and the development of a ‘secure base’ (Holmes, 1999). Bowlby’s attachment theory (1988) seems pertinent to the care coordinator relationship, hypothesising that this is “the propensity of human beings to make affectional bonds to particular others” (p.201). Attachment occurs as a consequence of a child’s need to remain in physical and psychological contact with their primary carer during threatening circumstances. Within normal childhood development, a secure attachment may develop, providing a safe base from which a child can explore their environment and relationships, returning to this secure base as needed. Ainsworth (1965) additionally viewed attachment as affecting the entire life cycle whereby relationships are internalised, informing an internal working model against which future relationships will be compared. Bowlby (1988) identified the working model as comprising two main components concerning the child’s concept of others and of
themselves; whether or not the attachment figure is dependable and responsive when needed, or whether or not the self is worthy of response from others, particularly carers.

The themes of Availability, Judgements, Feeling understood and Understood as an individual may be seen as integral in fostering an internal working model of a secure attachment. Bateman and Fonagy (2008) have emphasised the importance of forming a secure attachment relationship with healthcare professionals, that is consistent, boundaried, trusting and collaborative. Within their model of Mentalization-based treatment (MBT) for BPD, Bateman and Fonagy (2008) identified that a secure attachment relationship is important for the individual to learn to mentalize. Through the ability to mentalize it is possible to make sense of each other and ourselves, which can be achieved by the therapist mirroring emotions and providing a consistent and secure base for safe exploration of relational problems (Bateman & Fonagy, 2008). The themes of Feeling understood and Enabling understanding of self, viewed as integral in the development of a secure base within the care coordinator and client relationship, seem linked with the therapeutically beneficial processes of MBT.

The themes of Judgements and Feeling understood as an individual seem to highlight that for participants, forming an attachment relationship whereby validation and acceptance occurred was viewed as helpful. Elements of Linehan’s (1993) Dialectical Behavioural Therapy model of validation, acceptance and change seem relevant here to relationships with care coordinators.

Critical Evaluation

Limitations.

Whilst this analysis captures a comprehensive picture of the relationships considered for this particular group, the findings must be approached tentatively as this is a small scale study in a
particular location. Qualitative research does not have the intention of generalising findings to the wider population (Lyons & Coyle, 2007), however through generating related themes within the sample it is possible that these may be pertinent to a comparable group (Smith & Osborn, 2003). It is hoped that this may contribute to a greater understanding of the experience of relationships between those diagnosed with BPD and their care coordinators.

Those who participated in the study may have been motivated by particular positive or negative experiences of care coordinators. It is also important to consider that not all potential participants were equally likely to step forward. Care coordinators may have preferred to approach clients with whom they had predominantly good working relationships, however this was counteracted by four participants who were recruited independently via posters. Whilst the sample was homogenous, the all-female sample does not give consideration to the experiences of males diagnosed with BPD.

Whilst some information about participants such as total number of care coordinators they had worked with, or experience of therapy, was noted from discussion in interviews in Appendix F, further specific details were not available as this data was unfortunately not explicitly collated.

It is hoped that semi-structured interviews were helpful in facilitating participants to speak openly, however the implications of interviews being carried out at CMHT bases was not fully considered prior to the study. Interviews were held there due to lone working concerns, however the space was not neutral for participants. The rooms utilised for the interviews may have served as a memory echo associated with meeting and working with other professionals within them. This felt pertinent to those describing negative experiences of care and how this may have impacted them. However all participants were aware of the location prior to interview and were in agreement when consenting to participate.
The quality and credibility of the research was revisited and re-assessed following the guidelines of Elliot et al. (1999) (Appendix I).

**Clinical Implications**

This study provides an understanding of how secure attachments may develop in relationships with care coordinators. Participants’ accounts indicate what helps in experiencing a positive relationship, as well as what is unhelpful. Holmes (2004) theorised that when insecure attachments between individuals diagnosed with BPD and healthcare services develop, recovery is less likely. As such Holmes (2004) highlighted the importance of engagement, consistency and long-term commitment in relationships with therapists in order to lessen those features characteristic of BPD which threaten the success of relationships. This is supported as these factors were all discussed by participants as valuable in their relationships with care coordinators. The current research suggests that the care coordinator relationship is equally that of an important care giver and therefore how to foster the secure base should be at the forefront of care for those diagnosed with BPD. Bateman and Fonagy (2000) identified key features for effective treatment for people with BPD which included nurturing a powerful attached therapy relationship. The current research supports this, suggesting that it is imperative this be considered within the context of valuable and meaningful care coordinator relationships.

To support the development of secure attachments within these relationships, this research has reiterated factors such as longevity, trust, availability and understanding, as highlighted by participants. Careful consideration should also be given to the allocation of care coordinators in ensuring an appropriate ‘match’, enabling supportive relationships to develop.

Whilst the role of care coordinator is not specifically defined as therapeutic, this research has demonstrated the potential for this relationship to be therapeutically beneficial. It is pertinent
to consider the literature suggesting that therapeutic alliance is the best predictor for treatment outcome, regardless of therapeutic modality (Martin et al., 2000; Lambert & Barley, 2001), and how this may be relevant within the care coordinator relationship. Whilst care coordinators may not be trained in developing therapeutic relationships or in specific psychotherapeutic modalities, the quality of relationships with their clients can be considered an essential factor in recovery.

**Future Research**

The findings indicate the importance of the development of secure attachments in facilitating helpful and therapeutically effective relationships between those diagnosed with BPD and care coordinators. Given the existing literature considering the impact of professionals’ negative attitudes towards BPD (Cleary et al., 2002; Deans & Meocevic, 2006; Black et al., 2011) it is important to consider how these stigmatising attitudes affect the development of a secure attachment. The findings might also be explored within the context of clinicians experiencing high levels of burnout and feelings of helplessness in relation to treating those with BPD (Cleary et al., 2002) and how this may prevent the development of secure attachments. It would be of further interest to consider how the findings might be used in team formulation to support groups of professionals to develop shared understanding of a person’s difficulties, particularly in terms of helping others understand the person behind the diagnosis of BPD (Johnstone & Dallos, 2014).

As the care coordinator is a generic role drawn from various professional backgrounds, such as nursing and social work, it is likely that approaches towards relationships differ. Participants commented on the importance of professional role, skills and knowledge, implying different experiences with different care coordinators. Future studies might consider this to identify techniques drawn from various therapeutic models that are integrated
into the non-specifically therapeutic role of care coordinator, as well as evaluating the impact of tailored training.

The therapeutic alliance built within the care coordinator and client relationship warrants further consideration, particularly in terms of personal attributes or activities positively influencing the alliance, indicated as important from this research. Whilst it was not within the scope of this research to account for care coordinators’ views of the relationships, further research might consider the relationship from this standpoint.

**Summary and Concluding Comments**

The role of care coordinator was discussed by all participants as encompassing a variety of different activities from practical support such as arranging accommodation, to emotional support such as accompanying clients to funerals. This varied role involves a number of complex interactions, and whilst the relationship is not viewed as intentionally or overtly therapeutic, or driven by any one particular model, what can be understood is that this relationship has the potential to be beneficial or alternatively counter-therapeutic for those diagnosed with BPD receiving care from a CMHT.

This study adds to Nehls (2001), the only qualitative study examining a similar relationship, in confirming many of the themes identified in the original study but also illuminating how many of the factors discussed within the themes give rise to or inhibit the development of a secure attachment. Nehls (2001) hypothesises that the relationships between case managers and clients may be the “most potent therapeutic factor within case management” (p. 9) but does not consider how this role nurtures the development of a ‘safe base’ and secure attachments. This research goes further by providing an understanding of the processes in building and maintaining these attachment relationships and their importance in supporting or
hindering recovery. It is hoped that the findings may inform the theory and practice of how those diagnosed with BPD may be optimally supported in the community.
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Health Research Authority
NRES Committee South Central – Hampshire B
Level 3, Block B
Whitefriars
Lewes Mead
Bristol
BS1 2NT

E-mail: nrescommittee.southcentral-hampshireb@nhs.net
Telephone: 0117 342 1384

26 August 2015
(revised 01 September 2015)

Miss. Louise Bradbury

Dear Miss. Bradbury

Study title: A qualitative exploration of the relationship between clients with a diagnosis of Borderline Personality Disorder and their Care-Coordinators within the community mental health setting.

REC reference: 15/SC/0439
IRAS project ID: 168977

Thank you for your letter of 19 August 2015, responding to the Committee’s request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair, together with Ms. Ita Berry.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this favourable opinion letter. The expectation is that this information will be published for all studies that receive an ethical opinion but should you wish to provide a substitute contact point, wish to make a request to defer, or require further information, please contact the REC Manager, Miss Maeve Groot Bluemink, nrescommittee.southcentral-hampshireb@nhs.net. Under very limited circumstances (e.g. for student research which has received an unfavourable opinion), it may be possible to grant an exemption to the publication of the study.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.
Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

- The Committee raised concerns about the procedure for returning the Reply Slip. It considers that it should be returned directly to the researcher, not to the care coordinator or team manager. Therefore, the Committee requested that the second paragraph is replaced by: "I would like to discuss the study further and can be contacted as indicated below." and the final boldface sentence should be replaced by "Please post this completed Reply Slip back to ...." to be followed by the name and address of the researcher.

Recommendations:

- In the PIS the Committee noted that there is a small issue regarding the consistency of the statements regarding the limits of confidentiality. In the section "What will my involvement require" the wording used is "the researcher would talk with you before", while in the section headed "Will my taking part in the study be kept confidential" it is said that "This would usually be discussed with you first". In order to cover all eventualities, the Committee recommends inserting the word "usually" in the first statement so that it reads "the researcher would usually talk with you before".

- Regarding the reply slip, the Committee recommends you supply stamped addressed envelopes.

- On the Reply Slip the Committee recommends that in the first paragraph the word "them" should be replaced by "the researcher", so as to avoid any possible confusion about who would be asking the questions.

NOTE: The Committee noted in the Service User Consultation document, that development of the Interview Schedule is ongoing. Please be reminded that any changes to this would require a formal amendment, and that could be minor or substantial, depending on the nature of the changes proposed but in any case the REC should be sent any new version, as is the case for the above recommended changes.

You should notify the REC in writing once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. The REC will acknowledge receipt and provide a final list of the approved documentation for the study, which can be made available to host organisations to facilitate their permission for the study. Failure to provide the final versions to the REC may cause delay in obtaining permissions.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research
Application System or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database. This should be before the first participant is recruited but no later than 6 weeks after recruitment of the first participant.

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to request a deferral for study registration within the required timeframe, they should contact hra.studyregistration@nhs.net. The expectation is that all clinical trials will be registered, however, in exceptional circumstances non registration may be permissible with prior agreement from the HRA. Guidance on where to register is provided on the HRA website.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

<table>
<thead>
<tr>
<th>Document</th>
<th>Version</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Copies of advertisement materials for research participants</td>
<td>2</td>
<td>22 June 2015</td>
</tr>
<tr>
<td>Covering letter on headed paper [Response to REC]</td>
<td>1</td>
<td>13 August 2015</td>
</tr>
<tr>
<td>Evidence of Sponsor insurance or indemnity (non NHS Sponsors only)</td>
<td>1</td>
<td>03 March 2015</td>
</tr>
<tr>
<td>Evidence of Sponsor insurance or indemnity (non NHS Sponsors only)</td>
<td>2</td>
<td>11 August 2015</td>
</tr>
<tr>
<td>Interview schedules or topic guides for participants</td>
<td>1</td>
<td>28 June 2015</td>
</tr>
</tbody>
</table>
Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document “After ethical review – guidance for researchers” gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website:
http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/
HRA Training

We are pleased to welcome researchers and R&D staff at our training days – see details at http://www.hra.nhs.uk/hra-training/

15/SC/0439 Please quote this number on all correspondence

With the Committee’s best wishes for the success of this project.

Yours sincerely

[Signature]

Professor Ron King
Chair

Email:nrescommittee.southcentral-hampshireb@nhs.net

Enclosures: “After ethical review – guidance for researchers” [SL-AR2]
07 September 2015

Miss. Louise Bradbury

Dear Miss. Bradbury

Study title: A qualitative exploration of the relationship between clients with a diagnosis of Borderline Personality Disorder and their Care-Coordinators within the community mental health setting.

REC reference: 15/SC/0439
IRAS project ID: 168977

Thank you for your letter of 01 September 2015. I can confirm the REC has received the documents listed below and that these comply with the approval conditions detailed in our letter dated 28 August 2015.

Documents received

The documents received were as follows:

<table>
<thead>
<tr>
<th>Document</th>
<th>Version</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>IRAS Checklist XML [Checklist_04092015]</td>
<td></td>
<td>04 September 2015</td>
</tr>
<tr>
<td>Other [Reply Slip Version2 - tracked changes]</td>
<td>2</td>
<td>01 September 2015</td>
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<tr>
<td>Other [Response Letter to REC]</td>
<td>1</td>
<td>01 September 2015</td>
</tr>
<tr>
<td>Participant consent form [Track Changes]</td>
<td>5</td>
<td>01 September 2015</td>
</tr>
<tr>
<td>Participant consent form [Consent Form]</td>
<td>5</td>
<td>01 September 2015</td>
</tr>
<tr>
<td>Participant information sheet (PIS)</td>
<td>5</td>
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<tr>
<td>Participant information sheet (PIS) [Track changes]</td>
<td>5</td>
<td>01 September 2015</td>
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</tbody>
</table>
Approved documents

The final list of approved documentation for the study is therefore as follows:

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<th>Document</th>
<th>Version</th>
<th>Date</th>
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</thead>
<tbody>
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</tr>
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<td>Covering letter on headed paper [Response to REC]</td>
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</tr>
<tr>
<td>Evidence of Sponsor insurance or indemnity (non NHS Sponsors only)</td>
<td></td>
<td>03 March 2015</td>
</tr>
<tr>
<td>Evidence of Sponsor insurance or indemnity (non NHS Sponsors only)</td>
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<td>11 August 2015</td>
</tr>
<tr>
<td>Interview schedules or topic guides for participants</td>
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<td>IRAS Checklist XML [Checklist_04082015]</td>
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<td>04 September 2015</td>
</tr>
<tr>
<td>Other [CV Draycott]</td>
<td></td>
<td>17 February 2015</td>
</tr>
<tr>
<td>Other [CV Orchard]</td>
<td></td>
<td>02 February 2015</td>
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<tr>
<td>Other [Evidence of Research Training]</td>
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<tr>
<td>Other [Public and Patient Involvement Group - record of consultation]</td>
<td>1</td>
<td>11 August 2015</td>
</tr>
<tr>
<td>Other [Response Letter to REC]</td>
<td>1</td>
<td>01 September 2015</td>
</tr>
<tr>
<td>Other [Reply Slip Version 2 - tracked changes]</td>
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<td>Research protocol or project proposal</td>
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<td>20 June 2015</td>
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<tr>
<td>Summary CV for Chief Investigator (CI) [CV Louise Bradbury]</td>
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<tr>
<td>Summary CV for supervisor (student research) [CV Kate Gieeson]</td>
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</tbody>
</table>

You should ensure that the sponsor has a copy of the final documentation for the study. It is the sponsor's responsibility to ensure that the documentation is made available to R&D offices at all participating sites.

15/SC/0439 Please quote this number on all correspondence

Yours sincerely

Maeve Groot Bluemink
REC Manager

Appendix B: Research and Development Committee Approval
8 September 2015

Dear Louise

Re: A qualitative exploration of the relationship between clients with a diagnosis of Borderline Personality Disorder and their Care Coordinators within the community mental health setting.

Rec. Ref: 15/SC/0439

Thank you for submitting all the required documentation relating to the above study for Trust R&D approval.

I write to confirm that the study has Trust approval. The approval granted relates only to the specific Protocol V1 dated 29.06.2015, NHS R&D form 188977/839460/14/458. Any deviation from these documents will be deemed to invalidate this approval. The study must be conducted according to the Department of Health Research Governance Framework for Health and Social Care at http://www.dh.gov.uk. All material accessed in the Trust must be treated in accordance with the Data Protection Act (1998), The NHS Code of Confidentiality and Caldicott Principals.

We note that the local field supervisor for the study is Dr Melanie Orchard, and the academic supervisor is Dr Simon Draycott and Dr Kate Gleeson.

It is the responsibility of the Chief Investigator to ensure that the study is carried out in accordance with the protocol and the NRES favourable opinion letter dated 28.08.15. Amendments, including extending the project to other Trust sites, may require further approval.

The sponsor and / or the chief investigator must take appropriate urgent safety measures in order to protect research participants against any immediate hazard to their health or safety. Notification of any such action must be submitted to the relevant authorities and the R&D Office as agreed in the letter of agreement between the sponsor and the Trust.

The project must be completed within the timescale as set out in the Ethics application. If the project continues out of the timescale agreed, new permission(s) must be sought and obtained.
The Chief Investigator is to comply with the monitoring arrangements of the Trust by submitting quarterly reports; a template will be sent to you for your records. All publications relating to the study, and a final report for this project, to be sent to the Trust’s R&D Office. Kindly also submit a copy of the end of project notification submitted to NRES.

All external researchers who seek access to the Trust in relation to this study will need to obtain an honorary research contract by submitting a research passport, if appropriate, and be issued with a letter of access before entering Trust premises. Researchers who have a contractual relationship with an NHS body should submit the relevant documentation and request a NHS to NHS letter of access. Applications can be accessed on: http://www.ukcrcc.org/regulation/governance/researchpassport/

All parties to familiarise themselves and comply with Trust R&D policies and procedures, available on the Trust website:

Failure to comply with any of the above may result in withdrawal of Trust approval.

Please do not hesitate to contact me if you wish to discuss any aspect of this approval.

I wish you well with your study.

Yours Truly

R&D Facilitator
On behalf of the R&D Office

CC:

Dr Simon Draycott – University Supervisor
s.draycott@surrey.ac.uk
Dr Kate Gleeson – University Supervisor
Kate.gleeson@surrey.ac.uk
Appendix C: University of Surrey Research Approval

Miss Louise Bradbury
School of Psychology
Faculty of Health and Medical Sciences

11 September 2015

Confirmation of sponsorship by the University of Surrey

Dear Miss Bradbury,

Study title: A qualitative exploration of the relationship between clients with a diagnosis of Borderline Personality Disorder and their Care-Coordinators within the community mental health setting.

NHS REC reference: 15/SC/0439
University of Surrey reference: SPON/2015/014/FHMS

I am writing to confirm that the above study has satisfied the requirements of the University of Surrey Research Integrity and Governance Office. We are pleased to confirm that the University of Surrey, as a recognised Sponsor under the Department of Health’s Research Governance Framework for Health and Social Care, agrees to act as a Sponsor for your study on the basis of the documentation listed in the NHS REC Favourable Ethical Opinion letter of 07 September 2015.

Your study does not require review by a University of Surrey Ethics Committee. Permission to start recruitment is given provided that you comply with the conditions listed in your NHS REC Favourable Ethical Opinion letter and any additional condition letter(s). These conditions include, but are not limited to:

- Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.
- All clinical trials must be registered on a publicly accessible database before the first participant is recruited but no later than 6 weeks after recruitment of the first participant.

Ongoing sponsorship by the University is further subject to satisfactory reporting of the following to the Research Integrity and Governance Office as well as the NHS REC where they request this:

- Submitting substantial and notifying minor amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Serious Adverse Events and Suspected Unexpected Serious Adverse Reactions
- Progress and safety reports
- Notifying the end or early termination of the study or extension of the study beyond the expected end date

Please also ensure that you and your study staff are familiar and act in accordance with the University of Surrey’s Code on Good Research Practice and the Ethical Principles and Procedures for Teaching and Research.

Yours sincerely,

[Signature]

Dr Sophie Wehrens
Research Integrity and Governance Officer

Copy to. Dr Simon Draycott, School of Psychology, FHMS
Appendix D: Participant Information Sheet

Participant Information Sheet  Version 5, 01.09.15

A qualitative exploration of the relationship between those with a diagnosis of Borderline Personality Disorder and their Care-Coordinators within the community mental health setting.

Name of Researcher: Louise Bradbury, Trainee Clinical Psychologist

This information sheet invites you to take part in a research study. Before you decide whether or not you would like to participate it is important that you understand why the research is being done and what it would involve for you. Please take the time to read the following information carefully.

What is the purpose of the study?

The aim of the study is to explore how people with a diagnosis of Borderline Personality Disorder (BPD) experience their relationships and interactions with their care-coordinators in a community setting. The study is interested in finding out about the experiences of those who have been in receipt of care-coordination whilst being supported by a Community Mental Health Team (CMHT) or Community Mental Health Recovery Service (CMHRS). It is hoped that this research may help mental health professionals to have a greater understanding of these experiences and to hopefully build upon and improve the support and services that they offer to those with this diagnosis.

Who is carrying out the study?

Louise Bradbury is a Trainee Clinical Psychologist and the study will form part of her Doctorate in Clinical Psychological at the University of Surrey. The study is being conducted with the full knowledge and support of the [redacted] Trust.

Why have I been invited to take part in the study?

You have been invited to take part in this study because you have a diagnosis of Borderline Personality Disorder and have experience of a relationship with an allocated care-coordinator from your local CMHT/CMHRS.

Do I have to take part?

No, you do not have to participate. The researcher will explain the study and go through this information sheet with you, answering any questions you may have. If you are interested in taking part the researcher will then invite you to sign a consent form prior to the interview to show that you have understood this information sheet and have agreed to take part. You can change your mind and withdraw from the study up until the point of analysis of the data, without giving a reason. Should you wish to withdraw from the study at this point any data you provided will be destroyed and will not be included in the study. Please also note that there will be no adverse consequences in terms of the care or treatment you receive if you decide not to participate.
What will my involvement require?

If you decide that you would like to take part, you will be required to attend an interview with the researcher which will last up to 60 minutes. You will be interviewed about your experiences of your relationship and interactions with your care-coordinator. With your consent the interview will be audio recorded and transcribed by the researcher.

The interview will be held at your local CMHT or CMHRS. However, it is important that you are aware that the researcher does not work for the team and that the content of the interview will remain confidential. Your care coordinator will be aware that you have taken part in the study but will not be aware of what has been discussed in the interview. As with any contact with services, the researcher would only break that confidentiality should they feel that there is a risk of harm to yourself or to someone else. If they thought that this might be the case, the researcher would usually talk with you before discussing the information with anyone else.

Whether or not you choose to participate, it will not make any difference to the services you receive from your CMHT or CMHRS, or any other service.

What are the possible disadvantages or risks of taking part?

This research will hopefully provide you with an opportunity to discuss your views about your relationship with your care coordinator, however, sometimes it can be difficult to talk about your experiences, especially when they arouse strong feelings. You will not have to talk about anything that you don’t want to talk about.

The researcher is currently training to be a Clinical Psychologist, which means that they have experience of working with people with a variety of difficulties who may be distressed. There will be time at the end of the interview to talk about how you are feeling. However, should the interview leave you feeling distressed, they will discuss with you how best to arrange for you to talk to your care coordinator, another professional that you know, or duty worker, following the interview. Should you not feel comfortable with talking to your own care coordinator about this you can also contact the Crisis Helpline or [contact information removed].

What are the possible benefits of taking part?

It is unlikely that you will benefit directly as a result of taking part in the research. However, previous studies of this kind have found that some people enjoyed having the opportunity to talk through their experiences with someone who is not involved in their care or treatment.

In the long term it is hoped that the results from this research will help to improve services for those with a diagnosis of BPD.

What happens when the research study stops?

You will continue to receive support from your care-coordinator.
The results from this study will form part of a research project that will be submitted to the University of Surrey as part of a Doctorate in Clinical Psychology. It will be read by a variety of people, but there will be no identifiable information about you contained in the final report. Providing the research passes examination, it is hoped that it may be published in an appropriate journal. The results will also be made available to anyone who participates in the study should you wish to see a summary of the findings.

What if there is a problem?

If you have any concerns about any aspect of this study you can contact the researcher, Louise Bradbury who is the chief researcher (Details are at the end of this Information Sheet). If you remain unhappy and wish to make a formal complaint, you may do this by contacting the Research Supervisor, Dr. Simon Draycott (01483 686 886 s.draycott@surrey.ac.uk) or programme director Ms. Mary John (01483 689267 m.john@surrey.ac.uk).

Will my taking part in the study be kept confidential?

Yes. All of the information about you during the research will be handled in the strictest confidence. All information about you collected during the course of the research will be kept strictly confidential, and all of your identifying details removed so that it is anonymous. Therefore, no-one reading the study will be able to know whether or not you have taken part.

Personal data will be handled in accordance with the Data Protection Act 1998. Research data will be stored for at least 10 years in line with the University of Surrey policy.

Should you disclose that you or someone else is at risk then the researcher may need to report this to an appropriate authority. This would usually be discussed with you first.

Who has reviewed the study?

All research in the NHS is looked at by an independent group of professionals, called a Research Ethics Committee, which is there to protect our safety, rights, wellbeing and dignity. The study has been reviewed and received a favourable ethical opinion from the NHS Research Ethics Committee and the University of Surrey Faculty of Arts and Human Sciences Ethics Committee.

Thank you for taking the time to read this Information Sheet.

If you would like to participate in this research or would like to hear more information please complete the attached Reply Slip and post this to Louise Bradbury at the address detailed on the Reply Slip. Your contacts details will be passed to the researcher Louise Bradbury, who will contact you via telephone to talk through this Information Sheet with you and answer any questions which you may have. If you would still like to participate then a date and time will be arranged for the interview to take place.

If you would prefer to contact Louise Bradbury directly, her details are provided at the end of this Information Sheet. Please contact:

Louise Bradbury, Trainee Clinical Psychologist
University of Surrey
l.bradbury@surrey.ac.uk

Version 5, 01.09.15
REPLY SLIP, Version 2, 01.09.15

Study Title: A qualitative exploration of the relationship between those with a diagnosis of Borderline Personality Disorder and their Care-Coordinators within the community mental health setting.

Name of Researcher: Louise Bradbury, Trainee Clinical Psychologist

The researcher would like to understand more about your experience of your relationship with your care coordinator which will involve the researcher asking you questions about this during an interview. Further information about this is contained within the Participant Information Sheet, (Version 5, 01.09.15).

I would like to discuss the study further and can be contacted as indicated below.

Name: _______________________________________

Signature: ___________________________________

Date: _______________________________________

Please select:

☐ Telephone Telephone Number: _________________________

☐ Email Email Address: _____________________________

Please post this completed Reply Slip back to Louise Bradbury, C/O Kate Gleeson (Supervisor and Research Director) Faculty of Health and Medical Sciences, AP Building, University of Surrey, Guildford, Surrey, GU2 7XH.
Appendix E: Poster Advertisement

Do you have a diagnosis of Borderline Personality Disorder and currently have a care coordinator?

Would you be willing to talk about your relationship with your care coordinator during an interview with a researcher?

I am a Trainee Clinical Psychologist conducting a research project looking at these relationships as part of my Doctorate in Clinical Psychology at the University of Surrey. The study is being conducted with the full knowledge and support of [redacted] Trust and under the guidance of the University of Surrey.

If you are interested in taking part in the study please contact the researcher, Louise Bradbury, l.bradbury@surrey.ac.uk or your care coordinator who will be able to provide more information.

All interviews will be held at your local Community Mental Health Team at a convenient time. The interview will last no longer than an hour.

This study has been reviewed and received a favourable ethical opinion from the NHS Research Ethics Committee and the University of Surrey Faculty of Arts and Human Sciences Ethics Committee.

Please note that participation in this study will not impact on the care you receive in any way and all data obtained will be kept completely confidential.

Version 2, 22.06.15
## Appendix F: Participant Demographic Details

<table>
<thead>
<tr>
<th>Name</th>
<th>(Anonymised)</th>
<th>Age</th>
<th>Gender</th>
<th>Ethnicity</th>
<th>Years under care of current CMHT</th>
<th>Number of Care Coordinators</th>
<th>Time allocated to current Care Coordinator</th>
<th>Experience of Psychological Therapy</th>
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</thead>
<tbody>
<tr>
<td>Anna</td>
<td>31</td>
<td>Female</td>
<td>White British</td>
<td>7</td>
<td>1</td>
<td>7 years</td>
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<tr>
<td>Beth</td>
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<td>Female</td>
<td>White British</td>
<td>9</td>
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<tr>
<td>Claire</td>
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<tr>
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<td>5</td>
<td>1.5 years</td>
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<td>White British</td>
<td>12</td>
<td>3</td>
<td>10 years</td>
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<td>12</td>
<td>3</td>
<td>10 years</td>
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<td>Yes</td>
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<td>Fiona</td>
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<td>Female</td>
<td>White British</td>
<td>6</td>
<td>5</td>
<td>1.5 years</td>
<td>Yes</td>
<td>Yes</td>
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<td>10 years</td>
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<td>Yes</td>
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<tr>
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<td>White British</td>
<td>6</td>
<td>5</td>
<td>1.5 years</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Appendix G: Consent Form

Consent Form – Version 5, 01.09.15

PROJECT TITLE: A qualitative exploration of the relationship between those with a diagnosis of Borderline Personality Disorder and their Care-Coordinators within the community mental health setting.

Name of Researcher: Louise Bradbury, Trainee Clinical Psychologist

- I have read and understood the Participant Information Sheet Version 5, dated 1st September 2015. I have been given a full explanation by the researcher of the nature, purpose, location and likely duration of the study, and of what I will be expected to do. I have been given the opportunity to ask questions on all aspects of the study and have understood the advice and information given as a result.

- I understand that the research data collected during the study may be looked at by other individuals from the research team. I understand that all personal data relating to participants is held and processed in the strictest confidence, and in accordance with the Data Protection Act (1998).

- I understand that I will be asked to consent to the audio recording of my interview with the researcher.

- I understand that the final report from this study may use direct, anonymized and unidentifiable quotes from my interview.

- I understand that I am free to withdraw from the study prior to the point of analysis of the data without needing to justify my decision and without prejudice. Up until this point any data will be destroyed and will not be included in the study.

- I understand that in the event that I disclose that myself or someone else is at risk of harm the researcher may need to report this to an appropriate authority.

- I confirm that I have read and understood the above and freely consent to participating in this study. I have been given adequate time to consider my participation and agree to comply with the instructions and restrictions of the study.

I agree to take part in the above study:

----------------------------------------------------------------------------------------
Name of Participant       Date       Signature

----------------------------------------------------------------------------------------
Name of person taking consent       Date       Signature

Version 5, 01.09.15
Appendix H: Semi-Structured Interview Schedule

INTRODUCTION

- Re-introduce the research study and purpose of the interview.
- “I would like to understand more about your experience of your relationship with your care coordinator. I will be asking you some questions about this and am keen to hear about the different kinds of experiences that you have had whilst working with your care coordinator. This might mean talking about experiences that have been good and experiences that have not been good.”
- “Before we begin I would like to remind you that you do not have to talk about anything you do not wish to. If at any point during our discussion you feel upset, please let me know and we will decide whether you wish to continue.”
- “I would also like to remind you that anything you say within this interview will remain confidential and will not have an impact on the care you receive from the CMHT/ CMHRS or your care coordinator. However, if I am concerned that you or someone else might be at risk of harm I will have to break this confidentiality. Should this be the case I will discuss this with you in the first instance.”
- “Are you happy to begin?”

QUESTIONS

- Tell me about the kind of things a care coordinator does?
- What expectations did you have about your care coordinator and their role in your care?
  - What did you imagine they would be like?
- Has your experience of your care coordinator met these expectations?
  - How has it?
  - How has it not?
- Tell me about a positive experience you have had with your care coordinator?
  - How do you think this has affected you?
  - What impact has this had?
- Tell me about another experience that didn’t go so well?
  - How do you think this has affected you?
  - What impact has this had?
- How do you feel about your care coordinator? How big a part do they play in your life?
- What are the good things about your care coordinator?
- What are the less good things about your care coordinator?
- Can you tell me about any experiences with a different care coordinator?
  - How was this different?
- How is your relationship with your current care coordinator different to other relationships you have eg. with family members, friends, other professionals?
  - How does this relationship feel different?
- Is there anything else I need to know to help me understand more about your relationship with your care coordinator? Is there anything you would like to add?

ENDING AND DEBRIEF
Appendix I: Evaluating the Quality of The Research

a. Situating the sample

Demographic details of participants are contained within the Appendix, including brief details of length of time working with their current care coordinators and contact with CMHTS.

b. Grounding in examples

The process of analysis and interpretation has been demonstrated through excerpts from transcripts within the Results section. This allows for consideration of how accurately themes are reflected in participants’ experiences.

c. Providing credibility checks

As discussed a diary was kept throughout the research process to promote reflexivity and openly account for the influence of the researcher’s assumptions. Themes from these diary entries were discussed and addressed in supervision, and considered in light of the development of themes. The research supervisors carried out checks on the emergent themes from analysis in order to gain their perspectives on the data and challenge the researcher on their validity and relevance. Any discrepancies between researcher and supervisor were explored. Finally the researcher attended regular meetings with other doctoral researcher using qualitative methodology. These meetings were used to facilitate discussion on the process and validity of analysis, as well as for peer supervision.


d. Coherence

Elliot et al. (1999) advised that interpretations are presented in a way that tells a coherent narrative of the phenomenon being considered. This was supported through discussion with supervisors who reviewed the Results section.

e. Accomplishing general versus specific research tasks

It is advised that researchers do not overstate the relevance of their findings (Elliot et al., 1999), therefore the strengths and limitations are discussed in critique of the study within the discussion.

f. Resonating with readers

It is intended that the presentation of the research findings, including the examples taken from transcripts alongside the narrative of the researcher’s interpretations facilitates the reader’s understanding of the findings. The field supervisor, a Clinical Psychologist with expertise in community mental health care and BPD also reviewed the manuscript for readability and to consider relevance to other mental health professionals and participants.

Evaluating the quality of the research- Revisited

a. Owning one’s perspective

My interest in the experience of care coordination from the point of view of those with a diagnosis of BPD stemmed from my subjective experiences of witnessing these relationships handled poorly by professionals, as was anecdotally from clients I had worked with in a specific therapeutic setting for those with BPD. This led me to enter the research process with the assumption that the experiences I would hear about would be negative in the majority. When several participants contacted me via a poster in a CMHT waiting room I struggled
with the assumption that they might be motivated to participate based on significant negative experiences. Throughout the interview process this view was challenged by the seemingly positive experiences I heard about and a desire for some to extol the virtues of the good relationships with care coordinators. Any biases arising from these assumptions were acknowledged and discussed in regular supervision from field and academic supervisors. A self-reflexive research diary was also completed throughout the process which highlighted any biases as they arose.

d. Providing credibility checks

Credibility checks on the validity of themes were carried out in meetings with academic and field supervisors. The interpretations of the data was generally agreed on but in some instances themes were queried or further elaborated on. Through the supervision process the researcher was encouraged to consider questions such as what is not being seen when generating a theme and what is not being obviously spoken about, in order to illuminate more subtle interpretations of the themes discussed. Credibility of the data was audited solely by other psychologists, therefore consideration of themes from others such as those with a diagnosis of BPD may have helped bring different perspectives to the analysis during evaluation.

The researcher also attended regular meetings with peers utilising qualitative methodology for doctoral research. These meetings were used to discuss the process of analysis as well as being a space for peer supervision.

e. Coherence

The findings of the research have been categorised into broad master themes, superordinate and subordinate themes. These were then discussed in order to give a narrative of the findings
as it has been suggested by Elliot et al. (1999) that data should be presented in a way that provides a story or underlying structure of the phenomenon of interest. The research supervisors helped to ensure this was the case when reviewing the findings.

\textit{f. Accomplishing general versus specific research tasks}

Elliot et al. (1999) recommended that researchers be cautious in stating the relevance of their findings. The researcher was therefore careful to be mindful of this and any strengths and limitations of the research are discussed during the critique of the study.

\textit{g. Resonating with the reader}

It is hoped that the presentation of the findings, with the use of quotes from the interviews alongside the researcher’s interpretations of the data will sufficiently represent to the reader the phenomenon being investigated. It is also hoped that the findings are relatable to those who have a diagnosis of BPD and experience of relationships with care coordinators.
Appendix J: Excerpt from Analysed Transcript: Anna

I: so can you tell me the kinds of things that a care coordinator does?

Anna: umm well mine has like helped me with...she is a mental health social worker so she has helped me with benefits stuff and housing stuff as well as like having meetings with me to check in and see how I am doing. And she has referred me to therapies and stuff that she thinks would help me ummm and she has helped me like when I've been in crisis she's helped me like...get more support like more like going to inpatient or crisis house or whatever if that is what is needed. or just sort of had contact with me through a crisis and stuff as well.

I: Ok so that's quite a lot of different roles that they have. What about the kind of emotional support because you've mentioned some practical things.

Anna: yeah well for me it's been that she's been the consistent things all through. I know that's not true of everyone but I've had the same care coordinator for like, well since like 2008, so like 6 or 7 years.

I: So quite a long time really with the same person.

yeah...ummm so that has really helped me, the consistency and like having...
that person because I find it really hard to trust people. Like having that person that I can trust through like everything, different therapies or different problems I am having in my life.

I: so different times and different situations it's been someone who is really consistent that you feel that you can trust?

Anna: yeah. So like yeah like emotionally I think that's been the most important thing about her role.

I: ok. So did you have any care coordinators before this person?

Anna: No.

I: No. ok. So thinking back can you remember what your expectations were of what a care coordinator might do?

Anna: I didn't really understand it at all because I didn't really know anything about the system and also to start off with I wasn't referred for any therapy or anything... I would just see her... umm... so I don't really even know she was my care coordinator if you see what I mean? (Yeah) I was like this is just a person that I see from mental health services... ummm... so I guess then my expectation was just...
that she was there to support me like... in terms of my emotional problems and practical problems and stuff. Umm... and then I guess when I realised she was my care coordinator because she was talking about, I dunno like talked about it more as that was her role, and she was talking about... I think it was because I was going to see a psychiatrist for the first time... ummm... then... I don't know, I guess then my expectation was more like ok so she's there to ummm like if she can't give me the support I need to say ok what about this or what about that, then sort of ask those people and then we'll see if they can give me the support I need...

I: It sounds like she was a person who spoke to different people for you?

Anna: Yeah like my connection to any other help I might need if she couldn't give me that help.

I: And can you remember what you imagined it would be like? I know you said you didn't really know what that person was going to be like and what expectation you had because you didn't really know. But did you have an idea in mind of what you would like her to be like?

Anna: Ummm. It was a long
| Is it therapy? | time ago, I thought it would be kind of like therapy actually when I first saw her. You know, because it's like mental health services and I had only seen a counsellor before at university and I dunno like I had bits and pieces of contact with other CMHTs in other areas. But basically I had always left before it got to the stage of actually getting any help (ok). But yeah I guess I kind of thought she would be like a therapist and I would go and see her each week and like tell her my problems. But I also...I dunno I never thought I would trust her the way I trust her now and I always thought it would be a lot more like...well definitely to start with as well it was very like...I didn't trust her and like I probably like lied to her and stuff, or I kept stuff back. I took me a long time. So I guess my expectations was sort of that she would have this little role in my life and I could sort of limit it and be like...that's the stuff I talk to her about and that's like...I can control the borders of that very neatly and because...yeah...because I didn't really trust anyone and stuff.

| Expectations based on previous therapeutic relationships | Confusion - Is this therapy?

| hard to trust | 

| Looking for talking | 

| Trust takes time to develop | 

| Trust is different in the early stages | 

| Without trust, can't trust what she says. | 

| Ability to trust | 

| Is it therapy? | 

| Not got half before, usually left before. | 

| Thought it would be like therapy | 

| Common view of therapy? | 

| If I have to tell problems to... | 

| Didn't expect to trust like she does. | 

| Thought it would be different. | 

| Could trust her at first, used to lie without trust. Unable to tell truth about things. | 

| Took time to develop a little. | 

| Minus role at beginning of relationship | 

| What it implies, control? | 

| Only tell her what she wants to hear. | 

| Consents with what she says. | 

| Didn't trust people in general. Global lack of trust. | 

| TYPE A LONG TIME TO DEVELOP TRUST. | 

Anna: Oh a really long time and I wouldn't say it's a linear thing either because
we have had our ups and downs (laughs). Ummm

I: So it has taken quite a long time?

Anna: Yeah...and so like maybe after a year I felt like I was starting to trust her and then there was this thing with the police and she kind of...I didn’t like how she felt about it. That sounds really bad. Basically I was like “oh the police beat me up” and she was like “oh I’m sure they were just worries about you or whatever and they were trying to like stop you from hurting yourself or whatever.” I was like “I don’t think they really needed to beat me up to do that.” And I wanted to take it further and complain and stuff and she was like “I don’t think this is going to be what is best for you.” And I really felt like she’s part of the system and she is just taking the side of the system and that sort of thing. Ummm.

I: So it sounds like it was a bit of a challenge to have different opinions about something?

Anna: Exactly. So in terms of trusting her that was a real step back again because then I was like...yeah...I kind of felt like “oh no she’s not on my side.” Because I really felt as though it’s like there’s me and then there’s everyone else and if she’s...
Having been well supported through the weeks, I thought we had really benefited from the therapy. However, the final sessions were less effective, which was a shame. It seems that the therapist was not as engaged in the last few sessions as in the previous ones.

I have been reflecting on the impact of therapy on my daily life. I feel that it has helped me to manage stress and anxiety better.

Overall, I would recommend therapy to others who are struggling with similar issues.
though at the time I was like no I don’t want to see anyone else, I don’t want to talk to a stranger, I don’t want to like try and trust anyone else. I was really against it and she was like, have one or two sessions and see how it goes…you know…she really had to encourage me to do it.

Looking back I feel that that was really good that she didn’t just go on my diagnosis she went on me as an individual sort of thing and she was right because it was one of the things that has helped me the most. So that’s definitely been a positive. I guess it’s not necessarily a one off experience but I can see now that was really good of her.

I: Ok so that idea of being treated as an individual person and her understanding you and not just your diagnosis?

Anna: Yeah like cos I felt like. Well I guess it boiled down to consistency. I felt like she knew me because she had been seeing me.

I: And how do you think that has affected you longer term, that positive experience?

Consistency

Feeling understood

- being treated as an individual vs. diagnosis
- feeling understood
- understood as an individual

- hard to trust someone else
- didn’t want OT
- CIC encouraged her
- didn’t just go by diagnosis, instead thought about individual needs
- CIC was right, CIC knew how to meet her needs
- positive experience, feeling understood
- wasn’t a unique one, felt it was a good experience

Importance of Consistency

- CIC knew her because she had seen her a lot
Appendix K: Excerpt from Analysed Transcript: Helen

Helen: Um...not really I don’t think like. Obviously I had problems with my first one but I tried to avoid him so I didn’t really have those confrontations. I’m sure I’ve had arguments with care coordinators but they’ve never been anything too serious. I quite enjoy the way my care coordinator works with me, um, I think they have matched us very well together so if we do have some sort of negative experience it doesn’t really last that long. It’s not really serious if you get what I mean. And that was the same with my previous one before the one I’ve got the moment. I don’t think I had any with the last one, but...yeah.

1: How do you think you managed to work those situations out and get back to normal or resolve things?

Helen: I think just talking through it really just helps...I think because I am very reactive and my care coordinator knows that so there is to a certain extent...she will let me swear and moan and go on about how bad she is and then she will like...I think she will like give me time and she will know that eventually I will ring her and say ‘I’m really sorry, what can we do to sort this out, how do we get through this...you know. And she knows me...she knows me so well, she knows that she is going to get that anger and then I am going to be really angry and then she can expect a call the same week saying sorry I reacted you.
Enable understanding?

Feeling understood by T?

Learning difficulties

Enabling to understand her

Helen: I am a very open and honest person and especially if somebody is kind of informal like she is, you know, she's not strict, she's not you know...she's professional but she is not...yeah it's hard to explain. But I think like whereas you know sometimes, at first I would say something then I would say something a bit more serious and the fact the reaction I got from her allows me to judge how far I can go with her...and like she doesn't get embarrassed about things that I say, she doesn't get sort of angry if I say...even if I say something negative about her, if I criticise her she won't get angry with me, she will kind of try and help me see the right way about it. So I think that because she is so like...I suppose in a way she doesn't react like a maniac. When I say or do things she reacts very professionally towards me but still very friendly. I suppose that built my trust up to be able to be extremely open and honest.

We trying to work with her to help her manage situation differently.

She is open and honest able to be open if other person is informal her reaction depends on how other person acts. We act professionally get informal.

We react in a way that allows her to understand the boundaries in their relationship.

We don't get embarrassed by what she says.

We don't get angry if criticised.

We try to help despite what has happened.

We manage her reactions.

We act professionally towards her.

We are friendly.

S/C's response helped develop trust in the relationship.
You mentioned her being professional or having professional boundaries. What does it mean to be professional, how does it work exactly like you know store's general things that she does, all the generic things but she takes her own style on it. You know, she's been her own way of doing things. So if I give her a list or something I am going to tell her this is what I want her to do I have to tell her herself the professional thing is so she has to come across. I know that that point of view. The point is that we are not in a relationship with her it's not a relationship with her, it's not a relationship with her it's not a relationship with her. We trust her. We trust her. We trust her. We trust her. We trust her. We trust her.
I think it's important to consider how things have changed over time. Before, I didn't realize how much I cared for him, but now I see how much I've grown in the relationship. It's been a gradual process, and it's not always easy. Sometimes I wonder if I made the right decisions, but deep down, I know it was the best choice for both of us.

Looking back, I realize that I was often too busy with my own life to really understand what he was going through. I was always thinking about my future, my career, and my goals. It's only now that I can see how much he needed attention and support. And I think he felt the same way about me.

We've been through a lot together, and I'm grateful for every moment we've shared. It's not always easy, but we've learned to communicate and work through our differences. I'm proud of the person I've become because of this relationship. I don't know where I'd be without him, and I'm looking forward to what the future holds for us.
consequences of the relationship between me and before I do things. Yeah.

I: So, thinking about your current care coordinator in general, how do you feel about them? How big a part do they play in your life?

Helen: Massive part of my life. I suppose she, because she is so consistent I suppose she is probably the most important person in my life, but not in a bad way. Um... I do rely on her but I am not dependent on her, although there have been times when I have been because I have been so unwell, but I... you know I can live my life without her and then when something goes wrong I'm like OK I need to call her now because I need some help. So just knowing that you have got somebody there to help you when you need it, no matter what you have done, or what is going on, that is quite important. I don't know what the questions was now.

I: I was asking how you felt about them and how big a part they play...

Helen: I think she's amazing because she's done a lot for me like since I've been with her I've come so far on, on my sort of journey of recovery, I have come forward a lot and she has obviously been able to make that happen for me. So you know as a person with mental health problems the only thing you want is to get better and if someone is helping you do that then that's probably the most important thing for you.
Appendix L: Journal Guidelines for Authors

1. AIMS AND SCOPE

The Journal of Psychiatric and Mental Health Nursing is an international journal which publishes research and scholarly papers that advance the development of policy, practice, research and education in all aspects of mental health nursing. We publish rigorously conducted research, literature reviews, essays and debates, and consumer practitioner narratives; all of which add new knowledge and advance practice globally.

All papers must have clear implications for mental health nursing either solely or part of multidisciplinary practice. Papers are welcomed which draw on single or multiple research and academic disciplines. We give space to practitioner and consumer perspectives and ensure research published in the journal can be understood by a wide audience. We encourage critical debate and exchange of ideas and therefore welcome letters to the editor and essays and debates in mental health.

Please read the instructions below carefully for details on the submission of manuscripts, the journal's requirements and standards as well as information concerning the procedure after a manuscript has been accepted for publication in the Journal of Psychiatric and Mental Health Nursing.

Authors are encouraged to visit: Wiley Author Services for further information on the preparation and submission of articles and figures.

2. AUTHORSHIP, APPEALS AND PERMISSIONS

2.1 Authorship and Acknowledgments

Authorship: Authors submitting a paper do so on the understanding that the manuscript has been read and approved by all authors and that all authors agree to the submission of the manuscript to the Journal.

The Journal of Psychiatric and Mental Health Nursing adheres to the definition of authorship set up by The International Committee of Medical Journal Editors (ICMJE). According to the ICMJE authorship criteria should be based on 1) substantial contributions to conception and design of, or acquisition of data or analysis and interpretation of data, 2) drafting the article or revising it critically for important intellectual content and 3) final approval of the version to be published. Authors should meet conditions 1, 2 and 3.

It is a requirement that all authors have been accredited as appropriate upon submission of the manuscript. Contributors who do not qualify as authors should be mentioned under Acknowledgments.

Acknowledgments: Under Acknowledgments please specify contributors to the article other than the authors accredited. Please also include specifications of the source of funding for the study and any potential conflict of interests if appropriate. Suppliers of materials should be named and their location (town, state/county, country) included.

2.2 Appeal of Decision
Authors who wish to appeal the decision on their submitted paper may do so by e-mailing the editorial office with a detailed explanation for why they find reasons to appeal the decision.

2.3 Permissions

If all or parts of previously published illustrations are used, permission must be obtained from the copyright holder concerned. It is the author's responsibility to obtain these in writing and provide copies to the Publishers.

2.4 Copyright Assignment

Authors submitting a paper do so on the understanding that the work and its essential substance have not been published before and is not being considered for publication elsewhere.

Correspondence to the journal is accepted on the understanding that the contributing author licences the publisher to publish the letter as part of the journal or separately from it, in the exercise of any subsidiary rights relating to the journal and its contents.

If your paper is accepted, the author identified as the formal corresponding author for the paper will receive an email prompting them to login into Author Services; where via the Wiley Author Licensing Service (WALS) they will be able to complete the license agreement on behalf of all authors on the paper.

For authors signing the copyright transfer agreement

If the OnlineOpen option is not selected the corresponding author will be presented with the copyright transfer agreement (CTA) to sign. The terms and conditions of the CTA can be previewed in the samples associated with the Copyright FAQs below:

CTA Terms and Conditions
http://authorservices.wiley.com/bauthor/faqs_copyright.asp

For authors choosing OnlineOpen

Authors of primary research articles who wish to make their article available to non-subscribers on publication, or whose funding agency requires grantees to archive the final version of their article, may choose to publish OnlineOpen. With OnlineOpen, the author, the author's funding agency, or the author's institution pays a fee to ensure that the article is made available to non-subscribers upon publication via Wiley Online Library, as well as deposited in the funding agency's preferred archive. All OnlineOpen articles are treated in the same way as any other article. They go through the journal's standard peer-review process and will be accepted or rejected based on their own merit.

If the OnlineOpen option is selected the corresponding author will have a choice of the following Creative Commons License Open Access Agreements (OAA):

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3. SUBMISSION OF MANUSCRIPTS

Manuscripts should be submitted electronically via the online submission site http://mc.manuscriptcentral.com/jpm. Full instructions and support are available on the site and a user ID and password can be obtained on the first visit. Support can be contacted by phone (+1 434 817 2040 ext. 167) or e-mail (support@scholarone.com). If you cannot submit online, please contact the Editorial Assistant by e-mail (JPMHNedoffice@wiley.com).

3.1 Getting Started

Launch your web browser and go to the journal's online Submission Site: http://mc.manuscriptcentral.com/jpm.

- Log-in or click the 'Create Account' option if you are a first-time user.
- If you are creating a new account. - After clicking on 'Create Account', enter your name and e-mail information and click 'Next'. Your e-mail information is very important. - Enter your institution and address information as appropriate, and then click 'Next'. - Enter a user ID and password of your choice (we recommend using your e-mail address as your user ID), and then select your area of expertise. Click 'Finish'.
- If you have an account, but have forgotten your log in details, go to Password Help on the journals online submission system http://mc.manuscriptcentral.com/jpm and enter your e-mail address. The system will send you an automatic user ID and a new temporary password.
- Log-in and select ‘Author Center’

3.2 Submitting Your Manuscript

- After you have logged in, click the 'Submit a Manuscript' link in the menu bar.
- Enter data and answer questions as appropriate. You may copy and paste directly from your manuscript and you may upload your pre-prepared covering letter.
· Click the 'Next' button on each screen to save your work and advance to the next screen.

· You are required to upload your files.
- Click on the 'Browse' button and locate the file on your computer.
- Select the designation of each file in the drop-down menu next to the Browse button.
- When you have selected all files you wish to upload, click the 'Upload Files' button.

· Review your submission (in HTML and PDF format) before sending to the Journal. Click the 'Submit' button when you are finished reviewing.

3.3 Manuscript Files Accepted

The text file must be anonymous, and must contain the entire manuscript including abstract, keywords, text, references, tables, and figure legends, but no embedded figures. Figure tags should be included in the file. The title page will be uploaded as a separate file from the main text to avoid identification of the author during the review process, and should contain title, short title, author names, qualifications, affiliations, and highlight the corresponding author details and email, and any acknowledgments. The text should be double spaced on A4 (or nearest equivalent) with wide margins (5cm/1in), leaving the right hand margin unjustified and turning the hyphenation off. Use tabs, not spaces, to separate the data in tables and ensure all pages are clearly numbered. Manuscripts should be formatted as described below.

Manuscripts should be uploaded as Word documents or Rich Text Format (.rtf) files (not write-protected) and not as PDFs, plus separate figure files. GIF, JPEG, PICT or Bitmap files are acceptable for submission, but only high-resolution TIF or EPS files are suitable for printing. The files will be automatically converted to HTML and PDF on upload and will be used for the review process.

A covering letter/e-mail must also be included with each submission stating, on behalf of all the authors, that the work has not been published and is not being considered for publication elsewhere. It should also confirm the contact details and e-mail address of the correspondence author, in case there is a problem with the electronic file. All papers will then be peer-reviewed. Authors should ensure they keep an up-to-date copy of their paper for reference.

3.4 Blinded Review

Before peer review, all manuscripts are screened by the editors for their suitability for publication in the journal on the basis that they meet the criteria laid out in the Aims and Scope. Papers that pass the initial screening are assigned to an Editor and double-blind peer reviewed. The names of the reviewers will thus not be disclosed to the author submitting a paper and the name(s) of the author(s) will not be disclosed to the reviewers.

To allow double-blinded review, please upload your main manuscript and title page as separate files.

Exception to the double-blind rule
The editorial team requires that all clinical trials are registered in a publicly accessible registry. Registration of systematic reviews and observational studies is also actively encouraged. Reviewers are encouraged to check protocols as part of the review process.
and consequently will be able to identify authors names and organisational affiliations. Registered studies will therefore be subject to single blind review (i.e. the reviewer may be aware of the name and affiliation of the author but reviewers will remain anonymous). The registration number should be supplied in the main body of the paper for example the methods section and can be obtained retrospectively. The title page should also be included in paper.

3.5 Suspension of Submission Mid-way in the Submission Process

You may suspend a submission at any phase before clicking the 'Submit' button and save it to submit later. The manuscript can then be located under 'Unsubmitted Manuscripts' and you can click on 'Continue Submission' to continue your submission when you choose to.

3.6 E-mail Confirmation of Submission

After submission you will receive an e-mail to confirm receipt of your manuscript. If you do not receive the confirmation e-mail after 24 hours, please check your e-mail address carefully in the system. If the e-mail address is correct please contact your IT department. The error may be caused by spam filtering software on your e-mail server. Also, the e-mails should be received if the IT department adds our e-mail server (uranus.scholarone.com) to their whitelist.

3.7 Manuscript Status

You can access ScholarOne Manuscripts any time to check your Author Centre for the status of your manuscript. The Journal will inform you by e-mail once a decision has been made.

3.8 Submission of Revised Manuscripts

Revised manuscripts must be uploaded within 1 month of authors being notified of conditional acceptance pending satisfactory revision. Locate your manuscript under 'Manuscripts with Decisions' and click on 'Submit a Revision' to submit your revised manuscript. Please remember to delete any old files uploaded when you upload your revised manuscript. Please also remember to upload your manuscript document separate from your title page. Any changes made to the new manuscript should be highlighted in red and not as track changes. You should also upload a file which outlines how you responded to the reviewers’ comments.

4. MANUSCRIPT TYPES

Research and review papers:

The journal welcomes methodologically, ethically and theoretically rigorous original research (primary or secondary) which adds new knowledge to the field and advances the development of policy and practice in psychiatric and mental health nursing. We will consider research papers of up to 5,000 words and review papers of up to 7,000 words. The decision on the final word count rests solely with the Editor and Associate Editors.

Consumer and practitioner narratives:
As part of its mission to facilitate the translation of research into psychiatric and mental health nursing practice and give space to practitioner and consumer perspectives, *JPMHN* aims to engage with and be relevant to all those who are involved in the development of mental health knowledge, policy and practice. The journal therefore welcomes consumer and practitioner narratives which have the potential to improve mental health nursing practice and/or advance knowledge.

The narrative can be authored by a single person concerning their own experience, or jointly, for example, one person relating their own experience and another person providing context and analysis. In either case, the paper should contextualise the experience with reference to relevant literature (in the arts and/or the sciences) and answer the following questions: how does this experience fit within the context of the literature and how does it inform other consumers, practitioners or researchers?

Joint authors of consumer narratives should ensure that there is a genuine and equal collaboration, and that the contextualisation and analysis avoids any interpretation of someone else’s experience that has not been validated with that person.

This section will be subject to full double blind peer review. Papers must contribute to theoretical, conceptual, or methodological knowledge, and/or practice development. There is no need to provide an abstract, however an accessible summary is required (See MANUSCRIPT FORMAT AND STRUCTURE section 5.2). No more than 10 references are allowed. We will consider papers of up to 5000 words. The decision on the final word count rests solely with the Editor and Associate Editors.

**Letters to the Editor**

**Purpose**

- To provide readers of the journal with a mechanism for submitting comments, questions or criticisms about published articles as well as brief reports and commentary unrelated to previously published articles.
- To respond to a paper recently printed in the Journal.
- To share an alternate point of view to a paper recently published in the Journal.
- To draw readers’ attention to new evidence or other issues relevant to the Journal aims.
- To comment on newly released guidelines / legislation changes / significant reports.

**Guidelines**

- Keep your points simple and focused;
- Avoid personal comments about the authors;
- Provide evidence to support your position;
- You need to reference the points you make in the same way you would in a research paper.
- Correspondence may be edited for length and grammatical correctness. Authors will be asked to approve editorial changes prior to publication.
- Letters responding to articles published in the *JPMHN* will normally only be considered if they are submitted within six months of the papers online publication date. We will inform authors if a letter relating to their paper (if it is published in the *JPMHN*) is going to be published and give them the opportunity to respond. Authors of papers discussed in correspondence will be given an opportunity to respond (normally in the same issue) in which the original correspondence appears.
Essays and Debates in Mental Health

Purpose
• To explore a contemporary topic relevant to mental health nursing practice/service user care.
• To provide a rigorously developed theoretical perspective on a topic relevant to the Journal aims.

Guidelines
• A scholarly paper providing a new perspective, debating a contemporary issue, or introducing innovative practices:
  o Presented as a well-structured argument/scholarly exploration delivered in a coherent and systematic style.
  o Clearly related to the aims of the Journal.
  o A broad understanding of relevant literature is demonstrated.
  o Well-developed integration of ideas and concepts.
• The topic should be of international relevance and be written in clearly expressed English.
• There is no need to include an accessible summary or abstract, however, authors should provide an introductory paragraph which sets out the purpose of the article.
• Word length between 3-5,000 words.

5. MANUSCRIPT FORMAT AND STRUCTURE

5.1 Format

Language: The language of publication is English. Authors for whom English is a second language must have their manuscript professionally edited by an English speaking person before submission to make sure the English is of high quality. It is preferred that manuscripts are professionally edited. Visit our site to learn about the options. Please note that using the Wiley English Language Editing Service does not guarantee that your paper will be accepted by this journal.

5.2 Structure

All original studies and reviews of the evidence submitted to Journal of Psychiatric and Mental Health Nursing should include:

Relevance Statement: Only papers relevant to mental health nursing practice will be considered for publication in the Journal of Psychiatric and Mental Health Nursing. We require that corresponding authors submit a statement that-in 100 words or fewer, sets out the relevance of the work to mental health nursing practice. If authors do not convince the Editor in Chief of this, the work will not be considered for publication.

Title page: This should give: the title of the article, the names and initials of each author, their qualifications, the department and institution to which the work should be attributed, the name, address, and telephone numbers of the author for correspondence, and a short title of 40 characters or less if the paper title exceeds this limit, and any Acknowledgments.

Abstract: The abstract should be less than 200 words in length and should be followed by six keywords in alphabetical order for indexing purposes. You should as far as possible use the following structure for research papers: Introduction; Aim/Question;
Method; Results; Discussion; Implications for Practice. For consumer and practitioner narratives this should be: Introduction; Aim; Methods (if applicable); Thesis; Implications for Practice

Optimizing Your Abstract for Search Engines

Many readers looking for information online will use search engines such as Google, Yahoo or similar. By optimizing your paper for search engines, you will increase the chance of someone finding it. This in turn will make it more likely to be viewed and/or cited in another work. We have compiled these guidelines to enable you to maximize the web-friendliness of the most public part of your paper.

Accessible summary: In keeping with the aims and scope of JPMHN authors are required to include an easy-to-read summary of their papers as part of their submission. This is in the spirit of making research findings more accessible to non-academics, including users of mental health services, carers and voluntary organisations. It should also make scanning the Journal contents easier for all readers. The Accessible Summary should be structured under the following headings, with 1-2 bullet points under each:
- What is known on the subject
- What this paper adds to existing knowledge
- What are the implications for practice

Authors are asked to:
• Limit the summary to less than 250 words in total
• Express ideas in straightforward language
• Explain the importance of the paper's findings for a non-specialist audience.

Main text: This should begin on a separate page. Authors should follow established guidelines for their study design where these exist/apply:
• Randomised controlled trials: CONSORT checklist and flow diagram
• Non-randomised controlled trials: TREND checklist
• Observational research: STROBE checklists
• Systematic review and meta-analyses: PRISMA checklist and flow diagram
• Qualitative studies: COREQ checklist
• Quality improvement: SQUIRE checklist

Where there are no established guidelines for the study design, please use the same headings as the abstract.

Abbreviations should be written in full at the beginning of a sentence. Footnotes should be avoided. Spellings should conform to those used in the Concise Oxford Dictionary. SI units should be used throughout and authors should refer to Units, Symbols and Abbreviations published by the Royal Society of Medicine.
requirements will greatly improve the value of your trial report and may enhance its chances for eventual publication.

5.3 References

Please ensure that references in the text exactly match those in the manuscript's reference list. If editing sections of text please ensure that any references that are affected are amended accordingly in the reference list.

In the text, cite the authors’ names followed by the date of publication e.g., Bowers & Thompson (2013). Where there are three or more authors, the first authors name followed by et al. will suffice, e.g. Kennard et al. (2012). Where more than one reference is cited they should be listed in chronological order. Authors should use the examples given below for referencing style. References to personal communications or unpublished results should be in the text only i.e. (A.C. Bowers & J.M. Thompson pers. comm.) or (A.C. Bowers unpublished results).

The editor and publisher recommend that citation of online published papers and other material should be done via a DOI (digital object identifier), which all reputable online published material should have - see www.doi.org/ for more information. If an author cites anything which does not have a DOI they run the risk of the cited material not being traceable.

5.4 Tables, Figures and Figure Legends

Figures and tables should be numbered consecutively and their positions indicated clearly in the text. Each should have an appropriate caption or legend that clearly describes it. In the full-text online edition of the journal, figure legends may be truncated in abbreviated links to the full screen version. Therefore, the first 100 characters of any legend should inform the reader of key aspects of the figure. Illustrations should be referred to in the text, e.g. as Fig. 1, Fig. 2, etc., in order of appearance.

Preparation of Electronic Figures for Publication

Although low quality images are adequate for review purposes, print publication requires high quality images to prevent the final product being blurred or fuzzy. Submit EPS (line art) or TIFF (halftone/photographs) files only. MS PowerPoint and Word Graphics are unsuitable for printed pictures. Do not use pixel-oriented programmes. Scans (TIFF only) should have a resolution of at least 300 dpi (halftone) or 600 to 1200 dpi (line drawings) in relation to the reproduction size (see below). Please submit the data for figures in black and white or submit a Colour Work Agreement Form (see Colour Charges below). EPS files should be saved with fonts embedded (and with a TIFF preview if possible).

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Further information can be obtained at Wiley's guidelines for figures

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Acrobat Reader will be required in order to read this file. This software can be downloaded (free of charge) from the following website: www.adobe.com/products/acrobat/readstep2.html. This will enable the file to be opened, read on screen, and printed out in order for any corrections to be added. Further instructions will be sent with the proof. Hard copy proofs will be posted if no e-mail address is available; in your absence, please arrange for a colleague to access your e-mail to retrieve the proofs.

Proofs must be returned to the typesetter at charliehuang@toppanleefung.com within three days of receipt. Please note that if you have registered for production tracking e-mail alerts in Author Services, there will be no e-mail for the proof corrections received stage.
Major Research Project Proposal

A qualitative exploration of the relationship between clients with a diagnosis of Borderline Personality Disorder and their Care-Coordinators within the community mental health setting.

Word Count: 2945

(Excluding Title Page, References and Appendix)
Introduction

Background and Theoretical Rationale

It has been estimated that 1 in 20 community residents in Great Britain suffer from a diagnosable personality disorder, with estimates that 0.7% are diagnosed with Borderline Personality Disorder (BPD) (Coid, Yang, Tyrer, Robets & Ullrich, 2006). A high prevalence of personality disorder within the team caseload (52% of clients) has been found in a study of a Community Mental Health Team (CMHT) in the UK indicating a high level of interaction with this client group in community mental health settings (Keown, Holloway, & Kuipers, 2002). Those with a diagnosis of BPD have also been shown to have a high level of contact with mental health services (Comtois et al., 2003) further indicating the importance of considering interactions taking place in this setting.

At present multidisciplinary mental health care forms the main approach to care for these individuals, and in the UK the Care Programme Approach (CPA) was implemented in the National Health Service (NHS) for those with complex mental health difficulties (Department of Health, 1990). This involves allocation of a care coordinator, drawn from a variety of professional backgrounds including mental health social workers and community psychiatric nurses. Department of Health guidance on positive practice in this area has suggested that the impact of such relationships “is one of the most important determinants of success” (Department of Health, 2008, p.7).

Given the nature of difficulties associated with a diagnosis of BPD, including significant problems with maintaining relationships, interpersonal sensitivity, and preoccupation with real or imagined abandonment (APA, 2013) it is likely that the maintenance of relationships with clinicians would also prove challenging. Theoretically these difficulties have been linked to a high incidence of insecure attachment resulting from neglect or abuse from a
primary caregiver (Bateman & Fonagy, 2008). As a result of these attachment difficulties it has been suggested that individuals with a diagnosis of BPD either struggle to tolerate being alone or alternatively being close to others (Gunderson, 1996) presenting additional problems for developing meaningful relationships with clinicians. In practice it is likely that these difficulties may lead to over-dependence and fear of discharge as a result of fear of abandonment. In spite of these difficulties, case management approaches have been used successfully in therapeutic settings with this client group e.g. in the Dialectical Behaviour Therapy (DBT) model (Linehan, 1993) where studies have shown this style of case working to be beneficial (Verheul et al., 2003).

A review of the existing literature looking specifically at interactions between clients with a diagnosis of BPD and clinicians working within community mental health settings (not including treatment based on specific psychotherapeutic models) highlighted that this is an under-researched area with little focus on care provided in the UK and specifically the role of care coordinator (Bradbury, 2014). The majority of the literature focussed on the impact of attitudes on care provided (Black et al., 2011; Cleary, Siegfried & Walter, 2002; Deans & Meocevic, 2006) however these studies did not consider the perception of this care by clients and the real impact on working relationships. Ongoing stigma associated with the label of ‘personality disorder’ has been shown to lead to practice which appears discriminatory (Lewis & Appleby, 1988; Warne & McAndrew, 2007) and it is possible that this may play a significant part in the development of a supportive and collaborative care coordinator relationship.

In the USA ‘case management’ for those with a diagnosis of BPD has been considered in qualitative studies using an Interpretative Phenomenological Approach (IPA) (Nehls, 2000; Nehls, 2001). These studies considered both the experience of the clinician and the client in such relationships. The findings highlighted that there can be difficulties for case managers
in balancing power and control in these relationships and that the misuse of boundaries can present difficulties for this type of relationship. When considering the experience of those with a diagnosis of BPD, findings indicated that this group experiences better care when they felt that they were viewed as partners in their care during decision making. They suggested that case managers who adopted a non-judgemental stance were experienced as caring, and that being ‘treated like a person’ allowed them to feel competent and cared for. The role was seen as integral to their lives, and involved many facets of support from emotional to practical, particularly influencing their ability to live successfully in the community. These studies highlight the positive impact of good relationships with case managers, particularly in terms of what works well, however it would be helpful to consider any negative impact and provide a more well-rounded view of experiences in a community setting.

The Case Management Society of America (CMSA) describes case management as “a means for achieving client wellness and autonomy through advocacy, communication, education, identification of service resources and service facilitation” demonstrating similarities with the role of care coordinator. However, healthcare provision is funded differently in the UK and USA and therefore we cannot be sure that the provision or longevity of such support is equitable in both countries. This demonstrates a need for replication of Nehls’ (2001) study in the UK setting where care coordination and community mental health care has also recently been affected by financial cuts (Karanikolos et al., 2013). The long term nature of these relationships previously viewed as important in meeting the needs of the client group (Nehls, 2001) may be under threat in the UK as a result of the redesign of services.

From review of the existing literature in this area, there is little research into the relationships between clients with BPD and their care coordinators with a focus directed in the main toward the views of clinicians (Bradbury, 2014). The dominant focus on attitudes has resulted in a paucity of literature considering the client experience of these relationships, as
well as what are perceived by this group as helpful or unhelpful styles of interaction. It is possible that there may be discrepancies between the existing views of clinicians and those of the clients they are working with.

Previous research has noted the importance of building on our understanding of best practice in providing ‘continuous and comprehensive services from a single caregiver’, such as a care coordinator (Nehls, 2001). At present the government guidance on the role of care coordinator in every day interactions with clients is lacking, therefore it is hoped that the proposed study will have clinical implications in providing clearer guidance to inform more meaningful and helpful client-centred interactions. In particular it is hoped that the study may inform training for clinicians, repeatedly highlighted in the existing literature as a necessity in tackling negative attitudes and supporting those working with this complex client group (Cleary, Siegfried & Walter, 2002; Deans & Meocevic, 2006; Koekkoek, van Meijel, Schene & Hutschemaekers, 2009; Nehls, 2000).

Research Questions

“How do people with a diagnosis of Borderline Personality Disorder experience their relationships and interactions with their care coordinators?”

Method

Design

An exploratory qualitative approach will be used to answer the research question. The study will make use of semi-structured interviews, analysed using an interpretative phenomenological approach in order to understand how participants make sense of the relationships in question. The goal of interpretative phenomenological analysis (IPA) is to explore how participants make sense of their lived experiences, and in particular an
individual’s personal perception of their experience rather than an objective view of this (Smith, 2008). This methodology also accounts for the active role of the researcher in the research process and in this way attempts to ensure that the researcher gains an understanding of the experience from the point of view of the participants. IPA allows for detailed analysis of participants’ experiences which therefore suits the aims of this project in investigating clients’ experiences of relationships with their care coordinators.

Participants

The aim will be to recruit ten to twelve participants for the study, with the intention of obtaining data from six to eight interviews, as this has been suggested in the literature as an appropriate number for an IPA study (Turpin et al., 1997). With the time limitations of the project this seems an appropriate number of participants with the potential to generate large amounts of data.

As IPA requires a fairly homogenous sample in order to reduce the number of extraneous variables and allow the researcher to focus on factors relevant to the research question (Dallos & Vetere, 2005), purposive sampling will be used. Participants will therefore be recruited from a group for whom the research question is relevant. As the study is focussed on clients with a diagnosis of BPD and their experiences of their care coordinators in community mental health settings, participants will be recruited subject to the following criteria:

- All participants must have a diagnosis of Borderline Personality Disorder (according to DSM-V criteria).
- All participants must be service users at a Community Mental Health Team (CMHT) and with the same allocated care coordinator for at least 6 months.
- All have opted into the research project and provided written consent to do so.
Exclusion criteria for this study will include:

- Lack of capacity to consent to participation in the research.
- Any client in current receipt of a specific therapeutic intervention at the time of participation in the study where an individual therapist is involved.

Participants will be both male and female clients, and between the ages of 18 and 65 as this is the population served by the adult community mental health services that will be approached for recruitment.

It is anticipated that participants will be recruited from local services, specifically an NHS Trust in the south of England. Preliminary discussions have been held with a local CMHT regarding recruitment for the study and there is an agreement in principal to use of the team as a recruitment site subject to relevant ethical approval and agreement from the Trust Research and Development department. Other local NHS mental health Trusts could also be approached as potential recruitment sites.

**Measures**

The measures used will include a semi-structured interview, as this approach is flexible and follows the line of thinking of participants. This allows the researcher and participant to engage in flexible dialogue, with ongoing modification and development of the initial questions in order to gain an in depth picture of an individual’s experience (Smith, 2008).

The initial interview schedule will include a small set of open-ended questions, with additional prompt questions. The questions will be developed through consideration of those questions used in the existing literature exploring client relationships with care coordinators or case managers. For example:
• Can you tell me about a situation that you have had with your care coordinator that you feel has gone well?
• Can you tell me how your relationship with your care coordinator has been helpful for you?
• Can you tell me about a situation when your relationship with your care coordinator has been less helpful?

Procedure

Once approval from the Research and Development department of the relevant recruitment site has been obtained the study will be advertised through displaying posters and information sheets in relevant team buildings. With agreement of local team managers the researcher will attend team meetings attended by CMHT staff in order to give a presentation about the study to aid recruitment. Care coordinators within the team will be asked to alert potential participants to the study and obtain consent to pass on their contact details to the researcher. Anyone expressing an interest in participating will then be presented with an information sheet. Once fully informed of the purpose of the study potential participants will be asked to complete a written consent form agreeing to participation and dissemination of the findings of the study.

A suitable time will then be agreed for conduction of the interview. As the study involves contact with clients, in order to ensure the safety of both the researcher and participant and reduce the risk of lone working it is intended that interviews will be held at CMHT bases. Data will then be collected using semi-structured interviews and it is intended that these will last approximately one hour. The data will be captured using a digital voice recorder, and
following this will be transcribed verbatim. Any identifying information will be amended or removed from transcripts as necessary. See Ethics section for further information.

**Ethical Considerations**

As the study involves NHS service users ethical approval for the project will need to be acquired from the Research Ethics Committee (REC) corresponding to the NHS Trust hosting the research. In addition to this an application for ethical approval will also be made to the Faculty for Arts and Human Sciences Ethics Committee.

All potential participants will be informed of the aim of the study and advised of their choice to consent to participate. Due to the nature of the study which involves exploration of the current care that a participant is in receipt of from the CMHT, it will be important to ensure that participants are reassured that participation in the study should not impact on the care that they receive from mental health services. Participants will be provided with an information sheet detailing this and informing of them of their right to withdraw from the study at any point without prejudice.

To ensure confidentiality is maintained, all data recordings collected will be kept confidential on an encrypted password protected USB stick which only the researcher will have access to this. In addition to this all participants will be allocated a participant number to maintain their anonymity. For the purposes of write up and dissemination of the findings of the study participants will later be allocated a pseudonym.

It is possible that through the interview process information may come to light highlighting concerns about risk to the welfare of participants in relation to the care they receive. In this instance local Safeguarding Adults policies and procedures will be followed should an alert
be raised. Participants will be informed of this prior to commencement of the interview, and discussion held should the researcher become aware of any relevant concerns.

The interviewing process may also raise sensitive or distressing issues and as such details will be provided in the information sheet advising participants of where to seek further support and help e.g. local services, crisis line. Following each interview, time will be allowed for debriefing and to discuss any concerns raised as a result of participating. Contact details for the relevant care coordinator and CMHT Duty worker will be kept to hand by the researcher.

**R&D Considerations**

As the study involves recruiting participants via NHS sites an application will also be made to the Research and Development (R&D) department within the mental health NHS Trust. If further local NHS Trusts will be required for recruitment the appropriate R&D departments will also be approached for approval.

**Project Costing**

The main costs of this project include the printing of materials such as information sheets and consent forms. Additional costs may include reimbursement of travel expenses for participants, which is likely to be local travel. If any transcription is required from a service such as UK Transcription, this can cost approximately £1.00 per audio minute for verbatim interviews. Any cost which is not covered by the budget will be covered by the researcher.

**Proposed Data Analysis**

Data will be analysed using IPA, following the guidelines of Smith and Osborn (2003). As there is no definitive method for IPA, the guidelines are also intended to allow the research to be flexible. The following process will be used for this study:
1. The initial transcript will be read and re-read in order to allow the researcher to immerse themselves in the data. This will also ensure that the participant remains the focus of the analysis. Any thoughts, observations or questions should be noted in the right hand margin of the transcript.

2. Initial comments will be examined and emergent themes developed. These will be noted in the left hand margin of the transcript.

3. This process will be repeated for all participant transcripts prior to identifying superordinate themes, so that all data can be considered together.

4. Emergent themes will then be clustered into groups according to their meanings.

5. Superordinate themes will be grouped into master themes according to connections or relationships between their meanings. In this way participants’ experiences will be organised in order to address the research questions.

**Involving/ Consulting Interested Parties**

The Participant Information Sheet will be presented to the Service User coordinator at the University of Surrey to ensure that the information is in an accessible format and the language is jargon free. Service users will also be approached for feedback on the interview schedule once designed.

**Contingency Plan**

It is intended that participants are recruited from one local NHS Trust, however additional NHS Trusts providing community mental health services and care coordination may be approached should recruitment prove difficult. Due to the small number of participants
required for this design and the potentially large pool of participants within one Trust it is unlikely that this would be necessary.

The aim of the study is to conduct face-to-face interviews with the participants. In order to increase accessibility for inclusion in the research it is possible that interviews could potentially be completed via telephone whilst ensuring that adequate technology is used to record the interviews and maintain confidentiality.

**Dissemination Strategy**

The findings of the study may be presented at a conference in the form of a paper or a poster. The paper will also be submitted to a relevant peer-reviewed journal such as the Journal of Psychiatric and Mental Health Nursing which has published similar research in this field. Feedback will also be provided to the relevant NHS Trust from which participants are recruited.
References


Interactions Between Clients with Borderline Personality Disorder and Clinicians within Community Mental Health Settings: A Literature Review

Word Count: 7813

(Excluding Title Page, Statement of Journal Choice, Abstract, References and Appendix)
Abstract

This literature review aimed to consider the factors which play a significant role in the style of interaction used within the care coordinator and client relationship for people with Borderline Personality Disorder in a community mental health setting. PsychINFO, MEDLINE (EBSCO Interface) and Pubmed databases were searched and 11 papers were considered relevant for inclusion in the review. Results demonstrated that multiple factors negatively impact on interactions between clinicians and clients, including negative and judgemental attitudes, lack of training and knowledge and boundary misuse. Factors found to be helpful in interactions included collaborative approaches, clear communication, consistency, availability and accessibility, and trust. Most studies were qualitative in design with few using inferential statistics to analyse data therefore suggesting that findings were not generalisable. Most studies considered interaction from the point of view of clinicians with little focus on the client perspective. There was a lack of research conducted in the UK with little consideration given to the role of care coordinator, the main source of care provided outside of specific therapeutic interventions. This review highlighted a need for further research in this area, considering factors impacting on interaction between client and care coordinator from both points of view.
Statement of Journal Choice

The ‘Journal of Psychiatric and Mental Health Nursing’ was identified as an appropriate peer-reviewed journal to which this literature review might be suitable for submission. The scope of this journal is to consider papers that advance the development of policy and practice in psychiatric and mental health nursing. Papers published in the journal are written by authors from a range of professional backgrounds, including clinical psychology. The journal accepts review articles and has previously published this type of submission.

The journal aims to translate research into psychiatric nursing practice, with a particular interest in the consumer perspective. This journal seemed an appropriate choice given the statement of interest in articles considering implications for community based care which is the focus of this literature review. The editors also cite their interest in papers relevant to the development of broader areas of healthcare such as public policy and legislation. The journal has previously published papers considering the experiences of clients with Borderline Personality Disorder and their experiences of community psychiatric services, two of which were included in this review. Given the focus of this review on the client and care coordinator relationship and considering that this role is frequently filled by community psychiatric nurses, this seemed an appropriate journal to approach given its likely readership.

The editors have recently produced new aims for the journal which highlight the growing importance of service user involvement and the views of experts in improving the lives of those affected by mental health problems, therefore it seems that the finding of this review are particularly pertinent to these interests.
Introduction

The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) (American Psychiatric Association [APA], 2013) defines the features of a personality disorder as “impairments in personality (self and interpersonal) functioning and the presence of pathological personality traits”. Those with a diagnosis of Borderline Personality Disorder (BPD) in particular experience impairments with interpersonal functioning, relating to difficulties with empathy and intimacy (APA, 2013). The most recent studies of prevalence of personality disorder in Great Britain have estimated that approximately 1 in 20 community residents suffer from a diagnosable personality disorder, with estimates that 0.7% are diagnosed with BPD (Coid, Yang, Tyrer, Roberts & Ullrich, 2006). As no further epidemiological studies have been conducted in Great Britain since this time we cannot be clear of the current prevalence of BPD.

Multidisciplinary mental health care appears to form the main approach to care for individuals with mental health problems in the developed world. In the United States of America (USA) Community Mental Health Centres were developed using the concept of case management (Intagliata, 1982). In the UK the current model of the Community Mental Health Team (CMHT) was introduced in the 1960s following the move from institution based care to outpatient support for adults with mental health problems living independently in the community. Within CMHTs in the UK the Care Programme Approach (CPA) was developed in the 1990s as a standard of good practice for working with service users with complex mental health difficulties in the National Health Service (NHS) (Department of Health, 1990). This process involves the allocation of a care coordinator, drawn from a variety of professions including community psychiatric nurses or mental health social workers. A UK study of a CMHT found a high prevalence of personality disorders within the team caseload (52% of clients) and that the caseloads of community psychiatric nurses and occupational
therapists contained more clients with personality disorders (31%) than those of psychiatrists and psychologists (15%) thus indicating the high level of interaction with this client group (Keown, Holloway & Kuipers, 2002). As a result of this level of contact with community mental health services it is important that the interactions between healthcare professionals and clients in this setting are considered.

The National Institute for Health and Care Excellence (NICE, 2011) guidelines on ‘Service User Experience in Mental Health’ identified that the aim of the care coordinator role is to support the service user in a collaborative way, with the emphasis on assessment of needs and care planning. As the individual responsible for the overview of a client’s care, the role also involves referral to appropriate therapies and support services alongside general monitoring of mental health. It is expected that the service user would have regular contact with the care coordinator and therefore this would be a key relationship central to their care and wellbeing (NICE, 2011). Within these guidelines it was further highlighted that the role of care coordinator has historically not been clearly defined and as such is subject to local interpretation and policies leading to the potential for wide variability in the quality and provision of this type of care (NICE, 2011).

Guidance on positive practice in this area was considered in a Department of Health ([DoH] 2008) document advising that the care coordinator relationship involves “shared listening, communicating, understanding, clarification, and organisation of diverse opinion to deliver valued, appropriate, equitable and co-ordinated care” (DoH, 2008, p.7). It further highlighted that the impact of the quality of such relationships “is one of the most important determinants of success” (DoH, 2008, p.7). Despite these recommendations the UK Department of Health’s document Personality Disorder: No Longer a Diagnosis of Exclusion (National Institute of Mental Health in England [NIMHE], 2003) identified that people’s experiences of services indicated that despite the perceived benefits, CPA procedures were either not
followed or considered to be unhelpful. The lack of clarity surrounding the role of care coordinator, and government documents suggesting that the implementation of this type of care is variable highlights the need to investigate this area of community care more closely when considering the support this client group is currently receiving.

Some of the key difficulties associated with BPD are significant problems with maintaining relationships, characterised by interpersonal sensitivity, preoccupation with real or imagined abandonment as well as involvement in intense and unstable relationships (APA, 2013). In addition to these difficulties those with BPD may experience separation anxiety, fearing rejection or separation from significant others alongside fears of dependency and a loss of autonomy (APA, 2013). Bateman and Fonagy (2008) have theorised that these difficulties are associated with a high incidence of insecure attachment as a result of neglect or abuse from the primary caregiver. As a result of these attachment difficulties it had been theorised that individuals with BPD either struggle to tolerate being alone or alternately being intimate (Gunderson, 1996). This, alongside the APA criteria for a diagnosis of BPD (2013), therefore suggests that maintaining a close relationship with an allocated individual, such as a care coordinator, would present difficulties for the person with BPD.

Case management type approaches have been utilised in therapeutic settings, e.g. in the Dialectical Behaviour Therapy (DBT) model developed by Linehan (1993) designed to treat those with BPD. Empirical studies have demonstrated the efficacy of DBT for BPD (Verheul et al., 2003) suggesting that this style of case working with individuals with BPD can be beneficial and that there is potential for these individuals to interact successfully in relationships with those regularly involved in their care. Whilst this review is not focussed on existing treatments for BPD this evidence suggests that those with BPD are able to form helpful relationships with professionals in certain circumstances.
A further difficulty for this client group and engagement with mental health services remains with the ongoing stigma associated with the label of ‘personality disorder’. This presents difficulties for both the client and clinician involved in the relationship. The diagnosis itself has a tendency to precede the individual, leading to negative stereotypes and practice which appears discriminatory (Warne & McAndrew, 2007). This attitude appears pervasive throughout mental health services as psychiatrists were found to view patients previously diagnosed as personality disordered as manipulative, difficult to manage and unlikely to arouse sympathy (Lewis & Appleby, 1988). It is therefore likely that this would play a significant part in the development of a supportive and collaborative care coordinator relationship.

It is acknowledged that there is an existing literature considering the therapeutic alliance between clients with BPD and therapists, however in the context of the care coordinator and client relationship within community mental health teams whereby no one particular therapeutic model is being delivered this was not considered to be relevant to the scope of this review.

**Aims**

Given the prominence of the role of care coordinator in current NHS mental health services this literature review intends to focus on which factors play a significant role in the style of interaction used within the care-coordinator and client relationship. It should be clarified that the purpose of this paper is not to review existing approaches to treating BPD, but to focus on those factors impacting on general care in the community, as experienced by people under the care of CMHTs within the NHS.
Method

For the purpose of this review community mental health care was defined as services provided in a community setting on an outpatient basis using a care coordination approach. This definition does not include community treatment based on specific psychotherapeutic models.

Due to the disparate nature of the relationships being considered, a broad search strategy was designed. Initial searches were conducted using the term ‘borderline personality disorder’ in combination with the terminology ‘community mental health*’, ‘case manag*’, ‘care coordinat*’, ‘community psychiatric nurs*’ and ‘social work*’. This strategy and search terms were similar to those used in a recent review of community mental healthcare for people with severe personality disorder but which did not focus on the care coordinator and client relationship (Koekkoek, Meijel, & Hutschemaekers, 2010).

These searches were carried out using the databases PsycINFO, MEDLINE (EBSCO Interface) and Pubmed for articles published from January 1st 1990 to April 28th 2014. Articles were required to be in the English language due to a lack of resources for translation. Any study methodology of a qualitative or quantitative design was eligible for inclusion as long as the paper described a formal study design and reported data.

Abstracts and full-text articles generated from these searches were screened to check their relevance to the scope of the literature review. Articles were excluded from the review if they provided descriptions or evaluations of manualised or specific psychotherapeutic interventions for BPD; focussed solely on inpatient, hospital, forensic or therapeutic community settings; or referred to interventions involving adolescents (under 18 years old) or those over 65.
Figure 1. Flowchart of method for selection of papers included in review.
Results

All studies identified from the search process were evaluated using quality assessment criteria proposed by Kmet, Lee and Cook (2004) for both quantitative and qualitative papers. Eleven papers were identified as suitable for inclusion in this review (See Figure 1). Of these 11 papers, 6 were qualitative in design and 5 quantitative. The studies reviewed were grouped into categories according to their focus, with 5 investigating case management or care coordination, 2 considering the mental health ‘system’ in the community as a whole, 3 looking at attitudes of clinicians towards those with BPD and 1 focussing on trust between clients and clinicians.

Care Coordination and Case Management

A qualitative study by Nehls (2000) considered the role of case management for people with BPD in the USA. In this study 17 case managers working within a community mental health centre were interviewed individually about their experience of being a case manager. Data gathered from the interviews was analysed using an interpretive phenomenological approach which highlighted several key findings. The case managers interviewed in this study demonstrated a pattern of concern regarding self- monitoring. The themes interpreted by the authors suggested that case managers experience difficulties with expressing the appropriate amount of concern in response to self-harming and suicidal behaviour which can be common with this client group. Case managers were reported to describe accurately monitoring their responses to their BPD clients as challenging, creating a conflict between caring about the safety of their clients with unnecessary concern. Monitoring boundaries was also perceived as necessary for maintaining the case-manager-client relationship. It appeared that how boundary crossing was viewed differed, with some participants describing this as a protective function for the relationship and others suggesting that the fear of crossing boundaries could
lead to limiting the care the client received. The impact of boundary setting was also described by some as a potential barrier to the development of collaborative relationships and was over-emphasised in training.

The design of this study appeared appropriate for its aims to gain new knowledge and understanding of the role of case management as experienced by case managers, however the breakdown of settings from which interviewees were recruited was not made explicit and therefore does not account for any potential variability between roles of clinicians working in different teams. Due to the interpretive phenomenological approach used we are unsure of the questions asked of each participant as the flow of the interview would have been directed by points raised during the interview process. A clear method for analysis was described and efforts appear to have been made to verify the findings between the researchers conducting analysis, implying that they are credible. Whilst potential researcher bias is considered, reflexivity in relation to the process of analysis is not detailed in this paper therefore we are unclear of the impact of this on the interpretation of data by a clinician themselves. Given that interviews were conducted with a fairly large sample size for qualitative research (17 participants) it would strengthen the findings to demonstrate that themes were supported by several participants.

The implications of this study as stated by Nehls (2000) suggest that there is a need for case managers to balance retaining power and control whilst not representing themselves as too rigid or authoritarian in order to maintain relationships with persons with BPD. The misuse of boundaries in terms of controlling and minimizing contact with this client group indicates the likelihood for difficulties in the care coordinator and client relationship. The findings highlight this conflicting use of boundary setting as a ‘technique’ for working with those with BPD when considering what is in the best interests of the client.
Nehls (2001) conducted another qualitative study looking at case management, but this time from the perspective of those with BPD. Eighteen participants recruited from a community mental health team in the USA were interviewed about their experiences of working with their case managers. The data was analysed using an interpretative phenomenological approach similar to that used in the previous study and good consideration was given to the credibility of the findings. Three main themes were generated from the data, ‘My case manager treats me like a person’, ‘My case manager is more than a case manager’ and ‘My case manager has stuck with me for years’.

Participants highlighted that they had better experiences of care when they felt that they were viewed as partners in their care through making decisions together. Case managers who were perceived to take a genuine interest in their clients, who adopted a non-judgemental stance and evidenced good listening skills were viewed as caring by participants. Those participants who felt to have been treated ‘like a person’ stated that this approach allowed them to feel competent and care for, whilst those who experienced judgement from case managers felt disregarded and dissatisfied. Case managers were also viewed as integral figures in the lives of participants due to the wide range of services and support they provided, including practical and emotional support. Practical support was often viewed as particularly meaningful and relevant to improvements in the quality of life. An interesting finding was that case managers, rather than therapists were viewed as profoundly influencing participant’s abilities to live successfully in the community. There was also an awareness of tendencies to become dependent on case managers, and participants noted that there was potential for relationships with case managers to be misconstrued as friendships. The long term nature of these relationships was also viewed as important in meeting the needs of participants, with emphasis on availability and accessibility of case managers as helpful.
This study demonstrates that the relationship between case manager and client is potentially a powerful therapeutic factor, without the requirement for the implementation of any specific therapeutic model. Non-judgemental attitudes and collaboration were viewed by clients as important factors in interacting with case managers. This study mainly highlights the positive impact of good relationships with case managers and this is mostly framed in terms of what works well when discussed. Negative impacts could have been considered in greater detail to give a more well-rounded view of experiences.

Krawitz and Batchelor (2006) considered external factors impacting on the care provided by clinicians in a pilot study on defensive practice in a cross-sectional survey of a single group. In this pilot study 29 clinicians working in adult community, crisis and inpatient services of a district public mental health service in New Zealand completed a questionnaire developed to evaluate their beliefs and behaviours in treating people with BPD. Data was analysed using a quantitative approach, however this was only descriptive in nature. Key findings demonstrated that 85% of clinicians surveyed agreed with the statement that during the preceding year they had ‘taken a treatment approach that you feel is not likely to be in the client’s best interest but protects you from medico-legal repercussions’. The authors suggest that this has clear implications for client outcomes due to this discrepancy between clinician views on best practice and actual practice when working with clients with BPD. They consider that this defensive approach, driven by multiple factors including the media, senior managers and coroners, does not promote long term change in this client group. This could be considered in terms of its impact on interaction between clinicians and their clients.

Due to the pilot study design and descriptive nature of the analysis we are unable to make more general inferences about the findings and therefore the contribution of this study to the field must be considered with caution. On closer inspection, whilst 55% of the participants were reported to be recruited from adult community care, the remainder of the sample were
recruited from inpatient and crisis services leading to potential variability within the sample in terms of the findings. The sample size whilst small could be considered representative of the population studied as it contained all clinicians attending routine meetings within the geographical district. However, as a pilot study conducted in a single region the findings may not be generalizable to the wider area. The authors acknowledge some of these limitations in regards to making inferences about the findings but indicate that there is scope for further investigation taking these into account. The design of the study means that it does not add to the existing research body, but rather indicates that defensive practice is an area for future consideration when looking at factors impacting on the relationships between clinicians and clients with BPD.

A qualitative study on the use of the Care Programme Approach (CPA) which is associated with the care coordinator role was conducted in the UK by Rogers and Dunne (2013). The aims of this study were to explore service users’ experiences of the CPA whilst under the care of a CMHT. Whilst participants were recruited for the study from a specialist personality disorder service, inclusion criteria that were applied meant that all participants had experience of being cared for within a CMHT in the NHS. Data was gathered from service users (N=7) attending a focus group. A strength of this study was the use of a former service user with experience of facilitating focus groups in an attempt to address the potential impact of professionals on the data gathered, which was carefully considered by the authors. Whilst as far as possible the objectivity of the analysis was controlled for through calculation of inter-rater agreement (95% post discussion between analysts) no real consideration is given to the standpoint of the authors as mental health professionals who may be part of the CPA process themselves.

This study identified 7 themes, Having a Voice, Progression versus Consistency, Moving On from Services, Understanding Personality Disorder, Understanding Recovery, Lack of
Information, Follow Up and Accessing Treatment. Across these themes it seems that collaboration between client and care coordinator, communication and consistency are vital aspects in terms of relationships with mental health services. Comparisons were made between community mental health teams and specialist services indicating that the latter encouraged greater involvement and choice in care planning which was viewed as beneficial. A lack of understanding and knowledge amongst staff was highlighted by participants with the suggestion that specialised training should be required. Those participants highlighting positive examples of care described the significant impact of staff with a good understanding of their diagnosis as helpful in developing their own understanding of BPD. Rogers and Dunne (2013) concluded that their claims were justified as they were supported by existing research that has suggested poor staff training and knowledge impacts on clinician anxiety, affecting the way they relate to clients with BPD (Cleary, Siegfried, & Walter, 2002).

The role of care coordination as a factor impacting on engagement in psychological therapy for clients with BPD was considered in a UK study by Gaglia, Essletzbichler, Barnicot, Bhatti and Priebe (2013). This study looked at the both the characteristics of patients dropping out from dialectical behaviour therapy (DBT) and the impact of care coordination in explaining dropout rates. Data from 102 patients (90 female, 12 male) who were offered DBT from a specialised team was analysed. A number of standardized measures were used to screen for BPD e.g. SCID-II (First et al., 1997). Whilst these findings are of general interest in consideration of drop out from DBT, for the purpose of this review it is the findings relating to the role of care coordination which will be considered. The history of care coordination was assessed from patient records, looking at whether patients received care coordination at some point in the past and whether they were currently in receipt of this at the start of treatment.
The sample size was reasonable (N=102) allowing for a well powered study, however the largely uneven split between male (N=12) and female (N=90) patients may have biased the findings. A large number of variables were considered (ethnicity, employment status, living situation, treatment history, diagnosis of personality disorder, depression, post traumatic stress disorder, time in secondary care before DBT, baselines measures of severity of illness) which suggests that the model is fairly comprehensive for predictors of dropout. However, in particular relation to the role of care coordination in dropout rates, the details within this factor were lacking.

Findings from this study demonstrated that when multivariate logistic regression analysis was performed care coordination history was the only predictor variable to remain statistically significant, demonstrating that the odds of a patient receiving care coordination dropping out of DBT were 5.86 times higher than the odds of a patient who did not receive it. It was acknowledged that for all groups, fast rates of dropout occur within the early stages of treatment but this occurs at a faster pace for those experiencing care coordination.

A key limitation of the study was the lack of consideration of various factors such as the length of time patients were in receipt of care coordination, making it difficult to consider any impact of factors such as the quality or strength of the care coordinator and client relationship. The length of time in receipt of care coordination or frequency of contact were also not given due consideration. The drawback of this is that whilst this study suggests the findings are worthy of further consideration, there is no real indication of what it is about care coordination that is having an impact on increased dropout rates and whether this is due to any problems with interactions.
‘The System’

Koekkoek and colleagues (2009) conducted a study in the Netherlands assessing the problems perceived by professionals working in community mental health care for clients with BPD who do not receive specialised therapy. They surveyed 8 national experts with experience of treating clients with BPD using a four-phase Delphi procedure to identify and prioritise problems, drawing from their own personal experiences as well as those of their colleagues. Data was collected via focus groups and analysed using thematic analysis. This process produced 36 problems reflecting 5 categories on which consensus was agreed. The findings highlighted the view of professionals that a significant problem in community care is the difficulties those with BPD have with attachment to professionals, presenting difficulties with trust and leading to experiences where clients ‘drift’ through the healthcare system with no continuity of care. Alternatively dependency was viewed as problematic as many clients with BPD become long-term users of services. Pessimistic attitudes of professionals towards both patients and treatment were also viewed as a key problem, with this being attributed to a lack of specific skills for working with those with BPD. The study also highlighted that a lack of organisational support was felt to present a major issue, as professionals felt there was an absence of time for reflection on personal feelings and attitudes towards clients with BPD leading to difficulties in providing care.

The findings of this study highlighted the variety of factors negatively impacting on care provided in the community for those with BPD outside of specific therapies, the consensus being that professionals working in these settings do not have a good understanding of BPD or a coherent way of working with these clients. With a lack of clear guidelines for managing these types of relationships professionals may feel unsure how to work with this client group impacting on the care received. The Delphi method used assumes that consensus is reached on findings however it should be considered that the use of experts as participants is a step
away from those clinicians delivering care within community services and may not be representative of their experiences in interacting with clients.

A further study considered the lived experience of those with BPD and their views of contact with mental health services in the UK. Fallon (2003) interviewed 7 participants with BPD to consider the impact of various elements of services on the individual. The data generated from interviews was analysed using a clearly described constant comparative method of grounded theory. One of the four categories that emerged from the data and relevant to this review was ‘relationships’. Participants considered relationships as the most supportive variable in their lives, with emphasis on relationships that helped them to contain distressing emotions as the most beneficial. Participants highlighted key qualities such as being calm, patient, knowledgeable, flexible, empathic and being interested in them as people facilitated sustained relationships. Most reported experiencing negative attitudes and were sensitive to those that portrayed judgemental views with participants feeling able to trust those who set clear boundaries without being punitive. A further category ‘travelling through the system’ highlighted problems experienced with the CPA process. Participants highlighted a lack of explanation of the roles or function of the individuals they were seeing. In some instances participants felt integrated in the CPA process, however others reported that a lack of sustained contact with professionals led to difficulties in building productive relationships.

As this study considered participants’ experiences of services as a whole, it is unlikely that an interview lasting an hour would be able to capture the full experience of services. Whilst relationships with professionals are considered in the findings and factors leading to negative and positive interactions with care coordinators are hinted at, there is a need for further research to look at this area in more detail as the study was limited to providing a snap shot of care as a whole.
Attitudes

Cleary, Siegfried and Walter (2002) surveyed mental health staff in Australia in order to investigate existing levels of experience, knowledge and attitudes regarding the management of clients with BPD and in order to provide direction for the development of education and training for mental health staff in relation these findings. Data gathered from a 23-item questionnaire completed by mental health staff (N=229) employed in an Area Mental Health Service in Sydney were analysed using a quantitative approach. Results were analysed using descriptive statistics therefore whilst the findings describe the group being studied they cannot be generalised and thus the implications of the study must be regarded with caution.

Key findings of this study considering interactions with this client group indicated that 80% of participants found dealing with clients who have BPD to be ‘moderately’ to ‘very difficult’, with 84% admitting that working with this client group was more difficult than working with other clients. Some participants (29%) reported the feeling that they had a lack of training or expertise with this client group. Despite this finding a general good level of knowledge was identified as well as good knowledge in relation to current treatment options. A general desire for further training was endorsed by 76% of participants who wanted skills training workshops, with 95% of staff willing to spend one hour per month or more on further education or training. The authors claim that the study highlighted a clear need for training and the development of frameworks for team practice to support staff in feeling confident in working with this client group.

Due to the response rate to the survey at 44% it is unclear how representative the findings are of the population being studied, particularly in terms of the uneven split between staff working in various sites e.g. hospital, community mental health centres, with 22% based in the community. The authors do not consider this fully in terms of how the findings might be
skewed as a result of how staff working in different types of teams might experience different
styles of multidisciplinary team working. A further limitation in using the results of the study
to inform the development of training programmes is the restricted design of a structured
questionnaire which suggests to the participants areas of training they might consider helpful
and asks them to rate them. This suggests that the authors had predetermined ideas of what
they believed might be helpful in terms of training and it is not made clear where these ideas
where drawn from. The study does not appear to have allowed participants to suggest their
own ideas and requests for training, or at least this is not reported in the article. However,
this study does build on the research evidence that mental health clinicians lack confidence
with working with people with BPD and there is a willingness to improve this which seems
possible when provided with the appropriate support and training. It is therefore likely that
raising levels of confidence through training may have a positive impact on care coordinator
and client relationships.

Attitudes of psychiatric nurses towards patients diagnosed with BPD have also been studied
by Deans and Meocevic (2006). This study was also conducted in Australia, whereby
registered nurses (N=47) working in both community and inpatient services were surveyed
using a 50-item questionnaire. In this study there was a more even split between these two
work settings with 47% working in community settings and 53% in inpatient settings,
however the potential impact of the different settings is not considered by the authors. A
fairly good response rate (60%) was achieved suggesting that there was less potential for
selection bias than in the previous study discussed. Clear inclusion criteria were also used to
ensure that the sample contained nurses who had definite experience of working with people
with BPD, however the use of convenience sampling means that findings are unable to be
extrapolated.
The questionnaire administered in this study had been previously developed, however this remains unpublished and we are therefore unable to assume the measure was reliable or valid, meaning findings must be interpreted with caution. The descriptive analysis does not allow us to make generalisations beyond the data analysed in this study. Key findings stated that 89% of participants perceive people with BPD as manipulative, with only 44% reporting that they knew how to care for this client group. A low percentage of participants (6.4%) stated that they felt they always had to be available when the client with BPD needs me, despite 47% feeling that it is their responsibility to keep their clients safe. Interestingly 49% of participants felt that there would be legal consequences for them if the person with BPD committed suicide, echoing some of the findings on the use of defensive practice with this client group (Krawitz & Batcheler, 2006).

Whilst there are limitations with the measure used it seems that the results of this study were largely supportive of Cleary and colleagues (2002) in that working with this client group appears to be challenging and problematic. The negative attitudes which seem to have been elicited by the questionnaire, such as a fairly high level of endorsement of the item ‘people with BPD make me angry’ (32%) suggests that this is likely to have an impact on interactions with clients. It is important to consider the potential impact of social desirability effects as it is likely that there may have been some reluctance to endorse statements such as ‘people with BPD are time wasters’. It is interesting that 29.8% of respondents were ‘unsure’ when responding to the statement ‘people with BPD make me angry’ and whether this was due to reluctance to admit this, or due to a generalised feeling of uncertainty in relation to this client group. The findings of this study give a cross-sectional snapshot of the prevailing attitudes in the population being considered however we are unable to make any specific claims about the direct impact these attitudes have on interactions with those with BPD.
A more recent study surveying the attitudes of mental health clinicians towards BPD was conducted in the USA (Black et al., 2011). This was a much larger scale study of 706 clinicians using a 32-item self-report questionnaire, with 15 items concerning attitudes towards patients with BPD. The survey response rate was 48%, so whilst the sample was large it cannot be considered fully representative of the population being studied. It is also important to consider the motivations of those that chose to respond to the questionnaire, perhaps demonstrating a higher level of interest in BPD and potentially different attitudes to those who chose not to respond. A wider range of professional groups were considered than in the previous studies discussed, including psychiatrists, psychologists, social workers and nurses and differences were considered in terms of the findings. The population from which the sample was recruited is unclear, stating that the questionnaire was distributed in collaboration with expert clinicians at academic centres in the USA. Demographic data provided in the article infer that all clinicians had worked with clients with BPD in the past year although it was not specified that clinicians worked in any particular setting. How closely the findings relate to those clinicians working in community settings is difficult to determine.

In contrast to the previous two studies, the authors used inferential statistics to analyse the data. An ordinal logistic regression model was used to test for differences in survey responses including explanatory variables such as occupational subgroup, number of years caring for psychiatric patients and number of BPD patients cared for in the past year. Following this, analysis of covariance (ANCOVA) was used to test for differences in summary scales such as for Empathy, Treatment Optimism and Caring Attitudes, using these explanatory variables and covariates such as gender. The authors appropriately controlled for type 1 errors through the use of the Bonferroni correction and therefore utilised more
stringent p-values (p ≤ 0.003) when considering significance of findings due to the multiple comparisons performed.

Responses to the questionnaire showed that 47% of clinicians gave some endorsement to the statement ‘If I had a choice, I would prefer to avoid caring for a BPD patient’, although those participants with more experience in psychiatry were shown to be more confident in their ability to care for patients with BPD. Those who reported caring for higher numbers of patients with BPD had higher self-reported ratings of positive attitude towards their patients, perhaps also suggesting that their confidence grew with increased experience.

Significant differences were found between the various professions looked at, with nurses found to have lower ratings of empathy towards to patients with BPD than social workers as well as lower self-ratings of overall caring attitudes in comparison to all other groups. Social workers were found to have higher self-ratings of treatment optimism but also the highest ratings of dislike of BPD patients. Overall results suggested that there was a desire from all staff groups for training in the management and treatment of patients with BPD.

In considering the implications of findings, whilst subgroups of the varying professions were considered separately, it is important to note the uneven split of the sample which was predominantly psychiatrists and psychiatry residents (N= 353), compared with social workers (N=98), staff nurses (N=97) and psychologists (N=89). Therefore what appears at first as a large sample size is in fact much smaller when looking at staff groups individually potentially reducing the likelihood of finding significant results, particularly in conjunction with the p-value being set low at p≤ 0.003 for statistical significance.

Whilst a strength of this study is its use of inferential statistics in contrast to other studies using descriptive statistics, again the psychometric measures used are largely untested with
no assurance of reliability and findings should therefore be considered with caution and considered as exploratory.

In discussion of their findings the authors state that attitudes influence treatment outcome, however whilst this seems likely it is not clear how these findings demonstrate this assumption without a measure of the quality of treatment received by those with BPD. The results, consistent with previous studies discussed, again show a desire for more training in working with people with BPD with this study implying that greater levels and years of experience lead staff to feel more competent and more likely to express positive attitudes in interactions with their clients.

**Trust**

Langley and Klopper (2005) conducted a qualitative study in South Africa exploring which factors both patients with a diagnosis of BPD and clinicians caring for them consider helpful in facilitating their mental health care. Participants were recruited from community services in Johannesburg and an interpretive descriptive approach was used to analyse data gathered from 6 patients with a diagnosis of BPD and 10 clinicians with extensive experience of working with this client group. A real strength of this study was its consideration of both clinicians and patients with BPD, with other studies previously discussed focussing in the main only on clinicians.

The patient participants were interviewed individually and following this clinicians were either interviewed individually (N=4) or participated in a focus group (N=6) again using an initial opening question. A strength of the sampling was the mix of professions noted for clinician participants including psychiatrists, psychologists, psychiatric nurses and social workers giving a good representation of a multi-disciplinary team. A clear method of analysis was described with apparent good attention to verification of themes with the use of
independent experts to consolidating findings, however further attempts could have been made to check out themes with participants.

The authors acknowledge that they believed saturation to have been achieved in collecting the data despite the small sample size (as is common in qualitative research). It seems likely that the data is representative of the population being studied but this can only be assumed as no clear evidence is given in support of how saturation was reached, although the use of quotes from various participants does give an increased sense of credibility to the findings.

In this article only the first theme established from the data is discussed which is ‘Trust’. The authors identified trust as having significant importance in the clinician-client relationship, from the point of view of all participants. Within the theme of ‘Trust’ several subthemes were identified as important to these relationships. Patient participants considered that clinicians needed to be perceived to be available and accessible, needed to demonstrate trying to understand through listening and caring in order to feel emotionally and physically safe. Professionalism was also highlighted as important and considered to be demonstrated through honesty, maintaining confidentiality and through being treated as ‘an adult person’. All of these factors were seen to develop over time and that as result of the establishment of trust, hope for the future could be elicited. Clinicians agreed that trust took time to develop, viewing this as the foundation of the relationship and developed through honesty. They recognised the importance of knowing their patients fully and acknowledging the reality of their experiences. Clinicians stated the importance of being available and accessible but considered this within appropriate limits. Similarly to the patient participants clinicians also felt that as a result of trusting relationships hope for the future could be fostered.

These findings demonstrate the importance of trust as a foundation for therapeutic relationships which can be considered important in all nursing care. It is unfortunate that
within the scope of the paper only one main theme from this research was discussed, therefore the findings disseminated at this stage are relatively narrow. However, the consideration of the views of both the clinicians and patient participants in this study help to give a clearer sense of how these two groups interact.

**Discussion**

From the literature search conducted it seems that little is known about what patients with a diagnosis of borderline personality disorder perceive as acceptable or helpful in a community setting and the research has not focussed on client experience. Very little research has focussed on experiences within the community setting and the existing research is dominated by studies focusing on either inpatient care or specialist therapeutic interventions. Only three of the studies discussed considered the point of view of the person diagnosed with BPD in receipt of community care, with only Langley and Klopper (2005) recognising both points of view in the relationship between clinician and client within the same study. As relationships are two-way it does not seem appropriate to consider one without the other in giving a true impression of these interactions.

The research discussed in this review has demonstrated several factors that could be having a negative impact on the quality of care delivered with little consideration of what might be considered good practice and therefore beneficial. The majority of papers discussed in this review consider the potential impact of negative attitudes on care provided in the community which it is suggested will have a detrimental effect on the care delivered. However without the inclusion of a measure of the perception of care received by clients with BPD we cannot say how this is translated in reality in these working relationships.

The varying contexts in which these studies were conducted suggest overall themes that clinicians are lacking in confidence in working with people with BPD, and in some cases
expressing a desire not to work with this client group. It is however important to consider potential differences in the set-up of mental health community services in the populations studied (USA, Australia, South Africa). There is also a lack of consideration of the prevailing attitudes in the general population of the countries studied towards people with mental health problems, and in particular BPD and therefore findings cannot be generalised. Two of the studies also suggest the impact of concern by clinicians for legal ramifications in providing care which again may vary between countries according to the legal system involved and effect generalizability of findings. Overall little research has been based on the UK population with few studies conducted within the past 10 years, suggesting the need to look more closely at current experiences in this setting.

A further consideration when looking at the findings of studies on attitudes of clinicians is the lack of any comparison group. When considering attitudes to BPD in isolation we cannot be sure whether similar negative attitudes might be expressed towards working with anyone with a mental health diagnosis in general or if attitudes are discretely different for each diagnosis. Without such comparison groups it is hard to be certain whether the key findings highlighted in each study give a general picture of mental health care in the community or are specific to care for people with BPD.

The research examined in this review is largely exploratory in nature therefore it is difficult to conclude how far the findings can be extrapolated. Weaknesses in analysis through the sole use of descriptive statistics in some of the quantitative studies considered meant that there is little in terms of findings demonstrating statistical significance. The qualitative design of several of the studies discussed appears robust in terms of the methods of analysis employed, however, there is a general lack of acknowledgement of the potential assumptions of researchers which are likely to be swayed by their own positions as mental health clinicians.
It is clear that there is very little in terms of research focussed on care provided in the UK within community settings for people with BPD, and largely a lack of consideration of the specific role of care coordinator. With care coordination and the effective use of CPA stipulated for people with BPD in Department of Health guidelines (2008) it is pertinent that factors impacting on the quality and helpfulness of these services for people with BPD is considered in more depth. Although the findings of the studies discussed in this review are limited, it seems likely that negative attitudes and a lack of comprehensive training may be having a significant effect on how this type of care is implemented. How these factors relate to how care is perceived by those with BPD is yet to be considered, and has not been looked at in the UK.

When broadening to look at research evidence for psychological treatments for this client group Bateman and Tyrer (2004) highlighted that no one approach was viewed as more beneficial, however they considered several factors relevant to the success of treatment. They suggested that therapy should be well-structured, explicit, clearly-focussed and coherent, with importance placed on the treatment alliance and well-managed endings in particular. The study by Rogers and Dunne (2013) looking at the experience of the CPA process highlighted clients’ experiences of endings and the potential for feelings of rejection when moving on. It seems relevant that whilst the aims of the care coordinator role are not associated with providing a specific model of intervention, some of these factors mentioned by Bateman and Tyrer (2004) are likely to play a part in the care-coordinator and client relationship. Research by Goodwin (2003) gives further support to the idea that regular and dependable key workers foster secure relationships for this client group and are important for recovery. The idea of difficulties associated with insecure attachments as central to the experiences of those with BPD suggest that this could be considered in more detail within exploration of the care-coordinator role in future research.
This literature review has demonstrated that there is little existing research considering the relationships between clients with BPD and their care coordinators. The evidence base for factors which impact on the style of interaction between these two parties is heavily weighted towards the views of the clinician, with a particular focus on attitudes. There has been little research on the client views of these relationships and what may be perceived as helpful or unhelpful styles of interaction. This begs the question as to whether there are discrepancies between what clinicians might view as helpful as opposed to the views of their clients. As there is currently little in terms of government guidance on the role of the care coordinator in every day interactions with clients, with increased empirical evidence the NHS may be able to provide clearer guidance for informing the style of interaction that is best practice in these relationships.
References


Clinical Experience

**Adult Mental Health Placement: Community Mental Health Team**

On this community based placement I worked with adults from ages 18 to 65. I offered assessment and intervention for adults with diagnoses of Borderline Personality Disorder, Psychosis, Bipolar Affective Disorder, Obsessive Compulsive Disorder, Depression, Anxiety and Post Traumatic Stress Disorder. Therapeutic interventions offered included Cognitive Behaviour Therapy (CBT), Behavioural Activation, Acceptance and Commitment Therapy (ACT), Systems Training for Emotional Predictability and Problems Solving (STEPPS), Dialectical Behaviour Therapy (DBT), and Exposure and Response Prevention (ERP). In addition to individual therapy I gained experience in providing Family Work for Psychosis, and co-facilitated a rumination focussed CBT group, Wellness and Recovery Action Plan group and Carer’s group. I also developed skills in neuropsychological assessment using the WAIS-IV and ACE-III. I also had the opportunity to provide therapy using an interpreter and was involved in Safeguarding processes.

**Older People Placement: Older People’s Mental Health Services**

On this placement I worked with older people from ages 67 to 94 in a community setting. I offered assessment and intervention for older people with diagnoses of Anxiety, Depression, Health Anxiety, Bipolar Affective Disorder and Post Traumatic Stress Disorder. In additional to individual intervention I gained experience in providing a Mood Management group based on CBT principles. I developed skills in neuropsychological assessment of Alzheimer’s Disease and Frontotemporal Dementia. I also developed systemic skills through working with care homes to offer consultation and support with managing challenging behaviour.
Learning Disability Placement: Community Learning Disability Team

This placement was based within a community learning disability team where I worked with adults between the ages of 17 and 67. The placement involved working with those with Autistic Spectrum Disorders, Down’s Syndrome, and Fragile X Syndrome who were also experiencing mental health problems. Interventions provided were integrative, utilising both CBT and Systemic ideas. I gained further experience in the assessment of Learning Disabilities including assessments of cognitive ability and adaptive behaviour. I also carried out a Dementia assessment for a client with Down Syndrome. I had the opportunity to carry out detailed risk assessments and an assessment of sexual knowledge. In addition to this I provided consultation and indirect work with staff teams to support them with managing challenging behaviour in residential care settings. This included working with a client with significant physical disabilities and limited verbal communication skills. Finally I worked on the development of a training package for social workers detailing best practice in working with parents with learning disabilities.

Child Placement: Child and Adolescent Mental Health Services and Paediatric Developmental Clinic

This placement involved working with children and young people from ages 4 to 18 presenting with a variety of difficulties. Within CAMHS I gained experience in working with young people with diagnoses of Depression, Anxiety, Panic Disorder, Trichotillomania and OCD. I also worked with several young people engaging in deliberate self-harm, which involved detailed risk assessment and safety planning. I also offered CBT training and supervision for other members of the multi-disciplinary team.

On this placement I utilised a variety of psychological models and techniques including CBT, ACT, Mindfulness, Narrative work and Externalization. I also worked indirectly with a
parent using Solution Focussed Therapy to support them with their child who was presenting with challenging behaviour. I gained further experience of neuropsychological assessment, using the WISC-IV, WIAT-III and WPPSI-IV. In addition to this I observed and contributed to the scoring of several ADOS assessments for diagnosis of Autism Spectrum Disorders.

Within the Paediatric Developmental Clinic based in a general hospital I gained experience in the assessment of Autistic Spectrum Disorders and behavioural problems in young people. I was involved in co-facilitating a group for parents of children recently diagnosed with ASD to support them with managing the emotional impact of this, and considering behaviour management strategies.

**Specialist Placement: Family Psychology Service at a Specialist Cancer Hospital**

This specialist placement involved working with families where a parent was affected by cancer. The placement utilised a systemic approach to support families with enhancing communication and their knowledge of children’s understanding of illness, as well as supporting them to address their children’s emotional needs within the context of a parent with cancer. I worked with families with children from ages 5 to 21, offering both family sessions and individual support. The work also included addressing end of life and survivorship issues and was delivered in both outpatient and inpatient settings. I developed my understanding of the experience of the patient journey from diagnosis to treatment and the systemic impact of cancer.

I addition to these experiences I had the opportunity to take part in monthly complex case supervision facilitated by a Systemic Psychotherapist, as well as attending hospital Schwartz rounds.
PSYCHD CLINICAL PROGRAMME
TABLE OF ASSESSMENTS COMPLETED DURING TRAINING

### Year I Assessments

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<th>ASSESSMENT</th>
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<tr>
<td>WAIS-III</td>
<td>Short report of WAIS-III data and practice administration</td>
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<tr>
<td>Practice Case Report</td>
<td>Cognitive Behavioural Therapy with a 36 year old woman presenting with a diagnosis of Obsessive-Compulsive Disorder</td>
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<tr>
<td>Problem Based Learning – Reflective Account</td>
<td>A reflective account of the Problem Based Learning Exercise: The Relationship To Change.</td>
</tr>
<tr>
<td>Major Research Project Literature Review</td>
<td>Interactions Between Clients with Borderline Personality Disorder and Clinicians within Community Mental Health Setting: A Literature Review.</td>
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<tr>
<td>Adult – Case Report 1</td>
<td>Cognitive Behavioural Therapy with a 44 year old Man Presenting with a Diagnosis of Non-Organic Psychotic Disorder.</td>
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<td>Adult – Case Report 2</td>
<td>Cognitive Behavioural Therapy with a woman in her thirties presenting with a diagnosis of Obsessive-Compulsive Disorder.</td>
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<tr>
<td>Major Research Project Proposal</td>
<td>A qualitative exploration of the relationship between clients with a diagnosis of Borderline Personality Disorder and their Care-Coordinators within the community mental health setting.</td>
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### Year II Assessments

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<tr>
<td>Professional Issues Essay</td>
<td>“Successfully promoting psychological services to men, working class young people and cultural minorities present considerable challenges to clinical psychology where the majority of practitioners are white European females.” What challenges do you anticipate there will be for you as a clinical psychologist in attempting to reach out to these groups?</td>
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<tr>
<td>Problem Based Learning – Reflective Account</td>
<td>Problem Based Learning Reflective Account: The Stride Family.</td>
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<tr>
<td>Older People – Case Report</td>
<td>Neuropsychological assessment of a woman in her eighties presenting with ‘Memory Problems’.</td>
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<td>People with Learning Disabilities– Oral Presentation of Clinical Activity</td>
<td>Using an integrative approach to working with a women in her early twenties with Down’s syndrome and a significant learning disability.</td>
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### Year III Assessments

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<td>Service-Related Project</td>
<td>A service evaluation of the effectiveness of the Dialectical Behaviour Therapy service for individuals with a diagnosis of Borderline Personality Disorder.</td>
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<td>Personal and Professional Learning – Final Reflective Account</td>
<td>On becoming a clinical psychologist: A retrospective, developmental, reflective account of the experience of training</td>
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<td>Specialist – Case Report</td>
<td>Working systemically with a family experiencing serious illness.</td>
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