Helping interactions with patients with borderline personality disorder on admission wards, a qualitative study.

Name:	J.H.H.J. Berkers
Student number:	3719154
Status:	definitief
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Masteropleiding KGW, Verplegingswetenschap, Universiteit Utrecht

Supervisor:	Dr. Bauke Koekkoek
Teacher:	Dr. Claudia Gamel
Contact persoon Nijmegen	Dr. Harm Gijsman
Contact persoon Arnhem	Mw Juanita Bakker Schneijder

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SAMENVATTING
Helpende interacties met patiënten met een borderline persoonlijkheidsstoornis (BPS) op opnameafdelingen, een kwalitatief onderzoek.

Inleiding: Op psychiatrische opnameafdelingen bestaat het risico dat het contact tussen patiënten met BPS en psychiatrisch verpleegkundigen (PV-en) zich ontwikkelt tot een voortdurende ineffectieve interactie. Om dit risico te verkleinen kunnen ervaringen van patiënten met BPS worden gebruikt. Eerder onderzoek geeft hierin te weinig inzicht.

Doel en onderzoeksvragen: Dit onderzoek wil inzicht geven in interacties met PV-en, die als helpend worden ervaren door patiënten met BPS op opnameafdelingen. Dit inzicht kan worden gebruikt in de praktijk en bij trainingen van PV-en. De onderzoeksvraag is: 'welke interacties met PV-en ervaren patiënten met BPS als helpend om hun doel van opname te verwezenlijken?'.

Methode: Met twaalf participanten zijn semigestructureerd diepte-interviews gehouden na ontslag uit een opnameafdeling. Een 'grounded theory' benadering werd gebruikt voor de ontwikkeling van thematische beschrijvingen die inzicht geven in interacties die als helpend worden ervaren.

Resultaten: Veiligheid, tot rust komen en leren omgaan met symptomen en problemen worden door patiënten ervaren als doelen voor opname. De interacties met PV-en die als helpend worden ervaren bij het behalen van deze doelen zijn te beschrijven in drie thema's: 'help patiënten om hulp te vragen', 'begrijp de patiënt als mens' en 'help patiënten om te identificeren wat ze nodig hebben'.

Conclusie: De resultaten van dit onderzoek geven inzicht in interacties met PV-en die als helpend worden ervaren. Dit inzicht kan door PV-en worden gebruikt om negatieve effecten van opname te voorkomen en om effectieve interacties met patiënten te bewerkstelligen.

Aanbevelingen: : Het is aan te bevelen om open en duidelijk te communiceren wat patiënten kunnen verwachten, gebruik te maken van het goede contact dat veel patiënten hebben met enkele PV-en en de zorg te evalueren met patiënten.

Sleutelwoorden: borderline persoonlijkheidsstoornis, opname, psychiatrische verpleegkunde, relatie patiënt-verpleegkundige, patiënt ervaringen.

ABSTRACT

Helping interactions with patients with borderline personality disorder (BPD) on admission wards, a qualitative study.

Background: The contact between patients with BPD and mental health nurses (MHN-s), on psychiatric admission wards, is at risk to evolve into ongoing ineffective interactions. To reduce this risk, insight in experiences and perceptions of BPD patients on admission wards should be used. Herein, previous studies provide a lack of insight.

Aims and research questions: This study aims to provide insight in what interactions with MHN-s are perceived helping by patients with BPD on acute admissions wards. This insight can be used in practice and in training of MHN-s. The primary question is: 'what interactions with MHN-s do patients with BPD perceive as helping to achieve their goal of hospitalization?'.

Method: Semi-structured in-depth interviews were conducted with twelve participants after discharge from one of the six participating admission wards. A grounded theory approach was used to develop thematic descriptions of patients' experiences and perceptions of helping responses.

Results: Half of the patients perceived 'coming to rest' as the goal of hospitalization. Three themes emerged with regard to what interactions with MHN-s are perceived helping to achieve the goal of hospitalization: 'help patients to ask for help', 'understand the patient as a person' and 'help patients to identify what they need'.

Conclusion: This study provides insight in interactions with MHN-s that patient perceive as helping. This insight can help MHN-s to prevent negative effects of hospitalization and establish effective interactions with them.

Recommendations: It is recommended to communicate open and clear about what patients can expect, to make use of the good contact that many patients have with a few of the MHN-s and to evaluate with patients the care that is given.

Keywords: borderline personality disorder, hospitalization, mental health nursing, nurse-patient relations, patients' experiences

INTRODUCTION.

Borderline personality disorder (BPD) is a mental disorder, described as 'a pervasive pattern of instability in interpersonal relationships, self-image and affects, and marked impulsivity that begins in early adulthood and is present in a variety of contexts' (1). The prevalence of BPD is estimated at 1.4 % of the adult population (2). Approximately 5 % to 10 % of patients with BPD eventually die by suicide (3-6).

Hospitalization of patients with BPD is an issue of considerable debate among clinicians and researchers. Inpatient treatment is of unproven value for suicide prevention and can produce negative effects for patients with BPD, such as behavioural regression and conflicts with inpatient staff (7-10).
Guidelines recommend hospitalization when there is risk of suicide or aggression that cannot be averted by community care (11, 12). In addition, the Dutch guideline recommends agreeing upon a goal for hospitalization with the patient, prior to admission (12).

Staff in inpatient units often mainly consists of mental health nurses (MHN-s). MHN-s often perceive patients with a borderline personality disorder as difficult (10, 13-17). An initial difficult patient-nurse interaction can evolve into an ongoing ineffective interaction between patients and MHN-s (18). Often MHN-s perceive the difficult behaviours as either deliberately oppositional or as the opposite of that which is unintentional, involuntary and due to illness. These perceptions can result in either denial or exaggeration of illness. Therefore patients perceived 'difficult' are at high risk of not receiving appropriate care (16).
'Difficult' patients in a specialist setting, where patients are referred following seriously disrupted therapeutic relationships, frequently mentioned they felt rejected in other hospitals (19).

The Dutch guideline recommends training and supervision for MHN-s in inpatient settings, in order to establish and maintain a non-judgmental emphatic attitude and to promote an effective therapeutic relationship with patients with personality disorders (12). This recommendation is supported by a review of attitudes and perceptions of MHN-s towards BPD patients in acute mental health settings (17).

One of the elements of nursing practice and training should be gaining insight in patients' experiences and perceptions. Because of the risk of ongoing ineffective nurse-patient interactions, insight is needed in interactions with MHN-s that are perceived as helping by patients with BPD, in the context of admission wards. Studies on experiences and perceptions of patients with BPD provide limited insight in what interactions with MHN's in

inpatient settings are perceived helpful (20-23). Fallon (20) found that BPD patients on psychiatric wards just want to be listened to and to be given time and emotional support. Webb & McMurran found that patients with BPD agreed on two positive opinions: “staff was available to talk to” (21) and “helped patients overcome issues” (21). In a study on preventive psychiatric admission for patients with BPD, participants stated that “the easy accessibility of professionals on an admission ward was helpful” (22). Rogers & Dunne found that patients with BPD experienced “joint decision making” (23) and “having a voice” (23) as being helpful. In these studies the findings provide limited insight because they are not described in more detail as in the citations listed above, nor do they provide a theory (20-23). Also, none of the studies related the perceived helpfulness to the goal of hospitalization. Because of the recommendation to agree upon a goal prior to admission, the helpfulness of interactions with MHN-s can best be described in the context of that goal.

PROBLEM STATEMENT, AIM AND RESEARCH QUESTIONS.

The contact between patients with BPD and MHN-s, on admission wards, is at risk to evolve into ongoing ineffective interactions. Previous studies give limited insight in what patients with BPD perceive as helping interactions with MHN-s in the context of the goal of hospitalization.

This study aims to provide insight in interactions with MHN-s that are perceived helping to accomplish the goal of hospitalization, by patients with BPD on acute admissions wards. This insight can be used in practice, in training and in the development of theory and interventions that aim to establish effective interactions between patients with BPD and MHN-s on admissions wards.

The primary question is: what interactions with MHN-s do patients with BPD perceive as helping to achieve their goal of hospitalization? This question is preceded by the sub-question ‘What do patients with BPD perceive as the goal of their hospitalization?’.

METHOD

Design

A qualitative design is used as described by Boeije (24), derived from the grounded theory approach. The approach is explorative and flexible to the emerging findings. It is useful to answer the research questions because the current knowledge in the research area is limited. As grounded theory has its roots in symbolic interactionism and focuses on the processes of interaction between people (25), it is considered appropriate to answer the research question, which strongly relates to interaction.

Setting and sample

Participants were recruited from six acute admission wards of two general psychiatric services, in the east of the Netherlands. On the wards patients were treated with varying psychiatric disorders such as psychotic disorders, mood disorders and personality disorders. Patients who met the inclusion criteria were informed about the study during hospitalization by a MHN or physician.

The primary investigator worked as a MHN on one of the participating wards. On this ward the investigator did not initially inform eligible patients, neither was she allocated as primary nurse to eligible patients on the ward.

Convenience sampling was used to select participants. Variation in the sample was enhanced by selecting participants from open and closed wards. On closed wards autonomy of patients is more limited, which influences the interactions of patients with MHN-s.

Participants

In this study patients were included that met the following criteria: (1) having BPD as the main DSM-IV diagnosis, (2) being between 18 and 65 years of age, (3) being aware of having the diagnosis BPD, (4) speaking Dutch sufficiently well to share experiences and perceptions in an interview, (5) being discharged from one of the participating acute psychiatric hospital wards between April 2013 and January 2014. After two months, due to lack of eligible patients, the first criterion was extended to also include patients with main DSM-IV diagnosis ‘personality disorder not otherwise specified’ (PD-NOS) with at least three characteristics of BPD.

Ethics

A study protocol was used that was presented to the local ethical committee. The committee found a complete ethical review not necessary (registration number 2013/012). Participants gave their written informed consent. They received a gift card of 15 euro after the interview.

Data collection

Data collection and data analysis were performed in an iterative process. Within two weeks after discharge the participants were interviewed by the primary investigator at a location of their choice. These semi-structured in-depth interviews with individual participants were conducted using a topic list. The first question asked was: ‘How were you doing prior to the admission?’ followed by the topics: admission goal; interactions with MHN’s; helping interactions with MHN’s and suggestions for helping interactions both with regard to the appointed goal. The interviewer engaged in role taking to understand the participants’ perspective (24). Observational memos were made by the interviewer after each interview.

The interviews were audio taped and transcribed verbatim. Participant's characteristics and diagnosis were collected to allow assessment of transferability.

Data analysis

The data was analyzed using NVivo10 qualitative text analysis software. The principles of constant comparison, analytical induction and theoretical sensitivity were applied (24). Memos were written about new insights and methodological decisions. The phases of open and axial coding were carried out (24). The primary investigator coded and analyzed the interview data and discussed the findings with the supervising investigator four times during the whole process of data collection and data analysis. These supervising sessions served to discuss codes and memo's, keep a fresh perspective on the analysis process and minimize bias (24). The use of text analysis software and the distinction between theoretical and methodological memos contributed to the reliability of the study results. Through the described supervising sessions, the validity of the results was enhanced.

RESULTS

In total two closed wards and four open wards, with each 12 to 16 beds, participated in the study. During the data collection period 17 patients were eligible, of which 12 participants could be included. Four of the eligible patients did not want to participate for unknown reasons and one because she was too busy. Eleven participants had BPD, one had PD-NOS with characteristics of BPD. The interviews lasted 45 to 75 minutes. Because the recording of one interview failed, a summary of that interview was used for data analysis. All participants were interviewed once. In the last two of the 12 interviews no further insight was gained to answer the research question, thus data saturation appeared present.
The characteristics of participants (Table 1) show considerable variability in age, duration of admission, admission at open and closed wards and number of previous admissions.

(Table 1: Characteristics of participants)

The perceived goals of hospitalization are described to address the subquestion. To address the main research question, helping interactions are described in themes.

Perceived goals of hospitalization

"At one point, at home, so much is happening, that I cannot handle it any more. It is too much for me. Then I become suicidal and I have to choose for an admission, that gives me security and rest." (Participant 2)

Suicidality and no longer being able to cope at home are the most mentioned reasons for admission. Half of the participants state that 'coming to rest' is their goal for hospitalization.

Other perceived goals are: being in a secure environment, taking a distance from the situation at home and making it feasible to return home. None of the patients consciously considered or discussed the goal of hospitalization prior to admission. Eight out of twelve patients were admitted voluntarily.

Helping interactions

To come to rest and feel secure patients need a MHN who is nearby where they can go for help. In contact with a MHN they need to talk about what is troubling them in order to unwind and order their thoughts. Also, patients need help from MHN-s in coping with problems, symptoms of BPD, symptoms of comorbid disorders and other daily issues to make it feasible for them to cope in the home situation again. Patients reported interactions with MHN-s that help to fulfill these needs.

Three themes emerged with regard to interactions with MHN-s that are perceived to be helping: 'help patients to ask for help', 'understand the patient as a person' and 'help patients to identify what they need*'.* The first theme is related to the need of patients to go to a MHN for help. Their need to talk about what is troubling them is related to the second theme. The third theme is related to patients needing help in coping with problems and symptoms.

All themes of helping interactions consist of a combination of interactions that happened during the hospitalization prior to the interview and those that patients suggested in the interview to improve helpfulness.

Helping interactions: help patients to ask for help

"Precisely because the nurses do not look me up, then I do not feel welcome. Then it becomes even more difficult for me to look them up…

Just by showing interest, like 'how are you today, did you sleep well?', for me that is a welcome."

Interactions with MHN-s that make patients feel noted and welcome, make them feel at ease and help them to ask for help when they need it. These interactions are important because patients have difficulties to initiate contact with MHN-s and ask them for help. They report to be sensitive to signs that may indicate that they are ignored or rejected, which they often have experienced in the past and now try to avoid. Patients feel dependent on the MHN-s whether their need for help will be acknowledged and do not trust MHN-s to do so. They distrust MHN-s they do not know or whose behaviour may indicate that they will reject their needs for help. An inviting attitude helps patients to feel noted and welcome, for instance by MHN-s that look them up, show genuine interest or invite them for a conversation. Patients perceive that MHN-s also show interest in them by attending the patient group and by

participating in group activities instead of sitting in the office at the computer. Many patients want MHN-s to look them up and show interest in them more often.
Also, many patients report they want MHN-s to communicate more open and clear so they know what to expect from MHN-s. It often happens, for example, that MHN-s do not keep appointments that are made about looking patients up or inviting them for a conversation. An open communication and clear agreements that are consistently kept by MHN-s, is perceived by patients to help them to ask for help and to trust MHN-s.

Helping interactions: understand the patient as a person

"I can talk well with a few nurses…I notice if someone is listening attentively and is interested in my problems and in who I am…There are a few nurses who only see me as a patient, and with some I feel they see me as a person. I like that better. I think it is just really important that they see me as a person. That makes me get well." (Participant 10).

Being able to talk about what is troubling them helps patients. To do so, they need to feel taken seriously and understood. Half of the patients report they often wait with asking for a conversation until one of a few specific MHN-s is available, with whom they prefer to talk. In one case the preferred MHN was the MHN that was allocated to them as a primary nurse. Patients find the preferred MHN-s are genuinely interested in them and make an effort to understand them. With these MHN-s patients often have not only a nurse-patient contact but also a contact from person to person. Patients find it important that MHN-s show interest in them as a person, instead of only as a patient with BPD, in order to understand them. Patients experience equivalency, connectedness and trust in the contact with the MHN-s that they prefer to talk to. Many patients want MHN-s to have more time to talk.
Conversations that are perceived as not helping are also reported. In these conversations patients feel hindered to talk because MHN-s are not genuinely interested in what they say, and make no effort to clarify or understand the patient's perspective. This leads them to avoid contact with these MHN-s. Most patients, eight out of twelve, report interactions with MHN-s where they feel not taken seriously. Some patients report that MHN-s unfairly label their behaviour as symptoms of BPD and claim to know how things are for them.

Helping interactions: help patients to identify what they need

"The nurses had a lot of respect for the way I handled that problem myself. It really helped me that the nurses responded very positively." (Participant 5)

Most patients, eleven out of twelve, needed some help from MHN-s in coping with problems, and symptoms. Herein, many patients want to learn to cope in their own way. Thereby, it helps them when MHN-s validate the coping skills they already have. Patients want to have a say in how to deal with problems but also have difficulties to denominate what help they

need. In helping interactions MHN-s take this into account by helping patients to identify what they need. Their needs become clearer by asking patients about them and exploring them in a conversation, by discussing possible coping strategies, by giving feedback on patients behaviour and by evaluating the help given. MHN-s actively help patients by acting on what they have learned that the patient would want them to say and do, for example, by inviting the patient for a walk to regulate stress because this helped in the past. There is great diversity in the level of active help that patients needed from MHN-s during admission. Sometimes patients only needed MHN-s to motivate them by giving compliments. On the other hand, there were two patients that needed intensive observation and intervention from MHN-s to ensure safety. One of them reports MHN-s help her to gain control over her behaviour by giving feedback on signs that precede the loss of control.
A few patients reported they wanted more direct feedback from MHN-s to gain control over their destructive behaviour. Some patients missed having a voice in how to cope. Also patients reported MHN-s gave them advice that did not help and then they stopped asking these MHN-s for help.

DISCUSSION

The results provide insight in interactions with MHN-s that patients with BPD perceived as helping in order to achieve their goals for admission. Patients also report interactions with MHN-s that do not help but cause them to feel rejected and not taken seriously (18, 19). This hinders them to ask for help and can thus contribute to the risk of behavioural regression which is one of the negative effects hospitalization can have for patients with BPD (7-10). The first theme, ‘help patients to ask for help’, confirms that the accessibility of professionals on an admission ward is perceived helpful (22). It also shows that patients often need more than accessibility to actually go to a MHN and ask for help when they need it. ‘Difficult patients’ are considered to benefit from a structured environment and the strict adherence to a clear treatment plan (19). The description of the first theme shows that it helps patients with BPD to ask for help when they know what to expect from MHN-s, which is in line with providing clarity about treatment. The second theme, ‘understand the patient as a person’ is in line with studies where patients with BPD report it helps them to talk to MHN-s on a hospital ward (20, 21) and with what is called ‘a non-judgmental emphatic attitude’ in the Dutch guideline (12). In addition, it seems that for patients the symptoms of BPD are part of who they are. Labelling these symptoms, as symptoms of BDP can make them feel stigmatized. A good contact with a few MHN-s on the admission ward is very helpful for patients. This contact has similarities with the first three stages of a staged model for ‘difficult patients’, namely a contact where there is: ‘interest’, ‘closeness’ and ‘understanding & recognition’ (18). The last theme ‘help patients to identify what they need’ corresponds with

other studies where patients report they want to collaborate with MHN-s in dealing with problems (21, 23). Furthermore, it shows that it is not just about finding strategies to cope with symptoms and problems but also about actively helping patients to identify their needs. Since patients with BPD have difficulties with interpersonal relationships, having a good contact with a few MHN-s on admission ward is very helpful for them. Patients need the trust they can have in these MHN-s to ask for help, to talk openly and feel understood. They perceive these MHN-s as genuinely interested and empathic. This implicates that MHN-s on admission wards need to be able to establish and maintain such an attitude in the contact with patients with BPD.

Some limitations and strengths have to be brought to attention. The described helping interactions are not based on outcomes of hospitalization but merely on perceptions of patients. Of the 17 eligible patients, 12 were interviewed. Since the characteristics of 5 not participating patients are not known, selection bias cannot be ruled out. There is considerable variation in participant characteristics. Also the perceptions of the helping interactions contained many similarities. Therefore, it is justified to draw conclusions. But, because of the limited number of participants extrapolation of the results must be done with some caution. The themes described provide insight into patient's perceptions, as well as detailed descriptions of helping interactions.

Future research is recommended to gain further insight in how MHN-s and patients with BPD on admission wards can develop and maintain a good contact.

CONCLUSION

On acute admission wards patients with BPD have interactions with MHN-s that help to achieve three by patients perceived goals for hospitalization: to be secure, come to rest and cope with symptoms and problems. These interactions help patients to achieve the goals by helping them to ask for help, making them feel understood as a person and helping them to identify what they need. The provided insight in these helping interactions can give some indication for MHN-s in how to prevent negative effects of hospitalization and establish effective interactions with them. The described interactions may seem simple to apply without special training. However, to apply them in practice can be difficult and needs insight in the background of the behaviours of patients with BPD.

RECOMMENDATIONS

It is recommended to communicate open and clear about what patients can expect, to make use of the good contact that many patients have with a few of the MHN-s and to evaluate with patients the care that is given.

Table 1. Characteristics of participants

Participant characteristics	n
Gender: Female	11
Age (mean: 37 year)	
age range: 20-29 year	3
30-39	4
40-49	4
50-59	1
Duration of admission (mean: 42 days)	
1-14 days	5
15-28 days	3
>28 days	4
Number of previous admission:	
0-5	4
6-10	4
>10	4
Admission on open ward	6
Admission was both on open & closed ward	6
Voluntarily admitted	8
Living situation:	
Alone	4
With partner and/or kids	4
With parents	2
With others	2
Daily activities:	
Work	2
Volunteer work	7
Education/college	1
None	1
Else	1
DSM-IV Diagnosis Axis I:	
Post traumatic stress disorder	4
Dissociative disorder NAO	3
Psychotic disorder NAO	3
Depression	3
Any substance abuse disorder	3
Generalized anxiety disorder	1
Bipolar Disorder II	1
Affective disorder NAO	1
Eating disorder NAO	1
DSM-IV Diagnosis Axis II:	
Borderline Personality Disorder	11
Personality Disorder Not Otherwise Specified	1
Antisocial Personality Disorder	1
DSM –IV psychosocial problems, Axis IV:	
Problems with primary support group	8
Occupational problems	7
Housing problems	3
Problems related to the social environment	2
Other psychosocial or environmental problems	2
Economic problems	1

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