Development of a Learning Resource for Nurses Caring for Patients Diagnosed with Borderline Personality Disorder in the Mental Health Setting

by © Olivia Cobbs

A report submitted to the School of Graduate Studies in partial fulfillment of

the requirements for the degree of

Master of Nursing

Faculty of Nursing

Memorial University of Newfoundland

December 2021

St. John's Newfoundland and Labrador

Abstract

Background: Borderline personality disorder (BPD) is a complex, highly stigmatized mental health condition. Individuals with BPD have a pattern of behavior that includes unstable relationships, poor impulse control, intense anger, and self-mutilation. The intense symptoms of affected individuals are difficult for nurses to cope with and may lead to strained nurse-patient relationships. **Purpose:** To support excellent nursing care of individuals with BPD admitted to the provincial mental health facility, using a customized, self-directed educational resource. **Methods:** The project's development was guided by Knowles' adult learning theory and Peplau's theory of interpersonal relations. Methods were an integrative literature review, consultations with key stakeholders, and an environmental scan of educational resources. **Results:** The literature supported the challenges associated with nursing care for individuals with BPD and effective nursing interventions to address these challenges. The consultations supported a need for education and key topics to include in the learning resource, while the environmental scan provided invaluable resources to incorporate. A self-directed learning resource was developed with six modules. Each module includes learner objectives, activities, and best practices for caring for this population. Information is provided to facilitate the nurses' understanding of BPD and its challenges and increase their knowledge and use of nursing interventions. **Conclusion:** The self-directed learning resource meets the learning needs of one group of nurses working in a mental health facility but can be used by any mental health nurse who cares for individuals with BPD. Next steps will be the implementation and evaluation of the learning resource with nurses.

Keywords: Borderline personality disorder, mental health nursing care, education.

Acknowledgements

I am incredibly proud for completing my Master of Nursing degree, but it would not have been possible without the support of many people. Therefore, I would like to acknowledge those who supported me along the way.

To Dr. Joy Maddigan, my practicum supervisor: Thank you for your guidance and support throughout the completion of this practicum project. Your patience and calm demeanor were exactly what I needed during these challenging last few months, and I am extremely grateful to have had you as a supervisor. Your expertise in mental health nursing and your insightful feedback helped develop a project I am proud of.

To my colleagues at the Waterford Hospital: I would like to thank everyone who participated in the consultation sessions and shared their valuable knowledge. Thank you to all my co-workers for continuously checking in, which gave me the motivation I needed these last few months.

To my close friends: Thank you all for your support over the last few years. You provided happy distractions outside of studying.

Finally, to my parents and extended family members: I am forever grateful to have such a great support system. A special thank you to my grandmother, Nana T, for always giving me the best words of encouragement.

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Development of a Learning Resource for Nurses Caring for Patients Diagnosed with Borderline Personality Disorder in the Mental Health Setting

Borderline personality disorder (BPD) is a complex diagnosis surrounded by stigma and is associated with many barriers for nurses caring for this patient population. BPD is characterized by patients having a pattern of unstable relationships, poor impulse control, and self-mutilating behaviors (American Psychiatric Association [APA], 2013). The symptoms of BPD are severe enough to cause extreme distress and interfere with social and occupational functioning. Individuals with BPD often present to emergency rooms in crisis which manifests as episodes of self-harming and suicidal behaviors. They are often admitted to mental health inpatient units to manage the immediate risks of harm and promote recovery (Warrender, 2015).

Caring for patients diagnosed with BPD is challenging for healthcare providers as a number of obstacles can interfere with effective caregiving (Aviram et al., 2006). Individuals with BPD can leave even experienced professionals feeling mentally exhausted or overwhelmed (Sheppard & Duncan, 2018). Additionally, nurses have more negative attitudes towards this patient population than any other healthcare professional group (Black et al., 2011). Individuals with BPD can be challenging to care for due to their affective instability, intense anger, poor impulse control, labile moods, and self-mutilating behavior (APA, 2013). These intense symptoms can be difficult for nurses to cope with, sometimes contributing to unintentional strained relationships and negative feelings towards patients with BPD (Eren & Sahin, 2016). These often-negative experiences can negatively impact nurses' well-being and stress levels (Eren & Sahin, 2016).

Through my professional experiences working in the mental health setting, I have witnessed the negative attitudes, frustrations, and burnout that develop because of working, seemingly ineffectively, with this population. Working in the only psychiatric hospital in the

province of Newfoundland and Labrador (NL), the Waterford Hospital, nurses on the psychiatric assessment unit (PAU), and the short stay unit (SSU) are often the first contact for patients with BPD. Therefore, they play a critical role when caring for these individuals. Currently, there is little formal education on this complex diagnosis for staff on the SSU and the PAU, and nursing staff have verbalized the many challenges for caring for this patient population. They have expressed a lack of confidence and insufficient guidance on the appropriate responses when faced with challenging behaviors exhibited by individuals suffering from BPD.

To address this issue on the SSU and the PAU, the focus of this practicum project was to develop a learning resource on this topic suited to the unique learning needs of the nursing staff of these units. In consultation with the staff nurses on these units, it was identified that a self-directed learning resource would be the most beneficial way to address this knowledge gap. Nurses will have the self-directed learning resource to guide their nursing interventions rooted in best practice evidence. This learning resource will help decrease the uncertainties nurses face associated with caring for individuals with BPD. Having all this information accessible on both units and presented in an organized manner will benefit nursing staff with varying experience.

Practicum Goal and Objectives

The overall goal of the practicum project is to improve the effectiveness of the nursing care provided to individuals who have BPD while on the SSU and the PAU and improve nurses' experiences caring for this patient population. In addition, by developing and implementing a self-directed learning resource that identifies best practices, nurses can further enhance the health and well-being of this population and combat the challenges associated with their effective delivery of nursing care.

The key practicum objectives were:

1. To conduct an integrative literature review to i) explore the extent and impact of BPD, ii) identify the barriers associated with caring for individuals with BPD, iii) highlight the evidence-based nursing strategies most helpful in addressing the barriers.
2. To consult with key health system stakeholders to better understand the challenges facing this population on a local level and how the SSU and the PAU can provide a more effective, healing environment for individuals affected by BPD.
3. To conduct an environmental scan to review existing policies, procedures, or educational material from Canada and internationally publicly available on the internet or from other healthcare facilities to inform the development of this learning resource.
4. Using the research evidence and consultation findings to develop a learning resource with relevant, evidence-informed information on effectively working with individuals with BPD and their families.
5. To demonstrate the advanced nursing practice competencies: optimizing health systems, leadership, education, and research.

Overview of Methods

An integrative literature review was conducted to explore BPD and the challenges associated with nursing care for this patient population, along with nursing strategies most helpful in addressing these barriers. After completing the integrative literature review, consultations were conducted with a purposeful sample of key informants. These consultations were conducted to explore experiences caring for individuals with BPD, strategies to improve nursing care, and assessing knowledge levels and learning needs to curate a learning resource

for nurses on the SSU and the PAU. Lastly, an environmental scan was completed by contacting four healthcare facilities and conducting an internet search to gather information on available resources to inform the development of the learning resource.

Summary of the Integrative Literature Review

The integrative literature review provided evidence that implementing effective nursing interventions, promoting strong therapeutic relationships, and increasing the education provided to nurses can improve the quality of nursing care for individuals with BPD and improve nurses' experiences caring for this patient population. A copy of the completed integrative literature review can be found in Appendix I of this practicum report.

Methods

The literature search was conducted over one month, using four databases: CINAHL, PubMed, Google Scholar, and PsycInfo. The search was conducted to locate available quantitative, qualitative, and mixed-method studies from scholarly peer-reviewed journals published in the English language from the last ten years only (i.e., 2011-2021). Initial searches yielded 226 results, and 24 articles were deemed relevant to the review and read in full for further appraisal. Quantitative studies were critiqued using the Public Health Agency of Canada (PHAC) critical appraisal toolkit (2014). Qualitative studies were appraised using the Critical Appraisal Skills Program (CASP) checklist (2017). Mixed-methods studies were appraised using the Mixed Methods Appraisal Tool (MMAT; 2018), but the quality of the quantitative and qualitative components was also individually appraised.

Results

Seventeen articles were identified for analysis, including three quantitative studies,

11 qualitative studies, and three mixed-method studies. Four themes emerged from the literature: nursing care during brief hospital admissions, nursing interventions, therapeutic relationships, and education.

Nursing Care During Brief Hospital Admissions

The research highlighted essential components of a brief admission (BA) intervention. For example, Helleman et al. (2018) found that for a BA to be effective, the BA plan must i) be developed in consultation with the patient before admission, ii) include the aim of the BA and limit to how long the BA will last, and iii) have enforced limits. Multiple studies also echoed the importance of nurses planning daily activities to promote structure during BAs (Eckerstrom et al., 2019; Helleman et al., 2018).

Qualitative studies outlined that patients diagnosed with BPD had overall positive experiences with BAs. The BA intervention helped them overcome a crisis, practice autonomy, and reinforce newly acquired coping skills (Helleman et al., 2014; Helleman et al., 2016). However, from the nurse's perspective, there were conflicting findings on the effectiveness of BA interventions for individuals with BPD. Some nurses had a favorable view of BAs, highlighting that a BA reduced misunderstandings and promoted a nurse-patient relationship (Eckerstrom et al., 2019). However, other studies highlighted that nurses felt BAs were ineffective for individuals with BPD and that individuals with BPD should not be cared for in the hospital environment (McGrath & Dowling, 2013; O'Connell & Dowling, 2013).

Nursing Interventions

Nursing interventions that were effective when caring for individuals with BPD were evident amongst the review findings. Interventions included being non-judgmental, having

the ability to listen, being open-minded, and conducting a good risk assessment (Bowen & Mason, 2012; O'Connell & Dowling, 2013; Vandyk et al., 2019). In addition, the ability to build trust was also highlighted (Eckerstrom et al., 2019; O'Connell & Dowling, 2013), along with acknowledging difficult past experiences and providing unconditional acceptance despite self- destructive behaviors (Bowen, 2013).

Research also highlighted the benefit of a therapeutic framework to guide nursing practice in caring for individuals with BPD (Bowen 2013; O'Connell & Dowling, 2013; Stroud & Parsons, 2013; Warrender, 2015). For example, when nurses had a framework to guide their nursing care, they were more likely to express positive attitudes towards patients with BPD and viewed challenging behaviors as learning opportunities (Bowen, 2013; Stroud & Parsons, 2013).

Therapeutic Relationships

The theme of therapeutic relationships was divided into two sub-themes: relationships with nursing staff and relationships with peers. Regarding relationships with nursing staff, it was identified that participants appreciated nurses taking an active role in structuring therapeutic conversations and that these conversations should be informal, such as over coffee or during a walk (Helleman et al., 2014; Helleman et al., 2018). When a therapeutic relationship between the nurse and patient was not present, patients experienced abandonment, tension, rejection, loss, and anger (Helleman et al., 2014).

Conflicting findings were evident regarding patients' relationships with peers. Evidence showed that positive relationships with peers were essential for recovery for individuals with BPD (Bowen, 2013; Helleman et al., 2014). However, clinicians on an expert panel agreed that contact with other patients might induce stress in individuals with

BPD (Helleman et al., 2018).

Education

The research highlighted the effectiveness of education for nurses caring for individuals with BPD. For example, Knaack et al. (2015) implemented an anti-stigma program and found that this intervention was successful at improving healthcare professionals' attitudes towards individuals with BPD ($p<0.002$). Similarly, Dickens et al. (2018) implemented a one-day BPD training program, and staff felt the practical advice component in the program was helpful. In addition, research showed that nurses displayed more empathy regarding self-harm if they had previous education on this topic (Dickenson & Hurley, 2017). Furthermore, evidence showed that healthcare professionals with knowledge of the complexities of BPD also displayed higher levels of empathy (McGrath & Dowling, 2012; Warrender, 2015).

Limited research was found on education delivery methods. However, one study identified regular in-services and skills training as effective (Hauck et al., 2013). Similarly, McGrath and Dowling (2012) found that improved education and skills training for nursing staff would be the most probable way to improve nursing care for individuals with BPD.

Summary of Consultations

Consultations with key informants were conducted to ensure the learning resource would suit the unique learning needs of the nursing staff on the SSU and the PAU. A completed copy of the consultation report can be found in Appendix II of this report.

Methods

Consultations were conducted with the approval of the unit's manager through semi-structured interviews over one week. These interviews were conducted with two novice

nurses, two senior nurses, a psychiatrist, a nurse practitioner, and a patient care facilitator. A recruitment email was sent out to request their participation, along with an information letter that outlined the practicum project and its goals. Implied consent was achieved when the key informants arrived at the interview. Detailed handwritten notetaking was conducted during the interviews, and notes were then typed out on a private password-protected computer. No personal identifiers were included in the notetaking. Content analysis was conducted, and each interview was read through several times to extract key information.

Results

All seven key informants invited to participate agreed to an interview, and four themes emerged: challenges of caring for individuals with BPD, nursing interventions, brief hospital admissions, and education.

Challenges of Caring for Individuals with BPD

Participants identified the main challenges of caring for individuals with BPD as staff splitting and when individuals with BPD were not receptive to help. Key informants also felt individuals with BPD required a unique approach to care, which was often challenging. Caring for individuals with BPD was more cognitive based than other mental health diagnoses. The self- harm and suicidality behaviors were also identified as a challenge, as nurses felt extreme pressure that their nursing license might be at risk. Nurses managed this stress by talking to co-workers, working together, and using senior nursing staff as guidance.

Nursing Interventions

Key informants were asked what nursing interventions they found the most effective in caring for individuals with BPD. Interventions identified included: setting firm limits, validation, empathy, and consistency. Conversely, the least effective nursing interventions

included: being confrontational, defensive, argumentative, challenging, and dismissive.

Brief Hospital Admissions

Similar to the integrative literature review findings, consultations provided conflicting findings on opinions of the effectiveness of a BA intervention. Most of the nurses identified the benefits of a BA. However, some felt hospital admissions might be causing individuals with BPD to become dependent on the healthcare system. One nurse felt that a BA intervention was only enabling the behaviors of individuals with BPD. All key informants agreed that if a BA intervention is required, there needs to be a set duration and clear goals identified in the PAU before admission. Furthermore, all key informants identified that the SSU could be a more effective environment for individuals with BPD by increasing independence and structured activities on the unit for patients.

Education

It was evident that clinical nurses did not have any previous formal education on caring for individuals with BPD, and the knowledge they did have was from experience alone. Clinical nurses were also unaware of any resources that would be beneficial to improving understanding of BPD. Therefore, various topics were identified as essential to include in the learning resource. These topics included education on dialectical behavior therapy (DBT), self-harm, the diagnostic criteria of BPD, treatment options, and how to discuss the diagnosis with patients and families. Overall, it was evident that clinical nurses would prefer this education to be delivered as an online interactive self-learning approach with a case study.

Summary of the Environmental Scan

An environmental scan was conducted to identify if any policies, procedures, or educational materials existed within Canada or internationally that could inform the

learning resource development. A completed copy of the environmental scan report can be found in Appendix III of this practicum report.

Methods

Firstly, representatives from four different healthcare facilities were contacted via email. The Centre of Addiction and Mental Health (CAMH) was selected as this is the largest mental health teaching hospital in Canada. Homewood Health Centre in Guelph, Ontario, and the Borderline Personality Disorder Treatment Program in Halifax, Nova Scotia, were chosen to maintain consistency in treatment as patients from the SSU have been referred there and attended treatment at these centers. Outside of Canada, a specialized BPD inpatient unit at a hospital in the United Kingdom (UK) was contacted due to the vast amount of literature found in the integrative literature review from the UK. Unfortunately, despite multiple attempts, no content was provided from the healthcare representatives who were contacted.

Secondly, a comprehensive internet review was conducted to outline publicly available information to inform the learning resource development. A general internet search was conducted and a search of targeted websites from reputable Canadian and international organizations. Due to the lack of response from the four healthcare facilities, the content obtained from the comprehensive internet search alone was further analyzed for commonalities.

Results

Overall, eight resources were selected to inform the environmental scan due to their relevance and reliability. These resources included two clinical practice guidelines on the management of individuals with BPD for healthcare professionals from Australia and the UK (National Health and Medical Research Council [NHMRC], 2013; National Institute for

Health and Care Excellence [NICE], 2009). In addition, two resources were found to educate families of individuals with BPD (CAMH, 2009; Gunderson & Berkowitz, 2006), and two educational resources directed towards patients on DBT were found (McKay et al., 2012; Vivyan, 2009). Lastly, two resources that provided a brief introduction to BPD and treatment options were included (Gunderson, 2011; National Alliance on Mental Illness [NAMI], 2015).

Many of the resources included similar information. These commonalities included: BPD symptoms and causes, treatment options, self-harm and suicidality, nursing interventions, and education for families.

Borderline Personality Disorder Symptoms and Causes

Most resources included in this environmental scan contained information on the symptoms and diagnostic criteria (CAMH, 2009; Gunderson, 2011; NAMI, 2015; NHMRC, 2012). This information remained consistent across resources as each resource referenced the DSM-5 (2013). Furthermore, various resources included information on how BPD is caused by a combination of genetic, social, and psychological factors (Gunderson, 2011; NAMI, 2015; NHMRC, 2012).

Self-Harm and Suicidality

Three resources included information on self-harm and suicidality (CAMH, 2009; Gunderson, 2011; NHMRC, 2012). In addition, these resources provided information on assessing suicide risk in individuals with BPD. This assessment included monitoring for changes in usual patterns, worsening substance use, recent adverse life events, withdrawal from social circles, recent self-harm behaviors, and a plan with the means to carry it out (CAMH, 2009; NHMRC, 2012). Interventions for suicide risk included not leaving the patient alone, preventing access to means, and consulting with senior staff. Interventions for self-

harm included responding promptly, staying calm, and planning for future safety (NHMRC, 2012).

Nursing Interventions

Nursing interventions highlighted from the environmental scan in caring for individuals with BPD mirrored the interventions highlighted in the integrative literature review and consultations. These nursing interventions included: validating, being non-judgmental, staying calm, being non-threatening, being consistent and reliable, having good listening skills, being compassionate and respectful (Gunderson, 2011; NHMRC, 2012; NICE, 2009). Resources also included information on managing endings and transitions and creating realistic short-term and long-term goals with patients (NHMRC, 2012; NICE, 2009).

Treatment Options

Multiple resources identified treatment options for individuals with BPD, including pharmacotherapy, psychotherapy, and hospitalization. Consistent across the resources, it was identified that anti-depressants, mood stabilizers, anti-psychotics, and anti-anxiety medications effectively treated BPD symptoms (CAMH, 2009; Gunderson, 2011; NAMI, 2015; NHMRC, 2012; NICE, 2009). Two resources provided information to patients on DBT (Mckay et al., 2011; Vivyan, 2009). These included detailed education on the core components of DBT, which can also be deemed useful for nursing staff to improve their understanding of this type of psychotherapy. In addition, the information from the environmental scan on brief hospital admissions outlined that hospital admissions must be brief, with an agreed length and purpose discussed in advance with the patient (Gunderson, 2011; NHMRC, 2012; NICE, 2009).

Education for Families

Two comprehensive educational materials were found that specifically focused on education for families of individuals with BPD (CAMH, 2009; Gunderson & Berkowitz, 2006). These resources included information on BPD, stigma, treatment options, involuntary hospital admissions, warning signs of suicide, and helpful information on how families could manage day-to-day with a loved one with BPD. They also included information on how families should respond during a crisis or emergency. In other resources, it was identified that healthcare professionals need to educate families about the BPD diagnosis and reasonable expectations from treatment, encourage families to be involved and help families navigate health services (Gunderson, 2011; NHMRC, 2012; NICE, 2009).

Summary of the Learning Resource

Based on the findings from the integrative literature review, consultation process, and environmental scan, a self-directed learning resource was developed. This learning resource consists of six modules on nursing care for individuals with BPD. The completed self-directed learning resource can be found in Appendix IV of this report.

Theoretical Basis

Both Peplau's theory of interpersonal relations and Knowles' adult learning theory were identified to provide the theoretical underpinnings of the self-directed learning resource.

Peplau's Theory of Interpersonal Relations

Peplau's theory of interpersonal relations is a middle-range nursing theory that acknowledges the importance of patient experiences in nursing care (Hagerty et al., 2017). According to Peplau, for the relationship to be successful, it must pass through three phases: orientation, working, and termination (Hagerty et al., 2017).

In the orientation phase, nurses gain essential information about patients' unique needs and approach them with respect and positive interest (Hagerty et al., 2017). During the working phase, nurses become familiar with patients and provide reflective and non-judgmental feedback to help them clarify their thoughts (Hagerty et al., 2017). The final phase, the termination phase, marks the end of the nurse-patient relationship (Hagerty et al., 2017). Concepts of this middle-range nursing theory on a successful nurse-patient therapeutic relationship and associated phases were integrated into the learning resource with specific considerations for individuals with BPD.

Knowles' Adult Learning Theory and Self-Directed Learning

The learning theory that guided the creation of this learning resource is Knowles' adult learning theory. This decision to create a self-directed learning resource was based mainly on the information obtained from consultations with key informants. The results from the integrative literature review on education delivery were lacking and inconclusive. Self-directed learning resources are the preferred learning methods for nursing education because they are flexible, accessible, and cost-effective (Sparling, 2001). A self-directed learning resource is a comprehensive learning experience that includes well-defined objectives and resources for accomplishing the objectives (Sparling, 2001). In addition, a variety of media can be used, such as printed materials and audiovisual products (Sparling, 2001).

In line with the adult learning theory, learning should occur at the learners' convenience and according to their learning preferences (Teaching in Excellence and Adult Literacy, 2011). The self-directed learning resource created is interactive and convenient, and staff will be able to complete this learning on their own time at their own pace. The target learners also all have some knowledge and experience caring for individuals with BPD. Therefore, this learning resource continues to build on previous knowledge which is in line

with this theory.

Resource Content

The resource contains evidence-based practice recommendations necessary for nurses to care for individuals with BPD effectively. While each of the six modules in the learning resource focuses on specific topics, the modules consistently use the same format for the learner. The self-directed learning modules include an introduction, learner objectives, content relevant to the module topic, practical tips throughout, a reflection exercise, application of key evidence to nursing practice, and an interactive activity or quiz. Modules also include a variety of audiovisual aids, such as tables, illustrations, figures, and videos to support the learning further. At the end of the six modules, there is a general conclusion and a resource list for continued learning.

The first module is an overview of BPD. This module includes information on the diagnostic criteria and causative factors of BPD, treatment options, and realistic recovery outcomes. This module was essential as it provides the educational foundation for the remainder of the learning resource. Nurses also must recognize BPD in the professional setting, as early identification and intervention allows patients to resume a healthier lifestyle early on in life. In addition, this module contains a section on living with BPD, strengthened by a powerful video to help nurses fully understand the suffering of individuals with BPD and to help negate the negative attitudes nurses often hold towards this patient population. Finally, this module concludes with a crossword activity to tests learners' knowledge.

The second module includes education on the nursing challenges associated with caring for individuals with BPD. This module highlights challenges such as manipulation, staff-splitting, self-harm, and suicidality. Education is provided on the root causes of these

behaviors to help nurses understand the nature of the illness and its impact on those who live with it. This module also includes information on managing the professional stress associated with caring for individuals with BPD, along with a list of self-care tips for nurses. At the end of this module, a myth or fact activity that tests learners' knowledge is included.

The third module includes a review of DBT in our province and components of this therapy that can be implemented on inpatient mental health units. Examples of these components include healthy coping strategies, practical distraction activities, and mindfulness exercises. This module was essential to include as clinical nurses suggested this education in the consultation interviews. In addition, research indicated that healthcare professionals that received DBT informed training reported lower levels of burnout, less stigma towards this patient population, and more positive attitudes towards recovery (Knaack et al., 2015). At the end of this module, there is a case study of a realistic scenario where learners must demonstrate how to effectively prevent a patient from self-harming on the unit.

The fourth module highlights the importance of implementing effective nursing interventions and creating a successful therapeutic relationship to care for individuals with BPD. Effective and least effective nursing interventions are discussed, along with steps to conducting a good risk assessment. The importance of setting boundaries, fostering hope, and including patients in the plan of care was also included. Finally, an integral component of this module is developing, maintaining, and ending the therapeutic relationship guided by Peplau's theory of interpersonal relations with specific considerations for individuals with BPD. At the end of this module, a word search serves as a refresher for the associated skills and attributes necessary when caring for this patient population.

The fifth module includes information on brief hospital admissions to clarify

misconceptions noted by clinical nurses in the consultation interviews. There is also a brief overview of patients' and nurses' experiences of brief hospital admissions, along with information on improving inpatient mental health units for individuals with BPD. The concept of structure was repeatedly highlighted throughout the integrative literature review and consultation process. Therefore, a list of structured activities for nurses to implement on their unit is included. This includes links to these activities for ease of administration, such as adult coloring, guided painting, yoga, and guided meditation. At the end of this module, there is a true or false quiz to test learners' knowledge.

The sixth and final module, includes education for nurses on supporting families of loved ones with BPD. This module highlights the importance of approaching families in a non-judgmental manner, as families of individuals with BPD often face severe stigma. This module also includes information on educating families on the BPD diagnosis, their role during a crisis, considerations for the home environment, and self-care tips for families. There is also a component on cultural considerations for nurses, as not all families have the same understanding of mental health. To conclude this module, there is a multiple-choice quiz to test the retention of the information presented.

Developing this self-directed learning resource was essential to creating a learning experience that addressed the knowledge gaps and unique learning needs of nurses working in the SSU and the PAU. Clinical nurses requested learning that can be completed on their own time, at their own pace, and accessible on the computers at work. They also suggested interactive components and activities such as case studies to test their knowledge. Nurses can now use this self-directed learning resource to guide their nursing practice and increase confidence levels when caring for individuals with BPD. Hopefully, with this increased

education on the complexities of BPD, nurses on these units will become more effective, confident, empathetic caregivers and improve patient outcomes.

Advanced Nursing Practice Competencies

Throughout the development of this practicum project thus far, the following advanced nursing practice competencies outlined by the Canadian Nurses Association (CNA; 2019) were demonstrated: optimizing health systems, leadership, education, and research.

Optimizing Health System Competencies

According to the CNA (2019), advanced practice nurses contribute to the effective functioning of health systems. They engage team members in resolving issues, generating new nursing knowledge, and advocating for clients. Through the consultation component of this practicum project with key informants, I was able to identify a priority practice issue and the appropriate steps to begin resolving this issue in the best way to address nurses learning needs. Furthermore, through the remainder of my career as a nurse, I will continue to advocate for patients with BPD by contributing to this topic and raising awareness of the associated stigma.

Leadership Competencies

According to the CNA (2019), advanced practice nurses are leaders in their organizations, consistently seeking effective ways to practice and improve patient care. Throughout this practicum project, I identified problems on the unit and initiated change to address the challenges of caring for patients diagnosed with BPD. The self-directed learning resource provides the necessary education for staff nurses to care for this patient population and decrease these challenges while improving patient care. Through the research conducted

in this practicum project, I have personally gained a deeper understanding of the complexities of the BPD diagnosis. I have improved my attitude towards this patient population and will continue to be a role model for my co-workers.

Educational Competencies

Advanced practice nurses can plan, initiate, and coordinate educational programs based on needs and priorities (CNA, 2019). Through consultations with the nurses on my unit, I identified that education on BPD was required. I then developed a self-directed learning resource to address this learning need. Going forward, I plan to work in consultation with other advanced practice nurses to determine if other practice areas would benefit from this education. Beyond the creation of this learning resource, I will continue to act as a mentor for my co-workers by continuously creating opportunities to learn.

Research Competencies

Advanced practice nurses are committed to synthesizing and applying research evidence (CNA, 2019). This competency has been met by completing an integrative literature review using relevant and current qualitative, quantitative, and mixed-method studies. By appraising and synthesizing the data obtained through this process, the created self-directed learning resource provides nurses with current best practice strategies. I plan to continue improving my research skills and appraisal abilities going forward as an advanced practice nurse.

Next Steps

The plan for implementing the self-directed learning resource is to first have it accessible to nurses in my practice setting after approval from the unit manager. After manager approval, the online resource will be placed on the desktop computers at work. To introduce the resource to staff, I plan to attend a weekly call-in staff meeting to raise

awareness of the availability of this resource and to answer associated questions. An evaluation form will be printed and available for staff to fill out after completing the learning resource. Questions on this evaluation form explore whether nurses felt the information was relevant to their practice, if the suggested interventions were deemed useful, and if their confidence levels and attitudes improved. This form also includes a comment section to assess if nurses feel any changes should be made to provide a more effective learning experience.

Moving forward, I plan to share this learning resource with the clinical educator of the mental health and addictions program to hopefully have this education accessible on the Eastern Health learning management system. I would then recommend an electronic version of the evaluation form to be provided. The goal would be to promote this education for nurses doing orientation for the SSU and the PAU. I will also collaborate with the educator to determine if other units may benefit from this education, as it is reasonable to assume the associated challenges in caring for individuals with BPD exist elsewhere in the program.

For a more comprehensive evaluation, I would recommend chart audits to determine if the resource components are implemented in practice. For example, through chart audits, it can be determined if family education is being provided. A chart audit could also determine if there is a reduction in self-harm on the unit or if the appropriate interventions are being implemented by nurses when patients self-harm. If the self-directed learning resource is deemed effective, it could be presented at an education day for the mental health and addictions program or an annual conference (e.g., the Canadian Federation of Mental Health Nurses).

Conclusion

The goal of this practicum project was to create a learning resource for nurses in the

mental health setting, improve the effectiveness of the nursing care provided to individuals who have BPD, and improve nurses' experiences caring for this patient population. This goal was accomplished by conducting an integrative literature review, consultations with key stakeholders, and an environmental scan. Each process provided valuable contribution to the development of the learning resource. A self-directed learning resource with relevant, evidence-informed information on effectively working with individuals with BPD and their families was developed using the findings, which resulted in a comprehensive resource that addressed the unique learning needs of the nursing staff on the SSU and the PAU.

The process of developing this self-directed learning resource allowed me to demonstrate advanced nursing competencies in optimizing health systems, leadership, education, and research. I have become a more competent and knowledgeable practitioner by meeting the objectives in this practicum course, and I will continue to develop the required skills for advanced nursing practice. This practicum project's development has helped me become an effective agent of change while contributing to improved nursing practice and enhanced quality of care for individuals with BPD in the mental health setting.

Moving forward, I will continue to collaborate and consult with healthcare providers to effectively address challenges and advocate for patients' needs to provide them with the best nursing care possible. Furthermore, I will continue to advocate for nurses and ensure they are provided with the education required to care for various patient populations competently to minimize the challenges and stress they face in nursing practice.

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Appendices

Appendix I: Integrative Literature Review

Nursing Care for Individuals with Borderline Personality Disorder: An Integrative Literature Review

Olivia Cobbs, 200913283

Memorial University of Newfoundland and Labrador

Abstract

Background: There is an abundance of literature describing the negative experiences individuals with borderline personality disorder (BPD) have with the healthcare system. Healthcare professionals, especially nurses, have identified various barriers associated with effective provision of care for this patient population. Evidence conveys a sense of negativity towards individuals with BPD, impacting nurses' experiences caring for this patient population and the care these patients receive. **Objective:** This literature review aims to identify effective nursing approaches and interventions that will reduce care challenges and improve the inpatient care experience for individuals with BPD. **Methods:** A search strategy for this integrative literature review involving four databases was conducted; CINAHL, PubMed, PsycInfo, and Google Scholar. This search strategy initially produced 226 research studies that fit the inclusion and exclusion criteria. **Results:** Seventeen studies were included in this integrative literature review that addressed the outlined research questions. Of those included, 11 were qualitative research, three were quantitative research, and three were mixed-methods research. Study findings were analyzed, and four themes were generated: nursing care during brief hospital admissions, nursing interventions, therapeutic relationships, and a need for education to guide nursing practice. **Conclusion:** Findings will be used to guide the development of a learning resource for nursing staff on the short-stay and psychiatric assessment units at the Waterford Hospital in St. John's, Newfoundland and Labrador. Peplaus' theory of interpersonal relations and Knowles' adult learning theory will also guide the development of the learning resource.

Key Words: Borderline personality disorder, integrative review, nursing interventions.

Nursing Care for Individuals Diagnosed with Borderline Personality Disorder: An Integrative Literature Review

A personality disorder is a manner of thinking, feeling, and behaving that deviate from cultural expectations, creating distress or functional problems, and persisting over time (American Psychiatric Association [APA], 2013). Borderline personality disorder (BPD) is the most common type of personality disorder. It is characterized by instability of interpersonal relationships, self-image, emotions, and impulsivity across various situations, causing significant impairment (Skodol, 2012). The most dangerous features of BPD are self-harm and suicidality, with 70% of people with BPD making at least one suicide attempt in their lifetime (Wedig et al., 2012). Even more concerning, between 8-10% of people with BPD will complete suicide, which is 50% times the rate of suicide for the general population (Wedig et al., 2012). Given that individuals with BPD comprise up to 20% of all psychiatric inpatient admissions, it is essential to provide a therapeutic approach to this population (Gunderson, 2011).

BPD differs from other mental illnesses, making it extremely difficult to diagnose and treat (National Alliance on Mental Illness, 2017). Patients diagnosed with BPD are considered challenging to care for due to their emotional instability, intense anger, poor impulse control, and self-mutilating behaviors (APA, 2013). Due to the nature of these complex symptoms, mental health clinicians may withdraw from these patients to protect themselves from these distressing types of behavior (Aviram et al., 2006). Unfortunately, this withdrawal can be a significant barrier to effective treatment for these individuals, prompting further self-harm and suicidal behaviors.

Research has shown that mental health nurses hold the poorest attitudes of all

professional groups towards individuals with BPD (Bodner et al., 2011; Bodner et al., 2015). Negative reactions from nurses can lead to counter-therapeutic conditions, including premature termination of treatment, emotional distancing, a lack of belief in recovery, difficulty empathizing, and perceptions of patients as dangerous, manipulative, and more in control of their behaviors than other patients (Aviram et al., 2006; Knaack et al., 2015; Sansone & Sansone, 2015). In addition, nurses react to individuals with BPD more negatively and stigmatizing than patients with alternative psychiatric diagnoses, impacting the nursing care they provide for these individuals (Dickens et al., 2016). Care of patients with BPD can be extremely stressful and challenging for nurses. The frustrations associated with their challenging behavior can lead to negative attitudes from carers, which can impact patient's health outcomes.

Informal discussions with nursing staff on the short-stay inpatient unit and psychiatric assessment unit at the provincial psychiatric hospital in Newfoundland and Labrador indicated that the abovementioned problem also exists in this setting. Staff members confirmed the challenges of caring for individuals with BPD, expressed a lack of optimism in their recovery outcomes, increased hopelessness, and stress, and voiced a lack of knowledge and guidance in their nursing care. Despite these concerns, there is minimal formal education for nurses caring for individuals with BPD on these nursing units. Therefore, a learning resource will be developed to address the impact of this disorder and improve nurses' knowledge, attitudes, and the quality of nursing care provided to this patient population in the mental health setting.

A review of the literature was warranted to highlight best practices for inpatient mental health nurses when caring for individuals with BPD and education strategies most helpful in addressing the identified barriers. This integrative literature review provides

evidence that implementing effective nursing interventions, promoting strong therapeutic relationships, and increasing the education provided to nurses can improve the quality of nursing care for individuals with BPD and improve nurses' experiences caring for this patient population. This, in turn, will promote recovery and improve experiences for individuals with BPD.

Background

A personality is a longstanding way of perceiving, relating to, and thinking about the environment and oneself (Gunderson, 2011). When these traits are maladaptive and cause significant functional impairment or subjective distress, they constitute a personality disorder (Gunderson, 2011). There are ten classified personality disorders, with BPD being the most common and most complex. According to the DSM-V (2013) criteria, for a patient to be diagnosed with BPD, they must experience five out of nine criteria. These criteria include fear of abandonment, unstable or intense relationships, identity disturbance, impulsivity, suicidal or self- injurious behaviors, emotional instability, emptiness, anger, or psychotic-like perceptual disturbances. About 1 to 2 % of the general population have BPD, and it is more likely to be diagnosed at the age of 20, which is also the age group with the highest suicide risk (CAMH, 2014). This prevalence rate may also be even higher, as research has shown that over 40% of people with BPD have been previously misdiagnosed with other disorders like major depressive disorder and bipolar disorder (Ruggero, 2010). Research indicates that BPD has a higher incidence of occurrence than schizophrenia or bipolar disorder (McGrath & Dowling, 2012).

Individuals with BPD have been found to have significant impairment at work, in social relationships, and at leisure (Gunderson, 2011). They are highly sensitive and can react

with intense emotions to small changes in their environment (CAMH, n.d.). Living with BPD can often be described as living in constant emotional pain, and BPD symptoms are the result of efforts to cope with this pain (CAMH, n.d.). The manifestations of this disorder create barriers in aspects of everyday life, including relationships, education, work, recreation, and personal development (Hoffman et al., 2021). Affected individuals struggle to create close relationships, inhibiting their ability to find a significant other, and often destroy relationships with friends, family members, and their children (Hoffman et al., 2021). They may also struggle to collaborate with colleagues, impacting their careers. Not everyone with BPD has the same experiences or symptoms. Those who continue successful treatment often have a better ability to control their emotions and maintain healthy relationships and overall health (Hoffman et al., 2021).

The cornerstone treatment for BPD is psychotherapy, intending to decrease self-harm, suicidality, and the use of hospitals, emergency rooms, and medications (Gunderson, 2011). Psychotherapy can increase individuals' use of adaptive coping skills, reduce dysfunctional coping skills, and improve their quality of life and social adjustment (Robinson et al., 2018). A common type of psychotherapy widely used and validated is dialectical behavior therapy (DBT), which combines individual and group therapy to teach skills to regulate intense emotional states and diminish self-destructive behaviors. Other psychotherapies include cognitive-behavioral therapy (CBT) and mentalization-based therapy (MBT; Gunderson, 2011).

Medications are not typically prescribed as a primary treatment for BPD, but targeted medication for specific symptoms may be advised. Through a literature review conducted by Ripoll (2013), evidence suggested that anticonvulsants and atypical

antipsychotics are most effective in treating the symptoms associated with BPD due to their benefits on impulsivity. Anti-depressant medications can be helpful to treat comorbid mood and anxiety disorders. Additionally, brief voluntary admissions to an inpatient mental health facility have proved helpful for patients with BPD in a crisis (Helleman et al., 2018). However, despite these promising treatment options, patients often exhibit high rates of termination of treatment and ongoing dependence on the mental health system (Dickens et al., 2016).

Although BPD treatment has been extensively researched and identified, healthcare professionals, especially nurses, have identified various challenges to their effective care for this patient population. Evidence conveys a sense of negativity towards individuals with BPD, who are stereotyped by healthcare professionals and are assumed to be manipulative, and attention- seeking and have reported significant discrimination when attempting to seek help (Lawn & McMahon, 2015a; McGrath & Dowling, 2012; O'Connell & Dowling, 2013). Nurses are at the front line of care for patients when they present to emergency departments (ED) and when they are admitted to the hospital. Despite their essential role in caring for individuals with BPD, staff nurses have the lowest self-ratings on empathy towards patients with BPD and treatment optimism than all other health care providers (Black et al., 2011). Individuals with BPD in a qualitative study by Vandyk et al. (2019) described receiving negative reactions from healthcare workers. They felt their BPD diagnosis was enough for their needs to be dismissed, which led to subsequent ED visits.

When there is a non-therapeutic relationship between nursing staff and patients with BPD, it can negatively impact nurses' well-being and work-life by producing feelings of guilt, anger, frustrations, and hopelessness, which leaves nurses feeling that there is no way to

facilitate a favorable recovery for these patients (Eren & Sahin, 2016). In the mixed methods study by McGrath and Dowling (2012), nurses felt that patients with BPD were challenging, difficult, manipulative, destructive, and threatening, and caring for these individuals brought them tension and stress. In a systematic review by Dickens et al. (2016) on mental health nurses' experiences caring for individuals with BPD, researchers found that nurses reported feelings of inadequacy and powerlessness regarding their care due to the intense symptoms exhibited by individuals with BPD. The stress of caring for these individuals would cause them to dread going to work instead of having a positive desire to help. Nurses often experience anger, frustration, inadequacy, and feelings of being challenged in response to patients with BPD (Commons Treloar & Lewis, 2008). Care of patients with BPD is an important issue for nursing practice in that these often-strained relationships can have a substantial negative impact on nurse's well-being.

Families also struggled with caring for loved ones with BPD. In a mixed-methods study by Ekdahl et al. (2011), families of individuals with BPD felt they were tiptoeing around their loved one in fear something bad would happen. In addition, families felt psychiatric care lacked a comprehensive view and that nurses were seen as kind and caring but lacked the adequate knowledge to care for their loved ones. In a similar study by Lawn and McMahon (2015b), 88.2% of families of individuals with BPD did not feel they were taken seriously, and 62.4% reported that the diagnosis of BPD had never been explained to them by healthcare professionals.

Knowledgeable mental health nurses can aid in rehabilitating patients with BPD by using the relationships formed with these patients and implementing empathy and good communication skills while avoiding withdrawal (Ritter & Platt, 2016). Due to the complexity

of the diagnosis and the associated negative attitudes, it is challenging for nurses to care for patients with BPD if they do not have the appropriate education. By improving nurse's attitudes and knowledge of BPD and implementing successful nursing interventions, nurses can improve the quality of care they provide for this patient population and, in turn, improve patient outcomes. A need exists for formal education on BPD so that nursing staff are equipped with best practices on how to interact effectively and care for these individuals and help reduce the associated challenges highlighted by nursing staff. Given the difficulties that individuals with BPD have faced throughout their lives and the complexities and challenges associated with this diagnosis, it is essential to ensure nurses have a good understanding of BPD and that nurses' attitudes are conducive to developing a strong therapeutic relationship with these individuals (Stroud & Parsons, 2013).

Methods

Integrative literature reviews are important for the nursing discipline, as they have the potential to build nursing science and inform research, practice, and policies (Whittemore & Knafl, 2005). An effective integrative literature review includes clear identification of the problem and determination of a research question. Two research questions guided this integrative literature review:

1. What are best practices for inpatient mental health nurses when caring for individuals with BPD?
2. What educational initiatives have successfully demonstrated improvements in nurses' knowledge and attitudes related to caring for individuals with BPD?

Search Strategy

The literature search was conducted to locate available quantitative, qualitative, and

mixed-method studies from scholarly peer-reviewed journals published in the English language that addressed the review research questions. No restrictions were placed on the geographical location to obtain a global view of best practices in caring for individuals with BPD. Studies from the last ten years only were included in this search (i.e., 2011-2021) to ensure recent evidence. A focus was placed on obtaining nursing research only; however, other allied health journals were included if deemed relevant for this review.

Four databases were searched: CINAHL, PubMed, Google Scholar, and PsycInfo. Keywords included a variation of "borderline personality disorder," "nursing interventions," "nursing care," "psychiatric nurse," "mental health nursing," and "crisis inpatient unit." With the same search terms implemented for each database, initial searches yielded 226 results, with most of the studies found from Google Scholar (n=99), and the remainder from PubMed (n=85), CINAHL (n=35), and PsycInfo (n=7). A critical review of the titles and abstracts was conducted, and cross-referencing databases to assess for duplication of studies. Additionally, reference lists of articles were reviewed for usefulness. Leads were perused until the search strategies yielded redundant information. Once deemed relevant to the research question, 24 articles were read in full for further appraisal.

Quantitative studies were critiqued using the Public Health Agency of Canada (PHAC) critical appraisal toolkit (2014). Qualitative studies were appraised using the Critical Appraisal Skills Program (CASP) checklist (2017). Mixed-methods studies were appraised using the Mixed Methods Appraisal Tool (MMAT; 2018), but the quality of the quantitative and qualitative components was also individually appraised. Studies were assigned an overall quality, and data from each of the included studies deemed relevant to the research question were then read through for opportunities to categorize data. Studies were discarded if they

were appraised as low quality or lacked contribution to the review. Overall, the quantitative studies had weak study designs of medium quality. The quality of the qualitative studies varied, with a significant number of studies not having an identified methodology which decreased the rigor of some of the studies. Furthermore, mixed-method studies were deemed medium quality based on several strengths. Literature summary tables for select studies can be found in the Appendix.

Results

Seventeen articles were identified for analysis in this integrative literature review. Three quantitative studies, 11 qualitative studies, and three mixed-method studies were included. Study settings varied, with most studies conducted in inpatient mental health units (n=9). Some studies were conducted in community mental health services (n=4) and tertiary hospitals (n=3) but were deemed relevant to this review due to the nature of the findings and insight into best practices. One study, which sampled second year nursing students was included as it directly contributed to the second research question. Geographic settings varied, with most studies conducted in the United Kingdom (n=11), with the rest in the Netherlands (n=2), Canada (n=2), United States of America (n=1), and Sweden (n=1). Most of the studies were from nursing journals (n=15). Themes were developed from study results, and a synthesis of the findings was developed for each theme. Four themes emerged from the literature: nursing care during brief hospital admissions, nursing interventions, therapeutic relationships, and education.

Nursing Care During Brief Hospital Admissions

Six studies explored using a brief admission (BA) as a treatment option for individuals diagnosed with BPD and the associated nursing care during these admissions. Five of these

studies were qualitative studies (Eckerstrom et al., 2019; Helleman et al., 2014; Helleman et al., 2016; McGrath & Dowling, 2012; O'Connell & Dowling, 2013) and one was a quantitative study with a Delphi design (Helleman et al., 2018). In this context, a BA can be described as an admission to a hospital that has a predetermined maximum duration, a predetermined maximum number of admissions per year, and an outlined treatment plan (Helleman et al., 2014).

Helleman et al. (2018) identified that although a BA was widely used as an intervention for BPD, it lacked clear operational standards. Therefore, a modified Delphi research study was implemented. A multidisciplinary panel of experts was formed with a total of 74 participants, including nurses (n=62), psychiatrists (n=8), and researchers who have previously published on the treatment of BPD (n=4). Surveys were sent out to each participant to obtain a consensus on which components of a BA intervention were essential for patients with BPD. There was 100% consensus among the expert panel that the BA plan must be developed in consultation with the patient before admission. This plan must include the aim of the BA and the limit to how long the BA will last. Additionally, 94% agreed that limits must be enforced during the BA and that premature discharge is justified if aggressive behavior or self-harm was noted on the unit.

Although the findings from this study are essential to add to the existing knowledge of BAs, it is imperative to note the risk of selection bias due to the purposeful sample used to form the panel of experts. This was deemed necessary to ensure the participants were representative of the population of mental health experts. However, including patients' experiences in the study would have been beneficial due to their specific experiences with BAs. Furthermore, a lack of generalizability is possible due to the utilization of one single

hospital. Overall, this quantitative study was deemed medium quality based on these limitations.

Both studies by Helleman et al. (2014) and Helleman et al. (2016) explored the experiences of individuals with BPD during a BA intervention. In the phenomenological study by Helleman et al. (2014), 17 outpatients with BPD were interviewed. Participants described that using a BA intervention helped improve their self-esteem and helped them overcome a crisis without a loss of control. Worth noting, only one researcher was included in the interviews, and there was no identification if the interviewer critically examined their role, potential bias, and influence during the study. Similarly, in the descriptive case study of one individual with BPD over seven years, similar findings were reported (Helleman et al., 2016). The participant described how BAs had helped her overcome a crisis as a result of being in a safe and assuring environment. BAs had also helped her practice autonomy for her recovery and reinforced newly acquired coping skills. It is important to note that recall bias is the main limitation of this studydue to the retrospective nature of data collection. In both studies, the methodology was identified, and the researchers justified the research design making them overall good qualitative studies.

To explore nurses' perspectives of BAs for individuals with BPD, Eckerstrom et al. (2019) interviewed eight nurses to describe their experiences of caring for individuals with emotional instability and self-harm. Nurse participants found that direct communication during a BA reduced misunderstanding due to the predetermined focus of care and length of stay. Nurses also described using a BA to improve the nurse-patient relationship by providing structure and more emphasis on developing a caring relationship. The concept of structure was echoed in the Delphi study (Helleman et al., 2018), where 78% of the expert panel agreed that

the daily structure of a BA could help a patient gain control, while 94% agreed that nursing staff should aid in planning daily activities to promote this structure during the BA. Unfortunately, in the study by Eckerstrom et al. (2019), although the qualitative method was appropriately chosen to address their research goal, researchers did not identify a specific methodology which impacted the study's rigor. Nevertheless, this remained a good qualitative study due to several strengths. There was an in-depth description of the data analysis process that appeared sufficiently rigorous and a clear statement of findings.

Contrastingly, McGrath and Dowling (2012) conducted a mixed-methods study, and O'Connell and Dowling (2013) conducted a qualitative study, both exploring psychiatric nurses' experiences caring for individuals with BPD. In both studies, researchers found that nurses agreed that individuals with BPD should not be cared for in the hospital environment. The qualitative findings in the study by McGrath and Dowling (2012) revealed that participants suggested an outpatient specialized community service as the most effective treatment for this patient population, while nurses in the study by O'Connell and Dowling (2013) also agreed that the treatment environment of choice is in the community. However, participants in the latter study did acknowledge that a BA was sometimes necessary as a place of safety in times of crisis. However, two participants identified that a BA was counterproductive, as they felt issues that precipitated a crisis would continue to be present on discharge (O'Connell & Dowling, 2013).

Limitations exist for both studies. For example, McGrath and Dowling (2012) did not identify a specific methodology. However, researchers presented a strong recruitment strategy, with participants having extensive experience with individuals with BPD, which was appropriate to the study's aims, making this a good study providing valuable results. More

limitations were found in the study by O'Connell and Dowling (2013), which decreased its quality. Researchers did not mention a specific methodology and were not explicit on the data collection methods or how data was collected. Researchers did, however, discuss the contribution their study results made to existing knowledge but did not identify new areas where research is needed.

In summary, the importance of structure during a BA intervention for individuals with BPD was evident. It appears that BAs may have the potential to improve the nurse-patient relationship and reduce misunderstandings. Although the experiences from nurses and patients are overall positive, more research of stronger study designs is required to support the effectiveness and core components of a BA, along with nursing education on effective nursing care during BAs.

Nursing Interventions

Seven studies identified nursing interventions that were found to be effective when caring for individuals with BPD. One study was a cross-sectional non-experimental design deemed medium quality (Bowen & Mason, 2012). Six studies were qualitative (Bowen, 2013; Eckerstrom et al., 2019; O'Connell & Dowling, 2013; Stroud & Parsons, 2013; Vandyk et al., 2019; Warrender, 2015). This theme is divided into two sub-themes: nurses' strengths and skills and therapeutic framework.

Nurses Strengths and Skills

Five studies explored nurses' specific strengths and skills that were effective in caring for individuals with BPD (Bowen & Mason, 2012; Bowen, 2013; Eckerstrom et al., 2019; O'Connell & Dowling, 2013; Vandyk et al., 2013).

Bowen and Mason (2012) conducted a survey with 415 forensic nurses and 382 non-

forensic psychiatric nurses to explore the strengths and skills they identified as effective when caring for individuals with BPD. The non-forensic nurses identified their main strengths and skills as being non-judgmental, the ability to listen, being open-minded, and the ability to conduct a good risk assessment. In contrast, the forensic nurses identified their strengths and skills as being firm, setting limits, defining boundaries, being non-judgmental, and non-threatening. Although this study was appraised as medium quality, there are limitations worth noting. There was no attempt to assess the validity of the questionnaire they utilized for data collection. However, content validity can be assumed based on the nature of the questions. There was also only a response rate of 41.9% from forensic nurses. For a cross-sectional study, greater than 50% of those approached should have agreed to participate (PHAC, 2014).

In two qualitative studies, researchers conducted interviews to explore nurses' perceptions of good practice when caring for individuals with BPD. One was conducted with seven community health nurses (O'Connell & Dowling, 2013). One was conducted with nine clinicians, including nurses, who worked in a specialized treatment center for individuals with BPD (Bowen, 2013). Alternatively, Vandyk et al. (2019) explored patients' views by interviewing six individuals with BPD to explore their perspectives of ED visits and their interactions with the nursing staff.

Echoing the findings from the study by Bowen and Mason (2012), participants in the study by Vandyk et al. (2019) also identified the main strength for nurses in their care for individuals with BPD as the ability to be non-judgmental. O'Connell and Dowling (2013) also had similar findings as Bowen and Mason (2012), as participants identified the ability to be open-minded, listen, and conduct a good risk assessment were effective nursing interventions. Additionally, the ability to be empathetic was identified as a strength

in two of the studies (O'Connell & Dowling, 2013; Vandyk et al., 2019). The ability to build trust as a core skill was also identified in two studies, as they felt it empowered patients and provided them with opportunities to display confidence (Eckerstrom et al., 2019; O'Connell & Dowling, 2013). In the qualitative study by Bowen (2013), nurses discussed their key aspects of care as acknowledging difficult past experiences, including abuse, providing unconditional acceptance despite self-destructive behaviors, and recognition of individual strengths and personality.

The study by Bowen (2013) was a good qualitative study with several strengths. Most importantly, the researcher explicitly described their attempts to support the rigor of their research. For example, purposive sampling was conducted, along with an audit trail of data analysis. However, despite these strengths, the researcher did not explicitly justify the research design or identify a specific methodology.

Furthermore, Vandyk et al. (2019) conducted a strong qualitative study with minimal concerns. Researchers provided a thorough description of their chosen methodological processes. In addition, they explicitly described the process researchers took to address their own bias and influence during the study and engaged in reflective conversations, which enhanced the study's rigor. However, researchers did not include a set time between ED visits and the study period in their inclusion and exclusion criteria. Therefore, some participants who recently presented to the ED focused on their most recent visit, while others provided a more comprehensive view.

Overall, despite the absence of analytic study designs, the qualitative studies and cross- sectional study provided valuable information on effective nursing interventions in caring for individuals with BPD. It is apparent that being open-minded, non-judgmental,

trusting, and conducting a good risk assessment appear to be effective nursing interventions. However, it is evident more research is required of stronger study designs.

Therapeutic Framework

Four qualitative studies identified the benefit of a therapeutic framework to guide nursing practice in caring for individuals with BPD and how a lack of a framework has an impact on the care they provide (Bowen 2013; O'Connell & Dowling, 2013; Stroud & Parsons, 2013; Warrender, 2015). A therapeutic framework can be described as a model of care with a shared vision of treatment and a basis to understand behavior and competencies to address these behaviors (Stroud & Parsons, 2013).

Stroud and Parsons (2013) conducted a phenomenological study. They interviewed four community psychiatric nurses to gain a fuller understanding of how nurses understand the BPD diagnosis and how their constructs of BPD impact their approach to care. Researchers found that participants in their study voiced that when they had a framework to guide nursing care, they were more likely to express positive attitudes towards caring for patients with BPD. Conversely, when nurses did not have a framework to explain current behaviors, they viewed the behavior as manipulative and attention-seeking. This qualitative study was of good quality, as they explicitly justified their research design and its effectiveness in addressing the research goal. In addition, they provided an in-depth discussion of the implications of current and future research. However, the researchers did not explicitly state if they critically examined their role for possible bias and influence during data collection or analysis.

Bowen (2013) aimed to identify good practices among mental health professionals working in a specialized treatment center who utilized the therapeutic community model to

guide their practice. This model included involving the patients with BPD in their treatment plan, daily community meetings, involvement in risk assessment, and group-based therapy. After conducting interviews of four nursing staff working on this unit who followed this model to guide their care, participants expressed an optimistic view of recovery. They felt some behaviors usually seen as difficult were viewed as learning opportunities. Nurses in two other studies expressed that they would have appreciated an opportunity to seek support, most notably clinical supervision such as that offered in study settings where a framework was in place (O'Connell & Dowling, 2013; Warrender, 2015). Although appearing beneficial, further research is required to determine components of a therapeutic framework to implement in practice.

Therapeutic Relationships

One quantitative study (Helleman et al., 2018) and four qualitative studies examined the benefit of therapeutic relationships in the recovery of individuals with BPD (Bowen, 2013; Helleman et al., 2014; Helleman et al., 2016; Rogers & Acton, 2011). This theme is divided into two sub-themes: relationships with nursing staff and relationships with peers.

Relationships with Nursing Staff

Four studies highlighted the importance of the therapeutic relationship between individuals with BPD and nursing staff concerning their recovery (Helleman et al., 2014; Helleman et al., 2016; Helleman et al., 2018; Rogers & Acton, 2011). In the phenomenological study by Helleman et al. (2014), participants highlighted that the quality of their contact with a nurse was the most important aspect of their BA. Participants stressed the importance of making conversations informal by going for a walk or talking over a coffee. The nurse-patient relationship they found beneficial in

their treatment was the nurse taking an active role in structuring therapeutic conversations. In the study by Helleman et al. (2018), 84% of the expert panel agreed that patients should discuss emotions, thoughts, and stressors each day while admitted, and 76% agreed that the nurse needs to take the initiative in this conversation. In the descriptive case study by Helleman et al. (2016), the participant identified the importance of conversations with nursing staff to lessen tension. This therapeutic relationship often helped the participant recover from a crisis.

Contrastingly, Helleman et al. (2014) found that feelings of abandonment, tension, rejection, loss, and anger were reported to worsen without contact with a nurse. Additionally, in a qualitative study by Rogers and Acton (2011), researchers interviewed seven individuals with BPD to explore their experiences being cared for by nursing staff. Participants acknowledged the detrimental effects of a negative nurse-patient relationship, stating that nursing staff were noted to have negative attitudes towards their BPD diagnosis and were dismissive, unsympathetic, and insensitive. This lack of a therapeutic relationship contributed to the participants' poor experience during their BA. Although this study was well conducted, there are various limitations. Researchers did not identify a specific methodology, and they did not identify new areas where research is necessary. However, they had clear data recruitment and data collection strategies and a clear statement of findings.

Overall, these studies provided rich descriptions of patients’ and nurses’ experiences of the therapeutic relationship and its importance. Although these findings are important and add to existing knowledge, further research of stronger study designs is required before making inferences.

Relationships with Peers

Two studies identified positive relationships with peers as an essential part of recovery for patients with BPD (Bowen, 2013; Helleman et al., 2014), while one study found contrasting results (Helleman et al., 2018). In the study by Bowen (2013), each clinician mentioned peer support as good practice for patients with BPD, and peers could support each other when distressed. Similarly, Helleman et al. (2014) found that individuals with BPD voiced that contact and communication with other patients provided needed support throughout their BA. Contrastingly, Helleman et al. (2018) discovered that 80% of clinicians on the expert panel agreed that contact with other patients might induce stress and that it is imperative limits are set with fellow patients. Due to the contrasting views noted amongst the literature on the effectiveness of relationships with peers on recovery outcomes for individuals with BPD, this information can be used as a basis for further research.

Education

Seven research studies were retrieved that discussed the effectiveness of education for nurses caring for individuals with BPD. This included two cross-sectional studies (Dickenson & Hurley, 2011; Hauck et al., 2013), one uncontrolled before and after (UCBA) study (Knaack et al., 2015), two mixed-methods studies (Dickens et al., 2018; McGrath & Dowling, 2012) and two qualitative studies (Stacey et al., 2017; Warrender, 2015).

Knaack et al. (2015) and Dickens et al. (2018) conducted UCBA studies, but Dickens et al. (2018) included an additional qualitative component. Knaack et al. (2015) evaluated an anti- stigma program and its effectiveness in changing healthcare providers' perceptions towards individuals with BPD. The anti-stigma program included a three-hour educational workshop on BPD and DBT. Dickens et al. (2018) evaluated the effectiveness of a one-day BPD training program, including the science behind BPD and practical advice. Knaack et al.

(2015) found that the anti-stigma intervention was successful at improving attitudes towards individuals with BPD ($p<0.002$). Participants in the study by Dickens et al. (2018) voiced that the education was already known and more suited for undergraduate nursing students. More positively, staff felt that reflecting on their emotions in caring for individuals with BPD was helpful and that they benefited from the practical advice.

The study by Knaack et al. (2015) was appraised as medium quality, based on certain limitations. For example, random sampling was not used, but similar recruitment was applied to all participants. Furthermore, there was no attempt to assess the validity and reliability of the instrument used to collect data. In the medium quality study by Dickens et al. (2018), researchers did not provide an adequate rationale for using a mixed methods design to address the research question. However, a clear statement of findings showed the added value of conducting a mixed- methods study. Furthermore, for the qualitative findings, researchers discussed their own potential bias and position in the research.

In the study by Hauck et al. (2013), researchers administered a survey to 83 psychiatric nurses working with adult patients who self-harmed. With a similar approach, Dickenson and Hurley (2011) administered the self-harm antipathy scale to explore the antipathy of nursing staff working with patients who self-harm. In the study by Dickenson and Hurley (2011), researchers found that nurses displayed significantly lower levels of antipathy if they had received previous education in self-harm ($p=0.002$). Similarly, in the study by Hauck et al. (2013), researchers found that 86.7% of nurses in the study reported that continuing education about BPD would help in caring for individuals who self-harm. The study by Hauck et al. (2013) was deemed medium quality, based on the utilization of a valid and reliable data collection tool, multiple recruitment strategies, and the power was adequate to draw inferences.

However, some missing data was noted. Dickenson and Hurley (2011) also conducted a medium-quality study based on a lack of generalizability due to its focus on forensic inpatient units and the possibility of self- report bias.

Warrender (2015) assessed nurses' perceptions of the effectiveness of a two-day workshop titled MBT-S. This workshop was aimed to provide mental health professionals with the skills to care for individuals with BPD. Stacey et al. (2017) aimed to explore nursing students' experiences of a training program focused on BPD and their perception of its influence on attitudes and understanding. Alternatively, McGrath and Dowling (2012) explored 17 psychiatric registered nurses' interactions and levels of empathy towards individuals with BPD. In the studies by McGrath and Dowling (2012) and Warrender (2015), researchers found that participants with knowledge behind the complexities of BPD displayed higher levels of empathy towards individuals with BPD. Stacey et al. (2017) and Warrender (2015) also found similar results, that when nurses had more of an understanding of the reasons behind behavior, they no longer saw patients as deliberately difficult. Contrastingly, Dickens et al. (2018) found no change in the perception that individuals with BPD were difficult to treat after their education session.

Warrender (2015) and Stacey et al. (2017) conducted good qualitative studies with several strengths and limitations. Warrender (2015) identified the interpretive phenomenological approach to guide their analysis and sufficiently justified their research design choice. Alternatively, Stacey et al. (2017) did not identify a specific methodology and did not justify their choice in qualitative research. However, their data appeared sufficiently analyzed, and recruitment strategies appeared appropriate.

Two studies revealed nurses' suggestions for effective education interventions. In the

study by Hauck et al. (2013), 69% of nurses suggested that regular in-services and skills training workshops would be the most effective means of education. Similarly, McGrath and Dowling (2012) found that improved education and skills training for nursing staff would be the most probable way to improve nursing care for individuals with BPD.

Overall, evidence shows promise that increased education on BPD can improve nurses' attitudes and increase levels of empathy while improving confidence in caring for individuals with BPD. Skills training appeared to be a common suggestion in types of education requested on this topic.

Discussion

Overall, the quantitative findings resulted in a weak quality of evidence, based on direct evidence from multiple weak design studies, of medium quality (PHAC, 2014). Qualitative studies were the most common type of study and were used to gain a richer understanding of the experience of nurses in caring for individuals with BPD. However, the importance of qualitative research cannot be negated. This type of research describes issues that can be used as a basis for more research and can encourage nurses to listen to patients' detailed descriptions of their experiences or be aware of similar experiences other nurses globally are undergoing. In addition, this type of research can help nurses be more understanding, sensitive, and empathetic towards the experiences of individuals with BPD.

However, it remains clear that further research is needed. For example, it appears research has been developing throughout the United Kingdom on best practices for BPD, but only two studies were conducted in Canada, fitting the inclusion-exclusion criteria. Although this information is imperative and adds to the knowledge base on this topic, additional Canadian research is required to better inform nursing practice here in

Newfoundland and Labrador. Specifically, high-quality intervention studies to guide nursing practice are required.

It appears well documented that nurses have negative attitudes towards individuals with BPD and that patient outcomes are impacted by this negativity. As evidenced by the review findings, it is apparent that mental health nurses require further education and training for caring for individuals with BPD. It is also evident that nurses with education and training on BPD have more positive attitudes and increased empathy with this patient population.

The literature provides a clear basis that this issue must be addressed, and action needs to be taken to increase nurses' knowledge and confidence in caring for these individuals. Overall, the themes of this integrative literature review showed favorable outcomes with the use of BAs, specific nursing interventions, therapeutic relationships, increased education, and the implementation of therapeutic frameworks to guide nursing practice.

Theoretical Framework

A theoretical framework to guide the development of this learning resource was identified that highlighted the importance and nature of the therapeutic nurse-patient relationship. In addition, the adult learning theory was also chosen to ensure the unique needs of adult learners were addressed in the development of an educational initiative. Both Peplau's theory of interpersonal relations and Knowles' adult learning theory were identified to provide the theoretical underpinnings of the educational resource.

Peplau's Theory of Interpersonal Relations

Peplau's theory of interpersonal relations is a middle-range nursing theory that acknowledges the importance of patient experiences in nursing care (Hagerty et al., 2017). The effect of the nurse-patient relationship on the patients' experience of care is emphasized

in this theory. According to Peplau, for the relationship to be successful, it must pass through three phases: orientation, working, and termination (Hagerty et al., 2017).

In the orientation phase, nurses gain essential information about patients' unique needs and approach them with respect and positive interest (Hagerty et al., 2017). This step is essential for nurses caring for individuals with BPD due to the extensive literature addressing the negative attitudes nurses have towards them and the negative effects this has on their recovery outcomes (Black et al., 2011; McGrath & Dowling, 2012; Stroud & Parsons, 2013; Warrender, 2015).

During the working phase, nurses become more familiar with patients and provide reflective and non-judgmental feedback to help them clarify their thoughts (Hagerty et al., 2017). This concept is in line with the effective nursing interventions found throughout the literature. The ability to be non-judgmental was identified as the main strength for nurses caring for individuals with BPD (Bowen & Mason, 2012; Vandyk et al., 2019). The working phase is imperative, as it accounts for most of the nurses' time with the patients, and patients begin to accept nurses as care providers. In addition, patients with BPD struggle to maintain healthy interpersonal relationships; therefore, it is vital to establish this phase to prevent negative care outcomes. It also echoes the findings amongst the literature that nurses must initiate and structure therapeutic conversations (Helleman et al., 2014; Helleman et al., 2018).

The third phase is the termination phase. This phase is the final stage and marks the end of the nurse-patient relationship (Hagerty et al., 2017). The success of the termination phase is dependent on how successful the orientation and working phases were. This phase may be challenging to establish with individuals with BPD due to their intense fear of abandonment. Reassurance may be required, and reminders of outpatient resources to

support them.

Concepts of this middle-range nursing theory on a successful nurse-patient therapeutic relationship and associated phases will be integrated throughout the learning resource and help guide its development. The learning resource will be grounded in the importance of the nurse- patient therapeutic relationship in caring for individuals with BPD.

Knowles' Adult Learning Theory and Self-Directed Learning

The learning theory that will guide the creation of this learning resource is Knowles' adult learning theory. It will be used to provide insight into how adults learn and to best address the needs of the staff on both units (Teaching in Excellence and Adult Literacy, 2011). The basic assumption of adult learners is that they are self-directed and have past experiences that serve as a valuable resource for their learning and the learning of others (Candela, 2020). Furthermore, Knowles' (1984) stated that adults are motivated by present problems and personal experience. The benefit of self-directed learning is the lack of concern regarding scheduling staff; therefore, it can reach many nurses, and it is cost-effective (Sparling, 2001). Learning should occur at the learners' convenience and according to their learning preferences (Teaching in Excellence and Adult Literacy, 2011). Key concepts to follow when conducting self-directed learning include communicating ideas with employees, fostering collaboration, and encouraging opportunities for advanced learning (Rana et al., 2016).

Through a previous informal needs assessment, nursing staff have already identified a problem in their nursing practice. Therefore motivation, and readiness to learn already exist. The target learners also all have some knowledge and experience caring for individuals with BPD. Therefore, this learning resource will continue to build on previous knowledge in line with the adult learning theory. It will also be self-directed to accommodate the complexities of

a nursing schedule. Additionally, nursing staff will be involved in the creation of this learning resource through subsequent consultations. By incorporating this learning theory, the learning resource will be convenient for staff and become a frequently used learning resource to advance their knowledge and confidence in this area.

Implications for Nursing Practice

The literature included in this review has various implications for nursing practice. Although a range of barriers in caring for individuals with BPD were highlighted, the findings in this literature review on interventions to address these barriers are promising. This literature review offers evidence that delivering education to nurses and providing them with best practice evidence to guide their care for individuals with BPD has the potential to decrease these barriers and decrease frustrations in caring for this patient population. Nurses are voicing their need for education, training, and a framework to guide their nursing practice. Compelling findings from qualitative studies highlighted patients' negative experiences with the healthcare system and identified how nurses can improve their care. Nursing staff must provide structure for patients during their BA, initiate informal conversations to establish a therapeutic relationship, provide non-judgmental, open, honest communication, and conduct good risk assessments. Based on these recommendations, developing a learning resource to educate staff on the short stay and psychiatric assessment units is needed, as these are the nurses on the front lines for individuals with BPD in our province.

Conclusion

Although the barriers in care and negative attitudes from healthcare professionals towards individuals with BPD have been well documented in the literature, little has been done to solve this issue. Mental health nurses require education grounded on best practice measures

to guide their nursing practice and negate negative outcomes on themselves, patients, and families. Despite the lack of strong intervention studies, qualitative data provided rich descriptions of nurses' and patients' impressions of best practices. Evidence showed that education is needed and can effectively address this problem. Although it is apparent that more research is required, this integrative literature review emphasized the need for a learning resource to better prepare mental health nurses.

Evidence from this integrative literature review will be incorporated into the development of the learning resource. Nursing care during brief admissions and specific nursing interventions identified in this review will be included, along with the importance of nurses developing a therapeutic relationship with patients. Outlined education initiatives will be further explored and help guide the components of the resource. Furthermore, guided by Peplau's theory of interpersonal relations and Knowles' adult learning theory, this learning resource will hopefully improve nurses' knowledge and attitudes towards BPD and enhance their care to this patient population.

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Appendix A Literature Summary Tables

Study/Design	Methods	Key Results	Comments
Authors: Bowen (2013) Design: Qualitative Purpose: To explore the experiences of good practice among mental health professionals working in a service that provides specialist treatment for individuals with BPD.	N= 9 clinicians (i.e., 4 nurses, 3 social therapists, 1 art therapist, 1 psychiatrist) who worked on a specialized unit for individuals with BPD for at least one year. Country/Setting: United Kingdom/Specialized unit for individuals with BPD Data Collection: Semi-structured interviews lasting 1 and 1.5h including three broad questions. 1. What is your experience of good practice? 2. How have you learnt good practice? 3. What structures have supported this learning? Data Analysis: Thematic analysis approach. Recorded interviews transcribed by the researcher. Data coded into 4 themes. Audit trail of data analysis.	**Shared decision making** ● Importance of having structures in place to facilitate shared decision making. ● Importance of drawing on own experiences to add balance to a group's decision making. ● Uphold rules of the unit. **Social roles** ● Patients having jobs or groups on the unit. ● Being with the patient in a more authentic way. **Peer support** ● Staff must resist the role of all knowing. ● Patients should value the resources that they could provide to others, and that non-professional could provide for them. **Open communication** ● Daily meeting. ● Open communication with patients to avert crisis.	Strengths: ● Overall strong qualitative study with minor limitations. ● Purposive sampling. ● Data analysis was sufficiently rigorous. Conducted an audit trail. ● Thick descriptions of results. ● Limitations were identified. Limitations: ● Researcher did not explicitly justify the research design or research methodology. ● Did not identify new areas where research is necessary.

Study/Design	Methods	Key Results	Comments
Authors: Bowen and Mason (2012). Design: Non-experimental cross-sectional study Purpose: To identify the skills and competencies for both forensic and non-forensic nurses in caring for patients with personality disorders.	**N=** 797 nurses in clinical practice with experience with patients with personality disorders (PD). Non-forensic nurses: n=382 (76.4% response rate). Forensic nurses: n=415 (41.9% response rate). Country/setting: United Kingdom/Forensic nurses from high, medium, low, security settings. Non-forensic nurses with clinical practice in the UK. Data Collection: Postal survey sent to nurses, with data collected via an Information Gathering Schedule. Data Analysis: Microsoft excel, and SPSS used for statistical analysis.	Outcomes: 1. Main strengths and skills for nurses working with patients with PDs. 2. Main weaknesses 3. Main skills and competencies. 4. Least desirable attributes. **Non-forensic nurses** Outcome 1: Being non-judgmental, listening skills, and good risk assessment. Outcome 2: Frustration with the system, fear of aggression, and no skills to engage. Outcome 3: Being open minded, non-judgmental, and forming relationships. Outcome 4: Supercilious attitude, cynicism, and being judgmental. **Forensic nurses** Outcome 1: Being firm, setting limits, and defining boundaries. Outcome 2: Inability to engage, inability to resolve conflict, and impatience. Outcome 3: Being non-threatening, non-judgmental, and able to expect anything. Outcome 4: Over-reacting, being judgmental, and over confrontational.	Study Strength: **Weak** Study Quality: **Medium** Majority of appraisal items rated as moderate, none rated as weak. No compromise noted to internal validity of the study. Limitations: ● Demographics differed significantly between groups. ● Personality disorder is a wide term, and further research would be beneficial to identify specific problems within specific personality disorders as nurses' responses may differ. ● Low response rate in forensic nurse group (41.9%). ● No attempt to access validity of survey tool used, content validity can be assumed based on the nature of questions.

Study/Design	Methods	Key Results	Comments
Authors: Dickens et al. (2018). Design: Mixed methods (UCBA and qualitative). Purpose: To evaluate mental health nurses' experience of an educational intervention to improve attitudes towards individuals with BPD.	N= 28 nurses. Given a 1-day BPD training program including the science behind BPD, and practical advice. n=11 attended a follow up focus group. Country/setting: United Kingdom/One adult acute inpatient ward and one community day hospital team. Data Collection: Questionnaires (i.e., BPD cognitive attitudes and BPD knowledge) were delivered at three time points (pre and post intervention, and 4 month follow up). Semi-structured focus groups 4 months after intervention lasting between 60-90 mins. Audio recorded and coding applied for themes. Data Analysis: Quantitative data: All data analyzed using SPSS. Wilcoxon tests to determine pairs of scores with significant differences. Qualitative data: Coded into themes. Transcripts compared with coding frames. Final copy circulated to all authors for comments and changes.	**Quantitative Data** ● Positive changes on the treatment characteristics of individuals with BPD. ● No change in the perception that this group is difficult to treat. **Qualitative Data** Evaluating content/new learning vs. old: ● Participants found the education was already known material, more useful for undergraduates. Positive response from practical advice Care Setting/Inpatient versus day hospital experiences: ● Training interventions need to focus on the care setting where care is being delivered so that learning could translate to practice Longer term reflections/Change vs stasis: ● Staff reflecting together on emotions caring for patients with BPD was helpful.	Study Strength: **Weak** Study Quality: **Medium** ● Medium quality for both parts of study, appraised as a mixed-methods study and independently. Strengths: ● Researchers discussed their own potential bias and position in the research. ● Clear statement of findings added value of conducting a mixed-methods study. Limitations: ● Rationale not provided for using a mixed methods design. ● Study design uncontrolled and no randomization. ● Low retention for follow up (60%). ● Small sample size and lack of generalizability for quantitative findings.

Study/Design	Methods	Key Results	Comments
Authors: Eckerstrom et al. (2019). Design: Qualitative Purpose: Explore nurses' experiences with brief admissions (BA) for patients with emotional instability and self-harm.	N=10 nurses. RNs only and must workday shifts on this ward. Country/Setting: Sweden/Psychiatric clinic specialized in patients with emotional instability and self-harm. Data Collection: Semi-structured interviews. Interview guide included questions related to nurses' experiences working with BA. Interviews took place from Dec 2016 to March 2017 and lasted between 40 and 74 minutes. Interviews were audio recorded digitally and later transcribed verbatim. Data Analysis: Qualitative content analysis with an inductive approach. Open coding of transcripts and creation of categories.	**Provides security and continuity** ● Direct communication during a BA reduced misunderstanding. ● Predetermined focus of care and length of stay decreased arguments. **Fosters caring relationships** ● Shifts focus on forming a caring relationship with the patient. ● Increased understanding about the person behind the patient. **Shifts focus to patient's health** ● More equal relationship between nurse and patient. ● Patient's self-awareness and motivation increased with daily conversation. **Empowers the patient** ● Trusting the patient led to more constructive and responsible behavior because patients took initiative.	Strengths: ● Overall good qualitative study. ● Clear aims of research and qualitative method appeared appropriate to address research goal. ● In depth description of data analysis that appeared sufficiently rigorous. ● Clear statement of findings. Limitations: ● Researchers did not identify a specific methodology. ● No mention if researchers critically examined their own role, potential bias, and influence during analysis.

Study/Design	Methods	Key Results	Comments
Authors: Hauck et al. (2013). Design: Descriptive cross-sectional study. Purpose: To explore the attitudes of psychiatric nurses towards patients with BPD self-harming and the relationship between education level, gender, and years of service on psychiatric nurses' attitudes towards patients with BPD.	N= 83 psychiatric nurses (50.3% response rate). Country/setting: USA/Inpatient adult behavioral units of 3 psychiatric hospitals. Data Collection: An adapted version of the Attitudes towards Deliberate Self-Harm Questionnaire (ADSHQ) was hand delivered. This tool includes 19 items using a 4-point Likert scale, and measures clinicians' attitudes towards patients exhibiting self-harm and reflects the challenging behaviors of patients with BPD. Data Analysis: SPSS used for data analysis. Reliability of tool was calculated using Cronbach's alpha coefficient. ANOVA was performed on independent variables. Outcomes/Dimensions: 1. Confidence in assessment of clients. 2. Ability to deal effectively with self-harm patients. 3. Empathetic approach.	**What attitudes do psychiatric nurses hold towards patients with BPD?** -Psychiatric nurses' attitudes overall were relatively positive. (Range of scores on the ADSHQ is 19-76, with higher scores indicating a more positive attitude) Total score for all three dimensions (mean/range): 53.93(42-71). ● Years of experience were significantly correlated with the ability to deal effectively with self-harm (p=0.049). ● 86.7% of nurses need further education to enhance nursing care to BPD patients with self-harm. ● Examples of education include i) 74% suggested info to educate BPD patients with self-harm issues, ii) 69% regular in-services iii) skills training workshops, iv) 55% information on where to refer patients. ● Educational level was not significantly related to nurses' positive attitudes towards patients with BPD.	Study Strength**: Weak** Study Quality: **Medium** Strengths: ● Valid and reliable data collection tool. ● Power was clearly adequate to draw inferences. ● >50% response rate. ● Multiple recruitment strategies (formational meetings, flyers in RNs mailboxes, and emails). Limitations: ● Due to the quantitative methodology and restrictions on the questionnaire, some attitudes may not have been captured. ● Some missing data noted in demographics.

Study/Design	Methods	Key Results	Comments
Authors: Helleman et al. (2014). Design: Phenomenological study. Purpose: Describe lived experiences of patients with BPD with the use of a brief admission intervention.	N= 17 outpatients with a diagnosis of BPD and experience with brief admissions. Country/setting: The Netherlands Data Collection: Interviews conducted between January 2011 and August 2012 and lasting 45-75 minutes. Interviews were guided by an aide memoire which consisted of key words, which were used with the research question to guide participants. Data Analysis: Interviews were audio-recorded and transcribed verbatim. The meaning units in the transcripts were identified and analyzed by four researchers to reveal patterns. Outcomes: Categorized by main themes (See key results).	**Organization of the brief admission** ● Patients were very satisfied with the BA treatment plan. ● Rest or time out was important, or at other times, rhythm, activity, or conversation. ● Goal for BA was to overcome a crisis without loss of control. **The quality of the contact with a nurse** ● Contact with a nurse was the most important aspect of a BA. ● Nurses need to play an active role and structure the conversations. Informal was preferred, over coffee or on a walk. **Time out from daily life** ● Appreciated rest and distraction. ● Nurses need to identify pleasant activities. ● Contact with fellow patients. **The experienced value of the intervention** ● Improved self-esteem. ● Sense of security.	Strengths: ● Overall a good qualitative study. ● Clear statement of aims of research. ● Phenomenological methodology identified and deemed appropriate for addressing research goal. ● Recruitment strategy appropriate. Limitations: ● More information required to make data collection methods explicit (i.e., aide memoire). ● Researcher who conducted interview did not critically examine own role, potential bias, and influence during analysis.

Study/Design	Methods	Key Results	Comments
Authors: McGrath & Dowling (2012). Design: Mixed Methods (Descriptive cross-sectional/Qualitative). Purpose: To explore psychiatric nurses' interactions and levels of empathy towards individuals with BPD.	N= 17 psychiatric nurses with experience working with individuals with BPD, and at least 3 years of nursing experience. Country/Setting: United Kingdom/Community mental health Data Collection: Semi-structured interviews and during interviews, questions from the staff-patient interaction response scale were asked. The scale assesses the expressed empathy of staff towards individuals with BPD through scenario examples. Data Analysis: Interviews recorded and transcribed verbatim. Thematic analysis followed deductive approach to explore empathy. Qualitative data: Categorized by main themes (See key results). Quantitative data: Written responses to hypothetical patient scenarios to assess expressed empathy. Responses are scored representing three levels of empathetic care: 1) no care, 2) solution, 3) affective involvement.	**Qualitative** Challenging and difficult: ● Challenging to provide a "good" level of care. ● Avoid providing care until necessary. Manipulative, destructive, threatening behavior ● Pts with BPD have a "hidden agenda". Pts dishonest and not genuine. Preying on the vulnerable ● Tension and stress caring for these pts. ● Angry, frustrated, hurt. Boundaries and structure ● Need strict boundaries and firm limits. **Quantitative** ● Level 2 empathy noted in scenarios for individuals with BPD first admission. Multiple admission scenario resulted in level 1 empathy.	Study Strength: **Weak** Study Quality: **Medium** Limitations: ● Only one hospital used in the study, therefore a lack of generalizability. Including nurses from other hospitals could improve findings. ● Self-selected sample, and those who came forward may have already had an interest in BPD and more positive attitudes. ● Social desirability may be a factor for nurses answering scenario questions. ● Small sample for survey, no significant results. ● No identified qualitative methodology.

Study/Design	Methods	Key Results	Comments
Authors: Stacey et al. (2018). Design: Qualitative Purpose: To explore preregistered nurses' experience of a training program focused on BPD.	N=16 nursing students at the beginning of their second year of the mental health field of the graduate entry nursing program (59% of eligible students). Students were provided the education (i.e., KUF) as part of the theoretical element of their schooling in 6 sessions. This included approaches aimed at understanding behaviors associated with BPD. Country/setting: United Kingdom Data Collection: Two focus groups (8 students in each). Data was transcribed verbatim and fully anonymized. Data Analysis: Transcripts were read independently by four members. Combination of inductive and deductive approach was used. Outcomes: Categorized by main themes (See key results).	**KUF as an alternative view** ● Students had increased confidence to influence practice. ● Education instilled positive attitudes and cultivated the confidence to challenge negative attitudes of other practitioners. ● Increased awareness that students' responses to clients originated from their own attitudes and values. **Psychological understanding of the person** ● Students expressed the importance of modelling positive relationships so patients could understand adaptive ways of behaving. **Therapeutic Priorities** ● Awareness of how a patient's history could impact care. ● Consistency, stability, and team approach were beneficial.	Strengths: ● Overall a good study. ● Data appeared sufficiently analyzed. ● Recruitment strategies were appropriate. ● Researcher discussed in detail reason for choosing focus group as a data collection method. Limitations: ● Researchers did not identify a specific methodology. ● Researchers did not justify their design choice. ● More information required on how their focus groups were conducted. ● No direction for future research provided. ● More information required on why some participants did not participate.

Study/Design	Methods	Key Results	Comments
Authors: Warrender (2015) Design: Phenomenological Purpose: The purpose of this study was to explore staff perceptions of issues working with patients with BPD in the mental health setting and explore the impact mentalization-based treatment skills training (MBT-S) had on their clinical practice.	N=9 staff nurses having completed MBT-S with at least 6 months to use the approach in practice. Country/setting: United Kingdom/Four acute care mental health floors in one hospital. Data Collection: Semi-structured interviews with two focus groups. Focus groups were audio recorded and manually transcribed. Each 60 minutes in length. Data Analysis: Transcriptions were analyzed and coded using an exploratory thematic analysis. Three cycles of coding were included. No computer software was used. Outcomes: Categorized by main themes. (See key results).	**MBT-S** ● Participants described it as common sense, requiring minimal adjustment from ordinary practice. ● Improved consistency in their approach with patients throughout staff. ● Gave staff self-confidence to discuss self-harm and suicidality. **Changed staff attitudes of BPD** ● Participants had more of an understanding of the reasons behind behavior. ● Decreased frustrations by staff. ● Improved therapeutic relationships between staff and patients. ● Increased staff capacity for empathy.	Strength: ● Overall good qualitative study. ● Identified the use of a phenomenological approach. ● Justified their choice of study design well. ● Detailed explanation around recruitment and why some people chose not to take part. ● Main researcher was former staff and attended MBT-S training with participants. However, a neutral third party attended interviews to limit bias. Limitations: ● Only 3 participants attended group clinical supervision after the MBT-S, therefore it can be argued some participants did not get the true MBT-S education. ● Although briefly mentioned, more information required on if researcher examined their own role and potential bias.

Appendix II: Consultation Report

Consultation Report: Development of a Learning Resource for Nurses Caring for Patients Diagnosed with Borderline Personality Disorder in the Mental Health Setting

Olivia Cobbs, 200913283

Memorial University of Newfoundland and Labrador

Consultation Report: Development of a Learning Resource for Nurses Caring for Patients Diagnosed with Borderline Personality Disorder in the Mental Health Setting

Individuals diagnosed with borderline personality disorder (BPD) are highly prevalent in inpatient mental health units. Staff nurses have identified various challenges to their effective care of this patient population (Warrender, 2015). Evidence outlines that nurses may respond to individuals diagnosed with BPD in ways that are counter-therapeutic (Black et al., 2011; Dickens et al., 2016). This is an important issue to address because these negative reactions can substantially impact both the outcomes of individuals with BPD and nurses' well-being. For example, individuals with BPD may use negative behaviors such as being dishonest to gain attention and a positive response from nursing staff (Ritter & Platt, 2016). Power struggles are often described by nurses (Ritter & Platt, 2016). This can cause nurses anger, frustration, guilt, and hopelessness, leaving them to feel as if there is no way to facilitate a favorable recovery for individuals suffering with BPD (Eren & Sahin, 2016).

The setting of this practicum project is the short-stay unit (SSU) and the psychiatric assessment unit (PAU) at the Waterford Hospital in St. John's, Newfoundland and Labrador. It is the province's only psychiatric hospital, and nurses working on these two units are at the front line of care for individuals with BPD. However, there is little formal education provided to the nurses on these units about BPD and the identified challenges in caring for this patient population. Furthermore, it has been informally addressed as a practice problem for nurses on these units. Nurses have previously expressed frustration and a lack of guidance on their care for individuals with BPD. Therefore, the goal of this learning resource is to address the impact of this disorder, and improve nurses' attitudes, experiences, knowledge, and the quality of nursing care provided to this patient population in this setting. Through the integrative

literature review, various nursing interventions were highlighted, along with the importance of the therapeutic relationship, as well as the impact of educational initiatives on nurses. However, despite the value of these research findings, evidence suggested a wide variety of the interventions and educational initiatives. Therefore, it was crucial to obtain clarification through consultations with key stakeholders to ensure the learning resource is tailored to address preferred strategies and the unique learning needs of the target population.

Specific Objectives for the Consultations

To develop an effective learning resource, consultations with key stakeholders were conducted. These consultations were conducted to provide insight into the challenges identified in caring for individuals with BPD and provide guidance on the topics to include in the learning resource and the educational strategies that would be most effective in addressing their learning needs. Four objectives for the consultations included:

1) To explore the challenges associated with nursing care for individuals with BPD and how best to address these challenges.
2) To determine priority issues and topics to be included in the learning resource.
3) To further identify best practices and interventions identified by key stakeholders.
4) To determine the most effective educational strategy to address learners' needs.

Setting and Sample

The setting for the consultations was the Waterford Hospital, with the overall focus being on the SSU and PAU. Seven key stakeholders were invited to participate in a consultation interview to obtain insight from front-line nurses and other, in-house experts to improve understanding of the practice problem, and how to best approach the learning needs of nurses.

A purposeful sample was recruited. Four staff nurses who work on the PAU and SSU were contacted. These four nurses included two novice nurses (i.e., less than two years' experience working on the PAU/SSU) and two more senior nurses (i.e., greater than five years' experience working on the PAU/SSU). By including nurses with a range of experience, the learning resource will be beneficial for all nurses on these units, regardless of their experience levels. Furthermore, a psychiatrist, nurse practitioner, and patient care facilitator were invited to an interview, based on their extensive experience with individuals with BPD and working closely with the nursing staff on these units. If these individuals did not agree to participate, different experts would have been contacted that would have also provided valuable insight. For example, other nursing staff would have been invited to participate, and a psychiatrist who works part-time on the SSU, and a general practitioner who works closely with the nursing staff and individuals with BPD.

An email was sent out to request participation from these seven stakeholders in the consultation process. Furthermore, an information letter was included in the email that outlined the practicum project and its goals. This identified the voluntary nature of participation and how privacy and confidentiality would be upheld. A copy of the recruitment letter and information letter can be found in Appendix A and Appendix B respectively.

Data Collection

In the recruitment email, key stakeholders were offered flexibility in data collection methods to accommodate their complex work schedules. The options to meet in person or by telephone were be offered. The four clinical nurses and the nurse practitioner agreed to an in-person interview. These in-person interviews were conducted in a private office space in the PAU at the Waterford Hospital. The patient care facilitator agreed to an interview over the

phone, while the psychiatrist preferred an interview through video conferencing. Interviews were semi-structured and lasted between 15-25 minutes. Interview questions can be found in Appendix C. To ensure the quality of the data, I critically examined my role, potential bias, and influence during the formulation of the interview questions, data collection, and sample recruitment (Critical Appraisal Skills Programme, 2017).

Data Management and Analysis

Detailed handwritten note taking was conducted during the interviews. Following interviews, notes were typed out on my private password-protected computer, not accessible to anyone else. Paper copies of notetaking were destroyed immediately once transcribed to the password-protected computer. Content analysis was then conducted. Each interview was read through several times to extract key information related to the outlined objectives. Key information from the interviews were grouped into categories allowing for the development of themes.

Ethical Considerations

Permission was obtained from the manager of both units before conducting interviews. To determine if ethical approval was required for this practicum project, the Health Research Ethics Authority (HREA) screening tool was completed. The results indicated that the project did not require ethical approval based on number three of the screening tool. See Appendix D for the completed HREA tool.

Furthermore, a variety of measures were taken to protect the rights of all individuals involved in this project. It was ensured that all individuals involved in the consultation were aware that their involvement was voluntary. Implied consent was achieved when key stakeholders arrived at the interview. They were notified that their consent could be withdrawn

at any point. The project's purpose was explained through the information letter via email and in more detail during the interviews. At the beginning of each interview, I displayed appreciation for their time and expertise and asked key stakeholders if they had any questions about the information letter they received. Participants were also explained how the results of the interviews will be used. No participants' identifiers were included in this report, and results were based on experiences and suggestions alone.

Results

All seven key stakeholders who were invited to the consultation interviews agreed to participate. All interviews were conducted over one week between July 8th and July 14th, 2021. Following the consultation interviews, all notes were reviewed and organized into themes. This process took many subsequent readings to ensure the quality and completeness of the data. As a result, four themes emerged: challenges of caring for individuals with BPD, nursing interventions, brief hospital admissions, and education.

Challenges of Caring for Individuals with BPD

All seven key stakeholders were asked what challenges and frustrations they have experienced caring for individuals with BPD. Overall, the results were similar, as participants identified their main challenges as staff-splitting, care resistance, the unique approach of care required, and self-harm and suicidality. Furthermore, clinical nurses identified solutions to manage their professional stress associated with these identified challenges.

Staff-Splitting

Three clinical nurses and one other key informant identified staff splitting as the most challenging behavior of individuals with BPD. One nurse stated that when a patient became particularly difficult towards one specific nurse, they felt they were placed in the middle of a

situation, which generally caused tension on the unit for the remainder of this patients' inpatient stay. Another clinical nurse echoed these findings, stating that staff splitting can create an awkward atmosphere on the unit. Of concern, the third clinical nurse stated that this behavior often deters nurses from wanting to care for these patients. Furthermore, an additional key informant also identified staff-splitting as a challenge due to the conflict it causes on the unit. This key informant stated that inconsistency in nursing care might amplify these staff-splitting behaviors.

Resistance to Care

Three clinical nurses and one other key informant identified that it was extremely challenging when individuals with BPD were not receptive to help. One nurse described how these patients often requested a voluntary admission yet were not listening to advice from the care team and were not actively participating in the treatment plan. One nurse voiced that individuals with BPD often complained that no one was helping them, despite the exhaustive care the team was attempting to provide. Another clinical nurse echoed these findings and added that this resistance was frustrating, leaving them feeling hopeless for a positive recovery and feeling that their nursing care was ineffective.

Another key informant shared this perspective, stating repetitive admissions from the same patient were extremely frustrating. However, they identified that this was often not the patient's fault, as it was likely due to the long waitlist for community services. They identified that this delay in community supports often contributed to readmissions, as patients experienced another crisis, prior to having outpatient supports in place.

Unique Approach to Care

All key informants discussed how it was challenging to care for individuals with BPD

due to the unique approach of care they required, which differed from caring for individuals with other mental health diagnoses. The clinical nurses discussed how with most mental illnesses' medications are the primary treatment. However, with BPD, more nursing interventions are needed, leading to more hands-on care than other patient populations. One clinical nurse stated, "You have to help change the way they think, which is hard to do." An additional key informant comparatively stated that caring for individuals with BPD was more cognitive and behavior- focused than caring for other patients. Furthermore, a key informant echoed these findings and discussed how caring for individuals with BPD needs to focus on a DBT based approach, which requires more knowledge and practice than approaches for other patient populations.

Self-Harm and Suicidality

All the clinical nurses interviewed, and two other key informants identified self-harm and suicidality as a challenge in caring for individuals with BPD. Concerningly, three nurses stated they experienced constant fear of losing their nursing license due to these patients' impulsivity, self-harm, and suicidal behaviors. They felt an extreme amount of pressure that their nursing license might be at risk if the patient harmed themselves while under their care. One nurse even stated that caring for individuals with BPD caused more professional stress than any other mental health diagnosis due to these safety concerns.

The challenge of safety was echoed during the interview with another key informant, who voiced they were often left wondering, "Is this the time we discharge this patient, and something bad happens to them?". Another participant also shared this perspective and described the challenges of discharging a patient with BPD who remains suicidal. They identified that although this was necessary due to the ineffectiveness of a prolonged

admission, often, individuals with BPD emotions were too high to understand the treatment plan at the time of discharge. This same key informant also recognized that it drastically upset the clinical nursing staff when there was self-harm noted on the unit. This key informant showed a good understanding and discussed how individuals with BPD lacked positive coping skills, making them a more vulnerable patient population with an increased risk of self-harm and suicide.

Some participants discussed ways to combat this challenge and identified the importance of being more hypervigilant while caring for individuals with BPD. For example, two clinical nurses identified the importance of being meticulous, attentive, and observant, constantly watching for signs of impending self-harm. Another clinical nurse shared this perspective and stated, "You have to remind patients that they are in charge of their safety and that self-harming in the hospital would be counterproductive towards admission goals."

Solutions to Professional Stress

The four clinical nurses were asked how they managed their professional stress when caring for individuals with BPD. All four nurses identified talking to co-workers as the most effective way to deal with professional stress. One nurse stated it was essential to recognize that it was a team approach, and co-workers were there to help. Two nurses identified that talking to other nurses helped validate what they were feeling and their actions in a particular situation. Two of the novice nurses also discussed the importance of using senior nurses for guidance and that speaking to senior staff would ease their concerns once validated.

Alternatively, one nurse discussed leaving work at lunch to go for a walk, while another nurse identified deep breathing during a stressful situation as an effective coping mechanism for professional stress. Uniquely, one clinical nurse provided valuable insight on

professional stress, voicing the importance of identifying personal limits. For example, they described the necessity of speaking to the nurse in charge if a nurse-patient relationship was causing distress.

Nursing Interventions

All key informants were a sked what nursing interventions were the most and least effective in caring for individuals with BPD. A list of nursing interventions were identified that remained overall similar among the participants. This theme is broken down into five sub-themes: setting limits, validation, empathy, consistency, and least effective nursing interventions.

Setting Limits

Primarily, all key informants identified setting limits as an essential nursing intervention. One nurse further described the importance of openly communicating these limits to identify what is tolerated and not tolerated on the unit. Another nurse stated that caring for individuals with BPD can be highly time-consuming. Therefore, it was essential to communicate these limits with patients. An example provided by this nurse was to say to a patient: "After I finish giving out my medications at around nine o'clock, I will have time to come down and talk to you for 20 minutes". They stated that this was important because boundaries are often pushed. Another clinical nurse shared this perspective and stated, "I try not to linger or spend more time with these patients than I need to because then they might expect it the next shift when it is too busy to provide this. So, it is easier just to set a limit right away so we are both clear on the expectations and the time I can provide them".

Validation

Validation was a nursing intervention identified by one clinical nurse and two other

key informants. One clinical nurse stated, "I try to validate them as much as I can. I find this helps improve the relationship when they feel I understand their emotions". One key informant stated that to validate the patient, it was essential to communicate with them and tell them they made the right choice coming into the hospital and acknowledge their feelings. Another key informant discussed the importance of validation with this patient population to show that they can approach nursing staff and that their emotions are valid and accepted.

Empathy

Two clinical nurses and two other key informants identified being empathetic as an essential nursing intervention. One key informant noted that empathy was important, stating, "This is something that is lacking from somewhere in their world, so we need to give that to them." Two clinical nurses shared this perspective. One of these nurses stated, "I try to put myself in their shoes." The other nurse similarly stated, "I try to remind myself that some of these patients have been through a lot, and they do not regulate their emotions the same as me, and that is why they are reacting this way."

Consistency

Being consistent and presenting a unified approach to care was identified by five key informants. One clinical nurse stated, "Everyone needs to be on the same page to avoid conflict on the unit." Another key informant shared this perspective, explaining how the conflict was usually present when consistency was lacking between staff members. Another clinical nurse stressed the importance of communicating with the oncoming shift to promote consistency. Alternatively, a clinical nurse voiced concerns about a lack of consistency on the SSU, describing the importance of improving communication between nursing staff and the remainder of the interdisciplinary team to promote consistent care.

Least Effective Nursing Interventions

Each key informant was asked which nursing intervention they noticed to be least effective in caring for individuals with BPD. Similar interventions were identified by key informants, such as being confrontational (n=7), defensive (n=5), argumentative (n=3), challenging (n=2), and dismissive (n=1). One clinical nurse stated that it was important to avoid being argumentative in general, but especially with patients with BPD, as often, these patients have a history of trauma. Another clinical nurse stated, "In the face of all of their emotions, nurses need to be the calm ones and avoid being confrontational or argumentative as it just escalates the situation." Lastly, a key informant voiced how individuals with BPD fear abandonment; therefore, being dismissive towards them can be detrimental.

Brief Hospital Admissions

All seven key informants were asked about their knowledge on the effectiveness of brief hospital admissions for individuals with BPD and how they felt the SSU could be a more effective environment.

Knowledge of Brief Hospital Admissions

The clinical nurses who were interviewed provided conflicting responses on their opinion of a brief hospital admission intervention. Overall, most nursing staff correctly identified the benefits of a brief admission but still identified some concerns with this intervention. For example, two clinical nurses stated that although brief hospital admissions were beneficial for crisis intervention, they often worried admissions to hospitals may be causing individuals with BPD to become dependent on the healthcare system. Another nurse stated they felt a brief hospital admission was only beneficial for an individual newly diagnosed with BPD, as it provided an invaluable opportunity to set them up with outpatient

resources. Beyond this, the clinical nurse felt it was not helpful as they already have the tools they need out in the community. Alternatively, one nurse did not feel a brief hospital admission was effective for individuals with BPD and that each admission was solely enabling their behaviors.

The other key informants interviewed reported a more positive view on brief hospital admissions stating it was necessary for crisis intervention. One key informant stated, "A brief hospital admission serves its purpose during a crisis, and a couple of days removed from their stressors can make a big impact." Another key informant agreed that a brief admission is the best intervention for someone in a crisis. They described how it helps patients stabilize during a crisis, allows monitoring of medication changes, and connects patients with outpatient supports. Although, this key informant did identify that prolonged admissions could be damaging as patients may lose their coping skills and lose contact with their community resources. They also shared that a core component of a brief admission is that the patient needs to be receptive to the admission and its goals. Therefore, the admission should ideally be voluntary for it to be effective. All seven key informants agreed that if admission is required, there needs to be a set duration and clear goals identified, preferably in the PAU before admission.

Improving the Short-Stay Unit

When all seven key stakeholders were asked how they felt the SSU could be a more effective environment for individuals with BPD, valuable information was obtained. For example, increased independence was identified by four key informants. Three of the clinical nurses interviewed said they felt patients on the unit should be provided more independence and responsibility. One nurse stated that searching patients' belongings upon entrance to the

unit had an immediate negative impact on the therapeutic relationship, as it showed patients that they were untrustworthy. Another key informant stated that the recent change in rules on the unit of allowing patients to have their phone charger in their hospital room was a needed improvement. They further explained that although this was possibly setting patients up for an opportunity to self-harm, it also showed them they were responsible for their safety while admitted. Another clinical nurse agreed with this perspective and stated, "They need to be responsible for their safety in and out of the hospital."

All key stakeholders identified the importance of structure on the unit. They stated that a lack of structure, especially on night shifts and on weekends, negatively impacted the patients' experiences. Furthermore, one clinical nurse identified that more structured activities would increase opportunities to build a therapeutic relationship with patients. Another key informant identified that pastoral care and therapeutic recreation staff need to be used to their full capacity to promote structure. In addition, an increase in programming was needed on weekends, such as music therapy and more group sessions. They stated that promoting this would keep patients busy and promote good coping skills. Another key informant echoed these findings and discussed how plant therapy had been recently implemented on the unit and well-received by individuals with BPD.

Education

Education arose as a central theme once content analysis was conducted. This theme was further broken down into three sub-themes: lack of knowledge and education, specific topics for the learning resource, and delivery methods for the learning resource.

Lack of Knowledge and Education

When clinical nurses were asked if they felt they had the knowledge required to care

for individuals with BPD, the responses varied. Two nurses responded "somewhat" but stated this was due to experience alone, not from formal education. Only one nurse stated they felt they had the required knowledge. However, this nurse agreed that this was due to 25 years of professional experience alone. One staff nurse stated they did not have the knowledge required, as they had little to no knowledge on coping mechanisms to provide to these individuals or any knowledge on their outpatient care. Surprisingly, three of the nurses interviewed reported they have never had any formal education in the past on caring for individuals with BPD. Only one nurse stated they recalled any education, including one slide on BPD during their mental health and addictions orientation, but this was not beneficial or memorable.

All seven key informants were asked if they were aware of any available resources that would be helpful for nurses caring for individuals with BPD. Only two key informants identified any resources. One key informant identified that The Dialectical Skills Workbook (McKay et al., 2007) and the DSM-5 (American Psychiatric Association, 2013) would be helpful for nurses working in this setting. The other key informant identified three resources. The first one was a website often utilized by the interdisciplinary team for patient education titled Get Self Help (n.d.). The other two were books titled Stop Walking on Eggshells (Mason & Kreger, 2010) and I Hate You, Don't Leave Me: Understanding the Borderline Personality (Kreisman & Straus, 2010). This key informant stated that reading these books would likely improve professionals' understanding of BPD.

Specific Topics for the Learning Resource

Clinical nurses were asked what specific topics they would like to see included in the learning resource, and the responses were overall similar. For example, each nurse identified

requiring education on cognitive behavioral therapy (CBT) and dialectical behavior therapy (DBT). They felt that as this was the primary treatment for individuals with BPD, they should be provided the knowledge to implement some of these interventions for patients during their inpatient admissions. One staff nurse discussed how patients often assume nurses are trained in this area, and although delivering these therapies was not part of their nursing duties, it would be beneficial to have some knowledge of them.

Two clinical nurses requested more education on self-harm and how to respond to this behavior appropriately while patients are admitted to the SSU. They felt that although they have had experience with this happening on the unit, they never felt confident in their response and required guidance on addressing this behavior without escalating the situation. Additionally, based on the challenging behaviors exhibited by individuals with BPD, such as self-harm, these same two nurses requested a component in the learning resource on self-care for nurses.

Furthermore, two novice nurses stated that the learning resource should include more education on the complexities of BPD and what behaviors to expect to prepare newer nurses working on the unit. They felt this was important to include as this education was lacking during their orientation and it made their transition challenging because they felt unprepared to identify and effectively respond to the behaviors. Furthermore, they felt they needed more of this education to discuss the diagnosis confidently with patients and families. One nurse stated how it was complicated discharging a patient with BPD home when they remained suicidal, and families often left angry or returned shortly after discharge, not knowing how to promote safety at home.

The other key informants were asked what information they felt was essential for

nurses caring for individuals with BPD. Three key informants identified the importance of nursing staff having a good understanding of DBT and CBT and more of an understanding of the BPD criteria. For example, one of the key informants stated, "Nurses need education on the way individuals with BPD react and why they react this way." They also stated that an understanding of the medications used to treat symptoms of BPD was imperative. More specifically, they stated topics should include coping skills to try with patients and how to create a positive interaction with them. Lastly, a key informant stated that individuals with BPD have a history of trauma that likely shaped their personality and if nurses had a strong understanding of this, it would improve their approach to these individuals.

Delivery Methods

Overall, when clinical nurses were asked about the best way to deliver the education, there were conflicting findings. Three of the nurses recommended an interactive self-learning approach, wanting education they could complete on their own time due to their hectic schedules. One nurse stated they would appreciate something that they could keep on their phone or on the desktop at work to refer to at any time. Furthermore, one nurse stated that although a self-learning component would not be referred to quickly during a difficult situation, it would be helpful to review after a situation to validate their response to the situation. Three of the nurses suggested a case study that included a realistic situation and how to effectively respond.

Alternatively, one nurse suggested a half-day education day with guest speakers. They felt a self-learning component would not be enough to cover the vast amount of education required on this topic and felt an education day including guest speakers would be the most impactful. Another clinical nurse disagreed with this delivery method, stating how if the

learning was conducted in person, it would be easily forgotten.

Conclusion

The consultation process was highly beneficial to understanding the challenges and experiences of nurses caring for individuals with BPD and provided valuable insights from in-house experts. It was evident that staff-splitting, care resistance, the unique approach to the care required, and self-harm and suicidality were all challenges experienced by the participants. Furthermore, participants agreed that to care for individuals with BPD, nurses need to set limits, remain consistent and empathetic while validating their emotions. They must also avoid being confrontational, defensive, challenging, argumentative, and dismissive. It is also apparent that more education is required on the benefits of brief hospital admissions, as clinical nurses provided conflicting results on this topic. However, it was identified that increased structure and independence during brief hospital admissions are needed.

It was also apparent that clinical nurses lack the formal education required to care for individuals with BPD confidently. It was identified that an interactive self-learning resource would be preferred, and topics should include the complexities of BPD, treatment options, education on CBT and DBT, along with a self-care component for nurses and a realistic case-study. The valuable information gained from the consultation process will facilitate developing a learning resource for nurses on caring for individuals with BPD in the mental health setting. This will also ensure that the learning resource will be tailored to address preferred strategies and the unique learning needs of the target learners.

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Appendix A: Recruitment Email

To (whom this may concern),

As you may already know, I am completing my Master of Nursing degree at Memorial University of Newfoundland. As part of my final practicum project, I am developing a learning resource to address the challenges associated with nursing care for individuals with borderline personality disorder and exploring best practice interventions to address these challenges. The hope is that this learning resource will improve nurses' knowledge, attitudes, and experiences caring for this patient population and improve patient care outcomes.

I am sending you this email today to ask if we can meet in person or over the phone. This meeting would include consultation on what you think should be included in the learning resource and the best way to deliver this education to best suit the learning needs of the nursing staff on the PAU/SSU.

If you are interested in participating, please respond to this email to set up a time for a 20–30-minute interview. All information shared will remain anonymous and confidential. Your participation in this project is strictly voluntary. However, your feedback would be greatly appreciated.

If you are interested in participating, please see the attached information letter with more information regarding the practicum project.

Many thanks for considering my request.

Olivia Cobbs, BNRN

Appendix B: Information Letter

To (whom this may concern),

I would like to provide you with more information about this project and what your involvement would entail if you decided to take part. The title of this project is "development of a learning resource for nurses caring for individuals with borderline personality disorder in the mental health setting." This project is required to complete my Master of Nursing degree with Memorial University of Newfoundland.

Through an integrative literature review I have previously conducted; research has shown that staff nurses have identified various challenges to their effective care of individuals with borderline personality disorder (BPD). Nurses may respond to individuals with BPD in ways that are counter therapeutic. These negative reactions can substantially impact both the outcomes of individuals with BPD and nurses' well-being. Professionally, I have experienced the frustrations of caring for these individuals and have noticed a lack of formal education on this topic for nurses. Therefore, this practicum project aims to address the impact of this disorder and improve nurses' knowledge, attitudes, experiences, and the quality of care provided to this patient population in this setting.

Through the previously conducted integrative literature review, various nursing interventions were highlighted, along with the importance of developing a therapeutic relationship and the impact of educational initiatives on nurses. However, despite the value of these findings, it remains important to obtain clarification through consultation with experts to ensure this learning resource is tailored to address the preferred strategies and the unique learning needs of nurses on both units. I hope that these consultations will provide insight into the challenges associated with nursing care for individuals with BPD and provide guidance on the topics to include in the learning resource and the educational strategies that would be most effective.

Participation in these consultations is strictly voluntary. It will involve an interview approximately 20-30 minutes in length. Your consent will be implied through participation in the interview. However, you may withdraw this consent at any time. With your permission, detailed notetaking will be conducted during interviews. Following interviews, notes will be typed out on my private password-protected computer, not accessible to anyone else. I will destroy paper copies of notes immediately after being transcribed to my computer. Interviews will be read through to extract key information related to the outlined goals of the project. Although this project does not require ethical approval, various measures will be taken to protect the rights of individuals involved in this project. No participant identifiers will be included, and the results of the consultations will be used based on experiences and suggestions alone.

I am hopeful that through these consultations, I will obtain valuable information to guide the development of this learning resource.

Thank you for your consideration and time,

Olivia Cobbs, BNRN

Appendix C: Interview Questions

Registered Nurses

1) Do you have the knowledge required to care for individuals with BPD? Please explain. (Probe: what additional knowledge is needed?)
2) Have you received education in the past on caring for individuals with BPD? If so, what information was provided, and did you find it beneficial?
3) How does caring for individuals with BPD vary from caring for individuals with other mental illnesses? What do you do differently?
4) What nursing interventions do you find most effective in caring for individuals with BPD? What nursing interventions are least effective?
5) What do you know about the effectiveness of brief admission interventions (i.e., admissions to SSU) for individuals with BPD?
6) How do you think SSU could be a more effective environment for individuals with BPD and their families?
7) How do you as a mental health nurse develop a good therapeutic relationship with individuals with BPD?
8) Are there any resources you have found helpful in caring for individuals with BPD?
9) What are some of the challenges you have experienced caring for individuals with BPD on PAU and SSU?
10) Do you ever feel frustrated or stressed caring for individuals with BPD? Please explain. What do you do to manage your professional stress? What suggestions do you have for other nurses?

11) What specific topics would you like to see included in the learning resource?
12) What do you think would be the best way to deliver this education?

Psychiatrist, Nurse Practitioner, and Patient Care Facilitator

1) What information do you feel is essential for nurses working on SSU/PAU when caring for individuals with BPD?
2) Do individuals with BPD require different approaches to care compared to individuals with other mental health diagnoses? Please explain.
3) Are there any resources you would suggest that would help nurses caring for individuals with BPD?
4) What nursing interventions do you think are the most effective in caring for individuals with BPD? What interventions are least effective?
5) How do you suggest nurses promote a good therapeutic relationship with individuals with BPD?
6) What are some of the challenges you have experienced caring for individuals with BPD on PAU and SSU?
7) What is your professional opinion on brief admission interventions (i.e., admissions to SSU) for individuals with BPD?
8) What do you feel are the key components of a brief admission for individuals with BPD?
9) How do you think SSU could be a more effective environment for individuals with BPD and their families?
10) What specific topics do you think should be included in a learning resource for nurses on this topic?

Appendix D: Health Research Ethics Authority (HREA) Screening Tool

Student Name: Olivia Cobbs

Title of Practicum Project: Development of a resource manual for nurses caring for patients diagnosed with borderline personality disorder in the mental health setting.

Date Checklist Completed: June 14th, 2021

This project is exempt from Health Research Ethics Board approval because it matches item number three from the list below.

1. Research that relies exclusively on publicly available information when the information is legally accessible to the public and appropriately protected by law; or the information is publicly accessible and there is no reasonable expectation of privacy.
2. Research involving naturalistic observation in public places (where it does not involve any intervention staged by the researcher, or direct interaction with the individual or groups; individuals or groups targeted for observation have no reasonable expectation of privacy; and any dissemination of research results does not allow identification of specific individuals).
3. Quality assurance and quality improvement studies, program evaluation activities, performance reviews, and testing within normal educational requirements if there is no research question involved (used exclusively for assessment, management, or improvement purposes).
4. Research based on review of published/publicly reported literature.
5. Research exclusively involving secondary use of anonymous information or anonymous human biological materials, so long as the process of data linkage or recording or dissemination of results does not generate identifiable information.
6. Research based solely on the researcher's personal reflections and self-observation (e.g. auto-ethnography).
7. Case reports.
8. Creative practice activities (where an artist makes or interprets a work or works of art).

For more information please visit the Health Research Ethics Authority (HREA) at https://rpresources.mun.ca/triage/is-your-project-exempt-from-review/

Appendix III: Environmental Scan Report

Environmental Scan Report: Development of a Learning Resource for Nurses Caring for Patients Diagnosed with Borderline Personality Disorder in the Mental Health Setting

Olivia Cobbs, 200913283

Memorial University of Newfoundland and Labrador

Environmental Scan Report: Development of a Learning Resource for Nurses Caring for Patients Diagnosed with Borderline Personality Disorder in the Mental Health Setting

Working in the only psychiatric hospital in the province of Newfoundland and Labrador (NL), the Waterford Hospital, nurses on the psychiatric assessment unit (PAU), and the short stay unit (SSU) are often the first contact for patients with borderline personality disorder (BPD). Therefore, they play a critical role when caring for these individuals. Additionally, individuals with BPD comprise up to 20% of all psychiatric inpatient admissions (Gunderson, 2011). Nurses on these units have identified various challenges associated with caring for individuals with BPD which echoes the findings in the literature. Individuals with BPD can be challenging to care for due to their affective instability, intense anger, poor impulse control, labile moods, and self- mutilating behavior (American Psychiatric Association, 2013). These intense symptoms can be difficult for nurses to cope with, sometimes contributing to unintentional strained relationships and negative feelings towards patients with BPD (Eren & Sahin, 2016). These often-negative experiences can negatively impact nurses' well-being and stress levels (Eren & Sahin, 2016).

In consultation with the unit manager, nursing staff, and patient care facilitator of these units, it was determined that nurses' experiences caring for individuals with BPD was an area of concern needing to be addressed. These individuals agreed that the development of an easily accessible, nursing educational resource would begin to address the nurses' needs and increase their clinical competence. Presently, educational opportunities are limited, and no current educational material is available on the unit or presented in orientation that deals comprehensively with the associated challenges and issues of caring for individuals with BPD.

Nurses were feeling unprepared and uncertain. Therefore, a learning resource was identified as an effective way to reach all nurses in the program and begin to address their practice issues. Before beginning the development of the learning resource, an environmental scan was conducted to determine if other healthcare authorities have any existing educational materials within and outside of Canada or publicly available from reputable Canadian or international organizations. Programs found throughout the completion of this scan were analyzed to determine similarities or differences that existed to inform the learning resource development. The goal for the environmental scan was to determine what resources were already available on the topic and if they can be used or adapted to educate nurses in the PAU and the SSU. With the inclusion of an environmental scan, a more comprehensive learning resource will be developed.

Specific Objectives for the Environmental Scan

The objectives for the environmental scan are to:

1. Identify any nursing, patient, or family educational materials that exist on the internet that could inform the development of a learning resource on BPD for nurses.
2. Identify any existing educational materials, policies, or procedures on caring for individuals with BPD that are used in other healthcare facilities within Canada that could help inform the development of the learning resource.
3. Identify any educational materials, policies, or procedures on caring for individuals with BPD that exist in healthcare facilities outside of Canada that could help inform the development of the learning resource.
4. Identify and analyze commonalities between the retrieved materials to determine what information can be adapted to influence the learning resource development.

Sources of Information

There are two sources of information that guided the environmental scan. This included materials from websites and materials from other healthcare facilities

Websites

First, a general internet search was conducted to determine what educational resources were available for nurses on BPD globally. Google was utilized for this search, with a variety of search terms implemented such as: "borderline personality disorder," "education," "education for nurses," "education for mental health nurses," "crisis inpatient unit," and "brief admission." In addition, resources that include information for patients or families were also included if deemed relevant.

Beyond this, targeted websites from reputable Canadian or international organizations were reviewed for materials related to nursing care for individuals with BPD. Targeted websites included the Centre of Addiction and Mental Health (CAMH), the American Psychiatric Association (APA), the National Institute of Mental Health (NIMH), and the National Alliance on Mental Illness (NAMI). Available and relevant information from these websites were analyzed against all materials received.

Healthcare Facilities

Healthcare facilities within Canada were contacted regarding their current educational materials, policies, or protocols related to caring for individuals with BPD. Firstly, I contacted CAMH as this is the largest mental health teaching hospital in Canada and one of the world's leading research centers. The organization provides care to 34,000 patients each year with 530 inpatient beds and services ranging from counseling to treatment of acute mental illness (CAMH, n.d.).

Secondly, I contacted the Homewood Health Centre in Guelph, Ontario. This treatment center consists of a 300-bed mental health and addiction facility that delivers specialized care for various mental health diagnoses, including BPD (Homewood Health, n.d.). Thirdly, I contacted the Borderline Personality Disorder Treatment Program (BPDTP) in Halifax, Nova Scotia. This treatment program within the Nova Scotia Health Authority provides specialized treatment for adults with severe BPD (Nova Scotia Health, n.d.). Both treatment centers were specifically chosen, as patients from the SSU at the Waterford Hospital have been referred to them through our inpatient unit. As many have attended treatment at these centers, to maintain consistency in the nursing care provided, it would be helpful to have information on the care they provide.

Outside of Canada, I contacted a hospital in the United Kingdom (UK), based on the vast amount of literature from this country found through the integrative literature review. More specifically, I contacted the Fulbourn Hospital, which is in Cambridge, UK. This is a mental health facility affiliated with the University of Cambridge and part of the National Health Services (NHS), the UK's publicly funded healthcare system. This hospital includes various inpatient units, but most importantly, a 12-bed inpatient recovery unit for individuals with BPD (NHS, 2014). This unit is titled the Springbank Ward, which provides inpatient admissions with 24h nursing care for individuals with BPD (NHS, 2014).

Contact information for appropriate representatives was obtained from the respective websites of these hospitals, and one email was sent per hospital. When no specific contact information was listed from a representative from the department, the email was sent to the general inquiry email and asked to forward the information to the appropriate individual. In addition, the representatives were asked if they can provide any educational materials,

policies, or protocols related to their care of patients with BPD. See Appendix A for a copy of the email that was sent to these organizations.

Data Collection

Data collection consisted of three approaches i) conducting a general google search using specific search terms, ii) exploring targeted websites and iii) contacting staff from targeted clinical sites. The purpose of collecting data for the environmental scan was to obtain any educational resources, policies, or procedures available for nursing staff on BPD to inform the learning resource development. The information I was seeking was related explicitly to inpatient nursing care for individuals with BPD. This may include any targeted education, policies, or procedures these representatives may have.

For the information found through the internet search, all obtained information was publicly available, but will be referenced appropriately if used. For the organizations I contacted, the same email format was used to maintain consistency (See Appendix A). Any information obtained was confirmed to be current, reputable, and relevant before beginning data analysis.

Data Management and Analysis

Once the data collection component was completed, content analysis was conducted to manage and analyze the obtained data. The data was reviewed, and categories and subcategories of commonalities were created. Themes were created to link underlying meanings together in categories (Graneheim & Lundman, 2004). This helped develop a list of what trends appeared across the data. Finally, the data management and analysis were shared with the supervisor of this practicum project and summarized in this environmental scan report included in the practicum project to determine which information is pertinent for the learning

resource.

Ethical Considerations

The Health Research Ethics Authority Screening Tool was completed to determine whether ethical approval was required for the practicum project. The completion of this checklist determined that this practicum project does not require ethical approval as it matches number three. See Appendix B for a copy of this completed screening tool. Measures were also taken to protect the rights of the individuals contacted for this environmental scan. The emails exclusively stated the purpose of the environmental scan, that involvement was strictly voluntary, and how the results will be utilized. Voluntary informed consent was implied through an email response and information provided by the representatives. The representatives were made aware that any materials they share will be referenced appropriately. All emails obtained were kept under password security, not accessible to anyone else.

Results

Through the environmental scan process, information related to nursing care for individuals with BPD was assessed, along with educational materials for patients and families. Unfortunately, there was a limited response from health facility representatives. Therefore, only the information obtained from the website search was reviewed and analyzed for commonalities.

Healthcare Facility Responses

Of the four emails sent to the chosen healthcare facilities, three responses were noted. Unfortunately, one response was to indicate that there were no materials used in their facility that would be relevant to the practicum project. Two of the responses were to indicate that the

emails were forwarded to the appropriate individuals. These individuals responded to the forwarded email to schedule a time to speak. This information was provided in a subsequent email, but no response was obtained. Finally, a follow-up email was sent five days after initial contact, again with no response obtained. Thus, despite initially receiving a promising three responses from health facility representatives, no material was ultimately provided.

Resource Content

Overall, approximately 20 websites were reviewed for their relevance to the environmental scan. Four of these websites included a scan of the hospital websites discussed above that were contacted via email, which yielded no results. After examining the information from these 20 websites, a total of eight resources were selected to inform the environmental scan due to their relevance and reliability.

Firstly, two clinical practice guidelines on the management of individuals with BPD for healthcare professionals were found (National Health and Medical Research Council [NHMRC], 2013; National Institute for Health and Care Excellence [NICE], 2009). These practice guidelines are from Australia and the United Kingdom. In addition, two resources aimed towards families of individuals with BPD (CAMH, 2009; Gunderson & Berkowitz, 2006) and two educational resources directed towards patients on dialectical behavior therapy (DBT) were found (McKay et al., 2012; Vivyan, 2009). Finally, two resources were located that provided a brief introduction to BPD and treatment options that could be used by nurses, patients, or families (Gunderson, 2011; NAMI, 2015). An overview of the resources is outlined below in Table 1.

Table 1

Borderline Personality Disorder Resources

Resource	Organization	Format	Topic
Gunderson (2011)	National Alliance for Borderline Personality Disorder	PDF: BPD brief	BPD
Gunderson and Berkowitz (2006)	The New England Personality Disorder Association	PDF: Booklet for families	BPD
McKay et al. (2011)	New Harbinger Publishing	PDF or Book for patients	DBT
National Alliance on Mental Illness (2015)	Mental health organization	PDF	BPD
National Health and Medical Research Council (2012)	Australian Government	PDF: Clinical practice guideline	BPD management
National Institute for Health and Care Excellence (2009)	Department of Health in England	PDF: Clinical guideline	BPD recognition and management
The Centre for Addiction and Mental Health (2009)	Health authority	PDF: Booklet for families	BPD
Vivyan (2009)	Resource based website	PDF: Booklet for patients	DBT

Many of the resources included similar information and interventions in the care of individuals with BPD. Through content analysis, five themes arose such as i) BPD symptoms and causes, ii) treatment options, iii) self-harm and suicidality, iv) nursing interventions, and v) education for families.

Borderline Personality Disorder Symptoms and Causes

Through content analysis of the obtained resources, it was found that four resources included information on the symptoms and diagnostic criteria of BPD. These resources referenced the DSM-5 (2013) when outlining this information (CAMH, 2009; Gunderson, 2011; NAMI, 2015; NHMRC, 2012). These diagnostic criteria include frantic efforts to avoid abandonment, a pattern of unstable and intense interpersonal relationships, identity disturbance, impulsivity, recurrent suicidal behavior or self-mutilating behavior, affective instability, chronic feelings of emptiness, intense anger, or dissociative symptoms (APA,

2013). Therefore, the symptoms of BPD and its diagnostic criteria remained consistent across resources. More specifically, the resource by Gunderson (2011) included the most comprehensive explanation of each diagnostic criteria. The resource by CAMH (2009) provided an excellent and straightforward description of these criteria as it was designed for families of individuals with BPD.

Furthermore, within these same four resources, the origins of BPD were discussed and its causes. For example, various resources included information on how BPD is caused by a complex combination of genetic, social, and psychological factors (Gunderson, 2011; NAMI, 2015; NHMRC, 2012). Similarly, CAMH (2009) identified that genetic inheritance, biology, and environmental experiences all contribute to the development of BPD. Only two resources included information on how traumatic life events such as physical and sexual abuse during childhood or neglect or separation from parents may contribute to the development of BPD (NAMI, 2015; NHMRC, 2012). Overall, the symptoms of BPD, its diagnostic criteria, and causes remained consistent across resources, and this information will be utilized in the development of the learning resource.

Self-Harm and Suicidality

Only three resources included information on self-harm and suicidality (CAMH, 2009; Gunderson, 2011; NHMRC, 2012). It has been identified in these resources that the most dangerous features of BPD are self-harm behaviors and potential risk for suicide. Gunderson (2011) provided the most comprehensive background information on self-harm and suicidality, discussing how individuals with BPD often conduct these behaviors during dissociative experiences. However, Gunderson (2011) does not provide interventions for healthcare professionals when these behaviors are present.

Contrastingly, in two other resources, information was provided on assessing suicide risk in individuals with BPD (CAMH, 2009; NHMRC, 2012). Assessing suicide risk includes monitoring for changes in usual patterns, worsening substance use, recent adverse life events, withdrawal from social circles, recent self-harm behaviors, and having a plan with the means of carrying it out (CAMH, 2009; NHMRC, 2012). In the practice guideline by NHMRC (2012), it was identified that assessing suicide risk in individuals with BPD can be difficult for healthcare providers; due to individuals with BPD often living with persistent low-lethality self-harm and a relatively low immediate risk for suicide. However, this risk can change; therefore, a risk assessment is needed. Interventions for acute risk of suicide included not leaving the patient alone, preventing access to means, consulting with senior staff, and notifying the multidisciplinary team (NHMRC, 2012). Regarding self-harm, it was noted that immediate interventions included responding promptly, staying calm (i.e., no shock or anger), planning for future safety in collaboration with the patient, and consulting with other clinicians (NHMRC, 2012). After self- harm behaviors or a crisis, healthcare professionals must discuss safety issues with patients, interpret factors that may have provided relief, help deal with anger, and help them use a problem-solving approach (NHMRC, 2012).

The information from these resources was noted to be useful for implementation in the learning resource. Many of these practical suggestions can be used as guidance by nursing staff in the mental health setting. It was noted in the consultation process that nurses on the SSU and the PAU required more information on how to respond effectively to self-harm and suicidality.

Nursing Interventions

Various interventions for healthcare providers in caring for individuals with BPD were

outlined in three of the resources (Gunderson, 2011; NHMRC, 2012; NICE, 2009). However, these were not specific for nurses but are still deemed relevant and adaptable. It was noted in three of the resources that validation and having a non-judgmental approach were imperative for caring for individuals with BPD (Gunderson, 2011; NHMRC, 2012; NICE, 2009). The importance of being calm, non-threatening, consistent, and reliable was also identified (NHMRC, 2012; NICE, 2009). In addition, good listening skills were highlighted (Gunderson, 2011; NMHRC, 2012), along with being compassionate and respectful (NHMRC, 2012). These were attributes that were also identified from the integrative literature review and consultation process.

More specifically, the importance of healthcare providers immediately identifying each multidisciplinary team's roles and responsibilities to the patient were identified (NICE, 2009). Furthermore, exploring treatment options with individuals with BPD in an atmosphere of hope and optimism was highlighted with no false assurance (NHMRC, 2012; NICE, 2009). It was also identified that short-term and long-term goals need to be discussed with patients, but these need to be realistic (NICE, 2009). Patients must be encouraged to consider treatment options and different life choices and be aware of the consequences of their choices (NICE, 2009). The practice guideline by NHMRC (2012) appeared to be the most comprehensive, discussing specifically how nurses need to be able to recognize features of BPD, understand these individuals' specific needs, participate in risk assessment, establish referral links, and support family members.

Two resources similarly included information on managing endings and supporting transitions (NHMRC, 2012; NICE, 2009). This involves anticipating the ending of treatment or a transition from one service to another and the importance of discussing changes with

patients carefully beforehand. It is not uncommon for individuals with BPD to become upset when treatment comes to an end. Therefore, it is vital to plan these changes in consultation with the patient (NHMRC, 2012).

Treatment Options

Each resource identified treatment options for individuals with BPD. This included pharmacotherapy, psychotherapy, and hospital admissions.

Pharmacotherapy. It has been identified that medications have a role in the treatment of BPD. Although there is no specific medication for BPD, some medications have effectively reduced the impact of the symptoms of the disorder (CAMH, 2009). Amongst the resources that provided information on medications as a treatment option for BPD, it was consistent that anti- depressants, mood stabilizers, anti-psychotics, and anti-anxiety medications are effective in treating symptoms of BPD (CAMH, 2009; Gunderson, 2011; NAMI, 2015; NHMRC, 2012; NICE, 2009). However, two of the resources included important information on the risk of prescribing medications to this patient population due to their increased risk of overdose and non-compliance (Gunderson, 2011; NHMRC, 2012).

Psychotherapy. Two educational materials focused on providing information to patients on DBT (Mckay et al., 2011; Vivyan, 2009). Both documents were located from websites recommended through previous consultations with key informants. Education on DBT for nurses is deemed relevant for this environmental scan. Most of the key informants during the consultation process identified the importance of having more education on DBT. Therefore, information on DBT will be included in the learning resource from these two sources.

The comprehensive workbook found titled the Dialectical Behaviour Therapy Skills

Workbook by Mckay et al. (2012) is a 262-page document and is exceptionally comprehensive. Similarly, a more concise document titled Dealing with Distress: An Introduction to Healthy Coping Strategies by Vivyan (2009) was located. Both documents included an overview of DBT, distress tolerance skills, mindfulness skills, emotional regulation skills, and interpersonal effectiveness skills, each following the core components of DBT. In addition, healthy coping mechanisms are described throughout both documents, including but not limited to distraction, relaxation, positive affirmations, and meditation. Other resources contained consistent information agreeing that psychotherapy such as DBT and CBT were the cornerstone treatment for BPD (CAMH, 2009; Gunderson, 2011; NAMI, 2015; NHMRC, 2012). In addition, treatment goals included reducing suicide risk, improving relationships, learning coping skills, having the ability to deal with situations that trigger an emotional crisis, learning self-soothing and distraction techniques, reducing anger, depression, anxiety, and impulsivity (NHMRC, 2012).

Hospital Admission. The use of hospital admissions for individuals with BPD was a common theme in many of the resources. However, it was consistently identified that hospital admission must be brief, with an agreed length and purpose discussed in advance with the patient (Gunderson, 2011; NHMRC, 2012; NICE, 2009). A brief admission is utilized for a crisis and provides a safe place to gain distance and perspective (Gunderson, 2011). It should only be used for high risk of suicide or medically serious self-harm (NHMRC, 2012). Furthermore, if the admission begins as an involuntary patient, voluntary status should be resumed at the earliest opportunity (NICE, 2009). These features of a brief admission are consistent with the information obtained from the integrative literature review and consultations with experts.

Education for Families

Two educational materials were found that specifically focused on education for families of individuals with BPD (CAMH, 2009; Gunderson & Berkowitz, 2006). However, despite these being created for families, the information in these documents is relevant for nurses to improve their understanding and ability to educate family members.

The more comprehensive document is 62-pages and created by CAMH (2009). This guide is highly informative and encompasses a wide range of topics. Topics include information about BPD, stigma, treatment options for people with BPD, involuntary hospital admissions, warning signs of suicide, information for younger siblings, and self-care. Similarly, the 12-page information guide by Gunderson & Berkowitz (2006) is targeted towards families of individuals with BPD. This information guide differs slightly, as it did not include any background information on BPD or treatment options. Therefore, it was overall less comprehensive. However, it did include helpful information on how families could manage day-to-day with a loved one with BPD. Both information guides included strategies on managing during a crisis or emergency, along with the importance of setting limits on problem behaviors at home.

Other resources included brief information on family education. Gunderson (2011) discussed how families could help diminish the likelihood of recurring self-destructive threats by being present, listening without criticism, rejection, or disapproval. Furthermore, it was also identified in this resource that healthcare professionals need to educate families about the BPD diagnosis and its prognosis and reasonable expectations to expect from treatment (Gunderson, 2011). Similarly, it was identified that healthcare professionals should encourage families to be involved and inform them about local support groups (NHMRC, 2012; NICE,

2009). However, it was identified in multiple resources the importance of gaining patients' permission for family involvement (NHMRC, 2012; NICE, 2009). It is important to respect patients' choice not to involve their families but to give them a chance to change their minds in the future (NHMRC, 2012).

More specifically, the practice guideline by NHMRC (2012) provided detailed information on healthcare providers' role in family education. It was identified that families should gain knowledge and understanding of BPD, develop helping attitudes (i.e., empathy and non-judgmental), encourage independence, and cooperate with healthcare services. In addition, healthcare professionals need to value and support families, communicate, consider their culture, help them navigate health services and provide information about diagnosis and treatment, including management during a crisis (NHMRC, 2012).

Conclusion

The information retrieved through this environmental scan will be helpful to guide the learning resource for nurses on BPD. Although the findings were from several reputable resources, no single, comprehensive educational resource for nurses was found. Furthermore, the lack of responses from health facility representatives may also suggest there are limited resources available within other healthcare facilities. This further justifies the need and urgency for this practicum project.

Overall, the findings from the resources were consistent with the information obtained from the integrative literature review and consultation process. The development of the learning resource for this practicum project will include a combination of the commonalities found throughout the analysis of the resources throughout the environmental scan. The learning resource will include an overview of BPD symptoms and causes, along with

treatment options and an in-depth component on DBT. Furthermore, interventions to guide nursing care will be included, along with education on self-harm and suicidality. Finally, the education materials retrieved for families will inform nurses on how to educate families on BPD and how to care for their loved one at home. These publicly available educational materials that were located and analyzed can be combined to create a comprehensive learning resource addressing the nursing staff's unique learning needs on the SSU and the PAU.

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Appendix A: Email to Organizations

To (name of organization),

My name is Olivia Cobbs, and I am a Registered Nurse at the Waterford Hospital in St. John's, Newfoundland and Labrador (NL), working on a short-stay inpatient unit. I am also a Master of Nursing student at Memorial University in NL and am currently completing my practicum project to complete this degree. For this project, I plan to develop an educational resource on borderline personality disorder for nurses in the mental health setting. Through my professional experience and consultations with staff nurses on my unit, it has become apparent more education is required on caring for this patient population. Therefore, this practicum project aims to address the impact of this disorder and improve nurses' knowledge, attitudes, experiences, and the quality of care provided to this patient population in this setting.

To inform my project, I would like to determine what resources exist in other healthcare facilities regarding education, policies, or procedures on borderline personality disorder for staff nurses. It would be greatly appreciated if you could please share any educational information your organization has on this topic. I will be reviewing all materials that I receive from various hospitals, analyzing them for common themes, and using this information to help inform my learning resource. I will only be sharing this information with my practicum supervisor. If I decide to use any of your material within the resource, I will reach out to you again for written permission. It will be referenced and credited appropriately. Your participation in this is strictly voluntary, although I would appreciate any help you can provide.

I appreciate your time to read this email and helping me with this project. I would greatly appreciate any information or educational resources you could provide me from your organization. Please feel free to email me at any time to discuss any questions or concerns you may have.

Thank you,

Olivia Cobbs, BNRN
St. John's, NL
occ142@mun.ca

Appendix B: Health Research Ethics Authority (HREA) Screening Tool

Student Name: Olivia Cobbs

Title of Practicum Project: Development of resource manual for nurses caring for patients diagnosed with borderline personality disorder in the mental health setting.

Date Checklist Completed: May 21, 2021

This project is exempt from Health Research Ethics Board approval because it matches item number three from the list below.

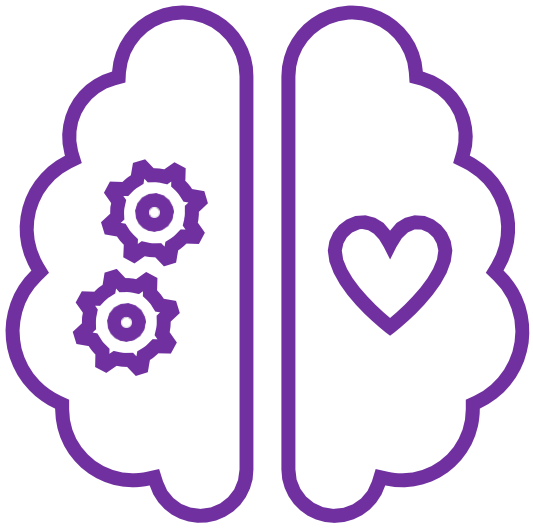
1. Research that relies exclusively on publicly available information when the information is legally accessible to the public and appropriately protected by law; or the information is publicly accessible and there is no reasonable expectation of privacy.
2. Research involving naturalistic observation in public places (where it does not involve any intervention staged by the researcher, or direct interaction with the individual or groups; individuals or groups targeted for observation have no reasonable expectation of privacy; and any dissemination of research results does not allow identification of specific individuals).
3. Quality assurance and quality improvement studies, program evaluation activities, performance reviews, and testing within normal educational requirements if there is no research question involved (used exclusively for assessment, management or improvement purposes).
4. Research based on review of published/publicly reported literature.
5. Research exclusively involving secondary use of anonymous information or anonymous human biological materials, so long as the process of data linkage or recording or dissemination of results does not generate identifiable information.
6. Research based solely on the researcher's personal reflections and self-observation (e.g. auto-ethnography).
7. Case reports.
8. Creative practice activities (where an artist makes or interprets a work or works of art).

For more information, please visit the Health Research Ethics Authority (HREA) at https://rpresources.mun.ca/triage/is-your-project-exempt-from-review/

Appendix IV: Learning Resource

Self-Directed Learning Resource

Nurses Caring for Patients Diagnosed with Borderline Personality Disorder in the Mental Health Setting



Developed by: Olivia Cobbs, BN, RN

December 2021

PREFACE

WELCOME to the self-directed learning resource for nurses caring for patients with borderline personality disorder (BPD) in the mental health setting**.** This learning resource was created for nurses on the short-stay unit (SSU) and the psychiatric assessment unit (PAU) at the Waterford Hospital in St. John's, Newfoundland and Labrador. Nurses' learning needs were identified through consultations with key stakeholders**,** an integrative literature review**,** and an environmental scan. As a result, nurses will have this self-directed, evidence-informed learning resource designed to guide their nursing interventions and decrease the uncertainties often associated with caring for patients with BPD.

This learning resource will be accessible online and beneficial for nursing staff with varying levels of experience. This learning resource can be completed at your convenience and at your own time and pace! It consists of six modules that provide education and skill building techniques for nurses to improve the effectiveness of the nursing care they offer to individuals with BPD. Each module is color-coordinated to make it easier to find your place after taking a break. The modules can be completed in any order, but it is recommended to read module one before reading any other modules. There will be some interactive parts along the way, and answer keys can be found at the end of each module**.** Each module includes an opportunity for reflection, useful facts and tips, and how to apply the content of each module to nursing practice.

The six learning modules include:

Module 1: Overview of BPD.

Module 2: Nursing challenges associated with caring for the individual with BPD.

Module 3: Education on DBT.

Module 4: Nursing interventions and therapeutic relationships.

Module 5: Brief hospital admissions and improving the SSU.

Module 6: Family education.

ENJOY YOUR LEARNING!

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Module 1: Overview of Borderline Personality Disorder

Module 1: Overview of Borderline Personality Disorder

The purpose of this module is to provide an overview of BPD, including diagnostic criteria, causative factors, treatment options, and recovery. This information will provide the foundation for the remainder of this learning resource and provide learners with increased knowledge to better prepare them to effectively care for individuals with BPD.

At the end of this module, there is a self-test in the form of a crossword!

Learning Objectives

After the completion of this module, learners will be able to:

1) List the DSM 5 diagnostic criteria for BPD.
2) Identify causative factors of BPD.
3) Value the personal challenges of living with BPD.
4) List the medications commonly prescribed for individuals with BPD.
5) Identify the goals of psychotherapy in the treatment of BPD.
6) Describe the purpose of hospitalization for individuals with BPD.
7) Understand realistic recovery outcomes for individuals with BPD.

Overview of Borderline Personality Disorder

A personality includes longstanding ways of perceiving, relating to, and thinking about the environment and oneself.[1] When personality traits become maladaptive and cause significant functional impairment or subjective distress, they constitute a personality disorder.[1]

There are ten classified personality disorders, with BPD being the most complex and most common. It is also the most devastating, with up to 10% of those diagnosed committing suicide.[1] About 1 to 2 % of the general population have BPD, and it is more likely to be diagnosed at the age of 20, which is also the age group with the highest suicide risk.[2] This prevalence rate may also be even higher. Research has shown that over 40% of people with BPD have been previously misdiagnosed with other disorders like major depressive disorder and bipolar disorder.[3] In addition, research indicates that BPD has a higher incidence than schizophrenia or bipolar disorder.[4]

Other mental health issues are common in people with BPD, which might make diagnosing BPD more difficult. For example, substance use disorders, eating disorders, and PTSD are all typical co-occurring illnesses with BPD. The co-occurring disorder symptoms can often make it challenging to diagnose BPD since they mirror or disguise signs of BPD.[5]

Diagnostic Criteria

According to the DSM-5 diagnostic criteria, BPD is a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and presents in a variety of contexts, as indicated by five or more of the following[6]:

Diagnostic Criteria

According to the DSM-5 diagnostic criteria, BPD is a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and presents in a variety of contexts, as indicated by five or more of the following[6]:

Abandonment fears → This includes frantic efforts to avoid real or imagined abandonment. These abandonment fears may be related to an intolerance of being alone.[1,6]

Unstable or intense relationships → Individuals with BPD cannot see their loved ones as other than idealized or devalued. In other words, black and white thinking![1,6]

Identity disturbances	→	This includes an unstable self-image or sense of self. Their values, habits, and attitudes usually mimic their close friends or family.[1,6]
Impulsivity	→	Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving and eating disorders).[6]
Suicidal or self-injurious behaviors	→	This includes suicide attempts, gestures, threats, or self-harm.[6]
Affective/emotional instability	→	Intense, volatile range of emotions that only lasts a few hours.[1,6]
Chronic feelings of emptiness	→	This should not be confused with boredom, as it is a visceral feeling felt in the abdomen or chest. It is associated with loneliness.[1,6]
Anger	→	Frequent displays of temper, fighting, and difficulty controlling anger.[6]
Psychotic-like perpetual distortions	→	This includes dissociative symptoms, where individuals may feel unreal or that the world is imaginary. Individuals with BPD may also be unrealistically self-conscious, believing that others are constantly talking about them or critically looking at them.[1,6]

Causative Factors

BPD is caused by a complex combination of genetic, social, and psychological factors.[1,7,8] Traumatic life events such as physical and sexual abuse during childhood or neglect or separation from parents may contribute to the development of BPD.[7,8] About 70% of people with BPD have a history of physical or sexual abuse.[1] Additionally, a fast-paced society with family situations that are unstable due to divorce, economic factors, or other pressures on the caregivers may encourage the development of this disorder.[1]

Living with BPD

Individuals with BPD have been found to have significant impairment at work, in social relationships, and at leisure.[1] They are highly sensitive and can react with intense emotions to

small changes in their environment.[9] Living with BPD can often be described as living in constant emotional pain, and BPD symptoms result from the efforts to cope with this pain.[9] The manifestations of this disorder create barriers in aspects of everyday life, including relationships, education, work, recreation, and personal development.[10] Affected individuals struggle to create close relationships, inhibiting their ability to find a significant other and often destroying relationships with friends, family members, and children.[10] They may also struggle to collaborate with colleagues, impacting their careers.

TIP: Not everyone with BPD has the same experience or symptoms!

Please click on the following link to a video for a depiction of what it can be like living with this disorder. *Source.* From "I Am Borderline", by Wright Institute Los Angeles, 2016, [11]
https://www.youtube.com/watch?v=rZdjbLFPr5k

Treatment Options

Images from Microsoft Word 2021

Hospitalization

Hospitalization of patients with BPD is usually for crisis management only and when the patient's safety is at risk. Hospitals provide a safe place where the patient can gain distance and perspective on a particular crisis and where professionals can assess the patients' medications, psychological and social problems, and resources.[1] Therefore, a hospital admission must be brief, with an agreed length and purpose discussed in advance with the patient.[1,8,12]

Psychotherapy

Psychotherapy is the cornerstone treatment for patients with BPD. Psychotherapy can decrease self-harm, suicidality, and the use of hospitals, emergency rooms, and medications.[1]

Psychotherapy aims to increase individuals' use of adaptive coping skills, reduce dysfunctional coping skills, and improve their quality of life and social adjustment.[13] A common type of psychotherapy widely used and validated is dialectical behavior therapy (DBT). DBT focuses on mindfulness and teaches skills to control intense emotions, reduce self-destructive behaviors, manage distress, and improve relationships.[14]

You will learn more about DBT in module 3!

Medications

There is no specific medication for BPD, but medication can be prescribed to reduce the impact of symptoms of the disorder.[5] Medication can be helpful by providing a period when the symptoms are reduced, which allows patients to focus on learning new coping skills and managing their behaviors.[5] Unrealistic expectations of the benefits of medication can undermine work on self-improvement.[1]

TIP: Concerns with medication use in this patient population are the risks of overdosing and non-compliance.[1]

Medications used in the treatment of the symptoms of BPD include:

Anti-depressants

Anti-depressants are used to treat depression and anxiety. SSRIs are most used, including paroxetine, fluoxetine, sertraline, citalopram, and escitalopram.[5]

Mood stabilizers

Mood stabilizers can help with outbursts of anger. Common ones used are divalproex, carbamazepine, and lamotrigine.[5]

Anti-anxiety

Anti-anxiety medications include benzodiazepines. Examples include lorazepam, clonazepam, and diazepam. However, these can be addictive when used long-term.[5]

Antipsychotics

Typical anti-psychotics, i.e., haloperidol and loxapine are used but atypical antipsychotics such as olanzapine, risperidone and quetiapine are more common. Atypical antipsychotics are also mood stabilizers.[5]

TIP: Nurses should encourage patients to participate in regular exercise, good sleep habits, a nutritious diet, taking medications as prescribed, and healthy stress management. Good self-care helps reduce common symptoms of BPD, such as mood changes, impulsivity, and irritability.[14]

Recovery

BPD is not necessarily a life-long disorder.[15] Individuals with BPD can respond well to evidence-based treatments, and these treatments are continuously improving. Although recovery requires hard work for patients in therapy and treatment. The first five years are usually the most crisis ridden.[1] Patients with BPD tend to begin their first treatment at the age of 18. However, symptoms usually start earlier.[16]As individuals with BPD age, their symptoms typically diminish. About 40-50% of patients remit within two years, and this rate rises to 85% by ten years.[1] Research over the years has identified that BPD has a positive trajectory over time, and early identification and intervention allows patients to resume a healthier course early on in life.[15] Those who continue successful treatment often have a better ability to control their emotions and maintain healthy relationships and overall health.[10]

Application of Key Evidence to Nursing Practice

It is essential to have a strong understanding of the diagnostic criteria of BPD to recognize this diagnosis in the mental health setting. BPD is often misdiagnosed, and early identification and intervention allow patients to resume a healthier lifestyle early on in life.

Nurses need to understand the suffering individuals with BPD face living with this disorder to avoid projecting negative attitudes and stigma on these individuals and their families.

Educate patients with BPD on their treatment options and realistic recovery outcomes. This education is important as unrealistic expectations can undermine individuals' work on self-improvement.

Encourage patients to follow their treatment plan as those who continue successful treatment have a better ability to control their emotions and maintain healthy relationships and overall health.

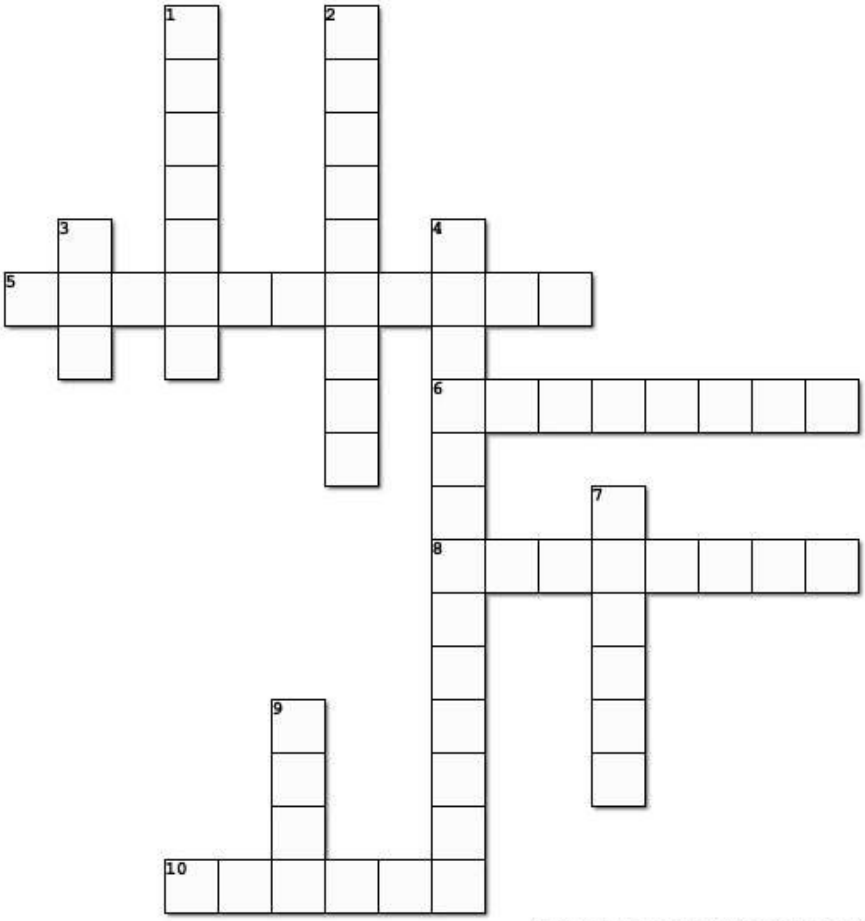
Reflection

1) Can you identify the most common diagnostic criteria?
2) What might you look for in a client's history to support a provisional diagnosis of BPD?
3) What are the most common symptoms you have noticed?
4) Picture yourself in their shoes for a moment with these overwhelming emotions. How do you think you would cope?

Test Your Knowledge!

MODULE 1 TEST

Complete the crossword puzzle below



Created using the Crossword Maker on TheTeachersCorner.net

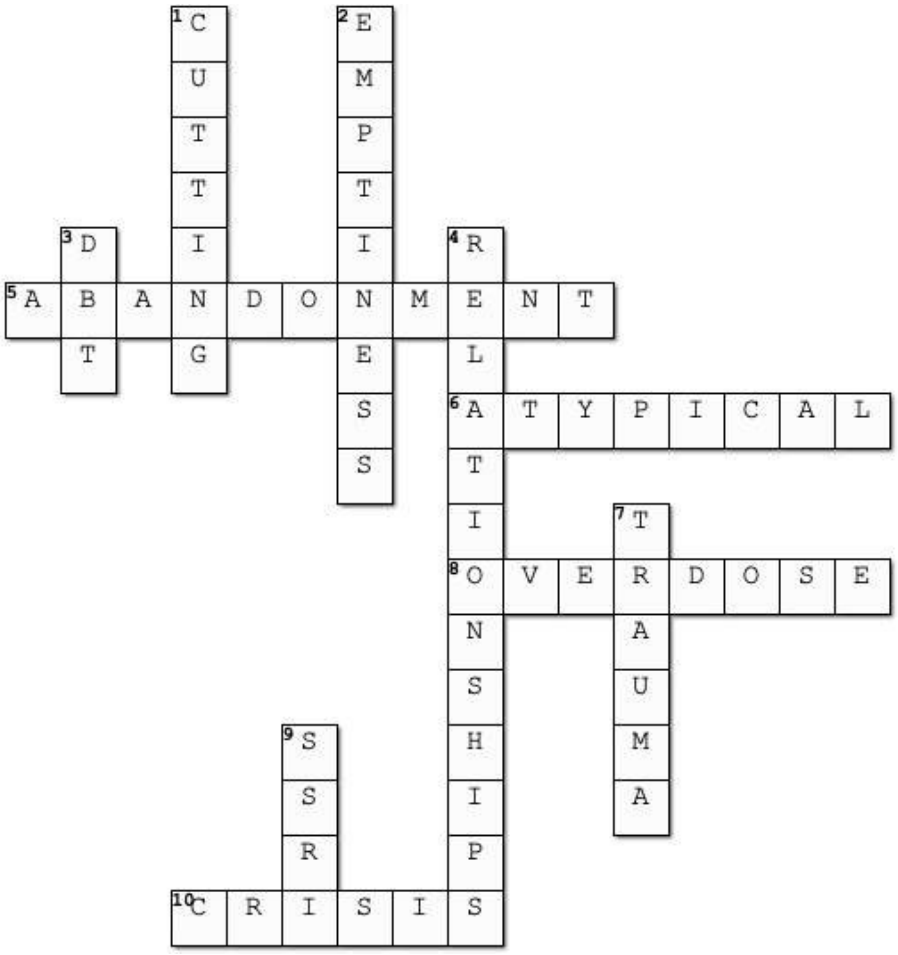
Across

5. Individuals with BPD have an extreme fear of _____?
6. What type of anti-psychotics are generally used for individuals with BPD?
8. What is a risk of prescribing medication for individuals with BPD?
10. Hospitalizations are useful during a _____.

Down

1. What is a type of self-injury?
2. Individuals with BPD often have chronic feelings of _____.
3. What is the cornerstone treatment for BPD?
4. What do most individuals with BPD have trouble maintaining?
7. What is something 70% of people with BPD have in common?
9. The most common class of anti-depressants used for treatment of BPD.

Answer Key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Module 2: Nursing Challenges Associated with Caring for the Individual with Borderline Personality Disorder

Module 2: Nursing Challenges Associated with Caring for the Individual with Borderline Personality Disorder

The purpose of this module is to better prepare nurses for the many challenges that can arise when caring for individuals with BPD. A growing body of evidence has established various obstacles to effective caregiving with this patient population. Therefore, this module includes information on the most common difficulties, including staff-splitting, manipulation, suicidality, and self-harm. Having a good understanding of the challenging behaviors of individuals with BPD will hopefully enable nurses to be more empathetic. Additionally, this module includes a component on self-care for nurses along with solutions to professional stress.

At the end of this module, learners will complete a "Myth or Fact" activity to test their knowledge.

Learning Objectives

After the completion of this module, learners will be able to:

1) Describe the detrimental effects of negative reactions from nurses towards individuals with BPD.
2) Identify the expected challenges associated with caring for individuals with BPD.
3) Understand the root cause for the complex behaviors exhibited by individuals with BPD.
4) Identify solutions to managing the professional stress associated with caring for individuals with BPD.

Module 2: Nursing Challenges Associated with Caring for the Individual with Borderline Personality Disorder

Healthcare professionals, especially nurses, have identified various challenges to the effective care for individuals with BPD. Evidence conveys a sense of negativity towards individuals with BPD, who are often stereotyped by healthcare professionals. These patients are assumed to be manipulative, and attention-seeking and they have reported significant discrimination when attempting to seek help.[1-3]

When a non-therapeutic relationship between nursing staff and patients with BPD exists, it can negatively impact nurses' well-being and work-life. It can cause feelings of guilt, anger, frustrations, and hopelessness, which leaves nurses feeling that there is no way to facilitate a favorable recovery for these patients.[4]

Individuals with BPD can present as attention-seeking, dramatic, and highly passionate, and their life situations appear chaotic and distressing.[5] These characteristics are often difficult to work with, leaving healthcare providers exhausted and overwhelmed.[5] Negative reactions by nurses towards individuals with BPD are counter-therapeutic for both the patient and the nurse. This negativity can lead the nurse to demonstrate emotional distancing, a lack of belief in recovery, difficulty empathizing, and perceptions of patients as dangerous, manipulative, and more in control of their behavior than other patients.[6-8] Common behaviors exhibited by individuals with BPD that healthcare providers find most distressing include manipulation, staff-splitting, self-harm, and suicidality.

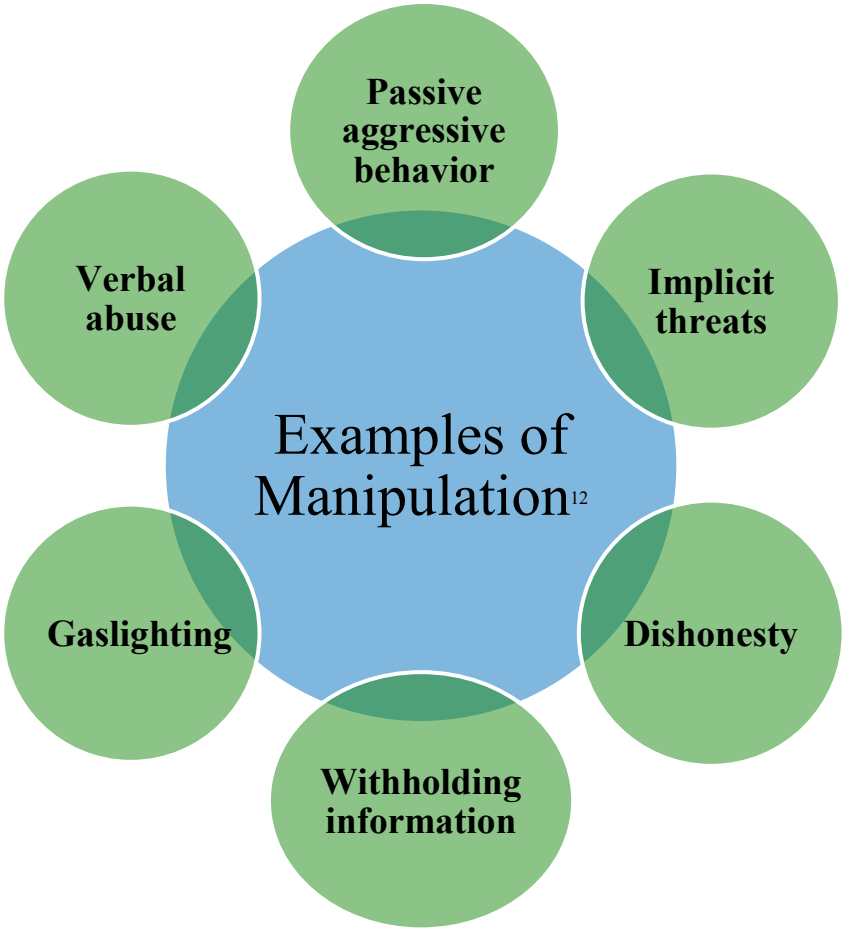
By understanding why individuals with BPD act the way they do, you can gain a better perspective on the nature of their illness.[9]

TIP: While it is challenging to be on the receiving end of patients' intense behaviors, it is important to remember at the root of the behavior is a person living and suffering with a debilitating psychiatric disorder.[5]

Manipulation

A common characterization of individuals with BPD is that they are manipulative.[10] It is essential to understand manipulation well because evidence has shown that carers who perceive individuals with BPD as manipulative also have less empathy for them.[10] Manipulation includes picking fights and challenging nurses and other health professionals, which may make individuals with BPD feel better for a short period.[11] See Figure 2.1 for examples of manipulation.

Figure 2.1 Examples of Manipulation



What are the reasons behind this behavior?

- Manipulation is usually rewarded with emotional validation in the short term, but often individuals feel worse in the long run.[11]
- When someone forces someone to do what they want, it may lead to feelings of satisfaction and control. This is a strong emotional reward for individuals with BPD, as they often feel like their own lives are out of control.[11]
- Sometimes the manipulative behaviors can be related to fears of being alone, leading individuals with BPD to want to force people to stay with them.[11]
- What is perceived as manipulation may be a desperate attempt to cope with the overwhelming fears of abandonment and rejection.[9]

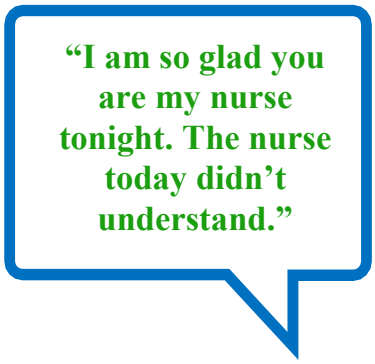
Splitting

Splitting is related to the black and white thinking discussed in **module 1**. It is the view that someone is "all good" or "all bad," not allowing for any grey areas.[13] Splitting is often present on inpatient units, where patients will try and play one staff member against another, by telling

different versions of a story to different people.[14] This can often cause tension on inpatient units between healthcare professionals, with staff members taking sides against each other if they aren't aware of this complex behavior. It is important for nurses to avoid becoming part of the splitting behaviors that generate tension and interpersonal conflicts between staff.14

What are the reasons behind this behavior?

Splitting is considered a defense mechanism by individuals with BPD to protect themselves against intense negative feelings such as loneliness, abandonment, and isolation.[13] Individuals with BPD struggle with overwhelming emotions and have extreme difficulty integrating the concept that good and bad can co-exist.[13] Splitting allows the individual to tolerate these overwhelming emotions by only seeing a person one way.[13] This makes it easier to manage the emotions they are feeling. They can put a label of "good" or "bad" and avoid the effort of analyzing how they think about someone or something that contains both aspects.[13,15]



TIP: Seeing things as all positive, or all negative, can leave an individual with BPD feeling exhausted and drained. It is also a strain on their interpersonal and professional relationships.[13]

Self-Harm and Suicidality

Self-harm and suicidality are the most dangerous and fear-inducing features of BPD.[16] Self-harm occurs in approximately 75% of individuals with BPD and often they will self-injure with no suicidal intent.[16] Commonly, self-harm can include cutting, burning, hitting, head banging, hair pulling, and swallowing items.[16] Additionally, up to 10% of individuals with BPD commit suicide.[16]

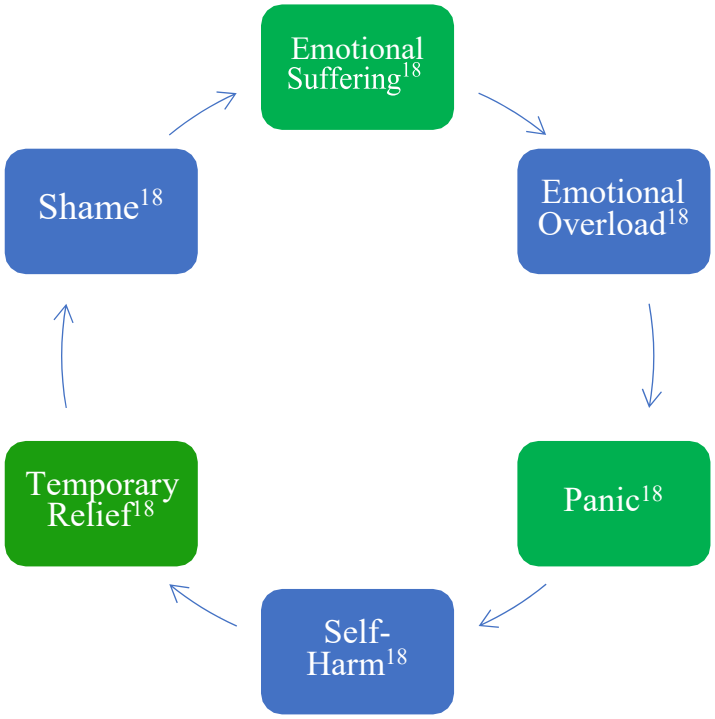
What are the reasons behind this behavior?

The motivations for self-injurious behaviors are complex, vary from patient to patient, and may serve different purposes at different times.[16]

- Sometimes, when numbness and emptiness prevail, self-harming may be the only way to experience feelings at all.[16]
- Patients report that causing themselves physical pain generates relief which temporarily alleviates from psychic pain.[16]

- Sometimes, people with BPD make suicide attempts when they feel alone and unloved, with a vaguely conceived plan of being rescued, which may alleviate the intolerable feelings of being isolated by establishing some connection with others.[16]
- The physical act may result in a release of endorphins, making someone feel better for a short amount of time. However, these physical and emotional feelings reinforce self-harm in the future.[11]
- The emotional reward that reinforces self-destructive behaviors are important to understand. Self-harm can offer temporary rewards that make them likely to be repeated but are followed by long-term damage.[11]
- These self-injurious behaviors can become addictive, and the goal is to break the cycle.[11] See Figure 2.2 for the cycle of self-injury.

Figure 2.2 The Cycle of Self-injury



TIP: People who have self-harmed should be treated with the same care, respect, and privacy as any other patient. Consider the likely distress associated with the self-harm.[17]

Solutions to Professional Stress

Healthcare professionals working with individuals with BPD have reported feelings of distress and anxiety and experiencing burnout at some point in their professional lives.[19] Nurses are often at the frontlines caring for this patient population for extended periods.[20] Poor attitudes towards individuals with BPD are a normal reaction to these individuals' complex behaviors.[8] As nurses, it is easy to neglect personal health while providing care to others.[21]

One way to combat professional stress when caring for individuals with BPD is to debrief with other co-workers. Due to the many challenges associated with caring for individuals with BPD, speaking with another colleague can help validate that quality of care was provided.[5]

Additionally, individuals with BDP, may challenge boundaries. Therefore, talking with other professionals can help to validate that the boundaries set were professional and appropriate.[5]

Finally, it is important not to personalize outbursts, negative talk, or manipulative behaviors. Focus more on the small successes that will come with patience and time.[5]

Self-care tips for nurses:

- Schedule self-care the same as you would your work schedule.[21]
- Enjoy hobbies.[21]

- Unplug from electronic devices.[21]
- Leave work at work.
- Engage in positive self-talk.[21]
- Don't be afraid to say no to additional responsibilities.[21]
- Spend time with people you care about.[21]
- Exercise.[21]
- Focus on nutrition.[21]
- Go outside.[21]
- Meditate.[21]
- Prioritize sleep.[21]
- Practice mindfulness.[21]
- Self-care can happen at work. Take breaks when you can.[21]

Reflection

1) Reflect on what you think is the most challenging aspect of caring for individuals with BPD and why.
2) What self-care activities from the provided list would be most helpful for you?
3) Identify how you usually cope with professional stress.

Application of Key Evidence to Nursing Practice

Understanding the root causes of the complex behaviors of individuals with BPD will help you gain a balanced perspective on the nature of the illness and its impact on those who live with it. Keep reading to gain more insight.

Splitting behaviors are designed to cause tension and conflict in inpatient units. Communication between nurses is essential to prevent or quickly identify emerging behaviors. Consider and demonstrate how this might be communicated professionally among nurses on your team.

Debriefing and team support have strong evidence of effectiveness. Ensure that you are open and supportive of colleagues when issues arise. Encourage debriefing on your unit as part of both professional development and self-care. Speaking with co-workers helps validate your professional actions but also provides an opportunity to learn new approaches.

Participate in regular self-care activities to improve your mental health, which will benefit your interactions and relationships with patients and colleagues.

Myth or Fact?

Identify if the below statements are myths or facts.

1) Individuals with BPD are manipulative and attention seeking.
2) Suicide threats by individuals with BPD aren't serious, it is only a cry for help.
3) Caring for individuals with BPD can be stressful for healthcare professionals.
4) Nurses often neglect their self-care while caring for others.
5) BPD is often stigmatized, even among nurses.

Answer Key

1) **MYTH:** If someone with BPD is acting out through manipulation or appearing attention seeking, it is due to a desperate attempt to cope with overwhelming emotions.
2) **MYTH:** All suicide threats should be taken seriously. Remember, up to 10% of individuals diagnosed with BPD complete suicide.[16] They are at an elevated risk due to their intense emotions and impulsivity.
3) **FACT:** Due to their complex behaviors, caring for individuals with BPD can lead to burnout.
4) **FACT:** Nurses neglect their own self-care, leading to anxiety and burnout. Therefore, it is so important to manage professional stress appropriately.
5) **FACT:** A common misconception is that individuals with BPD are purposely trying to manipulate those around them. Remember, these are symptoms from their mental illness.

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Module 3: Education on Dialectical Behavior Therapy

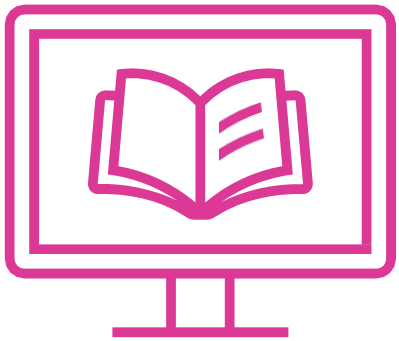
Module 3: Education on Dialectical Behavior Therapy

Although dialectical behavior therapy (DBT) is taught to patients in an outpatient setting by specially trained professionals, nurses should still have a basic understanding of DBT. This type of psychotherapy is the cornerstone treatment for individuals with BPD. During the consultation process of this practicum project through interviews with key stakeholders, nurses expressed interest in having an increased understanding of the components of DBT. It takes an extended period for patients to complete DBT. Therefore, only the basics will be reviewed in this module, and specific skills deemed helpful for the PAU and the SSU.

Learning Objectives

After the completion of this module, learners will be able to:

1) List the four main skills taught in DBT.
2) Identify unhealthy coping strategies.
3) Give examples of pleasurable activities to suggest to patients.
4) Identify practical distraction activities for patients to avoid self-harm.
5) Describe how to implement mindfulness exercises in the SSU setting.
6) Identify effective emotion regulation skills to promote on the SSU.
7) Describe the importance of effective interpersonal relationship skills for a patient struggling with overwhelming emotions.
8) Apply the DBT skills learned in this module to a case-study scenario.



Module 3: Education on Dialectical Behavior Therapy

What is DBT?

DBT is a form of psychotherapy developed for individuals with BPD.[1] It teaches people to accept their thoughts, feelings, and behaviors, along with the techniques to change them. These seem like opposite strategies, right? Well, dialectical means the existence of opposites! Individuals need to accept that their experiences are valid and make positive changes to manage emotions in the future.

Research indicates that healthcare professionals that received DBT informed training reported lower levels of burnout, less stigma towards this patient population, and more positive attitudes towards recovery.[2] Nursing staff can play a vital role in helping patients with their DBT skills, and even when comprehensive DBT training is not available, some training in DBT skills is advisable.[3] In mental health settings, nurses can implement interventions using the concepts of DBT to help individuals with BPD build effective coping strategies.[4]

Comprehensive DBT treatment is approximately 12 months long and delivered on an outpatient basis. Once a clinician on the DBT team receives the referral, they invite patients to complete an initial four weeks of DBT to determine client readiness, willingness, and commitment to participate.[5] Once comprehensive treatment begins, it consists of weekly skill training group sessions to teach individuals behavioral skills and weekly individual therapy sessions to assist individuals in applying skills specific to challenges and events in their lives.[5,6] The treatment also includes in-the-moment skills coaching, where clients can contact their therapist.[5]

Although nurses on the SSU and the PAU are not trained to provide comprehensive DBT treatment, it is still essential to understand the program and its components. It is also important to have the knowledge on this topic to help patients understand what to expect regarding treatment once referrals for DBT are sent from the PAU or the SSU.

There are four skills taught in DBT:

1. Distress Tolerance: The process of learning to cope during a crisis.[1]
2. Mindfulness: The practice of being present and focusing less on painful experiences in the past.[1]
3. Emotional Regulation: The ability to manage emotions without behaving in destructive ways.[1]
4. Interpersonal Effectiveness: The ability to communicate effectively and to protect relationships with others.[1]

These skills help people when distressed and replace unhealthy or harmful behaviors.[1] See Figure 3.1 which highlights unhealthy coping strategies.

Figure 3.1 Unhealthy Coping Strategies

DBT Skill #1: Distress Tolerance

For individuals with BPD, emotional pain feels more intense and happens more frequently than it does for those without BPD and affected individuals don't know how to cope with this pain.[7] Individuals with BPD may deal with this pain in unhealthy and unsuccessful ways. Although these unhealthy coping strategies may cause temporary relief, they will cause more suffering in the future.[7] That is what makes distress tolerance skills so important. Individuals with BPD need to learn how to deal with their pain in healthier ways. The distress tolerance skills that will be reviewed further include distraction, self-soothing, radical acceptance, self-encouraging statements, and self-affirming statements.

Distraction

Distraction is a distress tolerance skill that gives patients time to stop thinking about the pain, let emotions settle, and find an appropriate coping response.[7] There are healthy ways to distract from painful emotions. When a patient is experiencing a crisis or overwhelmed with negative emotions, there are distractive activities to encourage patients to use that can help prevent a situation from escalating. Distraction activities should be something that can be easily completed and on short notice.[8]

Below is a list of distracting, pleasurable activities to suggest to patients:

- Talk to a friend.[8]
- Stretch, yoga, exercise, or go for a walk.[7,8]
- Play a game.
- Watch TV or read a book.
- Draw, color, or paint.
- Plant therapy.
- Listen to a podcast.[8]
- Get a bath or shower.[8]
- Write down things you like about yourself.[7]
- Write a list of 5 things you are good at.[7]

TIP: Patients do not need to wait until they are overwhelmed to do these activities. They should be encouraged to do a pleasurable activity each day.[7]

Distraction from Self-Harm

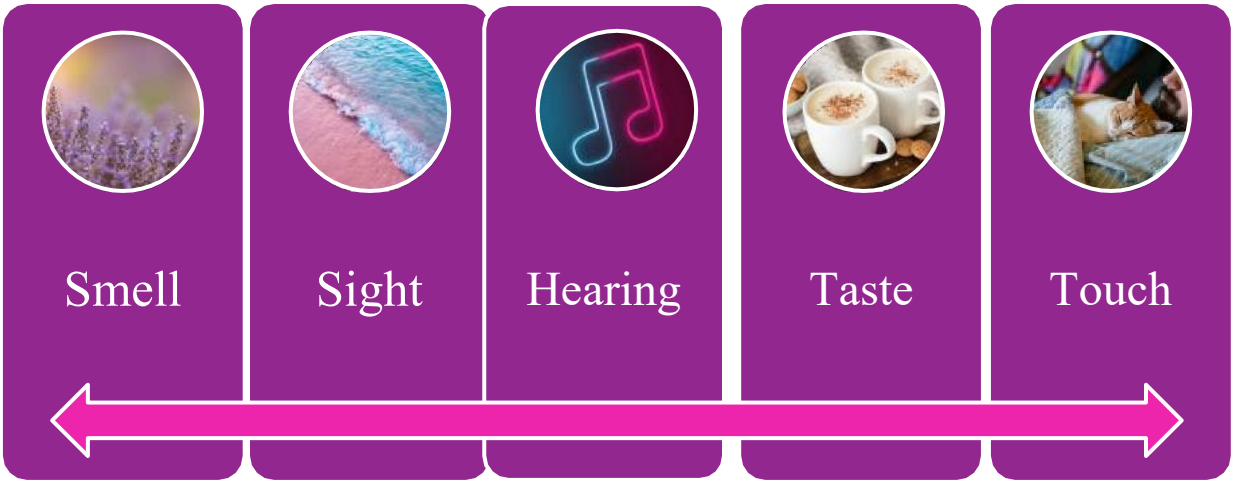
Below are some examples of distractive activities to encourage patients to do if they feel like self-harming:[7]

- Hold an ice cube in one hand and squeeze it.[7]
- Snap a rubber band on your wrist.[7]
- Splash cold water on your face.[7,9]
- Cry (Crying releases stress hormones!).[7]

Encourage patients to think of other healthy, non-harming ideas. First, help patients identify their self-harming behaviors and the temporary reward.[7] After this, help them identify the long-term costs and dangers of self-mutilation such as permanent scarring, infection, death, or feelings of guilt.[7]

Relaxation and Self-Soothing

Learning to relax is important! Relaxation slows the heart rate, reduces blood pressure, and helps distinguish healthier ways to cope.[7] Relaxation and self-soothing can be done using the senses: smell, sight, hearing, taste, and touch.[7] By encouraging patients to focus on the five senses, they can shift their focus from a stressful situation to something entirely different.[9]



Smell

- Sit out on the SSU patio and smell the outdoors.
- Get your favorite food brought in that smells good.
- Open your window and smell the fresh air.

Sight

- Look at a picture of a place that's soothing.[7]
- Look at nature pictures.[7]
- Draw or paint a picture.
- Look at pictures on your phone of people you love.
- Daydream.[7]

Hearing

- Listen to music.
- Listen to a podcast or audiobook.
- Call someone you love.
- Open your bedroom window and listen to the sounds of the outdoors.
- Use a white noise app on your phone.

Taste

- Eat your favorite meal.
- Have some ice cream,

- Have a cup of tea or coffee.[7]

Touch

- Take a hot or cold shower.[7]
- Take a bath.
- Wear comfy clothes.
- Wrap up in a cozy blanket.[7]

TIP: Help patients figure out which relaxation technique helps them the most. If it makes them feel worse, encourage them to try another one.

Radical Acceptance

Radical acceptance involves avoiding trying to change a past situation by getting angry or blaming the situation and refocusing attention on what can be done in the present.[7] Examples of coping statements to encourage patients to use:

- "I can't change what has already happened."
- "The present is the only moment I have control over."
- "It's a waste of time to fight what's already occurred."
- "This feeling will pass, and I will be ok."
- "I won't stress over things I can't change."

Self-Encouraging Coping Statements

Positive statements encourage people and help them cope through distressing times.[10] In addition, these statements give patients strength and motivation to endure difficult experiences.[7] Examples of self-encouraging coping statements to encourage patients to use:

- "I can ride this out and not let it get to me."
- "This won't last forever."
- "I have done this before, and I can do this again."
- "I'm not in danger right now."
- "This situation sucks, but it's only temporary."
- "I am strong, and I can handle this."
- "I choose to see this challenge as an opportunity."

Self-Affirming Statements

The purpose of self-affirming statements is to build a healthier self-image and serve as reminders of good qualities an individual possesses.[7] Despite overwhelming emotions, an individual can

handle a distressing situation in a healthier way.[7] Examples of self-affirming statements to encourage patients to use:

- "I'm a sensitive person who experiences the world differently."
- "Even though I forget sometimes, I am still a good person."
- 'There is a purpose to my life, even though I don't always see it."
- "I am here for a reason."
- "Each day I do the best I can."

DBT Skill #2: Mindfulness

What is mindfulness?

The mind wanders 50% of the time, but when mindfulness is practiced, the mind becomes stronger.[10] In addition, mindfulness is a practical way to notice thoughts, physical sensations, sights, sounds, and smells.[10] Often, individuals passively allow their attention to be dominated by distressing thoughts instead of focusing on the present moment. This is an important skill that patients can practice on the SSU.

Be in the moment, be here now.

Mindfulness means paying attention in a particular way.

On purpose.

In the present moment.

Non-judgmentally.[10]

TIP: Mindfulness requires patience and practice. See below for three mindfulness activities to encourage patients to use!

Mindful Breathing

Tell patients to sit comfortably, with their eyes closed and their back straight, and imagine a balloon in their stomach. Tell them that every time they breathe, the balloon inflates, and when they breathe out, the balloon deflates. Tell patients that thoughts will come to mind, notice these thoughts, and then bring attention back to the breathing.[10]

Focus on a Single Object

Tell patients to pick a small object to focus on (e.g., watch, cup, picture) and set a five-minute timer. Let them know they will eventually become distracted by their thoughts, but it is important to return their focus back to the object. Tell them to avoid touching the object first, just notice what it looks like (e.g., color, shape etc.). Then tell them to hold the object and notice its texture, temperature, and weight.[7] Tell patients to notice as many details as they can about the object.

Thought Defusion

This skill will give people the freedom to choose which thoughts they want to focus on and which thoughts they want to let go of.[7] Tell patients to visualize their thoughts floating away without obsessing or analyzing them. For example, tell them to picture themselves sitting by a stream, watching their thoughts float past on leaves. Tell them to just let the thoughts come and go and set a timer and do this for 3-5 minutes.[7]

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DBT Skill #3: Emotion Regulation

Emotion regulation skills help patients cope with their reactions to emotions.[7] People struggling with overwhelming emotions may have a tidal wave of distressing emotions that overcome them. When strong negative emotions are present, it's easy for people to use unhelpful and damaging coping strategies such as self-harm or substance use.[10] Patients learn these skills during their DBT therapy as outpatients, but nurses can remind them to practice them while on the SSU.

Recognizing Emotions

Individuals with BPD experience overwhelming emotions, which can be exhausting for patients and lead to unhealthy coping behaviors.[11] When patients are feeling overwhelmed, encourage them to identify the emotion they are feeling by saying the emotion out loud.[7] Doing this will highlight the emotion and help patients pay attention to what exactly they are feeling. The more you talk to a patient about their emotions, the less urge they may have to initiate an unhealthy coping mechanism.

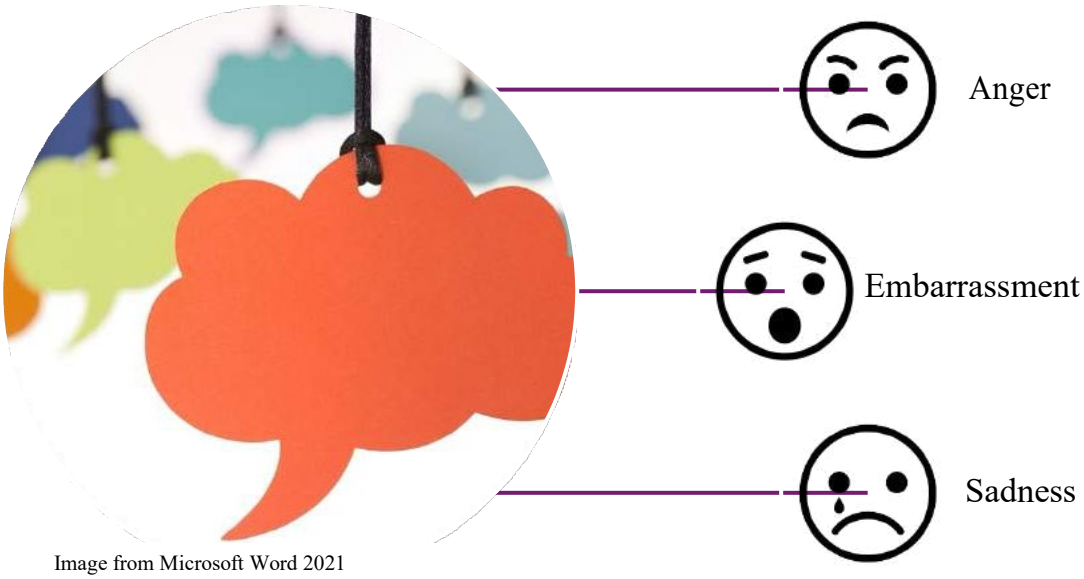

Image from Microsoft Word 2021

Increase Positive Emotions

Encourage patients to increase positive emotions throughout the day by doing pleasurable activities.[7] This is important because generally, people consider life going well if they have more positive experiences than negative experiences.[12] A pleasurable activity can be anything the patient enjoys doing. For example, nurses can encourage patients to call a friend, play a board game in the TV room, participate in plant therapy, read a book, etc.

PLEASE Master Acronym

To be emotionally healthy it is also important to be physically healthy.[12] The PLEASE Master Acronym is an emotion regulation skill to help remind individuals of the importance of caring for themselves physically.

Treat **P**hysical i**LL**ness: Take medications as prescribed and take care of physical health.[7]
Eat healthy.[7]
Avoid mood-altering substances (i.e., alcohol and drugs).[7]

Sleep well.[7]
Exercise.[7]
Achieve **Master**y: Do one activity each day to feel confident, capable, and accomplished. This helps people focus on strengths, instead of focusing on weaknesses.[7]

Opposite Action

Sometimes acting on emotions can create destructive outcomes and can intensify the emotions. Patients can be encouraged to try and change their emotions by using the opposite action.[7] This skill is not about pretending an emotion isn't happening. Instead, it is about recognizing it and using the opposite behavior to encourage a new emotion.[7] See Table 3.1 for examples of the opposite action skill.

Table 3.1 Opposite Action Skill

ANGER: Gets us ready to attack; it pushes us to attack or defend.	**OPPOSITE:** Show kindness or concern. Consider walking away.
SHAME: Gets us ready to hide. Encourages isolation.	**OPPOSITE:** Raise your head up, shoulders back, and provide eye contact.
FEAR: Gets us ready to run or hide to escape danger.	**OPPOSITE:** Stay involved and build courage.
DEPRESSION: Encourages inactivity and isolation.	**OPPOSITE:** Get active.
DISGUST: Encourages distancing and avoidance.	**OPPOSITE:** Push through and get through the situation.
GUILT: Activates us to seek forgiveness and repair violations.	**OPPOSITE:** Apologize and mean what you say.

DBT Tools. (2021). Opposite action skill. https://dbt.tools/emotional_regulation/opposite-action.php[13]

DBT Skill #4: Interpersonal Effectiveness Skills

Keeping relationships healthy requires interpersonal skills.[7] Keeping healthy relationships is often a challenge for individuals with BPD, and the goal of DBT's interpersonal effectiveness skills is to build and maintain positive relationships.[12] Below are two interpersonal effectiveness skills to encourage patients to use.

Mindful Attention

Paying attention during a conversation is essential. To pay attention mindfully, it is encouraged not to think about anything else while listening.[7] When mindful attention is practiced, trouble is noticed before it becomes overwhelming, which gives the individual time to ask clarifying questions that can help correct misconceptions and avoid conflict.[7] In addition, mindful attention prevents being surprised by a negative response that could have been anticipated or predicted.

RAVEN Acronym

If a patient is struggling with an interpersonal situation with staff, family, or friends and feels their needs aren't being met or understood, encourage them to use the RAVEN method.[14] It is important to remind them that conflict isn't always bad. They can negotiate while respecting both parties' needs, wishes, and emotions while working together to find a balanced solution.[14]

- **R**elax: Accept conflict calmly. Take a deep breath before speaking, and use deep, slow, intentional breathing.[7,14]
- **A**void the aversive: Keep in mind aversive strategies such as blaming, threatening, belittling that you might be tempted to use during conflict and monitor what you say to avoid them.[7]
- **V**alidate: Validate the other person's needs or concerns and focus on fairness so both parties can get some of their needs met.[7]Avoid temptation to get defensive or attack and try to compromise.[14]
- **E**xamine your values: Reflect on how you would want to be treated and reflect on the types of relationships that you aspire to have.[7,14]
- **N**eutral voice: Attempt to keep anger away from speaking tones.[7] Remind patients thatother people can pick up on cues from tone of voice, so even if their words are saying one thing, the tone may be communicating something entirely different.[14]

Reflection

1. What DBT skill do you think would be most helpful for patients on the SSU?
2. Can you think of a past situation that if a patient used one of these skills, the outcome of a situation would have been improved?
3. What is your biggest takeaway from this module?

Application of Key Evidence to Nursing Practice

Having a good understanding of DBT and its components is imperative. Research has shown that healthcare professionals who received this education have lower levels of burnout, less stigma towards individuals with BPD, and more positive attitudes towards their recovery. Therefore, continue to educate yourselves on this complex psychotherapy.

Implement the concepts of DBT on the SSU and the PAU to help individuals with BPD build effective coping strategies. You can play a vital role in helping patients with their DBT skills!

Encourage patients to practice distraction, self-soothing, radical acceptance, self-encouraging statements, and self-affirming statements while on the SSU to help them learn to deal with their pain and overwhelming emotions in healthier, safer ways.

Case Study

Jane is a 23-year-old female with a history of BPD. She just had a breakup with her girlfriend and failed her first semester of university. She was so upset; she did not show up to work and is now fired from her part-time job. Her parents are now mad at her for her bad grades and losing her job. Jane was so overwhelmed she self-harmed by cutting both of her arms. She was brought to the PAU and admitted to SSU for situational crisis. While on the SSU, Jane has been distraught, crying hysterically. Jane asks you to come to her room and talk to her. She tells you that she is feeling like self-harming again because she is so overwhelmed.

Think of some DBT based skills you could remind Jane of in this situation to effectively prevent the self-harm and help Jane during her crisis.

Possible Correct Answers

- Suggest that Jane hold an ice cube in her hand or snap an elastic band on her wrist instead. Help Jane identify the temporary reward for cutting and the long-term costs and dangers of the behavior.
- Suggest distraction: Check with Jane and see what distraction skills she finds effective. If she is unsure, suggest some! For example, suggest she listen to music, talk to a close friend, or watch tv.
- Encourage radical acceptance: “I can’t change what has already happened.”
- Encourage self-encouraging coping statements: “Feeling like this really sucks, but it won’t last forever.”
- Suggest self-soothing activities using any of the five senses.

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Module 4: Nursing Interventions and Therapeutic Relationships

Module 4: Nursing Interventions and Therapeutic Relationships

Throughout this module, you will be learning about nursing interventions effective for caring for individuals with BPD. Furthermore, the importance of the therapeutic relationship between individuals with BPD and nurses will be discussed, along with information on the three phases of a healthy therapeutic relationship.

At the end of this module, there will be a word search activity to find buzzwords for effective nursing interventions or attributes when caring for individuals with BPD.

Learning Objectives

After the completion of this module, learners will be able to:

1) Identify effective and ineffective nursing interventions when caring for individuals with BPD.
2) Demonstrate an understanding of conducting a good risk assessment, along with nursing interventions to respond to acute suicide risk, self-harm, and a crisis.
3) Identify ways to gain trust with individuals with BPD.
4) Understand the importance of creating healthy boundaries with individuals with BPD.
5) Describe the three phases of a successful therapeutic relationship.

Nursing Interventions and Therapeutic Relationships

Evidence outlines that nurses may respond to individuals diagnosed with BPD in counter-therapeutic ways.[1, 2] Knowledgeable mental health nurses can aid in rehabilitating patients with BPD by using the relationships formed with these patients and implementing empathy and good communication skills.[3] The information in this module highlights the importance of implementing effective strategies and creating a successful therapeutic relationship to care for this patient population.

Nursing Interventions

Throughout this section of the module, effective and least effective nursing interventions will be discussed, along with how to conduct a good risk assessment and gain trust with patients with BPD. Furthermore, the importance of setting boundaries, fostering hope, and including patients in the care plan will be highlighted.

Effective Nursing Interventions

- Be non-judgmental.[4,5]
- Have good listening skills.[4,6-8]
- Be open-minded.[4-8]
- Conduct good risk assessments.[4,8]
- Be firm, set limits, and define boundaries.[4]
- Validate.[6,7,9]
- Be compassionate, respectful, and empathetic.[6,7,9]

TIP: To effectively care for individuals with BPD, nurses need to take an active role in structuring conversations.[10, 11]

Least Effective

Individuals with BPD often have a history of trauma, and in the face of all their emotions, nurses need to be the calm ones and avoid escalating a situation.

Nurses need to avoid being:

- Confrontational.
- Defensive.
- Argumentative.
- Challenging.
- Dismissive.

See Figure 4.1 for a word cloud highlighting the attributes of effective nursing attributes when caring for individuals with BPD.

Figure 4.1 Word Cloud of Effective Nursing Attributes

Conducting a Risk Assessment

Conducting a good risk assessment is a necessary nursing intervention when caring for individuals with BPD.[4,8] Unfortunately, assessing suicide risk in individuals with BPD can be difficult for healthcare providers. Individuals with BPD often live with persistent low-lethality self-harm and a relatively low immediate risk for suicide.[7] However, this risk can change; therefore, a risk assessment is needed.[7]

A Risk Assessment Includes:

- Monitoring for changes in usual patterns.[7]
- Worsening substance use.[7]
- Recent adverse life events.[7]
- Withdrawal from social circles.[7]
- Recent self-harm (or changes in self-harm behaviors).[7,12]
- Having a plan with a means of carrying it out.[12]

Interventions for nurses when a patient is considered an acute suicide risk are highlighted in the boxes below, along with nursing interventions for patients who self-harmed or who are experiencing a crisis.

Interventions for Acute Suicide Risk

- Don't leave the patient alone.[12]
- Prevent access to means.[12]
- Consult with experienced staff members.[12]
- Notify the multidisciplinary team.[12]

Interventions for Self-Harm

- Respond promptly.
- Stay calm (i.e., no shock or anger).[12]
- Plan for future safety with the patient.[12]
- Consult with the multidisciplinary team.[12]
- Interpret factors that may have provided relief.[12]

Interventions During a Crisis

- Try to understand the crisis from the patient's point of view.[9]
- Explore the patient's reasons for distress.[9]
- Use empathetic open questioning, including validating statements.[9]
- Avoid minimizing the patient's reason for a crisis.[9]

TIP: Acknowledge difficult past experiences, including abuse, provide unconditional acceptance despite self-destructive behaviors, and recognize patients' strengths and personalities.[13]

Gaining Trust

Individuals with BPD have experienced rejection, abuse, and trauma and have encountered stigma.[7] Therefore, individuals with BPD find it challenging to engage others and build trust. Building trust is essential as it empowers patients and provides them with opportunities to display confidence.[8,14]

To encourage trust, it is crucial healthcare professionals:

- Be respectful.[7]
- Show empathy.[7]
- Be consistent.[7]
- Be reliable (i.e., keeping true to your word when you say you will talk to them later).[7]
- Listen.[7]
- Maintain a non-judgmental attitude.[7]
- Communicate clearly.[7]

Image from Microsoft Word 2021

Make conversations informal! Try having a conversation over a cup of coffee.[10]

Setting Boundaries

During a crisis, individuals with BPD may feel unable to cope. Healthcare professionals may feel pressured to take on the responsibilities for their needs, but this may undermine the individual's capacity to care for themselves.[7] Individuals with BPD should be actively involved in finding solutions to their problems, even during a crisis.[7]

It is essential to establish clear and healthy boundaries. However, individuals with BPD may interpret boundaries as a form of rejection, which may cause them to become emotional.[15] In addition, patients with BPD may have no understanding of boundaries; therefore, nurses need to set clear professional boundaries and consistently maintain them.[15] For example, nurses should outline the time allotted for a conversation, end the conversation on time, and avoid disclosing personal information even if the questions seem harmless and superficial.[15]

TIP: Try: "After I give out my medications, I will have time to talk to you for 20 minutes. This will be around nine o'clock".

Fostering Hope

It is important to express hope about the individual's capacity for change and give encouragement. However, it is essential not to give false assurances about the ease and speed of recovery.[7,9]

Image from Microsoft Word 2021

Including Patients in the Plan of Care

- Discuss with patients' realistic short-term treatment goals and realistic steps to achieve them.[9]
- Discuss realistic long-term goals, including those related to employment.[9]
- Encourage patients to consider treatment options and different life choices and be aware of the consequences of their choices.[9]
- Plan for safety in collaboration with the patient.[7]
- Work with the patient to identify potential triggers that could lead to a crisis and strategies deemed effective in responding to a crisis.[9]
- Discuss with patients how to access services if required.[9]

Developing, Maintaining and Ending the Therapeutic Relationship

The therapeutic relationship is vital in mental health nursing practice.[16] Some nurses develop positive relationships with individuals with BPD, while others have negative emotional reactions.[16] The therapeutic relationship between mental health nurses and individuals diagnosed with BPD is essential to successful treatment, and nurses' attitudes are a key component of this relationship.[16] When a therapeutic relationship between the nurse and patient is not present, patients may experience abandonment, tension, rejection, loss, and anger.[10]

According to Peplau's theory of interpersonal relations, for a therapeutic relationship to be successful, it must pass through three phases: orientation, working, and termination.[17]

Orientation Phase

In the orientation phase, nurses gain essential information about patients' unique needs and approach them with respect and positive interest.[17] This step is essential for nurses caring for individuals with BPD due to the extensive literature addressing the negative attitudes nurses have towards them and the negative effects this has on their recovery outcomes.[1,18-20] Approach individuals with BPD in a non-judgmental manner and be consistent and reliable.[9] Immediately identify each multidisciplinary team's roles and responsibilities.[9]

Working Phase

During the working phase, nurses become more familiar with patients and provide reflective non-judgmental feedback to help them clarify their thoughts.[17] The ability to be non-judgmental is the main strength for nurses caring for individuals with BPD.[4,5] The working stage is imperative, as it accounts for most of the nurses' time with the patients, and patients begin to accept nurses as care providers. In addition, patients with BPD struggle to maintain healthy interpersonal relationships; therefore, it is vital to establish this phase to prevent negative care outcomes. It is important that nurses initiate and structure therapeutic conversations.[10,11]

Termination Phase

The termination phase is the final stage and marks the end of the nurse-patient relationship.[17] The success of the termination phase is dependent on how successful the orientation and working phases were. This phase may be challenging to establish with individuals with BPD due to their intense fear of abandonment.[7] You should anticipate strong emotions and reactions upon discharge: therefore, discharge planning should be done in advance.[7] Discharge should never come as a surprise to the patient. Emphasize progress they have made, express confidence in their ability to manage outside of the hospital, encourage them to think about future goals and challenges and how they should approach them.[7] Patients may require reassurance and reminders of outpatient resources to support them.

Reflection

1) Think back on a time where your actions were counter therapeutic with an individual with BPD. With the information learned in this module, how could you have improved that situation?
2) What aspects of this module do you think would be most useful going forward?
3) Reflecting on the termination phase, can you think of a discharge that could have gone better with more communication?

Application of Key Evidence to Nursing Practice

Evidence shows that being nonjudgmental, open-minded, compassionate, respectful, and empathetic and having good listening skills are conducive to a positive nurse-patient relationship with individuals with BPD. Avoid being confrontational, defensive, argumentative, challenging, and dismissive as this can be detrimental to their recovery.

Research shows that it is difficult to gain trust with individuals with BPD, often due to their history of trauma, fears of abandonment, and previously experienced stigma with the health care system. However, being consistent and reliable and communicating clearly with this patient population can build trust. Building trust empowers patients and provides them with opportunities to display confidence.

There is strong evidence to support the need for a good risk assessment for individuals with BPD. Monitor for worsening substance use, recent adverse events, or changes in self-harm behaviors. When safety is at risk, respond promptly, stay calm, don't leave the patient alone, prevent access to means and consult with the multidisciplinary team and other nursing staff.

Don't undermine the importance of the therapeutic relationship as knowledgeable mental health nurses can aid in the rehabilitation of patients with BPD by using their relationships formed with these patients.

Word Search Activity

As a refresher of this module, find the associated skills and attributes that are necessary when caring for individuals with BPD.

Word Bank: Non-judgmental, open-minded, validate, firm, hope, compassionate, empathetic, listen, respectful, communicate, boundaries, trust, limits, consistent, reliable, humour, calm.

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Module 5: Brief Hospital Admissions

Module 5: Brief Hospital Admissions

Welcome to module 5! This module will include information about brief hospital admissions for individuals with BPD, including its purpose, benefits, and recommended components. There will also be a brief overview of patients' and nurses' experiences of brief hospital admissions. You will also be given information on improving the Short Stay Unit experience for individuals with BPD by promoting more structured daily activities. This module will help decrease the uncertainties regarding individuals with BPD being admitted to the hospital. This module will also include strategies to improve the SSU experience for individuals with BPD by promoting structure and encouraging open communication with discharge planning.

At the end of this module, there will be a “True or False” activity to test your knowledge.

Learning Objectives

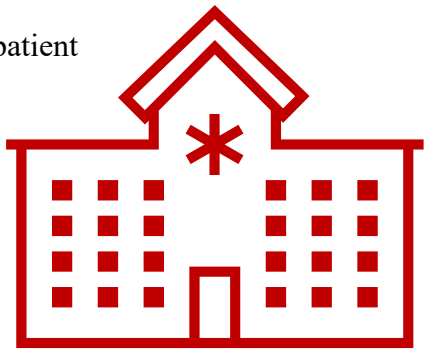
After the completion of this module, learners will be able to:

1) Understand the purpose of a brief hospital admission for individuals with BPD and the nursing approach most appropriate for this intervention.
2) Identify recommended components of an admission plan for an effective brief hospital admission for individuals with BPD.
3) Understand patients' and nurses' experiences regarding a brief hospital admission.
4) Identify nursing strategies to implement while discharging an individual with BPD to decrease their anxiety and distress.
5) Identify the benefit of nurses implementing structured activities on the SSU.
6) Discuss structured activities nurses can implement on the SSU.

Module 5: Brief Hospital Admissions

Often, the purpose of a brief hospital admission is to provide a time out for self-management in a safe environment in situations of increased stress and threatening crisis.[1] In addition, the brief admission aims to promote the patient's constructive coping strategies and prevent self-destructive behaviors.[1]

Brief hospital admissions can be described as an admission to a hospital with a maximum duration, a predetermined maximum number of admissions per year, and an outlined treatment plan.[1] However, it is not uncommon for brief admissions to lack clear operational standards.[2] Ideally, the admission plan would be developed in consultation with the patient before admission.[2] It is recommended that a plan should be formed in the emergency unit (i.e., the Psychiatric Assessment Unit) in collaboration with the patient that includes a clear goal for the stay, including how long it will last.[3]



Patients with BPD will experience crises, but disruptions in outpatient treatment by lengthy admissions should be avoided if possible.[4] Attempts must be made to maintain contact with their outpatient supports during their admission to the hospital.[3] Inpatient care can sometimes result in increased stress and self-harm that severely affects patients and may involve long inpatient stays where coercive measures are common, removing autonomy and self-care.[5]

Helping patients in crises while limiting their period of hospitalization without them feeling rejected is often a balancing act.[3] The attention should be focused on the interpersonal circumstances that triggered the crisis and the patient's feelings and thoughts about the situation.[3] Although brief admissions can be beneficial at times, psychotherapy remains the cornerstone treatment for BPD.

TIP: For BPD patients with complex illnesses who are at high risk and whose functioning is severely impaired, non-brief inpatient care may be indicated.[4]

Patients' Experiences of Brief Hospital Admissions

Research has shown that individuals with BPD found that a brief admission helped improve their self-esteem and helped them overcome a crisis without a loss of control. In addition, the brief admission helped them overcome a crisis by being in a safe and assuring environment.[6] They also found it helped them practice autonomy for their recovery and reinforced newly acquired coping skills.[6]

Patients reported the highlights of their brief admission as being listened to, talking to staff and fellow patients, getting a break from daily life, and gaining a sense of safety and control.[1] Negative experiences included a lack of contact with nursing staff, negative attitudes, and poor preparation and communication for discharge.[7] Patients described their relationship with nurses as an essential part of their brief admission.[1]

Nurses' Experiences of Brief Hospital Admissions

It is evident amongst the literature that some nurses feel individuals with BPD should not be cared for in the hospital environment and feel the treatment of choice for this patient population is in the community.[8,9] In addition, some evidence highlights that nurses felt admission to the hospital was counterproductive, as they felt issues that precipitated the crisis would continue to present on discharge.[9] This idea is not entirely wrong, as outpatient treatment is preferred, as mentioned in **module 1**. However, brief inpatient admission is often necessary for individuals with BPD, which is why it is important nurses receive education on this topic.

TIP: When a patient with BPD is admitted to hospital, they are often deemed challenging to care for by nurses. It is important to remember that nurses working in inpatient units often meet these individuals during their worst turmoil.[5]

Nursing Interventions

It is important nurses welcome the patient to the ward, introduce themselves, the team, and provide a unit orientation.[5]

They must also show:

- Warmth.[5]
- Acceptance.[5]
- Genuineness.[5]
- Openness.[5]
- Confirmation of current difficulties experienced by the patient.[5]
- Willingness to cooperate on equal terms with the patient.[5]

TIP: Remember, there will never be a "one size fits all" algorithm for the treatment of individuals with BPD.[4]

Discharge Planning Considerations

Discharging individuals with BPD from an inpatient unit can be complex. They are often reluctant to return to the community, leading to recurrent readmissions within a short period.[10] The period before discharge for an individual with BPD may cause heightened anxiety and distress. Often, this may lead to an escalation in self-harm and increased suicidal ideation just before discharge, often related to their anxiety about going back to their home environment. Discharge may also confirm their sense of rejection.[10]

As mentioned in **module 4**, discharge planning should be done in advance in collaboration with the patient. Additionally, discharge should never come as a surprise to the patient. Emphasize the progress they have made, express confidence in their ability to manage outside of the hospital, encourage them to think about future goals and challenges and how they should approach them.[11] Patients may require reassurance and reminders of outpatient resources to support them.[11]

Structure During a Brief Admission

Daily structure during a brief admission is imperative, as it helps patients gain control.[2] Therefore, nurses should plan activities to promote this structure during admission.[2] It is still essential to plan and promote structured activities, especially on the weekends, when the unit is often the least busy for patients due to the absence of rounds with the multidisciplinary team.

Image from Microsoft Word 2021

This concept of structure was repeatedly highlighted as an essential component of brief hospital admissions throughout this practicum project's integrative literature review and consultation components. Structured activities can reduce boredom, encourage interaction with other patients, and improve the nurse-patient therapeutic relationship.[12] In addition, structured activities can help patients develop social skills, confidence, motivation, and personal goals.[12] It can also help nurses interact more with patients and build a therapeutic relationship.[12] It is also a good time for nurses to assess the patient during these activities in an informal manner.

List of Structured Activities

- Board game or card came.
- Movie night.
- Guided meditation.[13]
- Stretching.[14]
- Guided painting.[15]
- Art projects.
- Yoga.[16]
- Enjoy time on the patio.
- Plant therapy.
- Snack time.
- Adult coloring.[17]
- Puzzles.
- Discussion group (e.g., travelling, animals etc.).

TIP: Click the hyperlink if available to see examples.

Reflection

1) Individuals with BPD being admitted to hospital is often a contentious topic among healthcare professionals. Reflect on your understanding of brief admissions for individuals with BPD.
2) What has been your experience caring for individuals with BPD on the SSU?
3) What structured activities do you think would be the most effective to implement on the SSU?

Application of Key Evidence to Nursing Practice

It is important for nurses to discuss realistic goals of admission and expected length of stay with the patient in the PAU. This early discussion has been shown to reduce misunderstandings during admissions.

Work together as a team to plan structured activities on the SSU. Structure helps patients gain control, reduces boredom, encourages interactions with other patients, and improves the nurse-patient relationship. This structure could also help patients develop social skills, confidence, motivation, and personal goals.

Despite the challenges associated with nursing care for individuals with BPD, nurses must encourage each other to show warmth, acceptance, openness, and genuineness while caring for this patient population

True or False?

1) Brief admissions are rarely recommended for individuals with BPD due to their overreliance on the healthcare system.
2) The period before discharge may cause heightened stress and anxiety for individuals with BPD.
3) Structured activities can reduce boredom, encourage interaction, improve confidence, motivation, self-esteem, and social skills.
4) The length of the brief hospital admission is decided by the patient.
5) While patients are admitted to the hospital, attempts must be made to keep patients in contact with their outpatient supports.

Answers

1) **False:** Brief hospital admissions are sometimes recommended for individuals with BPD to promote constructive coping skills and prevent self-destructive behaviors. Although, patients may indeed experience anxiety returning to their home environment.

2) **True:** Patients may experience increased suicidal ideation and thoughts of self-harm before discharge and may confirm their sense of rejection. That is why it is important nurses openly communicate discharge plans with patients. In addition, nurses must express confidence in patients' abilities outside of the hospital and remind them of outpatient supports.

3) **True:** It is important to collaborate with therapeutic recreation, and outside of their schedule, nurses can implement structured activities!

4) **False:** The expected length of the hospital admission should be discussed in the emergency department (i.e., the PAU) with the healthcare team and patient together.

5) **True:** A risk of more prolonged admissions is the loss of outpatient support services. Remember, psychotherapy is the cornerstone treatment for BPD.

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Module 6: Family Education

Module 6: Family Education

Welcome to module 6! The purpose of this module is to better prepare nurses in supporting and educating the families of individuals with BPD. This module includes information on the importance of educating families on the BPD diagnosis, treatment options, and realistic recovery expectations. This module will also include information on how to educate families regarding their role if their loved one with BPD experiences a crisis and steps to take during an emergency. Information on improving the home environment for individuals with BPD will also be discussed, including setting realistic goals, setting limits, and encouraging independence. Finally, there will be a brief component on self-care for caregivers and cultural considerations for nurses.

At the end of this module, there will be a multiple-choice activity to test your knowledge.

Learning Objectives

After the completion of this module, learners will be able to:

1) Understand the detrimental effects of stigma on the families of individuals with BPD.
2) Identify recommended information to provide families on BPD.
3) Identify a family member's role during a crisis at home.
4) Discuss appropriate interventions for families to initiate in the home environment to improve patients' recovery outcomes.
5) Identify the importance of self-care for families.
6) Understand the importance of cultural considerations when caring for patients and families.

Module 6: Family Education

Living with BPD is highly challenging for both individuals with the diagnosis and their loved ones.[1] Families living with individuals with BPD described their life as constantly walking on eggshells, never knowing what will trigger an outpouring of emotion or anger, and often feel manipulated by their loved one.[2] As a result, families often bear a significant burden. In addition, they feel misjudged and unfairly criticized when the person with BPD blames them for their suffering.[1]

Families of individuals with BPD can face severe stigma, including negative attitudes, behaviors, and comments.[2] Due to this stigma, families' social support networks may shrink, and they may fear negative attitudes if they are open about their situation.[2] In addition, due to the risk factors associated with BPD development in some people, including neglect and abuse, family members may feel blamed for their loved one's diagnosis.[2]

Healthcare professionals need to value and support families, communicate, consider their culture, help them navigate health services and provide information about the diagnosis and treatment, including management during a crisis.[3]

Consent for Information Sharing

Firstly, it is essential to gain patients' permission for family involvement.[3,4] Nurses need to ask directly whether the person with BPD wants their family to be involved in their care.[4] However, it is essential to respect the patient's right not to include their family if they decide so, but to allow them to change their minds in the future.[3] The choice to involve families should be continually reviewed.[3]

Providing Education to Families

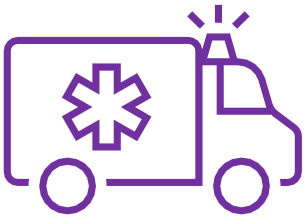
Healthcare professionals can develop good working relationships with families of individuals with BPD by acknowledging their important role in their recovery, recognizing their knowledge of the person, and respecting their views and concerns.[3] Families need to be educated on the diagnosis, the likely prognosis, reasonable expectations from treatment, and how they can contribute to the plan of care.[1] This information can improve communication, decrease

alienation, and relieve family burdens.[1] Misunderstanding of the illness might lead to unrealistic expectations of treatment.[3] Encourage families to learn about BPD and provide them with the necessary education on the diagnosis, treatment, and recovery, as mentioned in **module 1.**[2]

TIP: Remind families to that their loved one has a health problem, no different than someone with a physical health problem, and that the behaviors they are observing are the symptoms of this health problem.[2]

Family Members Role during a Crisis

Nurses must educate family members on what to do during a crisis. Advise families to stay calm and supportive towards their loved one with BPD, acknowledge their loved one, and let them know that they have been heard and understood.[2] Family members can play an essential role in diminishing the likelihood of recurring self-destructive threats by being present and listening to their loved ones without criticism, rejection, or disapproval.[1] In addition, families must support the affected loved one by offering to get them in contact with support services (i.e., therapist, mental health crisis line, family doctor, etc.).[2] Remind families to listen without arguing and not get defensive in the face of accusations and criticism.[5] Becoming aggressive when communicating with a person with BPD might cause further distress and worsen symptoms.[3]

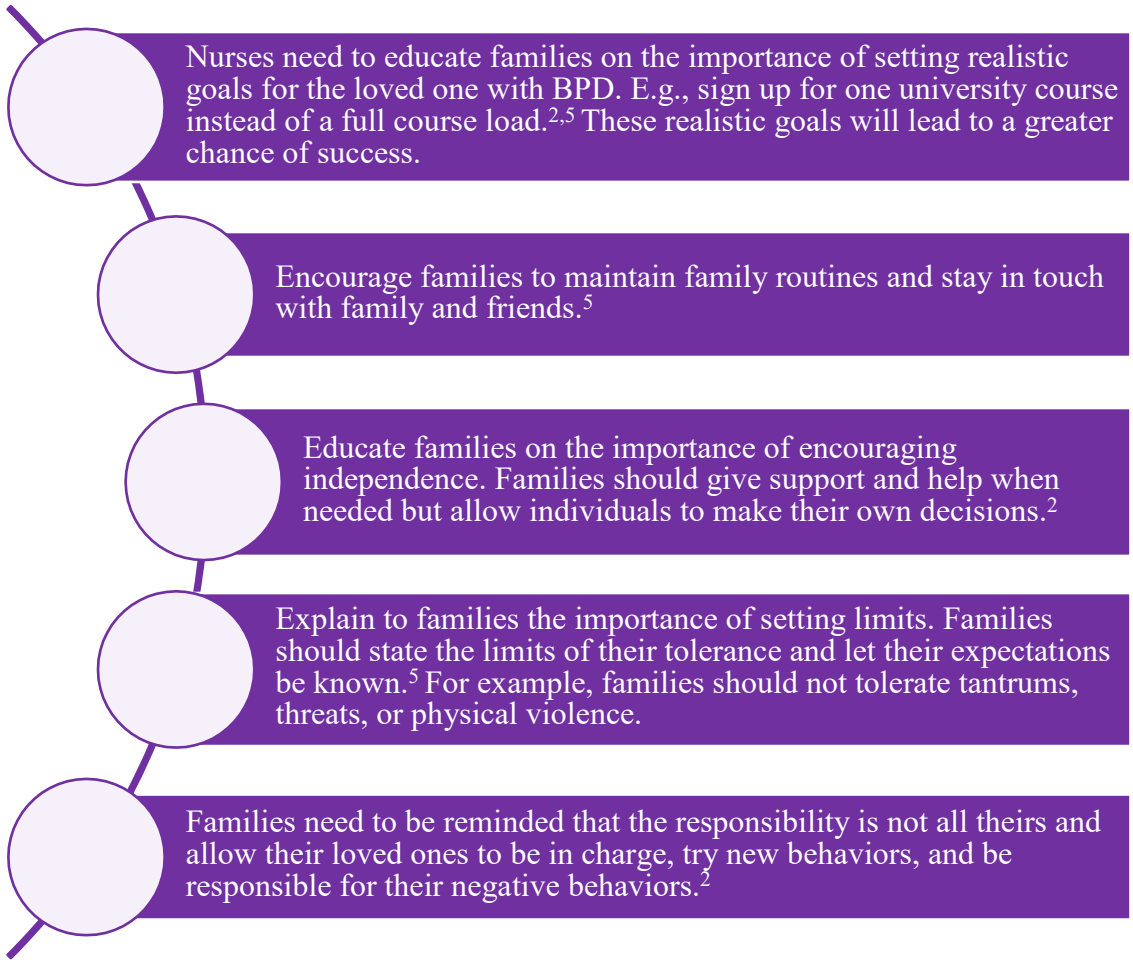


Encourage families to ask their loved ones directly about suicidal intentions. A crisis escalates to an emergency when threats of suicide, physical violence, or substance use are concerning.[2] The goal is to get them to an emergency department voluntarily. If this is not possible, 911 or the mobile crisis response team (MCRT) may need to be called. Although this is a difficult step to take, it is necessary if the situation involves potential harm or suicidal intentions, or perceived danger to the person or family.[2] Nurses need to ensure families of individuals with BPD are aware of the MCRT and how to contact them during an emergency.

Considerations for the Home Environment

When individuals with BPD are discharged from the PAU or the SSU, often, the families of these individuals feel unprepared to care for their loved one at home. Families should be encouraged to keep the home environment calm, especially when dealing with conflict.[2] They should be encouraged to take time to listen to their loved ones with BPD.[2] Families can support their loved ones by encouraging them to attend their treatment programs, take medications as

prescribed, live a healthy lifestyle by eating well, exercising, getting adequate sleep, and remaining abstinent from substances if this is a problem area.[2]



Self-Care for Families

BPD is as devastating for families as it is for the person with BPD.[2] Families may have had years of coping with intense anger, suicide attempts, threats, self-injury, or other impulsive behaviors as part of BPD. As a result, family members may feel burnt out and experience depression, anxiety, grief, and isolation.[2] Family members need to make time to care for their own needs. Self-care can reduce stress and give them more energy and patience to support their loved one with BPD.[2] Caregivers who pay attention to their own physical and emotional health can better handle the challenges of helping someone with a mental illness.[6] Encourage family members to seek support through family counseling, reconnect with family and friends, join a local support group or self-help group.[2-4]

Encourage caregivers of individuals with BPD to:

- Avoid feelings of guilt.[6]
- Notice the positive moments in their day.[6]
- Gather strength from others.[6]
- Practice relaxation.[6]
- Prioritize sleep.[6]
- Exercise and eat well.[6]

Cultural Considerations

Various cultures may experience more significant stigma because of their culture and what is acceptable within that culture.[2] Sometimes asking for help can be difficult for those whose culture does not encourage medical treatment or counseling.[2] In addition, not all families share the same understanding about mental illness, and some may experience tension between their own beliefs and those embedded in mental health practices.[7]

Nurses need to consider ethnicity, cultural diversity, faith, gender, income, education, language, and sexual orientation.[7] Different family types (e.g., blended, single parent, etc.) need to be recognized.[7] The circle of support can also include unrelated individuals who have taken on family roles, which needs to be considered.[7]

Nurses need to view each family and patient separately from others and determine their specific cultural preferences to avoid stereotyping. If you learn about a cultural norm that applies to the patient or their family, it should be documented and passed onto other healthcare members.[8] Nurses have a responsibility to understand and respect cultural differences and share them with other providers in the circle of care.[8]

Reflection

1) Reflect on a situation that involved complex family dynamics. Using the information learned in this module, how could this situation have been improved?
2) Imagine someone in your family was diagnosed with BPD. Reflect on what information you would find essential in supporting your loved one in the hospital and home.

Application of Key Evidence to Nursing Practice

Approach families with a nonjudgmental and caring attitude as families of individuals with BPD face severe stigma. They often feel blamed for their loved one's illness and fear negative attitudes if they are open about their situation.

Develop good working relationships with families of individuals with BPD and educate them regarding the BPD diagnosis and treatment options. This can improve communication with families, decrease misunderstandings, and relieve families' burden.

Advise families to stay calm and supportive towards their loved ones with BPD during a crisis. Educate them on the importance of setting goals, firm limits, maintaining family routines, and promoting independence. Families have an essential role in diminishing the likelihood of recurrent self-harm behaviors and promoting recovery.

Educate families on the importance of self-care as this can reduce stress and give them more energy and patience to support their loved ones. Caregivers who pay attention to their emotional health can better handle the challenges of caring for someone with a mental illness.

Take the time and learn about families' cultural norms, as not all families have the same understanding of mental health. Nurses are responsible for understanding and respecting cultural differences and sharing them with providers in the circle of care.

Multiple Choice Activity

(Answers are provided at the bottom of the next page)

1) Healthcare professionals need to support families of individuals with BPD by doing which of the following:
   a) Provide information on the diagnosis and treatment options.
   b) Consider families' culture.
   c) Navigate healthcare services.
   d) All the above.

2) What is the most important step before involving patients' families?
   a) Consider the families' culture.
   b) Gain the patients' permission for family involvement.
   c) Provide information on self-care for families.
   d) Provide education on the BPD diagnosis and treatment.
3) What is essential information for families to know to care for their loved one with BPD at home effectively?
   a) Set realistic goals, firm limits, and encourage independence.
   b) Threats and physical violence may need to be tolerated at times.
   c) Once home, the individual with BPD is now the family's responsibility.
   d) It is necessary to become defensive during conflict, as this is the only way to avoid positive reinforcement of behaviors.

4) Which statement is true regarding families of individuals with BPD?
   a) Family members should seek support through family counseling or support groups.
   b) Caregivers who pay attention to their own physical and mental health are better able to handle the challenges associated with caring for a loved one with BPD.
   c) Families need to avoid feelings of guilt.
   d) All the above.

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Answers: 1) d 2) b 3) a 4) d

Conclusion

Congratulations on completing this self-directed learning resource! Whether you are a newer nurse to mental health or an experienced nurse, I hope you learned something valuable from this education. You should now have the information you need to recognize BPD in the mental health setting, along with treatment options and realistic recovery outcomes. You are also more prepared to manage the challenging behaviors associated with this patient population and understand the root cause of these behaviors to decrease common misconceptions. You now have a basic understanding of DBT, along with some skills to implement in your unit. Furthermore, you now have a deeper understanding of the importance of the nurse-patient relationship and its effect on the recovery of these individuals and an improved understanding of brief hospital admissions. This information can be used to further educate individuals with BPD and their loved ones.

Finally, I hope you feel more confident in caring for this patient population, which helps diminish the challenges and professional stress often experienced. If you are interested in expanding your knowledge on this complex diagnosis, see the list of resources below.

Thank you for participating in this education!

Online Resources for Further Learning

CAMH: Information Guide for Families

Get Self Help Website

BPD Brief

Family Guidelines

Books for Further Learning

1) The Dialectical Behaviour Therapy Skills Workbook by McKay, Wood, & Brantley (2007).
2) DSM-5 by the American Psychiatric Association (2013).
3) Stop Walking on Eggshells by Mason & Kreger (2010).
4) I Hate you, Don't Leave me: Understanding the Borderline Personality by Kreisman & Straus (2010).

Image from Microsoft Word 2021

Appendix A

EVALUATION OF THE LEARNING RESOURCE

Please circle the number that best represents your response to each statement.

	Strongly Agree	Agree	Disagree	Strongly Disagree
1. The information in this learning resource was valuable and accurate.	1	2	3	4
2. This learning resource increased your interest in the topic of BPD.	1	2	3	4
3. The reflection and activities at the end of the modules contributed to your learning.	1	2	3	4
4. The interventions learned in this resource can be used in your area of practice.	1	2	3	4
5. Your attitude towards caring for individuals with BPD has improved.	1	2	3	4
6. Your confidence in caring for individuals with BPD has improved.	1	2	3	4

Please add any additional comments including how the Resource could be improved.

Comments:

_____
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