Exploring the Experience of Dialectical Behaviour Therapists: Challenging Therapeutic Pessimism Related to Borderline Personality Disorder

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ABSTRACT

The public mental health setting wherein clinicians work with clients diagnosed with borderline personality disorder (BPD) provides a continual challenge for clinicians. For many decades a pervasive therapeutic pessimism has surrounded any discussions of attempts to work with clients with BPD with this population being viewed as 'too difficult' and 'impossible to work with'. This pessimism and the ensuing counter therapeutic responses have been well documented in the psychiatric literature.

The development of treatments such as dialectical behaviour therapy (DBT), a cognitive-behavioural therapy, for BPD has provided a basis for therapy for which there is increasing evidence of successful outcomes. Despite this evidence, the pervasive pessimism has been slow to lift. A limited literature explores attempts to positively influence clinician responses to this clientele.

Within the public mental health service in which this research is based, DBT is well-established as a therapeutic modality. In the course of providing training, consultation and supervision for parts of this service, anecdotal evidence emerged suggesting that the impact of practising as a DBT therapist was greater than anticipated and DBT may provide a tool for facilitating a positive change in clinician responses.

Given that this perception is not described in the literature it was appropriate to begin research in this area employing a qualitative methodology. This research explored the experience and impact upon mental health clinicians in a public mental health service undertaking training in DBT and practicing as DBT therapists. In-depth, semi structured interviews were conducted in July 2005 with clinicians practising as DBT therapists.

Data analysis revealed a marked shift in perspective from 'management to treatment'. Participants described positive professional and personal impacts of training and practising as DBT therapists. An enhanced capacity for self-awareness and 'living life to the full' was described by a number of participants.

This initial research suggests that the practice of DBT by clinicians can generate a positive shift in both personal and professional identities that translates into a more

optimistic and humanistic approach to clients diagnosed with BPD. Such a change may represent a significant challenge to the prevailing mental health discourse and practice associated with BPD.

KEY WORDS: borderline personality disorder, dialectical behaviour therapy, clinical, health sciences, mental health, health personnel attitudes.

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GLOSSARY OF TERMS

Affect a psychological term denoting a 'feeling or emotion, particularly one leading to action' (Gregory & Zangwill, 1987, p. 12).

Assertive disengagement has been defined 'as where clinicians make every effort to ensure that clients with BPD are referred to other services outside of mental health' (Hazelton, Milner, & Rossiter, 2003).

Borderline personality disorder (BPD) is a 'pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity that begins by early adulthood and is present in a variety of contexts' (American Psychiatric Association, 1994, p. 668).

Dialectical behaviour therapy (DBT) is a treatment developed for persons with borderline personality disorder by Marsha Linehan. 'The treatment model integrates cognitive-behavioural procedures within a philosophical framework that incorporates Zen-Buddhist and dialectical perspectives' (K. A. Hawkins & Sinha, 1998, p. 379).

Clinical for the purposes of this document, relates to professional practice focused on the care of persons who are physically or mentally unwell.

Cluster B personality disorders are those described as exhibiting dramatic, emotional behaviours and include histrionic, narcissistic, antisocial and borderline personality disorders.

Conversational Model (Hobson) is described as 'an integrative model of therapy that combines psychodynamic, humanistic, and interpersonal theory and techniques' (Paley, Shapiro, Myers, Patrick, & Reid, 2003, p. 736).

Depersonalization has been defined as the experience 'of feeling detached from, and as if one is an outside observer of, one's mental processes or body (e.g., feeling like one is in a dream)' (American Psychiatric Association, 1994, p.502).

Dialectics is 'a process of change that results from an interplay between opposite tendencies' (Delbridge et al., 1995, p. 255).

Diathesis stress model suggests that 'constitutional vulnerability interacts with environmental stress so that the more vulnerable an individual, the less stress may be needed for BPD to develop' (A. Bateman & B. Fonagy, 2004, p. 27-28).

DSM-IV (Diagnostic and Statistical Manual of Mental Disorders, 4th Edn) is an agreed classification of mental disorders developed by the American Psychiatric Association. This classification was 'developed for use in clinical, educational and research settings...and are meant to be employed by individuals with appropriate clinical training and experience in diagnosis' (American Psychiatric Association, 1994, p. xxiii).

Dysphoria has been defined as excessive pain, anguish, agitation, disquiet, restlessness or malaise (The Centre for Cancer Education, 1997-2007). Further sources identify this as a confusing term for which multiple complex definitions exist.

Evidence-based practice (EBP) is 'the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients. The practice of EBP means integrating individual expertise with the best available external evidence from systematic research' (Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996, p.71-72).

Mental Health is 'a state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community' (World Health Organization, 2001).

Methodology is defined as 'a body of practices, procedures and rules used by those who work in a discipline or engage in an inquiry; a set of working methods' (Farlex, 2007).

Method is defined as 'the procedures and techniques characteristic of a particular discipline or field of knowledge' (Farlex, 2007).

Mindfulness 'an English translation of the Pali word *sati*. Pali was the language of Buddhist psychology 2,500 years ago, and mindfulness is the core teaching of this tradition. *Sati* connotes *awareness, attention,* and *remembering*' (Germer, 2005, p. 5).

Multiaxial Assessment system is designed to facilitate assessment on several axes. Each axis covers a different area of information. This system serves to guide the development of treatment plans. It may also be used to predict outcomes (American Psychiatric Association, 1994, p. 25).

Axis I	Clinical Disorders (such as anxiety disorders and depression)
	Other Conditions that may be a focus of clinical attention
Axis II	Personality Disorders
	Mental Retardation
Axis III	General Medical Conditions
Axis IV	Psychosocial and Environmental Problems
Axis V	Global Assessment of Functioning

Personality refers to 'enduring patterns of perceiving, relating to, and thinking about the environment and oneself' (American Psychiatric Association, 1994, p. 788).

Personality disorder refers to 'an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment' (American Psychiatric Association, 1994, p.647).

Personality traits are 'prominent aspects of personality that are exhibited in a wide range of important social and personal contexts' (American Psychiatric Association, 1994, p. 788).

Phenomenology is 'the science of phenomena, as distinguished from ontology or the science of being' (Delbridge et al., 1995, p.708).

Reflective practice as defined by a participant in this study suggests a capacity to 'consciously reflect *(ing)* on who you are, how you're reacting, and what you're doing' (R1: p.3). This concept is explored further in Chapter Three.

Therapeutic pessimism is broadly described in medical literature as 'an inclination to believe that a particular method of medical treatment will not produce any effective improvement' (Robertson, 2008). The definition of this term in psychiatric literature is explored in Chapter Two.

Treatment as usual (TAU) is the term frequently used in research where the usual treatment offered in a particular setting is described as the 'control condition' against which the treatment under scrutiny is compared.

Validity in qualitative research according to Tesch (1990) depends not on replicable outcomes but on 'the employment of a data "reduction" process that leads to a result that others can accept as representing the data' (p. 304).

Zen Buddhism is one of a number of different traditions of Buddhism. Principles of Zen that inform DBT include 'everything is as it should be at this moment,' the essence of acceptance of oneself, the world and other people (Robins, 2002).

KEY

Quotes from participants are coded as follows:

> **R** = Reference
>
> **No. 1-13** = participant number/code
>
> **p**. = page no. in transcript

E.g.   (R2: p.10) Quote on page 10 from transcript of interview with participant two.

CHAPTER ONE
PROJECT OVERVIEW

Research Topic

This research project was designed to explore the experience of mental health clinicians in a public mental health service who have learnt and practised as Dialectical Behaviour therapists.

The title of the project is as follows:

Exploring the Experience of Dialectical Behaviour Therapists:
Challenging Therapeutic Pessimism Related to Borderline Personality Disorder

The mental health setting where clinicians work with clients diagnosed with borderline personality disorder (BPD) provides a continual challenge for clinicians. This client population was viewed as 'too difficult' and 'impossible to work with'. Therapeutic pessimism surrounded any discussion of attempts to work with clients with BPD. The development of treatments such as dialectical behaviour therapy (DBT), a cognitive-behavioural therapy, for BPD has provided a basis for therapy for which there is increasing evidence of successful outcomes. This research examined the experience and impact upon mental health clinicians of undertaking training in DBT and practicing as DBT therapists.

Key Words: borderline personality disorder, dialectical behaviour therapy, clinical, health sciences, mental health, health personnel attitudes.

Research Justification and Rationale

In the public mental health setting, working with clients diagnosed with borderline personality disorder (BPD), a pervasive dysfunction of the emotion regulation system (*DBT Intensive Training Course*, 2000), provides a continual challenge for staff. For many years this client population was viewed as 'too difficult' and 'impossible to work

with'. An air of therapeutic pessimism surrounded any discussion of attempts to work with clients with BPD. Clinicians' high levels of frustration, distress and burnout further contribute to ineffective services. The negative impact of this pessimism directed towards consumers with BPD proves an extreme challenge to clinicians attempting to influence current practice.

The development of therapeutic models such as Linehan's Dialectical Behaviour Therapy (DBT) (Linehan, 1993a; Linehan, 1993b) provides a basis for focused therapy for which there is increasing evidence of successful outcomes. DBT is described as a cognitive-behavioural therapy for BPD and the 'single most remarkable entry in therapeutic strategies for borderline patients' (Gunderson, 2001) to appear since 1987. It has been suggested that one of the strengths of DBT is its 'capacity to invigorate and sustain enthusiasm for treating a group of patients who have often demoralized prior generations of clinicians' (Swenson, 2000).

While literature exists detailing the efficacy of DBT as delivered by health professionals with specialist training in psychological treatments (Bohus et al., 2000; Swenson, Sanderson, Dulit & Linehan2001; Swenson, Torrey & Koerner 2002), evidence suggesting that this approach is effective when offered by staff members working in standard mental health services is limited (K. A. Hawkins & Sinha, 1998; Swenson et al, 2001; Swenson et al, 2002). Claims that DBT provides a positive impact on clinician behaviours towards persons with BPD have been made (Swenson, 2000), however, to date research describing the impact of training and practice in DBT upon clinician attitudes, behaviours and experience of working with consumers with BPD is sparse. Research undertaken in the Hunter Valley Mental Health Service (NSW) sought to test whether the effectiveness of DBT could be replicated when implemented in a regionally-based public mental health service. One strand of this research addressed

staff knowledge, attitudes and experience regarding consumers with borderline personality disorder pre- and post-training in DBT (Hazelton et al., 2003; Hazelton, Rossiter, & Milner, 2006; Rossiter, Hazelton & Milner, 2004). Qualitative evidence from this project (Hazelton et al., 2003; Rossiter et al., 2004) suggested that DBT training and practice has had a positive impact on clinicians' personal and professional lives. Perseius, Ojehagen, Ekdahl, Asberg and Samuelsson (2003) likewise hint at a positive impact resulting from practice as a DBT therapist upon clinicians' personal lives.

Research Objectives

Aim: The aim was to examine and describe the phenomenon of learning and practising DBT from the participants' perspective and thus a qualitative research approach was appropriate. This project set out to explore mental health clinicians' experience of learning and practising as dialectical behaviour therapists. The paucity of material available describing this phenomenon further supported the decision to use an exploratory qualitative methodology.

Hypothesis: It was hypothesized that training in DBT has a positive impact on clinicians' practice with persons with BPD and provides an avenue for decreasing burnout associated with working with highly distressed and vulnerable clients. Outcomes from this research are likely to provide support for clinicians seeking to improve professional practice and treatment of persons with BPD.

Methodology

A phenomenological approach underpinned this research project and a qualitative methodology was used to examine how mental health professionals experience learning and practising as dialectical behaviour therapists. Inherent within qualitative research is the subjective stance of the researcher. The origins of the researcher's

philosophical leanings are grounded in existential phenomenology formed through extensive experience as a nurse counsellor and a therapist trained in a number of different therapeutic modalities.

Data Collection and Analysis

A purposeful sample of thirteen clinicians who had learnt and practiced as DBT therapists from the southern region of a public mental health service was interviewed for this research. Semi-structured in-depth interviews were employed as the method used for data gathering. An iterative and developmental process was used to analyse the interview transcripts. Identifying themes emerging from the transcript was undertaken in consultation with the independent interviewer and academic supervisors.

Findings

This initial research suggests that the practice of DBT by clinicians can generate a positive shift in both personal and professional identities that translates into a more optimistic and humanistic approach to clients diagnosed with BPD. Such a change may represent a significant challenge to the prevailing mental health discourse and practice associated with BPD.

CHAPTER TWO

PROFESSIONAL RESPONSES TO BORDERLINE PERSONALITY DISORDER – A REVIEW OF THE LITERATURE

'People with borderline personality disorder (BPD) present mental health services with challenges unlike those of other clients' (Cleary, Siegfried, & Walter, 2002, p. 186). Despite a rapidly expanding literature outlining efficacious treatment approaches for people with BPD, a pervasive therapeutic pessimism persists within many locations throughout public mental health services in Australia. This chapter presents a systematic and critical review of the literature as the background to this research which was designed to explore the impact of training in Dialectical Behaviour Therapy (DBT) upon mental health professionals' relationships and practices with people with BPD and their personal and professional experience.

Throughout this review, mental health professionals are referred to interchangeably as clinicians or mental health professionals. However, where referring directly to specific literature, the terms used within that document are employed. It will be noted that a significant percentage of the papers accessed refer solely to mental health nurses.

Borderline Personality Disorder: Understanding the nature and extent of the condition

History:

Although the use of the term 'borderline' was employed by a number of people decades earlier (Knight, 1954; Stern, 1938), BPD first appeared as a diagnosis in the Diagnostic and Statistical Manual – DSM-III in 1980 (American Psychiatric Association, 1980). A further twelve years passed before BPD was also listed in the World Health

Organization's International Statistical Classification of Diseases and Related Health Problems, Tenth Revision (ICD-10) (World Health Organization, 1992). Gunderson (2001) describes an exponential growth in the number of published clinical and empirical articles published on BPD since 1975. An increasing literature describing research into the nature, aetiology and prognosis for BPD is now available (Cloninger, 2002; Everett & Gallop, 2001; Pally, 2002; Zittel & Westen, 1998).

Defining BPD:

Personality disorders are described as a pattern of individual traits that display a range of chronic, inflexible and maladaptive behaviours that result in discomfort in social interactions and significantly impair social and occupational functioning (American Psychiatric Association, 1994). Within the currently described spectrum of personality disorders, BPD is described as part of the Cluster B disorders which also include histrionic and narcissistic personality disorders. BPD has been described as a 'pervasive disorder of the emotion regulation system' (Linehan, 1993a). It is characterized by emotional instability, problems with anger, unstable relationships, efforts to avoid loss, suicide threats, self-harm, impulsive behaviours, cognitive disturbances, unstable self-image and chronic emptiness (American Psychiatric Association, 1994).

Aetiology:

Gunderson (2001) suggests that currently almost all scientifically based hypotheses seeking to explain the psychopathology of BPD 'involve formulations of a core temperament – that is, the heavily genetically determined way in which a child perceives and reacts to the environment' (p. 296). He further argues that, just as very few illnesses and disorders are purely genetic, likewise BPD would appear to result from an interplay between genetic and environmental factors. Allen (2001)

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suggests that BPD is 'best conceptualized in terms of a diathesis-stress model.'[1] Linehan's (1993a) biosocial theory is a transactional model which 'assumes that individual functioning and environmental conditions are mutually and continuously interactive, reciprocal and interdependent' (p. 39). Linehan (1993a) postulates that BPD occurs in individuals who display a biological predisposition to emotional dysregulation and have experienced the impact of an invalidating environment. In support of hypotheses that suggest adverse environmental factors have a role in the development of BPD are multiple studies that identify the majority of people with a diagnosis of BPD as having a documented history of physical and sexual abuse, neglect, separations and disrupted attachments (Everett & Gallop, 2001; Johnson, Cohen, Brown, Smailes, & Bernstein, 1999; Pally, 2002; Wilkinson-Ryan & Westen, 2000; Zanarini & Frankenburg, 1997; Zanarini et al., 1997). Briere and Rickards (2007) further support such hypotheses when they describe results from a recent study that 'highlight the potential role of certain forms of childhood maltreatment in the development of identity disturbance, affect dysregulation, and relationship difficulties' (p. 502). The difficulties identified are consistent with those experienced by people with BPD. Following an extensive review of the current theories and research that attempt to produce a coherent model describing the aetiology of BPD, Allen (2001) suggests that 'multiple pathways to BPD stem from various combinations of different risk and protective factors' (p. 276).

Experiencing BPD:

These evolving theories on aetiology and the diagnostic criteria describing BPD, suggest that a person with this diagnosis experiences great suffering. Adler (1981), for instance, states that a person with BPD experiences feelings of panic, impulsivity and suicidal feelings at times of stress. Zittell and Westen (1998) also write that, despite

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[1] See Glossary of terms for explanation

the lack of clarity as to the aetiology of BPD, '...these are patients who struggle to manage enormous, overwhelming psychological pain with limited affect-regulatory skills...' (p. 18). In exploring BPD from the perspective of 10 patients with the disorder, Miller (1994) has also noted that those classified as having BPD have repeatedly identified feeling estranged, inadequate and despairing. The 'sense of emotional pain conveyed by these patients was overwhelming...Each person revealed an ever-present wish not to be alive' (p. 1217).

Zanarini et al. (1998) have likewise documented a stark picture of the distress experienced by people with BPD. Using semi-structured interviews, 146 inpatients with a diagnosis of BPD were interviewed three times. The results identify dysphoric states as highly specific to BPD. The researchers cluster these states into four areas: extreme feelings, destructiveness or self-destructiveness, fragmentation or 'identitylessness', and victimization. Each of these clusters is expanded with descriptions of the feelings and cognitions associated with each area e.g. victimization is illustrated thus; 'feeling like people hate me, like people are abusing me, like I'm being tortured, completely out of control, damaged beyond repair'. Zanarini and colleagues (1998, p. 205) have suggested that the content of the states and the high percentage of the time when some of them were reportedly experienced suggest an inner experience of despair and desperation among borderline patients that may not be appreciated by even the most knowledgeable of clinicians. This research led Gunderson (2001) to write that the results reported 'underscore that this disorder involves a terrible way to experience life' (p. 13).

The suffering associated with the experience of living with BPD is further compounded by significant co-existing mental illnesses such as anxiety and depression. A comprehensive study in which 379 people with BPD in an inpatient setting were

interviewed revealed over 90% of participants met the criteria for a mood disorder and almost 90% met criteria for an anxiety disorder. Additionally, 50% met criteria for panic disorder, social phobia or post traumatic stress disorder and approximately one third met criteria for a simple phobia (Zanarini, Frankenburg, Dubo et al., 1998). Unpublished research undertaken at the Centre for Psychotherapy, Hunter/New England Area Health Service, Newcastle, Australia further corroborates the premise that people with BPD experience profound suffering and distress. This study involved a review of 72 participants in a randomised controlled trial of Dialectical Behaviour Therapy (DBT). It identified complex presentations with high levels of co-morbidity. Data revealed participants met the diagnostic criteria not only for BPD, but for a number of disorders such as anxiety, depression, post-traumatic stress disorder, social phobias and other personality disorders and frequently for substance abuse disorders as well (Willcox, 2004).

A number of websites providing consumer information and discussion boards where people with BPD can find support provide a further lens for understanding the distress and suffering associated with this condition. One of the participants, Kate, a self-identifying sufferer of BPD (mjtacc, 2003) writes:

Deep Chasm

Here, no more, time ticks.

Only a deep chasm of nothingness and darkness.

The hopeless loneliness of a lost soul.

Caught in this unescapable torment of nothing.

Porr (2002), founder of The Treatment and Research Advancements Association for Personality Disorder (TARA), an organisation that has undertaken the role of increasing public awareness of BPD, writes of the plight of people frequently unable to access appropriate services in New York. Porr (2002) views people with BPD as 'desperate for relief', people whose 'behaviour can best be understood as maladaptive

methods of coping with constant psychic pain.' She suggests that they 'generally receive inadequate or inappropriate treatment in the community'. In a text written for people who care about a loved one with BPD, Mason and Kreger (1998) draw attention to the wider impact of this disorder. 'The very definition of a personality disorder is that it causes distress for both the person who has the disorder and those who interact with them' (p. 25-26).

A recent review of the literature describing the emotional experience of women with BPD adds further weight to the description of BPD as a disorder associated with much suffering. Holm and Severinsson (2008) identified three themes associated with emotional pain and distress as: 'the child who is emotionally abused and neglected; struggling with emotions leading to self-injury; and social problems related to difficulties in regulating emotions' (p. 29).

Not a Rare Disorder:

Contact with consumers of health services who have been diagnosed with BPD is an integral part of everyday work for public mental health services. Within the Australian community the prevalence of personality disorders (PD) is not insubstantial. A nationwide survey of mental disorders estimates a lifetime prevalence of one or more personality disorders in the adult population of approximately 6.5% (Jackson & Burgess, 2000). Analysis of this proportion of the population by diagnostic categories suggests that 1-2% of the adult population meet the criteria for BPD (Jackson & Burgess, 2000). Prevalence of presentations by people with BPD to mental health services has been estimated as 10% in outpatient settings and 15-20% in inpatient settings (Skodol et al., 2002). A further study has identified a diagnosis of personality disorder as 'a significant predictor of disability and mental health consultations independent of Axis I disorders such as depression and anxiety and physical

conditions' (Jackson & Burgess, 2002, p. 251). Research identifying the prevalence of BPD in general practice found a prevalence about 4-fold higher than that identified in general community studies (Gross et al., 2002). Yet this research noted that in general practice BPD was largely unrecognized and untreated and thus opportunities to provide appropriate care were missed.

Stevenson, Boyce and Brodaty (2007) describe comorbidity between major psychiatric disorders and personality disorders as a common problem in psychiatric inpatients in Australia. They state that up to 60% of young adults and 40% of older adults admitted will have a co-morbid personality disorder. These researchers suggest that the presence of a personality disorder has a widespread impact upon the person's ability to 'cope with illness, to seek out support and actively engage with caregivers in treatment.' Again, a failure to recognise the presence of a personality disorder has a negative effect on the outcomes for the affected person, as these factors can result in a lesser response to treatment, with longer recovery times and a greater likelihood of relapse and recurrence.

Contact with mental health services is substantially higher for the subsection of people with personality disorders who meet the diagnostic criteria for BPD (Trull, Stepp, & Durrett, 2003). This has been attributed to the frequency of suicidal and self-harming behaviours in BPD (Population and Public Health Branch - Health Canada, 2002). Given the degree of suffering experienced and the frequency with which these people seek help from mental health services it appears that a co-ordinated and effective response would be useful.

Health Professional Responses to the Disorder

Stigma, Stereotyping and Therapeutic Pessimism

While the pervasiveness of the suffering experienced by people with BPD would suggest the importance of a compassionate response from mental health professionals, the contrary is apparent from a review of the relevant literature. In a recent article discussing the rights of the mentally ill, Johnstone (2001). has argued that 'people suffering from mental illness and other mental health problems are among the most stigmatized, discriminated against, marginalized, disadvantaged and vulnerable members of society' (p. 200). Despite attempts at many levels of health management to change this situation, policy documents (Australian Health Ministers, 2003) suggest that the status quo has remained largely unaltered. Within mental health services it would appear that people with BPD are even more stigmatized than those suffering from other mental health disorders. English research suggests that BPD is viewed more negatively by nursing staff than a schizophrenia diagnosis and 'could have very damaging implications for individuals in terms of staff's stereotypical beliefs concerning dangerousness, optimism and social rejection' (Markham, 2003, p. 608). A further study of 50 registered mental health nurses found that 'staff reported less sympathy and optimism towards patients with a diagnosis of BPD and rated their personal experiences as more negative than...when working with patients with... either depression or schizophrenia' (Markham & Trower, 2003, p. 254).

The profound difficulties that many mental health professionals experience in their interactions with those with BPD frequently fail to reflect an understanding of the suffering inherent in their lived experience. Negative attitudes towards people with BPD and the difficulties encountered by mental health professionals attempting to care for these people have been repeatedly documented in both the North American and

British literature (Bowers, 2002; Fallon, 2003; K. Fraser, 1991; Hinshelwood, 1999; Markham, 2003; Markham & Trower, 2003; Nehls, 1998; Wright, Haigh, & McKeown, 2007). Zittel and Westen (1998) describe the most common reactions experienced by mental health professionals as rage and anxiety. They comment thus: '...rage because we sometimes find them emotionally manipulative and anxiety because they often make us worry that they are going to hurt themselves or have already done so...' (p. 5). The behaviours that provoke this rage and anxiety are also seen as within the control of the person and ongoing. This sense that the behaviours are within the control of the person with BPD is confirmed by a recent British study. Forsyth (2007) explored the effects of diagnosis and non-compliance with treatment tasks on the mental health workers' responses and noted that:

> staff were less optimistic in helping clients with BPD as they were more
> likely perceived to be in control of their behaviour and the negative
> events, resulting in less sympathy and helping behaviour from nurses
> (p. 34).

Factors described as impacting on delivery of services for people with BPD in North America include 'outdated theories, lay beliefs and prejudicial attitudes' (Nehls, 1998, p. 101). Linehan (1993a) suggested that the 'unrelenting crises and behavioral complexity of a borderline patient often overwhelm both the patient and the therapist' (p. 165). More recently Linehan et al. (2000) state,

> it would be difficult to imagine another set of behavioral characteristics
> more likely than BPD criteria to interfere with a therapist's and client's
> ability to form a mutually cooperative and stable therapeutic working
> alliance (p. 329).

Accordingly, mental health professionals frequently struggle to respond with empathy to clients in whom they perceive problem behaviours to be intractable, volitional and

attention-seeking. Sadly, this too often results in therapeutic pessimism i.e. a sense of hopelessness about treatment effectiveness (Nehls, 1998). Therapeutic pessimism has been defined as 'an inclination to believe that a particular method of medical treatment will not produce any effective improvement' (Robertson, 2008). However, the use of this term in psychiatric literature in relationship to a person with BPD suggests a fatalistic stance and implies a pervasive view of BPD as both untreatable and/or unresponsive to treatment and 'that the person is responsible for her/his behaviour and must therefore control it' (Crowe, 2008; Dolan, Warren, & Norton, 1997).   Background research undertaken prior to this study supports this interpretation of therapeutic pessimism describing findings in which participants identified people with BPD as 'difficult consumers' and treatment options as ineffective (Hazelton et al., 2006). Salekin (2002) speaking of therapeutic pessimism describes it as a pervasive belief that certain individuals 'are extremely difficult to treat, if not immune to treatment...and undermines motivation to search for effective modes of intervention...' (p. 79).   .

While attempting in the 1980s to positively address the difficulties experienced by clinicians in an inpatient unit caring for people diagnosed with BPD, Kaplan (1986) provided a 'flavour' of the language that has been and is still frequently used to describe the person with BPD:-

> The borderline patient is provocative, manipulative, and he has an
> almost uncanny ability to hone in and exaggerate one's personal
> idiosyncrasies....Sometimes...the borderline patient successfully defeats
> that which the hospital has to offer (p.436-437).

The adjective 'difficult' is frequently applied to people with BPD. In a review of literature describing nursing research concerning the phenomenon of the 'difficult patient' in the medical/surgical setting, MacDonald (2003) suggests that the primary

focus has been descriptive and tends to situate the problem within the patient. Likewise, within mental health services, the discourse surrounding people with BPD ascribes characteristics to them that accord with those noted by MacDonald (2003). These include behaviours that clash with those expected of the 'patient role' and, in particular, behaviours that are perceived as challenging nurses' competence and control. Not surprisingly, the reaction to such difficult behaviours in which a clinician feels his/her competence or control is under threat may be either to withdraw or to attempt more strongly to assert control. Blackley (2004), speaking of her experience in an inpatient unit, describes situations in which clinicians and patients 'become embroiled in intense negative battles, which may obliterate any potential for effective treatment.' In Deans and Meocevic's (2006) Australian study psychiatric nurses were largely found to perceive people with BPD as manipulative.

The pervasiveness of the negative attitudes expressed by mental health clinicians is further outlined by English educators, Wright et al. (2007) involved in training programs designed to address these difficulties. They note that 'the expressed discourse is often shrouded in emotive phraseology and accompanied with audible, tonal emphasis' (p. 240). Australian psychologists (Commons Treloar & Lewis, 2007) likewise describe situations where clinicians struggle to respond effectively.

> The characteristic dysregulation of affect and mood, and the seemingly unpredictable suicidal and self-harming behaviour, among other difficult-to-manage symptoms are common sources of mixed or volatile emotions experienced by clinicians in direct transference response to such patients (p. 34).

Writing for people with BPD, Chapman and Gratz (2007) likewise confirm the ongoing nature of the difficulties associated with this diagnosis.

...unfortunately, it seems that despite all the new information we are learning about this disorder, persistent myths about BPD continue to lead people astray and add to the stigma associated with this disorder (p. 28).

The impact of stigma upon consumers

The counter-therapeutic consequences of these clinician attitudes for people with challenging behaviours, where staff increasingly view difficult behaviours as provocative, manipulative and overly demanding, have been described as 'malignant alienation' (Morgan & Priest, 1991; Watts & Morgan, 1994). This negative view of the person results in treatment that could be described as rejecting. It has been suggested that in extreme situations this can lead to suicide, although evidence for this claim is now seen as somewhat tenuous (Morgan & Stanton, 1997). Increasing suicidality and decreasing functioning in clients with BPD in an inpatient setting where staff display negative reactions towards the client have also been described (Gunderson, 2001).

Consumer reports likewise describe negative consequences in response to being 'labelled' with a diagnosis of BPD. An adverse impact on the delivery of mental health care is noted as well as an impact on other forms of health care. The label was experienced as 'pejorative' and 'perpetuated a sense of being marginalized and potentially mistreated' (Nehls, 1999, p. 289). Provision of services was seen as 'intentionally limited' (Nehls, 1999, p. 290). Consumers also reported being made to 'feel undeserving of inpatient care' (Fallon, 2003, p. 397). Epstein (2004), an Australian consumer activist, describing the impact of being labelled as having BPD, has suggested that an additional layer of distress is associated with the experience of living with BPD.

> For me, the getting of a Borderline diagnosis was a profound moment.
> From that point on everything changed including the language that
> was used to talk about me behind my back (p. 3).

Hamilton (2004), in an overview of contemporary critiques of the spoken and written language employed by nurses in acute psychiatry settings, suggests a benign use for what, to the outside observer, appears to be pejorative language. 'Nurses often favour informal spoken language, at best reflecting a distinctive and engaged position in relation to patients'(p. 8). More recently Hamilton and Manias (2006) describe nurses' use of non-standard and informal language as reflecting

> nurses' resistance to the discourse of bioscience, and, at best reflects a
> distinctive and empathic position in relation to patients in the midst of
> ethical strain associated with involuntary treatment (p.91).

Epstein's (2004) comments would suggest that such language is not, however, experienced as indicative of therapeutic engagement.

It is possible to identify a number of factors that can be suggested as contributing to the stereotyping, attributions of stigma and therapeutic pessimism that result in such a negative impact upon people with BPD. These include counter transference and a continuing pervasive belief that caring for people with BPD is not the work of mental health professionals.

Countertransference:

Psychodynamic theory provides a lens for examining the sometimes harsh or distancing responses of clinicians towards people with BPD. It does so through the concept of countertransference. The validity of this concept has been debated over many decades, but it continues to be seen as useful in seeking understanding of one's internal responses to a client (Rosenberger & Hayes, 2002a). For the purposes of this

brief discussion, countertransference is understood as defined by Blanck and Blanck (1979 cited in McIntyre & Schwartz, 1998). They say that 'countertransference is seen as a manifested experience directly related to reactions from client contact, and the experiences can either benefit the client therapeutically or contaminate therapy' (p. 924).

Book, Sadavoy and Silver (1978) suggest multiple countertransference responses may arise in response to contact with clients who confront clinicians with behaviours that may either frighten or enrage. Frequently a client may be perceived as bad, manipulative and uncooperative with clinicians having difficulty perceiving the client as troubled, desperate and frightened. Clinician responses to difficult behaviours may then be pejorative and punitive. Clinicians may also identify with either the 'good' or the 'bad' within a client. If unaware of these identifications as countertransference, clinicians may participate in inter-staff fragmentation with a total disruption of the ability of the treating team to work effectively with the client. Clinicians may experience difficulty in regard to maintaining boundaries and appropriate limits in regard to client behaviours. Unawareness of countertransference reactions may result in clinicians becoming 'either uncaringly lax or controllingly sadistic around the issue of limit-setting' (Book et al., 1978, p. 529).

Unidentified countertransference responses may also result in an abuse of the diagnostic label, borderline personality disorder (Reiser & Levenson, 1984). Anecdotally, within the inpatient setting and at times in outpatient teams, the label 'borderline' can be heard as a 'wastebasket' term applied to a person exhibiting difficult behaviours. Reiser and Levenson (1984) suggest that the tendency to misuse the diagnosis may represent forms of therapist abuse including 'an expression of

countertransference hate', a disguise for sloppy diagnostic thinking and, at times, as 'a rationale for avoiding medical and pharmacologic treatment interventions' (p. 1532).

A study designed to examine therapists' countertransference reactions towards clients with either BPD or major depression noted a marked difference between responses to each client group (McIntyre & Schwartz, 1998). Clients with BPD were noted to evoke 'more extreme reactions of hostility and dominance...including tendencies to criticize, ridicule or punish...perceptions of doubt concerning the attitudes and intentions of others; and emotional detachment to minimize emotional investment' (p. 927). In contrast, clients with major depression were experienced as people for whom counselling was more likely to be beneficial and worthwhile.

Hinshelwood (1999, p.187-190) describes clinicians' response to the difficult behaviours of people with schizophrenia or severe PD as one of 'emotionally retreating from the patient and their experience' into the 'scientific' attitude. Unlike the unintelligible world of the person with schizophrenia, the person with a severe personality disorder confronts clinicians with 'a relationship too intensely suffused with human feelings – usually very unpleasant ones'. Unwittingly, clinicians' responses could then be experienced as a replication of the very abandonment and rejection that the person with BPD is desperately seeking to avoid. The dominance of a physically oriented medical science approach to conditions such as personality disorders is seen as contributing further to the negative responses frequently exhibited. Nathan (1999) suggests that the negative transference frequently displayed by clinicians confronted with the difficult behaviours of people with personality disorder can be seen as arising from hopelessness and powerlessness evoked by the apparent resistance of these disorders to medical science (Senate Community Affairs References Committee, 2002).

Not really core business

The strength of the countertransference reactions described above and the negative impact of stigmatizing and stereotypical responses upon consumers is clear. Yet mental health professionals' critical and punitive attitudes continue to prevail. This is despite empirical evidence outlining effective treatment programs and policy imperatives to address the deficiencies within mental health professionals' approaches to consumers, including those with BPD. Underpinning these difficulties is a debate as to whether BPD is indeed a mental disorder and whether management of people with BPD even lies within the province of mental health services (Kendell, 2002; Levy et al., 1999; Watts & Morgan, 1994). This debate is further complicated by discussions in which all personality disorders are examined as a unified category and seen by some as synonymous with psychopathic behaviour. The overlap between different diagnostic categories of personality disorder further confuses discussions as to whether people with a personality disorder have a right to care from mental health services or whether indeed these conditions are amenable to treatment. Cawthra and Gibb (1998) have proposed that those who espouse approaches to treatment have tended to base their arguments on an 'optimistic view that personality disorders are amenable to psychotherapeutic interventions' (p. 8).

Prompted by the continuing political agenda in the United Kingdom that seeks to mandate preventive detention of people with 'dangerous severe personality disorders', Kendell (2002) has examined whether there is a distinction between personality disorder and mental illness. He concluded that the current ambiguities in both definitions and basic information about personality disorders ensure that it is 'impossible to conclude with confidence that personality disorders are, or are not, mental illnesses' (p. 110). The inclusion of personality disorder within the

classifications of mental disorders prepared by both the World Health Organization (ICD-10) and the American Psychiatric Association (DSM-IV) is cited as evidence that both organisations see these conditions as of importance in the practice of psychiatry. Kendell (2002) notes, however, that unlike current responses to personality disorders in general there is evidence of an increasing readiness to view BPD as a mental disorder, perhaps opening up the possibility of a more positive response towards people with BPD in some areas of mental health care.

A further factor in a changing response to BPD is cited as the steadily growing evidence for effective therapies. Kendell (2002) cites the existence of an effective therapy as one of the prompts for the medical profession to change its opinion concerning the status of a particular condition, i.e. if there is a treatment available, the condition may then be reclassified as within the province of mental health services. A marked difference in psychiatric practice between Britain and North America is also noted as influencing whether or not people with personality disorders are seen as the province of psychiatry or indeed whether there is any treatment that is available. This difference arises primarily from economic and cultural influences. Kendell (2002) describes the economic limitations that constrain mental health services in Britain as fundamental to the reluctance of psychiatrists to attempt to provide treatment for people 'with deeply ingrained behaviours for which there were no proven therapies' (p. 114). In contrast, the North American system is described as markedly different where

> private office practice and various forms of psychotherapy, and the psychoanalytic concept of "borderline personality disorder" has provided a rationale for treating, as personality disorders, large numbers of patients who in Britain would mostly be regarded as suffering from recurrent depression (p. 114).

This difference between the two mental health systems is seen as significantly contributing to differences in opinion as to whether the management and treatment of people with BPD lies within the province of mental health services.

Within the public mental health service in which this research project was undertaken, some clinicians continue to loudly assert their belief that people with BPD should not be treated within mental health services. This belief was revealed in research that sought to evaluate the impact of training in DBT (Hazelton, Rossiter & Milner, 2006). Clinicians were asked to articulate the myths and messages that are heard in the workplace concerning people with BPD. Attendees repeatedly and consistently listed multiple stereotypical representations of people with BPD. These included descriptions of people with BPD as hopeless and helpless, a waste of resources, system abusing, unpredictable, manipulative and sabotaging of any attempts to help them (Hazelton et al., 2003; Hazelton et al., 2006). Clinicians were also able to identify the ways in which these 'beliefs' negatively impacted upon the quality of care offered to people with BPD.

The pervasiveness of these stereotypical views throughout mental health services is suggested by researchers in a number of different settings. Gallop (1988) reports her findings that 39 out of 42 nurses offered 'manipulative', 'trouble' and 'attention seeking' as the words that came to mind when asked to think of BPD. Consistent with mental health nurses in the research area, Gallop (1988) describes the dread and anxiety that staff experience when a person with BPD is about to admitted. She proposes that prior to admission 'the stereotypic category has been stimulated and staff are anticipating "trouble". The nurses' expectations of the category may well insure the consequence' (p. 20).

Further research has explored the impact of these negative belief systems surrounding the diagnosis of BPD. For example, in observing nurses' behaviours in a group therapy setting, Fraser and Gallop (1993) observed that nurses' responses to patients with BPD were less empathic than to people with affective disorders and 'other' diagnoses. These findings add additional weight to the idea that 'a diagnosis of BPD is a pejorative diagnosis that generates a negative and perhaps stereotypic response regardless of actual behaviour' (p. 339).

A recent Australian study (Deans & Meocevic, 2006) that surveyed registered psychiatric nurses likewise describes the majority of respondents as reporting negative attitudes towards people with BPD. The researchers report the 'most frequent response was that respondents perceived people with BPD as manipulative (89%)...and over half as engaging in emotional blackmail (51%)' (p. 46). Consistent with previously cited research, these authors express their concern as to the impact of such negative attitudes upon clinicians' ability to provide a therapeutic environment for people with BPD.

Policy Context

In contrast to the ongoing bleakness and negativity described in the current literature outlining attitudes, beliefs and practices towards people with BPD, there is strong public policy that understands the importance of this condition and mandates treatment. An examination of the national policy context for mental health services is important in order to understand the arena in which clinicians interact with people with BPD. Within Australia, the current political environment is informed by a health policy that seeks to address the concerns of mental health consumers. In 1992 the Australian Government began the long overdue and arduous process of reforming public mental health services. The initial National Mental Health Plan (Australian

Health Ministers' Advisory Council, 1992) was designed to provide a coordinated approach to mental health service reforms. This plan began the process of challenging the gross deficiencies of the custodial model of psychiatric care, the gap between research findings outlining best practice and the reality of health care delivery. A second plan followed in 1998 (Australian Health Ministers, 1998). Sadly, a comprehensive review (Groom, Hickie, & Davenport, 2003) prior to the release of the Third National Mental Health Plan (Australian Health Ministers, 2003) documented significant failure in implementing strategies outlined in previous plans echoing many of the concerns raised a decade earlier by the Human Rights and Equal Opportunity Commission (HREOC) (1993).

The failure to implement vitally important strategies to improve mental health services was attributable to a range of factors. These mainly involved a fragmented and often ad hoc approach to service development, insufficient resources to support required changes and marked deficits in the practice and responses of mental health professionals. Reports of negative and often punitive behaviours from staff/clinicians towards consumers continued to emerge (Groom et al., 2003). In contrast to the apparent reality within many sectors of public mental health services, the Third National Plan stated clearly that 'a mental health workforce that actively works against stigma and discrimination is fundamental' (Australian Health Ministers, 2003, p. 12).

Despite the focus for mental health services outlined in the Third National Mental Health Plan (Australian Health Ministers, 2003), continuing reports of the failure of mental health services in Australia appeared in independent reviews, media reports and parliamentary inquiries. Uncoordinated and fragmented service delivery and serious workforce shortages were identified as requiring urgent attention. 'There are serious workforce shortages across all mental health professional groups...This

shortage hinders the ability of government and non-government providers to meet the increasing demands for services' (Council of Australian Governments (COAG), 2006, p. 6). As the enormity of the difficulties became more apparent, discussions concerning a whole of government approach to the delivery of mental health services were commenced in early 2006. These discussions culminated in the release of a National Mental Health Action Plan 2006-2011 superseding the Third National Mental Health Plan of 2003-2008 (Australian Health Ministers, 2003; Council of Australian Governments (COAG), 2006). Amongst a number of different areas of focus, this plan places an emphasis on workforce development and building capacity. A raft of initiatives designed to enhance mental health care include funding for additional education places, scholarships and improved clinical training in mental health (Council of Australian Governments (COAG), 2006).

The 2006-2011 plan clearly identifies suicidal behaviours as a high priority target for public mental health services to address (Council of Australian Governments (COAG), 2006). A 2000 NSW State government evaluation of those at heightened 'risk' of suicide identified current or former mental health clients, psychiatric patients within 4 weeks post discharge and those who had made previous suicide attempts as amongst those in particular danger (NSW Department of Health, 2000). Initiatives in NSW were developed with the aim of, wherever possible, preventing death by suicide (NSW Department of Health, 2003) These government policies describe those in particular need of care and propose a picture of mental health services that adequately meets the needs of consumers. State-wide initiatives such as these have now been augmented through a wide range of projects funded under the National Suicide Prevention Strategy (Australian Government Department of Health and Ageing, 2006) while the federal policy describes an Expanding Suicide Prevention Programme to build further on the National Strategy (Council of Australian Governments (COAG), 2006).

Reviewing the current policy documents provides a view of a nationwide focus on improving the quality and availability of mental health services, including a strong focus on the prevention of suicide. Many people with BPD fall within the category of those attempting suicide. The previous discussion outlining the view that care of people with BPD is not part of 'core business' suggests that the interpretation of these policies may be directed towards those presenting with acute suicidal behaviours, in contrast to the ongoing or chronic suicidal behaviours of many people with BPD. Thus, the rhetoric appears to be far removed from reality for many consumers with BPD. Recent literature suggests mental health professionals at the service delivery level continue in many instances to exhibit the therapeutic pessimism and stigmatising behaviours that have been described for a number of decades (Deans & Meocevic, 2006).

What is happening at the level of service delivery?

The contrast between the experiences of people with BPD as described in the literature and the rhetoric of national policy mandating effective care for people with mental disorders is stark. An examination of service utilization data undertaken in the author's region revealed people with BPD were the highest users of inpatient and outpatient services while crude outcome data suggested limited beneficial outcomes resulting from these contacts. 'Treatment as usual' (TAU) (i.e. the treatment usually provided) in this region could perhaps be best described as 'assertive disengagement' where clinicians make every effort to ensure that clients with BPD are referred to other services outside of mental health (Hazelton et al., 2003). Assertive disengagement implies a confidence and self-assurance in the position taken to disengage as quickly as possible from people with BPD when they present for care. Earlier research in this region clearly supports this description of TAU as 'assertive

disengagement' with participants describing people with BPD as difficult and untreatable. This focus on actively and assertively disengaging with people with BPD who present for care was especially apparent in research undertaken in the semi-rural region of the area covered in this research (Hazelton et al., 2003; Hazelton et al., 2006). The stigmatization of people with BPD, beliefs that BPD is not part of 'core business' and a lack of understanding of the aetiology of BPD at times all contribute to the difficulties clients encounter when attempting to access care. However, without an understanding of the service context and the constraints affecting the work of clinicians in this area, TAU may appear as a heartless neglect of clients whose suffering is extreme.

In 2002 the Senate Community Affairs References Committee produced a paper investigating the crisis in health care resulting from the ongoing nursing staff shortage. A stark picture was revealed.

> Working conditions are often poor, with heavy workloads and lack of resources which adds to the stress of nursing staff. There is a lack of pay parity with other health professions. There is a high level of workcover claims in the mental health sector. There is a lack of career pathways which has resulted in low morale, lack of job satisfaction, and poor status...lack professional development opportunities and employer educational assistance schemes. All of these issues undermine the attractiveness of mental health nursing for new graduates and encourage professional stagnation of those already practicing (p. 163).

At the same time, a report prepared by the Mental Health Council of Australia (Groom et al., 2003) outlines its key findings thus: 'current community-based systems are failing to provide adequate services and support recovery from illness or protect against human rights abuses. Whilst current policies for community-based mental

health care are appropriate, the implementation of these policies falls far short of need' (p. iii).

The professional literature likewise describes a public mental health service that is fraught with a wide range of difficulties that impact both upon the delivery of effective treatments for people who present for care and on the well-being of mental health professionals. White and Roche (2006), in reviewing data obtained from a survey of mental health nurses in NSW, suggest that there are 'incontrovertible accounts of suboptimal service provision' (p. 217). They further describe the current workforce as out of touch with best practice and with the tools available to assist in optimising patient outcomes.

In Australia deinstitutionalisation of mental health services began in the 1960s, with mental health services moving from a custodial model of care to a community based service. Rosen and Teesson (2001, p. 732) describe the growth of community mental health services as 'somewhat haphazard'. In an attempt to address the haphazard manner in which services were delivered, various projects were undertaken to introduce more coordinated and effective outpatient care. Case management was seen as the means by which the difficulties could be addressed (Rosen & Teesson, 2001). A review of the literature evaluating case management models is outside the scope of this paper. However, the authors of a meta-analysis of the effectiveness of mental health case management suggest that 'both assertive community treatment and high-quality clinical case management should be a feature of mental health programmes' (Ziguras & Stuart, 2000, p. 1419). While evidence based medicine supports the use of case management, the realities of current service delivery appear to be less than ideal. Recent consumer evaluations of mental health services, as cited previously, describe a system that is struggling to deliver the most basic of services

(Groom et al., 2003). Howgego, Yellowlees, Owen, Meldrum and Dark (2003) cite anecdotal evidence suggesting that:

> most community services in Australia are likely to be characterized by an eclectic mix...(in which) the case managers with individual patient loads of 20-30...attempt to provide a gamut of services depending on (often conflicting) patient needs (p. 180).

Within the area health service in question, case management is likewise the identified model of practice. A recent survey of community health nurses revealed a concerning lack of adherence to any particular model and identified that clinicians had received limited or no training in how to implement case management (Harmon, 2006).

These difficulties are further compounded by excessive workloads. Muir-Cochrane (2001) quotes a community mental health nurse thus:

> We keep picking up new clients...and our numbers keep going up before we have had any expansion of community services. We are under siege really (p. 215).

King, Le Bas and Spooner (2000, p. 364) suggest that while 'intensive case management is relatively standardized....few descriptions exist of the work practices, team composition, and administration of standard clinical case management.' In a research project designed to explore the impact of caseload on the personal efficacy of mental health case managers, King et al. (2000) suggest that 'even the most cautious interpretation suggests that an inverse relationship exists between case managers' personal efficacy and caseload sizes' (p. 367).

It is within the context of overburdened public mental health services then, that clinicians are confronted with the challenges of providing services for people with BPD.

Community mental health nurses participating in research exploring case-management practices describe how 'long-term plans for clients were often over-ridden by the immediacy of other clients in crisis' (Muir-Cochrane, 2001, p. 215). Given these difficulties and beliefs that BPD is neither a mental illness nor part of 'core business,' it is possible to comprehend how 'assertive disengagement' has become TAU. A strong argument has already been mounted for offering services to people with BPD. Understanding that inappropriate management can 'make things worse', it could be suggested that in the absence of training, skills and time to deliver evidence based therapy, 'assertive disengagement' has been the wisest course of action.

What can be done?

Despite persistent assertions from some clinicians that BPD is not 'core business,' people with BPD regularly present to mental health services and clinicians are faced with a need to provide a response to the demands for care. Although various treatment approaches have been advocated over several decades the interventions have been largely unevaluated. Research findings describing the efficacy of particular approaches designed to treat BPD are now emerging. To date, however, the extant studies have had significant methodological and design problems including difficulties such as small sample size that reduces statistical power. Thus, caution is required in generalizing the results to other settings. Further, a number of studies have not compared the treatment under study with another active treatment and also lack measures of adherence or examination of therapist competence (Clarkin, Levy, Lenzenweger, & Kernberg, 2004). It is also important to note that 'treatment as usual' (i.e. the treatment normally provided in that setting prior to the research condition being implemented) (TAU) is not always clearly described and where it is defined there is no consistency between sites as to what constitutes TAU.

The challenges and difficulties inherent in attempting to conduct randomized controlled trials with this population are outlined by Roth and Fonagy (2005) in a recent critical review of psychotherapy research:

> This group of individuals is difficult to retain in treatment and tends to be reluctant to accept randomisation, to challenge the administration of manualised interventions and to be difficult to follow-up (p. 317).

Nevertheless, the following will address the seminal research that has examined treatment effectiveness in relation to BPD.

Dialectical Behaviour Therapy (DBT) to date appears to be the most researched and evaluated form of therapy for BPD although the evidence for efficacy needs to be seen as preliminary only. DBT has been described as the 'single most remarkable entry in therapeutic strategies for borderline patients' (Gunderson, 2001) to appear since 1987, not the least for its 'capacity to invigorate and sustain enthusiasm for treating a group of patients who have often demoralized prior generations of clinicians' (Swenson, 2000). DBT is based on a biosocial theory which views BPD as originating and 'being maintained by a lifelong mutually shaping transaction between a vulnerable temperament and an invalidating environment which leads to deficient emotion regulation skills and motivational problems'. It 'balances a relentless insistence on problem solving, informed by behavioural principles and techniques, with an attitude of acceptance embodied in validation, empathy, and a radical acceptance of things as they are "in the moment".'(Swenson et al., 2001). (A description of the philosophical underpinnings of DBT follows later in this chapter on page 36. For an outline of key features of DBT such as the main structural components, stages of therapy and mindfulness, see Appendix I).

Linehan and colleagues (1991) published the results of an initial randomised control trial designed to evaluate the effectiveness of 12 months treatment with DBT compared with TAU in the community with a sample size of 22 in each arm of the trial. A significant reduction in the frequency and medical risk of self-harming behaviours was identified in participants who received DBT.

A follow-up study (Linehan, Heard & Armstrong, 1993) sought to assess whether the improvements were maintained during a 12 month post-treatment period. Again significant improvements were noted in participants' self-harm behaviours and a decrease in inpatient days in the DBT arm. These findings have been further corroborated by a study (Linehan, et al., 2002) to evaluate DBT compared with TAU for women with BPD and substance abuse disorders. A number of non-randomized trials of DBT trialling the therapy for suicidal adolescents, incarcerated female juvenile offenders and an inpatient setting have also been reported with promising results (Barley, Buie, Peterson, Hollingsworth, & et al., 1993; Bohus et al., 2000; McCann & Ball, 2000; Rathus & Miller, 2002; Trupin, Stewart, Beach, & Boesky, 2002). Yet, caution is required in attaching too much weight to these results as much of the research underpinning them has been conducted by a single research group with very small sample sizes.

One major study evaluating DBT from outside of the Linehan group has been reported recently. Verheul et al. (2003) reported on a 12 month randomized clinical trial of DBT conducted in the Netherlands. Fifty-eight women were randomized either to DBT or TAU. The authors reported that DBT resulted in better retention in therapy with greater reductions in self-harming and impulsive behaviours when compared with TAU. Improvement was particularly marked amongst those with a history of frequent

self-harm.   Again the failure to compare DBT with another active treatment can be seen as a flaw in this research.

Despite these flaws, DBT has been embraced enthusiastically internationally revealing a marked disparity between the limited research findings about it and its widespread uptake within a number of different countries (Scheel, 2000).   Swenson (2000) suggests that 'DBT appeals because it brings together theoretical complexity and depth with a huge number of very pragmatic, directly usable interventions' (p. 90).

More recent publications reinforce the perception that DBT appeals as an effective, pragmatic approach. Two studies evaluating participants' use of particular components of the DBT program, more specifically the skills taught in skills training, have been published. Linedenboim, Comtois and Linehan (2007) report that the 'majority of participants reported practicing skills most days throughout treatment. Crisis survival and mindfulness skills were practiced most frequently...' (p. 148). Dewe and Krawitz (2007) describe DBT as now 'an accepted proven treatment for borderline personality disorder (BPD) with a robust research base...' (p. 222). They report on a pilot study examining participants' perceptions of which DBT skills they found to be most useful.

It is outside the scope of this literature review to provide a comprehensive critique of the current research evaluating psychotherapeutic approaches to the treatment of BPD. The difficulties inherent in evaluating the efficacy of various forms of psychotherapy, including 'the presence of co-morbidity, lack of specificity of psychotherapies, difficulties in implementing randomized controlled studies, changes of diagnostic criteria and lack of precise outcome measures' all pose multiple barriers to conducting research in this field (Simonsen & Tyrer, 2005, p. 69).   Nevertheless, there have been some impressive results produced by research into the efficacy of

psychotherapeutic treatments for BPD. Australian researchers, Meares, Stevenson and Comerford (1999) reported on a cohort of 30 patients who completed a 12-month therapy that used an elaboration of the Conversational Model of Hobson (interpersonal-psychodynamic psychotherapy). Outcomes were compared with a wait list of people with BPD who were demographically similar to the treatment group. Significant improvements were noted in the treatment cohort with improvement sustained at both 12 months and 5 year follow-up.

Bateman and Fonagy (1999) have also reported on their research evaluating the outcomes of psychoanalytically oriented, partial hospital treatment for BPD. Thirty-eight participants diagnosed as having BPD were randomized to either standard psychiatric care or partial hospital treatment that included both individual and group psychoanalytic psychotherapy for 18 months. The treatment condition was shown to have superior outcomes when compared with the standard psychiatric care or TAU. The authors note, however, that the sample size was small and further research needs to be done to evaluate this therapy.

Nevertheless, an 18 month follow-up study (Bateman & Fonagy, 2001) evaluating the durability of improvements was conducted with participants from the original study. They were reported to have maintained the improvements gained, including social and interpersonal functioning that was steadily advancing. More recently Bateman and Fonagy (2004, p. 36) have suggested that 'mentalization (the capacity to think about mental states of oneself and others as separate from, yet potentially causing actions)' is a core theme in many different forms of psychotherapy conducted with people with BPD. They view this factor as a potential explanation for the effectiveness of different treatments.

A meta-analysis of the 15 available psychotherapy outcome studies for personality disorders in general (Perry, Banon, & Ianni, 1999, p. 1312) identified psychotherapy as an effective treatment for people with personality disorders. These researchers recognized the limitations of attempting to conduct a meta-analysis of psychotherapy studies, and concern relating to generalizability to community populations was also noted. The authors suggest that psychotherapy may be associated 'with up to sevenfold faster rate of recovery in comparison with the natural history of disorders'. Noteworthy, however, was the paucity of outcome studies and the poor correlation in the tools used for assessment of both core pathology and outcomes between these studies.

Gabbard (2000) suggests that in spite of the limitations of the current research both DBT and psychodynamic psychotherapy appear to be very effective for BPD.   Roth and Fonagy's (2005) critical review of psychotherapy likewise acknowledges both the efficacy of DBT and psychodynamic therapy for people with BPD and notes the limitations imposed by the small sample sizes of current published research in this area.   A further concern is raised as to the transferability of the findings to routine practice. The authors suggest the importance of senior clinicians being trained in these approaches with a level of competence sufficient to provide supervision to clinicians in routine practice (Roth & Fonagy, 2005, pp. 318-319).

Recommendations have been developed for clinicians in Australia and New Zealand for the management of adults who present with deliberate self-harm. The team that prepared these guidelines identify DBT as a potentially effective treatment approach for adults with deliberate self-harm who meet the criteria for a diagnosis of BPD (Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines Team for Deliberate Self-harm, 2004).

Further support for the efficacy of psychotherapy appears in an emerging area of research that offers a beginning understanding of the neurological mechanisms involved in producing the benefits which 'talking therapies' have been claimed to effect. The limited view of the interface between psychology and neuroscience that reduces 'human nature and suffering to biochemical malfunctions' amenable only to chemical manipulations is challenged by authors from Yale University School of Medicine. Cappas, Andres-Hyman and Davidson (2005) suggest emerging advances in neuroscience offer an enhanced understanding of how psychotherapy may modify brain function. In a cogent presentation of 'seven principles of brain-based psychotherapy' the authors explore the implications of the findings of neuroscience for clinical practice. It is suggested that the findings from neuroscience can 'be useful to psychotherapy ...through validation of existing psychotherapeutic theories and interventions' (p. 374).

Recently, the World Psychiatric Association (Simonsen & Tyrer, 2005) published a review of developments in the treatment of BPD, confirming the difficulties associated with conducting outcome studies in personality disorders. The authors ascribe the recent developments of more tailored integrated therapies to new 'conceptions of personality pathology and new treatment paradigms' and state that the 'good message is that recent well-designed trials have underlined that these treatment programs work for most patients with personality disorders' (p. 70).

What is DBT?

This selected review of the literature provides evidence that therapeutic interventions can be effective for people with BPD. DBT is identified as the approach for which there is to date the most solid evidence base. In exploring whether DBT is an appropriate approach for use by clinicians in public mental health services it is important to

elaborate more clearly what DBT involves. Linehan's seminal work describes both the development and the process for delivering DBT as a therapy (1993a). Dimeff and Linehan (2001) describe the therapy as arising 'out of a series of failed attempts to apply the standard cognitive and behaviour therapy protocols of the late 1970's to chronically suicidal clients' (p. 10). DBT was developed experientially through a process of evaluating the impact, either positive or negative of the application of various therapeutic techniques. The target group with whom Linehan worked were women who presented as having met the criteria for a diagnosis of BPD and also had 'histories of multiple nonfatal suicidal behaviours' (1993a, p. 4). The philosophical underpinnings of DBT are clearly outlined in this manual. Linehan describes her focus as follows:

> One of the main goals of my theoretical endeavours has been to develop a theory of BPD that is both scientifically sound and nonjudgmental and nonpejorative in tone. The idea here is that such a theory should lead to effective treatment techniques as well as to a compassionate attitude (1993a, p. 18).

Linehan's theory of BPD is a biosocial theory hypothesising that BPD arises from an interaction over time between a biological vulnerability or predisposition to emotional dysregulation and an invalidating environment (Linehan, 1993a).This cognitive behavioural treatment is described by Linehan as 'for the most part, the application of a broad array of cognitive and behaviour therapy strategies to the problems of BPD, including suicidal behaviours' (1993a, p. 19). She further notes that 'each set of procedures has an enormous empirical and theoretical literature' (1993a, p. 20). However, Linehan (1993a, p. 20) clearly outlines the differences between standard cognitive and behaviour therapy and DBT. The following differences are outlined by Linehan as:

- A focus on acceptance and validation. This emphasis is identified by Linehan (1993a, p. 20) as arising from her studies in Eastern spirituality and meditation.

Validation is identified as a 'core strategy' of which there are two types. The first is described as a process in which the therapist 'finds the wisdom, correctness or value in the individual's emotional, cognitive and overt behavioural responses' (p. 99). The second 'has to do with the therapist's observing and believing in the patient's inherent ability to get out of the misery that is her life and build a life worth living' (p. 99).

- An emphasis on 'treating therapy-interfering behaviours'. Linehan (1993a) suggests that this focus is similar to 'the psychodynamic emphasis on "transference" behaviours' (p. 21). This aspect of the therapy is often explained to people with BPD thus: 'Therapy doesn't work if you don't come or if you don't do your homework.'

- A strong focus on the importance of the therapeutic relationship as integral to the therapy. Linehan (1993a) notes that this emphasis arises directly from her clinical work with suicidal individuals. 'At times, this relationship is the only thing that keeps them alive' (p. 21). She further notes that this aspect of the therapy was strongly influenced by the work of Kohlenberg and Tsai (1991) who 'developed an integrated behavioural therapy in which the vehicle of change is the relationship between therapist and patient' (Linehan, 1993a, p. 21).

- A focus on dialectical processes. (Dialectics is examined in further detail later in this chapter).

Ten years after the publication of her text outlining the therapy, Linehan's (2003) biography described DBT as combining:

> the technology of change derived from behavioural science with the radical acceptance, or "technology of acceptance" derived from both eastern zen practices and western contemplative spirituality. The practice of mindfulness, willingness, and radical acceptance from an important part of her treatment approach.

It is important to note that for clinicians to work effectively as a DBT therapist requires not only an ability to deliver the therapy but also a comprehension of the way in which the therapy is intertwined with the biosocial theory of BPD to form two inseparable strands.

Dialectics

An understanding of the concept of dialectics and its implications for both research and practice development is warranted in clarifying the potential usefulness of DBT as a tool to facilitate change in clinicians' behaviours towards people with BPD. Dialectics has been an important concept in both interpretive and critical social research. The Hegelian concept of dialectics, for example, was retained by Marx and is as seen as underpinning Marx's view of history (Brooker, 1999; Crotty, 1998). Hegel's dialectic (though apparently he never used this term, only the method) 'holds not only the notion of thesis and antithesis standing over against each other but also the notion of their interaction leading to a synthesis' (Crotty, 1998, p. 118). Linehan (1993a) describes DBT as grounded in the world view of dialectics. The concept of dialectics permeates the therapy with its paramount and all-encompassing target being 'to increase dialectical behaviour patterns' among clients with BPD' (p. 120).

Linehan identifies three distinct characteristics of the dialectical perspective. Firstly, it assumes a focus on a holistic or systemic view of reality that sees analysis of parts of a system of little value without a view of the relationship of these parts to the whole. Secondly, dialectics recognizes the complexity of any given system while at the same time focusing on the whole. Finally, dialectics recognizes synthesis between opposing viewpoints or positions as central and as a continuous process of change (Linehan, 1993ap.31-34)). Such an approach is intrinsically critical of dichotomous thinking, which is a major feature of BPD. Dichotomous thinking is viewed within the DBT model as evidence of 'dialectical failure' because it involves the maintenance of conflict between contradictory viewpoints and precludes the possibility of synthesis and transcendence (Linehan, 1993ap.35-36).

The practical application of this conceptualization led to the development of a therapy that incorporates strategies designed to encourage the development of dialectical thinking. It 'requires the ability to transcend polarities and, instead to see reality as complex and multifaceted' (Linehan, 1993a, p. 121). Again, Linehan (1993a) describes the overriding goal of DBT thus:

> ...not to get patients to view reality as a series of grays, but rather to help them see both black and white, and to achieve a synthesis of the two that does not negate the reality of either (p. 121).

A therapeutic modality grounded within the world view of dialectics thus provides a foundation upon which to challenge not only clients' dichotomous thought patterns but also the tendency of many health professionals to hold rigidly to viewpoints that are ineffective in treating BPD.

DBT in the Australasian setting

The literature review has suggested that DBT is at this point of time one of the most effective interventions available for BPD. A brief examination of the conceptual framework underpinning DBT has highlighted the potential that exists within this therapy to challenge the stigma, stereotyping and marginalisation of people with BPD. However, the research evidence comes from overseas studies undertaken primarily in the United States and in the United Kingdom and while the evidence suggests that this is the way forward, it is instructive to explore whether there is evidence that DBT is an effective treatment approach in the Australian context.

To date, no publications describing randomised controlled trials examining the efficacy of DBT in the Australasian population are available. Recently, New Zealand researchers, Brassington and Krawitz (2006), reported on a DBT pilot outcome study

of ten patients treated in a New Zealand study to 'ascertain the clinical utility and feasibility of implementing DBT into a standard New Zealand public mental health service' (p. 313). The preliminary results showed the clinical effectiveness of DBT and the authors suggest that their results indicate that DBT 'can be successfully implemented within existing public mental health services' (p. 313). Dewe and Krawitz (2007) have gone on to describe DBT as 'an accepted proven treatment for borderline personality disorder BPD with a robust research base' (p. 222) implying that the evidence is sufficient to have confidence in the generalisation of the results to the Australasian setting. From this standpoint, they have proceeded to research designed to examine patient views of the effectiveness of the individual skills taught in DBT.

Although published research on the use and outcomes implementing DBT in the Australian setting is limited to one pilot study, psychology and mental health nursing conferences over the past several years have seen a number of paper presentations describing the use of DBT in both public and private mental health services (Blackley, 2004; Hazelton et al., 2003; Rossiter, Hazelton, & Milner, 2003; Rossiter et al., 2004; Willcox, 2004).

What has been the response to the need for an effective treatment response in the area within which this research project was undertaken?

The following examines the implementation of DBT in one area in Australia. In a quest to address service difficulties and unmet need for effective treatment for people with BPD, a multi-disciplinary tertiary level mental health team based in the area in which this research project was conducted was established. Developed with the primary purpose of fostering the use of psychotherapeutic modalities within the wider service, the team provides clinical services for people with BPD and consultancy, education and supervision to clinicians. In 1999 clinicians in the team began to consider a possible

treatment approach to be offered on an outpatient basis for those with BPD. The choice at that time was seen to be either DBT (Linehan,1993a; Linehan, et al.,1991) or the Conversational Model as offered by Westmead Hospital, Sydney (Meares et al., 1999).

A decision was made to use DBT on the basis of availability of training (DBT exists in a manualised form). DBT as a therapy appeared to be an optimistic treatment approach with an emerging evidence base. It was seen as relatively easy to learn and to talk about and adaptable to the Australian setting. After an initial period of skill development during which some clinicians were able to attend intensive training in New Zealand conducted by the Linehan group, a randomized control trial was commenced. The focus of this research was to attempt to replicate Linehan's original research in the Australian public mental health service context.

A randomized controlled trial design in which 72 people with BPD were allocated either to the treatment condition (6 months DBT) or to 6 months TAU was employed for this project. After data collection, further intervention was offered. The intervention group were given a further 6 months DBT (as per Linehan's model) and the TAU group were offered entry into the DBT program. Funding difficulties resulting in a lack of research staff has resulted in a delay to the release of the final data. Preliminary reports suggest a decrease in episodes of self-harm, nights of hospitalization and the number of general practitioner consultations in the intervention group (Willcox, 2004). To date, DBT continues to be the primary treatment offered within this mental health service with a limited number of clinicians also trained in the Conversational Model (Meares et al., 1999). For those clients unable to access either of these two treatment modalities, TAU remains as largely 'assertive disengagement' in this region.

Although DBT is being used with anecdotal and case study evidence of efficacy in this region, the use of this therapeutic approach is based on the results of overseas research in the absence of Australian outcome data. This is however, perhaps not the most significant barrier to offering treatment for people with BPD. The effective implementation of DBT within the Australian setting clearly requires a major shift in attitude and behaviours for mental health providers. This raises the significance of the mental health professional role in the provision of effective treatment.

This chapter has explored the nature and extent of borderline personality disorder, the experience of people with BPD both from the point of view of the impact of the disorder upon their lives and the response that is frequently experienced when seeking assistance from mental health services. The discordance between mental health service responses, the policy context that describes services that provide care for people presenting with difficulties, such as those experienced by people with BPD, and the scientific evidence showing the evidence for effective treatments has been highlighted. Chapter Three will examine additional factors that impact on mental health professionals' attitudes and behaviours towards people with complex needs. As a background to describing the research undertaken for this project this chapter will also examine barriers and opportunities that contribute to whether clinicians are able to be effective service providers

CHAPTER THREE

BARRIERS TO EFFECTIVE PROFESSIONAL PRACTICE IN RELATION TO BORDERLINE PERSONALITY DISORDER – A REVIEW OF THE LITERATURE

In spite of research demonstrating positive treatment outcomes for people with BPD and government policies outlining the expectations that quality mental health services will be delivered, ongoing therapeutic pessimism towards this client group continues. Evidence of stigma and stereotyping by mental health clinicians has been outlined in Chapter Two, but, there are other areas of research that shed light on the factors that contribute to their responses to those with BPD. One of the most significant is the professional identity of mental health practitioners. This chapter examines the literature describing the nature of professional identity and the factors that influence its development. This is followed by an exploration of the literature surrounding relevant issues experienced by mental health professionals as they attempt to be effective service providers. The chapter will conclude by focusing once more on the issues specific to the person with BPD presenting for care and discuss the evidence that exists as to whether it is possible to change practice to enable a more effective response to people with BPD.

Identity development: Personal and professional identity

Beginning with the writings of James (1890 quoted in Neisser 1991)), theorists and researchers writing from psychological, psychodynamic and philosophical perspectives have explored and debated 'the self'. An exploration of a minute area of the psychological literature gives a glimpse of the complexity of the topic. Lewis (1991), for example, describes ongoing confusion about the use of the word 'self' and the complexity associated with attempts to conceptualize the notion. Arguably the earliest

conceptualizations of self were informed by essentialism: 'the claim that a single real authentic essence lies deep with each individual person (Neisser, 1991, p. 198), Such an approach, however, has been vigorously contested. In this vein, Lewis (1991) postulates that 'the self is not a unitary "thing", but a collection of aspects' (p. 234). He proceeds to discuss what he views as two major aspects of 'self' and to differentiate between subjective self-awareness and objective self-awareness. Subjective self-awareness being the capacity to focus on objects outside of ourselves, in contrast to objective self-awareness being when the person focuses inward upon themselves, i.e. 'we are the objects of our own consciousness' (Lewis, 1991, p. 234).

Likewise, Kagan (1991), suggests that the concept of self is both vague and challenging to research. He asserts that 'the qualities of self are multiply represented, that they are both conscious and unconscious, and that there is no unitary self' (p. 247). Neisser (1991) explores two aspects of self that he describes as previously neglected, i.e. the ecological self and the interpersonal self. Knowledge applicable to the ecological aspect of self is obtained through the individual's perceptions from the beginning of life of information that 'directly specifies their immediate situation in the environment' (Neisser, 1991, p. 199-200). The interpersonal aspect of self, the development of which arises from early infancy, is also seen as arising from perceptions resulting from social contact. 'People are often in social contact with one another...the ongoing interaction is evident in their mutual gaze and in the reciprocity of their gestures and vocalizations' (Neisser, 1991, p. 200). The development and functioning of the interpersonal self is seen as arising solely in the context of relationship with another (Neisser, 1991, p. 206).

Consistent with Neisser's descriptions of an aspect of self arising from interpersonal relationships are the writings of Axel Honneth, Professor of Philosophy at the

University of Frankfurt. He is described by Hardimon (1997, p. 46) as 'a central figure on the European philosophical scene, and perhaps the most prominent of the third generation of figures associated with the so-called Frankfurt School.' Honneth's (English translation 1995) social theory builds on the work of philosophers, Hegel and Mead, emphasizing the primacy of social relationships in the development and maintenance of a sense of self. He argues that a person's self-esteem and self-respect (both of these are identified as components of 'self') develop through his/her experience as it is reflected back from relationships with others. 'One's relationship to oneself, then, is not a matter of a solitary ego appraising itself, but an *intersubjective* process, in which one's attitude towards oneself emerges in one's encounter with an other's attitude toward oneself.' (Anderson, 1995, p. xii)

Honneth (English translation 1995, p. 79) incorporates within his theory Mead's conceptualization of 'self-respect' as 'the positive attitude towards oneself that one is capable of taking if one is recognized by the members of one's community as being a particular kind of person.' In developing his arguments for a sense of self that develops through relationship with the 'other,' Honneth (English translation, 1995) draws attention to a growing awareness within the psychoanalytic community, as illustrated by the works of Winnicott and Benjamin, that disorders such as BPD appeared to arise from 'interpersonal disturbances in the process of the child's detachment' (p. 97). Early experiences of 'reciprocal recognition' contributing to the development of a 'fundamental level of emotional confidence' are viewed as constituting 'the psychological precondition for the development of all further attitudes of self-respect' (Honneth, English translation, 1995, p. 107).

Honneth (English translation, 1995), thus identifies the development of an individual's sense of self as beginning with the earliest experiences of 'reciprocal recognition' and

this process continues in the context of a process of identification with others. Initially, this can be seen as occurring in interactions with primary care givers. As the individual develops, however, interactions with others involve an expanding network of social interactions and contexts. From this point, social psychology then provides a vast literature describing and theorising about the ways in which groups function to develop and modify an individual's identity and influence behaviour.

From a functionalist perspective, one of the main tasks of social groups is to provide members of the group with a social identity and a means by which group members can compare and evaluate their standing and functioning in the society in which they live (Tajfel & Turner, 2001). More recently, Van de Mieroop (2007) has suggested that 'anthropological and social constructivist insights have contributed to reinterpreting the conventional view of identity as a stable and consistent concept and adjusting this to the idea that it is an emerging and changing construct' (p.1120-1121). He further suggests that this idea has become a 'truism within the field of discourse studies' while acknowledging the complexity of identity as 'an extremely complex construct' (p. 1121).

For the purposes of this discussion, the focus will be primarily upon the groups of individuals that identify as professionals. Professional bodies are one of a large array of groups with which individuals may align themselves. Adams, Hean, Sturgis and Macleod Clark (2006) suggest that

> Professional identity as one form of social identity, concerns group interactions in the workplace and relates to how people compare and differentiate themselves from other professional groups...described as the attitudes, values, knowledge, beliefs and skills that are shared with others within a professional group and relates to the professional role being undertaken by the individual (p. 56).

Attempts at distinguishing between groups of individuals whose work in society defines their standing have resulted in labels such as professional, tradesperson, blue collar worker, and so on. As the focus of this exploration is on professional identity, for the purposes of this discussion, a profession is defined as

> an occupational group that is largely self-regulating. Such a group has the legitimate authority (usually delegated from government) to set its own standards for entrance, to admit new members, to establish a code of conduct, to discipline members and it claims to have a body of knowledge (achieved through education) which legitimizes its autonomy and distinctiveness (Drislane & Parkinson, 2002, on-line).

Fitzgerald and Teal (2003) describe professions as 'social entities, characterised by human behaviour of individuals with different levels of association and affiliation with their professions and the organisations in which they work' (p. 11). Claims as to the ways in which that knowledge will be utilised and how members of the particular profession will practice their social function are integral to the concept of professional identity. It is of interest to note Tajfel and Turner's (2001) suggestion that the aim of differentiation between groups is to 'maintain or achieve superiority over an out-group on some dimensions' (p. 102) and that this differentiation is essentially a competitive act. The significance and importance accorded to professional identity is illustrated graphically by Cohen (1981, p. 177 quoted in Adams et al, 2006, p.56) who writes: 'Our society permits subordinating all other relevant roles to the professional identity. The higher the status of the profession, the more this process of subordinating all other relevant roles will be allowed.'

Discussions within the literature regarding the professional identity of mental health clinicians are extensive and broad-ranging. Difficulties arise, however, when attempting an exploration of the literature on professional identity relevant to this

project. While participants in the project could be broadly described as 'mental health clinicians/professionals', the sample was drawn from five separate professions within mental health, i.e. psychiatry, social work, psychology, occupational therapy and nursing. Significant differences exist between the ways in which each of these professions promotes the development of professional identity and the strength of that identification (Norman & Peck, 1999; Peck & Norman, 1999).

British researchers, Peck and Norman (1999), have examined in some depth the traditional roles, interprofessional role relations and the impact of these differences upon community mental health team functioning as marked changes have occurred in mental healthcare delivery in the United Kingdom. The differences between the various professional groups are seen as arising from the different values and culture underpinning each profession. 'These differences originate in professional training and are maintained subsequently by socialisation' (Peck & Norman, 1999, p. 231).

The medical profession historically has a strong sense of professional identity and an extensive process of socialization and professional development. Many members of the profession continue to see an integral component of their role throughout their career as including the mentoring and educating of junior colleagues. In an age of increasing specialization within specialities, however, issues of shared professional identity within psychiatry have been raised. Hollins (2004) explores issues of identity by asking what psychiatrists do best, suggesting that skills unique to psychiatry play an integral part in the effective functioning of the multidisciplinary team. She comments '...within multidisciplinary health care teams we will probably be the only expert diagnosticians and the only discipline able to consider the possible physical causes of our patients' symptoms..' (p. 401).

Australian researchers, Fitzgerald and Teal (2003), describe at some length the differences among the professional subgroups or occupational subcultures within the medical profession, noting the marked differences between two groups providing care in a public hospital in Sydney. According to this research, marked tensions were noted when examining the ways in which two subgroups, visiting medical officers (VMOs) and staff specialists employed directly by the hospital, interact with the organisation. These differences are such that the researchers suggest that for change to be successful, managers 'need to have an understanding of professional identity constructs' (Fitzgerald & Teal, 2003, p. 18). Observations of a collaborative approach among nurses, allied health professionals and staff specialists and younger VMOs was cited as evidence that previously strongly held professional boundaries are less apparent.

A UK study conducted in London provides a snapshot of inter-professional role relations and professional identity as described by allied health professionals. Psychologists, social workers and occupational therapists are largely in the minority in both inpatient and community mental health staff. Peck and Norman (1999) identify a distinct social work culture that is nevertheless, under threat with changes in community mental health care in London. 'Social workers, usually out-numbered by health care colleagues, are obliged to defend their position, or compromise in ways that threaten to undermine the social work culture' (Peck & Norman, 1999, p. 237). Psychologists, on the other hand, although a minority have 'managed to differentiate themselves from other members of the CMHT (*community mental health team*) and to guard their specialist skills and special status' (Peck & Norman, 1999, p. 237). Within this same sample, occupational therapists were noted as being 'positive about their professional identity, but *(felt)* feel misunderstood and undervalued by other mental health care professions' (Peck & Norman, 1999, p. 238).

In direct contrast to the strong sense of professional identity articulated by the majority of members of the medical profession, nursing's identification as a profession is relatively recent. The transition from apprenticeship-style training to university based education commenced in the 1980s in Australia. 'In nursing there has been a development away from a profession almost entirely dominated by its neighbouring medical profession. This development has been expressed in the struggle for higher professional independence..' (Sundin, 2001, on-line). Mental health nursing initially involved a separate training from general nursing. With the shift to university based education, however, mental health nursing was subsumed within general nursing at least at the undergraduate level. The existing ageing mental health nursing workforce consists of a diverse range of nurses, some of whom do not have specialist qualifications... 'alongside those who completed a specific programme specializing in mental health at either a pre-registration or post-registration level' (Happell, 2006, p. 155) The debate in Australia as to what constitutes a mental health nurse (i.e. professional identity) continues to rage within mental health nursing literature (Happell, 2006; White & Roche, 2006). In the UK however, the shift to professionalization for community psychiatric nurses has proceeded much more rapidly. Godin (1996, p. 929) describes professionalizing strategies such as credentialling and legalism within community psychiatric nursing commencing in the 1970's. This is in marked contrast to Australia where the credentialling process for mental health nurses was launched in 2004 and has gained momentum in 2007 with the 100th credentialed mental health nurse celebrated (Australian College of Mental Health Nurses, 2007).

In a time when collaborative multidisciplinary teamwork in mental health care is the focus of policy makers, mental health nursing continues to struggle to create a professional identity separate from psychiatry. This struggle is well illustrated by an

emotive article by American nursing academics, Hogan and Shattell (2007). They reject the perceived role of mental health nurses as dispensers of medications prescribed by psychiatrists and ask, 'Have we given up the right to practice psychiatric mental health nursing by bowing to the biological interventions of psychiatry?' (p. 436).

As this discussion suggests, issues of professional identity and the strength of identification within professions varies markedly. This trend was also evident in the participants involved in this project. Nevertheless, they all shared a common role - that of therapist. Kottler (2003) describes the term therapist as the 'generic term for counsellor, social worker, psychologist, psychiatrist, family therapist, mental health worker, psychiatric nurse' (p. 3). Again, a vast professional literature explores issues related to identity as a therapist. Historically, dispute and debate among members of various therapeutic traditions have created divisions among therapists. Jung's rejection of Freud following his questioning of some of Freud's theories is perhaps the most well known of these disputes (Nagari, 2002). In Australia, the ongoing divisions among schools of therapy has recently come under scrutiny as a broadening of the distribution of Medicare funding for the provision of mental health services has resulted from reforms to mental health policy. A clinical governance initiative, the Psychotherapists and Counsellors Federation of Australia (PACFA), was established in 1998. The purpose of this organisation was threefold: to establish recognised standards for training, develop professional accountability and public protection and regulate therapeutic practice. PACFA has sought to draw 39 different associations together under the one umbrella with a focus on commonalities instead of differences (Psychotherapy and Counselling Federation of Australia, 2007). Likewise in the research literature a focus on identifying therapist qualities and behaviours that contribute to effective therapy in contrast to debate as to the particular type of

therapy has become apparent (Horvath & Symonds, 1991; Kottler, 2003; Kottler & Carlson, 2005a; E. Spinelli, 2008).

Literature discussing the development of professional identity as a therapist is sparse. Practice as a therapist is on the whole a solitary pursuit, with therapist and client engaged in therapy behind closed doors. 'Confidentiality, and therefore privacy, is an implicit part of the encounter...' (Kottler, 2003, p. 3). Halunka (Kottler & Carlson, 2005b) describes her training as a therapist where a strong emphasis was placed on remaining detached from the client. 'Any mention of the therapist benefiting from the therapeutic relationship implies unscrupulousness by the therapist. The paramount message is that the therapist is not to benefit from the relationship...' (p. 214). However, an emerging literature describes the experience of being a therapist and the changes that arise within the therapist through the process of providing therapy (Kottler & Carlson, 2005a, 2005b). Kottler and Smart (2006) recently reported upon interviews with twenty-three prominent therapists exploring the impact of the 'client who had changed them most'. Therapists interviewed identified profound shifts in their way of being in the world.

This brief review has highlighted the complexity of the concept of professional identity reinforcing Van de Mieroop's (2007) assertion that identity is not only a complex construct but also one that is changing. Exploring the complexity of the differences among the professions and within the different professions is of particular relevance, as repeatedly, attention is drawn to the changing nature of health care within Australia. Particular attention is given to the importance of clinicians having an ability to work collaboratively as members of a multidisciplinary team. Clearly, autonomous professional practice where little attention is given to collegiality is ineffective in an environment where the focus is on team work. Fitzgerald and Teal (2003) describe

differences in the ways particular professional groups may adapt to change, highlighting the importance of an understanding of 'professional identity constructs, which are central to the possibility of social bonding and interdependence required through health reform' (p. 18). Further support for Van de Mieroop's (2007) assertion of the changing nature of identity is found in Fitzgerald and Teal's (2003) concluding remarks '...received notions about the system of professions and fixed professional identities, and occupational culture is due for re-evaluation' (p.18-19).

At both a state and federal level, Australian government policies focus on improving mental health services. As has been outlined previously, the most recent government policy (Council of Australian Governments (COAG), 2006) draws attention to measures planned to address barriers to effective service provision, workforce shortages and to enhance professional development opportunities for clinicians. These new initiatives promise opportunities for mental health professionals with increased funding now available for further professional development and potential for alternative modes and places of practice. However, as briefly outlined in the previous chapter there are significant barriers to effective practice and they create ongoing challenges for clinicians. Under funding and staff shortages are particularly significant. Yet the very nature of the work required imposes further specific demands and challenges upon clinicians. Mental health professionals are daily confronted with the suffering of people who have experienced all manner of traumatic events in their lives. Todd (2007) states that 'listening and working with clients who have experienced traumatic events in their lives can and does impact on counsellors' professional and personal lives. Intense emotional reactions can emerge after hearing clients' traumatic experiences.' (p. 44). Kottler (2003) describes the intensity of the work thus: 'The experience of any practitioner would attest to the emotional as well as the intellectual strains of living constantly with clients' crises, confusion and intense suffering' (p. 2).

A range of terms describing the impact of caring upon mental health professionals appears in recent psychology, psychotherapy and medical literature. Among them are, most notably, compassion fatigue, burnout and vicarious traumatisation. Compassion fatigue has been described as a secondary traumatic stress reaction that can result as the consequence of knowing about another person's trauma or suffering and wanting to relieve that suffering (Figley, 2002). Rupert and Kent (2007, p. 88) describe burnout as a term 'widely used to refer to negative reactions to ongoing work-related stresses and emotional demands, particularly those experienced by human service professionals.' Vicarious traumatisation, as identified by Pearlman and Saakvitne (1995a), is defined thus:

> The inner transformation that occurs in the inner experience of the therapist (or other professional) that comes about as a result of empathic engagement with clients' trauma material (p. 31).

Vicarious traumatisation refers 'to the cumulative effect of doing trauma work across clients and to its pervasive impact on the self of the therapist' (Pearlman & Saakvitne, 1995b). It is now recognised as 'inevitable' when clinicians work with the difficulties and distress that people bring with them (Morrison, 2007). 'Risking exposure to vicarious trauma is an inherent part of the process when working with traumatized persons' (Sprang, Clark, & Whitt-Woosley, 2007).

> Research has also found that counsellors with a higher percentage of sexual assault survivors in their caseload reported more disrupted beliefs, more PTSD symptoms, and more self-reported vicarious trauma (Morrison, 2007, p. 5).

These findings have particular relevance given that research reveals a significant percentage of people with BPD have a history of traumatic events including sexual, physical and emotional abuse and neglect (Zanarini et al., 1997).

These difficulties are not unique to counsellors or psychotherapists. Taylor and Barling (2004) identify work-related problems for mental health nurses that are seen as contributing to carer fatigue (compassion fatigue) and burnout. These include the problems resulting from an under-resourced and short staffed public mental health service as well as difficulties associated with the nature of the work such as the 'nature of chronicity, concern for clients, unpredictability' (p. 120). Likewise, mental health nurses surveyed in Melbourne public mental health facilities reported high levels of stress particularly in the areas of emotional exhaustion and depersonalization (Happell, Martin, & Pinikahana, 2003). Fischer, Kumar and Hatcher (2007) identify a number of studies reporting on psychiatry as a stressful profession, with psychiatrists experiencing higher levels of emotional exhaustion, burnout and suicide than other medical disciplines.

Recent literature thus identifies a high personal cost of caring as experienced by mental health professionals. It is not an unreasonable conclusion to draw that the nature of the work, that is, working closely with suffering and troubled people, and the context within which this work is undertaken both contribute to less than effective care received by people who access mental health services.

The difficulties with emotional regulation and interpersonal relationships that are at the core of the suffering experienced by people with BPD are some of the factors that contribute so strongly to the often times rejecting, highly emotional and unprofessional responses from mental health clinicians. Wright, Haigh and McKeown (2007) bluntly emphasise this situation thus:

> However we care to define or make sense of it, the particular
> behaviour that typically leads to a personality disorder diagnosis is

likely to challenge and frustrate care staff engaged in attempts at therapy (p. 244).

Why then offer treatment?

Chapter Two provided an overview of health professionals' response to people with BPD including a high degree of therapeutic pessimism, stereotyping and often times hostile countertransference. Clearly these are people who present many challenges for clinicians and who may provoke anxiety and rage in staff. Given these extreme difficulties, a broader understanding of why treatment should be offered follows. National imperatives mandate that evidence based treatment be offered. As previously discussed, the degree of suffering associated with the condition suggests that an empathic response and effective treatment are required from clinicians. Reinforcing this expectation, Hazelton (2004) has argued persuasively for the adoption of human rights as a paradigm for mental health nursing practice. The basic human rights of each person in our community require at minimum mental health care that is effective and respectful. According to the United Nations (Principle 1.1, 1991) 'all persons have the right to the best available health care, which shall be part of the health and social care system'.

The founder of the Centre for Values, Ethics and the Law in Medicine at the University of Sydney speaking at the Australian Health Care Summit in 2003 asked, 'is this a society where I and my loved ones, in our time of trouble, can be sure to access care which is compassionate, thoughtful and appropriate? (Miles, cited in Little, 2003, p. 434), Johnstone (2001, p. 208) states emphatically, 'we all have a moral responsibility to question and call into question the status quo.' Addressing the moral injustice inherent in the stereotypical responses of many mental health professionals towards

people with BPD is essential if mental health services are to provide the care of which Miles spoke.

Aside from humanistic and moral imperatives to seek ways in which to relieve the suffering experienced by people with BPD, it could be suggested that the increasing need for cost containment and careful use of scarce resources provides a further rationale for pursuing effective treatment. People with BPD comprise some of the highest users of mental health services. As noted in Chapter Two, Australian researchers (Stevenson et al., 2007) suggest that 40 to 60 percent of patients in mental health inpatient units have a co-morbid personality disorder. Arguing for the use of evidence based therapies that have been shown to be effective for people with BPD, Gabbard (2000) suggests that if regular effective outpatient therapy is not provided, these people will still seek treatment. 'They are a highly treatment-seeking population and will one way or another find access to the health care delivery system'(p. 5).

In a review of the economic impact of psychotherapy Gabbard, Lazar, Hornberger and Spiegel (1997) reviewed 18 studies that had investigated the impact of therapy upon health care costs. Both studies by the Linehan group (1991; 1993) and Stevenson and Meares (1992) were identified as demonstrating that psychotherapeutic interventions resulted in significant cost effectiveness. Just as these studies indicate that delivering 'talking' cures appears to show effective cost savings, they also 'indicate ...a substantial cost in *not* providing the mentally ill with adequate psychotherapeutic support, not only in human terms but also in economic terms' (Gabbard, et al.1997, p. 154).

More recently, Bateman and Fonagy (2003) evaluated the health utilization costs and savings associated with the psychoanalytically oriented partial hospitalization treatment program offered in London. Costs associated with providing the treatment were found to be offset by the savings achieved as a result of a reduction in inpatient and emergency room treatments. As previously discussed, the suffering of individuals with BPD is often under estimated. Fonagy and Roth (2005) argue that the effect upon the wider community through the social impact of this disorder also warrants a continued focus on research to evaluate effective treatments.

Although the development of effective therapies such as DBT offer significant opportunities for mental health professionals to enhance the service provided for people with BPD, Wright et al. (2007) strongly assert that training in therapeutic approaches will ultimately be futile unless attention is first given to addressing the attitudinal difficulties that inhibit the development of a therapeutic relationship:-

> ...deconstruction of damaging representations and associated reclamation of the common humanity in our clients should be a core element of practitioner training and education. If it is not, therapeutic interventions which show promise in research studies may prove relatively useless in routine practice, and the policy goal of inclusive services will not move beyond mere rhetoric (Wright et al., 2007, p. 244)

Thus, while there is a need for ongoing evaluation of the efficacy of existing therapeutic approaches, of equal importance is a focus on addressing the continuing therapeutic pessimism that continues to pervade mental health services.

Changing Practice – Possible or Not?

The use of DBT is now well-established as a therapeutic modality within the area mental health service in which this research was conducted. Some evidence exists to suggest a positive impact on outcomes for some clients with BPD. Does this therapy also offer a means for impacting on the therapeutic pessimism that is evident? While arguing for effective care for people with BPD, it is important to avoid blaming mental health professionals or ignoring the impact upon clinicians of attempting to work with such challenging behaviours. Clinicians beginning DBT training described their experience of working with those with BPD. They spoke of 'feeling like we are making no difference' and described their treatment interactions with these clients as 'making us feel like we don't care'. Some reported that their interactions with those with BPD 'bring out our own worst features' (Hazelton et al., 2003).

Increased levels of burnout and stress associated with work with people with severe BPD are identified clearly throughout the literature. Fraser and Gallop (1993) suggest that the challenging and difficult behaviours associated with treating BPD contribute to the negative feelings that many clinicians experience. They report that 'patients may fail to validate the therapeutic role of the nurse by rejecting help offered, *(and)* engaging in behaviours that are difficult to manage on the unit', thus provoking the negative stereotypic reactions that are frequently observed (p. 336). Hinshelwood (1999) also suggests that the behaviour of people with severe personality disorders directly contravenes a basic premise of many clinicians' understanding of their work, that is, they are engaged in helping those unable to help themselves. In eschewing the view of the clinician as helper, the person with a severe personality disorder inadvertently challenges the clinician's view of him/herself with the result often being that described as 'negative transference'.

Providing effective evidence based treatment is clearly required, but the challenge remains. How do public mental health services implement such a treatment in the face of the stigma and stereotypical views that are so pervasive? What evidence exists for effective means of changing practice?

Recognition of the crucial need for enhanced service responses to clients with BPD is increasingly validated by the appearance of models such as the 'The Personality Disorder Capabilities Framework – Breaking the Cycle of Rejection' (National Institute for Mental Health in England, 2003). Designed to identify the capabilities required of staff to be able to work towards 'ending the marginalization of services to people with this deeply stigmatizing diagnosis' (National Institute for Mental Health in England, 2003, p. 4), the framework seeks to address the current deficits in care. These deficits are attributed to the lack of an 'explanatory framework for the challenging behaviours...or the skills to address these behaviours effectively' (National Institute for Mental Health in England, 2003, p. 7).

In New Zealand, a comprehensive discussion document developed to address the deficits in care for people with BPD was tabled (Krawitz & Watson, 1999). One of many issues identified as important is workforce training. The discussion document suggested that at a minimum, 40% of all mental health staff should receive basic training such as the two-day program developed by Krawitz (Krawitz & Watson, 1999). This training is described in later papers by Krawitz (2001; 2004, p. 554) and includes education that outlines 'current concepts of the diagnosis, aetiology, prognosis and treatment of BPD, combined with detailed discussions of the principles of treatment in the public setting.' The discussion document recommended that additional training to assist clinicians to develop skills in delivering treatment programs be provided for 20% of staff, especially those working in key areas such as on crisis teams (Krawitz &

Watson, 1999, p. 60-61). Of the several treatment models recommended, two approaches, DBT and Meares' self-psychology (Conversational Model), a psychodynamic therapy, are currently accessible in New South Wales.

Australian research identifying the difficulties that clinicians experience in treating BPD, and models for facilitating a change in practice, is sparse. Cleary et al. (2002) have reported on the results of a survey tool (not yet validated) designed to assess the experience, knowledge and attitudes of mental health staff regarding clients with BPD. Of 516 surveys distributed, 44% were completed (n=229). Conducted within a public health service in Sydney, results reveal staff members' perceptions that not only are clients with BPD difficult to treat, but existing treatment is seen to be inadequate. Respondents believed this to be the result of 'a shortage of services, the perception that the clients themselves are difficult to treat, and a lack of training and/or expertise' (Cleary et al., 2002, p. 189).

Negative attitudes, punitive behaviours and rigid beliefs were likewise apparent towards people with BPD within the area health service in which this research was conducted. In a focused attempt to address the deficits identified in the treatment of people with BPD, extensive preparation and planning over 12 months resulted in a project designed to introduce and evaluate the efficacy of an empirically based treatment for BPD in a standard public mental health service. To improve the prospects of changing practice, a project evaluating the education program conducted prior to the implementation of treatment was also undertaken. Using the research instrument developed by Cleary et al. (2002), participants were surveyed and then focus groups were conducted prior to commencing the training (Rossiter et al., 2003). A pervasive therapeutic pessimism was apparent. BPD was seen as basically untreatable. Respondents felt that it was futile to treat such frustrating clients. The

difficulties encountered by mental health professionals are starkly reflected in this quote:

> I guess my role is to try and...minimize self-harming somehow and ensure that the patient takes responsibility for their actions and to kind of minimize your reaction to their self-harming...I think I can certainly do it a lot more effectively if I knew what the hell I was doing.

Within this statement lies a potential key to addressing some of the current deficiencies in treatment. Indications exist that many mental health professionals are responsive to training designed to improve services for people with BPD. Cleary et al. (2000, p. 190) reported 95% of respondents perceived a need for further education or training and suggest that the results 'endorse the need for further service development and continued education, as well as research to improve current clinical practice.' Deans and Meocevic (2006) describe a majority of the psychiatric nurses surveyed in their research as expressing clearly that they felt unable to, or did not know how to, care for people with BPD.

Australian resources also reflect the fragmented and ad hoc nature of service development for people with BPD. A search for Australian models for training designed to educate staff about BPD and to facilitate the development of skills for more effective treatment of such clients, reveals a paucity of information. The only example of a statewide service is found in Spectrum, the Personality Disorder Service of Victoria that targets the care of people with personality disorders in that state. This service provides training programs in conjunction with consultancy services to mental health services. Krawitz (2001, p. 25) describes 'the development and delivery of a brief workshop on BPD for public mental health clinicians' delivered widely throughout Victoria and New Zealand. The content of the workshops includes a comprehensive overview of aetiology, treatment outcomes, consumer perspectives and medico-legal

and clinical risk-taking issues. Krawitz's (2001) initial limited analysis cited numerous requests for training, well-attended workshops and participants' enthusiastic response as evidence that public mental health professionals are eager to learn (p. 28).

A later comprehensive evaluation of the impact of the Spectrum-developed workshops identified a durable, positive attitudinal shift for participants attending the two day workshops conducted in Victoria (Krawitz, 2004). Workshops were attended by clinicians from public mental health services and drug and alcohol services. Reporting on results from 418 participants (62% of total attendees) who completed pre- and post-training, and 6-month follow-up surveys, Krawitz (2004) notes that 'the statistically significant improvements in clinicians' attitudes and perceptions of skill and knowledge at time 2 were maintained at time 3' (p. 556). According to Krawitz (2004), the large sample size was a strength of this study, compared with the unvalidated survey. Accordingly, it provides strong evidence of the usefulness of targeted training specifically designed to address the deficits in clinical knowledge and influence attitudes in clinicians working with clients with BPD.

Krawitz and Jackson (2007) recently published a pilot evaluation of training for mental health clinicians on borderline personality disorder that was co-led by a clinician and a consumer with BPD. Findings suggest that the inclusion of a consumer as co-leader in the training team resulted in the training being rated as superior to the results reported in the previous paper (Krawitz, 2004).

A different focus is apparent in a report on an initiative undertaken at Griffith University in Queensland to introduce a nursing course entitled 'Self-harm and therapeutic responses' (McAllister & Estefan, 2002). The course identifies as its focus, self-harm, a behaviour often associated with BPD but not unique to that condition.

Linehan's DBT (1993a; 1993b) appears to be the therapeutic model for understanding self-harming behaviours. From such a perspective the concept of dialectics is described as a 'key concept learned and reiterated throughout the course' (McAllister & Estefan, 2002, p. 579).

In Tasmania in 2003, a resource developed to enable general practitioners (GPs) to be able to provide more effective care for people with BPD was released (Southern Tasmanian Division of General Practice). Significantly, it reminded GPs of the limitations of public mental health services in providing appropriate treatment for all who meet the criteria for BPD. Where referrals to private services are considered, GPs are urged to check the interest and skill levels of the chosen professional. Anecdotally, education and support for staff within public and private mental health services within Tasmania is currently extremely limited (Pearson, 2003).

A wider search has revealed two potential sources of interest related to influencing clinicians' attitudes towards those with personality disorders. Bowers' (2002) comprehensive report describes work to identify 'the factors underlying and maintaining nurses' positive therapeutic attitudes to patients with severe PD, in order to inform a support and training strategy to nurture such attitudes' (p.30-31). This report refers specifically to nurses working within three English High Security Hospitals (n=2,503). Their clients were diagnosed as having dangerous and severe personality disorders (DSPD). Despite the extreme nature of the behaviours exhibited by these clients, the reports noted that some nurses have a positive attitude towards clients and were able to maintain their optimism and morale.

Bowers (2002) extrapolates his findings to general psychiatry. He suggests the 'rejecting attitude' found in general community and inpatient psychiatry staff is a

function of their psychiatric philosophy, moral commitments and cognitive-emotional self-management mechanisms (p. 157). Importantly, Bowers (2002) suggests that negative reactions to people with personality disorders are 'normal' and to be expected given the extremely challenging behaviours they exhibit. Consequently, nurses displaying these attitudes should not be blamed. Rather, he proposes that 'what should be encouraged and supplied, is education, supervision, challenge, development and growth' (p. 149). These findings suggest, as Bowers (2002) does, that all disciplines dealing with people with personality disorders 'require a thorough grounding in psychological models of the condition...*and the* skills and knowledge to choose from a range of effective responses to challenging behaviours' (p.150-151).

In a similar vein, Fraser's (2001) unpublished PsyD thesis reports on a project evaluating the impact of a 4-hour workshop on DBT upon the negative attitudes held by mental health professionals towards individuals diagnosed with BPD. Using a revised version of the Attitude Assessment Questionnaire developed by McIntosh (1998), 60 participants (all Masters level certified professional counsellors and social workers employed in a publicly funded mental health agency in Arizona) were surveyed. Thirty participants attended the 4-hour workshop on DBT. All participants were resurveyed one month post training. Fraser's (2001) results indicate a significant improvement in both attitude and willingness to treat people with BPD in participants attending the workshop.

The self-identified limitations of Fraser's study (2001, p. 88-90) mainly involve the use of an unvalidated instrument and the primarily white, Anglo, female composition of the group. A further limitation cited is the lack of information as to the durability of the positive changes. Given the extremely challenging nature of providing therapy for people with BPD, it could be suggested that the provision of a 4-hour workshop alone,

without additional training and ongoing support, makes these changes unlikely to persist. Fraser (2001) suggests future studies might focus on educational strategies to enable clinicians to more effectively develop a therapeutic relationship with clients with BPD, extending the variety of participants attending the program and measuring longer-term effects (p.93-95).

Clearly, there is a need for focused strategies to improve the management and treatment of people with BPD. Recommendations that could usefully inform projects targeting this area of concern have been outlined by a number of authors, including Bowers (2002). Yet there is a paucity of literature describing evaluated and effective training programs designed to improve attitudes and practices of mental health professionals working with people with BPD. Of those that have been reported only two (Fraser, 2001; Krawitz, 2004) describe an in-depth evaluation. However, the measurement tools employed have not been validated. In Fraser's (2001) work the durability of the improvement has not been evaluated.

Repeatedly throughout the literature the difficulties that staff and consumers experience are described. Suggestions as to what is needed, education, an effective and coordinated team approach and clinical supervision, are consistently proposed over decades of literature and yet the difficulties persist. Thus, research to develop effective education programs specifically designed to influence attitudes, knowledge and experience of mental health professionals towards people with BPD, and to rigorously evaluate the impact of these programs, is urgently required.

A Tool for Changing Practice?

A number of authors have described suggestions for improving clinicians' attitudes, knowledge and behaviours towards people with BPD. Suggestions for assisting

clinicians to improve inpatient care of people with BPD include the need to identify clearly the goals of treatment, provision of in-services for staff members, regular supervision and regular staff meetings (Johnson & Silver, 1988). Bowers (2002) highlights the importance of focused psychoeducation for clinicians in conjunction with a supportive team environment and regular clinical supervision. In reporting on a phenomenological study exploring the experience of nurses providing inpatient care for people with BPD, O'Brien and Flote (1997) make a number of recommendations designed to address the difficulties experienced. They point out that, 'nursing staff caring for people with BPD need the support of cohesive, supportive teams that have comprehensive models of care in place, and need to have adequate education and ongoing supervision' (O'Brien & Flote, 1997, p. 145). Furthermore, they suggest that all staff working with clients with BPD, including nurses, should be able to access clinical supervision similar to that provided within traditional psychotherapeutic models of therapy. The implementation of these recommendations is further reinforced by predictions of the likelihood of a continuing lack of suitable care without changes in practice. O'Brien (1998, p. 181) strongly asserts that a failure to adequately provide comprehensive treatment programs for people with BPD will 'result in the continuation of reactive responses that are ineffective, expensive and cause considerable occupational stress'.

In the light of the research to date on directions and strategies for dismantling the barriers to effective practice in managing and treating BPD; it is clear that we need to ask if the use of DBT as a treatment model meets the needs of clinicians for education, support and supervision. It has been suggested that Linehan's focus in developing DBT has not been restricted to developing an efficacious therapy for people with BPD. Rather, as Swenson (2000) has pointed out:

Linehan has from the beginning aimed explicitly to engage the mental health treatment community in changing its attitudes and practices towards this oft misunderstood and maligned client group (p. 88).

The DBT structure has all the ingredients required for improving practice as described above and is consistent with Roth and Fonagy's (2005, p. 484) assertions that successful approaches for treating BPD 'emphasize the importance of structure' and have a 'coherent theoretical base' (p. 484) The biosocial theory of BPD provides an understanding of the aetiology of this disorder that enables clinicians to move from a view of the person as 'bad' to that of someone who has missed out on the opportunity to develop the skills to regulate painful emotions. Accordingly, DBT is based on assumptions designed to challenge punitive clinician behaviours towards clients. For instance, one of DBT's major tenets is that the person is doing the best that they can. Further, clinicians are supported to adopt an optimistic stance towards client difficulties. A highly structured process that provides support for both clients and clinicians is a hallmark of DBT. The treatment includes individual therapy, skills training and phone coaching supporting the client as they progress through a very challenging therapy process. Weekly group supervision/consultation in which the group applies DBT to the therapist is designed to 'hold the therapist inside the treatment' (Linehan,1993a p. 101). This provides a space in which clinicians can reflect upon their use of self as a therapeutic tool and examine the impact of their own reactions upon the therapeutic relationship. . One of the primary functions of clinical supervision is to provide a space that allows or encourages 'reflective practice'. Hawkins and Shohet (1989) describe this as the provision of a 'regular space for the supervisees to reflect upon the content and process of their work' (p. 43). A participant in this study suggests reflective practice is a capacity to 'consciously reflect *(ing)* on who you are, how you're reacting and what you're doing' (R1: p.3).

Mantzoukas and Watkinson (2008) contrast reflective practice (RP) with evidence-based practice (EBP). They suggest that these terms constitute 'two very distinct and very different episteimologies, where reflection represents the contextual, subjective and explanatory type of knowledge and EBP the acontextual, generalized, unbiased and predictive type of knowledge' (p. 132). These authors argue that these two discourses are complementary rather than 'mutually exclusive as portrayed by most of the literature' (Mantzoukas & Watkinson, 2008, p. 129). DBT as an evidence-based practice promotes therapists' capacity for reflective practice as a vital component of the therapy. The inclusion of this regular consultation/supervision process recognizes the challenges of working with clients whose behaviour often provokes 'anxiety and rage' and whose sensitivity and vulnerability are easily provoked into escalating emotional distress.

While it is possible to argue the usefulness of DBT as a tool for changing practice and supporting clinicians in working with clients with BPD, little research exists exploring the usefulness of this therapy for this purpose outside of the specialist research unit staffed by highly trained DBT therapists. Hawkins and Sinha (1998) sought to examine whether clinicians in a public department of mental health in Connecticut could master the conceptual complexities of DBT. Using a formal examination format, 109 clinicians participated in the exam near to the commencement of training in DBT and again at or about 6 months after commencing training. The researchers report that their 'data indicates that a diverse cross-section of mental health clinicians were able to make considerable progress towards the acquisition of a sophisticated understanding of DBT' (p. 384). This result does not, however, indicate any change in practice or explore the professional or personal experience of clinicians using DBT as a therapy.

In a Swedish study, the only study of its kind to date (Perseius et al., 2003), the experiences of 10 clients who had participated in a minimum of 12 months of DBT and 4 therapists actively practising as DBT therapists were explored using a qualitative approach. The clients overwhelmingly described DBT as 'life-saving'. The therapists described their work as DBT therapists as positively changing their view of people with BPD. The importance of adhering to the model was seen as crucial to ensure success when using DBT. It was described as tough, hard work demanding that the therapist be consistently 'focused and engaged'. The impact upon the therapists' personal lives was also noted as indicated in the following comment: '...When I think about my private life and DBT, it has given me very much more than it has taken' (Perseius et al., 2003, p. 225).

Likewise in the area health service in which this research was conducted, an unexpected impact of the DBT implementation project commenced in 2003 was a number of statements from clinicians indicating the positive impact of learning DBT not only upon clinical practice but also upon their personal well-being. 'An unexpected finding...was the extent to which the...DBT training had had an impact on participants' personal lives' (Hazelton et al., 2006). Research by Perseius et al. (2003) supports the anecdotal evidence of a positive impact upon clinician well-being.

Conclusion

Borderline personality disorder is a disabling condition that permeates the daily lives of people experiencing it. At the same time, the literature reviewed above suggests that mental health clinicians involved in treating BPD face enormous difficulties, not the least of which is inadequate education and training. National directives, human rights concerns and a responsibility to practise ethically, in conjunction with constraints on the health budget, provide an imperative to implement evidence based practice.

Although recommendations for changing practice have been described in the literature for several decades, therapeutic pessimism and pejorative attitudes continue to pervade public mental health services. DBT has been described as a potential tool for addressing these difficulties because it proceeds from a strong theoretical basis and practice in which services are delivered to people with BPD in an optimistic manner. It is proposed that not only does training in DBT benefit the recipients of the therapy; it may also provide a means of supporting clinicians as they face both the professional and personal challenges of working as mental health professionals. In some cases it is possible that psychotherapeutic work, such as that entailed in the provision of DBT, also has broader health and wellbeing benefits for therapists.

CHAPTER FOUR
RESEARCH DESIGN

Overview of Research Design and Methodology

This project was informed by a phenomenological approach and employed a qualitative methodology in order to examine how mental health professionals experience learning and practising as dialectical behaviour therapists. Semi-structured in-depth interviews were employed as the method used for data gathering.

Theoretical perspective

A paradigm or 'theoretical perspective' is described as the philosophical stance that informs the methodology employed in a research activity (Crotty, 1998, p. 66). A phenomenological paradigm, as described in Heideggerian hermeneutics, underpins the approach taken to this research. Hermeneutic phenomenology is described as emphasizing the 'ontological over the epistemological' and, 'coupled with post modernist methodological leanings', is seen as residing 'within a constructivist/interpretive paradigm of inquiry' (Annells, 1996, p. 712). Fossey et al. (2002) describe interpretive methodologies as focusing 'primarily on understanding and accounting for the meaning of human experiences and actions' (p. 718). This study proposed to explore clinicians' 'lived experience' of learning and practising as dialectical behaviour therapists. Rather than seeking to develop a theory about this topic, the research sought understanding of clinicians' personal and professional experience as DBT therapists.

Pivotal to this approach is the concept of intentionality, described by phenomenologists 'as "the mind stretching forth into the world" and translating its stimuli into phenomenal objects' (Ernesto Spinelli, 1989, p. 12). This assumption

acknowledges the 'undeniable role of interpretation which lies at the heart of all our mental experience' (Ernesto Spinelli, 1989, p. 12). Mental experiencing is viewed as 'an individual's perceptions of his or her presence in the world at the moment when things, truths, or values are constituted' (Morse & Richards, 2002, p. 44) In existentialist terms, 'intentionality is a radical interdependence of subject and world' (Crotty, 1998, p. 45). Phenomenology further assumes 'that human existence is meaningful and of interest in the sense that we are always conscious of something' (Morse & Richards, 2002, p. 45)

A subjective stance is inherent within qualitative methodologies. It is thus appropriate to make clear the origins of my personal philosophical leanings that are grounded in existential phenomenology. Extensive training and practice in a number of therapeutic modalities, and thirteen years working as a nurse-therapist providing supportive psychotherapy for clients with chronic autoimmune diseases, has brought an increasing awareness of the value of understanding the 'lived experience' of both clients and clinicians. Exploration of the writings of a number of clinician authors (Frankl, 1986, 1997; Ernesto Spinelli, 1989, 1997; Yalom, 1980, 1989, 1992, 2002) whose work and practice is grounded in existentialism, has contributed to the stance adopted. Seven years training and practice as a DBT therapist, with the past five years immersed in both teaching and practice, further informs my current research focus.

My personal experience can be seen as providing a biased or perhaps highly subjective viewpoint of the benefits of DBT. This bias, based in both anecdotal and personal clinical experience, extends towards two areas. The first is that of DBT therapist and trainer for whom DBT has provided a positive means of working with clients who are very distressed. The second is an experience of DBT as a positive influence on the

negative attitudes frequently displayed by clinicians towards these clients. As a member of a multi-disciplinary, tertiary level mental health team involved in the delivery of DBT to people whose behaviours have previously frustrated and challenged other clinicians, I repeatedly hear high levels of enthusiasm and satisfaction expressed by my colleagues. My work as a clinical nurse consultant exposes me regularly to the negative attitudes and therapeutic pessimism expressed by mental health clinicians who have not had training or support in working with clients with BPD. This experience contrasts markedly with that of providing education and supervision for clinicians in DBT and noting with interest comments such as 'this training has changed my life'. Administrators and nurse managers also speak of a marked change in the therapeutic milieu following the implementation of DBT as the therapy available for clients with BPD.

Thus it was experience of the positive impact of practising as a DBT therapist upon professional and personal dimensions of my life and the lives of others that constituted a significant context for this study. As Minichiello and colleagues (1995) have commented, the research topic 'is posed in the context of previous work on the topic' (p. 45). Interestingly, such work has not included extensive research. However, an extensive literature review revealed only one limited study (Perseius et al., 2003) in which four DBT therapists describe the experience of training and practising as a DBT therapist (see Chapter Three). As outlined in Chapters Two and Three, the difficulties encountered by mental health clinicians attempting to work with clients with BPD are well documented (Book et al., 1978; K. Fraser & Gallop, 1993; Gallop, Lancee, & Garfinkel, 1989; Markham, 2003; Nehls, 1998). The prevailing culture within public mental health services towards this clientele can be seen as informed by a particular set of meanings that, while understandable, harbour their own form 'of oppression, manipulation and other forms of injustice' (Crotty, 1998, p. 81).

The paucity of research available in this area further justified the decision to employ a qualitative methodology. Similar studies exist exploring the lived experience of clients with BPD (Fallon, 2003; Nehls, 1999), and Spinelli and Marshall (2001) have employed a phenomenological approach in their exploration of the experience of a number of therapists from diverse schools of therapy. A phenomenological approach was also employed by O'Brien and Flote (1997) to explore the experience of nursing staff caring for a person with BPD in an acute inpatient unit. Kottler and Smart (2006) describe the outcome of research employing in-depth interviews where prominent therapists and theorists were asked to speak about the client who changed them most. Potential benefits of this have been suggested to include, 'the revelation of shared meanings;...the provision of multiple interpretations of the phenomenon; the unveiling of practices; the seeing of new ways of Being; commitment to understanding...' (Wilson & Hutchinson, 1991 quoted in Annells, 1996, p. 709). British researchers (Mackay, West, Moorey, Guthrie, & Margison, 2001), likewise employed a qualitative methodology, grounded theory, to explore counsellors' experiences of changing their practice with a focus of understanding individual experiences and to then develop a theory from that understanding that explains those experiences.

Methodology and Method

Qualitative methodology – 'The Phenomenological Method'

The phenomenological method is described as having three distinct, yet interrelated steps, or what Spinelli (1989) describes as 'rules'. These are the rules of epoché, of description and of horizontalization (or equalization).

The rule of epoché involves 'bracketing' initial biases and prejudices. The researcher puts aside assumptions and expectations. A researcher's ability to set aside his/her experiences completely and to be totally detached has, of course, been disputed by

numerous commentators including Heidegger (cited in Browne, 2004, p. 632). Spinelli (1989) suggests, however, that in some cases it *is* possible to bracket some biases and assumptions and that, 'even when bracketing is not likely or feasible, the very recognition of bias lessens its impact upon our immediate experience' (p. 17).

The rule of description, according to Spinelli (1989), requires that the researcher first describes his/her experience of being engaged in the research process, rather than proceeding immediately to interpreting, theorizing and explaining. Following this rule 'allows us to carry out a concretely based descriptive examination of the subjective variables which make up our experience'(Ernesto Spinelli, 1989, p. 18). This approach contrasts with the training of medical, allied health and nursing professionals in which the clinician assesses the 'patient' in order to develop a hypothesis and to formulate diagnoses for the purposes of treatment.

The rule of horizontalization (the equalization rule) requires the researcher to treat each descriptor 'initially as having equal value or significance' (Ernesto Spinelli, 1989, p. 18). As Spinelli explains:

> phenomenologists argue that if we are to embark on any worthwhile
> attempt to make sense...of our mental experience of the world, we
> must avoid making immediate misleading hierarchically based
> judgements.

A consistent attempt to use the phenomenological method has been described as bringing two distinct advantages to the conduct of clinical work and it could be suggested that these equally apply to qualitative research.

> The practice of the phenomenological method at the very least,
> minimizes our tendency to rely exclusively upon any one theory
> throughout the whole of our investigation...allows for theoretical

flexibility and 'open-mindedness' which is in keeping with the ideology
– if not the practice – of science (Ernesto Spinelli, 1989, p. 22).

Method

As distinct from quantitative research that seeks to make systematic observations, primarily through the use of statistical analyses, qualitative researchers collect data through 'participant observation, unstructured interviews and oral accounts' in order to identify themes apparent in the 'natural language of the participants' (Minichiello et al., 1995, p. 11). In choosing a qualitative methodology, a commitment is made to 'seeing the world from the perspective of the participants within that world, and to getting close to the participants' experience' (Simmons, 1995, p. 839). Consistent with the phenomenological construct and methodology that informed a qualitative approach in this study, data gathering was conducted by combining in-depth and semi-structured interviews. In the semi-structured interview, while the researcher sets the agenda and identifies the topics to be explored, 'the interviewee's responses determine the kinds of information produced about those topics and the relative importance of each of them' (Green & Thorogood, 2004, p. 80). In-depth interviews allow participants time to elaborate on the issues of importance to them within the context of the agenda. The interview schedule (see Annex G) was prepared for an independent interviewer employed specifically for this project to provide prompts for beginning the conversation.

Design and Nature of the Project

Sampling procedure

The potential sample for this study was limited. As the goal of the study was to interpret and understand the experience of clinicians training and practising as DBT therapists, a purposeful sampling was undertaken from medical, allied health and

nursing clinicians from within the southern region of a large public mental health service in New South Wales, Australia.

Given the small potential sample, a convenience sample, (i.e. those participants who were available and willing to participate) was used. The sample size sought was comparatively small. It was anticipated initially that the maximum number of participants would be no more than twenty because this was seen as sufficient to permit the degree of saturation required to enable identification of the key issues and themes expressed by participants in their accounts of the experiences of learning and practising DBT. Saturation, however, was reached by the time twelve interviews had been conducted. A thirteenth interview had already been scheduled, so a decision was made to proceed with it. Thus, the final number of interviews conducted was thirteen.

Sample Description

Participants ranged in age from 27 to 55 years of age. Of the thirteen participants, five were male and eight were female. As could be anticipated, participants were, with the exception of one person, university educated. Eight respondents held undergraduate degrees, three participants held masters degrees, with one of these also having a medical fellowship. One participant had a doctoral degree. The sole participant without a university education was educated through the TAFE (Technical and Further Education) system.

A broad spectrum of mental health professionals was represented in this sample as follows:

- One psychiatrist
- Four psychologists
    - One intern psychologist
    - Three clinical psychologists (one of these holds a doctoral degree)

- Three occupational therapists
- Three social workers
- Two nurses
  - One registered nurse
  - One enrolled nurse

All participants were employed by the one public mental health service in NSW Australia. This mental health service sits within one of eight area health services that compromise NSW Health. At the time of interview, six participants were employed in a multi-disciplinary, tertiary level mental health team that provides specialist services for people with borderline personality disorder, people with eating disorders and a limited number of persons with complex presentations outside of these two diagnostic groupings. This team is led by a director (at the time the research was undertaken the director was a clinical psychologist with a doctoral degree). The team is comprised of a psychiatrist, several psychologists, a social worker, an occupational therapist and a clinical nurse consultant. All members of the team work as therapists participating in the DBT program. Team members also participate in a wide range of other activities, including research, delivery of education programs, consultation to other parts of the area health service and consultation to other health services within New South Wales and to a limited area in Queensland.

A further six participants were employed in a semi-rural mental health service comprising a thirty-bed acute inpatient psychiatric unit and a community team largely focused on responding to acute presentations with a very small therapy team. This service is under the umbrella of the same area health service as the tertiary mental health service described above. Participants from this service were engaged in generalist mental health services and as such providing services to people with BPD was a component only of their work rather than the primary focus of service delivery.

The final participant worked across acute inpatient services and the tertiary referral service. All participants lived within the catchment area of the service in which they were employed at the time of the interview.

Experience working in the DBT model of therapy varied widely. The least experienced was a DBT therapist who had active involvement working in this model for six months but had over three years 'acquaintance' with DBT and familiarity with the DBT philosophical framework. The most experienced were clinicians who had practised as DBT therapists for six years. The average time working as a DBT therapist was 3.6 years.

Past experience working with other therapeutic modalities varied widely. These models included, cognitive behaviour therapy, narrative therapy, psychodynamic therapy (self-psychology) and solution focused therapy. Senior clinicians within the sample had a wide range of experience in a variety of settings, including working within an in-patient therapeutic community where a large percentage of people admitted met the criteria for BPD.

Those participants employed in the tertiary referral service had received focused training in the delivery of DBT and undertook an ongoing process of professional development, clinical supervision and consultation. A continuing focus on ensuring adherence to the model was in place. In 2000, this service had undertaken a self-initiated and directed program using Linehan's (1993a; 1993b) texts as the basis for developing their skill in the delivery of DBT. Four team members together with a clinician from a private mental health facility in Sydney, NSW then participated in the recommended training program delivered by Linehan's colleagues. This program held in New Zealand in 2000 and 2001 involved two five-day intensive workshops

(conducted six months apart) designed to support the implementation of DBT in the service.

An on-going process of consultation with Linehan's research program has continued from that time. Several team members (including the author of this thesis) have attended the DBT Strategic Planning Meeting held annually at the University of Washington, Seattle, USA. Written communication with DBT trainers in the USA has continued as a regular process of facilitating adherence to the model.

Careful attention has been given to replicating the DBT model as closely as is possible within a public mental health service. This replication has been achieved in all aspects with the exception of the provision of 24-hour contact with individual therapists. In this service, the phone consultation is provided via an on-call phone staffed by a roster of DBT-trained clinicians, all of whom are actively participating in the delivery of DBT. The on-call phone is available seven-days/week from 8.30am until 10.00pm.

Within the semi-rural mental health service a focused two-day training program was delivered to 100 clinicians in that area with the broad aim being to support the development of a DBT program in the service. Of those 100 clinicians, 25 self-selected to undertake a further two-day training program and then attend weekly training sessions to further develop their therapeutic skills. An evaluation of this program was published in Contemporary Nurse (Hazelton et al., 2006). A core group of clinicians then proceeded to participate as either individual therapists or skills trainers in the DBT program implemented in the service. The trainers for this program included the clinician from Sydney who had undertaken the Linehan developed training program in New Zealand, the author of this thesis and two other clinicians from the tertiary referral service. Consultation and supervision to this program was

provided for a further two years by clinicians from the tertiary referral service. Adherence to the model in this setting was as complete as possible within the constraints of an under-funded public mental health service. The phone consultation component was the most challenging component to deliver. Individual therapists were available to their individual clients during business hours, outside of business hours, people with encouraged to ring the mental health access line. This access line was re-directed to the in-patient unit after hours. Participants in the DBT program were encouraged to identify themselves as DBT participants and were provided coaching by the ward staff. (A focused training program for in-patient staff had been conducted to enable clinicians to provide this service.)

Clinical supervision/consultation is an integral component of an effective DBT program. Both settings described above maintained a commitment to ensuring that the DBT programs adhered as closely as possible to DBT as described by Linehan (1993a; 1993b). Given that, DBT is a complex multi-faceted therapy program, the ability of clinicians working in generalist services to master delivery of this therapy was a pertinent consideration for these services. Research by Hawkins and Sinha (1998) explored this question. The outcome suggested that clinicians 'occupying diverse roles acquired reasonable intellectual mastery over this complex model' (p. 379).

Ethics Approval

To enable access to this required sample, an application for ethics approval was submitted to the Hunter Area Research Ethics Committee. Ethics approval was granted in May 2005 for a period of three years. Ratification of this approval was then sought from the University of Sydney Ethics in Human Research Committee. This was received on the 21st June, 2005. Permission was also obtained from both the Acting

Area Director of Clinical Services and Nursing (Chris Kewley) for Hunter New England Area Health in order to recruit nurse therapists and the Clinical Director for Hunter New England Mental Health (Professor Vaughan Carr) to recruit medical staff and allied health clinicians to the project.

Recruitment

Potential participants were notified by an e-mail recruitment advertisement (see Annex H) and via the newsletters distributed by the Heads of Discipline on a regular basis. All clinicians in the service have access to e-mail services. Official communications throughout the service were all conducted via e-mail.

Interviewing Process

The student researcher for this project was educator, supervisor and consultant for many of the potential participants. This created a potential for a 'power imbalance' and the possibility of coercion. Accordingly, a decision was made to use a third-party to interview local participants. Agreement was obtained from Dr Jon Adams of the Qualitative Research Laboratory at the University of Newcastle, NSW to provide an independent interviewer. A contract between the interviewer and researcher was developed describing the process of consultation to ensure that the data collected was appropriate to the subject area and that the rights to the data and rights of publication were specified.

Interviews were sought as per the sampling process outlined and were conducted over an eight-month period from August 2005 until March 2006. Each participant was asked to consent to audio taping of the interviews. The following questions were employed as a guide for a conversation seeking to understand the experience of the clinician engaged in learning and practising as a DBT therapist. Basic demographic

data was collected first. This was followed by questions asking for thoughts and evaluations of practice.

- How long have you been involved in learning and practising DBT?
- What do you understand DBT to be? (major focus of the therapy)
- What prompted you to learn and practise as a DBT therapist?
- (Assessing confidence) Do you feel that this is an effective therapy? Do you like working in this therapeutic approach?

Then:

- How has DBT impacted upon your profession practice? In what ways?
- How has DBT impacted upon you personally?
- To what extent if at all do you think you are now a different practitioner and person as a result of your involvement in DBT?
- Is there anything you want to tell me that we haven't covered?

Interviews were scheduled at a time and place convenient to participants, for these participants this was either in their workplace or their home. Interviews were finished when the participant indicated that they had nothing further to say. Interview length varied from one interview of half an hour (due to time constraints in the participant's workplace) to one and a half hours with the majority of interviews being a minimum of one hour in length. Provision was made that if required, a further interview could be arranged to provide participants with the opportunity to continue the conversation describing their lived experience as DBT therapists. This provision was not however required.

Reliability and Validity

In order to ensure reliability, careful attention was made to recording observations and notes related to each interview and meticulous attention was given by the interviewer to transcribing each interview accurately.   As an independent interviewer was required for interviews with clinicians who have been students and supervisees of

the researcher, provision for close collaboration was arranged. During the data collection period, from August 2005 until March 2006, several meetings were scheduled with both researcher and interviewer to enable the interviewer to discuss progress with the researcher and to ensure that interviews were exploring the phenomenon under question.

Data Analysis

Analysis of the data was an iterative and developmental process. Transcriptions were read initially to obtain an overall understanding of the content. The researcher then examined the transcripts closely seeking to identify themes and quotes that reflect the identified themes.   This process continued as deidentified transcripts became available. An initial process of data segmenting or de-contextualising, as described by Tesch (1990, p. 115-123), was employed to assist in the identification of common themes. This involved deconstructing the transcripts by drawing out each participant's response to the specific questions or prompts that were employed to guide the interview process. Segments of text that were specific to the question and comprehensible as stand-alone units were chosen. These segments were reassembled in a process of re-contextualising that enabled the researcher to read all participants' responses to the specific issue as they were now grouped together.   As was anticipated, common themes emerged and saturation was reached as interviews began to reveal shared themes or shared meanings as identified in previous interviews. A process of immersing oneself further in the material was undertaken in order to seek ways of articulating the experience of interviewees and unveiling of practices hitherto unknown.

Repeated contact with the interviewer was made to collaborate on the meanings and themes identified. The interviewer was invited to return to interviewees to establish if

the emerging data was congruent with the interviewees' understanding and experience. Once saturation had been reached, the researcher began the first draft of the manuscript. Feedback was sought again from the interviewer, academic supervisor and associate supervisor (a Professor of Mental Health Nursing versed in both the context in which this research took place and in DBT). Feedback was incorporated into the final draft of the manuscript.

Credibility of findings is an important aspect of reporting data. In the background research completed to date, focus groups were conducted to explore the impact of a DBT education program (Hazelton et al., 2006; Rossiter et al., 2003; Rossiter et al., 2004). In presenting the findings at conferences in both Australia and New Zealand the degree to which those listening have identified with the findings has been striking. It could be suggested that the research to date is credible and that the subject matter is one to which mental health nurses and allied health professionals are able to relate. A further criterion for enhancing rigour is that of authenticity. In addition to ensuring the participants' voices are clearly identifiable within the text, 'a range of voices and views (including dissenting views)' (Fossey et al., 2002, p. 725) need to be represented. To this end, a diversity of participants was sought. Thus, although the sample was purposeful, no effort was made to exclude participants who could potentially present a dissenting view contrary to the hypothesis proposed for this research.

Subjectivity is inherent in all social relationships and practices, including research. Qualitative researchers seek to render this subjectivity explicit as Spinelli (1989) has explained. In my study, I have, thus, acknowledged the particular biases and beliefs that inform my view of the topic. Attention has also been given to placing the research

within the current social and political context in which public mental health professionals practise their work.

Information to Participants

An information sheet for participants (Annex E) was included in the applications for ethics approval. The information sheet aimed at providing participants with sufficient information about the project to enable him or her to make an informed decision regarding their participation.

Gaining Consent

A consent form (Annex F) provided candidates with the opportunity to formally signal their agreement to participate in the research project. Where possible a copy of both the Information Sheet and the Consent Form was forwarded to each candidate prior to the interview process. Where this was not possible, the participant was provided with this information at the commencement of the interview process and allowed sufficient time to read this prior to the commencement of the interview.

Confidentiality and Storage of Data

Confidentiality was assured to those participating in the one-on-one interviews. The independent interviewer employed as a research assistant for this project was responsible for collection of data. Initially, tapes and interview transcripts were accessible only to the interviewer (who signed a confidentiality agreement). Tapes and interview transcripts were numbered by a system known only to the interviewer. All data was de-identified before release to the student researcher.

All tapes and de-identified transcripts are kept in a locked filing cabinet in the office of the Chief Investigator, Dr Toni Schofield, Faculty of Health Science, University of

Sydney for a period of seven years as required by the Ethics Committee of that institution. At the end of this period, all tapes will be erased.

Project Limitations

In keeping with criticisms directed towards qualitative research as a whole, this project is likewise subject to the limitations inherent in this approach. These include a lack of generalisability, cautions regarding transferability, and the limitations inherent in interview data. Qualitative research as a whole makes no claims to provide findings that are generalisable. As a process designed to explore the experience of mental health professionals learning and practising as DBT therapists, the phenomenological approach taken towards analysis sought to ensure a rigour of analysis that is both accurate and transparent. While attention has been given to illuminate the subjective meanings of the phenomena under examination, the context in which this exists has also been clearly described. This provides information that can enable the individual reader to make his/her own decisions as to the transferability of the findings to other similar situations.

The scope of this project was limited by funding constraints. Apart from a small grant from the Centre for Psychotherapy to pay for the independent interviewer to conduct and transcribe the interviews, the project is largely self-funded by the researcher. Time limitations associated with conducting research as part of an academic program also imposed constraints on the study. Both of these factors prohibited a more extensive sampling that could perhaps have led to a more comprehensive view of the phenomenon of interest. Likewise, the decision made to interview only mental health professionals learning and practising as DBT therapists rather than include mental health professionals practising other forms of therapy presents a further limitation. It

could be suggested that without a comparator it is not possible to identify to what extent the results are specific to DBT

Although this sample includes a broad spectrum of health professionals, it can be suggested that it is not closely representative of public mental health services where registered and enrolled nurses comprise the largest percentage of mental health professionals. However, within the areas represented by this sample, only a small percentage of nurses employed in the services are directly involved as therapists within the DBT programs currently functioning.

As previously discussed a decision was made to employ an independent interviewer in order to avoid a potential power imbalance and to enable the researcher to be blind to the identity of the participants. However, despite considerable expense (i.e. through employing an independent interviewer unknown to any of the participants to conduct, transcribe and de-identify data to the researcher) it proved impossible to maintain anonymity for the participants.

A number of the participants approached the researcher on several occasions to discuss their experience of the interview process and to comment upon the research project, to make suggestions about possible additions to the questions asked and to express regrets at not saying all that they wanted to say: 'afterwards I thought about ...or wished that I had said...' At each of these discussions the participant was encouraged to take the opportunity to recontact the interviewer to add to the interview record.

The potential that the study sample was biased towards DBT presents a further limitation of this study. This was identified as such by some of the participants. who asked the researcher about the diversity of participants and made suggestions about

ways in which they thought the research should be extended. The reason given for this suggestion was cited as a concern that perhaps an overly positive bias would skew the outcome of the research given that participants who spoke of this saw themselves as passionate about DBT.

These limitations are more than offset, however, by the advantages of this project. Given the fraught nature of clinician interactions with people with BPD, interviewing therapists who are able to describe effective therapeutic relationships offered information that could inform future practice. The findings contribute to our knowledge and understanding of an area of clinical practice which to date has received extremely limited attention from researchers.

CHAPTER FIVE

FROM MANAGEMENT TO THERAPEUTIC TREATMENT OF BPD: THE IMPACT OF DBT TRAINING AND PRACTICE ON MENTAL HEALTH PROFESSIONALS

Before DBT

The pervasiveness of pejorative descriptors and therapeutic pessimism expressed by many clinicians towards people with BPD has been identified not only in psychiatric literature but also within the area health service in which this research was conducted. A review of clinical practice within a regional mental health team in this area prior to the implementation of DBT found that the approach to people with BPD, i.e. 'treatment as usual,' could best be described as 'assertive disengagement' (Hazelton et al., 2003). While the impact of this upon the clients can be seen as counter therapeutic, this approach on the part of clinicians can be seen as understandable or 'making sense' in light of the prevailing beliefs that BPD is untreatable. Views that people with BPD are not only untreatable but also unworthy of treatment and likely to cause trouble further strengthen clinicians' efforts to disengage when such people present to mental health services.

In this study, participants' descriptions of the ways in which mental health clinicians view borderline personality disordered clients were congruent with the reports in the international (K. Fraser & Gallop, 1993; Gallop et al., 1989; Kaplan, 1986; Nehls, 1998) and Australian psychiatric literature (Cleary et al., 2002; Deans & Meocevic, 2006; Krawitz, 2004; O'Brien & Flote, 1997)

> Looking at that angst in the staff on the wards and the conflict that arose between the clients and staff, ...staff seemed to be so sensitized to anything that they did, and very reactive in nature (R2: p.1).

I was working very much on the frontline...and...seeing the culture of a hospital setting, and seeing how people treated this group...It was really very tough....This is a very hard, awful group. We don't want to work with them...very stigmatizing'(R3:p.2).

But oftentimes it's just too hard and you can think I don't want to work with this group' (R6: p.5).

The following comment by one of the participants in this study graphically describes the prevailing myths held by mental health staff and illustrates Hazelton et al's (2003) concept of 'assertive disengagement' in their description of the clinical approach to people with BPD prior to DBT.

There was a view that people with borderline personality disorder are difficult to treat, that they are irritating, they don't really have a mental illness...and that if you ignore them, hopefully they'll go away...So I think a lot of them were given pretty short shrift...In a sense the treatment was, deal with the crisis,...once the crisis has been dealt with (and) smoothed over,...send them back to whence they came...In terms of any ongoing therapy,...there wasn't anything that was. ...specifically offered by the service (R8: p.3).

Some clinicians reported having attempted to work therapeutically with people with BPD prior to learning DBT. Their descriptions reveal that for some, not only were there significant difficulties, they also experienced feelings of frustration and a sense of being ineffectual and incompetent. For some, this frustration incorporated widely held views that BPD is 'untreatable' and that no effective treatments are available. For others, the prevailing attitudes held little sway, but while there was a desire to be able to treat these clients, the frustration of not 'knowing how' is clearly apparent.

My first experience I had with a client with borderline personality disorder was quite terrifying for me...I just had no idea what I was doing and I just felt like the client was...just out of control and I didn't

know what to do to help her, and I would come out of an hour session with her feeling like I'd been there for five hours and I had furniture thrown at me...and I just felt really ...under skilled to be able to help her... (R6: p.4).

Like, most therapists will...run from them. ...I didn't run from them, but I didn't know what the fuck to do with them (R6: p.15).

I found them challenging, difficult. What was (being done on the wards) wasn't working....Whatever I'm doing, whatever I'm being shown to do, is not (working) (R9: p.1, 2).

It was that real sense of frustration around the treatments that we used with other diagnoses. (These) are the only treatments that we know how to offer or that we can offer, and what we do know is that they don't work with these clients, so therefore, nothing works, we don't want anything to do with them, even though we're forced because we have to (R13: p.7).

Not only did clinicians find it challenging to work with clients with BPD, one participant observed that clinicians are frequently stigmatized by their colleagues for working with this group.

People are quite often abused for the fact that they work with people with borderline personality disorder. It's your bloody patient this, your bloody patient that...If they're not an Axis I then why are you working with them? (R7: p.9)

Axis I refers to a classification system that lists major mental illnesses such as schizophrenia and bipolar affective disorder as Axis I disorders, whereas conditions such as personality disorders are listed as Axis II and are frequently not seen as the province of public mental health services as discussed in some detail in Chapter Two.

This is a population that is still effectively being told to go away and get lost...People with borderline personality disorder are the

stigmatized of the stigmatized, and I mean there's secondary stigmatization that occurs for the staff that have worked with them (R7: p.11).

In contrast to these experiences, two participants had worked successfully with clients with BPD using other therapeutic models prior to learning and practising DBT. One clinician had previously learnt and practised a psychodynamic model of therapy with which he had experienced considerable success. 'I was already working with borderline patients before...' (R12: p.8). A second clinician had previously worked in a therapeutic community. '...I think I was also very comfortable within the structure that we used for this population before...' (R7: p.4). While acknowledging his own positive experiences, he was able to speak eloquently of the challenges and difficulties experienced within the wider service as noted earlier.

The ways in which the participants described the management of people with BPD, their personal experiences and those of their colleagues working within public mental health services, are entirely consistent with findings reported in the Australian and overseas literature.

Why get involved in DBT? Attractive or expedient?

Before exploring the impact of training and practice as a DBT therapist, it is useful to understand the reasons that these participants gave for becoming involved in delivering DBT. Some participants were attracted to DBT as a possible therapeutic modality while for others, their initial involvement was more one of expediency. For yet others, both expediency and attraction led to involvement in this therapy.

Specific features of DBT were cited as attractive and the focus for seeking training in DBT. Previous experience in mindfulness or an interest in the use of mindfulness in clinical practice attracted some.

> Its emphasis on mindfulness...it's certainly a great strength ...for workers to be working along those lines with people, the mindfulness aspect of it (R5:p.3).

> I'd already had had a mindfulness practice. I've been meditating for years, and ah I just saw mindfulness, and...I've always thought mindfulness was a really effective tool for...self development... for self help ... for therapy even' (R10:p.5).

For others the highly structured nature of the therapy was seen as likely to be supportive and nurturing for clinicians.

> ...structure for the patient and structure for staff, structure for the system...It's clear to all concerned the expectations of the therapy. I think they're articulated in a way that many other models of therapy don't do (R7:p.5).

The skills training component of DBT interested some and was seen as a potential vehicle for providing much needed skills for clients and as fitting well with clinicians' professional focus and interest.

> It was very focused on skill development and people's experience of applying those skills in their everyday life, and I guess in my profession (occupational therapy), that's fundamental to the way I think about practice, so I was attracted to it (R1: p.1).

The practicality and accessibility of the DBT framework and language were also seen as valuable. For other participants the existing evidence base was seen as both

attractive and important in making the decision to pursue DBT as a therapeutic practice.

> As a professional (psychologist) evidence-based theory is kind of a really important part of how we work and so DBT was the...therapy with most evidence (R6: p.4).

The basic tenets of DBT were seen as congruent with some participants' thoughts about their clinical practice. However, one participant cited her respect for those clinicians already practising DBT as a further motivator for becoming involved in the DBT program that was beginning in the tertiary referral service.

> I was also attracted to it because I had a lot of respect for the group of people who were wanting to promote and develop it (R1: p.1).

Rather than finding DBT an attractive option, some participants spoke frankly about it being expedient to become involved in the DBT program in their area.

> I thought it would be useful for me to be able to add another string to my bow if you like. I suppose it seemed like it was gonna happen whether I liked it or not, and so rather than stamp my foot and try a tantrum, well it would seem to be a better option to actually find out what it's about and...be a part of it (R8: p.4).

> I wanted to be part of the (tertiary referral service) and that was the model that was being used there (R12: p.2).

When asked what prompted another participant to learn DBT, the response was direct and blunt, 'Oh, because it was part of the job.' (R5: p.1). Yet another participant stated, 'Initially I had to because I was a student...There was no escape I suppose.' (R3: p.1)

Difficulties in dealing with people with BPD also drove some clinicians to seek 'something that would help' rather than continue to experience the sense of hopelessness and of being ineffectual that had characterized the participants' previous encounters with persons with BPD. This sense of hopelessness is also illustrated by language that was not always 'politically correct' and further serving to illustrate the ways in which clinicians struggle to engage with this group of people.

> From having worked with **one of the borderline personality disorders** (emphasis added) on one of the wards...I wanted to find new ways that perhaps you could work effectively with them (R2: p.1).

> It also ... provide(d) a structure that...gave me access to skills to be able to work with that client group (R6: p.4).

A unique opportunity to develop a new service provided an opportunity in which both expediency and attraction drew one participant to DBT as a therapeutic approach to try. A process of identifying possible therapeutic options was identified with the reasons for choosing DBT as the therapy of choice being clearly articulated. The choice made to implement DBT within this tertiary referral service then drew other clinicians from the wider service towards involvement in DBT.

> I think it's allowed me to work in a much bigger team environment, and so when we first set up the DBT model we attempted to set up...a service without walls...(with clinicians from a variety of services)... In that sense what it did was it had us facing each other (R7: p.8).

Interestingly, whatever the reason for becoming involved in practising DBT, participants throughout the interviews overwhelmingly spoke positively of their experiences of working as DBT therapists.

Pessimism to optimism: engaging therapeutically

When some participants spoke of attempts to offer treatment prior to learning DBT, they described the lack of a framework for understanding and responding to clients with BPD. Service-wide beliefs that these people were difficult to manage and untreatable were reported. Learning to be a DBT therapist offered participants a framework for thinking and responding differently to clients. The shift from therapeutic pessimism, frustration and helplessness to hopefulness, optimism and a capacity to engage the client and provide an effective therapy can be found within many of the transcripts. This shift was at times spoken of experientially and personally, while other participants describe it more from an observational perspective, noting changes within their colleagues and team. The enhanced capacity for engagement and effective treatment provision was attributed by some to various components or aspects of DBT and at times to changes in the participants themselves that have resulted from their becoming immersed to varying degrees in DBT. A detailed examination of how participants experience both themselves and the clients in this changed interaction, and some of the factors that they attribute to these changes follows.

A number of participants described their confidence in DBT as efficacious therapy. In discussing the efficacy of DBT, participants largely spoke of their own experience of working in the model. Few participants referred to existing outcome studies.

> My experience of working with some of the clients over the years, certainly illustrates to me that it's highly effective. (R1: p.2)

> Anecdotally, I, I can definitely say that we've had a decrease in presentations, a decrease in admissions... (R3: p.6)

Look I don't really know about what happens when people leave...but while they're in the program it does seem to minimise the self harm and suicidal tendencies and they do learn skills to regulate their behaviour and emotions a bit better.(R4: p.2)

I think it's a really effective therapy...unless...otherwise indicated I think it should be the first model of therapy that's used for people with borderline personality disorder. (R7: p.2)

Most participants were able to articulate the ways in which they have benefited from learning and practising as a DBT therapist and the ways in which their capacity to be with clients with BPD has changed. Confidence in now having a capacity to stay connected with clients is evident.

I feel like I could take a borderline client now and it didn't matter who it was and I'd be okay with them, and ...it could be a positive step for both of us (R6: p.15).

(I feel) able to do something with them ...instead of just band aiding the next explosion and the next explosion and actually treating them (R9: p.3).

A growing research base demonstrating efficacy, and a textbook and manual that clearly articulate the highly structured nature of this behaviourally focused therapy, provide a platform from which participants work. Participants spoke of the structure of the therapy as supportive and providing clarity. This was seen as positively impacting upon the clinician's capacity to engage therapeutically with clients.

The model is quite clear in what we do and what we don't do (R3: p.8).

I have a clearer framework within which to do the therapy...It's clear to everybody indeed where that process of therapy is going (R7: p.4).

I don't feel lost and confused...There's a structure to follow about...how to help them, what to do...that also leads them along what they need to achieve, and there's goals in that achievement (R9: p.3).

It's given me a framework... (R10: p.6).

It's very clear, it's very concise (and) it's in that manual. You know there's very set ways of doing things (R11: p.6).

It's an incredibly supportive therapy to work with. I think it helps you build a lot more confidence as a therapist... (R2: p.6).

The completeness of DBT as a model of therapy with a clearly articulated theoretical basis was expressly appreciated by some participants.

It's basically a pretty unified approach. Because it encompasses a theory as well as a treatment....It has some sort of theoretical basis which underpins why...certain strategies are used within the programme, which are explicit, which is good (R8: p. 8).

I like that there's a model that is well articulated, well thought out and it's helpful for people's behaviours (R12: p.4).

The supervision/consultation process or case consultation meetings for therapists (Linehan, 1993a, p.104-5) that forms an integral part of the structure of DBT was valued highly for its ability to enhance the level of support and validation that participants experience while working in this model.

There's a lot of back-up to ...the staff involved...compared to other therapies and in that way, it really does work against any risk of burnout (R2:p.2).

The consult group...builds a fundamental part of the program that allows therapists to talk with each other....I think that's probably the top key strength (R6:p.3).

> You've got the consult group...for the therapists, and also for the patients too because you get different perspectives... and that's a really powerful experience as well (R10:p.3).

> The consult group which is another really strong kind of support...You don't feel like you're trying to...work with someone on your own...I found that very useful (R11:p.7).

> The idea of having a consultation group where the patient is discussed and their difficulties with working with them, is incredibly important in supporting the therapist (R12:p.4).

Some participants viewed DBT as a pragmatic therapy developed by a clinician who knows a lot of people with BPD. This pragmatism was identified as a factor that participants particularly liked about DBT.

> Linehan had a good understanding of the population and she...just stepped back and went, okay, what are these folks missing and what do they need...I'll take this stuff, they need all of this, but no-one had put it together like that...It's just a good fit for the client group...She also brought some Eastern philosophy and some original thought, put that into the therapy...I think there was a wisdom of ...thinking to do that and being brave enough to do that (R6: p.6-7).

> The bottom line is that Marsha Linehan knows a lot about borderline patients and has taken some fairly conventional ways of trying to treat people that didn't work in borderline patients and has modified it so that it works (R12: p.3).

Participants did not always speak directly of their experience of the therapeutic relationship with their client. Yet the passionate and expressive language and the enthusiasm with which participants spoke about their work as DBT therapists suggest a markedly positive outcome.

I really like the fact that this...approach validates the individual's experience, what that is, and gives them some skills to manage whatever that response is (R1: p.7).

I think it's an amazing therapy to work with and...it's an incredibly supportive therapy to work with. I think it helps you build a lot more confidence as a therapist, but also (it enables you to be) a lot more aware of, and be willing to work within, your limits as a therapist, so that you're a lot more effective with your client.... It's fantastic (R2: p.6).

I love it. I find it very rich, and very dense, and very complex. I feel...more able to assist this client group than in using other therapies (R6: p.2).

Look I'm...actually enthused of it which is unusual for me. I like the model of therapy...We're really enthusiastic about this model because we've seen the results of the patients we work with... (R7: p.14).

Miracles. I love it (R9: p.2).

I do very much enjoy it. I find it very, very rewarding (R11: p.2).

While not all participants spoke so glowingly of their work as DBT therapists, those that expressed ambivalence still identified the positive components of working in this model.

I...probably enjoy more the reflective style of therapy, but I'm also enjoying the thoroughness of DBT and ...some of the clarity and the structure around that...(R5: p.6).

I think it's great...but sometimes I feel, ... (and) maybe this is my lack of experience,...I'd like to feel not quite so robotic...(R10: p.10).

I've got a mixed relationship with DBT. I think it's a useful model and I like it....I think DBT's good and I really value my learning from it (R12: p.2).

It is quite challenging, but then it's not as challenging as working without the structured approach of DBT (R13: p.2).

For some participants specific aspects of the DBT approach to treatment were described as influential in increasing their capacity to engage effectively with people with BPD. Linehan writes of the importance of boundary setting and of the therapist's capacity to observe their own limits, describe these clearly and maintain them within the therapeutic relationship (Linehan, 1993a, p. 135-137, 319-328). A number of participants referred to these issues and the value of understanding the principles described by Linehan (1993a). One participant, who had spoken of the usefulness of a clear structure and boundaries within therapy, identified the difficulties with maintaining healthy boundaries when working with people with BPD.

I know that boundary setting is difficult for...people with borderline, but also difficult for therapists to maintain too with this population, and...that's my personal experience (R10: p. 11).

Linehan's approach (1993a) to managing 'boundary problems' and other difficulties that frequently arise in attempting to engage therapeutically with people with BPD were viewed by one participant as supportive of therapists.

People often struggle, how do you deal with boundary problems, how do you deal with being rung after hours...All those things that get really messy often with patients with borderline personality disorder...She's written kind of eloquently and sensibly on those things. So not only is it a good treatment but also it has a lot on how to manage the very difficult situations with borderline patients (R12: p.4).

This emphasis in DBT upon therapist boundaries and limits was also viewed as enhancing clinicians' capacity for reflective practice.

Some of the success with DBT is your capacity to kind of know your own limits, and your own boundaries. I think it demands that you're consciously reflecting on who you are, how you're reacting, and what you're doing. And I think that's really good in ...practice (R1: p.3).

The beneficial impact of this reflective capacity is seen as not only helpful for therapists but is described as strengthening the therapeutic relationship. Participants also viewed discussion around limits and boundaries as an example of the transparency and honesty that they value in their work as DBT therapists.

You have to be aware of whatever you're struggling with and if it's something that's based on the client's behaviour and something that doesn't include change, then you do need ...in looking at therapists' limits...make them aware of that. So that you guys can both work out how...to keep working together in therapy (R2: p.8).

There's just that honesty, openness, clear boundaries, just articulating from the word go expectations, not only from the therapist, but also from the client (R3: p.5).

Appreciation and enthusiasm for the structure of DBT and the sense of clarity and confidence that participants experience as arising from practising DBT were expressed throughout the interviews. The sense of optimism and hope that participants expressed in the transcripts contrasts starkly with the pessimistic discourse that exists in the wider service outside of the DBT program.

I do feel that there are positives...because it does offer the hope...from the staff members' point of view. And from the clients' point of view it offers hope that there are things that will work because... traditionally there's been a real sense of dread and a real sense of negativity...and so it's that sense of belief...that you know this actually does work for the individual (R13: p.6).

One participant attributed this optimism to the emerging research base showing the effectiveness of DBT as a therapeutic approach to the treatment of BPD.

> There's a sense of optimism that comes with having research to support it. So people not only feel optimistic, but they also feel proud of research whereas previously there wasn't much research in psychotherapy (R12: p.4).

The impact of this sense of hope was described as impacting upon clients within the DBT program as well as therapists. The DBT program is structured such that each module of the skills training runs for eight weeks. These groups are closed to new entrants during the eight weeks and open at the commencement of each module resulting in groups that have a mix of participants at different stages in the program. This structure enables clients new to the program to observe other clients further on in the program.

> They have a chance to see someone ten months down the track ...and that their life was a real mess at the start as well, but they've been able to make changes in their life so there's a hopefulness about seeing that (R6: p.3-4).

Participants were thus able to speak at length of the ways in which the structure of DBT, specific components of the therapy, its pragmatism and research base contributed to their confidence and optimism.

Collaboration, compassion and respect

Training in and practising DBT impacted upon the ways in which clinicians were able to view clients with BPD. An empathic stance towards clients was evident when participants speak of their enhanced understanding of the experience of the client.

This increased understanding arises from learning about Linehan's (1993a) biosocial theory that hypothesizes that BPD:

> is primarily a dysfunction of the emotion regulation system; it results from biological irregularities combined with certain dysfunctional environments, as well as from their interaction and transaction over time (p. 42).

This is cited as directly influencing one participant's view of the client.

> Taking a much more non-judgmental stance towards the client...rather than just kind of getting angry and pissed off at the client for doing that... It helps you to understand how they've come to be that they were behaving in such a way (R6: p.5). .

For one participant DBT and the biosocial theory were valued thus,

> I like the fact that it gives people an explanation about who they are as a human being, and it kind of validates every aspect of their human experience (R1: p.7).

Another participant's enhanced awareness of the impact of an invalidating environment (Linehan, 1993a, p. 49-52) fostered her capacity to empathize.

> Cause they're very...needy... I think they do need a lot of time and effort because they've had such horrific backgrounds...such horrific abuse, shocking stuff. Makes my...toes curl... (R9: p.8).

Active participation in the DBT training program was seen by one participant as instrumental in influencing his understanding of the client's experience.

> By actually doing the training...you're almost forced to become more mindful and go through some of the process itself, so I think it really helps in...understanding what's actually happening, right here right now with...the client (R8: p.4).

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Another participant described how one of the assumptions that underpins DBT - 'the patient is doing the best that they can' (Linehan, 1993a, p. 106) - influences his way of being with clients.

> It's taught me and...reminds me (that) people are doing the best they can...I think... remembering that is one of the key things (R10: p.6).

This capacity for empathy grew for one participant as understanding and enhanced awareness developed.

> You know I think that people with personality disorders were thought to be from...a different planet, and it's, you know,...I mean we're all to some extent on that spectrum, so...I suppose it's recognition that...these people are really struggling and they need help (R8: p.6).

The beneficial impact of knowledge and understanding upon a clinician's capacity for empathy and ability to engage therapeutically with clients with personality disorders has been noted by Bowers (2002). In a comprehensive study designed to identify factors enabling some clinicians (nurses) to maintain a therapeutic stance, a conceptual framework for understanding a client's behaviours was found to have a beneficial impact.

> A particular set of beliefs and conceptions about psychiatry and the work of psychiatric nurses support positive attitudes. These include belief in and commitment to the importance of psychosocial factors in the cause of PD (personality disorders), and in the efficacy of treatment in producing improvements in patients' behaviour....giving nurses the capacity to understand the difficult behaviours...in a psychological way, rather than becoming angry and blaming them (Bowers, 2002, p. 145).

Likewise for these participants, it appeared that having a set of assumptions and a framework for understanding enabled them to develop and maintain a therapeutic alliance with people with BPD. These are clients who elsewhere would be, at minimum, seen as troublesome and often times openly rejected when presenting in distress.

Within DBT a basic tenet of practice is the role of the therapist as being one of collaboration with the client in a relationship that is based on equality and a shared understanding, 'DBT requires a collaborative relationship' (Linehan, 1993a, p. 439). A focus on developing a collaborative relationship is markedly at odds with the medical model of 'expert and patient' that continues to exist as the dominant paradigm within public mental health services. The importance of the therapeutic relationship as a major focus of DBT was emphasized by some participants.

> The focus on the relationship with therapist and client (is)...perhaps more of an equal relationship than in other therapies... (There is) a really big focus on...acceptance in that relationship...in the validation of that relationship (R5: p.6-7).

Participants spoke of the relationship with their clients and the value that they placed upon the DBT perspective of relationships.

> It's very much a dynamic therapy where you can be yourself. You can be upfront with people which I love (R8: p.8).

> The removal of the...power relationship between the client and the therapist... help(s) a patient to feel like they're an equal...and that the relationship that they're having with me is a real relationship...and that the relationship has a power to affect their relationships outside of here (R10: p.3).

I think one of the things that's particularly rewarding is...the strength of relationships that you develop with the client (R13: p.6).

For participants to have developed a capacity to develop a positive therapeutic alliance with people with BPD, to the extent that they were able to express this in such positive terms, is again markedly at odds with a 'treatment as usual' model of assertive disengagement.

Admiration for changes achieved

The impact upon clinicians of the progress achieved by clients within the DBT programs was powerful and served to enhance clinician motivation. Admiration for the courage required to achieve the changes and to persist with a challenging, confronting and, at times, very difficult therapeutic journey was apparent as participants spoke of their clients.

> They're encouraged to do things which make them feel uncomfortable and ...feel emotions that they normally might just ignore or kind of dampen. They have to be quite brave ...to go through that. When they do go through that they actually feel good that they've...stuck it out and feedback generally is one of the things that kept me kind of wanting to do it (DBT)...People were so enthusiastic about how their lives had changed (R11: p.11-12)..

> It takes a lot of courage and commitment to do that, I think its huge...You're very humbled often by their stories and what they've done and...you rejoice, you share in their joy when they...get it, you know. It's like, by George, she's got it, sort of stuff. You know you kind of get excited about how they go off into life with a whole bag of skills that means they'll enjoy their life, and have control and be in charge of their life (R1: p.7).

> We were seeing people's lives change radically. We were seeing them challenged within their lives but their skills allowing them to keep moving forward (R7: p.6).

This admiration and enthusiasm further illustrated the sense of a collaborative process in which the therapist is fully engaged with the client's struggles to build a life. It contrasts markedly with the pejorative and pessimistic discourse that frequently exists amongst mental health clinicians. Participants clearly expressed a capacity to view their clients as fellow humans struggling to survive against difficult odds.

Participants were thus able to describe an enhanced confidence in their capacity to work therapeutically with people with BPD and to speak of their confidence in DBT as a model of therapy. Descriptions of the ways in which they viewed their clients revealed not only compassion and empathy and an ability to work collaboratively, but also an absence of the pejorative descriptors so apparent within the discourse of many mental health clinicians.

Understanding DBT: Sophisticated theoretical understanding versus experiencing

DBT has been described as a complex therapy demanding a capacity to grasp effectively the principles and theoretical framework underpinning it. This complexity and the highly structured and intensive nature of the therapy have raised questions as to the ability of front-line clinicians to learn and deliver it (K. A. Hawkins & Sinha, 1998). Examining the ways in which participants described their understanding of DBT opens another window for viewing these clinicians' experience of working as DBT therapists and also offers an opportunity to examine the extent to which participants display an understanding of the foundational principles of the therapy.

The level of complexity and detail in individual responses varied widely when participants were asked at the outset of the interview, 'What is DBT?' However, throughout each interview, participants demonstrated a much more comprehensive working knowledge of the model than when first asked this question. This broader knowledge was demonstrated by frequent references to the foundational principles and requirements of DBT as clinicians spoke of their practice.

For some participants, DBT was initially described simply in terms of the practical skills component.

> Life skills for people...that have borderline personality disorder. Coping mechanisms that teach them how to get through life... (R9: p.2).

> A way of providing skills, if you like, to people who can't manage their behaviours that they find debilitate them (R11: p.2).

> This therapy isn't just about talking, it's about people doing, and applying things, and it encourages people to go out and explore their world, and take risk and...start asking for things...and building competencies, taking on hobbies and tasks...to master. (It's about people) being able to engage in their world....rather than being frightened of their world... (R1:p.8).

Other participants attempted a much more comprehensive explanation of DBT. Acknowledging the complex structure of the program and an attempt to address the theoretical basis for DBT appeared in some of these explanations.

> (It is) a program which has been devised specifically to treat this...population.... (It) is based on a theory of dialectic, ...as well as behavioural psychology,...and involves individual therapy, skills training, an on-call service, and a...consult where all the therapists meet to assist...people that have deficits in being able to regulate their

emotions and to help them develop the skills in order to do that (R6: p.2).

It's a parallel model of therapy that involves individual therapy ...skills training, consultation to the therapist ... on a regular basis to keep them in therapy. (There is) the provision of a phone service for patients to use to work their way through the difficulties that they're having, ...helping them to rely on their skills in the home setting, and it also involves consultation to the patient in and around how they deal with other parts of their system (R7: p.2).

Some participants also acknowledged DBT as a collection of different therapies with some noting that the strength of DBT lies in the way in which the various components are integrated into an effective therapy.

It uses a lot of the sort of theories and rationale from cognitive behavioural therapy, as well as...recognizing that using dialectics ...in working with people is quite useful because it acknowledges the...extremes of any person's point of view, but also looks at synthesizing and reaching a middle ground (R1: p.1).

It's essentially a behavioural program...focusing on behaviours and working through them, using fairly standard cognitive behavioural techniques but then there are added things of mindfulness and validation which are not part of CBT (R12: p.2).

When asked about the major focus of DBT, participants' responses reflected the tension acknowledged by Linehan (1993a, p. 19, 109) inherent in a therapy that seeks to balance acceptance strategies with change strategies. Some participants emphasized the relational aspects of DBT (i.e. acceptance strategies) while others focused more closely on the behavioural aspects of the therapy (i.e. change strategies).

These participants highlighted the strongly behavioural orientation towards skills acquisition as the primary focus of DBT.

> I think it's quite a pragmatic focus...teaching the skills to be able to manage (R4: p.1).

> In the first stage of therapy, which is primarily the model we use here, there is a hierarchy of targets. The first is keeping patients alive...(goes on to explain the hierarchy of targets)...However, in terms of delivery I guess skills acquisition sits side by side with the individual therapy (R7: p.2).

> It seems to me the main focus of...DBT...ultimately is to give the person skills so that they ...don't end up...self-harming or killing themselves (R8: p.2).

> Stopping self harm, I guess...but it's also much more about stabilizing emotions, and getting control of their emotions (R11: p.3).

> It's essentially a behavioural program so, targeting behaviours, focusing on behaviours and working through them, using fairly standard cognitive behavioural techniques but then there are added things of mindfulness and validation (R12: p.2).

While others acknowledged skills acquisition as important, they first highlighted the importance of the therapeutic relationship as the vehicle within which change was possible.

> I think that the major focus of DBT is...the establishment, maintenance, and then termination of a relationship with...the client, but what DBT gives you is a structure in which to facilitate that and ...help them learn the skills...to deal with that relationship as well as the other. ...issues that they come along to therapy for (R8: p.2).

> I think there are a number of things...and they all occur sort of simultaneously...I think relationship is one of the key things. (Links

these to agreed treatment outcomes) ...I suppose in conjunction with (therapy-interfering behaviours, suicide and parasuicidality), I think is the whole relationship...within therapy, and then developing relationships outside (R10: p.2).

Working with them around the acceptance component. Accepting themselves for who they are then...as well as using that as a means of assisting them with the behaviour change. That doesn't actually occur without the validation and acceptance of where they're currently at. So trying to work with them and assist them to be able to understand that process for themselves better, and give them skills that they can actually use (R13: p.2).

I don't know if you could single out one major focus....There's at least the focus on the relationship with therapist and client being ...perhaps more of an equal relationship than in other therapies, ...the idea being that....those relationships, ...if developed well, can provide people with a foundation to more forward in some way... (There's) a really big focus on... acceptance in that relationship...in the validation of that relationship... (R5: p.6-7).

Throughout the interviews, participants acknowledged the complexities of the therapy. They spoke at times of a wide range of its features such as the structural aspects, the hierarchy of targets, dialectics, assumptions and relationship aspects of practising DBT. Participants appeared, as a whole, to display an ability to use DBT terminology accurately and to articulate a personal understanding and experience of the therapy. Whether or not this understanding translates into more effective therapy is beyond the scope of this study. This would require regular adherence measures being undertaken, as is the practice when conducting a randomized control trial measuring the effect of DBT upon clients' symptoms.

In reflecting upon the explanations of DBT provided by these participants, it is important to remember that the focus of the interviews was primarily to explore the

participants' experience of learning and practising as DBT therapists rather than to test their theoretical understanding of DBT. Questions to participants asking about their understanding of DBT were preliminary to the main focus of the interview.

Conclusion

The participants in this study clearly demonstrated a capacity to engage therapeutically with people with BPD. An ability to see people with BPD as individuals who require therapeutic support rather than a 'diagnostic label' to be shunned was readily apparent. It appears that for some participants to be able to relate to these clients as people who are suffering rather than as a stigmatized diagnosis is a profound experience that has prompted reflection and discussion of the benefits received. This changed focus is at odds with the oft described therapeutic pessimism that pervades public mental health services. Although participants displayed enthusiasm and passion for their work as DBT therapists, they were not 'one-eyed' in their comments. The majority of participants were able to not only speak of the benefits of DBT but also to speak of the challenges that arise when practising as DBT therapists in their workplace and the limitations of the therapy.

CHAPTER SIX
COMPARING SPECIALIST MENTAL HEALTH WITH GENERALIST SERVICES

Two Distinct Groups of Participants

As already discussed in Chapter Four, a purposeful sampling was taken from medical, allied health and nursing clinicians from within one of the regions of a large mental health service. With one exception, participants at the time of interview were based in either of two separate services. They were able to be categorised into two different groups based on the types of training they had undertaken. Review of the data reveals a degree of overlap between participants' responses when they are separated into these groups according either to practice location or previous training. However, the difference that appears between the different groups is sufficiently marked to warrant exploring the data from different perspectives to examine whether these views further reveal a shift from managing a difficult diagnosis or condition towards providing therapeutic support for a person struggling with the effects of such a condition.

Focused Training in Psychotherapy/Psychology or Allied Health and Nursing

First, it is possible to see participants as falling into two distinct groups based on their professional background, past experience and training in working as a therapist. Participants were thus either trained in psychology or psychiatry, frequently with experience in providing psychotherapy or they had qualifications in nursing, social work or occupational therapy, with limited or no experience as a therapist, particularly in providing individual therapy.

The differences between these two groups is most marked when participants were asked to comment on the limitations of DBT. In particular, participants with extensive

experience of working with people with BPD using another model of therapy spoke at some length of the limitations of DBT and the potential these limitations had for reducing their effectiveness when working within the model.

> I think it misses some vital things ...there are traumatic experiences and they're usually in the childhood ... (that) are not seen as important, and in DBT to focus on that is considered counterproductive initially... I think those things are important and they come up in the therapy all the time. So I think there's things that are missing basically. And when you know those things are missing and you're working with someone within that DBT model you kind of go...and I know that there's this that's influencing what's happening here, but within that model I can't get to them (R12:p.6-7).

This tension was also expressed by another person within this group. However, for this participant there was a marked degree of ambivalence. While the structure of DBT was noted to be of value in conducting the therapy it was also seen as constraining at times.

> I think that structure is fundamental (in) that it means that people can do the therapy in a way that means it can be useful, but to the therapist at times, it can feel a bit like... I'm here again and I'd like to kind of go other places as well, but I can't because this is where we've gotta be right now (R6:p.17).

This participant's ambivalence was also expressed in regard to the complexity of the therapy and the implications that this could have for enabling an effective therapy.

> It is such a complex therapy and it's part of what I love about it, but it's probably a weakness that it's actually hard to keep it all in mind at the same time, and you can be...really developing your skills in one area, but then you end up letting something else slide because it's hard to keep it all balanced at the same time (R6: p.18).

In describing DBT Linehan identifies a hierarchy of primary targets (1993a, p. 166-173). Within this hierarchy three stages are listed, but only the pre-treatment and Stage I have been manualised in detail to date. Several participants raised concerns that Stage II had not been adequately described.

> I don't think they worked out what Stage II is in terms of a DBT frame. I think there are much better ways to work with trauma. In terms of working with ... the day to day issues that people still have, to be honest I think true evidence based practice is a combination of what, what's out there in the literature, what you know about it yourself in your own practice, and what you know about the patient, and so I will encourage people to use whatever model of therapy they use with trauma in general (R7:14-15).

> ...second stage is not really well thought out or discussed – and sometimes it gets a little behavioural and, that doesn't always help people with their anxiety... (R10:p.7).

This issue was expanded by one participant who expressed several times his concern that the positive effect of Stage I DBT may not be enduring.

> I guess my single...biggest concern about DBT is that...I suspect, and I think there's some evidence to support that relapse is higher than I think is necessary (R12: p.3-4).

> That's the concern I have with DBT, that...it won't necessarily be long-lasting (R12: p.11).

Participants trained in nursing, social work and occupational therapy were much less likely to be able to identify limitations or concerns about the therapy itself, tending to be generally positive in their comments. Where difficulties were identified they were attributed to service difficulties or seen as the participant's difficulty rather than attributing the problem to flaws in the therapy.

I mean I had problem areas, but I think that was more me than...with DBT itself (R11: p.7).

The main sources of critique of the therapy arose from participants who had extensive training in psychology, psychiatry and/or psychotherapy. For some of these participants previous experience of working effectively with people with BPD utilising other therapeutic models meant that they were more able to contrast the experience and impact of different models. It could be suggested that this training has enabled these participants to develop a stronger capacity for critical analysis and a better developed ability to reflect analytically on therapeutic practice. Further research, however, is needed to explore such a possibility.

Specialist Service or Generalist Semi-rural Mental Health Service

A further division characterized the participants into two distinct groups according to the location within which they were trained in DBT. One group was comprised of those who learnt and then practised DBT in the context of a specialist mental health service described generally as a multidisciplinary, tertiary level mental health team. The other group consists of clinicians who learnt DBT in a focused training program delivered prior to the implementation of DBT in a generalist service situated in a semi-rural area. The differences noted in the ways in which participants in these two groups spoke of their experiences was perhaps most apparent in the ways in which the second group spoke of the impact of DBT upon service provision, client outcomes and the changes they noted within their service. For this group, the changes noted were particularly striking, contrasting strongly with previous practice and experience as a generalist service expected to provide care for all who presented to the service.

It's...a really positive part of the services I think at the moment. For me it's a really stark contrast between the way DBT approaches supporting workers and clients and how other parts of the system seem to support workers and clients (R5: p.15).

People are confident, more willing, more understanding I suppose of...where the client's coming from...and thus more able to actually offer an appropriate intervention at the time (R8: p.3).

Participants from this group attributed these improvements to the structure of DBT which was seen as providing support not only for clients but also for clinicians, with an increased confidence, clarity and hope being reported. The benefits of the consult/supervision group in facilitating this sense of being supported were also described.

My sense is that previously it was hopeless for clinicians as well, that clinicians didn't know what to do. So not only for structure for the client, and hope for the client, but structure for the clinician and hope for the clinician (R3:p.7).

Having different perspectives, different levels of experience, ...it's quite helpful that you get new ideas and it helps you to...sit back and also you know it can be (that) sometimes, you get a pat on the back and that can be just what gets you through (R10:p.8).

In a setting where interactions with clients with BPD had been characterized by difficulties and the prevailing treatment had been 'assertive disengagement', the positive impact of DBT upon clinicians was marked. Participants from this group credited involvement in delivering DBT with facilitating stronger relationships amongst team members and greater levels of trust amongst participating clinicians.

We're actually talking quite openly about the work that we're doing, where the clients are at... I guess we're actually opening ourselves up

a little bit and we're a little bit more vulnerable...because we're actually working together on providing therapy for clients that are in a lot of distress. You do get that sense of mutual support. It increases your levels of trust and you do build a stronger relationship with ...the staff members that are involved, I feel (R13: p.5-6).

While this group spoke of the positive changes they had experienced within their setting, they also spoke openly of the difficulties they experienced in attempting to provide DBT as a therapy in a semi-rural regional mental health service. Some of the difficulties were attributed to service issues and constraints associated with them. They were seen as contributing to a tendency to stray from the model.

> It's not our core work; it's a part of our work...that's the bit that I think that gets difficult...Where I think if you do DBT eight hours a day every day, it would be a lot easier to do (R9: p7).

> Staff in mental health... are quite transient... Generally they move through quite rapidly ...so you do still get quite a number of staff that have some fixed beliefs that they've actually developed over time from experience in other services that will come in, and...so you still have staff that have those very negative pessimistic views, coming in to the service...That's obviously an ongoing challenge that we have, you know upskilling staff and educating them, and dealing with the attitude that they...have developed over time from previous experience. It's an ongoing... process that we need to be aware of, and we need to be constantly working with staff (R13: p.7-8).

One participant reported that for some clinicians within a service that was already overstretched and under-resourced, the implementation of DBT was seen as yet another demand that would be difficult or impossible to meet.

> It's sometimes on an individual level. It's just too hard sometimes. Some clinicians just find...it too hard to deal with this group, that nothing works and that the model itself, oh God it's something else

that I've gotta learn...It's yet another thing that they've got to learn, that they've got to change to be part of (R3: p.17).

Concerns also arose as to how clinicians might be able to offer a service to people with BPD who met the diagnostic criteria for the disorder but whose symptoms were not severe enough to either gain entry into the program or warrant such an intensive program for twelve months or more.

These are people that may have a borderline personality disorder, but not have it to the same severity and not be actually self harming repeatedly...So it's still the same diagnostic grouping, but it's a slightly different need (R13: p.13).

In this group of participants, the enthusiasm engendered by their experience working in the DBT program and seeing the positive outcomes achieved was such that they developed a pilot ten week skills based program for clients who were not eligible for the full DBT program. Given that people with BPD were previously seen as 'untreatable' and not part of 'core business' this change of focus is notable.

In addition to the challenges arising from service constraints, for some, difficulties arose from working in a model that was either at odds with previous practice or new to the particular clinician.

For me sometimes it feels like a very task centred type of therapy, and I also have a liking for lots of reflective stuff in therapeutic work as well, so...I'm struggling at the moment with...matching those two up, preferences-wise (R5: p.3).

When it's in the early stage...it's almost like...being a teacher for me, I've had that experience of being a teacher...and I'm still not sure that that's the therapy, or it's me. It's probably a combination of both (R10: p.10).

Although these participants identified constraints and challenges associated with attempting to provide DBT as a therapeutic option in their setting, their enthusiasm for DBT was apparent throughout their transcripts. Participants' enhanced capacity to engage therapeutically with people with BPD and develop a strong therapeutic alliance is clear.

In contrast to this group who had learnt and practised DBT within the context of a generalist, semi-rural mental health service, participants based in the multidisciplinary, tertiary level mental health team were markedly less vocal about the impact of DBT on the wider service. One participant who worked with the multidisciplinary team and also worked in another mental health team described the benefits of DBT thus:

> The whole package, you know the individual therapist and the field of training are also being supported and validated...It's a systems wide intervention. It's not a one-on-one intervention and I think that's one of the pluses (R1: p.8).

The only other participant from this group to speak of DBT from a team or service perspective was one who had been actively involved in the development of the implementation model for the semi-regional mental health service, had experience in providing training in DBT to other services and regularly provided DBT supervision to clinicians from other services. This participant noted the importance of the highly structured nature of the DBT program for clinicians new to working with people with BPD.

> ...the structure provides support, especially for newer therapists coming on board, and for the patient as well (R7:p.4).

> ...it provides a really solid structure to hold patients and therapists and systems alike, together in therapy....It's clear to all concerned the expectations of the therapy. I think they're articulated in a way that

many other models of therapy don't do...There's a clear set of skills that are there for both therapists and patients alike to learn (R7:p.5).

The weekly consultation groups...keeps people working within the model ...It also provides forums for people to actually talk through the difficulties they're having (R7.p9).

Anecdotal reports of a marked change in service usage when DBT was first used by the tertiary level team and later when implemented in the semi-rural mental service were also noted by this participant.

The feedback we started getting from the registrars fairly early...was that they were having far less admissions with this population once the DBT program got up and going...in terms of the work out at (the semi-rural mental health service) very quickly we got feedback from the staff on the wards that the atmosphere was really different by them just using some DBT-informed practice (R7: p.13).

Participants from the specialist multidisciplinary tertiary level team had been providing clinical services to people with BPD as core business for many years. They were generally enthusiastic about the benefits of DBT, the impact upon their own practise and the benefits for clients. However, while those within this team were well-acquainted with the difficulties experienced by people with BPD in accessing appropriate care, they had considerably less exposure to the daily challenges encountered by clinicians working in the wider service. Thus, unless participants had had active involvement with other parts of the service they were unlikely to comment about the marked change in practice that resulted from the implementation of DBT.

Clearly, mental health professionals throughout public mental health services are regularly confronted with the difficulties associated with people with BPD presenting for assistance. The participants in this research project located in the generalist semi-

rural mental health service demonstrated a shift in their approach to people with BPD. Their enthusiasm and passion suggested that their training and practise as DBT therapists had enabled them to be more supportive to people with BPD than prior to the introduction of DBT. However, Blennerhassett and Wilson O'Raghallaigh (2005) suggest that 'given the limited resources in many psychiatric settings, allied to the intensive nature of the programme and debate as to the generalisability of the research findings, further development of dialectical behaviour therapy is likely to be limited to specialist settings' (p. 279). It would appear that the ideal option for service delivery of DBT is specialist services such as the multidisciplinary, tertiary level team from which half of this project's participants were drawn. Nonetheless, the reality is that such specialist services are rare within Australia. Thus, addressing the deficits in treatment options for people with BPD is likely to be dependent upon the upskilling of clinicians in generalist mental health services.

Participants from the generalist service drew attention to a number of factors that were potential difficulties associated with attempting to deliver DBT in that setting. These included, as suggested by Blennerhassett and Wilson O'Raghallaigh (2005), service issues and resource constraints. In particular, the impact of rapid turn over of staff resulting in the reintroduction into the service of negative and pessimistic views of people with BPD was mentioned by one participant. While these concerns were raised, participants from the generalist service were overwhelmingly positive. They were able to identify the ways in which they believed their involvement as DBT therapists had made a difference to their personal and professional lives (as described further in Chapters Five and Seven) and enhanced service delivery to people with BPD.

Conclusion

Examining the data through the lens of either of the two divisions discussed in this chapter offers an expanded view of some of the factors that influence the ways in which participants describe their experience of training and working as DBT therapists. The focus discussed in Chapter Five outlining a move from management to treatment remains apparent. Professional qualifications and experience impacted upon participants' ability to critically reflect and comment upon the limitations of DBT and the potential of these limitations to reduce their effectiveness when working in the model. It is clear, however, that the context within which participants were practicing as DBT therapists influenced their experience of the impact of DBT upon their area of work and the ways in which they described this. The experience of therapists from generalist services reflected in this discussion suggests that the possibility of DBT being delivered outside of specialist services requires further examination.

CHAPTER SEVEN

DBT TRAINING AND PRACTICE IMPACTS ON PRACTITIONER IDENTITY

How does DBT practice facilitate a shift from patient management to treatment?

Prior to their training in, and practice of, DBT, the majority of participants in this study clearly identified an awareness of the dominant views towards people with BPD within the mental health service as one of hopelessness and despair. However, the compassion and enthusiasm with which they described their experience of actually working as DBT therapists contrasted markedly with the prevailing discourse. It appears that training and practice in DBT is associated with a shift from viewing BPD as a problem to be managed to a mental health disorder that demands humane treatment.

Knowledge of the conceptual framework underpinning DBT has been noted as a significant factor in providing clinicians with an alternative approach to thinking about and responding to clients with BPD. The enhanced understanding of clients' suffering and distress that results from training in DBT appears to enable clinicians to adopt an empathic stance towards clients. This capacity to work effectively with clients and then bear witness to the courage displayed by clients in undergoing the changes that occur in the course of therapy, further strengthens this empathic capacity. As outlined in Chapter Six some participants expressed ambivalence towards DBT as a therapy and others had critical reservations about it as a therapeutic approach. Nevertheless, there was an overall confidence in the efficacy of DBT as a therapy that was accompanied by a shift in practice.

In order to understand this shift in more depth, this chapter explores both personal and professional changes that the participants reported they experienced in learning and practising DBT. The discussion that ensues addresses factors that appear to have contributed to the changes and their significance for both therapists and clients.

Identity – a complex and changeable construct

Chapter Three explored a selection of the literature relating to concepts such as self and identity. Current understandings of the construct of identity reveal a shift from viewing this as a stable construct to an 'emerging and changing construct' of extreme complexity (Van de Mieroop, 2007, p. 1120-1121). Likewise the complexity of the construct of self has also been noted by a diversity of theorists (Anderson, 1995; Honneth, English translation, 1995; Lewis, 1991; Neisser, 1991). This chapter suggests that the adoption of a specific therapeutic approach and the development of the ability to practise it necessarily involves the practitioner's sense of self. Many participants in this study spoke at length of their experiences and their perceptions of the ways in which they had changed when they were asked to describe the impact of practising as a DBT therapist upon both their personal and professional selves.

Self-Awareness and an Increased Capacity for Living Life to the Full

For some participants, reflections upon the personal impact of training and practising as a DBT therapist revealed an increased capacity for self-awareness and an ability to moderate their responses to those around them.

> I think I am less judgmental of other people and ...probably more empathic. ...I like that I'm now more...willing and able to do things even if they're hard...I know that I can actually do quite difficult things despite the emotions that come up around those... (R6:p.14).

A greater awareness of myself...also those around me and my interactions with them, but a greater awareness around notions of self...When things are okay, when things are not quite so okay. Do I need to work on them, or do I need to just go, let it go (R3:p.17).

I think I'm much more accepting of myself and others (R7:p.10).

For one participant the extent of the positive impact on her self-awareness and the beneficial impact of that awareness unfolded throughout the interview as she repeatedly reflected upon the changes.

I think I'm much more aware of when I'm reacting more impulsively, or when I'm reacting more in an emotion mind, rather than perhaps a wise mind (R2:p.4).

I think just in my understanding of me in my own mind...The way my mind plays more of a role in creating emotions I guess... (I) have always been more of a worrier... being much more aware of the impact that that's going to have on me and how to manage that more effectively (R2:p.6).

Participants generously provided examples from their own lives to illustrate the ways in which their interactions with others close to them had been enhanced as they put into practice the skills that they were teaching to their clients. The interpersonal effectiveness skills, in particular DEAR MAN described in the DBT skills manual as guidelines for 'Getting what you want,' was noted to be particularly useful (Linehan, 1993b, p. 125). Participants in a recently published pilot study evaluating patient perceptions of the relative effectiveness of the components (skills) taught in DBT skills training likewise identified these interpersonal effectiveness skills as 'really useful' (Dewe & Krawitz, 2007). In this current study participants provided examples of ways in which the DEAR MAN skill was thoughtfully utilized including its application to interactions with a son-in-law (R1); interactions with immediate family members

where a positive impact on personal relationships and mental well-being were identified (R3); and an interaction at a conference with noisy neighbours in an adjoining hotel room (R6). Another participant described his growing awareness thus:

> I was not always cognizant of the whole describing what I want and expressing my emotions and asserting myself and reinforcement....it's helped me at times to think about...how to communicate what I want...and thinking about other people and the way I word things that...I'm a bit more aware of how I do that (R10:p.9).

Other participants suggested that DBT had provided them with a framework for living and understanding their lives. The impact was such that, as Linehan (1993a, p. 126) has stated, 'DBT is not a suicide prevention program, but a life improvement program.' For these clinicians, learning and practising DBT resulted in an increased capacity for 'living life to the full'.

> I think some of the fundamentals that this practice has really given me, like a model to work with that's very manageable and I've embraced in all areas of my life and I feel it's been very valuable...I find it very comforting to know that I've got a way of understanding things (R1:p.3).

> ...DBT, if I use those concepts in my own life it's more a richness of living I think. It facilitates a more um full living (R6:p.9).

The enthusiasm with which some participants described both their personal and professional experience of working as a DBT therapist reflected a level of passionate involvement and self-awareness. Given the potential difficulties associated with working with people with histories of severe trauma, such as vicarious traumatisation and burnout, the positive and protective impact upon well-being described by these participants was noteworthy. According to Dlugos and Friedlander (2001), passionately committed psychotherapists need to have a fervent involvement in other areas of

their own lives. They conclude, 'on a practical level, our results suggest that maintaining a passion for work as a therapist requires the discipline of balancing one's life with other meaningful activities...' (p. 304).

Several participants spoke of how an increased capacity for self-awareness impacted upon their lives, prompting an awareness of potential areas of hypocrisy or incongruency between the clinicians' own lives and the ways in which they practised as a therapist. An enhanced self-awareness enabled participants to reflect upon the responsibilities associated with being a therapist. The following comments illustrate the ways in which these participants described their realization that they needed to 'practise what they preach'.

> ...like thinking you know I'm asking my patients to do this, well bugger it, I've got to do it too...but I think it's important for me to practise what I preach, and to have an actual experience of what I'm teaching people (R10:p.8).

> ...we make it very, very clear you know that to clients we're in no way perfect and that when we're teaching skills, my God there's lots of stuff that we should be doing. You know that practising and preaching thing (R3:p.16).

> ...you know, ... I might sort of spend some time doing problem solving with a person in a DBT session and then walk away and think, ahh I could apply that, to you know, whatever's going on at home, or you know, wherever (R8:p.9).

The importance for therapists of having a capacity to recognize hypocrisy in their own lives is articulated strongly throughout Kottler's (2003) work, 'On Being a Therapist'. He comments, 'It is the ultimate hypocrisy of our profession that we do not or cannot do the same things we ask of our students and clients' (p. 57). And adds 'If we do not genuinely believe that the therapeutic tools of our profession can work on us, we have

no business practicing them on anyone else' (p. 217). Throughout the interviews in this study, many participants provided examples of the ways in which they employed the very skills that they endeavoured to teach to their clients commenting on the benefits received from their own practice of the skills.

A commitment to 'spreading the word': Raising the profile of DBT

The impact upon participants' professional identity and self-awareness from training and practice as a DBT therapist extended still further with participants identifying themselves as having a commitment to 'raising the profile of DBT.' The need to markedly improve the approach taken by mental health services towards persons with BPD has been clearly established within the literature review forming the background for this research. Participants were likewise aware of the need to improve services and indicated a perception that training in DBT was an effective route to achieving this. When participants were asked to identify their motivation for agreeing to participate in this project, a desire to raise the profile of DBT was noted within their responses.

It was apparent that most of the participants strongly supported encouraging others within the service to become involved in DBT because it had significantly improved the quality of service for many clients. 'I see DBT as being a really effective thing, and I would certainly encourage more therapists to get into it...' (R2: p.8) One participant described himself as '...driven by just that wish to see decent quality services provided for persons with BPD' (R7: p.17), while another participant felt that the outcome of the research '...may be useful to influence other clinicians to be involved.' (R10: p.13). The prevailing discourse about BPD was seen as an important area to challenge and

one participant felt that the research '...might dispel some of the myths in working with people with BPD, and not make it seem so hard...for clinicians.' (R10: p.14)

Some participants felt that DBT was perhaps not given the credibility that they felt it was due and their involvement in this research could be a means of improving the credibility of the therapy. 'I think this is another element that might give some credibility to this practice...' (R1: p.9). 'It needs to be given the credence that it's due' (R2: p.8). Participation in the research was viewed as an opportunity to do something 'that I think will help spread the use of DBT...' (R7: p.17).

Participants from the regional mental health team went much further than simply speaking about raising the profile of DBT in order to improve its credibility or encouraging other clinicians to deliver DBT and thus improve clinical care. An opportunity to speak of the impact of DBT at both a personal and a service level was identified as a further reason to participate in the research. 'It's been something that I've found really useful...' (R8: p.10).

> ...we've had discussions ourselves around the way in which DBT becomes part and parcel of your life...we talk at length about the way in which we've grown from it...I think it's really important...that we recognize and we reflect on the way in which it impacts on us, because...as a service, DBT has become a whole service approach...to acknowledge that it's done more than just affect the service... (R3: p.16-17).

The focus on the therapist's experience was seen as of interest, providing an opportunity to explore clinician's reflections 'on what changes the therapist, or what's their reflection in doing something in the services like.' (R5: p.15). For other participants their involvement in this project was to provide support for a colleague

and given their own interest in conducting research, they were supportive of others conducting research

> ...I'm very ...supportive of research including using myself as a guinea pig, in general. And I think for DBT in particular, I want to see these kinds of issues being thought about and talked about....I think the experience of DBT is also important (R12: p.13).

Overall, participants' eagerness to speak about their experience and to participate in this research revealed an enthusiasm and passion for DBT as a therapeutic approach. Furthermore, in the midst of very busy professional lives, participants were generous with their time and spoke openly about both their personal and professional experiences. In contrast to avoiding the negative connotations that are at times attached to clinicians who work with people with BPD, these clinicians identified themselves as DBT therapists with a passion for their work.

Capacity for self-awareness heightened by mindfulness practice

One of the major changes described by participants was an enhanced capacity for self-awareness and an increased personal appreciation of the value of learning and practising mindfulness and radical acceptance. Linehan (1993a, p. 20-21) acknowledges that the emphasis on these practices as core components of DBT arises from her personal experiences of 'studying meditation and Eastern spirituality'. 'The DBT tenets of observing, mindfulness, and avoidance of judgment are all derived from the study and practice of Zen meditation.' Linehan (1993a, p. 144) notes, however, that these skills 'are compatible with most Western contemplative and Eastern meditation practices.'

The inclusion of mindfulness based interventions within psychotherapy is gaining increasing attention within therapeutic circles. Kostanski et al. (2006) state that the

> ...demonstrated utility of mindfulness meditation within a wide range of
> physical and mental health contexts has resulted recently in it being an
> area of significant growth in psychological research (p. 16).

Brown and Ryan (2003), for example, conducted a number of studies exploring mindfulness and its role in psychological well-being and concluded that 'mindfulness is a reliably and validly measured characteristic that has a significant role to play in a variety of aspects of mental health' (p. 844).

For some participants this was their first exposure to such concepts. Several described the impact as pervasive.

> ...it's like I don't take things so personally anymore...it just gives
> me...the capacity to engage my wise mind regularly...it's just with me
> all the time (R1:p.3).

> ...it's quite an energizing place to be in...a sense of involvement in life
> which is...a deeper level in some way...of being deeply satisfied about
> what's happening...(R5: p.19)

> ...I just feel like my heart opens up a little bit and there's just
> this...lightness and a complete sense of being alive (R6: p.8).

> ...mindfulness and that's something that I'm just continually aware of
> in my life...it helped me to actually have more of a sense of being alive
> by using mindfulness um to actually notice kind of each moment...ooh,
> radical acceptance ... I think is also crucial (R6:p.9).

> The radical acceptance ideas have been really big. That this just is
> how it is. It's a big thing. Um, and once you can stop focusing energy
> on battling that because many of us do, it's amazing how much energy
> you've got to do other things (R3:p.17).

...and it's a very forgiving kind of way of thinking about yourself...You can drop the criticism and just think about how it is that you're going to try and handle yourself more gently and with a bit more loving kindness...You know, the whole love and kindness, in terms of how you treat yourself, and if you can treat yourself that way, then there's a better chance that you can treat other people that way (R4:p.10).

One participant gave a touching example of teaching his children mindfulness and radical acceptance and later observing his older child teaching and coaching the younger child in the use of these skills at times of distress. He also described the value of mindfulness and acceptance for himself thus:

I think that practice of mindfulness and that acceptance, has just made it easier to work what at times is a really difficult job, um, but not let that have an impact in other parts of my life. But most probably easier on myself and others outside of work (R7:p.10).

Another participant appeared to have come somewhat reluctantly to mindfulness practice initially.

...you're almost forced to become more mindful and go through some of the process itself... (R8:p.4).

He then provided an example of how mindfulness markedly assisted him in dealing effectively and calmly with his children at home after a busy day at work, going on to state,

I think the biggest one for me is...the whole idea of mindfulness and how useful it can be in everyday life (R8:p.4).

Some participants had already developed a mindfulness practice or had a well-established meditation practice prior to their involvement in DBT. One of these noted that his experience of learning and practising DBT had served to deepen his existing

mindfulness practice and that he was frequently reminded to ask, 'am I utilizing the moment?' (R5:p.18).

The benefits these participants experienced in their clinical practice from this reported enhanced capacity for self-awareness and practice of mindfulness and acceptance are consistent with those described by Robins (2002, p. 57). He emphasizes the importance of clinicians having their own mindfulness practice if they are to teach mindfulness skills. The capacity to step back from the intensity of emotion often experienced in interactions with persons with BPD and to regulate one's own emotions is seen as enabling clinicians to respond in a more thoughtful manner.

> One benefit of mindfulness is an increased ability to observe and describe the patient's behavior in session in a nonjudgmental manner, which can be particularly difficult when one feels criticized or is afraid that the patient may attempt suicide (Robins, 2002, p. 57).

Confirming the widely acknowledged benefits of mindfulness practice, several participants in this study spoke at length of benefits extending beyond their professional self and noted positive changes in their personal self and interpersonal relationships. 'Along with benefiting the life of the therapist in general, regular mindfulness practice can also help the therapist maintain direction throughout the challenging course of treatment that BPD patients present' (Robins, 2002, p. 57).

What is the significance of changing personal and professional identity?

Analysis of the data revealed a significant shift for participants in how they viewed themselves at both a personal and professional level. Basically it involved an enhanced ability to engage therapeutically with clients whom they previously saw as 'too difficult to engage'. As the data suggest, this engagement required more than well-developed

technical expertise. The robust awareness of both professional 'and personal 'selves' was fundamental. Adopting a particular therapeutic approach necessarily impacts upon a sense of self; furthermore, the ability to work relationally requires an awareness of self ('mindfulness') within that relationship. The importance of the ability to engage therapeutically cannot be underestimated. Kottler (2003) asserts, 'throughout the process of therapy, the relationship is our main instrument of cure' (p. 17). Thus the changes that the participants described in their own sense of self were integral to their capacity to provide supportive therapeutic treatment for people with BPD.

The person with BPD can be seen as experiencing difficulties associated with an early history of invalidation (as viewed by Linehan, 1993a) or a failure of reciprocity within the primary relationship (as described by object-relations theorists). In order to address these difficulties, therapists require a capacity to develop a therapeutic relationship with a person for whom intimate relationships have been damaging. Participants in this study described ways in which practising as a DBT therapist assisted both their professional development and their sense of 'self' in such a way that it significantly enhanced their capacity to develop a therapeutic relationship.

In addition, the changes in personal and professional identity reported by participants fostered an enhanced moral sensibility - an awareness of the significance of addressing inequities in access for a group of people denied mental health care. This was arguably associated with mindfulness practice which emphasises the suspension of judgments both on the part of the therapist and the person with BPD. These aspects of DBT support therapists in behaving in a just and moral manner towards a group of people previously identified as 'unworthy of care' and 'untreatable'.

The strain of working with people at high risk of self-harm and death by suicide has contributed to the continuing reluctance of many mental health professionals to work with people with BPD (Wright et al., 2007). The currency of this reluctance is illustrated again by another recent publication

> ...the common horrific and repeated self-inflicted injuries that this patient group can present with...are key sources of this rejection and distrust. The turmoil of emotions and general feelings of inadequacy from the mental health clinician...test the willingness of clinicians or therapists to become involved in the psychological treatment of patients with BPD. (Commons Treloar & Lewis, 2007, p. 34).

Yet the participants in this study were increasingly able to over-ride their antipathy and hostility in such situations, accepting and caring for those with BPD. While a dramatically altered clinical approach was central to this change, so too, was the shift in the practitioners' identity that occurred in the process – a shift that involved a more humanistic attunement to the other. The German social and moral philosopher, Axel Honneth (English translation, 1995) suggests that the exercise of recognising the specificity of the other has the potential for a change in an individual's practical relation-to-self. He asserts that 'only to the degree to which I actively care about the development of the other's characteristics (which seem foreign to me) can our shared goals be realized' (p. 129). The capacity to care about the development of people with BPD and to 'rejoice' in progress in the face of extreme distress as described by several participants in this study indicated the exercise of recognition and of change in personal and professional identity. Participants displayed a readiness to work with people who had been stigmatized as 'untreatable' revealing a heightened sense of moral responsibility that further strengthened the capacity for therapeutic intimacy.

The shift in personal and professional identity displayed by participants is congruent with Wright et al's (2007) argument that evidence-based treatment will be useless in practice unless practitioners are able to discard the prevailing stereotypical beliefs and stigmatizing behaviours that currently prevail in public mental health services. The capacity described by participants to deconstruct the damaging attitudes and beliefs about people with BPD and replace these with an empathic stance and enhanced self-awareness is integral to enabling therapeutic engagement and effective treatment outcomes.

In conclusion, the outcome of the changes described by these participants has major implications for both therapist and client. As described, the changes identified in the ways in which participants saw themselves at both a personal and professional level enable an enhanced capacity for therapeutic engagement. Given that people with BPD are seen as extremely difficult to engage in an effective therapy, this shift is vital in enabling therapeutic practice where the client benefits and both client and therapist are able to stay connected throughout the course of an often times challenging journey.

CHAPTER EIGHT
ZEN MINDFULNESS, COLLABORATIVE PROCESSES AND DBT STRUCTURE SUPPORT CHANGE

The often times overwhelming difficulties experienced by mental health clinicians in the course of their work with people with BPD have been described in Chapters Two and Three. The persistent nature of these problems is highlighted by descriptions of the difficulties in recent publications (Forsyth, 2007; P. D. James & Cowman, 2007; Wright et al., 2007). In contrast to these descriptions, however, there are significant recent accounts of positive outcomes from specific therapeutic approaches such as DBT (Brassington & Krawitz, 2006; Verheul et al., 2003). This project has explored the ways in which clinicians practising as DBT therapists report upon their experience. A marked shift in the discourse from one of difficulties to be managed to one of hopefulness and a capacity to practice therapeutically has been identified.

Chapter Seven has explored this shift in relationship to the reported changes in personal and professional identity associated with practise as a DBT therapist and the significance of these changes. This chapter will explore the factors intrinsic to the practice of DBT that support this shift from management to treatment.

Evidence exists detailing the positive impact of education about BPD upon negative attitudes towards people with BPD (Hazelton et al., 2003; Krawitz, 2001, 2004; Krawitz & Jackson, 2007). However, education designed to challenge negative attitudes alone is insufficient to enable mental health professionals to work effectively with people with BPD. The emotional lability and hypersensitivity to invalidation that epitomises interactions with someone with BPD, especially when he/she is in crisis, requires of mental health professionals a working knowledge of therapeutic strategies that will be effective. As has been outlined in Chapter Two, DBT has a small but

growing evidence base showing effectiveness in the treatment of people with BPD. A closer examination of the transcripts revealed numerous references to particular components of DBT that were identified by participants as contributing to the changes described. In describing DBT Linehan (1993a) outlines a 'number of distinctive defining characteristics'

> its overriding characteristic is an emphasis on "dialectics" – that is the reconciliation of opposites in a continual process of synthesis. The most fundamental dialectic is the necessity of accepting patients just as they are within a context of trying to teach them to change...This emphasis on acceptance as a balance to change flows directly from the integration of a perspective drawn from Eastern (Zen) practice with Western psychological practice (p. 19).

Dialectics permeates the therapy, and an ability to be able to grasp this concept and to be able to think dialectically is integral to effective functioning as a therapist. Linehan (1993a, p. 32) goes as far as to suggest that if this is taken seriously it has a transformative impact on clinical work. One participant spoke of dialectics thus:

> ...dialectics...one of those things that's so lovely about it is...DBT can be highly structured, and it is, and ...it's highly flexible and both of those things can be true at the same time. (R6: p. 11).

Further supporting the dialectical focus, Linehan (1993a) outlines a series of eight assumptions or philosophical positions that underpin the stance taken towards people with BPD and therapy. Therapists' attention is directed to these statements as assumptions, not facts, 'nonetheless, assuming and acting on the propositions...can be useful in treating' people with BPD (p. 106). These include the following assumptions that illustrate the dialectical focus on acceptance on the one hand and the need to change on the other.

1. Patients are doing the best that they can
2. Patients want to improve
3. Patients need to do better, try hard and be more motivated change

These assumptions, combined with a commitment to maintain a dialectical stance, further assist clinicians to work therapeutically. Chapter Five draws attention to how one participant described the changes that arose from holding the assumption that the 'the patient is doing the best that they can.' The value attributed to having a set of assumptions and a framework for understanding and guiding practice was also noted.

Developing a therapeutic alliance

In Chapter Seven the impact of mindfulness upon participants' capacity for self-awareness has been identified. The benefits of this self awareness upon participants' capacity to develop and maintain a therapeutic relationship with the person with BPD is also noted. The following discussion explores more fully the place of the therapeutic relationship in the treatment of people with BPD and how the specific strategies of DBT support therapists in their work. As noted previously, one of the core struggles experienced by the person with BPD is an inability to maintain healthy relationships with others. This is described in the DSM-IV as 'a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation' (American Psychiatric Association, 1994, p. 672). It follows that attempting to engage the person with BPD in a treatment program where the outcome is dependent upon the development of an effective therapeutic alliance is likely to be fraught with difficulties. A 1991 meta-analysis (Horvath & Symonds, 1991) exploring the relationship between working alliance and therapy outcome found that the quality of the working alliance is most predictive of outcome independent of therapeutic approach. Bender (2005), writing of the place of the therapeutic alliance in

the treatment of people with personality disorders, states that 'it has been suggested that the nature of the alliance established early in the treatment is more powerfully predictive of outcome' (p. 76). This writer asserts that 'work needs to directly address patient-therapist collaboration with clearly set boundaries and to focus on the therapeutic relationship itself when appropriate' (Bender, 2005, p. 84). Throughout the DBT text, Linehan (1993a) refers to an '...emphasis on the therapeutic relationship as crucial to progress in DBT...' (p. 21). The pre-treatment stage is focused on orientation to the therapy and commitment. Strategies designed to develop and strengthen commitment and the therapeutic relationship are employed repeatedly throughout the duration of the therapy (p.169, 444, 446-448).

Working collaboratively - consultation and supervision

The DBT strategies are integral to building and maintaining the therapeutic relationship. However, they are insufficient to enable clinicians to maintain the long-term therapeutic relationship required for an effective therapy. Clinicians need support to be able to remain in a therapeutic relationship fraught with the challenges peculiar to the difficulties experienced by people with BPD. It is for this reason that DBT has been designed as a team approach including specific features such as group consultation and supervision. Ongoing consultation and support in combination with the strategies specific to DBT enable the collaboration required for effective treatment.

Current Australian health policy directives repeatedly emphasize the importance of mental health clinicians working together as part of a multidisciplinary team to provide effective care for all people with mental health difficulties (Australian Health Ministers, 2003; Council of Australian Governments (COAG), 2006). These policies also place an emphasis on a wider collaboration that requires an ability to work with non-government organisations and external care providers (Council of Australian

Governments (COAG), 2006, p. 2). Yet, current literature identifies and documents the ongoing difficulties that impede the effective working of multidisciplinary teams. Factors such as differences in professional identity and culture are cited as responsible for the ineffectiveness of current team based approaches (Fitzgerald & Teal, 2003; Norman & Peck, 1999; Peck & Norman, 1999). In public mental health services the challenges that negatively impact on effective team work often times appear to be insurmountable barriers to successfully meeting the complex needs of people with BPD. When a system that can at times be described as chaotic in its function interacts with the chaos inherent in the life of the person with BPD, the outcomes are likely to be unsatisfactory. The pressures of staff shortages in under-resourced systems add to the heightened emotions that mental health professionals face when confronted with the emotional disregulation of the person with BPD. Frequent references to attempts to withhold treatment and deny access to mental health care are evident in the literature (Fallon, 2003; Nehls, 1999). Attempts to develop collaborative professional relationships frequently fail as clinicians become polarised around opposing views of how best to 'manage' the crises of the person with BPD.

As discussed in Chapter Three, Linehan's (1993a) acute awareness of the difficulties that surround attempts to care for people with BPD informed the development of a supportive structure for therapists in DBT. Linehan (1993a) repeatedly outlines an imperative that must be fulfilled if success in working with people with BPD is to follow. 'A cosupervision group, a treatment team, a consultant, or a supervisor is important for keeping therapists on track' (p. 108). Furthermore, she states her assumption that for any person to deliver DBT effectively, they must be part of a DBT team (2008a). In discussing therapeutic approaches that have some evidence of effectiveness, Blennerhassett and Wilson O'Raghallaigh (2005) draw attention to common factors between DBT and Bateman and Fonagy's (1999) partial

hospitalisation model. One of these factors is the 'regular therapist peer group supervision.' Linehan (2008a, on-line) states, 'current competing theories and treatments for BPD may differ from one another in dramatic ways: however, they all agree that therapists treating clients with BPD need support'.

The primary means for providing support to therapists is via the weekly consultation supervision meetings. This process is designed specifically to address difficulties commonly experienced by mental health services in attempting to deliver care to people with BPD. The functioning of this group within DBT is proscribed by a series of agreements designed to enable therapists to 'treat each other at least as well as they treat their patients'. In addition, the agreements are intended to facilitate staying within a DBT frame with patients' (Linehan, 1993a, p.117). These agreements directly target key areas where teams often experience significant difficulties. They include a dialectical agreement in which the consultation group agrees 'to accept, at least pragmatically, a dialectical philosophy...it simply points to the direction therapists agree to take when passionately held polar positions threaten to split the consultation team' (Linehan, 1993a, p. 117). In support of the assumption that people are doing the best that they can, the phenomenological empathy agreement requires that therapists 'search for nonpejorative or phenomenologically empathic interpretations of patients' behaviour' (Linehan, 1993a, p. 118). This assumption is further extended to the ways in which therapists respond to each other, encouraging a non-judgemental stance towards others. The fallibility agreement is designed to reduce defensive behaviours and enable therapists to support each other in remaining adherent to the DBT protocols.

> In DBT, there is an explicit agreement that all therapists are
> fallible...Thus there is little need to be defensive, since it is agreed

ahead of time that therapists have probably done whatever problematic thing they are accused of (Linehan, 1993a, p. 118).

Chapman and Gratz (2007) describe their own experience of working as part of a DBT team, stating,

> Therapists help each other stay motivated, act skilfully, and provide effective treatment...Essentially, the consultation team is like therapy for the therapists...we have found that this is one of the most rewarding aspects of doing DBT (p. 151).

Chapter Five notes the value ascribed to the consultation supervision group by participants in this project. The stability and support provided by a team approach enables therapists to work together and to have a constancy of purpose in the face of the frequent crises and chaos that normally epitomize situations associated with people with BPD.

This ability to work collaboratively fostered by the DBT consultation supervision group is not limited, however, to a collaborative relationship with colleagues. This focus is extended to fostering within therapists a capacity to work collaboratively with people with BPD. Rather than take the stance of the 'all-knowing' or 'expert' therapist, DBT encourages therapists to work collaboratively with people engaged in the therapy. 'Collaborative behaviours are viewed in DBT both as essential to treatment and as a goal of treatment' (Linehan, 1993a, p. 132). A recent qualitative study exploring factors contributing to disengagement or engagement processes with 'difficult to engage' patients states:

> One might conclude that clinicians and services who are able and willing to engage genuinely with patients on a partnership level are, in

turn, easier for the patients to engage with (Priebe, Watts, Chase, & Matanov, 2005, p. 443).

Participants in this research project represented five different professions. However, as described in Chapter Five, many spoke of the collaborative nature of their work as DBT therapists as one of the strengths of the therapy. Participants described an enhanced capacity to work relationally, both with clients requiring therapy but also as a team, as colleagues. This participant spoke of his/her view of the relational aspect of DBT. 'One of the major strengths is the relational aspects...it sits very well with me, value-wise, and core beliefs because it's a very equitable relationship' (R3: p.9). The team approach that is integral to DBT provides another benefit for therapists. Therapists working in isolation may at times be overwhelmed by the difficulties presented by the person with BPD. DBT therapists have multiple opportunities through the consultation supervision group to share the struggles they experience in therapy sessions with their colleagues. Furthermore, they are also able to share the joy of small successes and celebrate the gains made by their clients.

Reflective practice and mindfulness

The ability to work collaboratively with team members and clients is influenced not only by the consultation supervision agreements and structure of DBT. Chapter Seven drew attention to the role that mindfulness played in participants' descriptions of their change in personal and professional identity. In exploring the factors intrinsic to DBT that enabled participants to make the shift from management to treatment, the value of mindfulness as a key factor should not be underestimated. Linehan (1993a) describes mindfulness skills as 'central to DBT; they are so important that they are referred to as "core" skills' (p. 144). The usefulness of mindfulness is not, however, limited to people with BPD who are participating in a DBT program. Throughout the

discussion thus far, there have been frequent references to the intense emotions experienced by mental health professionals in contact with the emotional disregulation of people with BPD. Therapists require a capacity to sit with their own discomfort in the face of the person with BPD expressing hostility, distress and despair. Contrary to the instinctive response to disengage as rapidly as possible, in order to provide treatment for people with BPD therapists need to build a therapeutic alliance with the person. To achieve this requires affect tolerance on the part of the therapist. Fulton suggests that 'if we cannot tolerate our own difficult emotions, we may find it difficult to sit with our patients' powerful affects' (Fulton, 2005, p. 60).

> ...it helps you build a lot more confidence as a therapist, but also a lot more aware of, and be willing to work within your limits as a therapist, so that you're a lot more effective with your client (R2: p.6).

> ...it helps you to keep your mind on the job, what's happening, right here and be able to...(be) more adaptive if you like, rather than having an agenda (R8: p.5)

One participant expanded at some length upon the extent to which he believed the practice of mindfulness enabled clinicians to avoid reacting from their own emotional experiencing.

> ...there's a lot of people who are finding just that (the) practice of mindfulness has impacted on...other aspects of their working life...In the acute teams they work almost in crisis model...and what it's allowed for a lot of those staff is they can just (sit) back a bit from it...and make more sensible decisions about, well, what do I need to respond to? (R7: p.13)

In reviewing the usefulness of mindfulness as a component of clinical training, Fulton (2005) first draws attention to common factors in effective therapy. He describes the

outcome of research in this area finding that 'the most potent predictors of a positive treatment outcome are related to the quality of the therapist and the therapeutic relationship' (Fulton, 2005, p. 57). Mindfulness is repeatedly described as a potent tool for enhancing the capacity of an individual to be relational. Mindfulness on the part of the therapist is described by Surrey (2005) as supporting the therapist to 'attend to connection, and in the process, repair its breaches' (p.93). Siegel (2007) further suggests that mindfulness

> by bringing the individual closer to a deep sense of his or her own inner world...offers the opportunity to enhance compassion and empathy. Mindfulness is not "self-indulgent," it is actually a set of skills that enhances the capacity for caring relationships with others (p. 14).

As a core component of DBT mindfulness enhances therapists' capacity for self-awareness, to reflect upon their own practice. The importance of this capacity is described by Rosenberger and Hayes (2002b). They suggest that

> ...counselors' general self-awareness, especially combined with a clear theoretical orientation, may facilitate in-session management of CT (countertransference) such that avoidance behaviour is less likely to occur (p. 269).

Participants recognized the usefulness of self-awareness for improving their capacity to be relational.

> ...it helps you build a lot more confidence as a therapist, but also a lot more aware of, and be willing to work within your limits as a therapist, so that you're a lot more effective with your client (R2: p.6).

Furthermore, mindfulness practice is seen as a vital component of the consultation supervision group. Formal practice of mindfulness is included in each meeting

(Linehan, 2008b) and throughout the consultation process opportunities often arise for participants to pause and be aware of the dialectical tensions arising from opposing points of view. Thus, the inclusion of mindfulness practice serves to enable therapists' capacity to work collaboratively with colleagues and clients, to reflect upon their own practice and enhances the capacity for self-awareness. Therapists are thus more able to participate fully in a therapeutic process with people who have otherwise been seen as 'untreatable' and 'undeserving of care'.

Building a life worth living - hopefulness

Chapter Seven drew attention to DBT as a therapy that offers the possibility of a life worth living to people with BPD. Linehan (1993a) describes people with BPD as 'often discouraged, hopeless, and unable to see any nonsuicidal solution to their problems in living. Life and therapy are very difficult for them'(p. 243). Individual therapists work closely with clients assisting them to articulate their goals for a 'life worth living'. They actively encourage clients to work towards change. Therapists who hold out the prospect of a positive future and a life worth living present a stark contrast in a setting where the dominant discourse is one of pessimism and hopelessness in regard to the management of people with BPD. Fraser (2001) reported on the results of a four-hour training session designed to address negative attitudes towards people with BPD. The training describing Linehan's DBT was described as 'a powerfully persuasive message that positively impacted on the initial attitudes of the clinicians participating' (p.91) in the training. Holding hope that change is possible for people previously seen as untreatable could be seen as strongly impacting upon clinicians' willingness to attempt to provide treatment. In Chapter Five attention is drawn to participants' passionate descriptions of the changes they had seen in the course of their work as DBT therapists. The value of this hope has been described thus:

Perhaps Linehan's most important achievement with this therapy has been to instill a sense of hope in people with borderline personality disorder – and their therapists – that a life worth living may be an achievable goal (Blennerhassett & Wilson O'Raghallaigh, 2005, p. 279).

Accessibility for clinicians

In conjunction with the features specific to DBT outlined above, a further factor influencing the choice of DBT as a treatment option is the accessibility of the therapy. As a manualized therapy, DBT is more accessible than some of the other therapeutic options for the treatment of BPD. Participants in this study from the tertiary referral service spoke of a conscious decision a number of years ago on the part of the team choosing DBT as the preferred option. This decision was made on the basis of a readily accessible textbook and skills training manual (with all teaching handouts able to be photocopied). There was a view that it would be possible to 'teach themselves' to do this therapy as opposed to the alternative being to travel three hours each week to a teaching hospital to learn a psychodynamic therapy for BPD.

Teams in public mental health services now seeking to implement DBT as a therapeutic approach have access via an on-line site to a wide range of training materials using various mediums such as CD, DVDs and textbooks. This participant commented on the text thus:

> ....there's a fairly well written textbook...not only has she outlined and articulated how you do the therapy, but then she's also got a lot of stuff on what happens when you get to the typical problems with borderline patients. ... not only is it a good treatment but also it has a lot on how to manage the very difficult situations (R12: p.4).

While access to face-to-face training remains limited in Australia, on-line training for skills trainers is now available direct from Seattle (Linehan, 2008a). Furthermore, there

are now DBT teams in Australia with considerable experience in the delivery of DBT available to consult to services considering DBT as a treatment option.

Conclusion

Participants repeatedly identified factors specific to DBT that enabled them to work with people they had previously seen as, at minimum, challenging, if not to be avoided altogether. Certainly the skills developed throughout training and practice as DBT therapists were identified as fundamental to improving their clinical effectiveness as mental health professionals. As significant, however, were their understandings of how they perceived and responded to their clients. According to the participants, these were markedly enhanced through the combination of: a) the specificity of DBT content; b) a behavioural program that is tightly prescribed in combination with Zen mindfulness, and c) the socially collaborative processes involved in delivering this therapy. The experience of struggling with clinical and personal challenges, while being supported by both a conceptual framework and a DBT team assisted practitioners to achieve what would have previously been seen as 'impossible'.

CHAPTER NINE
CONCLUSION

Review of Research Question

Over many decades, clinicians in public mental health services in Australia have struggled to cope with the challenges associated with attempting to provide care for people with BPD. Stereotyping of people with this disorder as 'untreatable', in fact, 'impossible to work with', persists however. Often times those who suffer this disorder are seen as unworthy of care (Hazelton et al., 2006). Those clinicians who attempt to work therapeutically with people with BPD without an effective therapeutic framework oftentimes experience high levels of stress and frustration leading to burnout. Although an emerging evidence base documents significant progress in the development of effective therapeutic approaches to BPD (Bateman & Fonagy, 1999, 2001; A. Bateman & P. Fonagy, 2004; Bohus et al., 2000; Linehan et al., 1993; Meares et al., 1999; Stevenson & Meares, 1992, 1999; Verheul et al., 2003), current literature continues to describe stigmatising behaviours on the part of mental health professionals (Deans & Meocevic, 2006; Holm & Severinsson, 2008; P. D. James & Cowman, 2007; Wright et al., 2007). Within public mental health services in Australia, clinicians attempting to change these stigmatising behaviours face many challenges (Hazelton et al., 2003; Krawitz, 2001, 2004). The introduction of DBT within the area health service in which this research is located has provided the opportunity to explore in some detail attempts to change practice. This research project has examined the experience and impact upon mental health professionals of learning and practising as DBT therapists. The hypothesis underpinning this research is that training in DBT has a positive impact on clinicians' practice with persons with BPD and provides an avenue for decreasing the burnout often associated with working with highly distressed and vulnerable clients.

Summary of Findings Regarding the Research Hypothesis

Overall, this study strongly supported the original hypothesis. Data analysis revealed a marked shift from the prevailing discourse of management permeated by hopelessness and pessimism to one of optimism and therapeutic practice focused on the provision of DBT as an evidence-based treatment for BPD.

As background to this research, Chapters Two and Three reviewed the relevant literature. Chapter Two explored the nature and extent of BPD, the impact upon people who experience the disorder and the dominant responses from public mental health services. The difference between these responses and the policy context was also discussed. Current treatment options and the existing evidence base for these treatments identified a small but growing evidence base for therapeutic interventions such as DBT. Chapter Three described in further detail major barriers experienced by mental health professionals attempting to be effective service providers. The challenges of changing practice were also discussed as a background to the exploration of the participants' reports of the impact of training and practising as DBT therapists upon interactions with people with BPD.

Data analysis conducted in Chapter Four provided an opportunity to examine the impact of training and practising as DBT therapists on the way in which participants viewed their interactions with people with BPD. Chapter Five explored the shift from management to therapeutic treatment. Participants' descriptions of the service approach prior to commencing training in DBT were consistent with those reported in the literature. The interview transcripts revealed a marked shift from the dominant discourse of struggling to manage and/or assertive disengagement to engaging therapeutically and empathically after learning DBT. This shift was profound for most participants who spoke with passion and enthusiasm for their work. They were,

however, also able to identify the challenges arising in their workplaces and to speak of the limitations of the therapy.

Chapter Six explored data further from two different perspectives. The first approached participants' responses according their professional training. The second analyzed participants' experience according to the situation in which they practised as DBT therapists. Participants with prior training and experience in psychotherapy were more able to critically reflect and comment upon both the strengths and limitations of DBT. They discussed the impact they perceived these limitations to have upon therapeutic outcomes. The location in which participants practised also markedly influenced their ability to comment upon the impact of DBT upon the wider service. Participants located within the generalist, semi-rural mental health service spoke of the positive impact on their practice with people with BPD compared with those occurring prior to the introduction of DBT. These observations are highly pertinent given the discussion within the literature suggesting that DBT is only likely to be deliverable in specialist locations (Blennerhassett & Wilson O'Raghallaigh, 2005). This preliminary data would suggest that the possibility of DBT being delivered outside of specialist services requires further consideration.

Data analysis then proceeded to a second level in order to understand in greater depth the ways in which DBT training and practice influenced behaviour. Chapter Seven examined the changes participants described in both their personal and professional identity and the significance of these changes. An enhanced capacity for self-awareness and empathy enabled participants to respond more effectively in a relational capacity. This fostered the development of strong and supportive therapeutic relationships. Participants described an ability to work collaboratively, thus reducing the risk of burnout and vicarious traumatisation. They also provided

many examples of personal use of DBT skills noting the positive impact this produced on their own capacity to function in challenging situations. Participants confirmed the centrality of mindfulness as a core skill in DBT noting the benefit derived from their own practice of mindfulness.

Chapter Eight focused more closely on the factors intrinsic to DBT that enabled and maintained the described shifts. Repeatedly participants attributed the changes they had noticed and experienced to specific components of DBT. The highly structured and specific nature of a behavioural therapy in combination with Zen mindfulness was highlighted. The capacity to remain engaged with people who were previously seen as 'impossible to work with' was further attributed to the socially collaborative processes that are an integral component of working effectively as DBT therapists. Participants' perceptions and their responses to their clients were noted to be as important as these factors in enabling the shift from management to therapeutic engagement.

Reviewing the Implications and Significance of this Study

As this study explained, mental health professionals working in public mental health services face serious systemic challenges to efficacious service delivery such as significant resource shortages and, lack of ongoing clinical supervision and professional development. At the same time, mental health professionals continue to be faced with the difficulties associated with multiple presentations to services of people with BPD. Without a conceptual framework for understanding this disorder and training in effective approaches to BPD, the experience remains one of high levels of frustration for clinicians and unsatisfactory encounters for people who present for care.

Evidence in the form of large-scale randomised-controlled trials for the efficacy of DBT remains limited by the factors inherent in attempting to conduct research in the field of psychotherapy. Despite these limitations, DBT continues to be implemented in a number of settings in Australia. This study has highlighted the potential benefits that the practice of DBT has for therapists.

In order to implement DBT successfully and improve treatment options for people with BPD, fundamental changes need to occur. In the first instance, replacing the prevailing discourse of hopelessness and despair with a discourse of hopefulness is required. This change is essential not only at the service-delivery level but also at senior management level in order to facilitate and support the changes required of clinicians working at the coalface. Avenues such as professional development and education have been shown to address the attitudinal shifts required. These interventions, however, are insufficient to sustain the shift; clinicians need a framework for treatment that will enable an effective response. In addition, the intense nature of the work required predisposes clinicians to burnout and vicarious traumatisation unless a process of clinical supervision and consultation that is consistent and effective is established. Furthermore, the intensity and complexity of the work requires a team approach in which members are able to function collaboratively in the service of the best outcomes for the person with BPD.

DBT offers the ingredients required to enable and support the required changes. This study exploring the experiences of mental health professionals practising as DBT therapists has highlighted the positive impact upon participants' professional and personal identity as mental health professionals. Participants clearly described their perceptions of a shift in attitude, a positive change in personal and professional

identity and a strongly enhanced capacity to work effectively with people that they would have previously avoided.

This study has focused upon the experience of mental health professionals working with people with BPD, in particular addressing the difficulties of therapeutic pessimism and the impact of practising as a DBT therapist. Therapeutic pessimism, while perhaps most apparent in regard to people with BPD, is however expressed more widely in public mental health services in relation to a broad range of people with mental health disorders. A number of the lessons learnt from this study might have implications for addressing the problem of therapeutic pessimism in mental health services more generally.

Description of Limitations

As outlined in Chapter Four, this research is subject to the limitations inherent in a small in-depth study utilising a qualitative approach to data analysis. These include a lack of generalisability, a need to be cautious in regard to transferability and the limitations associated with interview data. However, given the paucity of research in this area to date, it was appropriate to use a qualitative approach in undertaking a preliminary or pilot study.

Recommendations for Future Study

Research exploring the sustainability of such changes to therapeutic practice in treating those with BPD is crucial if they are to be established and further developed within mental health services, especially in the public sector. Findings from such studies are vital in informing mental health policy development and resource allocation and management to support changes in practice.

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**Hunter New England
Area Health Service**

CK:LC:R Rossiter

24 March 2005

Ms Rachel Rossiter
Clinical Nurse Consultant
Centre for Psychotherapy
James Fletcher Hospital
PO Box 833
NEWCASTLE NSW 2300

Dear Rachel

Re: **Request for Permission to Interview Nurses for Doctoral Research Project**

Thank you for informing about your proposed research. This is a very important area of study and I wish you every success. Permission granted on clearance from the Hunter Research Ethics Committee.

Yours sincerely

CHRIS KEWLEY
Acting Area Director Clinical Services and Nursing

Annex B

Letter of Support,
Clinical Director Hunter New England Mental Health

Hunter New England Mental Health Administration
PO Box 833
Newcastle NSW 2300
Telephone   (02) 4924 6680
Facsimile   (02) 4924 6687
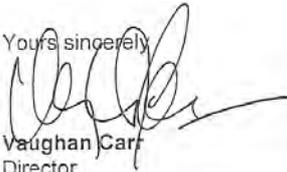Email   Vaughan.carr@hnehealth.nsw.gov.au

**Hunter New England
Area Health Service**

12 April 2005

Rachel Rossiter
Clinical Nurse Consultant
Centre for Psychotherapy

Dear Rachel

I give you permission to interview the mental health clinicians within HNE Health in the process of your research into Dialectical Behavioural Therapists.

Yours sincerely

Vaughan Carr
Director
Hunter New England Mental Health Services

Confirmation of Ethics Approval
Hunter Area Research Ethics Committee
Hunter New England

2 May 2006

HUNTER NEW ENGLAND
NSW⊕HEALTH

Dr T Schofield
Cumberland campus
University of Sydney
East Street
LIDCOMBE   NSW   2141

Dear Dr Schofield,

Re: Exploring the Experience of Mental Health Professionals Practicing Dialectical Behaviour Therapists (05/05/11/3.15)

The above protocol was approved by the Hunter Area Research Ethics Committee **13 May 2005.** The *National Statement on Ethical Conduct in Research Involving Humans* requires that an annual report is required for all research protocols that received approval from an Human Research Ethics Committee on the anniversary of that approval. Could you please complete the attached form and return it and any additional documentation (for example a half to one page summary of the progress of the protocol so far) by **31 May 2006.**

Please be advised that the duties of the Hunter Area Research Ethics Committee will be performed by the Hunter New England Human Research Ethics Committee as of 1 January 2006.

Yours Sincerely

Ms E McCall
Administrative Assistant

Human Research Ethics Committee
www.usyd.edu.au/ethics/human

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Email: r.todd@reschols.usyd.edu.au

The University of Sydney

NSW 2006 Australia

21 June 2005

Dr T Schofield
School of Behavioural and Community Health Sciences
Faculty of Health Sciences
Cumberland Campus – C42
The University of Sydney

Dear Dr Schofield

Title: **Exploring the experience of mental health professionals practicing as dialectical behaviour therapists**
PhD Student: Rachel Rossiter

Reference No.: 8384

Your recent application has been noted by the Executive Committee of the Human Research Ethics Committee and in doing so accepts the final approval from the Hunter New England Area Health Service – Hunter Area Research Ethics Committee.

In considering the ethical content of the study, the Committee acknowledges the right for you to proceed under the authority of the Hunter New England Area Health Service – Hunter Area Research Ethics Committee.

It is the responsibility of the Chief Investigator to provide a progress report every twelve months for the duration of the study and a final report on the completion of the study. Your report will be due on 30 June 2006.

The responsibility for complaints by participants about the research process will remain with the Hunter New England Area Health Service – Hunter Area Research Ethics Committee.

Yours sincerely

Gail Briody
Gail Briody
Manager
Ethics Administration
cc: Ms Rachel Rossiter, Centre for Psychotherapy, Hunter New England Health, P O Box 833, Newcastle NSW 2300

The University of Sydney

School of Behavioural & Community Health Sciences

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Rachel.Rossiter@hnehealth.nsw.gov.au

Information Sheet for the Research Project
Exploring the Experience of Mental Health Professionals
Practicing as Dialectical Behaviour Therapists

Version 2 5/12/2005

Dear Colleague,

We invite you to participate in the research project identified above which is being conducted by Rachel Rossiter as part of her Doctor of Health Science degree under the supervision of Dr Toni Schofield and Professor Mike Hazelton from the University of Sydney.

Why is the research being done?
Working with consumers with Borderline Personality Disorder (BPD) is frequently a very challenging part of the work of mental health professionals and can be associated with high levels of frustration, distress and burnout. While there is an increasing literature describing positive outcomes for clients with BPD from therapeutic approaches such as Dialectical Behaviour Therapy (DBT), research exploring the impact of training and practice as a DBT therapist upon clinicians is extremely limited. The research is being done to improve our understanding of the impact on staff of training and practice in DBT.

Who can participate in the research?
All mental health professionals in Hunter/New England Area Health Service who have trained in DBT and have either practiced this therapy in the past or are currently practicing as DBT therapists.

What are you being asked to do?
If you accept the invitation to participate in this study, you will be asked to attend an audiotaped interview conducted by an independent interviewer from the Qualitative Research Laboratory, University of Newcastle. The interview will be 1 hour in duration. The interview topics will include some demographic questions, questions about your experience of learning and practicing as a

DBT therapist and the impact that this has had on your professional and personal life. You will be able to review the recording to edit or erase your contribution. You will also be able to review the transcript of your interview and edit this prior to all personal identifying information being removed at the time of final transcription before release for analysis.

What choice do you have?
Participation in any and all aspects of the study is entirely voluntary and declining to participate will not affect an individual's status as an employee of Hunter New England Mental Health Service, or relationship with staff from the University of Newcastle or the University of Sydney. **Those agreeing to participate will be free to leave the study at any time without having to provide a reason.**

How will the information collected be used?
Participants need to be aware that all information collected may be used in a doctoral thesis in the first instance, but may also be used in publications and presentations arising out of the study.

How will your privacy be protected?
The information you provide during the interviews will be treated with the utmost confidentiality. Your interview will be audio taped and then transcribed into a word processing program. During transcription your name will be changed, so that only the interviewer knows your identity. The de-identified transcripts will then be given to the researchers for analysis. Following completion of the study all audiotapes will be kept in a locked filing cabinet in the Faculty of Health Science Building, University of Sydney for a period of five years and then erased.

Further information
If you wish to obtain further information about the results of the study you can do so by contacting Rachel Rossiter, Dr Toni Schofield or Professor Mike Hazelton. For further information about any aspect of the project please contact any of the researchers.

Yours sincerely,

Rachel Rossiter
Tel: 02 4924 6820
Rachel.Rossiter@hnehealth.nsw.gov.au
Michael.Hazelton@hnehealth.nsw.gov.au

Dr Toni Schofield
Tel: 02 9351 9577
t.schofield@fhs.usyd.edu.au

Professor Mike Hazelton
Tel: 02 4924 6602

This research has been approved by the Hunter Area Research Ethics Committee Reference No 05/05/11/3/15.

Complaints
Should you have concerns about the manner in which the research is conducted, it may be given to the researchers listed above, or, if an independent person is preferred, to Dr Nicole Gerrand, Professional Officer, Hunter Area Research Ethics Committee, Hunter New England Health, Locked Bag 1, New Lambton NSW 2305, telephone (02) 49214950, email Nicole.Gerrand@hnehealth.nsw.gov.au.

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Consent Form for the Research Project:
Exploring the Experience of Mental Health Professionals
Practicing as Dialectical Behaviour Therapists

Version 1, 20/03/05

Researchers: Dr Toni Schofield, Prof Mike Hazelton, Rachel Rossiter

I, _____ (please print your name) agree to participate in the above research project and give my consent freely.
I understand that the project will be conducted as described in the Information Statement, a copy of which I have retained.

I understand I can withdraw from the project at any time and do not have to give any reason for withdrawing.

I consent to participating in an audio-taped interview during which I will discuss my experience of learning to be a Dialectical Behaviour therapist and of practicing as a DBT therapist.

I understand that my personal information will remain confidential and that my identity will remain hidden to all except the study interviewer.

I have had the opportunity to have questions answered to my satisfaction.

Signature: _____

Date: _____

Title of Study: Exploring the Experience of Mental Health Professionals
Practicing as Dialectical Behaviour Therapists

- Thank you for agreeing to participate in this interview.

- You have had an opportunity to read the information sheet explaining the purpose of
- the study generally and this interview more specifically. If you have any questions, or
wish to clarify any matter related to the study, or the conduct of this interview please
feel free to raise these now, or at any stage during the interview.

- In the interests of safeguarding your anonymity I would ask that you refrain from
using your own name or that of any other colleague during the interview.

- If at any time you wish to erase any comment you have made, please let me know
and this will be done to your satisfaction.

Interview Topics:

A: Demographic questions.

1. Age
2. Gender
3. Social situation – does the person live locally?
4. Position in Mental Health
5. Education Background – highest qualification
6. Previous experience – other regions in which the person has worked.

B: Preliminary questions asking for thoughts and evaluations of practice.

1. How long have you been involved in learning and practicing DBT?
2. What do you understand DBT to be? (major focus of the therapy)
3. What prompted you to learn and practice as a DBT therapist?
4. (Assessing confidence) Do you feel that this is an effective therapy? Do you
like working in this therapeutic approach?

C:

1. How has DBT impacted upon your profession practice? In what ways?
2. How has DBT impacted upon you personally?
3. To what extent if at all do you think you are now a very different practitioner
and person as a result of your involvement in DBT?
4. Is there anything you want to tell me that we haven't covered?

D: Reasons for participating in the study.

DIALECTICAL BEHAVIOUR THERAPY
MENTAL HEALTH CLINICIANS' EXPERIENCE

Working with consumers with BPD is frequently a very challenging part of the work of mental health clinicians and can be associated with high levels of frustration, distress and burnout. While there is an increasing literature describing positive outcomes for clients with BPD from therapeutic approaches such as DBT, research exploring the impact of training and practice as a DBT therapist upon clinicians is extremely limited.

Researchers at the University of Sydney and Hunter/New England Area Health Service would like to talk to any mental health clinician who has trained and practiced as a DBT therapist.

If you would like to share your experience with us, then please call
………………………….

The University of Sydney

School of Behavioural & Community Health Sciences

Dialectical Behaviour Therapy

Major structural components (Linehan, 1993a)

- Individual therapy
    - Person with BPD allocated to an individual therapist. Therapist provides assessment, orientation to the program and assists the person to strengthen their commitment to participate.
    - Weekly appointments one hour/week. A minimum of 15 months required to cover pre-treatment stage and Stage 1.
    - Introduces person to distress tolerance skills, mindfulness and use of between session support prior to inclusion in skills training component.

- Skills training - 'psychoeducational therapy modules designed to teach specific behavioural, cognitive and emotional skills' (p. 87).
    - Two and a half hour group training delivered in modules of 8 weeks. Each module comprises two weeks of mindfulness training, followed by six weeks of distress tolerance, emotional regulation or interpersonal effectiveness training.
    - Participants attend a total of six modules throughout Stage I of the program (see Modus Operandi below for further detail).

- Between session support – primarily offered by means of phone consultation
    - Purpose of phone coaching as follows:
        - Intervene prior to unhelpful behaviours
        - Generalise skills outside of the therapy environment
        - Change or intervene in patterns of avoidance
        - Shape appropriate support seeking behaviours
    - Coaching used for:
        - Problem-solving – which skills to use in particular situations
        - Rehearsing a skill
        - Completing homework tasks
        - Repairing a relationship

- Therapist consultation group – 'Treating the Therapist' (p. 101)
    - 'The role of the DBT case consultation group is to hold the therapist inside the treatment (p. 101).

Stages of Therapy

Linehan (1993a, pp. 168-180) describes the stages of therapy in DBT as follows:

Pre-treatment Stage – Orientation and Commitment
This involves assessment, orientation to the program and working with the person with BPD to develop the person's commitment to the therapy.

Stage 1
Attaining Basic Capacities - Behavioural dyscontrol to behavioural control
The hierarchy of primary targets in individual therapy are:
- Decreasing suicidal behaviours
- Decreasing therapy-interfering behaviours
- Decreasing behaviours that interfere with the person's quality of life
- Increasing behavioural skills
The hierarchy of primary targets in DBT Skills training are:
- 'Stopping behaviours likely to destroy therapy
- Skills acquisition, strengthening and generalization
    - Core mindfulness skills
    - Interpersonal effectiveness
    - Emotion regulation
    - Distress tolerance
- Decreasing therapy-interfering behaviours' (p. 186)

Stage 2
Quiet desperation to emotional experiencing
This stage addresses 'the client's inhibited emotional experiencing. It is thought that the client's behavior is now under control but the client is suffering "in silence"...This is the stage in which post-traumatic stress disorder (PTSD) would be treated' (BehavioralTech LLC, 1996-2008).

Stage 3
Increasing Self-Respect and Achieving Individual Goals - Problems in living to ordinary happiness
'Stage III DBT focuses on problems in living, with the goal being that the client has a life of ordinary happiness and unhappiness' (BehavioralTech LLC, 1996-2008).

Stage 4
Incompleteness to capacity for joy
'This stage has been described as 'specifically for those clients for whom a life of ordinary happiness and unhappiness fails to meet a further goal of spiritual fulfillment or a sense of connectedness of a greater whole' (BehavioralTech LLC, 1996-2008).

NB: The texts written by Linehan (1993a; 1993b) focus primarily on the delivery of the pre-treatment stage and Stage 1 of DBT. Although Linehan has described the focus of Stages 2-4 to date these have not been manualized to the extent covered in disruptions of PreTreatment and Stage I. Bohus (2006) is actively working on the further development and articulation of Stage 2.

Modus Operandi

Pre-Treatment

Referral to treatment ⟶ Assessment Process ⟶ Accepted into DBT Program

Allocation to Individual Therapist

Commences individual therapy – 1hr/wk

Focus:
- Orientation to treatment
- Further assessment
- Gaining commitment
- Prepare for skills training

Proceed then to Treatment Phase
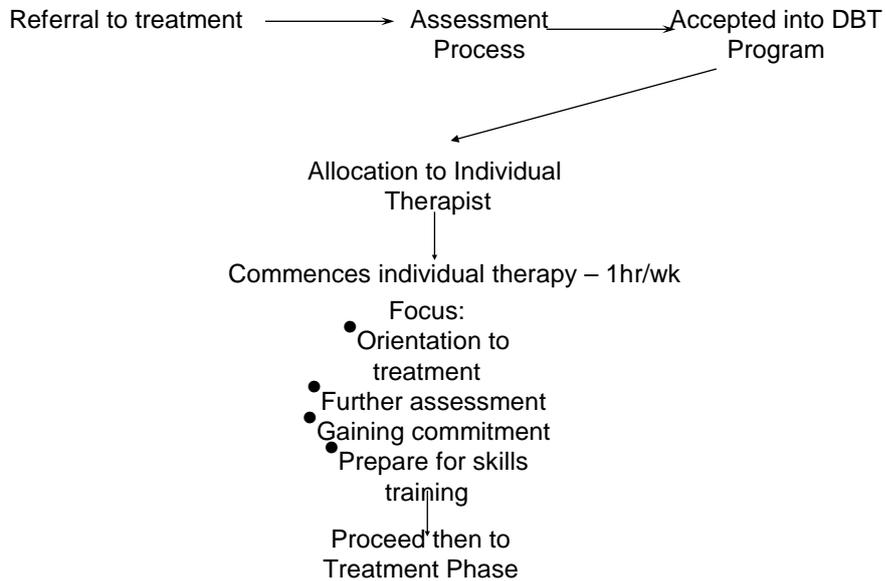
Stage I: Treatment Phase

Individual Therapy 1hr/week

Skills Training 2 1/2 hrs/week (approx 12 mths)

1	2	3	4	5	6
2 wks	2 wks	2 wks	2 wks	2 wks	2 wks
Core Mindfulness	Core Mindfulness	Core Mindfulness	Core Mindfulness	Core Mindfulness	Core Mindfulness
6 wks	6 wks	6 wks	6 wks	6 wks	6 wks
Interpersonal Effectiveness	Emotion Regulation	Distress Tolerance	Interpersonal Effectiveness	Emotion Regulation	Distress Tolerance

Phone Coaching

Phone available 8.30am – 10.00pm 7 days/week

Key Skills in DBT

The skills training component of DBT is described in great detail, including the provision of handouts and homework sheets, all of which are able to be photocopied to be used in the delivery of the therapy (Linehan, 1993b). Complete instructions for prospective skills trainers are outlined in the manual. Readers are encouraged to access the manual and textbook as the following provides a glimpse only of some areas of skills taught.

Mindfulness

Linehan describes mindfulness skills as 'central to DBT; they are so important that they are referred to as "core" skills. 'Mindfulness in its totality has to do with the quality of awareness that a person brings to activities' (Linehan, 1993a, p. 146). A New York Times journalist provides an effective description of the purpose of teaching mindfulness skills to people with BPD.

> One thing patients learn very early, for instance, is to notice when their emotions begin to stir, allow themselves to feel the storm whip up, then let it pass -- all without doing anything. This Zen-like self-observation, called mindfulness, is an exercise not in avoidance but in feeling and enduring emotional pain. It dramatizes one principle of the therapy: that what patients do can be independent of how they feel. Emotion does not have to rule behaviour (Carey, 2004, p. 1)

Participants are introduced to the concept of 'states of mind'. These states are described as 'reasonable mind', 'emotion mind' and 'wise mind'. Mindfulness is taught and practised throughout every aspect of the program. A set of clear instructions support the practice of mindfulness, these are as follows:

The 'What' Skills
- Observe
- Describe
- Participate

The 'How' Skills
- Non-judgmentally
- One-mindfully
- Effectively

(Linehan, 1993b, pp. 111-113).

Radical Acceptance

Radical acceptance, a skill vital to DBT, is defined as '*complete* acceptance from deep within' (Linehan, 1993a, p. 148).

Carey (2004) describes radical acceptance as

> the insistence that people in therapy accept who they are and not who they want to be. They cannot go back and repair their childhood, as awful as it might have been. They have blown precious relationships for

good. Most of all, they experience waves of rage, emptiness and despair far more intensely than other people do (p. 2).

Along side radical acceptance are further concepts such as the action of 'turning the mind' to make a commitment to accept and willingness to 'do just what is needed in each situation' 'listening very carefully to your wise mind'. In contrast to willingness is the concept of 'wilfulness' i.e. refusing to tolerate the moment (Linehan, 1993b, pp. 176-177).

Interpersonal Effectiveness Skills

This module of skills training presents the person with BPD with considerable challenges. The focus being to assist the person to develop more effective means of asking for what they need or saying no to requests. Group members are taught to utilise these skills while prioritising the most important focus for each interaction, i.e. achieving the objective, keeping the relationship or maintaining self respect.

Throughout skills training, Linehan (1993b) makes extensive use of acronyms as teaching aids. The following provides an example:

Guidelines for Objectives Effectiveness:
Getting What You Want

A way to remember these skills is to remember the term "DEAR MAN".

DESCRIBE
EXPRESS
ASSERT
REINFORCE

(stay) **M**INDFUL
APPEAR CONFIDENT
NEGOTIATE (p. 125)

Training Processes

BehavioralTech

'Behavioral Tech, LLC, founded by Dr. Linehan, trains mental health care providers and treatment teams who work with complex and severely disordered populations to use compassionate, scientifically valid treatments and to implement and evaluate these treatments in their practice setting'("BehavioralTech LLC," 1996-2008) .

Extensive information on training processes and guidelines are available on the website identified below:

http://behavioraltech.org/training/guidelines_new.cfm

It is important to note that currently there are no international affiliates for DBT training listed on the official Behavioral Tech website.

Swenson, (2000) a strong advocate for DBT, suggests that

> in 15 minutes, DBT can be coherently explained to a professional or a client. And in 80 hours of a 10-day intensive seminar spread over 6 months, the study and practice of the comprehensive treatment can begin (p. 90).

Identified strengths and weaknesses

DBT has achieved popularity as a treatment option despite the limited research base demonstrating efficacy in statistically significant sample sizes (Scheel, 2000; Swenson, 2000). Swenson (2000) attributes this popularity to a number of factors. He suggests that DBT 'contains within it four different orientations or models of treatment' (p. 89). These areas are seen as' biological, social-environmental, spiritual and behavioural' (p. 89) and as such are suggested to attract clinicians from a wide range of orientations who then find within DBT resonance with their approach to therapy.   He further asserts that 'DBT appeals because it brings together theoretical complexity and depth with a huge number of very pragmatic, directly usable interventions' (Swenson, 2000, p. 90).

A further strength of DBT is that it provides a supportive, highly structured team based approach that helps to avoid many of the difficulties associated with individual clinicians working in isolation with clients with BPD.

As identified in Chapter Two, a significant limitation of DBT is the very slim evidence base available to date demonstrating long-term benefits (Scheel, 2000). Scheel's (2000) extensive exploration of the empirical basis for DBT explores in close detail the research data available at the turn of the century. She highlights the need for further research to strengthen the claims made for DBT as an efficacious treatment for BPD. A further limitation is identified in regards to staff training and resources required for implementation of DBT. 'Specialized training and considerable staff time are required if the program is to be implemented in a fashion in keeping with the research base' (Scheel, 2000, p. 83).

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