Exploring the experiences of direct care staff working with adults with learning

disabilities who have a diagnosed borderline personality disorder

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Judith Storey

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Declaration

This thesis entitled 'Exploring the experiences of direct care staff working with adults with learning disabilities who have a diagnosed borderline personality disorder' has been submitted for the degree of doctorate in clinical psychology and is based upon work conducted by the author in partial fulfilment of the degree of Doctorate in Clinical Psychology at the University of Leicester. All of the work recorded in this thesis is original unless otherwise acknowledged in the text or by the references.

For mum and dad

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Word Count

		Body	References	Body + References
Section One:	Literature Review	8,643	2,972	11,615
Section Two:	Research Report	12,446	1,964	14,410
Section Three:	Critical Appraisal	5,340	847	6,187
Total excluding appendices				32,212
Section Four:	Appendices			3,770
Total including appendices:				35,982

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Addenda: **Transcripts**

Addendum: The interview transcripts are in two separately bound volumes

Abstract

Exploring the experiences of direct care staff working with adults with learning disabilities who have a diagnosed borderline personality disorder

Section 1.   Literature Review

Aim:　　　　To review the literature relevant to staff's experiences of working with people who have learning disabilities, who display challenging behaviour.

Method:　　A computerised literature search was conducted using various databases.

Results:　　Staff working with people who have a learning disability and who display challenging behaviour experience negative emotions. The literature regarding challenging behaviour and staff's experiences may benefit from incorporating existing research regarding the impact of organisational factors and the patients' mental ill health upon staff's experiences.

Discussion:　Methodological limitations in the existing research are discussed and future research ideas are proposed to enable a more holistic understanding of direct care staff's experiences.

Section 2:   Research Report

Aim:　　　　To explore the experiences of staff who have worked with learning disabled patients who also have a diagnosed borderline personality disorder.

Method:　　A free association narrative interview approach was used to analyse the accounts of eight direct care staff (Hollway & Jefferson, 2000).

Results & Discussion:　Working with patients who have a learning disability and a diagnosed borderline personality disorder is emotionally demanding. Participants did not appear comfortable in sharing their personal emotional experiences. It was thought this was because these were very painful and staff were concerned they would be criticised for voicing negative feelings about these patients. Staff appeared to manage their painful emotional experiences of their work by using a number of psychological defence mechanisms. These included projecting and expressing their negative feelings onto the organisation, and/or by trying to forget and repress these negative experiences.

Conclusion:　Organisational factors can be problematic and need to be addressed to reduce the obstacles staff experience in their work with patients who have a learning disability and also a borderline personality disorder. However, when staff comment upon these organisational factors they may also be indirectly expressing the emotional impact these patients are having upon them. Once the organisational factors have been addressed staff may begin to feel more supported and safe enough to being to explore the painful emotional reactions they have experienced in their work with their patients without the fear of being criticised by others.

Section 3:   Critical Appraisal

Critical reflections upon the research methodology and process are provided.

Author: Judith Storey

Section One

Literature Review

Exploring the experiences of direct care staff who work with people with learning

disabilities who exhibit behaviour that challenges those around them

1.   Abstract

Research that has attempted to explore the experiences of staff working with learning disabled adults who exhibit challenging behaviour has done so by looking at a number of issues including staff's emotional reactions, causal beliefs, behaviour and organisational factors. These, and the possibility that some forms of challenging behaviour may well be manifestations of mental ill health, need to be taken into account in future research. The recognition that learning disabled people may develop mental ill health, including Borderline Personality Disorder (BPD) may enable them to access more appropriate psychological treatments. Direct care staff have a key role in the implementation of any treatment package for people who have a Learning Disability (LD) and who exhibit challenging behaviour. It is therefore important to clarify whether working with patients who have a LD and a diagnosed mental health problem generates unique experiences for direct care staff, and whether these experiences require professionals to provide unique forms of support to these staff.

Keywords: Learning Disability, Challenging Behaviour, Borderline Personality Disorder, Staff's Experiences and Countertransference.

2.   Introduction

The aim of this review will be to outline the research that has explored the experiences of direct care staff working with people who have a Learning Disability (LD) and who have also been labelled as exhibiting challenging behaviour.

This review will begin by summarising the need and search strategy used for such a review. It will then go on to outline definitions for Learning Disabilities (LDs) and challenging behaviour. The clinical implications of challenging behaviour, prevalence rates and interventions used to manage this will then be discussed. Literature exploring specific aspects of staff's experiences in relation to challenging behaviour will then be summarised. It will be argued that some types of behaviour exhibited by a person with a LD have historically been labelled as challenging, but may be an indication of mental ill health. This is based on high prevalence rates of mental ill health for people who have a LD and who exhibit challenging behaviour. Reasons for such high prevalence rates and the way mental ill health may manifest in people with LDs are explored. An argument will be made that people with LDs are at greater risk of developing Borderline Personality Disorder (BPD) (Eaton & Menolascino, 1982; Jones, Davies & Jenkins, 2004). The reasons for this increased risk and the treatment programmes currently being explored for such a client group will be provided. These treatment programmes include psychodynamic approaches. The impact of introducing such approaches upon staff working within LD services is discussed. Using the evidence available the experiences of direct care staff working with patients who have a LD and also a BPD, and the type of support the staff may find helpful in relation to this type of work are explored. Methodological limitations of the research contained in this review will then be highlighted. It will be argued that there is a need for more qualitative research to complement and supplement the existing

research available. In light of this argument future research ideas will be put forward.

3.   Rationale For The Review

The rationale for the review is based upon the argument that the majority of people with LDs who display challenging behaviour (and who may have mental health problems) often receive on-going support from direct care staff (Mansell, 1993). It is these workers that are often asked to implement treatment packages and manage the behaviour of these patients. (The term patient and clients will be used interchangeably throughout this review and will refer to the person who has a LD receiving support either in hospital or community settings). A dominant belief in the psychology literature based on the existing research is that providing support to direct care staff in the form of training and supervision is indirectly supporting and potentially enhancing the care these patients receive (Emerson, Hatton, Bromley & Caine, 1998). Research that attempts to provide a more integrated and holistic view of the experiences of these direct workers may help those who are trying to support them have a greater appreciation of their overall needs. This increased appreciation and understanding will increase the likelihood that the support being provided is needed, welcomed and effective.

4.   Search Strategy

Searches included using strings of words based upon the nomenclature for 'learning disability'; 'challenging behaviour'; 'staff'; 'experience'; 'mental health'; 'personality disorder'; 'qualitative research'; and 'psychodynamic' within the computerised databases

Psych-Info (1887-2007), Med-line (1966-2007) and Web of Science (1970-2007). There was not a specific exclusion criterion to these searches due to the breadth of the topic. Cited searches were completed on key papers and experts in the various fields were contacted via email. The preliminary search was started between June and September 2005. A second search to ensure more recent papers had been included occurred between August 2006 and January 2007. This review therefore was as comprehensive as possible but due to time limits and resources is not systematic but narrative in structure and style.

5.   Definitions

5.1.   Learning Disability (LD)

To aid discussion the term learning disability/learning disabilities (LD/LDs) will be used throughout. This refers to a person who meets the following three criteria: a significant impairment of intellectual functioning (an IQ score below 69), a significant impairment of adaptive/social functioning and age of onset before adulthood (British Psychological Society, 2000). It is acknowledged that using such terms and criteria are not without their political and ethical dilemmas (Krahn, Hammond & Turner, 2006). For example these criteria are currently used to gate-keep services within Social Services and the National Health Service in the UK (Department of Health, 2001).

5.2.   Challenging Behaviour

The term 'challenging behaviour' was originally developed to encourage organisations to address aspects in their environment that may cause adults with LD to engage in behaviour that challenged (Blunden & Allen, 1987). As a way to facilitate this goal, research has attempted to identify, categorise and quantify types of behaviour that

staff and services tend to find challenging (Emerson & Bromley, 1995). This has arguably enabled psychologists to evaluate whether certain interventions have helped to 'reduce' challenging behaviour. However, this focus in the research literature, upon quantification and categorisation, has led researchers (and clinicians) to neglect to explore in as much depth other factors that may be having an influential effect upon the challenging behaviour that a person with LDs is said to exhibit. For example, even if the argument that it is actually possible to reliably measure challenging behaviour is accepted, which is debateable (Clegg, 1994), there has been very little focus upon the clients' views about their own behaviour, the topography of staff's behaviour or environmental factors (Blunden & Allen, 1987). It is thought that the neglect in research upon these potentially influential aspects regarding challenging behaviour has reinforced the discriminatory belief that challenging behaviour is an individual problem and that the treatment of such a problem should be focused on and in the person with LDs (Heyman, Swain & Gillman, 1998). To address this, the term challenging behaviour within this review will refer to the individual, social and environmental factors that may cause, maintain and/or reduce challenging behaviour.

5.2.1. Clinical implications.

Irrespective of the problems about the use of the term LD, and the narrow focus of the term challenging behaviour in research literature, there does appear to be a clinical need to explore the needs of a particular group of people who have a LD and who have also been labelled as engaging in behaviour that challenges those around them. This is because this type of behaviour has been shown to cause them, their families, and the staff that work with them, pain, injury and distress (Bromley & Emerson, 1995). It is therefore thought to be important to continue to explore individual factors regarding this type of behavior including the impact of mental ill health, but to also widen the focus to include

the physical environment in which the learning disabled person lives and/or the behaviour of others, namely the direct care staff that work with them. A greater understanding of these factors regarding challenging behaviour may help broaden the focus of interventions and improve their effectiveness.

5.2.2. Prevalence.

UK studies suggest that between five and 15 per cent of all people with LDs who are known to services show behaviours that present significant challenges to carers (Qureshi & Alborz, 1992). This appears to be similar to that found by North American studies (Borthwick-Duffy, 1994). However, these estimates of the prevalence of challenging behaviour need to be read with caution as they are influenced by methodological problems including differences in definition, measurement and sampling strategies.

5.2.3. Interventions.

A number of literature searches and meta-analyses have concluded that behavioural interventions appear to be the most effective interventions for reducing the incidence of challenging behaviour in people with LDs (Didden, Duker & Korzilius, 1997; Scotti, Evans, Meyer & Walker, 1991). These results should be read with caution. This is because up until recently medication and/or behavioural interventions were almost the only interventions used with people with LDs (Porterfield, Blunden & Blewitt, 1980). This was based on the mistaken, and arguably discriminatory, belief that other interventions would not be appropriate. This belief is being challenged and there exists a smaller but growing body of evidence for the success of other interventions based on systemic, psychodynamic and cognitive-behavioural approaches (Baum & Lynggard, 2006; Beail, 2003; Black, Cullen & Novaco, 1997).

Nevertheless, success of behavioural interventions provides support for the hypothesis that the behaviour of others (i.e. direct care staff) can have a direct influence on the clients' challenging behaviour (Ball, Bush & Emerson, 2004). This has led to research exploring the emotions staff report they experienced when working with people with LDs who engage in challenging behaviour. This is based upon the assumption that staff's emotional reactions to challenging behaviours may be influenced by their understanding about the causes of challenging behaviour (Hastings & Brown, 2002). Staff's understanding about what causes this behaviour may in turn influence their future interactions with this client group. Their beliefs about what causes particular behaviour in their clients may therefore influence the level of commitment they have in implementing behavioural interventions and as a result impact upon the quality of the service provided (Hastings & Brown, 2002, Mitchell & Hastings, 2001). Understanding what factors do influence staff's experience may in turn enable more effective support to be offered to these workers. The three factors, emotions, causal beliefs and reactions to challenging behaviour do appear to be linked and will now be outlined.

6.   Direct Care Staff's Experiences Of Working With Learning Disabled Adults Who Also Exhibit Behaviour That Challenges

6.1.   Staff's Emotional Reactions

The quantitative research that has explored the emotions staff experience has relied predominantly upon responses to questionnaires (Bromley & Emerson, 1995; Hastings & Remington, 1994). The evidence from this research suggests that staff frequently experience negative emotions when working with this client group (Hastings, 1996;

Mitchell & Hastings, 1998). These emotions include sadness, despair, anger, annoyance, fear and disgust (Bromley & Emerson, 1995). Variables, including level of staff experience, have been investigated to see if this influenced the level of negative emotions that staff reported. Hastings *et al*. (2003) found that the more experienced the staff the fewer negative emotions reported. It was suggested that the more experienced staff felt more able to deal with challenging behaviour (i.e. implement behavioural strategies) and so felt in more control and less negative about their clients. In contrast Hastings and Brown (2002) found that the more qualified/experienced staff expressed stronger negative emotions. They hypothesised that this maybe due to the increased responsibility these staff members felt for dealing with challenging behaviour. These two studies although appearing to be contradictory do suggest that the role of the staff member and the context in which they work may influence their experiences.

Qualitative studies exploring staff's feelings about challenging behaviour support the finding found by quantitative methodology, that when staff are asked if they experience negative emotions they report that, yes they do. However, these studies go on to report that staff's emotional reactions appear to be mediated by the way staff understand and relate to clients (Jahoda & Wanless, 2005). In turn factors such as the length of time staff have known the client and the perceived level of ability of the client appeared to influence the type of relationship that staff were able to establish with them and the emotions they experienced as a result of this (Clegg, Standen & Jones, 1996).

This research has highlighted the emotional experiences of direct care staff; they experience intense and potentially negative feelings when working with this client group. However, a major criticism is that this research appears to be based upon the assumption that staff will only have negative reactions when positive reactions are possible (Bell &

Espie, 2002). It also appears to reinforce the belief that it is bad to have negative emotions and that these should be eliminated. It is possible that where there is less reporting of negative emotions staff are simply not reporting their negative feelings for fear of reprisal from their managers (Hastings, 1995). However, this is often not considered and a reduction in the level of negative emotions being reported is simply viewed as a good thing by some (Hastings, 1995) when it could actually be an indication of staff denying such emotions as a way of coping (Thomas, 2001). Furthermore, the view that negative emotions should be reduced is in direct contrast with research in other disciplines that view the presence of negative feelings in response to clinical work as being understandable and clinically informative and should be analysed not eliminated (Main, 1957).

6.2.   Staff's Causal Beliefs

A number of studies have explored staff's causal attributions of challenging behaviour (Bromley & Emerson; 1995, Hastings, 1995; Hastings, Reed & Watts, 1997; Stanley & Standen, 2000). In the majority of these studies the researchers categorised the behaviour of the clients by their topography, (e.g. aggression to others, self-harm and stereotyped behaviour such as body rocking) (Hastings *et al*., 1997). The aim of these studies was to explore the level of staff's knowledge of behavioural approaches. They indirectly provide evidence that staff are aware of a range of causes of challenging behaviour. These include the person's internal mood state; their environment; self-stimulation and challenging behaviour as a form of communication (Hastings, 1996).

Studies by a number of researchers have argued that the beliefs staff hold about the causes of certain behaviours might influence their emotional reactions to it (Bromley & Emerson, 1995; Hastings, 1995; Hastings *et al*., 1997; Stanley & Standen, 2000). These studies have also suggested that staff's beliefs about what causes certain behaviours may

also influence what staff will feel is possible and appropriate to try to address in their work with clients (Bromley & Emerson, 1995; Stanley & Standen, 2000). For example if staff believe a particular behaviour is self-stimulatory i.e. body rocking, when staff observe a client engaging in this type of behaviour they may conclude that this client is bored. Staff may then address this by providing more activities. However the evidence to support the links between staff's causal beliefs, their actions and their emotional reactions to challenging behaviour has been inconclusive (Hastings, 2002).

6.3.   Staff's Behaviour

The research that has attempted to explore staff's responses to challenging behaviour is difficult to separate from the research exploring staff's reported emotions. This is because a great deal of the research has tried to explore the relationship between staff's emotions and behaviours. It also appears to provide contradictory findings. For example, Stanley and Standen (2000) attempted to explore the clients' level of ability and how this may influence the carers' perceptions of control, negative affect and response. The more able clients were and the more aggressive clients were to others, the less likely staff reported a desire to help. This supported the conclusion made by Oliver *et al.* (1996) that staff may cope with the negative emotions aroused in them when dealing with challenging behaviour by subsequently avoiding those clients in the future.

Hellzen *et al*. (2004) reported similar findings; staff that participated in their study expressed less of a desire to help when they believed the patient was more able and in more control of their aggressive behaviour. However, Hellzen *et al.* (2004) also found that despite these feelings staff reported that they actually provided more help and assistance to these particular clients. This study therefore suggests that there may be a difference between what the staff would like to do and what they actually did. One drawback with

this quantitative research is that it relies on staff's reports and not upon direct observation.

6.4.   Interim Summary

There do appear to be statistical correlations between staff's negative feelings, causal beliefs about certain behaviours, and their behaviour (Jahoda & Wanless, 2005), although such correlations are not evidence of a direct causal link (Hastings, 2002). However, the presence of these statistical correlations have been used as evidence to support the dominant belief that when working with clients with LDs, behavioural interventions are the treatment of choice for challenging behaviour, and staff continue to be encouraged to implement them and are criticised if they do not (Ager & O'May, 2001). Implicit in this recommendation is the belief that the more knowledge and confidence staff have about implementing behavioural interventions the more likely they will feel able to manage challenging behaviour. This belief also implies that if a person does engage in challenging behaviour this is a sign of staff failing, rather than due to other possibilities such as the emotional distress of the client or the physical environment. As a result, the most commonly cited recommendation to help support staff at present is for professionals to provide more training about behavioural interventions and to provide supervision to monitor their progress in utilising these methods (Allen *et al.*, 1997; Emerson *et al.*, 1998).

A number of studies challenge the view that training alone is effective by providing evidence that suggests training does little to improve staff morale or change their practice over time and place (Heyman *et al.*, 1998; McVilly, 1997; Rose, Jones & Fletcher, 1998; Smith, Parker & Taubman, 1992). It is possible that staff are simply not receiving the right training and working more collaboratively with direct staff would help improve the quality of training and improve their management of challenging behaviour (Clegg, 1994). This merits further exploration. However, it may also be prudent to begin to question the high

expectations placed on training to solve all the issues relating to challenging behaviour. Yet, this does not appear to happen very often in the LD literature. This may be due to the fact the recommendation of more training reflects researchers' beliefs about challenging behaviour and the role staff play in its cause and maintenance (Hastings, 1995). This particular recommendation keeps the focus upon the direct care staff and their role in terms of reducing challenging behaviour rather than exploring the other contributing factors such as organisational and cultural factors, that can be overlooked (Schein, 2003). Research undertaken from a more systemic and sociological perspective does appear to support the idea that staff training, although having a role in addressing challenging behaviour, will have little impact upon staff performance if it is provided without attention being paid to organisational change (Menzies, 1960). Organisational factors, and how these may influence staff's experiences when working with learning disabled people who exhibit challenging behaviour, will now explored.

7.   Organisational Factors

UK surveys have found that one third of staff working in LD services report high levels of stress (Hatton *et al.*, 1999) almost twice as high as the UK adult population (Bennett *et al*., 1995). Staff stress has been implicated in poor staff performance, for example, in relation to implementing behavioural interventions, staff absenteeism and turnover (Rose *et al*., 1998). It is recognised that a contributory factor to this high level of stress could be due to the fact that the staff who work in the LDs services come into contact with people who exhibit challenging behaviour (Hakeem & Fitzgerald, 2002). This is supported by the strong emotional reactions that staff report they experience in response to such behaviour (Hastings & Remington, 1994). These emotions may then go on to

negatively influence staff's psychological well-being and stress levels (Hellzen *et al.,* 2004). However, Hastings (2002) has recommended that this evidence should be viewed with caution due to the methodological weaknesses of this research including little exploration of alternative explanations. He concluded that there might well be other factors influencing staff's stress levels.

Other factors that may be influencing staff's experiences could be some of those identified in a study conducted by Emerson and Emerson (1987). This study asked staff to identify the main obstacles they thought were preventing them from implementing behavioural interventions. The responses from staff highlight a number of organisational factors that arguably did not and still do not get as much attention as staff's individual emotions, beliefs and behaviours. These organisational factors included staff shortages, the use of temporary staff, overcrowding and the heterogeneity of patient needs on any one ward as problematic, along with a lack of support in actually implementing recommended interventions (Emerson & Emerson, 1987).

The study by Hatton *et al*. (1995) found similar evidence to support the view that organisational factors play a key role in staff's experiences. This study found that staff reported finding challenging behaviour difficult and stressful but that they rated this as less stressful than organisational factors such as lack of resources, work overload, and difficulties with other staff such as high staff turnover and absenteeism. These factors often led to direct care staff who did not go off sick, having to work harder than before (Hochschild, 2003). Staff absenteeism also affected staff's style of interaction with clients; they became more custodial and interacted less with clients on consecutive working days (Duker, Seys & Van Leeuwe, 1991). It would appear that an optimal level of staff is needed for staff to feel able to concentrate on relationship issues with clients (Clegg *et al*.,

1996).

7.1. Interim Summary

It is possible that some staff would benefit from more training. However, it is equally possible that staff may experience the offer of help in the form of training as critical and invalidating, since it is based on the implicit assumption that staff do not know what to do. It also does not take into account factors such as sub-optimal staffing levels (Emerson & Emerson, 1987) that may be preventing staff from doing what they know they should be doing. It is therefore important for professionals to take into account the impact of organisational factors upon staff's experiences to avoid their offer of support being experienced as judgemental. Another aspect that may influence staff's experiences but that does not appear to have been explored in any depth is the mental health of people with LDs. This aspect will now be explored.

8. Mental Health Issues And Challenging Behaviour

In the field of LDs the majority of behaviour that is difficult to understand and manage is often labelled as challenging behaviour. The research that has explored staff's experiences of working with people who have LD is based upon this assumption. However, there is now growing evidence to suggest that some aspects of challenging behaviour may be an indication of mental health problems in people with LDs. For example challenging behaviour may be evidence of anxiety, depression, schizophrenia or personality disorders (Flynn, Matthews & Hollins, 2002; Marston, Perry & Roy, 1997; Moss, Emerson & Kiernan, 2000; Reiss, 1994). It will be argued that this is another factor that may have an impact upon the experiences of staff working with people with LDs.

The research exploring the link between challenging behaviour and mental ill health is very circumscribed when compared to research exploring challenging behaviour alone. A reason for this may be due to the effect of 'diagnostic overshadowing'. This is when professionals assume the behavioural problems of people with a LD such as self-injury, impulsivity, aggression and affective lability are a consequence of the LD (cognitive deficits, emotional immaturity, and neuro-dysregulation) rather than evidence of a separate mental health problem (Mason & Scior, 2004; Reiss, 1994). This lack of recognition of the mental health needs of people with LDs provides one explanation for their exclusion from mainstream mental health services and the lack of psychological therapy being offered to them (Department of Health, 1998). With the call for more integration of services (Department of Health, 2001) and the development of the Diagnostic Criteria for psychiatric disorders for use with adults with a Learning Disability (DC-LD) (Royal College of Psychiatrists, 2001) this segregation may diminish.

8.1.   Prevalence

In view of the lack of research exploring the impact of the mental health needs of people with LDs on staff's experiences, it is interesting to note that prevalence rates of mental ill health are higher for this client group compared with rates within the general population (Holden & Gitlesen, 2003; Hudson & Chan, 2002). Rates have ranged from 10% (Borthwick-Duffy & Eyman, 1990) to 91% (Linaker & Nitter, 1990). Clearly these rates need to be read with caution in view of the problems regarding diagnosis, sampling, and location i.e. hospital versus community. However, taking into account the traumatic life events and the discrimination that people with LDs experience (Hastings *et al.,* 2004; Thompson, 1997) it would be unwise to dismiss these rates as artefactual.

8.2.   The Link Between Mental Ill Health And Challenging Behaviour In People Who

        Have A LD

Bouras and Drummond (1992) explored the relationship between mental ill health
and challenging behaviour. They found nearly half of all behaviour problems appeared to
co-exist with a diagnosable psychiatric disorder within a sample of 318 adults living in the
community. Rojahn, Borthwick-Duffy and Jacobson (1993) reported similar findings and
found evidence that suggested that the more severe the challenging behaviour exhibited by
a person with LDs the more likely they were to have a mental health problem.

Research into how particular mental health problems may manifest in people with
LDs has been conducted (Kishore, Nizamie & Nizamie, 2005; MacHale & Carey, 2002;
Marston *et al*., 1997). Hemmings *et al*. (2006) attempted to identify specific mental health
problems with specific typography (types of behaviour). They suggested that symptoms of
depression appeared to be correlated more with challenging behaviour and symptoms of
anxiety correlated more with self-injurious behaviours. However it is acknowledged that
this type of research exploring the relationship between challenging behaviour and mental
ill health is still relatively new and problems remain regarding diagnosis and identification
of mental ill health in this client group (Holden & Gitlesen, 2003; Rojahn *et al*., 1993;
Tsiouris *et al.,* 2003). Nevertheless clinicians and researchers alike are now
acknowledging that challenging behaviour may be an indication of mental ill health in
people with LDs. With this acknowledgement comes the recognition that people with LDs
experience difficult thoughts and feelings and may benefit from adapted treatments
available to the general population (Whitehouse *et al*., 2006).

This review will focus upon BPD because many of its diagnostic criteria are
arguably similar to behaviours commonly observed and labelled as challenging in people

who have a LD (American Psychiatric Association, 1994; Hurley & Sovner, 1988; World Health Organization, 1993). These include self-injury, impulsivity and aggression. It is hypothesised that many people who have a LD and who have been labelled as having challenging behaviour may well have an undiagnosed BPD (Dunn & Bolton, 2004). The issues regarding the diagnosis of BPD will now be discussed.

8.3.   Diagnosis Of BPD

The diagnosis of personality disorder (PD) and in turn BPD is fraught with theoretical, diagnostic and ethical controversies (Kendell; 2002; Mental Health Foundation, 2001; Silk, 2002; Tyrer & Stein, 1993). For example it has been argued that because there is not an agreement on how to define 'personality' it is not possible for clinicians to define a 'disordered' personality (Jarrett, 2006; Parker *et al.*, 1993). The instruments that clinicians use to diagnose PD and BPD have also been called into question. This is because these instruments categorise and define mental health problems based upon behavioural manifestations of the disorder in question (American Psychiatric Association, 1994; World Health Organisation, 1993). Using such an approach to diagnosis has been heavily criticised for many reasons including their failure to take into account people's thoughts, feelings, and their social and political environment, (Boyle, 2007; Parker *et al.*, 1993). There are also many ethical issues regarding PD/BPD (Nehls, 1998). For example there is an on-going debate about whether PD/BPD should be defined as an illness. This debate has led to some to argue that PD/BPD is not an illness and is therefore not treatable (Kendell, 2002). It has been argued that this debate about treatability has been used to stigmatise and exclude people from treatment and services (Alwin *et al*., 2006; Department of Health, 2003). This controversy over treatability has also arguably contributed to clinicians reporting experiences of helplessness and hopelessness, and feeling less empathy and even reporting disliking for such patients

(Gallop, Lancee & Garfinkel, 1989; Lewis & Appleby, 1988). It has been argued that these reactions are a result of labelling (Nehls, 1998). There is now a small but growing body of evidence of successful psychological interventions which may help address clinicians' reported feelings of helplessness (Bateman & Fonagy, 1999; Linehan, 1993), and specialist services are being developed to try and avoid PD/BPD continuing to be a diagnosis that leads to exclusion (Alwin *et al*., 2006).

It is recognised that there continue to be problems associated with using the terms PD and BPD. However, there appears to be a clinical reality of a group of people that exhibit certain behaviours that seem to fit the categories of PD and/or BPD whose care needs challenge services. It is argued that changing the diagnostic measures, or terms to refer to PD and BPD will not change the clinical problem (Linehan, 1993; Naik, Gangadharan & Alexander, 2002; Paris, 1994; Sinason, 1989). Furthermore, these terms although unsatisfactory provide a starting point for clinical communication and further research (Alwin *et al*., 2006). Therefore in spite of the arguments against the use of such terms, they will be used here to aid discussion (Paris, 2005). BPD will therefore be defined in this review as a specific PD that is characterized by the presence of 'a pattern of instability of interpersonal relationships, self-image, and affects, and marked instability' that begins by early adulthood and is present in a variety of contexts (DSM-IV, American Psychiatric Association, 1994; ICD-10, World Health Organization, 1993) (See Appendix A for more details of the diagnostic criteria).

8.4.   Prevalence Of BPD In People With LDs

Prevalence figures for PD in the general population have been estimated at 2% (American Psychiatric Association, 1994; World Health Organization, 1993), whereas the prevalence rates in people who have a LD range from less than 1% (Deb & Hunter, 1991)

to 91% in a community setting (Goldberg, Gitta & Puddephatt, 1995; Khan, Cowan & Roy, 1997) and 22% (Reid & Ballinger, 1987) to 92% in hospital settings (Flynn *et al.,* 2002). These rates need to be read with caution in view of problems regarding diagnosis and sampling. Specific prevalence rates for BPD in people with LDs have yet to be developed. However a number of researchers have suggested that people with LDs have an increased risk of developing a BPD due to their organic predisposition to overreact to stimuli, their potential problems with understanding social-interpersonal interaction, their increased risk of suffering from childhood sexual abuse, and higher rates of experiencing attachment problems in childhood (Eaton & Menolascino, 1982; Flynn *et al.,* 2002; Jones *et al.*, 2004). It may therefore be unwise to dismiss the high prevalence rates of PD in LD as being inaccurate (Flynn *et al.,* 2002). Nevertheless, in clinical practice the diagnosis of personality disorders and in turn BPD does not happen very often (Naik *et al.,* 2002); this is possibly a reflection of diagnostic overshadowing (Reiss, 1994). It is therefore possible that direct care staff working with a person who has a LD and who is also exhibiting challenging behaviour may be working with someone who has a LD and an undiagnosed BPD (Dunn & Bolton, 2004; Moses, 1999).

8.5.   Interventions For Learning Disabled People Who Also Have A BPD

Interventions designed to help address BPD in people who have a LD are in the early stages of development, although it is generally agreed that due to the complexities of this disorder, interventions should be multi-modal, incorporating psychological, pharmacological and behavioural components (Dunn & Bolton, 2004; Esbensen & Benson, 2003; Goldberg *et al.*, 1995; Mavromatis, 2000; Wandel & Prince, 1991; Wilson, 2001).

In view of the long history of using behavioural and pharmacological approaches in the LD field it is thought that incorporating these approaches into a treatment package

designed to treat patients with a LD, and who also have a BPD, may not be too much of a cultural shift for direct care staff. However, this may not be the case when applying other psychological approaches (Sturmey, 2005) particularly developed from psychodynamic foundations. This is because behavioural and psychodynamic approaches appear to be based upon two different epistemological and ideological positions. This has led to many behaviourists rejecting psychodynamic ideas because they are not supported by what they recognise as evidence and vice versa. It may be more useful to attempt integration rather than to reject one or other approach, but epistemological differences may explain why there has been such conflict between these two approaches (Clegg, 1994).

One approach used from the psychodynamic field to help treat patients with a LD and also a BPD has included consideration of staff's countertransference reactions (Esbensen & Benson, 2003; Mavromatis, 2000). Countertransference reactions were described in these studies as feelings that the client aroused in the particular staff member. (See Appendix B for a more in depth account of countertransference and other related concepts). Such ideas have been utilised by individual therapists and staff teams with non-learning disabled people with BPD for some time (Book, Sadavoy & Silver, 1978; Brown, 1980; McIntyre & Schwartz, 1998; Rosenbluth, 1991). This is based on the belief that the emotions engendered in staff by specific patients, if reflected upon, will help increase staff's awareness of their patients' inner world (Book *et al.,* 1978; Brown, 1980). However, as explained, these ideas have not been used so widely within the LD field and may be harder to integrate into staff's existing knowledge and practice (Hodges, 2003).

8.6.   Staff's Experiences Of Working With Adults Who Have A LD And Also A BPD

The research in the non-disabled literature suggests staff experience patients who have a BPD as being more difficult to work with than patients who have other mental

health problems such as schizophrenia or depression (Markham & Trower, 2003; O'Brien & Flote, 1997). However, there has not been a study focusing specifically on the experiences of direct care staff working with learning disabled adults who also have a BPD. It is therefore unclear how staff experience these specific clients. Nevertheless, the small number of studies that have attempted to explore treatment packages for such patients do suggest that to be successful they require a great deal of support and commitment from the direct care staff (Esbensen & Benson, 2003. Team cohesion was also identified as being important in order to avoid the patient splitting the team (Wilson, 2001). There was also evidence that working with these particular clients could also elicit intense emotional reactions in staff (Wandel & Prince, 1991).

8.7. Interim Summary

There is clearly a lack of research exploring staff's experiences of working with learning disabled adults who also have a BPD. The evidence outlined here is based on research that was primarily focused upon treatment, which does appear to be similar in some ways to the research exploring staff's experiences of working with learning disabled adults who exhibit challenging behaviour (e.g., experiencing negative emotions). The main difference is that the researchers recommend that staff explore their countertransference. Historically, countertransference was thought to interfere with the staff's understanding resulting in behaviour that met the staff's needs rather than the client's, which was seen as something to be avoided (Kiesler, 2001). This may well help explain when staff do experience intense (possibly negative) emotional reactions towards their clients they may feel guilty, even ashamed, and try to conceal them due to this historical (and arguable dominant) belief that this is a sign of weakness (Main, 1957). This view has been challenged in non-learning disabled literature and it is now recognised that staff's feelings about a client can be informative (Casement, 1985). Countertransference is

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therefore possibly something to examine and to re-introduce to mental health nursing (Gallop & O'Brien, 2003). Such a suggestion appears to be in contrast with the LD literature, which often suggests strategies that appear to be aimed at reducing staff's experiences of emotions rather than using them for clinical use. It is possible that trying to reduce any type of emotional reaction that staff experience may be inappropriate if the staff are working with learning disabled adults who also have a BPD. This contrast in approach merely highlights the historical and ideological separation of research relating to LDs and mental health issues (Bouras & Holt, 2004). It is very important for staff to become more aware of the mental health needs of people with LDs as it may provide additional explanations and additional coping mechanisms when working with challenging behaviour (Berry, 2003; Dunn & Bolton, 2004).

9. Methodological Limitations Of Existing Research

Most research within the LD literature has been based on a realist epistemology using a quantitative methodology (Hastings, 1996). This has helped to generate an awareness of staff's experiences when working with people with LDs. However, quantitative methodology supports particular methods of exploring staff's experiences, these methods and their potential limitations will now be outlined. The impact of the power imbalances between researcher and participants will also be outlined along with the use of behavioural approaches in LDs research and how this may impact on patients and staff. One solution may be to engage in qualitative research.

9.1. Using Questionnaires

A key factor linked to epistemology is the measures that are thought to be

appropriate when exploring staff's beliefs and experiences. The most common measure used within LDs is the questionnaire. There are two main problems with this. Firstly, the questions used in a questionnaire are often based upon what the researcher assumes to be important factors rather than what the staff may feel to be important. The second problem is that there is an implicit assumption that the participant's responses to such questionnaires reflect conscious and rational thought, and that these responses are a valid and reliable measure of the participants' thoughts and feelings. It also implies that the participants have felt confident enough to put these thoughts and feelings down on paper for scrutiny. It is arguable that this is not always the case (Hollway & Jefferson, 2000).

9.2.   The Use Of Vignettes

In connection with these problems is the heavy reliance on using vignettes to depict challenging behaviour (Hastings *et al.,* 2003). Researchers have justified this on the basis that it would enable them to eliminate other potential variables such as context and relationship factors as this may influence and confound the staff's experiences and responses (Hastings *et al.,* 1997). However, context and the relationship factors do influence staff's feelings and actions and need to be explored concurrently (Jahoda & Wanless, 2005). Researchers have also argued that staff respond differently to vignettes; they in fact report stronger emotions to real life events. Furthermore, the use of vignettes appears to encourage very poor clinical practice, that is, making snap judgements about a person's behaviour without reference to context and relationship factors. Clinically it would be very poor practice to make assumptions about the causes (function) of a person's behaviour without doing a comprehensive functional analysis (Ball *et al.*, 2004).

9.3.   Power Imbalances Between Researcher And Participants

In the research reviewed there has been very little consideration given to the power

imbalances between researcher and participants and how these may influence the responses obtained. For example, there does not appear to be any appreciation that staff may feel anxious about being scrutinised and criticised as so frequently appears to be the case in this research (Clegg, 1994). The impact of this anxiety and staff's desire to answer in a socially desirable manner also does not appear to receive much attention (Crowne & Marlowe, 1960). This is in spite of the fact that researchers have reported that staff did not put their demographic details down for fear of being identified (Hastings & Brown, 2002). Staff's responses may also be influenced by the differences in status between them and the researcher. Indeed when the status of the staff who work with people with LDs is examined a little closer it may be surprising to note that even the more qualified (and arguably better trained and experienced) members of staff, such as LD nurses, appear to be the most marginalized and undervalued working group within nursing and arguably the National Health Service (Mitchell, 2000). Their practice is often scrutinised and criticised rather than explored in a collaborative manner. Perhaps it is no wonder they feel unable to provide their demographic details for fear of being identified and negatively evaluated (Hastings & Brown, 2002).

9.4. The Dominance Of Behavioural Approaches In LDs

9.4.1. The impact on clients.

In LD literature there appears to be a dominance towards applying learning theory/behavioural approaches not just to clinical settings but also to research ideas and methodology. This is understandable in view of the large body of evidence that supports the use of these approaches. However, other psychological interventions have simply not been explored. It is thought that this has been due to the discriminatory beliefs held about LDs (Thompson, 1997), rather than these other approaches being ineffective or inappropriate. Such discriminatory beliefs include not crediting people with LDs with

having thoughts and feelings of their own, and ignoring the existence of history, context, and family background (Clegg, 1994). This discrimination is reflected by the lack of research that has attempted to obtain the views of learning disabled clients themselves (Williams & Heslop, 2005). It is possible to argue that this is due to the complex issues around their capacity to consent to participate in research. However much more has been done by researchers to overcome these obstacles in other fields compared to that of LDs (Cole, Scott & Skelton-Robinson, 2000), for example, with older adults, who, it may be argued, have similar problems with cognitive deficits and challenging behaviour.

9.4.2. The impact on direct care staff.

The dominant use of behavioural theories to understand behaviour is also evident in the research conducted to attempt to explore direct care staff's beliefs about their clients' behaviour. If staff's responses and beliefs did not fit with this behavioural model, researchers often concluded that staff's beliefs were wrong and often criticised the staff for not knowing enough about their job. They went on to suggest that because of this lack of knowledge and application of behavioural models, staff must have been negatively reinforcing challenging behaviour (Hastings, 1995).

An alternative but less dominant view based upon the research literature is that staff continue to do their job to the best of their ability in spite of other professionals (and researchers) criticising them (Mitchell, 2000). The evidence suggests that 80 – 95% of people with LDs do not exhibit challenging behaviour (Qureshi & Alborz, 1992). Perhaps staff do not play such as large a role in triggering and maintaining challenging behaviour as previously argued (Hastings, 1995). There may be other ways to understand and manage challenging behaviour other than the well-researched behavioural approaches.

9.5. Using Qualitative Research To Explore Staff's Experiences

The quantitative research conducted regarding staff's experiences suggests that it is not just the behaviour their clients exhibit that influences their experience but many other factors. Qualitative research methods appear to be well placed to complement this research and attempt to explore how these factors interlink. The majority of the qualitative research studies that have endeavoured to do this are not without problems. Many are merely descriptive, simply replicating the results of quantitative research and are influenced by the same biases inherent in the quantitative research (Hastings, 1995). Nevertheless it is argued that this methodology does attempt to take the organisations' context into account, and attempt to be more collaborative with staff. Furthermore, there are particular qualitative methods that do not assume that participants are always answering in a conscious and logical manner (Hollway & Jefferson, 2000). They also utilise psychodynamic ideas as a way of understanding how people may unconsciously defend themselves from painful emotions by denying and projecting these feelings onto others. These may be useful ideas to use particularly in view of the fact staff working with learning disabled adults who have a BPD may experience intense emotional reactions to the work but may be ashamed of reporting them to a researcher (Main, 1957).

10. Future Research Ideas

10.1. The Experiences Of Staff

Staff's experiences of working with people with a LD, who exhibit challenging behaviour, appear to be influenced by many things. This includes patients' challenging behaviour, the patients' mental health and organisational factors, such as staff shortages. Future research could explore these factors and how they interact with each other. Future

research could also explore with staff what they think would be the most effective way to support them. Research could then go on to evaluate how effective these support strategies are and how they impact on both the staff and their clients.

10.2.   The Experiences Of Learning Disabled Adults

It would appear that there has been a lack of research that has attempted to obtain the views of people with LD. As a result little is known about patients' thoughts and feelings about the services they receive. Future research could try and obtain these and explore with them their reasons for engaging in challenging behaviour. It is arguable that it may not be just due to the practical and ethical obstacles of capacity and consent that has blocked progress. As Symington (1996) has argued this lack of research interest may actually be a reflection of an unconscious fear, or even contempt for this client group (Symington, 1996). These fears and discriminatory beliefs need to be actively challenged and addressed to help pave the way to enable researchers to feel confident in the value of conducting research into these areas. Once obtained the experience of patients could be explored in terms of how they interact with staff's experiences and affect each other within the context of their organisations and systems.

10.3.   Exploring The Use Of Alternative Psychological Interventions

There are biases of using behavioural approaches in the LDs field (Beail, 2003). It has been argued this is due to discriminatory beliefs about people with LDs (Symington, 1996). Now these beliefs are being challenged new approaches based on different psychological theory are being introduced (Beail, 2003). There is a need to explore the effectiveness of these different approaches and interventions, particularly in helping to manage challenging behaviour. Direct care staff play a key role in the implementation of any intervention Ager & O'May, 2001). Research could explore, if using different

interventions based on different theoretical foundations impact upon staff's and patients experiences in different ways.

11.   Summary And Conclusions

The main aim of this review was to outline the research that has explored the experiences of staff working with people who have a LD and who have also been labelled as exhibiting challenging behaviour. This has been done by providing summaries of the main findings regarding staff's emotional reactions, causal beliefs and behaviour in response to challenging behaviour. The evidence suggests that staff do experience negative emotions in relation to challenging behaviour (Bromley & Emerson, 1995). Level of experience of the individual workers and the context in which they work do appear to influence the amount of negative emotions they report experiencing (Hastings *et al.,* 2003; Hastings & Brown, 2002). Research has also demonstrated that staff are aware of a range of causal beliefs regarding challenging behaviour (Hastings, 1996). Staff's perception of their client's level of ability and level of aggression appears to impact upon their desire to help (Stanley & Standen, 2000). However the research exploring the relationship between these three variables, emotions, causal beliefs and behaviours have been as yet inconclusive (Hastings, 2002). Nevertheless, the statistical correlations that exist continue to be used as evidence to support the view that training in behavioural approaches (which is still the treatment of choice for challenging behaviour (Didden *et al.,* 1997), would help direct care staff feel more confident in managing challenging behaviour, which would reduce their negative emotions and improve their behaviour responses to such behaviour.

It has been acknowledged that training may help some staff, but the research

reviewed appears to suggest training alone does little to change their practice if organisational factors are not addressed simultaneously (Menzies, 1960). The organisational factors that staff have reported as affecting their experiences of working with people with LD who exhibit behaviour that challenges include staff shortages and lack of support to implement strategies that they were aware needed to be utilised (Emerson & Emerson, 1987). It has been argued that psychologists investigating staff's experiences of working with people who have LD rarely explore such organisational factors (Schein, 2003). In addition to organisational factors, it has been argued that the patients' mental health may also have a significant impact upon staff's experiences. Evidence was presented that suggested that there is a link between mental health and challenging behaviour (Bouras & Drummond, 1992). However, due to diagnostic overshadowing these mental health problems are rarely identified and thus explored for either patient or staff (Reiss, 1994).

The specific mental health problem of BPD was highlighted in this review. This was because a lot of the characteristics of this disorder could be arguably mistaken for challenging behaviour in people with LD (diagnostic overshadowing) (Dunn & Bolton, 2004; Moses, 1999). There is also evidence that suggests people with LD could be at increased risk of developing BPD due to biological, psychological and social factors (Eaton & Menolascino, 1982; Jones *et al.,* 2004). Little has been done to explore the needs of such individuals or the experiences of staff working with them. The evidence that is currently available focused on treatment, and suggested that these patients do elicit intense emotional reactions in staff (Wandel & Prince, 1991). However, the strategy that is recommended by this research is for staff to consider their countertransference, rather than additional training in behavioural interventions. This is clearly a different strategy, one that has been evaluated in the non-learning disabled literature (Main, 1957) but remains to

be explored in depth within LD literature.

Staff's experiences of working with people who have a LD appear to be influenced by many things, the behaviour of their clients, their mental health and the social and organisational factors of the service that they work in. It has been argued that there is a need for future research to explore how these issues interact and impact upon staff. This is because direct care staff often play a key role in the implementation of any treatment package for people who have a LD and who exhibit challenging behaviour (and who may also have mental health needs). It has therefore been argued that it is important to explore what issues impact upon the patients and also the staff so that the support that is provided is relevant and effective.

12.   References

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Section Two

Research Report

Exploring the experiences of direct care staff who work with patients with learning

disabilities and who also have a diagnosis of a borderline personality disorder

1.   Abstract

Exploring the experiences of direct care staff working with adults with learning disabilities who have a diagnosed borderline personality disorder

Objective: Experiences of direct care staff, working with people who have a Learning Disability (LD) and a diagnosed Borderline Personality Disorder (BPD), were explored using the free association narrative interview approach developed by Hollway and Jefferson (2000).

Method: This approach is based upon a critical realist epistemology, and utilises qualitative research methodology and psychodynamic concepts. As a result both the participants and the researcher were viewed as 'defended psycho-social subjects'. This understanding allowed for both conscious and unconscious material to be interpreted. Interviews were conducted with eight members of staff working within a National Health Service (NHS) LD service.

Results: Participants reported that they were able to manage their patients' behaviour, but appeared to find their patients' behaviour difficult to understand. Participants shared experiences of not having enough permanent staff, managing a complex patient mix and inadequate services for patients with Learning Disabilities (LDs) and mental health problems in the community, all of which they felt had an impact upon their work with their patients. These factors generated a level of anxiety but did not explain all the anxiety contained within their accounts. Participants' unconscious communication suggested that they were experiencing projections from their patients and this was understood to be an additional source of anxiety for staff.

Conclusion: Participants did not appear to be given the time or opportunity to reflect upon their work-related emotional feelings and often cope by trying to repress and forget painful experiences or displace these onto the organisation. Staff in LD services may benefit from exploring their emotional reactions to working with patients with LDs who also have a BPD. However for this to be successful changes need to occur on a systemic level including ensuring services are appropriately staffed. Future research could go on to evaluate if and how exploring staff's emotional reactions benefit them, and their patients.

Author: Judith Storey

2. Introduction

2.1. Staff's Experiences Of Working With People Who Have Learning Disabilities (LDs) Who Also Display Challenging Behaviour

Research exploring staff's experiences of working with people who have a Learning Disability (LD) have to date focused predominantly upon staff's experiences of challenging behaviour. This work has been done by predominantly utilising quantitative research methodology. It has therefore attempted to isolate measurable variables such as the topography of the patients' behaviour, or the emotions, beliefs or actions of staff (Hastings, 1995). The evidence from such research suggests that challenging behaviour can generate feelings of sadness, despair, anger, fear and disgust in staff members (Bromley & Emerson, 1995). It has also shown that staff are aware of many factors that may contribute to their patients behaving in challenging ways, including their internal mood state and environment (Hastings, 1996). This research has also indicated that staff's responses to their patients' challenging behaviour may be influenced by a number of aspects including the patients' level of ability and control in relation to their behaviour (Stanley & Standen, 2000).

The attempts that have been made to explore the dynamics between these three factors; staff's emotions, their beliefs about the causes of challenging behaviour and their responses to it has, as yet, been inconclusive (Hastings, 2002). Nevertheless the recommendation that staff are trained to implement behavioural approaches to address challenging behaviour is still made. This appears to be based on the implicit belief within the LD literature that if staff understand the form and function of their patients' behaviour they may feel more confident in addressing the behaviour, and experience less negative emotions in response to such behaviour (Hastings, 1995). Such recommendations are

supported by evidence that suggests behavioural approaches are successful in addressing challenging behaviour (Didden, Duker & Korzillius, 1997).

2.2.   Providing Training To Support Staff

Recommending staff have more training is positive because it aims to try and improve patient care. However, there is evidence to suggest training does not always help to improve staff morale or change their practice (McVilly, 1997; Rose, Jones & Fletcher, 1998). It is possible that the professionals who recommend more training have failed to take into account the impact organisational factors have upon staff. There is evidence to suggest a range of organisational factors such as staff shortages and the patient mix could be more stressful for staff than challenging behaviour. These organisational factors rather than staff's lack of knowledge about appropriate interventions could be preventing staff from implementing behavioural approaches (Emerson & Emerson, 1987; Hatton *et al.,* 1995; Schein, 2003). It is therefore possible that the recommendation of more training in behavioural approaches may make staff, who are often in less powerful positions, feel blamed, threatened and unlikely to open up about their true feelings about their patients' behaviour for fear of further scrutiny (Evans, 2006; Mitchell, 2000).

2.3.   The Possible Link Between Challenging Behaviour And Mental Health Problems

The recommendation of more training also does not take into account the possibility that the person with a LD may also have a mental health problem such as Borderline Personality Disorder (BPD), and/or that the staff's needs, approaches and experiences of working with such patients may be qualitatively different to that of working with someone who is displaying behaviour that challenges due to organic brain damage. However, this issue of the patients' behaviour possibly being a manifestation of a mental health problem (Marston, Perry & Roy, 1997) appears to have been explored separately

from research exploring staff's experiences of working with people who have a LD and who also exhibit challenging behaviour. This is despite the evidence that suggests people with LDs are at greater risk of experiencing mental ill health (and poor physical health) (Holden & Gitlesen, 2003). A number of researchers have gone on to argue that people who have a LD are potentially at greater risk of developing BPD due to their organic predisposition to overreact to stimuli, their potential problems with understanding social-interpersonal interaction, their increased risk of suffering from childhood sexual abuse, and higher rates of experiencing attachment problems in childhood (Eaton & Menolascino, 1982; Flynn, Matthews & Hollins, 2002; Jones, Davies & Jenkins, 2004). This is notable due to the similarities between the topography of challenging behaviour and the diagnostic criteria of BPD, which includes self-injury, impulsivity and aggression (Hurley & Sovner, 1988). It is possible that people who have a LD and who have been labelled as having challenging behaviour may well have an undiagnosed BPD (Dunn & Bolton, 2004).

2.4.   The Experiences Of Staff Working With People Who Have A LD And Also A BPD

The research that has explored the needs of patients who have a LD and also a BPD has focused upon evaluating treatment programmes (Esbensen & Benson, 2003; Mavromatis, 2000; Wandel & Prince, 1991; Wilson, 2001) rather than staff's experiences. These studies indicated that a multi-modal approach to treatment is necessary due to the complexity of these patients' needs. They also suggested that working with patients who have a LD and also a BPD can be extremely challenging for workers because of these patients' tendency to experience and express extreme emotional reactions. One recommendation to help staff address this was for staff to acknowledge their countertransferential reactions to their patients (Mavromatis, 2000).

2.5.   Countertransference

The concept of countertransference has historically been viewed as bad, because it was thought to contaminate staff's behaviour, resulting from unresolved personal conflicts (Kiesler, 2001) and was something to be avoided. This view may help to explain why, when staff do experience intense emotional reactions towards their clients they frequently feel guilty, even ashamed, about their feelings and try to conceal them due to the belief that such feelings may be a sign of weakness (Main, 1957). The concept of countertransference has since evolved and it is now recognised that staff's feelings about a client can be informative (Casement, 1985). This is because the staff can use feelings provoked by their clients to examine what it is about the client that is making them feel that way (Bateman, Brown & Pedder, 2000).

2.6.   Countertransference And Staff Teams

There are a number of studies that have explored the countertransference of staff teams working with patients who have a BPD but not a LD. These studies appear to support the suggestion that staff working with people who have a BPD and also a LD may benefit from being given the opportunity, and support, to reflect upon their countertransferential reactions to their patients (Book, Sadavoy & Silver, 1978; Brown, 1980; Rosenbluth, 1991). For example, Book *et al*. (1978) identified a number of possible signs and consequences of negative countertransference within a staff team. These included seeing the patient as bad, manipulative and uncooperative rather than troubled, desperate and frightened. Book *et al.* (1978) argued these feelings if not explored could result in a premature discharge of the patient, a move of placement or more stringent treatment. Book *et al.* (1978) went on to suggest that another possible sign of staff's countertransference could include some staff members feeling as though the patient can do no wrong, and others seeing the patient as doing no right. This, if not explored, can result

in inter-staff fragmentation and intra-client conflict that can lead to severe fragmentation of the treatment team and disruption of therapy. This is often referred to as 'splitting'. This refers to the patient's tendency to 'split' off, to get rid of, unwanted parts of their psyche (inner selves) that cause anxiety or pain by 'projecting' these parts of the self onto the therapist, such as strong emotions like hate and anger (Winnicott, 1949). This 'splitting' can have a powerful effect on the recipient if they then go on to feel and act on the emotion that the patient has projected on to them (Joseph, 1988; Puri, 1988) (that is the person identifies with the emotion that has been projected onto them, which is referred to as projective identification). There does appear to be a risk associated with not exploring staff's countertransferential feelings (Main, 1957).

However, exploring countertransferential feelings can be emotionally demanding for staff as it may mean admitting to having some extremely negative emotions but also because this phenomenon is often in the staff's unconscious awareness, necessitating supervision by a psychoanalytically oriented supervisor (Evans, 2006; Winnicott, 1949). Furthermore, it is recognised that behavioural and pharmacological approaches have been the treatments of choice in the LD field. Attempting to introduce psychodynamic approaches may cause too much of a cultural shift for some practitioners (Fauth, 2006). This is because behavioural and psychodynamic approaches are based upon two different epistemological and ideological positions (Clegg, 1994). To aid discussion the concept of countertransference is viewed as an idea and not as 'a truth' that has to be proved or disproved as scientific fact. Focusing upon the use of countertransference with staff teams is also not to ignore the many other approaches that have been found to be equally effective in helping patients with a BPD (Beck & Freeman, 1990; Linehan *et al.,* 1991; Perry, Banon & Ianni, 1999; Ryle & Golynkina, 2000). In fact it is argued that countertransference appears to be a concept that could be used in conjunction with many of

these other approaches as it is aimed at helping the staff manage the emotions aroused in them during their work with patients with a BPD.

Nevertheless, the appropriateness of using staff team's countertransference has not been explored in recent years. This is in spite of evidence that suggests emotions are possibly more intense in an in-patient (staff team) situation (Gallop, 1985). This is perhaps a reflection of current government policies of de-instutionalisation rather than a lack of clinical need. It may also be an indication that other approaches such as cognitive behavioural interventions are now more popular and used more frequently to try and understand staff's reactions. However, when staff do express negative emotions in response to their work with patients who have a BPD these cognitive behavioural approaches appear to engender criticism rather than understanding (Markham & Trower, 2003). This type of research runs similar risks to the research conducted in the LD field, that of creating a defensive staff group who are less likely to express their more negative feelings. Perhaps in response to this there has been a call for the re-introduction of psychodynamic approaches within mental health (Gallop & O'Brien, 2003).

2.7.   Aims Of The Research

The main aim of the present research was to explore the experiences of direct care staff working with patients who have a LD and also a BPD by asking them to give accounts of working with such patients. A secondary aim was to explore if using a concept such as countertransference would be appropriate and/or helpful in understanding their experiences.

3.   Methodology

The researcher's epistemological position, the theoretical framework and terminology used will now be outlined. The strengths and weaknesses of the theoretical framework will be discussed. The procedure, including how the data was collected, analysed, quality checked and disseminated is then summarised.

3.1.   Epistemological Position

The epistemological position of the research and the researcher is based upon critical realism (Guba & Lincoln, 1994). Such a position asserts that the way we perceive facts, particularly in the social realm, depends upon our beliefs and expectations (Bunge, 1993). This position argues that it is not possible to present an objective view of the world due to the inherent subjectivity within the production of knowledge (Hochschild, 2003; Madill, Jordan & Shirley, 2000). This epistemological position is congruent with the theoretical framework of the research.

3.2.   Theoretical Framework And Terminology

The qualitative research methodology developed by Hollway and Jefferson (2000) was utilised. This is based upon a psychoanalytical framework and has theorised the participants, the researcher and the social context. These ideas and the terminology used within such a methodology will now be outlined.

3.2.1   'The defended psycho-social subject.'

'Defended' is a psychodynamic term (Malan, 1979), which refers to unconscious psychological defences that all of us are thought to use to protect ourselves from 'seeing' and experiencing potentially distressing 'truths' and anxieties (Joseph, 1988). These intra-psychic defences are thought to significantly influence people's actions, lives, and

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accounts. This view states that it is not possible to take people's accounts of their experiences at 'face value' because of the defence mechanisms that they are employing. This view also holds that people are not necessarily always motivated to tell the 'truth' due to the distress this may cause them. It does support the view that it is possible to uncover participants' 'reality' by exploring how the participants share their accounts with the researcher (Hollway & Jefferson, 2000).

The term 'psycho-social subject' is used to illustrate simultaneously the psychological and social aspects of an individual participant (and researcher). It argues that people's inner worlds cannot be understood without knowing their experiences of their social world, and their experiences of their social world cannot be understood without knowledge of the way in which their inner world allows them to experience their outer world. Therefore the 'subject' cannot be known except through another 'subject' – the researcher (Hollway & Jefferson, 2000).

3.3.   The Strengths And Weakness Of The Theoretical Framework

The researcher was aware of evidence that suggested patients with a LD and also a BPD could provoke strong emotional reactions in the clinicians working with them (Mavromatis, 2000; Wandel & Prince, 1991). However, she was also aware that emotional reactions particularly negative ones appeared to be viewed in the LD literature as something to manage and reduce as opposed to something to be understood and reflected upon (Hastings *et al.*, 2003). It was therefore thought likely that the accounts from participants may be based on what they thought would be socially acceptable rather than their 'true account' (Crowne & Marlowe, 1960). It was thought that understanding the participants as 'defended psycho-social subjects' rather than viewing them as being dishonest would help explain in a non-judgemental way why participants may be reluctant

to share their emotional reactions. It would also enable the researcher to place and understand participants' emotional reactions/experiences within a social context.

However, the approach developed by Hollway and Jefferson (2005) has been criticised for focusing too much on the 'individual' and for using psychodynamic concepts such as the unconscious to interpret participants' accounts. The critics have argued that such a focus neglects the social aspects of the participants' accounts, and that psychodynamic concepts are unnecessary for data analysis (Spears, 2005; Wetherell, 2005). Hollway and Jefferson (2005b) have countered this criticism by arguing that they had developed their approach due to the apparent neglect of the individual in discourse analysis research. They went on to argue that using psychodynamic concepts help to understand 'why' participants position themselves in particular discourses rather than simply 'how' (Hollway & Jefferson, 2005b; Roseneil, 2006). Indeed this approach provided a theoretical framework to understand what the participants said, why they said it in the way they did, and why they did not say other things rather than just how they said it. It also enabled the researcher to understand and explain what they experienced themselves emotionally in their interactions with participants (Frosh & Emerson, 2005) and so enhanced researcher reflexivity (Gough & Madill, 2007).

3.4.   Procedure

Ethical approval was sought and obtained from the Local National Health Service (NHS) Research Ethics Committee, using the standardised NHS Research Ethics Committee Application Form (Appendix C). Permission to approach staff within a particular service was then sought and obtained from the relevant service development manager. This manager also gave permission for staff to participate in the research during their working hours. Once this permission had been given the researcher arranged an

informal meeting with staff at their place of work to discuss the research. After this meeting forty envelopes containing a copy of the Letter of Introduction for staff (Appendix D), a Participant Information Sheet for staff (Appendix E) and a copy of the consent form (Appendix F) were given to a staff member who had volunteered to distribute them throughout the whole staff team. Participants who were interested in taking part then completed the tear off sheet and returned it to the researcher using the stamped addressed envelope provided. The researcher then contacted each potential participant by telephone to arrange a time to meet. When the researcher and participant met, but prior to the actual interview commencing, the purpose of the interview was explained again and the participant was asked to re-read and sign the consent form. It was stressed to each participant that they could withdraw and were free to ask any questions at any time during the research.

Eight participants took part in the study. At the time of the research they were all working within a NHS provision that provided in-patient psychiatric assessment and treatment for adults with LDs who had been diagnosed as having a mental health problem and/or as exhibiting behaviour that had been defined as challenging. The participants included three females and five males; ages ranged from early twenties to late fifties. Six were trained LD nurses and two were nursing assistants. All of the participants had worked directly with at least one patient who had a LD and also a BPD, for a minimum period of six months. All participants were working full time on a permanent basis in the service. No additional details of the service or the participants will be provided to ensure confidentiality.

3.5.   Collecting Data Using The Free Association Narrative Interview Method.

This approach influenced by psychoanalytical literature (Kvale, 1999) and narrative

research approaches (Rogers *et al.,* 1999) utilised interviews as a method of data collection. The main aim was upon eliciting the participant's 'free association'. Free association is a psychodynamic term, which refers to whatever comes to mind when a person is asked to think and talk about a particular issue, and exploring the reasons why certain aspects came to the forefront rather than others (Malan, 1979). The researcher therefore began each interview by asking the participant an open-ended question about their experiences of working with patients who have a LD and also a BPD. Once the participant had responded, the researcher then encouraged the participant to expand and elaborate upon their account using prompts but trying to avoid 'why' questions. This was because 'why' questions are thought to generate more conscious and defensive answers (Hollway & Jefferson, 2000). A specific interview guide was also not used to structure the interview as it is thought this would also constrain and restrict the participant's free association (Hollway & Jefferson, 2000). Instead, the researcher drew up a list of specific areas of interest related to the research topic to ensure all aspects were discussed (Appendix G) and to also make specific interests (and biases) more conscious and open to scrutiny.

In line with this approach an attempt was made to interview participants twice. This had a dual purpose, to give the interviewer a chance to listen to the first interview and identify particular aspects of the participant's account that they thought would be interesting to explore further. It also gave the participant a chance to reflect upon the account they had provided in the first interview. Five participants expressed a willingness to do this. However, this was difficult to facilitate due to time constraints and shift patterns. As a result one participant was interviewed on one occasion for 105 minutes and three participants were interviewed twice. In the second interview participants built on their first account and appeared to be more relaxed with the research situation.

3.6.   Analysing The Data.

All interviews were digitally recorded and lasted between 30 and 105 minutes. The researcher then transcribed all the interviews as contemporaneously as possible. After an interview had been transcribed, the researcher then listened to the account and read the transcript simultaneously to check the accuracy. An attempt was made to represent the affective meaning and tone of the interview in the transcripts by including punctuation and making notes where appropriate about particular verbal and non-verbal communication (for more details about this see Addendum, Vol. 1. transcribing guidelines). However, it was recognised that the process of transcribing inevitably results in a loss of affective detail (W. Hollway, personal communication, 8 December 2006).

In view of this inevitable loss of detail in the written transcripts the researcher listened to the recording for a third time jotting down thoughts, ideas and feelings generated from listening to the account. This was in addition to the notes made immediately after each interview in the reflective journal. Areas the researcher thought might be useful to explore in more depth in the second interview were then jotted down ready for the next interview. Over the course of the analysis the transcripts were read and recordings listened to several more times to aid understanding and interpretations.

An attempt was made to keep the 'whole' of the participant's accounts in mind (referred to as the gestalt, Hollway & Jefferson, 2000) whilst also delving into parts of the data. This was achieved by writing summaries of each account, whilst in turn also making links between participants' accounts based upon the code and retrieve method advocated by other qualitative research approaches (McGillis Hall & Kiesners, 2005). This approach whilst fragmenting and de-contextualising the data provided a summary of the main themes the researcher thought the participants had talked about. This summary also

provided a framework for the researcher to use in her discussions with her supervisors about what and how she understood specific issues the participants had mentioned. This was used in addition to exploring the researcher's emotional reactions to the data.

3.6.1   Using the researcher's emotional reactions – countertransference.

In this approach, as in psychodynamic therapeutic work, the researcher's feelings aroused during the interview situation, and after whilst listening to the recordings and reading the transcripts, were analysed, with the aim of trying to understand and interpret the participant's accounts. The researcher's feelings were conceptualised as transference and countertransference, including projection and projective identification (for a more in-depth explanation of these concepts please see Appendix B).

It was recognised that the researcher was a defended subject and her interpretations could be biased and prejudiced due to unresolved and unconscious issues (Hollway & Jefferson, 2000). Every attempt was made to make the interpretations as conscious and explicit as possible. The researcher did this by making notes of what she had understood the participants had said, why the researcher thought particular aspects of the participants' accounts were more note-worthy than others, and then explored her justifications of her interpretation in the reflective journal. The researcher also discussed her understanding and interpretations with colleagues and her supervisors including a clinical psychologist and also qualified psychodynamic psychotherapist. This provided an opportunity to check the quality of the results. This was done by a process of mutual agreement in terms of the interpretations (Hollway & Jefferson, 2000; Madill *et al.,* 2000) and looking for consistency of meaning in terms of joint understanding of the particular excerpts from the transcripts discussed during supervision. The researcher also utilised her knowledge of the social and political context in which the participants worked, that of a NHS LD service,

applying her theoretical knowledge gained during her social work and family therapy/systemic training.

3.7.   Dissemination Plans

The key themes and ideas of the results were shared with each individual participant via email. All participants were given the opportunity to provide reflections about the accounts they provided during the interviews. A number did comment they thought the findings were interesting and appreciated that organisational factors had been included, but no one responded in any depth. The results were also shared with locally collaborating organisations. Upon successful submission there are plans to submit an adapted version of this research to an appropriate psychological journal (see Appendix H).

4. Results And Discussion

The results and discussion have been combined. It has been argued that this combined structure helps to present the findings in a more interesting and meaningful way (Sternberg, 2003). This has been achieved by using a structure similar to the one outlined by Labov and Waletzky (1972). This structure is based on the belief that personal narratives usually contain six common elements (Labov & Waletzky, 1972). This includes an abstract, which is a summary of the substance of the participants' narrative; an orientation, which includes information about the participants who provided accounts on which this narrative is based; complicating actions, which includes a description of unusual events; an evaluation of the way participants shared their accounts; resolution, which refers to what finally happened; and coda, which involves returning the perspective to the present. All bar one (the coda) of the six elements have been used here as headings to help structure the participants' accounts (the findings). The aspects of the participants' accounts that were thought to refer to that specific element are presented under that heading. The discussion of how these findings relate to previous research is then provided in conjunction with the researcher's interpretation of these findings. These are presented in a separate paragraph underneath the relevant accounts/findings. The aim of the interpretations is to highlight the dynamic relationship between participants, patients and organisational factors.

4.1. Orientation

The participants who took part in the research will now be described. The focus will be upon the level of experience the participants said they had of working with patients who have a LD and also a BPD. How this level of experience may have influenced the participants' overall experience of working with such patients is then explored.

Participants felt they had more experience and training in relation to working with people who have a LD rather than a LD and also a BPD. Participants felt that this might impact upon their ability to help other staff work with patients with a LD and also a BPD.

'I didn't know anything about personality disorders when I first, I've worked … where they had … people with learning disabilities … all I've done is learning disability training … we are then having to train the staff team in an area that we haven't been trained in properly ourselves.' (P.159/L106-118).

The participants also appeared to question the accuracy of the knowledge and theory that they did have in relation to working with patients with a LD and also a BPD.

'I can't come out with the theory, … that's my layman's term of understanding personality disorder … I don't know if I'm right or not. I could be wrong.' (P.163-164/L219-252).

Participants went on to talk about their experiences of struggling to find relevant information to help them in their work with patients with a LD and also a BPD.

'I … started reading things (about borderline personality disorders) … but … it's very hard to find information … specifically for people with learning disabilities that have got a personality disorder … (research) articles … doesn't really resemble what happens here.' (P.32/L664-680).

Participants also spoke of trying to get help from other services they felt had more

expertise of working with patients with a BPD but not a LD.

> *'I mean (the patient) should never have been in our service (the patient) should have been mental health ... it was learning as we went along, we made so many mistakes ... but (the patient) taught us a lot ... but we made mistakes because it was an area we just didn't have a clue about ... but we couldn't, when we said to mental health services this lady needs your care cos you've got the expertise, ... they just wouldn't take her, she's got learning disabilities and they didn't want to know, and there's that boundary of this brick wall between learning disability and mental health ... for a good six months it was, I would say , a constant battle, but then we sort of learnt the best way to manage her ... but you feel that they would perhaps get better care, better treatment (if they were in mental health services rather than LD services).'* (P.159-168/L130-149/L202-202/L360-361).

There appeared to be a clinical reality that participants did not have as much experience of working with patients who had a LD and also a BPD compared to other patients. Possibly as a result of this smaller amount of experience participants also appeared to lack confidence in the knowledge they did have about working with such patients. It appeared that these feelings of uncertainty could have been exacerbated by the lack of integration between services and research (and training available for such workers regarding mental health and LDs (Bouras & Holt, 2004). This left staff feeling ill equipped to care for patients with a LD and also a BPD. They felt they 'didn't have a clue' and made mistakes. Their attempts to seek help were rejected (and possibly experienced as rejection). As a result they had to rely on learning how best to manage and care for these patients from clinical experience.

Nevertheless, it is also arguable that such feelings of uncertainty are understandable and to be expected (to a certain extent) within a staff team working with patients who have a BPD regardless of their level of experience and theoretical knowledge. This is based upon the evidence that suggests patients with a BPD are extremely challenging to work with (Fraser & Gallop, 1993). Such feelings of uncertainty may therefore be linked to the difficulties staff experience on an emotional as well as on a practical and theoretical level when working with such patients (Main, 1957; O'Brien & Flote, 1997). It is possible that these feelings of uncertainty could be an indication of the participants experiencing projections of uncertainty from the patient. It would appear that participants cope with such feelings by using intellectual rationalisation, a psychological defence mechanism (Malan, 1979). As a result participants believe on a conscious level that the uncertainty they feel is due to a lack of knowledge and could be eradicated with training (which could be true to a certain extent). However, with this view such feelings of uncertainty do not need to be explored further. It is possible to argue that this defence mechanism is often supported by the research that often concludes staff simply need more training rather than explore such feelings (Hastings, 1995). However, there is evidence to suggest that more training does not always eradicate such feelings of uncertainty and suggests staff would benefit from exploring such feelings rather than trying to eradicate them (or not explore them), particularly if working with patients with a BPD (Main, 1957).

4.2.   Complicating Factors

Participants spoke of a number of complicating factors that appeared to be specifically related to working with patients with a LD and also a BPD, which appeared to make the participants' work-life more difficult. These factors have been labelled as either the patients' behaviour or organizational factors. These factors will now be outlined and how they may impact upon the participants' experiences will be discussed.

<u>4.2.1.   Aspects of the patients' behaviour.</u>

The issues participants raised that related to the patients' behaviour included trying to develop a therapeutic relationship with these patients; the patients' level of control and the patients' ability to target staff. Participants explained that these issues relating to the patients' behaviour influenced how they cared for these patients. Participants went on to raise the issue of the severity and the chronicity of the patients' behaviour, including the patients' violent behaviour and how such behaviour impacts upon them as staff and upon the patients' own treatment and discharge. All these aspects will now be outlined.

Participants recognised the importance of developing a therapeutic relationship with patients with a LD and also a BPD. However participants explained that they experienced these patients as trying to destroy this relationship. Participants tried to deal with this by trying to see beyond this (challenging) behaviour to understand what it was the patient needed.

> *'that's the most important (the therapeutic relationship) …   because that's what they always crave isn't it a relationship, so you've got to give them one, … even if they are foul and horrible to you, you've still got to have that … relationship, it's got to be nothing, nothing, will destroy it … and then … you'll find, they often have a veneer of a load of rubbish that they talk about, that's shock horror tactics, and once you get beyond that you can begin to help them because you know what they really need.'* (P.374/L163-170).

Nevertheless, participants spoke of experiencing these patients as having a lot more control over their behaviour and felt that these patients could stop behaving in such (challenging) ways if they wanted to.

'they have a lot more control than (other patients) … they <u>can</u> actually stop … (their behaviour) … if they wanted to'. (P.369/L28-33).

Participants also spoke of experiencing these patients as being able to individually target them.

'she'd also know things that pushed my buttons. … she'd know which things worked with individuals and … she never mixed it up … that was really tiring, cos she would just be on you and you knew, you'd trip up before she would if you weren't careful cos she was that good at it … she'd have a subject that she knew I couldn't, I wouldn't, I was weak on and she'd always manage to trip me up … she could work you out so well … you have to be so on your toes every second you were talking to her and it was <u>so</u> mentally tiring, you'd have to be <u>so</u> switched on, watched every word you said.' (P.161-162/L166-197).

Participants explained as a result of such behaviour, they felt they had to be firm with these patients. This way of interacting with patients appeared to challenge the participants' expectations of what their role of nursing (treating patients) should be like.

'it's a different way of being than what normal nursing (is all about), nurses are about supporting, caring, and looking after people, … but if you work like that with someone with a personality disorder … you'd get eaten alive, … being assertive with patients … it almost goes against what, … you should be doing … you don't expect to have to be … firm cos you expect people to want your help'. (P.245-247/L964-967/1020-1030).

Participants went on to describe more severe examples of behaviour these patients exhibited, including violence. It was at these times that staff and/or patients might be assaulted (and perhaps feel physically attacked). Participants were able to acknowledge intellectually that it was not always possible to prevent such incidents as they occurred by 'surprise'; however, participants still appeared to feel responsible for such events.

> *'there's always a surprise one (an assault) … I feel even worse if I was <u>there</u> and feel I could have done something … when somebody does get hurt, then you think, 'Right what could I have done to make it different?' 'Why did it happen?' … I do analyse things an awful lot.'* (P.451-453/L476-484/499-500/523-526).

Participants also felt scrutinised by management after such violent incidents.

> *'and they (a patient) get an injury or something bad happens, then they'll (management) be questioning your judgement all the time'.* (P.158/L80-82).

Nevertheless, participants appeared to believe that patients with LD and also a BPD were likely to exhibit severe behaviour and this was likely to be chronic and persistent in nature. However, participants explained that in spite of this, other professionals seem to expect these patients to stop engaging in such behaviour, and appeared to use it as criteria for discharge.

> *'people will often say well, … has (the patient) stopped,… hitting people, … 'No', 'Well how can you say (they are) ready to be discharged then?' Because that … will always be (how the patient behaves)'.* (P.502/L672-675).

Participants went on to explain that due to all these aspects relating to the patients' behaviour they found it very difficult to treat these patients. Participants explained they felt they could only help (treat) these patients if the patients wanted their help (treatment). Participants also commented that the patients' problems were often unclear and would tend to increase rather than decrease. This appeared to contrast with the participants' experience of treating patients without a BPD.

'they are incredibly difficult to nurse because unless they want the help, … there's no way you can help them … whereas with someone who comes in who's, … mentally ill, … there's something organically wrong. … you can do something to effect a change … we can sort it out … but with a … personality disorder it tends … it just grew and grew and grew and grew and there was so many other things that (the patient) introduced into it (makes a grimacing noise)'. (P.463-464/L786-809).

There is evidence to support the participants' beliefs that patients with a BPD benefit from a positive therapeutic relationship, but due to the patients' problems with attachment the boundaries of such a relationship are often tested (Linehan, 1993). Participants appeared committed to providing such a relationship despite these problems. Participants said they coped by trying to see 'beyond' the behaviour. However, added to the participants' beliefs that these patients had more control and had the ability to stop behaving in challenging ways if they wanted to, trying to see beyond the patients' behaviour is likely to be very emotionally demanding. Indeed there is evidence from the LD literature that suggests staff experience more negative feelings about their patients' behaviour the more able staff perceive their patients to be (Stanley & Standen, 2000). While evidence from the mental health literature indicates that staff experience and express

more negative feelings when working with patients with a BPD compared to patients with other mental health problems (Markham, 2003). It is possible that participants are able to rationally acknowledge that they need to see beyond the behaviour, but feel emotionally and physically drained from the work (Cleary, Siegfried & Walter, 2002).

Indeed, although participants in this study did not explicitly voice their negative feelings in response to such behaviour, there was a great deal of evidence of how difficult they found the work by the tone and language they used when sharing these experiences. For example, the researcher interpreted the participants' reports of feeling that these patients had the ability to target them, as evidence that the participants felt emotionally, (and possibly physically attacked), by such patients. It is also arguable that such feelings of being targeted were evidence of the participants experiencing projections from the patient. That is, the patient was projecting unwanted emotions such as vulnerability and helplessness onto the staff, hence making the participants feel it was a personal weakness in them. Although the specific emotion that got projected onto each participant appeared to be different due to the unique nature of the interactions between staff member and patient. Participants appeared to find this experience difficult to manage because it felt so personal. They also appeared to find it difficult to talk about. Participants labelled such experiences as having their 'buttons pushed' by such patients. It recognised that such terms are often a stereotypical concept/discourse used in reference to the behaviour of patents with a BPD (Gallop, 1988). However, within this study participants appeared to experience having their 'buttons pushed' as a very real and unpleasant, referring to a weakness in them rather attributing it to the patient.

Participants appeared to respond to such targeting (attacks) by attempting to be firm and assertive probably in an attempt to protect themselves from being 'eaten alive'.

However, participants appeared to find it emotionally difficult to be assertive with these patients as it went against their normal way of nursing. Participants appeared to be experiencing an internal conflict of wanting to care but also having a need to control such patients. As Book *et al.,* (1978) has argued the more severe the treatment the more likely this may be evidence of staff acting out their negative countertransference as a result of such unexplored feelings of being under attack. It is therefore important that staff are given the opportunity to explore this internal conflict between balancing care and control.

Participants went on to talk about their experiences of being physically attacked by such patients. Such experiences are difficult for staff, and experiencing hostile feelings in response to such attacks would be understandable (Bromley & Emerson, 1995). However, the dominant emotion expressed by participants appeared to be feeling personally responsible. The scrutiny from management about these violent incidents may have amplified this sense of responsibility. Clearly a balance between the needs of the patient and the needs of the staff is needed. Abuse of people with LDs does occur in institutions and measures need to be taken to prevent further abuse (Brown, 1999; White *et al.,* 2003)**.** However if all assaults are viewed only as bad and the fault of the staff, rather than an indication of the patients' problems of emotional regularity, this may paralyse staff's creativity. It may ironically also increase the risk of abuse by encouraging staff to deny and repress any problems they may have with patients for fear of being criticised and in turn attacked by management.

There appeared to be evidence that once a patient with a LD and also a BPD was admitted to this service they had a tendency to regress with their problems growing in size (Evans, 1998; Kaplan, 1983). This also appeared to delay their discharge. Research indicates regression is often common for patients with BPD when they get admitted to an

in-patient service (Ens, 1999). However, this regression coupled with the delays in discharging these patients appeared to make the participants feel helpless in helping these patients. The researcher interpreted such remarks as participants expressing a sense of failure and rejection from such patients. Indeed patients who are chronically 'ill' and do not get noticeably better are arguably difficult patients for nurses to cope with as these patients fail to validate the care-giving role of the nurse by remaining ill (Ens, 1999). Participants therefore understandably struggled with such feelings. It was the researcher's interpretation that one way participants tried to cope with such feelings was to use the defence mechanism of intellectual rationalisation (Malan, 1979), by remarking that staff can not help such patients anyway unless these patients want the help. Such a defence arguably protects participants from further conscious feelings of helplessness and failure when working with such patients.

4.2.2.   The organisational factors.

The organisational factors that had an impact upon participants' experiences of working with patients with a LD and also a BPD included staffing issues, the patient mix and inadequate local community services. These factors will now be outlined.

In relation to staffing issues, participants commented upon the value of having a consistent group of people to work with as this helped the shift to run more smoothly.

'we are well established, we know how we all work ... the shift runs much more smoothly, ... there's less friction involved with ... the patients because, ... (the staff) know what they are doing, they're experienced ... in this area ... if someone is aggressive, then they know what to do'. (P.437-438/L119-139).

However, participants explained that there were times when there was not enough staff to cover a shift. Participants said that at these times they might chose to work overtime. Participants explained that working overtime helped them to not only cover the shift, and keep the service safe, it also helped them supplement their wage.

> *'Part of it is choice, (doing overtime) I wouldn't do it for nothing … some of it is (a safety issue) … and it's about the team … I do … overtime … yeah, obviously … I don't do it for free, but, it's not just for the money … I'll stay until it's safe'.* (P.260-261/L1361-1389).

During the research overtime was banned for permanent staff. Participants explained that they were now only allowed to use 'bank staff' to supplement their team if they were short staffed. Participants explained that bank staff had care work experience but rarely experience (or training) of working specifically with people with LDs. The practice of using bank staff appeared to cause the team a lot of stress.

> *'the biggest support we … need, here, … is, time. For time you need staff. For staff you need the board to agree to give us some more. At the moment we are in that situation where we have got a certain amount of staff and the workload doesn't fit. So we get the most stressful things that happens to the staff some days is to realise there's only two of us that know what we're doing, and the rest are bank … it's heart breaking … cos some of the bank nurses wouldn't know … what a patient looked like, I mean, they aren't … trained, in learning disabilities … and that's stresses the staff out a lot worse than … a fight, … it's the fact that they've been on their own upstairs with three bank staff … and they are not empowered to do anything about it'.* (P.391-393/L621-663).

Participants added it also made them and the patients feel devalued.

'The devaluing by people … well (The Chair) devalues us completely, … (The Chair) says anybody can look after learning disabilities end of story, cos, (The Chair) put us on the bank and the bank staff can work, you've got seven staff, what are you worrying about, of which two might know what they are doing, the other side (The Chair) says are fine they're members of the human race, I don't think that's a very good qualification for looking after people with learning disabilities … But (The Chair) says that's fine, … till (The Chair) makes that big step of realising that people with learning disabilities are as valuable members of society as (they are) we will always (pause) be, I don't know, bullied by (The Chair) I suppose'. (P.391-393/L621-663).

Another organisational factor the participants raised related to the patient mix of their service. This term appeared to refer to having to provide care for a whole range of patients, who differed in age, gender, cognitive ability and mental health needs. Participants commented that at times the patient mix could be so diverse it made their job of managing and providing care for their patients very difficult. Participants added that when they also had patients who had a BPD as part of the patient mix this could make the situation even more difficult to manage. This was because of these patients' tendency to target the more vulnerable patients and demand a lot of time from the staff. At these times the staff described the patient mix as *'a ticking time bomb'*. (P.203/L1267-1268).

Participants went on to explain that they felt that the patient mix was one of their biggest problems, a problem they felt they had little control over.

'we are bound by the wishes of the consultants, they can bring in ... ten, one to ones, ... they expect (us) to run it, expect (us) to staff it, safely and wisely ... it is the main reason for the problems on here is the mix .... They don't consider who they already have got in. ... no control, ... how can I describe it? They have complete power. They can bring in anyone they want and they do. ... We might pretend we have but we have nothing. (P.410-411/L1096-1135).

Participants went on to identify a third organisational factor that impacted upon their work experiences: inadequate local community services. Participants explained that when a patient with LD and also BPD is discharged, and goes back to live in the local community, their placement often fails. Participants explained that this is because the local community services often cannot cope with the behaviour of such patients. As a result the success of discharge is often short lived.

'It falls to bits as soon as they go out again and then they are soon back which is very frustrating...and the whole cycle starts again'. (P.75-76/L523-530).

Participants explained that as a result of this, patients with LD and also a BPD often return back to the service. This can mean very long delays in finding placements that are able to successfully manage the behaviour of such patients.

'So we know that if (a patient with a LD & also a BPD) comes in, she's (in our service) for what ... eighteen months to two years and all you do is maintain, you manage them ... We don't want her back cos we know we'll be stuck with her'. (P.175-176/L545-556).

Staffing shortages within LD services is nothing new (Hatton *et al.,* 1999). However, it generated a great deal of stress and uncertainty for staff (and patients) in terms of not knowing who they are working with from shift to shift (Murphy & McVey, 2003). Deciding whether to do overtime or not appeared to be the only control the participants had over when and whom they worked with. This little bit of control was taken away from them during the period of the research project. Understanding overtime in this way helped the researcher to understand why staff expressed such strong feelings regarding not being valued. It was understood by the researcher that it was not just about losing extra money but also about losing power and control. This powerlessness was exacerbated by the use of bank staff to supplement their core team. Participants' felt that this implied that anyone could do their job; as a result they felt that their skills were not being recognised or valued by professionals outside of their service. The use of bank staff may have also generated feelings of envy in staff (Bott Spillus, 1988) as bank staff by default have more power and control over when and how often they work.

It was understood by the researcher that the participants did not simply want more people to work in their service, they wanted members of staff who are permanent and who are able to do the job satisfactorily. This is notable in view of the research that suggests a key factor in successfully being able to treat patients with BPD is having a staff team that feel supported by their administrators (Wilson, 2001).

In relation to the comments made about the patient mix in their service, there is evidence to suggest that in in-patient services the patient mix has become more complex over the years. These changes are possibly due to the changes in service provision and only the more severe cases were now being admitted to services. This has resulted in staff feeling that they have to work harder than ever (McGillis Hall & Kiesners, 2005).

Participants reported having to balance and meet the needs of individuals with many different needs, many of whom may display extremely challenging behaviour which could lead to potentially explosive (violent) situations within their service ('ticking bombs'). It was thought by the researcher that the participants' feelings of powerlessness over the patient mix may increase the level of stress the participants would understandably feel with regards to the complexity of their work. How the participants appeared to cope with such feelings of powerlessness was to engage in the psychological defence mechanism of denial, as a result they pretend they have power. This is perhaps because acknowledging on a conscious level (all of the time) they have nothing is too painful (Malan, 1979).

Repeat admissions to in-patient services appear to be relatively common for people with LDs who also have a BPD. This appears to be linked to the problems they appear to have with regulating their emotions and the problems they have with stressful events that are likely to occur throughout their life due to the interpersonal problems they have (Miller, 1989). It is possible to incorporate these admissions into a therapeutic plan (Miller, 1990). However it appeared that the patients the participants had worked with had been admitted due to the inability of the local community services to manage the temporary escalations in the patients' behaviour. Clearly this service was designed as a crisis intervention and so admissions were appropriate on this basis. This service managed these patients successfully for up to two years at a time. However, research suggests that both consistency, and a containing environment is required to help people with BPD to improve (Linehan, 1993). If patients are being given messages that they are not wanted and are unmanageable in the community this is likely to reinforce their belief that they are worthless and likely to escalate their problems (Murphy & McVey, 2003). Such a phenomenon is not new or unique to this service or local area. The more helpless the system and the workers become in relation to difficult patients, the more extreme the

treatment becomes (Main, 1957). The effect upon the participants was also clear; it generated feelings of frustration when they knew they were to have a patient with a LD who also had a BPD, as they knew they would be 'stuck' with this patient due to the lack of local service provision. The researcher also understood that the participants' feelings of powerlessness and helplessness in relation to these organisational factors interacted with the feelings generated within the participants by the patients' behaviour.

4.3.   Evaluation

There were a number of factors that appeared to influence what the participants said, how they said it, and in turn what they did not say. These will be briefly outlined.

One influential factor in how participants shared their accounts appeared to be their desire to help others understand their role, as they felt others misunderstood their service.

'I know people … (outside the service) … they think, … that we don't do anything … (the patients) stay here for ages … they think it's <u>our</u> fault that people stay here for too long and … it's not, … we want people to move on … there's more that goes on here I think than people give us credit for'. (P.112-113/130/L177-185/628-629).

Participants' accounts also appeared to be influenced by the low opinion they held of themselves within the NHS hierarchy.

'I'm… like the lowest of the low'. (P.55/L12).

Participants' also appeared to feel powerless.

'it depends who is in power at the moment how we are treated … Consultants have complete power. We have nothing'. (P.388/411/L534-535/1135).

Nevertheless, participants wanted to share their positive experiences of work.

'I try not to be pessimistic … and look at it positively'. (P.52/L1192-1193).

This contrasted with the difficulties participants appeared to have when trying to share their more negative feelings and experiences of working with patients.

'I do know … what you're after definitely, (pause) erm, (pause). Oh God, that's a hard one … I don't know. Do I ever get annoyed? (Pause) So hard, erm. … it's a hard one … I can't really answer it'. (P.495/L473-492).

Although participants appeared to find expressing their negative experiences and feelings about organisational factors a little easier.

'I was never angry, I was never, (pause) angry with the situation, but never with the people you're dealing with'. (P.456/L612-614).

These factors may have influenced what the participants shared with the researcher and how they shared it. Participants may have feared that their accounts would be misunderstood. There were certainly times when the meanings of words and actions were misunderstood by the researcher. Participants may have also felt powerless and of lower status in relation to the researcher. The researcher at times got a sense from how the participants were behaving and responding to the interviews, that they felt as if they were

being tested and scrutinised during the research. A level of anxiety regarding this was to be expected, as a research interview is not a familiar situation for many people. However the participants' anxiety appeared high even when this was taken into account. This may have been exacerbated by previous research that has claimed to present direct care staff's experiences but has appeared judgemental and critical in tone (Hastings, 1995). Participants perhaps attempted to protect themselves from this type of criticism by focusing on the more positive aspects of their job, so as not to appear negative. It is possible this desire to appear positive and not express negative feelings in relation to the patients may also be linked to the belief that it is not professional to have negative feelings about the patient and these emotions should be managed and not expressed (Hochschild, 2003). It was understood by the researcher that a safer way for staff to express negative feelings was to project and displace them onto the organisation/management (Shur, 1994).

4.4.   Resolution

This section will focus upon the emotional (psychological) strategies participants utilised to help manage with their day-to-day interactions with patients with a LD and also a BPD. These strategies included viewing the patients behaviour as a symptom of their illness, talking to colleagues, taking time out, displacement, building a harsh exterior, switching off and/or forgetting (repressing). These will now be outlined along with suggestions about why participants needed to engage in such strategies.

When asked about the ways they coped with their emotional reactions participants commented that they would try to understand the reason behind the patients' behaviour, viewing the behaviour as a sign of the patients' illness (P.148/L1102). Participants also said they would talk to their colleagues about the work if they were finding it particularly difficult. However, due to time pressures and events occurring within their service, this

type of informal support appeared at times difficult to obtain and provide to each other.

> *'but no you haven't got time, if there's rampaging going on you haven't got time to support staff, what you're doing is containing the situation so nobody else gets hurt.'* (P.378/L270-272).

Participants also spoke of using *'time out'* (P.303/L802). This strategy involved the participant physically moving away from the patient. However, this too appeared to be actually very difficult in practice.

> *'it isn't easy to, to take time out to be honest, but, <u>but</u> I'm saying that if you could and wanted to, you would be able to'* (P.482/L154-155).

Perhaps because of the lack of opportunity to discuss their work with other team members, and/or to physically leave the situation participants engaged in a number of what was interpreted by the researcher as more individual psychological coping strategies. For example, there was evidence that participants displaced their emotions about their work onto other things (arguably anger via road rage).

> *'take it out on the motorists on the way home'.* (P.86/L776).

Participants also spoke of developing and presenting a harsh exterior which had developed over time to help them avoid looking weak in front of the patients.

'we're all soft in the inside, but you've got to kind of present this sort of fairly harsh exterior. ... It's just like developed over the years. I just think if you (pause) (sigh) ... I don't know ... it's almost like ... they may be perceived as being weak. ... Yeah, and I think that's why you need to develop this sort of harsh, harsh, not that we're, we're, not bullies, we not, we're all soft'. (P.447/L373-381).

Using such strategies was interpreted by the researcher to mean that participants possibly did not have many opportunities to discuss their emotional feelings during work time. This helped to explain why when participants were asked to share their emotional feelings about their work with the researcher they appeared to struggle to access these feelings. This often resulted in participants appearing reluctant to discuss their emotional reactions in relation to their patients, often answering questions about how they had felt about a particular incident or situation by saying that it was *'part and parcel'* of their job to deal with difficult patients (P.445/L338). Participants appeared to find it more acceptable to express their emotional reactions about the organisation.

'It's not patient related, it's more sort of organisational, and, a lot of the organisational stuff annoys me and that will stay with me, but the patient stuff never does'. (P.458/L652-654).

Another explanation for why participants did not often discuss the emotional impact of their work with patients with a LD and a BPD was because they appeared to believe that expressing such feelings was forbidden.

'You want to smack 'em on the nose but you're not allowed to are you … You're not supposed to say things … like that but no, you don't, you'd never want to hurt them anyway no, you'd want to bloody kill them sometimes'. (P.87/L804-823).

Participants also appeared to view being emotionally affected by their work as a negative thing and a sign of personal weakness.

'that's the one area where I am weak in my emotions'. (P.350/L700).

When exploring further why participants appeared to find it difficult to talk to the researcher about their personal emotional reactions, it became apparent that there were significant risks for participants to think about their work in detail.

'I think if you thought about it you'd never go back to work. Yeah you'd never go back to work'. (P.64/L239-241).

'we'd all crack up (laughs). We'd all end up in a mental home'. (P.498/L552).

This helped to explain why participants appeared ambivalent about talking to someone outside of their service about their feelings.

'Actually, no, not really, because they don't really want formal support, they don't like it, they're suspicious … 'Why have you come to see me?' …. 'There's nothing wrong with me.' … but if you came … and made a relationship with the person and they got used to seeing you, and you came in every week you most likely do a wonderful job … to break the barriers down'. (P.388-390/L539-578).

This suspicion could also have been due to a lack of clarity regarding other professionals' roles.

'it's saying as a psychologist … I could achieve this, this, and this, whereas I haven't even got a clue what … a hoped outcome of when psychology gets involved.' (P.255-256/L1247-1250).

As a result participants appeared to value the ability to not think about their work.

'it's being able to, erm, switch off, you've got to be able to switch off … you've got to be able to switch off … you've got to switch off'. (P.29/L590-594).

This appeared to be particularly so in relation to painful and traumatic events.

'(the patient) pinned me up against the wall before …. Oh God, I can't remember, I think someone talked her down, I can't remember, … I'd forgotten about it until someone mentioned it to me … I thought 'God, I'd forgotten about that' … there aren't that many bad things that happen on the unit cos mainly cos of the way we manage it … but, erm, sometimes things do happen, … cos, you don't want to think about those time, you think back, how could I have managed it differently, how, what did I do wrong, did I not pick up the signs as quickly as I should … did I not see it coming … Yeah, I can't remember … I don't know, I think they just talked (the patient) down and it was for only a few seconds but it's, 'Bloody hell' you know, your feet are dangling and you're like 'Oh bloody hell' … yeah it was horrible, oh yeah, so but I'd completely forgotten about it until someone mentioned it, … To be honest that one I can't really remember'. (P.180-185/L665/775-801).

Nevertheless participants were aware that their emotional reactions could be informative.

'if you're not in touch with your emotions you won't be in touch with other

people's, ... that's the key, being in touch with your emotions'.(P.364/L1053-1057).

Participants were aware that using such strategies long term there was a risk that they would not be able to switch back on (P.304/819-820).

Participants when asked how they coped with their work did talk about the need of a range of arguably practical and psychological methods of coping. This provides indirect evidence, in line with previous research, that their work with patients who had a BPD was emotionally very demanding (Nehls, 1994) requiring a range of coping mechanisms. This is confirmed by the few, yet intense, emotions participants did feel able to share during the research. However, participants did not appear to be comfortable with discussing their emotional reactions with the researcher. It is possible this was because they did not know the researcher well enough and so did not feel safe enough. However, it was felt during the interviews by the researcher that participants wanted to forget about incidents as illustrated by the exerpt recalling a physical attack (P.180-185/L665/775-801). This strategy of forgetting/repressing was interpreted as a defence mechanism used by participants during their working day (and during the interviews) to protect them from remembering the pain and fear of the incident (Freud, 1914). During such accounts the researcher also felt that the participants were indirectly expressing a wish not to discuss such events and feelings any further. As a result the researcher felt a conscious pressure not to probe further. The researcher felt such a conscious pressure was perhaps linked to the unconscious projections from the participants onto the researcher about their fear of

being blamed and held responsible for such incidents.

It was also thought by the researcher that the accounts shared by the participants indicated a belief that it was bad to express negative thoughts and feelings about their patients. It was thought by the researcher that this was linked to the participants' belief that to be professional you 'never' (or should ever) experience such intense emotions (Hochschild, 2003). In contrast participants appeared to be more able to express their negative emotional reactions in relation to the organisation. These were understandable in view of their feelings of being scrutinised and de-valued by managers (as previously discussed). However, it was also felt by the researcher that the participants were projecting the anger they felt towards their patients onto the organisation, (and displacing this onto other motorists), as this was safer and more socially acceptable.

Participants did not mention a need for more training and/or for the need to talk to someone about their emotional experiences with patients with a LD and also a BPD very frequently. When they did participants appeared ambivalent. This ambivalence was possibly a result of their fear of looking weak and asking for emotional support. Indeed previous evidence suggests staff do find supervision very helpful when working with patients with a BPD (Bland & Rossen, 2005). In view of this the researcher felt participants would most likely benefit from being given the opportunity to reflect upon the emotional impact of their work, to reduce their need to repress and deny their more negative feelings about their patients who had a BPD, and thus avoid responding to unconscious negative countertransference (Book *et al,* 1978). However, for this support to be successful the person offering the support would need to visit regularly to 'break the barriers' (resistance) down first.

4.5.   Summary And Clinical Implications

Participants explained that they had little previous work experience of patients who have a LD and also a BPD before working in this service. They also spoke of difficulties in finding relevant theoretical information to help guide them in their work with such patients. Participants had to rely on their clinical judgements and adapt their approaches based on a trial and error approach. The lack of theoretical knowledge participants had about their patients reflected both a research and a clinical reality. There has not been a great deal of research conducted exploring the needs of patients who have a LD and also a BPD and/or the staff that care for them. Staff may benefit from being given support in applying and adapting what research evidence there is to their clinical work, and not being criticised when they find this difficult. It is almost to be expected that they will find this difficult in light of the chronicity and complexity of these patients needs.

Participants knew that these patients needed a strong, consistent and containing environment. Nevertheless this knowledge did not prevent participants from experiencing these patients as challenging. Participants felt that the type of behaviour the patients exhibited made it difficult to develop a positive therapeutic relationship with them. In view of the research evidence that indicates patients with BPD generate intense emotions within clinicians (McIntyre & Schwartz, 1998), problems experienced by the participants of building a therapeutic relationship were understandable and again to a certain extent to be expected. Participants may benefit from being reassured that the difficulties they have in relation to building a positive relationship with patients with a LD and also a BPD is possibly a symptom of the patients' problems rather than an indication of their poor practice. This understanding may help participants speak more freely about such feelings and experiences such as having their 'buttons pushed' without seeing it as a personal weakness in them as staff members.

Participants explained that it was not just the patients' behaviour that made their work difficult; it was also a number of organisational factors. These included poor staffing levels, the patient mix, and inadequate services within the community for patients with complex needs. Participants experienced these organisational factors as obstacles in their work and expressed a range of emotions as a result of them. The intensity of these emotions appeared high. Organisational factors appeared to be a very real problem for staff. Poor staffing caused a great deal of stress in the participants' daily working lives. However, when staff commented upon such factors it was interpreted by the researcher that staff may have also been trying to communicate their emotional reactions about other aspects of their work such as not feeling safe (being attacked and scrutinised), not feeling valued and feeling as if they were failing patients. If outside professionals wish to attempt to provide support, this dual understanding of organisational factors may help them appreciate the practical obstacles staff face in their work, in addition to the emotional reactions the staff experience in relation to their patients but rarely feel safe enough to express explicitly.

Participants did not appear to find it easy to talk directly or in much detail about their emotional reactions in relation to working with patients who have a LD and also a BPD. This might have been because they were too painful emotionally and/or participants did not feel safe enough to disclose them in an unfamiliar research situation. Nevertheless, when they did talk about it, participants described using a range coping mechanisms. These included talking to their colleagues and taking time out, although these strategies were difficult to implement consistently due to lack of time and staff. Participants also spoke of engaging in other more individual psychological strategies. These included 'trying to switch off' and not 'thinking about it'. Participants appeared to have developed

these strategies to help them manage experiences that appeared too painful for them to remember and hold in their consciousness. These strategies also appeared to be used due the participants' belief that holding negative feelings about patients was bad. As a result when these feelings were inevitably experienced participants tried to manage them by either forgetting them or projecting them out onto the organisation. When professionals supporting staff observe staff engaging in such defence mechanisms, it would be unwise to try to alter or remove them, i.e. encourage staff to explore the emotional impact of their work. This is because these strategies appear to help participants manage their current working environments. What may be more appropriate is for professionals to try and understand why staff need to utilise them; it is likely that they are very understandable if their working conditions and the complexity of their work is taken into account.

4.6.   Conclusion

Strong negative emotional reactions appear to be understandable when working with patients who have a BPD (Main, 1957). Staff working with patients with a LD who also have a BPD appear to also experience intense emotions and may benefit from support that normalises such emotions rather than perceiving these as a 'weakness'. It may be possible for staff to then go on to use these emotional reactions as a therapeutic tool, to help them understand the patient's inner world (Book *et al.,* 1978). Future research could evaluate with staff whether this type of support is beneficial or simply experienced as yet another threat. It is recognised that for this type of support to be successful change also needs to occur on a systemic level to provide staff with more time, control and safety in their working lives.

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Section Three

Critical Appraisal

1.   Introduction

The research utilised the free association narrative interview approach developed by Hollway and Jefferson (2000). The reasons for using this approach rather than another qualitative research methodology will be discussed. The advantages and disadvantages to using such a new approach will be outlined in general and then more specifically in relation to my research project.

2.   The Free Association Narrative Interview Approach

At the time of commencing this research project there was not any published work that had specifically explored direct care staff's experiences of working with people who have a Learning Disability (LD) and also a Borderline Personality Disorder (BPD). I felt an explorative qualitative research design would be the most appropriate design as opposed to a quantitative hypothesis generated project because the object of the research was to explore staff's emotional responses. Once I had decided that a qualitative research would be the most appropriate approach to take I knew I then had to identify an appropriate method. A number of issues guided my final decision. The first was the various factors that I had become aware of during the literature searches that might possibly impact on staff's experiences whilst working with patients who have a LD and also a BPD. The second was my own clinical and personal experiences regarding the influential impact defence mechanisms had upon the way people shared their experiences (Gough & Madill, 2007; Hollway & Jefferson, 2000). These two issues will now be outlined.

2.1.   Factors Influencing Staff's Experiences

Due to the lack of research that had specifically explored the experiences of staff working with patients with LD and also a BPD it was necessary to conduct separate literature searches in relation to both staff's experiences of working with patients with a LD, and staff's experiences of working with people who have a BPD.

The literature within the LD field appeared to have focused predominantly upon staff's thoughts, feelings and behaviour in response to working with challenging behaviour (Hastings, 1995). This research often appeared to conclude that staff experienced negative emotions in response to challenging behaviour (Bromley & Emerson, 1995). This research often recommended staff should be given more training to increase their knowledge about behavioural approaches in the hope that it would help to reduce the negative emotions they experienced in relation to challenging behaviour (Bromley & Emerson, 1995). However during my initial literature searches I also became aware of research that suggested training alone did not always improve staff morale or change their practice (McVilly, 1997; Rose, Jones & Fletcher, 1998); that organisational factors also had a significant impact upon staff's experiences (Emerson & Emerson, 1987) and that people with a LD may be at greater risk of developing mental health problems, and that these problems may manifest in their behaviour (Martson, Perry & Roy, 1997). However the findings of such research did not appear to have been amalgamated with the research that explored staff's experiences of challenging behaviour. The research therefore appeared fragmentary. This was possibly due to the fact that most of this research had been based upon quantitative research methodology, which often explores individual variables in isolation. This not only reinforced my decision to use a qualitative research methodology, it also made me realise that there appeared to be organisational/social factors along with more psychological factors that influenced staff's experiences. I wanted to find a methodology that would

enable me to explore both of these factors simultaneously.

During my searches within the LD literature I also became aware of a small number of studies evaluating treatment programmes for patients with LD who also had a BPD (Esbenson & Benson, 2003; Mavromatis, 2000; Wandel & Prince, 1991; Wilson, 2001). These indicated that a multi-modal approach to treatment was recommended due to the complexity of the patients needs. They also suggested (anecdotally) that working with patients who have a LD and also a BPD can be extremely challenging for workers because of these patients' tendency to experience and express extreme emotional reactions. One recommendation to help staff address this was to acknowledge their countertransferential reactions to their patients (Mavromatis, 2000). Such findings and recommendations appeared to be supported by the research that has explored staff's experiences of working with patients who have a BPD but not a LD in the mental health literature. This research appears to suggest that working with people who have a BPD generates a great deal of intense emotions for staff and these emotions are viewed as understandable and informative (Book, Sadavoy & Silver, 1978; McIntyre & Schwartz, 1998). The recommendations from such research appeared to contrast with the majority of the LD literature, which appeared to view negative emotional reactions as something to manage and reduce as opposed to trying to understand and reflect upon (Hastings *et al.*, 2003). Such contrasts were at times confusing yet thought provoking for me whilst considering the most appropriate research methodology. I began to question how staff working within a LD service would feel about talking about their emotions (possibly negative ones) and whether they would view such emotions as either understandable or as something that they should be able to manage and reduce.

I therefore concluded that in view of the many factors that had been identified as

potentially influencing staff's experiences and the potentially contrasting recommendations to help staff with their emotional experiences of patients I believed that I needed to find a qualitative research methodology that would enable me to explore all of these issues concurrently, i.e. both the organisational/systemic factors and the more individual/psychological factors that impact staff whilst working with such complex patients. I was aware that there was a number of possible qualitative research methods that could have been utilised based upon these criteria. These included Grounded Theory (Strauss & Corbin, 1998), Interpretative Phenomenological Approach (IPA) (Smith & Osborn, 2004) and/or Discourse Analysis (Coyle, 2000). However, as Frosh and Emerson (2005) have argued the majority of these approaches generally view participants' accounts as 'facts' and as the sole source of information for analysis. This contrasted with my own developing theoretical understanding of the subjectivity of both the participant and the researcher (Gough & Madill, 2007). This issue will now be outlined.

2.2.   The Subjectivity Of The Participant And Researcher

Before embarking upon this research, I was beginning to explore, through my personal and clinical experiences of both receiving and providing therapy, the impact of defence mechanisms upon a person's story. I was becoming aware of how our own inner psychological psyche impacts upon our stories and how we use these to protect ourselves from painful emotional experiences (Malan, 1957). As my knowledge and awareness grew regarding these psychological defences, in addition to the potentially stressful and influential factors that may impact upon staff's experiences of working with someone with a LD and also a BPD, I began to wonder (as Hollway and Jefferson have done) whether it was actually appropriate to take accounts at 'face value' as most of the qualitative research methods I was exploring seemed to be suggesting (Hollway & Jefferson, 2000).

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When I explored this issue further I discovered that Gough and Madill (2007) had argued that one of the main definable differences between qualitative research methods was how they differed in the view and understanding of the psychological subject (the researcher and participant included). Gough and Madill (2007) have argued using the definitions outlined by Parker (1999) that there are three different ways that the research subject can be viewed. They labelled these are 'uncomplicated', 'blank' and 'complex' subjectivity. They acknowledged that this was only one way of categorising the different models of subjectivity, but they asserted that they found using such categories had helped them to differentiate methods and approaches within the diverse field of qualitative research. These will now be briefly outlined.

The 'uncomplicated' subject has been defined as one whose action and/or speech is presumed to communicate the individual's real nature. That is the participant 'tells it like it is'. It is arguable that Grounded Theory (Strauss & Corbin, 1998) and IPA (Smith & Osborn, 2004) take this view of the participants. This view also holds the belief that participants are the experts in their experiences. Gough and Madill (2007) outlined the second category labelled as 'the blank subject'. The blank subject is one who is understood to be constructed in and through social discourse with often little exploration of the individual. This is a view that Gough and Madill (2007) argued was often underlying Discourse Analysis and methodology. Gough and Madill (2007) went on to outline a third view, that of complex subjectivity. They claimed that the free association narrative approach (Hollway & Jefferson, 2000) is beginning to be associated with such a theoretical understanding of the subject/participant. Gough and Madill (2007) argued that in marked contrast to other approaches the free association narrative interview approach does not regard research participants (or anyone) as experts in their lives. The theoretical understanding of the subject within the free association narrative interview approach will

now be outlined.

Hollway and Jefferson (2000) coined the term 'the defended psycho-social subject'. This theoretical term asserts that it is not possible or appropriate to take people's accounts of their experiences at 'face value' because of the defence mechanisms that they are employing (Malan, 1979). Defence mechanisms refer to unconscious psychological defences that all of us are thought to use to protect ourselves from 'seeing' and experiencing potentially distressing thoughts and anxieties (Joseph, 1988). These intra-psychic defences are thought to significantly influence people's actions, lives and accounts. Hollway and Jefferson (2000) went on to explain that they had developed the term 'psycho-social subject' to try and illustrate and explore the psychological and social aspects of an individual participant and researcher simultaneously. This view therefore asserts that that people's inner worlds cannot be understood without knowing their experiences of their social world, and vice versa (Hollway & Jefferson, 2000).

In view of my own beliefs about how accounts can be influenced by defence mechanisms and in light of the theoretical debates about subjectivity, it appeared that the free association narrative interview approach was the most appropriate methodology for me to use. I felt that this approach would enable me to explore the experiences of the participants, whilst not expecting them to be experts in their experiences. It would also enable me to view the participants and myself as defended subjects, and so explore both conscious and unconscious feelings and experiences (Frosh & Emerson, 2005). This would therefore enable me to analyse not just the words (text/data) that the participants provided within the interview situation, but also enable me to reflect upon other forms of information available to aid my understanding and later interpretations, such as 'how' the participants said what they said, 'why' they said it, and explore what they did not say

(Lillrank, 2002; Rogers *et al.*, 1999).

I also felt that the free association narrative interview approach would enable me to take into account the organisational and social discourses that may be influencing participants' accounts such as their unwillingness or inability to 'tell me how they really felt' due to fear of criticism, and inhibition as a result of the power imbalances between participant and researcher.

3.   The Advantages And Disadvantages Of The Free Association Narrative Interview Approach

As with any research approach there are always strengths and weaknesses. The free association narrative interview approach was no exception. Since this approach was published in book form in 2000 (Hollway & Jefferson, 2000) there have been a number of researchers that have successful used this approach (for example Bjerrum Nielsen, 2003; Froggett, 2002; Gadd, 2004; Roseneil, 2006; and also Walkerdine, Lucey & Melody, 2001). All have argued that using psychodynamic concepts helped their analysis. However, despite these examples of the benefits of using psychodynamic concepts and interpretations, this has been the very thing that has generated the most debate and concern from other researchers (Wetherell, 2005; Spears, 2005). To aid the discussion about the concerns raised by the use of psychodynamic concepts it is necessary to first provide an outline of the general theoretical debate regarding the importance and emphasis that has been placed on either/or both social and psychological factors within discourse analysis research. It is hoped that this outline will help explain why some researchers think that using psychodynamic concepts is positive whilst others feel this is unnecessary.

Hollway and Jefferson (2005) explained that they developed the free association narrative interview approach to help address the problems of dualism in theorising structure (social factors) and agency (individual factors). They explained that some theories have focused too much on the social discourses/structure to explain the positions people take. These theories often appear to view the individual as having little influence over the choices they make in their lives due to the impact of social factors. Hollway and Jefferson (2005) went on to explain that in contrast there appear to be theories that have theorised the individual as having complete control over their actions and disregard the impact social factors have on their behaviour/action. Hollway and Jefferson (2005) have argued that their approach was developed to explain how individuals make choices (rational and irrational/conscious and unconscious) within a social context without focusing more on one or the other factor.

Spears (2005) and Wetherell (2005) in reviewing Hollway and Jefferson's article outlining a negative case to exemplify the free association narrative interview approach agreed that the issues regarding the agency and structure debate do need to be addressed. However Spears (2005) was unsure that the case presented by Hollway and Jefferson (2005) achieved this, calling for more examples. Whereas Wetherell (2005) felt Hollway and Jefferson (2005) had merely simplified the argument to enable them to support their new approach. It is not the aim here to enter into this theoretical debate, but to acknowledge that is currently exists. How approaches theorise the individual and the social, and the interaction between the two, continues to be a source of heated debate (Hollway & Jefferson, 2005; Hollway & Jefferson 2005b; Spears, 2005; Wetherell, 2005). Such differences and criticisms have arisen as researchers clearly have different emphasis, different questions and use different conceptual frameworks. This is a positive thing and

hopefully with further conversation and exploration these conflicting ideas will bring

richness and with time even integration (Hollway & Jefferson, 2005b). Indeed both

Wetherell (2005) and Hollway and Jefferson (2005b) concluded that it is now more

beneficial to explore how the agency and structure impact on each other in practice rather

than continuing to solve this by theorising. Hollway and Jefferson (2005b) argued that

they have attempted to do this by using psychodynamic concepts to try and understand the

investments (they use this term as they argue the term choice implies rational and

conscious decisions) individuals make in relation to certain social discourses. It is the use

of these concepts that Spears (2005) and Wetherell (2005) appeared to disagree with the

most. The debate regarding the use of psychodynamic terms and interpretations will now

be discussed.

3.2.   The Use Of Psychodynamic Terms And Interpretations

The theoretical framework of Hollway and Jefferson (2000) has been criticised for

using psychodynamic concepts such as the unconscious, and the role these concepts play in

the interpretations made by the researcher regarding the participant's inner world. Spears

(2005) and Wetherell (2005) argued that the use of psychodynamic concepts was

unnecessary and did not add anything to the analysis or interpretation of the data. Spears

(2005) argued that the internal conflicts that Hollway and Jefferson (2005) alluded to in

their case study could have just as well been defined as a conflict between public and

private accounts rather than an unconscious conflict. Wetherell (2005) too criticised the

use of the concept of the unconscious (and countertransference) on the grounds that they

had not been adequately defined.

Hollway and Jefferson (2005b) accepted that there is indeed an on-going debate

about concepts such as the 'unconscious' within research and psychoanalysis, and this

includes a debate about the differences between hidden (private) versus unconscious. These concepts like the theoretical debate about subjectivity are not easily defined. However, Hollway and Jefferson (2005b) go on to explain that the irreducible feature (definition) of unconscious dynamics for them is that certain forces within any individual have decisive effects on their actions without being available to awareness and without them being amenable to conscious decision making (Layton, 2004). Therefore, in response to Spears (2005) suggesting that it may be more appropriate to use the terms private and public as a way of explaining and understanding the conflict and contradictions evident in a person's story, Hollway and Jefferson (2005b) explain that the conflicts are not about the difficulties a person has with sharing their conscious discourses/accounts. The conflicts are also not about a person's lack of resources to make sense of their situation. They believe the conflicts arise because the pain produced by the thought prohibits the full extent of their inner conflict being examined, hence it being held in the unconscious.

Hollway and Jefferson (2005b) went on to respond to the arguments that using psychodynamic concepts and ideas to inform their interpretations were unnecessary. They argued that these psychodynamic ideas enriched their analysis and so were therefore necessary. They explained that the ideas of unconscious, and countertransference helped them to tap into the emotional content of the accounts, for both the participant and the researcher. This is something that is not 'visible' within the text of a transcript but was experienced as very real by the researcher during the interview, and after when listening to the recording of the interview. Hence Hollway and Jefferson (2005b) argued that if they accepted Wetherell's (2005) view that interpretations should be made just on what is 'in' the data they would lose valuable information about the participants' experiences. Hollway and Jefferson (2005b) went on to acknowledge that the use of psychoanalytical concepts generates debates due to the theoretical and epistemological differences

specifically within discourse analysis and more generally within qualitative research methodology (Hollway & Jefferson, 2005b). However, they assert that these psychodynamic ideas provide a way to go beyond and beneath the data that other methods do not.

In light of these criticisms and counter-arguments regarding the use of the free association narrative interview approach, reflections about using such an approach will now be provided in relation to my own research.

4.	Reflections On My Own Research Project

The focus of the reflections upon my own research will be upon using the free association narrative interview approach in view of the concerns raised by Spears (2005) and Wetherell (2005) regarding the use of psychodynamic concepts. I will also reflect upon a more social/structural issue, the power imbalances between participant and researcher and how this may have affected the data.

4.1	The Free Association Narrative Interview Approach

4.1.1.	Collecting the data.

The free association interview approach looked on paper to be a very easy method of data collection. All I had to do was ask open-ended questions to facilitate the participant to freely associate regarding their experiences of working with patients with a LD and also a BPD. However, in reality I found that it required a great deal of discipline and practice and at times I reverted back to a more familiar style of directive interviewing. For example, at times I found myself asking 'why' questions. Asking 'why' questions

makes the assumption that people know why and can 'tell it like it is'. The free association narrative interview approach challenges this and in practice I found that when I asked a 'why' question the participants struggled to provide an answer. The question simply seemed to activate their defence mechanisms and led them to produce a guarded answer. This was not the type of response I was trying to elicit. Fortunately I managed to keep these slips to a minimum and did not feel these slips damaged the relationship between the participants and myself. In fact I was able to use these slips as feedback in terms of my interview style and as evidence to support the appropriateness of this approach.

However, there were still times when I was concerned that this different approach would not get all the information I needed as it does not automatically ensure systematic coverage of all topics that are of interest to the researcher. I often experienced this feeling of concern during the interviews. This was perhaps because I was so busy during the interviews attending to the dynamics of the interview, such as reassuring the participants that I found it difficult to attend to all of the information being shared both consciously and unconsciously. It was only after the interview when I listened to it again that I began to see this approach was facilitative and I was reassured that the approach helped produce a great deal of relevant information. This helped me feel more confident in being less directive, it also helped me understand the role I played in co-producing data. How I may either have helped to open up or close space down during the interview will now be discussed.

4.1.2. The researcher's role in producing the data.

The free association interpretive narrative approach holds the view that both the interviewer and interviewee use unconscious defence mechanisms to protect themselves from anxiety and pain. It was through reflection in my journal and discussing the

experiences of the interviews in supervision that I became more consciously aware of the part my own unconscious defence mechanisms may have played in encouraging or discouraging the participant to express anxiety provoking thoughts and emotions. For example, I became consciously aware of the fact that I was anxious that I might inadvertently uncover or expose poor practice within the service. If I did find this I would have a duty to report this. I am now aware that there may well be some reality to this belief (Department of Health, 2001) but it may have also been created by the literature that has focused upon direct care staff and heavily criticised them for not implementing certain interventions. I therefore found myself at times avoiding exploring these issues with participants.

I was also aware that due to my own personal experiences of loss just before the research project began I may have unconsciously tried to avoid painful feelings in others and that my own unresolved inner conflicts may have influenced the participants' responses (Malan, 1979). This may also help to explain why I at times asked factual 'safer' questions (Lillirank, 2002) rather than asking them how it felt for them. I was somewhat reassured that I had not completely closed the space down for participants, when they did express their emotions and at times became tearful. However, it was clear that they found this difficult and were concerned this would get them into trouble or be seen as a weakness. This contrasted with my own thoughts and feelings that have been developed through providing and experiencing therapy. I realise now I had been a little naïve to expect participants to feel at ease with sharing such intimate feelings after just one or two meetings. Their comments helped me appreciate that I had enabled them to express their feelings but that they were not used to, or comfortable, with this.

I am also aware that there was times during the interviews that I acted upon

feelings the participants were projecting into me. I already knew that I would be experiencing a certain amount of anxiety about doing the research as this would decide whether I would pass the training course or not. However I found I was experiencing a great deal more anxiety than I had expected. It is likely that I was picking up some of this anxiety being projected from the participants onto me. This was done on both a conscious and unconscious level. For example when I asked the participants about their experiences with the patients they talked about 'not thinking about it' because if they did 'they wouldn't go back to work'. I felt a conscious and unconscious pressure not to ask them any more questions about this. I now realise that this was an indication that participants simply did not want to talk about it because it was too painful. If I had been in a clinical setting this would have been explored in more depth, however this was not appropriate or ethical in this situation, and helps to highlight the differences between clinical and research interviews. This was therefore simply used as information during the analysis stage of the project. The analysis stage will now be discussed.

4.1.3. Analysing the data.

The aim of the research was to understand staff's experiences by analysing the content of their stories along with using my countertransference and theoretical knowledge to interpret how and why they shared the particular accounts that they did. One of the strengths of such an approach is that it therefore enables the exploration of the emotional interactions between the interviewer and interviewee. It also enables non-verbal communication and the 'unsaid' to be analysed. However, by its very nature this is also a potential weakness. This is because by exploring both the participants' and the researchers' conscious and unconscious thoughts and feelings it is very difficult for participants to fully consent to this type of research. I was extremely aware of this ethical dilemma and provided the participants with as much information as possible about the

research to enable them to consent as fully as they could. However in view of the issues raised by Hollway and Jefferson (2005) and also Spears (2005) and Wetherell (2005) I also made every attempt to ensure that 'no harm' was done to the participants (British Psychological Society, 1996) and made every effort to ensure my interpretations were justified and respectful to the participants' accounts.

In connection with using unconscious material to analyse the participants' accounts I was also concerned that I may be seen as exposing the staff's 'real' feelings about their work, feelings they either were not aware of or simply did not want to share. I also feared that these interpretations would be misunderstood and be experienced by the staff as yet another attack from a more powerful professional who did not understand them. I was also fearful that my interpretations would be taken out of context by other professionals and be used to criticise the staff. I was also aware that the interpretations were based upon only one or two sessions, unlike the many sessions in clinical practice and so there was a risk of 'over interpretation' (Frosh & Emerson, 2005). I therefore tried to keep the interpretations as conservative as possible and checked them with my supervisor(s).

4.2.   Power Imbalances Between Participant And Researcher

As a clinician I was aware of the impact power imbalances may have upon a therapeutic relationship (Gorell Barnes, 1998). However, I had not anticipated how much these would influence my research participants. This was because I started the research with the view that the participants were my colleagues, who would know a great deal more about adults who have a LD and also a BPD than I would. As a result I was caught off guard when it became apparent that the participants experienced me as more powerful than themselves and this seemed to generate a great deal of anxiety for them. As a result of this power imbalance participants appeared to be giving me the answers that they thought they

'ought' to give me rather than their 'true' feelings.

When exploring possible contributing factors for this power imbalance and resultant anxiety in the participants I realised that I had not appreciated the traditional power hierarchy within the National Health Service (NHS). I had also not appreciated the effect of being associated with the two key professionals who had commissioned the research. I had thought that being associated with these two professionals would help me to access participants, and encourage the participants to trust me. I had even included the names of these commissioners on the introductory letter. I had not taken into account the fact that these two professionals were from different disciplines to the participants I was trying to access. They also had a lot more power than the participants in terms of professional status (Mitchell, 2000). It became clear that the participants were treating me as being in a similarly powerful position to that of the commissioners.

Furthermore, unbeknownst to me at the beginning of the research, these potential participants had also experienced a great deal of research in the form of service evaluation and audits. The participants may well have thought my research was going to be yet another way of measuring their performance (and ultimately criticise them for not achieving the goals that had been set for them by others). This belief became evident when participants commented that they wanted to 'set the record straight' about what went on in their service.

In view of these issues it is understandable that many did not feel able to volunteer and those that did appeared to be anxious. Once I became sensitive to these issues I attempted to address them in a number of ways. I explained the purpose of the research to each participant in as much detail as possible. I emphasised the voluntary nature of the

study and my independent role. I also used my clinical skills to try and create a safe and trusting space within which the participants could share their experiences. It was reassuring to see that the participants who took part were able to relax during the interviews and began to trust me by sharing some aspects of their experiences. However, because of this experience I now appreciate that power imbalances between the researcher and the researched are not always predictable, although once identified measures can be taken to reduce this. Nevertheless I feel researchers need to be aware that there may be power imbalances present, either consciously or unconsciously, for both parties, and I feel it is the researcher's responsibility to be aware of this and ensure they do not abuse their power.

5.   Conclusions And Recommendations

I have found using this approach has been extremely labour intensive. I was required to not only learn a new interview approach, but also to familiarise myself with psychodynamic concepts and be able to engage in reflection upon participants' and my own unconscious processes. This was only possible via psychodynamic supervision, which again was time consuming and expensive. I also found using conscious and unconscious material to inform my interpretations anxiety provoking, knowing that these had generated a great deal of theoretical debate (Spears, 2005; Wetherell, 2005).

Upon reflection using a different qualitative research approach would not have raised as many issues for me. However, conversely I am also aware that if I had not used this approach I could have ran the risk of providing a rather one-dimensional view of the staff's experiences. I feel this approach encouraged me to explore both the psychological

and the social issues simultaneously, along with my role as researcher in terms of producing and analysing the data, in a lot more depth than I perhaps would have done using an alternative approach. Utilising such a research approach therefore has risks and generates a great deal of debate (Spears, 2005; Wetherell, 2005) but also has many benefits (Hollway & Jefferson, 2005b).

Recommendations for future researchers and trainees who may be considering embarking on a similar approach include: to ensure they have the time required to become familiar with using psychodynamic concepts and the support to explore the use of psychodynamic interpretations with like minded colleagues/supervisors; to ensure they are not exacerbating power imbalances by including information in their covering letters about commissioners; and finally they need to have the commitment to develop a deeper knowledge of epistemological and methodological issues in order to be able to disentangle the often complex issues when using a newer and more contentious research approach.

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Section Four

Appendices

Appendix A.

Diagnostic Criteria for Borderline Personality Disorder

A person needs to be assessed as having five or more of the following to be labelled/diagnosed as has having a Borderline Personality Disorder (American Psychiatric Association, 1994):

Frantic efforts to avoid real or imagined abandonment. The perception of impending separation or rejection, or the loss of external structure can lead to profound changes in self-image, affect, cognition and behaviour. These individuals are very sensitive to environmental circumstances. They can experience intense feelings of abandonment and inappropriate anger even when faced with unavoidable changes to plans or realistic time-limited separations such as when a person arrives late or has to cancel an appointment. They believe that this abandonment implies that they are 'bad'. This relates to an intolerance of being alone and a need to have other people with them. Their frantic efforts to avoid abandonment may include impulsive actions such as self-harm or suicidal behaviours.

A pattern of unstable and intense interpersonal relationships characterised by alternating between extremes of idealisation and devaluation. They may idealise potential caregivers at the first or second meeting, demand to spend a lot of time together and share the most intimate details early in a relationship. They can quickly shift to devaluing these carers if they perceive that that person is not there for them.

Identity disturbance: markedly and persistently unstable self-image or sense of self. This can take the form of sudden changes in opinions, plans, sexual identity, values and types of friends.

Impulsivity in at least two areas that are potentially self-damaging (e.g. spending, sex, substance abuse, reckless driving, binge eating)

Recurrent suicidal behaviour, gestures, or threats, or self-mutilating behaviour. They also display recurrent suicidal behaviour, gestures or threats to self-harm, which may be precipitated by threats of separation or rejection or by expectations that they assume

increased responsibility. After such behaviour they may have feelings of shame and guilt that may contribute to the feeling that they are evil.

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

Chronic feelings of emptiness.

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

Transient stress related paranoid ideation or severe dissociative symptoms. These episodes occur most frequently in response to a real or imagined abandonment. Symptoms tend to be transient, lasting minutes or hours. The real or perceived return of the caregiver's nurturance may result in a remission of symptoms.

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Appendix B

Psychodynamic Terms

Transference.

Transference is present in everyday relationships (Bateman, *et al.*, 2000). This is evident by the fact individuals do not approach new people as if they are totally unknown, but rather 'transfer' feelings and attitudes developed from earlier similar experiences. It is thought that the 'transferring' of such reactions is intensified when a person is anxious, ill or frightened. These experiences are thought to develop over time in childhood and form a template for how people behave and react to others in any given situation. For example if a person acquires the belief in childhood that they are not lovable then they are likely to make the assumption that no-one else will like them either and thus approach people with suspicion and hostility. It is believed that via treatment the individual becomes more aware of such attitudes in the here and now and learns that there is at least one person (the therapist or the staff member) who cares. The hope is that they will then be able to transfer and generalise this out in to the rest of their relationships. This is very pertinent to people with learning disabilities due to stigma, shame, guilt and the sense of loss many parents experience when they have a child that is born with learning disabilities which would (even temporarily) influence and affect their interactions with their baby and in turn the baby's emotional well-being (Hodges, 2003).

Countertransference

Historically, countertransference was viewed as bad, undesirable and thought to contaminate the therapist/researcher's behaviour arising from unresolved personal conflicts in the therapist/researcher's life. From this perspective the client/participant's transference stimulates the therapist/researcher's childhood based unresolved conflicts interfering with the therapist/researcher's understanding and provoking behaviour that meets the therapist/researcher's needs rather than the client/participant's (Winnicott, 1949). This belief may help to explain the view in other therapies/research methodologies that when a therapist/researcher experiences intense emotional reactions this needs to be managed and removed from analysis rather than interpreted (Hastings, 1995; Main, 1957).

The view of countertransference has been expanded to incorporate the entire therapist/researcher's reactions to a client/participant. There is also a view that the therapist/researcher's feelings about a client/participant can be informative rather than obstructive (Casement, 1985; Hollway & Jefferson, 2000). This is because the therapist/researcher can 'use' their feelings towards the client/participant to examine what it is in the client/participant that is making them feel this way (Bateman *et al.*, 2000). This is thought to be one way of trying to listen to the client/participant's unconscious communication invoked in the therapist/researcher. It is therefore important for the therapist/researcher to not only be open to the communication from the client/participant but also to be open to experience feelings that are quite unlike their own. The greater the freedom they have to resonate with the unfamiliar aspects the more it will enhance their receptivity of others (Casement, 1985).

There are many different aspects that make up the phenomena of countertransference. For example, the therapist/researcher may begin to feel what the client/participant may find difficult to acknowledge in him/herself (projected feelings) such as anger and rage. Alternatively the therapist/researcher may experience feelings that

would match the person the client/participant is transferring onto the therapist/staff member i.e. the therapist/staff begins to feel critical like the client/participant's critical parent/manager (role responsive). The important task for the therapist/researcher is to not only recognise what and when this is happening but to also be able to detach themselves from this so as not to act on it but to reflect on it. Clinically it would be the therapist's role to begin to help the client identify and label emotions that they may not have previously been able to identify and talk about. This can be emotionally very demanding for the therapist (Winnicott, 1949). Winnicott (1949) has gone on to stress the importance of the therapist to be able to tolerate and remain in touch with strong emotions such as hate. This is because it is often these types of emotions that the client cannot tolerate or be conscious of. It is therefore important that the therapist does not try and avoid such emotions, which would restrict the clients' opportunity to learn to manage them. However, it is not appropriate to do this in a research interview and such feelings should just be noted and analysed later (Hollway & Jefferson, 2000).

Projective identification.
         The concept of projective identification has been hotly debated. Klein argued that this is what happens when a person tries to ward off anxieties and impulses (Joseph, 1988). Many different aspects of projective identification have been suggested. One of the more commonly discussed aspects includes the client's tendency to 'split' off: getting rid of unwanted parts of the self that cause anxiety or pain by projecting the self or parts of the self onto the therapist. This 'splitting' can have a powerful effect on the recipient (Puri, 1988) and is also referred to as a defence mechanism (Hollway & Jefferson, 2000). Hurley and Sovner (1988) have remarked that this 'splitting' can be observed within a group of staff when some members will vehemently dislike, while others will passionately defend, the affected individual. In a clinical situation the task is to try and identify the projected emotions and give them back to the person so that they can become more integrated. However, this can threaten the client's balance and so is resisted if the therapist tries to give them back too soon. It is important to remember that this is another form of communication in the therapy room and so the therapist must be able to be open to it (Joseph, 1988). As this may cause distress, projective identification was merely noted in the research interviews and analysed afterwards.

         Casement (1985) provides a clear and simple example of projective identification. This involved a woman telling a terribly sad story with no sign of emotion whilst he as the therapist was literally crying inside. This helps to demonstrate that projective identification is often in the form of emotions. This is important to remember particularly when what is being communicated is beyond words or if it relates to unspeakable experiences or to pre-verbal experience. The role of the therapist is to learn to manage being in touch with these feelings more than the client has been. If this is possible the previously unmanageable feelings become more manageable for the client.

         One of the main difficulties of projective identification for the therapist/researcher is being able to identify when it is actually happening to them. For example Main (1957) reported that evidence of nurses acting on projective identification was when the nurses felt helpless and resorted to more extreme measures of treatment. In this example he argued that supervision was extremely useful in helping the therapist/nurses to examine their work and motives for certain treatments. Hence often the therapist/researcher is unconsciously aware of the projected feelings and needs supervision to help identify this in themselves and to help them become more consciously aware of it.

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Appendix C

Anonymised Ethical Approval Letter

Introductory Letter

Dear staff member,

My name is Judith Storey and I am training to become a clinical psychologist at XXXXX University. As part of this training I am carrying out a research project exploring the experiences of staff who work with adults who have a learning disability and a diagnosis of a borderline personality disorder.

Dr XXXXX, Consultant Psychiatrist and Dr XXXXXXXX, Consultant Clinical Psychologist have informed me that the Assessment and Treatment Unit have supported clients who have a learning disability and a diagnosis of a borderline personality disorder. I would therefore be really interested in your experiences.

It is my hope that this research will help develop a greater understanding and appreciation of the impact this type of work has upon staff.

Taking part in this study would involve meeting me for about an hour to discuss your experiences of working with people who have a learning disability and diagnosis of a borderline personality disorder. XXXXXXXXXXXX, Service Development Manager has authorised that this can be within your work time. This would be arranged at a time and date convenient for you. The interviews could take place either at your work-place or at XXXXXXXXXXXXXXXX. The interview will be recorded and the information you share at the interview will remain confidential. Taking part is totally voluntary.

If you would like to be involved and/or you would like more information please complete the attached sheet and return using the stamped addressed envelope provided.

Thank you for your time.

Yours sincerely

Judith Storey
Trainee Clinical Psychologist

Please tear off and send back to me using the self-addressed envelope

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Opting in form

Yes I am interested in taking part in the research project ☐

I am not sure I want to take part but would like to know more ☐

I understand that I am under no obligation to take part in the study and can withdraw at any time ☐

Name (in BLOCK CAPITALS please):…………………………………………...

Work address:……………………………………………………………………...

…………………………………………………………………………………..

…………………………………………………………………………………..

Telephone
number:………………………………………………………………….……………

I will contact you as soon as possible once I have received this form

PLEASE TRY TO RETURN SLIPS WITHIN 6 WEEKS OF RECEIVING THIS LETTER

Participant Information Sheet

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Title of Study:
Exploring the work experiences of staff working with adults who have a learning disability and a diagnosis of borderline personality disorder.

Chief Investigator:
Judith Storey, Trainee Clinical Psychologist

Contact details of Chief Investigator:
XXXXXXXXXXXX, School of Psychology, Clinical Section, 1XXXXXXX
XXXXXXXXXXXXX   Telephone: XXXXXX.

1.   What is the purpose of the study?
The purpose of this research is to explore the work experiences of staff who work with adults who have a learning disability and a diagnosis of borderline personality disorder.

2.   What will be involved if I take part in the study?
I will arrange a convenient time with you for the interview to take place during your work time. I am interested in talking to you about your experiences of working with adults who have a learning disability and a diagnosis of a borderline personality disorder. The interview will be recorded to ensure no information is forgotten, and later transcribed verbatim. I may take notes throughout the meeting. The meeting would last for approximately one hour.

3.   Will the information obtained in the study be confidential?
At the beginning of the interview you will be asked to sign a form consenting to our conversation being recorded. All the information you share with me will be kept strictly confidential during the course of the research. When the interview is written up, information that could be used to identify you, such as your name will be taken out. The only time I would have a duty to break confidentiality is if I became concerned about risk of harm to you or to others.

4.   Who is taking part?
All participants are staff members who have worked with adults who have a learning disability and a diagnosis of borderline personality disorder. Between 8 and 10 participants will be taking part.

5.   What are the possible disadvantages and risks of taking part?

I appreciate that it is possible talking about some of your experiences may be upsetting. If you do become distressed, you can chose to stop the interview. If you have found the interview particularly distressing and feel the need to talk to someone about the issues raised support will be available from your informal peer support group. In the unlikely event you require additional support this will be available from Dr. XXXXXXXXX, Clinical Psychologist and her team and/or Dr XXXXXX, Consultant Psychiatrist.

6.   What if I am harmed by the study?

Psychological research is covered for mishaps in the same way, as for patients undergoing treatment in the National Health Service (NHS) i.e. compensation is only available if negligence occurs.

7.   Who is organising and funding the research?

The study is being organised by me, Judith Storey, a trainee clinical psychologist at the XXXXXXXXXXX, employed by the XXXXXXXXXXX NHS Trust, who are funding the research. Clinically relevant research is a requirement of the training for NHS Clinical Psychologists.

8.   What happens after the interview?

The information taken from the interviews will be analysed and written up as a research document and submitted to the University XXXXXXX. The interview will be made anonymous, by taking out anything that could be used to identify you, and the content of the interviews will be treated as confidential. You can request a copy of your interview, either on CD or a copy of the typed manuscript. A summary of the main results will also be made available to participants who request it.

9.   Do I have to take part?

You do not have to take part if you do not wish to do so. If you decide to take part, you will be asked to re-read this information and you will be asked to sign a consent form. If at any point, you wish to withdraw from the study you may do so without justifying your decision.

10.   How do I get further details?

If you would like to discuss this study further you can leave a message for me, Judith Storey, on XXXXXXXXX, and I will return your call.

Thank you for taking the time to read this information

Consent Form (on University headed paper)

Title of study:
> Exploring the experiences of staff who work with adults who have a learning disability and a diagnosis of borderline personality disorder.

Chief Investigator:
Judith Storey, Trainee Clinical Psychologist

Please read this form in conjunction with the participant information sheet.

I agree to take part in the above study as described in the Participant Information Sheet. ☐

I have read and understood the Participant Information Sheet and have had the opportunity to ask questions and discuss the details with Judith Storey. The nature and purpose of the interview to be conducted, and my involvement in it have been explained to me, and I understand what will be required if I take part in the study. ☐

I understand that I am free to withdraw from the study at any time, without justifying my decision. ☐

I understand that the information I share will be treated as confidential. I understand that no information that may identify me such as my name, and professional details will be contained in the report of this project but direct quotations may be used. ☐

I understand the reasons why the research interview will be recorded. I understand that the information recorded during the interview will be treated as confidential and will only be used for this study. ☐

I understand that the recording will be destroyed on the first of the following two events, (i) if I withdraw my consent to participate in the study or (ii) on satisfactory completion of the project. ☐

I understand that compensation for any harm that arises from the project will only be available in a case of negligence. ☐

Signature of Participant…………………………   Date……………..

Name (in blocked capitals):………………………………………………………

I have explained the study to the above participant and s/he has indicated their willingness to take part.

Signature of Researcher:…………………………   Date……………..

Name (in blocked capitals)…………………………………………………

One copy for participant and one copy for research

<center>**Appendix G**</center>

<center>**Interview Topic Guide/Aide Memoire**</center>

<center>Introduction</center>

Personal introductions
Outline of research and structure of interview
Consent and Confidentiality
Explanation of note taking during the interview
Request permission to record the interview
Answer any questions the participant has

<center>General overview</center>

I am interested in your experiences of working with people who have a learning disability and a borderline personality disorder. Where would you like to start?

Areas of particular interest:

Experience: Knowledge base/Understanding.
Training: Formal and informal.
Day-to-Day management of these patients.

Impact on: The staff team.
On the individual staff member (Physical, Emotional, Knowledge).

Support/Help? What do you get now? Does it help?
How would you like it to be in the future?
Coping mechanisms employed by participants.

Other experiences at work:
- Are there any other aspects to your work we haven't covered?
- How was it – talking about your work experiences?

General probes
- Could you tell me some more about that?
- How does that make you feel?
- Could you describe that in a little more detail – I'm not sure I understand.

Ending interview
- Review consent.
- Provide de-brief, including information on access to support if necessary, procedure for analysis, future contact.
- Thank them for their time and effort.

Appendix H

Author Guidelines for the Journal of Applied Research in Intellectual Disabilities

(Summarised Version)

Journal of Applied Research in Intellectual Disabilities

Author Guidelines
Articles should not exceed 7000 words. Brief Reports should not normally exceed 2000 words. Submissions for the Letters to the Editor section should be no more than 750 words in length.

Cover Page
A cover page should contain only the title, thereby facilitating anonymous reviewing. The authors' details should be supplied on a separate page and the author for correspondence should be identified clearly, along with full contact details, including e-mail address. A suggested running title of not more than fifty characters, including spaces; and up to six key words to aid indexing should also be provided.

Main Text
All papers should be divided into a structured summary (150 words) and the main text with appropriate sub headings. A structured summary should be given at the beginning of each article, incorporating the following headings: Background, Materials and Methods, Results, Conclusions. These should outline the questions investigated, the design, essential findings and main conclusions of the study.
The text should proceed through sections of Abstract, Introduction, Materials and Methods, Results and Discussion, and finally Tables. Figures should be submitted as a seperate file. The reference list should be in alphabetic order thus:

Once completed, please return the form to the production editor at the address below:
Production Editor
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Blackwell Publishing
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Edinburgh EH2 3ES UK
E-mail: jarid@oxon.blackwellpublishing.com