Doctoral Thesis

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Multidisciplinary Team Perspectives of Borderline Personality Disorder and Clinicians' Experiences of Support

Nina Fernandes

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Division of Health Research

Lancaster University

LA1 4YF

Statement of Total Word Count for the Thesis

	Main text	**Appendices** ***(including references, tables & figures)***	**Total**
Thesis abstract	293	-	293
Literature review	7,945	7,600	15,545
Research paper	7,993	7,910	15,903
Critical appraisal	3,909	2,748	6,657
Ethics section	3,083	8,105	11,188
Total	23,223	26,363	49,586

Thesis Abstract

This thesis explores clinicians' experiences of working with individuals diagnosed with Borderline Personality Disorder (BPD) and psychiatrists' perspectives of supporting clinicians in their work with this client group. It includes a systematic literature review, research paper, critical appraisal, and an ethics section. The review uses thematic synthesis involving a three-step iterative process of synthesising clinician responses from 10 included papers. Four themes were derived from the synthesis which included, BPD: a polarising diagnosis, difficult patient status, caught up in the whirlwind, and when things go well. Clinicians can find their work with clients diagnosed with BPD challenging and have mixed responses to this diagnosis. The main factors perpetuating these experiences include workload pressure, limited experience of working with BPD, and when negative attitudes are ingrained in service cultures. Understanding the impact of childhood trauma which may lead to emotional distress, and support from the wider multidisciplinary team (MDT), were felt to enable constructive experiences with this client group. This highlighted the need to further understand how MDTs are led and supported in this work. The research paper explores psychiatrists' experiences of leading and managing MDTs in their work with individuals with a BPD diagnosis. Ten psychiatrists were recruited online. Data were collected using semi-structured interviews and analysed using Interpretative Phenomenological Analysis. Four themes were developed which included, MDTs are stress tested by this work, teams require scaffolding to work effectively, the burden of responsibility, and protect yourself. Participant responses indicated that systemic pressures affect MDTs. Reflective practice and training can improve service delivery. The critical appraisal discusses the wider practical, methodological, and ethical issues in which this research paper is contextualised. This thesis illuminates the need to understand clinicians within the context of their work and the client beyond their diagnosis.

Declaration

This thesis presents research carried out between September 2019 and March 2021 for the Doctorate in Clinical Psychology Programme at the Division of Health Research, Lancaster University. The research recorded is my own, except where due reference is made. This thesis has not been submitted for the award of any higher degree elsewhere.

Name: Nina Fernandes

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I dedicate this thesis to my best friend, my husband, Gordon and my son, Amir. Thank you, Gordon, for finding out about the course in Derby which gave me a chance to apply for training. You are my rock. Thank you for your love and patience. I look forward to the next chapter of our lives together. Amir, it is because of you that I was able to keep up the motivation to do this thesis. You put life into perspective, and I am so grateful to be your mum. I could not have done this without the both of you.

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Section One: Literature Review

Clinicians' experiences of working with individuals diagnosed with a Borderline Personality Disorder: A Thematic Synthesis

Nina Fernandes

Doctorate in Clinical Psychology

Division of Health Research, Lancaster University

Prepared in accordance with the 'manuscript submission guidelines' for the International Journal of Social Psychiatry

All correspondence should be sent to:
Nina Fernandes
Doctorate in Clinical Psychology
Division of Health Research
Lancaster University
LA1 4YG
Email: nina.fernandes@outlook.com

Abstract

Background: Borderline personality Disorder (BPD) is predominantly characterised by difficulties with mood and relational instability, poor self-image, self-injury, and suicidal ideation. Clinicians in mental and physical health settings encounter individuals with this diagnosis and report a range of experiences during their interactions. The recurrent theme encapsulated in the research is that clinicians find the work with this client group complex. **Aim:** The study aims to systematically review the current evidence for a range of clinicians' experiences of working with individuals diagnosed with BPD, in various mental and physical health settings.

Methods: A qualitative review methodology using thematic synthesis was used. "AMED", "CINAHL", "EMBASE", "MEDLINE Complete", and "PsychINFO" electronic databases were systematically searched using a combination of free and database subject search terms. The analysis included a three-step iterative process of transforming descriptive codes into analytical themes.

Results: Ten international studies were included in this review. The following themes emerged from clinicians' experience of working with individuals diagnosed with BPD: (1) BPD: a polarising diagnosis; (2) difficult patient status; (3) caught up in the whirlwind; (4) when things go well.

Conclusion: Clinicians adopt negative views towards clients because of a lack of training about the trauma aspects of BPD, limited supervision, reflection on their own emotional responses, and feeling unable to rely on teams for support. Therefore, clinicians may avoid working with this client group and use the BPD diagnosis to exclude clients from services. The review highlights the need to further understand how clinicians are supported in teams to improve client care.

Keywords: BPD; clinicians; experiences; negative attitudes; literature review; childhood trauma; teams; training; support

Introduction

Borderline personality Disorder [1](BPD) is classified in the Diagnostic and Statistical Manual (DSM) (American Psychiatric Association [APA], 2013) as a psychiatric diagnosis for individuals experiencing mood and relational instability, poor body image, and severe emotional distress, which can be significantly overwhelming for the person. Some individuals diagnosed with BPD also report visual and auditory hallucinations and other overlapping difficulties congruent with the diagnosis of psychosis (National Institute for Health and Care Excellence [NICE], 2009). Individuals in this population group may use self-injury and take drug overdoses to cope with difficult emotions (Paris, 2019), and they may use emergency services for crisis management (Borschmann et al., 2012). The risk of completed suicide is believed to occur in 10% of clients with a BPD diagnosis (NICE, 2009). The persistent and debilitating nature of distress affects their psychosocial and occupational functioning (Zweig-Frank & Paris, 2002).

BPD overlaps with other mental health diagnoses leading to inconsistencies in the way these clients are supported (Oldham, 2015). Recent research has indicated a high correlation between clients with a BPD diagnosis, childhood sexual abuse and invalidating family caring environments (McFetridge et al., 2015; Levy et al., 2011). Some have found the diagnosis useful when it serves to identify and validate distress and directs access to services (Nehls, 1999). The diagnosis has also invited criticism. Healthcare providers may misuse it when they exclude individuals with this diagnosis instead of opening supportive care pathways (Warrender et al., 2020). By pathologizing BPD, it can invalidate understandable human responses to traumatic experiences like sexual abuse, especially in women (Shaw &

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[1] The author is aware of the use of medical and diagnostic terminology when referring to BPD. This does not reflect the author's stance or that of the clinical psychology profession.

Proctor, 2005). Therefore, the impact of such adversity on individuals may not be wholly understood and subsequently overlooked.

Complex childhood trauma can lead to a dysregulated nervous system which negatively affects an individual's ability to self-regulate their emotions and build healthy attachments (Austin et al., 2007). This affects social and relational engagement (Austin et al., 2007). Yet, understanding the role that trauma plays is often lacking in staff groups in mental and physical healthcare settings. Clinicians may react rather than respond to the individual perceived to frequently present in crisis in a considered way (Aviram et al., 2006). Prejudiced and discriminatory attitudes are prolonged in the absence of an understanding of the individual's psychosocial context causing their repeated crises (Johnstone, 2014; Aviram et al., 2006). As such the BPD label is seen to contain more negative connotations rather than facilitating staff understanding that these are understandable responses to adverse childhood experiences (Johnstone et al., 2018).

Evidence-based therapeutic interventions are recommended for clinicians to use with this client group (NICE, 2009; Fonagy et al., 2017; Linehan et al., 1993). Interpersonal dynamics regarded as challenging and behaviours deemed impulsive resulting in risk uncertainties, have rendered individuals with this diagnosis as "difficult to treat" (Westwood & Baker, 2010). This may lead to exclusion or early discharge from services. Such responses may be viewed by this client group as a replication of rejection from key relationships, causing emotional overwhelm (Grambal et al., 2017; Veysey, 2014). Additionally, contextual factors, such as increased waiting lists alongside under-resourced services, may make healthcare providers cautious and lead to a reluctance in supporting clients in crisis (Lelliott et al., 2006). Hence the efficacy of national guidelines for BPD (NICE, 2009) have been contested (Recovery in the bin, 2017), as services are seen to repeat cycles of neglect towards people with diagnoses of BPD and personality disorders more generally (Mind, 2018).

Clinician responses to individuals with a BPD diagnosis have been well-researched in specific staff groups. Most of these studies uncover stigmatised views and staff bias in their interactions with this client population (Knaak et al., 2015; Markham, 2003; Markham & Trower, 2003). An integrative literature review on mental health nurses' responses to clients with a BPD diagnosis indicated that their views were widely varied because of their experiences (Dickens et al., 2016). It also emphasised a need for increased education and therapeutic skills to counteract negative attitudes in the nursing profession towards clients with a BPD diagnosis (Dickens et al., 2016). Another recent mixed-method review that evaluated the effects of an education programme on nursing staff's willingness to work with clients with a BPD diagnosis, indicated positive shifts in staff opinions post training (for example, using less accusatory language) (Dickens et al.,2019).

In terms of qualitative reviews, Ross and Goldner (2009) carried out a review of nurse attitudes in general health settings towards individuals with mental illness. Prejudiced and blaming views were illuminated in addition to an avoidance of individuals with a BPD diagnosis, compared to individuals with other mental health diagnoses (Ross & Goldner, 2009). Furthermore, Ring and Lawn (2019) compared clients' and clinicians' experiences of stigma in the BPD client group. Stigmatised views were maintained by a lack of understanding of BPD, affecting the quality of support offered by staff. This led to disillusionment in clients and clinicians. Therefore, the need for staff training to facilitate better care for clients emerges in most of these studies. It also outlines a need to understand a wider range of clinician views in various healthcare settings working with clients with a BPD diagnosis, especially as the evidence base calls for an interdisciplinary effort to care for clients (NICE, 2009).

Qualitative studies offer a helpful medium for in-depth exploration of a person's views and can provide richer study/sample insights (Thomas & Harden, 2008). Whilst this research exists, there are no qualitative literature reviews that have amalgamated these experiences. Furthermore, as this subject area has been well-researched using quantitative methodologies, a qualitative approach may be useful in understanding clinician perspectives surrounding commonly reported attitudes.

The findings of this review could benefit clinical psychologists (CP) as their role entails working in mental and physical health settings. CPs use various psychological approaches and extend this knowledge to teams to offer psychosocial perspectives relating to the factors leading to the development of mental health difficulties (Health & Care Professionals Council [HCPC], 2016). CPs are also well placed for systemic and joint work in addition to providing supervision and consultation to various staff groups working with individuals diagnosed with BPD.

Method

Aims

The aim of this research is to synthesise published qualitative research to enable a comprehensive exploration of clinicians' experiences of their work with individuals diagnosed with BPD. Therefore, this review aspires to answer the following question: "what are the perceptions, attitudes and experiences of clinicians who work alongside individuals with a BPD diagnosis and how does this influence their work?"

Design

This review uses thematic synthesis (Thomas & Harden, 2008). This approach is particularly suited to unearthing qualitative elements of mixed-method studies, heterogenous samples, and other data collection methods where qualitative findings may not be obvious (Thomas & Harden, 2008). Like thematic analysis (Braun & Clarke, 2006) in empirical research, it uses the author's interpretations and participant[2] quotations as data. This approach is divided into three steps to ensure that the review's findings are interpreted within the context of the results from the qualitative studies. An iterative three-step analysis includes line-by-line coding, which is subsequently transformed into descriptive coded themes. This is then interpreted and syphoned to form a small number of analytical themes.

The operating epistemological position was one of critical realism (Bhaskar, 2013). Critical realism assumes the existence of an underlying reality, the understanding of which differs according to various conditions, which research aims to identify and explain (Archer et la., 1999). Participant views are influenced by their experiences and their responses may be coloured by socially desirable perspectives. Archer et al. (1999) suggest that this epistemology enables the exploration of the 'why' beyond the 'what'. For example, the way in which services approach clients with a BPD diagnosis may influence the way clinicians conceptualise their own experiences of clients.

Search strategy

The Sample, Phenomenon of Interest, Design, Evaluation, Research Type (SPIDER) tool was used to guide the search (Cooke et al., 2012). By deconstructing the review question, it enabled a systematic focus on each of the important components of the research question. When these subject areas were combined, it enabled the formulation of a structured search. The SPIDER tool is predominantly used to extract qualitative and mixed-method studies and is therefore suited to this review.

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[2] The term 'participant' and 'clinician' will be used interchangeably and when the profession is unknown.

Table 1

SPIDER Tool

SPIDER Terms	Search Concepts
S-Sample	Clinical Staff
PI-Phenomenon of Interest	Experiences of working with clients diagnosed with BPD
D-Design	Qualitative research methodology
E-Evaluation	Interviews, Surveys, Storytelling, Focus Groups, Case Notes
R-Research Type	Qualitative/Mixed Methods

Inclusion and exclusion criteria

See table 2 for inclusion and exclusion criteria.

Table 2

Inclusion and Exclusion Criteria

Inclusion criteria	Exclusion criteria
• Qualitative and mixed-method peer reviewed journal articles published in the English language due to time and resource constraints associated with translation. • No date limiters. • Studies using a mixed methodology if clear themes were generated in the findings. • Clinicians included staff working in any health setting who encountered individuals diagnosed with BPD. • Studies reporting clinician experiences needed to specially include the work with clients with a BPD	• Grey literature. • Mixed publications of clinician and client views that cannot be separated. • Studies exploring experiences of clinicians in relation to personality disorders including BPD but where the experiences in response to individuals diagnosed with BPD cannot be separated.

diagnosis. This is to clearly demarcate clinician experiences with this client group due to the impact of the label on the clinician indicated by the research (see introduction). • Experiences include any face-to-face encounters defined by the one-to-one interaction with an individual diagnosed with BPD. • Data reporting clinician responses to individuals diagnosed with BPD that can be separated and extracted from clinician responses to other client groups. • Data reporting a clear distinction of clinician responses from experiences by individuals diagnosed with BPD.	• Studies reporting clinician experiences after attending training programmes on BPD. • Studies reporting clinician experiences of using therapeutic interventions with individuals diagnosed with BPD.

Electronic search strategy

The titles and abstracts of the following databases were searched in September 2020: AMED", "CINAHL", "EMBASE", "MEDLINE Complete", and "PsychINFO". These databases were selected because a similar scan of the Cochrane library within the BPD subject area indicated that they were used most frequently. Additionally, the titles and abstracts of up to five pages of Google Scholar, and a citation search of specific articles was also conducted and generated 24 papers for screening. These papers were also found in the above databases. The university's librarian checked and confirmed the search terms and strategy. To check each database's search was comprehensive and for adequate recall of the studies, a 'search strategy search test' was conducted with the librarian. Search terms containing references to qualitative research excluded relevant studies and were therefore not used.

A Boolean search resulted in search terms listed in Table 3 below. The Endnote (Version X9) bibliography manager was used to store the exported papers. A total of 100 duplicates were removed. The titles and abstracts of the resulting 323 studies were screened for their suitability. Individual papers were also read where further clarity about a decision to include/exclude was required. A full list of free search and database subject terms is appended (appendix 1-B). The following is a list of the free search terms.

Table 3

Boolean Search

Boolean Search	
Free search terms	("attitude *" OR "perception*" OR "opinion*" OR "thought*" OR "feeling*" OR "beliefs") OR TI ("experience*" OR "knowledge" OR "perspective*" OR "position*" OR "bias*" OR "view*") OR AB ("experience*" OR "knowledge" OR "perspective*" OR "position*" OR "bias*" OR "view*") ("clinician*" OR "therapist*" OR "counsellor*" OR "health professional*" OR "staff*") OR TI ("clinical psychologist*"OR "psychiatrist*" OR "social worker*" OR "mental health nurse*" OR "psychiatric nurse*" OR "occupational therapist*") OR AB ("clinical psychologist*" OR "psychiatrist*" OR "social worker*" OR "mental health nurse*" OR "psychiatric nurse*" OR "occupational therapist*") ("borderline personality disord*" OR "bpd" OR "emotionally unstable personality disord*" OR "eupd") OR TI ("borderline personality disord*" OR "bpd" OR "emotionally unstable personality disord*" OR "eupd") OR AB ("borderline personality disord*" OR "bpd" OR "emotionally unstable personality disord*" OR "eupd")

Critical appraisal

Appraisal of study quality for qualitative research has stimulated much discussion due to disagreements about the function of such quality checks (Boulton et al.,1996). However, the assessment of quality cautions researchers about the way findings are interpreted and generalised, and is therefore recommended (Thomas & Harden, 2008). This review uses the Critical Appraisal Skills Programme (CASP) tool (CASP, 2020), as it has a clear rating system. The CASP contains ten areas wherein the initial two questions guide the researcher to consider study suitability. Upon meeting these criteria, the paper is assessed against the remaining eight categories considering study design, sample, data collection, researcher-participant relationship, ethical issues, data analysis, findings and study utility. Duggleby et al.'s (2010), three-point rating system was used. Here, three points were given to studies demonstrating robust evidence, two points for moderate, and one point for poor quality evidence, leading to a final score. The study scores in this review ranged from 14-24 (see Table 4). For added rigour, the research supervisor scored a sample of the papers blind to the researcher's scores. Score discrepancies were discussed specifically in terms of the impact it may have on the review findings.

Table 4

CASP Quality Assessment

Study	Authors	Research Design	Recruitment Strategy	Data Collection	Relationship with the researcher	Ethical issues	Data Analysis	Findings	Value of Research	Total score
S1	Bergman & Eckerdal, (2000)	2	3	2	1	1	3	1	2	15
S2	Day, Hunt, Cortis-Jones & Grenyer, (2018)	3	3	3	1	2	2	3	3	20
S3	Koehne, Hamilton, Sands & Humphreys (2012)	3	3	3	1	3	3	1	3	20
S4	Ma, Shih, Hsiao, Shih & Hayter, (2009)	3	1	1	1	2	3	2	2	15
S5	Millar, Gillanders & Saleem (2012)	3	2	3	1	1	3	3	3	19
S6	Nehls, (2000)	3	2	3	2	1	3	3	3	20
S7	Stroud & Parsons (2013)	3	2	3	3	3	3	3	2	22
S8	Sulzer (2015)	3	3	3	3	2	3	3	3	23
S9	Treloar, (2009)	2	2	2	1	1	2	2	2	14

S10	Wollaston & Hixenbaugh, (2008)	3	3	3	3	3	3	3	3	24

Table 5 contains information regarding the contextual, methodological, demographic, and other relevant data pertinent to the review analysis from each of the included studies.

Table 5

Data Extraction

Study No.	Author, Year	Country	Research Question/Aim	Qualitative Design/ Data Collection	Sample	Findings
S1	Bergman & Eckerdal, 2000	Sweden	To broaden the understanding of what it means for caregivers to manage BPD patients.	Qualitative, grounded theory, interviews	Sample: n=29 including licensed nurses (63%), physicians (15%), social counsellors (11%) and psychologists (11%); Gender: 78% female and 22% male; Age: 30-62 years; Setting: outpatients and inpatients; Employment: 0-25 years	The study identified the social and psychological dimensions related to managing BPD patients and summarised these in two core concepts labelled professional skills of mental health work and frame of work organisation

S2	Day, Hunt, Cortis-Jones & Grenyer, 2018	Australia	To document changes to clinician attitudes to mental health since 2000 using a mixed-methods approach.	Qualitative, interviews, Storytelling	Sample: n=33 mental health nurses; Gender: male=11; female=22; Age: Mean age=42.21; Setting: Inpatient and outpatient units	Staff working in 2015 were more positive in their attitudes both on objectives measures but also in the kinds of language they used to describe their interactions with these clients.
S3	Koehne, Hamilton, Sands & Humphreys, 2012	Australia	To examine the discourse used by Child and Adolescent Mental Health Services (CAMHS) clinicians in relation to the use of the BPD diagnosis.	Qualitative interviews, Discourse analysis	Sample: n=23 mental health clinicians Setting: four community mental health teams, community day programme and acute inpatient unit belonging to CAMHS	The study shows how the category of BPD exists as an object of psychopathology within a complex group of social and power relations
S4	Ma, Shih, Hsiao, Shih & Hayter, 2009	Taiwan	To explore the contributing factors and effects of Taiwan's mental health nurses' decision-making	Qualitative, interviews, qualitative content analysis	Sample: n=15 nurses; Gender: female=15; male=0; Age: 23-48; Setting: acute	This study revealed that mental health nurses had attitudes towards their clients with BPD, their

			patterns on care outcomes for patients with BPD		or rehabilitation unit of a psychiatric health centre	unrelenting efforts to promote their patients' health and the active support of team members positively influenced care outcomes for this particularly difficult population
S5	Millar, Gillanders & Saleem, 2012	UK	To explore clinical psychologists' experiences and perceptions of clients with BPD.	Focus groups, Interpretative Phenomenological Analysis (IPA)	Sample: n=16 clinical psychologists and trainee clinical psychologists; Gender: female=16	The following eight superordinate themes emerged from the analysis: 'negative perceptions of the client', 'undesirable feelings in the psychologist', 'positive perceptions of the client', 'desirable feelings in the psychologist', 'awareness of negativity', 'trying to make sense of the

						chaos', 'working in contrast to the system', and 'improving our role'.
S6	Nehls, 2000	USA	To address the gap in knowledge by examining case management as it is practiced and experienced by case managers who care for persons with BPD	Qualitative interviews, IPA	Sample: n=17 case managers; Setting: Community Mental Health Centre	The analysis showed a pattern of monitoring self-involvement in terms of expressing concern and setting boundaries.
S7	Stroud & Parsons, 2013	UK	To gain a fuller understanding of how community psychiatric nurses (CPNs) make sense of the diagnosis of BPD and how their constructs of BPD impact their approach to this client group	Qualitative interviews, IPA	Sample: n=4 CPNs Gender: female=3, male=1; Setting: Community Mental Health Team (CMHT)	The results indicated that participants attempted to ascribe meaning to the client's presentation 'in the moment'.
S8	Sulzer, 2015	USA	To evaluate mental health clinicians', descriptions of patients with BPD, how the diagnosis of BPD affects the treatment clinicians are	Qualitative interviews, Grounded theory	Sample: n=22 which included the following: n=7 psychiatrists, n=8 psychologists, n=5	People diagnosed with BPD are routinely labelled "difficult," by professionals and

			willing to provide, and the implications for patients		licensed clinical social workers and n=2 BPD activists	subsequently routed out of care through a variety of direct and indirect means.
S9	Treloar, 2009	Australia & New Zealand	To provide the opportunity for clinicians across both emergency medicine and mental health service settings in three hospitals across Australia and New Zealand to comment on their experiences in working with patients diagnosed with BPD. To also provide some illustration as to the difficulties that may have contributed to the reported negative clinician-patient interactions found within the current literature base.	Qualitative interviews, Thematic Analysis	Sample: n=140 registered health practitioners. Gender: female=92; males=48 Setting: n=2 Australian Health Services & n=1 New Zealand Health Service	This investigation gives illustration to the key difficulties that clinicians have in working with patients diagnosed with BPD and suggests that interpersonal and system difficulties may have altered the provision of service that is available to this patient group
S10	Wollaston & Hixenbaugh, 2008	UK	By interviewing nurses, this study aimed to give them a voice and evaluate the validity of current theories on this subject	Qualitative interviews, Thematic analysis	Sample: n=6 psychiatric nurses Age: 20-40 years Setting: acute adult inpatient unit, community, and supported tenancy	In agreement with the existing literature, the participants tended to perceive BPD patients in a negative manner but only scratches the

surface of nurses'
subjective
experience

Data analysis

An inductive process was used to develop themes. Themes were coded and analysed by the lead reviewer and then shared with the supervision team for their feedback. Using NVivo, the coding and analysis process was conducted in three stages. The lead reviewer also discussed reflections with the research supervisor during the entire process to observe and address personal bias and maintain neutrality.

Stage 1.

In this stage the lead reviewer used line by line coding of the participants' responses and authors' interpretations, from the "results" or "findings" sections from the papers. Each line had new codes. However, a code could also be attributed to several lines and/or several codes were also used for a single sentence. This process was repeated with the introduction of new studies.

Stage 2.

In this stage, code relationships were created by grouping stage 1 codes, using descriptive themes. These themes remained close to the data from the original studies as they were consulted to ensure themes were carefully aligned with participant quotes and author interpretations. Themes were then organised and constructed.

Stage 3.

The relationship between the descriptive themes developed in stage 2 were examined and analysed to form more analytical themes that encapsulated clinicians' experiences of working with individuals diagnosed with BPD. Here the reviewer went beyond the original data to deepen insights and answer the review question. See Appendix 1-C for a list of descriptive themes contributing to the final analytical themes.

Results

Selected studies

Titles and abstracts of 323 studies were screened, which led to the exclusion of 288 articles. The full texts of 35 journal articles were read and assessed, resulting in 10 studies considered eligible for inclusion in the thematic synthesis. The studies were published between 2000 and 2018 and conducted in the UK (n=3), Australia (n=3), USA (n=2), Sweden (n=1), and New Zealand (n=1). The sample sizes ranged from 4 to 140 clinicians from a range of mental and physical healthcare settings. The results from the search strategy are recorded within the Preferred Reporting Items for Systematic Reviews and Metaanalyses (PRISMA) in Figure 1.

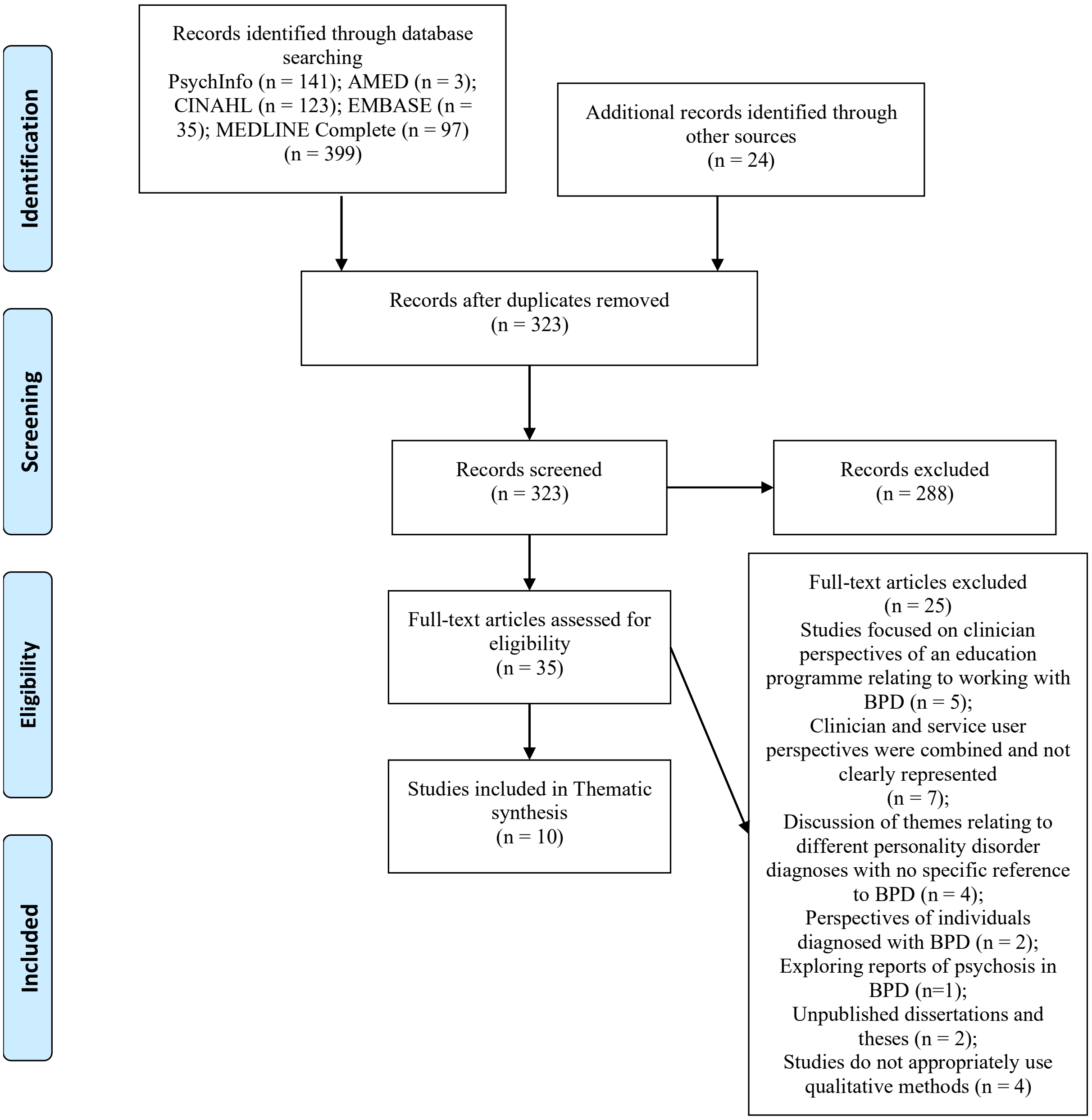

Figure 1. PRISMA Flowchart Diagram

Theme Development

The analysis process led to the development of four themes: BPD: a polarising diagnosis; difficult patient status; caught up in the whirlwind; when things go well. An example of how study themes were interpreted from participant quotes to contribute to the findings of this review is appended (Appendix 1-D). Table 6 shows the studies that contributed to each theme (see Appendix 1-E for the study key).

Table 6

Studies Contributing to Themes

Theme	S1	S2	S3	S4	S5	S6	S7	S8	S9	S10
BPD: a polarising diagnosis	X		X		X	X	X	X	X	
Difficult patient status	X	X	X	X	X	X	X	X	X	X
Caught up in the whirlwind	X	X		X	X	X	X	X		X
When things go well	X	X	X	X	X	X	X	X	X	

BPD: a polarising diagnosis.

This theme represents the views of clinicians who found the BPD diagnosis useful to understand and explain an individual's difficulties. It also includes responses of clinicians who found it invalidating, exclusionary and unclear. They also noticed emotional distress as a feature of BPD. Self-injury and expressions of suicidality were perceived as being ways in which individuals attempted to manage such distress.

Clinicians in some studies (S3, S5, S7) commented on the usefulness of the BPD diagnostic framework because their clients appeared to feel validated by it: "One person I had, said, 'That is me I know I have this, I'm sure I have'...'It's a relief to find somewhere where I fit…', and really delighted with the idea that 'There's somewhere I can hang this." (S5, p.120).

Some clinicians felt the usefulness of BPD was that it gave clients service access, "It's often a way of offering funding and linking up funding for, yeah, funding for treatment." (S3, p. 46). The BPD diagnosis also enabled some clinicians to legitimise and locate the origins of emotional distress and consider the influence of psychosocial factors leading to this diagnosis. For instance, one Community Psychiatric Nurse (CPN) shared this, "[the client is] more biologically vulnerable to being emotional and as they are growing up they are in an invalidating environment which means that they then have difficulties identifying their own emotions…" (S7, p. 246).

Positive meanings associated with BPD however was not representative of a wide range of clinician views in other studies (S1, S3, S5, S7-S9). One CAMHS clinician felt they had to use the BPD label as it was a systemic requirement rather than a reflection of their understanding of the client:

> I’ve got to say I’m not a fan of the label BPD. I actually tend to think in my head…a complex post-traumatic stress disorder symptom[at]ology, but the language I know that I need to, we kind of need to use is BPD. (S3, p. 45)

In some circumstances the label itself carried prejudice with some staff withholding care. For example: “For many providers, the decision to not provide care was linked to the impression that patients with BPD were manipulative people who feigned sickness to gain access to attention.” (S8, p. 86). Similarly, these healthcare practitioners questioned the legitimacy of the diagnosis, which appeared to interfere with the care they provided, “…[3]BPD is just an excuse for bad behaviour and nastiness” and “[O]nce labelled as BPD it is hard for the patient to be given an objective assessment.” (S9, p.31 & 32).

Some clinicians’ views suggested that on its own BPD seemed an unclear diagnosis and was understood better when compared with other mental health diagnoses. For instance, “My understanding of BPD is something that is very close to bipolar. They can be up and down and there is a fine line between [the two] diagnoses” (S7, p. 246). Clinicians also noticed this lack of clarity in their clients’ understanding:

> I think it’s hard for people to know what borderline means…I’ve certainly had patients ask me what does it mean that I’m borderline?...and you sort of explain it but, it…doesn’t sort of make sense to people, in the way that, say depression does, that’s sort of a more understandable sort of diagnosis. (S3, p. 50)

Through the comparison of diagnoses, another participant was able to emphasise the complexities associated with BPD “Depressive symptoms are cured by medicine. However,

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[3] Three ellipses points (…) denote the omission of words either at the start or at the end of a quote

this method is insufficient for BPD symptoms" (S1, p. 249). Hence, clinicians seemingly demonstrated a biomedical framework for understanding BPD.

Another common thread to participant responses was about the way they framed emotional distress within the discourse of the BPD diagnosis (S1, S5-S8). For example, some of the clinicians understood emotional expression as a coping mechanism for individuals with this diagnosis, "When their self-esteem is attacked and offended, they have to attack the surrounding environment in any way. They must get rid of the feelings they cannot keep to themselves" (S1, p. 248). One participant's response clearly demarcated emotional distress almost as a defining feature of BPD: "any borderline you know is high functioning. They are emotionally low-functioning." (S8, p. 87) and "…most individuals with BPD…they're not affecting people's lives negatively because they want to, or because they're trying to be manipulative, they just want the pain to go away." (S8, p. 87).

Some clinicians also noticed self-injury and suicidality as a means of managing distressing emotions which they felt enabled clients to express the intensity of these feelings. For example, "The self-harming is a means of communication to express their anxieties and conflicts" (S9, p. 32). Additionally self-injury was believed to be a punitive way to cope with stressful interpersonal relationships, "She self-harms a lot as well, but I think she directs it at herself because she feels she can't actually let it out at the person she's angry with…"(S5, p. 120). Furthermore, this case manager's experience indicates a level of self-doubt and uncertainty in caring for a client with BPD frequently reporting suicidality. For example, "She was suicidal on an ongoing basis. In fact, there was a rare case when she was not feeling suicidal to a greater or lesser degree." (S6, p.14).

Difficult patient status.

The term "difficult patient status" is taken from the title of one of the review studies (S8). This theme illustrates how factors such as a fear of litigation, feelings of mistrust in the client, the influence of team culture on the way that BPD is conceptualised, can set clinicians up to respond in unhelpful ways. Feeling powerless and under skilled combined with limited systemic support can also lead to clinicians reporting challenges whilst working with this client group.

The difficulties exhibited by this client group were viewed as less significant and not within the realms of mental health problems compared with other diagnoses. One healthcare provider shared the following: "…a schizophrenic may throw a chair at you too, but with the schizophrenic, it's not their fault and you have sympathy, whereas with the borderline you think they should be able to control themselves." (S7, p. 85). This also seems to suggest that clients with BPD are experienced as scheming when they express distress, captured in this study reporting the clinician's view,

> …this woman had been claiming to be suicidal for two years, calling the hospital every single day. The fact that she was still alive indicated to him that she wasn't suffering from suicidal ideation, but rather was seeking attention, and keeping him from people who were, as he put it 'really sick'. (S8*, p. 87)*

Branding clients with a BPD diagnosis as difficult at times seemed acceptable under the BPD label and allowed some clinicians to express their frustrations with this client group. A psychiatry trainee working in CAMHS had the following observations:

> So I think that it's, it's a way of describing some of the difficult patients without having to actually go through specific issues so there's a lot of assumptions that are made and so forth, but it's always said in quite a negative way. (S3, p. 49)

Disparaging attitudes towards clients with a BPD diagnosis were the accepted norm in some clinicians' views (S2, S4, S8-S10). For example, "[colleagues] I talked to were never happy about it [treating BPD]. I don't really know of anyone that enjoys that kind of work." (S8, p. 86). Individuals with a BPD diagnosis were not always believed and often viewed as controlling, resulting in clinicians feeling themselves to be powerless.

> …has the services very much wrapped around his finger. I'd say it is certainly more bad than mad but for some reason he has use of the services arm. Very manipulative, very disruptive to the ward he takes delight in stirring people up makes the whole ward unhappy when he is here… (S2, p. 315)

When the integrity of the clients was questioned, one nurse responded by controlling the care outcomes, "I actually withdrew from any sort of therapeutic liaisons with a client because I felt they were not genuine" (S10, p. 707).

Themes of clients being in control were evidenced when client difficulties were minimised. This case manager's response indicates a tone of frustration and lack of compassion when they seemed to experience their client's reports of suicidality/self-injury as repetitive.

> She called up one time, about the 5th time, and she was telling me that she was going to slit her throat right on the phone, right there...I told her that would probably make a big mess, and I also told her that I can't be the only one responsible in her life for keeping her alive. Well, I got to go. And she didn't make a mess. (S6, p. 15)

At times participant despondency, perpetuated by feeling unable to affect change in the client, led to clinicians reducing their care responsibilities towards them. For example a nurse on an inpatient unit said, "To me, it was unnecessary to spend so much time with them since they wouldn't change and we had so many other things we needed to do" (S4, p. 444).

There also appeared to be an acceptance about being discriminatory and openly rejecting of this client group (S4-S7). For example, “how do I treat BPD? I try to find another clinician (laughter).” (S8, p. 86). Such attitudes seemed to be normalised at a systemic level, “If people are diagnosed then sometimes they can be denied services.” (S5, p. 120).

Some clinicians seemed mistrusting of clients as they experienced them as defamatory. Consequently, they tended to be circumspect to protect and defend their work. For instance, “It’s all to do with risk…nothing else, just risk and litigation. A big part of it, we’ve got to cover ourselves really.” (S7, p. 249).

Sometimes clinicians felt unsure about the consequences to their work and therapeutic relationships, “To have the possibility to influence can have two sides and the downside is that I sometimes don’t know if I made the right decision and I still may be blamed for it.” (S1, p. 250). Clinicians who held more responsibility within teams tended to be cautious in their approach to client care, “As a CPN if something goes wrong then the buck stops with you and then I think that does not help staff to take positive risks” (S7, p. 249). Whilst another felt protected by care recording systems in place, “I often find it’s very, very useful to document any interactions with them” (S10, p. 707).

Challenges in the work associated with this client group were also attributed to limited team support which led to clinicians feeling powerless to affect change. This was reflected in the responses of this nurse who worked in an inpatient mental health setting, “I tried to convince my colleagues about my patients’ needs in the team meeting, but they did not pay attention to my concerns and I felt that they distrusted my judgement.” (S4, p. 443). Similarly, this mental health nurse expressed despondence and felt unsupported as they also experienced their team as inadequately skilled.

> I am unable to set a clear plan of action…I feel I have a lack of skill and basically [I'm] never sure what-ever action I take is going to be the right action. I have a lot of frustration when I work with her and I basically avoid her if I can. Because I just do not know what to do with her and I have found the people around me do not have any more skills. (S2, p. 315)

Some clinicians recognised a significant need to support this client group, but they felt constrained by what their services could offer in addition to feeling under skilled. This was reported in studies S1, S3, & S9.

> I have a real interest in learning about what might be helpful for these people because anecdotally I don't see them as improving in current provisions of mental health services and they are clearly a group of people who need something! (S9, p. 32)

Caught up in the whirlwind.

This phrase "caught up in the whirlwind" (S10, p.705) was used by one of the clinicians to describe the chaotic nature of difficult encounters with individuals with a BPD diagnosis and the resulting impact on clinician mental wellbeing. It highlights specific aspects of client-staff and colleague interactions, which clinicians experienced as negatively affecting their personal lives. It also captures the relational exchanges when clinicians have either been idealised or held in contempt during their work with individuals diagnosed with BPD. It illuminates some of the inconsistencies in the way clinicians have responded, leading to them espousing polarised views.

Some clinicians recognised that they were psychologically affected by challenging dynamics with clients, as they struggled to apply emotional boundaries. A mental health nurse shared the following, "Sometimes you would take those patients home, they've made you so upset with all their transference that you've got to actively manage your own response to that” (S2, p. 316). A CPN felt the emotional and physical impact of having to manage client distress, “I just found myself exhausted because of the challenges and the behaviours” (S7, p. 247). This was also evidenced in another clinician’s report believing that they had limited capacity to maintain emotional and professional boundaries, “You get frightened over your own anger. On those occasions you question your professional skills.” (S1, 248).

Some clinicians noticed that this affected their motivation to work. For example, one mental health nurse reported that, “It was so tiring to have a patient like her. In fact, I didn’t want to go to work.” (S4, p. 444). A case manager commented on the incessant nature of client work, which seemed to perpetuate the feeling of wanting to avoid contact, “Those sorts of things go on constantly, day after day, hour after hour, to where there are many times with clients I've felt that I was prisoner and didn't want to come in to answer my phone” (S6, p. 15).

Clinicians also expressed a sense of isolation in the work and consequently recognised challenging interactions with individuals diagnosed with BPD were perpetuated by the absence of adequate resources. For instance, this CPN expressed, “but I can also see how the frustration can manifest in the conversations that staff have as you get a lack of support and a lack of training.” (S7, p. 249). A CP’s response indicated a sense of overwhelm in managing clients, “if you’re getting the whole lot it’s really hard isn’t it because...it’s just you, as the person that’s holding this person together” (S5, p. 118). Such feelings were also experienced when this case manager felt that their knowledge of the client was questioned by the team, as they minimised the client’s reports of suicidality. For instance, “Is she really going to commit suicide? Is she really at risk? It was hard for me to ask for help because people kind of discount it as well, and yet, she had some pretty lethal attempts.” (S6, p. 14).

Additionally, a few studies demonstrated the tendency in some clinicians to take special relational positions, which some experienced as a projection of their client's feelings on to them (S1, S4, S5, S10). This psychiatric nurse reported the following: "I can make this person better; I can be the one that changes their impression about all those horrible people that they've come across in mental health." (S10, p. 706). Another clinician demonstrated an awareness of the idealised position from experience, "You became very important, you have a feeling of there isn't anybody else, though this is often a myth." (S1, p. 247). Some clinicians expressed a need to rescue, which also suggested a sense of wanting to instil hope in clients, "The patients consider nothing can help them. I will say 'don't you understand that I will help you" (S1, p. 248). For this case manager being viewed as special suggested that the client may have unrealistic expectations for their care from this clinician, "I think it is a problem when people feel like you're the most important person in their lives...a problem for me…because I can't offer what she wants...It's not mutual..." (S6, p. 16).

Some clinicians also noticed a short-lived honeymoon period during the initial stage of work, followed by feelings of impending doom towards clients due to significant ruptures in client-staff relationships. This rehabilitation nurse described the following: "I thought he was a 'good patient' at first…but three days later, he started to show a lot of difficult acting-out behaviours" (S4, p.443). A psychiatric nurse described unexpectedness in the way the clients responded, moving from one extreme to another.

> She'd gone from writing me little notes that were all quite sweet and on the back of postcards to writing me these long letters that were in capitals…in red felt tip pen…she was even threatening to kill me ...it was quite hard you know especially when you sort of are trying to help. (S10, p. 706)

Similarly, this nurse also acknowledged feeling personally affected by the change from being idealised to experiencing the client as contemptuous and splitting,

> Then everything changed. It was like a devastating war. He always told me how good another nurse was and how bad I was. Sometimes he couldn't stop insulting me…then, I was hurt and felt angry toward him, although I tried to ignore his insults (S4, p. 444)

Clinicians also reported extreme opinions in relation to their skills and general care responses towards individuals in this client group. For instance, "Some people will see the emotional needs of the client, other people will see the behaviours that they are displaying…those normally seem to be the two camps." (S10, p. 707). This clinician veered between feeling deskilled and confident, moderated by professional support, "Sometimes I feel I cannot manage the work with the patient. I feel bad and blame myself. However, in the next session of supervision I see alternative ways to handle the problems." (S1, p. 250).

Clinicians also tended to feel personally responsible for extreme emotional responses by clients leading to them either feeling skilled or deskilled as indicated in this CP's response, "one minute I'd go 'Wow yeah he's making progress, yeah!' and the next 'Oh my goodness, I'm incompetent and he's letting me know that', it was the kind of, the extremes of emotions you feel." (S5, p. 118). A trainee CP noticed extremes in the way that both clients and staff related to sessions.

> They could quite happily come back every day, you know, you think about closing off the end of a session, that might be difficult you know, the other side of that is they just don't want to see you at all. (S5, 117).

When things go well.

This theme represents some of the factors that have resulted in helpful interactions between clinicians and individuals with a BPD diagnosis. It also highlights key therapeutic methods that contribute to good client care and working relationships.

Several studies outlining clinicians' responses indicated that they had a genuine interest in this work (S1, S2, S4-S7). For example, "It is fascinating. There is frustration but also attraction. You want to get in contact with them, you think of what can be done, it is exciting..." (S1, p. 248). Some clinicians' positive regard for the client seemed to determine their approach. This CPN said, "[it is important] being genuine, validating the client and the distress or difficulty they are having...I think just being respectful, pleasant and interested." (S7, p. 248). Another nurse approached caring for clients with complexity as a learning opportunity, "I was still willing to take care of them and [to hope that] my experiences and competence might also be nourished" (S6, 444).

Some clinicians demonstrated a change of opinion by reflecting on the underlying issues affecting their clients in this client population and were thus able to validate client expressions of emotional distress. This psychiatric nurse shared the following: "She'd obviously had a significant history of sexual assault and had gone through some awful things as a child which made me feel, kind of, a lot more empathetic towards her, whereas initially I didn't feel any of that…" (S2, p. 315). Additionally, this CPN demonstrated an awareness of how their increased work experience with this client group and access to training opportunities, changed their opinions, "Over the years you gain knowledge and change your outlook" (S8, p. 245).

Clinicians also expressed more of an ability to offer support when they believed they clearly defined their caring role with the client, evidenced in this case manager's response,

> Set the boundaries right away…in terms of talking about what I can and cannot do…what's going to happen here and what's not going to happen here. You know that I'm not going to be there…that I'm not their friend. (S6, p. 15)

Similarly this CP noticed the benefits of exercising clear boundaries, "the more I've seen her, and the more I sort of stick to, you know, boundaries and she's aware of what the boundaries are, then the more comfortable she's actually becoming." (S5, p. 120). Boundaries also appeared to be followed to set clear expectations of the level of support clients can receive.

> I would have to set limits in terms of saying that she could only call once, so she really needs to save it up…to figure out which things were going to be the most important things, instead of, you know, calling me 2 and 3 times a week. (S6, p. 15)

It was also important to ensure such boundaries were maintained and some clinicians had ways to manage this. For this healthcare practitioner managing professional involvement helped achieve consistency: "consistent care was more manageable when fewer professionals were involved in client care" (S9, p. 33). Another clinician felt they needed to be reliable regardless of the client's presentation, "The only thing I could do was to handle their acting-out behaviours with routine care." (S4, p. 444).

Clinicians also emphasised the role of systemic support to improve the client's experience of care and valuing the opinion of clinicians who understand the client's presentation. This mental health clinician made the following suggestion about teamwork,

> …I think you just have to be very careful when you work in a team to keep it very cohesive and that's not treading on other people's toes, especially the ones that are dealing with the risk factors and are making the diagnosis and being respectful towards them (S3, p. 45)

Some clinicians also emphasised the importance of trust in working in multidisciplinary teams. They were able to learn from experienced clinicians as described by this theme:

> A senior colleague encouraged me to speak out about my negative feelings in caring for patients, so we [team members] could accept and show understanding for each other. We trusted each other and provided more consistent care for the patients. After expressing my emotions, my strength returned. (S4, p. 445)

Additionally, some clinicians found that using specific psychological and therapeutic approaches could facilitate understanding and empathy for the client. This CP found psychological formulations to be useful in understanding a client's circumstance. For example, "I suppose that's where things like...a formulation of all the different factors, that's where that kind of thing with these really complex cases, where that could be very, very useful" (S5, p. 120). This CPN was able to use specific therapeutic skills to understand the way in which clients relate and manage their emotional distress,

> The traditional view is about them being very manipulative and attention seeking, but in DBT I have not really found that. It is just about the distress they are in....you would look at it in terms of the client is trying to cope. (S7, p. 247)

Discussion

Clinician experiences of working with individuals diagnosed with BPD illuminated positive and negative views about the influence of this diagnosis on their behaviours and interactions with clients. Clinicians viewed emotional distress, self-injury, and suicidality as striking features of BPD. This occasionally evoked strong feelings in them and partly led to them doubting their clinical skills. Some clinicians held a negative bias as they perceived individuals with a BPD diagnosis as difficult. This formed a filter through which the client's difficulties were conceptualised. They also reported feeling consumed by emotional involvements with this client group, which impacted their ability to set professional and psychological boundaries, to protect their mental wellbeing. Some clinicians tended to reciprocate extreme relational positions. They reported feeling special in the client's presence or they expressed anger and contempt towards them. More positive encounters were mediated by prioritising consistent boundaries with clients, training, peer support and an ability to rely on multi-disciplinary teams (MDT) for their guidance. These findings are vital in considering the support needs of staff and the teams in which they work, to improve care provision for individuals diagnosed with BPD.

Clinician attitudes towards BPD tended to vary based on how they understood the diagnosis. The perception of clients as difficult, is reflected in the wider literature by Westwood and Baker (2010). Clinicians who either had limited experience, training, or support from the wider team, reported feeling isolated in their work and held prejudiced views. Johnstone et al. (2018) and Fanian et al. (2013) indicated how training relating to the psychosocial aspects of a client's difficulties alongside team support, can help reduce discriminatory views. Lelliott et al's. (2006) reflections on improving the quality of acute inpatient mental health settings validate that in the absence of such training, teams can function on a set of rules and unconsciously establish a culture of negative attitudes towards this client group. MDTs tended to assume polarised positions and had narratives imbued with blame and shame when there were limited opportunities for clinicians to reflect on the psychological processes of transference and countertransference (Evans, 2007). These processes illuminate a therapists' conscious and unconscious feelings and attitudes in response to a client (Kernberg, 1975). This highlights the need for teams to be adequately resourced and clinicians appropriately supported in this work.

Clinician skills and professional backgrounds also seemed to influence their approach to individuals diagnosed with BPD in this review. Research on nurse attitudes demonstrated that they were most likely to report negative views, usually in response to viewing clients as risky and in crises (Dickens et al., 2016; Bodner et al., 2011). Case managers exercised caution by limiting opportunities promoting ‘positive risk’, as they anticipated litigation from clients whose care they coordinated. Some nurses, CPNs and clinicians in inpatient and outpatient settings also tended to respond defensively to clients especially in situations where the client was in crisis. Research by Bodner et al. (2015) on psychiatrists and risk management, suggests that this staff group can rigidly adhere to the medical model due to fears of client death and litigation. Negative attitudes therefore reflect clinician anxieties around risk management, perpetuated by a limited understanding of BPD through the biopsychosocial lens (Warrender et al., 2020; Johnstone, 2014).

The service context also appeared to determine clinicians’ perceptions and experiences. Studies have shown that individuals with a BPD diagnosis accessed healthcare settings for medical interventions and a risk assessment in response to suicide attempts and self-injury (Veysey, 2014; Gallop, 1988). Clinicians in these settings tended to dismiss the legitimacy of client distress, they attributed self-harm to manipulation, and viewed clients as liable for their behaviours, resulting in strong emotional reactions towards them (Veysey, 2014). This is partly due to the stigma associated with personality disorders, which leads to less sympathetic responses to this client group compared to other psychiatric diagnoses (Aviram et al., 2006; Markham 2003). Similarly, staff working in crisis management services, inpatient or community settings, are more likely to be exposed to individuals diagnosed with BPD presenting in emergency (Warrender et al., 2020). Therefore, these clinicians tended to describe clients with a BPD diagnosis as risky, dangerous, difficult, and volatile (Aviram et al., 2006). Gallop (1988) explained how negative views can be readily accessed when single incidents become generalised to the entire problem picture and stereotypes form the default position from which they respond. These clinicians are also poorly supported to appropriately address the care clients with BPD require (Veysey, 2014). Clinician responses demonstrate how team culture could determine the tone of their work. Therefore, there is increasing pressure on services to re-examine their approach to this client group (Johnstone et al., 2018). MDT support is important. A lack of such provision has been linked with higher rates of staff burnout and preventing clinician learning about the client group from other disciplines (Lakasing, 2007).

Clinician reports of work avoidance, limited empathy, and a lack of willingness to support individuals with a BPD diagnosis may also be explained within the concept of 'Compassion Fatigue' (CF) (Joinson, 1992). Clinicians may become embroiled in the frequent exposure to this client group's severe emotional distress, relational overwhelm, narratives relating to sexual abuse and trauma. They may also struggle to separate clients' lives from their own, thus internalising their experiences. This leads to an unconscious blurring of boundaries (Figley, 1995). Progressive stages replicating a gradual loss of connectedness with compassion, culminate in a state of compassion exhaustion or CF (Joinson, 1992). Alongside physical health ailments, CF can present in clinicians as increased self-criticism, client blaming, and a loss of nurturance towards clients (Boyle, 2011). Mental and physical healthcare professionals including nurses, social workers and counsellors, are deemed to be at risk of developing CF (Boyle, 2011). This is because these clinicians are constantly exposed to clients' fear, suffering, pain and/or narratives of trauma, and do not receive consistent good quality supervision to help them process their responses. External systemic pressures, including mounting caseloads, also adds to this risk (Boyle, 2011). Echoed in the research by Bowen (2013) was that clinicians were more caring, empathic, and maintained healthy professional boundaries when they had constant access to team support, opportunities to learn and evaluate their practice. This was also a key finding from this review.

Strengths and limitations

This thematic synthesis is the first to specifically gather qualitative data for the purpose of a systematic review exploring a range of clinician views of working with individuals diagnosed with BPD. There were no methodological limiters applied to the initial search which enabled a wider exploration of clinicians' views of this subject area. All the studies used qualitative interviews as a method of gathering data. Qualitative interviews are designed to facilitate flexible and candid reflection of the individual's thoughts and experiences (Boulton et al., 1996). This enabled a broader exploration of clinician perspectives and provides a deeper understanding of their experiences of their work with this client group. It also allows for more targeted recommendations to be made to improve clinical practice.

Although this literature review adopted a comprehensive search strategy in this subject area, it cannot be certain that the search returned all the studies relevant to this review. Boland et al. (2017, p. 76) recognises this as a common limitation to literature reviews. Therefore, findings are discussed more generally and with caution as they may not be representative of individual differences within or across each profession and service context. Additionally, as the review included mixed-method studies, themes from some studies were sparse due to a greater focus on quantitative data analysis. All the studies were also in the English language due to a restriction on time and resources to translate information from other languages.

Recommendations for future research, practice, and policy

Within the UK mental health service structure, particularly in the public sector, psychiatrists in senior roles are expected to support and manage MDTs working with a range of mental health problems (Royal College of Psychiatry [RCPsych], 2019). As they are mainly the diagnosing clinicians in these contexts, it would be useful for research to explore their experiences of MDT work with clinicians working with individuals diagnosed with BPD. This has not been researched in the literature on BPD. This would enable valuable insights into the way psychiatrists manage some of the challenges arising in clinician experiences, to deepen insights into some of the factors that may influence how teams come to approach their work with individuals with a BPD diagnosis. It would also be useful to consider cultural variations in the way services respond to this client population.

Furthermore, clinicians demonstrated an increased understanding of client distress when they recognised the impact of childhood trauma (Dickens et al., 2019). Therefore, more training in psychological approaches could support staff to access knowledge about the client's context to promote more nurturing responses towards clients (Westwood & Baker, 2010). The use of psychological therapeutic frameworks to conceptualise BPD is also corroborated in the research (Westwood & Baker, 2010). This may include understanding the role of countertransference to aid clinicians in understanding some of the reasons underpinning their responses. This may be facilitated through reflective practice groups. CPs are best placed to facilitate reflective practice groups as they are trained in reflection, which is a professional requirement of their training (HCPC, 2016).

Clinicians may also benefit from working systemically with other professionals involved in the care of these clients. This may reduce feelings of isolation and present learning opportunities from different professional backgrounds. Such work would benefit from managerial support, given that the literature identifies that clinicians can tend to avoid working with clients. This is echoed in Fanaian et al's. (2013) research. Training entire staff teams on the links to early childhood trauma may also lead to more consistent team responses to this work. Some studies included in this review, captured clinician reports of the usefulness of Dialectical Behaviour Therapy (DBT) (Linehan et al., 1993) and other psychological therapies in affording a biopsychosocial approach to understanding the individual outside the diagnosis. Training and education in these approaches can supplement clinicians' skills.

Conclusion

The current review indicates how clinician experiences of individuals diagnosed with BPD can vary based on their knowledge, professional training, and the service context. Clinicians demonstrated compassion and empathy when they had a framework for understanding the individual beyond their diagnosis and felt able to rely on their teams for support. Alongside building work experience, consistent opportunities for training, reflection and supervision were also crucial to enhancing service delivery. This raises important considerations for the way services currently support clinicians when the BPD diagnosis forms an unhelpful lens through which they may respond to clients.

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	OR DE "Psychotherapists" OR DE "Social Workers" OR DE "Psychiatric Social Workers" OR DE "Therapists" OR DE "Occupational Therapists" OR DE "Psychotherapists") OR TI ("clinician*" OR "doctor*" OR "nurs*" OR "clinical psychologist*" OR "psychiatrist*" OR "mental health nurs*" OR "psychiatric nurs*") OR AB ("clinician*" OR "doctor*" OR "nurs*" OR "clinical psychologist*" OR "psychiatrist*" OR "mental health nurs*" OR "psychiatric nurs*")
("borderline personality disord*" OR "bpd" OR "emotionally unstable personality disord*" OR "eupd") OR TI ("borderline personality disord*" OR "bpd" OR "emotionally unstable personality disord*" OR "eupd") OR AB ("borderline personality disord*" OR "bpd" OR "emotionally unstable personality disord*" OR "eupd")	**AMED**-"borderline personality disord*" OR "bpd" OR "emotionally unstable personality disord*" OR "eupd" **CINAHL-**(MH "Borderline Personality Disorder") OR TI ("borderline personality disord*" OR bpd OR "emotionally unstable personality disord*" OR eupd) OR AB ("borderline personality disord*" OR bpd OR "emotionally unstable personality disord*" OR eupd) **EMBASE**-“borderline state” [MESH] **MEDLINE Complete**-(MM "Borderline Personality Disorder") OR TI ("borderline personality disord*" OR "bpd" OR "emotionally unstable personality disord*" OR "eupd") OR AB ("borderline personality disord*" OR "bpd" OR "emotionally unstable personality disord*" OR "eupd") **PsychINFO-**(DE "Borderline Personality Disorder" OR DE "Borderline States") OR TI ("borderline personality disord*" OR BPD OR "emotionally unstable personality disord*" OR EUPD) OR AB ("borderline personality disord*" OR BPD OR "emotionally unstable personality disord*" OR EUPD)
("attitude*" OR "perception*" OR "opinion*" OR "thought*" OR "feeling*" OR "beliefs") OR TI ("experience*" OR "knowledge" OR "perspective*" OR "position*" OR "bias*" OR "view*") OR AB ("experience*" OR "knowledge" OR "perspective*" OR "position*" OR "bias*" OR "view*")	**AMED**-"attitude*" OR "perception*" OR "opinion*" OR "thought*" OR "feeling*" OR "beliefs" **CINAHL-**(MH "Attitude+") OR (MH "Attitude of Health Personnel+") OR (MH "Nurse Attitudes") OR (MH "Occupational Therapist Attitudes") OR (MH "Psychotherapist Attitudes") OR (MH "Social Worker Attitudes") OR (MH "Caregiver Attitudes") OR (MH "Emotions+")

	EMBASE-“attitude to mental illness” [MESH] OR “emotion” [MESH] OR “experience” [MESH] **MEDLINE Complete-**((MH "Nurse-Patient Relations") OR (MH "Attitude of Health Personnel+") OR (MH "Attitude+") OR (MH "Frustration") OR (MH "Apathy") OR (MH "Anxiety") OR (MH "Hostility") OR (MH "Pleasure") OR (MH "Love") OR (MH "Emotions")) OR TI ("perspective*" OR "view*" OR "perception*" OR "opinion*" OR "experience*" OR "feeling*" OR "attitude*") OR AB ("perspective*" OR "view*" OR "perception*" OR "opinion*" OR "experience*" OR "feeling*" OR "attitude*") **PsychINFO-**(DE "Counselor Attitudes" OR DE "Health Personnel Attitudes" OR DE "Psychologist Attitudes" OR DE "Work (Attitudes Toward)") OR TI ((feeling* OR emotion* OR experience* OR attitude* OR perception* OR view*) N5 "to* patient*") OR AB ((feeling* OR emotion* OR experience* OR attitude* OR perception* OR view*) N5 (to* patient*))

Appendix 1-C

Thematic Synthesis Analysis of Stage 2 Descriptive Themes Contributing to Stage 3 Analytical Themes

Analytical Themes	Descriptive Themes
BPD: a polarising diagnosis	• Staff responses to the BPD diagnosis • Emotional distress key feature • Presence of adverse childhood experience • Self-injury has a communicative function
Difficult patient status	• Avoiding individuals with a BPD diagnosis • BPD diagnosis carries prejudice • Defensive practices • Despondence towards client group
Caught up in the whirlwind	• Battle of wills • Staff are personally affected by clients • Inconsistencies in staff responses • Sense of impending doom • Extreme responses in staff • Honeymoon stage • Staff special status
When things go well	• Staff skillset is important • Providing consistent care • The importance of boundaries • The need for team support

Appendix 1-D

An Example of Theme Development from the Study Author's Interpretations and Participant Quotations

Analytical Theme Five: When things go well

Studies which contributed to themes	Study author's theme interpretation	Participant Quotations Representing study theme
S1	Empathy for persons with BPD	*"The contact takes energy. Boys fight and their attempts at suicide are not as usual as girls. You must give shelter and maintain contact, not act, be there, as a resource to use."*
S2	Explanatory understanding	*"She'd obviously had a significant history of sexual assault and had gone through some awful things as a child which made me feel, kind of , a lot more empathetic towards her, whereas initially I didn't feel any of that."*
S3	Not disclosing diagnosis: holding the team line	*" …and I think that's good but I think you just have to be very careful when you work in a team to keep it very cohesive and that's not treading on other people's toes, especially the ones that are dealing with the risk factors and are making the diagnosis and being respectful towards them."*
S4	Differences in care outcomes	*"Finally, it turned out that I became more confident, she always complained about our contract, I knew what she needed and how to help her, because other workers were helping me. It was a good experience for both of us."*
S5	Desirable feelings in the psychologist	*"I suppose that's where things like…a formulation of all the different factors, that's where that kind of thing with these really complex cases, where that could be very, very useful…"*
S6	Monitoring boundaries	*"I think of what I learned,,,in school or in other training sessions…Is watch your boundaries and set limits and all those kinds of things, and nothing about, you*

		know, humanity, or connecting, or the importance of caring about somebody, I mean, none of that is talked about because it's so based in fear…"
S7	Interaction with clients	*"[It is important] being genuine, validating the client and the distress or difficulty they are having…I think just being respectful, pleasant and interested."*
S9	Techniques and strategies needed to improve service provision with BPD	*"it is valuable if a limited number of staff are involved in the care to provide consistent boundaries."*
S10	Care giving	*" She got really well in here and she's working now, she's got her own flat and hasn't self-harmed for about six months now and that's really good to see . . . you feel you've done some good, you've helped."*

Appendix 1-E

Study Key

Study Number	Author, Year
S1	Bergman & Eckerdal, 2000
S2	Day, Hunt, Cortis-Jones & Grenyer, 2018
S3	Koehne, Hamilton, Sands & Humphreys, 2012
S4	Ma, Shih, Hsiao, Shih & Hayter, 2009
S5	Millar, Gillanders & Saleem, 2012
S6	Nehls, 2000
S7	Stroud & Parsons, 2013
S8	Sulzer, 2015
S9	Treloar, 2009
S10	Wollaston & Hixenbaugh, 2008

Section Two: Research Paper

Psychiatrists' Experiences of Supporting Multidisciplinary Teams in Their Work with Individuals Diagnosed with Borderline Personality Disorder: An Interpretative Phenomenological Analysis

Nina Fernandes

Doctorate in Clinical Psychology

Division of Health Research, Lancaster University

Prepared in accordance with the 'manuscript submission guidelines' for the International Journal of Social Psychiatry

All correspondence should be sent to:
Nina Fernandes
Doctorate in Clinical Psychology
Division of Health Research
Lancaster University
LA1 4YG
Email: nina.fernandes@outlook.com

Abstract

Background: A multidisciplinary team (MDT) approach to caring for individuals diagnosed with Borderline Personality Disorder (BPD) is recommended. This helps to draw on MDT expertise to address the multifaceted needs of this client group. Psychiatrists work within MDTs. They often lead teams in this work because of their biopsychosocial and psychopharmacology training, which is deemed supportive to clinicians working with complexity.

Aim: The aim of this research is to understand the experiences of psychiatrists supporting MDTs working with individuals diagnosed with BPD.

Methods: A qualitative design was used. Data were collected using semi structured interviews and analysed using interpretative phenomenological analysis.

Findings: Nine consultant psychiatrists and one final year specialty psychiatry trainee participated in the study. Four themes emerged from their experiences; (1) MDTs are stress tested by this work; (2) teams require scaffolding to work effectively; (3) the burden of responsibility; (4) protect yourself

Conclusion: Psychiatrists' perspectives of clinicians indicate that clinicians can find their work with individuals diagnosed with BPD challenging because they lack an understanding of childhood trauma and spend insufficient time reflecting on interpersonal dynamics. Psychiatrists in turn report their work as complex. They can get caught in a tension of wanting to lead teams and find appropriate ways to rely on them for support. This may partly reflect the level of responsibility they hold in being the lead clinician managing risks pertaining to client death. Clinical psychologists have an important role in supporting psychiatrists and fellow clinicians through reflective practice and by sharing complex formulations through consultations with MDTs.

Keywords: Psychiatrists; MDT; childhood trauma; BPD; clinicians; team relationships; complexity; negative attitudes; empathy; experiences; interpretative phenomenological analysis, IPA.

Introduction

Psychiatrists[1] are medically qualified to undertake extensive post-graduate ‘apprenticeship-based training’ (Rosen & Callaly, 2005; p. 238), utilising a biopsychosocial approach to mental health (Royal College of Psychiatrists [RCPsych], 2012; 2017). Additionally, they are trained in reflective practice, psychotherapy and supervision (Gibson et al., 2019; Omer & McCarthy, 2010). Upon completion of their training, they qualify into senior positions usually as consultant psychiatrists in leadership and managerial roles in mental health services (RCPsych, 2010). Their expertise is in integrating biomedical frameworks with psychosocial information to treat people with mental health difficulties. Many advocate for psychiatrists to undertake senior positions in multidisciplinary teams (MDT) (RCPsych, 2010; McQueen et al., 2009; Boyce & Tobin, 1998).

Psychiatric services have evolved over the years across the world. Through the process of reorganisation and restructuring there has been a shift in the provision of mental healthcare away from long-stay hospitals to community-based care, with inpatient admissions for short-term acute care (Vize et al., 2008). Although psychiatry always held a psychosocial element to psychiatric knowledge, it replaced a dominant bio-genetic framework influenced by pharmacological developments, with a biopsychosocial paradigm of understanding mental health (Priebe, 2016). Alongside this was the integration of health and social care services in mental healthcare within the UK and internationally (Department of Health [DoH], 1999). This included thinking about the individual and their interaction with the system involving many other non-medical health professionals that comprised MDTs (Priebe, 2016). MDTs typically include social workers, occupational therapists, clinical psychologists (CPs), mental health nurses and team managers. The primary function of MDTs is to amalgamate the

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[1] Psychiatrist will be used as a generic term for the profession. Consultant psychiatrist will be used to specify job role

expertise of these different healthcare models to tailor mental health provision to the person using the service (Carpenter et al., 2003). Whilst this is not an exhaustive list of their duties, psychiatrists in MDTs assess client suitability for services, provide psychiatric diagnoses guided by the Diagnostic and Statistical Manual of Mental Disorders 5th edition (DSM V) (APA, 2013) and International Classification of Diseases 10 (ICD 10) (ICD, 2016). They also offer pharmacological therapy, psychotherapy, manage risk, and coordinate the care provided by MDTs (RCPsych, 2017; DoH, 2005).

The roles of psychiatrists in MDTs have been affected by wider systemic pressures. The recruitment crisis currently facing psychiatry in the UK (Choudry & Farooq, 2017) and the consequence of austerity measures, have led to a change in the consultant psychiatrist role, with a greater focus on targets and budgets and limited time for MDT consultations and reflective practice (Nutt & Keville, 2016; Rosen & Callaly, 2005). In a study exploring psychiatrists' understanding and use of formulation, some psychiatrists reported a disparity between service expectations of their roles and what they could realistically offer, due to significant time constraints (Mohtashemi et al., 2016). This suggests a risk of limited psychiatry involvement in team conceptualisations of client distress.

The National Institute for Health and Care Excellence (NICE) recommends an MDT approach to caring for clients with a Borderline Personality Disorder (BPD) [2]diagnosis (NICE, 2009). Effective teamwork has been shown to lead to more positive therapeutic encounters with clients with a BPD diagnosis and enhanced service delivery (Bowen, 2013). However, research with staff working within MDTs has also outlined negative attitudes towards clients with a BPD diagnosis, triggered by anxieties about the client's risk of harm

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[2] The author is aware of the use of medical and diagnostic terminology when referring to BPD. This does not reflect the author's stance or that of the clinical psychology profession.

(Brand et al., 2020). Interpersonal tensions between clinicians during risk management discussions have also been illuminated (Dean et al., 2018; Egan et al., 2014). Some studies suggest that this is partly due to the stigma associated with the BPD diagnosis (Kulkarni, 2015; Veysey, 2014). Anxiety amongst clinicians is exacerbated when this client group injure themselves and/or report an intention to end their life (Dean et al., 2018). Clinicians believe that this might lead to a reliance on MDTs for support (Krawitz & Batcheler, 2006; Cleary et al., 2002).

Psychiatrists are expected to guide and support the team in managing risk (RCPsych, 2017; Rosen & Callaly, 2005). Alongside this, MDT clinicians may need to foster their own safety and enhance their skills in working with clients with BPD. Training strategies like the ‘Knowledge Understanding Framework’ (KUF) personality disorder training (Davies et al., 2014) and the ‘consumer-clinician co-taught BPD training’ for clinicians, have been shown to lead to increased empathy, improved attitudes and understanding of individuals with this diagnosis (Krawitz & Jackson, 2007). It has also been demonstrated that ongoing conversations within supervision and reflective practice are paramount in maintaining these stances (Davies et al., 2012).

Psychiatrists may find it challenging when they experience MDTs as unsupportive of their roles. Studies of ineffective MDT working negatively impacting consultant psychiatrists noted that role conflicts, a lack of clarity in MDT leadership, limited team support, and team conflict may exacerbate these challenges (Herrman et al., 2002). Research investigating the psychiatrist role in MDTs also suggested that boundary setting, and prioritising psychiatrists’ and MDT wellbeing were mutually dependent (McQueen, 2009; Rosen & Callaly, 2005). Several studies have reported on the need to support and protect the psychiatry workforce due to increased reports of burnout in relation to these pressures (Kumar, 2007; Kumar, 2011; Mears et al., 2004). Client death and suicide have led to psychiatrists being personally impacted, with some taking a more authoritarian and circumspect approach to their work (Bodner et al., 2015). This highlights a need to understand how psychiatrists lead MDTs and respond to their work in the context of working with complex client presentations.

To address this gap, the aim of this study is to understand the lived experiences of psychiatrists to unearth their views and respond to challenges facing their fellow clinicians in teams they lead. This may provide useful insights into the support needs of psychiatrists and their perceptions of what MDTs require when working with such complexity. The research therefore aims to clarify the following: ‘How do psychiatrists experience their work supporting MDTs caring for clients diagnosed with BPD?’

This research is relevant to CPs as they also form an integral part of MDTs and are required to contribute to their effective functioning (BPS, 2017). A recommendation from Mohtashemi et al.’s (2016) research was for CPs and psychiatrists to share some leadership tasks. For instance, CPs are trained to provide MDT consultation, and to develop and communicate psychological formulations informed by theory and literature that complement the biopsychosocial perspective on mental health (BPS, 2017). Reflective practice and team training, which is part of the CP role, may also enhance staff expertise, confidence, working relations and improve client-staff interactions (Wood et al., 2019). Therefore, the value in this research for CPs is in understanding their roles in supporting psychiatrists with MDT care coordination for clients with a BPD diagnosis.

Method

Design

The study uses a qualitative methodology to enable in-depth explorations of psychiatrists’ experiences in this subject area. Agius (2013) recommends qualitative research as it enables extensive understandings of a participant's inner world and could be considered a first step to eliciting a range of responses around new ideas.

IPA (Smith et al., 2009) was chosen as it allows for an in-depth idiographic understanding of participants' internally understood meanings governed by external contexts, which may influence this process of meaning making (Smith & Osborn, 2015). It also implicitly and explicitly validates participant viewpoints by enabling a free exploration of their inner worlds (Willig, 2001). IPA adopts a distinctive 'double hermeneutic' stance, which invites the researcher's interpretation of the meaning the participant makes of their experiences (Smith & Osborn, 2015; Smith et al., 2009). This fits with critical realist epistemology which takes the position that a person's understanding of a phenomenon is influenced by an underlying reality and a range of factors that lie outside conscious awareness (Bhaskar, 2013). Therefore, this framework is deemed most suitable for answering the research question as it facilitates a rich understanding of psychiatrists' experience in their roles.

Ethical Considerations

The study has been approved by the Faculty of Health and Medicine Research Ethics Committee (FHMREC) at Lancaster University (see section 4). FHMREC reference: FHMREC19003. The lead researcher was alert to any signs of discomfort and ensured participants were made fully aware of their rights during the interview process and about how their data would be used during the entire duration of the study.

Setting

Data were collected from psychiatrists working in MDTs with no restrictions on the type of service in which they worked. IPA is concerned with small and homogenous samples as it helps in understanding specific phenomena, in particular situations, in a clearly defined group of people (Smith et al., 2009). The extent of demographic variability can vary depending on the study (Smith et al., 2009). The sample comprised psychiatrists working in senior roles supporting MDT staff in their work with clients with a BPD diagnosis. The service context was not judged likely to influence the experience of working with MDTs supporting this client group significantly.

Participants

The target sample for the study was 10 to 12 participants. This number is sufficient for an IPA study as it uses smaller sample sizes to afford richer exploration of each participant's experience (Smith et al., 2009). Table1 indicates the inclusion and exclusion criteria for participants.

Table 1

Inclusion and Exclusion Criteria

Inclusion criteria	Exclusion criteria
Consultant level and final year psychiatrists as they are required to chair and support MDTs and are expected to amass leadership competencies. Consultant and final year psychiatrists who have made a diagnosis of BPD. Consultant and final year psychiatrists working in MDTs. Consultant and final year psychiatrists working in mental health settings.	Consultant and final year psychiatrists working outside the UK and, therefore, operating outside the RCPsych UK regulations.

IPA advocates for samples to be selected purposively to focus the interpretations of the study to a specific experience (Smith et al., 2009). The homogenous sample used were psychiatrists in the final year of training and consultant psychiatrists. This level of seniority is likely to afford sufficient experience of working within MDTs to answer the research question.

Recruitment

The study was advertised via two social media platforms, Facebook and Twitter, to reach a wider pool of respondents. Interested participants eligible to participate were instructed to contact the researcher by telephone or email. Using social media as a platform for research recruitment offers a degree of flexibility and anonymity in participation (Gelinas et al., 2017). A potential disadvantage is that there is limited regulatory guidance to inform universities (Gelinas et al., 2017). Recruitment ended in July 2020.

Ten psychiatrists in total participated in the research. The lead researcher explained the study and sent a participant information sheet with an offer to arrange an interview date. Upon confirming an interview, the consent form was emailed to the participants, which they signed and returned prior to the interview.

Data collection

All the interviews were facilitated via Microsoft Teams (MS teams) as this was the chosen platform by the participants, as it offers secure encryption. Semi-structured interviews were used to collect data. On the day of the interview the lead researcher revisited the study information sheet and set aside time to answer any questions participants had, including what to expect from the interview. Participants were informed of their withdrawal rights and a deadline for this was reiterated. They were also reminded of the support mechanisms in place if they found any aspect of the interview challenging. Interviews only commenced after consent was shared verbally and through the signed consent form. A debrief sheet was shared and a verbal debrief was facilitated with each participant at the end of their interview.

The interview schedule was informed by research on the subject area and shared with the research supervisors prior to the commencement of interviews. The interview schedule is meant to be used as a guide, as questions develop with each interview, directed by curiosity about individual participant experiences (Smith et al., 2009). This reflects the nature of semi-structured interviews within an IPA framework and signifies the first phase of the interpretative process (Smith et al., 2009).

The interviews were audio recorded and transcribed verbatim by the lead researcher. The first interview was then shared with the research and field supervisors for their feedback on the interview process and schedule. Additional questions and approaches to the interview were discussed. No additional questions or prompts were recommended. The interview schedule included: exploring experiences relating to clients with BPD; experiences of MDT work; psychiatrists' interpretations of the issues affecting the MDTs' work with this client group; their understanding of support mechanisms/why they have worked and/or could help psychiatrists and teams. The full interview schedule has been appended to section 4 (Appendix 4-D).

Data collection ended when the target sample was reached, and enough data were gathered. This was judged by the quality of information and decided with the help of the research supervisors when no new information was gleaned. Although demographic variability is not the main priority of IPA (Smith & Osborn, 2015), having participants from a range of mental health contexts helped identify this end point to recruitment.

Data Analysis

Data were analysed using IPA informed by Smith et al. (2009). Transcripts were read numerous times to familiarise the researcher with the data. The double hermeneutic stance taken in IPA (Smith, 1996) includes two layers of interpretations at different time points. The first was the participant's interpretation of their experiences shared in the interview responses, recorded in their transcripts. The next was during data analysis, which involved the researcher's interpretation of the meaning psychiatrists attributed to their experiences. Using the guidance from Smith et al. (2009, p. 79-91), a complete analysis was first conducted for each participant. Participant case summaries were first written up to help the researcher to identify and understand contextual information pertinent to data interpretation (Appendix 2-B). The first stage of analysis involved recording annotations on the transcript. These included descriptive comments on the content of the transcript, notes of linguistic features and latent meanings conveyed. In this stage, the researcher attempted to stay close to the participant's own interpretations. In the next stage of analysis, emerging themes were developed from the annotations. These themes still remained close to the participant's interpretations but were less descriptive (Appendix 2-C). The third stage involved the researcher taking a more explicitly interpretative role in developing a set of higher order or superordinate themes from the emerging themes (Smith et al., 2009). This process was repeated for every participant. See Appendix 2-D for an example of one participant's themes. Finally, a set of overarching themes was developed from the 10 sets of superordinate themes. This enabled the researcher to remain close to each participant's voice.

Reflexivity

The need for reflexivity is implicit in IPA research from the construction of the research question to the end of the write-up process (Engward & Goldspink, 2020). The lead researcher explored how their profession, the researcher role, culture and gender identity in addition to their prior work experiences with clients with a BPD diagnosis in psychiatric services, provided a unique lens through which psychiatrists' experiences were interpreted. An audio reflective log following each interview was maintained to help document these initial responses. A transcribed excerpt of the researcher's reflections is appended (Appendix 2-E).

Supervision played an important role in ensuring the quality of the data collection and analysis process. The research supervisor was consulted during each stage of the analysis process. This helped to illuminate researcher bias and avoided the lead researcher's interpretations prematurely or unfairly interfering with the understanding of the participants' individual experience.

The study also benefitted from field supervision from a consultant psychiatrist and clinical psychologist who co-supervised this study. Both have extensive experience of working in MDTs and with clients diagnosed with BPD. Interview experiences and write up were discussed and shared for their feedback. This helped the lead researcher to adopt different perspectives to help check the validity of the interpretations.

Findings

Nine consultant psychiatrists and one final year specialty psychiatry trainee participated in the study. Participants[3] worked in children and young people's (CYP) and adult services, in inpatient and community settings. The interviews lasted an average of 40 minutes (range 25 to 51 minutes). See Table 2 for participant characteristics. IPA analysis led to the derivation of four overarching themes: MDTs are stress tested by this work, teams require scaffolding to work effectively, the burden of responsibility, and protect yourself. At

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[3] Pseudonyms are used to refer to participants. As indicated earlier, see Appendix 2-B for participant case studies

least eight out of the ten participants contributed to each of the overarching themes. See Table 3 for a graphic representation of how participant level superordinate themes contributed to these overarching themes.

Table 2

Participant Characteristics

Participant	Gender	Role	Service	Setting	Length of experience in the role
Maria	Female	Final year specialty psychiatry trainee	Child and Young People's Service (CYPS)	Community Mental Health Team (CMHT) Unit	4 years
Amy	Female	Consultant Psychiatrist	CYPS	Low secure forensic inpatient	3 years
Len	Male	Consultant Psychiatrist	Adult	CMHT	10 years
Lilly	Female	Consultant Psychiatrist	CYPS	CMHT	9 years
John	Male	Consultant Psychiatrist	CYPS	CMHT	12 years
Sean	Male	Consultant Psychiatrist	CYPS	CMHT	20 years
Mike	Male	Consultant Psychiatrist	General Adult	CMHT	10 years
Sally	Female	Consultant Psychiatrist	General Adult	Female Inpatient Unit	18 months
Dom	Male	Consultant Psychiatrist	General Adult	Inpatient Unit	4 years
Pam	Female	Consultant Psychiatrist	CYPS	CMHT	2 Years

Table 3

Graphic Representation of Participant Superordinate Themes Contributing to Overarching Themes

	Overarching Themes			
	Theme 1: MDTs are stress tested by this work	Theme 2: Teams require scaffolding to work effectively	Theme 3: The burden of responsibility	Theme 4: Protect yourself
Maria	Clinicians are vulnerable	Support clinicians using supervision and reflection	Demanding role	Take a step back from direct clinical work
Amy	Negative service culture influences staff views	Create opportunities for learning and reflection	Responsible for tackling prejudiced views	The importance of team reflection
Len	Challenging relational dynamics permeate teams	Teams should stay healthy	Working within rigid systems	Prioritise self-care needs
Lilly	Clients create polarised views		It can be lonely	Being open about worries with the team
John	Challenging team dynamics are expected	Teams should foster safety and security	Vulnerable in the senior clinician role	Finding relational safety
Sean	Clients can polarise teams	It helps to understand trauma	Complex work compounded by inexperienced views	
Mike	Teams can respond defensively		Negative staff attitudes make this work challenging	Freedom to exercise authority without question
Sally		The helpfulness of a clear plan	It can be tricky	Good rapport with MDTs
Dom		Supporting a psychosocial understanding of BPD	Challenging work	Turn outwards for support to stay afloat
Pam	MDTs are severely affected and respond inconsistently	Important to understand and support MDTs	Relentless and demanding role	The importance of peer support

Theme One: MDTs are stress tested by this work

In this theme psychiatrists shared how teams can be impacted by working with clients diagnosed with BPD and team cultures that normalise negative attitudes. These factors seemed to affect clinicians and staff relations. It also highlights the challenges of managing clinicians who struggled to maintain professional boundaries with clients.

Some participants reported that teamwork was made difficult when they experienced clinician views as prejudiced towards individuals diagnosed with BPD. They tended to position themselves as observers of these conversations but faced the dilemma of not wanting to collude with these attitudes. This quote suggests a sense of frustration in Amy when she perceived clinicians' views as discriminatory.

> It can be quite difficult to challenge that…if you are the only person kind of saying oh but have you stopped to pause and think about the traumas and you know why they may be behaving that way, rather than just kind of be thinking oh they're PD and a waste of space…[7]and people say that's actually acceptable. (Amy)

There was a notion that team cohesiveness can be affected by such differing views. This was especially if there is a perceived risk of failure in some psychiatrists' efforts to challenge such ingrained attitudes.

Similarly, Pam felt that unhelpful differing views within MDTs were influenced by clinicians' anxieties, leading to Pam interpreting them as being circumspect in their work with clients. For example, "Not all the MDT are happy that I'm comfortable with doing that…especially with this client you need this positive risk-taking attitude to manage these patients" (Pam).

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[7] Three ellipses points (…) denote the omission of words either at the start or at the end of a quote

Difficulties also presented in the way teams engaged with the diagnosis. For instance, Lilly discussed her difficulties in facilitating the development of a shared understanding of a client diagnosed with BPD because of varied standpoints about this diagnosis. This may have been exacerbated by a CYPS community setting in which Lilly works, where team members reportedly had high caseloads. Lilly reported the following: “It certainly is a much trickier conversation with colleagues about these issues if you’ve not even got an agreement on language that you’re using”.

Some psychiatrists noticed how working with this client group affected team communication and relationships. John highlighted that unhelpful team relationships seemed to be maintained by a lack of transparency about, and staff acceptance of, the impact that working with this client group can have on team dynamics.

> These situations never go away…so if you don't have these conversations, they're just going to be brushed under the carpet, this kind of problem is going to just grow and grow and grow and that probably will lead to a dysfunctional team. (John)

Similarly, Sean’s experience of supporting teams as a trainee and a consultant indicated a sense that clinician nature played a part in determining their response to these clients. His response also suggested that polarisation was inevitable.

> So, you always get some staff who were empathic who saw the patients as traumatised and suffering, and saw their repeated self-harming episodes as cries for help, and made attempts to rescue and get people to help them. Whereas other people in the team would see them as demanding manipulative self-destructive and untreatable. (Sean)

Mike was unsurprised by defensive responses across the MDT, regardless of a clinician’s training and experience in this work.

> I think even experienced staff members like managers can sometimes say that oh it's a personality disorder, we shouldn't take them into the service etc…there is that attitude turbulence among even experienced doctors and psychiatrists, so that is not correct. (Mike)

Another aspect of this theme related to challenges faced by participants in managing MDTs when clinicians had blind spots about their emotional reactions to clients. Maria experienced staff as being increasingly permeable to blurring professional boundaries when they were unaware of 'countertransference' responses.

> I think it also invokes certain feelings from the clinician themselves when they're caring for such a person that might be influenced by their own experiences…might be a response to what the emotion is instilled by the patient in you. (Maria)

Len shared his experience of noticing this in clinicians unconsciously re-enacting relational roles in the client's life during MDT meetings: "… sometimes, we're faced with clinicians or care coordinators getting quite sucked into those dynamics without them knowing, and it's kind of unconsciously, playing the rescuer role or, you know, blurring boundaries" (Len).

Theme Two: Teams require scaffolding to work effectively

This theme captures psychiatrists' views about protecting teams from the potential for ruptures and prejudiced reactions. They felt MDTs frequently encountered these issues whilst working with this client group. They shared their hopes of wanting to support MDTs with knowledge, aid reflection and foster good team relationships to increase empathy and collaboration with clients and team members. Occasionally it also meant supporting clients with their own understanding of their difficulties. They also discussed the need for teams to feel safe and to work cohesively.

Psychiatrists expressed the importance of understanding and supporting MDTs and particularly frontline clinicians who had frequent contact with clients with a BPD diagnosis. Pam shared her experience of supporting staff by recognising the twofold challenge for them in having to manage theirs and the client's anxious responses to risk. For example: "To talk to them as they become extremely anxious because these children are about to…self-harm is like so bad, like, yeah, so they themselves get very anxious…I do understand it's difficult on their part." (Pam).

Some psychiatrists felt it was important to set clear goals for treatment. Sally's response indicated that it was mutually beneficial for the team and clients when the team had a clear plan to manage inpatient admissions of clients with a BPD diagnosis.

> So far, I think we have managed it because we have got our own strategy. Like if anyone comes into the ward. If it's personality disorder patients we kind of keep them. When they come in, we assess them and kind of give them a discharge time set for them. (Sally)

A couple of psychiatrists experienced their roles as creating opportunities for team reflection especially when they experienced clinicians as being emotionally reactive to clients or when they noticed fraught interactions between staff. For example:

> …when you are dealing with cases that are complex and are stirring in often difficult feelings in everybody you know you need some sort of space to think about it and recognise it and you know ideally not in the midst of crisis, because then everybody's capacity for thinking is reduced you know with adrenaline running…it's not just the patient, professionals are also humans and we'll be responding you know in similar ways biologically. (Amy)

Amy also believed that these practices, if done safely, created less hierarchical team structures for clinicians' views to be heard and understood: "And I suppose it goes both ways you know, it's not to say that I always get it right. You know, so I'm quite keen, you know, to hear where people are coming from, and their perspective on it" (Amy).

Maria shared her experience of finding reflection with her supervisors useful as it enabled her to offload and process difficult feelings. She subsequently tended to replicate this approach whilst supervising junior clinicians.

> I felt that it's taken a lot of my mental effort…then I think I always kind of bring that into supervision to discuss with my consultant…I always kind of do a check in and to check how they've been doing in the week and if they've had any difficulties… (Maria)

Some psychiatrists felt that socialising clients and clinicians to understanding childhood trauma associated with the experiences of clients diagnosed with BPD promoted more empathy and understanding in them. Dom perceived that negative staff responses could be attributed to a lack of awareness and knowledge about the psychological and trauma aspects that influence the difficult relational dynamics that clients with a BPD diagnosis express. His experiences also indicated that when clinicians aligned more with the medical model, he experienced their clients as becoming reliant on medication to alleviate 'symptoms of BPD'.

> No one's attempted to normalise their experiences…so I think there's a need for educating the patient. One of the things that I do try and do is move them away from the medical model and try and get them to focus much more on the psychological intervention. (Dom)

Similarly, Sean believed that using the trauma framework especially in CYPS was more useful instead of conceptualising client difficulties within a personality disorder category: "…it more accurately describes things that happen to patients rather than there being something inexplicably wrong with the patient's way of dealing with the world, which is what personality disorder does…it feels personal" (Sean).

There was a recurrent theme from some psychiatrists of wanting teams to feel like safe and secure environments. For instance, John shared his view that having mutual respect in which clinicians could understand each other's perspectives and work towards similar goals, could enable this. "Open, honest communication…there is respect for each other and there is a sense that we're there for the same thing and there is a shared understanding of the task with different roles and people taking part in different ways" (John).

Len also discussed how team safety can be fostered through healthy relationships between clinicians. It was felt that this needed to be mutual and manifested through candid and open communication between team members.

> If we still maintain our bubbles and not, you know, open up and say how difficult or how things have been, then we're not creating a culture of safety…so you don't know if you've got like ten suicidal patients on your list and you know you're not sleeping over it. (Len)

Theme Three: The burden of responsibility

This theme represents the challenges psychiatrists experienced in having to manage risk and coordinate MDT work. It also depicts the demands placed on their personal resources. It outlines some of the issues in navigating client care in the context of the wider system and the perceived consequences of teams promoting a biomedical framework. It captures their experiences of feeling obstructed by their seniority in accessing support from MDTs, in addition to feelings of isolation in having to shoulder responsibility.

Maria described her role in supporting individuals who would fit the criteria of a BPD diagnosis in CYPS as demanding of personal and professional resources.

> I think somehow you kind of hold them in your mind all the time, and there's constantly a feeling that you have to do something, but I think you need to be realistic about what you can do. One thing that I have observed is if you feel like you're going to have a burn down…then it might be useful to kind of have more than one clinician involved. (Maria)

Some of these responsibilities and associated challenges were perceived to be unique to the senior clinician role. Sean expressed that risks of self-injury and a potential for client death in those diagnosed with BPD could personally affect psychiatrists as senior clinicians responsible for coordinating client care.

> …each death will be investigated…and you know you've suffered personally when patients kill themselves. So, having to deal with that I think is extremely difficult unless you're in a very, very well supported position, both in your personal life and your professional life. (Sean)

Similarly, Pam experienced her role as relentless and demanding, feeling a constant sense of responsibility for clients and the team. For example: "…although you involve so many agencies when there is a risky child, back of your mind you're sure that when the situation becomes unmanageable you will be called. You feel frustrated and sometimes you get upset" (Pam).

For Mike the difficulties of his role were in managing inexperienced staff, evidenced in this quote: "…some staff might not have that [psychological understanding], they might be very anxious. So then as a doctor your role becomes more difficult to manage them. So, it's always good to have a staff with good understanding and experience" (Mike).

Similarly, Dom wanted to advocate a biopsychosocial understanding of client distress and minimise the reliance on medical intervention. The following quote illustrates the challenges he perceived with some MDT clinicians in the adult inpatient unit.

> I do find resistance from nursing staff. I think they're very much within the inpatient setting, are very much medical model minded, often will say, You know "why can she not have PRN medication Why can we not just give her Haloperidol?" so there's very much a kind of buy into to the medical model. (Dom)

Contrastingly, for Len the challenge of a biomedical model orientated system was present when adult clients in CMHTs resisted the BPD label. There was a sense from Len's response that he felt stuck when an inflexible system was perceived as excluding clients. The quote below captures Len's predicament:

> There is a stigma associated with it which I think is true. So therefore they [patient] resent the diagnosis and the problem we have now in the NHS is that we have designed care pathways, based on diagnoses…our care pathway for the treatment is called PD care pathway…the patient is saying, I don't have personality disorder, then how would you provide care? (Len)

Some psychiatrists' reports indicated a tension in wanting to feel part of the team but also noticing the power and authority of their roles. For instance, Lilly expressed a sense of frustration about being seen to have all the answers because she was the senior clinician. For example, "I may have ended up feeling kind of a bit fed up or frustrated or angry that everyone's piled up all their stuff on to me and then what do I do with it?" (Lilly).

Her response also highlighted how the consultant role presented situations where she felt quite separate to the rest of the MDT. Uncomfortable feelings were also triggered in response to those managerial aspects of her role as it seemed to signify power over clinicians.

> There's a risk that I can step into a space where I think that because I'm senior I start to manage. There's a risk because in a way it can feel like I'm at the top of the pyramid of people asking for help…I've certainly felt guilty in the past of sometimes feeling like I'm carrying it all. (Lilly)

John described feelings of vulnerability and a recognition of power in his seniority when his decisions did not have the team's backing. He expressed having to tolerate the discomfort of resisting popular team views. Feelings of vulnerability were at times managed by a recognition of his authority in the decision-making process. However, this was accompanied by the risk of losing the team's support.

> …the team could feel that the team had different views about what needs to happen for the young person, and that sometimes led to decisions being imposed to the kind of hierarchy…the buck stops with you, if you're not necessarily in agreement with the team. (John)

Theme Four: Protect yourself

This theme represents the different ways psychiatrists described managing the demands of their roles. All the participants recognised these demands and a potential for mental exhaustion in their roles, adopting various methods of self-protection and self-care. This included relying on teams and focusing on a different role as safeguards against stress. The importance of reflection and supervision used meaningfully was also highlighted in maintaining safe boundaries in this work. Whereas for others their roles offered them a certain level of safety.

A few psychiatrists advocated for the use of MDTs to feel supported in their role. For instance, Sally appeared to find MDTs beneficial in the inpatient setting because of their accessibility and in being able to maintain a good rapport with clinicians. This seemed to enable her to strike a balance with client work. For example: “When I'm doing my inpatient job, it's more like it's not just patients I have the whole MDT team there. Yes, I've kind of been meeting with nurses or anyone where we will be…kind of joking around in between” (Sally).

John tended to feel supported when he believed it was safe to share the weight of thinking and planning with the team. The following quote expresses the crucial role team support plays for John: “So, it just feels, in many ways, a very, very lonely work. Very, very cruelly and exposed…the team is a very powerful tool, and it's a very helpful resource to make decisions” (John).

Similarly, Lilly experienced the brief team meetings as a useful way to invite the team’s support, as those meetings provided a forum for her to be open about her worries about clients. For example: “I think there’s something about creating that awareness that there’s somebody that you are worried about. Meeting twice daily is good because at the start of the day you say, ‘oh, I’ve got a lot of phone calls about such and such’ and at the end of the day somebody says, ‘how did that all happen’…so then, people check back in on you” (Lilly).

For Maria, staying safe in the role was also about sharing the responsibility of managing client care with other agencies. Whilst it mitigated that sense of being alone as a senior clinician, it also seemed to be a safety strategy against being viewed by staff as solely responsible for client risk management. For instance, “…signposting, or, you know, kind of working with just different agencies to kind of bringing that interprofessional working to kind of manage these patients” (Maria).

Some psychiatrists had self-care strategies to protect them from burnout. Len’s response suggested that his experience of being a consultant psychiatrist reinforced the need for robust personal care practices to manage his responsibilities in this work. For example, “Personally, so I kind of wake up and, you know, and spend that time in reflection and in prayer, and that gives an immense strength to deal with any challenges that comes” (Len).

Dom’s buffer against burnout and protecting himself from being overwhelmed by his role was by having a different focus from his consultant psychiatrist post.

> I suppose what's quite nice for me is that the medical education stuff that I do particularly undergraduates role allows the opportunity to almost kind of have something different that I can escape from, the clinical side of the job, which can be quite consuming. (Dom)

Some psychiatrists found team reflection invaluable in staying afloat in their role and managing complexity. For example, Pam experienced peer support as vital in helping with dilemmas around clients she deemed challenging: “We discuss the difficult cases in like peer group meetings which happen every month. Then there are other consultants, around us and then we have also CYPS groups, which you can discuss the case” (Pam).

Similarly, Amy experienced feelings of safety in teams that were well trained, who were willing to reflect on their emotional responses and demonstrated an ability to do this. It appeared that reflection and supervision were analogues of safety in her work.

> So make sure you know that there is that protective time and you know the expectation that this will be prioritised…the recruitment process that actually seeks

> out people who are well suited to those posts and you know, able to think in a certain way. (Amy)

Some participants felt protected by their authority and familiarity within teams as there was a sense that their opinions and guidance would be more readily received. For example, “I'm kind of fortunate enough to have like nurses who were kind of really experienced and who knows me from my training period…so they kind of…accept what I say” (Sally).

Similarly, Mike felt safeguarded by his position as a medical professional within the team, “Make sure that your roles are of a doctor or psychiatrist, and work within the principles of management of personality disorder. It's always good.” (Mike).

Discussion

Findings suggest that psychiatrists experience complexity in the ways that clinicians can respond to clients with a BPD diagnosis, impacting their roles in coordinating MDT care provision. MDTs could be challenging as this work impacts team relations, evokes negative views from clinicians towards clients, and tends to increase team anxiety in response to risk management. Psychiatrists also emphasised the importance of teams adopting strategies to safeguard them against these issues. For instance, expanding the team’s knowledge about the link between childhood trauma and BPD, could promote more empathic responses from clinicians towards this client group. They also recognised some of the challenges to their senior clinician roles in feeling burdened by responsibility and experiencing isolation from teams. They expressed a need to protect their roles to prevent burnout by engaging in self-care and self-protective strategies which can help protect their mental wellbeing. These findings are vital for the consideration of the support needs of consultant psychiatrists and their perceptions of what MDTs require whilst working with individuals diagnosed with BPD.

A key finding was about psychiatrists wanting to address the negative bias they observed in some clinicians in response to their work with clients with a BPD diagnosis. Mirrored in the research by Brand et al. (2010), some psychiatrists indicated that when they experienced staff as being prejudiced towards clients it led to polarisation within teams. They believed that these extreme opinions could be mitigated by offering training about childhood trauma which could help develop a shared understanding and appreciation of the complex and traumatic experiences of this client group. The need to advocate for equipping mental and physical healthcare staff with knowledge about early life adversity is mirrored in a few studies (Treloar, 2009; Krawitz, 2003). Having this understanding tended to minimise blame and led to more clinicians being able to validate client distress (Krawitz, 2003; Treloar, 2009). Some studies however caution against generalising the trauma understanding to clients with a diagnosis of BPD, as not every client with this diagnosis has experienced such adverse life experiences (Luyten et al., 2019). Furthermore, there may be a tendency to focus on early caregiver neglect and minimise, if not ignore, the impact of difficult peer, intimate and other broader relational conflicts affecting individuals throughout their lives (Salvatore et al., 2013).

Many psychiatrists therefore endorsed the view that the BPD diagnosis was helpful alongside a biopsychosocial formulation. Formulations complement or offer an alternative understanding to psychiatric diagnoses, as they conceptualise problems based on the psychosocial factors that contextualises a person’s life experiences (Johnstone, 2018). Following training and best practice guidelines, formulations provide rich narratives and concepts which deepen clinician insights into client difficulties (Johnstone, 2018; BPS, 2007). Research by Mohtashemi et al. (2016) suggests that psychiatrists valued collaborative formulations with psychologists in teams. Therefore, supporting clinicians’ understanding through formulations may be valuable in developing shared, deeper, and more humane understandings of individual difficulties.

Psychiatrists also expressed the need for reflective practice either formally or informally for clinicians to improve their knowledge, increase empathy and recognise some of the team tensions caused by polarisation. A study of trainee psychiatrists’ attitudes to ‘addictive disorders’ from reflective accounts of their experiences, indicated that such practices enabled them to recognise gaps in their knowledge, a lack of confidence in their work and negative bias towards people with these difficulties (Ballon & Skinner, 2008). Reflective practice can therefore support clinician mental wellbeing as it provides a non-judgemental space for staff to share their experiences and learn from others (Heneghan et al., 2014). This also resonates with recent research in which clinicians shared their experiences of reflective practice groups. They helped in considering new ideas, contained their anxieties, offered clarity in their work with clients and provided tools to maintain work-life balance (Carmichael et al., 2020). These groups also appeared to improve staff relationships. In another study, nurses’ perceptions of reflective practice resulted in increased frequency and quality of joint working experiences with colleagues and better relationships with clients (Buus et al., 2011). Therefore, the need for clinician reflection to improve their work with this client group is vital (Chartonas et al., 2017). Thus, findings from both this study and previous research indicates the need for reflective practice in this context.

Findings also highlighted a tension for psychiatrists advocating for an MDT approach to risk management whilst also adopting didactic methods to ensure client safety. Clinician worries regarding risk in clients with a BPD diagnosis are often at the fore for MDTs (Krawitz & Batcheler, 2006). This led to psychiatrists responding in authoritarian leadership roles to minimise theirs and the team’s anxious uncertainties surrounding client risk (Bodner et al., 2015). Adopting such methods might reflect wider systemic pressures on their roles of being the lead clinician overseeing client risk. Thompson (1998) studied the impact of how poor service structures, unclear role authority and limited resources for psychiatrists affected their decisions about client care.

These power relations emphasised in the context of client risk, may be understood within Winnicott's concept of 'containment' (Winnicott, 1971). When a child is emotionally distressed, they usually seek comfort from their parent[8] by transferring their feelings on to them. The role of the parent is to manage their own emotional responses that may mirror the child's feelings and instead reflect the entire image of the child and not just the overriding emotion they express (Winnicott, 1971). The child learns that they can move past such emotional responses as they can access other parts of themselves that can be nurtured to help them feel soothed. Transference and embodiment of distress are unconscious processes (Winnicott, 971). In their senior roles, psychiatrists may be sought to contain clinicians' distress, mimicking the parental role in a similar bid to be contained. Clinicians who struggle to contain their anxieties, who may also be positioned as parents to clients for containment of their distress, may subsequently embody the client's feelings and transfer these anxieties to psychiatrists. Psychiatrists responding from an authoritarian lens as indicated in Bodner et al. (2015), may struggle to manage their own distress and thus embody clinicians' anxieties. This may result in more didactic and circumspect responses. This may have an unintentional consequence of deskilling clinicians, by foregrounding clinician anxieties and taking ownership for all/most decision making. Instead, taking a considered and joint approach to risk management, drawing on the skills and expertise of the MDT might replicate the 'contained parent' reflecting the helpful skills which clinicians possess.

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[8] The term 'parent' is used generically to also indicate caregiver

Psychiatrists' experiences of needing to protect themselves and find buffers against burnout is mirrored in the literature surrounding the work with clients diagnosed with BPD (Dean et al., 2018). Whilst their role provides them with a certain level of autonomy, there is also an expectation that as senior clinicians, psychiatrists only require limited support. As such some psychiatrists felt isolated and vulnerable in their roles. Chartonas et al. (2017) noted that constant organisational restructuring leading to clinician uncertainty, impulsivity in clients' risk-taking behaviours, powerlessness about being unable to change distress, frustration, and a fear of failure, affected psychiatrists' wellbeing. These fears and worries are also contextualised in a system of constant funding cuts to staff resources (NHS England, 2014). Additionally, psychiatrists' reports of wanting to work in more supportive team environments is echoed in the literature. A lack of team support alongside unfair expectations of the psychiatrist role and higher caseloads, have led to burnout in psychiatrists (Lasalvia et al., 2009). Therefore, the need for improved support structures for psychiatrists to protect their mental wellbeing is reasoned (Bodner et al., 2015; Kumar, 2011).

Strengths and limitations

The study explores the experience of psychiatrists supporting MDTs working with people with BPD. Psychiatrists are an important profession to understand in their work directly and indirectly with clients due to their influence on teams and clients. Participants represented a range of experiences as they worked in both inpatient and community settings and in CYP and adult contexts, thus allowing the impact of different service contexts on their experiences of this work to be explored. Demographic variability also included diverse ethnic backgrounds of participants which enriched participant responses. Gaining varied cultural perspectives in psychiatrists is important due to the convergence of personality, personal beliefs and, socio-cultural factors which can influence client-clinician interactions (Avasthi, 2011). The sample was also coincidentally gender balanced. However, this does not reflect the gender make-up of the consultant psychiatry workforce from the most recent census in which 55.9% were male and 44.1% were female psychiatrists (RCPsych, 2019).

In this study, homogeneity may have been affected by the varied service contexts in which psychiatrists worked. For example, given that most inpatient settings provide short-term support for individuals in crisis, psychiatrists may have experienced clients with a BPD diagnosis in these contexts differently to psychiatrists in community services. Narrowing the focus to one group may have enabled a more nuanced understanding of how their roles may have been affected by working in comparable systems. Additionally, the findings cannot be generalised to represent the rest of the psychiatry workforce. This is because it is likely that the study attracted psychiatrists who may have had an interest in the topic area surrounding BPD being a contested diagnosis. These views were reflected in most of the psychiatrists' reports within the study.

Recommendations for future research, practice, and policy

This study highlights the need for clinicians to be offered regular time for reflective practice groups. Whilst psychiatrists are trained and expected to engage in reflective practice (Omer & McCarthy, 2013; Senediak & Bowden, 2007), this is a key leadership skill requirement of CPs (Heneghan et al., 2014; BPS 2017). CP facilitators of reflective practice may be more likely to enhance participation due to the profession being recognised as reflective practitioners (O'Neill et al., 2019). They may also be better positioned as facilitators as they are less susceptible to the organisational pressures afflicting psychiatrists' roles. It will be useful for all members of the team to attend these groups due to their utility in enhancing team collaboration (O'Neill et al., 2019).

Teams also need to be supported in their understanding of BPD and the way it manifests in an individual. Understanding trauma is one aspect of this learning which psychiatrists felt was important. Therefore, policy makers and service managers may consider the experience and support clinicians require when working with this client group. Staff training days may be one option for knowledge and skills to be shared. Joint working with experienced staff may be another, albeit resource intense option, which may enable the infiltration of key skills within teams. Additionally, CPs could also share the task of helping teams with complex formulations (Wood et al., 2019) surrounding childhood trauma and the impact this has on clients diagnosed with BPD. As indicated by Mohtashemi et al. (2016) psychiatrists reported valuing formulation as a shared task with psychologists. The findings of this study support this stance of wanting to enhance MDTs understanding through such joint working opportunities. Using experts by experience and co-producing care pathways, could be invaluable in addressing the stigma in staff responses to this client group.

Given that systemic pressures have been reported to increase the risk of burnout in psychiatrists and impact their approach to risk management (Kumar, 2007), it will be important for research to further explore how being the lead clinician overseeing clients reporting risks of suicide affects MDT work. Research may also seek to understand potential links between systemic pressures facing other frontline staff and negative attitudes towards clients in this population.

Conclusion

The current study identifies some of the role challenges that psychiatrists face in supporting MDTs with clients diagnosed with BPD. The senior clinician role can feel lonely when MDTs are experienced as demonstrating limited awareness of challenging interpersonal dynamics and resist sharing decision-making around risk management. As such there is a need for MDTs to be well supported whilst working with complexity. Overall, it supports the conversation regarding the need for a paradigm shift in the way the difficulties associated with the BPD diagnosis are conceptualised.

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Appendix 2-A

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Institute of Psychiatry, King’s College London
De Crespigny Park
London SE5 8AF UK

Tel: +44 (0)20 7848 0047

Email: dinesh.bhugra@kcl.ac.uk and andrea.livingstone@kcl.ac.uk

Appendix 2-B

Participant Case Studies

Amy

Amy (White British Other) has been a consultant psychiatrist for nearly three years. She currently works in a low secure forensic CYPS inpatient unit. Amy claimed to work in a well experienced team with highly trained clinicians. She reported that staff were able to immediately access and share their reflections in response to challenging relational dynamics compared with less experienced clinicians. She emphasised the importance of staff reflective practice training and for there to be a no-blame culture in staff towards clients with a BPD or PD diagnosis. She is passionate about the BPD diagnosis and the trauma conceptualisations that explain some relational difficulties.

Dom

Dom (White British) has been a consultant psychiatrist for four years. He works part time in a general adult inpatient unit and spends the remainder of his time as a lecturer in medical education in a medical school. Dom is passionate about evidence-based psychopharmacological treatments. He believes that childhood trauma and sexual abuse are not understood enough in relation to the formulation for BPD amongst clients, psychiatrists, and staff from other disciplines.

John

John (White British Other) has been a consultant psychiatrist for nearly 12 years in CYPS inpatient and community. He recently ended his inpatient CYPS consultant role and moved to community CYPS. John felt that teams played a crucial role in the success of the work with this client group and candid communication between staff was vital.

Len

Len (British Asian) has been a consultant psychiatrist for 10 years and he works in general adult CMHT. Len believes in keeping good relationships with MDTs and especially team managers. He feels that his team are good at sharing their concerns openly and respectfully during MDT meetings. However due to community case load pressures he does not think the MDT has enough opportunities and time to come together for reflective practice, which he finds important. Len's team uses the BPD pathway to support clients with this diagnosis. He finds that it can at times be a rigid way of supporting people especially when clients dislike this diagnosis.

Lilly

Lilly (White British) has been a consultant psychiatrist for nearly nine years in community CYPS. Lilly reported to find it unhelpful to work with BPD from a purely biomedical diagnostic perspective. She advocates for psychosocial explanations and believes it is important to understand early life trauma and adversity. Lilly has had personal experience of losing a friend to suicide and believes this has possibly influenced her interest in this topic. She also recalls her experience as a trainee in which she described two 'psychologically minded' psychiatrists working helpfully with personality disorders and wanting to emulate that. Lilly finds it helpful that she has a good relationship with the consultant psychologist especially in relation to feeling supported in the work with this client population.

Maria

Maria (British Asian) is a final year specialty psychiatry trainee in a community CYPS. She works part time and therefore reported to have taken four instead of three years to complete her final year. She has been offered a CYPS consultant psychiatrist role in three months' time. Maria described her initial interest in CYPS having stemmed from a learning disability placement. In her current role Maria finds that she has to step into the role of a supervisor to frontline nursing staff as she notices how frequently they deal with risk with limited opportunity for them to pause and reflect on the impact on their mental wellbeing. She believes that maintaining clear work life boundaries is vital to stay afloat in the senior clinician role.

Mike

Mike (British Asian) has been a consultant psychiatrist for the past 10 years in a general adult CMHT. Mike hoped to work as an adult psychiatrist and feels satisfied that he is in a post he enjoys. He completed his pre psychiatry training in India and then came to the UK to train as a psychiatrist.

Sally

Sally (British Asian) has been a consultant psychiatrist for the past 18months in a female adult inpatient unit. She said she enjoyed her role because of the good relationships she shares with the team but especially nursing staff. Sally did a training role in the same unit and is therefore known by staff, which she reported to find helpful. Sally appreciates her inpatient consultant role due to having fewer clients on her caseload that she compared with a community consultant who would have more. She also values the teamworking aspect which the inpatient role gives her as staff are always around.

Sean

Sean (White British) has been a consultant psychiatrist for the past 20 years in community CYPS. Sean initially trained as a GP whose interest in psychiatry was piqued when he had to assess a client believed to have voice experiences. Sean described feeling unskilled at this but extremely interested in their experiences as he learned more from them. During his psychiatry training Sean worked in a medical psychotherapy led personality disorder service which he reported to find challenging. Sean believes staff need to be extremely boundaried and self-secure in their work with clients with a BPD diagnosis.

Pam

Pam (British Asian) has been a consultant psychiatrist for nearly two years. She works in a community CYPS unit. Sally is passionate about working with children and believe staff need to work hard at supporting them. In relation to this client population Sally reported to struggle with calling BPD a mental health problem all the time and does not believe medication is the answer.

Appendix 2-C

An Example Section from Dom’s Transcript Demonstrating the Researcher’s Annotations/Summaries, Emerging Themes and Participant Level Superordinate Themes

		Annotations/Summary/*Initial ideas*	**Emerging Themes**	**Participant Level Superordinate Theme**
Interviewer	Okay, do you, how do you find it in terms of sort of being in these two different roles in terms of the approaches to your role. Do you feel it complements the work that you do, or do you have any other ideas about how it works with your general adult consultant psychiatrist role?			
Dom	Yeah, so, I think, I think it's been really important for me to be able to develop my medical education portfolio. Really because the inpatient…the general	***Suggests interests may be strategic*** **Escape route to prevent burnout or buffer to prevent burnout**	**Needing an escape** **Difficult role**	**Managing the demands of the role**
03:27	inpatient role is, is really busy.			**Challenging work**
03:30	You know, really, really stressful! I suppose what's quite nice for me is that the medical	***Again, states work is busy***	**Managing work stress**	
03:43	education stuff that I do particularly undergraduate	**Acknowledges challenge here as “stressful”**		
03:45	role allows the opportunity to almost kind of have something different than an escape from, you know, the clinical side of the job, which can be quite consuming. You know, on a day to day basis. Yeah. I think the best thing it's been the best thing for my consulting career actually was taken on the undergraduate role. About 20 months ago now.	**Needing a different focus from adult inpatient role which the medical education role provides** **Challenge of inpatient role is that it is relentless, stressful, escape and consuming** **Nonclinical role helps to balance/manage clinical work**	**Needing an escape** **Managing work stress**	**Managing the demands of the role**

		demands. Also, strategic to help with career		
Interviewer	All right. Well congratulations on that role that sounds like you're really interested in it and sort of finding the benefits in it. What I do know, and correct me if I'm sort of wrong or if I've misunderstood, is that psychiatrists, get a lot of experience working in different areas of mental health and then you get to choose your specialty Am I right			
Dom	Yes, that's correct.			
Interviewer	Yeah. So I			
04:29	I'm guessing that you've worked with EUPD or borderline PD client group or complex trauma however you conceptualise it. How do you conceptualise it, how do you understand it?			
Dom 05:00 05:05	And so, I think. So I mean I've worked with this patient group since I was a trainee, really. So, I mean, I guess, obviously. I've seen this patient group in numerous settings. So, the outpatient clinic setting or sort of routine views presenting in in in crisis, or A&E	**Repeated exposure to individuals dxBPD and establishes his knowledge and expertise in the area**	**Learning from experience**	**Managing the demands of the role**
06:36	either on a section 136 so brought in by the police...or just self-presenting. They're just sort of self-presenting to A&E crisis, and then also seen them in hospital as well. I suppose my perception of these patients, how I conceptualise them is that they are just incredibly complex. Think what is…what I've noticed is…there's a real stigma attached to the diagnostic label of emotion unstable personality disorder and I've had numerous patients say that to me. Actually, a lot of them sort of really dislike any sort of focus on that being their diagnosis, because of the stigma associated with it. I find, there's a real push towards trying to medicalize the patients in	***Use of "just self-presenting" noted twice, gives a sense that he sees clients as not knowing where to seek appropriate support but desperately needing it in the absence of different or perhaps clearer support pathways? Or does he just suggest a sense that he thinks these clients cannot contain their difficulties and so present in emergency services?*** **Clients dislike their diagnosis**	**Unhelpful communication of BPD diagnosis** **Working with complexity** **Unhelpful communication of BPD diagnosis**	**Challenging work**

06:37 06:57 06:59	terms of the difficulties they experience. So, you know, trying to sort of, you know, treat voice hearing. That's clearly trauma related but trying to treat it with anti-psychotic medication, you know, to treat the sort of the mood instability the chronic mood instability that you get with mood stabilising medication when actually the evidence base isn't really there. There's a, and it's a double-edged sword really because I find a lot of these patients very sort of medication focused and rather biologically minded	**Examples of seeing clients in crisis** **Thinks of complexity when thinks of these clients. *He is aware of the prejudice associated with individuals dxBPD and notices this in client reports as well.*** ***Aware that this diagnosis can be challenging for clients because of stigma***	**Medication is not the answer** **Role of educator** **Difficult role** **Medication is not the answer**	**Supporting a psychosocial understanding of BPD**
	and sort of very much wants what I call the magic pill to take away health problems for them. And it's often very difficult and a bit of a battle trying to sort of get some patients with these personality difficulties to actually understand that the goals and the treatment is actually psychological therapy DBT and MBT rather than sort of you know throwing up a cocktail of medication, at them and actually them experiencing unpleasant side effects.	**Tone of frustration (?) when he feels people discount difficult experiences and colleagues don't consider other explanations** **Against prescribing "cocktail of medication"** **Experiences clients as seeking medication and wanting medical explanations when he does not think this is rooted in evidence.** ***Seems to be guided by rational thinking which***		**Challenging work**
	So I think we do a lot [inaudible]	**View role of accurately signposting/educate client to evidence-based approaches of support as an important part of his role** **"bit of a battle" to explain to clients about the evidence base and not rely on medication and biological explanations**		**Supporting a psychosocial understanding of BPD**

Makes a case for why medication may be unhelpful. Important role of educator may also be emerging.

Appendix 2-D

A Narrative Summary of a Participant's Superordinate Themes Which Contributed to Each of the Overarching Themes

Overarching Theme Title	John's Theme Title	Theme Narrative
MDTs are stress tested by this work	Challenging team dynamics are expected	The work with clients with a BPD diagnosis in CYPS units was reported as 'tricky' and John described having 'mixed feelings' about it. One of the reasons was because he believed it negatively impacted staff and felt this was 'part and parcel' of this work. His mixed feelings seemed to also be about how ruptures in teams were opportunities for teams to understand each other and open channels of communication. John also thought that teams could only survive these challenges if they were open and honest, as difficult staff interactions could otherwise 'fester' and this led to 'polarisation'.
Teams require scaffolding to work effectively	Teams should foster safety and security	John's reports seemed to be experienced under the filter of some of his previous experiences of challenging team dynamics. He implied feelings of loss when he reported to struggled to maintain good teamwork and open channels of communication in response to work with this client group in a previous team. His examples of teams needing to have the approach of 'resolving conflict' and being able to 'agree to disagree', 'learn from mistakes' and 'start afresh' was what was important. He thought that teams needed to use their reflective capacity to understand what was going on for them emotionally to be aware of what they project on to the team and team relationships. John on many occasions described 'experimenting with risk' and 'trial and error' as healthy ways for teams to approach decisions.
The burden of responsibility	Vulnerable in the senior clinician role	John's experiences repeatedly reflected a tone of tension and vulnerability as he felt that he needed to be aware of his power and responsibility as a consultant psychiatrist. His observations of how teams can be susceptible and how even 'good teams can struggle' in their work with clients with a BPD diagnosis, reinforced this view. He appeared to place great stock in having the backing of a 'well-functioning' team especially linked with being supported with client risk management responsibilities. He identified feeling isolated in his role when most team members disagreed with his decision. He often emphasised that it was important for teams to disagree but as the 'buck stopped with me' he felt this burden in situations in which his 'gut instinct' decisions were different to the team's suggestions. This led to him feeling the burden of responsibility of having to risk 'disappointing the team' and a sense that may have caused ruptures. It also reinforced his point about team's needing to acknowledge and repair ruptures and avoid feigning support. John acknowledged his difficulty when some staff took this approach as opposed to those who felt able to voice their frustrations.

Protect Yourself	Finding relational safety	John described formal and informal supervision as useful when they were meaningful. His experiences indicated that supervision can at times be less about the supervisee’s needs and more about the ‘supervisor’s agenda’ of demonstrating that they are being supportive as a ‘tick box exercise’. He differentiated this with other conversations with professionals that he trusted, who did not have a supervisory role, of whom he experienced as genuinely supportive. He described these staff members as ‘gold dust’ and felt it was immensely important to ‘hold on to them with everything you have got’ as these relationships were rare and important to maintaining good mental health as a senior clinician.

Appendix 2-E

Transcribed Excerpt from the Audio Reflective Diary Following My Interview with Lilly

"Lilly's interview is complete. I really enjoyed that. Lilly really took the time to explain her thoughts. She seemed willing to open up about why she chose psychiatry. Lilly seemed to get a little emotional as she spoke about losing her friend. It felt bizarre not to be able to offer more than just an apology for her experience. She moved quite quickly through the memory and tied it to the point she was making about her interest in the role but also in being the 'rescuer', which she feels she has to monitor. It showed a vulnerability in Lilly... Actually… Lilly did a lot of this when she talked about her struggle in managing the expectations of a senior clinician and not going overboard in her responsibility to the team. I'm sure she said this was even when it wasn't asked for or something about needing to be careful to not step into the role of the supporter and instead just be able to listen? Lilly seems really interested in a psychological understanding of BPD and talked a lot about valuing her relationship with the consultant psychologist. She seemed candid about disliking when her opinion is second guessed after she does an out of hours assessment…"

Section Three: Critical Appraisal

Nina Fernandes

Doctorate in Clinical Psychology

Division of Health Research, Lancaster University

All correspondence should be sent to:
Nina Fernandes
Doctorate in Clinical Psychology
Division of Health Research
Lancaster University
LA1 4YG
Email: nina.fernandes@outlook.com

Critical Appraisal

The research discussed in section two of this thesis explores some of the challenges psychiatrists' experience as senior clinicians in supporting multidisciplinary teams (MDT) in their work with clients with a Borderline Personality Disorder (BPD) diagnosis[1]. The findings delineate the challenges in care responsibilities towards the team and clients. They also explore ways psychiatrists manage their roles when team tensions arise from client risk management and care. Their senior positions at times made it a challenge for psychiatrists to rely on teams for support. They emphasised the need to protect themselves to feel safe in their roles, to shield against burnout. Bolstering teams with training, supervision and reflective practice, were interventions they experienced as useful. Psychiatrists' narrative of this client group being complex is reflected in the wider research. This seemed to be amplified when they experienced fellow clinicians as having negative responses to clients with a BPD diagnosis, which appeared to result in team management challenges. More broadly, the study demonstrates how BPD can be an unhelpful lens that does not facilitate empathy with client responses to traumatic relational experiences, including abuse. It also recognises the need for psychiatrists and their fellow clinicians to be supported in this work by using team reflective practice groups and training.

The main research report discusses the salient strengths and limitations. Due to the practical limits of the paper, a wider discussion of research issues will be elaborated here. This paper aims to explore the factors that influenced the process of topic selection, methodological, and some ethical considerations. I hope that this critical appraisal provides a useful reflective account, which enables the reader to understand some of the contextual

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[1] The use of the BPD diagnosis does not represent the views of the lead researcher or the clinical psychology profession. It is used to reflect the language in the literature and for the purposes of the study.

factors influencing the research in section two. I conclude with consideration of the COVID-19 pandemic as a context for this research.

Practical, Methodological and Ethical Issues

Selecting the research topic and methodology

My interest in this research topic was influenced by my position in the debate about the use of diagnosis, the labels attached to them, and how these issues position clinicians in MDTs. Whilst psychiatric diagnoses can validate personal distress, they have also been described by some as reductionist, failing to capture the human experience (Spence, 2012). Formulations are one alternative to diagnoses (Johnstone, 2018). They are a core skill requirement of clinical psychologists (CP). In my experiences as a mental health professional within the National Health Service (NHS), diagnosis is generally given before a formulation is collaboratively discussed with the client and MDT. Formulations also tend to be mainly considered within the remit of what psychologists/psychological therapists do with clients. Formulations sometimes seem like add-ons rather than a necessary understanding that is purposefully tentative and dynamic to allow for a reformulation, considering the varying nature of a person's mental wellbeing and context. Diagnoses give individuals access to care pathways and guide intervention plans without the need for a client's formulation. Given that psychiatrists generally tend to be the diagnosing clinicians in mental health services, the power and responsibility psychiatrists appear to position these alternative approaches as supplemental to diagnoses. Although psychiatrists are trained in biopsychosocial formulations, this is not always associated with their roles. I therefore wondered whether clinicians seen to be offering formulations also experienced their skills as supplementary. This is echoed in Cooke et al's. (2019) research capturing CP's discontent at the authority of the biomedical model when it becomes the sole narrative of the client's experience and hinders psychosocial perspectives. Equally, I speculated whether psychiatrists could feel like they hold all the responsibility especially regarding the management of client risk, instead of this being shared with the MDT.

These interests were further developed and supported with the help of one of my supervisors (clinical psychologist), who wondered about contextualising the ways the BPD diagnosis is used in mental health services. BPD is the most common personality disorder diagnosis given to individuals (Shaw & Proctor, 2005). Its validity and utility have been widely debated by clinicians, researchers, and clients (Horn et al., 2007; Shaw & Proctor, 2005; Johnstone, 2000). Psychiatrists in practice seem to vary in their views about the utility of this diagnosis. As they are trained in using a biopsychosocial approach to understand mental health (Royal College of Psychiatrists [RCPsych], 2017), I became interested in learning more about how psychiatrists may bring this framework to MDT work in relation to individuals diagnosed with BPD. Some studies have highlighted how clinicians', mostly frontline staffs' experiences of clients with a BPD diagnosis, seem predominantly negative prior to training practises (Dickens et al., 2018; Westwood & Baker, 2010). They usually work in teams led by psychiatrists who also occupy leadership and management roles in the NHS (McQueen, John-Smith, Ikkos & Michael, 2009). Therefore, it was important for me to understand psychiatrists' roles in the context of MDT work.

I decided on a phenomenological approach to explore psychiatrists' experiences as it enables deep explorations of participants' lived experiences, considering individual differences, in a well-defined group of people (Pietkiewicz & Smith, 2014; Johnson, 2009). Prior to arriving at the decision to use Interpretative Phenomenological Analysis (IPA), I considered discourse analysis (Foucault, 1965; Parker, 1992). Discourse analysis would have been useful to understand the contextual influences on the usage of language and construction of meaning of the BPD diagnosis and how clinicians engage with it (Parker, 1992). I argue that this methodology would only partially meet the aims of the study, which is to explore the entire construction of the participants' inner world experience, including the use of language, in their formulation of thoughts in this subject area. The double hermeneutic stance which IPA offers was also a useful tool to make explicit the researcher's role in interpreting the nuances of participants' perspectives (Smith & Osborn, 2003). Phenomenological approaches such as IPA are extensively used by the health sciences (Smith, 1996) and have greater clinical utility because they enable a focus on the lived experiences of individuals in response to many sociocultural, and psychological life circumstances (Creswell, 2012). Therefore, IPA was suited for this research investigation as it allowed me to pursue a subject area requiring a deeper understanding of clinicians' attitudes to working within a diagnostic framework.

Addressing homogeneity queries

IPA recommends using as homogenous a sample as possible, meaning that participants have a shared core experience rather than simply sharing similar demographic characteristics (Smith & Osborn, 2015; Smith et al., 2009; 2003; Smith, 1996). The shared perspective psychiatrists participating in this study held was in MDT support, in senior clinician roles, working with clients with a BPD diagnosis. The varied service contexts in which the participants worked, i.e. children and young people's services (CYPS) and adult mental health, possibly compromised homogeneity. Although psychiatrists can make this diagnosis in young people (Chanen et al., 2016; NICE, 2009) they may have different experiences of individuals with this diagnosis. At the time the study was designed, it was not felt that including psychiatrists working in CYPS would compromise homogeneity. This is because it was assumed that they would only volunteer in line with the inclusion criteria on the advertising leaflet (see section 4), indicating a requirement of experience working with clients with a BPD diagnosis and supporting teams with this work. During an interview with Maria[2] who works in a CYPS setting, she reported avoiding giving this diagnosis in the team

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[2] Pseudonyms are used to protect the participants' identities.

in which she worked. Her rationale for adopting this view was that young people's personalities were constantly evolving and therefore a label of any personality disorder may be damaging and irreversible. I decided to keep Maria's data, as she reported supporting clinicians working with clients understood as having BPD 'traits' and recommended a BPD diagnosis for some clients transferred to adult services. With hindsight this felt to be an appropriate decision as Maria shared her stance during the interview process, and she drew from her experience of supporting this client group. This indicated that Maria shared experiences with other participants that did not compromise homogeneity.

Such hesitance to offer CYP personality disorder diagnoses is also echoed in Koehne et al's. (2012) research exploring clinicians' responses, the majority of whom were psychiatrists, to the BPD diagnosis with adolescents. They noticed that clinicians tended to describe client difficulties with other staff in terms of BPD traits and suggested that they held BPD as a framework to understand client difficulties. However, they reported discomfort and treaded carefully when using 'borderline terminology' (Koehne et al., 2012). In some cases, psychiatrists made the diagnosis but did not disclose this to the individual (Koehne et al., 2012). Not sharing BPD as a framework for thinking about a client requires careful consideration as it could compromise collaborative working and perpetuate power imbalances. It also makes me question the validity and utility of using the BPD diagnosis with CYP.

Furthermore, in the design stage of the study, I questioned if I needed to be clear about homogeneity in terms of recruiting participants with similar ethnic backgrounds and gender. The sample was unintentionally gender balanced resulting in a fair representation of psychiatrist views across the two identified genders. Ethnic diversity seemed to illuminate a range of responses and appeared to be explicitly referenced in another participant's responses (see 'bracketing'). IPA is premised on the individual's experience and their view of a shared phenomenon (Smith et al., 2009). Therefore, this was not an issue. Such demographic variability enabled a wide range of perspectives without compromising the core phenomenon which all psychiatrists shared. With the guidance of my supervisors, I was also clearer about when to end recruitment when no new or differing experiences were shared.

Managing the trainee and researcher roles

The process of asking questions to explore participant's inner world experiences was comparable to the therapeutic aspects of my role with clients. This was reinforced when a couple of participants associated their interview experiences to therapy in the debrief, describing their experiences of the interview as validating, tiring and exposing. The IPA interview process can make participants feel vulnerable as their lived experiences are exposed for scrutiny by the researcher (Eatough & Smith, 2017). Whilst, in some respects this mimicked therapeutic interactions, it also made me acutely aware that my position as a researcher required me to relate differently than I would as a clinician within an MDT. There was a shift in role in which I was exploring their ideas without any expectations for them to do the same. This required one-sided curiosity; ask questions but refrain from adding my reflections. Qualitative research findings are generated through the interactions between the participants and researcher, influenced by factors affecting individual and shared experiences (Guba & Lincoln, 1994). Therefore, it was imperative that I developed some degree of awareness of my position and assumptions, throughout this process.

I realised that my stance as a trainee psychologist required me to relate differently to psychiatrists, as I took the position of researcher. The process can be an opportunity for participants to share their experiences, but it may also make them feel exposed and vulnerable (Wigstaff et al., 2014). This illuminated a power differential to me, like the client-therapist interactions in which therapists are not expected to share their personal experiences but can share feedback and validate client experiences. However, as a researcher, I was unable to validate, offer reassurance or feedback about my thoughts in relation to participants' experiences. To manage this, I shared this with participants before the interviews commenced.

Being self-reflexive is therefore important as qualitative interviews can also emotionally impact researchers (Dickson-Swift et al., 2009). I was aware of transferring skills from my trainee psychologist role in active listening and asking open-ended sensitive questions to the researcher role. I attempted to remain mindful to avoid taking a therapeutic stance and manage my anxieties in relation to this role alteration. A researcher's ability to access their reflections and emotional responses are considered valuable sources of information and should feature within qualitative research (van Heughten, 2004; Bourne, 1998). Hence, conversations with my research supervisor prior to and following interviews helped me articulate some of these thoughts and feelings and provided a record for future reference.

Bracketing

The process of bracketing is described as a method of acknowledging and addressing our immediate assumptions, potential biases and experiences which may interfere with our interpretations of participant reports (Smith et al., 2009). I share my example of bracketing following my experience of a challenging interview with Mike[3]. A transcribed excerpt of my initial responses to this interview is appended (Appendix 3-A). To provide a context for understanding this process, it was the shortest interview lasting slightly over 25 minutes. During the interview, I experienced Mike's tone and his responses as guarded and reticent to share more when I asked him if he could elaborate on his thoughts. In addition to explaining the nature of IPA interviews and suggesting that I would only be asking questions at the

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[3] The interview references are from the recorded interview which Mike consented to using in this research.

beginning, I also noticed I repeatedly provided reassurance regarding the validity of his thoughts and that I was interested in his perspective. When asked to elaborate on his thoughts, Mike's response implied that he was unsure of the reasons for this request. I noticed that I had a strong emotional response when Mike described the challenges of a cultural shift as a medical professional of having his authority questioned in the UK, as opposed to his prior experience of being a doctor in India where he felt psychiatrists were better revered. Mike's feedback during the debrief process suggested that he expected the interview to take the form of a survey with closed responses. I felt confused about Mike's expectation of the interview when I explained this at the start, and when we revisited the previously emailed participant information sheet and consent form. I offered Mike breaks and reminded him of his right to end the interview and/or clarify questions if needed. I also re-checked if Mike still consented to the use of his responses given that the interview was not what he was expecting (See Appendix 3-B for an example of Mike's transcript).

After I noted my initial feelings of confusion, anxiety, and frustration I shared the following reflections with my research supervisor. I wondered about the premise of the IPA interview and had questions about Mike's perception of research being more akin to a quantitative methodology therefore feeling surprised by the nature of the interview. I therefore wondered whether this put Mike in a vulnerable position, as he was being asked to talk about his experiences in more detail than he expected. I also wondered about the possibility of a shift in power to a trainee from a different profession causing an imbalance of power, influenced by Mike's own professional and cultural context. I recognised my own position as a person of Indian origin in the psychology profession, my gender identity as female, my opinion as a trainee psychologist holding a position that questions the utility of diagnoses interacting with Mike's personal, professional and contextual features. I consequently noticed that I felt vulnerable and frustrated following the interview which I sought to manage by considering whether the short interview contributed enough to be included in the research. A discussion with my research supervisor led to a conclusion that there were more gains than losses to keeping the interview due to what it added in terms of the diversity of interpretation of the psychiatrist role.

Avasthi (2011) argues for a need to acknowledge the cultural influences on psychiatrists as it can offer a lens through which difficulties are understood. Whilst the Royal College of Psychiatrists regulates the practice of psychiatry within the UK, such cultural influences cannot be ignored. The psychiatric profession influences the way in which mental illnesses are construed and can distinguish between psychologically and biologically minded psychiatry (Avasthi, 2011). This enabled a way of framing the role of contextual/cultural factors. It was a revelation that my experience of the interview seemed challenging possibly because of my beliefs and contextual factors defining my position as the researcher, and who Mike represented in my internal world. This is resonated in Smith et al. (2009) who described the art of qualitative interviewing as being tougher than it seems if done well. With hindsight I would have taken more time to socialise Mike to the interview process, and with the initial descriptive questions about demographics. Sensitive research topics can generate emotionally charged responses which the researcher has to manage (Micanovic et al., 2019). Here sensitive refers to research akin to illness, death, grief, loss etc., (Micanovic et al., 2019). The issue of sensitivity is relevant as participants' may potentially feel exposed, during the process of divulging their personal experiences for scrutiny for research purposes.

The process of bracketing enabled me to understand some possibilities for considering Mike's responses and engagement with the interview, whilst remaining aware that these are still my assumptions, interpretations, and biases. It also unearthed the factors that influenced my responses to Mike's interview. It at times retriggered difficult emotions from the interview in me, of which I had to remain constantly aware to prevent this forming a lens through which I analysed his data.

Understanding Clinician Views

A common thread woven through psychiatrists' reports was that they believed it was imperative for MDT staff to learn to manage their anxiety in relation to client risk, to enable more empathic responses towards clients with a BPD diagnosis. Alongside this were recommendations for training and understanding of childhood adversity and early life trauma. Because of their training and from some of their experiences, they saw the value in reflective practice as a helpful way for staff to understand themselves and their relationships with clients. Guided by IPA, it was important to capture psychiatrists' experiences of what they thought would be supportive measures for MDTs in terms of their work with clients with a BPD diagnosis. I would however like to offer an interpretation of the context in which non-psychiatry staff's work may have been interpreted by participants, based on the systems in which they work.

MDT clinicians have high caseloads, limited time and come in most frequent contact with clients with a BPD diagnosis in crisis (Moore, 2012). Whilst training and knowledge is beneficial, their learning and improved approaches to client interactions are maintained by regular supervision and reflective practice (Davies et al., 2014; Moore, 2012). MDT staff, particularly those in the frontline, report anxious feelings and believe they are under-skilled in working with this client population because they do not have time for such practices that could support them in their roles (Moore, 2012). Often these staff members can be unjustly held accountable for their negative attitudes. Austerity measures have impacted the NHS by the culling of resource budgets resulting in staff feeling stretched to their limits as they are expected to do more to compensate for less (Nutt & Keville, 2016). Psychiatrists are also pressured and experience a change in their duties (Mohtashemi et al., 2016), reporting to feel like managers having to be responsible for budgets and a difficult balance to pursue clinical tasks like offering psychotherapy (John-Smith et al., 2009). Jones (2007) expressed that the task for senior clinicians, managers and policy makers is to improve the support to staff and clients to enable a robust workforce. Therefore, the significance of the wider context is vital to understand the conditions in which service delivery occurs.

Impact of COVID-19

I was not required to make any changes to the data collection or recruitment process because of the COVID-19 pandemic as I recruited participants online. I personally found this advantageous as it possibly enabled more psychiatrists to participate due to remote working arrangements. I was in turn able to offer flexible interview time slots, making recruitment and data collection a relatively straightforward process. I considered the possibility of including questions in the interview schedule about the impact of COVID-19 on their roles and MDT work. However, following a discussion with my research supervisor and one of my field supervisors (consultant psychiatrist), I did not make this addition. This is because the premise of the research was to understand psychiatrists' experiences regardless of the pandemic. It was also where the bulk of their experience could be referenced and located. However, understanding the current context in which they were working was important. Mental healthcare professionals are considered 'key workers' who, under the government guidelines in force at the time the study was undertaken, were required to attend the workplace unless they are in an 'at risk' category (Prime Minister's Office, 2020). Thus, if participants had raised issues relating to COVID-19 then these would have been explored, however, none did.

Arguments to prioritise the mental health needs of frontline and healthcare staff have been made to policy makers worldwide since the pandemic (Ornell et al., 2020; Johnson et al., 2020). It is therefore useful to consider psychiatrists' perspectives on this. In the debrief, one psychiatrist made a reference to the pandemic worsening feelings of isolation in relation to risk management. Recent research by early career psychiatrists who explored the impact of COVID-19 on mental health service delivery, identified limited opportunities for inter-disciplinary working, planning and preparation (Ransing et al., 2020). Additionally, a recent survey of mental healthcare staff's experiences of the impact of COVID-19 indicated that community and crisis service clinicians were not able to rely on external agencies for support due to closures (Johnson et al., 2020). Amongst social and caring needs, following infection control and social distancing were also difficult in such contexts, resulting in more staff taking sickness absence (Johnson et al., 2020). This suggests that the pandemic is likely to exacerbate risks of segregation for psychiatrists.

Mental health services are also facing changes to the nature of referrals from service users (Johnson et al., 2020). For example, the increased reported risk of suicide in response to the pandemic (Gunnell et al., 2020) and increased referrals for suicidal ideation to mental health teams (Chen et al., 2020), may affect how MDTs share the responsibility around risk management. Mental health staff are also being asked to support fellow clinicians and other healthcare workers due to the risk of burnout from working overtime and with reduced social interaction (Chen et al., 2020; Rajkumar, 2020; Johnson, 2020). It is possible that remote working policies to limit the spread of infection (Public Health England, 2020) may also affect the facilitation of formal and informal reflective practice groups. Therefore, fewer staff may be providing mental healthcare and have limited access to staff support groups. The potential impact of teamwork and staff mental health, when some staff work remotely, and some attend the workplace, requires further investigation.

Conclusion

In this critical appraisal I have attempted to contextualise the research paper by discussing some of the wider practical, methodological, and ethical issues emerging during the study. This research emphasises the need to understand the contextual pressures affecting psychiatrists and their fellow clinicians, as well as the constraints in accessing resources to enhance service delivery for clients. As clinicians, we have a duty to recognise and value the client’s interpretations of their circumstances and hold in mind their individual circumstances beyond the BPD diagnosis. Team biopsychosocial formulations that are dynamic in nature will help illuminate contextual pressures on clinicians and clients. However, systems which continue to be reactive, underfunded, and unchanged will continue to perpetuate defensive practice.

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Appendix 3-A

A Transcribed Excerpt of My Initial Responses to Mike Recorded Immediately After the Interview

"That felt strange, tricky! Did I forget to send the Participant Information Sheet? I feel quite confused by Mike's response about expecting the interview to be different. I should have spent more time checking this out with him, I would have had a clearer idea. I feel like a bit worried that I wasn't clear enough but I remember I went over the PIS…I think I put Mike on the spot and I don't think he liked having to explain himself to me. I think there was a shift in power or something felt odd about our dynamic in the session that made me feel like I should not be digging too much. I thought the examples of the personality disorder diagnosis in India was interestingly placed. What made him think of sharing that, I wonder? I might be reading too much into this at this point. I sensed a tone of frustration or stuckness when Mike described the difference in his decision-making capacity in the UK compared with what he could do in India. It bothers me that Mike is bothered about having to share a rationale for his decisions. I'm not sure I understand why this is a problem. Is there something I need to keep in mind for context about psychiatry training or the influence of pre psychiatry training and how perhaps culture/ethnicity sets people up for the senior role? I wonder whether my ethnicity and my role and my position as the researcher asking Mike to reflect may have felt like him not liking or wanting to explain himself as a senior clinician. I wonder if it felt like I was questioning his authority? He also said 'you need to be a psychiatrist to understand' the challenges of working with this client group. Was that Mike wanting to check my experience? Did he make an assumption about me not knowing enough to understand? He sounded reassured but did not seem to like it when I told him I was interested to hear his experiences regardless of my experiences..."

Appendix 3-B

An Example from Mike's Transcript

		Annotations/Summary/Initial ideas	Emerging Themes	Participant Level Superordinate Theme
Interviewer	Okay. And, again, because I'm interested to know about your role and your personal experiences. What, what has helped you. when you've sort of come up against these sorts of responses from staff or family members.			
Mike	I think if you, if someone really don't really understand you the only option for you is to explain clearly. Okay. About your own viewpoint and your own rationale for making such decisions. Okay, still it might not help.	Believes explaining rationale for decisions is helpful to staff even though they may not agree	**Explain rationale for decisions**	**Freedom to exercise authority without my authority being questioned**
Interviewer	And I guess because you, I asked you earlier on and you sort of confirmed that the challenge is different and it makes it, feels a bit more challenging with this sort of presentation. So when you're explaining and you're taking those steps to get people to understand. Maybe some of the decisions or whatever it is you want them to understand about risk. And it's not maybe taken on board, how do you feel about that in your senior role			

	when you're trying to do those things. What, what, comes up in your mind.			
Mike	Nothing really comes up in my mind.			**Freedom to exercise authority without my authority being questioned**
19:08	I, as I mentioned, I anticipate certain challenges, so if it happens, it happens. Once you know that you know certain responses can be there. Then you are not surprised.	*Anticipate specific challenges* Being certain about your responses helps to manage challenges and prevent surprises	**Confidence in decisions**	
Interviewer 19:26	So you expect it to happen. Okay, and does it help to expect these things in this presentation was that, is that, your way of working, usually			
Mike	Yep.			
Interviewer	Okay, and does it help to expect these things in this presentation was that is that your way of working, usually			
Mike	No, I think that the better experience anyone will expect, or this talk comes			
Interviewer	Okay, and is there more you want to say about this sort of theme of staff dynamics anything that I haven't asked you that you want to add to this to this question			
Mike	No, I think that you, you asked about it and I think, again, it's this question with	*Difficult to articulate feelings*		

	personality disorders are not easy, and the straightforward answer is sometimes it's very…it's very difficult to achieve in this short interview	*about PD in interview*		
Interviewer	I know it's a short amount of time but I don't…I'm not looking for straightforward answers if that helps you, so whatever your experiences are all valid and it's not about right or wrong so I'm only interested in your experience. What do you do if you feel like you have been supported in your role when working with, with this client group. What..what are your support experiences of working in this…this sort of work.			
Mike	I don't, I don't feel that we will get that feeling of complete support. Working with any patient groups as a consultant psychiatrist like characterised in a country like United Kingdom is difficult, within NHS. You always need to be cautious in what you tell, what you do. So it needs to be the correct thing. The personality disorders is more challenging as they mentioned that when someone sits in front of you or talk about suicide etc and if you don't do something which they expect or their family expected, can be challenging. And sometimes, you	Consultant psychiatrists in UK will never be fully supported due to authority being questioned Feels challenged when opinions are questioned Challenging to offer opinions that	**Unhelpful when consultant’s authority is questioned** **Struggle when questioned**	**Freedom to exercise authority without my authority being questioned**

	won't mean, you don't really feel supported. No	client with dxBPD talking about suicide does not expect		
Interviewer	I'm really sorry to hear that. But I know it's not an uncommon view. So you mentioned about the United Kingdom and the NHS Can you say a bit more about what you mean by that, why it makes it more challenging			
Mike	No…these patients can put the complaint against you, isn't it, no they can complain again, due to the organisation or GMC. So you got a responsibility to explain in that situation. Although you are trained to act in certain way, then you are bound to give explanations as well. So that is the challenge	Worries about complaints by clients Challenge of having to justify/explain despite being trained as a doctor and doing the job	**Fear of litigation** **Medical opinion should be trusted**	**Freedom to exercise authority without my authority being questioned**
Interviewer	Okay. Are there any..			
Mike	[cross talk] for example if it was in a different country where the authority for doctor is more. A doctor is the last word. The attitude itself is slightly better probably for managing personality disorder, because even the manifestation, we don't see much or 20 different for example, in India, where before I came, I think that there is a lot of passive, but because passive aggressive personality	*Doctors have more authority in other countries and so feel more protected as their word is the last word and can't be challenged*		

	disorders in India, in in in households. Females tend to be elated sometimes you know they don't really actively protest their abusive husbands, by hitting them more, but they, they will probably not cooperate with many things. And it could be a...this passive aggression traits are not that much in a country like UK. So, I think that there are a lot of cultural aspects as well. The doctor roll it over there [India] it is stronger opinion. Because we can hear [complaints] in the media. We can only go according to a certain, certain protocol.	Feel constrained by working protocols	**Constrained by lack of authority**	**Freedom to exercise authority without my authority being questioned**
Interviewer 23:49	And it is difficult work and while I don't know difficult is the right word, it is…it's tricky. It's challenging work. And that doesn't necessarily mean it's a bad thing. But I suppose what…what do you, what do you think? You mentioned earlier on about taking the stance of the, of having strict boundaries. Do you have different approaches or any other approaches that you use when you don't feel supported?			
Mike	No, I don't have any other approach that go according to what is the best approach to that.			

Section Four: Ethics

Nina Fernandes

Doctorate in Clinical Psychology

Division of Health Research, Lancaster University

Research Protocol

Study title: How have psychiatrists experienced multidisciplinary teamwork when they have supported clinicians working alongside clients diagnosed with a Borderline Personality Disorder?

Lead researcher: Nina Fernandes, Trainee Clinical Psychologist, Lancaster University Doctor of Clinical Psychology

Research team: Dr. Pete Greasley, Teaching Fellow, Department of Health Research, Furness Building, Lancaster University

Dr. Roxanna Mohtashemi, Clinical Psychologist, North West Boroughs Healthcare NHS Foundation Trust, Halton Recovery Team, The Brooker Centre, Halton Hospital, Hospital Way, Runcorn, WA7 2DA

Dr. John Stevens, Consultant Psychiatrist, Liverpool Early Intervention in Psychosis team, Training Programme Director – General Adult Psychiatry, Clinical Lead – Early Intervention, Baird House, Liverpool Innovation Park, Digital Way, Liverpool L7 9NJ

Background and rationale

The characteristics for the BPD diagnosis (referred to as Emotionally Unstable Personality Disorder (EUPD), by the International Classification of Diseases 10 [ICD 10], ICD, 2016) include mood variability, where individuals can struggle to regulate and manage mood changes. It also involves relational instability, a perceived sense of rejection in relationships, and impulsive behaviours, including self-injurious acts, with a tendency to engage in and report suicidal attempts (ICD, 2016). The Diagnostic and Statistical Manual of Mental Disorders 5th edition (DSM V) uses the term ‘borderline’ due to crossovers between ‘psychosis’ and ‘neurosis’ (APA, 2013). The National Institute for Health and Care Excellence (NICE, 2009) suggests that substance misuse may also be present as part of these difficulties (NICE, 2009). As repeated complex interpersonal trauma in early life is also associated with BPD, it is recommended that such contextual experiences are also considered in the diagnosis and intervention work with clients with BPD (Courtois, 2004).

Within the NHS, psychiatrists are trained to give such diagnoses. This is a system in which mental health problems are classified as a collection of symptoms, suggesting causal links to distress using the ICD 10 and DSM V (Bracken, Thomas, Timimi, Asen, Behr, Beuster et al., 2012). Psychiatrists provide evidence-based medicine to include a biopsychosocial contextual understanding of problems, and psychotherapy training. They prescribe psychotropic medication, assess and manage risk, and assume leadership roles, coordinating the care of individuals and support multidisciplinary teams (MDT) in their work with clients through consultation work (Royal College of Psychiatry [RCPsych], 2019).

In terms of staff response in relation to BPD work, the literature indicates that some clinicians expressed stigmatised views towards individuals with this diagnosis i.e. preconceived negative judgements resulting in hostile interactions and judgement towards people (Corrigan & Watson, 2002). Several studies have explored such attitudes in different staff groups including clinical psychologists (CP), crises service professionals, psychiatric nurses, but found that increased caseload exposure to people with this diagnosis, training around BPD and higher educational qualifications mediated more positive attitudes to this work (Day, Hunt, Cortis-Jones & Grenyer, 2018; Egan, Haley, Rees, 2014; Crawford, Adedeji, Price, & Rutte, 2010; Purvs & Sands, 2009). Negative responses included staff burnout, descriptions of individuals with BPD as ‘manipulative’ or ‘difficult’, were linked with limited training around BPD and a lack of MDT support (Lakasing, 2007; Koekkoek, van Meijel & Hutschemaekers, 2006; Foertsch, Manning & Dimeff, 2003; Laskowski, 2001). Research suggests that client interactions with staff can be directly linked to the way that MDT staff understand and approach their difficulties (Krawitz & Watson, 1999). MDT support and supervision facilitates more collaborative MDT work to prevent polarised views between MDT staff wanting to either rescue or seem rejecting of their clients with this diagnosis (Lakasing, 2007). NICE therefore recommends MDT support for staff working alongside individuals with the BPD diagnosis (NICE, 2009). This is part of the psychiatry role as they provide a diagnosis of BPD, coordinate and manage these clients and support MDTs in their work.

Aims and objectives

As psychiatrists in senior roles coordinate and lead on client care, this research aims to understand what their experiences have been in navigating the support needs of the MDT in their work with clients diagnosed with BPD. There are no empirical studies that have explored psychiatrists' responses/experiences of MDT work relating to the work with this client group. The implications for CP are in recognising the support needs of psychiatrists and the wider MDT in their work with this client group. Therefore, this research aims to explore psychiatrists' experiences of working with MDTs with people who have a diagnosis of BPD. Furthermore, the psychologist's role in team formulation could be enhanced with more knowledge of experience and challenges faced by different staff groups. This coincides with the values and training of the clinical psychology profession, to support staff by drawing on psychological models of consultation to improve service user experience (Division of Clinical Psychology, 2011).

Method

Participants

The aim is to recruit a minimum of 8 psychiatrists to provide a range of responses from the chosen sample. An upper limit of 12 psychiatrists across the UK would be interviewed without compromising on the quality of the analysis. As the premise of IPA studies is to explore each participant's unique experience in detail (Smith, Flowers & Larkin, 2009), a smaller sample is more likely to allow for participant views to be prioritised, as opposed to collecting generalised views about an event (Smith & Osborn, 2015). It would also allow for a more in-depth understanding of each participant's experience. Therefore, a sample size of 8-12 psychiatrists would constitute a meaningful sample and be within the remit of an IPA study (Smith, Flowers & Larkin, 2009).

The inclusion criteria for the study are as follows:

Inclusion:

- Final year psychiatrists and consultant psychiatrists working in England. Psychiatrists will need to be in the final year of training, prior to becoming consultants, as they will be required to chair MDTs and are more likely to have undertaken leadership roles at this stage of training. Consultant Psychiatrists assume leadership roles in MDTs which include case management and/or being the lead clinician.
- Final year psychiatrists and/or Consultant Psychiatrists who have given a diagnosis of BPD and worked within an MDT.
- Final year psychiatrists and/or Consultant Psychiatrists currently working in mental health settings including community and inpatient.

Exclusion criteria:

- n/a

Rationale for inclusion criteria

(1) Psychiatrists who are in the final year of training prior to becoming consultants as they will be required to chair MDTs and take leadership roles at this stage of training. Psychiatrists at this stage of training are required to demonstrate competencies in chairing, managing and working alongside MDTs. These include a range of mental health professionals such as mental health nurses, clinical psychologists, occupational therapists,

social workers. Psychiatrists who have not reached this level of training may not have had these experiences even if they have worked with MDTs and given a BPD diagnosis. Furthermore, more senior psychiatry trainees may have had exposure to working with individuals and MDTs relating to BPD; (2) Psychiatrists and/or Consultant Psychiatrists with experiences of undertaking leadership roles in MDTs: This falls in line with the aim of the research which is to explore psychiatrists' experiences of working with MDTs who have been care coordinators/lead clinician in this case. Given the level of complexity involved in working with these difficulties, in relation to managing impulsive risk - taking behaviour and difficult staff responses, it might be allocated to psychiatrists in more senior roles to manage.

Data collection

Semi-structured interviews will be used to collect the data. IPA prioritises the use of semi structured interviews as a meaningful way to begin the process of understanding participant experiences (Smith & Osborn, 2015). It also provides flexibility to participants to cover a broad range of ideas and responses related to the interview questions in addition to the initial interview schedule.

As such, the interview schedule will be developed alongside the project supervisors which includes a psychiatrist. Information about the study will be included within the Participation Information Sheet, Advertisement materials and the Consent Form. The questions will be designed to examine the following:

- What have psychiatrists' experiences of working with MDTs been, when they noticed challenges in staff work with clients with BPD?
- How do psychiatrists experience their roles of being senior clinicians supporting staff to navigate these challenges in their work with the BPD client group?
- What experiences of support have psychiatrists used themselves whilst supporting MDTs working with this client group?

Interviews will be carried out via Skype or MS Teams.

Materials

An audio recorder will be used to record these interviews. The other materials used during the recruitment and interview process will include, mobile telephone, project leaflet, Participant Information Sheet (PIS), Consent form, and a debrief sheet.

Procedure

Recruitment strategy

A purposive sampling approach will be used to recruit participants. The study will be advertised on Twitter tagged to the Royal College of Psychiatry (RCPsych) Twitter handle/account and similarly on the RCPsych Facebook page.

This project will be co supervised by Dr John Stevens, consultant psychiatrist alongside Dr Pete Greasley and Dr Roxanna Mohtashemi. The advertising flyer will be shared with this psychiatrist for them to share in peer supervision/consultation groups and on social media, through their social media account on the RCPsych Twitter and Facebook pages.

The lead researcher will contact a member/coordinator of the RCPsych directly via email or through telephone to assess if there are other ways to reach psychiatrists with these inclusion criteria through other non-NHS forums.

Steps for recruitment

i) The lead researcher will share the advertising flyer of the project with the project supervisors. The flyer will contain information on how to get in contact with the lead researcher. This will be via a mobile telephone number purely for research purposes given to the lead researcher by the Lancaster DClinpsy for thesis recruitment and interviews. The lead researcher’s university email address will also be included as part of this.

ii) The lead researcher and the psychiatrist supervisor will upload this document on Twitter tagged to the Royal College of Psychiatry (RCPsych) Twitter handle/account and similarly on the RCPsych Facebook page. Should a member of the RCPsych accept this, a flyer may also be shared directly with them.

iii) Interested participants will be instructed on the flyer to contact the lead researcher via the means mentioned above, following which a phone call or email will be returned giving verbal information about the study. If interested participants require further information to participate then this will be emailed to them. In both instances of contact (i.e. telephone or email) this will be followed up with an email version of the participant information sheet (PIS).

iv) Following this the lead researcher will request that participants who have read the PIS and interested in participating, to either contact the lead researcher or be contacted by the lead researcher to arrange a time for the interview to be conducted. The researcher will use Skype or MS teams to speak with the participants, in a private space within the researcher's home environment. Face to face interviews will not be offered because of the current government and Lancaster University's social distancing guidelines due to COVID-19

v) Prior to beginning the interviews, the PIS will be revisited. Verbal consent will be sought for the lead researcher to contact the participants interested in research. Participants will then complete a consent form with the lead researcher via Skype or MS Teams. An electronic version of the consent form will be emailed prior to the interview or at the start of the interview (if participants have access to computers during a telephone call) and then be instructed to email this to the lead researcher. Consent to participate will be obtained by the lead researcher.

vi) The PIS and consent form will contain information of the participants right to withdraw by a specified deadline of two weeks after the interview. This will also be reiterated verbally.

vii) Recruitment will be stopped once the upper limit of participants (12) or the lower limit (8) is reached if no further participants come forward.

Consent

Consent to participate will be obtained by the lead researcher. Verbal consent will be sought for the lead researcher to contact the participants interested in research.

Prior to beginning the interviews, participants will be guided to complete a consent form with the lead researcher via Skype or MS Teams. An electronic version of the consent form will be emailed prior to the interview or at the start of the interview (if participants have access to computers during a telephone call) and then be instructed to email this to the lead researcher.

The PIS and consent form will contain information of the participants right to withdraw by a specified deadline of two weeks after the interview. This will also be reiterated verbally.

The PIS will contain information pertaining to the two-week deadline which participants have if they wish to withdraw from the study and request heir interviews to be deleted. This will also be verbally reiterated at the start and end of the interviews.

Confidentiality

Consent forms and other identifying information:

Completed consent forms will be scanned and uploaded to a computer at the first possible opportunity following the interview. Hard copies will then be shredded. Electronic documents will then be stored on the university’s secure (password protected) cloud storage.

Only the research supervisors will be given access to this information. Identifying details of each participant will be deleted by the lead researcher upon project completion. Identifying details of each participant will be deleted by the lead researcher upon project completion.

Audio transcripts:

All interviews will be recorded on a voice recorder. The lead research is the only one who will have access to this. Each participant interview will be anonymised. A participant pseudonym will be selected and matched on a word table to the participant. This will be stored as part of the process above. The audio interviews will be stored in a separate folder in the cloud storage and only the lead researcher and research supervisors will be given access to this information

Following completion of the study, the anonymised transcripts will be transferred

securely to the Doctorate in Clinical Psychology Research Coordinator. They will be responsible for storing these anonymised transcripts and personal/identifying details (stored in a separate secure file) for a minimum period of 10 years, before deleting them.

As an added measure the audio recordings will be password protected (encrypted ZIP file) and only members of the research team will have access to this password. Until the audio recordings are transferred to a secure storage location the lead researcher will keep the voice recorder. Once transferred, the audio recording will be immediately deleted from the device.

Proposed analysis

The semi structured interviews will be carried out and transcribed individually by the lead researcher. The IPA process of analysis requires that each participant's interview transcript be examined in detail by veering between each line of meaning and the overall message from their responses, referred to as the 'hermeneutic circle' (Smith, 2007). In keeping with this, as each line is interpreted for the message it suggests, the researcher will record these notes beside the response on which it is based. This will be repeated for the entire transcript. The researcher will then return to the beginning of the transcript to start to document any emerging themes from these initial notes, then transforming them into brief phrases. Once these phrases are recorded. This process will be repeated for the remainder of the transcripts. As these theme clusters emerge, they will be checked against each transcript to ensure it uses participants actual words. Phrases from all the transcripts will then be transferred to a 'master theme table' for the process of reducing themes to the final set of themes, following the iterative interpretative process of clustering themes (Smith & Osborn, 2015).

Practical issues

The researcher anticipates some difficulties in participation in terms of keeping interviewing times or allocating long enough for interviews. The use of Skype or MS Teams interviews may provide flexibility to participants.

Ethical considerations

It is unlikely that this research topic, including the questions anticipated to be developed from the interview schedule, will trigger distress. However, as IPA emphasises an in-depth exploration of participants' experiences of working with MDTs where the BPD diagnosis has been known to trigger emotive responses in staff, this could trigger some levels of discussion about sensitive topics or difficult experiences. The lead researcher will be alert to any signs of distress and if this situation arises, the lead researcher will attempt to support participants and offer them options to take a break within the remit of the interview time or give them the option to either continue or end the interview. Participants will also be given a debrief sheet containing information about relevant support avenues. A verbal debrief will also follow every interview. Participants will be reminded of their right to stop the interview at any time before the interviews commence. Participants can withdraw from the study at any time before the interview, including the day of the interview. Participants will be able to withdraw their data for a period of two weeks following completion of the interview. Following this, the participants' data may have already been anonymised and incorporated into themes within the research write up. Therefore, the lead researcher will explain that this will make it difficult to withdraw following this point.

Given that this is part of a trainee clinical psychology research project, the lead researcher will need to ensure that they take an outsider perspective of psychiatry and remain mindful of personal biases from their work alongside psychiatry colleagues which could influence the data analysis process. The inclusion of a psychiatrist to supervise the project, the pilot interview and participant views during the transcribing process will aim to counteract such issues. Using thesis supervision from the research team and sharing thoughts from the lead researcher's reflective diary, are also ways to mitigate this issue.

Proposed timescales

August 2019

- Submit thesis proposal form and address any concerns raised from feedback.
- Receive approval from the course
- Begin documentation for ethics submission

September 2019

- FHMREC ethics to be submitted for the deadline on September 4th 2019

18th September 2019 to May 2020

- Maternity leave

May-July 2020

- Start literature review process
- Finalise research materials
- Begin writing introduction and method section of research paper
- Continue with literature review
- Begin recruitment
- Conduct interviews
- Transcribe after each interview

- Begin writing introduction and method section of research paper
- Continue with literature review

July-August 2020

- Analysis
- Feedback themes to participants
- Continue writing literature review and research paper

August- December 2020

- Continue writing literature review and research paper
- Submit drafts to supervisors for feedback

January 2021

- Submit thesis

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Appendix 4-A.

Participant Information Sheet

Participant Information Sheet

How have psychiatrists experienced multidisciplinary team work in response to diagnosing individuals with a Borderline Personality Disorder?

My name is Nina Fernandes and I am a Trainee Clinical Psychologist carrying out this thesis project as part of the Doctorate in Clinical Psychology at Lancaster University.

What is the study about?

The study aims to explore psychiatrists' experiences of multidisciplinary team (MDT) work with staff who have worked alongside individuals with Borderline Personality Disorder (BPD). The specific focus is on how psychiatrists navigate some of these challenges when they coordinate and manage the care of clients and support clinicians' work with the individuals with a BPD diagnosis.

Why have I been approached?

You have been approached because you are a psychiatrist in either the final year of your training or a consultant psychiatrist, who has worked in MDTs where you have supported the work of clinicians with individuals diagnosed with BPD. It is expected that you will have taken a senior role as the lead clinician coordinating team work for people with this diagnosis.

Do I have to take part?

Participation is optional. It is therefore completely up to you to decide whether you choose to take part. You can withdraw from the study at any time without giving a reason. If you have completed an interview, you have up to two weeks from the interview to withdraw from the study. This is because the lead researcher may have included the interview data as part of the overall analysis. The researcher will make every attempt to remove data, however, this may not be possible depending on how far the study has progressed.

What will I be asked to do if I take part?

If you decide to participate, you will be asked to complete an interview via Skype or MS Teams with myself. It is expected that this will take between one to two hours. I will ask you about your experiences relating to your experiences as a psychiatrist supporting clinicians work with individuals with a diagnosis of BPD and how you may have experienced staff relationships and responses in this respect.

Will my data be Identifiable?

Your data will not be identifiable, nobody besides my research supervisors (see names below) and myself will know what you say in these interviews. I will ask you if I can use quotes of what you said for when I write up the thesis. Any quotes I use will be anonymised.

This means that I will not use your name next to the quote, but I will ask you to choose a pseudonym that I can use instead.
The data collected for this study will be stored securely on a Lancaster University network drive. This will only be accessible to the research team (i.e. myself and my research supervisors) involved in the study. All interviews will be recorded on a voice recorder. The audio interviews will be stored securely in the following way: -

- Lancaster university's secure virtual file storage facility. Only accessible to the lead researcher
- Lancaster university's secure cloud storage. Members of the research team can be given access to this information containing participant identifying information.
- Following completion of the study, the anonymised transcripts will be transferred securely to the Doctorate in Clinical Psychology Research Coordinator. They will be responsible for storing these anonymised transcripts and personal/identifying details (stored in a separate secure file) for a minimum period of 10 years, before deletion.
- The typed version of your interview will be made anonymous by removing any identifying information including your name.
- Your personal data will be confidential and kept separately from your interview responses.
- You may only have access to your own audio recordings and not to other participants, as their information will be kept confidential in this way as well.

Are there any exceptions to this confidentiality agreement?
Yes. It is important to note that there are some limits to confidentiality: if what is said in the interview makes me think that you, or someone else, are at significant risk of harm, I will have to break confidentiality and speak to my research supervisors about this. I might then have to pass the information on to other relevant people. I will make every effort to keep you involved in this process, where a breach of confidentiality is required.

Lancaster University policy is that all electronic data will be stored for ten years after the submission of my research. The data will be stored by the Department of Clinical Psychology Research Coordinator in a password-protected file space on the university's server. The Data Custodian, i.e. the person who has ultimate responsibility for managing the usage and safety of the data, is the programme director of my doctorate course, Professor William Sellwood.

For further information about how Lancaster University processes personal data for research purposes and your data rights, please visit our webpage:
www.lancaster.ac.uk/research/data-protection

University web link.

http://www.lancaster.ac.uk/research/research-services/research-integrity-ethics--governance/data-protection/gdpr-what-researchers-need-to-know/

What will happen to the results?

The results will be summarised and reported as part of my thesis project. They can also be shared with you to help inform any future considerations regarding psychology's role and input in relation to this topic. The final report may be submitted for publication in an academic or professional journal.

Are there any risks?

There are no risks anticipated with participating in this study. I would encourage you to either inform me, the lead researcher, or contact my course at Lancaster University (see details below) if you experience any distress following participation. I may also encourage you to contact your GP if I have concerns about your wellbeing.

Are there any benefits to taking part?

Although you may find participation interesting, there are no direct benefits in taking part. There may be indirect benefits in terms of contributing to research in this topic area. You may also find this a useful avenue to talk about your experiences. Furthermore, the implications of this project may include supportive strategies for psychiatrists and the wider MDT as part of the research outcomes, whilst working alongside staff and individuals with a BPD diagnosis.

Who has reviewed the project?

This study has been reviewed by the Doctorate in Clinical Psychology programme and approved by the Faculty of Health and Medicine Research Ethics Committee at Lancaster University.

Who can I contact if I want to participate in this study and where can I obtain further information about the study if I need it?

You can contact me either via email or telephone on the following if you wish to find out more about the study and/or arrange an interview date and time: -
My university email: n.fernandes1@lancaster.ac.uk
Mobile: 07508375651

If you decide to participate and we have arranged an agreed interview date/time, I will ring you via Skype or MS Teams.

Complaints

If you wish to make a complaint or raise concerns about any aspect of this study and do not want to speak to the researcher, you can contact:

Professor William Sellwood Tel: (01524) 593998
Email: bill.sellwood@lancaster.ac.uk
Division of Health Research
Faculty of Health and Medicine
Lancaster University
Lancaster
LA1 4YG
If you wish to speak to someone outside of the Clinical Psychology Doctorate Programme, you may also contact:

The Counselling and Mental Health Service c/o The Base
A – Floor, University House
Lancaster University
Lancaster
LA1 4YW

Professor Roger Pickup Tel: +44 (0)1524 593746
Associate Dean for Research Email: r.pickup@lancaster.ac.uk
Faculty of Health and Medicine
(Division of Biomedical and Life Sciences)
Lancaster University
Lancaster
LA1 4YG

List of researchers involved in the study
Lead researcher: Nina Fernandes, Trainee Clinical Psychologist, Lancaster University Doctorate in Clinical Psychology

Research team:
Dr. Pete Greasley, Teaching Fellow, Department of Health Research, Furness Building, Lancaster University

Dr. Roxanna Mohtashemi, Clinical Psychologist, North West Boroughs Healthcare NHS Foundation Trust, Halton Recovery Team, The Brooker Centre, Halton Hospital, Hospital Way, Runcorn, WA7 2DA

Dr John Stevens, Consultant Psychiatrist, Liverpool Early Intervention in Psychosis team, Training Programme Director – General Adult Psychiatry, Clinical Lead – Early Intervention, Baird House, Liverpool Innovation Park, Digital Way, Liverpool L7 9NJ

Thank you for taking the time to read this information sheet.

Appendix 4-B.

Consent Form

Consent Form

Study Title: How have psychiatrists experienced multidisciplinary teamwork when they have supported clinicians working alongside clients diagnosed with a Borderline Personality Disorder?

We are asking if you would like to take part in a research project about your experiences of supporting clinicians in their work with clients diagnosed with Borderline Personality Disorder.

Before you consent to participating in the study, we ask that you read the participant information sheet and mark each box below with your initials if you agree. If you have any questions or queries before signing the consent form please speak to the lead researcher, Nina Fernandes

1. I confirm that I have read the information sheet and fully understand what is expected of me within this study ☐
2. I confirm that I have had the opportunity to ask any questions and to have them answered. ☐
3. I understand that my interview will be audio recorded and then made into an anonymised written transcript. ☐
4. I understand that audio recordings will be kept until the research project has been examined. ☐
5. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected. ☐
6. I understand that once my data have been anonymised and incorporated into themes it might not be possible for it to be withdrawn, though every attempt will be made to extract my data, up to the point of publication. ☐
7. I understand that the information from my interview will be pooled with other participants' responses, anonymised and may be published. ☐
8. I consent to information and quotations from my interview being used in reports, conferences and training events. ☐
9. I understand that the researcher will discuss data with their supervisor as needed. ☐
10. I understand that any information I give will remain confidential and anonymous unless it is thought that there is a risk of harm to myself or others, in which case Nina Fernandes may need to share this information with their research supervisor. ☐
11. I consent to Lancaster University keeping written transcriptions for 10 years after the study has been completed ☐

12. I consent to take part in the study ☐

Name of Participant___________________ Signature_____________________ Date _____

Name of Researcher ___________________Signature _____________________Date ____

Appendix 4-C.

Advertising Leaflet

- **Are you a Consultant Psychiatrist or a psychiatrist in your final year of training in the UK?**
- **Do you work with people with a diagnosis of Borderline Personality Disorder (BPD)?**
- **Would you be interested in sharing your experiences of supporting multidisciplinary staff working with this client group?**

Psychiatrists Working with People with a BPD diagnosis

My name is Nina Fernandes and I am exploring the experiences of psychiatrists when they work with staff offering support to this client group, for my doctorate in clinical psychology thesis. Your contribution will help me understand what is lacking, working and what more needs to be done, to support psychiatrists in this work.

What would be involved?

- **A 60-minute conversation (shorter or longer if appropriate) via MS Teams or Skype**

How can you participate?

Please contact Nina Fernandes (Lead Researcher) via email to ***n.fernandes1@lancaster.ac.uk*** or telephone on ***(0)7508 375651***

I look forward to speaking with you.

Appendix 4-D.

Interview Schedule

Interview Schedule

Introductions
- My name, job title,
- supervisors their name, job title

Introduce purpose of the study

"As you know I am interested in hearing about your experiences of working with MDTs when you have diagnosed individuals with Borderline Personality Disorder. The interview will follow a semi structured series of questions, which will be flexible depending on what information you feel is important to talk about. I may ask you to give more details about certain points as we go along or I may give you prompts if you are unsure what to talk about. I would like to remind you that this interview can be stopped at any point for a break or can be stopped completely. The topic may bring up some thoughts or ideas that are sensitive for you and if you would like to speak to anyone after this interview in regard to professional care of your clients. They will also be available on the participant information sheet."

Inform participant how anonymity and confidentiality will be managed

Give consent form and store this

Ask if they have any questions

Start…
Question topic area

1) What have your experiences of working with MDTs been, with clients with BPD?
   Prompts:
   Can you think of a recent example?
- How did you find this process?
- Did you experience any differing views either from clients or staff when you made this diagnosis?
- What was this like?
- What were your experiences of support?
- What challenges did you face?

2) How did you experience your role of being senior clinician supporting staff to navigate these challenges in their work with the BPD client group?
   Prompts:
   - What was it like being in a senior role and how did it help/hinder any decision making?

  - What is it like being a senior clinician having to make decisions about complex clients with an MDT?
  - How do you experience clinicians' responses to you in their work with such complexity? What do you think they expect of you?

3) What experiences of support have you used whilst supporting MDTs working with this client group?
Prompts:

- What do you think has gone well for you when you have had more positive experiences of support in this work?
- Have you had experiences where you being in your position as a senior clinician in this work as worked or hindered you or the clinicians in any way?
- How have you experienced clinicians when you have had dilemmas in this work? What would you have wanted to happen?
- Are there any aspects of your role that you particularly value or dislike and what might these be?

Start to draw the interview to a close. Thank the participant for their time and participation. Check if the participant needs to clarify any questions or responses. Be alert to any signs of distress during the interview or after. Reiterate their right to withdraw from the study within the two-week deadline. Debrief.

Appendix 4-E

Debrief Sheet

Debrief Sheet for researcher

Study Title: How have psychiatrists experienced multidisciplinary teamwork when they have supported clinicians working alongside clients diagnosed with a Borderline Personality Disorder?

The debrief is to be conducted at the end of the interview.

Debrief guidance (try to ensure that all these points are covered within the debrief):

- Thank the participant for participant in the interview
- Explore participants feeling around the process of being interviewed; are they feeling ok to leave and continue with their day?
- Does the participant feel ok to end the interview or would they like to add any more information?
- Is there anything that the researcher could do that would be helpful?
- Reiterate sources of support that are on information sheet and share them again if necessary (have an extra copy).
- Reiterate the contact details of the researcher and supervisors.
- Reiterate the purpose of the study, how the data will be stored and used.
- Confirm consent to participant and reiterate right of withdrawal prior to write-up.
- Ask if there are any questions or comments?

Appendix 4-F

Faculty of Health Research and Medicine Research Ethics Committee

Application Form

Faculty of Health and Medicine Research Ethics Committee (FHMREC)
Lancaster University

Application for Ethical Approval for Research

for additional advice on completing this form, hover cursor over 'guidance'.

Guidance on completing this form is also available as a word document

Title of Project: How have psychiatrists experienced multidisciplinary teamwork when they have supported clinicians working alongside clients diagnosed with a Borderline Personality Disorder?
Name of applicant/researcher: Nina Fernandes

ACP ID number (if applicable)*: N/A

Funding source (if applicable) N/A

Grant code (if applicable): N/A

***If your project has *not* been costed on ACP, you will also need to complete the Governance Checklist [link].**

Type of study

☐ Involves existing documents/data only, or the evaluation of an existing project with no direct contact with human participants. **Complete sections one, *two* and four of this form**

☒ Includes *direct* involvement by human subjects. **Complete sections one, *three* and four of this form**

SECTION ONE

1. Appointment/position held by applicant and Division within FHM Trainee Clinical Psychologist, Doctorate in Clinical Psychology

2. Contact information for applicant:

E-mail: n.fernandes1@lancaster.ac.uk **Telephone**: 07553944225 (please give a number on which you can be contacted at short notice)

Address: Doctorate in Clinical Psychology, Furness College, Lancaster University, Lancaster, LA1 4YG

3. **Names and appointments of all members of the research team (including degree where applicable)**

Dr. Pete Greasley, Teaching Fellow, Department of Health Research, Furness Building, Lancaster University
Dr. Roxanna Mohtashemi, Clinical Psychologist, North West Boroughs Healthcare NHS Foundation Trust
Halton Recovery Team, The Brooker Centre, Halton Hospital, Hospital Way, Runcorn, WA7 2DA
Dr. John Stevens, Consultant Psychiatrist, Liverpool Early Intervention in Psychosis team, Training Programme Director – General Adult Psychiatry, Clinical Lead – Early Intervention, Baird House, Liverpool Innovation Park
Digital Way, Liverpool L7 9NJ

3. If this is a student project, please indicate what type of project by marking the relevant box/deleting as appropriate: (please note that UG and taught masters projects should complete **FHMREC form UG-tPG**, following the procedures set out on the FHMREC website

PG Diploma ☐ Masters by research ☐ PhD Thesis ☐ PhD Pall. Care ☐

PhD Pub. Health ☐ PhD Org. Health & Well Being ☐ PhD Mental Health ☐ MD ☐

DClinPsy SRP ☐ [if SRP Service Evaluation, please also indicate here: ☐] DClinPsy Thesis ☒

4. Project supervisor(s), if different from applicant: Dr Pete Greasley and Dr Roxanna Mohtashemi

5. **Appointment held by supervisor(s) and institution(s) where based (if applicable)**:
Dr. Pete Greasley, Teaching Fellow, Department of Health Research, Furness Building, Lancaster University
Dr. Roxanna Mohtashemi, Clinical Psychologist, North West Boroughs Healthcare NHS Foundation Trust
Halton Recovery Team, The Brooker Centre, Halton Hospital, Hospital Way, Runcorn, WA7 2DA
Dr. John Stevens, Consultant Psychiatrist, Liverpool Early Intervention in Psychosis team, Training Programme Director – General Adult Psychiatry, Clinical Lead – Early Intervention, Baird House, Liverpool Innovation Park
Digital Way, Liverpool L7 9NJ

SECTION TWO
Complete this section if your project involves existing documents/data only, or the evaluation of an existing project with no direct contact with human participants

1. Anticipated project dates (month and year)
Start date: End date:

2. Please state the aims and objectives of the project (no more than 150 words, in lay-person's language):

Data Management

For additional guidance on data management, please go to Research Data Management *webpage, or email the RDM support email:* rdm@lancaster.ac.uk

3. Please describe briefly the data or records to be studied, or the evaluation to be undertaken.

4a. How will any data or records be obtained?

4b. Will you be gathering data from websites, discussion forums and on-line 'chat-rooms' no

4c. If yes, where relevant has permission / agreement been secured from the website moderator? no

4d. If you are only using those sites that are open access and do not require registration, have you made your intentions clear to other site users? no

4e. If no, please give your reasons

5. What plans are in place for the storage, back-up, security and documentation of data (electronic, digital, paper, etc)? Note who will be responsible for deleting the data at the end of the storage period. Please ensure that your plans comply with General Data Protection Regulation (GDPR) and the (UK) Data Protection Act 2018.

6a. Is the secondary data you will be using in the public domain? no

6b. If NO, please indicate the original purpose for which the data was collected, and comment on whether consent was gathered for additional later use of the data.

Please answer the following question *only* if you have not completed a Data Management Plan for an external funder

7a. How will you share and preserve the data underpinning your publications for at least 10 years e.g. PURE?

7b. Are there any restrictions on sharing your data?

8. Confidentiality and Anonymity

a. Will you take the necessary steps to assure the anonymity of subjects, including in subsequent publications? yes

b. How will the confidentiality and anonymity of participants who provided the original data be maintained?

9. What are the plans for dissemination of findings from the research?

10. What other ethical considerations (if any), not previously noted on this application, do you think there are in the proposed study? How will these issues be addressed?

SECTION THREE
Complete this section if your project includes *direct* involvement by human subjects

1. Summary of research protocol in lay terms (indicative maximum length 150 words):

The aim of this research is to explore psychiatrists' experiences of coordinating multidisciplinary teamwork (MDT) in relation to clients with a diagnosis of Borderline Personality Disorder (BPD). MDTs include a range of mental health clinicians such as nurses, social workers, clinical psychologists (CP), occupational therapists etc.

People with a diagnosis of BPD experience problems with relationships, have frequent changes in emotions, and may be more vulnerable to increased alcohol or drug use. Often these issues can lead to people reporting thoughts and plans of a suicidal nature. Research suggests that these problems may be linked to repeated traumatic childhood experiences of abuse and/or neglect. Individuals with BPD have reported to find therapeutic work difficult in relation to forming and maintaining therapeutic alliances with clinicians.

Clinicians have in turn reported to find their work with this client group challenging and unpredictable. Research on staff experiences has suggested that they can often avoid this work, when they have limited training of working alongside people with this diagnosis. MDTs can respond unhelpfully to their clients if their work is not carefully managed and they do not receive enough training and supervision to support them.

In the NHS, psychiatrists are the mental health clinicians, belonging to the MDT, who are trained to give this and other diagnoses. They are also trained in other skills including leading and coordinating client care, using talking therapies alongside medication prescribing, and risk management. Therefore, this study aims to understand how psychiatrists navigate some of these challenges when they coordinate and manage the care of clients and support clinicians' work with the individuals with a BPD diagnosis. This research outlines a role for CPs to understand the support needs of professionals who struggle to work with these individuals as this is part of their role.

2. **Anticipated project dates (month and year only**)

Start date: January 2020 End date: January 2021

Data Collection and Management
For additional guidance on data management, please go to Research Data Management *webpage, or email the RDM support email:* rdm@lancaster.ac.uk

3. Please describe the sample of participants to be studied (including maximum & minimum number, age, gender):

The aim is to recruit a minimum of 8 psychiatrists to provide a range of responses from the chosen sample. An upper limit of 12 psychiatrists across the UK would be interviewed without compromising on the quality of the analysis. As the premise of IPA studies is to explore each participant's unique experience in detail (Smith, Flowers & Larkin, 2009), a smaller sample is more likely to allow for participant views to be prioritised, as opposed to collecting generalised views about an event (Smith & Osborn, 2015). It would also allow for a more in-depth understanding of each participant's experience. Therefore, a sample size of 8-12 psychiatrists would constitute a meaningful sample and be within the remit of an IPA study (Smith, Flowers & Larkin, 2009).

The inclusion criteria for the study are as follows:
Inclusion:
- Final year psychiatrists and consultant psychiatrists working in England. Psychiatrists will need to be in the final year of training, prior to becoming consultants, as they will be required to chair MDTs and are more likely to have undertaken leadership roles at this stage of training. Consultant Psychiatrists assume leadership roles in MDTs which include case management and/or being the lead clinician.
- Final year psychiatrists and/or Consultant Psychiatrists who have given a diagnosis of BPD and worked within an MDT.
- Final year psychiatrists and/or Consultant Psychiatrists currently working in mental health settings including community and inpatient.

Exclusion criteria:
- n/a

Rationale for inclusion criteria
(1) Psychiatrists who are in the final year of training prior to becoming consultants as they will be required to chair MDTs and take leadership roles at this stage of training. Psychiatrists at this stage of training are required to demonstrate competencies in chairing, managing and working alongside MDTs. These include a range of mental health professionals such as mental health nurses, clinical psychologists, occupational therapists; social workers etc. Psychiatrists who have not reached this level of training may not have had these experiences even if they have worked with MDTs and given a BPD diagnosis. Furthermore, more senior psychiatry trainees may have had exposure to working with individuals and MDTs relating to BPD, (2) Psychiatrists and/or Consultant Psychiatrists with experiences of undertaking leadership roles in MDTs: This falls in line with the aim of the research which is to explore psychiatrists' experiences of working with MDTs who have been care coordinators/lead clinician in this case. Given the level of complexity involved in working with these difficulties, in relation to managing impulsive risk - taking behaviour and difficult staff responses, it might be allocated to psychiatrists in more senior roles to manage.

4. How will participants be recruited and from where? Be as specific as possible. Ensure that you provide the *full versions* of all recruitment materials you intend to use with this application (eg adverts, flyers, posters).

A purposive sampling approach will be used to recruit participants. The study will be advertised on Twitter tagged to the Royal College of Psychiatry (RCPsych) Twitter handle/account and similarly on the RCPsych Facebook page.

This project will be co supervised by Dr John Stevens, consultant psychiatrist alongside Dr Pete Greasley and Dr Roxanna Mohtashemi. The advertising flyer will be shared with this psychiatrist for them to share in peer supervision/consultation groups and on social media, through their social media account on the RCPsych Twitter and Facebook pages.

The lead researcher will contact a member/coordinator of the RCPsych directly via email or through telephone to assess if there are other ways to reach psychiatrists with these inclusion criteria through other non-NHS forums.

Steps for recruitment:
i) The lead researcher will share the advertising flyer of the project with the project supervisors. The flyer will contain information on how to get in contact with the lead researcher. This will be via a mobile telephone number purely for research purposes given to the lead researcher by the Lancaster DClinpsy for thesis recruitment and interviews. The lead researcher's university email address will also be included as part of this.

ii) The lead researcher and the psychiatrist supervisor will upload this document on Twitter tagged to the Royal College of Psychiatry (RCPsych) Twitter handle/account and similarly on the RCPsych Facebook page. Should a member of the RCPsych accept this, a flyer may also be shared directly with them.
iii) Interested participants will be instructed on the flyer to contact the lead researcher via the means mentioned above, following which a phone call or email will be returned giving verbal information about the study. If interested participants require further information to participate then this will be emailed to them. In both instances of contact (i.e. telephone or email) this will be followed up with an email version of the participant information sheet (PIS).
iv) Following this the lead researcher will request that participants who have read the PIS and interested in participating, to either contact the lead researcher or be contacted by the lead researcher to arrange a time for the interview to be conducted. The researcher will use Skype or MS teams to speak with the participants, in a private space within the researcher's home environment. Face to face interviews will not be offered because of the current government and Lancaster University's social distancing guidelines due to COVID-19
v) Prior to beginning the interviews, the PIS will be revisited. Verbal consent will be sought for the lead researcher to contact the participants interested in research. Participants will then complete a consent form with the lead researcher via Skype or MS Teams. An electronic version of the consent form will be emailed prior to the interview or at the start of the interview (if participants have access to computers during a telephone call) and then be instructed to email this to the lead researcher. Consent to participate will be obtained by the lead researcher.
vi) The PIS and consent form will contain information of the participants right to withdraw by a specified deadline of two weeks after the interview. This will also be reiterated verbally.
vii) Recruitment will be stopped once the upper limit of participants (12) or the lower limit (8) is reached if no further participants come forward.

5. Briefly describe your data collection and analysis methods, and the rationale for their use.

Data collection:
Semi-structured interviews will be used to collect the data. IPA prioritises the use of semi structured interviews as a meaningful way to begin the process of understanding participant experiences (Smith & Osborn, 2015). It also provides flexibility to participants to cover a broad range of ideas and responses related to the interview questions in addition to the initial interview schedule.

As such, the interview schedule will be developed alongside the project supervisors which includes a psychiatrist. Information about the study will be included within the Participation Information Sheet, Advertisement materials and the Consent Form. The questions will be designed to examine the following:
- What have psychiatrists' experiences of working with MDTs been, when they noticed challenges in staff work with clients with BPD?
- How do psychiatrists experience their roles of being senior clinicians supporting staff to navigate these challenges in their work with the BPD client group?
- What experiences of support have psychiatrists used themselves whilst supporting MDTs working with this client group?

Interviews will be carried out via Skype or MS Teams.

Data analysis:
The semi structured interviews will be carried out and transcribed individually by the lead researcher. The IPA process of analysis requires that each participant's interview transcript be examined in detail by veering between each line of meaning and the overall message from their responses, referred to as the 'hermeneutic circle' (Smith, 2007). In keeping with this, as each line is

interpreted for the message it suggests, the researcher will record these notes beside the response on which it is based. This will be repeated for the entire transcript. The researcher will then return to the beginning of the transcript to start to document any emerging themes from these initial notes, then transforming them into brief phrases. Once these phrases are recorded. This process will be repeated for the remainder of the transcripts. As these theme clusters emerge, they will be checked against each transcript to ensure it uses participants actual words. Phrases from all the transcripts will then be transferred to a ‘master theme table’ for the process of reducing themes to the final set of themes, following the iterative interpretative process of clustering themes (Smith & Osborn, 2015).

6. What plan is in place for the storage, back-up, security and documentation of data (electronic, digital, paper, etc.)? Note who will be responsible for deleting the data at the end of the storage period. Please ensure that your plans comply with General Data Protection Regulation (GDPR) and the (UK) Data Protection Act 2018.

Consent forms and other identifying information:
Completed consent forms will be scanned and uploaded to a computer at the first possible opportunity following the interview. Hard copies will then be shredded. Electronic documents will then be stored on the university’s secure (password protected) cloud storage. Only the research supervisors will be given access to this information. Identifying details of each participant will be deleted by the lead researcher upon project completion.

Audio transcripts:
All interviews will be recorded on a voice recorder. The lead research is the only one who will have access to this. Each participant interview will be anonymised. A participant pseudonym will be selected and matched on a word table to the participant. This will be stored as part of the process above. The audio interviews will be stored in a separate folder in the cloud storage and only the lead researcher and research supervisors will be given access to this information

Following completion of the study, the anonymised transcripts will be transferred securely to the Doctorate in Clinical Psychology Research Coordinator. They will be responsible for storing these anonymised transcripts and personal/identifying details (stored in a separate secure file) for a minimum period of 10 years, before deleting them.

7. Will audio or video recording take place? ☐ no ☒ audio ☐ video
a. Please confirm that portable devices (laptop, USB drive etc) will be encrypted where they are used for identifiable data. If it is not possible to encrypt your portable devices, please comment on the steps you will take to protect the data.

All audio interviews will be recorded on a device obtained from the Clinical Psychology Doctorate programme. This device cannot be encrypted therefore the following measures will be undertaken to ensure safe and secure storage and encryption: -
The audio interviews will be stored separately and only the lead researcher and research supervisors will be given access to the information on the cloud storage facility.
Following completion of the study, the anonymised transcripts will be transferred securely to the Doctorate in Clinical Psychology Research Coordinator. They will be responsible for storing these anonymised transcripts and personal/identifying details (stored in a separate secure file) for a minimum period of 10 years, before deleting them.

As an added measure the audio recordings will be password protected (encrypted ZIP file) and only members of the research team will have access to this password. Until the audio recordings are transferred to a secure storage location the lead researcher will keep the voice recorder. Once transferred, the audio recording will be immediately deleted from the device.

b What arrangements have been made for audio/video data storage? At what point in the research will tapes/digital recordings/files be destroyed?

Following completion of the study, the anonymised transcripts will be transferred securely to the Doctorate in Clinical Psychology Research Coordinator. They will be responsible for storing these anonymised transcripts and personal/identifying details (stored in a separate secure file) for a minimum period of 10 years, before deleting them. During this time the lead researcher may have the opportunity to access the audio transcripts to help with research and publication purposes.

Please answer the following questions *only* if you have not completed a Data Management Plan for an external funder

8a. How will you share and preserve the data underpinning your publications for at least 10 years e.g. PURE?

Once the project has been examined and passed, data will be securely transferred to the research coordinator. All electronic data will then be stored for ten years after the submission of the research. The data will be stored by the Department of Clinical Psychology Research Coordinator in a password-protected repository (via PURE). The Data Custodian is the programme director, Professor William Sellwood.

8b. Are there any restrictions on sharing your data?

Supporting data will only be shared on request with genuine researchers. Access will be granted on a case by case basis by the Faculty of Health and Medicine. The research team will have access to the raw data, strictly for the purposes of ensuring reflexivity during data analysis and for general guidance with the project. The research participants can request to see their transcriptions to ensure accuracy of this process with the researcher.

9. Consent

a. Will you take all necessary steps to obtain the voluntary and informed consent of the prospective participant(s) or, in the case of individual(s) not capable of giving informed consent, the permission of a legally authorised representative in accordance with applicable law? yes

b. Detail the procedure you will use for obtaining consent?

Consent to participate will be obtained by the lead researcher. Prior to beginning the interviews participants will be guided to complete a consent form with the lead researcher via Skype or MS teams. The consent form will be emailed prior to the interview or at the start of the interview (if participants have access to computers during a telephone call) and then be instructed to upload and send to the lead researcher.

The PIS and consent form contains information of the participants right to withdraw by a specified deadline of two weeks after the interview. This will also be reiterated verbally.

The PIS contains information pertaining to the two-week deadline which participants have if they wish to withdraw from the study and request heir interviews to be deleted. This will also be verbally reiterated at the start and end of the interviews.

10. What discomfort (including psychological eg distressing or sensitive topics), inconvenience or danger could be caused by participation in the project? Please indicate plans to address these potential risks. State the timescales within which participants may withdraw from the study, noting your reasons.

It is unlikely that this research topic, including the questions anticipated to be developed from the interview schedule, will trigger distress. However, as IPA emphasises an in-depth exploration of participants' experiences of working with MDTs where the BPD diagnosis has been known to trigger emotive responses in staff, this could trigger some levels of discussion about sensitive topics or difficult experiences. The lead researcher will be alert to any signs of distress and if this situation arises, the lead researcher will attempt to support participants and offer them options to take a break within the remit of the interview time, or give them the option to either continue or end the interview. Participants will also be given a debrief sheet containing information about relevant support avenues. A verbal debrief will also follow every interview. Participants will be reminded of their right to stop the interview at any time before the interviews commence.

Participants can withdraw from the study at any time before the interview, including the day of the interview. Participants will be able to withdraw their data for a period of two weeks following completion of the
interview. Following this, the participants' data may have already been anonymised and incorporated into themes within the research write up. Therefore, the lead researcher will explain that this will make it difficult to withdraw following this point.

11. What potential risks may exist for the researcher(s)? Please indicate plans to address such risks (for example, noting the support available to you; counselling considerations arising from the sensitive or distressing nature of the research/topic; details of the lone worker plan you will follow, and the steps you will take).

Due to the nature of the topic the lead researcher does not anticipate any risks. It is anticipated that Skype and MS Teams interviews are presumed to be most convenient for the participants given current government and university guidelines in lieu of COVID 19 social distancing measure.

12. Whilst we do not generally expect direct benefits to participants as a result of this research, please state here any that result from completion of the study.

The lead researcher does not expect that the study will have any direct benefits to the participants. There may be indirect benefits to participants of contributing to research on this topic area. They may also find this a useful avenue to talk about their experiences. Furthermore, the implications of this project may include supportive strategies for participants and the wider MDT as part of the research outcomes when participants work alongside individuals with BPD and staff.

13. Details of any incentives/payments (including out-of-pocket expenses) made to participants:

There will be no incentive payments for taking part in this research.

14. Confidentiality and Anonymity
a. Will you take the necessary steps to assure the anonymity of subjects, including in subsequent publications? yes
b. Please include details of how the confidentiality and anonymity of participants will be ensured, and the limits to confidentiality.

The lead researcher will be able to identify participants from the pseudonyms. Every effort will be made to maintain confidentiality by storing identifiable information, only accessible to the research team. Participants will choose a pseudonym and be referred by this name only following interviews and during the entire course of the project write up. Participant information and data will be stored and transported in a secure manner. Data are stored on the Lancaster University's secure cloud which is password protected and only accessible to the lead researcher. The participants consent forms, will be stored separately from the transcripts. The data from the audio recorder will be deleted as soon as it is transferred to electronically to university's cloud storage. Once the project has been examined and passed, data will be securely transferred to the research coordinator. All electronic data will be then stored for ten years after the submission of the research. The data will be stored by the Department of Clinical Psychology Research Coordinator in a password-protected file space on the university secure server. The audio recordings will be deleted once the project has been examined and following the 10 year duration for publication purposes. The Data Custodian is the programme director, Professor William Sellwood.

15. If relevant, describe the involvement of your target participant group in the *design and conduct* of your research.
It will be beneficial to recheck transcriptions with the respective interviewees where possible to ensure accuracy. This project has benefitted from input from a Dr John Steven (consultant psychiatrist) into the topic and study design as part of the review.

16. What are the plans for dissemination of findings from the research? If you are a student, include here your thesis.

This research will be submitted as part of the lead researcher's doctoral thesis requirement for the Doctorate in
Clinical Psychology.

Results of this study will be submitted for publication in academic/professional journals. Potential journals
that could be targeted are: British Journal of Psychiatry Bulletin, and Personality and Mental Health

The researcher will also aim to disseminate this research in the form of a presentation or poster in conferences.

The lead researcher will be required to disseminate findings at an annual event where doctoral these findings are shared with students and staff members of the Lancaster DClinPsy as part of the course requirement.

17. What particular ethical considerations, not previously noted on this application, do you think there are in the proposed study? Are there any matters about which you wish to seek guidance from the FHMREC?

Given that this is part of a trainee clinical psychology research project, the lead researcher will need to ensure that they take an outsider perspective of psychiatry and remain mindful of personal biases from their work alongside psychiatry colleagues, which could influence the data analysis process. The inclusion of a psychiatrist to co supervise the project, the pilot interview and participant views during the transcribing process will aim to counteract such issues. Using thesis supervision from the research team and sharing thoughts from the lead researcher's reflective diary, are also ways to mitigate this issue.

SECTION FOUR: signature

Applicant electronic signature: Nina Fernandes

Date 2.9.19

Student applicants: please tick to confirm that your supervisor has reviewed your application, and that they are happy for the application to proceed to ethical review ☐

Project Supervisor name (if applicable): Dr Pete Greasley, Dr Roxanna Mohtashemi and Dr John Stevens Date application discussed 2.9.19, 30.08.19, 01/09/19

Submission Guidance

1. **Submit your FHMREC application by email to Becky Case (fhmresearchsupport@lancaster.ac.uk) as two separate documents:**
    i. **FHMREC application form.** Before submitting, ensure all guidance comments are hidden by going into 'Review' in the menu above then choosing *show markup>balloons>show all revisions in line.*
    ii. **Supporting materials.** Collate the **following materials for your study, if relevant, into a single word document:**
        a. **Your full research proposal (background, literature review, methodology/methods, ethical considerations).**
        b. Advertising materials (posters, e-mails)
        c. Letters/emails of invitation to participate
        d. Participant information sheets
        e. Consent forms
        f. Questionnaires, surveys, demographic sheets
        g. Interview schedules, interview question guides, focus group scripts
        h. Debriefing sheets, resource lists

    Please note that you DO NOT need to submit pre-existing measures or handbooks which support your work, but which cannot be amended following ethical review. These should simply be referred to in your application form.
2. Submission deadlines:
    i. Projects including direct involvement of human subjects **[section 3 of the form was completed]**. The *electronic* version of your application should be submitted to Becky Case **by the committee deadline date.** Committee meeting dates and application submission dates are listed on the FHMREC website. Prior to the FHMREC meeting you may be contacted by the lead reviewer for further clarification of your application. Please ensure you are available to attend the committee meeting (either in person or via telephone) on the day that your application is considered, if required to do so.
    ii. The following projects will normally be dealt with via chair's action, and may be submitted at any time. **[Section 3 of the form has *not* been completed, and is not required].** Those involving:

   a. existing documents/data only;
   b. the evaluation of an existing project with no direct contact with human participants;
   c. service evaluations.

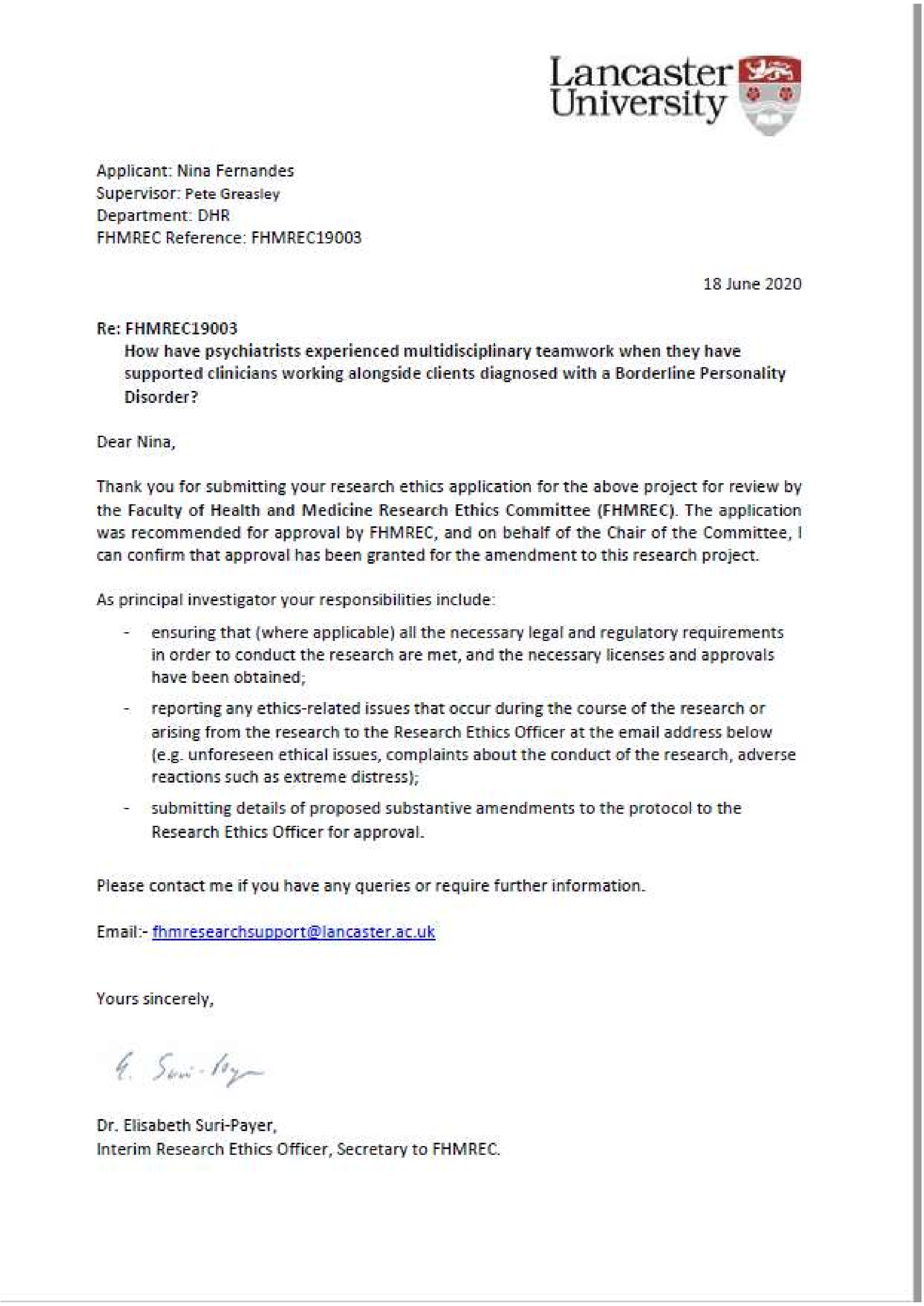
3. **You must submit this application from your Lancaster University email address, and copy your supervisor in to the email in which you submit this application**

Ethics documentation

A. Participant information sheet
B. Consent form
C. Advertising leaflet
D. Interview schedule
E. Debrief sheet

Appendix 4-G

Ethics Approval Letter



Applicant: Nina Fernandes
Supervisor: Pete Greasley
Department: DHR
FHMREC Reference: FHMREC19003

18 June 2020

Re: FHMREC19003
How have psychiatrists experienced multidisciplinary teamwork when they have supported clinicians working alongside clients diagnosed with a Borderline Personality Disorder?

Dear Nina,

Thank you for submitting your research ethics application for the above project for review by the **Faculty of Health and Medicine Research Ethics Committee (FHMREC)**. The application was recommended for approval by FHMREC, and on behalf of the Chair of the Committee, I can confirm that approval has been granted for the amendment to this research project.

As principal investigator your responsibilities include:

- ensuring that (where applicable) all the necessary legal and regulatory requirements in order to conduct the research are met, and the necessary licenses and approvals have been obtained;
- reporting any ethics-related issues that occur during the course of the research or arising from the research to the Research Ethics Officer at the email address below (e.g. unforeseen ethical issues, complaints about the conduct of the research, adverse reactions such as extreme distress);
- submitting details of proposed substantive amendments to the protocol to the Research Ethics Officer for approval.

Please contact me if you have any queries or require further information.

Email:- fhmresearchsupport@lancaster.ac.uk

Yours sincerely,

Dr. Elisabeth Suri-Payer,
Interim Research Ethics Officer, Secretary to FHMREC.