What is Helpful?
Determining Effective and Meaningful Support for Social Workers
Who Work with People with Borderline Personality Disorder

By

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What is Helpful? Determining Effective and Meaningful Support for Social Workers Who Work with People with Borderline Personality Disorder

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Abstract

Previous studies have shown that when working with individuals diagnosed with Borderline Personality Disorder (BPD), clinicians can face challenges including negative attitudes towards their clients, professional distress and feeling like they are not equipped to provide treatment. In turn, clients diagnosed with this disorder often experience stigma related to their diagnosis, lack of treatment options or dissatisfaction in the treatment that they receive. Clinical supervision is recommended in the literature as one way to address some of these issues, however, clinical supervision is not widely available. Using an Anti-Oppressive Practice (AOP) theoretical framework, this qualitative study endeavoured to understand what clinicians find to be effective and meaningful support in the absence of, in addition to, or specific to clinical supervision when working with clients diagnosed with BPD. Six social workers working in community mental health were interviewed. Theme analysis was used to examine the collected data. Themes related to experiences with supervision, challenges working with client with BPD, peer support needs, and BPD stigma were identified. These findings also suggest future research, policy and practice implications in this area to address the challenges of related to service provision for individuals diagnosed with BPD.
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Table 1

Page 35: Participant Identity Names
List of Acronyms

Anti-Oppressive Practice: AOP
Borderline Personality Disorder: BPD
Diagnostic and Statistical Manual of Mental Disorders: DSM
Dialectical Behaviour Therapy: DBT
Formalized Structured Supervision: FSS
Fraser Health Authority: FHA
Mental Health and Substance Use: MHSU
Introduction

Individuals diagnosed with Borderline Personality Disorder (BPD) are believed to account for the use of 10% of outpatient and 20% of inpatient mental health services (Bland & Rossen, 2005, p.507). The Centre for Mental Health and Addictions (2009) states that estimates on the prevalence of BPD in the general population are about six percent. This figure is based on United States numbers, as research for prevalence rates in Canada are limited. High risk behaviours such as suicidality, self-harm, impulsivity, and grandiose thinking are commonly associated with the disorder (Fazio-Griffith & Curry, 2009). Current information on BPD indicates that there are several issues connected with the treatment of BPD, including stigma around the diagnosis, the availability of treatment options and recommendations for clinicians regarding clinical supervision and education. Fanaian, Lewis and Grenyer (2013) report that negative clinician attitudes and stigma towards persons with personality disorders, including BPD, is believed by some clinicians to be a barrier to effective treatment. Fanaian et al. also highlight a lack of resources, education and support for clinicians, as well as a lack of clinician confidence as barriers to effective services.

Working with this population has been noted in the research to result in higher rates of burnout, and more feelings of inadequacy than working with people diagnosed otherwise from the DSM (Fanaian et al, 2013; Liebman & Burnette, 2013). However, the research has also suggested that clinical supervision and educational opportunities for clinicians working with this population can help to improve the treatment experience for both treating clinicians and their clients (Cookson, Sloan, Dafters & Jahoda, 2014). This study examined the question, “What elements of professional peer support do clinicians working with clients diagnosed with Borderline Personality Disorder perceive as the most meaningful and effective?” A literature
review was completed to explore the common themes in the current knowledge on BPD and clinical supervision, including approaches to clinical supervision, outcomes research, identified issues and considerations in clinical supervision as well as the knowledge gaps in this topic area. Anti-Oppressive Practice theory was used to inform the study. The themes that were discovered from the study will be detailed. The paper concludes with a discussion of the implications for research, policy and practice.

**Literature Review**

In the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5), the American Psychiatric Association (2013) defines Borderline Personality Disorder (BPD) as “a pervasive pattern of instability of interpersonal relationships, self-image and affects, and marked instability, beginning by early adulthood and present in a variety of contexts” (p. 325). Individuals diagnosed with Borderline Personality Disorder demonstrate affective instability, impulsivity, limited self-soothing abilities, self-destructive behaviours, including suicidal behaviour, unstable relationships, and feelings of emptiness (Aviram, Brodsky & Stanley, 2005; Fallon, 2003). Persons with this diagnosis often struggle with psychosocial functioning, have high levels of distress and disability, and experience a comorbid mental health disorder, including substance abuse, depression as well as other mood and personality disorders (Barber & Weinberg, 2010; Hermens, van Splunteren, van den Bosch & Verheul, 2011). BPD, as a comorbid disorder, has been found to interfere with outcomes for the treatment of the other mental health disorder (Barber & Weinberg, 2010). Research also shows that individuals with BPD use treatment resources at a disproportionately higher rate than other service users and this has been associated with high health care costs (Barber & Weinberg, 2010; Newton-Howes, Weaver & Tyrer, 2008).
Borderline Personality Disorder and Stigma

In their research on improving services for people with personality disorders, Fanaian et al. (2013) report that participants (mental health clinicians of varied professional backgrounds) highlighted the existence of a negative culture towards persons with personality disorders. They further stated a need to address the stigma and negative attitudes towards clients with personality disorders, in order to improve services for them. Cleary et al. (as cited in Bland & Rossen, 2005) report that in a study of nurses providing support to individuals with BPD, 84% of participants found individuals diagnosed with BPD to be the most difficult to work with compared to other unspecified “patient groups” (p. 508). Aviram et al. (2006) and Rizq (2012) discussed previous studies suggesting clinicians find those diagnosed with BPD more challenging to work with, and were more empathetic toward individuals with other mental health diagnoses. Aviram et al. (2006) also questioned the possibility that the stigma attached to a mental health diagnosis of BPD “unintentionally influences therapists and may inadvertently lead therapists to behave in ways that exacerbate symptomatic behaviour” (p. 251).

In their research on countertransference towards clients with BPD, Liebman and Burnette (2013) state that many clinicians feel that they are not equipped to effectively provide treatment. They also report that clinicians working with clients with BPD can have high burnout rates. Liebman and Burnette also report common stereotypes that are held by clinicians towards clients with BPD. Stereotypes include perceptions of dangerousness, behaviour being a choice and not due to their disorder, as well as assuming manipulative and acting out behaviours. Feelings of disdain, indifference and frustration have been found to be evoked in clinicians more toward clients diagnosed with BPD than clients with other disorders such as schizophrenia and depression. In their research around psychiatric nurses caring for clients with BPD in community
settings, O’Connell and Dowling’s (2013) findings also indicate BPD-specific stigma. They report studies have found that nurses feel “demonized, manipulated and threatened” by people diagnosed with BPD (p. 27).

Another issue that is discussed in the literature related to BPD stigma is around speaking to individuals about the diagnosis. O’Connell and Dowling (2013) found that participants noted issues around the diagnosis of BPD not being shared with the client. O’Connell and Dowling suggested that literature in this area is “controversial”. For example, one study found that people were not told about their diagnosis until they were recruited for a research study. It was also suggested by O’Connell and Dowling that many clinicians and researchers “have found the application of the diagnosis of BPD difficult in terms of the impact that such a label has on professional attitudes and consequent provision of treatment (p.31). These researchers also cited findings that suggested receiving a diagnosis helped service users to make sense of what they were experiencing. A study by Stalker et al. (as cited in Rogers & Dunne, 2011) found some patients with BPD were not informed of their diagnosis while in hospital, and were only informed via letter after their discharge. Rizq (2012) acknowledged the literature on negative clinician attitudes, but reported contradictory findings. She found that primary care counsellors working with clients diagnosed with BPD expressed feelings of empathy and concern for their clients as well as a sense of responsibility for them. In addition, it was reported that working with this population can evoke feelings of anxiety and insufficiency. Bowen (2013) also provided a study in which the participants, mental health clinicians of varied professional backgrounds, expressed empathy, optimism, and viewed difficult behaviours as opportunities for learning when working with individuals with BPD.
Treatment Options

The literature on treatment options for persons with BPD suggests that there are effective treatments, but they are often not readily available, and treating clinicians are in need of more training to provide them. Evidence based treatments for BPD include dialectical behaviour therapy (DBT), mentalization based therapy, schema therapy, and transference focused therapy (Barber & Weinberg, 2010; Fanaian et al., 2013; King, 2014; Rizq, 2012). O’Connell and Dowling (2014) state that DBT, developed by Dr. Marsha Linehan, is a multi-pronged approach that combines principles of cognitive behaviour therapy, mindfulness and an emphasis on the teaching and acquirement of new skills for clients. According to O’Connell and Dowling, research has suggested that DBT has been beneficial in reducing self-harm, anxiety, depression and hospital admissions for clients with BPD. For staff who are trained in DBT, it has been found to improve attitudes towards clients and engagement with them. Reviewing past studies of DBT, O’Connell and Dowling suggest that DBT appears to be the treatment of choice for BPD. However, this could in part be related to the lack of evidence that supports the efficacy of other therapies.

Fanaian et al. (2013) found that there is a desire among clinicians for clear protocols and guidelines for the treatment personality disorders, citing the clinical guidelines of the National Institute for Health and Care Excellence (NICE) in the UK. Participants in Fanaian et al.’s study discussed the need for clear procedures for assessment, crisis situations and clinical pathways to ensure that clients have the most appropriate treatment. The NICE protocol titled, *Borderline Personality Disorder: The NICE Guideline on Treatment and Management* (National Collaborating Centre for Mental Health, 2009) includes recommendations for psychological,
psychosocial and pharmacological interventions, the management of crisis and interventions in various levels of treatment (i.e. community and inpatient services).

Examining the local context of service provision for individuals with BPD, in British Columbia, The Healthy Minds, Healthy People: A Ten Year Plan to Address Mental Health and Substance Use in British Columbia was released in 2010 with the intention to improve mental health services. The focus is on mental health promotion and prevention for all citizens. Healthy Minds, Healthy People (British Columbia, 2010) directly identifies specific mental health issues in the strategic plan, including: perinatal depression, attention deficit disorder, depression, eating disorders, psychotic disorders, delusional disorders, major depression, and substance use issues. BPD is not identified anywhere in the strategic plan, despite evidence that BPD accounts for high use of services and health care costs (Barber & Weinberg, 2010; Newton-Howes, Weaver & Tyrer, 2008).

Issues related to treatment of persons with BPD in the community, versus inpatient hospitalization are also discussed in the literature. These issues include staff perceptions that inpatient admissions are inappropriate, and that individuals with BPD are better served in the community (Cleary, Siegfried & Walter, 2002; Helleman, Goossens, Kaasenbrood & van Achterberg, 2013; Rogers & Dunne, 2011). Rogers and Dunne (2011) state that although the research on inpatient experiences for individuals with personality disorders is limited, the existing knowledge suggests admissions tend to be ineffective and a negative experience for the service user. O’Connell and Dowling (2013) found in their research that participants (clinicians) felt that treatment in community was ideal. They noted a few participants who felt hospitalization was counterproductive, consistent with other findings that inpatient treatment can be counter-therapeutic if not delivered properly. Helleman et al. (2013) state that sometimes a
hospital admission may be required to “protect the patient and relieve the clinician. However, unplanned or long-term hospitalization of patients with BPD in a general psychiatric setting has proven to have limited value and negative side-effects” (p. 66). In their review of the literature, Helleman et al. (2013) conclude that effective brief admissions for individuals with BPD include five key components: discussion of goals; organization of a brief admission; admission procedure; interventions used; and conditions for an early discharge (p. 69-71).

Clinical Supervision

Specific definitions of what clinical supervision consists of are varied, however, there are some similar concepts about what supervision is in the literature. For example, the relationship aspect between supervisor and supervisee, for the purpose of improving patient or client care (Bland & Rossen, 2005; Bogo, Paterson, Tufford & King, 2011a; Bogo, Paterson, Tufford & King, 2011b; Cookson et al., 2014; Schofield & Grant, 2013). Schofield and Grant (2013) state that clinical supervision focuses on assisting a clinician with skill development, reflection on clinical, professional, and ethical issues, case conceptualization as well as providing mentorship and support. In his discussion of transference in clinical supervision, Schamess (2006) also includes that clinical supervision is different from administrative supervision because it is always case focused. There is also a suggestion in some of the definitions that the supervisory relationship is one between a less experienced clinician and a more experienced clinician (Bogo et al., 2011b; Schamess, 2006). There are a variety of theories and models used in clinical supervisions across the various disciplines (Cookson et al., 2014).

In their examination of common factors in supervision, Morgan and Sprenkle (2007) note that supervision encompasses varied definitions, tasks, and models, and there is not one
supervision model that is superior over others. Instead, Morgan and Sprenkle (2007) suggest that different models will be suited to different supervisors and that these “specific models are the medium through which common factors work and which provide the variety and diversity needed to match human complexity” (p.7).

O’Donoghue and Tsui (2013) reviewed 40 years of research on social work supervision. Included in their findings was the experience of supervision for social workers for administrative, educational and support functions. They found that the primary format of supervision was individual sessions between the supervisor and supervisee, and group or team supervision is a secondary approach to supervision when the supervisor was not a social worker. O’Donoghue and Tsui also list findings regarding supervisee preferences, which include: focus on education, support and practice; supervisors who held expertise, competence and skill; and supervisors who assisted in their practice and development of professional competence. Hair (2013) conducted a study of what social workers feel they need to provide effective services. The following themes were identified: need for supervision to promote knowledge, skill development, and emotional support; discuss ethical issues; concerns regarding including performance appraisals with supervision; duration of supervision; supervision training for supervisors; and a need for supervisors to be social workers.

In addition to individual and group supervision, Golia and McGovern (2013) discuss the use of peer supervision. They define this as “any facilitated, planned or ad hoc interactions with colleagues, particularly clinical social workers, psychologists…for the purposes of clinical training, professional development, and mutual aid and affinity” (p. 635). Golia and McGovern highlight these values of peer supervision: gaining advice on difficult cases; normalizing feelings
of anxiety inadequacy while allowing the development of confidence in skills; its availability in times of stress; and provision of support in a safe and less intimidating environment.

As noted, there are many models and approaches to clinical supervision across the disciplines (Cookson et al., 2014; Morgan & Sprenkle, 2007). One approach that does not appear to be widely discussed in the literature but is relevant to the theoretical framework of this paper is the use of anti-oppressive practice in clinical supervision. In a study on supervision, social justice and social work, Hair (2015) notes that realising goals of social justice has become a difficult task in the face of practice environments that are dominated by managerialism and fiscal reductions. It is also noted by Hair that there is little content to inform the pursuit of social justice goals in supervision or for guiding social workers in actualizing social justice in their practice.

Hair (2015) explored the needs of social workers around social justice and supervision conversations. She found that there was agreement among participants that supervision needs to: promote anti-racist, anti-oppressive practice; purposefully promote social justice and change; provide assistance and support in advocating for clients; and challenge unjust policies. Supervision conversations that engage social workers around self-reflection on their own personal and professional functioning, as well as ethical issues, were also noted in the study. Hair states that social work supervisors must be able to consider the long standing issues that social workers can experience as helper and controller, be able to recognize their professional and social power, and be transparent about their social location and privileges that come with related constructs of gender, race, ethnicity and class. According to Hair and O’Donoghue (2009), acknowledging our own social power assists in recognizing and resisting knowledge and actions that can be oppressive to those without privileged identities.
Strategies for addressing social justice and diversity issues include language and questions that elicit collaborative exploration and co-construction of meanings, for example “I am curious about” or “I wonder” that look at the meanings of human distress and how to effect change (Hair, 2015, p.366). Hair (2015) suggests that these questions can help social workers and supervisors identify how visible characteristics (gender, ableness, age, and race) influence how diversity is noticed and named.

**Clinical Supervision Outcomes Research.** Both general literature on clinical supervision and literature specific to treating persons with BPD highlight the benefits for clinicians and clients when the treating clinician is engaged in supervision. Cookson et al. (2014) state that the advantages of clinical supervision for mental health professionals include: reduced levels of stress, burnout and sick leave, reflection on practice, reducing negative consequences that can be associated with working with challenging behaviours and the development of clinical knowledge and competence. Clients are helped through improved patient care, according to Cookson et al. but the literature does not elaborate further on specific benefits to clients. Reporting similar benefits, Bogo et al. (2011b) also note that clinical supervision for social workers has been found to address the dissonance experienced in mental health settings between social work values and tasks. However, in their study on professional development and job satisfaction for mental health and addictions staff, it was found that clinical supervision was only one component related to job satisfaction, competence and development. Other factors that were mentioned in the findings were related to the complexity of meeting clients’ needs, interprofessional teams and organizational influences.

In their discussion of supervision for nurses working with patients with BPD, Bland and Rossen (2005) note that benefits include providing validation, insight and support for nurses,
helping to deal with the stresses of the job, and accepting accountability for their own for practice and development. Bland and Rossen provide an example of a clinical supervisor assisting a clinician to understand the power struggles that clinicians can engage in with this population and understand their limits to preventing destructive or self-harming behaviours. They state that, “these power struggles can lead to punitive consequences for the patient such as forced seclusion, forced restraint, forced medications and other oppressive measures … Refusing to work with or treat the patient because of these self-harm behaviours can lead to more self-harm or suicide,” (p.512).

Another common theme in the literature was issues and considerations for supervision. These include the availability of clinical supervision, discipline specific considerations, supervision in mental health settings, and the supervision relationship. The literature also addresses considerations specific to clinicians working with clients who have a diagnosis or characteristics of BPD.

Availability of Clinical Supervision. The literature indicates that the availability of clinical supervision is limited. Cookson et al. (2014) report both nursing and allied health professionals have indicated that what is sometimes termed clinical supervision is actually more administrative supervision. This complicates confidentiality and the content of supervision. Cookson et al. (2014) refer to research on clinical supervision that advocates for maintaining a separation between clinical supervision and line management supervision. Exploring clinical supervision in a mental health setting that moved to a program management model, Bogo et al. (2011b) also noted concerns around clinical issues not being addressed in clinical supervision time (i.e. time management) or supervisors appearing more as managers than clinical supervisors. The study suggests that when supervision focused on administrative issues it was
interpreted as critical and undermined the confidence of the clinician. Bogo et al. (2011b) found that some participants preferred their clinical supervisor to not be in charge of performance appraisal. They also noted that staff felt pressure to manage time pressures amongst all responsibilities, including supervision time. In a different study, Bogo et al. (2011a) also reported that participants found that workload demands and the crisis oriented nature of the job were barriers to scheduled supervision. Participants wanted access to scheduled supervision, as well as spontaneous opportunities when needed.

**Supervisory Relationship.** Clinical supervision literature highlights the relationship of the supervisor and supervisee. In an article on best practices in clinical supervision, Borders (2014) reports that the most empirically supported factor in the best practices guideline is that of the supervisory relationship. The importance of a safe and trusting environment, and viewing anxiety and resistance in a way that allows for growth and development are highlighted. Additionally, supervisors are recommended to address issues related to diversity, dual relationships and transference.

The roles of mandated and voluntary supervision are also emphasized. In his discussion on transference in clinical supervision, Schamess (2006) states that supervision comes in both mandated and voluntary forms. Mandated supervision is provided through the agency or academic institution that the supervisee is connected to, and a supervisor is assigned at no cost. Voluntary supervision is noted by Schamess (2006) to be a contractual relationship in which the supervisee chooses a supervisor. This is often paid for by the clinician who is in private practice, although social agency based clinicians may also choose to access supervision in this manner. Schamess notes that power dynamics can be observed in either arrangement. In a mandatory setting, the supervisor may be in control of salary, assignments and promotions. Alternately, for
those engaged in voluntary supervision, there is a reversal of this dynamic in terms of economic power because a supervisee has the opportunity to fire the supervisor.

Aside from the economic dynamic, there are also other concerns noted in the literature when a supervisee does not have a say in their supervisor. Cookson et al. (2014) note that 62% of the professionals in their study who were allocated their supervisor were not satisfied with this relationship (p. 33). The same participants also noted that their clinical supervisor was their line supervisor. Cookson et al. point out previous findings that indicate when professionals are able to choose their supervisor, the relationship and effectiveness of the supervision can be improved.

Schofield and Grant (2013) suggest more research is needed in the area of clinical supervision specific to the relationship and process that, “includes both supervisor and supervisee perspectives and explores how they work together to construct an understanding of the therapeutic process, and importantly how supervisors influence changing perceptions and behaviours in the supervisees” (p. 2). They highlight that this is important because of the potential impact on clinician careers and on clients. Schofield and Grant stated that research suggests when supervisees are disappointed with the supervisory relationship, it can result in supervisees having difficulty coping with adverse client events and can experience higher levels of despair and psychological problems. They state this suggests that poor supervisory relationships can result in avoidance of their supervisor, which can impact outcomes for the clinician and client. Problems identified in the supervisory relationship can include criticism, blame, unclear agendas and an instructive approach by the supervisor rather than a process that is interactive.
Mental Health Settings and Discipline Specific Concerns. Over the last few decades, organizational changes have impacted how mental health staff are supervised, both clinically and administratively. This often results in clinicians being supervised by a supervisor outside of their own discipline (Bogo et al., 2011a; Bogo et al., 2011b; Matthewson, 2007). The literature indicates that this can impact clinical supervision in various ways. In their study of clinical supervision for mental health staff, Cookson et al. (2014) point out that the variety of existing clinical supervision models do not always translate across disciplines. Reasons for this can include cultural or organizational differences, as well as the different roles and responsibilities that the different disciplines may have. They suggest that successful clinical supervision frameworks rely on their suitability to profession, speciality and location. Cookson et al. (2014) detail findings from their study that examined the experiences of both nurses and allied health professionals (social workers were not included in the sample). For example, it was found that inpatient nurses were less likely to receive clinical supervision compared to community based nurses. Additionally, the allied health professions reported receiving clinical supervision more often, and were more likely to choose their supervisor than nurses.

Bogo et al. (2011a) report that there are similarities in the nursing and social work literature on supervision, such as the value of availability, positive relationships, mutual communication and support, and having knowledgeable supervisors. Yet, there are also some differences between the two professions. For example, the social work literature appears to view supervision as a valued tradition, whereas some nursing literature views it as punitive and hierarchical. Using focus groups, Bogo et al. (2011a) explored common elements for providing quality supervision in a mental health setting and found that there were a number of themes that emerged including structure, content, and process of supervision. Participants both
acknowledged the value of supervision from other professions and the need to discuss profession specific concerns. Nurses, occupational therapists and social workers all expressed a need for profession specific discussion. Bogo et al. (2011a) conclude that despite concerns about inter-professional supervision, there are supervisor qualities that are considered beneficial regardless of their profession including being clinician focused, content oriented, expert knowledge and skills with the client population as well as an ability to promote learning and a sense of competence for clinicians (p. 135).

In their study of clinical supervision, Gardner, McCutcheon, and Fedoruk (2010) looked at formalised structured supervision (FSS). They compared this to informal supervision, which is often ad hoc in mental health settings. They refer to informal supervision as “superficial supervision” (p.258-259). In this model, clinicians may be resolving difficulties through informal discussions with their colleagues, but not engage in reflective supervision as they would in a more formalized setting. They point out concerns in both areas. They suggest that in looking at previous literature, there is a lack of empirical evidence that FSS is effective in improving client outcomes. There is an assumption that supervisors are adequately trained in providing supervision. The “superficial supervision” approach is usually casual and brief not allowing for time to adequately explore case issues. However, Gardner et al. (2010) conclude from their study that there is a place for both formal and informal supervision practices, and clinicians should be careful to not let informal consultations with colleagues replace formal supervision practices.

**Recommendations for Clinical Supervision and Education.** Throughout the literature that examined clinician attitudes towards individuals with BPD, there is a strong emphasis on the need for more training and clinical supervision. Fazio-Griffith and Curry (2009) and Liebman and Burnette (2013) both emphasize the need for the provision of clinical supervision and
education for students and new clinicians working with clients who have a diagnosis of BPD. The literature also suggests that the majority of clinicians would welcome increased education and clinical supervision when working in this area (Cleary et al., as cited in Bland & Rossen, 2005). Fanaian et al. (2013) suggest that clinicians would like more access to supervision, peer support and professional development opportunities, as treating personality disorders can lead to higher rates of burnout. Fanaian et al. also found that clinicians participating in the study felt that other service agencies that come into more frequent contact with individuals with BPD (i.e. police, other healthcare providers and community services) would also benefit from training in this area “to encourage an intensive and integrated case management approach” (p. 467). This would encourage coordinated and cross agency training. King (2014) also recommended the use of education and clinical supervision to help clinicians understand their conscious and subconscious influences on practice as well as achieving better treatment outcomes with the provision of specialized training for clinicians.

**Gaps in the Literature**

This literature review looked at a very broad scope of literature related to clinician attitudes towards Borderline Personality Disorder and clinical supervision. As Gardner et al. (2010) points out, the number of existing supervision models is close to the number of psychotherapies. It has been suggested by Cookson et al. (2014) that the large number of models available are used by different disciplines and are not always transferable among disciplines. Nor is a defined model always utilized in the clinical supervision setting. Further examination of social worker experience and relevant social work theoretical perspectives, such as Anti-Oppressive Practice or feminist theories, could be beneficial to add to this body of knowledge. Liebman and Burnette (2013) note that approximately 75% of those diagnosed with BPD are
women and also suggest that more negative clinician attitudes are elicited when symptoms are viewed as gender typical (p. 116). By applying a feminist or anti-oppressive framework to examine this issue, more information may be gathered to understand and highlight underlying issues such as gender role expectations, the impact of oppressive practices on exacerbating symptoms associated with BPD and system barriers to providing adequate and appropriate treatment to individuals with BPD. A greater understanding of all factors that impact clinician attitudes may also assist in informing effective clinical supervision.

Further research in evidence-based practice is recommended in the literature. Horvitz-Lennon, Reynolds, Wolbert and Witheridge (2009), Bartak, Soeteman, Verheul and Busschbach (2007), and Rogers and Dunne (2011) have called attention to the need for more research into evidence-based treatment for BPD. It has also been suggested that more examination of evidence based approaches to clinical supervision is needed. Milne, Aylott, Fitzpatrick and Ellis (2008) state that models of clinical supervision are “derived from applying models of therapy, and from extrapolating models from other fields, and from clinical experience” (p. 171). Milne et al. also state that supervision models have been poorly conceptualized in theory and research. Schofield and Grant (2013) note that the number of theoretical models of supervision is growing but the evidence base is limited. More information is needed on what the effective components of clinical supervision and the impact on client outcomes.

A common critique in the reviewed literature by the authors of various articles was around the limitations of qualitative research. Methods of data collection included the use of questionnaires, semi-structured interviews and focus groups. Due to small samples, self-selected participants or discipline specific studies, generalizations could not be made from the various research and therefore recommendations were made for wider range studies to further support
the work (Bogo et al., 2011a; Bogo et al., 2011b; Cookson et al. 2014; Fanaian et al., 2013; Matthewson, 2007; O’Connell & Dowling, 2013; Rogers & Dunne, 2011).

Another identified gap in the research is the knowledge and experience specific to social work. A number of the studies were based on nursing and other allied health professions perspectives related to attitudes towards persons diagnosed with BPD as well as clinical supervision but did not include social work (Cookson et al. 2014; O’Connell & Dowling, 2013, Fazio-Griffith & Curry, 2009). As the preceding information in this literature review has highlighted, the availability of clinical supervision available to clinicians in general and specific to those working with clients diagnosed with BPD is limited. The limited availability of clinical supervision is also extended to supervision being provided by one’s own profession. The research has noted differences among professions in views and approaches to clinical supervision and it is recommended that more research is needed in this area (Bogo et al., 2011a; Bogo et al. 2011b; Cookson et al., 2014). Examining the works of Bogo et al. (2011a) and Bogo et al. (2011b) suggests that while these differences exist, there are other more important qualities of a clinical supervisor such as expert knowledge in the particular area of client population, promoting a sense of competence, knowledge of and ability to teach skills, and reciprocity in supervision. Further research is needed to determine whether other qualities of a clinical supervisor can override the distinction of being of the same discipline, such as those noted above.

One final gap that has not been covered in the research is what, if anything, clinicians do in the absence of effective clinical supervision to support their practice when working in difficult situations. Gardner et al., (2010) suggest that in increasingly pressured work environments, informal methods of “checking-in” with peers, and hallway conversations are superficial and not
a sufficient replacement for a formalized supervision process. Bowen (2013) and Rizq (2012) both identified exceptions to the negative attitudes that clinicians working with individuals with BPD. Further research into the role of peer support and influence may be beneficial to contribute to this body of knowledge given the limited availability of clinical supervision in many practice settings.

Borderline Personality Disorder is a mental health condition that is known to cause distress for those who are diagnosed with it. It is also a diagnosis that is known to cause distress for those providing treatment to clients with BPD because of its complexity and often high risk nature of the disorder. The literature on BPD and the experiences of both client and clinicians suggests that clinical supervision can be instrumental in improving experiences for both. This literature review has highlighted a number of benefits of clinical supervision but also suggests that there are currently a number of issues and considerations that must be addressed through further research, practice changes and organizational changes. It is hoped that by gaining a greater understanding of clinical supervision and effective peer support, the stigma around BPD can be reduced among clinicians to better improve treatment for individuals diagnosed with BPD.

Theoretical Framework

This research study focused on the experience of social work clinicians working with individuals diagnosed with BPD, using an anti-oppressive practice (AOP) theoretical framework. This framework is important to examine, understand, and address the impact of a predominantly medical model perspective on systems, clients, and the BPD diagnosis.
Dominelli (2008) defines oppression as “a system of domination that denies individuals dignity, human rights, social resources and power,” (as cited in Corneau & Stergiopoulos, 2012, p. 267). Baines (2011) further explains that oppression takes place when “a person acts or a policy is enacted unjustly against an individual (or group) because of their affiliation to a certain group” (p. 2). Examples include exclusion from participating in various aspects of life, from right and freedoms or through having beliefs systems, laws and ways of life imposed on an individual or group. Baines lists various forms of oppression related to gender, sexual orientation, class, disability, and race, all of which can overlap, interact and reinforce one’s experience.

Larson (2008) defines AOP as a commitment to social justice that includes a clear theoretical and value base that promotes egalitarianism and power sharing, understanding how one’s social location informs relationships and practice, and a challenge to existing relationships with powerful groups over less powerful groups. AOP also involves specific practice behaviours and relationships that minimizes power imbalances as well as promoting equity and empowerment for service users. Having roots in the early days of social justice in social work, Baines (2011) states that AOP is a broad, umbrella term that encompasses a number of approaches to social justice. These include feminist, Marxist, postmodernist, Indigenous, poststructuralist, critical constructionist, anti-colonial and anti-racist perspectives. Baines points out that AOP is not a fixed approach but one that is continually evolving to analyze and address changing social conditions. Challenges can be triggered by global capitalism, neoliberalism and managerialism.

Like any theoretical framework, AOP has limitations. One is its transfer from education to practice. Strier and Binyamin (2014) note that while AOP has been widely adopted into social
work education, it is in its early stages, or a rarity, when it comes to use in public services. Larson (2008) echoes this struggle, noting that while AOP has been established in social work curricula, it is “distant and incongruent” with the dominant discourse and practice models, identifying mental health practice as an example. Corneau and Stergiopoulos (2012) suggest that, in Canada, where there is increasing immigration and changing demographics, the dominant medical model forces individuals to navigate a system that does not challenge structural, social or cultural factors that influence mental health. They suggest that AOP can be too general and could potentially mask specific forms of oppression. Corneau and Stergiopoulos (2012) also critique AOP as a framework based on professional knowledge. They caution professionals, in privileged positions, to abstain from defining what oppression is.

Larson (2008) notes that medical and biopsychosocial perspectives, which are steeped in hierarchy, patriarchy and power differentials, dominate the mental health system – even for social workers. Social workers can experience a dissonance between education and practice in a field that is often dominated by medically focused professions. Education focuses on diagnosis and assessment (i.e. the DSM), medical interventions and clinical counselling. In addition, mental health law often gives power over service users to professionals. Larson suggests a set of AOP principles that can be used to help social workers integrate AOP theory and practice into the reality of mental health practice settings: a) inviting service users to be full participants in all aspects of mental health services; b) using language and discourse that is respectful, egalitarian and empowering; c) actively deconstructing the medical model with service users and their families, and encouraging alternative healing perspectives and strategies; d) establishing just working relationships; e) promoting education; f) embracing cultural diversity and strengths perspectives in practice; e) promoting principles of social justice.
AOP and Borderline Personality Disorder

Van Den Tillaart, Kurtz and Cash (2009) note that when health care professionals ignore the social, political, cultural and historical factors of an individual’s experience and employ a medical model only approach, the individual is further stigmatized and stereotyped. Examining the experiences of women with a mental health diagnosis, Van Den Tillaart et al. argue that this type of approach results in practitioners “othering” the service user, causing further stigmatization and marginalization. The experience of those diagnosed with BPD is a good example of this. Examining historical accounts of gender bias in psychiatric nosology, Ussher (2013), reports that the criteria for a DSM diagnosis of BPD tends to characterize feminine qualities but also include additional characteristics like inappropriate anger which is associated as being more masculine, conjuring labels of “dangerous” and “damaged” for those given the diagnosis. BPD is documented in the literature to evoke negative reactions for the mental health clinicians working with them. Liebman and Burnette (2013) note that common stereotypes are that this group of service users are believed to be manipulative, dangerous, and that their behaviour is a choice. Clinicians feel that they are not equipped to work with this group, have high burnout rates and report feelings of disdain, indifference and frustration towards this diagnosis more than other mental health diagnosis. They suggest it is a diagnosis that is more commonly given to women. Ussher (2013) notes that a diagnosis of BPD can often be used as justification to deny mental health services.

However, despite denial of services for some, research indicates that service users diagnosed with BPD have high rates of service use and health care costs, experience comorbid disorders, have difficulties in psychosocial functioning, and have a suicide rate of approximately 10% (Barber & Weinberg, 2010, p.264). Studies also show that for many people diagnosed with
BPD, they have a history of serious trauma and neglect starting in earlier childhood (Briere & Scott, 2015). This suggests that in order to improve the experience of both service use and service provision for individuals diagnosed with BPD, a different approach, like AOP, is needed. For example, using the AOP principles previously noted by Larson (2008), would help clinicians see beyond the usual labels and instead see many possible layers of oppression that people with BPD may have experienced both within and outside of the mental health system. Using AOP, we have the opportunity to unpack the medical model discourse of what BPD means and question the pathology of an experience that often begins very early in life with severe trauma and neglect. The principles of establishing egalitarian relationships, use of language and embracing cultural diversity and service users’ strengths are also applicable. Promoting principles of social justice may produce the biggest change through drawing attention to oppressive agencies practices, working alongside service users to advocate for change and better treatment and to address stigma in the mental health field around BPD.

Available literature strongly recommends that clinicians working with individuals diagnosed with BPD receive regular quality clinical supervision, even though this is not available for all clinicians in mental health (Liebman & Burnette, 2013; Cookson et al., 2014; Gardner et al, 2010). For this study, the type of support clinicians received from their peers either in the absence of or in addition to clinical supervision was explored, with principles of AOP framing the study questions.
Research Design and Methodology

An exploratory, qualitative research design was used to explore the question: What elements of professional peer support do clinicians working with clients diagnosed with Borderline Personality Disorder perceive as most meaningful and effective?

Recruitment

A sample of 5-8 participants was sought for this study. Fraser Health social workers currently working in community mental health centres who had experience working with clients diagnosed with Borderline Personality Disorder were recruited to participate. Inclusion criteria consisted of: participants were required to be social workers, must work in community mental health centres and have had experience working with individuals with BDP. Exclusion criteria included: not having experience working with individuals with BPD, mental health clinicians who were not social workers and social workers who did not work in community mental health settings.

Convenience and snowball sampling were used to seek out participants. Using convenience sampling, an email with the Letter of Informed consent (Appendices A and B) were sent out to seven potential participants were already known to the principal investigator. Four participants were confirmed through this method. A request was also sent to the Mental Health and Substance Use Practice Lead for Social Work (Appendix C) to send the invitation out to a larger audience, snowball sampling, in order to meet the identified sample number who in turn sent it out the larger group of mental health social workers. Four participants came forward using this method, however only two participated in the study due to inclusion and exclusion criteria.
Data Collection and Analysis

Data was collected using a semi-structured interview guide (Appendix D). Interviews were conducted at a location chosen by the participants. The interviews lasted between 23 and 65 minutes. Demographics were collected from participants including: role, years working mental health and level of education. Permission from participants was requested to use a recording device to audio record the interviews and notes were also taken during the interview. To support confidentiality, the interviews were transcribed by the principal investigator and any identifying information or details were removed during the transcription process. The data (audio recordings, notes) has been protected by storing in a locked cabinet. A thematic analysis was conducted to identify common themes from participant interviews.

Ethical Considerations

Research approval was received from the University of the Fraser Valley Human Ethics Research Board as well as the Fraser Health Human Ethics Research Board (Appendix E and F for certificates). The study was deemed to be minimal risk. Participants were provided with a Letter of Consent (Appendix A) prior to agreeing to participate. Confidentiality was maintained by using pseudonyms. The location of the mental health centre they work for was not disclosed so that participants could not be identified in any manner. Also, as some of the potential participants may have working relationships with the principal investigator, they were advised that they are under no requirement to participate and can opt out at any time in the initial invitation to participate. The principal investigator did not have a supervisory or authority role with any of the potential participants.
Findings

Demographic Summary

Six participants were identified for the study. Semi structured interviews were carried out with study participants between May 2015 and October 2015. All six participants that volunteered to be part of the study were female and had between six and thirty-two years’ experience, with an average of 13 years as a social worker. Two of the participants held a Masters of Social Work Degree and the remaining four held a Bachelor of Social Work Degree. All six participants were registered with the BC College of Social Workers. Participants were all employed as clinicians at community mental health centres within the Fraser Health Authority, with four FHA centres being represented. Study participants chose an “identity name” of their choice, as noted in the table (Table 1) below. Participant “identity names” will be used in the narrative reporting of the research findings.

Table 1: Pseudonyms: Study Participants

<table>
<thead>
<tr>
<th>Participants</th>
<th>Pseudonyms</th>
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<tbody>
<tr>
<td>P1</td>
<td>“Diane”</td>
</tr>
<tr>
<td>P2</td>
<td>“Betty”</td>
</tr>
<tr>
<td>P3</td>
<td>“May”</td>
</tr>
<tr>
<td>P4</td>
<td>“Louise”</td>
</tr>
<tr>
<td>P5</td>
<td>“Caitlyn”</td>
</tr>
<tr>
<td>P6</td>
<td>“Esther”</td>
</tr>
</tbody>
</table>

Themes

The following is a summary of the findings from the analysis of data collected from study participants. Four themes emerged from these data: experiences with clinical supervision, challenges with working with clients with BPD, clinician support needs, and BPD stigma.
Theme 1: Experiences with Clinical Supervision

All participants worked on interdisciplinary teams. Five of the six participants identified being supervised by a nurse while only one participant, Diane, received clinical supervision by a social worker. Three participants identified that clinical supervision was not scheduled regularly, but was available as needed. Diane reported receiving regular clinical supervision as well as additional support as needed from her supervisor, who she felt had extensive experience. For the participants who received supervision by a nurse, they reported some mixed perceptions on their supervision experience.

This mixed experience was related to both the difference in professional approaches as well as in the specific skills of the supervisor. For example, Betty stated that “supervision is as good as the supervisor,” noting later in the interview that she felt like she received “pat answers” from her supervisor. She did not feel supported by her supervisor and suggested that it was a case of burnout for the supervisor. Betty also felt that different professions have different approaches, noting that she has previously sought support from the Mental Health and Substance Use Services clinical practice lead for social work. May also suggested that it would be beneficial for social workers working in mental health to have access to clinical supervision with a social worker when dealing with a challenging situation:

It would be amazing, it’s a pipedream, if we had access to clinical supervision. It wouldn’t be a slam against your nurse supervisor at all. It would be as a professional social worker, I’m going to have half an hour on the phone to consult with a person who is clinically astute in this, more than me.
Some participants also noted that supervision is not always clinical in nature and often has more of an administrative approach. May reported that the supervision she receives is administrative, not clinical, and focuses on processes, reviewing caseload, and task oriented details. She noted that she had never been asked things like “How are you doing in your job? How’s it going in your role?” Louise also noted that supervision is more administrative in nature and noted that her team had been without a supervisor for six months. She thought that once a supervisor was in place it would return to being monthly. She will seek supervision when looking for something specific stating, “With my supervisor I would probably be looking for specific direction, not so much the emotional support.”

Comfort with supervisors versus colleagues when seeking support at work was also noted by three of the participants. These participants identified that in general they felt more comfortable seeking support from a colleague versus a supervisor. They cited reasons such as a lack of a power differential, not being judged on work performance or competence, being able to “let loose,” and be more genuine. However, two of the participants stated that generally they felt more comfortable seeking support from a colleague, but with their current supervisor they felt comfortable seeking support from their current supervisor. For example, Esther stated:

Not so much with my current supervisor right now because she’s very supportive but with some supervisors, I might worry more about if I admit to struggling with something. My competence might be questioned or that it might just be dictated to me what I have to do.

Theme 2: Challenges Working with Clients with BPD

All participants identified certain challenges that they can experience when working with clients with BPD. These challenges included a lack of relevant training, lack of effective services
for clients with BPD, as well as practice challenges from working with the behaviours or situations that clients with BPD may present with.

Four participants identified a lack of clinician knowledge and training to be able to support clients in their recovery, as well as a lack of available evidence based services, such as DBT. Esther identified that,

We don’t have the full service that people with this diagnosis need. You know what works for schizophrenia…it’s not necessarily what people with these complex emotional needs and impulsivity are needing or wanting…. They are complex needs and the services that we have don’t always match.

Louise suggested that the availability of clinicians with any specific BPD related training is limited, “No one has any real training on the most effective methods of working with BPD, the more evidenced based ones anyways. We all try to do our best to piece it together.” Betty and May each referred to clients that they have worked with in the past who had to seek DBT outside the health authority because their mental health centres did not have provide the specialized program.

May also made the connection between an increased need for support when there is a lack of resources (i.e. DBT), “As a clinician, if you don’t have the right resources for them, you actually need more support.” What was not clear from the information gathered from the participants is whether the lack of training and relevant programming for clients with BPD is related to limited funding for education and training for clinicians or whether it was that it was not considered a priority for MHSU services.
Participants identified challenges related to working with clients diagnosed with BPD based on the particular behaviours and situations that have been associated with the disorder. For example, issues related to risk and vulnerability including suicide risk and self-harm behaviours were noted by four of the six participants. The experience of clients frequently being in crisis and experiencing chaos in their lives was also talked about by most participants and how that can take up a lot of clinician time. For example, participants in the study identified that this frequent occurrence of crisis and chaos can often result in increased calls as well as requests for appointments and increased support. One participant, Caitlyn, noted “I almost feel like I don’t even get to a place where I can do a bit of therapy or skill building in a formal way until they are a bit more stable.” Caitlyn also noted that clients with BPD may engage with services “differently” than clients with other diagnoses, noting that clinician patience is needed:

I think with clients with that diagnosis, I want to be a little more patient with them. I kind of look at it as a little bit more of a long term service. They are going to engage differently at different times. I often feel like when I’m first engaging with them they are kind of testing me out.

Participants discussed the challenge of maintaining appropriate professional boundaries with clients with BPD. They identified professional boundary setting as an area for which they may seek support from colleagues or in clinical supervision – this aspect will be discussed further in a subsequent theme. Betty talked about feeling like being pulled in too much by clients with BPD, “Especially when they are going through a crisis time, they can become very dependent, be calling consistently and asking for things that I’m not always able to provide.” Diane noted an awareness for herself around maintaining boundaries, stating “I find it difficult to
set boundaries, but when I have it works.” Esther spoke about the challenge of re-establishing boundaries after loosening them:

A couple of times I’ve gotten myself into some muddy waters when I did relax my boundaries about how often I could see clients, way over and above, I got myself doing things outside of my role. Still what could see (*sic*) within a professional boundary from the way I saw it but maybe taking on the role of crisis worker, healthcare worker, just offering more services because the client gave good rationale why I couldn’t refer to those services or why they didn’t feel safe receiving those services…only realizing later that pulling back any services was triggering that sense of abandonment in the client.

Participants also noted that their work with clients with BPD can seem more complicated and less straightforward than work with clients who do not have a BPD diagnosis. Esther noted the work “feels less cut and dry.” She stated that “I think there’s a lot more capacity for self-blame and questioning. Something about the therapeutic relationship leaves me doubting myself and so I need additional validation and support.” Three participants expressed feeling like sometimes being tested by clients with BPD. Referring to work with clients with BPD who may be expressing suicidal ideation or self-harm behaviours, Diane identified struggling with trying to figure out what a client wanted, stating, “It doesn’t seem to be as straightforward. You always feel like you are being tested.” Caitlyn commented that “I often feel like when I’m first engaging with them they are kind of testing me out and kind of show me their worst and see what my reactions are to it.” May stated that she felt like clients with BPD know how to elicit emotions, “They seem to be able to pluck- they know your buttons they just learn them.”
Another challenge that participants spoke about were their personal reactions related to their work with clients with BPD. Louise stated, “Challenges are my own personal response to their behaviour and just trying to keep non-judgemental, to not insert my own personal beliefs into treatment.” Betty spoke about the challenge of maintaining balance for herself when working with clients with BPD as the work can be overwhelming. She felt that “it’s easier to get caught up in the drama they create, the crises…you just get pulled in.” For May she noted that “You’re sucked dry, you’ve been working with them, your other stuff doesn’t get done, you’re feeling overwhelmed…it’s just so many emotions.”

Helpful Practices

A sub-theme also emerged from the data identifying helpful practices that participants have noted in response to some of these challenges. One that was noted by half of the participants was around connecting clients with additional resources in the community. Diane noted that for clients with BPD they often do not have many other supports and,

When they come to you, you’re their everything. So then they try to use you in that way, and so the challenge is not to be used that way. So I try to often hook them up with other community support people, so I’m not the only support person.

A second helpful practice that was identified by four of the six participants was that talking with the client about the diagnosis was helpful as clients can experience a sense of relief when this occurs. Esther, who was the only clinician to have received training in DBT, noted that by taking the training she was able to talk to her clients in a language in which they felt understood and as a clinician provided her with an approach in which to see individuals with BPD in a more understanding way.
A third helpful practice recognized by five of the six participants was understanding the role of trauma and early experiences having an impact on clients with BPD. Diane and Esther both referred to negative experiences in early childhood for clients with BPD. Directly referring to trauma, Betty spoke of wanting look more deeply at the connection between Post Traumatic Stress Disorder (PTSD) and BPD:

If I could rewind my life about thirty years, I’d get the education to figure out if BPD really just stems from PTSD. I haven’t had the time or the chance to explore the research on that but it’s got to be very highly correlated. If that’s actually true we should have a lot more compassion.

May also highlighted the connection between trauma and BPD:

We are learning more and more about our client group…how much trauma has impacted people….My hope would be that people with BPD would be seen as trauma survivors instead of personality disordered persons….It’s just quite the label. It means your personality is all disordered, who wants that? But if you could say your trauma has affected your behaviour, it affects your responses, it affects your cognition, sometimes your feels are firing too much….If we could start talking about how the trauma has affected people.

Two participants also noted practices to address “in the moment pressures” with Betty noting that she would open her door when talking to a client to feel more grounded, and May noting a small reminder sheet that she would keep on her desk to help keep conversations focused and present oriented.
Theme 3: Clinician Support Needs

Participants were all able to identify their support preferences from colleagues and supervisors, regarding challenges working with clients with BPD. Study participants noted a number of ideal characteristics of peers from whom they seek support, including being: empathetic, non-judgmental, genuine, providing a safe place, caring, and maintaining confidentiality. The specific areas of support that were reported by participants in the study were around debriefing, maintaining boundaries, receiving candid feedback, professional skills support and preferences of professional background of peers when seeking support.

Debriefing

Participants talked about the need to be able to debrief or process situations with someone. Three of the participants noted a need for validation of their experience. For example, Esther noted that, “Something about the therapeutic relationship leaves me feeling – doubting myself – and so I need additional validation and support.” She also stated that there is a need for reassurance that not knowing what to do is not always a reflection of a lack of skills, and reminders from colleagues that the work is challenging because the clients’ needs are challenging. Another participant, Caitlyn, also noted that “Sometimes it’s just incredibly frustrating work with some of our clientele, and you just need to go talk about a frustrating situation and have somebody say, ‘yes that’s frustrating’.”

Maintaining Boundaries

Also commonly mentioned by all but one participant was the need for support around maintaining boundaries with clients. Betty noted that even now that she knows the job better, support with boundaries is still needed:
Sometimes a reality check that my boundaries are okay, I think that’s a really big one. Maybe before it was advice, when I didn’t know my job as well. Now that I know what I should do, it’s more needing to know that have, or haven’t I crossed the line emotionally to getting too wrapped up in it?

Esther noted receiving support from both peers and in clinical supervision to maintain boundaries. She also talked about her experiences with clients with BPD when boundaries became relaxed and she found herself fulfilling more roles and the difficulties that the client experienced when she tried to re-establish some of those boundaries. She highlighted the need for support in this area:

I’m looking for somebody whose gonna (sic) help support me to maintain those boundaries without being dismissive or judgemental of that compassionate stance…I want support to maintain the boundaries while still trying to come up with creative solutions and the best possible care for the client.

_Candid Feedback_

A majority of the participants identified that they want peer feedback that is honest, even if it is different from their own opinion, or their colleague has a different idea as to how a situation should be handled. Louise noted that “I don’t particularly go to people that will just nod, I want someone that’s going to be objective and challenge me.” Betty said she found it helpful to have her peers be honest in their feedback about their observations about her wellness, although for her this is something that she seeks for a group of social work friends outside of her workplace, “I have a group of social work friends that know me well. They know when I’m doing well and when I’m not.”
Professional Skills Support

While it was mentioned by all participants, support for treatment planning and decision making did not seem to be as at the forefront of support needs as those already mentioned. Support with decision making around issues of safety and risk were mentioned, but some participants noted that this may be something that they ultimately seek support for from their supervisors. Diane was one participant who noted that in certain situations she would seek advice from her supervisor first, “Life or death decisions then I would need to go my supervisor. If she’s not there, then I’d go to the next person whose opinion I value the most.” Another participant noted that if there were considerations to make around certifying someone under the Mental Health Act, which is something that she may ultimately go to the supervisor about.

Participants also highlighted that there is a need for support with finding focus and direction in their work with clients with BPD. One participant, Louise, stated that she was looking for perspective and objectivity to help with treatment planning because, “I find it easy to get derailed.” Another participant, May, noted the value of “Just being heard and then a little feedback, often keeping the main thing the main thing. What is your role with that person? Keeping it focused on that so I can honour them.” Caitlyn stated that in addition to having support with feedback on whether she is in the right direction, resource support is also important.

Self-Reflection

Acknowledging that their work can be challenging, participants were asked about opportunities for self-reflection when seeking support from their colleagues. Esther and Diane both felt like there is opportunity for self-reflection when seeking support from colleagues. Esther stated:
I think there is a tremendous opportunity for self-reflection. I’m blessed with coworkers who really take the time to listen and to support that self-reflective process and maybe don’t leave it for that one day, maybe even checking back a day or two later…. It’s part of that ongoing process to reflect. Well how did it go last time, what was it like, what was the outcome for the client, what was the impact on me personally… there’s a lot of opportunity for self-reflection and carrying that knowledge back to practice.

Alternately, Esther noted that with regard to self-reflection in clinical supervision it is more time limited and comes from a more pragmatic place. Louise stated that there is opportunity and stated, “I’ve sought out people where I know I will get, if they have a different opinion than mine, they will give it to me”. In contrast, Betty felt that opportunities for self-reflection was peer dependent and felt like the opportunity for self-reflection was lacking in clinical supervision as well.

Caitlyn felt that opportunities for self-reflection when seeking support from a peer was dependent on the peer and was also limited by time constraints stating,

Depends on the peer. We are very limited in our time. I think that the opportunity to self-reflect is quite limited. That’s not a part of my working day most days. Not that I don’t desire to do that but I don’t have the time to do that.

However, thinking about her growth and change over her career, she has become more self-reflective on her own stating:

I am a bit more self-reflective, I want to maybe think about things before I make action plans with people….I don’t do much of this in supervision, the stuff that I seek out from
my colleagues, I wouldn’t be discussing any of that. This feels more self-reflective. I don’t do that in supervision with my manager or with my colleagues.

When asked if they had ever been made aware of their own bias or negative attitudes towards clients with BPD through supervision, only one participant stated that she had. However, some participants noted that with time, experience and support they have made changes to their practice. Caitlyn noted that she become aware of some of her own biases towards BPD, not through supervision but from observing her peers,

I think I have learned some of my own biases about it from watching some of my coworkers… I find that some of my coworkers are very compassionate towards the diagnosis so I have learned about my own bias from hearing people frame it in a different way…where there’s hope for people to recover and build on their skills and gain some control back.

Participants reflected on issues that they have come to be aware of, such as too much focus on solving problems for clients, triggers for questioning their own practice, making an assessment too soon and over-functioning in their role. For example, Esther, who spoke often about the challenge of maintaining professional boundaries, has realized that maintaining boundaries is a way of showing care and compassion for clients. She stated that she identified her own codependency traits which have given her the ability to step back and respond in a manner that is more empowering to clients. Louise highlighted that she has “become more sensitive to people’s experiences and how they affect their current functioning,” and this has allowed her to respond in a way that clients know that “I have their best interest at heart.”
Profession Preferences

There were varied responses on whether participants preferred to seek support from a social worker. While most found the support of nursing colleagues and supervisors to be helpful, there was some feedback from participants that at times having the ability to consult or receive support from social workers was also preferred. Only two participants stated feeling that a colleague’s discipline mattered when seeking support from a peer. For example, two participants mentioned that they have established social work support outside of their primary work setting. May discussed that in addition to the support within her work setting, she started meeting with social workers who work at the same physical location in various program. Similarly, Betty talked about the support that she gets from a group of friends outside of work who are also social workers. Another participant, Caitlyn, stated that she would go to a social worker around systems navigation or ethical issues. She also noted that in relation to working with someone with BPD, she has a social worker colleague with DBT training but added there is also a nurse with the same training that she could also go to. She stated that:

I do naturally seek out social workers more because I feel they speak the same language. Their approaches are probably going to be a bit more in line with what I would feel comfortable doing in my day to day work.

Two participants noted that their primary source of support on their team was a nurse. These participants happened to work at the same site, but on different teams. Some participants noted that they may seek out certain co-workers or disciplines in certain circumstances. For example, if they had a medication questions some may be more likely to seek out a nurse. A few participants noted that they may be more likely to seek out social workers for support.
Alternately, years of experience played a role for Esther who noted that earlier in her career, she would have been more likely to seek out a social worker but now it is less a concern for her. Overall five of the six participants expressed feeling supported by their colleagues at work and having positive regard for their colleagues.

The role of the psychiatrist was also noted by half of the participants. For example, Diane noted that the psychiatrists that she works with were not always as supportive as the rest of the team, but that cooperation with client work was the value of working with a psychiatrist. Betty and Diane noted that they experienced psychiatrist reluctance to take on clients with BPD. With regard to working with psychiatrists, May noted that:

The psychiatrist you work with is key. If you have a psychiatrist that is tender hearted and sees it as a real important mental health issue for which recovery and skills need to be explored and worked on, you will have a really good team. But if you don’t, and you have “that’s just personality stuff,” you are in a very different place as a case manager.

Theme 4: BPD Stigma

Stigma around the diagnosis of BPD within the mental health setting is also a common theme among participants, affecting participants in their daily practice as well as how their clients experience service within this setting. Issues relating to stigma included how referrals for service are handled, labels that this population receives, discrimination related to this diagnosis versus other mental health diagnosis, discrimination within the acute care setting and feelings about disclosing a client’s BPD diagnosis when seeking support are discussed in this theme.

Participants shared labels and attitudes toward people with BPD that they have encountered. Two participants made reference to people being referred to as a “flaming PD”
(personality disorder), “Attention seeking,” “cutter” (referring to self-harm behaviours), and “frequent flyer” (referring to frequent use of services) were also labels referenced by participants. Dismissive or negative attitudes, as well as jokes and black humour were also identified as issues related to stigma and a diagnosis of BPD. One participant noted that this can even start from when a client presents to reception, “even from reception, they’ll say ‘this person’s a personality disorder.’ Then there’s this expectation that, oh I’m going to see these types of behaviour then.”

Many participants noted discrimination for someone with a BPD diagnosis compared to other clinical disorders and how service providers can feel like those with BPD should not receive services, or there is less compassion for these clients. Some participants also noted that individuals may receive a BPD diagnosis prematurely, or that it is used to describe anyone with challenging behaviours. Caitlyn noted that sometimes people can blame those with BPD for their behaviour, seeing it as a moral failing instead of framing it as an illness:

I think that there is a lot of blame, that people kind of see it as a moral failing because people are so frequently in crisis. I think that they are seen as attention getting or kind of using these tactics for other purposes. I don’t know if it’s always framed as an illness. I don’t know that there is always a lot of compassion for it.

Similar experiences were echoed by Louise having encountered black humour and negativity directed at BPD as well as sentiments like "it serves them right", or “they’ve burned their bridges,” and “this is what they deserve.” Another challenge noted was that other mental health related issues could be ignored when there is a diagnosis of BPD. Reluctance to provide services was noted as an issue related to stigma in community mental health. Diane commented
about team meetings where new clients are assigned to staff, saying “I’d like to say it doesn’t happen, but on some level it does, that people tend to shy away from the referrals that have personality disorder components.” Betty reported also having the experience of coworkers and psychiatrists declining to work with certain clients. Esther noted the eye rolling and dismissive comments that she had observed when certain clients with BPD were brought up or presented for service. May suggested that the debate amongst team members, social workers and nurses, still exists around how individuals with personality disorders should be treated in community mental health.

Stigma in acute care settings was also discussed by five participants. Esther noted the relationship between BPD stigma and the defensive stance that acute care staff may take with this population may actually trigger the individual, which escalates their behaviour and makes it even harder to access services. She also felt that the mental health system is trying to fit those with BPD into a service model that doesn’t fully meet their treatment needs. Louise also recognized issues within the acute system:

Certainly within the acute systems, there’s a lot of stigma. A lot of disregard of the depression and anxiety, the comorbidities. Just completely writing them off because of the emotional instability. There can be a lot of disregard of their experience and their emotion. Not receiving the appropriate medical care, that’s the big one that I see. Having a negative experience with the nurses, social workers and physicians within acute care.

Participants had also had varied but similar responses to whether they feel it is necessary to disclose a person’s diagnosis when seeking support from a colleague. For example, Esther stated, “Yes and no. No, because I don’t like to label my clients, and it can influence perhaps the
advice that someone gives.” But she also noted that there may be some value on identifying the diagnosis as a short cut for explaining the risks or needs for support that may come with working with a client with BPD. The rest of the participants all felt that they did not feel it necessary to disclose the diagnosis, and did not do so. However, all noted that disclosing the diagnosis could potentially impact the support or advice that they received because of the stigma related to the diagnosis. However, a few participants shared the above perception in general, felt that specific to their current team, stating a diagnosis of BPD would not impact the support or advice they received.

**Limitations to the Study**

The small size of the sample is a limitation of this study. There are a number of issues associated with this: a lack of gender and cultural diversity in the sample, exclusion of input and experiences from other professions working in mental health and participation was limited to one health authority. Related to this were possible limitations around participants being willing to come forward and be part of this study, which may be suggestive that they have a particular bias or interest in this topic. Therefore, generalizations cannot be made about the findings to the larger mental health setting. Another consideration that should be made is that based on this design, it is left to the participants to confirm that the individuals with whom that are working with meet the criteria for having a diagnosis of BPD and therefore it cannot be confirmed that the clients and experiences that they referenced were in fact based on a BPD diagnosis.

As noted in the literature, definitions of clinical supervision can vary. The study findings could have been strengthened by exploring what each participant defined as clinical supervision. From a theoretical framework perspective, the study could have been further strengthened by exploring further exploring participant perceptions on how AOP principles could be integrated
into their practice. For example, examining the role that the medical model, gender, power imbalances and cultural diversity factor into each relationship; clinician/client, supervisor/supervisee, and peer/peer.

Finally, although all participants expressed empathy and positive regard for individuals with BPD, this writer also recognizes the potential stigmatizing impact of using a diagnostic category on a service user group who is already stigmatized by this diagnosis. In keeping with the AOP theoretical framework, it would be ideal in future research to include those with a diagnosis of BPD to be included in the formation of the research design and as participants in their experiences.

**Discussion**

This qualitative study endeavored to understand what clinicians find to be effective and meaningful support in the absence of, in addition to, or specific to clinical supervision when working with clients diagnosed with BPD. The provision of clinical supervision has been highlighted as an evidence based practice for service provision for clients with BPD, and as being helpful to improve attitudes and practice for clinicians who work with clients with BPD (Barber & Weinberg, 2010; O’Connell & Dowling, 2013). However, as noted in the literature and by participants of this study, the provision of clinical supervision in a mental health setting can be limited (Cookson et al., 2014; Bogo et al., 2011b). Themes arising from this study included: experiences with clinical supervision; challenges working with clients with BPD; clinician support needs and BPD stigma.

Anti-Oppressive Practice, as a theoretical framework for this paper, provided for further examination of how the current practices and structures of the mental health setting impact individuals with a BPD diagnosis. Participants spoke about the systems challenges that occur
including stigma, negative attitudes and labels, as well as a lack of resources for individuals with BPD. It was reported that clients with BPD could be viewed as attention seeking, blamed for their behaviour and denied or viewed as not as deserving of services as clients with different mental health diagnoses. Participants also highlighted the connection between early life experiences and trauma with those diagnosed with BPD. Framing this research from an AOP perspective highlighted that, despite more emphasis on recovery oriented approaches in the mental health system, the medical model continues to be the dominate influence in policies and practices, failing to address the role of trauma and oppression in the experiences of those diagnosed with BPD.

Although discussions with participants did not specify how to address these issues directly, participants did suggest that quality clinical supervision as well as peer support can be helpful in their work with clients with BPD. The study would have been strengthened by examining if and how participants integrate AOP into their work. For example, a conversation with participants as to how they could work alongside their clients with BPD to challenge both the negative labels as well as the diagnostic labels that are given to them, and how to address some of the issues that they experience when faced with negative attitudes and stigma would have captured a fuller picture of AOP principles and practices that are used, or not used by social workers working in mental health.

There were consistencies noted between the information found from past research and this study. While the overall sense was that participants tended to hold positive regard and empathy for their clients, they did express some areas of difficulty in their practice including working with clients who are frequently in crisis, demonstrate high risk behaviours and high needs as well as the internal struggles that they as clinicians may experience when working this
population. These findings are supported by the previous works of Rizq (2012) and Bowen (2013) which both noted participants who expressed various feelings towards clients with BPD, including empathy, optimism and a sense of responsibility, while acknowledging the difficulties that can arise from working with this clientele.

In previous research, clinical supervision is both recommended for clinicians working with BPD and highlighted as lacking in availability for clinicians. Study participants’ experiences with supervision share commonalities with the reviewed literature: clinicians are often supervised by someone from another discipline and often the supervision that is provided is not clinical. As with the previous research findings, there were mixed perceptions around whether the profession of a colleague, in this case social work, matters when seeking support and supervision. For example, Bogo et al. (2011a) concluded that there are supervisor qualities that are seen as beneficial regardless of the supervisors’ professional background. Similarly, the findings from this study suggest that participants’ mixed perceptions were not limited to profession alone but also of the skill level or approach of the supervisor. Participants also expressed mixed feelings on whether the profession of a colleague mattered when seeking peer support. The findings of this study appear to be consistent with Golia and McGovern’s (2013) findings that discussed the value of peer supervision in supporting clinicians to deal with difficult situations, availability of support in times of stress and accessing support in a less intimidating environment.

It is hoped that this study will add to the current knowledge in the area of clinical and peer supervision around what clinicians identify to be helpful support from their colleagues when working with clients with BPD, either in addition to or in the absence of clinical supervision. There is a need to address issues related to the medical model discourse of mental health services
and the stigma that clients with BPD experience. Clinical supervision and peer support for clinicians is only one aspect that needs to be addressed in order to alleviate the impact of a medical model perspective and BPD stigma, implications for practice, policy and research will be discussed further the in the next section.

**Implications for Policy, Practice and Research**

The findings of this study are consistent with some of the findings of previous research that examines issues that clinicians who work with individuals diagnosed with Borderline Personality Disorder may experience. The following section will highlight future implications for social work policy, practice and research.

This research highlighted the need for increased clinician education about BPD as well as evidence based practices that are readily available for clients with BPD. It is hoped that this would reduce the oppressive factors that individuals diagnosed BPD experience within acute and community mental health services that encompass a medical model perspective. Increased education and training in areas such as DBT and trauma informed practice could be beneficial and help alleviate clinicians’ experiences related to feelings of inadequacy in their work with clients with BPD. Further, this may provide clinicians with a better understanding of their clients’ experience, beyond the diagnostic label put upon them.

The findings from this study suggests that as social workers we should question how we can demonstrate leadership in mental health services. It also suggests the need to promote principles of AOP in practice to improve mental health services for individuals with a diagnosis of BPD. To achieve this, there is a strong implication, based on these findings and existing literature that clinicians need to be supported through clinical supervision and peer support to
address not only the challenges that arise from working with clients with BPD but also the challenges of providing service within a medical model system. For example, it was pointed out by one study participant and by Aviram et al. (2006) that the behaviour of clinicians can be influenced by negative attitudes towards BPD, which in turn can exacerbate the symptoms of BPD, reinforcing the negative beliefs and stigma related to the disorder. Therefore, there is an implication that service providers must take responsibility for the role that their own behaviours play in this issue. Access to increased clinical supervision, peer support and education can help to examine these issues and strengthen the skills and knowledge base of clinicians.

For social workers who may have been educated from an AOP perspective but are working in a setting that does not operate with AOP values and beliefs, there is an implication for a need to provide opportunities to engage in discussion and reflection that views these issues through the AOP lens. This is recommended by Hair (2015) who suggests that clinical supervision should include a focus on anti-oppressive practice in order to promote social justice and change. As already noted, Hair stated that clinical supervision should be a venue for focus on self-reflection and addressing ethical issues as well as for getting support to advocating for clients and challenging unjust policies. This seems especially relevant for clinicians working with individuals diagnosed with BPD in order to dig deeper into the complex dynamics of this work including: the implications of working in a medical model focused system, stigma and oppression experienced by individuals in and out of the system, power imbalances in the therapeutic relationship and the potential reactions experienced by clinicians when working with their clients. In addition to AOP focused clinical supervision, we should also consider the role that AOP informed peer support can play in supporting social workers to examine these issues.
Although much of the literature has indicated that clinical supervision can create a positive outcome for clients as well as being an important activity for professionals and quality assurance, there is some criticism that there is a lack of research to support that (Schofield and Grant, 2013). This study suggests that social workers working in community mental health would benefit from opportunities to seek and receive support that can assist them in their practice with clients with BPD. Further research is needed to examine if these findings can be generalized to the larger population of mental health clinicians and if they translate into better treatment outcomes for clients. Future research should also examine whether there is a clinical supervision model or common factors of existing models that works best for supporting clinicians who work with individuals diagnosed with BPD.

The identified lack of clinical supervision and list of barriers to receiving quality supervision, combined with the findings around what study participants find to be effective and meaningful support from their peers, suggests a need to examine how to build capacity for peer support and supervision in community mental health settings. While clinical supervision should not be replaced by peer support, there is also an implication from this study that more research is needed to develop an improved and integrated approach between clinical supervision and peer support. Recommendations for this include further support and education to strengthen clinician skills in the area of peer supervision, as well as efforts by mental health administrators to provide formal peer supervision opportunities (i.e. regularly scheduled peer supervision meetings, practice councils) in addition to the more informal peer support that study participants discussed.

There is a distinct gap in the literature around how AOP can support clinicians, and influence clinical supervision models when working with clients with BPD. Future research should examine how AOP focused supervision can support clinicians to examine the role that the
medical model’s discriminatory approaches as well as how our own privileges and social location impact clinical practice and the treatment of individuals diagnosed with BPD.

This research, coupled with past research, has important implications for policy changes for improving access to effective treatment for individuals with BPD. For example, there is a need for clarification of eligibility for services and referral process for service providers. This is important so that eligibility for services is inclusive of all needs and are not left for interpretation which diagnoses qualify for services. This may include clinical practice guidelines for community and acute treatment. Individuals with a lived experience of BPD should be involved in these discussions in. As suggested by Larson (2008) in his discussion of anti-oppressive practice in mental health, service users should be involved in all levels of mental health services, including policy and program evaluation.

Larson (2008) also emphasized the use of language and discourse that is respectful, egalitarian and empowering, deconstructing the medical model with service users and their families, and the promotion of social justice principles. In consideration of the findings from this study and existing literature that speaks to the negative attitudes and stigma related to BPD there is an implication that included in a review of current mental health policy and procedures, attention should be given to the development of a standards of practice and clients’ rights policy the better addresses these issues and holds service providers accountable to providing socially just treatment.

Conclusion

Following previous research that highlighted the negative attitudes and perceptions that mental health clinicians may hold towards individuals diagnosed with Borderline Personality
Disorder, as well as the lack of available clinical supervision that has been recommended to address this issue, this qualitative study endeavoured to understand what clinicians find effective and meaningful support in the absence of, in addition to, or specific to clinical supervision when working with clients diagnosed with BPD. Themes identified from this study included: experiences with clinical supervision, challenges working with clients with BPD, clinician support needs and BPD stigma. The findings from this study were consistent with previous research and may also add to the knowledge on how peer support can complement clinical supervision. These findings also suggest implications for social work research, policy and practice that, when integrated with an AOP approach, can work towards improving the challenges within the mental health system that impact service provision for people diagnosed with BPD. This includes providing available, effective clinical supervision and peer support that addresses the issues created by a medical model focus and stigma related to BPD. Future research should include exploration of best practices for clinical supervision and peer support to empower social workers to better examine practice issues and strive towards socially just treatment for individuals diagnosed with BPD.
References


What is Helpful?
Determining Effective and Meaningful Support for Social Workers
Who work with People with Borderline Personality Disorder
Letter of Informed Consent

Hello. My name is Kristy Kardos and I am student of the Masters of Social Work program at UFV. As part of my studies I am doing a research study that I would like to invite you to participate in. The ethics of this research study has been reviewed and approved by the UFV and Fraser Health Research Ethics Boards. Your participation is entirely voluntary, so it is up to you to decide whether or not to take part in this study. Before you decide, it is important for you to understand what the research involves. This consent form will tell you about the study, why the research is being done, what will happen to you during the study and the possible benefits, risks and discomforts.

If you wish to participate, you will be asked to sign this form. If you do decide to take part in this study, you are still free to withdraw at any time and without giving any reasons for your decision. If you do not wish to participate, you do not have to provide any reason for your decision not to participate. Please take time to read the following information carefully before you decide.

Purpose/Objectives of the Study
Previous research suggests that for some mental health clinicians report some struggles when working with individuals diagnosed with Borderline Personality Disorder. For my study I would like to examine the role of clinical supervision and support for coworkers to find out what social workers working in the mental health field find to be helpful when working with this population.

Procedures involved in the Research
You are invited to participate in a onetime 45-60 minute interview to give your thoughts and experience in this area. The interview location will be at your convenience. You will be asked a list of questions related to what your experiences have been (i.e. what has been helpful, what type of support are you looking for when seeking support). If you are willing, I would like to audio record the interview and will also take notes. All of the information that you provide will be kept securely. Your personal information will be kept confidential and I will not use your real name in my study write-up.

Version 2, 2015 April 28 1 of 4 FHREB Approved 2015 05 11
Who Can Participate
Inclusion Criteria:
1. Participants must be social workers
2. Participants must be working in community mental health centres
3. Participants must have had experience working with individuals with Borderline Personality Disorder

Exclusion Criteria:
1. No experience working with individuals with Borderline Personality Disorder
2. Mental Health clinicians who are not social workers
3. Social workers who do not work in community mental health

Potential Harms, Risks or Discomforts to Participants
While there are no foreseeable risks associated with this study, you are free to withdraw from the study at any time.

Potential Benefits
There are no anticipated direct benefits to study participants. However, it is hoped the information gathered from this study will contribute to the existing knowledge around what effective and meaningful support is for social workers working in the identified area to benefit clinicians as well as service users.

Confidentiality
Your confidentiality will be respected. However, research records and health or other source records identifying you may be inspected in the presence of the Investigator or his or her designate by representatives of and UFV Research Ethics Board for the purpose of monitoring the research. No information or records that disclose your identity will be published without your consent, nor will any information or records that disclose your identity be removed or released without your consent unless required by law.

You will be assigned a unique pseudonym as a subject in this study. As all participants will be from community mental health centres, each will be given a number to protect your identity (i.e. Mental Health Centre #1, #2, etc). Only this will be used on any research-related information collected about you during the course of this study, so that your identity [i.e. your name or any other information that could identify you] as a subject in this study will be kept confidential. Information that contains your identity will remain only with the Principal Investigator and/or designate. The list that matches your name to the pseudonym that is used on your research-related information will not be removed or released without your consent unless required by law.

Your rights to privacy are legally protected by federal and provincial laws that require safeguards to insure that your privacy is respected. Further details about these laws are available on request.
Data collected from your interview will be kept securely in a locked filing cabinet. Electronic documents will be password protected and stored on a USB that will also be locked in the filing cabinet. Audio recordings will not include your identifying information. Information collected from the study will be destroyed five years after the study in May 2021.

**Participation**
Participation in this study is voluntary and you may withdraw at any time. You can choose to not answer any questions that make you uncomfortable. If you choose to withdraw from the study, you may request that your data be destroyed.

**Study Results**
The information collected from this study may be published at a later date, as part of my MSW major paper, in academic publications, and presented at community or academic meetings. A copy of the report will be available in the UFV library.

**Questions**
If you have any questions about the study, please contact the principal investigator, Kristy Kardos (kristy.kardos@student.ufv.ca or 604-316-2436). If you have any concerns about this research study, please contact Adrienne Chan, UFV Associate Vice President of Research, Engagement, and Graduate Studies, at 604-557-4074 or Adrienne.chan@ufv.ca. Alternately, if you have any concerns or complaints about your rights as a research subject and/or your experiences while participating in this study, contact the FHREB co-Chairs by calling 604-587-4681. You may discuss these rights with one of the co-chairmen of the Fraser Health REB. The ethics of this research project have been reviewed and approved by the UFV and Fraser Health Human Research Ethics Board.
**Consent Form**

By signing below, I agree to participate in this study, titled “What is Helpful? Determining Effective and Meaningful Support for Social Workers Who work with People with Borderline Personality Disorder”

- I have read the information presented in the letter of informed consent being conducted by Kristy Kardos, MSW Program at the University of the Fraser Valley.

- I have had the opportunity to ask questions about my involvement in this study and to receive any additional details.

- I understand that I have the right to withdraw from the study at any time and that confidentiality and/or anonymity of all results will be preserved.

- I understand that I am not waiving any of my legal rights as a result of signing this consent form.

  - [ ] I consent to audio recording during the study interview
  - [ ] I do not consent to audio recording during the study interview

Name (please print) ________________________________________________________________

Signature _________________________________________________________________________

Date ______________________________________________________________________________

Kristy Kardos, Principal Investigator ________________________________________________

Date ______________________________________________________________________________

Once signed, you will receive a copy of this consent form.
Appendix B

Email Recruitment Script (Convenience Sampling)

Hello,

I am a student enrolled in the Master of Social Work program at the University of the Fraser Valley. As part of my studies I am completing a research study on what social workers consider to be effective and meaningful support when seeking clinical supervision or support from peers when working with individuals diagnosed with Borderline Personality Disorder. As a social worker working in mental health, I would like to invite you to be a part of this research. All that would be required of you is to participate in a confidential 45-60 minute interview to get your thoughts on the subject. I have attached a more detailed letter outlining the study, what you can expect from the study, confidentiality, etc. The ethics of this research study has been reviewed and approved by the Fraser Health and UFV Research Ethics Boards.

If you are willing to participate in this study please respond to me as soon as possible. You are under no obligation to participate. I may check back with you in two weeks if I have not heard from you. Also, if you are aware of any other social workers who may be interested in participating, please feel free to pass this information on to them.

Thank you for your time and consideration,

Kristy Kardos
Appendix C

Email Recruitment Script (Snowball Sampling)

Hello everyone, Please see request for participants in a very important research project about SW support with. If you are interested you may contact Kristy.Kardos@fraserhealth.ca

Thank you.

Ivy Williams  BSW. MSW .RSW
Clinical Leader, MH&SU Social Work
Fraser Health Authority
Site: Surrey Memorial Hospital
RM  B15 TimberCreek, bldg
Tel. 604- 396-2610  ivy.williams@fraserhealth.ca

From: Kristy Kardos [mailto:Kristy.Kardos@student.ufv.ca]
Sent: Thursday, August 20, 2015 8:27 AM
To: Williams, Ivy
Subject: Fwd: Invitation to Participate in MSW Research Project on Borderline Personality Disorder

Hi Ivy,

I am looking for a few more participants to help me complete my MSW research project. If you can think of any social workers working in community mental health who might be interested and willing to participate, would you mind forwarding this to them?

If you have any questions let me know. The Information on the study is attached.

Thanks,

Kristy Kardos
Appendix D

INTERVIEW QUESTIONS

1. Do you currently receive regular clinical supervision? (Details, profession, scheduled…)

2. Do you seek out support from coworkers in the absence of readily available clinical supervision?

3. Tell me about issues or challenges that may come up when working with a client with BPD for which you may seek support? Does this support look different?

4. When seeking support, is it necessary to identify the person’s diagnosis? Do you think that impacts the support/advice?

5. What type of support are you looking for?

6. What kind of opportunity is there for self-reflection when seeking support from a peer?

7. When it comes to seeking support from a peer, does their discipline matter?

8. Have you ever experienced a colleague’s attitude or language toward a client diagnosed with BPD to have an impact your own attitudes or actions?

9. How can peer support differ from seeking support from your supervisor?

10. Overall, what do you see as ideal characteristics in a peer when seeking support?

11. Have you ever had any unique experiences when receiving supervision, specific to BPD?

12. Have you ever been made aware of your own bias or assumptions towards BPD through supervision?

13. How do you see people with BPD experiencing stigma/oppression in ways that other people with other diagnoses don’t?

14. How has this affected how you give or receive support to coworkers?

15. Reflecting on your own practice, what have you grown/changed/learned about yourself or others? How do you integrate this into supervision?
# Certificate of Human Research Ethics Board Approval

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<thead>
<tr>
<th>Certification:</th>
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<td>The protocol describing the above-named project has been reviewed by the UFV Human Research Ethics Board, and the procedures were found to be in compliance with accepted guidelines for ethical research.</td>
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Andrea Hughes, Chair, Human Research Ethics Board

*NOTE: This Certificate of Approval is valid for the above noted term provided there is no change in the procedures or criteria given.

If the project will go beyond the approval term noted above, an extension of approval must be requested.*
LETTER OF AUTHORIZATION TO CONDUCT RESEARCH

Date: 2015 May 11  
Address: 32900 Marshall Rd  
City/Province: Abbotsford, BC  
Postal Code: V2S 0C2  
FHREB File #: FHREB 2015-039  
Study Protocol #: Version 2, 2015 April 28

Study Title: What is helpful? Determining what is effective and meaningful support for social workers who work with people with borderline personality disorder.

The following required applicable approvals have been received and are in order:

- FHREB Certificate of Initial Approval  
  Date: 2015 May 11  
  Consent Required and approved Version 2, 2015 April 28
- Consent not required
- Reason: Implied Consent for survey  
  The signed signature page of the consent form for a specific study must be submitted to Health Records/Health and Business Analytics for the release of any of that participant’s personal information.
- Consent Waived

- Department Agreement for Providing Research-related Services Authorization Services (DAR Form)  
- Not Applicable
- Health Canada Letter of No Objection  
  Not Applicable
- Privacy Impact Assessment (PIA)  
  N2 Privacy and Confidentiality SOP template attached. Please ensure this SOP is used to maintain confidentiality of data.
- Not Applicable

- Health Canada Letter of No Objection  
  TRAINING:  
  Note: N2 CITI courses available at www.citiprogram.org for all FH researchers. Indicate affiliation as Fraser Health.
- Not Applicable
- Clinical Trial Registration No.  
  Registered at:  
  www.ClinicalTrials.gov
  www.ClinicalTrials.gov
- Not Applicable

Funding: Cost-Centre Not Required  
- Cost-Centre Required: Budget: $  
- Unfunded
- Industry: REB fee received
- Grant-in-aid
- Grant awarded to non-Fraser Health Institution

Agreements:

- Executed Clinical Trial Agreement for Industry Sponsored Trials
- Affiliated Researchers: Executed “Research Collaboration Agreement” dated:
- Research Grant Contribution Agreement dated:
- Name of Granting Agency:

This letter authorizes the principal investigator to begin research-related procedures in compliance with all FH Research-related and privacy policies.

Please note that FH Research Policy prohibits over-spending on research grants by the principal investigator.

Authorized by:
Susan Chunick  
Director, FH Department of Evaluation and Research Services

Fraser Health Authority  
Evaluation and Research Services  
400 – 13450 102nd Avenue  
Surrey, BC V3T 0H1  
Tel (604) 597-4436  
Fax (604) 930-3425