An exploration of support workers' views on working in a community mental health, supported-living service: An Interpretative Phenomenological Analysis.

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ABSTRACT

Over the last three decades, evidence of mental health professionals' negative views towards the diagnosis of borderline personality disorder has been well documented within the literature. However, research on the social care profession is limited, therefore, this study explored the views of support workers who work with service users with this diagnosis. Five semi-structured interviews were conducted, and an Interpretative Phenomenological Analysis was used to analyse the data. Three Superordinate themes emerged from the analysis: *Support Worker as 'Mother'; Service User as 'Other'; and 'Sad beneath the Bad'.* Findings illustrate that working with service users with this diagnosis in a social care context and setting is both rewarding and challenging. Support workers report positive perceptions and experiences towards service users; contrary to the nursing literature. Where negative perceptions were expressed, efforts were made to understand the situation holistically. Implications and future research directions are discussed.

KEY WORDS:	SUPPORT WORKER	BORDERLINE PERSONALITY DISORDER	INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS	STAFF EXPERIENCE	STAFF PERCEPTON

Introduction

Borderline Personality Disorder (BPD) is characterized by a severe instability in interpersonal relationships, self-image and affect regulation, and impulsive behaviours with a tendency to engage in self-injurious activities and suicidality (APA, 2013:646). Over the last three decades, evidence of mental health professionals' negative views towards patients with the diagnosis of BPD has been well documented within the literature; most noticeably amongst nurses (Loader, 2017). However, limited research exists exploring the social care profession, specifically individuals employed as Support Workers (SW). In contemporary healthcare, SWs (and other occupations belonging to this workforce) are heavily relied upon as frontline workers across the health and social care sector, for individuals with long and enduring mental health difficulties, who require care and support in a variety of contexts and settings (McCrae et al., 2008).

Background

The Support Worker

The SW profession belongs to the adult social care workforce which is estimated at approximately 1.58 million members and deployed throughout the health and social care sector and are widely utilized within the mental health sector (Skills for Care, 2017). Notably, reforms in mental health provision saw a shift from asylum-based care provided by nurses, towards a community-based, 'case management system' and the integration of SWs (McCrae et al., 2008). Similarly, the recruitment of SWs for specialist, inpatient services, for individuals with acute manifestations of mental distress has also increased (McKenna et al., 2007).

Additionally, it is well documented that this workforce is largely unqualified, Skills for Care (2017) estimated that members without professional accreditation is approximately 50%. However, measures were introduced to upskill the workforce with 'basic care skills' through the Care Quality Commissions' care certificate, however, approximately 72% of the non-qualified workforce have failed to engage with it (Skills for Care, 2017).

The literature surrounding the term 'Support Worker' is both limited and ambiguous, this is perhaps a reflection of the many services where SWs are recruited (Nancarrow et al., 2005). However, Manthrope et al (2010) at Kings College London provided a working definition for a SWs role and purpose,

> *"A person who is employed on an individual basis to foster independence and provide assistance for a service user in areas of ordinary life such as communication, employment, social participation and who may take on secondary tasks in respect of advocacy, personal care and learning."* (Manthrope et al., 2010:7).

Manthrope et al's (2010) definition illustrates two key aspects of a SWs role and purpose, that is, to provide both 'practical' and 'emotional' support for vulnerable

individuals within society. Further, McCrae et al (2008) suggested that SWs provide the aspects of care that is most important to the individual. A number of papers, for example Manthrope et al (2010) and Crawford et al (2007) have reported that service users (SU) highly value this form of help. A multi-method review of a community-based Personality Disorder (PD) service by Crawford et al (2007) found that staff felt personal qualities were more important than qualifications, therefore, suggested employing individuals from a non-mental health background would reduce the likelihood of preconceptions around the diagnosis and be more effective for working with individuals with this diagnosis (Crawford et al., 2007). Similarly, SUs relayed that non-clinical staff were less judgmental and more holistic with their views on the person thus, focused less on the diagnosis which enabled a trusting relationship to be formed (Crawford et al., 2007). Importantly, these findings indicate a potential value for SUs in their relationships with SWs.

Borderline Personality Disorder and Professionals

Since its inception, the BPD diagnosis remains a contentious, controversial and highly stigmatized psychiatric phenomenon in contemporary healthcare (Furnham & Kolzeer, 2015; Horn et al., 2007). BPD is associated with an instability in interpersonal relationships, self-image and affect regulation, and impulsive behaviours with a tendency to engage in self-injurious activities and suicidality (APA, 2013:646; Bateman & Fonagy, 2010) with approximately 8-10% of individuals successfully completing suicide (Paris & Zweig-Frank, 2001).

BPD is overrepresented within Community Mental Health Teams outreach services and caseloads (Hill et al., 2016). Further, epidemiology studies have estimated the prevalence of BPD symptomology within 1-2% of the community (ten Have et al., 2016; Torgensen et al., 2001). However, there is uncertainty around the aeitology of BPD, it is broadly described as an interaction between biological and psychosocial factors (Leichsenring et al., 2011). Moreover, one way of understanding BPD comes from the major developments of pychodynamically informed psychiatrists Anthony Bateman and Peter Fonagy, who have driven the developmental model of BPD (Fonagy & Bateman, 2004). This theoretical perspective is underpinned by the attachment theory, and subsequent, attachment styles (Ainsworth & Bell, 1970). This approach suggests that childhood psychological trauma can shape ones' internal working model and, therefore, disrupts healthy development (Bateman & Fonagy, 2010).

Specifically, disorganized and insecure attachments have been associated with BPD (Bateman & Fonagy, 2010). Moreover, If the child's primary caregiver does not provide a secure base, this can disrupt childhood and adulthood mentalization capabilities (Fonagy & Adshead, 2012). The inability to understand, both implicitly and explicitly the mental states of oneself and others can be characterised by emotional dysregulation and interpersonal difficulties associated with BPD (Bateman et al., 2017).

BPD was first introduced as a psychiatric classification in 1980; shortly after, research began to emerge concerning professional's negative views towards patients with this diagnosis. Over the last three decades, similar findings have

been documented within the literature, across a number of mental health professions; most noticeably amongst nurses (Loader, 2017). Evidence suggest that BPD is often rejected by mental health professionals as a 'true' mental illness (Woolaston & Hixenbaugh, 2008), therefore, patients are demedicalized and assigned to a 'difficult patient' status rather than the conventional 'sick role' (Sulzer, 2015). Consequently, BPD symptomology is perceived as negative behaviours instead of psychopathology or a genuine psychiatric presentation (Loader, 2017). consequently, episodes of self-injury, suicidality and aggression are considered within the patients control (Lewis & Appleby, 1998).

Earlier research by, Lewis and Appleby (1988) found psychiatrists viewed BPD patients as 'less deserving of care' and were described as 'attention-seeking', 'annoying' and as having 'greater control' over their distress. Similarly, contemporary quantitative investigations report psychiatrists rated higher on negative attitudes, lower on empathy (Bodner et al., 2015a); and higher on antagonistic judgments towards BPD patients (Bodner et al., 2011) with one study finding a preference toward patients with depression (Chartonas et al., 2016). Moreover, research by Bodner et al (2015b) found a strong association between the psychiatrist's negative attitudes and a fear of suicide amongst patients, this could perhaps explain why Black et al (2011) found that psychiatrists prefer to avoid BPD patients (Black et al., 2011). Equally, other professions have demonstrated negative perceptions toward their patients such as: psychotherapists (Bourke & Grenyer, 2013) and Clinical Psychologists (Millar et al., 2012)

However, the largest number of empirical studies have been conducted on the nursing profession (Sansone & Sansone, 2013). The research supports claims that nurses make greater negative attributions towards patients with BPD (Loader, 2017), describing them as 'bad' (Ross & Goldner, 2009) 'manipulative' (Deans & Meocervic, 2006) and a 'destructive whirlwind' (Woolaston & Hixenbaugh, 2008). Interestingly, Sansone and Sansone (2013) argue that nurses reactions are 'a very human reaction' to the challenges associated with severe psychopathology. Further, similar negative perceptions were found in student nurses (Nesbitt, 2016), however, Jones and Wright (2017) argued student nurses negative perceptions were influenced by qualified nurses.

Studies suggest that nurses report experiencing a number of negative emotions from contact with BPD patients for example, anxiety (Stroud & Parsons, 2013); confusion (Winship, 2010); hopelessness (Ma et al., 2008); and frustration (McGrath & Dowling, 2012) when met with adverse behaviours. This often leads to a lack of sympathy (Markham & Trower, 2003); empathy (McGrath & Dowling, 2012); and disengagement (or social distancing) with the patient (Westwood & Baker, 2010) that, in turn, compromises the care delivered (Markham, 2003). Moreover, evidence suggests that nurses demonstrate greater desirable feelings towards patients with depression and schizophrenia than BPD (Forsyth, 2007; Markham & Trower, 2003), however, most worryingly is nurses distancing themselves from patients with BPD, especially as patients with this disorder have a tendency to be sensitive to abandonment and rejection (Leichsenring et al., 2011). Past literature highlights mental health professionals working in medical settings often view patients with BPD pejoratively and this, in turn,

compromises patients care, therefore, the present study addresses a population of non-clinical professionals in a community setting who work with individuals in domiciliary or social support capacity.

Research Aim and Questions

The wealth of research concerned with professionals' negative views of the diagnosis of BPD, coupled with the limited research on the expanding social care profession within community, mental health services provided the initiative for the current research project. The overall aim of the present study was to explore the views of SWs who are employed in a community mental health, supported-living service, towards their SUs with the diagnosis of BPD; thus, combining a preferred, yet largely unqualified workforce with a clinically challenging population. So, therefore, the research questions are:
- How do support workers view their service users?
- What experiences do support workers report in their role?

Method

Research Design

The aim of the present study was to explore the subjective accounts of participants in the context of their role as a SW working with their SUs, therefore, to generate a rich detailed understanding of their perceptions and experiences, qualitative research was required. One-to-one, semi-structured interviews were conducted to collect data and an Interpretative Phenomenological Analysis (IPA) was chosen to analyse the data.

IPA is a method of psychological enquiry, theoretically grounded in phenomenology (conscious lived experience), hermeneutics (interpretation) and ideography (particular perspective in context) which together form its distinct epistemological framework and research methodology (Shinebourne, 2011; Smith, 2004; 1996). Additionally, IPA involves a double-hermeneutic analytical process whereby, the participant is attempting to understand the phenomena; whilst the analyst is attempting to understand the participant trying to understand the phenomena (Smith, 2004; 1996). In short, IPA aims to 'give a voice' to participants whilst 'making sense' of 'their world' through third-person, psychologically-informed interpretations (Larkin et al., 2006).

Participant

Five participants were recruited via purposive sampling, as suggested by Smith et al (2009), in order to obtain a homogenous sample, meaning participants must share adequate experience of the phenomena (object or event) under investigation. Additionally, participants were recruited on meeting the inclusion criteria specifically, (a) employed as a SW in supported-living service; (b) minimum of twelve months experience of working with adults with the diagnosis of BPD; and (c) not be deemed a vulnerable person (see Table I for participant summary). All participants met the inclusion criteria for present study and volunteered to partake. Participants then received an email from the

researcher's account (15069559@stu.mmu.ac.uk) with enclosed copies of the research documents (see Appendix I-VI).

Table I. *Participant Descriptions*

Participant	Gender	Age	Length of Service (Years)
1	F	28	>2
2	F	30	>1
3	F	33	>2
4	F	51	>1
5	F	27	>2

Additionally, small sample sizes are characteristic of IPA research, samples of 3-6 are recommended for undergraduate projects (Hefferon & Gil-Rodriguez, 2011). This refers to the IPA ethos that 'less is more' (Reid et al., 2005) meaning, the richness and uniqueness of each participants subjective experience, could perhaps be lost with a larger number of participants (Smith et al., 2009).

Data Collection

Five semi-structured interviews were conducted at Manchester Metropolitan University's (MMU) Birley Campus, lasting approximately 30-45 minutes each. The total audio-data collected exceeded the three hours recommended by Wood et al (2012) for an undergraduate qualitative research project. Semi-structured interviews were decided upon due to the flexible and open-ended nature which mirrors a familiar conversational experience for the participant (Smith et al., 2009). This less-invasive approach would enable a rapport to be built allowing greater coverage of richer material in a safe environment (Smith et al., 2009).

King and Horrocks (2010) advise researchers of qualitative investigations to be mindful of the power dynamics and relational style between interviewer-interviewee when discussing sensitive material. So, the researcher followed Price's (2002) guidance on sensitive data interviewing which outlined several levels of data sensitivity, ranging from low-to-high, therefore, the researcher began with the 'least' sensitive material, such as: activities, tasks and progressed tentatively toward the 'most' sensitive data, for example perceptions and experiences.

A number of materials were used to aid in the data collection process. An interview guide consisting of seven open-ended questions formulated by the researcher with respect to the research aims was used to assist the researcher with his enquiry (Smith et al., 2009) (Appendix VI). Open-ended questions allow the participant to give a rich, in-depth account of the phenomena; allowing the researcher to 'prompt' the participant for further elaboration and 'funnel' down from general to specifics to ensure the researcher is able to get as close as possible to the participants lifeworld (Smith et al., 2009). The interview-data was recorded on an Olympus VN-733PC Digital Voice Recorder. Post-collection, audio-data was transcribed verbatim into written-text (Appendix VIII) and inputted onto a Microsoft Word Document.

Analytical Technique

IPA requires an idiographic, case-by-case approach during data analysis (Pietkiewicz & Smith, 2014). The step-by-step guidance provided by, Smith et al (2009) was followed during data analysis. Data familiarity and immersion was the first stage of analysis, this requires multiple readings of the transcript and the annotation of interesting or salient information (Pietwiewicz & Smith, 2014). Commentary is made on the participants account by, summarizing or paraphrasing, including preliminary interpretations of potential similarities, differences. The next stage involves primarily working on the notes rather than the transcript and developing them into emergent themes, however, the development of emergent themes must reflect the primary source of information. (Smith et al., 2009). Next, emergent themes are clustered dependent on their conceptual qualities, each given a descriptive title (Pietwiewicz & Smith, 2014). Emergent themes are inputted to a table with accompanying evidence; this was completed for each transcript. Once all transcripts have undergone the process, a final table of superordinate themes and subsequent subordinate themes was produced (see Table II for summary), this encompassed the findings from across all transcripts and the superordinate themes indicative to all or most of the participants.

Table II. *Summary of superordinate and subordinate themes found across the transcripts.*

Superordinate Theme	Subordinate Theme
Carer as 'Mother'	Desirable Feelings The Support Worker-Service User Bond
Service User as 'Other'	Unwell-ness The Borderline Personality
Sad beneath the Bad	

Ethics

Ethical approval was granted by MMU through the application for ethical approval form (Appendix VII); coupled with a detailed outline of the research project through the research protocol. In addition, the present study was in accordance with the ethical code of conduct outlined by the British Psychological Society (BPS, 2009).

Analysis and Discussion

Three superordinate themes emerged from the analysis namely, *Support Worker as 'Mother'*; *Service User as 'Other' and Sad beneath the Bad* (see Table II); each superordinate and subsequent subordinate themes will be discussed, respectively.

Support Worker as 'Mother'

Support Worker as 'Mother' was the first superordinate theme to emerge from the analysis with two subordinate themes namely, *Desirable Feelings* and *The Support Worker-Service User Bond*. The aforementioned themes explore the role of a SW as a caregiver and illustrate positive perceptions and experiences towards their SUs. All SW narratives shared a positive view towards SUs. References were made to the complexities and uniqueness of human behaviour as high levels of understanding, protection, acceptance, compassion, kindness and empathy were expressed by the SWs. Additionally, SUs were portrayed as highly valued, [SW1, Line 220] 'vulnerable people' which, in turn, evoked a caregiver response from the SW.

> *"They are just people y'know, really good people with very sad stories"* [SW3, Line 79-80].

> *"…I am just trying my best to care for the vulnerable people."* [SW4, Line 263-264].

Similarly, each SW reiterated the caregiver status through the nurturing of the SUs' individuality. As shown in the extract below [SW1, Line 88-90] the SW will promote the growth and personal development of the SU in an empowering and individualized manner.

> *"…you promote their wellbeing; their independence…erm…promoting their individuality and to be who they want to be."* [SW1, Line 88-90].

The first subordinate theme: *Desirable Feelings* was conveyed across all narratives. SWs expressed empathy, pride and protectiveness towards the individual. Empathy, was evidenced throughout each transcript SW4 describes empathy as the ability to 'walk in that person's shoes' [SW4, Line 233]. As an example of empathy, SW3 described a situation where she noticed somebody was anxious at spending their first night in the supported-living service. In this extract she accepts this may be an unsettling experience for the individual and this led SW3 to provide extra care and attention.

> *"I was working nightshift […] a lady came to our service that day on transition […] but looked very anxious […] she was in a new place she was in her early twenties so it's a big deal init moving to a new service with new staff faces and new environment […] I said if you want I can do checks [observations] on you so you know I am around and then [..] I popped in for a brew before midnight"* [SW3, Line 85-98].

SWs also conveyed a number of rewarding experiences whereby; an individual has achieved a goal and this manifests as a sense of pride within the SW.

> *"…Like when they achieved something you feel a sense of achievement and proud of them, happy for them. There was a time when a lady went for a running competition and won a medal and when she came back [I]*

couldn't stop smiling because [I] shared her happiness, not in a fake "oh that's good", but more like [I] wanted to hear more…" [SW3, Line 53-58].

In the extract above, the reciprocity of pride and sense of achievement was conveyed. SW3 explicitly states that this was a genuine experience for them. Additionally, all SWs expressed they felt protective of their SUs' physical and psychological health. Albeit, a desirable feeling; SWs reported experiences of distress and worry when their SU's safety and security was compromised.

> *"Stressful. You are constantly worr[ied] because you don't know where they are. It was late at night and anything could happen to them. It was scary, because we didn't know where she had gone…"* [SW1, Line 197-199].

In the extract above, SW1 [Line 197-199] expresses negative feelings from a situation where a SU had absconded during the evening. This evoked despair and worry within the SW as they could not be sure of the SUs' safety.

The *Desirable Feelings* subordinate theme contrasts with previous empirical research on nurse's experiences. Generally, with the exception of a small number of studies (Giannouli et al., 2009), professionals fail to report any positive appraisals of working with BPD patients (Sansone & Sansone, 2013). Moreover, it has been well documented that nurses demonstrate lower levels of empathy towards patients with BPD (McGrath & Dowling, 2012). Further, contrasts are highlighted whereby nurses will negatively appraise and socially distance themselves from the patient that, in turn, compromises their care (Westwood & Barker, 2010). However, the present study shares commonalities with the 'seeing the person' behind the BPD patient phenomenon (Loader, 2017:3). Bowen (2013) argued that a more holistic view of the individual can promote desirable and positive attitudes within the professional. In the present study, SWs view their SUs in a holistic and positive fashion, thus concurs with Bowens (2013) claims.

The second subordinate theme: *The Support Worker-Service User Bond,* evidences that SWs express a strong bond exists between them and their SUs. SWs conveyed they felt that individual would seek them out for comfort during events of distress or anxiety. Also, SWs described how they would reassure the individual during times of high emotionality. SW4 provides an example where she describes an incident that happened whilst she worked the nightshift. Further, illustrating how the individual had specifically sought her out, for comfort and support in the relationship between them.

> *"…its quite often that they struggle to get to sleep they just…just need to be reassured that somebody is there for them[…] yeah the person in question wouldn't let any other staff in, they [service user] requested that I went in […] I think I was a calming influence […] I got the feeling that the person in question seemed to relate to me more than other staff but I guess 'cause everyone's different… I guess it was our relationship."* [SW4, Line 32-84]

Interestingly, SW4 is describing a situation where the individual is seeking out a caregiver during episodes of emotional distress, in order for the SW to comfort and soothe them within the confines of the relationship; which was perceived to be relatively secure. This experience is testament of the attachment theory; interestingly, in this case, it seems as if the SW and individual are showing signs of a secure, reciprocal bond or attachment.

Service User as 'Other'

Service User as 'Other' was the second superordinate theme to emerge from the analysis with two subordinate themes: *Unwell-ness;* and *The Borderline Personality.* Othering is a psychological, social and linguistic process of disempowerment and exclusion which reinforces a dominant-subordinate relationship between individuals (or groups); simply put, othering is a process of distinguishing between 'us' and 'them' categories (Roberts & Sciavenato, 2017; Johnson et al., 2004).

Briefly, *Unwell-ness* was drawn from the narrative of SW1 and SW4. SW1 and SW4 formed a dichotomy through a medical discourse between psychological wellness and unwell-ness. Identifying that unwell-ness was a deviation from healthy psychological functioning. *The Borderline Personality,* was illustrated within the SWs narratives as a perceived difference between self and other with an emphasis on psychiatric diagnostic terminology.

SW narratives highlighted a noticeable difference between the member of staff and their SUs with respect to their psychologies. The extract below by SW3, [Line 69-79], suggests that SUs demonstrate both an instability and uncontrollability in their affect and cognition, however, comparably the SW conveys these reactions as unwarranted with respect to the situation or event.

> *"Borderline personality disorder is about mood swings, I think like…I could be sad or happy so can they, but they can <u>be a bit more</u> than happy or sad…like depressed […] I think it's a lot to do with <u>how they react</u> to stuff…like they may <u>hurt themselves</u> to deal with all these big emotions […] Like <u>if someone is angry about something I think is small</u> like they will hurt staff because they are super stressed." [SW3, Line 69-79].*

As shown in the extract below [SW1, Line 49-53], differences between the SWs and SUs' psychologies were reiterated and reflected through the use of impersonal pronouns namely, 'them' and 'they' allowing SWs to convey that this was not an experience they, themselves belonged too.

> *"…it can be how <u>they</u> present when <u>they</u> are becoming unwell. Where that day you might see [th]em, <u>they</u> might not be unwell and <u>they</u> are happy[…] …then you might notice warning signs of <u>them</u> becoming unwell."* [SW1, Line 49-53].

Interestingly, the previous extract by SW1 [Line 49-53] highlights not only a perceived difference between the SWs and SUs psychologies, but a dichotomy within the SUs' psychological health namely, well and unwell.The *Unwell-ness*

subordinate theme manifests from the narratives of SW1 and SW4 and conveyed as a difference between the psychologically-well 'self' and psychologically-unwell 'other' through a medical discourse. Therefore, psychologically-unwell is understood as a deviation from social convention and healthy psychological functioning. SW1 describes this otherness-phenomenon as 'mentally-unwell' [SW1, Line 64] which can lead to the individual becoming 'poorly' [SW1, Line 64].

SW1 and SW4 present a salient theme that contrasts with previous empirical findings. The de-medicalization of BPD to 'difficult patient' status has been well-documented within the literature (Sulzer, 2015). However, the *Unwell-ness* subordinate theme illustrates a more medicalized view, through the individual being perceived as 'mentally-unwell' or 'poorly' when deviating from convention thus, re-medicalizes SUs with this diagnosis [SW1, Line 64].

The second superordinate theme, *The Borderline Personality* was drawn from the analysis. *The Borderline Personality* appeared across all participants narratives through their descriptions of the SU with great affinity toward psychiatric diagnostic terminology, such as: 'impulsive' [SW1, Line 318-319], 'manipulation' [SW4, Line 241], chaotic [SW1, 67-69], competeveness, attention-seeker, jealousy. However, psychiatric descriptions were used when events or situations arose that were deemed to be 'strange behavioural patterns' [SW4, Line 108].

> *"…There was a situation when two female service users, one of them had self-harmed and then literally straight after that the other one had self-harmed as well. So you was literally going from one person to the next person and because you were providing the support and the attention to the first service user at that time the other one <u>almost seemed jealous</u> in a way and <u>wanted that attention</u> there and then so then the second one <u>started acting out</u> them behaviours that <u>I think is for the attention</u> she was missing out on. I found that really hard because you was just from one to the other and it was all just like self-harm and like and stuff. […] Well in my experience when one is <u>acting out</u> those behaviours, another person will see that and almost <u>up the ante</u>. Its sorta like <u>"I am more poorlier than you!"</u>…This is what I need, its about me! and I think its that its to do with "I need this…I am ill" sorta thing…erm…but I don't…I don't like know why though, but I have seen it so many times like in other places when two service users were friends it was never a healthy relationship it was about who was poorlier…<u>like a competition</u> but it always seems to be focused on negatives I think." [SW5, Line 127-147].*

The extract above [SW5, Line 127-147], describes an event where the SW had dealt with two separate cases of deliberate self-harm, however, the SW has viewed the second incident as a continuation of the first incident. This connection was constructed as an episode of 'acting out' on behalf of the SU as they wanted attention, thus became 'jealous' because another SU was being provided with 'support and attention'. SW5 expresses this view as a competition, whereby the SU was trying to communicate and establish that they are 'poorlier' than others and to do this they must 'up the ante'. *The Borderline Personality*,

subordinate theme shares similarities with previous research where professionals 'other' individuals into categories such as: chaotic (Millar et al., 2012); manipulative (Deans & Meocevic, 2006); impulsive and so on. However, SWs delineate between the person and the BPD, of which the latter is affiliated with negative attributions.

Sad beneath the Bad

The final superordinate theme: *Sad beneath the Bad* was drawn from the analysis and represents how SWs make sense of SUs challenging behaviours. All participants reported times where SUs have self-injured; or showed signs of aggression. The SWs narratives expressed that these types of behaviours, presented many risks to the individual and, therefore, were perceived as 'bad stuff' [SW3, Line 37]. However, SWs discussed how they felt more was going on than simple 'bad' behaviours and began to develop several 'hypotheses' for the root 'cause' of challenging behaviours. The 'hypotheses' developed postulated that emotional dysregulation and subsequent challenging behaviours were derived from historical events or adverse childhood experiences (ACEs); and were communicating a need; misunderstandings; or a rejection from a loved one.

Unanimously, SWs communicated that SUs struggled with affect regulation and that this led to challenging behaviours.

> *"I think they are not just hurting themselves because they can they are doing it cause they feel shitty init or something" [SW3, Line 135-136].*

SW3, SW4 and SW5 suggested that challenging behaviours were a result of historical events or ACEs that 'caused' the individuals to express themselves in self-damaging ways. The extract below [SW4, Line 119-225] illustrates the belief that lifetime adversities can impact the way an individual can see or respond to the world and others.

> *"…there are underlying problems with a lot of these people that they have different upbringings. It could be that they [have] always been in abusive relationships […] when I hear about the people's childhood and how they have been in abusive relationships or the kinda rough life they've had you can understand how they see the world differently from the way I see it if they have never been shown the affection or taught what's acceptable in the outside world." [SW4, Line 119-225].*

All SWs believed that challenging behaviours were a way of expressing or communicating a need and that it was the SWs responsibility to find and uncover what that need was and provide alternatives not only on an individual level, but on a service level too.

> *"We use to support somebody the family would come and see them and the family wouldn't give them a hug or nothing. No physical contact at all. It started to unravel that they wanted a hug, so we then introduced a little*

hug […] Just that bit of physical contact. We did see slowly the behaviours reduced." [SW1, Line 239-247].

The extract above [SW1, Line 239-247] highlights a case where the SW had introduced a form of social touch or contact after recognizing the need of the individual. Subsequently, this led to a reduction in challenging behaviours after that need was met. SW2 and SW3 discussed situations where the individual misunderstood an employee's intention which subsequently led to an escalation and the onset of challenging behaviours.

"*There was a lady who thought that a manager wasn't talking to her for some reason…I was thinking at the time that this wasn't the case…I think that this lady just felt like that…oh yeah its because the manager was talking to another service user and this lady felt that she wasn't important…like the other service user […] I tried to get her to see the situation from the managers point of view that she was talking to someone and it wasn't about her not being important it was just a misunderstanding.*" [SW3, Line 205-214].

Interestingly, the previous extract from SW3 [Line 205-214] describes an event where the SW helped the SU to mentalize (thinking about what the manager was thinking). Mentalizing is the ability to understand, both implicitly and explicitly the mental states of oneself and others; and can be characterised by emotional dysregulation and interpersonal difficulties found in BPD (Bateman & Fonagy, 2010).

SW5 discussed that particular challenging behaviours are a result of the individual feeling rejected by a third party and by not replicating the rejection behavioural-escalation can be intercepted. The extract below evidences a situation where the SU was rejected by a loved one and this, in turn, led to a rejection of the SW that was not reciprocated.

"*…she was quite distressed and angry I think something had happened with her boyfriend and she just wasn't happy about it and felt really <u>rejected</u> and sorta felt like I don't want all these people coming in when they are going to leave as well. So, I think she was sort of putting on a hard exterior to sorta push everyone away because someone she had loved had gone away as well. […] Yeah, I think because the <u>rejection wasn't replicated</u>, and I wanted to see her and support her that it probably reassured her plus there is always a risk that she will hurt herself when she is distressed.*" [SW5, Line 186-212].

The Sad beneath the Bad superordinate theme conveyed the sense-making processes of SWs in relation to presentations of challenging behaviours. The 'hypotheses' purposed tend to oscillate within the parameters of intrapersonal and interpersonal tensions that the individual struggles to cope with. Interestingly, SWs may have used processes of othering in superordinate theme two to describe behaviours, however, within superordinate theme three evidence of meaningful interpretation of the antecedents leading to challenging behaviours are taken into account.

Summary of Findings

The above findings from the present study can be best understood through the positioning theory; albeit, a number of psychological concepts, theories and models were beginning to emerge from the SWs narratives namely, attachment, mentalization and othering; the positioning theory encapsulates the research findings holistically. Moghaddam and Harre (2010) suggests individuals take upon different positions (roles, duties) in relation to the social context they are in, and these positions are not always equal. Further, positioning theory is concerned with how individuals ascribe 'us' and 'them' positions (Moghaddam & Harre, 2010).

In this study, the multifaceted relational framework between SWs and SUs was conveyed as an active, dynamic process whereby, positions were altered and refined in order to maintain and retain a positive view of the individual. Further, SWs ascribed themselves and their SUs in number of roles depending on the change in behaviours (or context), for example SWs placed the SU into a 'vulnerable person' category; ascribing themselves, a caregiver role as the SU was believed to require care.

Interestingly, when changes in SUs behaviour led to negative experiences, for example with episodes of self-injury; SWs repositioned themselves and their SUs in terms of psychological health. This was constructed through a medical discourse and the use of psychiatric terminology which conveyed a difference between psychological wellness and un-wellness, with the latter assigned to SUs. The altering of positions enabled SWs to maintain a positive view of SUs, as their behaviours were a result of being ill or unwell. The remedicalization of SUs by SWs was salient not only within the present study, but with respect to the larger body of literature. As, evidence suggests that professionals often demedicalize patients (Sulzer, 2015).

However, although, similarities were shared between the present study and the preexisting literature, with respect to negative connotations of individuals with this diagnosis. SWs positioned these behaviours as a separate sense of self specifically, the 'borderline personality', whereas medical professionals report these behaviours as controllable and characterological.

In summary, over the last three decades, evidence of mental health professionals' negative views towards patients with the diagnosis of BPD has been well documented within the literature; most noticeably amongst nurses. However, findings from this study highlight positive perceptions of working with BPD SUs. Perhaps, differences found within the present study, are a reflection of the differences in the training, role, purpose, setting and responsibilities between the well-established nursing profession (and other mental health professionals) and the ill-defined, social care workforce.

Implications

The present study supports previous literature in the suggestion that working with individuals with the diagnosis of BPD can be challenging (Loader, 2017).

However, differs from the majority of preexisting literature by identifying SWs positive perceptions of the client. These findings are encouraging and provide an insight into the value of community mental health, supported-living services and its employees.

Limitations

Present study is not without limitations. A qualitative research paradigm was adopted meaning, this study shares the methodological limitations concurrent with this particular type of research, such as: generalizability and traditional scientific empiricism (Bannister et al., 2011). Further, semi-structured interviews employed during data collection were at risk of a social desirability response bias from the participants (Collins et al., 2005). Additionally, the participant sample was fairly homogenous as instructed by authors (Smith et al., 2009) (see Table I). However, the sample was unrepresentative of both genders; and restricted to non-specialized, support-living settings. Lastly, findings of the present study were drawn from the data through the authors interpretation, therefore, findings may not be replicable by another author.

Future Research

Future research on the social care profession could focus on identifying skills and challenges met by SWs in their role. Further, perhaps future research would benefit from exploring the psychological concepts found within the present study to better understand the experiences between a highly deployed, largely unqualified workforce and a challenging client group, which this study has found encouraging.

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