International Journal of Qualitative Methods

INTERNATIONAL INSTITUTE FOR QUALITATIVE METHODOLOGY (IIQM)
UNIVERSITY OF ALBERTA

Article

Developing the Therapeutic Use of Self in the Health Care Professional Through Autoethnography: Working With the Borderline Personality Disorder Population

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Abstract

Frequently stigmatized, misdiagnosed, improperly treated, and discounted is the suffering of the patient with Borderline Personality Disorder (BPD), and it can be a serious, agonizing, tenacious, and draining mental illness. Present-day research illustrates that patients with BPD are in fact the largest consumers of mental health services, utilizing every treatment genre more frequently and in greater quantities than any other mental health taxonomy. They experience more complex and destructive symptoms, more perpetual misery and encumbrance, an unpredictable usage of outpatient services, and extensive treatment modalities and psychiatric admissions. A review of current literature reveals this consistent notion: the attitudes of health care professionals toward patients diagnosed with this elaborate disorder tend to be disparaging. The aim of this article is to critically analyze the prospect that autoethnography (or narrative research) is a strategic, useful tool for mental health professionals to improve empathy and identification with patients suffering with BPD. As a qualitative research method, autoethnography is advantageous for creating connections between care provider and patient. It can deepen their mutual and divergent experiences while generating empirical knowledge from the professional's narrative reflection and through the *therapeutic use of self* with the patient.

Keywords: autoethnography in nursing, borderline personality disorder, empathy, nurse as helper, suffering, therapeutic relationship, therapeutic use of self

Acknowledgements: The author would like to thank Dr. Ian Smith of St. Joseph's Healthcare, Hamilton, Ontario for the kindness he has shown to his many patients, and for those lives he has saved. This article was written in memory of Christine, a patient with BPD who died by suicide.

This article sets out to examine whether autoethnography in qualitative research can in fact enhance the therapeutic use of self for health care professionals working with Borderline Personality Disorder (BPD) patients. In order to do so, one must historically review the role of nurse as helper, define therapeutic use of self, analyze the difficulty in building a therapeutic relationship with the BPD patient, and, finally, appraise the qualitative form of autoethnography and its value to the therapeutic relationship between carer and patient.

The intention of this article is to encourage health care providers to put their challenging work into narrative, qualitative form in order to assist in the establishment of the therapeutic relationship with the patient with BPD, while also contributing to empirical data.

Literature Review

For this article, an extensive literature review was performed via the snowball method on English language articles in OVID, CINAHL, and Medline, which were searched using keywords such as autoethnography in nursing, ethnography in healthcare, Borderline Personality Disorder, empathy and nurse as helper, suffering, therapeutic relationship, and the therapeutic use of self. Seventy peer reviewed journal articles from 2001-2011 were critically analyzed.

Although this article frequently makes reference to the nursing profession, it is intended to broaden interest in autoethnography for a variety of health care specialists in the mental health arena. Therefore, the terms *nurse* and *health care professional* are used interchangeably throughout to address a larger audience.

Research indicated that over the last twenty years, words like empathy, humanism, and therapeutic relationship have appeared with increasing magnitude in the nursing literature, becoming interwoven with “the art of nursing” (Mallik, 1997). This notion of the art of nursing is based on ethical theories as seen in the interpretive paradigm. This is in contrast to former foundations that venerated skills or procedures as the foundation of nursing (Woodrow, 1997). Within the “New Nursing” ideal, the word nurse conjures up images of helper, healer, counselor, and advocate. This is related to the established trust in the professionalism and skill of nurses. Yet this axiom still provides little guidance for mental health nurses treating patients with Borderline Personality.

The traditional biomedical model considered the role of the nurse as helper under physician control, professionally disconnected and emotionally detached from the patient (Porter-O’Grady & Malloch, 2006). Its emphasis on the importance of duties was a safeguard against over involvement with patients and the potential of sexualisation of the nurse-patient relationship, particularly in mental health (May, 1991). Nursing encouraged the viewpoint that the patient was a biological being to be attended to by the nurse, who provided care with emotional impartiality and distance, principles endorsed by the nursing profession (Williams, 2000).

Even mental health nursing curricula concentrated on procedural courses such as medication administration, anatomy and physiology, infection control, and pharmacology—programs intended unequivocally to teach skills (Kleiman, 2005). Although intimacy and empathy are imperative doctrines in the clinical relationship, the basics of humanism are not taught in curricula in medical and nursing schools (Branch et al., 2001).

These customary ideas regarding detachment were eventually challenged through primary nursing and the interpretive paradigm, endorsing individualized nursing care and focusing on each patient’s distinctiveness (Mercer & Reynolds, 2002). Likewise, these modern philosophies

demonstrated assurance in the intimate nurse-patient relationship, believing it fundamental to nursing's contribution to patient health, comfort, and recovery (Dziopa & Ahern, 2009).

Nursing research, thus far, has been rooted within social sciences, bringing forth several established research paradigms. Autoethnography is a recent methodology in qualitative research, which is increasingly being utilized in a variety of health sciences (Anderson, 2006). The number of researchers implementing it is rapidly increasing (Ellis & Bochner, 2000, p. 736). Autoethnography adopts the premise that we cannot separate ourselves from who we are, what we know, and how we understand the world, because these concepts are a crucial part of how we understand others and their world (McIlveen, 2008).

Through the clinical encounter, the use of autoethnography can assist the health care provider to intellectually enter into the patient's perspectives, beliefs, and experiences (Eriksson, 2002). Evidence suggests that empathy is consistently lacking in modern medicine and primary care; therefore, autoethnographic data, analysis, and interpretation is a solution for bringing empathy back to the clinical experience, while assisting providers to gain understanding of the patient (Anderson, 2006). This popular form of self-narrative, self-reflective journaling is becoming an acceptable form of investigation in the social sciences (O'Byrne, 2007).

It is inherent to the psychiatric milieu that health providers establish rapport, develop trust, and demonstrate empathy with consumers of mental health services. Despite the importance of this issue, the perceptions and attitudes of psychiatric nurses toward patients diagnosed with BPD have, in fact, received little research attention. Moreover, this insufficient research discloses that mental health nurses admit to low scores in empathy and treatment optimism toward patients with BPD (Black et al., 2011).

Autoethnography is a useful tool that can inspire the professional to write about personal experiences with patients suffering from BPD. Autoethnography functions as primary data, exploring the carer/patient relationship while establishing their connection to each other and assessing their similarities and differences (Lipp, 2007). This form of research is a robust collaboration between the personality of the writer, patient, and literature, allowing communicative change, personality assessment, and personal and professional growth in the various members of the healthcare team (Silverberg, 2003).

The Difficulty in Building a Therapeutic Relationship with Patients of BPD

Mental health literature is fraught with the harmful effects that some diagnoses have on health care provider attitudes (Rossen & Bland, 2005). The need for a therapeutic relationship between nurse and patient is not a new concept; in fact, it has been viewed as rudimentary to mental health nursing for decades (Barker, 2001). Psychiatric nurses in particular are being challenged to change the way they traditionally relate to clients, to shift from biomedical care to holistic, ethical care (Sumsion & Law, 2006). Ideas like compassion, moral commitment, and empathy, and notions of the therapeutic use of self and reflective practice, are increasing in appearance in nursing journals (Brien, 2001). Nevertheless, psychiatric nursing practice has continued to integrate various aspects of the medical model, emphasizing neuroscientific theories of mental illness and placing nursing paradigms and nursing practice models in low profile within psychiatry (Barker, 2001).

Recently, considerable research has been conducted to observe professional attitudes towards patients with Borderline Personality Disorder (Fagin, 2004). What is known is that people with BPD face stigma and unkind attitudes from health care providers (Deans & Meocevic, 2006).

While regarded by most clinicians as a valid diagnosis, a marginal group would favor not working with BPD patients at all, which ultimately affects care and treatment outcomes (Filer, 2005). Studies have shown that a diagnosis of Borderline Personality Disorder will sway the quality and degree of collaboration that mental health clinicians have with patients (James & Cowman, 2007). An examination of statements made by health care providers on their experiences in working with this population revealed that many encounter uncomfortable personal responses, feeling frustrated, inadequate, and challenged (Commons Treyloar, 2009). Moreover, many BPD patients feel that health professionals are not willing or interested in becoming involved in their psychotherapeutic treatment (Markham, 2003). Patients often describe contact with mental health providers as grim, typified by insolence, negative attitudes, and punitive comportment (Shattell, Starr, & Thomas, 2007).

Nurses, in particular, encounter numerous difficulties in the treatment of patients with BPD. These can consist of physical and verbal abuse, distancing, apprehension, exploitation, and staff splitting (Adshead, 2001). In turn, nurses may react with resentment, bias, and damaging opinions (Bland, Tudor, & McNeil Whitehouse, 2007). Negative labeling of patients, such as "borderline" or worse, becomes somewhat ordinary within the mental health milieu (Horsfall, 1999). Moreover, the opinion that the patient with BPD acts out merely for attention, not really requiring hospitalization, is common among mental health professionals (Hewitt & Coffey, 2005). Building rapport with patients with this disorder takes time, fortitude, determination, and trust, but regrettably mental health nurses often struggle with burnout and frustration (Crawford, Adedeji, Price, & Rutter, 2010).

Demanding, strict, and unsupportive environments, coupled with an absence of positive role models and undervalued work, lead the mental health nurse to anxiety and poor job satisfaction (Cleary & Freeman, 2006). Similarly, nurses often receive little or no relevant training in personality disorders. Staff members endeavor to provide a therapeutic environment for recovery, but patients with BPD can seem challenging because of destructive behaviors such as self-harm, staff splitting, and chronic suicidality (Bland & Rossen, 2005). Staff splitting refers to efforts by patients with borderline personality disorder to split or divide the health care team. This can be done by pitting staff members against each other, telling different stories or sharing secrets to certain members of the team, and suggesting that only particular staff can empathize with them (Elder, Evans, & Nizette, 2009). Nonetheless, each patient with BPD deserves well-trained, empathetic, and supportive health care providers skilled to abate these therapy destroying behaviours.

The Therapeutic Use of Self

Establishment of the therapeutic relationship with patients with BPD requires reflective practice and the therapeutic use of self. This concept requires the mental health provider to possess self-awareness, self-knowledge, and empathy, attention to ethics, and boundaries and limits within the professional role (Kwiatek, McKenize, & Loads, 2005). The use of self employs positive communication techniques between provider and client. These include active listening, silence, open-ended questions, restating, reflecting, clarifying, validating, focusing, summarizing, and being cognizant of one's own values and the differences between professional and client (Raingruber, 1999). The therapeutic use of self refers to the extensive praxis of evaluating one's characteristics, morals, and expertise in connections with others (Kwiatek, McKenize, & Loads, 2005). The therapeutic relationship and the therapeutic use of self are essential to positive outcomes for the BPD patient population (Taylor, Lee, Kielhofner, & Ketkar, 2009).

Self-awareness is the skill of reflecting on one's subjective thoughts, feelings, and actions, as well as realizing that as a provider of care, one may convey an attitude that could obstruct the therapeutic process. With the development of this understanding, the mental health clinician is able to identify that her experiences with BPD are shaped by race, culture, health, socio-economic surroundings, gender, education, and childhood events (Hugo, 2001). Furthermore, past and present relationships, accomplishments, beliefs, issues, and concerns affect her ability to reflect and use her therapeutic self with the patient with BPD. Through attainment of this self-knowledge, she can distinguish between her experiences and ideals and those of the client (Grando, 2005).

Self-disclosure, the sharing of personal information with others, has been recognized as an important discussion within nurse-client therapeutic relationships in psychiatric mental health nursing (Ashmore & Banks, 2002). It can facilitate reciprocal self-disclosure by the client while normalizing the client's experiences (Gray Deering, 1999). It is, however, a concept that has been problematized because although appropriate self-disclosure by the nurse has been accepted, inappropriate self-disclosure has been seen as detrimental to patient recovery (Stickley & Freshwater, 2006).

The awareness gained through the use of therapeutic self can cultivate caring relationships with clients, while augmenting a deeper, more profound perception of the nurse's personal and cultural biases, knowledge, and viewpoints (Walker & Redman, 1999). At the core of mental health nursing is the therapeutic nurse-client relationship. The nurse can create and uphold this dynamic relationship with the BPD client by using nursing knowledge and skills, and by applying a considerate approach and manner. The therapeutic relationship in mental health contributes to the patient's well-being and comfort. The relationship between carer and BPD patient can be based on trust, respect, empathy, and professional intimacy (Jukes & Aldridge, 2000).

The therapeutic use of self gradually develops as a facet of one's personality, unfolding with time, practice, and wisdom (Perraud et al., 2006). This use of self by the clinician allows him to embrace his finest interpersonal, curative methodologies, allowing him to build and refine the therapeutic alliance between provider and patient (Manthey, 2001). According to Taylor, a vital element of the helping relationship is the nurse's sincerity, and he claims that the genuine nurse is the most effective (Taylor, 2001). The ideal use of self in the helping relationship is the integration of person, skill, and principles. The capacity to use self in the role of helper is shaped by levels of self-awareness, openness to growth, appreciation of human limitations, and varying degrees of skill in interpersonal relations (Foster, McAllister, & O'Brien, 2006).

Autoethnography and the Mental Health Nurse

Over the last century, the interpretive paradigm has splintered the limitations found in positivism, emphasizing a connection between theory development and language, and encouraging qualitative methodological approaches such as phenomenology, ethnography, and hermeneutics (Trayar, 2009). This paradigm deeply depends on tangible instruments such as interviewing, observing, and analyzing existing work, thus ensuring an acceptable interchange between researchers and participants in order to collaboratively create an evocative authenticity. This is typically done through qualitative techniques. Qualitative research is founded on the hypothetical conviction that reality is socially constructed and flexible (Spry, 2001). The preliminary phases in the qualitative research process are similar to that used by the positivist researcher; the research topic is identified, refined, and clarified, and then a literature review is undertaken and the thesis takes shape (Reeves, Kuper, & Hodges, 2008). Qualitative research can be exploratory and

descriptive in its aim, designed to ascertain what can be learned about the inquiry. The autoethnographer interprets the world as a socio-psychological construct with many multiple, interconnected realities (Silverberg, 2003).

Autoethnography is self-awareness and reportage of one's own experiences and introspections, and it functions as a primary data source (Patton, 2002, p. 86). It takes the therapeutic use of self one step further by integrating the professional's feelings, biases, beliefs, and concerns into narrative form, thus allowing her to improve relationships with patients.

Reflexivity in qualitative research means that the health provider partakes in a significant exploratory process of reviewing her prejudices, theoretical tendencies, and preferences as researcher and participant (Schwandt, 2001, p. 224). Ellis and Bochner (2000) defined autoethnography as a genre of writing and research that exposes various layers of consciousness, connecting the nurse to patient (p. 739). It is a conduit where the mental health nurse can entrench herself in theory and practice, establishing trust and validity with her patients while adding to the methodological collection of nursing research (McIlveen, 2008). This narrative approach is an "autobiographical account whereby mental health nurses can communicate their lives and experiences with patients" (Bruner, 2004, p. 694).

Hoshmand (2005) projected three types of narrative research: an evocative report of a privately assembled self-account in its earliest narrated form; a recitation of a dialogically created narrative or set of narratives in the account form; and a storied interpretation of an experience fashioned from interviews, written reports, observations, and artefacts (p. 181). These forms of autoethnography can be used by any psychiatric health care provider to complete a narrative analysis connecting her to a specific incident or emotion in the clinical experience. This form of research, however, is not meant to be autobiographical, but rather a critical, transparent, personal expression and exploration that is entrenched in theory and practice using the lived experience of the clinician (McIlveen, 2008).

There are limited guidelines on how to write an autoethnographic narrative analysis. Since it is the meaning of the story that is significant in autoethnography, strict scholarly format is not always utilized. Narrative form allows the researcher, in this case the mental health professional, to utilize the usual rigors of research in health care, providing a framework for excellence and dependability (Ellis, 2000). This form of reporting provides an authentic and robust version of the author's experiences, and also plays a critical part in establishing the worth of autoethnography as valued research with scholars and peers. However, because of the potential for limitations and lack of rigor in autoethnographic research, authors should mention these issues when reporting their research findings (McIlveen, 2007).

Discussion

Consideration of 70 articles revealed few empirical findings on the use of autoethnography in mental health nursing. Quantitative empirical studies were limited to the physiognomies of difficult patients, while qualitative studies mostly considered social processes, such as the professionals' implicit and explicit judgments about patients with Borderline Personality Disorder (Koekkoek, Berno van Meijel, & Hutschemaekers, 2006).

To date, there has been a dearth of research on how mental health nurses cope with the BPD population. The ultimate objective of this article is to encourage health care professionals to establish therapeutic relationships with BPD clients through autoethnography, a boundless tool that not only adds to empirical knowledge but also develops a better appreciation for patients, and a greater satisfaction in psychiatric care.

In their 2006 article, Foster, McAllister, and O'Brien stated, "the exploration of the self is a central and basic place to commence nursing practice" (p. 5). In fact, they claimed that consideration of one's own feelings, thoughts, and experiences contributes to the use of self in mental health nursing. Foster et al. defined autoethnography as a qualitative research method that unites the researcher's personal self to their practice. Furthermore, they conjectured that this evolving research method is relevant to mental health nursing education and clinical practice. They stated that little research has gone into creative, critical narratives in mental health, even though these narratives could offer the legitimization that nurses need. Foster et al. identified the importance of the therapeutic relationship between client and nurse as a crucial area in psychiatric mental health nursing (p. 44). Mental illness not only challenges the patient's sense of self, their connection to others, and the meaning of their life experiences but also the nurse's as well. Through empathy, warmth, respect, patience, and trust, health professionals can utilize the therapeutic use of self in clinical practice.

Conclusion

It is important that as frontline care providers, we promote humanized care through a holistic approach, one that preserves the BPD patient's dignity and generates the therapeutic encounter (Duff & Bedi, 2010). This relationship must remain ongoing and meaningful while communicating honesty, humility, and mutual respect. It is based on a partnership that negotiates care (Krauss, 2000). As seen in psychiatric nursing, the therapeutic relationship requires continual consideration, both in philosophy and in practice (Dziopa & Ahern, 2009). Through the use of self, the psychiatric nurse is there for her patients, and constantly, dependably, and unfalteringly endorsing that therapeutic relationship (Evans, 2007).

In research, the therapeutic use of self through autobiographical and narrative ethnography is a foundation for data collection and analysis from which greater sociocultural issues can be revealed. The health provider's individual stories can be employed to seek understanding of the client's view of the world. In scribing one's own life experiences, scholarly research becomes more accessible to a larger group of people, instead of just those in academia. In its qualitative addition to scholarly work, the use of autoethnography requires courage, vulnerability, determination, and confidence from the mental health professional (Foster, McAllister, & O'Brien, 2006).

Autoethnography can be a valuable research method, which connects the clinician to the patient with Borderline Personality Disorder, by linking the researcher's personal self to empirical knowledge. Few published materials exist from mental health nurses working with patients with BPD. Although the carer-patient relationship can be arduous at times, autoethnography is an effective way to build a therapeutic alliance with the patient and also support a promising research method for this topic.

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