

## **The experiences of people with borderline personality disorder admitted to acute psychiatric inpatient wards: a meta-synthesis**

### **Abstract**

**Background:** Acute psychiatric inpatient care is recommended for people with borderline personality disorder (BPD) to manage a crisis. Qualitative research exploring service user experience is valuable for the development of evidence-based treatment guidelines.

**Aim:** To conduct a meta-synthesis of qualitative research exploring the experiences of people with BPD on acute psychiatric inpatient wards.

**Method:** Literatures searches of five electronic databases. Data was analysed using a three-stage theme identification process.

**Results:** Eight primary studies and three first-hand accounts met the inclusion criteria. Four overarching themes were found to explain the data: contact with staff and fellow inpatients; staff attitudes and knowledge; admission as a refuge; and the admission and discharge journey.

**Conclusion:** Similar experiences of acute psychiatric inpatient care were reported by people with BPD across the studies. Opportunities to be listened to and to talk to staff and fellow inpatients, time-out from daily life and feelings of safety and control were perceived as positive elements of inpatient care. Negative experiences were attributed to: a lack of contact with staff, negative staff attitudes, staff's lack of knowledge about BPD, coercive involuntary admission and poor discharge planning.

### **Declaration of interest**

The authors declare no conflicts of interest. The authors alone are responsible for the content and writing of this article.

**Keywords:** borderline personality disorder, acute psychiatric, meta-synthesis, qualitative, systematic review, lived experience, inpatient, narrative accounts, health services research, crisis intervention

## **Introduction**

Best practice in the treatment of Borderline Personality Disorder (BPD) is an area of contention due to a lack of robust evidence for the psychological, psychosocial and pharmacological interventions commonly used (NICE, 2009). A lack of specialist services for people with BPD has meant that the majority are managed within general mental health services such as community mental health teams (CMHTs) (NCCMH, 2009) and day hospitals (NICE, 2009). Current NICE (2009) guidance stipulates that people with BPD should only receive short-term acute psychiatric inpatient care in order to manage crises which cannot be contained within other services due to a significant risk to self or others. The perceived difficulties of supporting people with BPD within mental health services are well-documented, with this client group often being referred to as “difficult and disruptive” (Piccinino, 1990, p.22) and “unpopular with staff” (Fagin, 2004, p.94). This is reflected by people with BPD who describe living with a ‘label’ for which they feel judged, blamed and negatively perceived by health professionals (Nehls, 1999). An abundance of empirical research has demonstrated the negative attitudes of healthcare professionals towards people with BPD (Markham, 2003; Markham & Trower, 2003; NIMHE, 2003; Deans & Meocevic, 2006; Morris, Smith & Alwin, 2014).

Livesley (2003) suggests that prolonged acute inpatient admission provides more opportunities for people with BPD to develop maladaptive patterns through interaction with staff dynamics. Despite being recommended only as a last resort (CAAPC, 2015), the prevalence of inpatients with a diagnosis of BPD has been reported as between 15 and 25 percent (Weight & Kendal, 2013). An alternative to unplanned inpatient

admission is the use of regular brief planned admissions, also referred to within the literature as the brief admission intervention (BAI). BAIs are incorporated into crisis plans which are developed jointly between patients and community mental health professionals, with the duration of admission stipulated as part of the plan (Helleman, Goossens, Kaasenbrood et al., 2014b). BAIs are recommended by the Dutch Multi-disciplinary Guideline Committee (2008 cited by Helleman et al., 2014a) and a recent review carried out in the Netherlands suggested that the BAI was effective in the prevention of self-harm and suicide in people with BPD (Helleman, et al., 2014a). However, this suggests that it was merely successful in controlling symptoms of a crisis rather than having any long-term therapeutic benefit. Indications for brief versus extended inpatient hospitalisation are also outlined in US practice guidelines for the treatment of patients with BPD (American Psychiatric Association Practice Guidelines, 2001). Comparatively, UK guidelines do not recommend BAIs as part of crisis management; although they do suggest that the length and purpose of the admission is agreed in advance (NICE, 2009).

Consideration of the feasibility, appropriateness and meaningfulness of healthcare from the service user's viewpoint is important for the development of evidence-based treatment guidelines (Korhonen, Hakulinen-Viitanen, Jylha et al., 2013). Exploration of service users' healthcare experiences is typically performed through qualitative research (Korhonen et al., 2013) which examines the experiences, feelings and attitudes of people in relation to a particular phenomenon (Ryan, Coughlan & Cronin, 2007). Some primary qualitative research has explored the experiences of people with BPD admitted to acute psychiatric inpatient wards; however, a review of the findings from these existing studies has yet not been undertaken. Therefore, using the meta-synthesis methodology, a systematic literature search of existing qualitative research was carried out with the aim of understanding the experiences of people with BPD who have been admitted to acute psychiatric inpatient wards. In contrast to the narrative synthesis

approach whereby words and text are used to explain findings, including those from statistical studies (Popay, Roberts, Sowden et al., 2006), the meta-synthesis approach involves the amalgamation of qualitative data, i.e. words and text, from several studies to aid deeper understanding of a given topic area. It is anticipated that by synthesising qualitative research which explores the experiences of people with BPD in acute psychiatric wards, the role of treatment for this client group in this setting, particularly that provided by mental health nurses, can be better understood.

## Method

Meta-syntheses interpret aggregated findings from a number of qualitative studies in order to produce novel insights and theories (Walsh & Downe, 2005). The aim of a meta-synthesis is to generate theories, generalisations, or interpretations through the integration or comparison of original findings from qualitative studies (Sandelowski, Docherty & Emden, 1997). Specifically, meta-syntheses are useful for promoting greater understanding of lived healthcare experiences (Walsh & Downe, 2005).

The development of a systematic search strategy was aided by an initial literature search whereby relevant keywords were identified in order to refine the search terms and criteria for the present meta-synthesis. The PRISMA flowchart (Moher, Liberati, Tetzlaff et al., 2009), seen in figure one, was adapted for the meta-synthesis approach and depicts the search process. Inclusion and exclusion criteria were identified using the SPIDER (**s**ample, **p**henomenon of **i**nterest, **d**esign, **e**valuation, **r**esearch type) search strategy tool (Cooke, Smith & Booth, 2012). Table one outlines the inclusion and exclusion criteria using the SPIDER tool components. In addition to these criteria, only research published in English was included. A search for journal-published studies and books was carried out in four electronic databases (CINAHL, Medline, EMBASE and PsycINFO) from their dates of inception until April 2015. The following search terms were

used: "borderline personality disorder" or "emotionally unstable" *and* "experience," "attitude," "view," "perception," "emotion," "feeling" or "perspective" *and* "psychiatric hospitals," "psychiatric units," "psychiatric care," "mental health ward" or "mental health hospital," *and* "patients," "psychiatric patients," "inpatients," "hospitalisation," "patient admission," "admit," or "admission". To achieve a wider and more in-depth meta-synthesis (Walsh & Downe, 2005), a search was also carried out on the OpenGrey European database of grey literature. Potentially relevant articles were selected for full text evaluation to ensure they met the inclusion criteria. Overall, this resulted in the final selection of seven journal-published qualitative studies, one unpublished thesis and three journal published first-hand accounts of living with BPD. Table two displays the characteristics and methodological features of the included primary qualitative studies.

The Critical Appraisal Skills Programme (CASP) assessment tool (e.g. Carlsen, Glenton & Pope, 2007; Downe, Simpson & Trafford, 2007) was used to assess the quality of the included studies. Variation was found in the level of methodological rigour across the studies; there was greater depth of description of the data collection and analysis processes in some studies. Consideration of the researchers' own potential biases is an important part of qualitative research, however, this was lacking amongst the included studies (Milton Keynes Primary Care Trust [MKPCT], 2002). Taken together, these limitations impact upon the reliability of the findings from the first authors. Despite this variability in quality, all of the studies were included because knowledge is seen as constructed within the qualitative research paradigm and the meta-synthesist's interpretations of the studies' findings may be different to those of the original researcher(s) (Walsh & Downe, 2005). Reporting of the meta-synthesists' own positions and preconceptions can improve reflexivity rather than introduce bias (Malterud, 2001). The present authors' interpretations of the data may be influenced by their experiences of working with people with BPD as mental health clinicians. Furthermore, the research question was identified whilst the first author was carrying out a placement on an acute

psychiatric ward as a student mental health nurse and perceived negative staff attitudes towards the BPD diagnosis, thus this may have lead to an expectation to find patient reports supporting this in the literature.

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Data analysis followed a three-stage process similar to that used by Taylor, Shaw, Dale et al. (2011). Firstly, all data relevant to the research question was extracted and labelled as 'first order' themes. Similar first order themes were then clustered together to form 'second order' themes. Finally, similar second order themes were grouped together to form super-ordinate 'third order' themes (Walsh & Downe, 2005). Given that the lived experience articles (Williams, 1998; Desmond, 2004; Van Gelder, 2008) were not primary research studies, data from these sources was not incorporated into the identification of themes but was instead used to add depth to the meta-synthesis.

Given the nature of constructivist research, interpretation of the data by other meta-synthesists may have been different. Reflexive data analysis therefore involved cultivation of dialogue between the authors; the identification of themes was primarily carried out by the first author, with these findings being critically reviewed by the second author who looked for competing themes (Malterud, 2001). Malterud (2001) argues that agreement should not necessarily be the goal within qualitative research employing multiple researchers. However, in this case, consensus was achieved between the authors in the initial identification of themes.

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## Results

The eight studies were from three countries: UK (4), USA (2) and The Netherlands (2). The total number of participants across all of the studies was 90, with

the samples ranging from five to 30. Small sample sizes are typical of qualitative research; the use of large samples would hinder deep analysis and thus reduce the internal validity of the findings (Sandelowski et al., 1997). Data collection in six of the eight studies used semi-structured interviews (Gregory, 2011; Helleman et al., 2014b; Horn, Johnstone and Brooke, 2007; Koekkoek, Snoek and Oosterwijk et al., 2010; Nehls, 1994; Nehls, 1999), one used unstructured interviews (Fallon, 2003) and another used a focus group (Rogers and Dunne, 2011). All participants had a diagnosis of BPD and their age, where reported in five of the eight studies, ranged between 21 and 61 years.

Much of the rich qualitative data on the experiences of living with BPD provided in the personal accounts is beyond the scope of the present review; therefore, only data supporting the themes identified in the empirical studies was extracted from these sources. To offer a brief summary of each account: Williams (1998) suggests ways in which mental health professionals can help in recovery from BPD, including the role of hospital admission. Desmond's (2004) account of living with BPD throughout her teenage years and early adulthood includes her experiences as a psychiatric ward inpatient. Van Gelder's (2008) narrative aims to give the reader "a sense of what it's like to live with BPD" (p. 244) and includes some reflections on her experiences of hospitalisation. Interestingly, each personal account appears to have been written from the perspective of being recovered from BPD rather than being a current service user or inpatient.

The identified first order themes were clustered together to develop the following eleven second order themes: talking; being listened to; contact with fellow inpatients; staff attitudes towards BPD; staff knowledge and understanding of BPD; time-out; safety; control; discharge planning; use of the Mental Health Act (MHA) 1983; and dependency. These were then clustered together to develop the following four third

order themes: contact with staff and fellow inpatients; staff attitudes and knowledge; admission as a refuge; and the admission and discharge journey. The three stage process of identifying themes is demonstrated in table three. Text from the included studies is used here to assist in explaining the findings; text quoted from the original authors is indicated using single inverted commas (‘’), whilst double inverted commas (‘‘‘’’) are used to directly quote participants’ speech.

#### *Theme 1: Contact with staff and fellow inpatients*

This most prevalent theme was represented by data in seven studies (Nehls, 1994; Nehls, 1999; Fallon, 2003; Gregory, 2010; Koekkoek, Snoek, Oosterwijk et al., 2010; Helleman, Goossens, Kaasenbrood et al., 2014b) and developed from the three second order themes ‘talking,’ ‘being listened to’ and ‘contact with fellow inpatients.’ Having the opportunity to talk was perceived as a fundamental element of acute psychiatric wards:

“‘I guess for me the brief term plan offers just a chance to talk’” (Nehls, 1994, p.6)

Therapeutic benefits were reported as a result of having the opportunity to talk to professionals such as mental health nurses:

“‘The nurses think about things which I cannot think about at such moments. What I can do to find distraction, for example (and) how to handle things the next time. You learn what causes the problems, why you react the way you did’.” (Helleman et al., 2014b, p.446).

Opportunities for talking with staff appeared to provide emotional support to people with BPD. Therefore, a lack of such opportunities was emotionally detrimental and meant that the admission was less positive:



“It can be very frustrating. I felt so alone. I thought the staff would check on me, but they left me all alone. The panic didn’t become less. I didn’t get any structure, support, or feedback”.’ (Helleman et al., 2014b, p.447).

‘Being listened to’ was another element perceived as an important part of admission and was reported in six studies (Nehls, 1994; Nehls, 1999; Fallon, 2003; Gregory, 2010; Koekkoek et al., 2010; Helleman et al., 2014b). Admission was described as unhelpful when participants did not feel listened to and this was attributed to inpatient wards being too busy (Gregory, 2010). However, many participants valued being listened to by professionals, including mental health nurses, during times of emotional distress and felt that this was sufficient without the need for expert therapy (Fallon, 2003).

‘A participant described what mattered to her when she was contemplating suicide: “...caring sensitive persons who just listen and hear and respond from inside...maybe you’re inexperienced...but I as a consumer don’t care about that...”’ (Nehls, 1999, p. 290)

Contact with fellow inpatients was described as a useful and helpful part of admission in three of the studies (Koekkoek et al., 2010; Rogers & Dunne, 2011; Helleman et al., 2014b) and a first-hand account (Desmond, 2004). Describing her time spent on a psychiatric ward, Desmond (2004, p.5) states she “made a lot of friends” in hospital and that she and other inpatients were “bonded together through [their] collective pain”. In the studies, contact with people with similar difficulties was experienced as a good source of emotional support:

‘Contact with fellow BPD patients [provides] emotional support that is hard to find in non-BPD patients.’ (Koekkoek et al., 2010, p. 131)

The experience of having contact and shared understanding with both staff and fellow inpatients is described in the following extract of being hospitalised with BPD:

‘In 2001, when the country grieved the tragedy of 9/11, I sat in a hospital day room with three over-medicated women...The orderlies, the nurses...all seemed to finally share what I’d been feeling all along, as though the entire nation and my interior world had something to finally agree on.’ (Van Gelder, 2008, p. 247)

In summary, ‘contact with staff and fellow patients’ was the most common theme found in data from the primary studies as well as first-hand accounts. The importance and expectation of talking to and being listened to by staff during inpatient admission is highlighted, along with the benefits of having contact with fellow inpatients. The experience of admission was described as less positive and unhelpful when there were no opportunities for contact with staff.

#### *Theme 2: Staff attitudes and knowledge*

Two second order themes ‘staff attitudes towards BPD’ and ‘staff knowledge and understanding of BPD’ contributed to the generation of the third order theme ‘staff attitudes and knowledge.’ Data relating to this theme were found in five studies (Nehls, 1999; Fallon, 2003; Horn, Johnstone & Brooke, 2007; Gregory, 2010; Rogers & Dunne, 2011). Many participants in the studies described the negative attitudes of acute psychiatric ward staff towards people with BPD; for instance, some reported that staff unfavourably compared them to people who were experiencing mental illnesses such as schizophrenia:

“‘Ah it’s not as bad as schizophrenia”” (Rogers & Dunne, 2011, p. 229)

What’s more, many participants reported feeling as though staff thought that people with BPD did not warrant care and that they were “wasting a bed” (Rogers & Dunne,

2011, p.230). Such perceptions led people with BPD to feel “undeserving of inpatient care” (Fallon, 2003, p. 397).

Some participants also perceived staff as having a lack of knowledge and understanding of BPD, particularly of the reasons for the behaviours which people with BPD may display:

“There’s a lot of people that don’t understand PD. They put it down to ‘you’re just playing up, you’re being a pain in the bum’.” (Rogers & Dunne, 2011, p. 229)

Other perceptions of staff included a lack of desire to understand BPD. Whilst talking about the care received during a BAI, one participant described how she felt about care which prioritises risk management:

“They’re [mental health professionals]...more interested in protecting the...self-destructive [behaviour], but not paying attention to the causing of it” (Nehls, 1999, p. 290).

Mental health nurses were also viewed as avoiding opportunities to engage in helping people with BPD when they referred them to more specialist clinicians:

‘When they were presented with deeply disturbing emotional problems nurses usually dealt with this by advising the person to seek out expert help, for example by contacting their psychologist.’ (Fallon, 2003, p.397)

However, it was also noted that greater consistency in care was experienced where acute psychiatric ward staff had been educated by more experienced informants, such as psychologists, about “behaviour in relation to [people with BPD’s] personal histories, especially how their personalities and behaviour had been influenced by abusive events” (Fallon, 2003, p. 398).

In summary, acute psychiatric ward staff have been perceived as lacking knowledge of BPD and as having negative attitudes towards people with this diagnosis. More specialist mental health clinicians such as psychologists were viewed as having greater knowledge and understanding of BPD than nurses on the wards. As inpatients, many people with BPD described being met with negative and discriminatory attitudes of staff which led to some feeling rejected and undeserving of care.

### *Theme 3: Admission as a refuge*

The theme of 'admission as a refuge' reflects the more positive aspects of admission to an acute psychiatric ward that people with BPD experienced. The second order themes 'time-out,' 'safety seeking' and 'control' contributed to the generation of this theme. 'Time-out' was identified as a theme by the authors of three studies (Nehls, 1994; Koekkoek, et al., 2010; Helleman et al., 2014b). Admission to an acute psychiatric ward was viewed by some participants as providing time-out from daily life by providing rest, sleep and diminished responsibility:

'...the admission ward...is a space where they can take time off from their daily problems and responsibilities.' (Koekkoek, et al., 2010, p. 131)

The second order theme 'safety' was found in three of the studies (Nehls, 1994; Rogers & Dunne, 2011; Helleman et al., 2014b). Admission to an acute psychiatric ward was reported as helpful for providing practical and psychological safety for people with BPD who were experiencing a crisis:

'When the risk of suicide became too high, clients viewed the hospital as a place to keep themselves safe. One client expressed: "I feel a tremendous relief when I

get on the unit and turn in my pocket knife and the extra pills I have". (Nehls, 1994, p. 5)

The usefulness of psychiatric hospital admission in maintaining or regaining control is also perceived as important for people with BPD in overcoming a crisis (Nehls, 1999; Koekkoek et al., 2010; Helleman et al., 2014b). Control was also described in relation to the ward environment and the effects of the BAI, for example:

'The structure of a ward with its planned coffee breaks and meal times can help patients regain control of their lives' (Helleman et al., 2014b, p. 447)

'Another important positive element [of the BAI] is the control participants have over their own treatment' (Koekkoek et al., 2010, p. 131 – 132)

Awareness of the availability of hospital admission was also perceived as enabling maintenance of control in managing a crisis at home:

'When at home, the foresight of being re-admitted within a few weeks facilitates participants to deal with a crisis.' (Koekkoek et al., 2010, p.132)

To summarise, admission to acute psychiatric wards was experienced by many people with BPD as a refuge; particularly by those who have used the BAI. The importance of having time-out from daily life, as well as opportunities to seek safety and rediscover or maintain control during a crisis were highlighted as important elements.

*Theme 4: Admission and discharge journey*

The second order themes 'discharge process,' dependency' and 'use of the MHA' contributed to the generation of the third order theme 'admission and discharge journey.' Experiences of the discharge process were varied; positive experiences involved joint decision making and the use of Section 17 leave for those detained under the MHA prior to discharge (Fallon, 2003; Rogers & Dunne, 2011). Comparatively, negative experiences were described as being rushed (Horn et al., 2007; Rogers & Dunne, 2011), with people feeling rejected (Gregory, 2010) and unprepared for life back in the community (Rogers & Dunne, 2011), for example:

"I mean I forgot how to cook and everything, and I had three young children and when they discharged me I just didn't know where to begin" (Rogers & Dunne, 2011, p. 229)

Dependency on hospitalisation was experienced as a key element of the 'admission and discharge journey' by participants in three of the studies (Nehls, 1994; Gregory, 2010; Rogers & Dunne, 2011) and one first-hand account (Williams, 1998). Participants reported the experience of being regularly discharged and readmitted to acute psychiatric wards, a process which has been described using the term "revolving door" (Desmond, 2004, p.5; Rogers & Dunne, 2011, p.229). The theme of dependency was revealed where admission was reported as a positive experience that people with BPD can become "addicted" to (Nehls, 1994, p. 5). Dependency on admission also appeared to be associated with participants feeling cared for in hospital:

"I was just in and out of hospital but at least in hospital I felt cared for".  
(Gregory, 2010, p. 70)

'When my doctor wouldn't hospitalise me, I accused him of not caring' (Williams, 1998, p. 174)

Comparatively, Williams (1998, p.174) criticises hospitalisation as a treatment approach for people with BPD and states that it “activates needy feelings and perpetuates the patient’s sick self-image in her own eyes and those of staff.” Indeed, Williams (1998, p.174) describes her personal experience of psychiatric hospital admission as thus:

‘My self-destructive episodes – one leading right into another – came out only after my first and subsequent hospital admissions, after I learned the system was usually obligated to respond...It prevented me from having to make a choice to get well or even finding out that I wasn’t as helpless as I believed myself to be.’

Williams (1998, p.174) goes on to argue that repeated hospitalisation denies people with BPD the autonomy to realise their recovery and describes reminding herself of her “ever-growing time out of hospital” as a major motivation in pursuing her own recovery.

The experience of being detained under a section of the MHA in an acute psychiatric ward was reported by participants in two of the studies (Fallon, 2003; Rogers & Dunne, 2011). In Fallon’s (2003) study, participants felt angry at restrictions of their liberty when sectioning powers were used to detain them. Also, some participants experienced being coerced into staying on the ward voluntarily to avoid being detained on a section:

“I had an interview with the psychiatrist, who said I could stay voluntarily or he’d put me under section” (Rogers & Dunne, 2011, p. 229)

In summary, an array of experiences of the discharge process was described, ranging from collaborative and effective, to rushed and rejecting. Also evident in the data were the feelings of dependency on hospitalisation which were evoked by the experience of cyclical readmission. What’s more, many people with BPD reported

negative feelings and experiences in relation to use of the MHA to detain them on acute psychiatric inpatient wards.

## **Discussion**

The findings from the present meta-synthesis suggest that people with BPD have both positive and negative experiences of admission to acute psychiatric wards. This echoes findings from previous research exploring the acute psychiatric care experiences of people with mental health diagnoses other than BPD (Quirk & Lelliott, 2001; Walsh & Boyle, 2009). The finding that people with BPD perceived staff to have negative attitudes towards them supports existing research (Markham, 2003; Markham & Trower, 2003; NIMHE, 2003; Deans & Meocevic, 2006; Westwood & Baker, 2010; Bodner, Cohen-Fridel & Iancu, 2011; Weight & Kendal 2013; Morris et al., 2014). However, it should be noted that the majority of perceptions of negative staff attitudes were reported by participants in Rogers & Dunne's (2011) study whose data collection technique was a focus group attended by just ten of a total of 65 service users invited from a community personality disorder service. It is therefore possible that only those whose experiences had been negative were more likely to participate as they felt compelled to express their concerns.

The findings from this meta-synthesis counter the assumption that mental health professionals have greater empathy for the people they support and are unlikely to engage in stigmatising behaviour (Bates & Stickley, 2013). According to social learning theories, people form attitudes based on what they learn from others (Bernstein, Penner, Clarke-Stewart et al., 2006); thus it could be argued that negative attitudes towards people with BPD held by staff in mental health services are perpetuated as staff model the feelings, beliefs and behaviours they have learned from one another. Attitudinal



change can result from providing people with information which they can process and critically analyse (Bernstein et al., 2006). It is likely, therefore, that some negative attitudes held by staff about BPD stem from a lack of knowledge about the condition. Indeed, participants in the present meta-synthesis also perceived ward staff as having a lack of knowledge and understanding of BPD, thus highlighting a need for additional training for staff working on acute psychiatric wards to increase knowledge about how to support people with BPD.

The NCCMH (2009) highlights the value of specialist personality disorder services in delivering support, training and advice to secondary mental health services such as acute inpatient wards. Research indicates that health professionals are interested in further training in order to improve their knowledge and understanding of BPD (Cleary, Siegfried & Walter, 2002; James & Cowman, 2007; Bodner et al., 2011). In order to work effectively with this client group, NICE (2009) guidance states that professionals should be aware of the likelihood that many people with BPD will have had past experiences of rejection, abuse and trauma, and encountered stigma associated with self-harm.

In the wider political context, tackling negative staff attitudes towards BPD would assist in achieving an objective of the Department of Health's (2011) 'No Health Without Mental Health' policy for fewer people to experience stigma and discrimination. A review evaluating the effects of the 'Time to Change' campaign against stigma and discrimination towards people with mental health problems found a lack of improvement in the amount of discrimination experienced by service users from healthcare professionals (Henderson & Thornicroft, 2013). Corrigan (2000) highlights that people who are labelled with a mental health problem can continue to be stigmatised even when they do not display behaviours which are attributed to the diagnosis. This is supported

by evidence that people with BPD have been rejected from services, including inpatient wards, merely upon receiving their diagnosis (Horn et al., 2007; Morris et al., 2014). Advocating a person-centred approach, Rogers (1957) states that knowledge of a person's diagnosis is not necessary in order to facilitate therapeutic engagement. Although some people find diagnosis helpful, mental health labels promote practice within the medical model (Scott, 2010) which has traditionally dominated acute psychiatric inpatient care (Baguley, Alexander, Middleton et al., 2007).

In spite of the aforementioned criticisms of acute psychiatric care for people with BPD, this meta-synthesis also highlights positive elements of ward admission, such as the opportunity for time-out from daily life. This supports findings from previous research that acute psychiatric wards are perceived by service users as a sanctuary and distraction from the outside world (Walsh & Boyle, 2009). Interestingly, however, data from this theme came only from those studies which explored the BAI. As noted by Koekkoek et al. (2010), only participants who were happy with the BAI may have agreed to participate. What's more, the rationales for these studies may have lead the researchers to be biased in their reporting of the results; for example, Helleman et al.'s (2014b) rationale was the literature gap in patients' perceptions of what makes a brief admission effective; thus, they may have ignored data which highlighted how the BAI is ineffective. Also, it is unclear how much the interviewers in these studies guided participants to provide positive feedback as the keywords used in the interview schedules which guided the semi-structured interviews were not stated (Koekkoek et al., 2010; Helleman et al., 2014b). In addition to time-out from daily life, the themes of safety and control were also only found in those studies exploring the BAI. This suggests that the BAI enables acute psychiatric wards to effectively fulfil their purpose of providing a safe space during a crisis (CAAPC, 2015) as well as ultimately offering people with BPD a sense of control over their recovery.

Another important finding that emerged from the study was that people with BPD feel dependent on inpatient wards. Fagin (2004) suggests that ward staff should be prepared for people with BPD being regularly readmitted and that they should adopt a historical perspective to reflect upon how the person has changed over time. Enhancing hope amongst staff about the potential for future change may enable them to engage with people with BPD in a more recovery-oriented way. Jones, Nolan, Bowers et al. (2010) also point out that many people admitted to psychiatric wards find it difficult to let go of the safety they experience as inpatients. This could explain the finding in the present study that many people with BPD found the discharge process stressful. As highlighted by Fagin (2004), the Care Programme Approach is a useful tool for enabling discussion of boundaries, expectations and responsibilities of all involved in the care of the person with BPD to ensure a more effective discharge and reducing feelings of dependency on inpatient admission. Williams' (1998) argument in her lived experience article, that hospitalisation is counter-productive in the psychological recovery of people with BPD, contradicts the theme of 'dependency' found in the primary studies. However, given that Williams (1998) outlines her position of no longer being symptomatic of BPD, this adds weight to the finding that the symptomatology of BPD fosters a feeling of dependency on inpatient wards.

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Most people in England receive acute psychiatric care on a voluntary basis (CAAPC, 2015); however, the present findings support previous research that some people in the UK experience being threatened with detention under the MHA in order to prevent them from leaving hospital (Gilburt, Rose & Slade, 2008). The MHA Code of Practice (Department of Health, 2015, p.116) states that: "the threat of detention must not be used to coerce a patient to consent to admission to hospital or to treatment." As well as being morally concerning, this practice may further undermine the ability of

people with BPD to take care of themselves (NCCMH, 2009). Such 'de facto detention' could be attributed to defensive practice whereby clinicians prioritise self-protection from blame over the patient's best interests (Mullen, Admiraal & Trevena, 2008). Doctors have reported feeling pressurised into "practicing defensive medicine" on acute psychiatric inpatient wards and feel that this is unacceptable and non-therapeutic for service users (CAAPC, 2015, p.13).

Contact with ward staff, including talking and being listened to, was highlighted as an important and expected part of admission by people with BPD. However, the present study's finding that people with BPD sometimes experienced a lack of contact with ward staff supports existing research on service user experiences of acute psychiatric care (Walsh & Boyle, 2009). In the present meta-synthesis, this was attributed to staff being too busy or uninterested in supporting people with BPD. Being listened to by nurses was reported as sufficient (Nehls, 1999); however, it was also perceived that nurses may refer people with BPD to experts because they felt they lacked the knowledge for effective therapeutic engagement (Fallon, 2003). These findings suggest that acts of compassion by nurses, such as finding more time to listen (Morris et al., 2014), could greatly improve the experiences of people with BPD on acute inpatient wards. In a wider context, the findings support the Royal College of Nursing's (2014) assertion that a shortage of mental health nurses in the UK is detrimental to service users' care experiences. The finding that contact with fellow patients is a positive experience of acute inpatient ward admission supports existing research (Quirk & Lelliott, 2001; Gilburt et al., 2008; Jones et al., 2010) and suggests that empathy and mutual understanding between inpatients is important, particularly where there is a lack of opportunities for contact with staff.

When considering the limitations of the present study, it is pertinent to acknowledge that a criticism of the meta-synthesis methodology is that the integrity of primary qualitative research is destroyed once it is summarised (Sandelowski et al., 1997). Despite this, as the scope of the findings from meta-syntheses is wider than that of single qualitative studies, they are likely to be more generalisable to the phenomenon being studied (Zimmer, 2006).

Furthermore, as two of the reviewed studies were carried out in The Netherlands and two in the USA, generalisations about the provision of acute psychiatric care for people with BPD in the UK are made cautiously. Although some findings were comparable across the three countries in which the reviewed primary studies were carried out, more negative experiences appeared to be reported in the UK studies. However, this may have been influenced by the fact that the non-UK studies explored experiences of the BAI rather than unplanned admissions. To further explore the efficacy of the BAI, future research should specifically compare experiences of people with BPD using the BAI compared with unplanned admissions.

It is also noteworthy that all of the reviewed studies based their findings on participants' retrospective ratings of their experiences in acute psychiatric wards. This may have lead to a potential recall bias whereby participants' recollection of past events is distorted (Hassan, 2005). Interestingly, research suggests that people with BPD may be more susceptible to a recall bias of negative rather than positive emotions (Ebner-Priemer, Kuo, Welch et al., 2006). Future research could therefore focus on exploring the experiences of people with BPD during their admission to acute psychiatric wards.

The first author's interest in the experiences of people with BPD was developed through carrying out a placement on an acute psychiatric ward as a student mental health nurse and perceiving negative staff attitudes towards the BPD diagnosis. Given the importance of reflexivity in qualitative research (MKPCT, 2002), consideration that this experience may have influenced the data analysis is important. However, the findings that people with BPD have both positive and negative experiences of acute psychiatric inpatient care suggest a lack of reporting bias. Reflexivity could have been further augmented by the use of a reflexive diary as suggested by Moon (2008) wherein the researcher critically analyses their own experiences, assumptions and potential bias during the data analysis process.

**Commented [A4]:** I will delete this paragraph as it is pretty much the same as what I've added about my 'own position' in the methodology.

## Conclusion

The findings from this meta-synthesis have highlighted positive and negative elements of acute psychiatric inpatient care experienced by people with BPD. Although some findings were comparable across the three countries, less positive experiences appeared to be reported in those studies carried out in the UK in which participants had unplanned admissions rather than the BAI. Of significance was the perception of negative staff attitudes towards people with BPD as this finding supports existing literature and highlights the importance of the education and training of staff.

Overall, the findings are informative for the development of a care pathway for people with BPD as they suggest that, despite the dependency on hospitalisation that some participants reported, acute psychiatric inpatient care is perceived by service users themselves to have an important role in crisis management. However, changes to acute psychiatric inpatient service provision and mental health nursing practice are still required in order to further improve the experiences of care for people with BPD.

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