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Trust as a foundation for the therapeutic intervention for patients with borderline personality disorder

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A qualitative, exploratory, descriptive and contextual study using an 'interpretive descriptive approach' was undertaken in order to develop a practice-level model for the facilitation of mental health of patients diagnosed as having Borderline Personality Disorder by the community psychiatric nurse. The context of the study was the in the Psychiatric Community Services in the greater Johannesburg region, South Africa. Individual and focus group interviews were conducted with patients and mental health clinicians representing the multidisciplinary team with experience in managing the condition, either in a personal capacity or as professional mental health practitioners. Themes extrapolated from the transcribed interviews were further explored and a practice-based theory was constructed. This article reports on the first theme 'Trust', the concept identified by both patients and clinicians as crucial for the establishment and maintenance of the therapeutic relationship that forms the vehicle for care of patients with this disorder in psychiatric mental health care.

Keywords: Borderline Personality Disorder, community psychiatric nursing, therapy

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Introduction

Borderline Personality Disorder (BPD) is characterized by a pattern of instability of interpersonal relationships, self-image and affect, and marked impulsiveness beginning by early adulthood and present in a variety of contexts (American Psychiatric Association 1994, p. 654). Self-mutilation and substance abuse are common (Kaplan *et al.* 1994, p. 739). Mortality is high – between 6.7 and 8.5% of the patients succeed, by error or design, in completing suicide (DeMoore & Robertson 1996, p. 489). Clinicians perceive them as difficult and are likely as feel overwhelmed and disempowered, resulting in multiple referrals (Lewis & Appleby 1988, Fergusson & Tyrer 1991).

Borderline personality disorder

Few statistics exist regarding the prevalence of BPD in South Africa, however, Fainman (2001, p. 34) estimates the prevalence of personality disorders in the general population as 11–23%. As these clients are 'frequently self-harming, high users of costly services', (Blackshaw *et al.* 1999, p. 9) it can be deduced that the costs in human and financial terms are significant. Multiple short-term admissions are advocated in order to assist the patient to regain control of the current crisis and equip them with coping skills (Higgit & Fonagy 1992, p. 36, Nehls & Diamond 1993, Stone 1993, Nehls 1994, Norton & Hinshelwood 1996, p. 723). Casualty departments, crisis intervention facilities, private and non-governmental organizations and informal psycho-

social support services are utilized disproportionately. However, in most cases these facilities cannot offer the continuing care because of staffing and financial constraints and the demand placed upon them by all sections of the population. The majority of patients admitted to psychiatric inpatient facilities in South Africa suffer from major mental disorders and few facilities are able to offer programmes suited specifically to these patients with personality disorders. Privately funded therapy is costly and, in the long term, requires commitment from the patient, but the patients' tendency to impulsive, self-destructive behaviour, neediness, sensitivity to perceived rejection and inability to form and sustain meaningful relationships frequently jeopardize the relationship.

The South African government's policy is to move towards community-based primary health care (African National Congress 1994, p. 19, S.A. Government, Department of Health 1995). Clients are assessed and, if possible, their treatment is managed at this level. Those requiring specialized assistance beyond the scope of a primary care practitioner would be referred to a specialist mental health care provider for assessment, follow-up and ongoing therapy; the community psychiatric nurse (CPN) is one such provider: 'Psychiatric nurses provide the bulk of the services, supported by a relatively small number of psychiatrists' (Freeman & de Beer 1992, p. 340, South African Nursing Council 1992, p. 4, S.A. Government, Department of Health 1995, p. 4, Moodley 1997, p. 5, Gauteng Province Department of Health 2003).

Much has been written about managing patients in a hospital setting (Sansone & Sansone 1991, Westen 1991, Nehls 1994) and the management of the process of psychotherapy has received attention (Fonagy 1991, Linehan *et al.* 1991, Nehls 1991, Goldstein 1993, Malcom 1994 (unpublished), Perris 1994, Shearin & Linehan 1994). However, there is a paucity of research into the management and care of these patients on a long-term basis in the community by CPNs (Clarkin *et al.* 1991, Nehls 1991, 1992, 1994, Sansone & Sansone 1991, Searight 1992, Chessick 1993, Dallam 1997, Profis 1997).

Increasingly, patients are expected to assume a greater responsibility for and an active role in the management of their health and lifestyle. Their expectations, experience and expertise must be acknowledged, respected and form the basis of care (Lutzen 1996 quoted in de Raeve, p. 73). Little is known about what patients with a psychiatric diagnosis, particularly those with a diagnosis of personality disorder, perceive as acceptable or helpful care. Programmes that address both the patient's needs and the clinician's resources in terms of knowledge, skills and attitudes are required in order to assist clinicians, particularly community psychiatric nurses, to care for clients in the community.

As an advanced psychiatric nurse practitioner, I proposed that insight into the experience of patients and clinicians would provide a basis for a model to facilitate the mental health of the patient within the family and the community. Against this background, the following central question emerged: what factors do patients and clinicians living with or caring for people with such a condition consider helpful in facilitating their mental health?

A qualitative, exploratory, descriptive and contextual study using an 'interpretive descriptive approach' (Thorne *et al.* 1997, pp. 169–177) was undertaken in order to develop a practice-level model for the facilitation of the mental health of the client diagnosed as having BPD by the (CPN). Psychiatric Community Services in the greater Johannesburg region, South Africa comprised the context of the study. This article reports on the first theme extrapolated from data collected from patient and clinician interviews and focus groups, that is, 'Trust'.

Methodology

Permission from the University Ethics Committee, provincial and hospital management authorities as well as unit managers was solicited and granted for the study. Patients and clinicians participated voluntarily, having been given detailed written information, and signed a consent form. Anonymity, confidentiality and the right to withdraw at any stage of the study were assured.

Twenty possible patient participants 'willing and able to critically examine the experience and their response to the situation . . . willing to share the experience with the interviewer.' (Morse 1991, quoted in Holloway & Wheeler 1996, p. 75) were purposively selected from the outpatients and psychotherapy unit records of a specialist referral hospital. Inclusion criteria required that all had received the diagnosis of borderline personality disorder according to DSM IV criteria and that all had experience of being both inpatients and outpatients as well as experience of attending individual and group therapy with a mental health professional in private practice. (Six participants, five women and one man, were interviewed before saturation was attained) (Creswell 1998). Patient participants were interviewed individually, using an informal, conversational style, in a private office or in their home; each interview lasted for 1 to 2 hours. An open question was posed: '. . . (Name), as you know, I'm interested in what patients like you have found personally helpful in maintaining their health. Tell me, what have you found helpful?'. The patients were encouraged to reflect upon specific incidents in order to elicit thoughts and feelings, which, as far as possible, were a true personal interpretation of what actually happened to illustrate their perspective. Initially, most of

the participants recounted stories about the helpfulness of hospital care or individual mental health professionals. Thereafter, their experiences of helpful strategies and resources offered by other people and organizations, both formal and informal, and personal strategies and strengths and resources, which they utilized in managing their life, were recounted.

Following this, clinicians were interviewed. Inclusion criteria required that they had extensive experience in the management of borderline personality disorder in both the private and public mental health systems and that they represented all members of the multidisciplinary mental health team. A consultant psychiatrist who also had training and experience in psychoanalysis, an advanced psychiatric nurse practitioner, a psychiatric social worker in private practice and a psychiatric community nurse were interviewed individually ($n = 4$). Two psychiatrists (one was a consultant on a psychotherapy unit), a clinical psychologist, two advanced psychiatric nurses and a counselling psychologist ($n = 6$) participated in a focus group discussion.

The clinician participants were interviewed either individually in their consulting rooms or in a focus group discussion that took place in the lounge of a psychiatric hospital. The question asked was: 'In your experience, what are interactions and therapeutic management factors which you have found to be useful and of benefit to your patients with BPD?'. All interviews were tape recorded and transcribed verbatim. In addition, during the interview and immediately thereafter field notes were taken and later added to the transcribed material.

Results and discussion

Data analysis using the eight steps for systematically analysing textual data described by Tesch (1990 quoted in Creswell 1994, pp. 153–155) proceeded concurrently with the process of data collection, interpretation and writing. Guba's model was used to ensure the trustworthiness of the data (Krefting 1991, p. 215). Matrices were used to organize the data – arranging the categories and themes into tables that allowed for a systematic display of the information and the identification of negative cases (Miles & Huberman 1994). Comparisons were made with earlier interview transcripts until certain patterns and themes became evident: trust, a working relationship, focus and 'carrying on'. In identifying these as helpful factors, patients indicated that these were attributes that they believed they lacked and that they felt they needed help in developing. Themes extrapolated from the interviews with clinicians were astonishingly similar: trust, a working alliance, focus and constancy. Tables 1 and 2 provide a summary of the identified themes and subthemes. A consolidation discussion was arranged with independent experts where the results of the analysis were discussed. The themes were then subjected to recontextualization in the literature (a literature survey), described and excerpts from the transcripts and observational notes appended in order to illustrate the relevant theme.

It was evident that all participants identified trust as essential for the establishment and maintenance of a therapeutic alliance, stressing that without trust any intervention was unlikely to succeed.

Table 1
Themes and subthemes extrapolated from patient and clinician interviews

Theme	Patients' subthemes	Clinicians' subthemes
Trust	Trust a foundation	A foundation, hook or anchor
	Holding and caring	Knowing the client
	Available and accessible	Takes time, start slowly
	Listening – trying to understand	Being there: available and accessible
	Professional	Honesty
	Hope	Acknowledging the reality of the patient's experience
		Hope
A working relationship (Patients)	Responsibility	Contract
A working alliance (Clinicians)	Containing	Responsibility
	Learning skills	Containment
Focus	Resources, activities and interests, family, friends, religion, a job keeps you focussed and helps	Focus on strengths
		Focus on reality
		Enlist other resources
		Choice of therapeutic approach
		The community psychiatric nurse as primary clinician
Carrying on (Patients)	Carrying on	A long-term commitment
Constancy & commitment (Clinicians)	Knowing and accepting yourself	Consistency
	Choices, but you have to have yourself to make them	Your own support system
		Making mistakes
		Choices

Table 2
Subthemes extrapolated from patients and clinicians on the theme 'Trust'

Patient: Subthemes	Trust, a foundation
	Holding and caring
	Available and accessible
	Listening – trying to understand
	Professional
	Hope
Clinician: Subthemes	A foundation, hook or anchor
	Knowing the patient
	Takes time, start slowly
	Being there: available and accessible
	Honesty
	Acknowledging the reality of the patient's experience
	Hope

The results regarding the theme 'Trust' are presented and illustrated by excerpts from the transcripts. For clarity, patients are identified by the term patient (Pt and number of the interview) in brackets after the excerpt, individually interviewed clinicians by the abbreviation Cl and number of the interview and those in the focus group by the abbreviation FG.

Trust

Trust was described by every patient as a foundation, the essential requirement for the establishment and maintenance of any relationship. In the therapeutic relationship, this trust or belief in the other person was linked to the concept hope. Once trust was established, the patient began to believe that the clinician might help them, and this provided the basis for the therapeutic relationship:

> Because first you've got to build up trust in the person you've got to talk to. You start opening up once you've started trusting that person. (Pt: 2).

Clinicians described trust as an anchor, a hook or foundation and maintained that the establishment of a trusting relationship was essential prior to any more dynamic interventions being implemented:

> It's more a holding until we are able to work in therapy (FG). Consistency, limits, bonding with the patient so the holding relationship comes (FG).

There were certain conditions that were thought by patients to be essential for the development of trust: that the clinician needed to be perceived as **available** and accessible, **trying to understand** by listening, **caring,** which conferred a feeling of being held and contained so that they felt **emotionally and physically safe, professional** evidenced by attributes such as honesty in all interactions, maintaining confidentiality, not relating to the patient as an 'expert' but as an adult person, remaining calm and not over-reacting to the issue under discussion and maintaining strict confidentiality. Only when satisfied that the clinician was sufficiently experienced, professional, flexible and empathic would the person be deemed trustworthy and a foundation for the therapeutic contract be laid. They also maintained that developing trust took **time**, and that the trustworthiness of the clinician and of the therapeutic relationship would be **tested** and, if perceived to be wanting, the patient would have difficulty in continuing the relationship. Four of the patients stated that if they perceived that both the clinician and the relationship were trustworthy, they were able to hope: 'There is hope that somehow I'll get there . . .' (Pt: 4)

Clinicians described trust as a **foundation, hook or anchor** for the relationship. They concurred that **trust took time** to develop and emphasized that the clinician should start slowly and not attempt interpretive therapeutic strategies until a trusting therapeutic alliance had been firmly established. The importance of **knowing the patient** was emphasized: a full history, knowledge of the patient's strengths and patterns of coping as well as their support system being deemed essential: '. . . a full history, collateral, some idea of core personality strengths and what ego resources there are, and then consistency in building on those strengths to build up . . . give a sense of self . . .' (Cl: 3). In addition to this, they also stressed that empathy, understanding and **acknowledging the reality of the patient's experience** and the fact that, whilst the manner in which the person attempted to manage their problems might be less than effective or damaging, given the person's often traumatic past it had to be acknowledged that it was the 'best they could do'. Being **available and accessible** (within negotiated limits and whilst maintaining professional and personal boundaries) to support the patient when vulnerable or in crisis provided continuity, stability and a safe place for the patient: 'they need containment and structure and direction and confrontation and kindness and honesty . . . some kind of crutch to help them . . . once you get past that, then you can start to move with other things.' (FG) **Honesty** was also emphasized as a means of reinforcing the establishment and maintenance of trust. Interestingly, they also linked the emergence of **hope** to the establishment of trust: '. . . the stability of the caregiver and their commitment, that's a big anchor to the foundation, because you have to carry that hope when they can't.' (Cl: 3).

Available & accessible

The patients were realistic in that they acknowledged that being available for them at all times was not humanly possible, but they suggested that an agreement could be reached as to contacting the therapist at set times. Negoti-

ating the terms of when and how to contact the counsellor, they concurred, both reassured them and helped them postpone the urge to act impulsively:

> If you know you can get in contact at some stage, you know, you said I can phone . . . nine o'clock . . . that it's an agreed upon thing and you don't abuse it. (Pt: 1).

> It feels like there's just a million jumbled up thoughts, it helps writing to my therapist. You have to have somebody to receive them, . . . Fax: them just by somebody receiving it, just little things . . . listen, I'm not in control, its very, very containing. (Pt: 1)

With regard to the issue of availability, clinicians cautioned that limits needed to be set. All stressed that structure, containment and direction were essential to impress upon the client the issue of their own responsibility and to enforce reality:

> . . . magical thinking, the omnipotence of the therapist – always able to rescue and be there . . . must be aware of their own limitations, otherwise they will act out because they've had enough. (Cl: 1).

In addition to this, clinicians underlined the importance of maintaining limits and being honest with the patient about this so as not to become overwhelmed with the patient's problems and prevent the breakdown of the relationship due to therapist 'burn out'.

> They get disappointed but this is reality testing . . . to see us also a human being with own needs and vulnerability . . . also to help patients with their omnipotence. Otherwise the therapist will act out too because they've had enough. (Cl: 1).

Caring

All participants continually returned to the theme of caring, stating that they would believe that the person cared if he or she was perceived as trying to understand their frame of mind or emotions by really listening to them and trying to understand their reality at the present time, by being available when they needed them and by accepting them as they were. Phrases used were:

> Well, they're there for you. (Pt: 5);

> Just be there for them! (Pt: 2);

> Just accepting me for who I am. Not for what the world expects you to be. Just being there. (Pt: 4)

> If other people see a you and not just a . . . a thing, a problem, then maybe you can also see a you and maybe start to even work on it, to try to work, you know? (Pt: 6)

> Don't just break it off, acknowledge me as a person . . . , ordinary conversation – saying 'take care' means so much! (Pt: 1)

Feeling emotionally and physically safe was an important element of trust. Participants frequently mentioned the fear of losing control, of not feeling contained or held. However, just as frequently, they mentioned that they did not want control imposed upon them but agreed that they needed to be held or contained. A number of suggestions were put forward as to how the clinician could help with containment and self-control without imposing the control arbitrarily. Helping the client structure time, negotiating limits and boundaries that needed to be set and the issue of medication were some of the means identified:

> You can do anything as long as you have that final choice. I think options are really important . . . freedom in a way, cause you feel so trapped by your own pathology, you need a way out of it, and I think that's in choice. (Pt: 1)

Winnicott (1965) speaks of a holding relationship, the significant object (initially the 'good enough' mother and in this case the therapist) acting as a 'container' for the strong emotional storms of the patient. The holding, containing relationship is one means of reassuring the client that the clinician is there to assist the client in retaining control and, where necessary, assume control on his or her behalf. All patients conceded that there had to be limits and boundaries – both in the therapeutic relationship and with regard to their behaviour. This concession was accompanied by the reflection that they did not necessarily like the limits imposed but they were useful. Limits and boundaries were described as being like a:

> double edged sword (Pt: 1) and:

> like a knife edge, walking a fine line (Pt: 4).

One patient interpreted limits in another way:

> . . . it means that the dangers are recognised and considered, the person understands (Pt: 3).

The 'holding' could also be interpreted as 'held together'. The therapeutic alliance, the experience of a firm but concerned and caring and consistent 'other', structuring the client's day, the counselling sessions, imposing limits and boundaries, maintaining a focus on goals, an emphasis on managing the vicissitudes of their tumultuous daily lives by using and adding to their strengths and positive coping mechanisms all impose a physical and emotional holding that allows patients to experience a feeling of safety and containment.

Because one of the defining features of borderline psychopathology is impulsive behaviour for which the proper antidote is limit setting, all schools of thought emphasize this aspect of treatment. Although limit setting is intrinsically a behavioural technique, its importance in the treatment of patients with borderline personality disorder is to defy neat categorization in just one school of therapy. Rockland (1992) in discussing supportive therapy, Kernberg (1993, cited in Paris 1998) in transference-focussed psychotherapy, Gunderson (1984) in analytically oriented

therapy, and Linehan (1993) in dialectic behavioural therapy all advocate limit setting as one of the important supportive interventions.

As with limits, patients recognized the value of imposing structure on their time and activities:

> Ja, structure, but I've got to know why, negotiate, ja it's helpful (Pt: 4);
>
> I was so busy, I didn't have time, that's the thing! But it was hard – I've never worked so hard! (Pt: 6);
>
> . . . a job, it gives you focus. (Pt: 5).

Four patients, in the course of the interviews, admitted that a contract that set out limits and boundaries to be observed, tasks to be undertaken and responsibilities assumed in a formal agreement was helpful but insisted that the terms of the contract be negotiated.

Negotiation rather than imposing terms, limits and consequences affirms the person's adulthood or 'personhood' and it was apparent that the participants had experienced being treated in a manner that had negated this. All had experienced the situation of having conditions or actions imposed upon them in response to their behaviour.

Clinician participants all advocated using a contract to reinforce the mutuality of the partnership and the client's responsibility, and to help empower the client, emphasize limits and boundaries and state who could be informed of the client's condition at specific times and instances when the client could contact the therapist: '. . . it's all about responsibility; based on the contract and the fact that there's honesty. The responsibility is theirs.' (Cl: 2)

Trying to understand

All patients maintained that talking to someone helped – the clinician talking to them in a manner that acknowledged them as people or engaging them in a conversation that helped them focus on something other than their own distress. When asked how the therapist or clinician might demonstrate this, the basic counselling skills of therapeutic communication were given: attending closely with evident concern and interest, just being there and using touch:

> . . . not pushing me away, you get pushed away. Um . . . someone listening and trying to show that they were trying to understand. You don't even have to understand. (Pt: 2);
>
> Listening to me, not to what I've done or even to what I'm trying to say even to myself, you both try to understand. (Pt: 6)

Listening did not imply that the person did understand, in fact, it was not important to understand exactly what the patient was trying to say but rather to focus on the tone of the message and try to clarify the content for the patient. As one participant said, she sometimes did not understand herself! Another stressed that whilst she might know intellectually what she was feeling, she did not understand it at a more visceral level. As with trust, one participant said that she would test that the other person was listening and trying to understand by:

> Throwing out clues . . . amazing when they're picked up – it shows that they're really listening and understand. Then they stop you and say 'what's this?' (Pt: 1)

Cody (1999) cites Reed-Pervis & Dakin in discussing therapeutic approaches that might be used in health visiting, maintaining that health visiting is fundamentally therapeutic and asserting that the practice of health visiting is based on establishing a relationship with clients. These approaches include 'active listening skills; 'being with' a person; and questioning. This relationship facilitates disclosure, providing the health visitor is a good listener and, after disclosure, the practitioner can effect an increase in the client's self-esteem and sustain the disclosure at the client's pace – a mode of intervention that, she asserts, is both desirable and accepted health visiting practice.

Talking to friends and family was viewed somewhat differently. Friends appeared to be relied upon to step in and support them when they were distressed. It was mentioned by five of the patient participants that friends were far more tolerant than family members who were generally perceived as judgmental, overprotective and had the tendency to overreact to emotional situations. Where friends were perceived as withdrawing their support or being insufficiently caring, this was perceived as rejection. In contrast, one participant claimed that friends were one of the factors that caused her to make the decision to start taking responsibility:

> She said she couldn't go on, being called every time there was a crisis, to rescue me – she was there as a friend, not as a therapist, she was right. (Pt: 1)

Friends also kept them focussed:

> they force you to go out, do things, they keep you focussed. (Pt: 5).

However, it was acknowledged that, should the friend also be distressed, talking to one another could result in both affecting one another and worsening the situation.

Clinicians agreed that friends, family and work colleagues were important, both as friends and, in the case of colleagues at work, for providing a structured environment. One clinician insisted that patients provide the names of friends or family members as resources to be contacted when she was concerned about the well-being of the patient; this was then written into the contract. She maintained that doing so was an act of establishing the formal relationship as well as an act of reassuring the patient about the clinician's trustworthiness, of reinforcing the safety of the person, and of ensuring that the clinician had resources to call should a crisis arise. Another mentioned

that any kind of stable relationship augured well for progress and stressed that patients should be assisted to develop and nurture their relationships:

> . . . once they get into a stable relationship you find that the support – friend, lover, whatever – if that's sustained, it tends to contain them to a large degree. (FG)

Professional

Patients would adjudge clinicians as professional if they were honest, if they maintained confidentiality, if they were able to apply different therapeutic strategies with flexibility rather than demonstrate expertise in any particular school of therapy and if they remained calm but empathetic when entrusted with emotive issues. Buckley (1994, p. 524) remarks that central to the therapeutic posture of object relations theorists such as Fairbairn, Winnicott and self-psychologist Kohut is the empathetic stance they adopt towards the client ensuring the 'safety of the therapeutic situation'. This allows the person to experience a 'good object' who will be internalized and thus mitigate or repair deficits in the self-structure resulting from inadequate parenting.

Four participants stressed the need for the clinician to interact with them as people, not patients, and relate to them on an adult-to-adult level. The need for the significant others, may they be friends, family or professional helper, to treat them as people, not as problems, objects or children, was forcefully articulated:

> I'm not just a case or a problem or a parcel or a thing. I've got problems, ja, but I'm not just a problem! (Pt: 6).

Gross (2001, pp. 207–217) argues that the therapist needs to communicate integrity to the patient in order to protect the person and engender trust. When honesty is emphasized as a requirement from both parties in the relationship and when it is demonstrated by the clinician, the patient is likely to reciprocate by being honest in turn. One clinician said:

> . . . when the contract is explained to them, I've found my patients to be quite honest, actually. One patient said 'I know I signed the contract and we discussed honesty, I need to tell you that a week ago I went and . . .' but she came to tell me! (Cl: 2)

Thorne (1996, in Dryden, pp. 132–133) states simply that unless therapists can relate in such a way that patients perceive them as trustworthy and dependable, therapy cannot take place.

Trust takes time

Patient participants emphasized that trust took time to develop:

> It took me a long time to trust, a good couple of years to even trust her. (Pt: 6);
>
> It takes me a long time, a very long time. (Pt: 4)

McHale and Deatrick (2000, pp. 213–215) found that trust is a process that requires time to develop, exists at varying levels, requires a mutual intention and reciprocity and is characterized by expectations – each person involved relies on and expects something from the other. Cardasis *et al.* (1997) maintain that, as individuals with BPD have failed to achieve object constancy, effective therapy requires that the therapist use time as a vehicle for change, make few interventions initially but maintain an attentive interest without offering interpretations or prescriptions for action. This allows the patient to gradually adjust to the idea of self-continuity over time and this also reassures their feelings of unease with separateness and fear of abandonment.

Hope

Four of the patient participants linked the establishment of trust to the emergence of hope. It appeared that, once trust was established, hope in a goal or something to look forward to began to be engendered:

> Something it's worth looking forward to. Maybe having a down day and feeling really bad but you know that it's not going to be like this forever. (Pt: 2).

Clinicians appeared to agree with the issue of hope emerging when trust was established:

> I think it's a big anchor to the foundation, you have to carry that hope. (Cl: 3);
>
> A trusting alliance if you can hook them, you may hold them. (FG)

Many BPD patients have been sexually or physically abused (Van der Kolk *et al.* 1989, Ogata *et al.* 1990, Brodsky *et al.* 1997). Holmes (1999) attributes the genesis of severe personality disorder to a fundamental failure of a nurturing early environment and the achievement of a 'secure base'. Drawing on the attachment theory originally espoused by Bowen, he posits that the genesis of BPD is the result of a failure to achieve a secure base. This is attained when the child's initial experience of the caregiver (usually the mother) is secure and is demonstrated by sustained contact with and active enjoyment of the baby, interpretation of the baby's needs, responsiveness and effective soothing. Ainsworth *et al.* (1978) identified enduring response patterns where the process leading to secure attachment is thwarted; in socially deprived or sexually abused children a 'disorganized' pattern was elicited. These children displayed regression or bizarre behaviour when faced with loss and an incoherent or disjointed narrative style. Follow-up studies (Ainsworth 1989) indicated that these children

did find a strategy to manage loss or distress: they assumed a caregiver/parental or protector role. The issue of trust taking time to develop and testing trust was notable in the patient participants' experience. People who have experienced violence and betrayal as children will be confused as to what or who is trustworthy. Underlying this confusion is overwhelming rage and hurt and an inability to trust oneself. This is related to the patient's propensity to 'act out', engaging in seductive behaviour, observing the therapist's reaction to emotion-laden disclosures and vacillating in commitment to therapy, in order to test the trustworthiness of the therapist and to increase his or her level of control in order to address the fear of imminent betrayal.

Patients with BPD tend to regress easily; this regression is evident in the therapeutic relationship. This is vividly illustrated by the following remark:

> . . . and it's always a longing back to that first experience of being held or being contained. You just know more. You still want to be treated like you were the first time (Pt: 1).

On reflection, it appeared that, in identifying the qualities of professional helpfulness and trustworthiness the participants sought in other people, they were identifying qualities that they felt were deficient in them. None of the participants trusted themselves – they believed that they were not worthy of being listened to, being trusted and being understood. They did not trust their own ability to maintain their composure, set their own realistic goals or remain trustworthy. Perhaps what they are hoping for in the other person is an 'accessory ego' – someone to hold or contain the emotions or abilities they believe that they are unable to supply and, consequently, a resource for them. As trust develops, so they begin to trust themselves and the world around them and hope emerges.

Hjelle & Ziegler (1981, p. 121) state that: 'The psychosocial strength or virtue gained from successful resolution of the trust/mistrust conflict is termed hope by Erikson. Trust in other words becomes the capacity for hope.', and 'Hope as the first psychosocial strength also serves to maintain the individual's belief in the meaning and trustworthiness of a common cultural world.' Maintaining and re-affirming the foundations of the relationship is important throughout. Just as the themes merge – so the aspects of the relationship (and their perceived importance at any time) cannot be considered entities or themes in themselves.

Conclusion

The emphasis on trust as a foundation for a therapeutic relationship was repeated throughout the interviews with both patients and clinicians. Although this study focussed on people affected by borderline personality disorder in a psychiatric community context, nurses in all fields rely on the therapeutic relationship as a basis for intervention. Barnum (1998) states that nursing theorists such as Watson, Patterson and Zderad, Orlando, King and Peplau all reinforce the interactional nature of nursing, despite varying in many different ways. Guidelines issued by the National Health Service in the UK in its 1992 *Health Report* (Department of Health 1992) state that the relationship between patient and caregiver is recognized as being of fundamental importance. Whether practising in general nursing, midwifery, in the community context as primary health care practitioners in mental health services or any speciality discipline, the nurse-patient relationship is essential for the nurse to offer and the patient to accept quality nursing care. The principles of establishing and maintaining this trust as espoused by patients and clinicians should be applied in any nurse–client relationship.

In engendering trust, the clinician not only establishes the basis for the therapeutic relationship but also conveys the assurance that they are trustworthy and the expectation that the patient is to be trustworthy in the relationship and will in turn be trusted and, moreover, has the capacity to trust himself or herself. Relationships may be viewed as feedback loops, because the behaviour of each person affects and is affected by the behaviour of each of the other persons. If trust is not achieved in the relationship, scepticism and mistrust may prevail. As such, the lessons learned from patients and clinicians with experience in helping people who find it difficult to trust may be applied in nursing care generally.

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