# FACILITATION OF MENTAL HEALTH OF WOMEN LIVING WITH BORDERLINE PERSONALITY DISORDER

BY

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A dissertation submitted as partial fulfilment for the

MAGISTER CURATIONIS

In

PSYCHIATRIC NURSING



In the

FACULTY OF HEALTH SCIENCES

At the

UNIVERSITY OF JOHANNESBURG

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OCTOBER 2012

## DEDICATION

This research is dedicated to all the women living with borderline personality disorder.

**ACKNOWLEDGEMENTS**

- **God**

For allowing me the opportunity to do my Mini-dissertation . For giving me the strength and ability to finish my studies.

- **Professor Marie Poggenpoel, Professor Chris Myburgh and Doctor Annie Temane**

For the amazing support, guidance and advice.

- **The participants of the research study**

The women who told me their life stories, the study would not have been possible with out them. I was deeply humbled by their life stories.

- **My family**

For their support and patience during the study.

- **Sbongakonke (My son)**

Seeing you was my inspiration to complete my studies and always motivated me.

**ABSTRACT**

**FACILITATION OF MENTAL HEALTH OF WOMEN LIVING WITH BORDERLINE PERSONALITY DISORDER**

Few studies have been done on life stories of women living with borderline personality disorders in South Africa. It was therefore considered to find out how women diagnosed with borderline personality disorder would tell their life story. For the researcher working in a psychotherapy ward, where women are mostly diagnosed with borderline personality disorder, and the care of these women is of vital importance, as mental health care providers understand them less.

The research aimed to explore and describe the life stories of women living with borderline personality disorder and to formulate guidelines for psychiatric nurse practitioners to facilitate the mental health of women living with borderline personality disorder.

A qualitative, explorative, descriptive and contextual study design was used. Data were collected through semi-structured interviews focusing on the question “Tell me your life story,” Tesch’s method was used for data analysis and an external coder was utilised. Eight participants were interviewed.

In the findings it is evident through the life stories of women living with borderline personality disorder that there are childhood experiences of living within an unsafe space related to unhealthy family dynamics, boundary violations and educational challenges. They experienced chronic feelings of emptiness in the relationship they also presented with a pattern of unstable interpersonal relationships and compromised mental health, which was evident through early onset of mental problems, emotional upheaval, looking for emotional escape and having different trigger factors. Lastly all these women yearned for facilitated mental health.

Guidelines were formulated to address childhood experiences of living in an “unsafe space” through family therapy, individual therapy and educational support structures. Feelings of chronic emptiness in the relationship with the self were dealt with in ongoing individual therapy. Unstable relationships were dealt with through Dialectical Behavioural Therapy. Compromised mental health guidelines were formulated based on health promotion and prevention through early diagnosis of mental health challenges and early referral to tertiary institutions. Lastly guidelines were formulated to ensure facilitation of mental health, mobilisation of resources and implementation of services by the psychiatric nurse practitioner.

## OKUFINQGIWE

## UCWANINGO OLUHLOSE UKUVEZA INGCINDEZI YABESIFAZANE

Lapha eNingizimu Afrikha izifundo ngengcindezi esezingeni lokugcina ngokwesimilo somuntu wesifazane zincane. Ngakho-ke kucatshangwa ukuthi kucwaningwe ukuthi abesimame abatholakala benengcindezi yezinga lokugcina ngokuziphatha kwabo bangaxoxa kanjani ngomlando wempilo yabo. Abacwaningi abasebenza egumbini cishe labaningi abagula lokhu kugula. Ukunakekelwa kwalaba besimame abatholakale benale ngcindezi yokuziphatha kubalulekile kakhulu kubacwaningi abasebenza egumbini labo njengabanakekeli babanengcindezi ngokwengqondo kunokubaqonda.

Ucwaningo luhlose ukuveza luchaze umlando wabesifazane abaphila nengcindezi yokugcina ngokwesimilo bese kwakhiwa imihlahlandlela yabahlengikazi balo mkhakha wengcindezi ukuze bahole imikhakha yezokugula ngengqondo yabesifazane abaphila nengcindezi yokuziphatha nesimilo esisezingeni lokugcina.



Kuyekwasetshenziswa indlela yezifundo ezisezingeni eliphakeme,eyokucwaninga ngokufunisela,echazayonesuselwa kokubhaliwe. Kwaqokelelwa izibalo ngendlela yezinhlolovo ezihleliwe kubhekiswe embuzweni othi” Ngixoxele ngempilo yakho? ” Indlela ka Tesch isetshenzisiwe ukuhlaziya izibalo kanye nomthetho ozimele. Inhlolovo yenziwe ebantwini abayisishiyagalombili.

Kokutholakele kuyekwacaca ezingxoxweni ngezimpilo zabantu besifazane abaphila nengcindezi yokugcina yokuziphatha ukuthi kunezinto ezenzeka ebuncaneni behlala ezindaweni ezingaphephile ezihlobene nemindeni engahlelekile, imingcele enokuhlukumezeka nezinselele zokufunda. Babanemizwangedwa nobuze abaphila nayo engapheli ehambisana nokungazazi nokungaqondi imvelaphi yabo. Baveza izimpawu zobuntekenteke bobudlelwano ekuphileni nokudela impilo ngokwengqondo, okubonakeleekuqaleni kwezinkinga zengqondo, impi ngokwe mizwa efuna lapho engasizakala noma abalekele khona ukuze athole ukusizakala khona

nokuba nezinto ezihlukene eziyisisusa. Ekugcineni bonke laba besifazane balangazelela impilo eholwayo ngokwengqondo.

Kwenziwe imihlahlandlela yokubhekana nezinto zokuphila ezenzeka ebuncaneni endaweni engaphephile ngendlela yokulapha umndeni wonke eyokulapha ubuyena nezinhlelo zokusekela ngokwemfundo. Imizwa yokuphilaze ebudlelwaneni bobuwenauqobo ilungisiwe ngendlela eqhubekayo yokulapha ngawedwa. Indlela yokuphila engaqondakali ibhekiwe ngamaqembu asekelayo nokuqalisa ukulapha nge-Dialectical Behavioural Therapy. Kuqanjwe umhlahlandlela wokuzidela empilweni ngokwengqondo osekwe ukugqugquzela ezempilo nokuvikela ngokwengqondo ngokudalula izinkinga zengqondo zisuka-nje nokuthumela emazingeni aphezulu ezemfundo zisuka. Okokugcina kwakhiwa imihlahlandlela eqiniseka ukuholwa ngokwengqondo nokusetshenziswa kwezinsiza ngabahlengi noma abahlengikazi bezinga eliphezulu kwezengqondo.

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# CHAPTER 1

# 1. OVERVIEW OF THE STUDY AND RATIONALE

## 1.1 BACKGROUND

The Diagnostic and Statistical Manual IV-TR (Sadock & Sadock, 2007:706) states that borderline personality disorder is diagnosed predominantly in females. According to Skodol and Bender (2003:349), a 3:1 female to male ratio is quite pronounced for the mental disorder and subsequently led to speculations about its cause, as well as to some empirical research. Borderline personality disorder is a severe psychiatric disorder characterised by marked impulsivity, unstable affects and conflicted interpersonal relationships.

Repeated suicide attempts and acts of deliberate self-harm are very common among patients living with borderline personality disorder (Perseius, Anderson, Asberg & Samuelsson, 2006:302). Because patients living with borderline personality disorder can evoke strong and often negative responses among nurses and other professionals; this group of patients can be perceived as difficult and demanding (Bhebhe & Fuller, 2009:18). The researcher therefore decided to study the life stories of women living with borderline personality disorder in order to gain understanding of their personal experiences.



## 1.2 RATIONALE

For the researcher, who works in a psychotherapy ward where women are mostly diagnosed with borderline personality disorder, the care of these women is of vital importance, as mental health care professionals understand them less. The life stories of women living with borderline personality disorder will be studied and guidelines developed based on Dialectical Behavioural Therapy (DBT) to assist psychiatric nurse practitioners to facilitate the mental health of these patients. Borderline personality disorder is associated with a

range of negative connotations. The diagnostic criterion in the Diagnostic and Statistical Manual for Mental Disorders (Sadock & Sadock, 2007:706) defines borderline personality disorder as a pervasive pattern of instability of interpersonal relationships, self-image and affects, as well as marked impulsivity that begins in early adulthood and is present in a variety of contexts. Patients that suffer from borderline personality disorder are characterised by psychosocial impairment and high mortality. Up to 10% of patients commit suicide; a rate almost 50 times higher compared with the general population. Mental health professionals view people diagnosed with borderline personality disorder as one of the most challenging groups of mental health service users. They are likely to experience negative interactions with mental health professionals because of their highly challenging behaviour. The challenging behaviour that mental health professionals experience includes disruptions in the ward, manipulation and splitting of mental health professionals. Their behaviour in the ward is seen as a microcosm of their internal world and serves as a way to survive in a world that is unpredictable and dangerous (Callan & Howland, 2009:13). Their suffering goes unacknowledged and thus increases their readmission rates into psychiatric institutions (McDonald, Putsch & Wilson 2010: 87). Dialectical Behavioural Therapy (DBT) has been successfully used with patients living with borderline personality disorder and suicidal behaviour. Some of the elements of DBT are derived from Alexander's (Sadock & Sadock, 2007: 954) view of therapy as a corrective emotional experience. The aim of this therapy is to improve interpersonal skills and decrease self-destructive behaviour. DBT assumes that all behaviour is learned and that borderline patients behave in ways that reinforce or even reward their behaviour, regardless of how maladaptive it is (Sadock & Sadock, 2007: 954). DBT assumes that individuals living with borderline personality disorder lack key interpersonal self-regulation skills; personal and environmental factors may frequently block and inhibit their use of behavioural skills or reinforce their maladaptive actions. DBT is designed to facilitate the learning of new skills, the embedding of these skills into the individual's repertoire and the generalisation of newly developed skills across contexts (Feigenbaum, 2007:52). Findings suggest that DBT may be effective in retaining clients in treatment, reducing in-patient bed days,

reducing the frequency of self-harm and suicide attempts and reducing substance abuse (Feigenbaum, 2007:66).

Women were chosen for this study because firstly they are largely the ones mostly affected by borderline personality disorder in terms of statistics. Secondly, according to a study done by Shifona, Poggenpoel and Myburgh (2006:6), women under normal circumstances are affected by life's major changes such as marital problems, job changes, assumptions of major social roles and the evolution of an adult self during early and middle adulthood. During middle adulthood important gender changes occur. According to Erikson's theory of development (Friedman & Schustack, 2009:138), which is intimacy versus isolation from the age of 18 to 25, major psychosocial conflict can occur during this stage. During this stage normal people must be able to love and work. The goal of this stage is that the individual should find companionship with similar others and then develop the ability to create strong social ties without losing oneself in the process (Friedman & Schustack, 2009:138). If this does not happen the person may become self-absorbed and self-indulgent (Sadock & Sadock, 2007:955). Patients living with borderline personality disorder are described as having identity problems, unstable relationships, lack of impulse control, emotional instability and feelings of emptiness, often in combination with anxiety, depression and substance abuse (Holm, Berg & Severinsson, 2009:561). Women diagnosed with borderline personality disorder have affective, behavioural, interpersonal, self and cognitive dysregulation (Feigenbaum, 2007:51). With such dysregulation in different areas women living with borderline personality disorder struggle to find meaning in their suffering and search for mental health professionals who can collaborate in an emotional and therapeutic way, thus making it safe for them to tell their stories (Holm & Severinsson, 2008:28).



## 1.3 PROBLEM STATEMENT

The researcher works in a psychotherapy ward as a psychiatric nurse practitioner. According to ward statistics more females patients are admitted

to the psychotherapy ward diagnosed with borderline personality disorder compared to male patients. In a study conducted by Gubb (2010:42), it was discovered that women in South African especially black women, between the ages of 18 and 25 years who are diagnosed with borderline personality disorder needed care the most because of their social environments and the health care system. These females would often be turned away at health care facilities because they are less understood and seen as complex patients. When seen by the psychologist the session only lasted for 15 minutes because of the high number of patients. By the time these patients are admitted to psychiatric institution, they have demonstrated many impulsive acts. It is imperative to do this study, as a great need exists to understand these women's life stories in order to increase understanding among psychiatric nurse practitioners and to formulate guidelines according to which utmost care could be rendered.

The researcher asks the following questions:

- what are the life stories of women living with borderline personality disorder; and
- what guidelines can be formulated for psychiatric nurse practitioners to facilitate the mental health of women living with borderline personality disorder?



## 1.4 RESEARCH PURPOSE

The purpose of the study is to explore and describe the life stories of women living with borderline personality disorder and to formulate guidelines for the psychiatric nurse practitioners to facilitate the mental health of women living with borderline personality disorder.

## 1.5 RESEARCH OBJECTIVES

- To explore and describe the life stories of women living with borderline personality disorder.

- To formulate guidelines for psychiatric nurse practitioners to facilitate the mental health of women living with borderline personality disorder.

## 1.6 PARADIGMATIC ASSUMPTIONS

According to Morse and Field (2006:199), “a paradigm is a collection of logically connected concepts and propositions that provides a theoretical perspective or orientation that frequently guides research approaches towards a topic”. A paradigm can also be defined as a model or framework for observation and understanding, that shapes both what is seen and how it is understood (Babbie, 2005:32). The paradigmatic perspective of this study will be based on the Theory for Health Promotion in Nursing (Department of Nursing Science, University of Johannesburg, 2009:9). The Department of Nursing Science, University of Johannesburg, adopts this perspective. The paradigmatic perspective focuses on the promotion of health of individual, family group and community (Department of Nursing Science, University of Johannesburg, 2009:3).



### 1.6.1 META-THEORETICAL ASSUMPTIONS

Meta-theoretical assumptions are important beliefs that the researcher has about the person, the environment, mental health and interactive patterns with regard to the study. The meta-theoretical assumptions are not testable and deal with the researcher’s views on man and society (Department of Nursing Science, University of Johannesburg, 2009:3). The paradigmatic perspective of the researcher with regard to this study is the view of a person as an integral part of the environment (Burns & Grove, 2005:55). A person is shaped by his or her world and is thus constrained to establish meaning by means of language, culture, history, purposes and values. No single reality exists as each individual experiences his or her own reality. Reality is thus considered to be subjective; an experience considered unique to the individual (Burns & Grove, 2005:55). In the context of this study the researcher assumed the following:

**Person**: is the woman living with borderline personality disorder. According to the Theory for Health Promotion, a whole person embodies body, mind and spirit and functions in an integrated, interactive manner with the environment (Department of Nursing Science, University of Johannesburg, 2009:4).

**Body**: includes all anatomical structures and physiological processes pertaining to the individual; in this case it would be the woman diagnosed with borderline personality disorder. (Department of Nursing Science, University of Johannesburg, 2009:4).

**Mind**: refers to the capacity and quality of the psychological processes of thinking, association, analysis, judgement and understanding of which the individual is capable. (Department of Nursing Science, University of Johannesburg, 2009:4).



**Spirit**: refers to that part of the individual that reflects his or her relationship with God. The spirit consists of two interrelated components that have an integrated function, namely the conscience and relationships. (Department of Nursing Science, University of Johannesburg, 2009:4).

**Environment**: includes an internal and external environment. The internal environment consists of the dimensions of body, mind and spirit. The external environment consists of physical, social and spiritual dimensions (Department of Nursing Science, University of Johannesburg, 2009:5).

**Psychiatric nursing**: is a speciality in the nursing profession in which the nurse directs efforts towards the promotion of mental health, the prevention of mental disturbances, early identification of and intervention in emotional problems and follow-up care to minimise the long-term effects of mental disturbance (Uys & Middleton, 2002:39).

**Mental Health:** is a state of being in which a person is simultaneously successful at working, loving and resolving conflicts by coping and adjusting to the recurrent stresses of everyday living. This does not mean that a mentally healthy person has no problems. He or she might at certain times experience severe distress, but is generally able to cope with the distress (Uys & Middleton, 2002:746).

### 1.6.2 THEORETICAL ASSUMPTIONS

The study will be conducted inductively. After analysing the results it will be contextualised in the literature.

**Definition of concepts**

- **Woman :** a woman is a female human. The term woman is usually reserved for an adult (http://en.wikipedia.org/wiki/Woman). In this study, the woman will be an adult female between the ages of 18 and 40 years.



- **Borderline personality disorder :** according to the DSMIV-TR it is a pervasive pattern of instability of interpersonal relationships, self-image; and affects, as well as marked impulsivity by early adulthood and present in a variety of contexts (Sadock & Sadock, 2007:786). In this study; it will be women who already know that they suffer from borderline personality disorder.

- **Facilitation :** the act of making easy or easier (http://www.answers.com/topic/facilitation#AmericanHeritageDictionary) According to the University of Johannesburg, Department of Nursing Science Paradigm (2009:7), it is a dynamic, interactive process for the promotion of health by creating of a positive environment and mobilising resources, as well as the identifying and bridging obstacles

in the promotion of health. In this study, the researcher, who is a psychiatric nurse practitioner, will formulate guidelines to facilitate the mental health of women living with borderline personality disorder.

### 1.6.3 METHODOLOGICAL ASSUMPTIONS

Methodological assumptions reflect the researcher's views of the nature and structure of the science of the discipline. They also give form to the research objective and the research context, which in turn influence the decisions about the research design (Department of Nursing Science, University of Johannesburg, 2009:9).

The researcher will follow a qualitative approach and apply strategies of trustworthiness to ensure rigour in the research. The evaluation of rigour in this study will be based on the logic of the emerging theory and the clarity with which it sheds light on the studied phenomena (Burns & Grove, 2005:55). This research method will also be a way of gaining insight by means of the discovery of meaning, thus increasing the body of knowledge in nursing.



## 1.7 RESEARCH DESIGN AND METHOD

### 1.7.1 RESEARCH DESIGN

The design of this study is a qualitative design (Burns & Grove, 2005:23). The researcher selected a qualitative design because it focuses on gaining insight by means of discovering meaning. A phenomenological approach will be used in the qualitative design. According to Burns and Grove (2005:27), the purpose of a phenomenological study is to describe experiences (or phenomena) as they are lived. In phenomenological research the researcher identifies the essence of human experiences as described by the participants. It also involves studying a small number of participants through extensive and prolonged engagement in order to develop patterns and relationships of meaning. In this process, the researcher brackets or sets aside his or her

own experiences in order to understand those of the participants in the study (Creswell, 2009:13). The researcher will use an explorative, descriptive and contextual design method. These three aspects will be explored in detail in chapter 2.

### 1.7.2 RESEARCH METHOD

The research will be conducted in two phases. Phase one will be concerned with exploring and describing the life stories of women living with borderline personality disorder. Phase two will be concerned with describing and formulating guidelines for the psychiatric nurse practitioner to facilitate the mental health of women living with borderline personality disorder. The phases will be described below.

#### 1.7.2.1 PHASE 1: EXPLORATION AND DESCRIPTION OF WOMEN LIVING WITH BORDERLINE PERSONALITY DISORDER



A phenomenological approach will be used. In phase 1 the population and sample, data collection and data analysis will be discussed.

**a) POPULATION AND SAMPLE**

The available population for this study is the women diagnosed with borderline personality disorder in the psychotherapy ward. The women will be purposively sampled to participate in the research. This involves the conscious selection of participants by the researcher (Burns & Grove, 2005:352). The inclusion criteria for the participants is women between the ages of 18 and 40 living with borderline personality disorder, who know their psychiatric diagnosis and who are admitted to a psychotherapy ward. In addition, they should have joined the DBT group in the ward.

**b) DATA COLLECTION**

Within the qualitative methodology data collection and data analysis occur at the same time, since the researcher will be collecting data and will be analysing it at the same time. The researcher will conduct semi-structured interviews. The researcher's objective is to describe the participant's life story without being influenced by any preconceived ideas that she may have. According to Burns and Grove (2005:540), unstructured observation involves spontaneously observing and recording what is seen with the minimum prior planning and therefore the researcher will use this data collection technique, as her objective is to describe the unknown phenomena. the researcher will observe the non-verbal behaviour as well as the dynamics of the participant. The researcher will be able to pick up on non-verbal communication, body language and verbal communication as well as to reflect on it and interpret it (Okun & Kantrowitz, 2008:52). The researcher will observe non-verbal cues, such as the participant's body position, eye contact, body movements, body posture, facial expression, general appearance and voice (Okun & Kantrowitz, 2008:52). The question below will be posed to all the participants:



***"Tell me your life story."***

The researcher will use her facilitative communication skills during the interview in order to continue the interview (Okun & Kantrpowitz, 2008:75). The most commonly used kinds of facilitative communication skills are minimal verbal responses, reflecting, clarifying, summarising and processing the relationship (Okun & Kantrowitz, 2008:75-76). One interview should at least last 45 minutes to an hour. The duration of the interview will depend on the participant's level of participation, the interest of the participant and the level of richness of data presented in the interview.

The interviews conducted will be audiotaped. They should be recorded in a conducive environment. The environment should be free from distractions and noise. The researcher will use reflective remarks; these are the researcher's thoughts while interviewing the participants (Burns & Grove, 2005:549). As the notes are reviewed, observations about them should be written down

immediately. These notes help the researcher in “retaining a thoughtful stance” (Silverman, 2011:66)

### c) DATA ANALYSIS

According to Creswell (2009:183), data analysis in the qualitative paradigm involves making sense out of the text and image data. The researcher will spend a significant amount of time analysing the data. This will give the researcher a chance to become deeply immersed in the data, therefore obtaining the ability to reflect on possible meanings and relationships of the data (Denzin & Lincoln, 2009:183). Open coding is when material is organised into chunks or segments of text in order to develop the general meaning of each segment (Denzin & Lincoln, 2009:187). Results will be discussed with an external coder, who has a PhD in mental health nursing and is experienced in qualitative research, and consensus reached.

### d) LITERATURE CONTROL



In this study, the purpose of the literature review would be to compare the findings of existing knowledge with those of the study at hand. This would assist in the formulation of guidelines for the psychiatric nurse practitioners to facilitate the mental health of women living with borderline personality disorder. The literature review will be done after data collection and analysis to inform and support the qualitative study. This means that the researcher seeks to listen to the participants and to build an understanding based on what is heard (Creswell, 2009:26).

## 1.7.2.2 PHASE 2: GUIDELINES TO FACILITATE THE MENTAL HEALTH OF WOMEN LIVING WITH BORDERLINE PERSONALITY DISORDER

Guidelines will be derived from the results of phase 1 and contextualised within the literature.

## 1.8 MEASURES TO ENSURE TRUSTWORTHINESS

According to Rossouw (2003:180), there are four very important aspects when dealing with trustworthiness in the qualitative paradigm, namely credibility, transferability, dependability and confirmability.

Credibility includes prolonged involvement in the area of the study, triangulation, member checking, examining the phenomena under different circumstances and critical discussion with peer group members (Rossouw, 2003:180). With regard to prolonged engagement, the researcher works in a psychotherapy ward, which will give the researcher the opportunity to have extensive exposure to the environment. Triangulation: the researcher will use unstructured observations and recording of field notes to achieve data thickness by means of the data collection methods. The researcher will interview the participants. Peer examination: the researcher will involve someone from outside the context of the study to explore the meanings that may be found. Member checking: the researcher will continue to validate and clarify her interpretations with the participants. Examination of the phenomena under different circumstances: the researcher might have to interview a participant more than once due to, for example the participant not feeling well, which may impact the way in which participant responds in the initial interview.



Transferability is when data saturation occurred and the researcher is able to transfer the findings to a similar context (Rossouw, 2003:183). Here the researcher must provide a clear and in detail description of the selected sample in order to transfer the findings to a similar context. A rich description is given of the research results, including direct quotations from the participants' interviews.

Dependability and a dense description of research methodology, includes an investigative audit as well as triangulation. With an investigative audit, an external coder will confirm the data in order to determine the reliability of the data. It will also include a step-wise replication of the research method and code-recode procedure of data analysis. This will be further explored in chapter 2.

Confirmability is the guarantee that the researcher's finding, conclusions and recommendations are supported by the data collected. This means that the data provided represents the information that the participants provided and that the interpretations of the data are not figments of the researcher's imagination (Polit & Beck, 2010:196 Confirmability is accompanied by an audit, which is the chain of evidence of the research process. In this study the researcher will need an external coder to perform this step. The external coder and the researcher will come to an agreement with regard to confirmability of the data.

## 1.9 ETHICAL MEASURES

Before the study commences, approval will be obtained from the institution from which the patients will be. Approval from the ethics committees at the University of Johannesburg and the University of the Witwatersrand will also be obtained (refer to appendixes A and B).



The researcher will conform to all the fundamental ethical principles. According to Dhai and McQuoid-Mason (2011:13-14), the researcher must take the following four fundamental ethical principles into consideration while conducting the research process: the principle of respect for autonomy, the principle of non-maleficence, the principle of beneficence and the principle of justice.

### 1.9.1 Respect for autonomy

The principle of autonomy refers to the individual's autonomous choice and decision-making. It also involves taking into consideration the right to giving informed consent and respecting confidentiality. The principle of autonomy acknowledges the person's right to self-determination. This means that an individual has the right to make his or her own choice with respect to participating in the study. The consent form will be structured in such a way

that the participants can easily understand it. The researcher will assure that individuals are not forced or in any way obliged to participate in this study by giving them the choice to participate in the study. The participants may at anytime withdraw form the study. The researcher will respect this right by avoiding the use of any type of coercion. According to Burns and Grove (2005:194), the researcher must avoid deceiving of the participants. Deceiving means to misinform of the participants for research purposes. Therefore the researcher must assure to inform the participants of her research purposes.

According to Seale, Gobo, Gubrium and Silverman, (2004:233), the participants have the right to privacy. Privacy indicates the general circumstances under which personal information will be shared with or withheld from others. The researcher will maintain the privacy of the participants by conducting private interviews with the participants and also by promising to keep the interviews private and confidential. The participants' names will be kept confidential and will not be published in the study.



According to Seale et al (2004:233), confidentiality is the researcher's management of private information shared by a participant that must not be shared with others without the authorisation of the participant. The researcher is obliged to protect the participant's identity and the location of the research. In order to maintain confidentiality the researcher will give each participant a code number to protect her anonymity. The actual signed consent forms will not be attached to the study itself (Burns & Grove, 2005:189). According to Burns and Grove (2005:193), obtaining informed consent is important to conduct ethical research. Consent is the participant's agreement to participate voluntarily in the study. Certain information will be included in the study. The participants should be assured of anonymity and confidentiality. They should also be given the opportunity to withdraw should they want to. The researcher will inform the participants about the recording of the semi-structured interviews. The participants' permission will be obtained to audiotape the interviews. The interviews will be kept under lock and key and destroyed two years after the publication of the research.

### 1.9.2 Principle of non-maleficence

The principle of non-maleficence is defined as the principle of avoiding harm or doing as little harm as possible (Dhai & McQuoid-Mason, 2011:14). This will require the researcher to assess the risk-benefit ratio in order to promote the well-being of the participants. The researcher needs to maximise the benefits and minimise the risks of the study (Burns & Grove, 2005:191). In this study; potential benefits include: improved care of women diagnosed with borderline personality disorder as the psychiatric nurse practitioner will have a better understanding of the disorder. In addition formulated guidelines to assist the psychiatric nurse practitioners in facilitating the mental health of women diagnosed with borderline personality disorder. Another benefit is that disclosure of information brings healing to the individual. Potential risks include emotional distress from sharing personal experiences, in which case the interview will be stopped immediately and the participant will be offered debriefing.



### 1.9.3 Principle of beneficence

Beneficence means doing good for others and promoting others' interests and well-being (Dhai & McQuoid-Mason, 2011:14). The researcher will consider the principle of beneficence by managing the interviews appropriately. The researcher will conduct the studying such a way as to protect the participants from discomfort and harm (Burns & Grove, 2005:199). The researcher will do this by asking appropriate questions as well as monitoring and observing the participants for any signs of distress (Burns & Grove, 2005:199).

### 1.9.4 Principle of justice

Justice is the last principle. It indicates fairness and equity for the participants in the study. The researcher will ensure fair selection of the participants in the study. This indicates that the researcher will exclude social, cultural, racial and sexual biases in society. The researcher will select participants for reasons directly related to the problem and purpose of the study (Burns & Grove,

2005:198). The participants of the study have the right to fair treatment by the researcher. The researcher will treat all participants with equal respect. The researcher will do this by keeping to appointment times as scheduled with the participants and agreed upon. The participants may benefit from the research findings and therefore the participants will be informed of the research findings.

## 1.10 DIVISION OF CHAPTERS

Chapter one - Overview of the research study
Chapter two - Research method and design
Chapter three - Results of the study and literature review
Chapter four - Guidelines for the facilitation of mental health in women living with borderline personality disorder, recommendations, limitations and conclusion.



## 1.11 SUMMARY OF CHAPTER ONE

The purpose of this chapter was to provide an overview of the study that is to be conducted. The rationale, followed by the statement of the problem, was clearly outlined. The research question and objectives were identified and followed by a clarification of the researcher's paradigmatic perspective. This was subsequently followed by the research design and method that will be used. The chapter concluded with an explanation of the ethical measures that will be adhered to for the duration of the study. Chapter 2 follows with the proposed design and methodology of this research study.

# CHAPTER 2
# RESEARCH DESIGN AND METHOD

## 2.1 INTRODUCTION

In this chapter the researcher will discuss the research design and method of this study. Boetjie (2010: 19) defines research design as the arrangement of conditions for collection and analysis of data in a manner that aims to combine relevance to the research purpose with economy in procedure. It is also a blueprint for conducting a study that maximises control over factors that could interfere with the validity of the findings (Burns & Grove, 2005: 734). To explore the lived experiences of women living with borderline personality disorder a qualitative research design would be appropriate, as it captures experiences or events as they naturally occur. This research design also excels at capturing people's thoughts and feelings. It also offers insight that is important to viewing situations and people holistically and is therefore ideal to answer broad questions that need in-depth description (Mateo & Kirchhoff, 2009:112).

## 2.2 RESEARCH DESIGN

A qualitative, explorative, descriptive and contextual design will be utilised in this study.



### 2.2.1 QUALITATIVE RESEARCH

According to Creswell (2009:4), qualitative research is a means of exploring and understanding the meanings that individuals ascribe to a human problem. Data is collected from the participant's setting and data analysed inductively, which means building from particulars to general themes. The researcher then interprets the meaning of the data. In this study the researcher seeks to understand the life stories of women living with borderline personality disorder. She will interpret the data in order to formulate guidelines for psychiatric nurse practitioners to facilitate the mental health of women living with borderline personality.

### 2.2.2 EXPLORATIVE RESEARCH

There is very little knowledge in South Africa about this field of study. Therefore an exploratory research will be conducted. The objectives of an exploratory study are to satisfy the researcher's curiosity and desire for a better understanding, to test the feasibility of conducting a more extensive study and to develop methods to be employed in a subsequent study (Babbie, 2005:89). The researcher will explore the life stories of women living with borderline personality disorder, using semi-structured interviews. Semi-structured interviews provide participants with the freedom to explain a situation in their own words (Morse & Field, 2006:76). This will make the qualitative research valuable and the analysis to be interesting and significant. It will also include asking one central open-ended question, which is, "Tell me your life story." The researcher will use facilitative communication skills to facilitate the interview such as clarification, paraphrasing, probing, focusing and listening (Okun & Kantrowitz, 2008:52). The researcher aims to audiotape and transcribe these interviews so that the meaning of the life stories of women living with borderline personality disorder will be understood.



### 2.2.3 DESCRIPTIVE RESEARCH

According to Morse and Field (2006:20), because there is little information on the life stories of women living with borderline personality disorder and their experiences are a new phenomenon in the research field, a descriptive research would be appropriate. A descriptive research provides an accurate portrayal or account of the characteristics of a particular individual, event or group in real-life situations for the purpose of discovering meaning, describing what exists, determining the frequency with which something occurs and categorising information (Burns & Grove, 2005:734). Based on the research findings, guidelines will be formulated for the psychiatric nurse practitioners in order to facilitate the mental health of the women living with borderline personality disorder.

### 2.2.4 CONTEXTUAL RESEARCH

This research is said to be contextual because the concerns relating to the women living with borderline personality disorder are said to be unique to each person, which is the context in which that specific person can be understood (Burns & Grove, 2005:56). The researcher will identify similarities and differences in the life stories of these women with the themes that will arise from the research. The researcher will also respect that the women's experiences are unique and will not generalise because she works in this environment. This study is said to be contextual as it will be conducted in a psychotherapy ward in a public psychiatric hospital and it will be women between the ages of 18 and 40 years diagnosed with borderline personality disorder.

## 2.3 RESEARCH METHOD

This research will be carried out in two phases. Phase 1 will be concerned with exploring and describing the life stories of women living with borderline personality disorder. Phase 2 will be concerned with describing and formulating guidelines for the psychiatric nurse practitioners in order to facilitate the mental health of women living with borderline personality disorder.



### 2.3.1 PHASE 1 - Exploring and describing the life stories of women living with borderline personality disorder

A phenomenological approach will be used in this study. Phenomenological studies examine human experience by means of descriptions provided by the people involved. In this process the researcher brackets or sets aside her own experiences in order to understand those of the participants in the study (Creswell, 2009:13). The purpose of this approach is to describe what the people experience with regard to that specific phenomenon, as well as how they interpret the experience or what meaning the experience holds for them. In the context of this study, the women living with borderline personality

disorder will tell their life stories. This phase will be described in terms of population and sampling, data collection, data analysis and literature control.

#### 2.3.1.1 POPULATION AND SAMPLING

In this study, the researcher has chosen the women living with borderline personality disorder from a psychotherapy ward where the researcher is currently working. This population was chosen, as it was easily accessible for the researcher.

**a) Population**

According to Babbie (2005:112), the population of a study refers to a group about whom the researcher wants to draw conclusions. In this study the population will be all the women living with borderline personality disorder in the psychotherapy unit in a psychiatric public hospital, who already know about their diagnosis..

**b) Sampling Method**



For the purpose of this study, purposive sampling was selected. This type of sampling involves the researcher consciously selecting certain participants to include in the study (Burns & Grove, 2005:353). These participants are selected because their information is rich. This sampling is the best way to gain insight into a new area of study or to obtain in-depth understanding of a complex experience or event. It also increases the range of data exposed by the participants. The inclusion criteria for this study are women living with borderline personality disorder and who are between the ages of 18 and 40 in a psychotherapy ward in psychiatric public hospital. These women should be admitted to the psychotherapy ward. They must know about their diagnosis prior to participating in the study. They must have started the Dialectical Behavioural Therapy (DBT) group as a means to empower them with coping skills. They must be willing to participate in the study freely, must have signed a consent form and must be willing to be audiotaped. The number of participants to be interviewed will be based on data saturation. Saturation of data occurs

when additional sampling provides no new information, only redundancy of previously collected data (Burns & Grove, 2005:750).

#### 2.3.1.2 DATA COLLECTION

Data collection is the process of selecting participants and gathering data from these participants (Silverman, 2011:65). Data collection will be described under the following: semi-structured interviews, role of the researcher and field notes.

**a) Semi-structured interviews about life stories**

A life story is designed to reconstruct and interpret the life of an ordinary person. The life story can be used to understand the meanings of various states of health. It can also aid in understanding how the women interpret the meaning of health behaviour, lifestyles, illnesses, the meaning of the symptoms and their experiences of the treatment. Interviews will be audiotaped and transcribed. Life stories or life histories, as defined in Babbie and Mouton (2001:283), are "the full length account of a person's life in his or her own words". The participant will either write down the episodes of life or tape-record them. Plummer, in Babbie and Mouton 2001:284), suggested that life histories or stories need to be viewed in a humanistic and phenomenological perspective, which implies the following:

i) a concern for the subjective reality of the individual: The researcher will understand the participant better through the telling his or her or life story;

ii) process, ambiguity and change, according to Plummer in Babbie and Mouton (2001:283), in quest for generalisability, impose order and rationality on experiences and worlds that are more ambiguous, more problematic and more chaotic in reality. The life stories technique is suited to discovering the confusions, ambiguities and contradictions that make up our everyday life experiences;

iii) perspective on totality: life stories view the totality of the biographical experience as "a totality which necessarily

weaves between biological bodily needs, immediate social groups, personal definitions of the situation and historical change both in one's own life and in the outside world"; and

iv) a tool for history: life stories allow the researcher to move continuously between the changing life story of the individual participant and the social history of the same participant.

According to Denzin and Lincoln (2009:250), life stories focus on the here and now reality. They reflect human feelings and lived experiences. Life stories assert that telling, hearing and unravelling stories bring healing. In this study, semi-structured interviews will be conducted and the women's life stories will be used to find meaning so that their states of health can be understood. These will be audiotaped and transcribed.

**b) The role of the researcher**

According to Morse and Field (2006:64), the researcher's role is to establish rapport with the participants and to gain their trust. This depends on the researcher's interviewing techniques and facilitative communication skills. The amount and quality of the data depend on the researcher's ability. Thus the researcher becomes the instrument for the success of data collection. The researcher must also be able to remain objective and not to be easily swayed by the participant's emotions. The facilitative communication skills that the researcher will use will be discussed next.



**Clarification** is an attempt to focus on or understand the basic nature of the participant's statement (Okun & Kantrowitz, 2008:77).

**Reflection** refers to communicating to the participant the researcher's understanding of his or her concerns and perspectives (Okun & Kantrowitz, 2008:76).

**Summarising**: The researcher synthesizes what was communicated during the session and highlights the major affective and cognitive themes. Summary is a type of clarification. It is important at the end of the session

or during the first part of a subsequent session. It is important, as it provides the researcher with an opportunity to encourage the participant to share his or her feelings about the researcher and the session (Okun & Kantrowitz, 2008:78).

**Probing** is used by the interviewer to obtain more information in a specific area of the interview (Burns & Grove, 2005:747).

**Making minimal verbal response** is the verbal counterpart of occasional head nodding. These are verbal cues such as “mmm! and Uh huh, which indicate that the researcher is listening and following what the participant is saying (Okun & Kantrowitz, 2008:78).

**Responsive listening** is defined as attending or paying careful attention and responding to the verbal and non-verbal messages and the apparent and underlying thoughts and feelings of the participant (Okun & Kantrowitz, 2008:64).



**Non-verbal communication**: non-verbal communication skills communicate warmth, understanding, attentiveness and efficacy, apart from and in congruence with verbal behaviour. The non-verbal communication skills include occasional nodding, smiling and hand gesturing, maintaining good eye contact, using facial animation, leaning toward the participant, speaking at a moderate rate and talking with a firm and supportive voice (Okun & Kantrowitz, 2008:64).

**c) Field notes**

Notes of observations are important to take down in order that the researcher can make theoretical sense (Burns & Grove, 2005:540). It has been said that it is difficult to remember things that have been observed. Field notes are made to minimise the loss of data. Field notes are descriptive accounts in which the researcher objectively records what is happening in the setting (Morse & Field, 2006:92). In addition, Bothma,

Greeff, Mulaudzi and Wright (2010:217) describe field notes as a written account of the things the researcher hears, sees, feels, experiences and thinks about in the course of the interviews and are much broader, more analytic and more interpretive than a listing of occurrences. The notes must include non-verbal communication such as gestures and facial expressions. Verbal communications must include the manner in which the participant conveys the message and any private dialogue that may occur between the participant and the researcher. In this research the researcher will make observational and personal notes. These will assist the researcher in giving a brief of what happened during the interview and of own reflections on the experiences regarding the interviews and the participants.

#### 2.3.1.3 DATA ANALYSIS

The data analysis process is conducted to reduce, organise and give meaning to data (Burns & Grove, 2005:733). The transcribed interviews together with the field notes of the women living with borderline personality disorder's life stories, will be reduced so that common themes are given meaning. Tesch's method (Creswell, 2009:186) is used in qualitative studies to organise the data collected from the interviews to data that has meaning. The steps are described below.



Step1: The researcher gets a sense of the whole. He or she reads all the transcripts carefully, perhaps jotting down some ideas as they come to mind.

Step 2: The researcher picks one document, the most interesting one, the shortest and the one on top of the pile, goes through it and asks, "What is this about?" The researcher does not think about the substance of the information but its underlying meaning and write this in the margin.

Step 3: The researcher makes a list of all the topics and cluster similar ones together. The researcher then forms these topics into columns, perhaps arrayed as major topics, unique topics and leftovers.

Step 4: The researcher now takes this list and goes back to the data, abbreviating the topics as codes and writing the codes next to the appropriate segments of the text. The researcher tries this preliminary organising scheme to see if new categories and codes emerge.

Step 5: The researcher finds the most descriptive wording for the topics and turns them into categories. The researcher looks for ways of reducing the total list of categories by grouping topics that relate to one another. The researcher can perhaps draw lines between the categories to show interrelationships.

Step 6: The researcher makes a final decision about the abbreviation for each strategy and alphabetises the codes.

Step 7: The data belonging to the same category is assembled in one place. Preliminary analysis is performed.

Step 8: If necessary, the researcher can recode the existing data.



For the researcher to remain objective and to reduce bias, an external coder is used (Morse & Field, 2006:166). The researcher and the external coder will have a consensus meeting about the findings. The external coder is a person who is experienced in qualitative research.

#### 2.3.1.4 LITERATURE CONTROL

In qualitative studies, a literature control is done after data analysis has been performed. This is done to expand the findings and to make connections with the existing knowledge. Relevant literature will be used as a means to enhance the findings and to demonstrate a clear connection with prior theory and research (Mateo & Kirchhoff, 2009:210).

### 2.3.2 PHASE 2 - Guidelines for the psychiatric nurse practitioners to facilitate the mental health of women living with borderline personality disorder

The results in phase 1 will be used to issue guidelines for the psychiatric nurse practitioners to facilitate the mental health of women living with borderline personality disorder.

### 2.3.3 MEASURES OF TRUSTWORTHINESS

Trustworthiness in qualitative research is the degree of confidence that researchers have in their data, assessed by using the criteria of credibility, transferability, dependability, confirmability and authenticity (Polit & Beck, 2010:196). Table 2.1 is a summary of the strategies that will be applied to this study to ensure trustworthiness.

**Table 2.1: STRATEGIES TO ENSURE TRUSTWORTHINESS**

| STRATEGY | CRITERIA | APPLICABILITY |
|---|---|---|
| Credibility | Prolonged engagement | Building trust by honouring anonymity, honesty and openness.<br><br>Establish rapport by spending time with the women living with borderline personality disorder.<br><br>Saturation of data reached through data collection of semi-structured interviews. |

| STRATEGY | CRITERIA | APPLICABILITY |
|---|---|---|
| | Triangulation of data | Multiple methods of data collection are used, namely semi-structured interviews and field notes.<br><br>Literature control will be conducted as a method of triangulating data.<br><br>Multiple investigators that include two external supervisors and an external coder. |
| | Peer evaluation | Peer evaluation will be conducted.<br><br>The study will be presented at research forums and conferences. |
| | Member checking | Informal member checking is done during interviews by clarifying and summarising with the participants.<br><br>Discussion with the participants will provide them with an opportunity to add material, make changes and offer interpretations.<br><br>Discussion with colleagues will take place as a form of member checking. |
| | Reflective journal | The researcher will use a reflective journal and field notes. |

| STRATEGY | CRITERIA | APPLICABILITY |
|---|---|---|
| | Authority of the researcher | The researcher completed a research methodology programme and gained skills in conducting research.<br><br>This study has three supervisors with post doctoral qualifications and vast experience in research. |
| | Structural coherence | The study will focus on women living with borderline personality disorder.<br><br>Guidelines for psychiatric nurse practitioners will be formulated to facilitate the mental health of women living with borderline personality disorder. |
| Transferability | Dense description of results supported by direct quotations of participants | The results are described in depth with direct quotations from the interviews.<br><br>The results are recontextualised in the literature |
| | Nominated sample | The demographic information of participants will be provided. |
| Dependability | Code-recoding procedure of data analysis | A consensus meeting or discussion will be held with the external coder after data analysis.<br><br>Data quality checks. |

| STRATEGY | CRITERIA | APPLICABILITY |
|---|---|---|
| | Dense description of research methodology | All aspects of the research are fully described. This includes the methodology, characteristics of sample and process, as well as data analysis. |
| | Step-wise replication of the research method | A dependability audit will be done.<br>Research methodology is described in detail. |
| Confirmability | Chain of evidence | The researcher will keep all the transcripts as proof of the work done. |
| | Audit strategies | Documents of audiotapes of interviews, transcribed materials and field notes will be kept as audit trail. |



#### 2.3.3.1 CREDIBILITY

Credibility refers to confidence in the truth of the data and interpretations thereof. Credibility involves two important aspects, namely that the study is carried out in a way that enhances the believability of the findings and taking steps to demonstrate credibility to external readers (Polit & Beck, 2010:539). The aspects discussed in the paragraphs that follow are also important in maintaining credibility in a study.

**a) Prolonged engagement in the field**

This is important in establishing rigour and integrity in qualitative study. Investing sufficient time when collecting data in order to have an in-depth

understanding of the women under study. This will assist to test for misinformation and distortions, and to ensure saturation of important categories. It is also important in order that a rapport can be established with the participants (Creswell, 2009:192). The researcher will have prolonged engagement as she is working full-time in the psychotherapy unit.

**b) Triangulation**

Triangulation refers to the use of multiple referents to draw conclusions about what constitutes the truth. It aims to overcome intrinsic bias that comes from single-method, single-observer and single-theory studies (Polit & Beck, 2010:543). There are various kinds of triangulation. Data triangulation, which entails obtaining the same data at different points in time. Method triangulation, which entails using multiple methods of data collection for the same phenomenon. In this study, the researcher will conduct semi-structured interviews, together with observation, to maintain triangulation. The researcher will involve an external coder in this study in order to maintain investigator triangulation.



**c) Peer evaluation**

This is to enhance the accuracy of the account. This strategy, involving interpretation beyond the researcher and investing in another person, adds validity to an account (Creswell, 2009:192).

**d) Member checking**

The researcher will provide the participants with feedback about emerging interpretations to obtain the participants' reaction. This is done to assess whether the researcher's interpretations are good representations of the participants' realities (Polit & Beck, 2010:545). The researcher would have to clarify the interpreted message with the women living with borderline personality disorder.

**e) Reflective journal**

The researcher will keep a journal in which she will reflect her thoughts about the research at all times. In this journal, the researcher will also keep record of

the participant's non-verbal communication, gestures and her own thoughts at the time of the interview.

**f) Authority of researcher**

The researcher is a master's student and also has expertise in the psychotherapy unit. The researcher also completed a programme in research methodology. This study also involves two promoters with post doctoral qualifications and vast experiences.

**g) Structural coherence**

The life stories of the women living with borderline personality disorder should be the focus of the researcher and nothing else.

### 2.3.3.2 TRANSFERABILITY

Transferability refers to the extent to which the qualitative findings can be transferred to other settings. It is the researcher's responsibility to provide enough descriptive data in the research so that the study can be applicable to other contexts (Polit & Beck, 2010:539).



a) **Nominated sampling**

The study should be applicable to a different unit where there are women living with borderline personality disorder. Purposive sampling was used as a sampling method in this study. The demographics of the participants were provided. The study should be applicable to women between the ages of 18 and 40 years, of any race and colour. They should be admitted to a psychotherapy unit.

**b) Dense description of results supported by direct quotations of participants**

Descriptive research provides a wealth of rich, descriptive data that is collected by means of interviews and observations. Direct quotations of the participants will support the richness of the descriptive data.

### 2.3.3.3 DEPENDABILITY

This refers to the stability or reliability of data over time and over conditions (Polit & Beck, 2010:539). It includes the dense description of the research methodology, where dense descriptive data is collected by means of the semi-structured interviews, observation and field notes.

**a) Step-wise replication of research method**

The researcher will keep record of all the steps followed in conducting the research study, thus enabling future researchers to replicate the same study in other contexts.

**b) Code-recode procedure of data analysis**

The researcher will consult with the independent coder about the categories and themes found on the transcripts.

**c) Dependability audit**

The independent coder will be used during data analysis. The two supervisors and co-supervisors will also evaluate the study before it is presented to an outside examiner as a means of ensuring trustworthiness.



### 2.3.3.4 CONFIRMABILITY

This refers to objectivity; that is, the potential for congruence between two or more independent people about the data's accuracy, relevance and meaning. Does the data provided represent the information that the participants provided and are the interpretations of the data not figments of the researcher's imagination (Polit & Beck, 2010:539)?

a) Dependability audit of whole research process

With the researcher working together with the supervisors under supervision, the whole research process will be monitored for accuracy and relevancy of data.

b) Chain of evidence

The researcher will keep accurate record of the process of the study in order that other researchers can capture the process and reach the same consensus.

## 2.4 ETHICAL CONSIDERATIONS

The researcher is responsible for conducting the research in an ethical manner. Certain ethical principles must be demonstrated for the research ethics committee to approve the research study. Ethical principles should be demonstrated from the onset of the research study to avoid any discomfort to the participants. According to Dhai and McQuoid-Mason (2011:14), there are four main ethical principles. They are the principles of respect for autonomy, non-maleficence, beneficence and justice. These were fully discussed and described in chapter 1.



## 2.5 COMMUNICATION OF FINDINGS

Findings will be communicated in a narrative format. In qualitative research, analysing stories is a powerful way to make a point. Readers in different perspectives can perceive stories. When stories are analysed, the researcher unpacks the structure of the story. In this study, the researcher will unpack the life stories of women living with borderline personality disorder.

## 2.6 SUMMARY OF CHAPTER 2

This chapter described the research method and design. The research is qualitative, exploratory, descriptive and contextual. Measures to ensure trustworthiness and ethical considerations were also discussed. Chapter 3 will discuss the findings of the semi-structured interviews and include the literature review.

## CHAPTER 3

## 3. LIFE STORIES OF WOMEN LIVING WITH BORDERLINE PERSONALITY DISORDER

### 3.1 INTRODUCTION

This chapter will focus on the implementation of the research design that was introduced in chapter 1 and elaborated on in chapter 2. Here the life stories of women living with borderline personality disorder will be critically explored and described. The central storyline will be expressed as depicted by the themes and categories. Data saturation was reached after eight participants were interviewed and themes and categories were identified.

### 3.2 DESCRIPTION OF THE DEMOGRAPHIC PROFILE OF THE POPULATION

Eight women diagnosed with borderline personality disorder participated in this research. The women were between the ages of 18 and 40. All of them were single with regard to marital status. Three of the women were in-patients in the psychotherapy unit and five of the women were already discharged. Two of the discharged women were interviewed at their homes. The themes and categories are explained in table 3.1



The women living with borderline personality disorder were purposively sampled to tell their life stories. Data collection was done by means of semi-structured phenomenological interviews and field notes. This was done for the purpose of triangulation to ensure trustworthiness. These interviews were conducted mostly at the hospital to which the participants were admitted; some interviews were conducted in the comfort of their homes and in the language with which the participant was comfortable. Informed consent was obtained from the participants prior to conducting the interviews. They were also informed that interviews would be audiotaped and transcribed. It was also clarified that participation in the study was completely voluntary and that confidentiality would be maintained throughout the study. Participants were

also informed that they would not be penalised for not participating. All participants were asked the question:

***"Tell me your life story."***

A qualified external coder, who is a doctoral graduate with sound knowledge in the field of qualitative research, verified the authenticity of the semi-structured interviews, the themes and the categories. The researcher also credibly translated the transcripts that were in another language than English. The external coder's results are included in this chapter.

## 3.3 RESEARCHER'S EXPERIENCE

This research study emotionally touched the researcher. Although working with these women extensively on a daily basis, working on this study gave the researcher another view on their struggles and how they yearn for "normal" lives. The researcher had to remain objective in this study. These women also wanted someone to hear their stories about a lifetime of struggles with themselves and significant others. It was clear to the researcher that these women had significant childhood instability and trauma, struggled with themselves internally and lacked their families' involvement.



## 3.4 DISCUSSION OF RESULTS AND LITERATURE CONTROL

Table 3.1 presents the themes and categories.

**Central storyline**: Women living with borderline personality disorder tell stories of living in an unsafe space during their childhood. Their life stories depict chronic feelings of emptiness in relationships with self and depict a pattern of unstable interpersonal relationships and compromised mental health. They yearn for facilitated mental health.

**Table 3.1 THE THEMES AND CATEGORIES OF THE STORIES OF WOMEN LIVING WITH BORDERLINE PERSONALITY DISORDER**

| Themes | Categories |
|---|---|
| **3.1.1 Theme 1**<br>Life stories depicting childhood experiences of living in an "unsafe space" | 3.1.1.1 Unstable family dynamics<br>3.1.1.2 Boundary violations<br>3.1.1.3 Educational challenges |
| **3.1.2 Theme 2**<br>Life stories depicting chronic feelings of emptiness in the relationship with the self | 3.1.2.1 Distorted self-image and lack of identity |
| **3.1.3 Theme 3**<br>Life stories depicting a pattern of unstable interpersonal relationships | 3.1.3.1 Under-involved family<br>3.1.3.2 Unstable interpersonal relationships with others<br>3.1.3.3 Loneliness and cultural stigmatisation |
| **3.1.4 Theme 4**<br>Life stories depicting compromised mental health | 3.1.4.1 Early onset of mental problems (teenage years)<br>3.1.4.2 Emotional upheaval<br>3.1.4.3 Looking for emotional escape (unhealthy coping)<br>3.1.4.4 Trigger factors |
| **3.1.5 Theme 5**<br>Life stories depicting a yearning for facilitated mental health | 3.1.5.1 Turning points in mental health facilitation |

### 3.4.1THEME 1: LIFE STORIES DEPICTING CHILDHOOD EXPERIENCES OF LIVING IN AN "UNSAFE SPACE"

From the eight interviews conducted, it became clear that the women had childhood experiences that made their living space "unsafe". This was particularly significant in all of them, as it influenced the way they viewed their lives currently. It is suggested that early childhood experiences disrupt crucial normal stages of childhood development and predispose these individuals to subsequent psychiatric sequelae (Waite & Gerrity, 2010:51). It was also found that long-term consequences of childhood trauma include attachment problems, eating disorders, depression, suicidal behaviour, anxiety, alcoholism, violent behaviour, mood disorders and posttraumatic stress disorder (Waite & Gerrity, 2010:52).

#### 3.4.1.1 Unstable family dynamics



Stability in a family is crucial for the upbringing of any individual. In society, each family member has a part and a role to play. The father is regarded as the head of the family who gives direction and provides for the family. He is also seen as the protector of the family. The mother resumes the responsibility of running the household; she is the caregiver and plays the role of nurturer. The children could play various roles that are overseen by the parents. Extended family members could play a supportive role with regard to the primary family. However, in this study it is evident that the participants played various adult roles in their childhood. They were not yet ready for responsibilities implied by these roles. It was evident that there was some instability in terms of family dynamics. A participant spoke about how she had to take on the role of her mother at an early age. Certain dynamics in the family, such as separation and divorce, also caused a lot of instability for the participants. Having to stay with the extended family because of unfavourable circumstances was also an indicator for instability. As their families were unstable, they were faced with having to live with parents abusing substances instead of being role models, as is clearly stated below:

*"I was 12 but I had to take a role of my mother to take care of my brother."*

*"I would take care of myself through most of the day because my mom worked two jobs and my sister was out with friends most of the time from when I can remember because she also just doesn't want to sit alone at home with me."*

*"We and my brother we separated, after that … because my parents divorced and so my brother wanted to stay with my dad and I loved staying with my mom; so that's how we got separated. I was 10 years old."*

*"And I lived with my mother, my aunt and my grandmother and we were quite a big family."*



*"So when he was there it was quite a lot of mixed emotions because I really loved my father so I wanted him to be there but when he was there he used to drink a lot, fight with my mom, come home drunk; he would stumble up the stairs because we lived in like a block of flats. So he would crawl up the stairs and you know that's the memories I remember."*

Research findings pointed to the prevalence among patients with borderline pathology of early traumatic experiences, such as prolonged, painful physical illness, experience or witnessing physical and sexual abuse, severe early loss and abandonment, or a chaotic family structure (Magnavita, 2004:101). Unhealthy or unstable family dynamics are described as the inability to perform the usual expected family roles and fulfil obligations related to these duties and responsibilities, thus creating a sense of powerlessness in accomplishing previously desired activities (Denham, 2003:29).

#### 3.4.1.2 Boundary violations

A boundary violation in the context of this study is physical, emotional and sexual abuse. Each of the women described their experience of feeling unsafe, as their boundaries were violated. The nature of the boundary violation varies. Sexual abuse by close family members became evident. The participants were traumatised by having to live with these persons who violated them. They experienced further trauma when having to keep the secret about what has happened out of fear for the possible consequences with which they might have to live if they disclose what happened. One participant witnessed her mother being shot in front of her and now has to relive this trauma for the rest of her life. One of the participants mentioned that she has confusing memories because she did not know how to make sense of the sexual abuse. Not being able to make sense of what happened to her clearly shows how her boundaries were violated. This clearly indicates early childhood damage to all the participants, as the boundary violations occurred in early childhood.



*"And there is also a lot of confusing memories because he wasn't there a lot so I really wanted to be close to him but I have memories of, uhm, very sexual, uhm, abusive nature."*

*"So we were on this farm for quite a long time and on this farm, (sigh), I think it was most of my trauma at that point took place because my, (short silence), I'll just say my uncle use to, mostly my uncle and my father used to like in the evenings, early afternoons, they were quite controlling so we had to sit around a round table in the kitchen. They would ask us questions; I can't remember exactly what they would ask us but basically if you looked at a wall and it was white, at the end of the evening they wanted you so confused and brainwashed by their ideas that if they told you that is black, you had to say that wall is black."*

*"Year 2000, ja, in 2000 on the 15 February my mom was shot by her boyfriend and I was the witness."*

*"My brother abused me from the age of  till I was 12."*

Boundaries are defined as invisible limits surrounding the individual; they protect the integrity of a person. When boundaries are permeable they welcome interactions with others and allow information to flow freely (Arnold & Boggs, 2011:250). Children who have been exposed to chronic physical abuse, sexual abuse or emotional neglect often show insecure, avoidant or ambivalent attachment to their primary caregivers. These children will also be predisposed to seek inappropriate sexualised outlets; possibly as an expression of anger and possibly due to a need for self-soothing (Dowdell & Cavanaugh, 2009:30).

#### 3.4.1.3 Educational challenges



The women living with borderline personality disorder had to face educational challenges such as dropping out of school and under-performing because of living in such "unsafe spaces". Due to the stressors they encountered in various parts of their lives, most of the women's education was the first indicator of deterioration of functioning.

One particular participant was performing well at university until she had to stop because of her mental illness. Attending classes became a challenge to one of the women. Because school is where most time is spent, most of the decline in achievement will occur there.

*"First year I was doing public relations. I did my first year, the second year and then during the second year I relapsed. I was admitted for depression. I wasn't coping."*

People at school saw the other woman bunking classes.

*"… until someone noticed it at my college, like the SCR could see that I'm bunking classes. Though I'm around on campus, she could see that my marks dropped."*

Due to moving to a new environment in a new country, her performance at school also dropped.

*"But after that, since we moved from the farm we moved in a nearby town (sigh), I went to school which was also quite intense because after experiencing all these things at home; the home situation wasn't safe and I get to school and I didn't know the language and I think you know thinking back it was actually funny because my first class that I had was Afrikaans and then we had Zulu (laughs). And I couldn't even master English."*



It is clear from the direct quote that the disrupted family circumstances also disrupted their schooling; most of the women performed poorly academically. Research shows that the early onset of mental disorders during childhood and adolescence may have an impact on development, and in particular on educational attainment; thus it contributes significantly to lower educational achievement (Myer, Stein, Jackson, Herman, Seedat & Williams, 2009:354).Functional skills acquired from education provide the basis and foundation for lifelong learning and offer individuals opportunities to progress as well as to address aspects such as attitude, self-esteem and motivation (Tennant & Howells, 2010:172).

### 3.4.2. THEME 2: LIFE STORIES DEPICTING CHRONIC FEELINGS OF EMPTINESS IN THE RELATIONSHIP WITH SELF

This theme focuses on the distorted self-image and lack of identity that were evident in the women living with borderline personality disorder. There was a sense of worthlessness, powerlessness and feelings of emptiness. The

women living with borderline personality disorder had a feeling of being different and always needed acceptance. This need resulted in unplanned pregnancies and remaining in abusive relationships. The women living with borderline personality disorder have this void and filled their emptiness by engaging in unplanned actions.

#### 3.4.2.1 Distorted self-image and lack of identity

The women who were interviewed displayed a repeated sense of worthlessness, powerlessness and emptiness. The following quote shows evidence of this:

*"Umh, I was always like in the background. Nobody else was more important and, umh, he used to hold guns to my head. He used to beat me up."*



Due to this feelings of emptiness in themselves, the women would have this need to be accepted and would remain in abusive relationships or have unplanned pregnancies. It is clear from the above quote that this participant stayed in this volatile relationship because she felt worthless.

Another example demonstrated in the interviews is one where a participant restricts her food intake and binges just to gain acceptance from her sister and mother:

*"So I want to be beautiful like my sister and my mom; so I'm just gonna eat and then eat in big quantities because my mom used to praise me; ja, you know, you are so courageous because you eat all your food, very good girl."*

Getting involved with dangerous people masks the feeling of worthlessness for that time, as is demonstrated below:

*"Eventually I got this boyfriend and he was a drug dealer. You know I just thought it was great to hang around with like you know the top guys. It was like a hip thing to do."*

The women also felt ashamed and experienced being tired of living:

*"I didn't tell them the reason so I did it. I just said I'm tired of living. I don't want to live anymore and it's best if I die."*

They also feel different than others:

*"I thought something was wrong with me."*

Literature defines self-image as the perception of self as object; a distinct, ever-present and identifiable "I" or "me" (Magnavita, 2004:41). Arnold and Boggs (2011:529) define self-esteem as the emotional value that a person places on his or her personal self-worth in relation to others and the environment. The self is especially significant in that it provides a stable anchor to serve as a guidepost and to give continuity to changing experiences (Magnavita, 2004:41). Thus, self-image, despite the many particulars of one's character, appears to be predominantly either of a positive or negative quality (Magnavita, 2004:41). In the context of this study, all the women's self-images had a negative quality. It is clearly demonstrated that the women tried to compensate for their lack of self-esteem by involving themselves in situations where they were around dangerous people, feeling ashamed of themselves and feeling different.



### 3.4.3. THEME 3: LIFE STORIES DEPICTING UNSTABLE INTERPERSONAL RELATIONSHIPS

It is evident from this study that unstable interpersonal relationships involved the under-involved family in which the women living with borderline personality experienced a lack of support and understanding with regard to the difficulties

they personally went through. They feel rejected and abandoned by their families, as well as isolated and not accepted for who they are. This theme also focuses on the unstable intimate relationships with others as a result of lack of trust, betrayal and remaining in the abusive cycle. Lastly it focuses on the cultural stigmatisation and feeling lonely as a result.

#### 3.4.3.1 Under-involved family

Having an uninvolved family, resulted in these women having to deal with a lot of difficulties on their own without the support they needed to cope. In this study, the women living with borderline personality disorder verbalised that their families were not supportive of them in times of need. It seems like they would have liked the input of their families during such difficult decision-making stages. This lack of support resulted in feelings of rejection:

*"I fell pregnant to this guy. So I was 17 and in matric. So my mom wasn't there for I think three or four months and during this period I fell pregnant and I didn't really have anybody to turn to, so I decided to take this decision on my own and my boyfriend at that time wasn't very helpful."*



This participant felt isolated, as she was treated differently than other kids in the house:

*"You know and she would always just isolate me and when ever she did something with her kids and other cousins which were not her kids. She'd take them out or something, she would say, no, you stay 'cause I don't want to do anything for you to try and kill yourself."*

The following quotation demonstrates another family member ignoring or refusing to see the abuse that was going on in the house. This led to the woman blaming herself for the abuse that she suffered:

*"I don't have a good relationship with my brother and sister and, uhm, 'cause my sister used to see my brother coming out of my room at night but, umh, she says that she never did. But umh, it used to happen often."*

This woman experienced not being loved by her family because she was different. They did not show any interest when she was away from home. Her family did not even inform her about a death in the family.

*" … but then when I was in London (UK) my granddad died and, uhm, he was 94 and that really upset me 'cause I got quite close to him when I was staying with him, and I remember my mom did not phone to tell me; she sent me an e-mail. So then I remember and then I phoned my parents here and the first thing my dad answered and said 'what do you want'."*

Family dynamics in relation to the women provide an awareness of the family relationships that can be rallied for support or that may need special attention because of the negative impact they have on the women's situation; they also assist in determining who else in the family needs help, as well as with awareness of cultural and family factors that influence the women's attitudes, beliefs and willingness to take action related to their health (Arnold & Bogg, 2011:247)



In a study conducted by Bland, Tudor and McNeil Whitehouse (2007:205), unstable interpersonal relationships are related to high incidence of parental loss, prolonged parental separation and feelings of neglect during childhood; all contributing to the patients' later fears of abandonment. They often feel misunderstood, different and disconnected from their families. Borderline patients have scored high in anger towards both their mothers and fathers due to unresolved trauma. They were also exposed to role-reversing experiences with their mothers during childhood (Bland, Tudor & Whitehouse, 2007:205).

#### 3.4.3.2 Unstable interpersonal relationships with others

Patients living with borderline personality disorder evidently showed that they experience problems with interpersonal effectiveness. One participant said that because she always reacted to things in a certain way, she was not even believed when abused by her brother:

*"And that was very difficult and my mom confronted my brother with the abuse. He basically said I'm imagining things and you know it ended up like a fight and that was it, and I couldn't do anything and that continued; not the sexual abuse because that stopped but the physical abuse continued throughout."*

Because their relationships started impulsively, it ended impulsively, leaving the patients with several unresolved feelings. As can be seen from the quote below, one participant was left with anger and rage:

*"I started dating this guy; after a while he passed away and I found out from his cousin that he was HIV positive and he didn't tell me and had I had sex with him and he could have infected me and I felt I could be angry with him and till this day I'm still angry at him because I felt he didn't love me."*

The quotation below demonstrates the impulsivity of the women. This participant would rather have a one-night stand without emotional involvement than a long-standing relationship in which she will have to invest a lot of herself.



*"I rather just go with somebody just for one time instead of having a relationship."*

This woman was feeling empty and hollow due to the instability in her relationships:

*"And I had these boyfriends. I jumped from the one boyfriend to the other, to the other, to the other. Always looking for somebody to give me some love and attention but I just couldn't get even, though I was in relationships with them. I just didn't feel like it was sufficient."*

This woman reacted directly in accordance with her emotions without thinking of the consequences her behaviour might hold in store. Her partner was lying to her. They became involved with people who cheated:

*"But eventually, uhm, I started getting paranoid because he lied to me a lot and I just couldn't live with that anymore cause I was constantly wanted to check his phone, check his e-mail and, umh, he was lying actually in retrospect now."*

Their relationships are highly unstable because they respond with intense emotion to every conflict and also act out impulsively when problems arise in relationships (Paris, 2010:49).

#### 3.4.3.3 Loneliness and cultural stigmatisation

From the interviews it is evident that the women were seen as different and felt different and unwanted. They also experienced that they were not understood with regard to the emotional challenges they experienced. The women living with borderline personality disorder had to deal with the community that was unsupportive as well and rejected them because of their mental illness:



*"And you know obviously in the black community, it's very difficult to have a mental illness."*

*"People in my neighbourhood found out that I was in a psychiatric hospital and there is a stigma around that."*

*"So it was quite a secluded place; there weren't any other kid or families, it was just them, these people and us; my mother, my sister and I."*

*"They made me feel like I didn't belong there. So my aunt decided to throw me out so I didn't have any where to go."*

This woman told a story about how she was expected to just deal with it, and that counselling, which is reaching out for help, was not seen as something that would help her:

*"No I think my family was not used to this counselling things. They just believe in dealing with stuff; so there was no counselling."*

There is a growing stigmatisation regarding people living with mental health problems. Stigmatisation is where a brand or visible mark is placed on the foreheads of people who are different (McDougall, Armstrong & Trainor, 2010:204).

### 3.4.4 THEME 4: LIFE STORIES DEPICTING COMPROMISED MENTAL HEALTH

The women living with borderline personality disorder also noted that their mental health was compromised. There was an early onset of depression. They failed to deal with their emotions and would resort to unhealthy coping mechanisms that are destructive in nature. All this was linked to triggering events in their lives.



#### 3.4.4.1 Early onset of depression

Due to the early events of trauma in their lives, the women were initially diagnosed with depression. This depression correlates with the developmental stage of menarche in a women's life, and thus these women would not have been able to understand what was happening to them emotionally.

For example, the following participant started feeling depressed at the age of 14, which is also the same time as her menarche:

*"At the age of 14 I started being depressed; I started feeling down most of the time; I didn't know what was wrong."*

Another participant was about 16 when she could not make sense of what was happening to her:

*'I think I must have been depressed; my mom took me to the doctor and they gave me vitamins and that was in grade 11."*

The following participant verbalised that her depression even affected her performance at school, which made her more depressed:

*"I didn't do well at school and she couldn't deal with the fact that I was a little depressed."*

Depression is evident in early teenage years and becomes a reoccurring theme through to adulthood. Puberty is associated with elevated hormonal levels, which help to sculpt these new neural circuits, leading to behavioural changes. However, adolescence is also accompanied by psychosocial challenges (Paris, 2010:54). Women are said to be at a greater risk of depression during their child-bearing years. Depression is also seen as a normal sequelae of reproductive events, such as menstruation, pregnancy, post partum and the transition to menopause which makes the accurate diagnosis of depression challenging (Keyes & Goodman, 2006:62).



#### 3.4.4.2 Emotional upheaval

Emotions are a state of the mind due to socio-psychological physical embedded responses or even biochemical factors in the blood stream (http://wiki.answers.com/Q/what_is_emotional_escape). Upheaval is defined as a sudden, violent disruption or upset (http://www.thefreedictionary.com/_/dict.aspx?word=upheaval).

The women living with borderline personality disorder experienced various kinds of emotions. Due to the events that occurred in their lives, they did not know how to manage these emotions.

The participant quoted below revealed feelings of shame and guilt due to an attempted suicide that she told nobody about:

*"So I decided well then that I'm not going to tell anyone and till this day no one knows that I've tried to kill myself."*

This participant felt blamed after the fraudulent signing of invoices at work. She also felt victimised because of her retrenchment:

*"We work in accounts department and found signatures and the invoices that were my responsibility and, umh, they sort of put blame on me. I got retrenched from there. I got depressed because they took the side of the other woman who was pregnant at work and not me."*

The following participant experienced being perceived different at home. She perceived to be singled out and incapable of doing things for herself. She experienced feelings of isolation and helplessness as a result:



*"I was the odd one out. I still am. My mom checks up on me and tells me to go to my room and it's almost like I'm incapable of thinking for myself or everything I do is wrong."*

The participant experienced a lot of confusing moments during which she could not see things that are supposed to be enjoyed in that light. Her comparing food and sexuality with safety and the unity of a family also gave rise to confusion:

*"So it was quite a (sigh) confusing environment to be around with food and sexuality and just safety and family you know."*

#### 3.4.4.3 Looking for emotional escape

Emotional escape is defined as the purging of that mental state in free outbursts, diverting your mental state or lowering the biochemical-inducing factors in your body (http://wiki.answers.com/Q/emotionalescape). In the context of this study, the women tried various ways to escape emotionally; ways that were easy or accessible for them. One of the ways was suicidal behaviour. It was clear that self-mutilation helped them to manage their terrible memories, tremendous emotional pain and life's turmoil. Defence mechanisms are ways by which we protect ourselves from things that we do not want to think about or deal with (http://psychology.about.com/od/theoriesofpersonality/ss/defensemech.htm). The following participant's story clearly demonstrates the defence of denial. She thought she did not need help with her issues:

*"I was very hesitant 'cause I thought I don't need help."*

She escaped her emotions by acting out and using substances to escape or mask her emotions:



*"When I was younger I would take things from the drinks cabinet and it would be anything I could get my hands on and I also used to smoke weed quite a few times and I tried coke as well."*

Cutting is seen as self-harming behaviour. The participant quoted below wanted to release her anger and confusion. The cutting eventually soothed her:

*"Then I started cutting because I was so confused 'cause I was so angry. I was so emotional. I wanted to die but I couldn't. It was the only thing at that point that could actually calm me down."*

In other cases, the women got trapped in situations in which they felt increasingly hopeless and could see no way out:

*"I was hopeless. I ended up purging."*

Another defence used in their stories is blaming and not taking responsibility. The women living with borderline personality disorder showed an external locus of control; they find it easy to blame others rather than themselves:

*"Umh, I don't blame her for that. We were the ones who had to go to school without shoes, meals, because my mother did not buy that for us."*

Chiles and Strosahl (2005:4) suggest that suicidal behaviour is often designed to solve problems in a person's life rather than to end it. In a study by Keltner, Schwecke and Bostrom (2009:4), they tried to understand the meaning behind their thinking, emotions and behaviours.

Schmidt and Davidson (2004:6) describe self-harm by means of cutting as a form of self-punishment, but it can also be done to help release tension, or even to make the person feel more alive. Schmidt and Davidson (2004:4) also state that an outsider may view the situation as not hopeless, but because of the persons' particular upbringing, beliefs or values, they cannot free themselves from the trap they are caught in.



#### 3.4.4.4 **Trigger factors**

A trigger is defined as something that initiates something (http://en.wiktionary.org/wiki/trigger). The women living with borderline personality disorder experienced various trigger factors to their mental problems. Trigger factors could be relational conflict, unstable living conditions, unemployment or unstable job situations or professional rejection and financial strain. It is also evident that the triggers are unavoidable circumstances and part of life.

The following participant experienced that the poor relationship she had with her aunt triggered her:

*"Basically that I was having problems with my aunt and I didn't want to live anymore and that I'm very unhappy."*

The following participant experienced that she could not handle being talked about, and this became a trigger for her:

*"People would say things behind my back."*

For the following participant, the straining relationship between her and her mother caused her to act impulsive:

*"A couple of weeks ago I had a big argument with my mother and I ended up smashing up my whole room and I never done anything like that before."*

Her partner breaking up with her triggered the following participant and she acted impulsively by taking pills:



*"I took quite a few overdoses during that time. I usually take pills. It was either when he was breaking up with me."*

Stressful life events such as relationship, conflicts and crises, physical and sexual abuse, academic difficulties and functional impairment from physical disease and injury were identified as trigger factors that compromises people's mental health and that can lead to suicidal attempts (Miller, Rathus & Linehan, 2007:20).

### 3.4.5 THEME 5: LIFE STORIES DEPICTING A YEARNING FOR FACILITATED MENTAL HEALTH

In telling their stories, the women living with borderline personality disorder, saw the need for change and facilitated mental health. This is when the women living with borderline personality disorder would mobilise their internal and external resources to improve their mental health. To yearn is to have an

intense feeling of loss or lack and longing for something (http://www.thefreedictionary.com/yearn).

#### 3.4.5.1 Turning points in mental health facilitation

The participants reached a point in their lives where they see the need to surrender and request help for their struggling. Turning points are crucial for participants. Some see it as a time for new beginnings, which is hopeful. Others see it as a difficult time, as they have to give up what have been "normal" coping skills for them. The participants decided to mobilise their own internal resources and seek help. They were open to receiving accepted interventions. External resources are another factor, which in this case were the professionals who offered early diagnosis and treatment such as psychotherapy and medication.

The following participant reached the turning point through viewing her mother - how difficult it was for her - and decided to seek help:



*"I don't think it's very easy for any parent and then the next day I saw a psychologist and a psychiatrist and then they decided to send me a psychiatric ward."*

The participant quoted below viewed her turning point as time to start taking care of herself and to not to worry about the other person. That feeling of entitlement helped her to seek help:

*"I think right now I am entitled to sort myself and not to worry about him. Just to be a little selfish because I've been taking care of him the whole while and now it's time to take care of me and not throw it down the drain."*

For another participant the turning point came when she used drugs. She was hit by the reality that she needed to stop and start doing something about her life:

*"It was almost like a miracle; it might sound strange to some people but for me it was a reality and I was walking home after this whole big weekend out and all this drugging and I was coming down and I had this cognition that if I don't stop now, it's almost like a premonition or a vision that if I don't stop now I will die. And all of a sudden I was able to stop using drugs and I did."*

It is evident that the women mobilised their own internal resources to seek help. An internal drive and being motivated are important factors in managing personality disorders.

## 3.5 SUMMARY OF CHAPTER 3

Chapter 3 explored and described the life stories of women living with borderline personality disorder. In chapter 4 guidelines for the psychiatric nurse practitioners will be formulated in order to facilitate the mental health of women living with borderline personality disorder.

# CHAPTER 4
# GUIDELINES FOR THE FACILITATION OF THE MENTAL HEALTH OF WOMEN LIVING WITH BORDERLINE PERSONALITY DISORDER, RECOMMENDATIONS, LIMITATIONS AND CONCLUSION

## 4.1 INTRODUCTION

In chapter 3, the results of the life stories of women living with borderline personality disorder were discussed. In this chapter, guidelines will be formulated based on the themes and categories identified. The psychiatric nurse practitioners will be expected to facilitate the mental health of women living with borderline personality disorder using the guidelines formulated in this chapter.

Managing women diagnosed with borderline personality disorder will require that a sense of psychic equilibrium is established and maintained (Spurling, 2005:544). It is therefore relevant that guidelines for the psychiatric nurse practitioners are formulated based on the Theory of Health Promotion in Nursing to sustain this equilibrium (Department of Nursing Science, University of Johannesburg, 2009:2). Practical problems encountered during the research, limitations and recommendations will be also discussed.



Table 4.1 summarises the themes and categories discussed in chapter 3 with the corresponding guidelines.

## 4.2 GUIDELINE 1: ADDRESSING CHILDHOOD EXPERIENCES OF LIVING IN AN "UNSAFE SPACE"

Unsafe childhood experiences were identified as having a negative impact in the lives of women living with borderline personality disorder. The damage was already done; however, the guidelines will focus on enabling the women living with borderline personality disorder to deal with their issues from childhood and to stay in the "here and now", enabling them to live productive lives.

**Table 4.1: Themes, categories and guidelines**

| THEMES AND CATEGORIES | GUIDELINES |
|---|---|
| **Theme 1: Life stories depicting childhood experiences of living in an "unsafe space"**<br>1.1 Unstable family dynamics<br>1.2 Boundary violations (physical, emotional and sexual abuse)<br>1.3 Educational challenges | **Guideline 1: Addressing childhood experience of living in an "unsafe space"**<br>1.1 Commencing family therapy<br>1.2 Commencing individual therapy<br>1.3 Educational support structures |
| **Theme 2: Life stories depicting chronic feelings of emptiness in the relationship with the self**<br>2.1 Distorted self-image and lack of identity | **Guideline 2: Addressing chronic feelings of emptiness in the relationship with the self**<br>2.1 Ongoing individual therapy |
| **Theme 3: Life stories depicting a pattern of unstable interpersonal relationships.**<br>3.1 Under-involved family<br>3.2 Unstable interpersonal relationships<br>3.3 Loneliness and cultural stigmatisation | **Guideline 3: Addressing a pattern of unstable relationships**<br>3.1 Family support groups and referral to family therapy<br>3.2 Participation in Dialectical Behavioural Therapy to address these issues |
| **Theme 4: Life stories depicting compromised mental health**<br>4.1 Early onset of depression (teenage years)<br>4.2 Emotional upheaval<br>4.3 Looking for emotional escape (unhealthy coping skills)<br>4.4 Trigger factors | **Guideline 4: Addressing compromised mental health**<br>4.1 Early diagnosis of mental health challenges at a primary health-care level and the management thereof<br>4.2 Early referral and commencement of coping skills training; that is, Dialectical Behavioural Therapy (DBT) and group therapy. |
| **Theme 5: Life stories depicting a yearning for facilitated mental health** | **Guideline 5: Facilitation of mental health, mobilisation of resources and** |

| THEMES AND CATEGORIES | GUIDELINES |
|---|---|
| 5.1 Turning points in mental health facilitation | **implementation of services by the psychiatric nurse practitioner**<br>5.1 Nursing process<br>**5.2** Facilitative communication skills |

### 4.2.1 Commencing family therapy

It is evident from the study that the women living with borderline personality disorder experienced ongoing instability in the family structure. The psychiatric nurse practitioner will need to address the family dynamics in a family therapy space. The family members should be called in and commencement of family therapy arranged. This will only start once individual therapy started in order that the psychiatric nurse practitioner can get to know the woman. In a study by Langley and Klopper (2005:26) they postulated that trust and empathy are indispensable for the patient-nurse relationship to work. The patient needs first to feel that the psychiatric nurse practitioner understands her before any work can be done. The family therapy needs to focus on the current dynamics that occur in the family. Issues such as divorce, abandonment, substance abuse, role reversal and lack of sound role models need to be the primary focus in the family therapy sessions. Dowdell and Cavanaugh (2009:35) suggest that the families and individuals should be offered support groups to encourage communication to their level of understanding. Stobie (2009:214) states that due to the nature of clients living with borderline personality, the families experience a lot of chaos, thus needing timely crisis intervention. The psychiatric nurse practitioner therefore needs to offer crisis intervention skills in order to contain the patient.



### 4.2.1 Commencing individual therapy

The initial relationship between the psychiatric nurse practitioner and the women diagnosed with borderline personality disorder needs to be built on trust. These women were exposed to unsafe spaces and their boundaries were violated from early childhood. Therefore their relationship with the psychiatric nurse practitioner must simulate safety at all contacts. When

feeling safe, the patient will feel comfortable to express any underlying feelings and unresolved issues. During individual therapy, the psychiatric nurse practitioner should remain consistent at all times in order to provide the patient with structure. It is important that the psychiatric nurse practitioner emphasises how the cycle of the patterns in the patients' lives work and how to break this cycle. The psychiatric nurse practitioner should be able to effectively understand when to apply a moment of pause between thoughts and action, as patients diagnosed with borderline personality disorder have difficulty controlling their impulses. Family members should also be educated about boundary violations, as they could be unaware of the boundary violation to which they expose the women.

### 4.2.2 Educational support structures

The Education White Paper (Department of Education, 2001:7) states that the Ministry of Education appreciates that a broad range of learning needs exists among the learner population at any given time, and that when these needs are not met, learners may fail to learn effectively or be excluded from the learning system. In this regard, different learning needs arise from a range of factors including physical, mental, sensory, neurological and developmental impairment, psycho-social disturbances, as well as differences in intellectual ability, particular life experiences or socio-economic deprivation (Department of Education, 2001:7). It would be crucial for the psychiatric nurse practitioner to liaise with the relevant structures at early detection of learning difficulties. In this research, the borderline personality structure was evident in the previous generations; it would thus be important to note these patterns and to do something about it in order that the cycle does not continue with their children. These issues could also be addressed in the parenting groups, in which the psychiatric nurse practitioner needs to be competent. The psychiatric nurse practitioner would need to mobilise out-reach programmes to schools where these issues are communicates to teachers, school children and parents. The role of the psychiatric nurse practitioner expands outside the women diagnosed with borderline personality disorder.

## 4.3 GUIDELINE 2: ADDRESSING CHRONIC FEELINGS OF EMPTINESS IN THE RELATIONSHIP WITH SELF

These could be addressed in individual therapy. The psychiatric nurse practitioner would initiate this by obtaining a complete history of the women. The foundations of this relationship will be trust and safety. The women should be encouraged to speak about the triggers of these empty feelings, as this would be crucial for understanding the origin of these feelings and hopefully assist in managing it. This would also be managed in the Dialectical Behavioural Therapy (DBT) as part of emotional regulation. DBT is based on a biosocial theory pioneered by Marsha Linehan. It was first used to treat chronically para-suicidal behaviour in adult women. DBT is used primarily to help people living with borderline personality disorder to manage their self-harm. This is achieved by developing self-awareness, reducing impulsivity and by means of emotional regulation and positive coping skills. Linehan describes the features of borderline personality disorder in terms of "dysregulation" (Linehan, 1993[b]:15) This means that people often struggle with their sense of self and frequently describe feeling empty, unreal or "cut off". To address these feelings, the women need to go through the steps of DBT, which include mindfulness, interpersonal effectiveness, emotion regulation and distress tolerance (McDougall et al, 2010:152).



## 4.4 GUIDELINE 3: ADDRESSING PATTERN OF UNSTABLE INTERPERSONAL RELATIONSHIPS

Unstable interpersonal relationships become the centre of the problems challenging women living with borderline personality disorder. This is a reflection of how they interact with people around them. The patterns of their relationships are unstable and generally conflicted. The interpersonal relationships include relationships with immediate family members, partners, friends and colleagues at work.

### 4.4.1 Family support and family therapy

The psychiatric nurse practitioner need to be skilled in performing family therapy where the family would be encouraged to express their feelings. The psychiatric nurse practitioner will assist in modifying the family's functioning in order to enable them to solve problems and manage conflict effectively. The problems presented will direct the goals for family therapy. Family support groups would entail involving only the family members of women living with borderline personality disorder to express their feelings about living with these women. It will also involve educating the family about the pathology of the disorder and how to manage certain behaviours in an effective way.

### 4.4.2 Participating in Dialectical Behavioural Therapy

It is important that the psychiatric nurse practitioner be skilled in facilitating DBT groups, thus addressing interpersonal effectiveness. Dialectical Behavioural Therapy (DBT) was originally developed for chronically suicidal patients; however, it evolved into a treatment for borderline personality disorder patients. It is a comprehensive treatment that serves the function of enhancing behavioural change, improving motivation to change and assuring that new capabilities generalise to the natural environment. It entails structuring the treatment environment in the ways essential to support the women living with borderline personality disorder and it also enhances the therapist's capabilities and motivation to treat the patient effectively (Dimeff & Linehan, 2001:10). The primary focus in DBT would be to stabilise the women and to achieve behavioural control; this includes any threatening behaviour like suicidal behaviour and any acting out, for example substance abuse. The secondary focus is to maintain stability and to reduce ongoing relapses (Dimeff & Linehan, 2001:11). The role of the psychiatric nurse practitioner here would be firstly to be trained in DBT to that gain an understanding of the DBT. Secondly the psychiatric nurse practitioner will need to offer group therapy based on the principles of DBT.

## 4.5 GUIDELINE 4: ADDRESSING COMPROMISED MENTAL HEALTH

Compromised mental health can be managed effectively if detected early. The women living with borderline personality disorder reached a point where they could see their compromised mental health; however, psychiatric nurse practitioners need to be skilled in diagnosing borderline personality disorder.

### 4.5.1 Early diagnosis of mental health problems at a primary health-care level and management thereof

The women would need to be diagnosed very early in order that early management can be done. This would also entail the accessibility of mental health services in the community and the availability of more trained psychiatric nurses to deal with the population of borderline personality disorders.



### 4.5.2 Early referral and commencement of DBT

Once the primary health level diagnosed the borderline personality disorder by means of proper referral, the women need to commence treatment. Psychiatric nurse practitioners at the community level need to assist with early referral to tertiary institutions and also with monitoring discharged women for any relapse. The benefits of DBT include that patients who underwent DBT have increased Global Assessment Scale scores; the participants have less para-suicidal behaviour, less anger and better self-reported social adjustment (Koons, Robins, Tweed, Lynch, Gonzalez, Morse, Bishop, Butterfield & Bastian, 2001:371).

## 4.6 GUIDELINE 5: FACILITATION OF MENTAL HEALTH, MOBILISATION OF RESOUCES AND IMPLEMENTATION OF SERVICES BY ADVANCED NURSE PRACTITIONERS

### 4.6.1 Nursing Process

This would require the psychiatric nurse practitioners to be very proactive. As mentioned earlier, The Theory of Health Promotion in Nursing (Department of Nursing Science, University of Johannesburg, 2009:8), promotes that the psychiatric nurse practitioners work by focusing on the nursing process. The psychiatric nurse practitioner needs to implement all the proposed guidelines. To implement these guidelines, the psychiatric nurse practitioner would need to work with other members of the multi-disciplinary team. Due to the nature of patients living with borderline personality disorder, they are manipulative. Their destructive behaviour can split staff members. This kind of behaviour is a microcosm of their internal worlds and serves as a way to survive in a world that is unpredictable and dangerous (Callan & Howland, 2009:14). Implementation, according to the mentioned theory, speaks about nursing actions reflected by mutual involvement between the psychiatric nurse practitioner and the patient and also the mobilisation of resources (Department of Nursing Science, University of Johannesburg, 2009:8). The psychiatric nurse practitioner needs to be a good communicator, meaning that she must be able to liaise with the various departments to ensure holistic care of the women. The various departments would include the Education Department for educational challenges and education, the Social Welfare Department for referral for grants, the Police Department for safety concerns and the appropriate referral to members of the multi-disciplinary team. Callan and Howland (2009:14) also talk about holistic management of borderline personality disorder. This includes the administration of the medication that would be prescribed to manage any other symptoms. Their model of managing borderline personality disorder includes understanding the underlying behaviour, which would be done in therapy; it includes that staff be clinically supervised, the team being objective and maintaining a therapeutic stance in order that staff use their own reactions as a key to understand these women. Their model also includes making the patients' stay as short as

possible and telling them their discharge date early; this helps with regressing behaviours. The model also entails having contracts that outline acceptable and unacceptable behaviours and having consequences for unacceptable behaviours. The model lastly includes having to reinforce the expression negative feelings in words rather than in actions, for example in the case of self-inflicting injuries.

### 4.6.2 Facilitative Communicative Skills

The facilitative communication skills are clarification, reflection, summarising, probing, and making minimal verbal responses, responsive listening and non-verbal communication (Okun & Kantrowitz, 2008:77). The research will need to be competent in using the skills in order to assist in the therapies.

## 4.7 CHALLENGES ENCOUNTERED DURING THE STUDY



Initially the researcher was challenged with not enough participants to partake in the study. The researcher had to change her population through the University of the Witwatersrand, from using in-patients only to using both in-patients and out-patients. She also had to change the ages to 18 to 40. Participants cancelling appointments at the last minute also posed a challenge, resulting in new appointments having to be scheduled.

## 4.8 LIMITATIONS OF THE STUDY

This was one of the few studies of this nature done in South Africa. Therefore insufficient theories and literature were available to analyse and compare the result of this study with. This study was done in a psychotherapy ward with patients who have done the psychotherapy programme of eight weeks; therefore the results are only contextualised in the institution in which the study was conducted.

## 4.9 RECOMMENDATIONS

### 4.9.1 Psychiatric Nursing Research

The researcher would recommend that this study be done again but in different contexts. This study could also be done, not focusing on women only.

### 4.9.2 Education

Psychiatric nurse practitioners should have a curriculum that focuses on promoting, maintaining and restoring the mental health of persons living with borderline personality disorder at an advanced level.

### 4.9.3 Nursing Practice

The activity in question is psychiatric nursing that promotes the mental health of the patient (Department of Nursing Science, University of Johannesburg, 2009:9). It is evident from the research that women living with borderline personality disorder face a number of challenges. In order to promote, maintain and restore their mental health, it is necessary to manage their mental health holistically, as human beings with a mind, body and spirit, who also interact with their external environment physically, mentally, socially and spiritually. The primary health care level should also develop structures developed for quicker referral to tertiary institutions. The South African Nursing Council should develop a scope of practice for psychiatric nurse practitioners.



## 4.10 CONCLUSION

The purpose of this study was to explore and describe the life stories of women living with borderline personality disorder and to formulate guidelines for psychiatric nurse practitioners to facilitate the mental health of these women. The paradigmatic perspective of the study was guided by the Theory of Health Promotion in Nursing, which reflected and provided focus on the women as a person (body, mind and spirit), as well as the parameters for nursing service and beliefs in the nature of man, health, illness and nursing (Department of Nursing Science, University of Johannesburg, 2009:5). A

holistic approach was applied to conducting this study. A qualitative, descriptive, explorative and contextual design was used to conduct the study. Eight women living with borderline personality disorder were interviewed by posing one central question, namely “Tell me your life story”. Some of the women were admitted to a psychotherapy unit and some were already discharged. This Semi-structured interviews were conducted, which were audiotaped and transcribed. Permission to conduct the study was obtained from the various ethics committees and from the women participating in the study. Measures to ensure trustworthiness were followed throughout the study. Data analysis was done. Open coding was used to organise the data from the interviews into data that has meaning. An external coder analysed the data for confirmation. The researcher and external coder held a consensus discussion to discuss identified themes. A literature review was conducted based on the themes identified. The life stories depicted various factors contributing to the women’s mental health. Guidelines to facilitate their mental health were formulated to ensure the promotion of their health. Conclusions were drawn and guidelines outlined for the psychiatric nurse practitioner to facilitate the mental health of women living with borderline personality disorder. This will ensure that resources are mobilised to promote, maintain and restore mental health as an integral part of their health and wholeness. Recommendations for nursing practice, education and research were also stated in the research.

## REFERENCE LIST


Arnold, E.C & Boggs, K.U. (2011). *Interpersonal relationships: professional communication skills for nurses*. 6th edition. USA: Elsevier Saunders.

Babbie, E. (2005). *The basics of social research*. 3rd edition. Canada: Wadsworth.

Babbie, E. & Mouton, J. (2001). *The practice of social research.* Canada: Oxford University Press.

Bhebhe, S. & Fuller, M. (2009). Improving the management of women with borderline personality disorder. *Nursing Times*, 105(1):18-19.

Bland, A.R., Tudor, G & McNeil, W. (2007). *Nursing care of inpatients with borderline personality disorder. Perspectives in Psychiatric Care,* 43(4):204-212.

Boeije, H. (2010). *Analysis in qualitative research.* London: Sage Publications.

Bothma, Y., Greeff, M., Mulaudzi, F.M & Wright, S.C.D. (2010). *Research in health sciences.* Cape Town: Heinemann.

Burns, N. & Grove, S.K. (2005). *The practice of nursing research: conduct, critique & utilization*. 5th edition. Philadelphia: Saunders.

Callan, J.A. & Howland, R.H. (2009). Borderline personality disorder: inpatient psychiatric nursing management. *Journal of Psychosocial Nursing,* 47(5):13-14.

Creswell, J.W. (2007). Qualitative inquiry and research design. Choosing among five traditions. Thousand Oaks: Sage.

Chiles, J.A. & Strosahl, K.D. (2005). *Clinical manual for assessment and treatment of suicidal patients.* USA: American Psychiatric Publishing Inc.

Defence mechanism. Available from: GOOGLE http://psychology.about.com/od/theoriesofpersonality/ss/defensemech.htm (Accessed 8 April 2012).

Denham, S. (2003). *Family health: a framework for nursing*. USA: Davis Company.

Denzin, N.K. & Lincoln, Y. (2009). *Collecting and interpreting qualitative materials.* United Kingdom: Sage Publications.

Department of Education. (2001). *Education White Paper: Special Needs Education. Pretoria*: Government Printers.



Dhai, A. & McQuoid-Mason, D. (2011). *Bioethics, human rights and health law: principles and practice.* Cape Town: Juta.

Dimeff, L. & Linehan, M.M. (2001). Dialectical Behavior Therapy in a nutshell. *The California Psychologist,* 34:10-13.

Dowell, E.B. & Cavanaugh, D.J. (2009). Caregivers of victimised children. Differences between biological parents and foster caregivers. *Journal of Psychosocial Nursing,* 47(6):29-36.

Emotional escape. Available from: GOOGLE http://wiki.answers.com/Q/what_is_emotional_escape. (Accessed 8 April 2012).

Emotional escape. Available from: GOOGLE http://wiki.answers.com/Q/emotionalescape. (Accessed 8 April 2010).

Facilitation. Available from: GOOGLE http://www.answers.com/topic/facilitation#American_Heritage_Dictionary. (Accessed n 6 February 2011).

Feigennaum, J. (2007). Dialectical behaviour therapy: an increasing evidence base. *Journal of Mental Health,* 16(1):51-68.

Friedman, H.S. & Schustack, M.W. (2009). *Personality classic theories and modern research.* 4th edition. USA: Pearsons.

Gmeiner, A. & Shank, S. (1998). *Facilitating communication*. California: National Centre of Continuing Education.

Gubb, K. (2010). Reflections on society as a borderline mother. *Psycho-analytic Psychotherapy in South Africa,* 18(1):40-57.



Holm, A. & Severinnson, E. (2008). The emotional pain and distress of borderline personality disorder: a review of the literature. *International Journal of Mental Health Nursing*, 17:27-35.

Holm, A., Berg, A. & Severinnson, E. (2009). Longing for reconciliation: a challenge for women with borderline personality disorder. *Issues in Mental Health Nursing*, 30:560-568.

Keltner, N.l., Schwecke, L.H, & Bostrom, C.E. (2007). Childhood sexual abuse, PTSD, and borderline personality disorder. *Journal of Psychosocial Nursing,* 47(7):4-6.

Koons, C.R., Robins, C.J., Tweed, J.L., Lynch, T.R., Gonzalez, A.M., Morse, J.Q., Bishop, G.K., Butterfield, M.I. & Bastian, L.A. (2001*).* Efficacy

of dialectical behavior therapy in women veterans with borderline personality disorder. *Behaviour Therapy,* 32:371-390.

Keyes, L.M. & Goodman, S.H. (2006). *A handbook for the social, behavioural and biomedical sciences.* USA: Cambridge University Press.

Langley, G.C. & Klopper. (2005). Trust as a foundation for the therapeutic intervention for patients with borderline personality disorder. *Journal of Psychiatric and Mental Health Nursing*, 12:23-32.

Linehan, M.M. (1993b). Skills training manual for treating borderline personality disorder. New York: Guilford Press.

Magnavita, J.J. (2004). *Handbook of personality disorder: theory and practice*. USA: John-Wiley & Sons Inc.

Mateo, M.A. & Kirchhoff, K.T. (2009). *Research for advanced practice nurses from evidence to practice.* USA: Springer Publishing Company.

McDougall, T., Armstrong, M. & Trainor, G. (2010). *Helping children and young people who self harm - an introduction to self-harming and suicidal behaviours for health professionals.* New York: Greengate Publishing Services.

McDonald, M., Pietsch, T. & Wilson, J. (2010). Ontological insecurity: a guiding framework for borderline personality disorder. *Journal of Phenomenological Psychology*, 41:87.

Mental health. Available from: GOOGLE http://en.wikipedia.org/wiki/Mental_health. (Accessed 6 February 2011).

Miller, A.L., Rathus, J.H. & Linehan, M.M. (2007). *Dialectical behavior therapy with suicidal adolescents.* USA: The Guilford Press.

Morse, J.M. & Field, P. (2006). *Nursing research: the application of qualitative approaches.* 2nd edition. United Kingdom: Nelson Thornes.

Myer, L., Stein, D.J., Jackson, P.B., Herman, A.A., Seedat, S. & Williams, D.R. (2009). Impact of common mental disorders during childhood and adolescence on secondary school completion. *South African Medical Journal*, 99(5):354-356.

Okun, B.F & Kantrowitz, R.E. (2008). *Effective helping interviewing and counselling techniques.* 7th edition. United States of America: Thomson Brooks/Cole.

Paris, J. (2010). *Treatment of borderline personality disorder: a guide to evidence-based practice.* USA: The Guilford Press.

Perseius, K., Anderson, E., Asberg, M. & Samuelsson, M. (2006). Health-related quality of life in women patients with borderline personality disorder. *Scandinavian Journal of Caring Science*, 20:302-307.



Polit, D.F. & Beck, C.T. (2010). *Essential of nursing research. Appraising evidence for nursing practice.* 7th edition. China: Lippincott Williams & Wilkins.

Rossouw, D. (2003). *Intellectual tools: skills for human sciences.* Pretoria: Van Schaik.

Sadock, B.J. & Sadock, V.A. (2003). *Kaplan and Sadock's synopsis of psychiatry: behavioural sciences/clinical psychiatry.* 9th edition. USA: Lippincott Williams & Wilkins.

Schmidt, U. & Davidson, K. (2004). *Life after self harm. A guide to the future.* USA: Brunner-Routledge Publications.

Seale, C., Gobo, G., Gubrium, J. & Silverman, D. (2004). *Qualitative research practice.* London: Sage Publications.

Shifona, N.N., Poggenpoel, M. & Myburgh, C.P.H. (2006). Life stories of depressed adult women in peri-urban Namibia. *Curationis*, 29(2):2-11

Silverman, D. (2011). Qualitative research. 3rd edition. London: Sage Publications.

Skodol, A.E. & Bender, D.S. (2003). Why are women diagnosed with borderline more than men? *The Psychiatric Quarterly*, Winter, 74(4):349-360.

Spurling, L. (2005). Combined therapy with borderline patients. *British Journal of Psychotherapy,* 21(4):543-558.

Stobie, M.R. & Stromskie-Klingshirn, D.M. (2009). Borderline personality disorder, divorce and psychotherapy. The need for family crisis intervention strategies. *The American Journal of Family Therapy*, 37:414-432.

Tennant, A. & Howells, K. (2010). *Using time not doing time. Practitioner perspectives on personality disorder and risk*. Singapore: John-Wiley & Sons Inc.

University of Johannesburg. (2011). *Department of Nursing Science Paradigm: Theory for Health Promotion in Nursing*. Johannesburg: Department of Health Sciences.

Uys, L. & Middleton, L. (2002). Mental health nursing. A South African perspective. 3rd edition. Cape Town: Juta & Co.

Upheaval. Available from: GOOGLE http://www.the freedictionary.com/_/dict.aspx?word=upheaval. (Accessed 8 April 2010).

Weite, R. & Gerrity, P. (2010*)*. Assessment for and response to adverse childhood experiences*. Journal of Psychosocial Nursing*, 48(12):52-59.

Woman. Available from: GOOGLE http://en.wikipedia.org/wiki/Woman. (Accessed 6 February 2011).

Yearn. Available from: GOOGLE http://www.thefreedictionary.com/yearn (Accessed ).

**APPENDIX A**

## APPENDIX B

**APPENDIX C**

**APPENDIX D**

**APPENDIX E**

**TO: TARA, THE H. MOROSS RESEARCH COMMITTEE**

**REQUEST TO CONDUCT RESEARCH**

I, Nompumelelo Mthethwa, would like to request permission to conduct the research titled “Facilitation of mental health of women living with borderline personality disorder” as a requirement for a degree of Magister Curationis in Psychiatric Nursing Science. The study will be done under supervision and guidance of Professor M. Poggenpoel, Professor C.P.H. Myburgh and Dr A. Temane, Department of Health Sciences and Education at the University of Johannesburg.

The objectives of the study are to

1. explore and describe the life stories of women living with borderline personality disorder, and
2. formulate guidelines for psychiatric nurse practitioners to facilitate the mental health of women living with borderline personality disorder.



After obtaining your permission, phenomenological individual interviews will be conducted with the purposively chosen women with their consent, for 45 to 60 minutes, whereby they will describe their life stories as women living with borderline personality disorder. Only one open-ended question will be asked during the interview: “Tell me your life story.” This interview will be audiotaped and transcribed verbatim for verification of findings by an independent psychiatric nurse specialist and my supervisors. The audiotapes will be kept under lock and key; only my supervisors and I will have access to the audiotapes. The audiotapes will be destroyed two years after publication of the research.

Arrangements will be made with the women once permission has been granted by you, as to the place where the interviews will be conducted (at a place convenient to the women admitted to the hospital). Research findings will be made available to the women on request.

Participation in this study is voluntary and that even during the course of the interview the women can terminate the interview without any penalty. The women will not be paid for participating in the study.

In order to protect the women's identity, I will undertake the following:

a. to omit or disguise the women's name when discussing information pertaining to the study;
b. to keep all raw data under lock and key when not in use;
c. to ensure that no one except my supervisors and the psychiatric nurse specialist comes into contact with the raw data; and
d. to leave with my contact details in case the women need to see me in connection with any matter arising from the study.

The women's participation in this study has the potential of benefiting other women who find themselves in similar situations. The direct benefit to the women is that they will have the opportunity to verbalise their experiences of suffering from borderline personality disorder.



My address
751A Buthelezi Street
Zola North
1868

My contact number is 083 716 2511, and communication to be done between 16h00 and 18h00.

NOMPUMELELO MTHETHWA RN
MCUR (Psychiatric Nursing Science) Student

MARIE POGGENPOEL RN; Phd
PROFESSOR: DEPARTMENT OF NURSING SCIENCE

CPH MYBURGH BSc; Hons, M.Comm, D.Ed.HED
PROFESSOR: DEPARTMENT OF EDUCATIONAL PSYCHOLOGY

ANNIE TEMANE RN
D CUR: DEPARTMENT OF NURSING SCIENCE

**APPENDIX F**

**TO THE PROSPECTIVE PARTICIPANT**

**REQUEST TO CONDUCT RESEARCH**

I, Nompumelelo Mthethwa, invite you in a research project entitled “Facilitation of the mental health of women living with borderline personality disorder” as a requirement for a Magister Curationis degree in Psychiatric Nursing Science. The study will be done under supervision and guidance of Professor M Poggenpoel, Professor CPH Myburgh and Dr A Temane of the Department of Health Sciences and Education, at the University of Johannesburg.

The objectives of the study are to

3. explore and describe the life stories of women living with borderline personality disorder, and
4. formulate guidelines for psychiatric nurse practitioners to facilitate mental health of women living with borderline personality disorder.



After obtaining your permission, a phenomenological interview will be conducted for 45 to 60 minutes, during which you will describe your life story as a woman living with borderline personality disorder. Only one open-ended question will be asked during the interview: “Tell me your life story” This interview will be audiotaped and transcribed verbatim for verification of findings by an independent psychiatric nurse specialist and my supervisors. The audiotapes will be kept under lock and key; only my supervisors and I will have access to the audiotapes. The audiotapes will be destroyed two years after publication of the research.

Arrangements will be made with you once permission is granted by you, as to the place where the interview will be conducted (at a place convenient to you). Research findings will be made available to you on request.

Participation in this study is voluntary and that even during the course of the interview you can terminate the interview without any penalty. You will not be paid for participating in the study.

In order to protect your identity, I will undertake the following:

- to omit or disguise your name when discussing information pertaining to the study;
- to keep all raw data under lock and key when not in use;
- to ensure that no one except my supervisors and the psychiatric nurse specialist comes into contact with the raw data; and
- to leave my contact details in case you need to see me in connection with any matter arising from the study.

Your participation in this study has the potential of benefiting other women who find themselves in similar situations. The direct benefit to you is that during the interview you will have the opportunity to verbalise your experiences as a woman who suffers from borderline personality disorder.



My address
751A Buthelezi Street
Zola North
1868

My contact number is 083 716 2511, and communication to be done between 16h00 and 18h00.

NOMPUMELELO MTHETHWA RN
MCUR (Psychiatric Nursing Science) Student

MARIE POGGENPOEL RN; Phd
PROFESSOR: DEPARTMENT OF NURSING SCIENCE

CPH MYBURGH BSc; Hons, M.Comm, D.Ed.HED
PROFESSOR: DEPARTMENT OF EDUCATIONAL PSYCHOLOGY

ANNIE TEMANE RN
D CUR: DEPARTMENT OF NURSING SCIENCE

**APPENDIX G**

**FACILITATION OF MENTAL HEALTH OF WOMEN LIVING WITH BORDERLINE PERSONALITY DISORDER**

I _____ give my permission to participate in the research study.

_____
Participant



_____
Researcher

**APPENDIX H**

**FACILITATION OF MENTAL HEALTH OF WOMEN LIVING WITH BORDERLINE PERSONALITY DISORDER**

I _____ give my permission that the interview with me can be audiotaped.

_____
Participant



_____
Researcher

## APPENDIX I

## PARTICIAL TRANSCRIPT

| | **Transcription** |
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| | |
| **I** | Good morning X. |
| **P** | Good morning. |
| **I** | You have agreed to participate in the study and I would like to ask you to tell me your life story. |
| **P** | Yes I did agree to participate. As you know my name is X, I was born in 1979 the 19th of September. I grew up with my grandmother, my late father's mother. I am the eldest of four siblings and that is basically my family history. I grew up with my grandmother because of my mother like, she didn't really want me around, so not like I had a choice but I had to grow up with my grandmother. I went to school from there and I was send off to boarding school at the age of about 11, 10-11, went to boarding school and at the boarding school came home weekends and so forth and so on.<br><br>Ja at my grandmothers place and then in grade 10, then it was still standard 8, I fell pregnant with my first child and I couldn't go back to boarding school and then I was raised further and my son was raised further by his grandmother and that's the end of that story.<br><br>And then I met another person. I like, I didn't have uh-uhm, like how can I say, I never enjoyed my youth, like I never had uh, I was never a teenager. When I was a teenager at the age of 15 I had my first child and then as time went on at the age of 17, I was in grade 12, ja 17, I fell pregnant with my second child. And then that was a kind of promising relationship; the man was caring, we lived together. And then a couple of years down the line, four, five years down the line things went wrong and |

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| | we broke up and then that's my second son and then I moved back to X. |
| **I** | To your grandmother's place? |
| **P** | No I like, no I moved, I moved to, ja I moved back to X, I was living at my mom's for like not even two months and then I have this other friend and then I went to, she, I told her that I am actually looking for a place. By then I wasn't working but my second child's father was agreeing to pay to help me out until I was stable.<br><br>And then I got a place in Soweto and I lived there for like almost seven years and then I moved back to X because I met another guy; baby no three's father. That relationship didn't last very long. We had a baby and then like the child is staying, currently the child is living with him because I wasn't stable at that time and then he agreed to take the child.<br><br>And then 19.. you can say from, ja say from 1999, ja 1999 I was kind of on my own, alone. You know I had to look out for myself and do what is pleasing me. |
| **I** | How old are you? |
| **P** | I am 32 now. |
| **I** | And when you started taking care of yourself how old were you? |
| **P** | When I was really-really on my own, I was around 21 – 22. I had to now, I was on my own, there was no family, no friends, no baby fathers and all that, I was on my own where I had to look out for myself you know. Learn the hard way that life is not just a fairytale and all that. Ja and I coped here and there you know.<br><br>I joined the police service as a reservist in 2001. Then things started |

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| | looking up where I could actually cope and we didn't get a salary but at least you know we could, we could manage, it depends on the group you were working with. If you are on less than three people they will actually like take money out from their pockets and like give you something on the month end.<br><br>Or if you don't have money you can just go to your commander and tell them I need this and they will try and make a plan and give you money or work in one of the permanent member's space and then they will pay you on the rate that they think is appropriate.<br><br>Ja and I was in the police and then I met boyfriend number four and then things went very well. Finally I got somebody that was caring, loving, understanding, providing financially and emotionally he was there. But then I don't know what went wrong there and then he became very abusive. Very-very abusive to the extend where if I see him I already get scared because I already know what is gonne happen. |
| **I** | Was it your first boyfriend that was abusive? |
| **P** | Ja it was my first boyfriend that was abusive and if I say abusive he was abusive in a way that you can think this person can really kill you now you know if he gets angry. And then he was abusive like I use to get a hiding every weekend for nothing. Whenever he goes out he doesn't get his way outside or whatever happened outside I never use to know, then he will come home and hit me and stuff like that.<br><br>Then I got this place where I am currently living now. This is five years back now that I got this place and then everything was going well. I got a job; I was working at an old aged home. I enjoyed working there you know being able to help the old people but it was nice working there. |
| **I** | So you stopped being a reservist? |

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| **P** | Ja I stopped being a reservist, no I was still working as a reservist but that was now a full time job. Monday to Sunday and afterhours because you have to have 16hours in the reservists, after hours or on weekends I'll go and work.<br><br>And then things got so hectic that he started accusing me of going out with the guys that I am working with. You know he will start harassing me and all those things and I've laid a couple of complaints of abuse and then they will send me from this pillar to post. No you have to go, know the procedures to go there, go there, get the protection order you know. And each and every time he hits me I go to the police station with the protection order I mean I know how it works and what is supposed to be done but you'll get people that is so incompetent that you know they don't really want to do anything about it. They'll just take it ag, you just made the case today, tomorrow you withdraw the case and that's how it went on and went on.<br><br>Until, it was, I can't remember 2001 it was, I was sleeping, I was asleep in this room and then he kicked, he managed to kick the door open, he kicked the door open while I was sleeping. And then he stabbed me and I don't know what else happened. I woke up in Barra like two, three days after that. |
| **I** | Did you have a fight with people there? |
| **P** | I, what happened; I wasn't here and he had a key to my place and he started stealing my stuff. He was using drugs so he started stealing my stuff and I didn't notice but then after that I started, when I want something I'll see no man this thing is gone, where is this thing. I asked him why do you come to my place if I am not there, can I have my key back, he didn't want to give my key but then apparently he went to make another key. |

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| | And then he gave me my key but then he still had a key. So if anything should go missing I wouldn't suspect him because he gave my key back. One of his friends told me no he did go make another key. And when he started stealing my stuff I did go make a case against him again. The police, you know he'll keep on running away or whatever. And the last time was when he did hit me and I woke up in Barra and I was unconscious and I was paralysed from the waist down and my right hand side I did lose feeling, sensation in my right hand side. |
| **I** | Where did he stab you? |
| **P** | He stabbed me on my, in my spine like just two inches away from the spine but it affected my spine and then ja on my right hand. I had a broken jaw and bruised face you know and all of that. I was in hospital for almost two months. Ja then I got better you know and then, but then after that I was, *(short silence)*, things weren't the same anymore. |
| **I** | With him? |
| **P** | With, he was like on the run from the police, the police was looking for him. He was arrested and he managed to escape on his way to Sun City, they took him to Johannesburg prison and I don't know where and how he escaped but then he was on the run and the police was looking for him. And I didn't live here, I was living in a woman's shelter. I was living in a woman's shelter until the police had like arrest him and stuff like that.<br><br>But then things weren't the same anymore. I was always scared and I had you know my self-esteem was like low and I was always scared like you know. If I go out is everybody gonne see that I'm scared and will every man take advantage of me, you know little stuff and things like that. Ja and then in 2000 things went on, he got re-arrested and then I felt safe again. |

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| | I could, I moved back to my room and like I am staying now, my children are not staying with me, they living with my grand, with my mother and my other one is living with his grandmother and the one is living with his father. But I see them weekends, holidays, whenever they want to come they come here but they never sleep over. They say I am too strict cause eight o'clock they have to be in bed. And then, ja and then… |
| **I** | It was the kids choice to stay with the grandparents or was it your choice? |
| **P** | It was my choice. But they all big now so they-they understand now that you know, I just feel like I can't let them stay with me because I am not stable, I don't have a job. I can't provide for myself so it's gonne be unfair if I'm an adult, I can go without food, I can you know just tell myself ag I'm not gonne, I'll just have bread and eggs. But then the child will come and he will want cold drink and he wants this and this and I can't provide it now. So whenever I'm working you know then I do give them whatever I can. Try and make up, I won't be able to make up but I can just try to you know. Just give them whatever they want and it's gonne make them happy at that time.<br><br>And then everything was fine, I lived here on my own. And then 2009, ne it was 2009, no 2010, ja it was last year in February, I was in this room. I don't know what happened. I use to have tablets, I use to steal some tablets from my cousin because she always said it makes her feel like sleepy and you know it helps her to sleep. So I would also take her tablets and feel okay it makes me, it makes me like, it gave me a nice feeling and I would just fall asleep without thinking anything or being stressed or you just sleep.<br><br>And I liked that feeling because I didn't have to think about what's gonne happen tomorrow, what am I gonne eat tomorrow, it just… for days on end I will just stay in this room, drinking, passing tablets, whatever tablets |

I could get my hands on I would just drink that. It went on for a month, from like January until I had an overdose, ja, in February then I had an overdose.

At the time I knew what I was doing. And I knew what was going to happen, I was going to die because this is now too much, I mean 150 tablets, definitely something is gonne happen. And then I woke up the following day, on the 10th, I woke up and I wasn't dead and I was disappointed because I wasn't dead. And I was having all these pains and dizzy and I couldn't get up and luckily I don't know what happened that day but the pastor just came here by my place and they found me. He took me to hospital, I was at X hospital, I was for three weeks in medical then I went to the psychiatric ward, at ward two at Helen Joseph.

And ja and when I got there I was still suicidal, I was still, I was still angry at God for not you know letting me die. Because my problems weren't gonne be solved now people are still gonne be looking at me with she's a coward or why did she do that or you know not knowing I have a problem and I don't know how to talk about it or where to get help. I mean that was, it was the easy way out but for me it felt like I am not gonne be a burden anymore. Then from there I was send to ward four and five at Barra, uh ward eight, discharged and went back to ward four and five.

What I've learned from that experience that you know there is, there is help and it helps to talk. The sessions that I had with my therapist really helped me and just to be among people that weren't really in your shoes but you tell yourself I thought I was the only one that is going through this. God is making me go through this and you know and why am I going through this but then there were other people and they were there for other reasons but most of us I think the suicide brought us all there, trying to kill yourself or whatever happened.

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| | And what I've learned from that experience is that it helps to talk. But for me, I'm-I'm a very closed person, I like to be by myself and you know. If I feel like I become too depressed or too stressed now I will just come to my room, switch on the Tv and you know watch Tv. The Tv is on but I'm basically not interested in what is playing there. And then I know what is gonne happen, I'm gonne start feeling worthless and empty.<br><br>And then I'm not gonne lie, the other day, two weeks back that feeling came about and I'm only having my cipramil and my aspirin and I was saying to myself well this won't even make me dizzy. Now I was thinking of taking it but then something just gave in and said no man they won't do you anything so why you even bother you know. And then I just left it and you know I just prayed, my bible, just read my bible and you know pray and then I felt better again.<br><br>And then that is why I am sitting here because obviously two weeks ago I was feeling horrible and I was feeling so, I can't be feeling my head all the time. I have to do something to help myself to feel better and then always the question comes down to what can make me feel better. What I need now is a job. I-I-I'm stable, I have stability but I need security, I need a job you know. And also in ward four and five I was diagnosed that I am HIV positive so since then I have been taking live easy you know. Uhm, no relationships.<br><br>I-I was drinking, from about March I was drinking a lot. I started drinking again and I was drinking a lot. It's now two months that I haven't been drinking. I was just, I just knew, I just went back to being my old self you know, drinking you know, just to not to think and you know not to be in the real life. Just to be drunk and then you, it's like you don't care what's going on around you when you drunk you know. You just drunk and you are enjoying yourself right now.<br><br>I'll make sure I'll get down to the party buzz, know Monday this is |

happening and this is happening, Tuesday that is happening, just so that I can come back and sleep. Tomorrow, tonight again I have to wake up and pull myself together, going out, going to drink you know, stuff like that.

And then I was sick, I was sick. I was sick to the point where I thought now I am going to die. My chest was like, I went for a TB test, it came back negative, I was like coughing and coughing and coughing. And then I went, immediately when I started coughing it was like, it was painful in my chest, I went to the clinic. I went, I told them okay I am coughing and it's painful in my chest and the first thing, they first said no go for a TB test and I went for the TB test. After two weeks I got my results, it was negative.

And the cough was getting worse and the pain in my chest was getting worse. And then they send me to X and I went for X-rays and stuff and at the X-rays they picked up pneumonia and asthma. But I did have a touch of asthma but I didn't, I wasn't, I didn't need any medication for that. Just when my chest starts closing then I would go to the clinic for nebulisers. As you can see now I am on the asthma treatment because now it has spread, it was like I have asthma now, full blown asthma. If I don't get oxygen then you know my chest pulls tight and I can get an asthma attack and stuff like that.



And that's when I decided now I have to stop. I am going to kill myself; it's either the asthma is going to kill me or drinking is gonne kill me. And I just, it wasn't easy but I had to again lose my friends. Not that they are bad influence but because with my friends I can, I have access to whatever. Ja then, like now no more friends, no more going out, sitting at home and it works for me. For now it is working.

It's just that sometimes I don't have that will power you know, that, to tell myself that I can make it, I can, I can like say no and resist. I can resist but then in this society it is like you, you weak if you don't do what I'm

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| | doing, then you weak. |
| **I** | For example the drinking? |
| **P** | Ja the drinking and then you are not fun to be around and we don't hang out with you because you are a spoil sport and stuff like that. And I remember what my therapist use to tell me; it's like, which means those are not friends. And really they are not friends because they won't come here during the week to see if I am okay or just come and sit and we have cool drink or just talk and you know.<br><br>But when we drink or when we have to drink, when we going out or when it's a party they'll come or they'll make the means to come and fetch me or you know when I feel like no man I don't have anything nice to wear, they will even borrow me something nice to wear and say no let's go, call me and send a car to fetch me and … But when I'm sick and on my own then nobody comes so those are really not friends, they are drinking partners. Then those are not friends, they are drinking partners.<br><br>Ja so it's two months now; I haven't touched alcohol, stopped smoking. It's not easy but I am trying my best. Sometimes when my chest is a bit quiet then I'll just have *(said with a laugh)* a cigarette to smoke, which I am not supposed to do. Ja and for now I'm just like now I said okay it's the end of the year, ja if you can still get a job you know even if it is just for December time it will be okay but definitely next year I need to do something.<br><br>I don't know where do I start because I don't have any financial uhm you know somebody that can help me I mean if I want to go and do something so that I can have a … I have a diploma in computers because I don't have Matric and it's difficult to find a job. Ja and anything that is gonne come next year, anything you know, just to survive. |

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| **I** | But how are you surviving now? |
| **P** | Uhm currently, I am going, uhm my grandmother lives on her own ne, not on her own, my uncle lives with her but my granny is old, she is 92. So they have asked me to like you know come just to go and be with my grandmother during the day then I clean the house and I do the cooking.<br><br>Because I was, I asked my uncle for R400 one month and then he said no he doesn't have any and he asked me what is it for and I told him no I need to, I was working last year after I came out of TARA I got a job but then after six months they didn't renew my contract and then I borrowed, still I was working there and I took it out on account so I have to pay it like every month. So he said no he will pay the Tv for me, okay that is sorted.<br><br>My rent; there is this other girl, we friends, we go to the same church, I do her washing for her ne but like this month that passed now I was so sick. This month September, I was so sick the whole month. I like, I couldn't even do my own washing. My sister did my washing for me. And another thing if I am working in water, I'm working in cold water it also affects my chest and then I become sick and then I was very sick this month that passed now. And then I couldn't do the washing and stuff like that and so they couldn't pay me.<br><br>Like I was sitting the whole morning sending sms's, I just need R500 just to pay my rent. So I will see, I still have until Friday to get that R500. How am I gonne get it I don't know but I will just try my own best to try and get that R500. For a person that is not working, that is a lot of money. But other than that she helps me but it's-it's not gonne be fair if like because I didn't even tell her that I don't have money. Maybe if I can tell her like I don't have money she will give me the money. But then some people will say okay she didn't do the washing and ah I can't pay her you know. |

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| | So I don't even want to go there but I'll try by all means to get something. If I don't get, my landlord has just to bear with me, it's not like I do it every month. I pay my rent sommer before, immediately when I have money I just keep, R100, R200, R500 even before month end I pay my rent. I'm not like a bad payer so I think he can really just give me another chance or just wait until I have the money.<br><br>Ja food wise, I love them bread and eggs, *(laugh),* which is okay as long as I'm eating. And then like I say I am cooking there by my grandmother and in the afternoons I will have something before I come home and then when I get up in the morning I will make myself breakfast.<br><br>Ja it's working for me for now since I don't have a job it is working for me. So it's okay, sometimes it is irritating and it's, it depresses me because I wake up and I can only make myself a cup of coffee. There is no bread, there is no wheat-bix and there is no nothing to eat. Then I have to wake up even if I don't want to even on a weekend when I feel like just staying at my house you know, just being here. I have to get up and say okay now I have to go to my grandmothers because I am hungry and I have to go and eat. You know but otherwise it's okay. |
| **I** | And where is your mom now? |
| **P** | She is living two streets away from here. We don't like, my mother and I we don't get along, ever since I was young we don't get along. It's not like I can go to my mother and tell her now like okay I don't have money for my rent. I can't do that, we never had that kind of a relationship and *(short silence)* it's like she is not very supportive. So I don't even bother because I know I don't get the motherly love that or you know that mother and daughter relationship, there isn't.<br><br>And I am a mother myself and I am old already, grown up already so why |

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| | must I still you know be like go to her because she will tell you; you are an adult, you have to provide for yourself, I don't have a husband that is working for me that I can give you this or give you that. Even if I am hungry I will rather go to my grandmother to eat. My mom is just living here, two streets away. I would rather go to my grandmother which is up there in extension seven, go eat there. Because I know when I get there she is gonne say this and I am gonne get angry and then we gonne start having words with each other then I end up not going to her place for the next two, three months. We will walk each other pass in the street, I won't greet her and she won't greet me.<br><br>And my son is staying there and then I don't know how is it gonne happen unless she will need to tell me something and then she will send my son and then I will send my son back and he will be the in between person. But then that's how it's always been and ja it's like that with my mom. Just like that. We keep each other on a you know distance. |
| **I** | And then just taking you a bit back, growing up with your grandmother, at what age? |
| **P** | From, say from four – five. Because my father passed away when I was like uhm a year ja and then like-like I was told my mother was also living there by then. |
| **I** | At your grandmother's place? |
| **P** | With my granny ja. Then I don't know what happened then and then she like, she moved out and then she, I was with her and then… |
| **I** | With your mother? |
| **P** | Ja I was with my mother and then my mother was drinking a lot, she was drinking a lot from what I can remember as I was growing up now. And I |

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| | remember there was a time when, *(short silence),* I was in grade one, I was in grade one because I was attending school just up the road from my mother. And you know why I remember this because I was so young and I was so scared, not scared, I thought it's normal, this is how life is supposed to be. Mothers get drunk then they come home and they perform. There was one day where she put me out of the house 03h00 AM in the morning, I was in grade one. |
| **I** | Why? |
| **P** | She was drunk and then she was like ja you better fuck-off to your grandmother and them, I don't want you here and she packed my things in my schoolbag. It was 03h00 AM, I will never forget, it was 03h00 AM and I walked from my place to my granny's place which is, it is not far but it was very-very dangerous. Then it was, there was these gangs, young ones and the dirty kids, they use to fight amongst each other, they use to rape young girls and I mean seriously rape people and kill people.<br><br>And luckily there is this other guy, he, so I was known by the dirty kids and I was known by the young ones because my grandmother lives on that side and my mother lives on this side. And I was a very cheeky child. When you would call me I would tell you why you calling me, they said I mustn't talk to strangers or I will greet you and if you ask me how, and my uncles were well known this side and this side, so they knew now this is mother-mothers children so you know don't bother them you know. They'll take you across the road if they see the cars and stuff like that.<br><br>And then this one guy, it was, it was late, to me it was late at night because it was dark. Then he got me and he is like where you going to, they use to call me "kaffer myt", because at my grandmother I am the only one with dark complexion because my mother is a Xhosa and then my granny and them are fair complexion with long hair. So I was the only one that was like that and they use to call me that. |

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| | Then he said "kaffer myt" where you going, I said no I am going home and he said why you walking this late and I'm like no my mother said I must go home. Then he picked me up and he took me to my grandmother and then my grandmother was crying mos now because it was so late and everything. That was during the week. The Saturday I was playing outside with the boys, we were playing marbles, then my cousin told me there's your mother coming.<br><br>Then I got up and I ran to my grandmother and they were fighting over me, the one was pulling me this side and the one was pulling me this side. She was screaming give my child and my grandmother was you not getting this child and going to take you to welfare and that's how I ended up going to boarding school because of the welfare was involved now.<br><br>And then they said she is not a good mother you know, I can't live with her because she is getting drunk and everything. And then my grandmother agreed that I could live there you know and then the welfare said no you know rather she goes to a boarding school. That's how I ended up at the boarding school.<br><br>Ja, that's all. What else? |
| **I** | With the father of your child you became pregnant at the age of 15? |
| **P** | Ja. |
| **I** | Was it a consensual relationship? |
| **P** | Well, the first pregnancy, uhm the basic thing, it-it was consensual; okay I didn't know that I was gonne fall pregnant. Really I didn't know, I was still dumb by then, I didn't know that, I knew that having sex was wrong, I knew that. If you have sex you gonne get the baby but at 15 I thought |

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| | you go to the shop and get a baby. I didn't know that I was, you actually gonne fall pregnant and have a baby, I didn't know that.<br><br>I would say it was consensual because when we were kissing I got the strange feeling in my body and ja and obviously the person told me that we have to do this when you get that feeling, so we had sex and okay I enjoyed it. Whether I enjoyed it or whether it was good, I didn't know the difference like I know now okay this is sex and when you touch somebody this is what's gonne happen like that one, two or three. Like now if you have unprotected sex you gonne either fall pregnant, have an SDI or end up with HIV. So don't have unprotected sex.<br><br>I'm an adult, I am 32, to tell me to abstain it is gonne be like telling me not to cross the road or cross the railway line. I'm gonne tell myself there is no train coming and I can beat that train before it comes but telling me to abstain is like telling me not to cross the railway. I will rather say no I will use a condom, not the ones that we get from the clinic but the ones that we buy. At least I will be safe, I won't be getting anything and I won't give anybody anything. That is what I know now but then I didn't know anything like that.<br><br>So for now, like I said I am not in a relationship, since I was discharged from hospital, I haven't been in a relationship. And it is not about, it's like I think to be in a relationship especially if you are not married or if you are not committed to a one partner, a relationship is basically to have proper sex only, that is what I came to realise.<br><br>Because it's been now, it's been a year now since I have been out of hospital and in that time when I was there, for those seven months that I was in hospital, in and out of TARA and Helen Joseph, it was almost seven months I didn't have any sexual relationship. Up until now I haven't had any sexual relationship. So I had once, one weekend ja, but then you know that was just a weekend thing and never ever after that. |

So I don't feel I don't have that lust feeling to say I need to be sexually satisfied. I have too many things I am going through, too many things that I don't think, that I don't feel like you know it's just one of the things. If it comes it comes and if it doesn't, whatever.

Ja so the first time I think if I have to be honest I think I can't say it was not consensual. I will be lying to myself or I would be lying. I didn't have any guidance; I didn't because that happened on the holidays, during the school holidays when I came home from the boarding school. That's when the sex started. And I went back to boarding school and that's where I found out that I was pregnant.

So I didn't get any guidance yet about sex. We did life orientation but it was, then it was still covered like, you know it wasn't open like if you do penetration, this is gonne happen. Like our children know now, babies are in the stomach and give birth to them via the virgina or giving birth by C-section. You know children know these days.



Like my sister's child, she's two, I said mommy must go buy a baby there by Shoprite, she said no mommy don't buy a baby, mommy baby in stomach. I am like oh my word! To me they could still say they going to Shoprite. Two year old tells me no mommy baby in stomach. So the child knows the baby is in the stomach. Two year old catch eye when somebody asks to kiss them. Do you understand it's just the way they are and they way I think they so advanced so.

If I had to say daddy it wasn't consensual sex, I don't know, was it consensual? I don't know because if I have to really think about it, was it consensual, I didn't know what I was doing. I didn't know what I was doing, I just knew that I got this feeling and the next best thing I was naked and you know and we had sex.

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| | But was it consensual, did I actually give this person the right, I don't know *(laughing).* I honestly, that's a tough one, that is a tough one, was it consensual, I don't know. Did I have to say yes I want it, was I asked do you want it, I can't remember that I was asked, no I can't remember. So I don't know *(laughing).* I also need to find out that now *(laughing).* I don't know, no really I don't know. |