Perspectives of crisis intervention for people diagnosed with 'borderline personality disorder': an integrative review.

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REVIEW ARTICLE

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Perspectives of crisis intervention for people diagnosed with "borderline personality disorder": An integrative review

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Accessible Summary

What is known on the subject?

- People diagnosed with "BPD" often experience crisis and use services
- "BPD" is a controversial diagnosis, and the experience of crisis and crisis intervention is not well understood

What this paper adds to existing knowledge?

- People diagnosed with "BPD" have different experiences of crisis, and using the diagnosis alone as a basis for deciding care and treatment is not appropriate
- There are many human factors which can influence how professionals deliver care to people diagnosed with "BPD"

What are the implications for practice?

- The education of staff, views on responsibility, team conflicts and access to clinical supervision can have an impact on how care is delivered, and should be addressed by organizations providing crisis care.
- Access to care often occurs when a person is self-harming or suicidal, but does not address underlying distress. Crisis care should go beyond managing behaviour and address any underlying needs.

Abstract

Introduction: "Borderline personality disorder" ("BPD") is associated with frequent use of crisis intervention services. However, no robust evidence base supports specific interventions, and people's experiences are not well understood.

Aim: To explore the experiences of stakeholders involved in the crisis care of people diagnosed with "BPD."

Method: Integrative review with nine databases searched January 2000 to November 2017. The search filtered 3,169 titles and abstracts with 46 full-text articles appraised and included.

Results: Four themes were constructed from thematic analysis: crisis as a recurrent multidimensional cycle, variations and dynamics impacting on crisis intervention, impact of interpersonal dynamics and communication on crisis, and balancing decision-making and responsibility in managing crisis.

Discussion: Crisis is a multidimensional subjective experience, which also contributes to distress for family carers and professionals. Crisis interventions had limited and subjective benefit. They are influenced by accessibility of services, different understandings of "BPD" and human dynamics in complex decision-making, and can be experienced as helpful or harmful.

Implications for practice: Subjectivity of crisis experiences shows limitations of the diagnostic model of "BPD," emphasizing that interventions should remain person-centred. While thresholds for intervention are often met after self-harm or suicidality, professionals should review approaches to care and support people with underlying distress.

KEYWORDS

borderline personality disorder, crisis, crisis intervention, emotionally unstable personality disorder, health services, integrative review, personality disorder, therapeutic relationship

1 | INTRODUCTION

"Borderline personality disorder" ("BPD") in the Diagnostic and Statistical Manual of Mental Disorders (DSM) (American Psychiatric Association (APA), 2013) (synonymous with "emotionally unstable personality disorder" in the International Classification of Diseases (ICD) version 10 (World Health Organization (WHO), 1992)) is a diagnosis associated with frequent crisis (Borschmann, Henderson, Hogg, Phillips, & Moran, 2012). Meeting the DSM-5 diagnosis requires five or more of nine criteria to be present, and although there are no essential core features, experts generally agree on symptoms of severe emotional dysregulation, strong impulsivity and social–interpersonal dysfunction (Fonagy, Luyten, & Bateman, 2017).

Estimates see "BPD" affect 0.7% of the UK general population (Coid, Yang, Tyrer, Roberts, & Ullrich, 2006), with most international figures between 0.5% (USA: Samuels et al., 2002) and 1.4% (0.95%, Australia: Jackson & Burgess, 2000, 0.7%, Norway: Torgersen, Kringlen, & Cramer, 2001, 1.4%, USA: Lenzenweger, Lane, Loranger, & Kessler, 2007, 1.1%, Germany: Arens et al., 2013). However, some estimates reach 2.7% (USA: Tomko, Trull, Wood, & Sher, 2014) and 5.9% (USA: Grant et al., 2008). Differentiation may relate to difficulties obtaining accurate personality assessments in national surveys for personality disorders, opposed to other diagnoses (Tyrer, Reed, & Crawford, 2015).

The experience of people diagnosed with "BPD" (PdxBPD) in crisis is poorly understood, and treatment response is ill-defined. Onset of crisis in "BPD" is associated with a precipitating event, reduction in motivation and problem-solving ability, and an increase in help-seeking behaviour (Sansone, 2004). PdxBPD are associated with repeated crises (Borschmann et al., 2012), with crisis frequently related to suicidal threat (Borschmann & Moran, 2010) and impulsivity associated with suicide completion (McGirr et al., 2007).

Studies across the last 20 years indicate that between 70% (Gunderson & Ridolfi, 2001) and 84% of PdxBPD may attempt suicide, multiple times (Soloff, Lynch, Kelly, Malone, & Mann, 2000). Suicide completion rates range between 3.8% (Zanarini, Frankenburg, Hennen, Bradford Reich, & Silk, 2005) and 10% (Paris, 2002). Crisis intervention is often in response to attempted suicide and defined as "an immediate response by one or more individuals to the acute distress experienced by another individual, which is designed to ensure safety and recovery and lasts no longer than one month" (Borschmann et al., 2012, p. 2). A Cochrane Review found no adequate randomized control trial (RCT) evidence to support the use of any specific crisis intervention for "BPD" (Borschmann et al., 2012). Clinical decisions are challenging without an established evidence base.

Improving understanding of crisis is necessary, with suicide among PdxBPD more frequent than the general population (Pompili, Girardi, Ruberto, & Tatarelli, 2005). This issue has international significance, with WHO member states having a global target of a 10% reduction in suicide by 2020 (WHO, 2014). Controversially "personality disorder" diagnoses also comprise more than half of requested and received assisted suicides, legal in some European countries (Kim, De Vries, & Peteet, 2016; Thienpont et al, 2015).

The most recent available figures show high service use with PdxBPD constituting 4%–6% of primary care attenders (Gross et al., 2002; Moran, Jenkins, Tylee, Blizard, & Mann, 2000), 9%–10% of psychiatric outpatients (Lieb, Zanarini, Schmahl, Linehan, & Bohus, 2004; Zimmerman, Rothschild, & Chelminski, 2005) and 20% of psychiatric inpatients (Zanarini, Frankenburg, Khera, & Bleichmar, 2001). People often require intervention from psychiatric and emergency services (Comtois & Carmel, 2014; NICE, 2009) with hospital admission patterns potentially frequent and lengthy (Dasgupta & Barber, 2004).

Psychological therapies have proved effective in reducing "BPD" symptoms (Choi-Kain, Finch, Masland, Jenkins, & Unruh, 2017; Stoffers-Winterling et al., 2012), though such therapies are distinguished from crisis intervention as they are often longer-term and delivered in specialist services. It has been argued that high-quality generalist treatments may be "good enough" to treat PdxBPD, but "high-quality" care requires modest adaptions to

current treatments, which may be ineffective or harmful (Bateman & Krawitz, 2013). The National Institute of Clinical Excellence (NICE) (2009) has guidelines for the care of PdxBPD, though these are countered by the reactionary "not so NICE guidelines" (Recovery in the Bin, 2017) indicating that services may not always deliver as they should. UK-wide, there has been widespread recognition that the needs of people with all "personality disorder" diagnoses are often unmet (Mind, 2018).

There is a vast critique of "BPD" as a construct, and complications around how the diagnosis is understood. It has no core features, is a highly heterogeneous diagnosis (Oldham, 2015; Trull, Distel, & Carpenter, 2011) and is associated with multiple comorbidities (Coid et al., 2009; NICE, 2009). It is argued as a flawed, highly contentious and damaging label which carries significant stigma (Johnstone, 2014; Johnstone et al.., 2018), particularly at the interface of mental health care (Ring & Lawn, 2019).

There is a high correlation between childhood sexual abuse and "BPD" (Herman, Perry, & Van Der Kolk, 1989; McFetridge, Milner, Gavin, & Levita, 2015) and PdxBPD are 13 times more likely to report adverse childhood experiences than non-clinical control groups (Porter et al., 2019). It is thus argued that symptoms can be understandable responses to trauma and that diagnosis can be invalidating, framing "what people feel and do" into "something they have or are" (Johnstone et al., 2018, p. 28). There are movements campaigning for "BPD" to be abolished, embraced by professionals and people with the diagnosis (A Disorder for Everyone, 2019; "Personality Disorder" in the Bin, 2016).

The ICD-11 removed "personality disorder" categories, updating to a dimensional model focusing on clinical utility (Tyrer, 2014, 2018; WHO, 2018). Classifications now move from personality difficulty, through to mild, moderate and severe "personality disorder," with anankastic, detached, dissocial, negative affective and disinhibited domain traits present to aid description (Tyrer, 2018). However, "BPD" is the most researched "personality disorder" with links to evidence-based treatment, and recommendations were made for a "borderline pattern" qualifier to allow PdxBPD to maintain access to treatments (Reed, 2018). This was accepted, and "borderline pattern" appears in the ICD-11 (WHO, 2018).

"BPD" is a complex phenomenon with unclear aetiology, epidemiology and diagnostic validity. However, despite debate, controversy and recent diagnostic changes, the "BPD" diagnosis will continue to be used for the time being and will influence care delivery. The experiences of crisis intervention for PdxBPD are valuable, to increase understanding of this complex area. The high use of services, and potential for suicide completion in particular, demands crisis intervention be further explored.

2 | METHOD

2.1 | Review protocol and registration

Papers from January 2000 to November 2017 were accessed through several databases, ensuring the search was comprehensive. The nine databases were Cochrane Library, CINAHL, MEDLINE, SocINDEX, PsycINFO, PsycARTICLES, Web of Science, Knowledge Network and ProQuest. To ensure completeness, further articles were identified through the reference lists of included papers (Aveyard, Payne, & Preston, 2016). The SPICE (setting/perspective/intervention/comparison/evaluation) framework (Booth, 2004, 2006) was used to develop an effective search strategy and refine the questions being asked (see Table 1).

Comprehensive search terms were developed (see Table 2) by identifying relevant terminology, identifying synonyms and using terms already found in relevant publications (Aveyard et al., 2016). The wildcard symbol "*" was used to capture variations of root words (Hewitt-Taylor, 2017).

The question was: "What are the experiences and perceptions of PdxBPD, their family carers and professionals around crisis intervention for 'BPD'?" Specific aims should be a logical continuation of the research question (Hewitt-Taylor, 2017), and the following sub-questions were explored (see Table 3).

TABLE 1 SPICE framework (Booth, 2004, 2006)

Setting All settings in the UK and Ireland, continental Europe, Europe, the United States, Canada, Australasia and New Zealand
Perspective People with a diagnosis of "borderline personality disorder"/"emotionally unstable personality disorder," their family carers and professionals involved in their care.
Intervention Crisis intervention for people diagnosed with "borderline personality disorder"/"emotionally unstable personality disorder"
Comparison Comparison may be drawn between: • The perceptions and experiences of people diagnosed with "borderline personality disorder"/"emotionally unstable personality disorder," their family carers and professionals involved in their care. • Variations in people's experience of crisis and clinical outcomes from intervention.
Evaluation Clinical outcomes, views and experiences of crisis intervention

TABLE 2 Literature search terms

Search 1: ("Borderline personality disorder" OR "emotionally unstable personality disorder" OR "BPD" OR "EUPD")
AND
Search 2: (Cris* OR emergenc* OR urgent OR risk* OR acute* OR critical* OR intensive* OR respon* OR Self-Injurious Behav* OR self harm* OR self injur* OR self mutilat* OR self poison* OR overdos* OR self burn* OR self cut* OR suicid*)
AND
Search 3: (experien* OR prefer* OR belie* OR perce* OR attitud* OR opinion* OR view* OR judg* OR reaction* OR impression* OR feel* OR satisf*)

*Wildcard—utilized to capture variations of root word.

Inclusion and exclusion criteria were developed with reference to the University of Melbourne Guidelines (2019) (see Table 4).

The protocol for this study was developed in collaboration between all authors and registered with the International Prospective Register of Systematic Reviews (PROSPERO) (Warrender, Bain, Murray, & Kennedy, 2017). The full protocol can be accessed at http://www.crd.york.ac.uk/PROSPERO/display_record.php?ID=CRD42017075123.

2.2 | Data collection

The review captured papers January 2000 to November 2017, with details reported through the PRISMA flow diagram (Moher, Liberati, Tetzlaff, & Altman, 2009) (see Figure 1). To increase quality assurance, two reviewers from the team were involved at each stage of the process: reviewing titles and abstracts, agreeing inclusion of papers, data extraction, data analysis and synthesis.

2.3 | Quality appraisal

Papers were appraised using the Mixed Methods Appraisal Tool (MMAT) (Hong et al., 2018). This tool has specific questions for five categories of empirical study, qualitative research, randomized controlled trials, non-randomized studies, quantitative descriptive studies and mixed-methods studies. Each study was reviewed against relevant criteria. Scoring is discouraged (Crowe & Shepard, 2011; Higgins & Green, 2008), and excluding studies on the basis of quality is not recommended (Hong et al., 2018). The MMAT was therefore used to aid description. Percentages of affirmative MMAT responses were recorded, with negative responses requiring comment in the data extraction table (Table 5).

2.4 | Thematic analysis

Braun and Clarke's (2006) thematic analysis framework guided analysis and organization of data. Data were analysed by all authors, identifying patterns within the data set which were relevant to the research questions. This was initially a theoretical thematic analysis, providing a detailed analysis of data set content relevant to research questions (Braun & Clarke, 2006). However, themes evolved through interpretation, identifying the significance of patterns in relation to not only research questions but relevant literature presented in the introduction to this paper. Themes were presented to provide a "concise, coherent, logical, nonrepetitive, and interesting account of the story the data tell" (Braun & Clarke, 2006, p. 23). These themes give readers an in-depth narrative of the human experiences, influences and variables associated with crisis and crisis intervention for PdxBPD.

2.5 | Findings

Fifty-seven full-text papers were assessed with 46 included in the review (Table 5). This comprised 24 qualitative, 19 quantitative and three mixed-methods studies. Papers were from the UK (n = 16), Australia (n = 6), the United States (n = 4), Germany (n = 3), the Netherlands (n = 3), Sweden (n = 3), Switzerland (n = 3), New Zealand (n = 2), Belgium (n = 1), Ireland (n = 1), Norway (n = 1) and Spain (n = 1). Two studies took place across two locations, Australia and New Zealand (n = 1) and Germany and Switzerland (n = 1).

Twenty-nine papers collected data on PdxBPD, eleven on professionals, with family carers the least represented with six. Gender was overwhelmingly female in PdxBPD participants, who all met or had met DSM diagnostic criteria. Professionals included practitioners from mental health nursing, psychiatry, psychotherapy, psychology, counselling, case management, social work, art therapy, police and occupational therapy.

Many papers were qualitative with small sample size, though agreement about quality in qualitative research is elusive (Aveyard et al., 2016). It is argued that weaker studies would simply contribute less, rather than distort findings (Thomas & Harden, 2008).

Some papers were represented once and others across themes. Findings illuminate a variety of perspectives which may reflect the experience of "crisis" and intervention for PdxBPD. Four themes emerged; crisis as a recurrent multidimensional cycle, variations and dynamics impacting on crisis intervention, impact of interpersonal dynamics and communication on crisis, and balancing decision-making and responsibility in managing crisis.

TABLE 3 Literature review questions

1.	What do people[a] understand by "crisis"?
2.	What forms of crisis intervention are utilized and what do they do?
3.	In which contexts do these crisis interventions take place, and does the context impact on experience?
4.	What are the barriers and facilitators to people feeling a crisis intervention has been beneficial?

[a]"People" refers to the multiple perspectives of: (a) People diagnosed with "BPD" (PdxBPD); (b) Families and carers (family carers); (c) Health, social care and emergency services staff (professionals).

TABLE 4 Inclusion and exclusion criteria (University of Melbourne 2018)

Criteria	Inclusion	Exclusion	Rationale
Date range	Publications between January 2000 and September 2017	All publications prior to the year 2000	The last 20 years have seen an increase in understanding regarding "personality disorders" and improvement in available treatments. Landmark publication "no longer a diagnosis of exclusion" (NIMHE, 2003) set out guidance for appropriate care for people diagnosed with personality disorders
Exposure of interest	Primary research studies evaluating crisis intervention, or including experiences of crisis and/or crisis intervention	Interventions that go beyond 1 month	Crisis intervention defined as an action to "ensure safety and recovery and lasts no longer than one month" (Borschmann et al., 2012)
Geographic location	Primary research studies performed in the UK and Ireland, continental Europe, Europe, the United States, Canada, Australasia and New Zealand	Primary research studies not performed in the UK and Ireland, continental Europe, Europe, the United States, Canada, Australasia and New Zealand	Personality disorder diagnoses are culturally defined and have been critiqued as a cultural disapproval of behaviour (Nyquist Potter, 2009). Therefore, countries with similar culture would provide a more valid data set. Also diagnostic criteria are not used universally across the globe
Language	Literature written in English language only	Literature not written in the English language	Chosen countries publish in the English language. Review team unable to read other languages. Cost and time of translation not feasible within study timeframe
Participants	People diagnosed with "borderline personality disorder" and "emotionally unstable personality disorder" aged 18 and over, their family carers and the professionals involved in their care (inclusive of comorbidities but only where the primary diagnosis is BPD)	Studies where primary diagnosis is eating disorder or substance use, and any study where "BPD" is not the primary diagnosis or participants are aged below 18	To increase the validity of the findings, studies exclusively using "BPD" as the primary diagnosis were necessary
Peer Review	Peer-reviewed studies only	Non-peer-reviewed studies	Peer review is a sign of a study's quality assurance
Reported outcomes	All outcomes		All outcomes required to build a comprehensive picture of the study topic
Setting	All settings		Crisis intervention may take place in a variety of contexts
Study design	All study designs		Integrative review captures a diversity of primary research
Type of publication	Empirical studies (quantitative, qualitative and mixed-methods studies) will be included	Systematic reviews, editorials, commentaries or letters, discussion papers, opinion papers and non-empirical studies	Primary research required for integrative review

2.6 | Crisis as a recurrent multidimensional cycle

Twenty-eight papers characterized crisis as a recurrent, unpredictable, subjective, multidimensional and overwhelming experience. Internal or external triggers precipitated self-harm, which was a self-management or help-seeking strategy. Distress was paralleled in experiences of family carers and professionals. The word "crisis" did not feature in all papers, though all included experiences of feeling out of control. Two additional terms were identified: "aversive tension" (Stiglmayr et al., 2005, 2008) describing extreme emotional dysregulation which often precedes self-harm, and "agitation," with measures including tension, uncooperativeness, hostility and poor impulse control (Damsa et al., 2007).

Crisis is complex with subjective precipitating factors. Brooke and Horn's (2010) interviews (n = 4) identified distal and proximal factors, while Black, Murray, and Thornicroft's (2014) (n = 9) described internal and external dynamics. Distal factors included histories of trauma (Brooke & Horn, 2010; Henderson, Wijewardena, Streimer, & Vandervord, 2013; Holm & Severinsson, 2011) and proximal factors/external dynamics related to interactions with

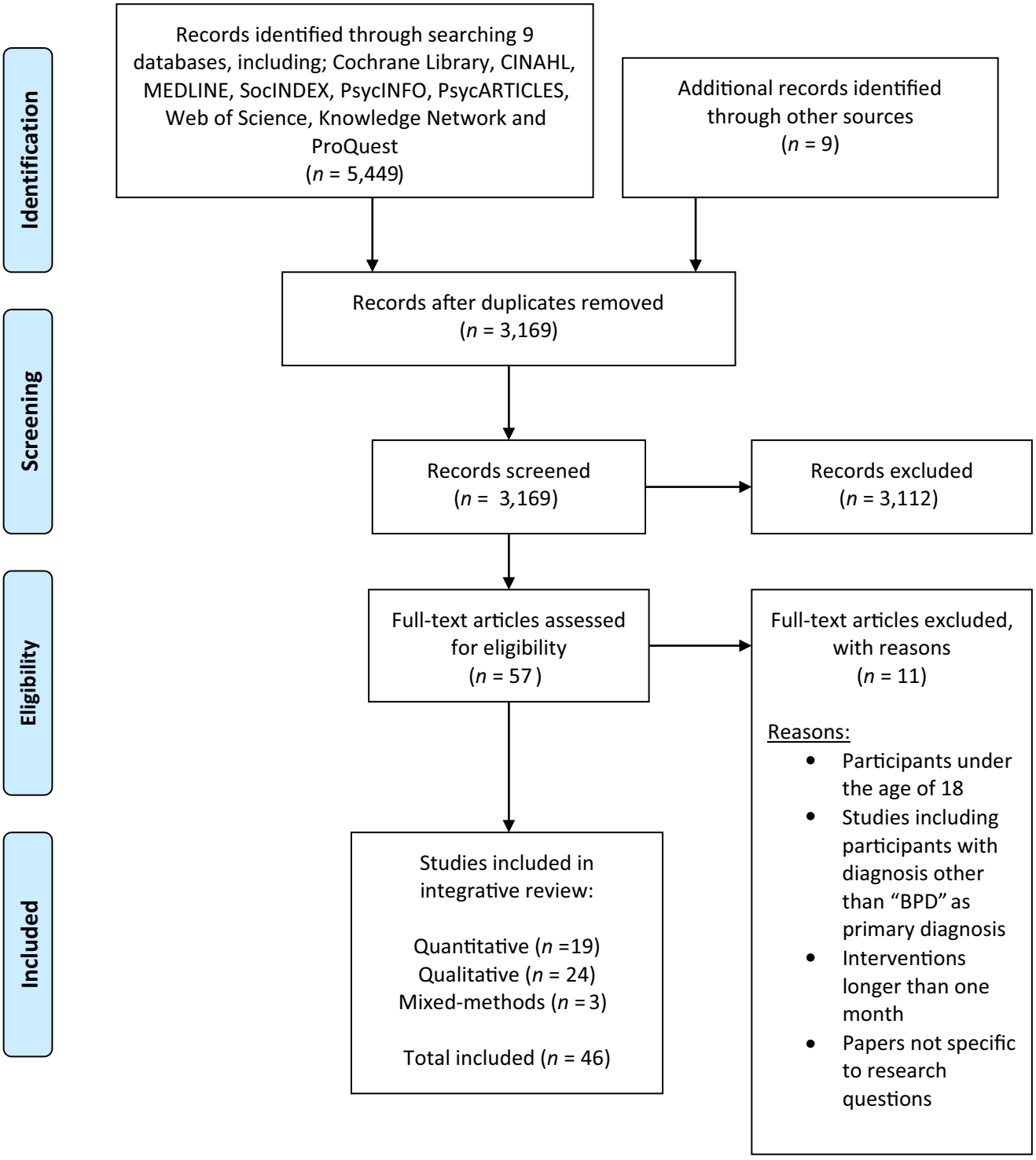

FIGURE 1 PRISMA 2009 flow diagram [Colour figure can be viewed at wileyonlinelibrary.com]

others (Black et al., 2014; Brooke & Horn, 2010; Brown, Comtois, & Linehan, 2002; Henderson et al., 2013). Internal dynamics also saw crisis arise within the self (Black et al., 2014). Quantitative studies identified PdxBPD self-reporting triggers as feeling rejected, being alone, failure (39%, *n* = 63) (Stiglmayr et al., 2005) and inner helplessness (Stiglmayr et al., 2008). "BPD" was distinguished from other diagnoses in that tension arises from a negative view of the self (Stiglmayr et al., 2008).

PdxBPD felt crisis could arise suddenly, sometimes without warning and impact on emotional and perceptual states. Henderson et al.'s (2013) qualitative case series (*n* = 4) described crisis as having a quick onset, sometimes without warning signs (Helleman, Goossens, Kaasenbrood, & Achterberg, 2014). PdxBPD felt on edge, overwhelmed by emotions (Perseius, Ekdahl, Asberg, & Samuelsson, 2005) as if they were going to explode (Brooke & Horn, 2010), with a desperate need to gain peace or escape (Holm

TABLE 5 Data extraction

Author (year)	Aims	Setting and participants (Country)	Methods	Key findings	MMAT appraisal (% of affirmative quality responses)
Bergman and Eckerdal (2000)	To broaden understanding of what it means for professionals to manage PdxBPD	Inpatient and outpatient service 29 professionals (Sweden)	Qualitative Grounded theory Individual interviews	Need identified for emotional support and education on BPD. Differing levels of education on BPD and this influenced approaches to working with PdxBPD Organizations/teams that fail to work together and collaborate effectively perceived to have a negative impact on patient care	100%
Berrino et al. (2011)	To assess whether crisis intervention at a general hospital is a suitable management strategy for PdxBPD referred to the emergency room for self-harm	Crisis intervention unit 200 PdxBPD 100 crisis intervention, 100 treatment as usual (Switzerland)	Quantitative Prospective 3-month follow-up using patient records	Crisis intervention unit had 8 beds, max 5-night stay, intensive interdisciplinary care and daily clinical supervision After 3 months CI group had reduced rates of self-harm and hospitalization (8% + 8%) compared to TAU (17% + 56%) Treatment failure was defined as suicidal crisis with supplementary inpatient treatment and was observed in both groups (CI = 14/TAU = 56). CI was more cost-effective than TAU	80% Crisis intervention group also received unplanned co-interventions
Black et al. (2014)	To understand the phenomenology of BPD from the patients perspective	Dedicated personality disorder service 9 PdxBPD (UK)	Qualitative Interviews	PdxBPD experienced dramatic perceptual and psychological changes, impacts on ability to communicate, experience of pain, memory loss and hallucinations. Responses to crisis were help-seeking and self-harm. Families were perceived as either protective or burdensome. People felt a cycle as recovery from suicide attempt could generate new feelings and further suicidal thoughts. Crisis is multidimensional, with a complex relationship between internal and external factors in the experience of crisis. Crisis can arise from within the person (internal factors) as well as through experiences with others (external factors)	80% Unclear why interpretive and not descriptive phenomenology
Borschmann et al. (2013)	To examine the feasibility of recruiting and retaining adults with a diagnosis of BPD to a pilot RCT investigating the potential efficacy and cost-effectiveness of using a joint crisis plan	Community mental health team 88 PdxBPD 46 (TAU plus joint crisis plans) 42 TAU alone (UK)	Quantitative Pilot RCT, feasibility study Self-report questionnaires	JCPs were acceptable to participants JCPs used both during and between crises Approximately half of participants reported a greater sense of control over their problems and improved relationship with their mental health team No evidence that JCPs reduce instances of self-harm	60% 13 PdxBPD (14.7%) dropped out before follow-up Treatment as usual for PdxBPD varied greatly

(Continues)

TABLE 5 (Continued)

Author (year)	Aims	Setting and participants (Country)	Methods	Key findings	MMAT appraisal (% of affirmative quality responses)
Borschmann et al. (2014)	To investigate crisis treatment preferences	Community mental health 41 PdxBPD (UK)	Qualitative Open discussion (using crisis plan subheadings as a basis) on joint crisis plans created by participants	Variation in people's preferences regarding crisis intervention, emphasizing the importance of individually tailored crisis plans Being treated with dignity and respect and receiving emotional and practical support is important to PdxBPD Some PdxBPD identified the importance of connecting with others during crisis, but several indicated the desire to be left alone during a future crisis. Specific treatment refusals during crises included particular types of psychotropic medication and involuntary treatment	100%
Bowen (2013)	To explore the experiences of good practice among mental health professionals working in a service that provided specialist treatment for PdxBPD	9 clinicians (4 nurses, 3 social therapists, 1 art therapist, 1 psychiatrist) (UK)	Qualitative Semi-structured interviews	Professional role felt to be to slow things down, to help PdxBPD to think Shared decision-making and shared responsibility felt to be important Interpersonal issues between PdxBPD and professionals seen as a repetition of experiences outside their care, though this was seen as an opportunity for learning Professionals felt that when PdxBPD placed staff in the expert role it was unhelpful. Professionals felt when PdxBPD become disillusioned with staff, they look to their own resources	100%
Brooke and Horn (2010)	To explore the meanings of self-injury and overdosing and the relationship of each to the other for women who have fulfilled the diagnostic criteria for BPD	Psychotherapy service 4 PdxBPD (UK)	Qualitative Interpretive phenomenological analysis Interviews	Both distal and proximal factors perceived as potential antecedents to crisis Crisis symptoms included feeling "like a pressure cooker," "about to burst" and dissociative experiences Self-harm identified as a private form of self-help for regaining control of emotional dysregulation, or public form of communicating distress People have progressive systems of coping with distress, ranging from cutting to burning and overdosing	100%
Brown et al. (2002)	To better understand the reasons for suicide attempts and non-suicidal self-injury in women diagnosed with BPD	75 PdxBPD (USA)	Quantitative "Parasuicide history interview" Recorded a comprehensive 47-item semi-structured interview measuring details of single parasuicide episodes	People may feel that crisis is something to be reduced or expressed. Motives for suicidality are complex, and people may have multiple reasons. 20% of participants cited interpersonal triggers to suicidality	80% PdxBPD confirmed reasons from a prepared list. New reasons not collected as data

(Continues)

TABLE 5 (Continued)

Author (year)	Aims	Setting and participants (Country)	Methods	Key findings	MMAT appraisal (% of affirmative quality responses)
Carter et al. (2005)	To compare the initial clinical management of hospital-treated deliberate self-poisoning patients with major depressive disorder (MDD) or borderline personality disorder (BPD)	Hunter Area Toxicology Service (HATS) 639 participants 484 dx MDD 116 PdxBPD 39 PdxBPD/MDD (Australia)	Quantitative Data from HATS database	Diagnostic group had no effect on length of stay in the HATS unit, or psychiatric follow-up. PdxBPD less likely to have a GP follow-up arranged. For mild-to-moderate suicidal ideation, PdxBPD were more likely to be discharged to a psychiatric hospital than people dx MDD. Diagnostic label may have an impact on clinical management	100%
Commons Treloar (2009)	To explore experiences of clinicians across emergency medicine and mental health service settings in Australia and New Zealand in working with patients diagnosed with borderline personality disorder (BPD)	Mental health services and emergency medicine 140 registered health providers (Nurses, allied health and medical staff) 90 mental health service, 50 emergency medicine (Australia and New Zealand)	Qualitative Demographic questionnaire Open comment section asking for experience or interest in working with PdxBPD	Conflict in their teams regarding approach to working with PdxBPD Crisis perceived to be an ongoing issue for PdxBPD Professionals identified uncomfortable feelings in themselves, feeling frustrated, inadequate and challenged. Professionals felt that current services were unsuitable for PdxBPD's needs Need identified for specific education on BPD and clinical supervision Professionals confirmed that some other professionals refuse to treat PdxBPD based on diagnosis	100%
Damsa et al. (2007)	To observe the safety and efficacy of olanzapine 10 mg IM medication in patients with acute agitation	25 PdxBPD who refused oral medication in an emergency room (Belgium)	Quantitative Prospective observational study	Measures of psychomotor agitation included "uncooperativeness," "hostility," "impulsivity" and "excitement." Reductions in psychomotor agitation after monotherapy with 10 mg IM olanzapine in patients with BPD Intervention used when PdxBPD refused oral medication, with physical restraint required in 20 patients (80% of the sample)	80% Measures of agitation included being "uncooperative" though unaccounted variable of physical restraint used in 80% of the sample

(Continues)

TABLE 5 (Continued)

Author (year)	Aims	Setting and participants (Country)	Methods	Key findings	MMAT appraisal (% of affirmative quality responses)
Dunne and Rogers (2012)	To explore carers' experiences of the caring role, and experiences of mental health and community services	Community Personality Disorder Service 8 carers for PdxBPD (UK)	Qualitative Focus groups Thematic analysis	Some professionals experienced as unprofessional and unhelpful, e.g. stigma and being told it is "just behaviour" Mixed experiences of care plans being shared Carers felt overlooked by MH services, with staff not realizing the 24/7 role of carers Carers experience their own distress Carers feel unskilled and expressed wish for more information on how to handle situations Need identified for an appropriate "crisis base" Carers said PdxBPD unable to articulate why they feel the way they do Challenge identified in "the line between support and enablement"	100%
Ekdahl et al. (2011)	To describe significant others' experiences of living close to a person with borderline personality disorder and their experience of encounter with psychiatric care	19 family carers to PdxBPD (Sweden)	Qualitative Free-text questionnaire group interviews	Carers described a 24-hr duty of constant worry, calling it a "permanent crisis" Carers' well-being mirrored that of their loved one, with no line between. If PdxBPD are unwell, carer is unwell. Carers felt powerless and frustrated that PdxBPD did not recover despite efforts of family and health care Guilt felt due to preconceived ideas that parents were responsible for development of BPD Professionals sometimes signalled that no help was needed from carers Responsibility was felt to be all-or-nothing. Carers held full responsibility with carer until the person was in hospital; then, they had no responsibility Carers experienced professionals with little knowledge, who focused on some symptoms but not the big picture	100%
Giffin (2008)	To hear the voice of a small sample who have a family member receiving treatment for severe personality disorder	Mental health services 4 family carers to PdxBPD (Australia)	Qualitative Informed by grounded theory Unstructured in-depth interviews	Families feel traumatic stress as they experience their child self-harming, attempting suicide and being near death. Families feel the burden of care was put onto them as professionals would use family support as a reason to avoid clinical crisis intervention. Families did not feel supported by professionals, and heard contradictory advice regarding how much to support their loved one. Families felt there were no discharge plans	80% Approach to data analysis not clear

(Continues)

TABLE 5 (Continued)

Author (year)	Aims	Setting and participants (Country)	Methods	Key findings	MMAT appraisal (% of affirmative quality responses)
Helleman et al. (2014)	To describe the lived experiences of PdxBPD with use of the brief admission intervention	Inpatient wards 17 PdxBPD (the Netherlands)	Qualitative Interviews Descriptive phenomenology	Results of brief admission can be positive or negative. PdxBPD described contact with a nurse as the most important part of brief admission. Lack of contact contributed to negative affect. PdxBPD reported greater autonomy and responsibility after having a choice of admission	100%
Henderson et al. (2013)	To explore the characteristics of recurrent self-inflicted burn patients	Hospital burns unit 4 PdxBPD (Australia)	Qualitative Semi-structured interview Case retrospective study of admissions	PdxBPD who recurrently self-inflicted burns often had a history of trauma Precipitating factors to self-burning included proximal issues such as arguments with others PdxBPD had experienced their crisis as having a sudden onset PdxBPD had described dissociative experiences prior to self-inflicted burning	80% Approach to data analysis not clear
Hoffman et al. (2004)	What is the level of knowledge of family members of PdxBPD about BPD? How does knowledge correlate with burden, depression, distress and expressed emotion?	32 family members of PdxBPD (USA)	Quantitative In-person interviews Self-report instruments	More than a third of family members knew very little about BPD Greater knowledge about BPD was associated with higher levels of family burden, distress, depression and greater hostility towards PdxBPD	80% Rationale for quantitative rather than qualitative or mixed-methods approach not clear
Holm and Severinsson (2011)	To explore how a recovery process facilitated changes in suicidal behaviour	13 PdxBPD (Norway)	Qualitative Exploratory design Interviews	All participants identified distal factors of trauma and violation Crisis was described as a need to gain peace and escape Suicidality could be PdxBPD's desire to take responsibility for themselves PdxBPD had difficulty thinking of others in times of crisis, and how suicidality may impact on loved ones PdxBPD felt the need to hide their experiences of wanting to kill themselves PdxBPD saw barriers to feeling crisis intervention was beneficial were having responsibility removed, not having the power to make their own decisions, nurses indicating that they may be selfish and not being seen as a person	100%
Horn et al. (2007)	To explore user experiences and understandings of being given the diagnosis of BPD	5 PdxBPD (UK)	Qualitative Semi-structured interviews Interpretive phenomenological analysis	PdxBPD felt they were rejected from services and had care withdrawn on the basis of their diagnosis Participants described being asked to leave inpatient ward and perceived this to be a result of receiving the diagnosis	100%

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TABLE 5 (Continued)

Author (year)	Aims	Setting and participants (Country)	Methods	Key findings	MMAT appraisal (% of affirmative quality responses)
Hughes et al. (2017)	To provide insight into the lived experience of clinicians working with PdxBPD who self-harm	Community mental health teams 4 professionals (UK)	Qualitative Phenomenology Unstructured interviews	Participants felt that PdxBPD pushed responsibility towards the clinician Variation in views regarding the balance of clinical risk-taking and avoiding undue risk. Difficulty described in balancing patient responsibility with professional responsibility and duty of care. Fear of being blamed in the event of a patient suicide and this contributed to anxiety	100%
Koekoek et al. (2010)	To establish the preliminary effects of preventive psychiatric admission of patients with severe borderline personality disorder	Inpatient unit 11 PdxBPD (11 service data 8 consented to interview) (the Netherlands)	Mixed-methods Administrative records, cross-checked with individual patients' files. Individual semi-structured interviews	PdxBPD evaluated preventative admission positively PdxBPD using preventative admission felt more control over crisis and felt encouraged to self-manage symptoms until the next admission Preventative admissions sees a slight decrease in services used in terms of inpatient days	90% Quantitative measures of quality of therapeutic alliance only obtained from professional, not PdxBPD
Krawitz and Batcheler (2006)	To conduct a pilot survey about clinician views on defensive practice when working with adults with borderline personality disorder	Community mental health, acute inpatient and crisis teams 29 professionals (New Zealand)	Quantitative Self-report survey questionnaire	Professionals admitted to making decisions which are not in PdxBPD's best interests but protect professional from legal repercussions. PdxBPD's families/friends were cited as an influence on defensive practice Media cited as biggest influence on defensive practice	60% Sampling strategy not clear. Inclusion and exclusion criteria not given. Approach to data analysis not clear
Lawn and McMahon (2015a)	To explore experiences of care from the perspective of Australians dx BPD	153 PdxBPD (Australia)	Quantitative Online survey	Feeling suicidal, feelings of self-harm and feeling unsafe were the most common reasons for PdxBPD when seeking hospital admission. PdxBPD had difficulty accessing services. PdxBPD reported high levels of distress when refused hospital admission. 65.4% (n = 78) reported experiencing discrimination, particularly as inpatients Variation in preferences regarding care: Usefulness of identifying early warning signs, developing crisis plans and hospital admission was mixed, some finding these helpful and some unhelpful	100%

(Continues)

TABLE 5 (Continued)

Author (year)	Aims	Setting and participants (Country)	Methods	Key findings	MMAT appraisal (% of affirmative quality responses)
Lawn and McMahon (2015b)	To explore carers experiences of being carers, their attempts to seek help for PdxBPD and their own needs	121 family carers of PdxBPD (Australia)	Quantitative Online survey	Carers perceived lack of choice of support services, difficulty accessing support when needed and lack of long-term consistent support all as contributing to anxiety in PdxBPD Carers perceived the most challenging issue for the PdxBPD was not being taken seriously Carers had often asked for PdxBPD to be admitted to hospital but been refused. GPs were rated as the most responsive health professionals. Identifying early warning signs, developing a crisis plan and hospital admissions were perceived by carers as very unhelpful (25.4%, *n* = 18; 28.6%, *n* = 20; and 23.9%, *n* = 17, respectively)	100%
Little et al. (2010)	To explore the emotional reactions, concerns and beliefs related to working with PdxBPD by health and non-health-related agencies	Police, health and welfare and mental health services 378 professionals (Australia)	Quantitative Self-report questionnaire	Different agencies respond in different ways to PdxBPD Police saw PdxBPD as a nuisance Mental health staff believed PdxBPD were best managed out of hospital and without medication Mental health staff more likely to understand why a person either was not admitted or was being discharged despite ongoing suicidality than police or health and welfare professionals	80% Variation in sample sizes of professional groups. Police (*n* = 210) Health and welfare (*n* = 120) Mental health (*n* = 51)
Lohman et al. (2017)	To identify key resources for and barriers to obtaining supportive and treatment services for BPD from the perspective of individuals seeking information or services related to BPD ("BPD care seekers")	BPD resource centre 500 randomly selected subscripts from 6,253 resource requests (USA)	Mixed-methods Retrospective design Grounded theory Descriptive statistics Unstructured interviews regarding service needs and experiences Phone call requests	Available resources for crisis intervention did not meet current demand. Families indicated they lacked skills in dealing with PdxBPD's issues Families desired more communication with health services	100%
Markham and Trower (2003)	To investigate how the psychiatric label "borderline personality disorder" (BPD) affected staff's perceptions and causal attributions about patients' behaviour	Inpatient mental health 48 professionals (UK)	Quantitative Questionnaire	Mental health nurses considered PdxBPD to be in control of their challenging behaviour This notion of control contributed to less sympathy for PdxBPD	100%

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TABLE 5 (Continued)

Author (year)	Aims	Setting and participants (Country)	Methods	Key findings	MMAT appraisal (% of affirmative quality responses)
McGrath and Dowling (2012)	To explore registered psychiatric nurses' (RPNs) interactions and level of empathy towards service users with a diagnosis of borderline personality disorder (BPD)	Community mental health 17 professionals (Ireland)	Qualitative Descriptive Semi-structured interviews, followed by scenarios and typical response to measure empathy	PdxBPD described as having stigma already attached to them as they arrive at the service Professionals indicated threat of suicide was the most distressing thing working with PdxBPD	80% Approach to data analysis not clear
McQuillan et al. (2005)	To examine the effectiveness of an intensive version of dialectical behaviour therapy for patients in an outpatient setting who met criteria for borderline personality disorder and who were in crisis	Outpatient dialectical behavioural therapy 127 PdxBPD (Switzerland)	Quantitative Depression Inventory, Hopelessness Scale, Social Adaptation Self-Evaluation Scale	Treatment completion and retention rates were high, meaning this intervention is acceptable to PdxBPD PdxBPD showed improvements on depression and hopelessness scales	80% 18% participant dropout (16 of 87)
Morris et al. (2014)	To explore the experiences of individuals with a diagnosis of BPD in accessing adult mental health services and to better understand which aspects of contact with services can be helpful or unhelpful	Adult mental health services 9 PdxBPD (UK)	Qualitative Semi-structured interviews	PdxBPD considered the relationship the most important thing for them, being treated like a person and not a diagnosis or case number PdxBPD described non-caring care, perceiving staff reluctant, unable to work with them, unwilling or unable to dedicate time to their relationship PdxBPD described services as reactive not proactive regarding risk and felt thresholds for intervention were only met in immediate risk of suicide – once crisis over service not interested in underlying distress PdxBPD felt that having the diagnosis meant that all difficulties were viewed in terms of BPD, distress seen as "difficult"	100%
Nehls (2000)	To study the day-to-day experiences of case managers working with PdxBPD	Community mental health 17 professionals (USA)	Qualitative Interpretive phenomenology Unstructured interviews	Crisis viewed as an ongoing and constant issue for PdxBPD Suicidality the biggest challenge for professionals, with difficulty in knowing how to balance over- and under-concern with suicidal threat. Professionals felt responsibility for PdxBPD's safety was transferred from patient to professional	100%

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TABLE 5 (Continued)

Author (year)	Aims	Setting and participants (Country)	Methods	Key findings	MMAT appraisal (% of affirmative quality responses)
Pascual et al. (2007)	To determine factors associated with hospitalization and decisions to prescribe psychotropic medication for patients with borderline personality disorder seeking care at psychiatric emergency units	Psychiatric emergency service Records of 540 PdxBPD, from 1,032 visits (Spain)	Quantitative Review of records including sociodemographic, clinical, social, therapeutic information and Severity of Psychiatric Illness (SPI) score	PdxBPD accessed psychiatric emergency service through self-referral, through ambulance and police. Ambulance most common. Reasons for referral included depression, anxiety, psychosis, drug abuse/dependence and disruptive behaviour. The most common reason for referral, outside "other," was disruptive behaviour Decision to hospitalize was associated with risk of suicide, danger to others, severity of symptoms, difficulty with self-care and non-compliance with treatment Psychiatrists often prescribe medications for PdxBPD in the psychiatric emergency service	100%
Perseius et al. (2005)	To investigate life situations, suffering and perceptions of encounter with psychiatric care among 10 patients with borderline personality disorder	Various psychiatric care settings 10 PdxBPD (Sweden)	Qualitative Narrative interviews	PdxBPD perceive crisis as feeling on edge, being overwhelmed by emotions. PdxBPD may try to hide or "mask" their distress. PdxBPD identified caregivers as having a double role which potentially relieves or adds to suffering	100%
Philipsen et al. (2004)	To assess the impact of 0.4 mg naloxone administered intravenously compared to placebo	Inpatient and outpatient psychiatric care, recruited from Dialectical behavioural therapy programme 9 PdxBPD 5 given naloxone, 4 given placebo (Germany)	Quantitative Double-blind crossover study Observer scales and self-report instruments	0.4 mg naloxone was tolerated well by all PdxBPD Naloxone showed best improvement in dissociative symptoms in those PdxBPD with the greatest number of DSM-IV BPD symptoms Naloxone not concluded to be more effective than placebo All reported subjective analgesia during self-mutilation	60% Method of participant allocation to treatment or placebo not clear PdxBPD reported subjective analgesia of self-mutilation, yet impact of injection not accounted for. PdxBPD also used personal anti-dissociative skills
Prada et al. (2017)	To assess the usability and efficiency of an App for monitoring and reduction of aversive tension in 16 PdxBPD over a 6-month period	Recruited from dialectical behavioural therapy programme 16 PdxBPD 12 completed the self-report questionnaire (Switzerland)	Quantitative Self-report questionnaire	App was found to be user friendly and accessible Use of the app led to a reduction in aversive tension for PdxBPD (unclear the specific mechanism through which the app was successful in achieving this)	80% PdxBPD concurrently on a DBT programme which may have impacted experience

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TABLE 5 (Continued)

Author (year)	Aims	Setting and participants (Country)	Methods	Key findings	MMAT appraisal (% of affirmative quality responses)
Rizq (2012)	To explore the experiences of five primary care counsellors working in the NHS with clients identified as diagnosable with borderline personality disorder (BPD)	NHS primary care 5 professionals (UK)	Qualitative Interpretive phenomenology Semi-structured interviews	PdxBPD were perceived as struggling to maintain boundaries, often contacting professionals in crisis outwith expected contact Professionals often felt uncertain what do to and whether action was needed. Professionals felt responsibility for the safety of PdxBPD Professionals felt that PdxBPD have high expectations of services and are sensitive to disappointment Professionals felt that therapeutic relationships were what was needed, but could re-traumatize when ending	100%
Rogers and Acton (2012)	To explore the experience of service users being treated with medication for the BPD diagnosis	Recruited from specialist personality disorder service 7 PdxBPD (UK)	Qualitative Semi-structured interviews	PdxBPD felt they had little choice regarding the use of medication in an inpatient setting PdxBPD felt that medication was used due to a lack of resources PdxBPD felt that staff had been dismissive of their distress PdxBPD felt that staff believed that "nothing worked for BPD" and that "PdxBPD would be in repeated crises"	100%
Rogers and Dunne (2011)	To explore the inpatient experiences of service users with a personality disorder	Inpatient mental health care 10 PdxBPD (UK)	Qualitative Focus group	PdxBPD felt that staff compared them to other diagnoses, and saw them as having more control than patients with schizophrenia PdxBPD did identify some good joint decision-making with professionals Following frequent admissions, PdxBPD felt they were just "dumped" or left in the ward De facto detention described as PdxBPD were told they could be voluntary patients or they would have to be sectioned	100%
Slotema et al. (2017)	To investigate the relation between auditory verbal hallucinations (AVH) in BPD and suicidality	Outpatient personality disorder service 89 PdxBPD 27 with auditory verbal hallucinations (AVH) 62 without AVH (the Netherlands)	Quantitative Electronic medical records Psychotic Symptom Rating Scales	PdxBPD with AVH showed a higher frequency of suicidal plans and attempts in the month prior to the study The number of crisis service contacts and hospital admissions was higher among PdxBPD with AVH than those without Severity of AVH predicated presence of suicide plans Presence of AVH predicted shorter duration until hospitalization	100%

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TABLE 5 (Continued)

Author (year)	Aims	Setting and participants (Country)	Methods	Key findings	MMAT appraisal (% of affirmative quality responses)
Staebler et al. (2009)	To examine subjective emotional responses to films in borderline personality disorder at two assessment points, while in acute crisis then 8 months later	Recruited from a psychiatric hospital 30 PdxBPD 27 dx depression 30 in the non-clinical control group (Germany)	Quantitative Beck Depression Inventory Symptom Checklist–90-Revised (subjective experience of symptoms) Questionnaire of Thoughts and Feelings (QTF) Emotion Scale (self-report inventory)	Acute crisis defined as "in hospital" PdxBPD had a similar emotional reactivity to stimuli when in crisis or not in crisis When not in crisis scores on QTF (questionnaire on thoughts and feelings) PdxBPD were still in pathological range Negative thinking may be enduring in PdxBPD	80% Incomplete outcome data at the 2nd assessment: 87% PdxBPD (26/30), 70% Depression (19/27)
Stiglmayr et al. (2005)	To examine the subjective appraisal of aversive tension under conditions of daily life in patients with borderline personality disorder (BPD)	Recruited from psychiatry and psychotherapy service 63 PdxBPD 40 healthy controls (Germany)	Quantitative Self-report through hand-held PC	States of aversive tension occurred in PdxBPD more than in healthy controls 39% of PdxBPD described rejection, being alone and failure as precipitating factors to aversive tension Supports view that PdxBPD experience more frequent, more intense and longer lasting aversive tension	100%
Stiglmayr et al. (2008)	A systematic examination of different clinical groups' experience of inner tension	Department of clinical psychology and psychotherapy 117 participants 30 PdxBPD 30 dx depression 27 dx anxiety disorders 30 with no diagnosis (Germany and Switzerland)	Mixed-methods Open questionnaire Qualitative content analysis	Inner tension was categorized as having cognitive, emotional, physical and behavioural aspects of tension, action tendencies and coping mechanisms. The experience of tension in PdxBPD is triggered by a sense of inner helplessness The experience of tension for PdxBPD was distinct from tension in other psychiatric disorders	90% The study did not measure the intensity of inner tension
Turhan and Taylor (2016)	To assess the patterns of service use by PdxBPD taken on for crisis resolution and home treatment between 2010 and 2013	Intensive home treatment team (IHTT) 27 PdxBPD (64 referrals) (UK)	Quantitative Demographic and clinical data collected Clinical global impression scale	Majority of community referrals cited "deterioration in mental state and increase in suicidal behaviour" as the reason for IHTT. A small number of patients were responsible for the majority of referrals, showing the ongoing nature of crisis for some PdxBPD. Improvement was noted in most PdxBPD after IHTT. In 34% of cases, IHTT was not enough to manage suicide risk and PdxBPD were hospitalized	100%

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TABLE 5 (Continued)

Author (year)	Aims	Setting and participants (Country)	Methods	Key findings	MMAT appraisal (% of affirmative quality responses)
Veysey (2014)	To explore the experiences of eight people with a BPD diagnosis who self-identified as encountering discriminatory experiences from healthcare professionals	8 PdxBPD (New Zealand)	Qualitative Semi-structured interviews Interpretive phenomenological analysis	PdxBPD experienced both helpful and discriminatory experiences with professionals PdxBPD with significant self-harm histories reported more discriminatory experiences Discriminatory experiences had an impact on PdxBPD's self-image Individuals who offered PdxBPD hope through investing in them was seen to be helpful	100%
Walker (2009)	To examine and explore the subjective experiences of women who self-harm with a diagnosis of BPD	4 PdxBPD (UK)	Qualitative Face-to-face in-depth narrative interviews	PdxBPD described their self-harm scars impacting on their self-hood, thinking people see the scars and not the person PdxBPD felt they received a reputation as a "self-harmer" and accessing services saw professionals assume it was always the same issue	100%
Warrender (2015)	To capture staff perceptions of the impact of mentalization-based therapy (MBT) skills training on their practice when working with people with a diagnosis of BPD in acute mental health	Acute mental health unit 9 professionals (UK)	Qualitative Focus groups Interpretive phenomenological analysis	Professionals voiced confusion and uncertainty of approach and saw the inpatient environment as not conducive to working with PdxBPD Hospital admissions described as recurrent and "back, forth" Professionals described uncertainty in the purpose of hospital admissions for PdxBPD Professionals found MBT skills useful in increasing consistency of approach, ability to tolerate risk, empathy and empowerment when working with PdxBPD Professionals welcomed clinical supervision as a supportive measure	100%

& Severinsson, 2011). Perceptual changes included dissociative experiences (Black et al., 2014; Brooke & Horn, 2010; Henderson et al., 2013), while Slotema et al.'s (2017) quantitative study (n = 89) found PdxBPD with auditory verbal hallucinations correlated with a higher frequency of suicidal plans and attempts. Reasons for referral to emergency services included depression, anxiety, psychosis, drug abuse/dependence and disruptive behaviour (Pascual et al., 2007).

PdxBPD described difficulty articulating their experiences (Black et al., 2014; Helleman et al., 2014). This was confirmed by family carers (Dunne & Rogers, 2012). Some attempted to hide their experience of crisis (Holm & Severinsson, 2011; Perseius et al., 2005), at times to protect family (Black et al., 2014). Conversely, sometimes PdxBPD had difficulty thinking of others (Holm & Severinsson, 2011).

Professionals viewed crisis as an ongoing issue for PdxBPD (Commons Treloar, 2009; Nehls, 2000; Rizq, 2012; Rogers & Acton, 2012), and a quantitative study (n = 27) found a few PdxBPD comprising the majority of referrals (13 = 78%, 5 = 53%) to an intensive home treatment team (IHTT) (Turhan & Taylor, 2016). Through focus groups (n = 9), professionals described hospital admissions as recurrent "back, forth" admission cycles, adding that admission for one person lasted "3 or 4 years" (Warrender, 2015).

PdxBPD may have enduring negative emotional states which could impact experiences of crisis. A quantitative study of self-reported emotional responses found emotional reactivity similar whether PdxBPD were in crisis or not, indicating that negative thinking may be enduring (Staebler, Gebharda, Barnett, & Renneberg, 2009). Furthermore, hourly self-reporting over 48 hr saw aversive tension found to be more frequent, more intense and longer lasting in PdxBPD than in healthy controls (Stiglmayr et al., 2005). Unsuccessful suicide attempts could become a cycle of crisis, where feelings of failure reinforce suicidal thoughts (Black et al., 2014).

PdxBPD self-managed crisis through self-harm, or seeking help from professionals (Black et al., 2014). Self-harm, predominantly cutting and burning, was a self-managed personal crisis intervention. This was used as a response to dissociation (Black et al., 2014; Henderson et al., 2013) or emotional dysregulation (Brooke & Horn, 2010; Henderson et al., 2013), with people reporting subjective analgesia (Philipsen, Schmahl, & Lieb, 2004). Some people described progressive systems of coping, moving through self-harm to suicidality (Brooke & Horn, 2010). Brown et al. (2002) found self-harm had a dual role, for reducing or expressing the feeling of crisis. Difficulties articulating distress could lead to self-harm as a means of communication (Brooke & Horn, 2010). A quantitative online survey found that feeling suicidal, feelings of self-harm and feeling unsafe were the most common reasons for PdxBPD seeking hospital admission (Lawn & McMahon, 2015a). Decisions to hospitalize were often associated with risk of suicide (Pascual et al., 2007).

Family carers could experience a parallel crisis to PdxBPD. Dunne and Rogers (2012) focus groups found family carers experiencing their own distress, with unstructured interviews finding distress related to PdxBPD self-harming and attempting suicide (Giffin, 2008). Free-text questionnaires and group interviews (n = 19) saw distress described as a permanent crisis and 24-hr duty of constant worry, which included powerlessness and frustration and mirrored the experience of PdxBPD (Ekdahl, Idvall, Samuelsson, & Perseius, 2011). Over one-third of family carers in a quantitative study (n = 32) knew little about "BPD" (Hoffman, Buteau, Hooley, Fruzzetti, & Bruce, 2004), while focus groups in a grounded theory retrospective study found family carers lacked skills for helping PdxBPD's issues and wished for more information on how to handle situations (Dunne & Rogers, 2012; Lohman, Whiteman, Yeomans, Cherico, & Christ, 2017). However, greater knowledge about "BPD" was associated with higher levels of family burden, distress, depression and greater hostility towards PdxBPD (Hoffman et al., 2004). This may link to guilt felt by families due to preconceived ideas that parents are responsible for development of "BPD" (Ekdahl et al., 2011).

Furthermore, professionals experienced distress. Interviews (n = 29) identified a need for emotional support (Bergman & Eckerdal, 2000) with the threat of suicide considered the most distressing (Hughes, Bass, Bradley, & Hirst-Winthrop, 2017; McGrath & Dowling, 2012). Professionals further described feeling frustrated, inadequate, challenged (Commons Treloar, 2009), confused, uncertain, drained and personally distressed (Warrender, 2015).

In summary, crisis has multiple triggers, is subjective and people manage their distress in different ways. Crisis was recurrent and could have a quick onset, which may be linked to enduring negative thinking. The constant nature of crisis could contribute to distress in family carers and professionals, who may mirror PdxBPD's crisis. The subjectivity of crisis experience may make it a challenge to treat, though threat of self-harm and suicide is often the reason for crisis intervention.

2.7 | Variations and dynamics impacting on crisis intervention

Twenty-five papers explored access to care during crisis. The impact of professional interventions, resources available, treatment options and preferences and variables impacting on team approaches emerged.

PdxBPD experienced challenges accessing care. Self-referral could be difficult to arrange in the midst of crisis, and while PdxBPD could self-refer to a psychiatric emergency service, ambulance was the most common means of arrival (Pascual et al., 2007). Helleman et al.'s (2014) qualitative study (n = 17) found PdxBPD using preventative hospital admissions felt security and reassurance knowing admission was available. To the contrary, some PdxBPD and carers were refused hospital admission and reported significant distress (Lawn & McMahon, 2015a, 2015b). Morris, Smith, and Alwin's (2014) qualitative study (n = 9) saw PdxBPD describe services as reactive rather than proactive regarding risk, feeling thresholds for intervention were only met in immediate risk of suicide. Pascual et al.'s (2007) quantitative retrospective examination of patient records (n = 540) reported that though PdxBPD did self-refer, professionals' decisions to hospitalize were often based on suicide risk.

Access to and continuation of care can be influenced by the "BPD" diagnosis. PdxBPD in a qualitative study (*n* = 5) felt they were excluded from services or had care withdrawn based on their diagnosis (Horn, Johnstone, & Brooke, 2007), and professionals confirmed they had witnessed colleagues refusing to treat PdxBPD (Commons Treloar, 2009). In contrast, for mild-to-moderate suicidal ideation, PdxBPD were more likely to be discharged from toxicology services and admitted to psychiatric hospital than people diagnosed with depression (Carter, Lewin, Stoney, Whyte, & Bryant, 2005).

Professional interventions were often standard care, though took place in a variety of contexts including inpatient settings (Helleman et al., 2014; Koekoek, Van Der Snoek, Oosterwijk, & Van Meijel, 2010; Philipsen et al., 2004; Warrender, 2015), a crisis intervention unit (Berrino et al., 2011), emergency departments (Damsa et al., 2007; Pascual et al., 2007), toxicology service (Carter et al., 2005), a "BPD" resource centre (Lohman et al., 2017), intensive home treatment (Turhan & Taylor, 2016) and an intensive outpatient therapy (McQuillan et al., 2005). Professionally influenced interventions included joint crisis plans (Borshmann et al, 2013) and a smartphone application (Prada et al., 2017). PdxBPD accessed their general practitioners for support and referral to other services, and they were rated by family carers as the most responsive professionals (Lawn & McMahon, 2015b).

Hospitalization was common, though had subjective value. Preventative hospital admission saw a slight decrease in services used in terms of inpatient days recorded, and was evaluated positively by PdxBPD (*n* = 8) (Koekkoek et al, 2010). However, PdxBPD experiences of a 3-night hospital admission with support were both positive and negative (Helleman et al., 2014). Focus groups of inpatient mental health nurses (*n* = 9) using mentalization-based therapy (MBT) skills felt more empowered and able to facilitate positive changes for PdxBPD, though no patient outcomes were recorded (Warrender, 2015). Some professionals considered hospitals too busy and not conducive (Warrender, 2015), feeling that PdxBPD were best managed as outpatients without medication, receiving consistent support (Little, Trauer, Rouhan, & Haines, 2010).

There were positive impacts of services specifically purposed to manage crisis intervention. Admission to a crisis intervention unit (*n* = 100) saw reduced rates of self-harm (8%) and hospitalization (8%) compared to treatment as usual (TAU) (*n* = 100, 17% and 56%) (Berrino et al., 2011), and IHTT (*n* = 27) noted improvement in most PdxBPD (Turhan & Taylor, 2016). However, these interventions showed limited benefit for suicidality, with IHTT not enough to manage suicide risk in 34% of cases where PdxBPD were hospitalized (Turhan & Taylor, 2016). Although improved compared to TAU, the crisis intervention unit still recorded treatment failure through suicidal crisis (Berrino et al., 2011).

McQuillan et al.'s (2005) quantitative study on intensive outpatient dialectical behavioural therapy showed acceptability with high treatment completion and retention rates, and improvements on depression and hopelessness scales. A quantitative study on joint crisis plans co-developed by PdxBPD and mental health teams showed no reduction in instances of self-harm, though was used by 73.5% (*n* = 25/34) during a crisis, contributing to a greater feeling of control for 47.1% (*n* = 16/34) of participants followed up (Borschmann et al., 2013). A smartphone application using mindfulness-based exercises was evaluated as user friendly, and though mechanisms of change were unclear, it contributed to reduction in aversive tension (Prada et al., 2017).

Crisis intervention using specific medications was reported in two papers. Damsa et al. (2007) found intramuscular olanzapine (10 mg) reduced agitation; however, this was after refusal of oral medication and included 80% (*n* = 20/25) of participants being physically restrained. Naloxone (0.4 mg) administered intravenously showed improvement in dissociative symptoms, though was not better than placebo (Philipsen et al., 2004). Medications were often prescribed at a psychiatric emergency service (Pascual et al., 2007), though PdxBPD in a qualitative study (*n* = 7) felt that medication was often used due to a lack of appropriate resources (Rogers & Acton, 2012).

Outcomes of crisis interventions are influenced by several factors. Resources available did not always meet demand (Lohman et al., 2017), and family carers (*n* = 121) described a lack of choice in services for PdxBPD (Lawn & McMahon, 2015b) and identified the need for an appropriate base and crisis accommodation (Dunne & Rogers, 2012). Commons Treloar's (2009) qualitative study (*n* = 140) saw professionals across emergency medicine and mental health services perceive current services as unsuitable for PdxBPD's needs. Once crisis and imminent risk of suicide were over, PdxBPD felt professionals were not interested in their underlying distress (Morris et al., 2014). Family carers further identified a lack of long-term consistent support as contributing to anxiety in PdxBPD (Lawn & McMahon, 2015b).

PdxBPD's preferences for care included therapeutic relationships giving emotional and practical support, while specific treatment refusals included particular medications and use of involuntary treatment (Borschmann et al., 2014). PdxBPD were mixed in perception of the usefulness of identifying early warning signs, developing crisis plans and hospital admission (Lawn & McMahon, 2015a). These were respectively found to be very unhelpful for around a quarter of carers in the study (25.4%, *n* = 18; 28.6%, *n* = 20; and 23.9%, *n* = 17).

Professionals identified conflict in teams regarding approaches to working with PdxBPD (Commons Treloar, 2009), describing lack of collaboration negatively impacting care (Bergman & Eckerdal, 2000). Family carers echoed this and at times heard contradictory advice (Giffin, 2008). An inter-agency quantitative study (*n* = 378) found that health and welfare, mental health and police responded to PdxBPD in different ways (Little et al., 2010).

Conflict could be due to different levels of education on "BPD" which varied between professionals (Bergman & Eckerdal, 2000). Family carers experienced staff with little knowledge (Ekdahl et al., 2011), some telling them "it's just behaviour" (Dunne & Rogers, 2012). Professionals identified the need for specific education on "BPD" (Commons Treloar, 2009), and while they utilized clinical supervision (Berrino et al., 2011) and emphasized its importance (Commons Treloar, 2009), it was not always

accessible (Warrender, 2015). Focus groups (*n* = 9) saw teams using MBT skills describe increased consistency in their approach (Warrender, 2015).

To summarize, PdxBPD had varying experiences of accessing care which could be influenced by diagnosis. Professional interventions took place in a variety of contexts but were most often non-specialist inpatient units and emergency departments, and showed limited or subjective benefit. Outcomes may be influenced by resources available, thresholds for intervention, conflict in teams, differing levels of professional education and access to clinical supervision.

2.8 | Impact of Interpersonal dynamics and communication on crisis care

This theme was illuminated by 22 papers, highlighting interpersonal dynamics as a trigger to crisis and relationships holding contradictory roles in relieving or adding to suffering. Reputations for self-harm and the "BPD" diagnosis itself could contribute to discriminatory experiences.

Interpersonal issues could precipitate crisis (Black et al., 2014) and be a catalyst to self-harm (Henderson et al., 2013), with rejection self-reported as a precipitating factor to aversive tension (Stiglmayr et al., 2005). Brooke and Horn (2010) found PdxBPD used self-harm as a means of regaining self-control and inhibiting interpersonal behaviour which may be deemed inappropriate. A quantitative study (*n* = 75) using clinical history interviews recorded instances of parasuicide (suicide without supposed intent to die) and found 20% had an interpersonal influence (Brown et al., 2002). However, this study did not define parasuicide, and acknowledged limitations in that self-reporting of intent may not be known or remembered.

Social relationships had a subjective role, with PdxBPD's preferences in crisis contrasting between connecting with others and the desire to be left alone (Borschmann et al., 2014). Black et al. (2014) found relationships with family could be protective against suicide, as a purposeful family role and responsibility engendered self-preservation. However, the same study found this responsibility to protect loved ones could lead PdxBPD to hide their distress.

PdxBPD (*n* = 17) valued contact with professionals (Helleman et al., 2014), and particularly those who invested in them and offered hope (*n* = 8) (Veysey, 2014). PdxBPD valued being treated like a person (Morris et al., 2014), shown dignity and respect, and receiving emotional and practical support (Borschmann et al., 2014). Collaboration was valued, as 47.1% (*n* = 16/34) of PdxBPD self-reported that developing joint crisis plans with professionals had improved their relationships (Borschmann et al., 2013). An aspect of crisis is a difficulty communicating and articulating experiences, and a qualitative study interviewing professionals (*n* = 9) described their role as slowing things down and helping PdxBPD to think (Bowen, 2013).

Relationships with professionals had a duel role. Qualitative studies found they could relieve or add to suffering (Perseius et al., 2005) (*n* = 10) as PdxBPD experienced both helpful and discriminatory experiences (Veysey, 2014) (*n* = 8). Through interviews, professionals (*n* = 5) perceived that PdxBPD have high expectations of them and are sensitive to interpersonal disappointment due to adverse childhood experiences, further considering therapeutic relationships potentially re-traumatizing patients when ending (Rizq, 2012). Professionals perceived PdxBPD's difficulties with them as a parallel process and a repetition of experiences outside of care, though also valuable opportunities for learning (Bowen, 2013).

PdxBPD described "non-caring care," with some professionals perceived to be reluctant, unwilling or unable to work with them or dedicate time to therapeutic relationships (Morris et al., 2014), and lack of contact in an inpatient context contributing to negative emotions (Helleman et al., 2014). PdxBPD experienced professionals being dismissive of their distress (Rogers & Acton, 2012) (*n* = 7), describing being "dumped" or left in wards following frequent admissions (Rogers & Dunne, 2011) (*n* = 10). Dismissiveness was confirmed by family carers, with focus groups describing some professionals as unprofessional and unhelpful (Dunne & Rogers, 2012) (*n* = 8), and an online survey identifying the most challenging issue for PdxBPD as not being taken seriously (Lawn & McMahon, 2015b) (*n* = 121). Self-reporting emotional reactions of health and non-health-related agencies (*n* = 378) found the police as more likely to see PdxBPD as a nuisance, as in contrast to mental health professionals, police felt they needed to be available all the time (Little et al., 2010).

PdxBPD had perceived discrimination from professionals. An online survey found that 65.4% (*n* = 78/96) of PdxBPD who had accessed care for 10 years or more had experienced discrimination, particularly as inpatients (Lawn & McMahon, 2015a). Some PdxBPD felt they were not seen as a person (Holm & Severinsson, 2011; Walker, 2009), and Walker's (2009) narrative interviews (*n* = 4) found PdxBPD perceive their reputations as a "self-harmer" as overshadowing other issues. Veysey's (2014) qualitative study found through semi-structured interviews that PdxBPD (*n* = 8) with self-harm histories had increased experiences of discrimination, which impacted on self-image.

Stigma attached to the "BPD" diagnosis had a further impact. Interviews saw mental health nurses acknowledge the stigma attached to PdxBPD as they arrived at their service (McGrath & Dowling, 2012) (*n* = 17) and a questionnaire found reduced sympathy for people with the diagnosis (Markham & Trower, 2003) (*n* = 48). PdxBPD felt their distress was often viewed in terms of "BPD," and they could be misunderstood as being deliberately difficult (Morris et al., 2014). PdxBPD described professionals indicating they were selfish (Holm & Severinsson, 2011), and family carers acknowledged a stigma from professionals who described distress as "just behaviour" (Dunne & Rogers, 2012).

In summary, this theme showed the complex nature of social and professional relationships. Interpersonal issues were often a trigger to crisis, with social relationships of varying benefit. PdxBPD emphasized the value of the therapeutic relationship with professionals, though also described its double role through experiences of "non-caring care," often experiencing discrimination which was sometimes related to diagnostic stigma.

2.9 | Balancing decision-making and responsibility in managing crisis

Nineteen papers contributed to balancing decision-making and responsibility in managing crisis. Shared decision-making was identified as important, though experiences of this varied with complexity in power dynamics. There were often differing views on where responsibility lay for the management of crises, and this created difficulties for professionals and family carers.

PdxBPD welcomed choice and joint decision-making, though decisions were not always collaborative. PdxBPD (n = 17) with choice of hospital admission reported an improved sense of autonomy and responsibility (Helleman et al., 2014). Koekkoek et al (2010) (n = 8) identified that preventative hospital admission contributed to feelings of control over crisis, with PdxBPD feeling that having access to admission if needed and having control over their own treatment promoted their ability to self-manage their own difficulties. Focus groups of PdxBPD with experiences of inpatient settings identified good joint decision-making (Rogers & Dunne, 2011) and professionals also emphasized its importance (Bowen, 2013). Although noted in under half of the participants (47.1%, n = 16/34), using a joint crisis plan had contributed to greater feelings of control over problems (Borschmann et al., 2013). Professionals (n = 9) described their being placed in the expert role as unhelpful, shared decision-making encouraging shared responsibility, and that PdxBPD becoming disillusioned with them could lead to looking inward to their own resources (Bowen, 2013).

The removal of responsibility and choice was not welcomed by PdxBPD. Holm and Severinsson's (2011) qualitative interviews (n = 13) saw PdxBPD describe having responsibility removed and lacking the power to make decisions as a barrier to effective intervention. Involuntary treatment was a specific treatment refusal in joint crisis plans (Borschmann et al., 2014), though this was used at times with 9/13 PdxBPD reporting difficulty accepting this and feeling violated (Holm & Severinsson, 2011). Particular psychotropic medications were a specific treatment refusal in some joint crisis plans (Borschmann et al., 2014), though PdxBPD described little choice regarding the use of medication in inpatient settings (Rogers & Acton, 2012). Furthermore, 80% of all participants (n = 20) in one study were physically restrained prior to medication administration (Damsa et al., 2007).

Power dynamics appeared to play a role in treatment, with the act of refusing the advice or guidance of professionals interpreted as pathology. "Uncooperativeness" was a measure of agitation (Damsa et al., 2007), while "noncompliance with treatment" was a reason for hospitalization (Pascual et al., 2007). The illusion of choice was noted by Rogers and Dunne (2011, p. 229) through de facto detention, with PdxBPD describing experiences as inpatients where professionals told them that they could be voluntary patients, "or we can section you" using mental health legislation. Some PdxBPD identified powerlessness and the paradox of being told to use their strengths, yet simultaneously having decisions made on their behalf (Holm & Severinsson, 2011).

Uncertainty emerged regarding who should hold responsibility for PdxBPD. Three qualitative studies using interviews found professionals felt responsibility for the safety of PdxBPD (Rizq, 2012) and sometimes felt this was transferred to them by patients (Hughes et al., 2017; Nehls, 2000). However, some PdxBPD countered that suicidality could actually be through their desire to take responsibility for themselves (Holm & Severinsson, 2011). Hughes' (2017) interviews found some community mental health teams (n = 4) feared being blamed in the event of patient suicide. Furthermore, Krawitz and Batcheler's (2006) quantitative self-report questionnaire found that decisions are sometimes made outwith PdxBPD's best interests to protect professionals from legal repercussions. Defensive practice was influenced by the PdxBPD's family and friends, though the biggest influence was cited as the media (Krawitz & Batcheler, 2006). Nonetheless, this was contradicted by a self-report questionnaire (n = 378) across professional agencies, which found that though the police felt they needed to be constantly available, there were no concerns in any group regarding damage to professional credibility nor legal consequences if suicide were to occur (Little et al., 2010).

Family carers described an all-or-nothing responsibility transaction between them and professionals. Qualitative studies using focus groups, interviews and questionnaires found family carers held full responsibility until their significant other was in hospital, then felt overlooked and had no responsibility (Dunne & Rogers, 2012) (n = 8), and were sometimes told by professionals that they were not needed (Ekdahl et al., 2011) (n = 19). Giffin's (2008) unstructured interviews (n = 4) saw family carers perceive that responsibility was often left with them, with their support used as a reason to avoid professional intervention. Family carers' involvement in care was often limited, though Lohman et al. (2017) randomly reviewed resource requests (n = 500) to find that they desired more communication with professionals. Family carers also had mixed experiences of care plans being shared (Dunne & Rogers, 2012) and felt there were no discharge plans (Giffin, 2008).

Professionals struggled with suicide risk and felt uncertain whether intervention was required or not (Rizq, 2012). Nehls' (2000) interviews with professionals (n = 17) described this as balancing over- and under-concern. Hughes et al. (2017) found professionals from community mental health teams (n = 4) describe balancing patient responsibility with professional responsibility, and found considerable variation in professional views regarding risk. This variation in views corresponds with carers being given contradictory advice by professionals (Giffin, 2008). Family carers' experience paralleled that of professionals, describing the challenge of balancing support and enablement between themselves and PdxBPD (Dunne & Rogers, 2012).

Mental health professionals appeared the most comfortable with handing responsibility back to PdxBPD and were more understanding than police or health and welfare of why a person may be discharged or not admitted to hospital for ongoing suicidality (Little et al., 2010). PdxBPD felt that they were compared to people with other diagnoses and seen as having more control than patients diagnosed with schizophrenia (Rogers & Dunne, 2011). This was confirmed in a study of mental health nurse attitudes, which viewed PdxBPD as being in control of their behaviour (Markham & Trower, 2003).

This theme saw PdxBPD welcome choice and joint decision-making. However, decisions were not always collaborative and the

removal of responsibility was perceived as a barrier to effective intervention, particularly recognizing power dynamics between PdxBPD and professionals. There was uncertainty between professionals, family carers and PdxBPD as to who held responsibility, with family carers describing their responsibility as all-or-nothing. Both professionals and family carers described difficulty in balancing the level of responsibility they shared with PdxBPD for their safety. Mental health professionals appear to be the most comfortable in handing responsibility back to PdxBPD.

3 | DISCUSSION

This integrative review will inform evidence-based practice around crisis intervention for PdxBPD with RCTs lacking (Borschmann et al., 2012). Crisis is a subjective term and crisis intervention is not well understood. This justified an integrative review, including a broad and diverse range of literature (Aveyard et al., 2016). This approach is appropriate to defining concepts and reviewing theories (Whittemore & Knafl, 2005) and can provide foundations for future knowledge and research.

The contribution of this review to existing knowledge comes through the synthesis of 46 papers which highlight key themes on this complex topic. The overall quality of research was good, with affirmative MMAT responses ranging between 60% and 100%. The vast majority (29/46) achieved all affirmative responses, while negative responses often related to a lack of clarity rather than poor research practice. Some studies did not acknowledge the variables which may influence their outcomes, and this review contributes to the understanding of these factors.

A conceptual map of the potential journey from crisis to crisis intervention (see Figure 2) provides a visual representation of themes discussed.

Sansone (2004) described crisis as being precipitated by an event, and this review identified events as internal or external, triggered from within the self or interpersonally. The influence of both self and others may be understood through the concept of mentalization. Mentalizing is "the process by which we make sense of each other and ourselves, implicitly and explicitly, in terms of subjective states and mental processes" (Bateman & Fonagy, 2010, p. 11). Difficulties mentalizing are influenced by childhood trauma or neglect and can lead to difficulties in the experience of oneself, and a vulnerability to interpersonal interactions (Bateman & Fonagy, 2010). It would however be unfair to suggest that all difficulties for PdxBPD in interpersonal relationships were due to their failure to mentalize, given family carers' and professionals' descriptions of stigma and discrimination.

PdxBPD experienced crisis in different ways, not surprising given the heterogeneous diagnosis. Sudden and recurrent onsets may relate to the consistent availability of triggers which could come from self or others, and recurrent crises may relate to enduring negative thinking. Emotional dysregulation and perceptual changes were features of crisis, and these would further impact mentalizing ability. The experience of feeling overwhelmed was consistent with general definitions of crisis (James & Gilligand, 2005), though the subjectivity

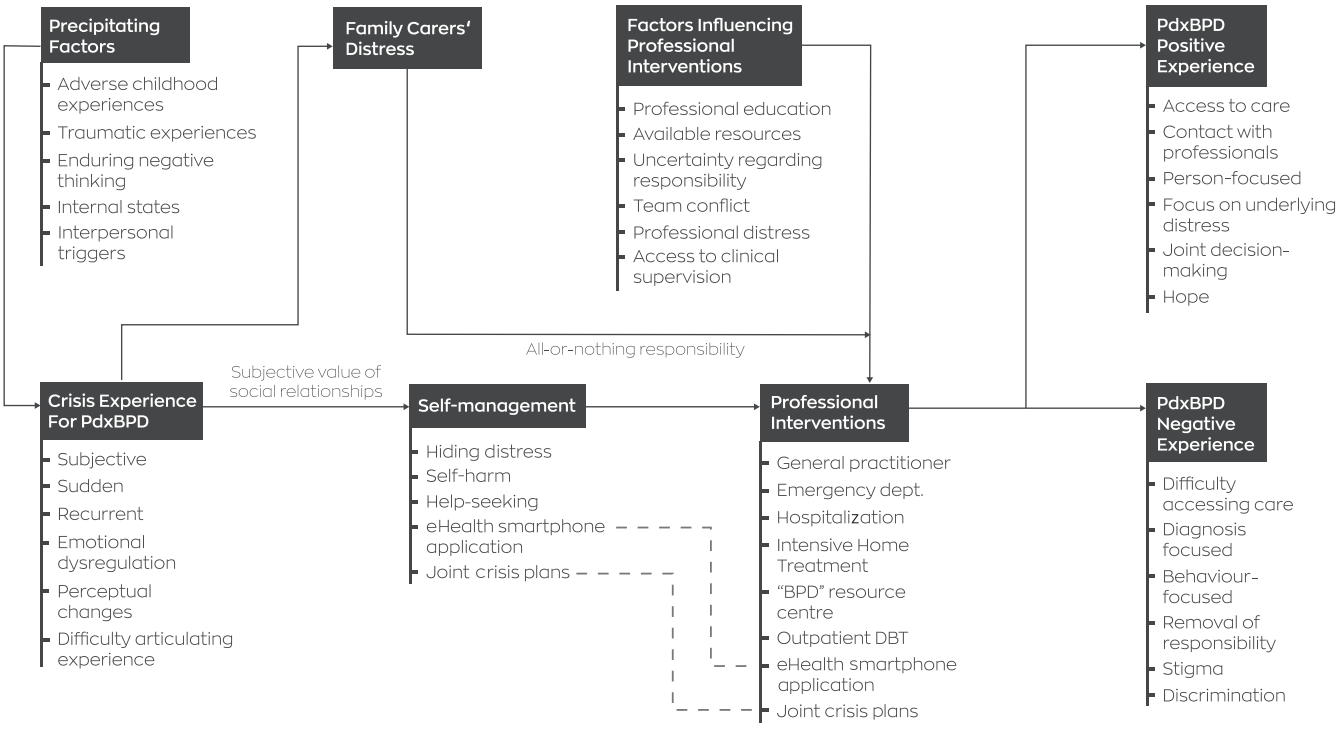

FIGURE 2 A conceptual map showing the potential experiences of people diagnosed with "borderline personality disorder," their families and carers and professionals involved in their care, relating to crisis and crisis intervention. This captures the potential journey from precipitating factors of crisis, to the crisis experience and crisis intervention, identifying experiences, influential factors and culminating in what was experienced as helpful and unhelpful for people with the diagnosis

of experiences indicates the need for sufficient flexibility in any intervention, remaining person-centred rather than diagnosis-centred.

A prominent self-management strategy for PdxBPD was self-harm. Felitti et al.'s (1998) study on adverse childhood experiences (ACEs) proposed that health risk behaviours such as smoking and obesity are viewed as societal problems, yet are solutions from the perspective of individuals. There is a high prevalence of ACEs in the histories of PdxBPD (Herman et al., 1989; McFetridge et al., 2015) and people who self-harm in general (Everett & Gallop, 2000; Vivekananda, 2000). This review found the "problem" of self-harm was often a solution for PdxBPD. Professional responses sometimes did not see beyond self-harm, treating personal solutions as problems, and not exploring the underlying distress. Self-management also contrasted between hiding distress and help-seeking, with hiding distress emphasizing the subjective value of social relationships and complex relationships with family carers.

Family carers experience distress, which paralleled crisis for PdxBPD, yet often had limited involvement with care and all-or-nothing responsibility. This emphasizes the importance of the "triangle of care" (Carers Trust, 2016) with carers involved in care planning and treatment, in true partnership working between people experiencing mental distress, family carers and professionals. However, this experience may not be unique to crisis intervention for PdxBPD, with a literature review across diagnoses finding that collaborative decision-making was not a regular experience and that there was an "us and them" divide between family carers and professionals (Doody, Butler, Lyons, & Newman, 2017).

Though some interventions contributed to reduced self-harm and hospitalization, improvement on depression and hopelessness scales and improvement in dissociative symptoms, largely interventions were of subjective and limited benefit. This review identified factors which may influence the quality of any crisis intervention. Professionals described deficits in resources and knowledge, and their own need for support. Targeted education on "BPD" can impact staff attitudes (Commons Treloar & Lewis, 2008; Miller & Davenport, 1996; Shanks, Pfohl, Blum, & Black, 2011), and it may be prudent to target professionals' basic training (Warrender & Macpherson, 2018) and have education co-produced with experts by experience (Dickens, Lamont, Mullen, MacArthur, & Stirling, 2019). Given the prevalence of trauma histories in PdxBPD, trauma-informed care should also inform therapeutic relationships (Sweeney, Filson, Kennedy, Collinson, & Gillard, 2018). Clinical supervision has been specifically recommended to professionals working with PdxBPD (Bland & Rossen, 2005) and may be particularly valuable given complexities in decision-making and potential for team conflicts. Professional decision-making regarding risk has been described as an ethical dilemma, with well-intended decisions having the potential for iatrogenic consequences (Warrender, 2018).

PdxBPD had positive and negative experiences of care. These were polarized between feeling professionals were person-centred or diagnosis-centred, having access to care or finding it difficult, being included in joint decision-making or having responsibility removed, and feeling a therapeutic relationship had been established or experiencing stigma and discrimination. Regardless of any interventions design, these factors influence the experience. Furthermore, given interpersonal relationships as a potential trigger to crisis, professional stigma and discrimination can have an iatrogenic and counterproductive impact, as PdxBPD may be triggered back into crisis and feel worse in care (see Figure 3). The lack of hope has been described as a self-fulfilling prophecy, where the attitudes of professionals contribute to poor outcomes (Warrender & Macpherson, 2018).

3.1 | Implications for practice

The subjectivity of crisis experience shows the limitations of diagnosis, emphasizing that any intervention should remain person-centred. While thresholds for intervention were often met after self-harm or suicidal behaviour, professionals should review the ease of access to their services and ensure care goes beyond behaviour management and supports PdxBPD with underlying distress. PdxBPD preferences for care were not surprising or unrealistic in having access to care, joint decision-making and valuing therapeutic relationships. These findings highlight that PdxBPD may have poor experiences of care and that limited resources, deficits in knowledge, uncertainty, team conflict, distress and a lack of clinical supervision are potential factors which influence how professionals respond. Family carers should have access to appropriate support to manage their own distress, and the opportunity to be involved in care planning as per the triangle of care.

3.2 | Limitations

Limitations of this review include the exclusion of groups including under-18s, and people with comorbid "BPD" though not as their primary diagnosis. Furthermore, the exclusion of other personality disorders was necessary to aim for validity around a common experience, and thus, the difficulties and complexity of all personality disorder diagnoses have not been captured.

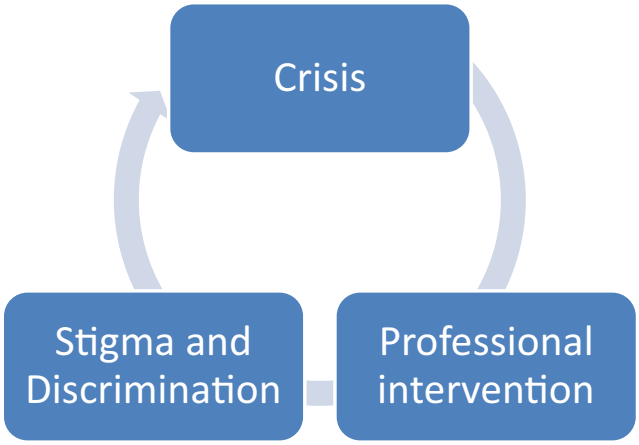

FIGURE 3 The crisis intervention interpersonal cycle of crisis [Colour figure can be viewed at wileyonlinelibrary.com]

4 | CONCLUSION

The experience of crisis for PdxBPD is complex, with subjectivity in precipitating factors, experience and ways of coping. Family carers experience their own distress and require support, and should be given more opportunities for involvement by professionals. Interventions are available, though often standard care, and despite showing some benefit to PdxBPD, there is inconsistency in that people have positive and negative experiences of care. Several factors influence professional interventions, and implications for practice suggest a review is required of crisis intervention services. This review will inform future research by highlighting the complexity and array of human factors in the delivery of crisis intervention, which may have an influence on recorded outcomes. Future research may be wise to focus on perspectives within single cases, comparing PdxBPD, family carer and professional perspectives on shared experiences, to provide in-depth exploration of interpersonal factors.

5 | RELEVANCE STATEMENT

People diagnosed with "BPD" frequently present to healthcare services in times of crisis and are often cared for by mental health nurses. This review captures the experience of people with the diagnosis, family carers and professionals involved in their care. "BPD" is a controversial and complex diagnosis with crisis intervention common but not supported by a robust evidence base. Therefore, the collation of a broad range of literature is important to increase understanding of this area. The review highlights important themes for all professionals to consider when providing crisis care for people with the diagnosis.

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