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Experiences of women living with borderline personality disorder

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ABSTRACT

There is limited understanding of the experiences of women living with borderline personality disorder. It was therefore decided to discover how women living with this disorder would tell their life story. For the researcher, who worked in a psychotherapy ward where most women were living with borderline personality disorder, the care of these women was of vital importance, as they were less understood by mental health care providers.

The research aimed to explore and describe the experiences of women living with borderline personality disorder. A qualitative, explorative, descriptive and contextual study design was used. Data was collected through in-depth phenomenological interviews that focused on the central question, "Tell me your life story". Eight participants living with borderline personality disorder were interviewed. Tesch's method for data analysis was used (Creswell, 2009:186), along with an independent coder. Measures to ensure trustworthiness and ethical principles were applied throughout the research.

From the findings obtained by means of the interviews of women living with borderline personality disorder, it was evident that there were childhood experiences of living in an unsafe space, related to unhealthy family dynamics, boundary violations and educational challenges. They experienced chronic feelings of emptiness in their relationships with the self. They also presented with a pattern of unstable interpersonal relationships and compromised mental health, which was apparent through the early onset of mental problems, emotional upheaval, looking for emotional escape and having different trigger factors. Lastly, all these women yearned for facilitated mental health.

1. Introduction

Due to their lack of understanding of the underlying dynamics of the disorder, nurses often find it difficult to work with patients with borderline personality disorder (Osborne & McComish, 2006:40). Borderline personality disorder is associated with a range of negative connotations. The diagnostic criterion in the Diagnostic and Statistical Manual for Mental Disorders (Sadock, Sadock, & Ruiz, 2015:750) defines

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borderline personality disorder as a "pervasive pattern of instability of interpersonal relationships, self-image and affects, as well as marked impulsivity beginning by early adulthood and is present in a variety of contexts". Patients who suffer from borderline personality disorder are characterised by psychosocial impairment and high mortality. Up to 10% of patients commit suicide; a rate almost 50 times higher compared with the general population. Mental health care professionals view people who are diagnosed with borderline personality disorder as one of the most challenging groups of mental health service users. They are likely to experience negative interactions with mental health care professionals because of their highly challenging behaviour, which includes disruptions in the ward, manipulation and splitting of mental health care professionals. Their behaviour in the ward is seen as a microcosm of their internal world and serves as a way to survive in a world that is unpredictable and dangerous (Callan & Howland, 2009:13). Splitting is a primitive dissociation defence used by a person with borderline personality disorder to avoid conflict. It is the inability to integrate contradictory experiences. The person has an "all or none" mentality about others and people are viewed as either "good" or "bad" (Kniesl & Trigoboff, 2013:486).

According to Erikson's theory of development (Friedman & Schustack, 2009:138), in the stage of intimacy versus isolation, from the age of 18 to the age of 25, major psychosocial conflict can occur. During this stage normal people should be able to love and work. The goal of this stage is that the individual should find companionship with similar others and then develop the ability to create strong social ties without losing oneself in the process (Friedman & Schustack, 2009:138). If this does not happen, the person may become self-absorbed and self-indulgent (Sadock et al., 2015:171). Women diagnosed with borderline personality disorder have affective, behavioural, interpersonal, self and cognitive dysregulation (Feigenbaum, 2007:51). With such dysregulation in different areas of their lives, women living with borderline personality disorder struggle to find meaning in their suffering and search for mental health care professionals who can collaborate in an emotional and therapeutic way, thus making it safe for them to tell their life stories (Holm & Severinnson, 2008:28).

Women were chosen for this study since firstly they are statistically the ones mostly affected by borderline personality disorder. Secondly, according to a study done by Shifiona, Poggenpoel, and Myburgh (2006:6), under normal circumstances women are affected by life's major changes such as marital problems, job changes, assumptions of major social roles and the evolution of an adult self during early and middle adulthood. Patients living with borderline personality disorder are described as having identity problems, unstable relationships, lack of impulse control, emotional instability and feelings of emptiness, often in combination with anxiety, depression and substance abuse (Holm, Berg, & Severinsson, 2009:561). Women diagnosed with borderline personality disorder attract the most attention through behaviours such as poor impulse control and deliberate self-harm (Westwood & Baker, 2010:657).

2. Problem statement

The researcher worked in a psychotherapy ward between 2007 and 2013 as an advanced psychiatric nurse practitioner. According to the researcher's observations, more female patients diagnosed with borderline personality disorder were admitted to the psychotherapy ward compared with male patients. Gubb (2010) wrote an article on "Reflections on society as a borderline mother". In this study Gubb (2010:42) reported that women in South Africa – especially black women – between the ages of 18 and 25 years – who are diagnosed with borderline personality disorder, needed care because of their social environments and the health care system in the country. Gubb (2010:42) states that the social environment in South Africa is one in which these women have no hope for a better future and no belief that they are in charge of their own destinies.

In South Africa, where high levels of violent crimes contribute to high levels of hyper vigilance, trauma and loss result in women living with borderline personality disorder suffering from emotional instability and a combination of anxiety and depression. These females would often be turned away at health care facilities because they are less understood and seen as complex patients. When seen by the psychologist, the session only lasts 15 min due to the high number of patients. When these women are admitted to psychiatric institutions, they have demonstrated many impulsive acts. The challenges that the women face clearly reveal that the health care system is unable to cope with the complexity of women living with borderline personality disorder. Gubb's study (2010) indicates the complexity of the health system that patients with borderline personality disorder come across, as well as the difficulty of maintaining their health in South Africa.

Langley and Klopper (2005:23–32) also conducted a study on trust in South Africa, titled "A foundation for the therapeutic intervention for patients with borderline personality disorder". This study highlights the challenges that patients diagnosed with borderline personality disorder cause. These challenges include human and financial costs due to the multiple and short-term admissions when they found themselves in a crisis. In Langley and Klopper's study (2005:24), patients living with borderline personality as well as clinicians were asked what they found helpful in maintaining the health of patients living with borderline personality disorder. Trust was identified as an important aspect in forming a relationship, as it was a foundation for the working relationship. These two studies conducted in South Africa have not explored the experiences of women living with borderline disorder in a South African context. Therefore it was imperative for the researcher to conduct this study, as a great need exists to understand these women's lived experiences in order to increase understanding among psychiatric nurse practitioners.

The researcher asked the following question:

- "What are the lived experiences of women living with borderline personality disorder?"

3. Research purpose

The purpose of the study was to explore and describe the experiences of women living with borderline personality disorder.

4. Definition of key concepts

4.1. *Experience*

In phenomenological research, experience refers to several individuals' meaning of a concept or a phenomenon. The focus is on describing what the women living with borderline personality have in common as they experience a phenomenon (Creswell, 2009:114).

4.2. *Woman*

A woman is an adult female human (Soanes, 2013). In the context of this study, a woman is an adult female between the ages of 18 and 40 living with borderline personality disorder.

4.3. *Borderline personality disorder*

The Diagnostic and Statistical Manual 5 (American Psychiatric Association, 2013:663) states that borderline personality disorder is diagnosed predominantly in females. Borderline personality disorder is a severe psychiatric disorder characterised by a pattern of instability in interpersonal relationships, self-image, affects and marked impulsivity, and present in a variety of contexts as indicated by five or more of the following: feelings of abandonment, pattern of unstable and intense interpersonal relationships, identity disturbance, impulsivity in at least two areas that are potentially damaging, recurrent suicidal behaviour, affective instability, chronic feelings of emptiness, inappropriate intense anger and transient stress-related paranoid ideation or severe dissociative symptoms. In this study, women living with borderline personality disorder were interviewed.

5. Research method and design

5.1. *Research design*

The design of this study is qualitative, exploratory, descriptive and contextual (Burns & Grove, 2009:23), based on a phenomenological approach to inquiry. This design was deemed appropriate because it focuses on gaining insight by means of discovering meaning about the lived experiences of women living with borderline personality disorder. Creswell (2009:13) indicates that the purpose of a phenomenological study is to describe experiences or phenomena as they are lived and described by the participants.

5.2. *The setting*

5.2.1. *Population and sampling and context*

Women diagnosed with borderline personality disorder in a psychotherapy ward were used because they were easily accessible since the researcher worked in this ward. A purposive sampling was used to select the women living with borderline personality disorder. Purposive sampling involves the researcher's conscious selection of participants (Mateo & Kirchhoff, 2009:159). The inclusion criteria for the participants were the following:

- women between the ages of 18 and 40 years, diagnosed with borderline personality disorder;
- women living with borderline personality disorder who were admitted to the psychotherapy ward.

6. Data collection

In-depth phenomenological interviews were conducted to collect data until saturation was reached. Saturation of data occurs when additional sampling provides no new information; only redundancy of previously collected data (Burns & Grove, 2009:750).

In the qualitative methodology, data collection and data analysis occurred at the same time. Bracketing was applied, since the researcher's objective was to describe the participant's life story without being influenced by any preconceived ideas (Burns & Grove, 2009:729). The central question that was asked of the participants was:

"Tell me your life story."

Each interview with the women living with borderline personality disorder was at least 30–45 min long. With the participants' permission, the interviews were audio taped in a conductive environment, free from distractions and noise. Observations and field notes were made as part of data collection methods. The researcher's observations were retained using filed notes to record activities as well as the researcher's interpretation of those activities (LoBiondo & Haber, 2014:276). The researcher's observations and field notes have been made after each interview, and these were noted. The researcher used the observation and field notes to remark on some direct quotations to indicate the participant's non-verbal activities during the interview. The researcher also interpreted the observations made, which assisted the researcher in making sense of what the participants have said.

7. Data analysis

The transcribed interviews and field notes collected during the interviews of the lived experiences of women living with borderline personality disorder were reduced and organised, and gave meaning to data. Data analysis was conducted using Tesch's method (Creswell, 2009:186), which is used in qualitative studies to organise the data collected from the

interviews into data that has meaning. Data was coded by developing and applying a list of codes to new segments of data each time an appropriate segment was encountered. A priori codes were developed before examining the current data. An experienced independent coder developed "inductive" codes after a direct examination of the data (Dongre, Deshmukh, Kalaiselvan, & Upadhyaya, 2009:3). An independent coder was used to ensure the researcher's objectivity and to reduce bias (Morse & Field, 2006:166). The researcher and the independent coder had a consensus discussion about the findings.

8. Trustworthiness

According to De Vos, Strydom, Fouché, and Delport (2011:419), there are four very important aspects when dealing with trustworthiness in the qualitative paradigm, namely credibility, transferability, dependability and confirmability; all of which were applied to this study. Credibility was ensured by prolonged engagement. The researcher worked in the psychotherapy ward when the study was conducted, which extensively exposed the researcher to the environment and gave her the opportunity to engage with women living with borderline personality disorder. The researcher enhanced triangulation by using data collection methods such as observations and recordings of field notes to achieve data thickness by means of in-depth interviews. By involving an expert – who has a PhD in psychiatric nursing – to code the data, and presenting the research study at two international and national conferences, the researcher attained peer examination. Lastly, member checking was achieved when the researcher validated and clarified her interpretations with the participants.

To enhance transferability, the researcher triangulated multiple resources of data from different sources. A clear and detailed demographic description was provided of the selected sample in order to transfer the findings to a similar context. A rich description was given of the research results, including direct quotations from the participants' interviews.

Dependability was enhanced by means of a dense description of research methodology, where all aspects of the research are fully described. A dense description of the research methodology was provided. Data was confirmed in order to determine the reliability of the data and a consensus meeting or discussion was held with the independent coder after data analysis.

Confirmability was justified by an audit, which is the chain of evidence of the research process. The transcripts, audiotapes and notes are still kept by the researcher as proof of the chain of evidence.

9. Ethical considerations

Approval was obtained from the ethics committees of the University of Johannesburg, Faculty of Health Sciences Academic Ethics Committee (reference number AEC 23/01-2011), the University of the Witwatersrand, Faculty of Health Sciences, Human Subjects Ethics (reference number R14/49), as well as the institution where the study was conducted, before the study commenced.

Dhai and McQuoid-Mason (2011:13–14) state that the researcher must take the following four fundamental ethical principles into consideration while conducting the research process: the principle of respect for autonomy, the principle of non-maleficence, the principle of beneficence and the principle of justice. The principle of autonomy was respected by allowing the participants to make an informed decision before signing an informed consent form; their confidentiality was respected throughout the research by not exposing their names. The participants were also not forced to participate in the study and could withdraw from the study at any time. Their privacy was maintained by conducting private interviews.

With regard to the principle of non-maleficence, the participants' risk-benefit ratio was assessed prior to their involvement in the study. The participants were offered debriefing sessions should they require it as a result of the interviews.

To ensure beneficence, the researcher conducted the study in such a way as to protect the participants from discomfort and harm. The researcher did this by asking appropriate questions, as well as by monitoring and observing the participants for any signs of distress throughout the interviews.

To ensure the principle of justice, the researcher guaranteed the fair selection of the participants in the study. The researcher excluded social, cultural, racial and sexual biases in society (Grove, Gray, & Burns, 2015:107) and only selected participants for reasons directly related to the problem and purpose of the study. The participants were treated fairly and with respect.

10. Discussion

10.1. *Findings*

Eight participants diagnosed with borderline personality disorder participated in this study. Two of the participants were White and six were Black. With regard to their marital status, all of them were single. The average age was 28 years. The ages of the participants ranged from 20 to 40 years. None of the participants have children. The results of the analysis of the transcribed in-depth interviews are summarised in Table 1.

10.1.1. *Theme 1: life stories depicting childhood experiences of living in an "unsafe" space*

From the eight interviews conducted, it became clear that the participants had childhood experiences that made their living space "unsafe". Under this theme, participants identified unstable family dynamics, boundary violations and educational challenges.

10.1.1.1. *Unstable family dynamics*. Participants in this study reported unstable family dynamics. Certain dynamics in the family, such as separation and divorce, also caused a great deal of instability for the participants. This subtheme is supported by the following direct quotation:

Table 1 – Themes and categories.

Themes	Categories
1.1 Theme 1 Life stories depicting childhood experiences of living in an "unsafe space"	1.1.1 Unstable family dynamics 1.1.2 Boundary violations 1.1.3 Educational challenges
1.2 Theme 2 Life stories depicting chronic feelings of emptiness in the relationship with the self	1.2.1 Distorted self-image and lack of identity
1.3 Theme 3 Life stories depicting a pattern of unstable interpersonal relationships	1.3.1 Under-involved family 1.3.2 Unstable interpersonal relationships with others 1.3.3 Loneliness and cultural stigmatisation
1.4 Theme 4 Life stories depicting compromised mental health	1.4.1 Early onset of mental problems (teenage years) 1.4.2 Emotional upheaval 1.4.3 Looking for emotional escape (unhealthy coping) 1.4.4 Trigger factors
1.5 Theme 5 Life stories depicting a yearning for facilitated mental health	

"We and my brother we separated, after that … because my parents divorced and so my brother wanted to stay with my dad and I loved staying with my mom; so that's how we got separated. I was 10 years old" (Participant #2).

Another participant said:

"I would take care of myself through most of the day because my mom worked two jobs and my sister was out with friends most of the time from when I can remember because she also just doesn't want to sit alone at home with me" (Participant # 4).

Denham (2003:29) confirms that unhealthy or unstable family dynamics have a negative impact on a person, as they cause one to have an inability to perform usual expected family roles and fulfil obligations related to these duties and responsibilities, thus creating a sense of powerlessness in accomplishing previously desired activities.

10.1.1.2. *Boundary violations*. The participants experienced boundary violations in and through their lives. This was supported by the following direct quotation:

"We lost all contact with my father's after the whole kidnapping incident. I mean from my mother's side. What used to happen then was, with all of my cousin we all have a cousin who was a year or two around the same age as them above and beneath and I fall on a very weird gap on my own and I did not have any people that I can relate with age cause when we were like seven, they were like four years older than me and that was a big gap so I was a bit of a loner and I think that's how I ended up being molested by one of my older cousins" (Participant #1). (She looked away from the researcher when saying this.)

And another participant demonstrated this by saying:

"Because my parents got divorced and so my brother wanted to stay with my dad and I loved staying with my mom, so that how we got separated, mmh, let me see. Year 2000, ja, in 2000 on the 15th of February my mom was shot by her boyfriend and I was the witness. Apparently, I don't know the whole story but I was told that they had an argument that day, you know, that led to the incident. I don't have the full details, I was just a witness. I just saw this guy, you know, ja, shooting my mom, so. But I knew the guy because they were dating. Apparently he was a married man, so they were having a secret affair, so it was about that" (Participant # 2). (With tears running down her face)

Boundaries are defined as invisible limits surrounding an individual; they protect the integrity of a person and when these boundaries are violated, the sense of protection and comfort is lost (Arnold & Boggs, 2011:129). Dowdell and Cavanaugh (2009:30) confirm that children who have been exposed to physical abuse, sexual abuse or emotional neglect often show insecure, avoidant or ambivalent attachment to their primary caregivers. These children will also be predisposed to seek inappropriate sexualised outlets; possibly as an expression of anger and possibly due to a need for self-soothing.

10.1.1.3. *Educational challenges*. The study findings revealed that at some point in these women's lives, they experienced educational challenges. This subtheme was supported by the following direct quotations:

"… until someone noticed it at my college, like the SCR could see that I'm bunking classes. Though I'm around on campus, she could see that my marks dropped" (Participant # 4).

Another participant said:

"But after that, since we moved from the farm we moved in a nearby town (sigh), I went to school which was also quite intense because after experiencing all these things at home; the home situation wasn't safe and I get to school and I didn't know the language and I think you know thinking back it was actually funny because my first class that I had was Afrikaans and then we had Zulu (laughs). And I couldn't even master English" (Participant #3).

The early onset of disruptions during childhood and adolescence may have an impact on development, and in particular on educational attainment; thus it contributes significantly to lower educational achievement (Myer et al., 2009:354).

It is suggested that unsafe early childhood experiences "disrupt crucial normal stages of childhood development and predispose these individuals to subsequent psychiatric sequelae" (Waite & Gerrity, 2010:51). It has also been found that long-term consequences of childhood trauma include attachment problems, eating disorders, depression, suicidal behaviour, anxiety, alcoholism, violent behaviour, mood disorders and posttraumatic stress disorder (Waite & Gerrity, 2010:52).

Research findings point to the prevalence of early traumatic experiences among patients with borderline pathology such as prolonged, painful physical illness, experiencing or witnessing physical and sexual abuse, severe early losses and abandonment, or a chaotic family structure (Magnavita, 2004:101).

10.1.2. *Theme 2: life stories depicting chronic feelings of emptiness in the relationship with the self*

The participants' life stories depicted chronic feelings of emptiness. This theme comprised a subtheme of distorted self-image and lack of identity. The participants who were interviewed displayed a repeated sense of worthlessness, powerlessness and emptiness.

Distorted self-image and lack of identity.

This sub-theme was supported by the following direct quotations:

> *"Umh, I was always like in the background. Nobody else was more important and, umh, he used to hold guns to my head. He used to beat me up"* (Participant # 5). (She lowered her voice.)

Another example that was demonstrated in the interviews is one where a participant restricts her food intake, then binges, just to gain her sister and her mother's acceptance.

> *"So I want to be beautiful like my sister and my mom; so I'm just gonna eat and then eat in big quantities because my mom used to praise me; ja, you know, you are so courageous because you eat all your food, very good girl"* (Participant # 8) (Laughing)

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

> *"Eventually I got this boyfriend and he was a drug dealer. You know I just thought it was great to hang around with like you know the top guys. It was like a hip thing to do"* (Participant # 5).

The participants displayed a sense of worthlessness, powerlessness and feelings of emptiness. The participants had a feeling of being different and always needing acceptance. This need for acceptance resulted in unplanned pregnancies and the women remaining in abusive relationships. The participants experienced a void and filled their emptiness by engaging in unplanned actions that resulted in negative consequences. Spondenkiewitcz, Speranza, Taieb, Corcos, and Revah-Levy (2013: 288) confirm that poor self-image hinders the construction of identity; the patients with borderline personality disorder have a blurred view of themselves both in childhood and in later life. This negative self-image results in difficulty expressing themselves and the fragmented representation that they have of themselves. "The self is especially significant in that it provides a stable anchor to serve as a guidepost and to give continuity to changing experiences" (Magnavita, 2004:41). Thus, self-image, despite the many particulars of one's character, appears to be predominantly of either a positive or a negative quality (Magnavita, 2004:41). In the context of this study, the participants' self-image had a negative quality. As has been clearly demonstrated, these women tried to compensate for their lack of self-esteem by engaging with dangerous people and feeling ashamed of themselves.

10.1.3. *Theme 3: life stories depicting a pattern of unstable interpersonal relationships*

A pattern of unstable interpersonal relationships was depicted. In this theme, there were four subthemes, namely under-involved family, unstable interpersonal relationships with others, loneliness and cultural stigmatisation. The participants in this study experienced a lack of support and understanding with regard to the difficulties they personally went through, as a result of their under-involved family, which in turn led to unstable relationships with others. These women felt rejected and abandoned by their families, as well as isolated and not accepted for who they are because of the lack of support from their under-involved families. This theme also focused on the unstable intimate relationships with others as a result of a lack of trust, betrayal and remaining in the abusive cycle. Lastly, it focused on the loneliness and cultural stigmatisation of these women. The loneliness was a result of feeling left out and labelled by the society for being diagnosed with a mental illness. The participants felt that they did not fit in with their families and with society.

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

One of the participants stated:

> *"... but then when I was in London (UK) my granddad died and, uhm, he was 94 and that really upset me 'cause I got quite close to him when I was staying with him, and I remember my mom did not phone to tell me; she sent me an e-mail. So then I remember and then I phoned my parents here and the first thing my dad answered and said 'what do you want'"* (Participant # 5).

Another participant said:

> *"I fell pregnant with this guy. So I was 17 and in matric. So my mom wasn't there for I think three or four months and during this period I fell pregnant and I didn't really have anybody to turn to, so I decided to take this decision on my own and my boyfriend at that time wasn't very helpful"* (Participant # 7). (Cried as she told this.)

Borderline patients have scored high in anger towards both their mothers and fathers due to unresolved trauma. They were also exposed to role-reversing experiences in relation to their mothers during childhood, which has an impact on the family being under-involved (Bland, Tudor, & Whitehouse, 2007:205). Family dynamics concerning the women provide an awareness of the family relationships that can be rallied for support or that may need special attention because of the negative impact they have on the women's situation. They also assist in determining who else in the family needs help, as well as assisting with awareness of cultural and family factors that influence the women's attitudes, beliefs and willingness to take action involving their health (Arnold & Boggs, 2011:247).

10.1.3.2. *Unstable interpersonal relationships with others*. Participants in this study experienced difficulty with regard to their interpersonal relationships with others. This was clearly demonstrated by the following participant:

> *"And I had these boyfriends. I jumped from the one boyfriend to the other, to the other, to the other. Always looking for somebody to give me some love and attention but I just couldn't get even, though I was in relationships with them. I just didn't feel like it was sufficient"* (Participant # 4).

Another participant said:

> *"I rather just go with somebody just for one time instead of having a relationship"* (Participant # 6).

A study conducted by Bland, Tudor, and Whitehouse (2007:205) confirms that unstable interpersonal relationships are related to high incidence of parental loss, prolonged parental separation and feelings of neglect during childhood; all contributing to the patients' later fears of abandonment. They often feel misunderstood, different and disconnected from their families.

10.1.3.3. *Loneliness and cultural stigmatisation*. Lastly, these women experienced cultural stigmatisation that resulted in feelings of loneliness. Stigmatisation was clearly demonstrated said the following quote of a participant:

> *"People in my neighbourhood found out that I was in a psychiatric hospital and there is a stigma around that"* (Participant # 4).

Another participant said:

> *"So it was quite a secluded place; there weren't any other kids or families, it was just them, these people and us; my mother, my sister and I"* (Participant # 8).

Link and Phelan (2001) in Rivera-Segarra, Rivera, Lopez-Soto, Crespo-Ramos, and Marques-Reves (2014:3) confirm that stigmatisation is a social process where the "elements of labelling, stereotyping, separation, status loss, and discrimination co-occur in a power situation that allows the components of stigma to unfold". Another element of the stigmatisation process, as proposed by Link and Phelan (2001) in Rivera-Segarra et al. (2014:12), is the loss of status. Discrimination leads to unequal outcomes as a result of cultural stigmatisation, which supports their assertion in referring to their partners' rejection to marry them, which, in turn, leads the person to feel less normal, lonely and discriminated against because of the condition.

10.1.4. *Theme 4: life stories depicting compromised mental health*

The participants in this study also noted that their mental health was compromised. The subthemes are an early onset of mental health problems in the teenage years and emotional upheaval. They would resort to unhealthy coping mechanisms that are destructive in nature in their attempts to find an emotional escape. All this was linked to triggering factors in their lives.

Early onset of mental health problems (teenage years).

Some of the participants verbalised having mental health challenges during their teenage years. The following quotations demonstrate their earlier struggles:

> *"At the age of 14 I started being depressed; I started feeling down most of the time; I didn't know what was wrong"* (Participant # 4).

> *"I think I must have been depressed; my mom took me to the doctor and they gave me vitamins and that was in grade 11"* (Participant # 1).

Mental health problems, such as depression, were evident in early teenage years and become a recurring theme through adulthood. Puberty is associated with elevated hormonal levels, which help to sculpt these new neural circuits, leading to behavioural changes. However, adolescence is also accompanied by psychosocial challenges (Paris, 2010:54). In addition, depression is seen as normal sequelae of reproductive events such as menstruation, pregnancy, post-partum and the transition to menopause, which makes the accurate diagnosis of depression challenging (Keyes & Goodman, 2006:62).

10.1.4.1. *Emotional upheaval*. The participants experienced various kinds of emotions. Due to the events that occurred in their lives, they did not know how to manage these emotions, as illustrated by the quotations that follow.

One participant said:

> *"Basically I was having emotional problems with my aunt and I didn't want to live anymore and that I was unhappy … and we used to be very close at one stage in our lives"* (Participant # 7).

Another participant said:

> *"A couple of weeks ago I had a big argument with my mother and I ended up smashing up my whole room and I never done anything like that before"* (Participant #6).

Svoboda (2013:80) confirms that patients with borderline personality disorder swing from happiness to despair, often in minutes, and each emotion is vastly disproportionate to its trigger. They experience overwhelming emotions and never achieve self-regulation of emotions since they are unable to tolerate any distress (Svoboda, 2013:80).

Looking for an emotional escape (unhealthy coping).

Some of the participants verbalised that they looked for an emotional escape as they were unable to express their emotions. This emotional escape resulted in unhealthy coping mechanisms. In the context of this study, the participants tried various ways to escape emotionally; ways that were easy or accessible for them. This was demonstrated by the following quotations:

> *"Then I started cutting because I was so confused 'cause I was so angry. I was so emotional. I wanted to die but I couldn't. It was the only thing at that point that could actually calm me down"* (Participant # 3). (Clenching her fists)

> *"I was hopeless. I ended up purging"* (Participant # 5).

Chiles and Strosahl (2005:4) suggest that suicidal behaviour is often designed to solve problems in a person's life rather than to end it. Schmidt and Davidson (2004:6) describe self-harm by means of cutting as a form of self-punishment, but it can also be done to release tension, or even to make the person feel more alive. Schmidt and Davidson (2004:4) further state that an outsider may not view the situation as hopeless, but because of the persons' particular upbringing, beliefs or values, they cannot free themselves from the trap in which they are caught. As demonstrated by the direct quotations above, feelings of depression, hopelessness, separation and rejection are strongly associated with self-mutilating behaviour (Starr, 2004:35). Starr (2004:35) also indicates that social issues such as relationships, career or school pressures cause unhealthy coping mechanisms.

10.1.4.2. *Trigger factors*. The participants in this study experienced various trigger factors relating to their mental problems. Trigger factors could be relational conflict, unstable living conditions, unemployment, unstable job situations or professional rejection, and financial strain. The findings were supported by the following quotations:

> *"I took quite a few overdoses during that time. I usually take pills. It was either when he was breaking up with me"* (Participant # 7).

> *"People would say things behind my back and this would make me cut myself"* (Participant # 4). (Looking at her wrists)

Miller, Rathus, and Linehan (2007:20) corroborate that stressful life events such as relationships, conflicts and crises, physical and sexual abuse, academic difficulties and functional impairment from physical disease and injury are trigger factors that compromise people's mental health and that can lead to suicidal attempts.

10.1.5. *Theme 5: life stories depicting a yearning for facilitated mental health*

In telling their stories, the participants saw the need for change and facilitated mental health. Yearning for facilitated mental health in the context of this study included the participants' reaching out to a positive environment and wanting the resources to promote their mental health. The process of mental health promotion also comprises the identification and bridging of obstacles. This is when the participants would mobilise their internal and external resources to improve their mental health. Facilitated mental health entails the optimal functioning of the woman living with borderline personality disorder in social, occupational, and other important areas of functioning.

All the participants who were interviewed experienced a turning point in their lives where they wanted to change. This turning point was reflected in the following statement made by one of the participants:

> *"I think right now I am entitled to sort myself and not to worry about him. Just to be a little selfish because I've been taking care of him the whole while and now it's time to take care of me and not throw it down the drain"* (Participant # 3).

Another participant said:

> *"I'm going to be fine"* (Participant # 6).

Yet another participant revealed:

> *"I just taking it one day at a time because I know I want to get better"* (Participant #2).

This meant that the women living with borderline personality disorder yearned for change in their ways of living. To yearn is to have a strong feeling of loss and longing for something (Soanes, 2013:1074). The participants in this study have demonstrated that they want progress in their lives. In a study done by O'Connell and Dowling (2013:33), it is reported that individuals with borderline personality disorder have a need for progress in their lives even though it is a slow process. Thus, the individuals living with borderline personality disorder need psychiatric nurses who will be open, honest, empathetic, have the ability to listen, be calm, have patience, be knowledgeable and be flexible in order to assist the women further in their quest for facilitated mental health (O'Connell & Dowling, 2013:33). Further research by Bowen (2013:492) indicates that individuals with borderline personality disorder who are supported by their mental health care practitioners develop a greater sense of responsibility for their own lives and futures with regard to having facilitated mental health. They also have better outcomes.

11. Recommendations

It is evident from the research that women living with borderline personality disorder face a number of challenges. In order to promote, maintain and restore their mental health, it is necessary to manage their mental health holistically, as human beings with a mind, body and spirit, who also interact with their external environment physically, mentally, socially and spiritually (University of Johannesburg, 2011:4). The researcher recommends that a model be developed to assist in managing the challenges that the women living with borderline personality disorder face and to facilitate their mental health in a holistic manner.

12. Limitations of the study

The researcher experienced a constraint regarding the scheduling of the appointments, as the participants had busy schedules in the psychotherapy ward. This limitation was addressed by means of prolonged engagement to accommodate the participants' busy schedule in the psychotherapy ward. The study was undertaken in a psychotherapy ward in a psychiatric hospital and therefore the findings are not representative of all women living with borderline personality disorder. The researcher addressed this limitation by indicating that the results are in the context of this study. Another limitation is the fact that the researcher was still a staff member, which might have made the participants tensed. The researcher noted that some of the participants were scared initially but relaxed through the course of the interviews.

13. Conclusion

The findings of this study revealed that the women living with borderline personality disorder had faced a number of challenges, as was evident in their life stories. The results displayed a majority of negative life stories; however, there was also evidence of reaching out for positivity and the hope that their lives could change for the better. There was strong evidence of internal and external turmoil because of emotional upheaval and unstable relationships with others. This was a clear indication of unresolved negative childhood experiences. The prevailing sentiment of this study is the demanding nature of the women living with borderline disorder, which makes these women difficult to manage. This emphasises the need for further research to be done into developing a model for the facilitation of their mental health. It is also evident from the nature of the challenges and the chaos in their lives that they need external interventions to facilitate their mental health.

REFERENCES

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington: American Psychiatric Association.

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

Bland, A. R., Tudor, G., & Whitehouse, D. M. (2007). Nursing care of inpatients with borderline personality disorder. *Perspectives in Psychiatric Care, 43*(4), 204–212.

Bowen, M. (2013). Borderline personality disorder: clinicians' account of good practice. *Journal of Psychiatric and Mental Health Nursing, 20*, 491–498.

Burns, N., & Grove, S. K. (2009). *The practice of nursing research: Appraisal, synthesis and generation of evidence* (6th ed.). Philadelphia: Saunders/Elsevier.

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

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

Creswell, J. W. (2009). *Research design qualitative and mixed methods approaches* (3rd ed.). USA: Sage Publications.

De Vos, A. S., Strydom, H., Fouché, C. B., & Delport, C. S. L. (2011). *Research at grass roots for the social sciences and human service professions* (4th ed.). Pretoria: Van Schaik Publishers.

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

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

Dongre, A. R., Deshmukh, P. R., Kalaiselvan, G., & Upadhyaya, S. (2009). Application of qualitative methods in health research: an overview. *Online Journal of Health and Allied Sciences, 8*, 1–5.

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

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

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

Grove, S. K., Gray, J. R., & Burns, N. (2015). *Understanding nursing research an evidence-based practice* (6th ed.). China: Elsevier.

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

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

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

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

Kniesl, C. R., & Trigoboff, E. (2013). *Contemporary psychiatric-mental health nursing* (3rd ed.). USA: Pearson Education Inc.

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

Lo Biondo-Wood, G., & Haber, J. (2014). *Nursing research methods and critical appraisal for evidence-based practice* (8th ed.). China: Elsevier.

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

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

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

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

Myer, L., Stein, D. J., Jackson, P. B., Herman, A. A., Seedat, S., & Williams, D. R. (2009). Impact of common mental disorders during childhood and adolescence in secondary completion. *South African Medical Journal, 99*(5:2), 354–356.

Osborne, L., & McComish, J. F. (2006). Working with borderline personality disorder. Nursing interventions using dialectical behavioral therapy. *Journal of Psychosocial Nursing, 44*(6), 40–47.

O'Connell, B., & Dowling, M. (2013). Community psychiatric nurses' experiences of caring for clients with borderline personality disorder. *Mental Health Practice, 17*, 4.

Paris, J. (2010). *Treatment of borderline personality disorder: A guide to evidence-based practice*. USA: The Guilford Press.
Rivera-Segarra, E., Rivera, G., Lopez-Soto, R., Crespo-Ramos, G., & Marques-Reves, D. (2014). Stigmatization experiences among people living with borderline personality disorder in Puerto Rica. *The Qualitative Report, 19*, 1–18.
Sadock, B. J., Sadock, V. A., & Ruiz, P. (2015). *Kaplan and Sadock's synopsis of psychiatry: Behavioural sciences/clinical psychiatry* (11th ed.). USA: Lippincott Williams & Wilkins.
Schmidt, U., & Davidson, K. (2004). *Life after self-harm. A guide to the future*. USA: Brunner-Routledge Publications.
Shifiona, N. N., Poggenpoel, M., & Myburgh, C. P. H. (2006). Life stories of depressed adult women in peri-urban Namibia. *Curationis, 29*(2), 2–11.
Soanes, C. (2013). *Oxford South African pocket dictionary* (3rd ed.). South Africa: Oxford University Press Southern Africa.
Spondenkiewitcz, M., Speranza, M., Taieb, O., Corcos, M., & Revah-Levy, A. (2013). Living from day-to-day – qualitative study on borderline personality disorder in adolescence. *Journal Canadia Academy of Child & Adolescent Psychiatry, 22*(4), 278–290.
Starr, D. L. (2004). Understanding those who self-mutilate. *Journal of Psychosocial Nursing & Mental Health Services, 42*(6), 33–40.
Svoboda, E. (2013). *Kings and queens of chaos. Psychology today, September/October, 80–87*.
University of Johannesburg. (2011). *Department of Nursing Science Paradigm: Theory for Health Promotion in Nursing*. Johannesburg: Department of Health Sciences.
Waite, R., & Gerrity, P. (2010). Assessment for and response to adverse childhood experiences. *Journal of Psychosocial Nursing, 48*(12), 52–59.
Westwood, L., & Baker, J. (2010). Attitudes and perceptions of mental health nurses towards borderline personality disorder clients in acute mental health settings: a review of literature. *Journal of Psychiatric and Mental Health Nursing, 17*, 657–662.