"It's not you; it's us!"

The relevance of Mental Health Team psychodynamics to the care of Individuals with Complex Emotional Needs

Michael Haslam, Sue Ellis & Marcia Plumridge

Abstract

As the support for trauma-informed approaches and awareness of the power imbalances within the caring relationship are increased, this paper proposes that it is time to revisit the issue of team dynamics and their potential impact upon responses to Individuals with Complex Emotional Needs. Considered through the dual lens of psychodynamic theory and complexity, and using the role of the Psychiatric Liaison Nurse to illustrate points made, it is argued that Mental Health Teams have the potential to experience intense emotions and anxieties that arise from systemic conflict; reflecting the inner experience of Individuals to whom they deliver care. Where these anxieties are not contained and remain unresolved, teams may resort to using primary defence mechanisms to protect themselves, potentially leading to invalidating responses and care that is retraumatising. Recommendations to enhance team effectiveness and to mitigate the potential preventable harms that might occur due to team dynamics are discussed.

Key points

1. Mental Health Teams can be subject to the same unconscious and emotional processes as their individual members.
2. Team protocols are socially constructed as a defence against the direct psychological demands of care provision, but team members may still experience anxieties resulting from external and systemic pressures.
3. If anxieties are not contained and resolved, teams may employ defence mechanisms to guard their members against further conflict and anxiety.
4. There are parallels with individuals in crisis as teams may become 'disordered' themselves; potentially mirroring the inner experiences of those to whom they deliver care.
5. The result for Individuals under their care, particularly those with Complex Emotional Needs, may be invalidation and a lack of compassionate responses.
6. A greater understanding the impact of team psychodynamics can promote more relational ways of working and mitigate the potential preventable harms that might otherwise occur

Key Words

Teams; defence mechanisms; anxiety; psychodynamics; personality disorder; trauma-informed

Introduction

The purpose of this paper is to provide a basic discourse around the psychodynamics of Mental Health Teams, specifically within the context of responses to Individuals with Complex Emotional Needs[1]. Psychodynamic theory appears to have fallen out of favour within modern Mental Health Nursing in the UK, making way for Cognitive-Behavioural approaches which place emphasis upon how thoughts and perceptions influence the way people behave. Yet psychodynamic theory remains highly relevant to the care of Individuals with Complex Emotional Needs, particularly as countertransference reactions, detrimental to care delivery, may be present within the caring relationship (Caputo, 2020). Despite this relevance, however, there remains a paucity of literature examining the impact of psychodynamics within Mental Health Nursing (Yaseen, *et al*. 2013).

[1] Whilst this discussion is underpinned by literature relating to the diagnostic label of 'Personality Disorder', the term 'Complex Emotional Needs' has been chosen as one that is also inclusive of those Individuals who have no formal diagnosis, or who are diagnosed with other conditions though share similar experiences of emotional distress.

This paper revisits the notion that groups are first and foremost people and are therefore subject to the same recurrent emotional states and unconscious processes as their individual members (Bion. 1961). It is argued that when teams are under pressure, they too are likely to experience collective anxieties; many of which arise from external and systemic issues. Where these anxieties are not contained, the potential is increased for Mental Health Teams to mirror the inner experience of Individuals to whom they deliver care, potentially replicating the misuse of power in their formative relationships. Team dynamics may therefore have a detrimental impact upon compassionate responses, particularly where Individuals experience emotional crises, leading to invalidation and care that may be re-traumatising. The pertinence of this issue is increased, considering the current support for trauma-informed approaches that promote awareness of power imbalances in caring relationships (Johnstone, *et al*. 2018; Cleary & Hungerford, 2015; Bateman, Henderson, & Kezelman, 2013). An understanding of team psychodynamics is therefore needed, to support relational ways of working with Individuals accessing services and to promote better care outcomes, particularly with those Individuals experiencing crisis or who are considered 'stuck' in treatment (Huxley & Ireland, 2018).

Whilst it is important to clarify that these issues are not unique to any specific Mental Health Team, or even that they are inevitable, the Psychiatric Liaison Nurse role has been chosen here to illustrate some of the issues discussed, as a role that not only bears the day-to-day emotional burden of direct contact with Individuals experiencing emotional crises, but is also one that is inherently associated with additional systemic conflict and anxiety.

Anxieties that already exist due to interpersonal and intrapsychic conflicts

The primary source of conflict and thus the clearest source of anxiety, is that that exists directly between the nurse and the individual they care for. Nurses often bear the full and concentrated impact of stress arising from direct care interactions (Menzies Lyth, 1988) and for Mental Health Nurses such as the Psychiatric Liaison Nurse, who frequently encounter Individuals in crisis, there are the additional demands of containing people emotionally, as well as physically (Caputo, 2020). Nursing Individuals with Complex Emotional Needs particularly is perceived as being 'undesirable' (Dickens, *et al*. 2016; Lewis & Appleby, 1998); interactions often being high in interpersonal conflict (Murphy & McVey, 2003) and so are anxiety-provoking and less positively reinforcing.

Such feelings are amplified towards Individuals if transferences are present in the caring relationship, giving rise to counter-transference phenomena (Freud, 1912). Individuals with Complex Emotional Needs often elicit powerful emotional responses and processes (Ramsden, Prince & Blazdell, 2020), with Mental Health Nurses reporting feelings of frustration, anger, and helplessness (Bhola & Mehrotra, 2021), mirroring those emotions described by Individuals experiencing crisis themselves. Furthermore, where the value of the therapeutic relationship and use of 'self' is widely acknowledged as being central to care-delivery for Mental Health Nurses (Hurley, 2009), a breakdown in relations resulting from the direct psychological demands from the Individuals they care for, may give rise to intrapsychic conflict and contradictory feelings, such as guilt, anxiety, and resentment (Morrissey & Higgins, 2019; Menzies Lyth, 1988).

Additional anxieties that arise from systemic issues

In addition to the emotional processes that occur as a direct consequence of the caring relationship, Mental Health Teams are also likely to experience additional collective anxieties arising from systemic issues, many of which relate directly to the definition and attainment of the Team's primary task itself. Within the UK health service, primary tasks are traditionally defined by the biomedical model and the language used is reflective of this; service inputs defined as 'illness', whilst outputs are 'recovery', and 'cure'. Individuals with Complex Emotional Needs, therefore, were historically excluded from Mental Health services (National Institute for Mental Health in England [NIMHE], 2003) on the basis that there was no distinct and immediate cure, and the concept of 'recovery' was as ill-defined and as unique as the individuals themselves. For the Psychiatric Liaison Nurse, the lack of clear definition around the primary task particularly when working with complexity continues to give rise

to individual and collective anxieties. Contacts are often limited to unscheduled, one-off events and so interventions are restricted only to the first phases of treatment as described by Livesley (2007), focussing upon behavioural responses; maintaining safety by assessing and containing risk, and supportive interventions to contain dysregulated emotions (Aitkin, 2007).

Furthermore, responses to Individuals with Complex Emotional Needs may also be adversely affected by conflicting priorities regarding the primary task. As the clinical interface between both Mental Health services and the Acute General Hospital, a unique aspect of the Psychiatric Liaison Nurse role is that they function first as a member of their own team, and then are also commissioned to serve multiple teams across the acute hospital; each with different ideologies and conflicting interests in the team's function, responsibilities, and desired outputs. An example of conflicting priorities may be around the attainment of the four-hour standard in the Emergency Department (ED). In the UK, where Health Service outcomes are externally defined and monitored through government targets, the four-hour standard is perceived as a measure of effectiveness, however its pursuit may risk a distortion in clinical priorities and therefore, the potential to impact upon a safe, effective, and positive discharge (Haslam & Jones, 2020; Haslam, 2019). Despite the Individual's increased emotional arousal, the potential presence of co-morbidities, possible self-destructive behaviours and complex social issues, the Psychiatric Liaison Nurse may still be pressured for a rapid assessment and discharge within the constraints of these limited timeframes, even when the crisis period has not yet been resolved and contrary to recommendations (NHS England, 2016; NICE, 2013; 2009). Patient-focussed care and relational approaches are therefore juxtaposed with this target-driven assembly-line service provision (Epstein, 2011).

Anxieties are also increased as the primary task of teams becomes difficult to accomplish. For Individuals with Complex Emotional Needs, frequent crises requiring support are already common in EDs (Warrender, *et al*. 2020; Shaikh, *et al*. 2017) as Individuals seek support at the 'peripheries' of health care (Bateman & Tyrer, 2004). In the UK, however, the National Health Service, free at point of contact, are seeing the numbers presenting to ED, rise exponentially (NHS Digital, 2020). Infinite demand and increased need may result in teams being required to accept an ever-rising number of referrals which place a strain upon the finite resources available.

Problematic Service Responses

Where team members have little support and their collective emotional and psychological anxieties are not effectively contained, teams may become reactive in their responses resorting to anti-task phenomena. These unintentional practices serve team members by unconsciously defending them against anxiety, despite them being counter therapeutic (Ramsden, Prince & Blazdell, 2020). Employing primary defence mechanisms (such as those described below), Mental Health Teams exhibit behaviours not dissimilar to that of the Individuals they care for. With no mechanism, however, for resolution, there is the risk that these psychological defences become a part of the culture of the team, and so the team itself becomes dysfunctional. These practices risk the potential re-traumatisation for the Individual receiving care, particularly if their experience of care replicates an earlier misuse of power (Johnstone, *et al*. 2018; Clarke, *et al*, 2015).

Avoidance

Teams under pressure, are often unable to differentiate between pathological anxiety and the anxiety arising from actual danger. The Nurse may therefore already experience an increased state of anxiety before even meeting with the individual and will therefore go to lengths to avoid confronting the source (Young, 2003; Menzies Lyth, 1988). Where anxieties often arise from the direct psychological demands placed upon the Mental Health Nurse from the Individuals they care for, team protocols may be socially constructed by their members as defence systems (Menzies Lyth, 1988). Referral systems to the Psychiatric Liaison Team, for instance, potentially act as a buffer between the Nurse and individual. These systems reduce the accessibility of the Nurse therefore making it possible for avoidance behaviours and leading to an informal rationing and prioritisation of care (Foster, 1979). Engaging also in more functional or bureaucratic tasks such as paperwork, divert the Mental Health Nurse from

involving themselves directly with the distressed individual (Hanley, Scott, & Priest, 2017). Furthermore, when faced with direct conflict, team protocols may provide opportunity for members to "Hide behind their badge" or uphold the importance of their specialism and so display defensive behaviours in avoidance of the task at hand (Young, 2003), an example of which may be "That is not my role".

Depersonalisation and categorisation

Whilst the labelling of Individuals with Complex Emotional Needs may be a manifestation of countertransference reactions, it might also be argued that such behaviours are a common buffer against the anxiety of the direct nursing role within Mental Health Nursing. Depersonalisation and categorisation of patients, reducing them to diagnoses or symptoms, are defence mechanisms that inhibit full nurse to patient contact. In a similar manner to those behaviours described by Menzies Lyth (1988), it may be that Individuals seeking care are referred to by their diagnosis or presenting complaint, such as "The 'PD' in cubicle four". This reductionist approach allows the Mental Health Nurse to remain detached from negative feelings elicited by the Individual in crisis, thus buffering them from direct contact with the Individual's overwhelming distress.

Splitting

Splitting is a primary defence mechanism whereby internal polarised views of self and others arise as a result of the conflicting emotions. Within vulnerable teams, physical examples of 'splits' may also be observed, manifesting themselves as the identification of external enemies or a distrust of other clinicians (Barrett, 2020; Bion, 1961). Splitting in teams may occur where the Individual's polarised thinking is projected onto team members, thus replicating their inner experience of identifying others as 'all good' or 'all bad', however, it is important to recognise that not all causes of splitting, are instigated by the individual seeking care (Bateman & Tyrer, 2004). It may be that splitting is simply the result of ineffectual team communication or the physical representation of unresolved transferences from individual team members. Consequently, Mental Health Teams with pre-existing limitations and susceptibilities, may find that dealing with complexity merely highlights existing splits as opposed to causing them. This lack of cohesion within the team is considered counter therapeutic as it potentially impacts upon decision-making, evokes inconsistencies in care and so leads to a fragmented service response.

Projection and displacement

Within the UK health service, Mental Health Teams are interdependent, functioning together to affect the behaviour of the whole. Repeat presentations and admissions to crisis services therefore are an indication that local services are not working well together and that there may be a lack of inter-agency communication and cooperation (Commissioning Quality Care [CQC], 2015); particularly an issue for those with Complex Emotional Needs for whom services should be integrated (Livesley, 2007). Displaced negative emotions and insecurities of individual team members may be projected onto others outside of the team. This process can be detrimental to patient care as poorly coordinated services that are not functioning optimally may contribute to the individual's underlying distress (Shields & Mullen, 2007).

The displacement and projection of negative emotions onto the Individual may also occur on occasions where recovery is not certain and complete (Menzies Lyth, 1988), as may often be the case when working with Individuals with Complex Emotional Needs. Those teams dealing with mental health crises, such as the Psychiatric Liaison Team rarely see those who have successfully progressed through treatment and instead are faced daily with their perceived 'failures'; those Individuals who return and are re-referred to the team. Frequent attendances and the risk of disconnection with interventions and treatment are frustrating to Mental Health Nurses, challenging the notion that they are 'perfect caregivers' by presenting them with evidence to the contrary. On such occasions, the responsibility for negative experiences of team members may be assigned to the individual as a defence against the complex feelings often of guilt, shame, or even loathing towards them (Linehan, 1993; Obholzer & Roberts, 1994). A consequence of attributing blame to the individual for 'disengaging' as opposed to accepting that the team were ineffective in engaging them, may be a threat of the withdrawal of services and

treatment. At these times, the Mental Health Nurse may be experienced by the Individual receiving care as invalidating and rejecting. Displaced emotions may therefore increase the risk of negative judgements, exclusionary practices (NIMHE, 2003) and re-traumatisation.

Treating the 'disordered' team

A lack of understanding regarding psychodynamics mean that team members have limited insight into individual and organisational anxieties when dealing with complexity, and consequently they may fail to notice how the team enacts a misuse of power (Ramsden, Prince & Blazdell, 2020). Where there are parallels with the Individuals they treat, such as reduced insight, dysregulated emotions and interpersonal conflict, it might also be logical to apply those same treatment strategies to the team, with initial aims to contain dysregulated emotions and to minimise self-disparaging behaviours (Livesley, 2007) before increasing the capacity for self-reflection and function. From a psychodynamic viewpoint, it is the team's lack of awareness and understanding of its emotional processes that impedes effective work with the Individuals it cares for and so bringing such processes to team members' awareness is therefore essential (Caputo, 2020; McLeod & Kettner-Polly, 2004). Group supervision would promote reflective practice and reflexivity, whilst encouraging insight into causes of splitting and enabling collaboration (Morrissey & Higgins, 2019).

Different causes of splitting, such as those caused by ineffectual team communication, individual transferences, or an external manifestation of polarised thinking, may need different types of intervention (Bateman and Tyrer, 2004). As with the Individual with Complex Emotional Needs, if the Mental Health Team has a fragmented sense of self, the goal might be to improve integration and adaptation (Livesley, 2007). Where the issue of splitting arises therefore, directly from the team's members, face-to-face developmental feedback from peers may drastically reduce conflict (Druskat & Wolff, 1999). Where splitting occurs however, as a direct consequence of interactions with Individuals with Complex Emotional Needs, the effective use of reflection may be useful, offering insight into the patient experience.

The importance of education for Mental Health Nurses working with Individuals with Complex Emotional Needs has been emphasised (Fanaian *et al*, 2013; NIMHE, 2003). Where there is a lack of education and therefore understanding of Individual emotional processes, compassionate responses to the Individual are reduced (Ramsden, Prince & Blazdell, 2020) and so the risk of re-traumatisation is increased, particularly where Individuals are most frequently encountered in crisis states. Education and training have not only been shown to reduce stigmatising attitudes (Clarke, *et al*. 2015) but along with clinical supervision, may enhance team members emotional awareness in relation to their own countertransference reactions (Caputo, 2020).

Implications and value

Considering team dynamics through the lens of psychodynamic theory is not without its limitations. Whilst arguing against taking a reductionist approach with Individuals, Psychodynamic Theory in itself, may be considered as a reductionist approach due to the oversimplification of the human mind into the id, ego, and superego and the five psychosexual stages, whilst also ignoring concepts of individual free will and mediational processes. Furthermore, psychodynamic theory has no real empirical basis, Freud, using only case studies to evidence his work. That said, with the awareness and support for trauma-informed approaches increasing (Cleary & Hungerford, 2015), applying this approach to teams is a useful framework by which services can start to consider how individual and team dynamics impact upon the treatment and potential outcomes for Individuals with Complex Emotional Needs. An awareness of team psychodynamics has the potential to address the power imbalances in the caring relationship, promoting relational ways of working and supporting compassionate responses. The result will hopefully mitigate some of the potential preventable harms that might otherwise occur.

Conclusion

This paper considered the responses of Mental Health Teams to Individuals with Complex Emotional Needs through the lens of psychodynamic theory. Using an example of the Psychiatric Liaison Nurse role, this paper argued that Mental Health Teams can be subject to the same unconscious and emotional processes as their individual members. Where team procedures are socially constructed by their members as defence systems against the direct psychological demands of care provision, anxieties may still arise not just from the direct caring relationship, but also from systemic issues, particularly those in relation to the definition and attainment of the team's primary task. If said anxieties are not appropriately contained, Mental Health Teams may exhibit behaviours not dissimilar to those of the Individuals cared for, increasing the risk of invalidating responses and even re-traumatisation. Recommendations to enhance team performance and effectiveness included increasing the Teams awareness of emotional processes through education, reflection and supervision. By revisiting Psychodynamic Theory, therefore, it is possible that a greater understanding the impact of team dynamics and dysfunction can promote more relational ways of working and mitigate the potential preventable harms.

References

Aitkin, P. (2007) *Mental Health Policy Implementation Guide: Liaison Psychiatry and Psychological Medicine in the General Hospital.* Royal College of Psychiatrists. London.

Barrett, J. (2020). *Working Effectively with Personality Disorder, Contemporary and Critical Approaches to Clinical and Organizational Practice*. Edited by Ramsden, J. Prince, S. & Blazedell, J. Pavilion Publishing & Media Ltd: Shoreham by Sea

Bateman, J., Henderson, C., & Kezelman, C. (2013). *Trauma-informed care and practice: towards a cultural shift in policy reform across mental health and human services in Australia. A National Strategic Direction, Position Paper and Recommendations of the National Trauma-informed Care and Practice Advisory Working Group*. Sydney, Australia: Mental Health Coordinating Council.

Bateman, A. W. & Tyrer, P. (2004). Services for Personality Disorder: organisation for inclusion. *Advances in Psychiatric Treatment*. Vol10; pp425-433

Bhola, P. & Mehrotra, K. (2021). Associations between countertransference reactions towards patients with borderline personality disorder and therapist experience levels and mentalization ability. *Trends Psychiatry Psychotherapy*

Bion, W. R. (1961). *Experiences in Groups*, London: Tavistock.

Caputo, A. (2020). Telling a Complicated Grief: A Psychodynamic Study on Mental Health Nurses' Countertransference Reactions to Patients' Suicidal Behavior. *Archives of Suicide Research*

Clarke S, Taylor G, Bolderston H, Lancaster J, Remington B (2015) Ameliorating Patient Stigma Amongst Staff Working with Personality Disorder: Randomized Controlled Trial of Self-Management Versus Skills Training. *Behavioural & Cognitive Psychotherapy*, 43(6), 692-704 Cambridge University Press

Cleary, M., & Hungerford, C. (2015). Trauma-informed care and the research literature: How can the mental health nurse take the lead to support women who have survived sexual assault? *Issues in Mental Health Nursing*, 36(5), 370–378.

Commissioning Quality Care (CQC) (2015) *Right Here, Right Now*: *Mental Health crisis care review*. CQC. Gallowgate.

Dickens, G. L., Lamont, E,& Gray, S. (2016) Mental Health Nurses' Attitudes, Behaviour, Experience & Knowledge Regarding Adults With a Diagnosis of Borderline Personality Disorder: Systematic, Integrative Literature Review. *Journal of Clinical Nursing*, 25(13-14) 1848-1875

Druskat, V. U. & Wolff, S. B. (1999) Effects and timing of peer appraisals in self-managing work groups. *Journal of applied psychology*. Vol.84; pp58-74.

Epstein, R. M. & Street, R.L. (2011). The Values and Value of Patient Centred Care Annals of Family Medicine Mar; 9(2): 100–103

Fanaian M, Lewis KL, Grenyer BFS (2013) Improving Services for People with Personality Disorders: Views of Experienced Clinicians. *International Journal of Mental Health Nursing* 22(5) 465-471

Foster, P. (1979) The Informal Rationing of Primary Medical Care. *Journal of social policy*. Vol. 8(4); pp489-508

Freud, S. (1912) *The Dynamics of Transference*. Standard Edition 12.

Gross R., Olfson M., Gameroff M., Shea, S., Feder, A., Fuentes M., Lantigua R., & Weissman M.W. (2002). *Borderline personality disorder in primary care.* Archives International Medicine. 162(1):53–60

Hanley, B., Scott, H. & Priest, H. (2017). The impact of organisational change on professionals working within a Community Mental Health Team (CMHT): a psychodynamic perspective, *Psychoanalytic Psychotherapy*, 31:2, 176-194

Haslam, M. & Jones, E. S. (2020). The impact of the Emergency Department target upon the discharge decision for people who self-harm. *Journal of Public Mental Health*. Vol. 19 (2)

Haslam, M. (2019). How the emergency department four-hour target affects clinical outcomes for patients diagnosed with a personality disorder. *Emergency Nurse*, Vol. 27 No. 4, pp. 20-24.

Hurley J. (2009). A qualitative study of mental health nurse identities: many roles, one profession. *International Journal of Mental Health Nursing* 18, 383–390.

Ireland, C. A. & Huxley, S. (2018). Psychological Trauma in Professionals Working with Traumatised Children, The *Journal of Forensic Practice* 20(3), 141-151

Johnstone, L., & Boyle, M., with Cromby, J., Dillon, J., Harper, D., Kinderman, P., Longden, E., Pilgrim, D., & Read, J. (2018). *The Power Threat Meaning Framework: Towards the identification of patterns in emotional distress, unusual experiences and troubled or troubling behavior, as an alternative to functional psychiatric diagnosis*. Leicester, England: British Psychological Society.

Lewis G, & Appleby L, (1988) Personality Disorder: The Patients Psychiatrists Dislike. *British Journal of Psychiatry* Vol 153 (1) 44-49

Linehan, M. (1993). Cognitive Behavioral Treatment of Borderline Personality Disorder. Guilford Press.

Livesley, J. W. (2007). An integrated approach to the treatment of personality disorder. *Journal of Mental Health*. Vol.16(1). pp131-148.

Mcleod, P. L. & Kettner-Polley, R. B. (2004). Contributions of Psychodynamic Theories to Understanding Small Groups. *Small Group Research*. 35(3):333-361

Menzies Lyth, I. (1988). *Containing anxiety in institutions: Selected essays, Vol. 1*. Free Association Books.

Morrissey, J., & Higgins, A. (2019). "Attenuating Anxieties": A grounded theory study of mental health nurses' responses to clients with suicidal behaviour. *Journal of clinical nursing*, 28(5–6), 947–958

Murphy, N. & McVey, D. (2003) The Challenge of Nursing Personality Disordered Patients. *The British Journal of Forensic Practice*. Vol.5(1); pp3-19.

National Institute for Mental Health in England (NIMHE) (2003). *Personality Disorder: No longer a diagnosis of exclusion.* NIMH(E). Leeds.

National Institute for Health and Care Excellence (2013). *Self-Harm: Quality Standard*. NICE, London.

National Institute for Health and Care Excellence (NICE) (2009). *Borderline Personality Disorder: Treatment and management.* NICE.

NHS Digital (2020) *Hospital Accident & Emergency Activity 2019-20: Official statistics*. NHS Digital. England. Retrieved June 2021 from: https://digital.nhs.uk/data-and-information/publications/statistical/hospital-accident--emergency-activity/2019-20

NHS England (2016). *Achieving Better Access to 24/7 Urgent and Emergency Mental Health Care – Part 2: Implementing the Evidence-Based Treatment Pathway for Urgent and Emergency Liaison Mental Health Services for Adults and Older Adults*. NHS, Leeds.

Obholzer, A. & Roberts, V. Z. (1994). *The Unconscious at Work* (2nd Edition) Routledge.

Ramsden, J., Prince, S. & Blazdell, J. (Eds) (2020). *Working Effectively with Personality Disorder, Contemporary and Critical Approaches to Clinical and Organizational Practice*. Pavilion Publishing & Media Ltd, Shoreham by Sea

Shaikh, U., Qamar, I., Jafry, F., Hassan, M., Shagufta, S., Odhejo, Y.I. and Ahmed, S. (2017). Patients with borderline personality disorder in emergency departments. *Frontiers in Psychiatry*, Vol. 8 No. 136, pp.1-12.

Shields, F. & Mullen, T. (2007). Working Across Whole Systems: Using Managed Clinical Networks. *Mental Health Review Journal*, Vol. 12 No. 4, pp. 48-54.

Tyrer, P., Reed, G. M. & Crawford, M. J. (2015). Classification, assessment, prevalence, and effect of personality disorder. *The Lancet*. Vol.385(9969); pp717–726.

Warrender, D., Bain, H., Murray, I. & Kennedy, C. (2020). Perspectives of Crisis Intervention for People Diagnosed with "Borderline Personality Disorder": An Integrative Review, *Journal of Psychiatric and Mental Health Nursing* 28(2) 208-236, Wiley

Yaseen, Z. S., Briggs, J., Kopeykina, I., Orchard, K. M., Silberlicht, J., Bhingradia, H., & Galynker, I. I. (2013). Distinctive emotional responses of clinicians to suicide-attempting patients-a comparative study. *BMC Psychiatry*, 13, 230.

Young, R. M. (2003). *The psychodynamics of institutions. Unit for distance learning* MA in Psychoanalytic studies. University of Sheffield