Daily Occupations and Adaptation to Daily Life Described by Women Suffering from Borderline Personality Disorder

Ingrid Falklöf & Lena Haglund

a Department of Psychiatry, Linköping University Hospital, Linköping, Sweden
b Department of Social and Welfare Studies, Linköping University, Linköping, Sweden


To cite this article: Ingrid Falklöf & Lena Haglund (2010): Daily Occupations and Adaptation to Daily Life Described by Women Suffering from Borderline Personality Disorder, Occupational Therapy in Mental Health, 26:4, 354-374

To link to this article: http://dx.doi.org/10.1080/0164212X.2010.518306

PLEASE SCROLL DOWN FOR ARTICLE

Full terms and conditions of use: http://www.tandfonline.com/page/terms-and-conditions

This article may be used for research, teaching, and private study purposes. Any substantial or systematic reproduction, redistribution, reselling, loan, sub-licensing, systematic supply, or distribution in any form to anyone is expressly forbidden.

The publisher does not give any warranty express or implied or make any representation that the contents will be complete or accurate or up to date. The accuracy of any instructions, formulae, and drug doses should be independently verified with primary sources. The publisher shall not be liable for any loss, actions, claims, proceedings, demand, or costs or damages whatsoever or howsoever caused arising directly or indirectly in connection with or arising out of the use of this material.
Daily Occupations and Adaptation to Daily Life Described by Women Suffering from Borderline Personality Disorder

INGRID FALKLÖF
Department of Psychiatry, Linköping University Hospital, Linköping, Sweden

LENA HAGLUND
Department of Social and Welfare Studies, Linköping University, Linköping, Sweden

Clients suffering from Borderline Personality Disorder have significant impairments in relation to health. Despite this, their occupational status is rarely described. The aim of this study was to examine how women with Borderline Personality Disorder describe their daily occupations and adaptation to daily life. The study included nine participants. The data were collected using a semi-structured interview and were analyzed using content analysis.

Theme: Having few organized daily activities and poor personal causation prevent changes in adaptation to daily life. Two categories: performance and self-image, and four subcategories: competent or incompetent to perform, positive self-image, and lack of self-image were identified.

KEYWORDS Borderline Personality Disorder, content analysis, mental disorder, OCAIRS-S, occupational therapy

INTRODUCTION

In Western culture there is a common attitude that a person is defined by what she does in life. Today we can notice a growing opinion among social and developmental psychologists that a person’s sense of self develops largely as a result of her experiences in daily life. Our daily occupations are important for self-identity. But human occupations, although they are a
part of our daily life, are complex. Our everyday occupations organize our lives. Occupations provide us with a context for interaction with others and enable us to connect with and adapt to our environment. They also allow us to express ourselves and who we are. Different occupational choices depend, for example, on biological, ecological, psychological, and cultural factors (Christiansen & Townsend, 2004).

Throughout the history of the profession, the connection between health and occupation has been strong. Adolf Meyer, whose ideas significantly shaped early occupational therapy, emphasized that a balance between different kinds of activities such as work, rest, play, and sleep, is important for the individual’s experience of health and well-being (Meyer, 1997).

Even in the occupational therapy literature of today, we can find significant support for the idea that a balance of occupation is important for health (Canadian Association of Occupational Therapists [CAOT], 2002; Kielhofner, 2002, 2004, 2008; Wilcock, 2006; Hasselkus, 2002; Christiansen & Townsend, 2004; Björklund, 2000; FSA, 2005).

Occupational therapists use the word “occupation” in a broad sense and not as a synonym for the words “activity” or “task”. The different words can be seen as forming a hierarchy. At the lowest level is the task that is used to accomplish the activities that are part of occupations. Human beings engage in tasks to perform activities required by occupations (Christiansen & Townsend, 2004).

Wilcock suggests that occupation should be understood in the light of the concepts of doing, being, and becoming. To do is closely linked to our daily activities. Throughout our lives we are engaged in doing different kinds of activities, some for our survival and some for fun and enjoyment. To be can be described as to exist. Maslow (1999) uses the word as something different from action. From this point of view it has something to do with contemplation and enjoyment of inner life. But to be can also be used when describing our different occupational roles, for example, to be a student, to be a parent, and so on. Through occupations we constantly develop and become different. Occupational therapists have an important role in enabling occupation and occupational change. Wilcock (1999) stresses the need for a dynamic balance between doing, being, and becoming, both from the perspective of individual health and for the development of our profession.

The Model of Human Occupation (MOHO) seeks to explain how occupation is motivated, patterned, and performed. To understand human occupation we must understand the individual and his/her volition, habituation, performance capacities, and the physical and social environment.

The model describes the nature of doing occupations and the consequence of doing over time in the life of a human being. Different levels of doing can be identified:

- **Occupational participation**, which refers to a person’s engagement in work, play, or activities of daily living. Occupational participation is
Occupational performance consists of different acts that lead to occupational participation, for example, taking a shower or dressing when completing participation in activities of daily living. Performance refers to underlying abilities and is affected by performance capacities, habituation, volition, and the environment.

Occupational skills are defined as observable, goal-directed actions that a person uses while performing. In the Model of Human Occupation, skills are divided into motor skills, process skills, and communication and interaction skills (Fisher, 2003; Kielhofner, 2002).

Occupational participation results in occupational adaptation which means how a person is able to develop and change in response to challenges. It can also be defined as “...constructing a positive occupational identity and achieving occupational competence over time in the context of one’s environment” (Kielhofner, 2008, p. 107). Occupational identity refers to the subjective meaning of a person’s occupational life and competence and has to do with when a person is putting the identity in action.

We cannot say anything about the quality of someone’s life through studying how much time someone spends doing different kinds of activities and occupations. To assess quality of life it is more important to study attributes of engagement in occupations that have a bearing on well-being and health (Christiansen & Townsend, 2004).

Clients suffering from Borderline Personality Disorder (BPD) have significant impairments in health compared to the normal population. Despite this, their occupational status is rarely described in occupational therapy literature.

BPD is a medical diagnosis discussed in the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV; American Psychiatric Association, 1991), the system used by the American Psychiatric Association. In the WHO International Classification of Diseases (ICD-10; WHO, 1997) system of classification it is called Emotionally Unstable Personality Disorder. It is a severe psychiatric disorder characterized according to the DSM-IV system by at least five of these criteria:

1. Frantic efforts to avoid real or imagined abandonment.
2. A pattern of unstable relationships characterized by alternating between extremes of idealization and devaluation.
3. Identity disturbance: persisting and markedly disturbed, distorted, or unstable self-image or sense of self.
4. Impulsiveness in at least two areas that is potentially self-damaging.
5. Recurrent suicidal threats, gestures, or behavior, or self-mutilating behavior.
6. Affective instability: marked reactivity of mood usually lasting a few hours and only rarely more than a few days.
7. Chronic feelings of emptiness.
8. Inappropriate, intense anger or lack of control of anger.
9. Transient, stress-related severe dissociative symptoms or paranoid ideation.

The disorder is most common among women. Self-damaging behaviour and suicide attempts frequently occur and can be understood as a strategy to handle the problems described above. About 10% of the group commits suicide (The Swedish Council on Technology Assessment in Health Care [SBU], 2005).

The prevalence of Borderline Personality Disorder is about 0.7–5.4% of the general population (SBU, 2005). According to SBU (2005), between 70,000 and 140,000 people of the Swedish population, are estimated to meet the criteria for this diagnosis. Ten to 12% of all psychiatric outpatients and 20% of psychiatric inpatients meet the criteria for the diagnosis (Fruzetti, 2002), consequently occupational therapists in psychiatric care often meet clients with this disorder.

Clients with BPD often show occupational patterns characterized by “active passivity” and “apparent competence”. Active passivity can be described as a tendency to approach problems passively and helplessly instead of actively and with determination. The person is often actively trying to get others to solve her life problems but remains passive about solving problems on her own. Apparent competence refers to a tendency to appear competent and able to cope with everyday life at some times, and at other times to appear not to be competent. The client’s competence is very variable and conditional. A client suffering from BPD has problems communicating her vulnerability clearly (Linehan, 1993).

Persons with BPD also have a negative body image. They often dislike their bodies and have difficulty in perceiving them as integrated entireties (Hulting, 2003).

In a search of literature in the databases AMED (Allied and Complementary Medicine), CIHNAL (Cumulative Index to Nursing and Allied Health Literature), Medline, and Psycinfo in November 2006, only one article on both occupational therapy and Borderline Personality Disorder, was found. The purpose of the study was to describe the planning, implementation, and evaluation of a women’s community living skills course. The majority of the women had been diagnosed with BPD, but not all of them. The study does not report on how the women described their daily occupations and adaptation to daily life (Clark, Ball, & Maltby, 2006). No article was found when combining the keywords Emotionally Unstable Personality Disorder and occupational therapy.
Occupational therapists need to increase their knowledge about people suffering from BPD and how it affects occupations in daily life. Furthermore, occupational therapists need to document the knowledge to make it available for research and thereby support these clients in a better way.

Aim

The aim of this study was to examine how women with BPD, describe their daily occupations and adaptation to daily life.

MATERIAL AND METHOD

Participants

The participants in this study had been diagnosed with BPD and had been included and committed to a Dialectical Behavioral Therapy (DBT) out-patient program in the southern part of Sweden. The diagnosis had been made according to the DSM-IV criteria. The DBT program had 12 participants during 2007. Nine of the participants agreed to take part in the study. Of these nine, four had committed to the DBT program within a month and five had made their initial commitment to the program 12–15 months earlier. All participants were women and they were between 20 and 39 years old. The mean age of the group was 26 years.

The Dialectical Behavioral Therapy Programme

DBT (Linehan, 1993) is a psychosocial treatment derived from Cognitive Behavioral Therapy, developed specifically to treat people with BPD. The treatment itself is based largely on behavioral therapy with some cognitive therapy elements as well. Dialectical philosophy has a great impact on the therapy, which also incorporates mindfulness practices from the Zen Buddhist tradition as a central component.

There are four essential parts to the program:

1. Individual therapy in which the therapist and client discuss issues that come up during the week, recorded on diary cards. During the individual therapy, the therapist and client work towards improving skill use. The therapy follows a treatment target hierarchy in which self-harming and suicidal behaviours take first priority, followed by therapy interfering behaviors. Then there are quality of life issues and therapy, finally work toward improving the subject’s life generally.

2. The skills training group, which usually meets once a week for about 2–2.5 hours, in which clients learn to use specific skills that are broken
down into four modules: core mindfulness skills, emotion regulation skills, interpersonal effectiveness skills, and distress tolerance skills.

3. Telephone consultation with the individual therapist between psychotherapy sessions is an important part of the therapy. This strategy aims to decrease para-suicidal and suicidal behavior. Another aim is to coach the client to generalize DBT behavior skills in everyday life. A third aim is to offer the client an opportunity to handle conflicts and misunderstandings between the sessions.

4. Case consultation, meeting once a week, offers the therapists consultation and supervision. Treating BPD clients is enormously stressful for the therapists and therefore the consultation team is an important part of the therapy (Linehan, 1993).

The DBT method can be divided into four stages:

1. To achieve behavioral control and reduce life-threatening behavior such as suicide-behavior, homicide, aggression, and violence. Decrease therapy-threatening behaviors, for example, not attending sessions and not collaborating in therapy. This stage also includes reducing severe quality of life threatening behaviors such as addiction and high risk sexual behavior. This stage lasts for about one year.

2. Decrease Post Traumatic Stress Disordered related problems and effective emotional experiencing. This stage included emotional discrimination and labelling as well as self-validation.

3. Focus on problems in living, for example, education- and employment-related difficulties, and how to improve relationships. Primary targets include to increase self respect, to solve problems in living and to modify dysfunctional interaction patterns.

4. Enhancing the capacity for sustained contentment and joy. This stage focuses on enhancing self awareness and a mindful engagement in living. It also includes acceptance and closeness of self and others (Fruzetti, 2002).

A systematic literature review, made by the Swedish Council on Technology Assessment in Health Care, has shown scientific evidence that DBT reduces self-injurious behavior and that this effect remains at two-year follow up (SBU, 2005). In a grading scale of three levels, DBT will meet criterion of grade three. Treatment also appears to reduce the need for hospitalization and reduce drug use among people with addictions. According to SBU, DBT appears to be a promising form of treatment for patients with borderline personality disorder.

Six different randomized studies have shown that DBT decreases self-harming behavior and reduces treatment interruptions, and that this effect will be preserved two years after the treatment has been completed.
No study concerning cost effectiveness of the DBT method has been found (SBU, 2005).

Procedures

The data were collected through interview assessment, namely The Occupational Circumstance Assessment—Interview and Rating Scale—Swedish version 4.0 (OCAIRS-S; Haglund & Henriksson, 2001). The assessment is based on the Model of Human Occupation. It provides a structure for gathering, analyzing, and reporting data on a client’s own comprehension of values, goals, personal causation, interests, habits, roles, skills, environmental impact, occupational participation, and adaptation. It can be used with a wide range of clients and would be appropriate for adolescents and adults who have the cognitive and emotional abilities to participate in an interview (Kielhofner, 2002). Several studies have found evidence of good inter-rater reliability and validity (Kielhofner, 2008; Haglund & Henriksson, 1994; Haglund, Thorell, & Wålinder, 1998; Shei Lai, Haglund, & Kielhofner, 1999). A study made by Haglund and Henriksson (1994) has shown evidence of content validity in OCAIRS-S. At least 60% agreement is provided by the therapists, when matching items to domains. The same study indicates that the instrument have at least a moderate strength of interrater reliability. The result of the study showed a variation of .50–.82 according to Intraclass Correlation Coefficient.

Studies have also found that the assessment has the ability to effectively discriminate between clients with different degrees of psychiatric illness (Haglund, 1997; Shei Lai, Haglund, & Kielhofner, 1999).

The participants in this study were informed about the study and invited to enter it by means of a letter delivered by their individual DBT-therapist. They were informed that participation in the study was voluntary, and that they could withdraw at any time. They were asked to answer the invitation using an enclosed letter. Each participant decided where the interview should take place. Eight of the participants were interviewed at the program location and one chose to be interviewed at her home. The first author conducted all the interviews. The interviews were recorded and lasted from 40 minutes to one hour.

Data Analysis

To achieve an understanding of how the informants’ experience their situation, this study was based on qualitative methodology. A latent qualitative content analysis was made of the information gathered in the OCAIRS-S interviews (Polit & Beck, 2004).

Content analysis is a method that could be used both in quantitative and qualitative approaches. Initially, content analysis dealt with systematic,
objective, and quantitative descriptions of the manifest content in different sorts of communication. Gradually it has been developed and today it is also used to include interpretations of latent content. The manifest content is answering the question *what*? and the latent content is answering the question *how*? Qualitative content analysis is often used in nursing and educational research (Graneheim & Lundman, 2004).

In this study the nine recorded interviews were transcribed by the first author and read through several times to obtain a sense of the totality, which is important in content analysis. Statements, phrases, or words relating to the same central meaning were joined together into meaning units. The meaning units were condensed, which means they were shortened, still preserving the core. The next step in the analysis was to label the condensed meaning units with a code. The various codes that emerged were compared based on differences and similarities and sorted into four subcategories and two main categories, which formed the manifest content. Finally, the underlying meanings, the latent content of the categories, were formulated into a theme (Graneheim & Lundman, 2004).

To illustrate the content of the subcategories several quotations are reported in the findings (Graneheim & Lundman, 2004). In the findings, the quotations are marked with a number showing which interview they are derived from.

**FINDINGS**

The analysis of the interviews resulted in a summarizing theme: *Having few organized daily activities and poor personal causation prevents changes in adaptation to daily life.* The theme represents the latent content or the underlying meaning of the categories *performance* and *self-image*. It summarizes how the informants describe their daily occupations and adaptation to daily life. The categories are divided into four subcategories *competent to perform*, *incompetent to perform*, *positive self-image*, and *lack of self-image* (see Figure 1).

**Performance**

This category consists of how the informants describe their daily occupations. The description is made both in a positive way with examples of strong interests giving their life meaning, and in a negative way with participants experiencing great challenges in organizing their daily occupations and finding that whether they are feeling well or not has a great impact on the performance. In summary, there are many more examples of incompetence than of competence.
The informants give several examples of activities they find enjoyable and satisfying. These activities give their life meaning and help them feel a sense of competence.

"I take care of dogs, dogs with a lot of problems, I foster them and try to find new homes for them..." (6)

There are examples of the informants describing themselves as competent in terms of different interests.

"I think I am rather good at furnishing, cooking..." (3)  
"I am fairly good at writing..." (2)

There are several examples of informants preferring different patterns of leisure activities such as creative interests, athletic interests, and socialization.

"I sometimes work out, I take singing lessons..." (7)  
"I enjoy athletics...see friends...go to the library and borrow books and read..." (5)

In the interviews you can see examples of how the informants use different forms of activities to help make changes in their lives. The changing actions that are described are of both concrete and abstract character. There are examples of how they try to handle their lives in another way and to practice new skills.

"I have understood that it is possible to get help from other people. Before, I didn’t think that way." (9)
I try to handle my life and accept it the way it has been, not just go over it again and again, just accept it in a way…” (8)

**INCOMPETENT TO PERFORM**

This section contains a great deal of information. All of the informants describe a life with very poor organization of daily activities. It includes all sorts of daily occupations such as self-care, productivity, and leisure.

“It has been a big effort to do things I know are good for me in order to have normal routines.” (5)

“…to do my daily routines is the hardest and it means to get up in the morning, eat, shop, do the laundry, and take a shower. Everything has been hard for me.” (4)

The capability changes and the way the informants feel has a great impact on performing daily life activities.

“What I do depends on how I feel.” (6)

“Sometimes it is really easy and sometimes I can’t manage it at all. Those days my home will be a ruin, dishes all over the place, dust bunnies all over the place, I will not give a shit about it.” (2)

The informants give examples of how they fail to change their situation. One example is making plans and not being able to follow through with them. Sometimes the plans are too detailed to be able to follow. The consequences of not being able to realize the plans can be disastrous.

“I make a lot of plans but I’m not able to follow them…” (1)

“I do try to plan a lot; sometimes I almost do it in a manic way. But unfortunately I always fail to follow what I have written down and the result of this is a doubling of anxiety.” (4)

**Self-Image**

Self-image is described both in a positive and a negative way. The interviews give examples of how the informants struggle for change and even expect some success in this struggle. Generally there are more frequent examples of lack of confidence. The experiences of not fulfilling demands from the environment as well as from themselves are described as a heavy burden. There are also several examples of informants not thinking they will be able to make changes. The fear of failure prevents goal setting and efforts to change their lives.
POSITIVE SELF-IMAGE

The informants struggle to manage their lives and to make changes. Besides giving examples of how they accomplish different kinds of activities they describe some examples of how good self-confidence helps them in changing their life circumstances.

“I think I will find a solution. I just have to find some kind of stability in life.” (4)
“I do fight to change... I do think I will be able to find out something.” (5)

Self-Image Problems

As with performance there are more examples of self-image problems when analyzing the picture of self-image in the interviews. There are obvious examples of difficulties fulfilling their inherent demands. They describe a life with many obligations.

“...I do think life is full of duties...” (1)
“I’m not as tolerant as I think I should be.” (6)
“I can’t accept that I don’t feel well and that this is the only thing I can do.” (5)

They describe shame and are displeased with the way they try to manage their daily lives.

“Displeased, I’m really displeased.” (3)
“I do feel ashamed the way I do it.” (9)
“It’s easy to think that you are a failure.” (9)

To have good relations is very important. All of the informants value this as the most important factor in life. But they also describe relations as some of the most difficult things in life to handle. For some, the result of this is to withdraw and for some it results in many conflicts.

“Relations are some of the most important things in life but sometimes some of the most difficult things.” (5)
“I do want more contact with people but I don’t dare to make contact.” (7)
“It turns into different sorts of conflicts, troubles. Relations are some of the things that are difficult in life.” (8)

To be validated in relationships means a lot for self-confidence. It is very difficult when you don’t meet what you think are other people’s expectations.

“I’m really bothered by what other people think of me. I do care about other people’s opinion of me, so of course I really get influenced by my environment.” (4)
“What really bothers me is what my sister expects me to do...I think she makes me feel ashamed.” (5)

Notable in the analysis is the lack of description of a locus of control. Examples of how to make changes in life are rather few. The interviews are more filled with examples of not believing in change.

“I often think everything is without meaning.” (5)
“...my future is rather pessimistic...” (4)
“I think I will be left in this mess.” (6)

There are also examples of difficulties in goal setting. The way to handle life is to just take the day as it comes, without planning.

“It is difficult to plan for the future and it is difficult to set goals.” (8)
“...I think I have just been floating along with the stream.” (2)

One reason for this could be fear of failure. The informants give examples of how they have been unsuccessful in reaching goals. There are also examples of not having an alternative when understanding the impossibility of reaching their goal of being perfect.

“I think it's difficult for me to set goals because I'm scared it will not turn out the way I wish.” (8)
“I have failed so many times, so I don't want so say anything (about goal-setting).” (9)
“...I thought that you have to be perfect and now when I understand it's impossible I can't make an effort.” (9)

DISCUSSION

This study stresses that people suffering from BPD have great problems in organizing their daily occupations and adaptation to daily life. A primary goal of occupational therapy is to enable clients to participate in activities of everyday life (CAOT, 2002; FSA, 2005; Kielhofner, 2008). In view of this statement and the fact that there are many people diagnosed with BPD in psychiatric care, there is a great challenge for occupational therapists to meet the needs of these clients.

In this study the word adaptation refers to how the individual fits the demands of the environment (Christiansen & Townsend, 2004). The word adaptation can be used by occupational therapists in a broader sense. According to Kielhofner (2008) the use of the word adaptation has changed among occupational therapists. It has been used to describe the extent to
which a person is able to develop, change in response to challenges, or
achieve a state of well-being through what he or she does. Kielhofner pro-
poses that occupational adaptation has two distinct and interrelated ele-
ments—occupational identity and occupational competence. He stresses
the importance of the specific context in which the occupation takes place.
The context gives opportunities and support, as well as imposing constraints
and demands on occupation, and it has a great impact on the adaptation
(Kielhofner, 2008).

The reason for choosing interviewing as a method in this study was
because it was judged to be the most useful method to avoid the risk of drop-
outs. Experiences from the ongoing DBT therapy program showed that the
clients had problems recording their targeted behaviors on their diary cards.
Interviews carried out on one occasion were judged as less demanding to the
participants and reduced the risk of dropouts. On the basis of that, other
methods such as self-reporting methods, for example, using activity
schedules, were not chosen.

OCAIRS-S is an instrument that gathers information about the client’s
own view of his/her daily life. The client’s own ideas, needs, and desires
should guide the occupational therapist. The occupational therapist must
try to understand the client’s perspective of health and occupation. The
client’s own view of his or her situation is a prerequisite for change (FSA,
2005). Although the information gathered from OCAIRS-S interviews covers
a wider area than the specific intent of the study, it was judged to be a proper
instrument for this study as all of the information is useful when analyzing
obstacles to and supports for daily occupations.

Scientific rigor in qualitative approaches is built on descriptions of how
trustworthy the findings are in addressing validity and reliability. The parti-
cipants who took part in the study had the opportunity to accept the request
on their own; therefore, participation was directly related to the clients’ will-
ingness to attend the interviews. All the participants completed the inter-
views, and that may be a sign of interest in the study. They appreciated
the opportunity to be listened to and to tell their story.

Another aspect of trustworthiness is the role and impact of the inter-
viewer. A meeting between two individuals can never be totally objective.
The human being is a subject, and she is able to communicate and reflect
when meeting another human being. Both parties enter the meeting with
their own history and their own pre-understanding. In qualitative research
this can be used as an advantage, not an obstacle (Starrin & Svensson,
1998). The fact that the interviewer who also is the first author was familiar
with the OCAIRS-S gave her the opportunity to adapt the questions and make
the interview more probing. Being part of a DBT team led her to be well pre-
pared to discuss the problems this group of clients suffers in their daily lives.

The process of logically probing findings, and rethinking and reconsi-
dering the data, verified that the findings emerge from the interview data.
All the interviews were conducted by the first author and were then tape recorded and transcribed verbatim by the interviewer. The interviews were read by the first author, who also organized and developed the codes, categories, and themes. Discussion and evaluation with others highlighted the importance of being aware of the theoretical outlook and personal experiences in order to avoid conceptual blindness. To increase the trustworthiness in the analysis, the tentative categories were discussed by two peers and revised. A process of reflection and discussion resulted in agreement about how to sort the codes.

The issue of conformability and the scrutinizing of the transcript coding, categorization, and themes were dealt with by the co-authors to validate the fact that the findings had been truthfully extracted from the data.

One limitation of this study is that the sample size was small. Because of this, it is not possible to generalize the result. Instead, the result is reported as a description of individual experiences, which is of great value when answering the question how?, as well as the question what? This is of importance when trying to understand human nature and life circumstances (Starrin & Svensson, 1998).

There are some other ongoing studies, on the participants of this study, and because of that they are well diagnosed. As a result of this it has been easier to ensure that the participants in the study have fulfilled the criteria of the study, that they had been diagnosed with BPD, and had been included in a DBT program. These are factors that increase the credibility of the study.

The aim of this study was to examine how women with BPD described their daily occupations and adaptation to daily life. The participants in the study had been in the DBT program for different periods. Five of the participants had committed to the DBT program within 12–15 months and four within one month. When examining the results of the interviews on the basis of how long participants had been in the DBT program, no differences could be seen. This study did not indicate any difference in how clients described their daily occupations and adaptation to daily life within one month after committing to the DBT program or after 12 months in the DBT program. There could be many reasons for this. One reason is, of course, the fact that there were few participants. Another reason could be that OCAIRS-S is not a proper instrument for identifying changes that occur in the first stage of DBT. The primary treatment goal in DBT is to decrease self-harming behavior. This first stage lasts for at least one year (Linehan, 1993). This was confirmed when studying the participants who had been in the program 12–15 months. In their case records a decrease in self-harming behavior and days as in-patients are noted. During the first month after entering the program, an average of four occasions of self-harm were reported per client, and 12 months after entrance no self-harming occasions were reported. The number of days as an inpatient
During the first 6 months after entrance, days as inpatients were on average 23, and from 6 to 12 months after entrance, 4 days, on average, as inpatients were reported. These behavior changes that were seen in the case records were not obvious in the OCAIRS interviews. In the OCAIRS-S interviews there were no questions about self-harming behavior. It is important to understand the different purposes of different kinds of information gathering, and the purpose of an OCAIRS interview is to gather, analyze, and report data on the extent and nature of a person's occupational adaptation (Haglund & Henriksson, 2001).

In occupational therapy it is emphasized that changes occur only when a client accomplishes her own change. What clients do and how they think and feel about what they are doing, motivates change (Kielhofner, 2002). According to Wilcock (1999), the being and the doing is involved in the change and the becoming. Considering this, lack of self-efficacy and personal causation are great obstacles to the process of change. The interviews gave us examples of how the informants have experienced many failures in their lives. They have problems in goal setting and express a pessimistic view of the future. This is something that differentiates this group from other young people today. A recently published study about attitudes and values of youth in Sweden shows that 80% of Swedish young people from the age of 16–29 have an optimistic view of the future (Ungdomsstyrelsen, 2007).

There are also examples of how the informants are content with their abilities. They describe different interests and performance capacities. A fundamental approach in occupational therapy is client-centred therapy. This means that the occupational therapist must try to develop a conceptual understanding of the client with attention to the client's desires and experiences. Occupational therapy promotes changes through occupational engagement. To be therapeutic, an activity must involve an actual occupational form, and should not be a contrived activity. The activity must have relevance and meaning for the client. To be successful, the activity must enable the client to feel competent and to be satisfied by doing what matters to her. It is important to focus on interventions that allow for success and to support the client to find goals that are possible to reach. This study shows that these clients have different interests and describe a feeling of capability when engaging in some of these interests. In other words it is possible to find activities that are therapeutic to the clients (CAOT, 2002; Kielhofner, 2002; Levin, Kielhofner, Braveman, & Fogg, 2007).

In the interviews, there are examples of how lack of self-confidence influences motor, process, communication, and interaction skills. There are also examples of how the feelings of not meeting what you think are other people's expectations influences skills. In interview number five, for example, the informant is filled with shame when this happens. According to the dictionary, shame is an uncomfortable feeling that arises
when you have done something wrong or embarrassing (Sinclaire, 2006). Nathanson constructed the compass of shame, described by Elison, Pulos, & Lennon (2006). It is a conceptual model of four different coping styles: attack, withdrawal, attack others, and avoidance. There are examples of all these different styles in the interviews. Knowledge about these different coping styles is important for occupational therapists when meeting persons suffering from BPD and when trying to understand their behavior and needs. There is a need for further study in order to build up knowledge about how shame influences skills and the possibility of making changes in life.

The informants value human relations as one of the most important factors in life. This is something that is common among the youth of today. A study of attitudes and values of Swedish youth shows that a majority consider family and friends as the most valuable thing in life (Ungdomsstyrelsen, 2007). What differs in this study is that the informants describe great problems in relationship skills. The informants give examples of how their problems affect family relations and relations with friends, workmates, and fellow alumni.

Many daily occupations have an obvious connection to different kinds of social relations. To be a part of a social environment and be able to handle social relations in a proper way has a great impact on self-image. For example, the theory of symbolic interactionism developed by G. H. Mead (Hwang, Lundberg, Rönberg, & Smedler, 2005), considers the mind and self of the human being to emerge out of the social process. It is one of many theories in psychology and social psychology that stresses the importance of being able to master social relations.

It is well known that persons suffering from BPD have communication and interaction skill problems. The problems arise especially when performing different kinds of social skills. Therefore, one of the elements of skills training in DBT is Interpersonal Effectiveness Skills (Linehan, 1993). Group therapy has a long tradition as a therapeutic tool in occupational therapy. Occupational therapy groups provide the client with an opportunity to test and use new skills. The client’s doing and interaction in the group facilitates a process of occupational adaptation through which she is enabled to more effectively participate in the environments that surround occupational life (Howe & Schwartzberg, 2001; Mosey, 1986).

The OCAIRS-S was chosen as a tool to gather information about how clients with BPD describe their daily occupations and adaptation to daily life. Every interview however, has also been rated according to the OCAIRS-S rating scale. When comparing the scores with a study by Haglund (1997) the profiles of the scores in this study are very similar to the profile of the scores from OCAIRS-S interviews made with clients suffering from bipolar disorder. The profile differs greatly from the profile of clients suffering from major depression and differs slightly from that of clients suffering from
schizophrenia. As with clients with bipolar disorder, clients in this study scored low on the items habits, output, and life history patterns. Today there is an ongoing discussion about whether BPD is a valid diagnosis, or if BPD should be considered a variant of affective disorders. Clinically it can be difficult to diagnose clients who present both impulsivity and affective instability (Magill, 2004; Gunderson, 2006). This study shows that clients with BPD are low functioning in terms of daily occupations and that their performance limitations are quite similar to those seen among clients suffering from bipolar disorder. The study does not take a position on the issue of whether BPD is a valid diagnosis or a variant of affective disorders. As occupational therapists we want to add another aspect to the discussion from an occupational performance perspective.

Scientific studies have shown support for DBT as a valuable treatment for BPD patients (SBU, 2005). As a consequence of that, it is important to appraise the usefulness of the DBT model in occupational therapy. Is DBT however, consistent with the occupational therapy paradigm? In current occupational literature, we can find great support for the idea that occupational therapy is a scientific field of its own and that theorists, researchers, and practitioners should work together to generate knowledge about what could or should be done in practice. The conceptual foundations of occupational therapy can be seen in three different types of knowledge; the paradigm that defines the nature and purpose of the field, conceptual practice models, which provide a rationale for and guide practice, and related knowledge, which supplements unique knowledge of the field. This means that occupational therapists, in addition to their own unique knowledge, need additional knowledge from other scientific disciplines such as medical science, psychology, sociology, philosophy, and anthropology (Creek, 2002; Kielhofner, 2004; Stein & Cutler, 2002).

The main goal of DBT is to help the client to increase mindfulness and dialectical behavior, and to live a life worth living (Linehan, 1993). This goal accords well with the overall goal in occupational therapy to enable clients to participate in activities of everyday life (CAOT, 2002; FSA, 2005; Kielhofner, 2008). According to Cole (2005), DBT can be seen as a method that occupational therapists have the qualifications to learn and work with. We want to argue that DBT can be helpful to occupational therapists by providing a conceptual model for understanding occupational problems connected with BPD and it can also be helpful when developing rationales to guide practice. One example is the common problem of dichotomous thinking among BPD clients. In the interviews in this study it is possible to find examples of how this kind of thinking results in occupation problems. One of these is when an informant describes how she makes up detailed schedules (“I almost do it in a manic way”) even though she does not manage to follow them in her daily activities. Another example is when an informant speaks about cleaning up her apartment and thinks she has to do it in such an ambitious way,
and the result of this is that she is not able to initiate the activity. When the client has a tendency towards dichotomous thinking combined with apparent competence it is easy to misjudge the client’s ability to realize her plans. It is important to be aware of the different kinds of cognitive styles common among clients with BPD in order to be able to support them effectively. As the example above shows, the use of activity schedules must take into consideration the specific cognitive style of dichotomous thinking when proposed as part of a treatment plan.

The concept of mindfulness is an essential part of DBT derived from the Buddhist tradition (Linehan, 1993). It can be described as a method of being awake and fully aware. To perform an activity in a mindful way means to perform it with full awareness. To be in a state of mindfulness also means to be present in the actual moment. The skills training in DBT offers practical exercises as a means of learning the mindfulness skills (Linehan, 1993). Several scientific studies show that mindfulness is an effective method of handling physical or psychological pain and of reducing negative effects of stress (Ekelund & Kihl, 2006; Asberg, Sköld, Wahlberg, & Nygren, 2006). The concept of mindfulness has similarities with the way Wilcock (1999) looks upon occupation, especially the concepts of being and doing. The experiences of using mindfulness skills in DBT and support from scientific studies may be helpful to occupational therapists in the ongoing work of developing the concept of occupation.

SUMMARY

This study provides important information about clients suffering from BPD and their daily occupations. It gives a clear view of their great problems in organizing and adapting their daily lives. It indicates that OCAIRS-S is a useful tool for gathering information about daily life and that MOHO provides valuable knowledge to occupational therapists on how to support these clients effectively. This knowledge could be very useful in the teamwork around the client. It is also obvious that knowledge of DBT could support occupational therapists in further developing their understanding of these clients’ occupational problems and developing their treatment methodology. There is still a need for further studies to improve knowledge about occupational problems among clients suffering from BPD, as well as the possible effects of DBT on daily occupations.

REFERENCES


Clark, E. L., Ball, A., & Maltby, S. (2006). How a successful course developing community living skills was designed, facilitated, and evaluated with female clients, the majority of whom have been diagnosed with borderline personality disorder and previously described as difficult to engage. Occupational Therapy in Mental Health, 11(1), 31–34.


_Occupational circumstance assessment interview and rating scale, Swedish version 4.0._ Linköping, SE: Department of Neuroscience and Locomotion, Division of Psychiatry, Faculty of Health Science, Linköping University.


_A functional approach to group work in occupational therapy._ Baltimore: Lippincott Williams & Wilkins.

The body as phenomenon—A qualitative study of how young women with the diagnosis Borderline Personality Disorder relate to and experience their body. Linköping, SE: Department of Neuroscience and Locomotion, Division of Psychiatry, Faculty of Health Science, Linköping University.


_Cognitive behavioural treatment of Borderline Personality Disorder._ New York: Guilford Press.

_The Canadian Journal of Psychiatry, 49_(8), 551–556.

_Toward a psychology of being_ (3rd ed.). New York: John Wiley & Sons.


_Pyschosocial components in occupational therapy._ New York: Raven Press.

_Nursing research: Principles and methods_ (7th ed.). Philadelphia: Lippincott Williams & Wilkins.


_Kvalitativ metod och vetenskapsteori._ (Qualitative Methods and Theory). Lund, SE: Studentlitteratur.


