Original Article

Self-Reflective Practice, Autoethnography, Storytelling, and Critical Incident Analysis in Exploratory Nursing and Midwifery Research: Facing Social Illnesses and Borderline Personality Disorder

Carlo Lazzari[1], Elda Nikolou-Walker[2], Liang Liu[2]

[1]Department of Psychiatry, International Centre for Healthcare and Medical Education (ICHME), London, [2]Department of Health, Social Care and Education, Middlesex University, London, UK

Abstract

Background: Hospitals are experiencing a surge in social admissions, saturating beds required for more severe pathologies. Nurses, midwives, and other health care workers can explore this issue by using self-reflective practice to research this phenomenon in depth. This study presents primary qualitative research methods in nursing and midwifery to explore novel hospital presentations. **Materials and Methods:** The study was conducted from February 2023 to January 2024. We describe the theoretical and practical applications of qualitative inquiry, including Kolb's self-reflective practice, storytelling, autoethnography, and critical incident analysis, to improve research practice in nursing and generate practice-based evidence and strategies for policy. **Results:** We crafted and analyzed four prototypical vignettes of people who typically present with social illnesses, epitomized by borderline personality disorder and its impact. By merging patient stories with nurses' autoethnographies, we can expand insider views and research tools in qualitative research. **Conclusions:** Qualitative exploratory analysis provided robust and convincing accounts of how nurses and midwives can face and relate to problematic situations in health care. Nurses can use both patients' narratives and their own to extract salient points and guidance for understanding, theorizing, changing, and policymaking.

Keywords: *Borderline personality disorder, critical incident techniques, hermeneutics, narration, nursing, qualitative research*

Introduction

People without severe mental or physical disorders but who are homeless, jobless, lonely, refugees, substance abusers, undergoing life crises, or living difficult social and familial situations frequently have social illnesses (SIs); people with borderline personality disorder (BPD) are usually over-represented among them.[1] When social alienation causes depression, meaninglessness, normlessness, loneliness, and loss of touch with reality, hospitals may help.[2,3] Pandemic loneliness and social isolation may raise mortality risk by 60%,[4] with England seeing an 11% rise since 2022.[5] Severe impairments, high suicide risk, unfavorable consequences on mood, significant social expenses, and protracted treatment characterize BPD.[6] BPD is typically found in emergency departments following suicide attempts or threats and is responsible for 500,000 visits per year in the USA.[6,7] About 1.6%–1.7% of the general population has BPD, which accounts for a large number of public health facility patients seeking social admissions into hospitals or frequently requesting appointments in health facilities.[1,7–10] International regulatory nursing organizations are increasingly requesting that nurses and midwives extract elements from their clinical practice for self-reflection and use clinical cases and critical incidents as a trigger for reflection, research, and remedial action.[11,12] Applying reflective practice and critical incident analysis allows nurses to reinforce their achievements, create middle-range theories, and make recommendations for policymaking.[12]

Nursing and midwifery research can help improve the assessment and treatment of health conditions and develop insights into social problems in general.[11,12] Nursing research is a method of science that produces new understanding and

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Address for correspondence:
Carlo Lazzari, International Centre for Healthcare and Medical Education' (ICHME), K1 Kent's Hill, Timbold Drive, Milton Keynes, MK7 6BZ, United Kingdom. E-mail: carlolazzari2015@gmail.com

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validates existing information that affects nursing practice both personally and indirectly.[11,12] The goals of nursing research include explaining, controlling, forecasting, and predicting phenomena in practice.[12] The methodical blending of the finest available research data with clinical knowledge, patient insights, and safety considerations to provide high-quality care is known as evidence-based practice.[12] Qualitative research in nursing, as in this study, aims to answer questions about the living practices, values, drives, activities, and opinions of patients and staff.[13] Therefore, qualitative inquiry seeks to understand and interpret personal experiences and social settings where nurses and midwives operate.[13] Furthermore, nurses and midwives can grasp reality through qualitative research via an insider or 'emic' perspective.[13] This study aims to provide instruments to attend fundamental nursing research inquiries addressing 1) ontology questions in order to understand the configuration and characteristics of reality in the setting and population described and what can be known about them, 2) epistemological questions to extract the nature of the relationship between the knower (nurses and other health care professionals) and the object of study and what can be known, and 3) methodological questions to answer issues on how the enquirer can discover the truth in the object of interest.[14]

The research questions addressed in the current study were the following:

How can nurses, midwives, and other healthcare workers explore critical incidents and improve their clinical practice by using autoethnography and self-reflective practice to understand SIs, BPD, and other issues of interest?

What emerging middle-range theories for population health can be extracted by exploratory nursing research on BPD and SI?

Materials and Methods

The current qualitative ethnographic study adopted a grounded theory approach to extract salient theories from the scenarios analyzed. In line with an interpretive approach, the ontology was that individuals, nurses, and midwives involved in the scenarios constructed their reality. The epistemology of the study was that reality needed to be interpreted through an emic or inside perspective. In line with ethnographic research, the aim was to study people in their natural environment through exploratory research. Although we used prototypical vignettes for confidentiality, we applied theoretical sampling and selected stories, which helped us craft insights and theories using a grounded theory approach. With thick descriptions of cases and in-depth analysis, we aimed to the transferability of our findings. Credibility was reached by familiarity with the settings, reflective commentaries, and multidisciplinary debriefing to confirm our hypotheses and conclusions. Dependability was reached by detailing our research methods and data collection and analysis.

The current study took place from February 2023 to January 2024 in several public hospitals in the UK. The authors are clinical practitioners, health care workers, and academics who study the social effects of BPD in society. From BPD patients visiting accident and emergency departments (A and E), we created fictitious narratives incorporating individual patient stories to enhance healthcare research and policy while maintaining confidentiality. The study used an inductive method to identify SI-BPD connections, using Aristotle's classification of rational knowledge; our interpretive approach focused on causal linkages and on behaviors, beliefs, and desires. Extensive observation and interviewing were crucial for uncovering 'how' and 'why' questions and narrative analysis was also used.[11–18]

Fictitious educational vignettes, often accompanied by verses, pictures, and sounds, are creative, contemplative narratives reflecting human existence; they aid medical and nursing students in understanding patients' perspectives and help protect confidentiality.[19–23] Ethnographic research uses fiction and facts to represent historical events, while constant comparison enhances critical analysis; ethnography can use vignettes and short hypothetical narratives to explore overcoming adversity, team dynamics, moral dilemmas, and knowledge; vignettes simplify understanding and provide valuable data for real-world decision-making.[24–29] The present study used a fictitious vignette approach to improve information quality and minimize ethical concerns, while first-person narratives provided insight into social context and disability factors from service users' perspectives; narratives are a hermeneutic research method for understanding reality.[30–35]

Autoethnographers use narrative analysis to investigate cultural practices, reflecting on experiences and events. They use grounded theory and constant comparative techniques to detect commonalities and examine critical incidents in nurse settings.[24,36–38] Critical incident analysis (CrInAn) is a health care method used to analyze and interpret situations, considering remedial actions; it focuses on the impact of a crisis on personal experiences, highlighting emotional distress and potentially unfavorable outcomes.[39–43] Kolb's self-reflective practice in nursing enables the creation of middle-range theories (MRTs) based on critical incidents to enhance knowledge by linking theoretical and empirical information.[44–46]

A unitary reflective model was created using Kolb's reflective cycle to analyze our data and narratives.

Kolb's model's first stage of concrete experience highlighted our central concerns, namely patient narratives and critical incidents.[47,48]

The second stage of self-reflective practice included Kolb's reflective observation, which entailed thinking about the experience[47,48] and autoethnography of nurses' coping

strategies reflecting how the critical incidents impacted nurses' work and feelings.

The third stage included abstract conceptualization, which was about learning from experience, understanding its meaning, and creating MRTs.[47,48] This was the stage where we utilized theory creation.

The fourth stage, active experimentation, implemented our conjectured theory,[47,48] resulting in policies that address observable phenomena and societal disorders.

Self-reflection was promoted via reflectivity and reflexivity. Reflexivity involves continuous self-criticism and self-appraisal in research, assessing inner feelings, emotions, and motives. It helps create methodological rigor for reliable qualitative study outcomes by understanding how researchers' values and views influence study outcomes.[49–52] The reflective observations in the current research endorse nurses' and midwives' reflexivity. Eidetic phenomenology emphasizes reflectivity, focusing on consciousness to understand lived experiences.[53,54] Dewey suggested that reflectivity is a dialogical activity that fosters shared learning environments; it entails retrospectively examining past actions to obtain essential insights to inform future events.[53,54]

Autoethnographers may claim their experiences are their own, yet they may implicate friends, coworkers, neighbors, relatives, customers, and community members.[55] This study employed composite characters to protect participant identities by condensing many narratives into one or by fictionalizing a portion of a tale to mask the researcher's time, place, and distance from an event.[55] We combined comparable tales and vignettes based on primary storylines from memory.[56] Since fictitious vignettes were based on the storyteller's imagination, participants may have suffered only indirect damage. Data interpretation ethics are founded on researchers' subjective biases in data analysis, who may want particular results and favor certain interpretations.[57] When a participant's autonomy is ignored, two types of ethical conflicts arise: (1) the first and most common involves vulnerable people like children, adolescents, wards, people who are deprived of their freedom, or people with severe physical or mental health issues, and (2) people in lesser power situations, such as subaltern positions, or patients whose physicians are also their researchers.[58] The research basis, policy, and practice translation are affected by conscious and unconscious biases in data processing and interpretation of what we see, say, and hear.[59]

Ethical considerations

The procedures followed were per the ethical standards of regional organizations and the Helsinki Declaration of 1975, as revised in 2000.[60] The NHS Health Research Authority (https://www.hra.nhs.uk/) UK cleared our application (UK/MedEd/CL/23/SocIs) from any restrictions, as we used fictitious vignettes and not direct accounts from real people. The NHS Health Research Authority did not require ethical approval because the study (1) excluded people identified through their use of health services and adult social care services, including healthy controls, (2) did not prospectively gather data from health organizations and adult social care users, and (3) did not use previously collected data that could identify past or present users (https://www.hra.nhs.uk/).[61] The current study also had the approval by the local ethical committee because it used fictitious stories for educational purposes and not primary data from patients.

Results

Our Concrete Experience or Critical Incident No. 1 relates to a 37-year-old male with a dual diagnosis of substance misuse and BPD disorder who is trying to get hospital admission to access a safe bed (fictitious story). He attempted to assault a member of our staff when we communicated that he did not need hospital entry. He told us the following:

> I live in a park tent. I drink beer for sleeplessness. When I can't afford beer, I become scared and go to A and E. Like my friends, I mix alcohol, legal highs, and cannabis. I prefer hospital admission when it is too cold outside. I go to A and E when I can't afford beer or vodka or when I'm detoxing. I drink to forget. When old memories overpower me, I self-harm.

Our reflective observation suggests that homeless drug and alcohol abusers are increasingly presenting with false neurological and mental symptoms, complicating hospital or A and E release. Healthcare workers struggle to help relapsed and readmitted patients. We often argue with these persons because they may be antisocial, threatening, and dangerous to other patients and staff. Through our abstract conceptualization and MRT, we postulate that complex SIs require interdisciplinary collaboration. Still, patients may resort to opportunistic behaviors when limited social resources and health care are scarce, and population requirements exceed the health care supply. Our active experimentation to tackle this problem occurred through an interdisciplinary nursing evaluation, shared care plans, electronic patient records, and an ISBAR-structured handover (introduction, situation, background, assessment, and recommendation), which aid in managing difficult situations, expediting assessments, and facilitating discharges for patients with SI from A and E [Figure 1].

Our Concrete Experience or Critical Incident No. 2 relates to a 23-year-old woman with BPD and suicidal ideation who seeks hospital admission to deal with an overdose of prescribed medication (fictitious story). She complained to hospital managers as we did not admit her to a psychiatric hospital. She reported:

> I've been sexually and psychologically abused my whole life, also in my family. At age 15, I ran away

Figure 1: Homeless people might seek hospital admission for warmth and comfort due to concerns about food, shelter, and alcohol (Photo: CL)

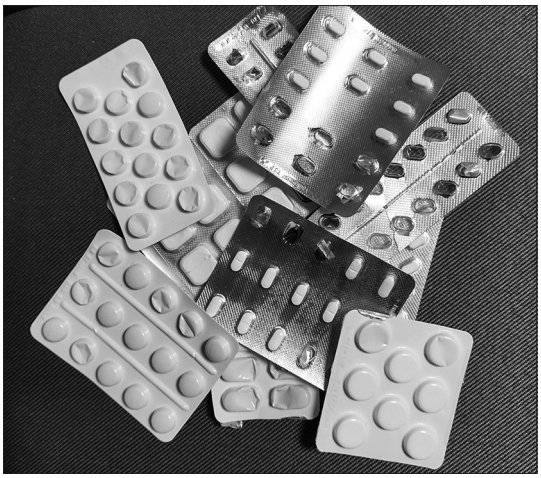

Figure 2: Attempted suicide by overdose is one of the most frequent presentations of BPD in A and E also due to easy access to medication (e.g. paracetamol) in any shop. Some patients can reiterate this behavior several times and re-refer to A and E quickly (Photo: CL)

> from home and slept rough. I eat and live near trashcans. Drugs help me forget and reduce flashbacks. I often overdose on paracetamol due to depression and want to die. Yesterday, after calling an ambulance, I went to A and E for an overdose of paracetamol and antidepressants. A hospital makes me feel secure. If you discharge me, I'll jump off a bridge.

Our reflective observation suggests that managing suicidal individuals' discharge is stressful for nurses and other health care practitioners, posing risks of professional inquiry, court appearance, job loss, emotional conflicts, and disciplinary actions. Therefore, our abstract conceptualization and MRT postulate that young people with BPD often ruminate (have constant intrusive dark thoughts) about their feelings of depression, tormented by reminiscences of their upbringing, childhood violence, and disrupted attachment. Social paranoia leads to community isolation, social phobia, agoraphobia, and fear of criticism. On the other hand, positive early attachments, supportive networks, jobs, and structured lives can instead prevent suicide and improve health. Aiming to promote a change, our active experimentation is meant to use low doses of antidepressants, mood stabilizers, reassurance, and community referrals to help resolve crises, particularly for young female BPD sufferers. In A and E, we aim for a reassessment in 24 hours, which might allow a crisis to dissolve [Figure 2].

Our Concrete Experience or Critical Incident No. 3 relates to a 34-year-old woman with BPD who is seeking hospital admission to access anxiolytics (fictitious story). She came several times in a row the day after she was discharged. However, she once assaulted a member of staff when intoxicated. She reported:

> I cannot live. My mind is ruined. I came to A and E to assist myself since my doctor won't give me diazepam. I am bipolar. I have fits. I never sleep. I hear voices instructing me to harm myself or others. Because I was nasty to a nurse who wasn't listening, the police handcuffed me. I'm usually worried and sad. I have PTSD [post-traumatic stress disorder], memories, racing thoughts, and insomnia. Two days ago, you sent me home without giving me my sleeping tablets. If you do the same, I'll complain since I suffer from insomnia and am in agony; trust me when I say I'm sick. [Figure 3]

Our reflective observation suggests that the number of benzodiazepine abusers has increased in our clinic, frequently presenting dramatic and factitious accounts of anxiety and suicide ideation. Health care workers are frustrated by the inability to set limits and satisfy patients' demands for restricted medication. We also become exasperated and burned out with their impatience and frequent A and E visits ('revolving door behavior'). Through our abstract conceptualization and MRT, we postulate a higher number of hospital visits due to restricted medication availability, with more women than males joining this number. Anti-anxiety and sleep medicines from different hospital assessments or family physicians might be accrued with multiple prescriptions by claiming undocumented anxiety and insomnia to other health care units. Antisocial BPD women may smuggle banned drugs for money or share them with acquaintances. To promote a change in nursing practice, our active experimentation occurs by understanding that drug abusers rely on medicine and medicalizing their pain, making it difficult for nurses and other practitioners to give community help. Nurses struggle to aid them due to their disagreements with health care providers. Our LRRP method includes listening to the patient, reflecting, reassuring, and planning for discharge. Offering alternatives or community links helps reduce A and E strain [Figure 3].

Our Concrete Experience or Critical Incident No. 4 relates to a 52-year-old woman with BPD and social anxiety who is seeking hospital admission to evade solitude and

Figure 3: A woman was allegedly smuggling restricted medications from a psychiatric service in a public park, causing a public outcry and a report to the police (Photo: CL)

neighbor abuse (fictitious story). She refused to leave the hospital and A and E after medical clearance and returned the following day. She commented:

> Night and day, my neighbor is loud. Throwing glasses on my balcony disrupts my sleep. Night-time door-pounding wakes me. Hearing their sex sounds all day is annoying. Violent noises evoke memories of my past abuse. She and her boyfriend are violent drug users; therefore, I'm scared. I hear them screaming and fighting. I reported it to the police, but nothing occurred. Because young people in the park assault lonely people, I avoid it certain hours. My antidepressants failed. Sometimes I ruminate and think that my problems are insoluble, so I took an overdose of paracetamol.

Our reflective observation is that mental health in SI is a multifaceted issue that requires nursing and other health care professionals' relaxed approach to addressing complex patients. However, despite our efforts to provide support, we often face restricted resources and the feeling of hopelessness that comes from witnessing human tragedies as impotent carers with limited social assets. Therefore, through our abstract conceptualization and MRT, we postulate that a biopsychosocial model can help highlight the importance of supportive social networks and companionship in preventing adverse social and mental health outcomes, such as vulnerability to violence, violent neighbors, homelessness, social phobia, anxiety, isolation, and sedentary lifestyles. Consequently, through our active experimentation, we encourage supportive networks, facilities, and telemedicine to be implemented to address the mental health needs of those who cannot attend hospitals in person, including addressing domestic violence victims' needs. Progressive exposure programs (health carers accompanying service users with social phobia during their outdoor activities), community mental health teams, and doctor-assisted physical assessments are also being implemented to support service users struggling with housing, reinforce community links, and help those unable to come to community health facilities.

Our Concrete Experience or Critical Incident No. 5 Refers to young women of 25 years with a diagnosis of BPD and on multi-antidepressant therapy who still feels she is unable to control her emotions and mood swings:

> I am on the maximum dose of two antidepressants, and I'm still feeling depressed. My thoughts keep racing, and I have mood swings. I dissociate and ruminate about my past trauma. I keep self-harming and am unable to stop. I have already taken an overdose in the past, and I believe that the current medication is not helping me. I live how I can; I spend most of my time at home, as I'm paranoid around people. After the psychotherapy I still feel the same.

Our reflective observation was that as nurses and health care professionals, we are often blamed by patients that the medication we offer does not help them 'feel happy,' and we start feeling we are missing our goals. The biopsychosocial model is not clear to many patients with chronic depression who rely entirely on medication to improve their well-being and lifestyle. Our abstract conceptualization and MRT is that psychotropic medication alone does not help people overcome depression or anxiety, as they also self-isolate and cut bridges with society. As the human brain is socially wired, the lack of social interaction impedes people's access to collateral support and an emotional buffer, which is hindered by social isolation and rumination (constant intrusive thoughts). Mental health deteriorates in the current trend of agoraphobia and lack of social skills, opportunities, and interactions. Through active experimentation, we provide young people with chronic depression and social isolation encounter groups and tertiary services in informal meetings. Through targeted psychosocial interventions, we aim to avoid individuals becoming deskilled in social abilities and entering into irreversible loops of introspective ruminations, pessimistic thoughts, and catastrophizing.

Our Concrete Experience or Critical Incident No. 6 refers to a middle-aged man of 45 years with multiple attendances at emergency departments joining one of our outpatient community appointments; he claimed he suffered from psychosis and heard voices telling him to harm himself and others:

> I am on methylphenidate, diazepam, and pregabalin, but my doctor does not want to give me the medication, and I am now running out of it and starting to have fits. I have plans to kill myself if you discharge me from the hospital as you did one week ago. I cannot sleep at night, and I have a foggy head that I cannot remember what I did yesterday.

At the psychiatric assessment, he reported delusions, paranoias, and hallucinations, which were not congruent with his presentation. It appeared that he was feigning

symptoms for some reason. As he became more agitated, we organized immediate transportation to the emergency department to be assessed by the liaison psychiatric team. He was discharged the same day with no diagnosis of enduring mental illness. From our reflective observations shared in the MDT (multidisciplinary) meeting, we felt that he was seeking a social admission to escape from a police charge of affray. Yet, we felt the tension of doing something immediately for people who appear desperate and unwell. Our abstract conceptualization and MRT is that more and more men suffering from unemployment, social isolation, antisocial behaviors, and living marginalized will seek hospital admission to alleviate the burden of homelessness or self-isolation. Hospitals are now becoming the only social buffer from distress, and having a hospital bed will be a primary goal of a large fringe of the population unable to modulate emotions, despair, and self-segregation. Through active experimentation, we endeavor to promote positive risk-taking in cases like this. Experience, triangulated assessments, and access to electronic notes will often clarify the nature of these presentations and reduce (or increase) the risk alert. To reduce social admissions to hospitals, we provide a list of tertiary service contacts, including walk-in centers for people undergoing life stress. There are organizations helping men in crisis. Suicide presentation requires actions in the community through home visits that we facilitate together with a day-after appointment and pharmacological interventions with three-day prescriptions [Figure 4].

Figure 4: The existence of conflicting health and social models (e.g. encouragement to smoke cannabis, here displayed on a public mural) has generated existential conflicts in the new generation (Photo: CL)

Discussion

Autoethnography enables nurses and other health care professionals to reflect, reflex, and use CrInAn on real-life situations and social phenomena. Patient storytelling may show health care stakeholders new meanings. Storytelling gives value to people, places, and actions.[62] Health system narratives forecast future advancements while being situated in the past.[62] Autoethnography examines nurses' daily routines and patients' tales in order to humanize societal phenomena. Hearing patient/stakeholder stories deepens nurses' and midwives' crises and tragedies. Nurses might explore how patients regard us as service providers from an insider-patient perspective. Additionally, interpretivism and hermeneutics may show how patient narratives alter healthcare practitioner autoethnography and vice versa. Narrator-reader confidentiality is vague in ethical autoethnography and storytelling. Thus, exploratory research may reveal the causes of societal illness and health care professionals' responses by reporting patients' clinical tales without violating confidentiality. Furthermore, stories may disclose hidden social aspects and how people see participative and communal interactions, which quantitative surveys may overlook.[63] Helping patients recount their stories may expose hidden feelings. One study linked self-harm to alexithymia, an emotion processing deficiency that makes it hard for persons to express their emotions, develop a dictionary for feelings, and mostly have externally focused thinking.[64] The findings of our past study indicated that nurses' and doctors' empathic listening might help patients reframe their life stories and apply new meanings to improve their health-related behaviors.[65]

The present study showed how nurses and midwives can use self-reflective practice and qualitative narrative analysis to gain insights and tips on improving their practice and cast work-based MRT from their daily activities, patient narratives, and reflective journaling.[66] Improving nurses' research skills (1) increases their satisfaction with data and narrative extractions, (2) encourages curiosity and originality in extracting meanings and patterns from patient stories and nurses' and midwives' reflections on them, (3) increases critical mindfulness about nurses' and midwives' interpretation of objects/persons/clinical events they are analyzing, and (4) helps nurses and midwives craft reports that are sufficiently influential to attract policymakers.[67]

Our study's primary limitation is linked to qualitative analysis per se, which always carries the drawback of personal interpretations of the world. This only allows the transferability of findings to similar settings and patients. We also did not follow up on whether the strategies adopted to promote change reached their goal. An area of improvement is to endorse more extensive studies on using prototypical vignette narratives and their impact on nursing and midwifery work-based learning.

Conclusion

Nurses and health care providers adopting autoethnography to reflect on patients' storytelling can help untangle deep knowledge of patient's thoughts and behaviors at hospital presentations. Exploratory nursing research integrated with critical incident analysis is a qualitative tool that can extract insights from patient stories to hypothesize nursing MRTs

and propose policies for change based on practice-based evidence. Using robust qualitative research methods can inform practice and generate insights and theoretical healthcare models for better care and quality improvement.

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Conflicts of interest

Nothing to declare.

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