

A Survey of the Knowledge, Experience and Attitudes of Irish Psychiatric Nurses Regarding Clients Diagnosed with Borderline Personality Disorder

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Glossary of Abbreviations

ABA	An Bord Altranais (The Irish Nursing Board)
ADON	Assistant Director of Nursing
A&E	Accident & Emergency
ANP	Advanced Nurse Practitioner
APA	American Psychiatric Association
BPD	Borderline Personality Disorder
CBT	Cognitive Behaviour Therapy
CMHN	Community Mental Health Nurse
CNM	Clinical Nurse Manager
CNS	Clinical Nurse Specialist
CPN	Community Psychiatric Nurse
DBT	Dialectical Behaviour Therapy
DON	Director of Nursing
DoHC	Department of Health and Children
DSH	Deliberate Self-Harm
DSM-IV	Diagnostic and Statistical Manual (4th edition)
ICD-10	International Classification of Diseases (10th edition)
MDT	Multidisciplinary Team
MHO	Midland Health Board
NIMHE	National Institute for Mental Health in England
PD	Personality Disorder
RPN	Registered Psychiatric Nurse
WHO	World Health Organisation

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Abstract

The aim of this research was to gauge the knowledge, experience and attitudes of Irish psychiatric nurses towards clients with a diagnosis of Borderline Personality Disorder. It also hoped to elicit the opinions of these nurses concerning the care and service delivered to these clients and how it might be improved. A quantitative survey was employed, using an adapted version of a previously tested questionnaire. All nurses working in a clinical role (n=157) within one psychiatric service in the Republic of Ireland were posted a copy of the questionnaire, of which 65 were returned yielding a response rate 41.4%. The results indicate that attitudes towards working with clients with Borderline Personality Disorder are positive, but practically all staff perceive them as a difficult client population to work with. Staff knowledge is reasonable but community staff appear to have higher knowledge levels than inpatient staff. The majority of respondents believe that the care currently delivered to these clients is inadequate for a variety of reasons and believe that agreed treatment protocols and the establishment of a specialist service for Borderline Personality Disorder are required in order to provide adequate care. The author discusses the findings and concludes that the health services need to rethink the care they offer to clients with Borderline Personality Disorder if best practice is to be achieved. Also, staff working with these clients require appropriate support, supervision and education.

Chapter 1

Introduction and Significance of the Study

1.1 INTRODUCTION

In this chapter the author will examine the rationale for choosing to research attitudes towards clients diagnosed with Borderline Personality Disorder (BPD). As this diagnosis attracts extensive debate the first section will be devoted to highlighting this debate and providing a definition of BPD. In the background section the author's developing interest in the phenomenon of negative attitudes will be outlined. Then in the section on the significance of the study the researcher will go on to relate the importance of this issue to the development of the psychiatric services and the treatment of clients with a diagnosis of BPD. In this section the aims of the study and the research questions will also be outlined.

The admission of those with a personality disorder (PD) to Irish psychiatric services is considerable, accounting for about 4% of the admissions and accounting for about 3% of inpatient days, (Daly and Walsh 2003a, 2003b, Daly et al. 2004). International research indicates that while an estimated 2% of the population meet the diagnostic criteria for those with BPD, approximately one quarter of these will present with the severest symptoms and be well known to local psychiatric services, (Krawitz and Watson 2003). Although the rate of suicide for those with BPD is similar to that of schizophrenia and bipolar affective disorder, (about 10%) the figure almost quadruples for those who are severely effected, (Krawitz and Watson 2003). The low rates of the disorder reported in the Irish statistics may be linked to the reluctance of

some clinicians to diagnose someone with BPD, (Becker and Lamb, 1994, Becker 2000). Either way, BPD is common and frequently fatal. It is paramount that the psychiatric services be able to meet the needs of these clients and to engage with them in a constructive way. Unfortunately, given the nature of the disorder, (the clinical features include frequent and intense anger, fear of abandonment, unstable relationships and dramatic changes in mood), this is not always easy.

1.2 DEFINITION OF BPD

The diagnosis of BPD is a controversial one within psychiatry. Smith (2000) claims that the diagnosis of PDs in general, is merely an invention of psychiatrists and therefore has no value. This view is endorsed by the UK based mental health charity MIND, who have described the diagnosis of PD as a “dustbin diagnosis” for patients considered different or difficult, (Munro 1999). However, it is important to note that similar arguments have been levelled at other, more accepted mental illnesses, such as schizophrenia, (Breggin 1991, Allen 2000, Johnstone 2000, Lynch 2001). Also psychiatrists frequently disagree on the diagnosis of a patient and the confusion is amplified by the existence of two separate diagnostic criteria, the first of which is the Diagnostic and Statistical Manual for the Mental Disorders (currently in its fourth revised edition - DSM-IV-TR) which is published by the American Psychiatric Association (APA) in 2000. The second is the International Classification of Diseases (currently in its tenth edition - ICD-10) which is published by the World Health Organisation (WHO) in 1989.

The borderline subtype also attracts unique criticism. Becker and Lamb (1994) found that professionals were more likely to attribute a diagnosis of BPD to women than

men when presented with the same case studies where only the sex of the client was changed, which they suggest questions the validity of the diagnosis as its very existence may be the result of sex biases. Simmons (1992) echoes this idea claiming that angry and promiscuous women are likely to be diagnosed with BPD while males exhibiting the same characteristics are more likely to draw a diagnosis of antisocial personality disorder. Becker (2000) has further argued that the current trend to see BPD as a “consequence of character” has led many professionals, concerned about blaming clients, to embrace diagnoses that are seen as a result of fate, such as post-traumatic stress disorder, instead. She also cautions that such movements are attempting to further medicalise women's problems, as was previously done with the diagnosis of hysteria, and avoids addressing the social issues underlying them, such as incest and rape.

Despite this controversy, the diagnosis of BPD is used within clinical practice on a daily basis and therefore it is in existence and information on how it is used and perceived by clinical staff could contribute to the care received by clients diagnosed with BPD. The definitions provided by the APA (2000) will be used in this study for two reasons. The WHO has not updated its definitions in sixteen years while the APA definition was updated in 2000 and also appears to be used more frequently in the professional literature. It must be noted however that the existence of two separate criteria for diagnosing psychiatric disorders further complicates the picture but the two guidelines are very similar. The main difference is that the ICD-10 lists borderline as a subtype of “emotionally unstable personality disorder”. A PD is a rigid way of interacting with and perceiving the world. It usually has an onset in adolescents and is stable over time resulting in considerable distress or damage to the

individual's social functioning, (APA 2000). The APA describe ten separate subtypes of PD with an eleventh category (Personality Disorder Not Otherwise Specified) provided for individuals who, while exhibiting evidence of a PD, do not fit neatly into one of the ten subtypes. BPD is one of the ten subtypes and along with the antisocial, histrionic and narcissistic subtypes composes the dramatic-emotional styles of PDs, often referred to as cluster B, (APA 2000). The APA view the essential feature of BPD as a general pattern of unstable relationships, self concept and mood with extreme impulsivity that manifests itself before early adulthood, (APA 2000). The full diagnostic criteria for BPD is reproduced in Appendix A.

1.3 BACKGROUND OF THE STUDY

The author has worked as a psychiatric nurse for a number of years and has observed how nurses frequently hold negative attitudes and display a lack of patience and dislike for working with certain clients, particularly those diagnosed with BPD. Research completed outside of Ireland has shown repeatedly that negative attitudes exist and these studies will be discussed in Chapter 2. The writer became concerned that these negative attitudes were likely to inhibit the nurse-patient relationships these clients experienced and consequently the quality of care they received. Also, the controversy that exists surrounding the diagnosis could effect staff's motivation and interest in working with these clients or lead to conflicting opinions among staff, possibly resulting in adverse effects on client care.

An interesting development in this area is the decision of the Irish government to disallow the detention of certain patients to psychiatric care against their will, even where they are suicidal, in the new Mental Health Act, (DoHC 2001). Namely those

with a primary diagnosis of PD or substance abuse are exempt from committal. Given that approximately 80% of those with BPD attempt suicide and 10% of those diagnosed with the disorder succeed in killing themselves (Lieb et al. 2004), such a stance would appear to be at odds with the DoHC's (1998) own strategy to identify those at risk of suicide with a view to preventing such outcomes. This writer believes that this could be seen as displaying a lack of concern for patients who have been repeatedly shown in the literature to be viewed as difficult or troublesome patients.

1.4 SIGNIFICANCE OF THE STUDY

PDs account for approximately 3% of all inpatient days with in excess of 1,000 admissions per year, (Daly and Walsh 2003a & 2003b). The APA (2000) claim that the prevalence of BPD is about 2% of the general population (double the prevalence of schizophrenia) and as high as 10% and 20% among psychiatric outpatients and inpatients respectively. Gerson and Stanley (2002) and Paris (2002) both estimate the prevalence of deliberate self harm (DSH) among clients with BPD to be approximately 70% (cited in Trull, Stepp & Durrett 2003) and this behaviour is usually recurrent. According to the National Parasuicide Registry Ireland (2004) there are over ten-thousand cases of DSH presenting to Accident and Emergency (A&E) departments annually and a considerable number of these are likely to be clients with BPD. These figures indicate that clients with BPD have a high level of engagement with the psychiatric and medical services. More recently the large number of individuals treated for DSH has been front page news in the local and national press, (Donnellan 2004 and The Weekender 2004). While it is unlikely that all these clients have BPD it is likely that due to the nature and prevalence of the disorder many of

them are likely to fit the diagnostic criteria and therefore have a huge impact on health care expenditure.

Given the prevalence of BPD it would appear to be vital that nurses and other health care staff are able to meet their needs. Nehls (1998) has described the services provided in the US for those with BPD as a “nonsystem of care” given how fragmented and disorganised they are. The writer believes that Nehls description of the US services could be equally applied to services in Ireland. The writer has also become concerned that the negative attitudes he has observed and which have been highlighted in the literature reviewed in Chapter 2, could have serious implications on the quality of care these patients receive. Therefore, the possibility that such negative attitudes exist among Irish nurses should be a research priority in mental health nursing. If negative attitudes are identified, action is required to reduce any negative effects they might have on patient care. It is hoped that this research study could start to address the phenomenon of negative attitudes and thereby improve the care of those patients diagnosed with BPD.

While conducting the literature review the writer decided to broaden the scope of the study to examine nurse's experience and knowledge of BPD along with attitudes. This was mainly prompted by the absence of previous research on this topic from an Irish perspective. It is hoped that this wider scope might provide more information which may point towards ways of addressing the negative attitudes, (e.g. education, workshops, etc.), if they are found to exist as well as providing an overall picture of Irish nurses knowledge and experience of BPD. The objective for this study can be stated as:

To develop an understanding of the knowledge, experience and attitudes of Irish psychiatric nurses towards BPD in order to provide some guidance on developing services for this client group.

1.5 RESEARCH QUESTIONS

Cormack and Benton (1996) suggest that one cannot carryout research without firstly identifying a research question as the research questions are vitally important in helping to develop the research framework and to focus efforts appropriately. While Cormack and Benton recommend developing a primary research question followed, if necessary, by secondary questions this author has decided that three equally important research questions are necessary.

The research questions are as follows:

1. Do psychiatric nurses hold negative attitudes towards clients with a diagnosis of BPD?
2. What is the current level of knowledge and experience of Irish nurses towards BPD?
3. What are the opinions of Irish nurses towards the current state of services and care for clients with BPD?

1.6 SUMMARY

As outlined above, BPD is approximately twice as common as schizophrenia and places a huge burden on the health services due to frequent admissions and attendances to A&E by these clients. If the health service wishes to provide quality care to these clients it is necessary to address the negative attitudes and educational needs of Irish psychiatric nurses. An assessment of these is therefore indicated. In Chapter a literature review on attitudes towards those with BPD will be described as

this review is instrumental in the development of the research project. Chapter 3 will then provide a description of the research design, making reference to the relevant literature as appropriate. The results will be presented in Chapter 4 followed by a discussion of the findings, with reference to the international research, in Chapter 5. The sixth and final chapter will outline the conclusions and recommendations.

Chapter 2

The Literature Review

2.1 INTRODUCTION

A research study requires an extensive review of the literature in order to question practice in a meaningful way and to learn from previous mistakes, (Benton & Cormack, 1996). For this study the literature will be reviewed under five subheadings. Firstly, a definition of attitudes will be offered along with a discussion on the importance and relevancy of attitudes to nursing. Sections two to four will provide an overview of the literature and research relating to attitudes in three areas: 1) literature related to attitudes towards BPD specifically, 2) literature relating to the concept of difficult patients and 3) literature related to the attitudes towards mental illness. Lastly, while not specifically related to attitudes, the few studies available which study the patients experience of BPD will be examined. The broadness of the literature review was decided upon due to the relatively small number of studies on attitudes towards BPD specifically. It is hoped that by examining a variety of studies a greater understanding of the various research methodologies used to examine attitudes might be achieved.

2.2 ATTITUDES: DEFINITION AND IMPORTANCE

It is important when commencing a study to define the key concepts and their importance. As you will see in the subsequent sections, attitudes are frequently mooted in the professional literature. The Oxford Dictionary provides a useful and simple definition of attitudes as ‘a settled way of thinking or feeling,’ (Pearsall ed.,

2001). This definition highlights the important aspect of attitudes as being a stable and persistent pattern, used by an individual to perceive and interact with the world.

Many leading nurse theorists propound the importance of patient-relationships within psychiatric nursing, (Travelbee 1971, Peplau 1989). If nurses do hold negative attitudes towards a client, it is likely to have an effect on the nurse-patient relationships and ergo patient care and outcomes. Holmqvist (2000a) found that staff feelings were more closely related to outcome for clients with BPD than those with a psychotic disorder. Edelmann (1996) claims that attitudes have a considerable influence over how a person views or thinks about a situation but suggests that the link between thoughts and attitudes on behaviour is less clear. However, Edelmann makes the mistake of excluding emotions. Cognitive behavioural theory has contended for decades that a person's view of the world (attitude) will influence both their emotions and behaviours in relevant situations, (Ellis 1994a). This hypothesis has been supported by numerous studies including Dryden et al. (1989), Moller et al. (1998), Bond and Dryden (1997) and (2000) and Chamberlain and Haaga (2001a) and (2001b). Barker (2001) provides anecdotal evidence of the effects negative attitudes towards clients with a PD had on a legal case in the UK. Barker describes an apparently straight forward rape case that was thrown out after a psychiatrist testified that the victim, whom he had never spoken to, was probably lying as she had a PD.

2.3 ATTITUDES TOWARDS BPD

Only five studies were identified that attempted to specifically examine attitudes towards clients with a diagnosis of PD, (Lewis & Appleby 1988, Bowers 2002, Cleary et al. 2002, Markham & Trower 2003 and Markham 2003). Lewis and

Appleby's study only focused on the attitudes held by psychiatrists towards PD's in general. In this study 240 psychiatrists in Great Britain were given brief vignettes of case histories, which they were asked to read before completing an accompanying questionnaire. The case histories in each of the six vignettes were identical except that previous diagnosis was randomly changed to one of either PD or depression, or no previous diagnosis was offered. The questionnaire supplied contained semantic differentials measured on a six point Likert type scale. A good response rate of 72% was achieved and the results showed that usually a previous diagnosis of PD lead to more critical attitudes on the part of the psychiatrists, even if they did not agree with the diagnosis. No limitations to the study are mentioned by the authors who claim that case vignettes are very useful in measuring attitudes. A definite strength of the study was the high response rate, but from the point of view of this research this study is seventeen years old and does not mention nurses nor focus on BPD. Due to the large differences between the various PDs it would seem appropriate for a study to specify a type, e.g. antisocial, borderline, etc., as attitudes might vary in relation to subtype.

Bowers (2002) was the first study identified which explicitly dealt with psychiatric nurse's attitudes towards clients with a PD, but like Lewis and Appleby, Bowers did not focus specifically on BPD. This was a comprehensive study involving questionnaires sent to all 2,503 (24% response) nurses working in the UK forensic hospitals and in-depth interviews with 121 nurses. Bowers' research showed how some nurses view those with PD as 'evil' and 'monstrous.' He also found that the nurses who were most likely to have positive attitudes towards PD's were young, in senior posts and often female, (Bowers 2002). In a previous publication Bowers (1998) suggested that some diagnoses may guide staff's expectations and reactions in

regard to that patient. The resulting negative emotions and behaviours towards that patient cause a vicious circle whereby what makes these patients difficult to deal with is not their diagnosis, but rather the way nurses think and act towards them, (Bowers 1998). While Bowers (2002) study was a very large scale and comprehensive endeavour utilising a variety of methodologies and data collection methods, it is important to recognise that it examined the attitudes of nurses working in the three special (forensic) hospitals in the UK and did not focus on BPD. The clients being discussed here are likely to fit into the UK legal definition of 'severe and dangerous personality disorder' and be legally detained for a crime. Therefore, they are unlikely to be representative of the BPD patients seen in the general psychiatric services in Ireland.

An Australian study attempted to measure the knowledge, experience and attitudes towards clients with BPD, (Cleary et al. 2002), and focused on the attitudes of all health professionals and not just psychiatric nurses. The authors achieved a response rate of 44% from a sample of 516. They used a 23-item questionnaire, which they developed specifically for the study and respondents were asked to provide demographic information as well as to rate their knowledge, experience and attitudes towards clients with a diagnosis of BPD. Overall, Cleary et al's study found that the majority of the staff believed they had a role in the care of clients with BPD, 95% were willing to engage in further training and 84% of the respondents believed that working with clients with BPD was more difficult than working with other clients. Methodologically, this was quite a broad ranging study as it covered knowledge and experience as well as attitudes and achieved a respectable response rate from quite a large sample.

Markham and Trower (2003) used a similar design to that of Lewis and Appleby described earlier. They asked fifty qualified mental health nurses in the UK to complete questionnaires relating to a client with a particular diagnosis (BPD, schizophrenia or depression). The questionnaires described six challenging behaviours (e.g. setting off a fire alarm when there was no fire) and asked respondents to give a possible cause for the behaviour and to rate this cause on various measures such as patient control on a 7 point Likert scale. They were also asked to rate their sympathy for the client following each of the six challenging behaviours and at the end of each questionnaire their overall optimism for change by the client was rated. In the end 150 questionnaires were therefore completed with each nurse completing the questionnaire for each of the three diagnoses. Markham and Trower's results found that nurses responded more negatively to clients with BPD than either of the other diagnoses. They tended to view BPD patients as more in control of their negative behaviours, staff had less sympathy and optimism for these patients and tended to view their personal experiences of caring for them as more negative than when working with clients with schizophrenia or depression. Again this was a study based in the positive paradigm but it had a relatively small sample but uniquely focused on staff sympathy and causal attributions. However the respondents were chosen from the one English Trust using convenience sampling.

A second article was published by Markham (2003) based on additional data from the study above. The fifty nurses participating in the study by Markham and Trower (2003) were also asked to complete two additional questionnaires related to each of

the three diagnoses: depression, schizophrenia and BPD. One questionnaire related to social distance and asked the nurses to rate their agreement or disagreement with eleven statements relating to the type of social contact one would be willing to have with someone diagnosed with each of the disorders. The eleven statements included items such as whether they could imagine falling in love with or be willing to work alongside someone with that disorder. A second questionnaire containing eight statements measured on a six-point Likert scale was used to measure beliefs about the dangerousness of individuals with the diagnosis. Overall the nurses were more socially rejecting of clients with BPD than those with schizophrenia or depression and also rated those with BPD as being more dangerous than other clients. Again, the convenience sampling of only 50 nurses was rather small but the use of previously tried and tested instruments to measure social rejection and perceived dangerousness provides extra validity to the findings.

A few other studies uncovered in the literature search are relevant to this section of the literature review. Gallop et al. (1989) obtained 124 responses from nurses' on a questionnaire that gave nurses four case summaries of patients and asked the nurses to give their likely response to five potential questions or requests from each of the patients, such as requesting to stay in bed. The results indicated that nurses were more likely to respond in a belittling or contradictory manner to those with BPD. They were also less likely to be empathetic towards these clients, compared to clients making similar requests but who were not diagnosed as having BPD. One of the weaknesses of this study is that it asked nurses for their likely response to hypothetical situations and therefore might not reflect actual responses in real situations. However, a subsequent study by these authors adds considerable weight to their initial findings.

Fraser and Gallop (1993) undertook a study whereby a researcher sat in on twenty group sessions on inpatient units which were facilitated by seventeen nurses and attended by 164 patients with various diagnoses. At least one patient in each group was diagnosed with BPD and the researcher who observed the groups was unaware of the diagnosis of patients when observing the group. While observing the group, they rated the nurse facilitating the group based on their confirming and disconfirming responses and interactions with each patient in the group. The results indicated that nurses were less empathetic and confirming in their responses towards those diagnosed with BPD compared to other diagnoses. This study validates the earlier findings of Gallop et al. (1989), as it measures actual responses.

Carter et al. (2005) compared the management of patients with BPD and depression after they had presented to hospital after an episode of deliberate self-poisoning. The results indicate that those with a BPD are more likely to be referred to inpatient psychiatric care and less likely to be discharged to the GP than those with a diagnosis of depression. While this study shows that patients with BPD tend to be treated in a different manner to those with other diagnoses, they do not necessarily prove a causal link between negative attitudes and negative care. For example, the difference in treatments may be more closely correlated to a lack of knowledge on appropriate treatments than negative attitudes.

An extremely large nationwide Swedish study on the process and outcome of psychiatric patients in 'treatment homes' has been widely reported in the literature and some of its findings also deserve mentioning here, (Holmqvist 2000a and 2000b, Holmqvist and Armelius 2000, Armelius and Holmqvist 2003, Holmqvist and

Armeliu0004). While this study was not specifically about attitudes towards those with a diagnosis of BPD, it did examine the relationship between staff feelings and various variables such as patient diagnosis and staff member's self-image. The study mainly involved the assessment of 143 patients in 24 psychiatric units who were subdivided based on their personality organisation into one of three subtypes: borderline, neurotic or psychotic. Over five years, staff reported on their feelings towards clients on a feeling checklist twice yearly using a previously tested tool. Holmqvist (2000b) reported that the borderline patients tended to evoke fewer relaxed feelings and quite a high level of aggressive feelings in staff. In contrast staff were more likely to respond with sad and self-critical feelings towards psychotic patients and with warm and helpful feelings towards those with neurosis. Also, patient's positive outcome appeared to be related to clear-cut and unambiguous staff feelings. A further paper published by Holmqvist (2000a) examined the relationship between the reported staff feelings towards patients and the patient's subsequent treatment outcome. This study found that staff feelings were more closely associated with outcome for borderline patients than for psychotic patients. Interestingly, in the first year of treatment negative staff feelings were correlated with positive outcome and positive feelings associated with negative outcome. This pattern changed after the first year to a situation where strong staff feelings, either negative or positive, were associated with positive outcome and indifference was deleterious. Caution should be exercised when apply these findings to clinical practice as the relationship between how the patient perceived the staff feelings and how (if at all) the feelings were conveyed to the patients was not addressed. Also this study related to staff who were engaged with BPD patients over a number of years, but in Irish mental health services staff rarely get the opportunity to build such long term relationships with clients,

especially in residential units.

Holmqvist and Armelius (2000) compared the staff ($n = 163$) feelings with the results of a self-image questionnaire, which they completed at the commencement of the study. These results were then examined to identify any correlations with the findings from the earlier studies. The analysis of results showed some relationships between staff feelings and their self-image. For example, staff who were normally helpful and uncontrolling in their approach towards clients tended to have a positive image of their mother while those who were controlling, unhelpful and rejecting tended to have negative images of both their parents and a more protecting view of themselves. Differences were also evident based on the sex of the staff member, with negative feelings by male staff being closely related to images of their father as critical while for female staff the same response was related to the image of their father as freedom giving. A subsequent paper examined the relationship between a staff member's feelings towards a patient and the staff and patient's self-image, Armelius and Holmqvist (2003). The study further examined these relationships in relation to the various gender combinations between staff and patient, (e.g. male staff with female patient, female staff with female patient, etc.). The results indicated that for male staff member's feelings towards patients were altered considerably by the staff's self-image and not significantly by the patient's self-image. For female staff the reverse was true, staff feelings were influenced greatly by the patient's self-image. Overall, staff feelings were influenced more by self-image (either staff or patients) than by diagnosis. Similarly, Johnson and Webb (1995) carried out a small scale study on the role of social judgement in general nurses coming to view patients as popular or unpopular. They also reported that the idea of the unpopular patient varied

considerably from nurse to nurse and was not as closely related to labels as often reported in the literature.

A further analysis of the data by Holmqvist and Armelius (2004) examined the relationships between patient's self and parent images in relation to treatment outcome. Again this paper was based on the data gleamed from the same national Swedish study outlined previously. Specifically this paper examined the relationship between staff feelings early in long-term treatment and positive outcomes and patient's self-image a number of years later. Holmqvist and Armelius (2004) concluded that staff tend to have three basic patterns of reacting to a patient's self-image. In the first pattern the staff identify with the patient's image of the parent and feel as positive about the patient as the patient believes their mother did. The second and third patterns are in contrast as to how the patients experienced their parents. In one of these patterns the staff may respond to the patient's view of parents as submissive and tolerant by imposing boundaries in order to prevent the repeating of possible destructive relationship patterns. In the third pattern, staff attempt to compensate for a dominant or over controlling image of parents by being particularly accepting and supportive. The thrust of the findings was if a patient with BPD has an image of mother as freedom giving, they may use this freedom in destructive ways leading to the chaos frequently found in the relationships people with BPD have with others. The goal for staff is therefore not to over identify with the image of mother and continue the maladaptive relationship pattern, but rather to challenge the patient in relation to their image of their mother. Holmqvist and Armelius (2004) report that when staff provided this challenge to patients with BPD they improved.

As can be seen from this section of the literature, there are numerous studies which indicate that nurses and other health professionals tend to view those with a BPD as being more difficult to treat and feeling less positive and sympathetic towards them compared to other patients. In general staff view patients with BPD as 'difficult' and less enjoyable to work with. Links could be made between these attitudes and nurses' tendency to be less empathetic towards those with BPD and the difference in the approach to those who overdose depending on diagnosis of depression or BPD. However, the various studies published by Holmqvist and Armelius show that it is not as simple as viewing the borderline client as being 'difficult' as other factors such as patient and staff self-image have at least an equivalent, if not a greater influence on staff feelings. Given this view of the borderline patient as 'difficult' it would seem appropriate to examine the literature related to difficult psychiatric patients.

2.4 THE "DIFFICULT" PATIENT

Various studies have attempted to examine the notion of the 'difficult' patient. While this is not the focus of this study, there is likely to be considerable overlap as those studies which examined attitudes towards those with BPD tended to report that they were viewed as difficult to treat and work with. Therefore, this section will examine briefly these studies and how they might relate to this study.

Armitage (1980) reports on how certain patients in general medical settings came to be viewed as "difficult", but the fact that she makes no attempt to describe the methodology behind her research means that caution in relying on the results she reports is advisable. Her study would appear to be routed in the naturalistic paradigm as it is based on evidence gleamed from direct observation of staff meetings and

discussions. Armitage identifies a number of patient characteristics that can lead to them being viewed as difficult such as not complying with the staff's image of the appropriate patient role. Some patients were viewed as not being legitimate patients as they were seen to be taking up resources without adequate cause and Armitage cites the example of a patient who was admitted with chest pain that started while out drinking with friends and was not taken seriously until tests confirmed a 'genuine' cause for his illness. This legitimate patient role was further tested in regard to those who were admitted following deliberate self-poisoning who were again seen as not having a legitimate illness as they have made themselves ill. However, more sympathy was available to those who described a 'legitimate' trigger to their distress, such as a divorce, than those who could not report a reason. Armitage also reports that patient's relatives may also be seen as 'difficult' if they are viewed by staff as being either uncooperative with care plans, for example refusing to accept their relative home, or are overly questioning of the care being provided. Again despite this being a study of difficult medical patients that has little or no information on methodology, some interesting themes emerge within it.

Marshall (1985) conducted a study into whether or not nurses enjoyed caring for particular types of patients. Staff on three psychiatric wards were asked to rate on a visual analogue scale, the degree to which they enjoyed caring for their patients at the beginning and end of a three week period. Only those patients who remained on the wards for the full three weeks were included, giving a sample of 35 patients, and 18 staff. Again only a small sample was used and this study does not focus on attitudes based on diagnosis, which is the basis of this study. However, the results did indicate that a patient's popularity does not appear to follow any particular pattern as staff

tended to view nursing the same patient differently. Sharp (1990) used a unique and simple approach in her research into unpopular patients. She simply asked eight nurses on an acute psychiatric ward to assign a numerical rank order to twelve common psychiatric diagnoses depending on which they enjoyed nursing the most. Each diagnosis could therefore receive a score of 8 to 96, the higher the score the more enjoyable the nurses perceived nursing such clients. Unsurprisingly, 'psychopathy' was scored as the least popular of all the diagnoses. While this study has huge limitations such as the ridiculously small sample and the fact that all the respondents worked on the same unit it does indicate a simple and clear method of measuring the popularity of different diagnoses.

Gallop and Wynn (1987) conducted semi-structured interviews with 25 nurses and 12 junior doctors or psychiatric residents. They found that nurses and doctors reported similar patients as being difficult and PD was the patient diagnosis most frequently cited. However, a difference between nurses and doctor's response was noted as nurses tended to respond more emotionally whereas doctors appeared to be able to distance themselves emotionally and therefore respond with less effect to patients. This study was further expanded by Gallop et al. (1993) who examined the views of staff towards 117 patients who were consecutively admitted onto a short-stay psychiatric ward to try and ascertain which patients were likely to be viewed as 'difficult to treat.' The study took place over eleven months, using two subscales of the Hospital Treatment Rating Scale (HTRS), and compared the responses of nursing staff (n=13) to those of junior doctors (n=8). The HTRS consists of a list of 25 problems that patients may exhibit during their hospitalisation that are rated on a six-point Likert scale to indicate how strongly the patient exhibits that behaviour. The

HTRS may be further subdivided into six subscales and the two used in this study, the overall extent of treatment difficulty subscale and the patient problem list subscale. While some overlap existed between staff on the characteristics of difficult patients, in general, nurses' view of difficult patients tended to revolve around patient behaviours that undermined the nurses' role while doctors tended to view those who did not respond to medication as difficult.

Lancee and Gallop (1995) conducted a further study where 40 nurses in four separate psychiatric units were asked to complete the full HTRS questionnaires about their difficulties in treating 249 patients. They found that only patient violence was cited in every unit to be a difficulty for nurses in treating patients. They concluded that the interaction of various factors, such as patient characteristics, resources available and treatment philosophies, gave rise to some patients being perceived as difficult. This study counteracted one major flaw evident in most of the other studies as it drew its sample from a number of different treatment facilities aiding generalisability. Similar results were found by Colson et al. (1986) in their study on 'difficult' patients, which utilised the same instruments in a study examining the staff perceptions of 127 patients. However, Colson and colleagues opted to complete the questionnaires retrospectively, based on the evidence available in the patient's case notes. In this writer's experience, patient notes do not tend to be detailed enough to allow retrospective research to be accurate.

Holyoake (1999) carried out a unique study by not focusing on difficult patients but rather on favourite patients. He undertook a descriptive and exploratory study to examine how favouritism exhibits itself and is perceived by colleagues by

interviewing fifteen 'trained and untrained' nurses working on an inpatient adolescent psychiatric unit. One of the interesting findings of this study is that staff viewed having a patient diagnosis or behaviour one did not wish to work with was acceptable but having a specific patient one did not want to work with was unacceptable. This situation, where not wanting to work with patient A as I don't like him is unacceptable but not wanting to work with patients A, B and C as they have BPD or tend to self-harm is fine, would seem to allow a situation whereas long as the nurse can find a legitimate reason for their dislike for a patient, everything is fine. Holyoake's study adds some interesting and rich data to the area of attitudes towards patients and is one of the very few qualitative studies in the area of attitudes.

2.5 ATTITUDES TOWARDS MENTAL ILLNESS

As mentioned earlier, this study hopes to examine the area of attitudes towards those with a diagnosis of BPD. Therefore, this section will examine some of the literature on attitudes towards mental illness in general as these studies may help in the formulation of the research methodologies.

The stigma of mental illness is frequently discussed in the literature and the introduction of programmes to promote positive attitudes towards mental health is one of the actions outlined in the latest health strategy, (Department of Health and Children 2001b). Murphy et al. (1993) surveyed the attitudes of 155 randomly selected adults in the Republic of Ireland towards the mentally ill in Ireland using a 29-item questionnaire scored using a Likert scale. Respondents expressed low levels of fear and high levels of sympathy towards those with a mental illness with those who indicated higher knowledge of mental illness indicating the least fear and most

sympathy. Those who were sympathetic tended to be younger, less educated and less financially well off. Crisp et al. (2000) carried out a much larger scale study of public attitudes towards mental illness in the UK. A random sample of 1737 adults (over 16 years) were interviewed to obtain demographic data as well as asking the person to respond to eight topics in relation to seven common mental disorders including schizophrenia, panic attacks and depression, but no PDs were included. The participants responded on a five-point Likert type scale to each item in a similar fashion to the Irish study with the added information of asking them to respond in relation to each diagnosis separately. The results indicated that those with schizophrenia and drug addiction were most likely to be viewed as dangerous and their difficulties self-inflicted. Interestingly, the UK study did not indicate that there was much difference between the attitudes of younger respondents compared to older respondents.

Sidley and Renton (1996) used Likert scales to measure general nurse's attitudes towards patients who self-harm. Again this study had a reasonable sample size of 250 and a response rate of 37% (107) with the entire sample was taken from the one hospital. The results indicated that while the nurses held mainly positive professional attitudes towards the treatment of those who self-harm they reported negative personal responses to caring for them, such as viewing the self-harm as 'attention-seeking' or believing their colleagues do not enjoy caring for those who self harm. The authors of one of the studies on attitudes towards BPD (Cleary et al. 2002), were previously involved in a study on the knowledge, experience and attitudes of mental health staff towards patients with problematic drug and alcohol use. Siegfried et al. (1999) sent a 47-item questionnaire to 536 mental health professionals, from various

professions, in Sydney and achieved an impressive response rate of 63%. The findings from this study indicated that while staff perceived drug and alcohol misuse as problematic they also felt ill prepared to care for these clients and therefore the authors concluded that more training was indicated.

Some recent studies have examined attitudes towards patients using vignettes or brief descriptive accounts of patients, (Brinn, 2000, Hugo, 2001). Brinn (2000) sent 200 general nurses questionnaires that presented them with vignettes of three different clients, each of whom had unstable diabetes but two of whom carried an additional psychiatric diagnosis. The nurses were then asked to rate their expectations and probable emotions towards the patients on ten-point Likert scales. This study showed that nurses were likely to be less positive towards patients whom they felt unable to care for which may be relevant to nurses' attitudes towards clients with BPD. A fairly superficial examination of findings as well as use of a previously untested questionnaire were identified as weaknesses. Hugo (2001) used vignettes of clients with depression and schizophrenia to measure the attitudes of 266 mental health professionals towards clients with mental illness. However, he focused on the professional's expectations around prognosis with or without treatment, rather than general attitudes, and BPD was not mentioned. From a methodological point of view the authors recognise that the sample used was small but do not recognise that the study only distributed questionnaires to staff in two sites, which is likely to effect the generalisability of the results.

Hellzen et al. (2003) carried out a study in Sweden to examine whether psychiatric nurses' choice of person-centred or symptom oriented approach to care is influenced

by the diagnostic label rather than the clinical picture. They took a vignette of a patient with dementia and changed it to one of schizophrenia, but left the description of the clinical presentation unchanged. They then asked 75 nurses to respond to thirteen questions relating to their likely nursing care for the person described in the vignette. They found that nurses were more likely to respond to a patient with a past diagnosis of schizophrenia in a more symptom oriented approach, even when the presenting picture is of dementia. They also found that nurses tended to become more symptom focused the longer qualified they were.

As can be seen from this review of the literature on the 'difficult patient' many of the behaviours likely to be seen as difficult are frequently displayed by those with a diagnosis of BPD, such as being overly emotional, rejecting of help and be seen to suffer from disorders that are likely to be viewed as self-inflicted. Johnson and Webb (1995) claim that researching difficult patients does not offer the predictability previously claimed by other writers as the term is quite ambiguous and likely to vary considerably from setting to setting. James (2003) further criticises research on difficult patients as it assumes that negative attitudes are an interpersonal rather than an intrapersonal process that promotes the apportioning of blame to the patient who is "difficult" rather than the nurse who is unable to meet the patients needs. With this in mind, the author believes that caution is needed when researching "difficult" patients as it may add to the idea that patients are either difficult or easy and remove nursing responses from such situations.

2.6 FROM THE PATIENT'S PERSPECTIVE

Over recent years the “lived-experience” of patients diagnosed with BPD have been the focus of some studies and publications. While not necessarily about nurses’ attitudes, these publications do provide a unique perspective on the nursing care frequently received by patients. Kaysen (1993) a novelist who was hospitalised in the 1960’s when she was eighteen, later got access to her case notes and found she was diagnosed as “borderline personality” and subsequently wrote the book “*Girl, Interrupted*” about her experience of psychiatric hospital. Her book re-counts vivid accounts of her first episode of self-harm as well as her attitude towards the diagnosis of BPD now. The book is also peppered with stories of the care she received and the often negative way she perceived it. For example, she refers to herself and her fellow patients as “early feminists” due to their reluctance to shave their legs as a nurse would have to be present to observe them with the razor, (Kaysen 1993, p. 57). Williams (1998) provides a briefer account of her experiences of living with BPD. This is a particularly interesting article as it is written specifically for professionals and offers a patient’s account of what is helpful and unhelpful. She outlines the distress she felt as a result of her disorder and offers advice to professionals regarding helpful strategies such as the importance of the client feeling supported, cared for and not “written off” by the clinical team.

More formalised research was conducted by a number of authors. Breeze and Repper (1998) carried out an ethnographic study whereby they interviewed six patients who were perceived by staff as being difficult. The purpose of their study was to gain an understanding of the experiences and perceptions of care from the perspective of those patients deemed by nursing staff to be ‘difficult.’ In this study all patients described their unhappiness and experiences of not having any control or input into

the care they received, at least at times. Some patients even recounted incidents where they perceived they were threatened or coerced into behaving in more “appropriate” ways and only one patient could recall having input into their nursing care plan. All patients identified good nursing practices as being able to have normal conversation with their nurse, having input into decisions and feeling the nurse was respectful. This study highlights the difficult patient's perception of the care they receive as not always being helpful and at times, blatantly disrespectful. However, this research is not specifically about BPD.

Castillio et al. (2001) describes a unique study whereby a group of patients diagnosed with PD carried out research (following training) on the views of those diagnosed with PD towards their diagnosis. Unfortunately, this study failed to specify which type of PD they were examining and therefore it has participants from various subtypes, mainly borderline and antisocial. This tendency to clump PDs together appears to assume that the experiences of those with one subtype would be similar to those with another but given the differences between the categories this may be a dangerous assumption. This being said, some interesting findings of this study were participants reporting their tendency to find out their diagnosis indirectly or by accident, pointing to a reluctance of medical staff to offer the diagnosis to clients or adequately explain it. Seventy-two percent of respondents believed that they had been poorly treated due to having a diagnosis of PD.

Three studies were identified which specifically examined the experiences of those with a BPD. The first two are from the US (Miller 1994, Nehls 1999) and the most recent one is a UK study, (Fallon 2003). Miller interviewed ten patients an average of

six times each over the course of a year. Miller was struck by the similarities within the experiences of the ten patients and an example of this was the perception of all the patients as not meeting the social standards expected of them and feeling alienated from others. Some patients spoke about being terrified of disapproval or rejection, particularly from key professional such as therapist, and frequently withheld information to defend against this.

Nehls (1999) carried out in-depth interviews with some thirty patients diagnosed with BPD in order to uncover the “meaning of being diagnosed with BPD”. The first theme identified by Nehls was living with the label, whereby clients perceived the diagnosis as providing an adequate summary of their difficulties but felt that it often resulted in their being judged negatively by professional. Respondents reported frequently receiving poor treatment by professionals. Secondly, the respondents felt that their behaviour was rarely understood by staff and behaviours employed to reduce stress, such as self-harm, were usually dismissed as manipulative or attention seeking, further increasing the perceived lack of support. The third theme uncovered was the difficulty in trying to access a service. Because of their diagnosis, clients felt that they were deliberately kept at arm's length by the service when all they wanted was someone who was willing to listen and spend time with them. Overall, the participants had no difficulty with the diagnosis nor denied it's relevance to them, however they did perceive that they were stereotyped as a result and therefore received inadequate, uncaring and prejudiced treatment.

Fallon (2003) carried out interviews with seven clients diagnosed with BPD in order to uncover the 'lived experience' of contact with the psychiatric services as well as

their opinions regarding the ideal role of the service. In terms of living with the diagnosis, the clients described the hopelessness and misery they felt as well as the role of self-harm as a short-term intervention employed to release pent up emotions and tensions. Interestingly, clients reported the service as being reluctant to give them the diagnosis with two participants only being told their diagnosis when they were recruited for the study. Castillio et al's (2001), research also reported that patients perceived that the service was reluctant or slow to provide a diagnosis of PD. This similarity is all the more interesting as both these studies are UK studies and neither of the American studies (Miller 1994 and Nehls 1999) report this tendency. In regard to service response, participants in Fallon's study reported believing that the 24 hr crisis services and having prepared crises plans were helpful but they also reported that the services were often overly controlling (e.g. admission against their will) or unresponsive (e.g. not being allowed access to someone to simply talk to when upset). Particularly helpful interventions were the assigning of a key worker who was perceived by the patient as being interested in them and willing to listen and be supportive.

2.7 METHODOLOGICAL ISSUES OF STUDIES REVIEWED

As can be seen from this literature review, there is numerous studies relating to the attitudes of staff towards those with BPD. The studies on attitudes discussed here are almost exclusively of a quantitative design typically using a questionnaire of some description. This is unsurprising as a quantitative design is propounded as the most suitable research methodology when examining attitudes, (Edelmann 1996). Some other studies have been identified which give indications as to the attitudes of staff either from direct observations of their behaviour or through patient accounts of care

received. Kelly and May (1982) recommend actual observation over quantitative questionnaires on the grounds that actual observation is a better representation of real life. This author believes that this view is somewhat over simplifying matters. While such studies may indicate actual behaviour of nurses in practice, which gives a true reflection of an actual clinical situation, they also have particular weaknesses. As Edelmann (1996) highlights, attitudes are stable belief positions towards a topic and are not transient. Observing a nurse's behaviour in a group for example does not allow for other factors which might be impinging on the nurse's behaviour that day such as tiredness, personal problems or other stressors. Caution should be exercised therefore when drawing conclusions from behaviour alone. Similarly qualitative research reports on the experiences of the participants only and are unlikely to be very generalisable. For this reason, quantitative methods would appear to be the most suitable approach to measuring attitudes with observational and qualitative studies used to enrich and elaborate on the findings. Ideally, a mixed methodology approach, usually referred to as triangulation, should be utilised whenever possible.

Kelly and May (1982) in their literature review on 'good and bad patients' provide a useful framework for evaluating the literature on attitudes under four headings, empirical, methodological, epistemological and theoretical. From an empirical point of view the literature reviewed can be criticised as the results are all contradictory. While one researcher states that patient popularity is related to diagnosis others claim it is due to particular patient characteristics and yet others claim patient and staff self-images are to blame. The result is a confusing situation where it is difficult to make any definite conclusions. It would seem likely that attitudes and behaviours towards patients are best understood in terms of the relationship between three factors: patient

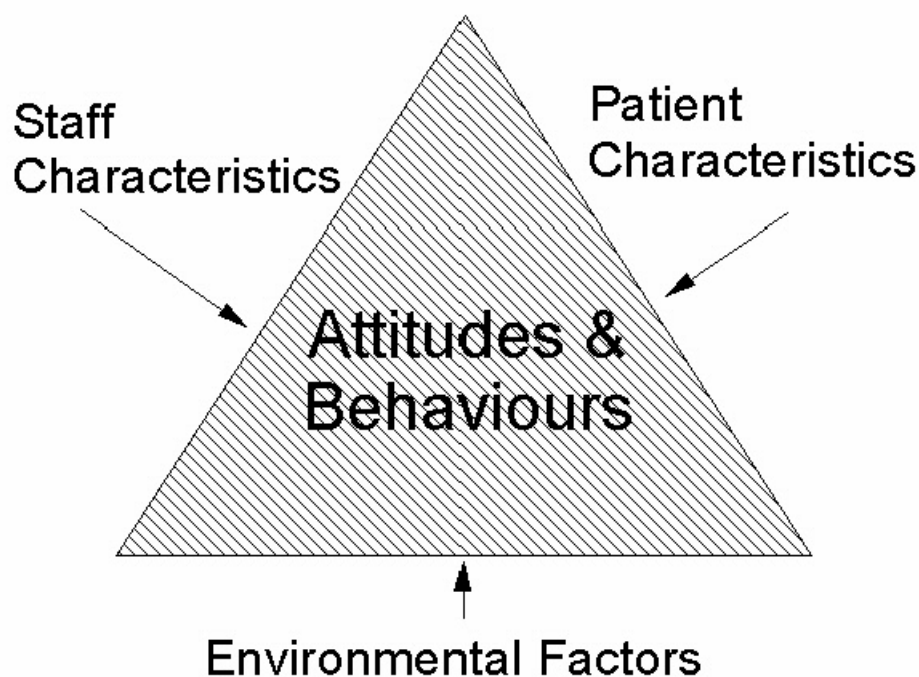
characteristics, nurse characteristics and environmental factors. Patient and nurse characteristics includes such factors as personality, psychological make-up, behaviours and experiences while environmental factors includes ward culture, the policies of the ward, staffing levels and other stressors that might impact on the staff and patient's coping skills on a day to day basis. This author believes that the relationship and interplay between these three factors will determine the attitudes and behaviour of staff and that none alone are sufficient to account for them. This relationship is presented diagrammatically in Fig. 1.

From a methodological point of view the studies can be criticised on sample size and response rate. Also most of the studies were carried out within a single hospital or ward which means that the culture and biases specific to that particular clinical environment may influence the findings making the generalisability of the results somewhat questionable. Many of the studies used questionnaires and Likert Scales, which supports Edelmans (1996) claim that they are suitable for measuring attitudes but Kelly and May (1982) argue that questionnaires are useful but are poor substitutes for actual observation.



From an epistemological perspective it can be argued that the research discussed is not sound as it does not actually establish cause and effect. For example, if every

Fig. 1: the determinants of attitudes & behaviours



patient who is disliked has a certain diagnoses, this does not necessarily mean that they are disliked because of their diagnosis and other factors such as ward culture might explain the attitudes. Using a number of data collection methods (triangulation) might help with improving the quality of the data. The credibility of findings using a questionnaire could be bolstered considerably by either observing nurses interactions with patients in real clinical situations or by comparing the descriptions of patients with varying diagnoses contained within the case notes.

When critiquing the literature from a theoretical perspective many of them can be criticised for taking a very simplistic view of 'difficult' patients. Most of the studies simply tried to identify characteristics within the patient that cause the patient to be disliked, but what about nurses role in the relationship. This relates closely to Johnstones' (2000) observation that when psychiatric patients fail to get better they are blamed rather than blaming the system which has failed them. James (2003) has also argued that attitudes towards patient are often better explained by the nurse's cognitive processes rather than the patient's behaviour. Only the Swedish national study appears to have addressed these issues by examining the nurse from a psychological perspective. Also, despite identifying four studies on the lived experience of those with a PD, only Nehls (1994a) attempted to elicit the perspective of nurses and this was a very specific study on perspectives towards brief hospital treatment plans.

2.8 SUMMARY OF LITERATURE

Due to the poverty of literature on BPD, literature from other areas such as difficult patients and attitudes towards mental illness in general were also examined. The literature on attitudes towards BPD indicate that in general these clients generally receive poor care, find their needs unmet, while nurses and other mental health professionals find these clients difficult to work with, lack confidence and often have negative or less sympathetic responses to them compared to other clients. Questions as to whether those with BPD have a genuine mental illness also appear in the literature, particularly in opinion pieces from the UK. The question as to whether BPD is considered a mental illness may have considerable ramifications for patients if they are in health care facilities and deemed by staff not to be unwell. Some of these

negative attitudes and beliefs around BPD become understandable when the literature on the concept of the “difficult” patient is examined, as these studies produce lists of characteristics which staff are likely to associate with the BPD patient. These include being non-compliant with staff advice and requests, not having a legitimate illness and causing their own difficulties, (e.g. self-harm). Other studies have identified staff characteristics such as gender and self-image in order to explain attitudes towards those with BPD. When taken together, all these findings indicate that attitudes are probably not determined by any single trigger or variable but by the relationship between a variety of stimulants. The research reviewed which examined the patient's perception and experiences of care would seem to support the opinion that the care received is often perceived as unhelpful and delivered by staff who are frequently unsympathetic and ill-prepared for dealing with those with BPD.

The literature review also indicates that the most commonly used approach to measuring attitudes is quantitative surveys with some other research approaches used to develop upon these findings. It would appear that a general consensus exists that questionnaires are the most valid form of data collection, save for the use of triangulation. Despite the plethora of studies available which examine the concepts of attitudes and difficult patients there is little research available on how to deal with negative attitudes. While the identification of negative attitudes and unpopular patients is necessary it should only be a means to end, the end being the improvement of attitudes and the care so called difficult patient's experience.

The search of the literature failed to turn up and literature from Ireland related to difficult patients let alone specifically examining attitudes towards those diagnosed with BPD. While anecdotal evidence and this author's experience indicate that those with BPD are often perceived as difficult to work with, it is probable that the attitudes and behaviours of nurses will vary considerably between health care settings. An example of this may be the fact that user research in the UK highlighted patients with BPD not being told their diagnosis as a difficulty while similar research from the US did not uncover the same problem. Irish research on the attitudes towards those diagnosed with BPD is required, as relying on the findings of studies carried out in Australasia, America and Britain might lead to false assumptions being made.

With the findings of the literature review in mind the author attempted to design a study based on Irish psychiatric nurse's attitudes, knowledge and experience of BPD. Along with this overall focus the literature also provided some guidelines on how this might best be achieved, which included:

The use of quantitative measures with a relatively large sample is preferable.

As this is the first such study from an Irish perspective the scope should be

deliberately kept broad, therefore the inclusion of knowledge and experience along with attitudes.

The study should not try to simply prove the cause of negative attitudes but rather to highlight some of the likely incentives to negative attitudes.

Nurses working in a variety of settings (e.g. community, ward, etc.), should be included.

With these points in mind the author set about to develop a study on Irish psychiatric nurse's knowledge, experience and attitudes towards BPD.

Chapter 3

Research Design

3.1 INTRODUCTION

The following chapter will outline how the study was carried out including the methodologies and approach used along with the rationale behind these decisions. Along with the methodologies used, the actual process of carrying out the study will also be described, such as study setting, gaining access and sample selection. As previously mentioned, Cormack and Benton (1996) recommend that the research aims, objectives and questions are vitally important as they help guidance in designing a coherent and focused study. It is therefore appropriate to restate the objective of this study along with the chosen research questions.

The objective of the study is:

- To develop an understanding of the knowledge, experience and attitudes of Irish psychiatric nurses towards BPD in order to provide some guidance on developing services for this client group.

To achieve the objective the following research questions were chosen:

1. Do psychiatric nurses hold negative attitudes towards clients with a diagnosis of BPD?
2. What is the current level of knowledge and experience of Irish nurses towards BPD?
3. What are the opinions of Irish nurses towards the current state of services and care for clients with BPD?

3.2 RESEARCH PERSPECTIVE AND APPROACH

Edelmann (1996) has suggested that the most common approach to measuring attitudes is questionnaires and this claim was certainly supported by the literature review with very few studies identified which did not use questionnaires. Before embarking on this research the author was aware of the debate within nursing regarding which is the most suitable method of research for nursing. The two sides to this debate can be summarised briefly as those who claim that the reductionistic philosophy of quantitative research is irreconcilable to the humanistic philosophy of nursing. On the other hand there are those who claim that if nurses are to gain credibility as a profession we need to embrace the current evidence-based practice trend and engage in so called hard research of a quantitative design. However, it is now generally agreed that this schism has become overly polarised so as not to reflect the reality that both research approaches can provide useful information, (Clarke 1998, White 2003).

Clarke (2004) points out that the particular strength of qualitative research is that it allows for findings that appear contradictory and discordant to be presented. This makes it particularly useful in helping the researcher gain an understanding of people's opinions and experiences but Clarke cautions against nurses overuse of this approach. Therefore, while qualitative research may have provided insights into some of the attitude's nurses might hold it would not have allowed us to assess the prevalence of these attitudes or nurse's knowledge with any degree of statistical accuracy. The author decided that given the reasonable number of articles on nurse's attitudes towards BPD in the international literature a quantitative study, with a

questionnaire based on these findings, would be useful in gaining an understanding of Irish Nurses knowledge and attitudes. The researcher therefore used a quantitative design. As no research on Irish nurse's attitudes towards clients with a diagnosis of BPD exists, the researcher believes that the larger sample accessible through a quantitative design will aid the generalisability of the findings.

Within the quantitative paradigm there are three subtypes of research: descriptive, correlational and experimental, (Carter 1996). Descriptive research aims to describe the characteristics of individuals or groups or to determine the frequency with which a variable occurs while correlational attempts to describe the statistical relationship between two or more variables. Experimental research attempts to examine cause-and-effect relationships between variables and Carter (1996) suggests that due to the control of variables allowed by experimental methods they are the most powerful form of quantitative research. Given the nature of this study, absolute cause-and-effect relationships to explain nurse's attitudes do not exist and attitudes are likely to be better explained by the interplay between numerous variables. For this reason the author deliberately kept the scope of the research broad rather than to try and prove any particular hypothesis. While experiments (or quasi-experiments) have been attempted to explore whether or not nurses interact differently with those with BPD they do not prove why the nurses might interact differently. With this in mind it was decided that experimental research was not appropriate to research nurse's attitudes and knowledge of those with BPD. Therefore, this study was mainly a descriptive survey as it attempted to explain some of the characteristic attitudes and beliefs of nurses with some additional statistics to examine correlations also included.

3.3 POPULATION, SAMPLE AND SAMPLING

The study aims to examine the attitudes, knowledge and experience of nurses working in clinical posts in Ireland, towards clients with a BPD. For this study, nurses working in clinical posts were defined as nurses whose job requires them to have regular patient contact as part of that patient's care and treatment. Atkinson (1996) defines population as every individual whom the researcher wishes to make statements about, therefore the population in this study is every psychiatric nurse working in a clinical post within Ireland. Cohen et al. (2000) suggest that when carrying out research, decisions regarding sampling need to be made in four key areas: the sample size, the representativeness and parameters of the sample, access to the sample and the sampling strategy to be used. These guidelines were used when making decisions related to sampling in this research.

3.3.1 The Sample Size

It is preferable to take the entire population as the sample (a census), but this was not chosen for this study as the fiscal and time limitations were too great so a sample of the population was sought. A sample is the group of people from whom the researcher intends to collect information, (Atkinson, 1996). As psychiatric nurses work within a variety of locations, (e.g. inpatient units, hostels, day hospitals), with a variety of patients, (e.g. chronically and acutely ill, various diagnoses etc.), a sample was required which would contain a cross section of nurses working in all these areas. For this reason it was decided that one complete catchment area should be surveyed.

Within the Irish Health Service a catchment area refers to a geographical area that was previously serviced by a district mental hospital and usually correspond to county borders. In Dublin and Cork catchment areas tend to be divided in line with

community care areas, (Government of Ireland 2004). The most recent Report of the Inspector of Mental Hospitals (Government of Ireland 2004), lists thirty-four separate public psychiatric services with nursing complements ranging from 22 to 315, with a mean of 162 nurses per service. The total population of nurses in public mental health services adds up to 5,509.69 however one must remember that this figure will include some nurses who do not work in clinical roles. The vast differences in numbers of nurses in a service may be explained by some catchment areas being attached to former district mental health services and therefore having more long-stay and care of the elderly wards. Meath mental health service for example has only one inpatient unit and provides no long term or rehabilitation services, which goes some way to explaining their having only fifty-five nurses despite having a rather large catchment area.

3.3.2 The representativeness and parameters of the sample

The selection of a catchment area could be referred to as a cluster sample. While acknowledging that this may not be as scientifically robust as random sampling, the researcher believes that the surveying of one complete catchment area will allow a good cross section of nurses working in different roles and settings to be included. Cohen et al. (2000) suggest that cluster sampling is often used in small scale studies as a means of getting around the time and financial difficulties posed by random sampling. To improve the representativeness of the sample, any catchment areas that did not provide a full range of psychiatric services (acute inpatients, hostels, rehabilitation, day hospitals, community etc.) were excluded. One Dublin catchment area was finally chosen as it had a larger number of nurses than average (186) and provided the full range of community, residential and inpatient services, facilitating

both acute and continuing care needs. The researcher recognises that as a result of this sampling strategy the results may be representative of the views of staff working in a particular service which has its own culture, and not of psychiatric nurses across Ireland so care should be taken when attempting to generalise the findings to other catchment areas.

Certain inclusion and exclusion criteria were applied. To be included a nurse has to be qualified and working in the catchment area on a regular, rostered basis. Any nurses whose job required them to engage in primarily management, educational, administrative or research roles were excluded. The purpose of these exclusion criteria was to obtain responses only from those nurses working in a clinical role as those working in non-clinical roles may have considerably different opinions, knowledge and attitudes. As student nurses have not completed their training, their level of knowledge and experience is likely to be considerably different from those of qualified nurses and so were also excluded. Due to the lack of standard training among nurses aides as well as the limited number of locations in which they are employed it was agreed not to include them either.

3.3.3 Access to the sample

While a number of Dublin catchment areas met the requirements the one that was finally chosen was located closer to the researcher so as to make visiting the site as necessary easier. A letter was sent to the Director of Nursing (Appendix B) asking him for permission to use the catchment area for the study. Permission was granted and the staff allocations department provided the author with a list of all nursing staff in the area who worked in clinical roles, (n = 157).

3.3.4 Sampling strategy

As previously mentioned, for the purpose of this study cluster sampling was used.

While random sampling would have been statistically more powerful it does have some distinct disadvantages including:

An Bord Altranais could have been employed to forward questionnaires to a random sample of psychiatric nurses but they could not have guaranteed that they would be working in psychiatry let alone in clinical roles.

Questionnaires sent via An Bord Altranais may not achieve a good cross section of nurses from the various clinical locations.

The time and fiscal costs to such a sampling approach would have been considerable.

With all these factors in mind it was deemed appropriate that a large, single catchment area was appropriate as a sample for this study.

3.4 STUDY SETTING

This study will survey the knowledge and attitudes of all the nurses working in clinical roles in one large psychiatric catchment area. The catchment area has a nursing complement of 186 nurses, 157 of whom work in clinical roles and therefore made up the sample. A full spectrum of mental health services is provided and the service also provides clinical placements for student psychiatric nurses as well as student general and mental handicapped nurses.

3.5 DATA COLLECTION METHODS

As discussed in the research perspective and approach section, questionnaires were chosen as the data collection method due to their being widely accepted as a means of collecting information on attitudes and knowledge, (Edelmann 1996). A questionnaire can be described as “a method that seeks written or verbal responses from people to a written set of questions or statements”, (Parahoo 1997). It was also hoped that by allowing respondents to answer questionnaires anonymously more honest responses might be obtained.

Following from the literature review the author decided that the use of an existing questionnaire should improve the validity of the findings, reduce the labour (and therefore costs) involved in developing a new questionnaire and make it possible to make comparisons with the international literature. Cleary et al's. (2002) study stood out as being a broad study, focusing on knowledge, experience and attitudes towards BPD and therefore having a similar focus to this study. The author made contact with the lead author from that study and a copy of their questionnaire obtained (Appendix C) as well as permission to use it or part thereof, (Appendix D). However, as Cleary et al's. study was carried out in Australia and surveyed numerous professions it required some editing to make it suitable for this study. Appendix E contains this questionnaire following some initial amendments for the purpose of this study. Examples of changes made included removing the question related to which professional group the respondent belonged and replacing it with one on job title.

The questionnaire received from Cleary contained numerous questions that had a number of potential answers supplied and respondents are asked to tick a box to indicate the appropriate answer. Overall the questions were deemed suitable and so

did not require editing. Question ten however asked those respondents who indicated that care for those with BPD was inadequate whether or not it was due to any of three reasons provided, with space provided for them to insert a reason that was not listed. The author felt that this question was particularly narrowly asked as respondents could only agree or disagree meaning that respondent's level of belief in the statement goes unchecked. It was therefore decided to add a five-point Likert scale to elicit richer data from respondents. Edelman (1996) identifies numerous scales used to measure attitudes such as the Thurstone and Guttman methods as well as semantic differentials but Likert Scales were chosen as the author believed that they are the most widely used scale and easiest to understand. The literature review also indicated two other reasons as to why these clients may be difficult to treat. These were that these clients were 'untreatable' and secondly whether those with a PD have a mental illness in the first place. These two issues were hotly debated in the UK nursing literature and so the author decided to include them as additional options as to reasons why BPD is difficult to treat, (see for example Strong 1998, Barker 1999, Flood 1999, Shad 1999, Allen 2000, Smith 2000).

Questions twelve and thirteen asked the respondents to indicate whether they agreed or disagreed with six statements related to symptoms and treatment of BPD while question fourteen provided four statements related to outcome in BPD and respondents were asked to identify the false statement. The author decided to elicit more responses by asking respondents to indicate whether each statement was true or false, hopefully making it less likely that someone could simply guess the correct answer. No further changes were made to the questionnaire until after the pilot study was undertaken and these changes are discussed in the pilot study section.

A poster was circulated around the service approximately one week before the questionnaires are distributed. This poster outlined the research and asked staff to participate, (see Appendix F). The idea came from a psychologist colleague who had used a similar technique in one of their studies and believed it increased the response rate by generating interest in the study. It was also hoped that the poster would inform people about the study, allowing anyone who did not receive their questionnaire to obtain one. This was especially important as some nurses in the service work 'relief' and so move work locations frequently. This approach was rewarded by the author being contacted by a nurse who had read the poster but not received their questionnaire and wished to participate. Following a pilot test, the questionnaires were then sent to each nurse on the list received from the allocations department, along with a covering letter that again outlined the study and guaranteed anonymity (Appendix F). Any nurse who wished to partake was requested to complete the questionnaire and then to forward it to the researcher using the internal posting system and envelope provided. As mentioned by Parahoo (1997) one of the biggest problems with questionnaires is poor response rates and so the internal posting system was used in order to make the return of questionnaires convenient for respondents. It was hoped that this convenience along with the guaranteed anonymity might promote a higher response rate. Two weeks after the questionnaires were distributed a reminder poster was sent to each clinical area reminding staff of the study and requesting staff members who were interested in participating to complete and return the questionnaire.

3.6 DATA ANALYSIS METHODS

The majority of the data that will be gathered by this study will be either nominal or ordinal data. Data that can be broken into categories but which have no numerical relationship is referred to as nominal while ordinal is used to describe data that is measured and placed in a rank order but cannot be given an accurate numerical measurement such as Likert scales, (Donnan 1996a). Edelmann (1996) articulates some of the weaknesses of Likert scales, which can be highlighted using the example of the Burns Depression Checklist (BDC) which is a 25 item questionnaire that claims to measure respondent's level of depression on a 5 point Likert scale, (Burns 1980). As each one of the twenty-five symptoms listed in the BDC are rated and assigned numerical value, we can easily examine the scale to determine which symptoms are the most problematic for the client. However, if we simply add the scores to obtain a single numerical rating for the depression much valuable data may be lost. Which symptoms are the most troublesome for this client? Does he have any suicidal thoughts? The answers to these questions may be obtained if the scores for each symptom are examined individually. Also, as Likert scales are subjective measurement it is easy for a client to give a false response, either deliberately or on purpose.

For this reason, the author will present results on each question individually so as not to lose valuable data by clumping data together. As mentioned earlier, ten questions assess the respondent's knowledge in relation to such aspects as the diagnosis, treatment and outcome of BPD. These questions were developed by Cleary et al. Based on the relevant literature will be added together to provide a score out of ten to rate respondent's knowledge but the results from each question will also be presented. The author believes that such a score allows levels of knowledge to be compared

between different variables. The data received from completed questionnaires was coded and programmed into a computer. They were then examined using the Statistical Package for the Social Sciences (SPSS Version 11).

Descriptive statistics are used to summarise the most important findings of a study, (Donnan 1996a). The data collected was analysed using some of the common methods in descriptive statistics, including the standard deviation and mean. The standard deviation is a method of measuring the 'average spread of data around the mean,' (p. 314) while the mean is simply the total of all the responses divided by the total number of responses, (Donnan 1996a). Research such as this often reports data which is somewhat skewed. The degree of skewness of the data will effect the type of data analysis methods used and the individual tests used will be presented in the result's section. Inferential statistics are used to make judgement and generate hypothesis about a population based on the data obtained from a sample of that population, (Donnan 1996b). Inferential statistical methods will be used to test for correlation's between the various variables. As parametric methods are reliant upon the normal distribution of data and the use of non-random sampling non-parametric tests were deemed more suitable for this research, (Welkowitz et al. 2000).

3.7 PILOT TEST

A pilot study is a small-scale trial of the proposed research design, which helps to test the design of the proposed research, (Presly 1996). As the questionnaire is untested in its new format and the author had no research experience it was vital that a pilot test be carried out. Before the researcher carried out the formal pilot test two mental health professionals who were not part of the sample group were asked to complete

the questionnaire and then to comment on it. These two reviewers made some useful comments regarding the lack of clarity in some of the instructions on the questionnaire as well as the layout. For example, in question fifteen, which assesses confidence in working with clients with BPD it was suggested that clarification of the differences between identification and assessment of BPD was needed so these items were reworded. The author edited the questionnaire based on this feedback and represented the questionnaire to the two reviewers. At this point they indicated that they thought the questionnaire was ready for use and more user friendly so the formal pilot test was undertaken and this version of the questionnaire was used in the pilot study, (see Appendix H). Permission was sought and granted to carryout the pilot test with the staff of one acute ward in Dublin. This sample contained nurses working on an acute admissions unit and as Community Mental Health Nurses, (CMHN). Van Teijlingen and Hundley (2002) caution against using data gathered from a pilot study in the results of the main study as this could lead to a contamination of the results, especially when the main study participants are likely to receive a revised version of the questionnaire. For this reason, nurses from a different catchment area were selected for the pilot study as it avoided the risk of contamination without depleting the original sample size. Twenty questionnaires were distributed (12.7% of main study sample) and eventually fifteen (9.6% of main study sample) were returned. These results were analysed and the respondents asked to provide written feedback and comments on the questionnaire and this feedback as well as the responses to the questionnaire was used to further develop the questionnaire. Parahoo (1997), cites Crosby et al. (1989) who points out that 10 or 12 drafts of a questionnaire may be required before a suitable one is ready for use.

Once the analyses of the results from the pilot study were completed a number of further changes were made to the questionnaire. Appendix I shows the final format of the questionnaire that was used in this study. The changes made were as follows:

In question 2 the less than 30 year old age bracket was subdivided further into a less than 25 year old and 26 to 29 year old category. This was due to there being a large number of respondents in their twenties and the author believed that there were likely to be considerable differences between 21 and 29 year olds.

An option to indicate working as a CMHN was added to Question four.

In question 10 the respondents supplied a number of additional reasons as to why they thought that the care received by those with BPD was inadequate. These were funnelled down into three main themes 1) clients not being told their diagnosis, 2) team disagreements regarding treatment plan and, 3) treatment being overly medicalised. These three themes were added to the questionnaire for the main study.

In question nineteen, where respondents are asked to rank various resources in terms of which would be the most helpful to the respondent, the instructions were reworded and two new resources were added: 1) training in Dialectical Behavioural Therapy (DBT) and, 2) a liaison service in A&E.

Once these amendments were made the questionnaires were sent to the 157 nurses in the main study sample.

3.8 ISSUES OF RELIABILITY AND VALIDITY

Before we can discuss the reliability and validity of the questionnaire, a definition of the terms is required. Reliability can be seen as the degree to which a questionnaire is

able to consistently measure the phenomenon that is being studied and validity refers to the ability of the questionnaire to measure the actual phenomenon of interest, (Bowling, 1995 cited by Watson 1999). For example a weighing scales is only reliable if it consistently weighs one stone as fourteen pounds. Similarly it is valid only when it is used to measure weight. A point to note is that a weighing scales that consistently weighs a stone weight as thirteen pounds could be said to be reliable as it consistently defines weight in the same manner. However, it would not be a valid measurement as its definition of a stone is not in keeping with the actual definition of a stone.

Parahoo (1997) provides a useful framework for testing the reliability and validity of a questionnaire. He suggests that the questionnaire be examined using two questions to check both validity and reliability. To check the validity of the questionnaire we must first ask if the questionnaire answers the research questions? The researcher believes that the questionnaire does answer the research questions provided respondents understand the questions. As mentioned previously, a pilot study was carried out to ensure that participants understood the questions and believe it can reflect their attitudes and opinions.

The second question we must ask to check validity is 'do the questions adequately represent the different attributes of the concepts or the different aspects of the issues being studied?' (Parahoo 1997). The questionnaire is one that has been previously developed and has been revised to ensure it fully addresses the concepts involved although the authors of the questionnaire do not address issues of reliability and validity in their report. This author believes that as the questionnaire will be mainly

used to report descriptive statistics this lack of clarity is less of a problem but means that any inferential or correlational statistics should therefore be used cautiously. At the end of the questionnaire respondents were given the opportunity to make further comments, which the author believes it is important as the topic has received little attention in the literature and this is the first study of its kind in Ireland.

To check the reliability of the questionnaire the statements should also be checked to ensure that they are clear so that the respondent can understand and respond to them in the same way each time he is presented with them, and that each respondent interprets the questions in the same way, (Parahoo 1997). Secondly we must ask whether or not the respondents interpret the instructions in the same way? To check the degree to which the instructions are understandable by the respondents numerous pilot studies were undertaken and appropriate changes made to the questionnaire based on the feedback received. The Cronbach's alpha is a statistical test used to measure the internal consistency of a questionnaire and once computed gives a reliability coefficient between .00 and +1.00 with higher score indicating a greater level of internal consistency, (Polit and Hungler 1999). Once all the questionnaires were returned the Cronbach's alpha was calculated using the SPSS-11 package and a coefficient of .79 was achieved indicating a considerably high level of internal consistency within the tool used. Cleary et al. (2002) did not report on the internal consistency of the version of the questionnaire they used for their research and so no comparison is possible.

3.9 ETHICAL CONSIDERATIONS

An Bord Altranais, (ABA) (2000) provide a section on the responsibilities of a nurse who is undertaking research in their code of practice. These guidelines appear to be aimed primarily at studies involving patients but can be broken into three sections and used to discuss ethics regarding any research.

Firstly, ABA suggests that when undertaking research the nurse must take great care so as to protect the confidentiality of participants and provide enough information to participants so that they can make an informed decision regarding their participation in the study. The confidentiality of participants in this study was guaranteed as the researcher was not even aware who completed questionnaires and who did not. The poster and cover letter emphasised to respondents that participation in the study was voluntary and confidentiality was assured, (see Appendices F and G). The researcher also provided contact details to participants in case they required further information. Also, any members of the sample who do not wish to take part in the research could simply do so by not completing the questionnaire. As the researcher was not aware who had or had not completed a questionnaire he was unable to exert pressure on potential respondents.

Secondly the ABA guidelines suggest that the researcher must check that the appropriate bodies have sanctioned the research and that participant's rights are protected. To comply with these guidelines the researcher sent a letter (Appendix B) and a copy of the research proposal to the Director of Nursing of the catchment area to seek approval to contact nurses in their service. Informal discussions with the Director of Nursing uncovered that while the catchment area operated an ethics committee, this research would not require ethics approval from them as no patients

or patient details were to be used. For this reason the author sought ethical approval from the ethics committee in the Royal College of Surgeons in Ireland, which was subsequently granted, (Appendix J).

The ABA (2000) guidelines also suggest that the researcher should be aware of and comply with any ethical guidelines in place at the site. In the initial letter to the Director of Nursing the researcher will request that a copy of any relevant policies and will undertake to comply with them.

¹Chapter 4

Findings from the Study

4.1 INTRODUCTION

This chapter presents the results of this study. The majority of the results are based on descriptive statistics but the Spearman Rho was used to check for correlation's between variables and so some statistically significant correlation's will be reported where appropriate. The results will be presented under four subheadings. The first section will outline the demographic characteristics of the respondents while the second and third sections will describe the staff opinions of services for those with BPD and knowledge of BPD, respectively. The fourth section will report the findings related to staff confidence and their view of their role in caring for borderline clients. The concluding section will offer a summary of the findings.

4.2 DEMOGRAPHIC DATA

Out of the 186 nurses working in the service, 157 nurses were identified who met the inclusion criteria and therefore constituted the sample. The 29 nurses excluded worked in either educational or management roles or were on long-term sick leave. Responses were received from sixty-five nurses, yielding a response rate of 41.4%. The age profile of respondents was evenly spread with 43% of the respondents under forty years old. There was a small but significant correlation between place of work and length of time qualified as a nurse, ($r = 0.327$, $p = 0.00$). When these figures were broken down further they revealed that 32% of inpatient nurses were under five years qualified while in the community this figure was 15%. Just over half of respondents were employed as staff nurses with one quarter working as Clinical Nurse Managers (CNM). With regard to work location, the majority of the respondents were working in the community as CMHNs and on Home-Care teams (32%), rehabilitation (30%)

or in the acute inpatient units (26.6%). Only one person indicated that they worked in care of the elderly. Two thirds of respondents worked in their indicated place of work for five years or less with 21% working in their area for over ten years. This contrasted sharply with respondent's length of time qualified as a psychiatric nurse with only a third of respondents less than ten years qualified indicating a relatively mature and experienced workforce. These results are summarised in table 2.

Some interesting statistics were uncovered in relation to job title. Respondents were asked to indicate whether they worked as a staff nurse or in a promotional post such as a CNM or Clinical Nurse Specialist (CNS). There was significant correlation found between being in a promotional post and length of time qualified ($r = 0.452$, $p = 0.000$) and age ($r = 0.310$, $p = 0.013$). However, there was an even stronger correlation between place of work and job title ($r = 0.494$, $p = 0.000$), indicating community staff were considerably more likely to be in a promotional position than their inpatient colleagues. These figures are summarised in table 1.

Table 1: Comparison of job title and work location.

Work Location	Staff Nurse	Clinical Nurse Manager	Clinical nurse Specialist
Inpatient	72%	25%	3%
Community	37%	26%	37%

Table 2: Profile of respondents.

Demographic Item	No. Of Respondents	
Total survey population	157	
Response rate	65	
Sex		
Male	21	
Female	44	
Age group (years)		
25 years or less	5	

26-29 years	6	
30-39 years	17	
40-49 years	25	
50 years or more	12	
Job Title		
Staff Nurse	37	
CNM 1 or 2	16	
CPN/CMHN or CNS	11	
Missing	1	
Usual work location		
Acute inpatient unit	17	
Care of the elderly	1	
Rehabilitation unit/ hostel	19	
Day Hospital/Centre	6	
Community/Home-Care	21	
Length of time in this clinical area		
Less than 2 years	20	
2 -5 years	23	
6 - 10 years	8	
11 - 15 years	5	
More than 15 years	9	
Length of time qualified as a nurse		
Less than 2 years	5	
2 - 5 years	11	
6 - 10 years	6	
11 - 20 years	18	
21 years or more	25	

4.3 SERVICES FOR BPD

One quarter of staff stated that they had daily contact with clients diagnosed with BPD with another quarter stating that they had contact with such clients once or twice a week. Crosstabs revealed that of the staff working on inpatient settings, those working on acute units were twice as likely to report daily contact with clients with BPD than those working on rehabilitation units or hostels, (43% compared to 21%). Just over 50% of community based staff reported having at least weekly contact with clients diagnosed with BPD.

Four-fifths (81%) of respondents stated that they believed that care was inadequate for clients with BPD and those who indicated that care was inadequate were asked to rate

their level of agreement with eight possible reasons as to why the care is inadequate, on a five-point Likert scale. Table summarises the responses of participants to each of the eight reasons listed. It is important to note that 18.4% (n=12) respondents indicated that they thought care was adequate and so did not rate the eight reasons for inadequate care and some respondents did not provide a rating for each item. For this reason, the percentages below are based on the responses provided by various numbers of staff ranging from 47 to 52.

Table 3: Reasons for inadequate care. 81% (n=51) of respondents indicated that care was inadequate.

Reason for inadequate care	Strongly Agree	Agree	Do Not Know	Disagree
Shortage of Services for BPD	22 43.1%	28 54.9%	1 2%	- -
BPD clients are difficult to treat	15 30%	29 58%	1 2%	5 10%
Treatments are over medicalised	16 30.8%	28 53.8%	4 6.2%	4 6.2%
Team disagreements about treatment	12 23.1%	31 59.6%	3 5.8%	6 11.5%
Clients not told their diagnosis	10 19.6%	23 45.1%	7 13.7%	10 19.6%
Respondent lacks training and/or expertise	8 16%	23 46%	3 6%	16 32%
Clients with BPD are not mentally ill	1 2%	14 28%	10 20%	21 42%
Clients with BPD are untreatable	1 2.1%	2 4.3%	5 10.6%	26 55.3%

A staggering 98% endorsed the idea that care was inadequate due to a lack of resources. Over 80% of the respondents agreed or strongly agreed that clients with BPD being difficult to treat, treatments being overly medicalised and disagreement among the multidisciplinary team (MDT) contributed to the inadequate care. At the other end of the scale, over 80% rejected the statement that care was inadequate due to those with BPD being untreatable. Half of the respondents disagreed with the statement that those with BPD were not mentally ill contributed to their inadequate

care, with a further 20% indicating that they were unsure. Only two of the statements relating to inadequate care divided the opinions of respondents. Just over 60% of respondents indicated that they agreed that lack of training or expertise on their behalf contributes to the inadequate services for those with BPD while over thirty percent also rejected this statement. With respect to clients not being told their diagnosis contributing to inadequate care, almost 65% agreed, 21% disagreed while just under 14% of respondents reported being unsure.

The correlation's between variables were examined using the Spearman Rho test with a significance level of $p=0.05$ set. Perhaps unsurprisingly viewing care as being inadequate due to those with BPD not being mentally unwell was highly correlated with the view that those with BPD are untreatable, ($r=0.727$, $p=0.000$). The view that care was inadequate due to MDT disagreements was highly correlated with the view that care is inadequate due to a lack of services, ($r=0.719$, $p=.0000$), it is overly medicalised ($r=0.714$, $p=0.000$), and clients are not told their diagnosis, ($r=0.693$, $p=0.000$). The opinion that MDT disagreements had a negative impact on care was mildly correlated with the view that short-term psychotherapy is of use for those with BPD, ($r=0.285$, $p=0.026$). There was also a significant relationship ($r=0.429$, $p=0.001$) between believing that care for BPD was inadequate due to the respondent lacking training or expertise and the view that clients with BPD are difficult to care for. Perhaps unsurprisingly there was also a correlation between the position that clients with BPD are difficult to treat and the view that this difficulty in treating them is responsible for their inadequate care, ($r=0.451$, $p=0.000$). There was no correlation found between any of the demographic variables and any of the reasons as to why care might be inadequate.

Respondents were also given the opportunity to identify any additional reasons as to why they believe care for those with BPD is inadequate and in all, twenty-one additional comments were made. This qualitative data was analysed using content analysis to identify themes and frequency of an item being reported was taken as an indication of its importance. Eventually four main themes were identified. The first theme, organisation of care, was the largest containing seven comments. As regards organisation of care for those with BPD, respondents identified lack of key workers, inappropriately long hospital admissions and lack of specialised teams to handle these clients as reasons for inadequate care. However, many of the comments in this theme identified an inappropriate behavioural or symptom focused approach to care as diverting attention from the clients real emotional and psychological difficulties. This fitted neatly with the second theme, which was inappropriate types of care being offered. The overriding message in this theme was that counselling and psychological approaches are both necessary and lacking for BPD. The third theme consisted of four statements relating to team disagreements and inconsistencies in providing care for these clients but unfortunately respondents did not elaborate as to whether the inconsistencies were between nurses or nurses and other professions. MDT disagreement was however offered in the questionnaire as one of the reasons as to why care may be inadequate for those with BPD. One respondent who works on an acute inpatient unit described the inconsistencies quite eloquently:

Stigmas and bad feelings are common among some staff, whereas pity and emotions of other staff can be high. These opinions conflict. (Q. 20).

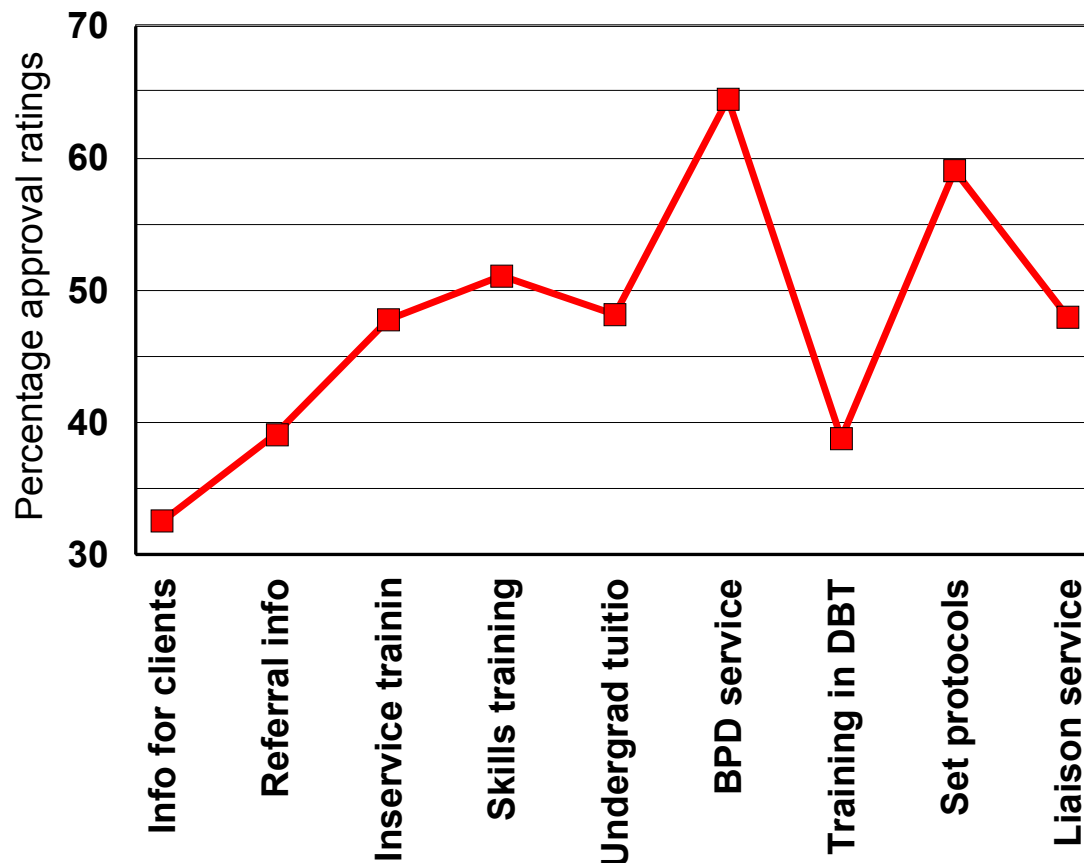
The final theme identified was training and expertise of staff. A lack of skills, training and understanding of client's problems among all staff was suggested with one

respondent specifically naming consultant psychiatrists as being in need of education in how to plan care for those with BPD. One respondent suggested that experience and support may make up for a lack of formal training but clinical supervision was lacking which has an adverse effect on care.

In order to ascertain respondent's views as to how care for those with BPD might be improved a list of ten possible resources was provided and respondents were asked to rank these in order of which they believed might be the most helpful in improving care. The list of resources included items such as supervision, additional training (either workshops or in-service) and the development of specialist services. A resource rated as being most important by all respondents would receive a score of 650, while a resource that was ranked as being the least helpful would score just 65. Once the overall scores were calculated, they were converted to approval scores represented as percentage points, with a high percentage score representing higher levels of approval for that resource by staff. The level of approval for the resources ranged from 32.5% to 64.5%. The mean approval score was 45.82% with a standard deviation of 10.35%. Of the resources listed, the least favoured were information for distribution to clients, supervision/team support and training in DBT with approval ratings of just 32.5%, 35.1% and 35.8% respectively. The most helpful resources in the staff's opinion were a specialised service for those with BPD (64.5%), standard protocols for the management of clients with BPD (59.1%) and skills training workshops (51.1%). Interestingly, the need for increased undergraduate education and training on the subject of BPD received the fourth highest approval rating of 48.2%. The results are summarised in fig. 2.

Fig 2: Percentage approval ratings for resources to improve care for clients with BPD.

Respondents were also asked to comment on any additional resources that might be needed to improve care for those with BPD. This was in addition to the responses



reported earlier in relation to reasons as to why care for those with BPD is inadequate.

Two respondents mentioned that they believed psychological treatments would benefit those with BPD with one of these specifically mentioning long-term counselling. From the nursing perspective, the need for clients with BPD to be dealt with tactfully by staff was highlighted as was the need for a key worker system. Finally, a 24 hour outreach service in preference to hospital treatment was also suggested.

4.4 STAFF KNOWLEDGE OF BPD

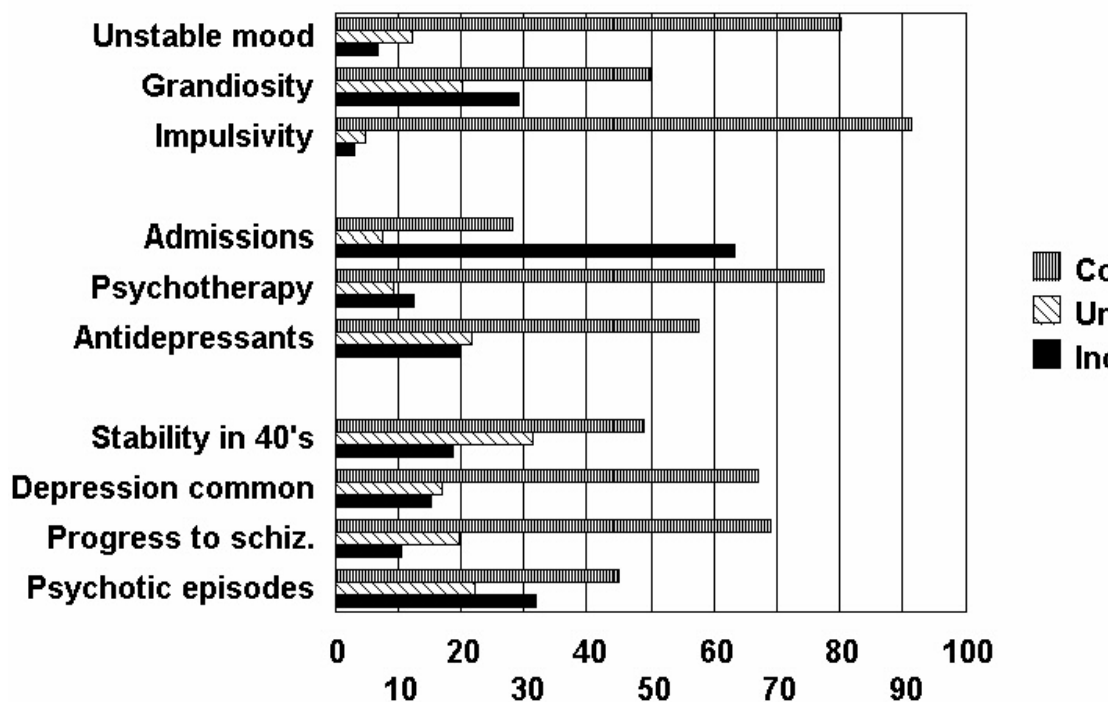
Only 3% (n=2) of nurses reported having any specific training on BPD outside of their undergraduate training and both consisted of a single workshop or lecture rather than an actual specialist course. It is important to remember that there was a significant correlation between the respondent believing that care was inadequate due to their lack of knowledge or expertise and perceiving clients with BPD as being difficult to care for, ($r=0.429$, $p=0.001$). As mentioned earlier, respondents were asked ten questions to assess their knowledge of BPD. These ten questions assessed knowledge in three subcategories: diagnosis, treatment and prognosis and course of the disorder. The mean number of questions answered correctly was 5.8 out of ten (standard deviation 1.8), with the numbers of questions answered correctly ranging from two to nine. Sixty percent of respondents got six or more questions correct. The responses for each question are summarised as percentages in fig. 3.

From a demographic perspective, only place of work was significantly correlated with the number of questions answered correctly, ($r=0.268$, $p=0.032$). Closer examination reveals that approximately half of staff working on wards scored below the average of 5.8 questions correct, and this is true for both acute and rehabilitation settings. In the community however only about 25% of staff scored below the average point. When knowledge scores were examined separately ward staff were found to score a mean of 5.3 questions correctly (SD 1.8) with community based staff scoring a mean of 6.6 questions correctly (SD 1.6). Fig 4 presents a diagrammatic overview of knowledge scores compared to work location. There was no statistically significant correlation between overall knowledge scores and confidence or finding clients with BPD difficult to work with.

 **Fig. 3: Overview of staff responses to questions as percentages.**

Of interest here is that three respondents took time to make additional comments in relation to the diagnosis of BPD at the end of their questionnaire. One respondent

Fig. 3: Nurses knowledge of BPD

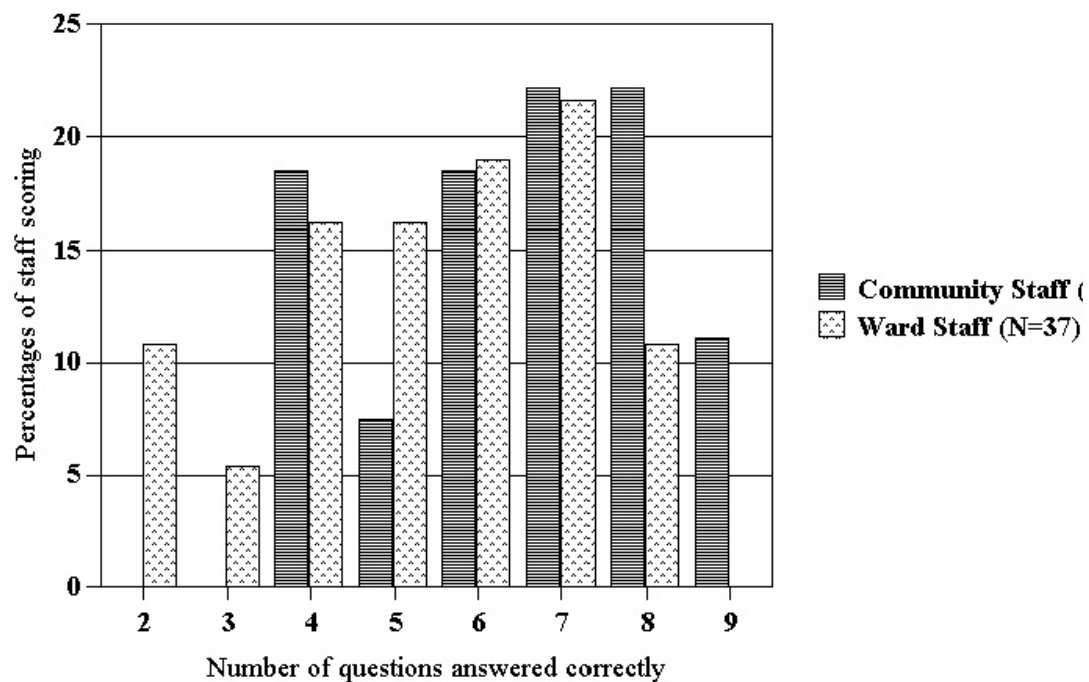


stated that while they answered the questionnaire they do not like to place people in categories while another wondered whether BPD is simply a manipulative way for the client to “get what they want”. One wonders whether these staff members feel the same about some of the other, perhaps less controversial diagnoses such as schizophrenia. The other comment suggested that services are overly focused on presenting symptoms and do not therefore treat the underlying problems.



4.4.1 DSM-IV Criteria for BPD

Fig 4: Number of questions answered correctly and location of work



Four fifths of respondents correctly identified unstable moods as a criterion for BPD and 92% of respondents also recognised impulsivity as being a criterion for the disorder. On a less positive note only half of the respondents recognised that grandiosity was not a feature of BPD. Thirty percent of respondents indicated that grandiosity was a feature of BPD while the remaining 20% admitted to not knowing.

4.4.2 Treatment of BPD

Almost two-thirds (63.5%) wrongly agreed with the statement, 'patients with BPD should not be hospitalised' with only 27.7% of staff disagreeing with the statement. Almost 78% correctly agreed that short-term psychotherapy may be useful for those with BPD. Correctly answering this question was significantly correlated with the opinion that clients not being told their diagnosis contributed to their inadequate care, ($p=0.349$, $p=0.006$), and less significantly with the view that MDT disagreements contributed to the inadequate care received by these clients, ($r=0.285$, $p=0.026$). Meanwhile, 58% of respondents correctly agreed that antidepressants may be of use for the depression experienced by those with BPD with one fifth admitting that they were unsure. Interestingly, a recognition that those with BPD suffer a high incidence of depression is relatively weakly correlated with the view that antidepressants may be of benefit, ($r=0.247$, $p=0.049$).

4.4.3 Prognosis and course of BPD

Four questions were asked to assess respondent's knowledge of the prognosis and course of BPD and these questions appeared to be some of the most difficult for respondents. Less than half of respondents (49.2%) correctly agreed that 'a significant number' of people with BPD achieve some stability in their 40's with over thirty percent indicating that they do not know. There was a weak yet significant correlation between length of time qualified and correctly recognising that some clients with BPD achieve some stability later in life, ($r=-0.261$, $p=.039$) and correctly recognising that clients with BPD may benefit from admission, ($r=-0.251$, $p=0.046$). In fact, the number of nurses qualified over ten years who answered these question correctly was 61% for the stability question and 71% for the admission question. The corresponding scores for staff qualified less than ten years by comparison is only 27% and 45%

respectively. There was also a correlation between being older and recognising that some clients with BPD may have short psychotic episodes, ($r = -0.259$, $p = 0.042$). These findings are all the more significant given that there was no correlation between length of time qualified or age and overall knowledge score. Respondents similarly found the question asking whether those with BPD may have short-lived psychotic episodes, difficult. Only 45.2% correctly agreed with 22.6% indicating that they do not know. More promisingly almost 70% correctly disagreed with the statement 'BPD can progress to schizophrenia.' When asked to identify whether the statement 'people with BPD have a high incidence of depression' was true or false, 67% correctly answered true with only 15.4% incorrectly stating it was false.

4.5 CONFIDENCE OF STAFF AND THEIR PERCEIVED ROLE

Staff confidence in their abilities was relatively high with approximately three-quarters of respondents stating that they were very or moderately confident in the identification, assessment and management of BPD. Confidence dropped slightly in relation to developing care plans with 65% reporting to be very or moderately confident at developing them for those with BPD. Three-quarters of respondents also indicated that they found clients with BPD to be very or moderately difficult to look after and 80% believe that they are more difficult to look after compared to other clients. Only 1.5% ($n=1$) of respondents believed that those with BPD were easier to care for than those with other psychiatric disorder. Overall staff were quite definite that they had a role to play in the treatment of those with BPD. Staff strongly agreed that they had a role in the assessment of clients with BPD (79.4%) and their management, (87.3%). Education was also seen as an important role by these nurses with the vast majority stating that they had a role in the education of clients (87.1%)

and their families or carers (83.9%). Despite this high level of confidence among staff almost 90% indicated that they would partake in further training if it was available. There was no significant correlation's between confidence and any of the demographic variables, such as age, gender, length qualified or work location. Neither was confidence correlated with knowledge scores.

Given the importance of accurate identification of disorders in order for them to be treated appropriately it was decided to assess how frequently staff obtained information from clients on particular areas when undertaking a history. While Table 4 summarises the findings from this section a couple of items are particularly worth mentioning. A history of abuse or rape with the area least assessed by respondents with only 42.2% stating they always obtain such information with a further 15.4% usually obtaining this information. Similarly, only 45.3% of respondents always enquired into sexual history while only 48.4% obtaining information on contact with police. A history of abuse or rape and contact with the police were the only two areas where a significant number of nurses reported rarely or never obtaining information about, (12.5% and 10.9% respectively). The area to receive the most attention by staff when taking a history was family history with 87.5% stating they always did so. Areas related to safety were also very likely to be probed when taking a history with 85.9% always assessing the client's history of DSH and suicidality, with a further 79.7% always obtaining information relating to a history of aggression.

Table 4: How often nurses reported gathering information on specific topics when obtaining histories from clients.

When taking a history is information gathered on	Always	Usually	Occasionally
Drug and alcohol history	73.4%	21.9%	4.7%
Family history	87.5%	10.9%	1.6%
Sexual history	45.3%	25.0%	23.4%
Relationship history	60.3%	30.2%	6.3%
Contact with police	48.5%	20.3%	20.3%
History of DSH/suicidality	85.9%	12.5%	1.6%
History of aggression	79.7%	12.5%	4.7%
History of abuse or rape	42.2%	15.6%	29.7%

4.7 CONCLUSION

The results of this research have provided considerable light on Irish psychiatric nurse's attitudes, knowledge and experience towards those with a diagnosis of BPD and the service provided for them. Staff reported having regular, often daily, contact with clients with BPD. While staff almost unanimously agreed that those with BPD were more difficult to care for than clients with other psychiatric disorders they also tended to reject the ideas that those with BPD are not mentally ill or are untreatable. Staff were also of the opinion that they had a role to play in the assessment, management and education of clients with BPD and their families and the vast majority of staff reported that they would partake in further training if it was made available. Knowledge of BPD was reasonably high but there was a disparity between the knowledge of community and ward based staff.

As regards the services for those with BPD the majority of staff believed that they are inadequate. The inherent difficulty in treating BPD was recognised as being a major contributor to the inadequate care but other factors such as MDT disagreements, overly medicalised approaches, lack of appropriate services and training were also believed to have a negative impact on care delivery. The development of a specialist service and standard protocols were viewed by staff as being most likely to improve

the service received by those with BPD. Improved education and the provision of in-service and skills training workshops were also viewed as likely to be helpful but staff were less enthusiastic about training in DBT. Supervision and the provision of information for clients and relatives were also viewed as less important by staff. Chapter 5 will discuss the findings of this study in relation to the international literature and the developments taking place in the Irish mental health services.

Chapter 5

Discussion of Results

5.1 Introduction

If the results outlined in the previous chapter are to be of benefit to nursing practice they must not be looked at in a vacuum. Tierney (1996) states that the purpose of a discussion section is to draw out the meaning of the findings, and can best be summarised by asking the question “so what?”. In order to answer the “so what” question, the findings from this study will be discussed in relation to the relevant literature on BPD in the following four topics.

1. Demographics: the demographic data gathered on respondents will be discussed.
2. Knowledge and experience: the findings regarding knowledge and experience of respondents in relation to BPD will be debated.
3. Attitudes: the findings will be examined in relation to nurses attitudes towards BPD.
4. Services: finally a discussion will be held in order to consider the findings in relation to best practice in the provision of services for BPD.

These four topics are closely related to the research questions, which were:

1. What is the current level of knowledge and experience of Irish nurses towards BPD?
2. Do psychiatric nurses hold negative attitudes towards clients with a diagnosis of BPD?

3. What are the opinions of Irish nurses towards the current state of services and care for clients with BPD?

As we can see the subsections within this chapter correspond to the research questions except for the demographics section, which was included to allow an opportunity to discuss some salient points uncovered by the demographic information but which do not correspond directly to the research questions.

5.2 Demographics

The demographical information of staff working in a mental health service is of great importance as it provides indications of the experience of its staff. Cowman and Gill (2002) carried out a study into the education and training needs of psychiatric nurses working in the Midland Health Board (MHB) in Ireland. This report provides a detailed description of the demographic details of staff in the that health board and also compares them to the overall national demographic trends within psychiatric nursing, which were provided by An Bord Altranais. Their report will therefore be used to collate the demographic details from this study with. The gender mix of staff in the MHB and the respondents to this survey are exactly the same with both reporting males as comprising 32% of all staff. The age profiles however are quite different. In the MHB only 18% of nurses are under forty years old, whereas in this study the figure was 43%. It is important to note that the figure reported in this study is nearer to the national figure of 39% of nurses under forty, (An Bord Altranais figures cited in Cowman and Gill 2002). The MHB has 46% of it's staff employed as staff nurses, including those in Senior Staff Nurse posts, while this study found that 56% of respondents were employed as staff nurses. This figures are likely to be closer in reality as the MHB figures include Directors and Assistant Directors of Nursing

and other staff who were excluded from this study. As regard work location, the figures available in the MHB study were recalculated, removing those staff who reported working in areas that would not have been covered by this survey such as learning disabilities and administration. It was found that approximately 73% of respondents in the MHB were based on inpatient units but in this survey only 56% of staff reported being based on inpatient units. This considerable difference may be related to the community-based philosophy of this study site, where home-care teams were in operation, resulting in CMHNs and Home-Care nurses accounting for 32% of respondents.

One clear message comes across in the literature on BPD - they are a difficult client group to work with, (Bowers 2002, Krawitz and Watson 2003, National Institute for Mental Health in England [NIMHE] 2003), and this view was endorsed by the respondents of this study. Given this inherent difficulty in working with BPD one would assume that the most skilled and experienced staff members should be involved in their care. While the catchment area studied had an age profile similar to the national average, the tendency to have the majority of younger and less experience staff working on inpatient units, where staff reported the most contact with BPD, needs to be questioned.

5.3 Knowledge and Experience

As regards any specific training in BPD only two respondents (3%) had additional training outside of undergraduate lectures, which contrasts sharply with the 32% of respondents who reported having participated in lectures, workshops and supervision sessions on BPD in a similar study of multidisciplinary teams in Australia, (Cleary et

al. 2002). Whether this lack of training opportunities is a symptom of a lack of training available to all Irish professionals, or just nurses is beyond the scope of this study. However given the high numbers of staff stating that they find those with BPD difficult to work with and that almost 90% indicated that they would partake in training if made available, it would appear likely that suitable training and education in relation to BPD is unavailable. This should be addressed given the evidence for positive benefits of training reported in the literature, (Miller and Davenport 1996, Krawitz 2001 & 2004). The importance of this training is underscored by the finding that around two-thirds of respondents believed that the care was inadequate for those with BPD due to their lack of training or expertise and this belief was correlated with viewing those with BPD as being difficult to treat. Cleary et al. (2002) found that only a third of their respondents viewed their lack of training as a factor that contributed to inadequate care and one wonders whether the increased level of education and training on BPD reported by their participants may account for their increased confidence. However, levels of confidence and finding BPD difficult to work with was not found to be correlated with knowledge scores in this study. This would seem to indicate that having more knowledge does not appear to increase confidence in one's abilities and some respondents who had low knowledge scores actually rated themselves as very confident. In practice this means that staff may not always be able to objectively judge their own knowledge deficits and therefore may not partake in training that they may need.

The overall scores on the knowledge questions were reasonably high but the lower scores observed among inpatient staff is of concern. Given the frequent contact between inpatient staff and clients with BPD it is vital that they have access to

appropriate education and training. Faulkner (2004) points out that inpatient care is increasingly been seen as a less popular career choice resulting in staff often opting to leave the inpatient units to work in services seen as more dynamic. Cohen (2001) describes how the enthusiasm behind developing 'dynamic' community services may make recruiting to inpatient settings even more difficult and those that remain on the inpatient unit can feel increasingly demoralised, further damaging the quality of inpatient care. While Faulkner (2004) suggests that good quality education and training can help to maintain the enthusiasm of ward staff this author believes that it is often more difficult for ward staff to attend seminars and workshops compared to community staff who may be able to reorganise their workload to facilitate their attendance at seminars. This leads to a cycle where inpatient staff are unintentionally excluded from training opportunities further decreasing the attractiveness of working in these areas. A realistic means of dealing with this problem may be the development of self-instructional programmes, which have been found to improve the knowledge and attitudes of inpatient nurses towards BPD, (Miller and Davenport 1996).

Knowledge of the diagnostic criteria for BPD was relatively high and was very similar to the results reported by Cleary et al. (2002). Of interest is the fact that in both this study and Cleary's, only about half of the staff recognised that a grandiose sense of self importance is not a feature of the DSM-IV diagnosis of BPD. Compared with Cleary's results on knowledge of treatment options, again similar results were found in relation to the use of antidepressants and short-term psychotherapy. However, almost two-thirds of staff indicated that they agree that those with BPD should not be admitted despite evidence that inpatient care may be a positive intervention, (Nehls 1994b, Gabbard et al. 2000, Dean 2001, Krawitz and Watson

2003). In Cleary et al's (2002) study almost twice as many staff answered this question correctly. One could argue that these wrong answers are a reflection of attitudes towards admissions rather than actual knowledge, however one respondent commented that research had shown that clients with BPD do not benefit from inpatient care. While carrying out the literature review for this research, the researcher did not come up with any research proving this and actually came up with numerous contradicting it. This point will be discussed further in the discussion on services for BPD later in this chapter.

Staff also had some difficulty in the questions related to the prognosis and course of BPD. Those respondents who correctly recognised that clients diagnosed with BPD often obtain considerable stability over a number of years tended to be older and longer qualified. This knowledge may be based on personal experience, that is seeing patients improve, rather than on the results of research such as that by Meares, Stevenson and Comerford (1999) and Zanarini et al. (2003). Perhaps the inclusion of these findings in educational programmes might help to improve the optimism and enthusiasm of nurses, especially younger and less experienced ones, as progress with BPD clients is often slow and requires a long-term perspective in order to avoid burnout, (Krawitz and Watson 2003). The nurses in Bower's (2002) study also reported looking beyond the here-and-now to the long-term perspective also helped them maintain their optimism during difficult times.

As we have seen, while knowledge scores were reasonably high, education is needed as it can help to maintain enthusiasm, positive attitudes and confidence in staff's own abilities. Most importantly, some of the staff here answered questions related to

treatment of BPD incorrectly and this misinformation among staff is likely to lead to inappropriate and poor quality practice. Inpatient staff appear to be in particular need of this training and should be viewed as a priority as they tend to have the most contact with patients, especially when they are at their most unwell.

5.4 Attitudes

Given the broad focus of this study to include knowledge and experience, it is not as focused on attitudes as some other studies (e.g., Markham 2003, Markham and Trower 2003). However, the results do provide an initial appraisal of nurses' attitudes. As mentioned earlier, the majority of staff experience caring for those with BPD as difficult and also more difficult to care for than clients with other psychiatric disorders. This would appear to be in keeping with the general view of working with BPD and the percentages of staff reporting the diagnosis as difficult to treat are similar to those found in the Australian study by Cleary et al. (2002), on whose questionnaire this study was based.

An interesting finding is that a large number of staff appear to reject the notion that those with BPD do not have a mental illness. In the DSM-IV, clients are evaluated on a number of different levels referred to as Axes. On this axial system PDs are placed on axis two, along with mental retardation and the pervasive developmental disorders such as Asperger's. The major psychiatric disorders, such as schizophrenia and depression, are placed on axis one. This may contribute to the view that PDs are not mental illnesses, but rather developmental problems that are unlikely to be amenable to treatment. This separation between those with mental illnesses and those with a PD appears to have been adopted by the Irish government who, in their recent Mental

health Act (2001), explicitly remove those with a PD (and substance abuse disorders) from their definition of mental illness. In this study over 60% of psychiatric nurses did not support the view that those with PD are not mentally ill. This exclusion has the result that those with PDs cannot be admitted to psychiatric care against their will, even when actively suicidal, unless that have another 'mental illness.' This is despite the fact that the rates of successful suicide among those with BPD are similar to the rates of those with schizophrenia and bipolar affective disorder, (Krawitz and Watson 2003), and the Irish government have already stated that suicide prevention programmes are to be intensified, (Department of Health and Children 2001).

An indication of the reasonably positive attitudes of Irish psychiatric nurses towards BPD was an almost unanimous rejection of the idea that those with BPD are untreatable. This finding would appear to be in keeping with the evidence available from research over the last ten to fifteen years indicating that a number of interventions can help bring about positive outcomes for those suffering with BPD, (Linehan 1993, DeCoux-Hampton 1997, Meares, Stevenson and Comerford 1999, Wilberg et al. 1999, Gabbard et al. 2000, Low et al. 2001). Another positive finding was the that over 80% of staff perceived the assessment, treatment and education of those with BPD as part of their nursing role and this again, is similar to the findings of Cleary et al. (2002).

The finding that viewing those with BPD as being mentally unwell was correlated with believing they were also treatable, may have significant implications for the maintenance of enthusiasm and optimism of staff working with clients who have a BPD. Krawitz and Watson (2003) recommend that an ability to remind oneself of

progress, even small ones, is likely to maintain the enthusiasm of staff during difficult periods. Bowers et al. (2002) also found that remaining positive towards PDs was related to the belief that they are treatable. Bowers (2002) also suggests that rejecting the evil or bad labels and reminding oneself of the abuse or traumas the PD patient has experienced also helped nurses stay positive but this was not assessed in this study. Markham and Trower (2003) found that nurses tended to view those with BPD as more in control of their behaviour and therefore less sympathetic towards them when compared to their levels of sympathy towards those with schizophrenia or depression. This would further suggest that the artificial divide between mental illness and PD, as fostered by the Mental Health Act, may actually contribute to negative attitudes and lack of sympathy for BPD. This divide therefore needs consideration, especially in light of recent research findings that indicate the role of various biological factors in the development of BPD, (Trull et al. 2003, Lieb et al. 2004). The value and helpfulness of articles suggesting that as PDs do not fit with the “traditional analytical paradigms of mental illness” and are therefore subject to praise and blame needs to be questioned, (Bray 2003, Bjorklund 2004).

The fact that a number of respondents took the time to comment on their uncomfortableness with the diagnosis of BPD is of interest. While it is unclear as to exactly why staff may be uncomfortable with the diagnosis it would appear to be a common feeling with Becker and Lamb (1994) finding that many clinical staff prefer to diagnose patients, particularly women, with post-traumatic stress disorder even when they meet criteria for BPD. Also, Williams (2002) in her article on BPD cautions nurses to be wary of using labels. This is an interesting position given that numerous user studies and accounts found that patients are relatively happy that the

BPD diagnosis reflected their own view of their problems and are therefore not as uncomfortable with the diagnosis as nurses are, (Miller 1994, Williams 1998, Nehls 1999, Fallon 2003). It is unlikely that the diagnosis of BPD will remain in use and so it is important that nurses gain a clear understanding of the concept. Krawitz and Watson (2003) recognise the controversy surrounding the diagnosis and encourage a broad conceptualisation of the disorder using various theories and perspectives to understand the disorder rather than sticking to one formulation. This approach might help staff to become familiar with the concept of BPD and more objective in their understanding of it. This is made all the easier by the numerous articles appearing which describe BPD from various theoretical standpoints such as object relations (Yeomans and Levy 2002), attachment theory (Holmes 2003), cognitive-behavioural theory (Ellis 1994b, Mills et al. 2004), and even as a shame response, (Crowe 2004).

In summary, it would appear that most staff hold relatively positive views and endorse the nurse's role in providing care for these clients, but a degree of frustration is evident as most staff view care as being inadequate. An uncomfortableness with the diagnosis of BPD among nurses was reported by a small number of participants and this would appear to be in keeping with trends within the international literature. Further examination of this may be of benefit as it was beyond the scope of this research. Most staff perceive clients with BPD as more difficult to care for than clients, which leads us to our next section.

5.5 Services for Clients

The provision of appropriate services for those with BPD is somewhat ambiguous with various models being proposed in the literature. NIMHE (2003) recommend the

development of specialist services for BPD, especially in areas of high concentration of the disorder and the respondents in this study indicated that this would be the most helpful resource in improving the treatment of BPD. However, the reality is that in most parts of Ireland those with BPD will be cared for in the mainstream mental health service and so this section will examine the results of this study in relation to the literature on caring for BPD in general adult mental health services. To elucidate this discussion it shall be divided into a number of subsections:

A Team Approach

Crisis Management & Inpatient Care

Long-Term Management & Outpatient Care

5.5.1 A Team Approach

A worrying finding of this study is that over 80% of staff believe that MDT disagreements lead to inadequate care. The term splitting is often used in the professional literature to describe the cognitive tendency of those with BPD to view others (and themselves) as all bad or all good, resulting in some staff being idealised and others demonised, (Krawitz and Watson 2003). Splitting was never intended to describe a process whereby the client with BPD causes the MDT disagreements but the author believes it is frequently used in this manner in practice. MDT disagreements are likely to be recognised by the patient, increasing their cognitive splitting of staff as good and bad with potentially detrimental effects, (Gallop 1985, Gallop 1988, Krawitz and Watson 2003). If care is unguided, with drastically different approaches being taken to manage clients with the same disorder, it is unlikely that they all will be receiving treatment in accordance with best practice and so team disagreements will ensue. Disagreements are therefore more likely to be the

result of poor practice, knowledge or teamwork rather than the patient's behaviours. Krawitz and Watson (2003) suggest that the use of standard treatment guidelines by all staff can aid teamworking and staff in this study gave considerable endorsement to the development of standard treatment protocols for BPD. In the UK (NIMHE 2003) and the US (American Psychiatric Association 2001) national organisations have developed treatment guidelines but no such national organisation exist in Ireland. It might therefore be appropriate for services to either adopt one of these guidelines or to develop their own treatment protocols and this need for improved and co-ordinated strategies in the care of those with BPD has been recommended by other researchers and writers, (O'Brien 1998, Cleary et al. 2002).

Many staff reported agreement with the statement that an overly medicalised approach was leading to inadequate care and this was correlated with MDT disagreements. Numerous articles, books and studies have been published on the use of various psychotherapeutic strategies with BPD, (Nehls 1992, Lenihan 1993, Ellis 1994b, DeCoux-Hampton 1997, Meares et al. 1999, Low et al. 2001, Spradlin 2003, Freeman and Frusco 2004 and Mills et al. 2004). Given the proven benefits in using psychotherapeutic strategies with BPD, it is now accepted that a treatment plan will only be successful for these clients if such strategies are utilised, (American Psychiatric Association 2001, Krawitz and Watson 2003). Unfortunately, there is evidence that counselling and psychotherapy are in short supply within the Irish Mental Health services, (Expert Group on Mental Health Policy 2004a and 2004b), and this will need to be addressed if appropriate services are to be provided for those with BPD. The relationship found between MDT disagreements and staff viewing

care as being overly medicalised may be better explained by the lack of treatment options rather than actually choosing a different approach.

5.5.2 Crisis Management & Inpatient Care

As mentioned earlier, working with clients with BPD can be stressful and Irish nurses appear to share this view. Farquharson (2004) states that ward staff are particularly susceptible to burnout when working with difficult patients as on a ward the “therapy hour” never ends. Previous research has already identified the emotional stress involved in caring for clients with BPD, (O’Brien and Flote 1997, Nehls 2000) and much has been written about managing the countertransferences within the nurse-patient relationship and some specifically focusing on BPD, (Gallop 1985 & 1988, O’Kelly 1998, Melia et al. 1999, Wilkins and Warner 2000 and Rayner et al. 2005). Supervision has been reported as vital to help staff working with clients diagnosed with BPD to negotiate these countertransference issues (NIMHE 2001, Bowers 2002, Duff 2003, Krawitz and Watson 2003, Faulkner 2004) but staff in this study rated supervision and team support as one of the resources that would be least likely to be helpful. Why staff viewed supervision as a relatively unimportant resource, despite the fact that the consensus among experts is that it is vital, may be due to the lack of supervision available to Irish mental health nurses. High-quality clinical supervision has been proven to reduce burnout and poor-quality or an absence of supervision may increase job dissatisfaction, (Hyrkas 2005). Bland and Rossen (2005) suggest that CNSs may be the ideal candidate to provide clinical supervision to staff on issues such as team dynamics and countertransference and treatment decisions.

Given the considerable suicide risks that those with BPD may present with, inpatient treatment may be required from time to time. The current myth that inpatient care is counterproductive for BPD was present among the participants on this study and is unlikely to be helpful as it may increase staff frustration and damage nurse-patient relationships, (Eastwick and Grant 2005). As less empathic limit setting styles have been shown to increase violence and anger among inpatients, (Lancee et al. 1995), action should be taken to support nurse-patient relationships and prevent burnout. Evidence suggests that patients can do very well in long-term residential care when psychotherapy is provided, (Gabbard et al. 2000) or in therapeutic communities, (Kelly et al. 2004). Given the poor availability of psychotherapy and the fact that therapeutic communities are almost non-existent in Ireland it would be difficult to justify the use of long-term admissions for BPD in Ireland. Maltzberger (1994) points out that treating chronically suicidal patients is very stressful for all staff involved and the patient's suicidal behaviour frequently evokes a strong counter-suicidal response among staff. As the diagnostic criteria for BPD include suicidality and self-harm counter-suicide measures frequently become the focus of care resulting in long admissions to acute inpatient units, which do not provide appropriate treatments such as psychotherapy and skills training. Maltzberger (1994) argues that such practice is deleterious to such patients as it creates a cycle of admissions aimed at reducing risky behaviours and easing staff tensions, but in the long-term the patient's emotional difficulties are not addressed.

Client controlled short-term crisis admissions of about 48 hours, have been discussed in the literature as being useful for clients with BPD, (Nehls 1993, 1994a & 1994b, Krawitz and Watson 2003). Krawitz and Watson (2003) encourage the view that

inpatient units are a place of respite and not treatment and some clients with BPD have spoken about how crisis admissions are more helpful than long-term admissions, (Williams 1998). If crisis admissions were developed and incorporated as part of an overall treatment protocol for BPD, their admissions would be more likely to be seen as helpful by staff, improving morale and enthusiasm in working with such clients. Inpatient admissions can also be improved by including therapeutic individual and group activities such as teaching problem solving and cognitive-behavioural skills, (Gallop 1992, Krawitz and Watson 2003). The next section will examine the longer term treatment of BPD, which ideally will take place in the community. This author believes that some of the activities described in that section, such as group and individual psychotherapy and education, can also be used to improve inpatient stays.

5.5.3 Long-term Management & Outpatient Care

The expert view is that medication is of limited use in treating BPD, (American Psychiatric Association 2001, Dean 2001, Krawitz and Watson 2003). While medications may be of some benefit in aiding co-morbid psychiatric diagnoses, stabilising mood and coping with crisis it should only ever be used as an adjunct to psychosocial treatments. Dean (2001) specifically cautions against a situation where clients come to engage in magical thinking and expect a tablet to cure the disorder resulting in less emphasis on the psychosocial interventions. Large numbers of nurses reported feeling that care for BPD was overly medicalised and while it is unclear from this study whether this is a reality, the public perception is that the Irish psychiatric services in general are overly reliant on medications, (Lynch 2001, Expert Group on Mental Health Policy 2004b). If medications are being over used, research is needed

to find out why. For example, if treatments are overly medical is this due to a lack of psychosocial alternatives?

The mainstay of treatment for BPD needs to be psychotherapy, (Dean 2001, American Psychiatric Association 2001, Krawitz and Watson 2003). Dialectical Behavioural Therapy (DBT) is a form of cognitive behavioural therapy (CBT) designed specifically for the treatment of BPD. Other therapies, particularly CBT, have been found to be helpful and there are various articles and books outlining their use both on an individual and group basis, (Nehls 1992, Lenihan 1993, Ellis 1994, Miller, Eisner and Allport 1994, Kern et al. 1997, Davidson 2000, McVey and Murphy 2001). Staff indicated in the study that they believe a specialist service for BPD would be the single most beneficial means of improving care. The costs involved in developing such a service may be prohibitory but Clinical Nurse Specialist and Advanced Nurse Practitioner Posts could be developed to provide CBT, both individually and in groups, to those with BPD along with other psychosocial interventions. This would improve the care for the client and would be likely to be cost effective for the health services given the high usage of resources by these clients.

Another area that requires consideration from our findings is the diagnosis. While international figures place the prevalence of BPD at 15-20% of psychiatric inpatients (Dean 2001, Trull et al. 2003), barely 4% of Irish admissions are diagnosed with any PD, (Daly and Walsh 2003). This low level needs to be examined as the disorder may be under diagnosed and research has shown that detection of BPD can improve when appropriate assessment strategies are used, (Zimmerman and Mattia 1999, Schotte 2002). About two thirds of nurses in this study believed that clients not being told

their diagnosis of BPD was having a negative impact on their care. Clients with BPD not being told their diagnosis would be an unsurprising finding as only about 60% of Irish psychiatric patients state they were given any form of diagnosis, (Expert Group on Mental Health 2004a). What is worrying about clients not being told their diagnosis but is that expert opinion on BPD underscores the importance of giving clients a diagnosis and explaining clearly what it means, (American Psychiatric Association 2001, Schotte 2002, Freeman and Fusco 2004). Hoffman et al. (2003) suggest that the family and carers of those diagnosed with BPD can also benefit from being made aware of and educated on the diagnosis and this is in keeping with current calls for more family involvement in psychiatric care, (Mental Health Commission 2005). Similar to the results found by Cleary et al. (2002), the nurses in this study reported a strong belief that the education of patients and families about BPD and it would seem appropriate that this role would be supported and developed. Cowman et al. (1997), highlighted the importance of client education in the Irish psychiatric nurses' role and the nurses in this study gave strong validation to their role in educating clients with BPD and their families about their disorder.

The finding that only 42% of respondents 'always' enquire into a history of abuse or rape when taking histories from clients is of interest to this discussion as up to 70% of clients with BPD have a history of childhood sexual abuse and also have high rates of other forms of physical, sexual and emotional abuse, (Herman et al. 1989, Krawitz and Watson 2003, Lieb et al. 2004). In a study by Gallop et al. (1995) nurses reported a variety of reasons for not enquiring into abuse histories when they were assessing clients, such as fear of upsetting the client further and not being able to deal with the client's emotional difficulties if they were abused. Goater and Meehan (1998) found a

dearth in the detection and awareness of sexual abuse also existed among psychiatrists. These findings are important for a number of reasons. Bowers (2002) found that an understanding of the negative life events that may have contributed to the development of a PD helped to increase positive attitudes and enthusiasm among nurses. Secondly, if sexual abuse is not detected this may have a negative impact on the client's treatment as the issues related to it cannot be dealt with, regardless of diagnosis, (Gallop et al. 1995, Goater and Meehan 1998). This research would lend support to the claims of previous writers, (Gallop et al. 1995, Boutcher and Gallop 1996), that psychiatric nurses require education to learn how to effectively and sensitively assess abuse and this would improve the care received by all clients who may have suffered abuse.

This section has attempted to present the findings of the study in-light of the current literature on services for BPD. The main conclusion is that a co-ordinated and agreed treatment plan is needed for BPD. Staff will also require education and support if they are to fulfil their role in caring for those with BPD.

5.6 Conclusion

Based on the findings of this research and other literature available a number of conclusions can be offered based on the research questions.

Attitudes towards BPD appear reasonably positive with staff reporting a willingness to work with these clients.

Staff report considerable experience and contact with BPD but knowledge is average and so needs action in order to improve it, especially in relation to prognosis and

treatment. Staff based on inpatient settings appear particularly in need of further education.

Staff view services for those with BPD as inadequate for a variety of reasons and some form of treatment protocols or standards might help improve the situation.

Chapter 6

Conclusions and Recommendations

6.1 INTRODUCTION

This chapter will draw together the findings of the study and provide a succinct overview of them by way of conclusion. Based upon these conclusions, numerous implications for nursing practice, education and management will be offered. The limitations of the study and suggestions for future research will also be offered.

6.2 CONCLUSIONS

This section will outline the conclusions drawn from the findings of this study. In order to present them in a meaningful way they will be presented in relation to the research questions set at the outset of this study. These research questions were:

1. Do psychiatric nurses hold negative attitudes towards clients with a diagnosis of BPD?
2. What is the current level of knowledge and experience of Irish nurses towards BPD?
3. What are the opinions of Irish nurses towards the current state of services and care for clients with BPD?

6.2.1 Attitudes

Overall staff appeared to hold reasonably positive attitudes towards BPD with most staff indicating that they believed clients with BPD are mentally unwell and are treatable.

Staff who believe BPD is not a mental illness are more likely to view them as untreatable.

A small number of staff reported an uncomfortableness with the diagnosis and stated they do not use it in practice.

Staff were strong in their view that they have a role in the assessment, treatment and education of clients, and their confidence in their abilities in these roles was relatively strong.

6.2.2 Knowledge & Experience

Most staff have contact with clients with BPD at least weekly and inpatient staff tend to have contact more frequently than community staff.

A considerable number of staff believe that their lack of training and expertise on BPD contributes to the inadequate care received by these clients and believed that in-service and skills training workshops would be of help in addressing these knowledge deficits. Increased education on BPD in undergraduate training is also viewed by staff as being required. Very few staff receive any additional training on BPD once they qualify.

Staff who perceive themselves as lacking training and expertise are likely to report finding clients with BPD as more difficult to work with. However, actual knowledge scores do not have an impact on a respondent's perception of how difficult clients with BPD are to care for or their confidence in assessing or developing care plans for such clients.

Community staff scored statistically higher in terms of knowledge than those working on inpatient units. However age and length of time qualified were not correlated with increased knowledge.

The diagnostic criteria, the benefits of admissions and prognosis are areas that staff appear to have particular knowledge deficits.

Supervision is not viewed by staff as likely to be particularly helpful.

6.2.3 Services

80% of staff believe that the care received by clients with BPD is inadequate and they believe that a shortage of services, overly medicalised treatments, MDT disagreements and the inherent difficulty in treating BPD as being the main reasons as to why care is inadequate.

Clients with BPD not being told their diagnosis was viewed by a majority of staff to impact negatively on their care.

Poor organisation of care, such as no key worker, prolonged hospital admissions and lack of specialist teams were named by staff as leading to inadequate care, along with care that is overly medicalised. MDT disagreements and a lack of appropriate training and skills were also named as being likely to detract from the quality of care.

Staff believe that a specialised service for clients with BPD along with agreed treatment protocols were the resources that would best improve their care.

A large number of staff do not regularly assess a client's sexual history, or enquire into whether the client has a history of abuse and rape when taking a history.

Community based staff are more likely to be working in a promotional post, such as Clinical Nurse Manager or Specialist, than staff working on inpatient units.

6.3 LIMITATIONS OF THIS STUDY

The limitations of a study are important as they allow one to objectively assess the importance and merits of the findings. The main limitations of this study will be outlined here along with some of the measures taken to address them. The first limitation is the questionnaire used and a previously tested questionnaire was used in order to boost the quality of the findings. However, the questionnaire was edited in order to make it suitable for this study and so a pilot test was undertaken in order to check that the revised version was suitable. The Cronbach's alpha coefficient of 0.79 indicates that the questionnaire achieved a considerable level of internal consistency. It is also important to bear in mind that the questionnaire assessed a variety of variables such as knowledge and attitudes to services along with attitudes. While the author believes that this is a strength of the research, especially as it is the first of its kind undertaken in Ireland, it is not as strong a measure of attitudes as some other studies. For example, one of the key components of attitudes is emotions, which were not assessed in this study.

The sample was drawn from one catchment area, which means that the results may be more of a representation of knowledge and attitudes from that catchment area rather than Irish nurses in general. However, the author believes that the catchment area chosen provides a good representation of nurses, with a large variation in age, work location and job title reported. The response rate of 41.4% is similar to the response rates of other studies on attitudes and considerably higher than some. One of the major strengths of this research is that it focused on BPD and not simply on PD's as other studies have done. The reason why this is a bonus is the different PDs are considerably different and staff are likely to have different knowledge, experience and

attitudes towards them. Despite these limitations the author believes that this study does provide a good overview of Irish psychiatric nurse's knowledge, experience and attitudes towards BPD.

6.4 RECOMMENDATIONS FOR FUTURE RESEARCH

While this study provides some direction in the management of BPD future research is needed to examine some of the findings at a deeper level and also to study variables that were beyond the scope of this research. These are:

In line with the current trends in engaging user and carers in the mental health services (Mental Health Commission 2005), research to uncover the opinions of those diagnosed with BPD and their carers, towards the care they receive is required.

More research, ideally using numerous data gathering techniques is required to confirm the findings of this study that nurses attitudes towards BPD are relatively positive. Studies such as those by Gallop et al. (1989), Fraser and Gallop (1993), Markham (2003) and Markham and Trower (2003) could be replicated to test this. Qualitative research to explore the lived experience of working with clients diagnosed with BPD as well as the reasons behind staffs apparent uncomfortableness with the diagnosis. Ideally this research should be multidisciplinary in order to address the difficulties posed by MDT disagreements reported by respondents in this study.

Research is needed to evaluate the effectiveness of all educational programmes delivered to nurses, including in-service training.

As services develop for BPD and other client groups, research to evaluate the outcomes for the clients are required.

6.5 IMPLICATIONS FOR NURSING

The findings from this study highlights numerous areas of concern which may have considerable implications on nursing. These implications will be tendered under the subheadings of practice, education and management.

6.5.1 Practice

Services for clients diagnosed with BPD are practically non-existent resulting in clients receiving inappropriate and ad-hoc care which most nurses believe is inadequate. In line with expert opinion, a specialised service is ideally the best treatment for BPD, especially in areas of high morbidity, (NIMHE 2001, Krawitz and Watson 2003).

If a specialist service is not feasible clients presenting with BPD may need to be treated in the generic psychiatric services. In this case standardised treatment protocols should be developed and adhered to.

The treatment for BPD is primarily psychotherapy based and such services need to be developed if appropriate treatment is to be delivered. Ideally DBT, CBT or psychoanalysis are the therapy modalities most likely to be effective with BPD.

Given the stress that comes with working with BPD burnout and low morale are frequent. High quality clinical supervision has been shown to be beneficial in counteracting such negative situations and therefore should be provided to all staff working with them, but particularly those acting as key workers.

6.5.2 Education

Undergraduate nurse education does not appear to be providing staff with the knowledge and skills required to work effectively with BPD and the third level institutions providing such education need to review curriculum's to ensure that this fault is addressed.

Given the developments in the management of BPD in recent years, regular and appropriate in-service training is needed to address this. Research has shown that appropriate programmes can have a positive influence on the knowledge and attitudes of practitioners towards BPD, (Krawitz 2001 & 2004), even when delivered as a self-instructional programme, (Miller & Davenport 1996).

Ward staff appear to have a particular need to receive appropriate training in relation to BPD and should be seen as a priority for such programmes.

6.5.3 Management

Management have a responsibility to ensure that appropriate training and supervision is provided to all staff and a comprehensive training needs analysis would be appropriate to establish what training is needed.

Inpatient staff may find it particularly difficult to avail of training and management will need to consider how best to provide training to these staff.

The development of mentorship and personal development plans have been recommended to maintain morale and enthusiasm of staff working with clients with BPD (Duff 2003) and could be developed by management.

The allocation of staff to their work location needs to be considered as the majority of experienced staff tend to work in the community. Promotional opportunities appear to be more available for community based staff, which encourages

experienced staff to leave inpatient settings in order to obtain promotions, perhaps to the detriment of the inpatient units. Promotional opportunities, such as CNS and ANP posts, within the inpatient setting are needed to encourage experienced staff to stay in these difficult areas. This was the purpose of the introduction of such posts in the first place, (Government of Ireland, 1998).

It has been recommended that CNSs and ANPs would be particularly suited to providing education, mentorship and supervision to other nurses and this should be a major component of their role.

Many staff reported that MDT disagreements were common and having a negative impact on patient care and management need to be proactive in addressing this problem. The development of clinical pathways or protocols may go some way to deal with the disagreements but the establishment of a MDT committee to examine the care and treatment of those with BPD may also be required.

6.6 SUMMARY

This study set out to examine the knowledge, experience and attitudes of Irish psychiatric nurses towards clients with a diagnosis of BPD as well as to gain an understanding of staff's opinions of the current provision of services for these clients. The author believes that the research was successful in this regard and the implications of these findings for nursing practice, education and management are offered, along with suggestions for future research.

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Appendix A

Diagnostic Criteria for Borderline Personality Disorder

‘A pervasive pattern of interpersonal relationships, self-image, and affects, and marked impulsivity beginning in early childhood and present in a variety of contexts as indicated by five of the following:

- 1
1. Frantic efforts to avoid real or imagined abandonment. **Note:** Do not include suicidal or self-mutilating behaviour covered in Criteria 5.
2. A pattern of unstable and intense interpersonal relationships characterised by alternating between extremes of idealisation and devaluation.
3. Identity disturbance: markedly and persistently unstable self-image or sense of self.
4. Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). **Note:** Do not include suicidal or self-mutilating behaviour covered in Criteria 5.
5. Recurrent suicidal behaviour, gestures or threats, or self-mutilating behaviour.
6. Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).
7. Chronic feelings of emptiness.
8. Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).
9. Transient, stress-related paranoid ideation or severe dissociation symptoms.’

American Psychiatric Association (2000) p.710

Appendix B

Letter to the Director of Nursing of the study site

Dear Sir / Madam,

I am currently undertaking a part-time Masters Degree in Nursing with the Royal College of Surgeons in Ireland.

As part of the research module contained in this course I plan to carry out research study into nurses' attitudes towards clients with a diagnosis of borderline personality disorder. I am focusing on nurses working in clinical posts in any setting. This may include staff nurses, CNMIs, CNM2s, CNSs and CPNs. I will be asking each nurse who participates to complete a questionnaire which will take them about ten to fifteen minutes.

I am writing to seek permission from the you, as Director of Nursing, for permission to use your service as the site for the study. I assure you that the service and individual nurses will not be identified in the study or any report arising from it. If you grant me access to your service I will require a list of all the nurses who are likely to meet the criteria I am looking for.

Enclosed is a copy of the proposal for the study. I will be available, at your convenience to answer any queries you may have. The study has been approved by the ethics committee in the Royal College of Surgeons. I would also be grateful if you could forward any relevant policies or guidelines on carrying out research in your catchment area, to me.

Thank you for considering this proposal and I look forward to hearing from you.

Yours sincerely,

Philip James

APPENDIX C
QUESTIONNAIRE USED BY CLEARY
ET AL. (2002)

STAFF EXPERIENCE, KNOWLEDGE AND ATTITUDES REGARDING CLIENTS' WITH A BORDERLINE PERSONALITY DISORDER

Dear Colleague

The aim of this survey is to improve the management of people who have a diagnosis of borderline personality disorder (BPD). In order to identify ways of improving the service for this client group, it is important to ascertain staff experience, knowledge and attitudes regarding clients' with a BPD. We would therefore be grateful if you would take the time to complete the following questionnaire. Your response will be treated as anonymous at all times.

Please return your completed questionnaire to Michelle Cleary, Clinical Nurse Consultant, Research Unit, Rozelle Hospital, via internal mail.

PLEASE INDICATE YOUR ANSWERS BY TICKING THE APPROPRIATE BOX

1. What is your gender?

- ☐ 1. Male
- ☐ 2. Female

2. In what age group are you?

- ☐ 1. 30 years or less
- ☐ 2. 31 - 40 years
- ☐ 3. 41 - 50 years
- ☐ 4. > 50 years

3. What is your profession?

- ☐ 1. Registered nurse
- ☐ 2. Enrolled nurse
- ☐ 3. Psychiatrist
- ☐ 4. Psychiatry registrar
- ☐ 5. Psychologist
- ☐ 6. Social worker
- ☐ 7. Occupational therapist
- ☐ 8. Other - please specify.....

4. How many years in total have you been working in Mental Health?

- ☐ 1. < 2 years
- ☐ 2. 2 - 5 years
- ☐ 3. 6 - 10 years
- ☐ 4. 11 - 15 years
- ☐ 5. >15 years

5. What is your most frequent place of work?

- ☐ 1. Psychiatric hospital
- ☐ 2. Psychiatric unit in general hospital
- ☐ 3. Community Health Centre
- ☐ 4. Child and Adolescent Unit
- ☐ 5. Other - please specify.....

6. Are your work duties mainly:

- ☐ 1. Clinical?
- ☐ 2. Management / Administrative?
- ☐ 3. Other - please specify.....

7. Have you ever done any specific training in relation to care of people with a diagnosis of Borderline Personality disorder (BPD)?

- ☐ 1. Yes - *Please describe the type of training received in space below:*
☐ 2. No - *go to question 9*
Please describe the type of training received:

.....

8. When was your most recent training:

- ☐ 1. In the last 2 years?
☐ 2. 2 - 5 years ago?
☐ 3. More than 5 years ago?

9. Approximately how often do you come into contact with a client who has a diagnosis of BPD?

- ☐ 1. daily
☐ 2. 1 - 2 times per week
☐ 3. 1 - 2 times a month
☐ 4. 5 - 6 times a year
☐ 5. once a year or less
☐ 6. never

10. Overall, how adequately do you consider that your clients who have a diagnosis of BPD are managed?

- ☐ 1. Adequately - *go to question 12*
☐ 2. Inadequately

11. If you thought management of your clients with BPD was inadequate do you believe this is because: *Tick as many boxes as necessary*

- ☐ 1. You lack training and/or expertise.
☐ 2. There is a shortage of services to treat this client group.
☐ 3. The clients themselves are very difficult to treat.
☐ 4. Other - please specify.....

12. For each of the following statements please state whether you agree, disagree or don't know.

The DSMIV diagnosis of BPD is characterised by:

	Agree	Disagree	Don't know
1.Unstable mood with rapid shifts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.Grandiose sense of self-importance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.Impulsive behaviour particularly self-destructive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

13. The following statements refer to the treatment of people with a BPD. Please state whether you agree, disagree or don't know *for each statement.*

	Agree	Disagree	Don't know
1. Patients with BPD should not be hospitalised	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

II.	Short-term psychotherapy can be useful to manage crises in patients with BPD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
III.	Antidepressant medication is of no benefit to depression experienced by people with BPD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

14. In your opinion, which of the following statement(s) is false of people with a BPD:

Tick *one box only*

- ☐ 1. A significant number attain some stability in their 30s and 40s
- ☐ 2. People with a BPD have a high incidence of depression
- ☐ 3. BPD can progress to schizophrenia
- ☐ 4. May have short-lived psychotic episodes

The following questions will help determine staff needs.

15. When you take a history from clients, please indicate the frequency with which you obtain information for each of the following:

	Always	Usually	Occasionally	Rarely/never
1. Drug and alcohol history	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Family history	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Sexual history	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Relationship history	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Contact with police	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. History of self-harm and suicidality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. History of aggression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other
comments:.....
.....

16. How knowledgeable do you consider yourself in each of the following areas:

	Very	Moderately	Only a little	Not at all
1. The identification of BPD.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. The assessment of BPD.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. The management of BPD.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

16. How confident are you in undertaking the following:

	Very	Moderately	Only a little	Not at all
1. Identification of BPD.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Assessment of BPD.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Ongoing management of BPD.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Awareness of specialist services for BPD.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5. Referral to specialist services for BPD.

☐
☐
☐
☐

18. How difficult do you find dealing with clients who have a BPD?

- ☐ 1. Very difficult
- ☐ 2. Moderately difficult
- ☐ 3. Slightly difficult
- ☐ 4. Neither difficult nor easy
- ☐ 5. Easy

19. How difficult do you find dealing with clients who have a BPD compared to other clients?

- ☐ 1. More difficult
- ☐ 2. The same
- ☐ 3. Less difficult

20. As a mental health professional do you see yourself as having a role in:

	Yes	No	Unsure
1. The assessment of clients with BPD.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. The management of clients with BPD.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. The referral of clients with BPD.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Educating and providing information to clients with BPD.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

21. Which of the following resources would be most helpful to you when working with clients with a diagnosis of BPD:

Tick as many boxes as

necessary

- ☐ 1. Information for distribution to clients
- ☐ 2. Information on where to refer clients
- ☐ 3. Regular in-services about issues
- ☐ 4. Skills training workshop
- ☐ 5. Increased education during undergraduate education/training
- ☐ 6. A specialist service for those clients who have a BPD
- ☐ 7. Standard protocols for management of BPD
- ☐ 8. Other - please

specify.....

22. If further education or training regarding clients with BPD were provided, how much time would you be prepared to spend on training?

- ☐ 1. None
- ☐ 2. 1 hour per month
- ☐ 3. 2 hours a month
- ☐ 4. More than 2 hours a month

23. Are there any other comments you would like to make about this subject?

Thank you again

for your time.

*Please return your completed questionnaire to Michelle Cleary, Clinical Nurse Consultant,
Research Unit, Rozelle Hospital, via internal mail.*

Appendix D

Permission to use Cleary et al's (2002) questionnaire

From: Michelle Cleary [mcleary@roz.cs.nsw.gov.au]
Sent: Sunday, January 4, 2004, 8:53pm
To: Philip James [philipjames@o2.ie]
Cc:
Bcc:
Subject: Re: the article you published on BPD in 2002
Attachments: pd2.doc 51k

Dear Phil,

Please find attached the questionnaire which you are welcome to use all of, or parts thereof. If you should use it, we would appreciate it if you would acknowledge us.

Professor Mile Hazelton's research in the area of BPD may also be of interest/ relevance. He recently presented a paper at the ANZCMHN conference 2003. His email address is: Michael.Hazelton@Newcastle.edu.au

Good luck with your study.

Best wishes,
Michelle

APPENDIX E
QUESTIONNAIRE FROM CLEARY ET
AL. (2002) FOLLOWING SOME INITIAL
EDITING FOR THIS STUDY

STAFF EXPERIENCE, KNOWLEDGE AND ATTITUDES REGARDING CLIENTS' WITH A BORDERLINE PERSONALITY DISORDER

Dear Colleague

The aim of this survey is to improve the management of people who have a diagnosis of borderline personality disorder (BPD). In order to identify ways of improving the service for this client group, it is important to ascertain staff experience, knowledge and attitudes regarding clients' with a BPD. We would therefore be grateful if you would take the time to complete the following questionnaire. Your response will be treated as anonymous at all times.

PLEASE INDICATE YOUR ANSWERS BY TICKING THE APPROPRIATE BOX

1. What is your gender?

- ☐ 1. Male
- ☐ 2. Female

2. In what age group are you?

- ☐ 1. 30 years or less
- ☐ 2. 31 - 40 years
- ☐ 3. 41 - 50 years
- ☐ 4. > 50 years

3. What is your current job title?

- ☐ 1. Staff Nurse
- ☐ 2. CNM 1 or 2
- ☐ 3. CPN/CMHN or CNS
- ☐ 6. Other - please specify.....

4. What is your most frequent place of work?

- ☐ 1. Psychiatric hospital
- ☐ 2. Psychiatric unit in general hospital
- ☐ 3. Community Health Centre
- ☐ 4. Child and Adolescent Unit
- ☐ 5. Other - please specify.....

5. How many years in total have you been working in this Clinical Area?

- ☐ 1. < 2 years
- ☐ 2. 2 - 5 years
- ☐ 3. 6 - 10 years
- ☐ 4. 11 - 15 years
- ☐ 5. >15 years

6. Have you ever done any specific training in relation to care of people with a diagnosis of Borderline Personality disorder (BPD)?

☐ 1. Yes - *Please describe the type of training received in space below:*

☐ 2. No - *go to question 9*

Please describe the type of training received:

.....

.....

.....

7. When was your most recent training:

☐ 1. In the last 2 years?

☐ 2. 2 - 5 years ago?

☐ 3. More than 5 years ago?

8. Approximately how often do you come into contact with a client who has a diagnosis of BPD?

☐ 1. daily

☐ 2. 1 - 2 times per week

☐ 3. 1 - 2 times a month

☐ 4. 5 - 6 times a year

☐ 5. once a year or less

☐ 6. never

9. Overall, how adequately do you consider that your clients who have a diagnosis of BPD are managed?

☐ 1. Adequately - *go to question 12*

☐ 2. Inadequately

10. If you thought management of your clients with BPD was inadequate do you believe this is because:

	Strongly Agree	Agree	Don't Know	I
1. You lack training and/or expertise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
2. There is a shortage of services to treat this client group	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3. The clients themselves are difficult to treat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4. The clients are untreatable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
5. The clients do not have a mental illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Any other reasons:

.....

.....

.....

11. For each of the following statements please state whether you agree, disagree or don't know.

The DSM-IV diagnosis of BPD is characterised by:

	Agree	Disagree	Don't know
--	-------	----------	------------

1.Unstable mood with rapid shifts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.Grandiose sense of self-importance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.Impulsive behaviour particularly self-destructive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

12. The following statements refer to the treatment of people with a BPD. Please state whether you agree, disagree or don't know for each statement.

	Agree	Disagree	Don't know
I. Patients with BPD should not be hospitalised	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
II. Short-term psychotherapy can be useful to manage crises in patients with BPD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
III. Antidepressant medication is of no benefit to depression experienced by people with BPD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

13. For the following statements please indicate whether you believe it to be True or False of people with BPD:

T F

- ☐ ☐ 1. A significant number attain some stability in their 30s and 40s
- ☐ ☐ 2. People with a BPD have a high incidence of depression
- ☐ ☐ 3. BPD can progress to schizophrenia
- ☐ ☐ 4. May have short-lived psychotic episodes

The following questions will help determine staff needs in relation to their dealings with clients with BPD.

14. When you take a history from clients, please indicate the frequency with which you obtain information for each of the following:

	Always	Usually	Occasionally	Rarely/never
1. Drug and alcohol history	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Family history	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Sexual history	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Relationship history	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Contact with police	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. History of self-harm and suicidality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. History of aggression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other
comments:.....
.....

15. How confident are you in undertaking the following:

	Very	Moderately	Only a little	Not at all
1. Identification of BPD.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Assessment of BPD.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Ongoing management of BPD.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Awareness of specialist services for BPD.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Referral to specialist services for BPD.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

16. How difficult do you find dealing with clients who have a BPD?

- ☐ 1. Very difficult
☐ 2. Moderately difficult
☐ 3. Slightly difficult
☐ 4. Neither difficult nor easy
☐ 5. Easy

17. How difficult do you find dealing with clients who have a BPD compared to other clients?

- ☐ 1. More difficult
☐ 2. The same
☐ 3. Less difficult

18. As a mental health professional do you see yourself as having a role in:

	Yes	No	Unsure
1. The assessment of clients with BPD.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. The management of clients with BPD.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. The referral of clients with BPD.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Educating and providing information to clients with BPD.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

19. Which of the following resources would be most helpful to you when working with clients with a diagnosis of BPD:

Tick as many boxes as

necessary

- ☐ 1. Information for distribution to clients
☐ 2. Information on where to refer clients
☐ 3. Regular in-services training
☐ 4. Skills training workshop
☐ 5. Increased education during undergraduate education/training
☐ 6. A specialist service for those clients who have a BPD
☐ 7. Standard protocols for management of BPD
☐ 8. Other - please

specify.....

20. If further education or training regarding clients with BPD were provided, how much time would you be prepared to spend on training?

- ☐ 1. None
- ☐ 2. 1 hour per month
- ☐ 3. 2 hours a month
- ☐ 4. More than 2 hours a month

21. Are there any other comments you would like to make about this subject?

Thank you

again for your time.

Appendix F
Poster circulated before the questionnaires were distributed

All Nursing Staff Please Help

Currently I am planning to carry out a study into the knowledge, experience and attitudes of nurses towards clients with a diagnosis of Borderline Personality Disorder. This study is being undertaken as part of a Masters Degree but it is also hoped that it will help to develop the nursing care for these clients.

I would be grateful if all nurses in the service, who work regularly with patients (i.e. Staff nurses, CPNs, CNM 1&2's, CNSs etc.), could take about 10 minutes to complete a simple questionnaire. I will be forwarding these questionnaires over the next week or so to each staff member and I would be grateful if all staff who fit the criteria above could complete a questionnaire. Participation is voluntary and I assure you that all questionnaires will be treated in the strictest of confidence.

Please contact me at the number or e-mail address below if you do not receive a questionnaire in the next 2 weeks and

**are interested in taking part or if you have any queries
regarding the study.**

**Thanking you,
Philip James
(086) 12345678
philipjames@rcsi.ie**

Appendix G

Letter of explanation attached to each questionnaire

Dear Colleague,

I am currently undertaking a Masters Degree in Nursing with the Royal College of Surgeons in Ireland. As part of my research module I plan to examine the knowledge, experience and attitudes of psychiatric nurses towards clients who have a diagnosis of borderline personality disorder. I wish to survey each nurse working within this catchment area who work regularly with clients, (e.g., staff nurses, CPNs, CNM 1&2's, CNSs etc.).

Permission has been granted by the Director of Nursing to contact nursing staff in this service. If you have regular contact with patients as part of their care and treatment, (i.e., not for research or education purposes) please complete the enclosed questionnaire and return it to me in the envelope provided. This will take approximately 10 minutes and all information gathered will be treated with the strictest of confidence, I will not even know who or has not returned a questionnaire. Please answer each question as honestly as you can. I hoped that the results of this study may help improve the care these clients receive and a copy of the final report will be available to staff on request.

If you have any queries please contact me using either the phone number and e-mail address provided. Thank you for your help in completing the research study.

Yours sincerely,

Philip James
(086) 12345678
philipjames@rcsi.ie

APPENDIX H
QUESTIONNAIRE USED IN THE PILOT
STUDY AND ADAPTED FROM CLEARY
ET AL. (2002)

STAFF EXPERIENCE, KNOWLEDGE AND ATTITUDES REGARDING CLIENTS' WITH A BORDERLINE PERSONALITY DISORDER

Dear Colleague

The aim of this survey is to improve the management of people who have a diagnosis of borderline personality disorder (BPD). In order to identify ways of improving the service for this client group, it is important to ascertain staff experience, knowledge and attitudes regarding clients' with a BPD. We would therefore be grateful if you would take the time to complete the following questionnaire. Your response will be treated as anonymous at all times.

PLEASE INDICATE YOUR ANSWERS BY TICKING THE APPROPRIATE BOX

1. What is your gender?

- ☐ 1. Male
- ☐ 2. Female

2. In what age group are you?

- ☐ 1. 30 years or less
- ☐ 2. 31 - 40 years
- ☐ 3. 41 - 50 years
- ☐ 4. > 50 years

3. What is your current job title?

- ☐ 1. Staff Nurse
- ☐ 2. CNM 1 or 2
- ☐ 3. CPN/CMHN or CNS
- ☐ 6. Other - please specify.....

4. What is your most frequent place of work?

- ☐ 1. Psychiatric hospital
- ☐ 2. Psychiatric unit in general hospital
- ☐ 3. Community Health Centre
- ☐ 4. Child and Adolescent Unit
- ☐ 5. Other - please specify.....

5. How many years in total have you been working in this Clinical Area?

- ☐ 1. < 2 years
- ☐ 2. 2 - 5 years
- ☐ 3. 6 - 10 years
- ☐ 4. 11 - 15 years
- ☐ 5. >15 years

6. Have you ever done any specific training in relation to care of people with a diagnosis of Borderline Personality disorder (BPD)?

- ☐ 1. Yes - *Please describe the type of training received in space below:*
☐ 2. No - *go to question 9*

Please describe the type of training received:

.....
.....
.....
.....

7. When was your most recent training:

- ☐ 1. In the last 2 years?
☐ 2. 2 - 5 years ago?
☐ 3. More than 5 years ago?

8. Approximately how often do you come into contact with a client who has a diagnosis of BPD?

- ☐ 1. daily
☐ 2. 1 - 2 times per week
☐ 3. 1 - 2 times a month
☐ 4. 5 - 6 times a year
☐ 5. once a year or less
☐ 6. never

9. Overall, how adequately do you consider that your clients who have a diagnosis of BPD are managed?

- ☐ 1. Adequately - *go to question 12*
☐ 2. Inadequately

10. If you thought management of your clients with BPD was inadequate do you believe this is because:

	Strongly Agree	Agree	Don't Know	I Disagree
1. You lack training and/or expertise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. There is a shortage of services to treat this client group	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. The clients themselves are difficult to treat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. The clients are untreatable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. The clients do not have a mental illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Any other reasons:

.....
.....
.....

11. For each of the following statements please state whether you agree, disagree or don't know.

The DSM-IV diagnosis of BPD is characterised by:

	Agree	Disagree	Don't know
1.Unstable mood with rapid shifts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.Grandiose sense of self-importance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.Impulsive behaviour particularly self-destructive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

12. The following statements refer to the treatment of people with a BPD. Please state whether you agree, disagree or don't know *for each statement*.

	Agree	Disagree	Don't know
I. Patients with BPD should not be hospitalised	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
II. Short-term psychotherapy can be useful to manage crises in patients with BPD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
III. Antidepressant medication is of no benefit to depression experienced by people with BPD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

13. For the following statements please indicate whether you believe it to be True or False of people with BPD:

T F

- ☐ ☐ 1. A significant number attain some stability in their 30s and 40s
- ☐ ☐ 2. People with a BPD have a high incidence of depression
- ☐ ☐ 3. BPD can progress to schizophrenia
- ☐ ☐ 4. May have short-lived psychotic episodes

The following questions will help determine staff needs in relation to their dealings with clients with BPD.

14. When you take a history from clients, please indicate the frequency with which you obtain information for each of the following:

	Always	Usually	Occasionally	Rarely/never
1. Drug and alcohol history	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Family history	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Sexual history	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Relationship history	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Contact with police	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. History of self-harm and suicidality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. History of aggression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other

comments:.....

.....

15. How confident are you in undertaking the following:

	Very	Moderately	Only a little	Not at all
1. Identification of BPD.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Assessment of BPD.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Ongoing management of BPD.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Awareness of specialist services for BPD.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Referral to specialist services for BPD.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

16. How difficult do you find dealing with clients who have a BPD?

- ☐ 1. Very difficult
☐ 2. Moderately difficult
☐ 3. Slightly difficult
☐ 4. Neither difficult nor easy
☐ 5. Easy

17. How difficult do you find dealing with clients who have a BPD compared to other clients?

- ☐ 1. More difficult
☐ 2. The same
☐ 3. Less difficult

18. As a mental health professional do you see yourself as having a role in:

	Yes	No	Unsure
1. The assessment of clients with BPD.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. The management of clients with BPD.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. The referral of clients with BPD.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Educating and providing information to clients with BPD.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

19. Which of the following resources would be most helpful to you when working with clients with a diagnosis of BPD:

Tick as many boxes as

necessary

- ☐ 1. Information for distribution to clients
☐ 2. Information on where to refer clients
☐ 3. Regular in-services training
☐ 4. Skills training workshop
☐ 5. Increased education during undergraduate education/training
☐ 6. A specialist service for those clients who have a BPD
☐ 7. Standard protocols for management of BPD
☐ 8. Other - please

specify.....

20. If further education or training regarding clients with BPD were provided, how much time would you be prepared to spend on training?

- ☐ 1. None
- ☐ 2. 1 hour per month
- ☐ 3. 2 hours a month
- ☐ 4. More than 2 hours a month

21. Are there any other comments you would like to make about this subject?

for your time.

Thank you again

APPENDIX I
QUESTIONNAIRE USED IN THIS
STUDY AND ADAPTED FROM CLEARY
ET AL. (2002)

STAFF EXPERIENCE, KNOWLEDGE AND ATTITUDES REGARDING CLIENTS' WITH A BORDERLINE PERSONALITY DISORDER

PLEASE INDICATE YOUR ANSWERS BY TICKING THE APPROPRIATE BOX

1. Are you

- ☐ 1. Male?
- ☐ 2. Female?

2. In what age group are you?

- ☐ 1. 25 years or less
- ☐ 2. 26 - 29 years or less
- ☐ 3. 30 - 39 years
- ☐ 4. 40 - 49 years
- ☐ 5. 50 years or more

3. What is your current job title?

- ☐ 1. Staff Nurse
- ☐ 2. CNM 1 or 2
- ☐ 3. CPN/CMHN or CNS
- ☐ 6. Other - please specify.....

4. What is your usual place of work?

- ☐ 1. Acute in-patient unit
- ☐ 2. Care of the elderly
- ☐ 3. Rehabilitation unit / hostel
- ☐ 4. Day hospital / centre
- ☐ 5. Community
- ☐ 6. Other - please specify.....

5. How long have you been working in this Clinical Area?

- ☐ 1. Less than 2 years
- ☐ 2. 2 - 5 years
- ☐ 3. 6 - 10 years
- ☐ 4. 11 - 15 years
- ☐ 5. More than 15 years

6. How long have you been qualified as a Registered Psychiatric Nurse?

- ☐ 1. Less than 2 years

- ☐ 2. 2 - 5 years ago
- ☐ 3. 6 - 10 years ago
- ☐ 4. 11 - 20 years ago
- ☐ 5. 21 years or more

7. Have you ever received any specific training in relation to care of people with a diagnosis of Borderline Personality disorder (BPD)?

- ☐ 1. No
- ☐ 2. Yes - *Please describe the type of training received in space below:*

.....

.....

.....

8. How often do you come into contact with a client who has a diagnosis of BPD?

- ☐ 1. daily
- ☐ 2. 1 - 2 times per week
- ☐ 3. 1 - 2 times a month
- ☐ 4. 5 - 6 times a year
- ☐ 5. once a year or less
- ☐ 6. never

9. Do you consider that your clients who have a diagnosis of BPD are managed:

- ☐ 1. Adequately - *go to question 11*
- ☐ 2. Inadequately

10. If you thought management of your clients with BPD was inadequate do you believe this is because: (please answer for each option)

	Strongly Agree	Agree	Don't Know	Disagree
1. You lack training and/or expertise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. There is a shortage of services to treat this client group	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. The clients themselves are difficult to treat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. The clients are untreatable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. The clients do not have a mental illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Clients are often not told their diagnosis and therefore cannot learn to cope with it	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. There are frequent disagreements with the multidisciplinary team as to how to best treat these clients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. BPD has been overly medicalised and therefore the treatments used are inappropriate, e.g. medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Any other reasons:

.....
.....
.....

11. For each of the following statements please state whether you agree, disagree or don't know.

The DSM-IV diagnosis of BPD is characterised by:

	Agree	Disagree	Don't know
1.Unstable mood with rapid shifts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.Grandiose sense of self-importance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.Impulsive behaviour particularly self-destructive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

12. The following statements refer to the treatment of people with a BPD. Please state whether you agree, disagree or don't know for each statement.

	Agree	Disagree	Don't know
I. Patients with BPD should not be hospitalised	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
II. Short-term psychotherapy can be useful to manage crises in patients with BPD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
III. Antidepressant medication is of no benefit to depression experienced by people with BPD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

13. For the following statements please indicate whether you believe it to be True or False of people with BPD:

T F Don't know

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1. A significant number attain some stability in their 30s and 40s
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2. People with a BPD have a high incidence of depression
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3. BPD can progress to schizophrenia
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4. May have short-lived psychotic episodes

The following questions will help determine staff needs in relation to their dealings with clients with BPD.

14. When taking a history from clients, do you obtain information for each of the following:

	Always	Usually	Occasionally	Rarely/never
1. Drug and alcohol history	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Family history	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Sexual history	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Relationship history	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Contact with police	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. History of self-harm and suicidality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

____ A liaison psychiatric service in Accident and Emergency
____ Supervision / Team support
____ Other - please
specify.....

20. If further education or training regarding clients with BPD were provided, would you be interested in undertaking the training?

- ☐ 1. Yes
☐ 2. No

21. Are there any other comments you would like to make about this subject?

again for your time.

Thank you

Appendix J

**Ethical approval received for the study from the
Ethics Committee, Royal College of Surgeons in
Ireland**



Department of Psychology

Mercer Building, Mercer Street Lower, Dublin 2, Ireland.
Tel: +353 1 402 2428 Fax: +353 1 402 2329 email: Psychology@rcsi.ie

Professor Ciarán O'Boyle
B.Sc., PhD, RegPsychol. AFPsSI, AFBPsS
Professor and Chairman

Professor Hannah McGee
BA, PhD, RegPsychol. FPsSI, AFBPsS
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Royal College of Surgeons in Ireland

RC

RCSI Research Ethics Committee

Chair: Ms B. Nolan

Convenor: Prof. H. McGee

Please quote our reference number in all correspondence: MSN 014

10th June 2004.

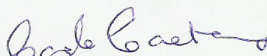
Mr. Philip James,
91, Balreask Manor,
Trim Road,
Co. Navan.

Dear Philip,

**Re: REC MSc Application: MSN 014 – Nurses attitudes towards clients with
borderline personality disorder**

We are pleased to advise that ethical approval has been granted for this study.

Yours sincerely,

pp 
Ms. B. Nolan
(Chair)
Research Ethics Committee