

THE UNIVERSITY OF HULL

A Qualitative Investigation of the Experiences of Nursing Staff working in a Secure  
Personality Disorder Unit.

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by

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## **Overview**

The portfolio has three parts: a systematic literature review, an empirical study and a set of Appendixes.

### **Part one**

A systematic literature review, reviewing the empirical literature relating to staff attitudes towards patients with a personality disorder in an inpatient setting. It aims to present the current understanding of staff attitudes and the components which attribute to this.

### **Part two**

An empirical paper which explores the experiences of nursing staff working in a secure personality disorder unit using qualitative methods. Nursing staff both qualified and unqualified attended semi-structured interviews with the main researcher. These interviews were analysed using Interpretive Phenomenological Analysis (IPA). The data was analysed and the emerging themes are presented and discussed at length, drawing upon existing literature to discuss the implications. The study's methodological limitations are also discussed and potential areas requiring for future research are identified.

### **Part three**

The Appendixes which support the work in the first two parts and includes a reflective account of the research process.

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## **Part One**

### **Systematic Literature Review**

**Staff attitudes to personality disorders in an inpatient setting – a Systematic  
Literature Review**

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This paper is written in the format ready for submission to *The Journal of Clinical  
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### **Synopsis**

**Objective:** Currently, research highlights that staff have a central role in inpatient settings and with personality disorder patients. Furthermore, research states that staff can have negative attitudes towards patients with a diagnosis of Personality Disorder (PD). In order to understand what the nature of staff attitudes is, a systematic literature review was necessary. This review clearly presents current understanding and identifies research gaps. Thus informing future research and clinical practice; it is hoped this will improve the circumstances for both staff and patients.

**Design:** A selection criterion was used to identify publications from searches of several electronic databases; manual searches of reference lists were then conducted. The quality of each study selected was evaluated using established checklists and key findings in relation to attitudes were extracted.

**Results:** Twelve studies were reviewed, eight of which employed a quantitative methodology and four of which employed a qualitative methodology. The main findings extracted from the studies related to: attitudes toward individuals with PD and their behaviour; attitudes toward PD as a psychiatric diagnosis compared to other psychiatric diagnosis; emotional experiences and reactions; attitudes related to profession; views related to the organisation and provision of services for PD.

**Conclusions:** The results of this review suggest that the attitudes of nurses and health care professionals towards patients with a diagnosis of PD are negative and there appears to be a corresponding need for improvement in the clinical management of BPD

(and PD) patients (Deans & Meocevic, 2006). The focus, it would seem, needs to revolve around clinical opportunities and this resonates with what “No longer a Diagnosis of Exclusion” (DoH, 2003) identified in 2003. Staff in several studies expressed that they felt they needed further training and would partake in it if it was offered (James & Cowman, 2007; El- Adl & Hassan, 2009). This would appear to be valuable in offering equal opportunities to patients regardless of diagnostic label.

*Key words: Personality disorder, attitudes, staff, in-patient*

Word count: 11,882

## Staff attitudes to personality disorders in inpatient settings – A Systematic Literature Review

### **Personality Disorder**

Personality disorder (PD) is defined as a pervasive enduring pattern of behaviour and experience which is inflexible, leads to considerable distress or impairment for the individual and is deviant from cultural norms (APA, 2000). Personality disorders are often linked with high risk behaviours (Pidd & Feigenbaum, 2007), as well as characteristics such as lack of remorse for actions and a lack of response to negative consequences or punishment (Pidd & Feigenbaum, 2007). A diagnosis of Borderline Personality Disorder (BPD) differs from almost all other diagnoses of PD, with the person often exhibiting help-seeking behaviour (Higgitt & Fonagy, 1992). BPD is also associated with high levels of self injurious behaviour (DSM-IV, 2000). Some personality disorders are considered to be more represented in services such as BPD (Higgit & Fonagy, 1992). Research has highlighted that nurses who work with patients with a diagnosis of PD often perceive them to be manipulative, particularly with the BPD population (Deans & Meocevic, 2006), complaining, 'attention seeking' or 'trouble' (Gallop & Lancee, 1986). Often, patients are perceived as emotionally unstable, uncooperative, highly anxious, depressed and aggressive (Sarosi, 1968). Lewis and Appleby (1988) found psychiatrists viewed patients with PD to be 'less deserving' of care than other patients. Other associated behaviours, such as impulsivity and sexual promiscuity, are particularly challenging to staff (Pidd & Feigenbaum, 2007).

### **Personality Disorder and Services**

In 2003 the National Institute for Mental Health (NIMHE) produced guidance on personality disorder (PD) called *Personality Disorder: No longer a Diagnosis of Exclusion* (DoH, 2003). It was seen by many as an important move towards ending the marginalisation of services for people with a stigmatising diagnosis of personality disorder (NIMHE, 2003). Its aim was to ensure services were developed but that staff would be equipped with the education and training they need to work effectively with people with a PD (NIMHE, 2003).

Personality disorder in secure mental health settings is a particular problem and can be associated with the occurrence of ‘challenging’, ‘hostile’ behaviour that professional staff have to manage positively (Bateman & Tyrer, 2003). Within medium secure environments staff relationships are hugely significant and professional staff have a central role within the social networks of clients. Some clients see staff as their family (McCann & McKeown, 1995). The centrality of staff relationships to clients is enhanced in locked environments due to limited family contact and restricted community access (Dennis & Leach, 2007). Currently, there are consistent experiences amongst both inpatient and community staff when working with people with a diagnosis of personality disorder (El-Adl & Hassan, 2009).

An effect of diagnostic label may be the opportunities a patient has for therapeutic intervention, with fewer opportunities being given to an individual with a diagnosis of BPD (Mason et al, 2010a). Previous literature has identified that staff

working with people with a diagnosis of PD often experience strong negative emotions (Gunderson, Najavits, Leonhard, Sullivan & Sabo, 1997; Adler, 1993). There is also burgeoning evidence in forensic psychiatry settings that care planning is influenced by diagnostic labels (Mason, Ricman & Mercer, 2002).

### **Attitudes of Staff Toward Personality Disorders**

As is stated by Bateman and Tyrer (2003; page 10): “Reactions of staff to patients with PD commonly subvert the task of treatment and lead to inappropriate actions on the part of staff.”. The emotional responses staff experience towards patients with a diagnosis of PD are disruptive and may harm both staff and patients (Beck et. al, 1990). The initial optimism experienced by healthcare professionals when working with patients with a diagnosis of PD can quickly shift to pessimism when staff engage therapeutically with the individual (Burnham, 1966). Moreover, people’s concepts of PD may be diverse and not congruent with the diagnostic meaning thus influencing peoples’ stereotypes and stigma towards PD (Berrios, 1993). Staff experiences of strong negative emotions whilst working with people with a diagnosis of PD may result in stereotypes being more negative and severe than those stereotypes for other diagnostic labels such as schizophrenia (Markham & Trower, 2003).

Attitudes toward PD are likely to be a key driver behind the emotional and behavioural reactions of staff toward patients who have been given a PD diagnosis. Professionals’ avoidance or withdrawal from the care of these patients can be due to their dislike of them and judgement that patients with PD are less deserving of care than other patients with other diagnoses (Lewis & Appleby, 1988). In 2002 Bowers



conducted extensive research in all forensic hospitals in the UK. The results indicated that nurses who held more positive attitudes towards patients with a PD diagnosis were in senior posts, female and young. Many nurses held negative attitudes including viewing patients with a diagnosis of PD as 'evil' and 'monstrous'. Nurses have been found to respond in a belittling or contradictory way to patients with a diagnosis of BPD and to feel and behave less empathetically towards them (Gallop et. al, 1989). One study compared nurses' responses to patients in a group with various diagnostic labels. The researcher was blind to the diagnosis and rated the nurses' interactions with patients. They identified that patients diagnosed with BPD had less empathetic and less confirming responses from nurses than patients with other diagnostic labels (Fraser & Gallop, 1993)

Several explanations exist for such findings and observations. One hypothesis is that nurses hold less sympathetic views towards patients with a diagnosis of BPD because they view the problem to be separate to mental illness (Markham, 2003). Therefore, as they do not feel BPD is a mental health problem, they view the patient as being in control of their negative behaviour (Lewis & Appleby, 1988; Markham & Trower, 2003). Staff attributions of a person being in control of their challenging behaviour often leads to more negative emotions such as high levels of anger and less sympathy (Sharrock, Day, Qazi & Brewin, 1990). Additionally, patients perceived as ill are considered less accountable for their negative behaviours (Markham 2003).

Another hypothesis regarding negative feelings experienced by nursing staff comes from a psychodynamic perspective. This hypothesis suggests PD patients overuse certain defence mechanisms such as splitting and projection. This overuse of

defence mechanisms means that whilst nurses are interacting with the patients they often experience feelings of anger, hopelessness and guilt (Gabard & Wilkinson, 2000). Staff experiences of helplessness with patients with a diagnosis of BPD could also be attributed, in part, to patients' self injurious behaviours. Research suggests this puts the patient in a role foreign to the usual 'sick role', leaving staff feeling helpless (Fincham & Emery, 1998).

Furthermore research conducted by Mason et al (2010a) looked at inter-professional differences and found nurses and 'non-nurses' both considered patients with PD difficult to engage and treat. Studies investigating the effectiveness of nursing therapeutic interventions have been limited but those which have been conducted have emphasised the difficulties, in forensic and non forensic settings, of treating and managing people with a diagnosis of PD (Mason et al, 2010b). The treatment of individuals with a diagnosis of PD and specifically BPD is complex and health professionals who have been trained to work with patients with a diagnosis of psychosis or mood disorder may not feel adequately equipped to work with patients with a diagnosis of BPD (El-Adl & Hasan, 2009). There are varied characteristics associated with BPD, such as sleep disturbance, frustration, hopelessness, despair, agitation and depression. Research suggests these behaviours are more likely to influence nurses responses to BPD patients (O'Brien, 1998). Additionally, there is some evidence that patients with a diagnosis of BPD can have their destructive behaviours reinforced by long term inpatient admittance. This may be difficult for nurses to tolerate and understand (Koekkoek, Van der Snoek, Oosterwijk & Van Meijel, 2009). Furthermore, behaviour associated with BPD such as chronic suicidality can be extremely demanding

and draining on staff members working in inpatient care (Gallop, 1992). Kaplan (1986) found that when admitted to an inpatient unit, patients frequently communicated a sense of entitlement due to their need for special attention which would elicit angry responses from patients and staff on the unit. Research also suggests the nature of inpatient settings can challenge patients' attempts of securing dominance and staff can respond to aggression, attempting to gain control and order. This can increase the patient's need for control as their need for dominance is persistent, the patient's aggression can thus increase (Daffern et al, 2010). Therefore, at times, staff members' attempts to lower levels of aggression can ultimately increase them as the patient needs to feel dominant and in control. Moreover, aspects such burnout may influence staff members attitudes Tillet (2003) described burnout as a recognised syndrome amongst the helping professions. It can comprise of depersonalisation, emotional exhaustion and lowered personal accomplishment (Maslach, Jackson and Leiter, 1996). Depersonalisation is associated with negative and cynical feelings and attitudes towards clients (Maslach, Jackson and Leiter, 1996). Additionally, staff experiencing there team as unsupportive and view themselves recieveing poor social support has been associated with burnout (Makoto and Masao, 1994). However these aspects are areas of uncertainty in the literature which the review may help clarify.

### **Rationale for Systematic Literature Review**

Currently, research highlights that staff have a central role in inpatient settings and with personality disorder patients. Furthermore, research states that staff of different backgrounds hold potentially negative attitudes towards patients with a diagnosis of personality disorder. The potential consequences of negative attitudes are the emotional and behavioural reactions of staff toward patients. Negative attitudes

have been associated through research with less empathetic and less confirming responses from nurses for patients with BPD compared to patients with other diagnostic labels (Fraser & Gallop, 1993). Despite these findings, the precise nature of ‘negative attitudes’ toward people with PD in in-patient settings has yet to be fully documented and synthesised. This systematic review aimed to provide this synthesis and, in doing so, help to inform future research and clinical practice, which in turn will improve circumstances for both staff and patients in in-patient settings.

### **Research Aim and Question**

The main objective of this review is to clearly identify the current understanding of staff attitudes towards personality disorder patients in inpatient settings, including secure and forensic environments.

Specifically, this review aimed to answer the following question:

What is the nature of staff attitudes towards patients with a diagnosis of personality disorder?

### **Method**

#### **Data Sources and Search Strategy**

This review aimed to capture a broad range of findings and data from different conceptual and epistemological perspectives relating to the views and experiences of staff working with people who have a diagnosis of PD. Detailed information regarding the nature and correlates of staff attitudes was sought. In order to capture a broad range

of evidence relating to these aims, both qualitative and quantitative studies were included.

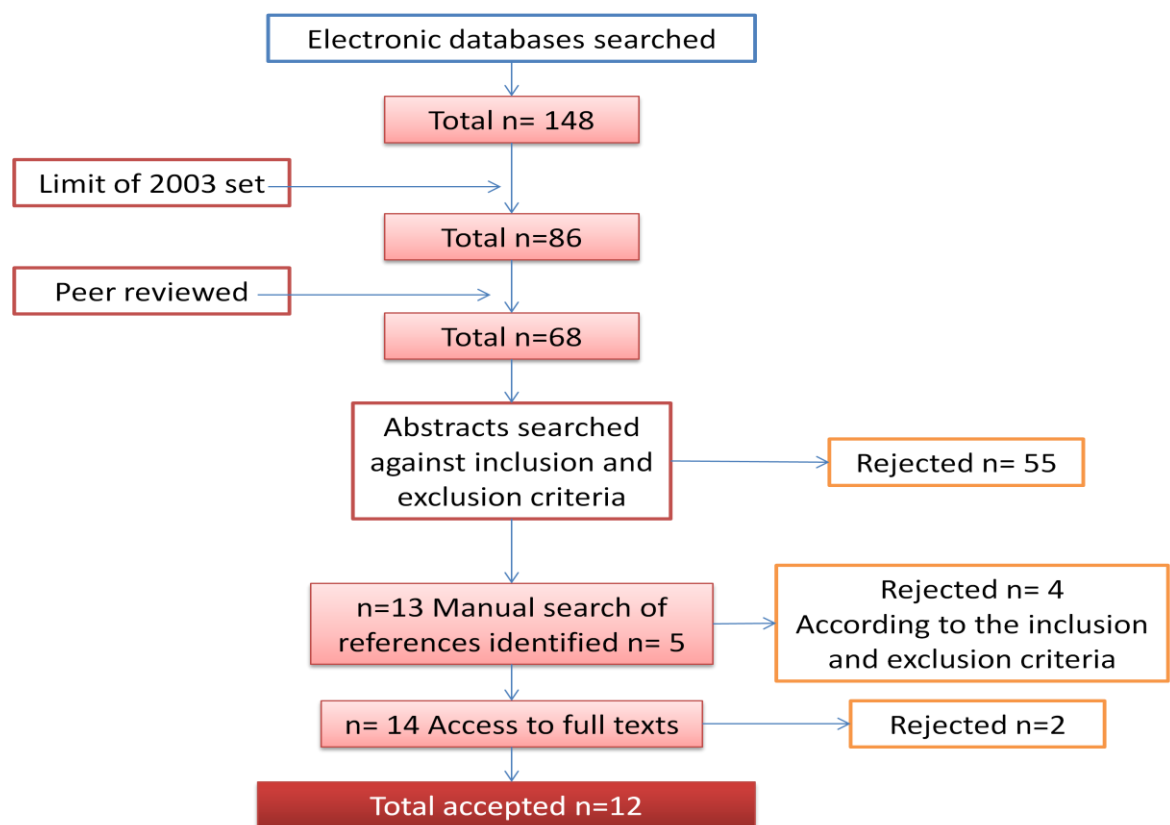
Electronic databases (PsychINFO, PsychARTICLES, MEDLINE and CINAHL) were searched for published articles evaluating staff attitudes to personality disorders in inpatient, secure/forensic inpatient settings. The terms (\*indicates truncation) used were:

( Staff OR health professional\* OR mental health professional\* OR mental health personnel\* OR psychiatrist\* OR nurs\* ) AND ( Attitude\* OR view\* OR opinion\* OR perception\* OR perspective\* OR "nurs\* attitude\*" OR "Psychiatrist\* attitude\*" ) AND ("Personality disorder\*") AND ( Secure OR Forensic OR in\*patient ).

From the initial search 148 papers were identified. A limit was set of 2003 to December 2011. The year of 2003 was selected as “No Longer a Diagnosis of Exclusion” (DoH, 2003) was published in that year. This paper identified that PD was a stigmatising diagnosis. Additionally, it identified that service users with PD found a number of aspects of services unhelpful such as “staff not being interested in causes of behaviour”; staff having “dismissive and pessimistic attitudes” (DoH, pg 22, 2003). Moreover, a few secure units were found to actively exclude PD patients due to a belief that they lacked the skills, resources and training to deal with PD patients. “No Longer a Diagnosis of Exclusion” (DoH, 2003) and “Breaking the Cycle of Rejection: The Personality Disorder Capabilities Framework” (NIMHE, 2003) both aimed to change the development of services for PD including staff perceptions and training of staff. Therefore, research into aspects of difficulty identified such as staff attitudes should flourish.

The limit set reduced the possible articles to 86. Only peer reviewed articles were included, reducing the possible articles to 68. These were searched through using abstracts and full texts where abstracts were deemed uninformative; 55 were excluded using the inclusion and exclusion criteria (see below). For example 2 were excluded due to the focus of the research regarding medication; 10 studies reviewed patient perspectives only and 7 studies were excluded due to the focus of the research being on the conceptualisation of diagnosis such as narcissism. These studies therefore did not meet the inclusion criteria. A manual search of the resultant 13 papers identified 5 articles and 4 were excluded according to the inclusion and exclusion criteria. Two articles although initially appearing suitable were removed following access to the full text. Thus leaving twelve suitable articles according to the criteria (see Figure 1).

Figure 1. *The study selection process.*



**Study selection (inclusion and exclusion criteria)**

Studies were screened against the following inclusion criteria:

- Experiences and views of staff working with patients with a diagnosis of personality disorder.
- Studies which were investigating the nature of staff attitudes
- Studies published after 2003 (Personality Disorder: No longer a diagnosis of exclusion (DoH, 2003)).
- Peer reviewed studies.
- Studies conducted with inpatient staff or including a large sample of staff working in inpatient settings.

Due to the broad nature of the review question inclusion criteria regarding study design were not applied. The aim of this was to capture a broad range of findings and data relating to the views and experiences of staff from different conceptual and epistemological perspectives.

Studies were screened against the following exclusion criteria

- Studies which did not include a specific focus on personality disorder.
- Studies which did not include staff working in an inpatient setting
- Literature reviews or other non-empirical papers.
- Case studies

- Studies not printed in English
- Studies which have not been peer reviewed

The rationale for the inclusion and exclusion criteria can be found in Appendix B.

### **Study Quality Assessment**

In order to assess methodological quality two checklists were utilised. The first was specifically for studies involving quantitative methodology and was based on that developed by Downs and Black (1998) (See Appendix C). This checklist was designed to profile and provide a rating of the methodological strengths and weaknesses of each study. There is both an overall score for quality and profile scores of quality of reporting, external validity and internal validity. The checklist involves a point scoring system, with 'yes' being represented by '1' and 'no' being represented by '0'. Each study was given an overall quality rating, with the maximum score being 13/13. Some of the criteria within the checklist were of particular interest such as whether the variables were clearly defined, whether the characteristic of the participants included in the studies were clearly described and whether the limitations of the study were clearly described.

The second quality rating checklist used was a methodology checklist recently developed for qualitative studies (National Institute for Health and Clinical Excellence (2007) (See Appendix D). This checklist has a number of responses to questions such as 'appropriate', 'unclear' and 'not appropriate' or 'clearly described', 'unclear' and 'not represented'. All the positive statements were marked '1' and ambiguous or



negative statements were marked as '0'. The checklist was designed to rate quality in qualitative studies using four guiding principles: research should be contributory, defensible in design, credible in claim and rigorous in conduct. Due to the nature of the review some criteria were of specific interest, such as, was appropriate participant sampling and recruitment strategy for the research question used; were the implications of the study clearly defined and were the limitations of the study discussed. This is due to the review specifically looking at staff and having an interest in the impact of the nature of attitudes. Each study was given an overall quality rating and the maximum score was 13/13.

To ensure reliability of scoring and to validate the scores an independent rater blind rated four of the studies, two quantitative and two qualitative. The independent rater rated 100% in agreement with the researcher. The results of the checklist scores for the quantitative studies can be found in Appendix E. The results of the checklist scores for the qualitative studies can be found in Appendix F.

### **Data Extraction and Synthesis**

Data extraction was conducted using a form specifically designed for this purpose (see Appendix G). The information collected from studies included study aim, design, characteristics of sample, variables studied, methodology, results and findings. The aim of the review was to review the nature of staff attitudes towards patients with personality disorder. As such the studies identified following a search of the databases mostly covered perceptions and experiences of staff members, using different epistemological and methodological approaches. Due to both quantitative and

qualitative studies being included a meta-analysis was not possible. Furthermore, the focus of the studies and aims of the review pointed towards using a narrative synthesis to pull together and identify any differences in the views and experiences which were gathered by studies using different methodologies. Once data extraction sheets had been generated for the studies a narrative synthesis of their findings began.

## **Results**

### **Overview of Search Results**

Twelve studies met all selection criteria and were included in the review they were obtained via database searches. Study selection methodology is depicted in Figure 1.

Of the twelve studies, eight employed a quantitative methodology (Bowers et al, 2006; Mason et al, 2010a; James & Cowman, 2007; Markham, 2003; Markham & Trower, 2003; Mason et al, 2010b; El- Adl & Hassan, 2009; Deans & Meocevic, 2006; and four employed a qualitative methodology (Woollaston & Hixenbaugh, 2008; Kurtz & Turner, 2007; Grounds et. al, 2004; Fortune et. al. 2010). The studies which used a quantitative methodology (see Table 1) tended to conduct surveys to investigate attitudes towards personality disorder and, specifically, BPD, to investigate differences in attitudes in relation to diagnostic labels and identify differences between professionals. In contrast, the studies which used qualitative methodologies tended to focus on the direct experiences, perspectives, values and beliefs on working with people with a diagnosis of personality disorder.

The quantitative studies provided less rich data due to the restrictions of the survey designs and variations in measures used. In general, designs were more variable, data collection methods were mainly surveys, sample sizes were larger than qualitative samples and findings were presented statistically. All but one of these studies were conducted in the UK and Ireland. Deans and Meocevics' (2006) study was conducted in Melbourne, Australia. Participants (1457 in total) were members of multidisciplinary teams working within the NHS either in inpatient settings and/or community settings. If a study included a sample of inpatient staff and a sample of community staff it was included, providing inpatient staff participants and community staff participants were clearly described. For the study conducted outside of the UK the participants worked in Central East psychiatric inpatient unit and psychiatric community services (Deans & Meocevics, 2006).

For the qualitative studies (see Table 2), participant samples were small, with 133 in total. These studies used face to face semi-structured interviews, in the main, to collect data, which were then analysed using thematic frameworks. Thematic content analysis was used by three of the four qualitative studies (Fortune et al., 2010; Grounds et al., 2004; Woollaston & Hixenbaugh, 2008) whilst Kurtz and Turner (2007) used grounded theory. Despite thematic content analysis being used by three studies methodologies still varied with Grounds et al., (2004) using vignettes. Importantly, all studies were interested in the views and/ or experiences of staff and to a large degree were descriptive, although involved varying conceptual and methodological positions. The similarity in the inherent aims of all the studies allowed for information to be synthesised in a narrative way; identifying commonalities and differences between the

studies reviewed to attempt to identify the nature of staff attitudes towards patients with a PD diagnosis.

Tables 1 and 2 summarise the characteristics and key findings of the twelve studies.

### **Quality Assessment and Data Synthesis**

The results of quality assessments are presented in Appendices E and F. Quality assessment ratings for the quantitative studies were variable ranging from 3/13 to 11/13. No studies were excluded due to poor quality scores as reliability and validity of findings was analysed and discussed. The merits of each study were assessed using the checklists described and this then formed part of the narrative synthesis. By including all studies and then analysing the reliability and validity of the results within the text, all pertinent information could be included in the review and readers can also be guided on how trustworthy and generalisable this information is. The majority of studies were poor at reporting attrition of participants. High scoring studies had clear research objectives, defined variables clearly and reported results well. The majority of studies related their conclusions to their main questions or objectives. In general, the studies were poor at using standardised measures, choosing to mostly use researcher designed ones specifically for the study or adapted versions of standardised measures.

The quality assessment ratings for the qualitative studies ranged between 8/13 and 11/13. The majority of the qualitative studies were of high quality. The main strengths of studies were clear objectives, clearly reported and rigorous qualitative methodologies, and clear presentation of information such as participant demographics. High ratings were given to studies where there was adequate sampling as this increases validity and reliability of the findings. Two studies (James & Cowman, 2007; Grounds et al., 2004) did less well at presenting research questions. Additionally, some studies

did not report the implications of the findings or their limitations clearly; samples were often small and focused within specific settings.

Table 1

*Data from the quantitative studies included in the review.*

Author(s)	Quality rating	Study aim	Methods and Participants	Key Findings
Bowers, Carr-Walker, Allan, Callaghan, Nijman & Paton (2006).	10	To investigate links between “attitude to PD and job performance, perception of managers, personal well-being, burnout and interaction with inmates.”	<p>Longitudinal study</p> <p>data taken at baseline, eight and sixteen months.</p> <p>three phases were conducted</p> <p>Participants</p> <p>59 Prison officers working on new Dangerous and Severe PD unit within a UK prison.</p> <p>11 senior officers</p> <p>The Governor of the DSPD unit</p>	<p>Findings suggested that attitudes towards PD prisoners did become more negative during the second set of 8 months.</p> <p>Participants who did become more positive described fewer bad change events and more good.</p> <p>Better attitude to personality was associated</p>

			<p>1 psychiatric nurse</p> <p>Majority of officers aged in their thirties and forties.</p> <p>Ratio of male to female officers was 4.5-1.</p> <p>Measures used:</p> <ul style="list-style-type: none"> <li>• Attitude to Personality Disorder Questionnaire (APDQ, Bowers, McFarlene, Kiyimba, Clark, &amp; Alexander, 2000).</li> <li>• Staff Attitude to Personality Disorder Interview Follow Up (SAPDI-FU).</li> <li>• Interaction Observation Checklist (OC, Sandford, Elzinga, &amp; Iversen, 1990; Sason-Fisher, Poole, &amp; Thompson, 1979;</li> </ul>	<p>with a number of factors:</p> <ul style="list-style-type: none"> <li>• lower stress,</li> <li>• greater mental well being,</li> <li>• lower burnout,</li> <li>• a more positive perception of managers</li> <li>• improved work performance.</li> </ul> <p>There was a lower mean of enjoyment for staff taking sick leave although causality was not clear.</p>
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			<p>Tyson, Lambert, &amp; Beattie, 1995)</p> <ul style="list-style-type: none"> <li>• The Behaviour Index (Devised for the study)</li> <li>• General Health Questionnaire (GHQ-12, Goldberg &amp; Williams, 1988).</li> <li>• Maslach Burnout Inventory (MBI, Maslach &amp; Jackson, 1981)</li> <li>• NEO-FFI (McCrae &amp; Costa, 1985)</li> <li>• Official records were also examined</li> </ul>	
Mason, Caulfield, Hall and Melling	9	To establish if differences in perceptions of diagnostic labels existed within and	<p>Survey design</p> <p>Professionals working in High, Medium and Low secure psychiatric services in the UK.</p>	Findings suggest there is an agreement across the disciplines surveyed.



(2010a)		between two groups of professionals.	<p>Participants</p> <p>416 Forensic Psychiatric Nurses; 129 Females and 287 Males.</p> <p>129 Non-Nursing professions;</p> <p>(33 Medical</p> <p>45 Psychologists</p> <p>21 Social Worker</p> <p>30 Occupational Therapists)</p> <p>81 Females and 48 males.</p> <p>Measures used:</p> <ul style="list-style-type: none"> <li>• Questionnaire designed by researchers.</li> </ul>	<p>Patients with a diagnosis of PD were considered as more of a management concern than patients with a mental illness who were considered to be more treatable and responsive to clinical intervention.</p> <p>Results “infer nurses and non-nurses consider PD patients difficult to engage and/or treat. The professionals lack confidence in the outcome or efficacy of clinical interventions with the PD patient group.” (pg 340)</p>
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James and Cowman (2007)	9	To describe the experiences and attitudes of nurses who deliver nursing care to clients/patients with BPD	<p>Survey design</p> <p>Participants</p> <p>157 nurses working in the community and inpatient settings.</p> <p>21 Male and 44 Female.</p> <p>Working in:</p> <p>17 Acute inpatient unit</p> <p>1 Care of the elderly</p> <p>19 Rehabilitation unit/hostel</p> <p>6 Day hospital/centre</p> <p>21 Community/homecare</p>	<p>Experience and confidence of staff</p> <p>A high number of respondents believed that BPD clients are more difficult to look after than other clients they also indicated they found these clients difficult to look after.</p> <p>Attitudes of staff</p> <p><i>Views on services for BPD</i></p> <p>specialist services were the most endorsed by the respondents. The majority of respondents believed that care was inadequate for clients with BPD mostly due to a shortage of services.</p>
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				<p><i>Attitudes towards caring for BPD</i></p> <p>Staff felt they would partake in additional training if provided but that they identified they had a role in the management and treatment of BPD clients. The majority felt that their role in the education of clients, their families and their careers was important.</p>
Markham (2003)	11	To evaluate the effects of the label BPD on staff attitudes and perceptions	<p>Repeated measures factorial design</p> <p>Participants</p> <p>50 Registered Mental Health nurses</p>	<p><i>Experiences of working with patients with a diagnosis of BPD</i></p> <p>Staff were more negative about their experience working with BPD compared to</p>

			<p>21 Health Care Assistants</p> <p>Majority of staff had worked with more than 5 BPD patients.</p> <p>Measures used:</p> <ul style="list-style-type: none"> <li>• Social distance (modified from Ingamells et al., 1996)</li> <li>• Beliefs about dangerousness a scale developed by Link et al., (1987)</li> <li>• Optimism: Four statements taken from (Dagnan et al., (1998)</li> </ul>	<p>other patient group additionally they were least optimistic patients with a BPD diagnosis.</p> <p><i>Social rejection</i></p> <p>Nurses expressed more social rejection towards patients with BPD. HCAs did not make this distinction.</p> <p><i>Dangerousness</i></p> <p>Patients with a diagnosis of schizophrenia were perceived to be less dangerous than patients with BPD. HCAs did not make this distinction.</p>
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Markham and Trower (2003)	9	The aim of the study was to investigate how the psychiatric label 'borderline personality disorder' (BPD) affected staffs perceptions and causal attributions about patients' behaviour	<p>Questionnaire within participants design. Adult or older adult in-patient facilities of an NHS trust.</p> <p>Participants</p> <p>48 qualified Mental Health Nursing (12 males and 33 females; 3 participants did not identify their gender)</p> <p>Mean age was 38 (SD= 9.3) and mean length of nursing experience was 12.7 (SD= 8.9).</p> <p>Measures used:</p> <ul style="list-style-type: none"> <li>• Attribution questionnaire (Modified</li> </ul>	<p>Patients with a label of BPD attracted more negative responses from staff than those with a label of schizophrenia or depression.</p> <p>Causes of their negative behaviour were rated as more stable and they were thought to be more in control of the causes of the behaviour and the behaviour itself.</p> <p>Staff reported less sympathy and optimism towards patients with a diagnosis of BPD and rated their personal experiences as more</p>
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			<p>version of Dagnan et al., 1998)</p> <ul style="list-style-type: none"> <li>• Short examples of challenging behaviour (based on Dagnan et al., 1998)</li> </ul>	negative than their experiences of working with patients with a diagnosis of depression or schizophrenia.
Mason, Hall, Caulfield, Melling (2010b)	7	To identify if differences of nurses perceptions exist according to diagnostic labels.	<p>Survey design</p> <p>Working in high, medium and low secure settings.</p> <p>Participants</p> <p>416 Qualified Forensic Psychiatric Nurses</p> <p>122 from High secure (88 males and 34 females)</p> <p>159 from medium secure (9108 males and 51 females)</p> <p>135 from low secure</p>	<p>For all levels of security there was a focus on the management of people with a PD.</p> <p>For medium and low secure units there was a focus on the clinical treatment for those with a diagnosis of mental illness; this was not the case for high secure.</p>

			(91 males and 44 females)	
El- Adl & Hassan (2009)	3	To examine the adult mental health clinicians experience whilst working with individuals diagnosed with BPD and ways of supporting them.  to identify training needs	<p>Cross sectional survey</p> <p>adult mental health clinicians employed by Northamptonshire Healthcare NHS Foundation trust</p> <p>Participants</p> <p>185 Mental health personnel</p> <p>40 Psychiatrists</p> <p>Within Community Mental Health teams:</p> <p>60 Community Mental Health Nurses</p> <p>25 Mental Health Social Workers (SW)</p>	<p>Working with BPD is experienced as stressful and challenging by the majority.</p> <p>85% agreed training was needed.</p> <p>Majority of clinicians experience managing individuals diagnosed with BPD as challenging.</p> <p>Their comments on perception of patients as manipulative, stressful, difficult to work.</p>

			<p>10 Occupational Therapists (OT)</p> <p>3 Psychologists</p> <p>Within an inpatient unit:</p> <p>40 Psychiatric nurses</p> <p>4 OT</p> <p>3 Psychologists</p>	
Deans & Meocevic (2006)	6	To describe psychiatric nurses attitudes towards individuals diagnosed with BPD	<p>Survey conducted in Central East psychiatric inpatient unit and psychiatric community services located in Melbourne.</p> <p>65 registered nurses</p>	<p><i>Emotional reactions when caring for someone with BPD</i></p> <p>The most frequent response from participants was that they perceived people with BPD as manipulative. Many</p>



			<p>Measures used:</p> <ul style="list-style-type: none"><li>• Questionnaire developed by Little (1999).</li></ul>	<p>consistently had negative emotional reactions towards people with BPD. Over half of the participants viewed them as engaging in blackmail. Over one third reported that they perceived people with BPD as nuisances and that they made them feel angry. Fewer than half the participants reported knowing how to care for people with BPD.</p> <p><i>Responsibility for actions</i></p> <p>Suicide and breaking the law was viewed by the majority of participants as the patient with BPDs responsibility. Half of the</p>
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				<p>participants felt it was their responsibility to keep the person with BPD safe. The results showed mixed concerns for the level of fault if the person with BPD committed suicide. Half felt there would be legal consequences for them if the person with BPD committed suicide.</p> <p><i>Management of clients with BPD</i></p> <p>One quarter of respondents felt that the patient should be managed by specialist services, half felt there should be a number of agencies involved. A small proportion felt the person with BPD should be</p>
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				medicated (11%), admitted to hospital (15%) and should never be admitted to hospital (9%).
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Table 2

*Data from the qualitative studies included in the review.*

Author(s)	Quality rating	Study aim	Methods and Participants	Key Findings
Woollaston & Hixenbaugh (2008)	11	The aim was to explore nurses relationships with BPD patients from their	Semi-structured interviews Thematic analysis was used to raise themes from data.	One core theme and four major themes were identified. The core theme was 'Destructive Whirlwind' Theme 1: Care Giving

		own perspective.	<p>Participants</p> <p>6 Nurses</p> <p>Working:</p> <p>4 Acute adult ward</p> <p>1 in the community</p> <p>1 Supported tenancy scheme.</p> <p>All had experiences of working on psychiatric wards.</p> <p>length of service 2-17years.</p> <p>Age range early 20s to late 40s.</p>	<p>Theme 2: Idealized and demonized</p> <p>Theme 3: Manipulation</p> <p>Theme 4: Threatening</p>
Kurtz & Turner	11	To explore needs of staff	Semi-structured interviews	Other colleagues and society outside the unit including

(2007)		who care for offenders with a diagnosis of PD	<p>All working on a specialist personality disorder secure ward.</p> <p>Grounded theory was used to analyse the data.</p> <p>5 Nurses (3 male and 2 female)</p> <p>1 community nurse (male)</p> <p>1 probation officer (male)</p> <p>2 Psychiatrists (1 male and 1 female)</p>	<p>the media were viewed as having an unsympathetic attitude to PD.</p> <p>Staff expressed a desire for deeper and more genuine contact in their relationships with patients, whole person not just behaviour.</p> <p>Feeling physically safe but emotionally vulnerable.</p> <p>Staff reported emotional vulnerability.</p> <p>The levels of control exerted were viewed as infantilising patients and prevent positive risk taking.</p> <p>In addition it was viewed as affecting communication.</p>
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			<p>1 psychologist (female)</p> <p>1 OT (female)</p> <p>1 SW (female)</p> <p>1 Teacher (female)</p> <p>14 participants in total.</p> <p>Years in profession 2 years- 33 years.</p>	
<p>Grounds, Gelsthorpe, Howes,</p>	11	<p>The aim was to elucidate the values, beliefs and</p>	Semi-structured interviews	<p>The decision was more difficult in the case of patients with mental illness with substance abuse and PD they</p>

<p>Melzer, Tom, Braugha, Fryers, Gatward and Meltzer (2004)</p>		<p>professional insights underpinning decisions to admit patients to medium security units.</p>	<p>Participants 55 lead clinicians (Majority were psychiatrists) from 36 medium secure units</p>	<p>were viewed as</p> <ul style="list-style-type: none"> <li>• not responding to treatment</li> <li>• would wear out staff</li> <li>• and have a detrimental effect on other patients.</li> </ul> <p>Results from interviews indicated that some decisions which were regretted involved patients with a degree of mental illness and an ‘untreatable personality disorder’ this resulted in others being affected adversely and an extended stay.</p> <p>Approximately half of participants felt a primary diagnosis of PD would not be admitted as they would be viewed as unsuitable due to being considered as</p>
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				<p>untreatable and also frequently causing disruption amongst staff and patients in the unit.</p> <p>Influence of patients views</p> <p>Resources were viewed as too scarce to admit patients whose stays would be ‘unproductive’. For patients with PD who were considered for psychological treatment, the participants attitude towards co-operation with treatment was viewed as crucial.</p> <p>Half of participants said their units had taken the decision not to admit patients with a primary diagnosis of severe PD the only exception being if they had come from a specialist unit.</p>
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Fortune, Rose, Crawford, Slade, Spence, Mudd, Barrett, Coid, Tyrer & Moran (2010)	8	The aim was to obtain the perspective of service users and staff on: a) the experience of receiving treatment b) the experience of delivering treatment, within new forensic services for PD offenders	<p>Semi- structured interviews</p> <p>Thematic analysis was applied to qualitative interviews</p> <p>Service settings</p> <p>Three services in the UK.</p> <p>1-an inpatient medium secure unit and residential services,</p> <p>2- an inpatient medium secure unit and a community team</p> <p>3- an inpatient medium-secure unit, a community team and a</p>	<p>Power struggles amongst disciplines were reported.</p> <p>Many felt they'd underestimated the emotional impact of the clinical work and described it as relentless and draining.</p> <p>Nearly all participants had felt afraid of service users at some point.</p> <p>Staff left frequently and service users perceived newly recruited staff as naive, vulnerable and easily manipulated.</p>
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			<p>residential service consisting of two hostels.</p> <p>Participants</p> <p>30 service users</p> <p>22 staff</p> <p>Staff</p> <p>6 managers (including 1 psychiatrist and 1 senior nurse)</p> <p>1 psychiatry,</p> <p>3 psychologists,</p> <p>5 nursing,</p> <p>3 health care assistants</p> <p>2 OTS</p>	
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			<p>2 probation and social work.</p> <p>Their mean age was 43 years (range 29-60).</p> <p>All had been working in the services for 18 months-3 years.</p>	
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## **Main Findings**

Five broad themes emerged from a narrative synthesis of the findings of the included studies, with reference to the aims of the review. These were: attitudes toward individuals with PD and their behaviour; attitudes toward PD as a psychiatric diagnosis compared to other psychiatric diagnoses; emotional experiences and reactions; attitudes related to profession; views related to the organisation and provision of services for PD. Tables 1 and 2 present the methodology and overall findings of the studies.

### **1. Attitudes toward individuals with PD and their behaviour**

With some exceptions, all the studies, both quantitative and qualitative, identified negative attitudes towards individuals with PD and their behaviour. Interestingly, negativity was described both through the actions and perceptions of staff. For example, James and Cowman (2007) described ‘critical’ attitudes but illustrated this through examples such as ‘belittling’.

As part of a repeated measures factorial design Markham (2003) investigated whether registered mental health nurses working in in-patient mental health facilities held different beliefs about BPD as compared to depression and schizophrenia. Measures of perceived dangerousness, social distance, optimism for change and ratings of personal experiences were taken. Personal experience was measured using a bi-polar scale ranging from ‘extremely positive’ to ‘extremely negative’. The authors reported that participants were more negative about their experience of working with BPD as compared to the other patient groups. They were also least optimistic about patients with a BPD diagnosis. Despite these findings and their resonance with other work in this area, this study had several limitations. For example, staff were aware they were

being asked about different diagnostic groups and, as the authors suggest, participants might have felt research demands were to answer consistently across all 3 diagnostic groups. Potentially, the participants' views of research demands could have minimised their responses to the scenarios; their attitudes towards BPD could have been even more significantly different. Rather than relying on pre-assigned statements, including qualitative methodologies could have increased the richness and validity of the data (Markham, 2003).

Several other studies suggest that optimism regarding the possibility of treatment is one key element of care staff attitudes toward PD; with staff being less optimistic about BPD patients and expressing less sympathy (Markham & Trower, 2003; Markham, 2003). This is illustrated by Grounds et al., (2004) whose qualitative data indicated lead clinicians were less optimistic about patients with PD. PD patients were also viewed subjectively as having adverse effects on other patients due to their behaviours (Grounds et al, 2004). One methodological strength of this study was the use of a sampling strategy which gave a representative spread of gender of participants, experience of participants and unit characteristics such as newer and older, rural and urban units. Additionally, a relatively large sample for a qualitative methodology was used, with 55 participants increasing generalisability of findings. A possible weakness was the use of vignettes this may have influenced the cases clinicians recall of the decision making process with participant bias. The participants may have assumed the researchers were looking for specific examples or perspectives based solely on the vignettes rather than more generalised aspects of decision making.

Further aspects of the nature of staff attitudes towards patients with PD identified in the research relates to how participants think of patients with PD and their

behaviour. Wollaston and Hixenburgh (2008) investigated nurses' perceptions of patients diagnosed with borderline personality disorder using a sample of six participants, four of whom worked in acute adult wards, one worked in the community and finally one worked in supported housing scheme. The aim of the research was to explore nurses' relationships with BPD patients from their own perspective, using semi-structured interviews to gather data. Experienced nurses reported their subjective experiences of working with BPD patients. Results identified one core theme which entailed BPD patients being described as a 'destructive whirlwind'. Four other themes were identified; Theme 1: Care Giving; Theme 2: Idealized and demonized; Theme 3: Manipulation and Theme 4: Threatening. Within Theme 1, Care Giving, participants saw BPD patients as a homogenous group whom all have the same behaviours. A potential limitation of the generalisability of these results is that although all participants had experiences of working on psychiatric wards not all of the six participants worked on psychiatric wards at the time of the research (4 did, 2 did not). This may be a limitation due to participants retrospectively recalling perceptions as opposed to talking about here and now experiences. The sample for this study looked only at nurses' perceptions of patients with a diagnosis of BPD rather than any diagnosis of PD which limits the generalisability of the results.

Beliefs about the tendency for people with PD to be 'manipulative' are reported in some studies. Deans and Moecevic, (2006) surveyed registered nurses employed in a psychiatric inpatient unit and psychiatric community services using a 50 item questionnaire developed by Little (1999). The most frequent response given was that people with a diagnosis of BPD are 'manipulative'. Over half of the respondents felt BPD patients engage in 'emotional blackmail'. These findings are striking but a key

limitation of this study was that the survey instrument was not tested for reliability or validity; its psychometric properties are therefore not clear. Participants in the qualitative study conducted by Woollaston & Hixenburgh (2008) were described as being disruptive likened to a 'destructive whirlwind' which is demanding and draining. They also described the idea that, as a patient group, BPD patients are dishonest and that this results in manipulative behaviours. Dishonesty was linked by participants to a perceived lack of genuineness on the part of people with a diagnosis of BPD. Interactions were talked about in the context of the patient having an agenda, with the staff responding by trying to find the 'real reason' behind their actions or what they were asking for (Woollaston & Hixenbaugh, 2008).

The findings of some studies relate to the perceived impact of PD on relationships between staff and patients. Markham (2003) reported that registered mental health nurses expressed less social rejection towards patients with a diagnosis of schizophrenia or depression and perceived them to be less dangerous than patients with a BPD label. Participants in the study conducted by Woollaston & Hixenbaugh (2008) saw people with PBD as attempting to split the staff team and that this resulted in them feeling divided. This could support why staff are more socially rejecting towards BPD patients as they see them as manipulative. Additionally, if patients' behaviour is perceived as attempting to split teams then patients may be viewed as dangerous.

Not all studies report negative attitudes toward people diagnosed with PD on the part of professional staff. Bowers et al (2006) conducted a study in which they investigated whether it is possible to predict which staff will adjust positively to working with people with PD. They also aimed to confirm links between attitudes to PD and factors such as job performance and wellbeing. They investigated this in a new

dangerous and severe personality disorder unit within a UK prison, conducting a longitudinal study using a number of measures. Their findings suggest that attitudes towards PD prisoners did become more negative, as defined by the Attitude to Personality Disorder Questionnaire (APDQ; Bowers et al, 2000), over a period of approximately 18 months. However, some participants remained positive. One attitude towards PD related to staff expressing interest and liking towards PD patients and a result of this interest and liking was that staff were more open to new experiences and ideas when working with patients with PD (Bowers, et al, 2006). Participants who became more positive over 18 months experienced fewer adverse change events and more positive ones, identified through interviews. A more positive attitude towards PD patients was associated with a more positive perception of managers, lower stress, greater mental well being, lower burnout, and improved work performance. The questions asked in these interviews were general such as “has anything that you’ve heard made you rethink your views?” through to the more specific, e.g. “what about the education and training you’ve received?”. A limitation of this finding was that no examples were provided as to what was considered a good or bad change event. Among the limitations of this study, however, are that the issue of direction of causality was not made clear; a controlled trial might be able to investigate these issues more thoroughly. Additionally, concepts of working relationships and group formation were not investigated this could have impacted some of the factors for example if the group was in the ‘storming’ phase (Tuckman. 1965) when measures were completed.

There is supporting evidence for more positive views towards PD. Kurtz and Turner, (2007) found that staff expressed positive views about working with people with PD, stating that a job in a different environment may be dull. Additionally, staff



were drawn towards the challenges of the work and patients were viewed as more lively (Kurtz & Turner, 2007).

## **2. Attitudes toward PD as a psychiatric diagnosis compared to other psychiatric diagnosis**

Several studies have explored the more general attitudes and perceptions that professional staff hold in relation to PD. Markham and Trower (2003) investigated how the psychiatric label of PD affects nursing staff's perceptions and causal attributions about patients' behaviours. Registered mental health nurses in adult and older adult in-patient facilities were asked to complete an attribution questionnaire based on that developed by Dagnan et al (1998). The nurses were given vignette-based scenarios and asked to generate one major cause for each of the behaviours described in the vignettes. They were then asked to rate their attributions in terms of stability and controllability on a 7-point likert scale. Participants' also rated their levels of sympathy and optimism on a 7-point bipolar scale. They completed these measures in relation to diagnoses of BPD, Schizophrenia or depression. The findings indicated that participants' attitudes towards BPD individuals were more negative and more negative responses to patients with a BPD label were found. The causes of these patients' negative behaviours were rated as more stable and the patients were thought to be more in control of the causes of their behaviour and their behaviour itself. Further research using a between-groups design and qualitative methodologies may add to the validity of these findings since the within-participant design may have incurred participant bias. An additional participant bias may relate to stereotypes as the scenarios included female patients only; the participants may have had stereotypes about female patients, affecting perceptions which relate more to gender than diagnostic label. Nevertheless, Markham and Trower

had a relatively strong methodology using standardised measures although they did adapt them.

Mason et al., (2010a) investigated potential differences in perceptions of diagnostic labels in a forensic setting, surveying differences between nurses and other disciplines (medical, psychologists, Social Workers and Occupational therapists) in high, medium and low secure services. A questionnaire measuring four poles of binary constructs mental illness clinical, mental illness management, personality disorder clinical and personality disorder management was sent to 1200 forensic psychiatric nurses (416 completed and returned the questionnaire) and 300 other non-nursing professionals (129 completed and returned the questionnaire). Both nursing and non-nursing groups were found to hold a 'management' perspective for individuals labelled with PD and a 'clinical' focus for individuals' labelled with mental illness. This implies that nursing professionals continue to perceive PD as not amenable to change through active treatments. This might limit the degree to which people with PD gain access to potentially effective treatments and interventions. This study, however, was not without its limitations. The response rate was low and the non nursing professionals' views on the diagnostic labels were not investigated. Additionally, there is an underlying assumption that a 'management' approach is undesirable compared to a clinical approach and it may be useful to explore this concept further (Mason et al, 2010a).

Mason et al, (2010b) investigated whether nurses' perceptions of diagnostic categories of mental illness and PD differed, looking at differences in perceptions of diagnostic labels across the different levels of secure psychiatric services. A survey design was used in low, medium and high secure services in the UK with forensic psychiatric nurses participating. Results indicate nurses considered PD to be a

management issue and less of a clinical one. The difference between their perceptions is greatest in high secure services and less difference is seen in medium and low secure services. The limitations to this study include a restrictive methodology using quantitative data only and excluding other professionals. Furthermore, results may not be generalisable to other services as forensic services may be very different to other services. The results identified professionals working with PD patients considered them to be less treatable than patients with mental illness as a primary diagnosis (Mason et al, 2010b).

In comparison to other diagnoses, BPD tends to receive the most negative responses amongst professional staff (Markham, 2003; Markham & Trower, 2003). Research supporting this can be found when exploring changes to nurses' perceptions according to their length of experience; Woollaston and Hixenbaugh, (2008) found nurses who were more experienced described going through a process of having to accept they could not help their BPD patients. This subjective account supports the evidence suggesting that there are more negative responses toward BPD compared to other psychiatric diagnoses and that psychiatric diagnosis can determine professionals' attitudes and responses (Markham, 2003; Markham & Trower, 2003; Mason et al, 2010a).

### **3. Emotional experiences and reactions**

As a component and correlate of staff attitudes, the emotional experiences of staff and their reactions to people with PD have been documented in several studies. Staff generally describe negative experiences when working with patients with PD (Bowers et. al, 2006; Markham, 2003; Markham and Trower, 2003; Deans & Meocevic,

2006). Subjective personal accounts also support reports of negative experiences (Grounds et al, 2004; Wollaston & Hixenbaugh, 2008).

El- Adl and Hassan (2009) conducted a cross sectional survey of adult mental health clinicians. In general participants reported a good ability to diagnose BPD. Participants reported that working with patients with PD can be challenging, stressful and difficult (El- Adl & Hassan, 2009). A limitation to this study was that the survey was designed by the researchers for the purposes of the study and was not piloted. Therefore validity and reliability of the findings is not as high due to no standardised measures being used. However, both Kurtz and Turner, (2007) and Wollaston and Hixenbaugh, (2008) found supporting evidence of negative emotional experiences and high levels of stress amongst professionals working with people with PD. Bowers et al, (2006) identified that staff who had lower levels of enjoyment also had more absences due to sickness. A limitation of this study, however, was that causality was not clear.

Research investigating clinical nurses working in a psychiatric service in Dublin, Ireland found that BPD clients were more difficult to look after than other patients (James & Cowman, 2007). This study used a descriptive survey research design with a questionnaire adapted from an Australian study (Cleary et al. 2002). A pilot study was conducted to assess content and face validity and some adaptations were made. One limitation of the study was that its aim was to describe nurses' experiences and attitudes to clients/patients with BPD. It may have been more appropriate to include opportunities for open ended questions and qualitative data in order to properly capture participants' lived experiences in offering support to people with PD. Nonetheless, in this study nurses felt BPD patients weren't getting better. These findings concur with those of Wollaston and Hixenbaugh (2008). In their study, nurses felt they couldn't treat

BPD patients and their reaction to this was to experience hopelessness and experience feelings of inadequacy. Furthermore, findings suggested nurses felt used and devalued (Woollaston & Hixenbaugh, 2008). Fortune et al (2010) found many of the participants in their qualitative study felt they had underestimated the emotional impact of the clinical work with PD patients and described it as relentless and draining.

Several studies report that negative emotional reactions to people with PD on the part of staff are often associated with feeling unsafe. Bowers et al, (2006), for example, found that those prison officers who reported negative emotional reactions to offenders with PD also reported feeling less safe than them. Qualitative work is particularly illustrative of this. Subjectively, staff report feeling afraid of patients with PD at some point (Fortune, 2010). Kurtz and Turner (2007) explored the needs of staff who care for offenders with a diagnosis of PD through semi-structured interviews. The participants were all working on a specialist personality disorder secure ward. Grounded theory was used to analyse the data. Their findings were presented in terms of key contextual factors and areas of concern. They presented findings that nurses report feeling vulnerable at work. A consequence of feeling vulnerable was instability which could lead to isolation.

Evidence that staff experience negative emotions and reactions to PD patients can be found from further qualitative data. Woollaston & Hixenbaugh (2008) identified that relationships with patients were described subjectively as challenging; with staff describing experiences of being idealised, although initially pleasant, often ending in them feeling very uncomfortable from the attention or being demonised as they could not meet the patients' expectations. Nurses reported distress when patients threatened to harm property, themselves and others. This distress, according to nurses' personal accounts, was due to

nurses knowing something was going to happen. Additionally, they felt responsible for these behaviours which they believed the patient had control over and this led to feelings of resentment (Woollaston & Hixenbaugh, 2008).

#### **4. Attitudes related to profession**

Several studies present evidence that attitudes to PD are subject to professional background and healthcare context. Openness and collaboration between staff groups had high value placed on it when working with patients with a diagnosis of personality disorder (Kurtz & Turner, 2007; Grounds et al, 2004). However, in several subjective accounts, participants voiced concerns that professional colleagues do not understand the difficulties of working with patients with a diagnosis of personality disorder (Kurtz & Turner, 2007; Woollaston & Hixenbaugh, 2008).

There was a marked difference between professions' perspectives in some studies (Bowers et al, 2006; Markham, 2003). Alternatively, some results demonstrate consistency across the disciplines, particularly in multi-professional groups where having a shared vision and approach was particularly valued according to Mason et al, (2010a) and Grounds et al (2004).

Fortune et al (2010) evaluated new services for personality disorder offenders looking at both staff and service user perspectives. Three services in the UK were investigated; an inpatient medium secure unit and residential services, an inpatient medium secure unit and a community team and finally an inpatient medium-secure unit, a community team and a residential service consisting of two hostels. Participants consisted of permanent members of staff from each professional group including psychiatry, psychology, nursing, occupational therapy and social work. The service

users were all eligible to be participants due to the service's strict inclusion and exclusion criteria. All were males treated with a primary diagnosis of PD. Interviews were conducted with all participants. The results indicated that subjectively staff reported seeing differences in views of people with PD as representing power struggles amongst disciplines. The results also indicated that staff left frequently, though it is not clear what the causes of this were attributed to. The study does describe some methodological limitations as the interviews were carried out whilst services and treatment programmes were still evolving, so response biases may have been present.

Kurtz and Turner (2007) report that comments to co-workers regarding co-workers actions could be regarded as attacking and, additionally, there were fears of suggesting changes to colleagues within staff teams and outside staff teams. Isolation within the staff group was viewed as having a devastating impact (Kurtz & Turner, 2007). Findings regarding team relationships were limited to qualitative studies. Fortune et al (2010) and Kurtz and Turner (2007) employed a methodology of participants being recruited within one unit each, this may be a limitation to the findings.

Several studies report that staff can feel under skilled in relation to working with PD. Some nurses interviewed by Woollaston & Hixenbaugh (2008) described feeling inadequate stating through personal accounts during interview that they needed to understand there are specialist people who are better at treatment. Other studies identified that staff often desire and need further training in relation to PD (see James & Cowman, 2007; El- Adl & Hassan, 2009). Conversely, Kurtz and Turner (2007) found that staff experienced personal satisfaction when they felt they understood patients' problems.

### **5. Views related to the organisation and provision of services for PD**

Several studies present evidence that attitudes to PD encompass specific attitudes toward the organisation and provision of services for people with PD. Grounds et al (2004) investigated, qualitatively, access to medium secure psychiatric care in England and Wales. Lead clinicians (predominantly psychiatrists) participated, responding to a semi-structured interview schedule. The participants were sent vignettes prior to interview which were a starting point for investigating the decision making processes in relation to admission to services. Results suggest that clinicians have a strong gate-keeping role with a number of pressures on their decision making such as a need to remain collaborative with colleagues and appropriateness of patients. Appropriateness depends on a number of unit factors such as staff skills, current patient mix, whether successful treatment within 2 years could be achieved and availability of beds. Approximately half of participants felt that those with a primary diagnosis of PD would not be admitted to the medium secure units as they would be viewed as unsuitable due to being considered as untreatable and also frequently likely to cause disruption amongst staff and patients in a unit. Resources were viewed as too scarce to admit patients whose stays would be 'unproductive'. For patients with PD who were considered for psychological treatment, the participants' attitude towards co-operation with treatment was viewed as crucial. Half the participants said their units had taken the decision not to admit patients with a primary diagnosis of severe PD, the only exception being if they had come from a specialist unit. A limitation, however, of these findings is the limited sample of lead clinicians. Only further research including other staff involved may provide more valid and reliable data. Personality disorder, although investigated specifically, was not the sole focus of the study. Therefore, findings such



as half the interviewees stating their unit had decided to limit patients admitted with a primary diagnosis of severe personality disorder except from specialist services were not investigated further.

Research has identified that staff perceive care to be inadequate for patients with a diagnosis of PD, and more specifically in some studies, BPD (James & Cowman, 2007). Support for this finding was identified through subjective accounts by Woollaston & Hixenbaugh, (2008). There were high levels of agreement amongst staff that there should be a number of people/agencies involved and that PD patients should be managed by 'specialist' services (Deans & Meocevic, 2006). Specialist services were most endorsed for improving care to clients (James & Cowman, 2007). Some medium secure units described subjectively only accepting patients with a primary diagnoses of personality disorder if they had come from a specialist unit, otherwise it was thought as a poor diagnosis to admit people to units and units chose to opt-out of these patients where possible. They reported PD patients stay was longer than other patients and thus they regretted admitting them when they had (Grounds et al, 2004). The subjective experiences reported regarding level of security was that participants felt it created a cut-off environment from society, there was a common perspective that being a medium secure personality disorder in a ward meant as a service they were cut-off from the rest of the organisation (Kurtz and Turner, 2007). However, this does not seem to have been investigated by the other studies.

## **Discussion**

### **Key Findings and Conceptual Implications**

This review aimed to explore and synthesise the nature of staff attitudes to patients with a diagnosis of personality disorder in a secure/forensic and inpatient

settings. The majority of included studies looked at participants' experiences and perceptions; none of the studies reviewed were intervention studies. Additionally only two of the studies reviewed the interaction between patient and staff attitudes/perceptions. Despite the variation in study methodologies and no studies using the same standardised measures of surveys; a degree of commonality was identified with five broad themes emerging. Those themes were: attitudes toward individuals with PD and their behaviour; attitudes toward PD as a psychiatric diagnosis compared to other psychiatric diagnosis; emotional experiences and reactions; attitudes related to profession; views related to the organisation and provision of services for PD.

These five themes allow for a clearer understanding of the current literature regarding health care staff attitudes towards patients with a diagnosis of personality disorder. Interestingly, half of the studies included nurse participants only (Woollaston & Hixenbaugh, 2008; James & Cowman, 2007; Markham, 2003; Markham Trower, 2003; Mason et al., 2010b; Deans & Meocevic, 2006). This may be due to nurses being 'frontline' staff (Gerrish et al., 2007). However, Markham (2003) found a difference between health care professionals and registered mental health nurses; nurses expressed more social rejection towards patients with BPD. Interestingly, health care assistants did not make this distinction and health care assistants can also be considered frontline staff.

Furthermore, all research identified that at least some of their participants held negative attitudes toward PD or BPD. Research suggests attitude towards PD can be a factor behind the emotional and behavioural reactions of staff toward patients who have been given a PD diagnosis. Professionals' avoidance or withdrawal from the care of these patients can be due to their dislike of them and judgement that patients with PD

are less deserving of care than other patients with other diagnosis (Lewis & Appleby, 1988). Furthermore, research identifies that the absence of a positive relationship with a case manager is associated with poorer patient outcomes in terms of patient psychopathology (Solomon & Alexander, 2009).

Across several studies, staff described negative experiences and negative emotions when working with patients with PD (Bowers et al., 2006; Markham, 2003; Markham & Trower, 2003; Deans & Meocevic, 2006; Grounds et al., 2004; Wollaston & Hixenbaugh, 2008). The emotional responses staff experience are disruptive and may harm both staff and patients (Beck et al., 1990). Additional ramifications of negative experiences and emotions, as identified through research, are that staff attitudes and responses have the potential to ameliorate or exacerbate challenging behaviours exhibited by patients. For example high levels of criticism and hostility can have adverse consequences for staff and patients, including high levels of stress or burnout (Dennis & Leach, 2007).

Markham (2003) suggests staff are least optimistic about patients with a BPD diagnosis. Previous research has suggested that patients diagnosed with BPD had less empathetic and less confirming responses from nurses than patients with other diagnostic labels (Fraser & Gallop, 1993). Moreover, Grounds et al., (2004) indicated lead clinicians were less optimistic about patients with PD. Importantly, this is supported by longstanding research conducted by Burnham (1966) who suggested the initial optimism experienced by healthcare professionals can quickly shift to pessimism when staff engage therapeutically with the individual with a PD diagnosis (Burnham, 1966).

Professionals' responses were investigated in a number of different ways and some of the studies highlighted potential differences between professional groups, or within teams, with participants feeling colleagues did not understand the difficulties of working with patients with a diagnosis of personality disorder (Kurtz & Turner, 2007; Woollaston & Hixenbaugh, 2008). The consequence of this appeared to be isolation. Research suggests that teams can cause considerable emotional turmoil. Many people do not experience the team they work in as supportive, but rather rivalrous and on occasions destructive (Nitsun, 2006)

James and Cowman (2007) identified that their nurse participants felt that specialist services were best for improving care to clients. Deans and Meocevic (2006) found that high levels of agreement were present amongst staff that there should be a number of people/agencies involved. They agreed that PD patients should be managed by specialist services. Bateman and Tyrer (2003) discuss the specialist team approach towards treatment of PD, including the needs for specialist personality disorder wards. They identify that patients need to feel the staff responsible for their care communicate effectively, frequently, get on well together and have clear boundaries. Collaboration and consistency within the team is also vital. The multidisciplinary specialist team approach has advantages for patients with severe personality disorders who require frequent risk assessment, demand continual engagement and have multiple needs, as well as provoking powerful counter-transference reactions (Bateman & Tyrer, 2003).

Fortune et al., (2010) aimed to obtain the perspective of staff on the experience of delivering treatment within new forensic services for PD offenders, no other studies explicitly set out to explore views on services. Fortune et al (2010) found that staff felt they had underestimated the emotional impact of working with PD patients, staff found

the work relentless and draining. The possible consequences of this are that staff may be susceptible to burnout. Burnout comprises of depersonalisation, emotional exhaustion and lowered personal accomplishment (Maslach, Jackson and Leiter, 1996). The staff in Fortune's (2010) study may have been describing emotional exhaustion and lowered levels of personal accomplishment. One hypothesis regarding the emotional experiences of working with PD patients suggests PD patients overuse certain defence mechanisms. A consequence of the overuse of defence mechanisms means nurses, when interacting with the patients, often experience feelings of anger, hopelessness and guilt (Gabard & Wilkinson, 2000).

### **Methodological Issues**

Despite the majority of the studies included in the review coming from a quantitative methodological position, the majority were surveys and had considerable limitations. Only four studies included in the review used standardised measures and these measures differed between studies. Only Bowers et al., (2006) used a specific measure of attitudes towards PD (APDQ; Bowers et al, 2000). Deans and Meocevic (2006) used a questionnaire designed by Little (1999) which included a section on emotional reactions. Other questionnaires or measures looked at attributions, optimism and beliefs about dangerousness. Bowers et al., (2006) conducted a survey sample with a large sample size using a number of standardised measures. Methodologically, this was probably the strongest study and as such the findings are probably the most accurate and therefore trustworthy. The main limitation of this study was, however, that causality of the results was unclear.

Markham and Trower (2003) and Markham (2003) both asked participants to answer questionnaires and/or discuss vignettes related to three different diagnoses; BPD,

Depression and Schizophrenia. This is of interest as a diagnosis of Borderline Personality Disorder (BPD) differs from almost all other diagnosis of PD with the person often exhibiting help-seeking behaviour (Higgitt & Fonagy, 1992). This may affect the generalisability of the results as other PD diagnoses may elicit different attitudes or experiences from participants. Although, Bowers et al (2006) did look at personality disordered patients in general and identified similar concepts to those studies comparing differences in perception according to diagnostic label. Bowers et al (2006) sample was mainly prison officers working in a Dangerous and Severe Personality Disorder (DSPD) unit with only one nurse participant which limits the generalisability of the results including within this review as all other studies included participants who trained within medical professions.

Fortune et al (2010) investigated using a mixture of health care staff participants and identified that staff reported feeling afraid of patients with PD at some point. Conversely, Kurtz & Turner (2007) found that staff felt a complete sense of physical safety, however, this was offset by a perception that they were under threat emotionally from external colleagues. Kurtz and Turner (2007) proposed a hypothesis for this using Maslow's model for the hierarchy of needs', stating if the participants had not felt physically safe they could not have addressed the more complex concern of relationships with colleagues (Maslow, 1962).

None of the studies included in the review are intervention studies, Thus a recommendation from the review that the apparent gap in research be filled regarding interventions to address staff attitudes and perceptions.

**Limitations of the review**

One limitation of this review may lie in the exclusion of studies published prior to 2003. The justification behind this was that the paper 'Personality Disorder: No longer a diagnosis of exclusion' (DoH, 2003) may have helped shift attitudes and focus research on interventions which have high efficacy for changing problems such as the stigma associated with PD and negative attitudes associated with PD. However, it appears that post-2003 studies have explored perceptions but few intervention studies have actually been completed (none were identified through the current search strategy). Moreover, staff attitudes and experiences appear to remain negative regarding this patient group.

Another potential limitation was that two different quality assessment checklists were used and one was adapted. Although this provided a focused check according to general methodology, quantitative or qualitative, because the quantitative studies mostly looked at participants' perceptions and opinions one checklist may have been more suitable as it may have made comparisons between the quality of qualitative and quantitative studies more achievable. The inclusion of both quantitative and qualitative papers allowed for inclusion of a wide range of studies. However, this limited the level of detail for comparison meaning a narrative synthesis was conducted focusing on general emergent themes. Additionally, the studies often used measures and tools designed by the researchers and at most piloted them within a similar service thus offering validity.

**Summary and Implications**

The results of this review suggest that the attitudes of nurses and health care professionals towards patients with a diagnosis of PD are predominantly negative.

Therefore, there appears to be a need for improvement in the clinical management of BPD (and PD) patients (Deans & Meocevic, 2006). However, Mason et al, (2010a), (2010b) have identified that patients with a diagnosis of personality disorder are worked with from a 'management' focus whereas individuals labelled with a mental illness receive a 'clinical' focus. Therefore, diagnostic label appears to contribute to professionals' responses, i.e. if the service user is 'managed' or has an opportunity for a more positive clinical outcome. The focus it would seem needs to revolve around clinical opportunities and this resonates with what "No Longer a Diagnosis of Exclusion" (DoH, 2003) identified in 2003. Staff in several studies expressed that they felt they needed further training and would partake in it if it was offered (James & Cowman, 2007; El- Adl & Hassan, 2009). This would appear to be valuable in offering equal opportunities to patients regardless of diagnostic label. D'Silva, Calton and Duggan (2005) conducted a pilot study to investigate the impact of a single day of training as a way of disseminating good practice. Six months after attending the training questionnaires were sent out to the delegates and just over half returned them. The results suggest a modest effect on practice with some changes to practice being reported. The limitations of this study are that it was based on self reports with no other measure to confirm reliability and validity of responses so there may have been response bias.

### **Future research**

Due to the increasing evidence regarding staff negative attitudes and experiences when working with patients with a diagnosis of personality disorder, further intervention studies appear to be necessary. In particular, the objective effectiveness of training programmes in various clinical contexts requires further research and



evaluation. Previous work has indicated factors which appear to be associated with better attitude to personality disorder patients, including lower stress, greater mental well being, a more positive perception of managers and improved work performance (Bowers et al, 2006). Intervention studies looking at ways to lower stress and increase mental well-being and improve perceptions of managers may be valuable additions to the existing literature.

In general, a gap seems to relate to the exploration of experiences of staff working within specialist services. Only one study included in this review looked at staff caring for offenders with a diagnosis of personality disorder and this focussed on the needs of staff as opposed to their experiences (Kurtz & Turner, 2007). Understanding the subjective experiences of care staff in relation to PD may allow for a more detailed understanding of their attitudes, emotional responses and behavioural reactions.

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## **Part Two**

### **Empirical Research**

**A Qualitative Investigation of the Experiences of Nursing Staff working in a  
Secure Personality Disorder Unit**

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This paper is written in the format ready for submission to *The Journal of Clinical  
Psychology*. Please see Appendix A for the guidelines for authors.

### Abstract

This qualitative study aimed to explore nursing staff experiences of working on a medium secure personality disorder (PD) ward. Eight nursing staff participated both qualified and non-qualified, male and female. Participants took part in semi-structured interviews and the content was analysed using Interpretative Phenomenological Analysis (IPA). Four super-ordinate themes emerged from the data. Within each super-ordinate themes a number of sub-ordinate themes emerged. Themes suggested that staff experience strong emotions. They identified actions and emotions in relation to working life on the ward which were challenging. The findings of the research in relation to existing literature, research limitations, clinical implications and suggestions for future research are all discussed.

*Keywords: Personality disorder, nurses, experiences*

(Word count: 13,791)

A Qualitative Investigation of the Experiences of Nursing Staff working in a Secure  
Personality Disorder Unit

### **Overview of the Literature**

#### **Personality disorder and challenging behaviour in secure mental health settings**

Personality disorder (PD) is defined as a pervasive enduring pattern of behaviour and experience which is inflexible and leads to considerable distress or impairment for the individual and is deviant from cultural norms (APA, 2000). Previous literature has identified that staff working with people with a diagnosis of PD often experience strong negative emotions (Gunderston, Najavits, Leonhard, Sullivan & Sabo, 1997; Adler, 1993). This may be due to a diagnosis of PD often being linked with high risk behaviours that are likely to be challenging to staff, including impulsivity and sexual promiscuity (Pidd & Feigenbaum, 2007) as well as characteristics which are said to underpin behaviours such as a lack of remorse for actions and a lack of response to negative consequences or punishment (Pidd & Feigenbaum, 2007). Borderline PD (BPD) differs from nearly all other PDs by frequent help-seeking behaviour and a wish to change (Higgitt & Fonagy, 1992). Research has highlighted that nurses who work with patients with a diagnosis of BPD often perceive them to be manipulative (Deans & Meocevic, 2006; Bowers, 2002) complaining, ‘attention seeking’ or ‘trouble’ (Gallop & Lancee, 1986). Patients with a diagnosis of PD are often perceived as emotionally unstable, uncooperative, highly anxious, depressed and aggressive (Sarosi, 1968). Lewis and Appleby (1988) found that psychiatrists viewed patients with PD to be ‘less deserving’ of care than other patients.

Bateman and Tyrer (2003) state that despite a diagnosis of personality disorder being common (El-Adl & Hassan, 2009), treatment is still governed by ‘whim’, ‘opinion’

and ‘dogma’. Furthermore, they state that “Reactions of staff to patients with PD commonly subvert the task of treatment and lead to inappropriate actions on the part of staff (Bateman & Tyrer, 2003, pg 10).” Significantly, personality disorder in secure mental health settings is a particular problem and can be associated with the occurrence of challenging, hostile behaviour that professional staff have to manage positively (Bateman & Tyrer, 2003).

In these settings, staff relationships with patients can be hugely significant. Within the social networks of clients, professional staff have a central role and some clients see staff as their family (McCann & McKeown, 1995). The centrality of staff relationships to clients is enhanced in locked environments due to limited family contact and restricted community access (Dennis & Leach, 2007). As a bare minimum, the mental health professional must therefore maintain a ‘steady’, ‘skillful’ and ‘competent approach’ despite anxiety, provocation and the ‘pressure to transgress boundaries’ (Bateman & Tyrer, 2003).

More generally, it is increasingly being recognised that, in a range of settings, staff attitudes and responses have the potential to ameliorate or exacerbate challenging behaviours linked to mental health problems (see below). Despite this, few studies have directly examined the subjective experiences of staff as they attempt to make sense of and respond to challenging behaviour, particularly in the context of PD and secure mental health settings.

### **Possible Components of Staff Experiences**

#### **1. Expressed Emotion (EE)**

It has been well established that the psychosocial environment affects patients suffering from severe mental illness (Barrowclough et al, 2001) and an important component of this environment in in-patient settings relates to the quality of relationships



between staff and service users. One way that the emotional 'climate' between patients and staff members can be conceptualised is through the concept of expressed emotion (EE), which relates to the perceived quality of social interactions between a patient and their formal or informal caregiver. There are a number of components to EE such as critical comments, hostility and emotional overinvolvement. High EE typically is characterised by criticism or hostility and/or high emotional overinvolvement; low warmth is a further feature of high expressed emotion (Brown & Rutter, 1966). Research has indicated that the affective environment is a reliable and valid predictor of a patient's functioning (e.g. Butzlaff & Hooley, 1998). Research has shown that high EE may be evident in staff working with people who have long term mental illness (Barrowclough et al, 2001) and high EE can have adverse consequences for staff and patients, including high levels of stress or burnout (Dennis & Leach, 2007). The absence of a positive relationship with a case manager is also associated with poorer patient outcomes in terms of patient psychopathology, according to Solomon & Alexander (2009). However, this study did not look at case managers experiences and the meaning behind the negative or positive relationship.

A study into EE staff-patient relationships (staff being key-workers or a team nurse) in 3 forensic services for inpatients with a history of mental disorder and offending found 55 out of 75 relationships were high in EE and that part time staff might be more punitive (Moore et al, 2002). Additionally, the amount of time staff members have spent in a job role seems related to EE, with newer staff showing less criticism and more warmth. Marsh and Evans (2006) found that the more training an individual has the less punitive they are. Although, their study had a number of limitations as it had a relatively small sample size, was in a specific area and only used hypothetical patients and situations therefore their results are less generalisable. Furthermore, other work suggests that overinvolvement could

be a feature of the experience of some staff members in in-patient settings and this could relate to issues such as burnout. Fagin (2004) suggests that staff support groups and supervision looking at counter-transference reactions, particularly with junior staff who may become over involved, are very important. Therefore, overinvolvement may be present with this inpatient staff group compared to other inpatient settings. Within a medium secure unit for staff caring for people with Learning Disabilities (LD), 31% of the staff respondents were found to have critical and negative relationships, which was found to be higher in male staff and healthcare workers. Additionally, the results showed some elements of high burnout for staff (Dennis & Leach, 2007).

Subsequently, taken together, work in this general area suggests that issues such as warmth, criticism, hostility and overinvolvement are important potential features of the experiences that staff members have in responding to challenging behaviours in in-patient settings. However, research examining the actual subjective experiences of staff working in such environments, particularly in secure PD settings, and what kinds of experiences might underpin or relate to the expression of high and low EE is scarce. Some research has looked at the needs of staff working with offenders with a PD diagnosis (Kurtz & Turner, 2007). However, this study did not explore the meaning of this to them or in general their perceptions of offenders and/or personality disorder.

## **2. Staff Attributions and Attitudes**

In addition to EE, there is some literature suggestive of links between attributions (beliefs about the causes of a person's behaviour. Weiner, 1980), staff responses and their broader attitudes toward the people to whom they provide care. Barrowclough et al., (2001) proposed that causal attributions about patient's behaviours may be associated with general

negative attitudes. Furthermore, when using subjective self-report scales, staff and patients showed variability in expressed and perceived negative ratings, patients appeared to be sensitive to negativity. There were some indications that staff were attuned to negative attitudes towards them but to a lesser degree than patients. Interestingly, research suggests staff members tended to view the behaviours of patients they felt less positively toward as more controllable. Importantly, patients viewed less positively were more likely to have behavioural disturbances in the subsequent 7 months after the relationship ratings were made, and this association remained robust even when patients' symptom levels were controlled for. This research was conducted using participants with a diagnosis of schizophrenia and staff living/working within sheltered residences (Van Humbeeck, et al., 2004). Thus different researchers have shown behavioural disturbances can be linked with internal attributions and negative attitudes. It is unclear what common themes amongst staff are present when considering interactions with patients and patients' behaviours.

Cottle, Kuipers, Murphy and Oakes (1995) examined how hospital staff members felt after a violent incident towards the perpetrator of the incident as well as the reasons the staff gave for what they thought caused the incident. They found that anxiety often increased the week after an incident but after approximately a month returned to the baseline level. EE was high (criticism and hostility) following an incident and remained high a month later. Correspondingly, the attributions they gave were internal to the patient, external to themselves, personal to the patient and uncontrollable to themselves (Cottle et al, 1995). Nevertheless, it remains unclear how staff in other settings might make sense of patients post-incident and what experiences might underpin the formation of attitudes and attributions.

Jones and Hastings (2003), reporting on a study carried out in a learning disabilities setting, suggested that self injurious behaviour attributed to external control is associated with depressive or angry emotional responses from staff, while self injurious behaviour

attributed to internal control was associated with relaxed and confident emotional reactions from staff. Importantly, beliefs amongst staff that a patient can control their challenging behaviours have also been associated with staff experiencing negative emotions such as more anger (Sharrock, Day, Qazi & Brewin, 1990; Markham & Trower, 2003). Thus, staff attributions about behaviours have the potential to affect their emotional, cognitive and behavioural responses.

An additional factor which can impact staff is regarding attitudes. Research suggests that health care professionals' attitudes are important (Atkinson et al, 1996). Sears et al. (1998) suggests that attitudes have three components: cognitions, affect, and a behavioural element, which are triggered when contact with an object is made. The cognitive component comprises of thoughts, opinions and beliefs; the affective domain comprises of feelings and the behavioural element relates to actions/ behaviour. Research suggests attitudes to PD as a diagnosis can affect staff cognitions, affect and behaviour. One study compared nurses' responses to patients in a group with various diagnostic labels. The researcher was blind to the diagnosis and rated the nurses' interactions with patients. They identified patients diagnosed with BPD had less empathetic and less confirming responses from nurses than patients with other diagnostic labels (Fraser & Gallop, 1993). Other research has found that many of their nurse participants held negative attitudes including viewing patients with a diagnosis of PD as 'evil' and 'monstrous' (Bowers, 2002).

### **3. Staff Stress and Burnout**

According to Tillet (2003) burnout is a recognised syndrome amongst the helping professions. Burnout comprises of depersonalisation, emotional exhaustion and lowered personal accomplishment (Maslach, Jackson & Leiter, 1996). Depersonalisation is associated with negative and cynical feelings and attitudes towards clients (Maslach et al,

1996). Role ambiguity, conflict, lack of support and supervision are all additional potential sources of burnout (Ekstedt & Fagerberg, 2005). Both Maslach et al., (1996) and Tillet (2003) found that the symptoms of burnout can include emotional, cognitive and behavioural components. For example, emotional effects such as irritability, apathy and bitterness can be experienced. The cognitive components experienced can be poor concentration and distancing. The behavioural effects of diminished contact and work avoidance can also be experienced.

Alarcon (2011) conducted a meta-analysis on job demands, resources and attitudes and their relation with burnout in a work setting. The analysis included studies involving healthcare workers. The results suggested that lower resources, lower adaptive organisational attitudes and higher demands are associated with burnout. Melchoir, Bours and Schmitz (1997) conducted a meta-analysis of the related variables of burnout in psychiatric nursing and found that working environment and job characteristics such as staff support and involvement, role conflict and job satisfaction can be sources of burnout. Research regarding the environment suggests, within medium secure environments, work includes intensive interactions with others which may also lead to burnout (Kilfedder, Power & Wells, 2001). Factors such as exhaustion, cynicism and a sense of inefficacy were described by Maslach (2003) as chronic job and interpersonal stressors capable of causing burnout (Maslach, 2003).

### **Rationale for Present Study**

Research suggests that interactions between staff and patients with PD can be challenging due to the behavioural concomitants of PD. In addition, studies suggest that staff can have negative attitudes and attributions or high levels of negative emotions when

working with PD clients. This, in turn, could affect patients, with possible increases in behavioural disturbances.

Despite this it is not clear what lived experiences there are amongst nursing staff in a secure specialist ward. There appears to be little understanding of how staff members' subjective experiences impact them at work and how staff feel in the current social climate towards the diagnosis PD and patients with a PD diagnosis, which necessitates a qualitative study. Research has shown the advantages of training staff and offering further supervision when working with patients with PD. Therefore identifying common themes in the experiences of staff members working in this environment could help further focus training and supervisory processes in order to improve working environments, understanding and attitudes.

### **Research Questions**

1. What effect does working with patients with a diagnosis of a personality disorder in a secure setting have on nursing staff?

*The aim underpinning this question was to explore and discover aspects of general feelings towards PD and general experiences working on a specialist ward. The focus here included issues such as attitudes, stress and, potentially, burnout.*

2. How do nursing staff members' levels of experience, knowledge and training impact upon their experience of working life?

*The aim here was to explore vulnerabilities or strengths of staff members and how this influences their interpretations, actions and emotions in relation to working with people who have a diagnosis of personality disorder.*

3. How do staff define negative experiences with patients and what are their experiences of understanding and responding to them?

*The related aim here was to explore challenging behaviour, incidents, and 'negative' interactions and staff responses or feelings towards these. The focus of this aim was issues such as attitudes, attributions and expressed emotion on the part of care staff.*

Overall the research aimed to provide an insight into the experiences of staff working with patients with PD in a secure inpatient environment, particularly their feelings about PD and their attitudes to PD. Through looking at how levels of experience, knowledge and training relate to their actual experiences, the vulnerabilities and strengths of staff can be identified. This could help inform the design of future training and support, including the provision of supervision. Staff members' experiences of and responses to challenging behaviours associated with PD, as previous research suggests, could impact upon patients and the psychosocial environment, so a greater understanding may have clinical and managerial implications in terms of helping improve working practices and ward conditions.

## **Method**

### **Design**

Since the key aims of this study related to the lived experiences of staff members in secure PD settings and previous research with this specific cohort is lacking, a discovery-orientated qualitative approach was used in this study. Interpretative Phenomenological Analysis (IPA) was used as an analytical framework in order to explore how participants made sense of their social and personal experiences when working with people with PD, including the interpretations and meanings that particular experiences and states held for

them (Smith, Flowers & Larkin, 2009). IPA was chosen because its three underpinning theoretical perspectives - phenomenology, hermeneutics and idiography- fit with the nature of this research; the researcher was attempting to investigate the subjective experiences and personal narratives of nursing staff and from this interpret how they draw meaning from their experiences. Therefore phenomenology, hermeneutics and idiography fit due to the researcher wanting to explore distinct experiences of people in specific contexts in which these experiences occur (Langdridge, 2007). These accounts were interpreted for meaning beyond the claims of the individual (Smith, Flowers and Larkin, 2009) and attempt to uncover the meaning of the individuals experiences focusing on concrete experiential accounts (Smith, Flowers & Larkin, 2009). Additionally, IPA was chosen over other qualitative methods as it is consistent with the epistemological position of the research questions, which are based on 'critical realist' and interpretivist perspectives, i.e. truth is subjectively defined and although there is no specific truth which can be determined and known for certain, researchers can attempt to find the subjective truth of the participants which impacts on their world, beliefs and actions. Semi-structured interviews were conducted using a pre-designed interview schedule (Appendix H) to collect data, which was then transcribed and analysed using IPA.

### **Participants**

Participants were nursing staff, qualified and non-qualified, male and female. They were recruited voluntarily from a specialist personality disorder secure ward based within a well established medium secure forensic unit in England. The rationale for completing the study in one unit only was based on the unit being representative of the services offered on specialist PD wards and therefore being generalisable to the field. In practical terms the ward was accessible to the researcher and agreed to participate. The ward was opened two years prior to the research being conducted and was opened as a psychology-led ward. It is an all male ward with 15 beds; during the research it was running at 12 beds filled. Patients



on the ward are on different pathways such as being stepped down from high secure services, prison transfers or patients who have been repatriated from other medium secure services. The main diagnosis is emotionally unstable PD with antisocial traits and there is also a high presence of histrionic and paranoid PD with narcissistic traits. All patients have a history of violence and aggression, with a high number being convicted sex offenders. Participants were identified using the following criteria. The inclusion criterion was defined as any nursing staff, both qualified and non-qualified, who worked on the ward. Nursing staff who had not worked on the ward for more than a month or were not based on the ward were not approached to participate in this study. Any staff who were not employed in a nursing capacity were not approached to participate in this study.

During the data collection period, 8 staff members (3 male and 5 female) consented to take part in the study. One potential participant declined to take part due to fears regarding possible implications from what they could report during the interview. The overall age range was 26- 44 years (mean = 35.97 years, SD = 7.46 years). The demographic characteristics of the participants are summarised in Table 1. Due to the size of the staff group on the ward no detailed demographics could be provided as staff would be identifiable and confidentiality would be breached.

## **Measures**

A short paper-based questionnaire was used to collect participant demographic information (including gender, age, job title, working hours, number of years qualified, number of years working with PD clients, additional qualifications, number of hours worked per week, length of time on ward) before each interview took place (Appendix I) . This information was gathered purely to contextualise the qualitative data that was gathered by subsequent face to face semi-structured interviews (Smith & Osborn, 2003).

The structure of the interviews was guided by an interview schedule comprising of open ended questions based on underpinning research questions (see above) and theoretical concepts including attitudes, EE and burnout. Prepared prompts were used if and when required for clarification or to elicit further information so that research questions were explored fully. The average length of interviews was 44 minutes 49 seconds (range: 29 minutes 40 seconds to 71 minutes 2 seconds). A questionnaire which stated the preliminary themes which had been identified was used as a validity check (See Appendix H). The participants provided their comments and the themes were altered accordingly.

Table 1.

*Participant demographic information*

	n	Mean Age	Standard Deviation	Mean Hours Per Week	Standard Deviation	Mean Years in PD Service	Standard Deviation	Mean Time on Ward (Years)	Standard Deviation
Total	8	35.97	7.46	35.81	8.21	4.19	3.66	1.83	0.36

The sample includes 3 qualified nurses, 3 student nurses and 2 healthcare assistants.

\*Reporting of working hours was based on contracted hours with most participants describing significantly higher hours worked per week than their contracted hours.

## **Procedure**

### **Data collection**

The recruitment commenced only after research governance permission was granted by the local NHS Trust and ethical approval was obtained from the Post Graduate Medical Institute at the University of Hull (Appendix J). In order to recruit participants, members of the nursing team on the ward were approached and provided with an information sheet which contained information on the study and how they could participate (see Appendix K). The participants were given the opportunity to ask any questions or concerns regarding the study, alongside the provision of the information sheet.

Following this, written consent was sought from each participant regarding participating in the interview. They also completed a subsequent questionnaire and permission to audio record the interview was sought (Appendix L). Participants were free to withdraw from the study at any point with no adverse impact. Following the interview, participants had the opportunity to ask questions and explore any issues raised during the interview with the researcher. Throughout the interview each participant's level of distress was monitored by the researcher. All participants were offered immediate support by the researcher if they felt they needed it. None of the participants required this.

Upon the completion of data analysis, seven weeks after the interview, participants were contacted and invited to complete a questionnaire relating to the themes identified from the interviews, in order to explore their validity. Subsequently, participants received feedback regarding the findings of the study in the form of a

written summary which was posted and/or emailed to them (depending on preferred choice of contact).

### **Data Analysis Procedures**

All interviews were audio-recorded, processed onto an encrypted memory stick and then transcribed by the researcher into text form. No personally identifiable information was included in the interview transcripts. Audio recordings were permanently deleted and destroyed once the interviews had been fully transcribed. Interpretative Phenomenological Analysis was used to analyse the interview transcripts. Transcripts were transcribed and analysed in the order in which they were collected. The data analysis procedure was consistent with the four stage IPA data analysis process as outlined by Smith et al. (2009).

A close line by line analysis was conducted with regard to the experiential understandings, claims and concerns of each participant. This allowed for the identification of emergent patterns, initially from each transcript and then across multiple transcripts. The themes were then coded and mapped in relation to each other, allowing for their refinement. The use of computer software (NVIVO 9, 2010) was utilised to manage the data and organise it into the identified potential themes. By identifying patterns between themes the researcher was able to develop super-ordinate and sub-ordinate themes. The significance of these themes to the research questions was then assessed. A peer-based IPA supervision group was also used to help increase the validity of interpretations. Peers shared transcripts and reviewed the thematic structures to ensure that the interpretations were grounded in the research data and researcher bias was reduced and reflected upon. The researcher in this case had previous experiences with the ward and staff thus a focus of supervision during the iteration process was regarding the researcher and their role. In addition, a summary of

themes was fed back through a questionnaire to participants for validation this also helped to ensure a lack of researcher bias.

## Results

The data analysis generated four super-ordinate themes, with eleven themes in total (Table 2). The themes are presented below with supporting quotes' all participants have been anonymised using pseudonyms.

Table 2.

*Super-ordinate themes with corresponding subordinate themes*

Super-ordinate themes	Subordinate themes
The diagnosis	<i>Interest and identification</i> <i>Assumption of early experiences</i> <i>Value of a label</i>
Language and Communication	<i>Finding the 'right' way to communicate</i> <i>Language and reflection</i>
'Roles on the ward'	<i>Responsibility and control</i> <i>Expectations</i> <i>Risk and safety</i>

Difficulties and challenges	<i>Boundaries</i>  <i>Perceptions and the impact of emotions.</i>  <i>The Team</i>
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### **Super-ordinate Theme: The Diagnosis**

This over-arching theme related to how participants understood and related to PD as a psychiatric diagnosis. This included their identification of and interest in PD as a ‘label’. This theme also included assumptions participants made about the experiences patients with personality disorder have had. The value attached to the label personality disorder was a further identified sub-theme. It was clear that diagnosis as a construct in general was important and seen as a significant part of nurses job roles. Many participants talked about ‘working with the diagnosis’ and that this dictates how people are seen; put simply, they felt without a diagnosis ‘you can’t treat them’ (e.g. Emma 154-155). This was based within the idea that without a diagnosis a service is unavailable. Nursing staff appeared to adopt a medical approach to helping and caring for people with PD and this meant that patients were often seen in a sick role.

### **Sub-ordinate Theme: Interest and Identification**

The term identification was used as it described participants identifying with personality disorder as a diagnosis. Participants also used personality disorder as a way of ‘knowing’ what the patients would be like. Thus using it as a model to identify the type of patient and therefore type of work they would be experiencing. Most of the interviewees

expressed a positive interest towards personality disorder in one way or another. They described the patients as ‘lively’;

*“they are complex yeah but they’re also enjoyable people you know they’re much more enjoyable than some of the other patient groups” (Alice 107-108)*

Most participants viewed PD in normalising terms and laid emphasis on their attempts to approach patients as individuals. The view that personality disorder is very common was expressed by all;

*“there’s more people out there... with personality disorder (laughs) than there are detained” (Alice 36-39)*

*“I suppose you treat them like you would any other member of the public or erm society really.” (Dennis 6).*

What this meant to participants differed, with some expressing they felt it was used as a tool by professionals and patients.

*“I think it’s more of an excuse” (David 7)*

To some degree, participants voiced doubts about the diagnosis of PD but also alluded to a sense of ‘just knowing’ when someone has a PD;

*“You think “you’re definitely personality disorder” (Christine 119)*

### **Sub-ordinate theme: Assumption of Early Experiences**

The participants all had assumptions about the patients’ early experiences and thinking around this seemed associated with sympathy, which in turn allowed participants to make sense of how their patients behave now. A commonality was the idea that people



with personality disorder had a specific type of upbringing. It was seen as a challenge by most, perhaps a 'barrier' to overcome.

*"I think personality disorders for me is, is ingrained in people from an early age erm because of the lives they've had and I think it's difficult for them to break it and I think you can't expect too much of that you have to, I think it's difficult for them to break it and I think if you expect too much of a big thing then you're setting them up to fail" (Helen 20-23)*

In contrast, some participants diverged from the common expression of sympathy for patients due to a difficult upbringing; instead they expressed feeling there was an element of choice for the patients in the secure setting. Most participants talked about the difficulty they sometimes experience of 'separating the two from a prisoner to a patient' (David 153). However, all participants expressed the importance of seeing patients as patients.

*"I can understand yeah they've had a hard upbringing but I think the person themselves has that choice to make they have had because you can go the wrong way or the right way." (David 13-15)*

#### **Sub-ordinate theme: Value of a label**

The participants placed a clear value on 'the label' (Alice, 19; Helen 22; David 13; Dennis 180) of PD; most voiced a belief that care and treatment were dependent on the patient having a diagnosis. It was described as having 'gumption' (Alice 18), implying that for these staff a diagnosis of PD drives the kind of care they provide. Labelling seemed to be thought of as a necessity even though current thinking may not be ideal;

*“it’s such a broad term and erm everybody knows everyone has got traits of personality problems so I suppose it’s not the best, not the best term to describe, to describe the patient with it really but then what would you have different?” (Dennis 21-24)*

Participants felt there was a value to ‘knowing’ what you’re working with.

*“I do think there’s some erm benefit in knowing what we can work with” (Alice 194-193)*

*“It’s a helpful tool to help decide how to treat em because you can’t say everyone is the same because they’re not.” (Helen 245-246)*

Commonly, however, participants wondered whether it would be possible to have an alternative to the label of personality disorder and this seemed to indicate a certain level of ambivalence toward PD as a diagnosis;

*“I don’t think it will be around for long, I really don’t. Erm the word disorder, your personality is disordered doesn’t sound right” (Frank 15-16)*

The idea that the label is flawed because of human error was also apparent; ‘consultants use the diagnosis for difficult patients’ (Frank 174). Participants used language such as PD diagnosis being a ‘bit woolly’ (Dennis 148) and ‘wishy washey’ (Alice 158).

Some participants questioned if personality disorder exists.

*“They are actually saying that there isn’t such thing as personality disorder aren’t they?” (Christine 41-42)*

Participants felt there was still some way to go with the label and people perceived patients with a diagnosis of PD struggle to get any sympathy (Alice 44) from others. Participants all talked about the degree to which they felt equipped to deal with PD;

*“to be honest, I think, I think everybody could do with some more training around personality disorder and the assessments” (Dennis 202-203)*

There seemed to be a dual approach with the value placed on the label on one hand it is seen as helpful, on the other hand it seems to signify flaws and difficulty.

### **Super-ordinate theme: Language and Communication**

A second dominant theme was tied to language and communication.

Communicating with each other and patients is something all participants discussed as a central issue in their experiences. Communication seemed to be the way the staff team built relationships and heavily influenced the way they managed situations. It was also a vehicle through which they viewed and reflected upon their experiences.

### **Sub-ordinate theme: Finding the ‘right’ way to communicate**

Participants all talked about knowing ‘when to talk’ and knowing when to ‘step back’.

*“...okay to disengage which we do a lot, you know we move away then go back and you have to do all that” (Helen 208-209)*

Participants felt being able to talk to patients was a valuable skill. It is seen as a way to meet the patients’ needs. The act of trying to meet patients needs was valued and therefore a focus for staff. The tool of communication could help with this focus, not using this tool was seen as causing more harm than good.

*“...they will say that the patient and the staff members do a lot with them erm and sit and chat to them and try and... you know, meet their needs...” (Christine 549-551)*

*“there’s no harm in asking more questions you see anything else I think you cause more harm not being curious.” (Frank 508-510)*

Using humor was also talked about as a tool and a positive way to communicate and de-escalate situations (Frank 406-411). Consistency was also important in communicating.

*"I just remain the same with them you know all the way, all the way through you know, no point in raising your voice, no point in you know shouting because it just, you're just going to escalate things so erm we deal with each situation as it rises you know..."*

*(Emma 32-35)*

There was also a concept throughout the interviews of interpreting what people say such as not taking things at face value. The participants talked about reading into what patients' said. They also talked about filtering what they thought into something they 'could' say.

*"At the end of the day even though we are nurses we are human, do you know what I mean, you are going to think "blooming heck, I understand what you're going through" and you can see that, and you can say yeah, you've got to say "you do something about it then in the right channels but not by kicking off" (Christine 449-453)*

One way seen as the right way to communicate was giving patients an opportunity to 'vent' which was touched upon by all participants. This was seen as cathartic for patients and good for the safety of other patients. It was seen as an important part of therapeutic relationships so facilitating time for patients to 'vent' is a regular occurrence. The setting this happened in was also talked about by participants, all stating it was important it was 'private'.

*"listening is the important thing, basically its fine you know, appropriate room, place where he can vent his frustrations..." (David 233-234)*

*"sometimes if somebody's being disruptive we're able to solve that solution allowing them the vent for want of a better word" (Emma 58-60)*

All participants talked about the importance of how they communicate with each other. The need for an alternative language to help them provide care and support was alluded to by several participants. Frustration seemed attached to this;

*“what we really needed and what would have really helped from the beginning...is some sort of framework to use to umm a different type of language so when we first opened we were gona use CAT...Yeah that never came off” (Alice 204-205, 217-210)*

The consequences of not having a shared language seemed to relate to people feeling stuck.

*“So we’ve sort of been in limbo land now” (Alice 212)*

Clearly, language and communication are important, with the right way to communicate being valued. Staff seem to have identified an area of need, where they feel a shared language would be helpful. Currently, their communication seems to highlight the differences they have from each other. As well as a shared language having a practical element it seems that a shared language would serve to draw the team together.

*“Umm we’ve had no commonality on how to deal with these patients so mmm we’ve had to use the only language we know.” (Alice 214-215)*

### **Sub-ordinate theme: Language and reflection**

It was expressed by all that reflection was important but at times difficult, perhaps due to the kinds of language used in relation to patients. Participants expressed a common need for a shared language of emotion.

*“We need to use emotional language to get someone to actually reflect” (Alice 239)*

*“...I can’t reflect if I’m using terminology that’s industrial... we need to start using emotional language otherwise it doesn’t work so ermm I think that’s the frustrating bit*

*because we are at that stage where we know we should be using different language” (Alice 242-244)*

In contrast, not reflecting was seen as a common occurrence but considered as damaging.

*“I mean people work a lot and I think because they don’t have that time to step back, I think sometimes you can forget the little things.” (Helen 111-113)*

*“they do need a lot of supervision but that’s generally the same with all nurses we’re not very good at supervision we’re not very good at reflection” (Alice 89-90)*

The difficulty of reflecting openly and honestly and communicating to each other what is going on was a common experience. Participants described a balancing act which could cause stress. They interpreted each other as attacking at times when opinions were shared.

*“a lot of this is about reflecting on incidents and we’ve only really really started to do that and be truthful with each other without people getting upset because I still pick staff up on terms but I still have to support staff in and I try to speak to them straight away when I think there’s something going wrong and some of them still get upset have a cry outside and come back in. I don’t wanna be here all that sort of thing” (Alice 302-306)*

When participants felt they had reflected honestly, they felt they had taken a risk but had acted because they needed to. They appeared to feel they were taking the stress for the team; they were taking the stress in order to change something for the better.

*“sometimes you have to keep quiet erm and sometimes you know you have to say it.” (Helen 305-306)*

**Super-ordinate theme: 'Roles on the ward'**

An overarching theme concerned participants' role identities on the ward. They discussed seniority and experience; mainly in terms of responsibility and control. There was a focus around control on the ward and how this relates to risk management and safety. A difference between members of the staff team highlighted by all participants was regarding expectations and levels of control.

**Sub-ordinate theme: Responsibility and control dilemmas**

Participants described an awareness of their responsibilities and this included feeling they had to take control of situations.

*"you have to manage him, manage the situation before he then spirals out of control and does something serious" (Dennis 387-389)*

*"When they've lost control and I tell them right enough's enough you're obviously not making the right choices you're making dangerous choices now and I'm taking control" (Alice 475-476)*

*"but you have to do it, do you know what I mean" (Christine 295-296)*

There were examples of when participants had not taken control. This seemed to be for a number of reasons relating to responsibility, job role and authority

*"you abide by all the rules but sometimes you might not agree with it but you have to do it and that can be quite, on yourself it can be quite "I can only do it like this" or "I can only change that" but not everyone has the same working" (Helen 91-93)*

The process of deciding what to act on was talked about specifically in the context of patient's actions and noticing what is important overall. Patients actions were seen as

challenging in different ways and the responsibility to act on them and take control was often a balancing act for staff. Importantly, there was also the concept of pre-empting difficulty.

*“I expected it. I, I pre-empted it from last week” (Dennis 365)*

*“Pre-empted it would be a difficult time” (Emma 270)*

The balance of control and care was difficult for staff, they seemed to constantly try and interpret how they should act in terms of taking control. The responsibility of this was viewed as a burdening.

*“I would change that patients have more control over doing tasks” (Helen 581)*

*“I think things are challenging in different ways if I see a patient who I know who is definitely grooming...That’s really important to act on...Were as another case if somebody’s made a weapon it’s important to act on” (Alice 374-379)*

### **Sub-ordinate theme: Expectations**

The staff all talked about the importance of the expectations they have of themselves and those their patients might have of them.

*“there’s an expectation from everybody there that you have got to take a lead role even though nobody actually says anything you’ll have most of your members of staff there then you take that lead role to process a lot of erm things and emotion around that erm but again its something I’ve had to do for years on end so its automatic.” (Dennis 423-427)*

*“they expect a lot don’t they sometimes” (Alice 112)*

They also talked about their expectations of colleagues’ actions on the ward stating there was a hierarchy of who deals with what. This was viewed as having both positive and



negative connotations according to where people were in the hierarchy. When staff were in a position of expecting action from a colleague this could be viewed as negative.

*“...there might be a situation where a nurse is leading and we’re all thinking*

*“please do something about this now” (Helen 203-206)*

*“The expectation at the minute lies with staff, so staff get burnt out really around*

*trying to organise activities which can only be limited” (Dennis 378-380)*

### **Sub-ordinate theme: Risk and Safety**

Within people’s roles on the ward, risk was experienced as a significant factor.

Risk appeared to represent some difficulty for participants. It seemed in the early establishment of the ward that risk had been difficult for people to manage and therefore it has a strong focus now. Risk would cause dilemmas for participants with an immense pressure being present to keep everyone safe. It seemed keeping everyone safe is the primary focus on the ward but focus on safety seemed to constrain participants too, preventing them from carrying out the more therapeutic side of their work. Interestingly participants faced important choices about how to respond to risk and for some, inaction was a way of managing risk as much as taking certain actions. Each participant talked about a tipping point which, once reached, means they have to respond to the risk and after have to take patients off the ward. Participants described taking patients off the ward as a safety measure. There was a fear that if patients were distressed or oppositional in the wrong place (in front of other patients) there could be a ‘domino effect’ (Helen and Frank). Participants described examples where one patient’s escalation caused others to escalate which was then a risk and safety issue.

*“the other area that we really need to work around is risk and that’s what we’re trying to do now...but it’s taken us two years even to come to something that were filtering it through” (Alice 255-259)*

*“predominantly working with security and the risk and it’s about keeping everybody safe” (Gina 86-87)*

Throughout the interviews participants reflected on the ways they manage risk and this seemed to differ in a day and according to people’s roles on the ward. Overall, uncertainty was associated with risk by all participants and there was a clear idea that they have to constantly observe risk and re-evaluate it. A current struggle seems to be that levels of ‘positive risk’ taking are not well defined. This causes issues within the multi disciplinary team (MDT) and is a source of difference amongst participants.

*“I understand there’s some acceptable risk that needs to be taken but the trust and the content of the MDT we don’t agree on what acceptable risk is yet” (Alice 274-276)*

*“I think we should take positive risks all the time but sometimes I think some staff think well why can’t we do that but then I’ve got on the other side somebody self harms so they should be on constants and never come off em” (Alice 354-356)*

People appeared to question where they were with risk and safety throughout the day. It seemed to be a malleable concept which regularly shifted and represented a significant challenge;

*“you need to be safe and so numbers are very important erm and distraction is the key on here so keeping patients active and busy is massive, it is the biggest thing on here.” (Helen 129-131)*

Participants appeared to find safety easier to talk about in terms of risk possibly seeing the management of risk as a tool to maintain safety. Participants seemed aware that at times they were more at risk and not as safe as at other times.

*“there’s times I’ve been on here and I’ve thought “oh I don’t feel safe” (Helen 207)*

*“can be quite frightening as well if they’re starting to up the ante as well erm, cos you know you’re dealing with large guys so it’s not as if you’ve got a small child erm so that to me would be I suppose the down side of it really” (Gina 50-52)*

### **Super-Ordinate theme: Difficulties and challenges**

A fourth over-arching theme emergent from the interviews was that of the difficulties and challenges the participants face. This seemed to cover three aspects: ‘Boundaries’, which involved talking about relationships and actions; ‘Emotions, perceptions and impact of emotions’; how they felt working on the ward and what the experience was like as well as their perceptions and beliefs about patients, and; ‘The Team’; referring to differences within the team and the perceived impact of that.

### **Sub-ordinate theme: Boundaries**

Participants felt that boundaries between staff and patients could get ‘blurred’. There was a universal idea from participants that they had all ‘blurred’ boundaries at some point but that keeping them was important, they seemed to feel that when boundaries had not been maintained it was because they had been ‘led’ into it by the patient. Although boundaries were talked about by all participants, Alice, Emma and Dennis talked in terms of ‘blurred/blurring’. Christine talked about boundaries in terms of ‘respect’. Helen and David talked about boundaries in terms of ‘relationships’ and ‘rules’.

There was a consistent idea that staff could be led into blurred boundaries by patients and that it was their job to watch the boundaries.

*“when they are working quite closely the patients can get drawn in erm at different levels so you, you might get someone that gets drawn in over something that seems really trivial but when you start unpicking it, it’s probably just a tip of the iceberg what perhaps they are drawn into.” (Dennis 55-58)*

*“you’ve got to have boundaries do you know what I mean because erm they will try and over step it erm and its about having respect, you respect them but they’ve also got to take that respect for you” (Christine 216-219)*

The difficulty of recognizing blurred boundaries was talked about. However, all participants seemed to describe the ability to recognise blurred boundaries describing it like a ‘sixth sense’ (Helen and David).

*“something happens and you have sort of something that’s kind of sixth sense that tells you that really shouldn’t be happening and then you get, I suppose it’s a feeling that you get...” (Dennis 87-89)*

The idea that boundaries are perceptions was the view of some participants. Other participants talked about more concrete concepts, giving illustrations of when it had gone wrong in the past.

*“You have to be very careful about blurred boundaries and also what is blurred boundary because a blurred boundary can be somebody’s understanding of a blurred boundary so what I think is a blurred boundary might not be what you think is a blurred boundary...so who’s right?” (Alice 77-84)*

*“it’s just about being aware of your boundaries as well, don’t be too emotionally involved erm or drawn in really, as in feeling quite sorry for them” (Gina 145-145)*

Participants throughout talked about the difference between people regarding what is acceptable and what isn’t in terms of relationships and boundaries. Boundaries were

thought of as a way of keeping both staff and patients 'safe' and 'secure' on more of an emotional level as opposed to a management level.

*"It's that security, even though you've said "no it's not acceptable you can't behave this way" but they're also, it can makes them feel secure that you've actually took the time out to care to do that so it is, it's is about having the boundaries, having that relationship, having a good relationship but having boundaries to make them feel secure and you feel secure..." (Helen 43-47)*

### **Sub-ordinate theme: Perceptions and impact of emotions**

This sub-ordinate theme covers the commonality participants had of the emotions they experienced working on the ward in general and more specifically towards patients. The impact of this on their personal lives was also explored. Participants' attitudes towards patients and perceptions and beliefs about patients characteristics were described with a large degree of commonality between participants. Emotions were talked about in a number of ways and there was a common view that people could 'catch' others' emotions. The transfer of emotions was seen as purposeful and deliberate by patients. This was something which was seen as dangerous to participants and a 'big problem'.

*"Erm I suppose there is a lot of transfer of emotions from, between erm patients to staff. There's a lot of manipulation, there can be a lot of subtle, subtle manipulation which is as risky as violence and aggression ...one of the big problems is to get over emotionally involved with the patients. (Dennis 37-41)"*

In particular, there was a fear of becoming like a patient. The perception was patients emotions could rub off and if you stayed working with them for to long they would rub off permanently. There was a view that therefore that the strong emotions experienced could have permanent consequences.

*“I don’t think it’s particularly an area that, it’s probably advisable not to stay in long term because just purely, you know potential burn out erm and you more or less that’s transferrable and Ill become like a patient (LAUGH).” (Gina 27-29)*

The participants all talked about negative emotions towards patients, often linking this to how they perceive the patients feel, behave or treat them.

*“umm I find it quiet difficult to work with patients who are very negative all the time...It’s tiring, it’s emotionally tiring and it’s very easy to opt out of their meetings you have to be very careful that you don’t become avoidant as well” (Alice 407-410)*

*“I think you run through different stages and you might be back to angry, you’re back but then with your training in the past you, you, you learn to control that so to someone else they think you’re sat there and you’re just listening but really you are running through emotions.” (David 224-227)*

Some patients were described as being more difficult to work with than others.

*“he’s not just a glass half empty his glass is empty completely and that’s completely challenging all the time” (Alice 471-418)*

Some of this was related to the challenge of a patient’s emotions for the individual staff member rather than a difficult patient. The challenge seemed to be based around specifically how the participant was left feeling because of how the patient felt. Staff described needing to protect themselves from this. Participants appeared to be describing shifting from an emotional level of relating to a management level of relating in order cope with the challenges.

*“Sometimes I get disappointed and sometimes I want to protect them and I am totally, totally aware of that and what I do is I become the complete opposite... And I sort of get myself going and what I end up doing is getting quite hard with them...And I have to*

*protect myself from my own emotions really but yeah I get disappointed” (Alice 483-484,494-495)*

*“I just think for him to feel that low, I just find it sad, that upsets me a lot more than someone screaming and shouting or swearing” (Helen 440-441)*

Participants described the idea of not being able to give the patient ‘hope’ or do anything to help, with sadness or negative emotions.

*“it’s very hard to umm give him any hope” (Alice 420)*

*“I suppose I just feel hopeless and helpless I just don’t know what to do” (Alice 427)*

Sometimes people punctuated this conversation with the fact that they had good days.

*“you do have your really good days and you do have unfortunately so bad days.”  
(Emma 396-398)*

*“you can have some great days, real positive days and you know it can, it can be really good fun and interesting and it keeps you busy but patients are very, very demanding because they want your constant attention so, that can be draining at times, some days.”  
(Helen 11-14)*

The cost of working on the ward was seen as staff missing out on things, particularly time with family. Participants described being ‘all burnt out’ (Helen 399) by the time they got home.

*“we miss out on a lot of stuff that they miss out on but I don’t think anyone ever recognises that” (Helen 391-392)*

The difficulties staff have emotionally when working with patients was seen as particularly difficult in the beginning. Participants appeared to be describing a learning

curve for working on the ward, working with the patient group and coping with the emotional impact; it is possible they were talking about a desensitisation process.

*“I was waking up during the night having horrific dreams umm and having sweats but the sweats was intense it was like id wet the bed it was intense but thats how intense the dreams was. I always say to someone if you manage 12 weeks on a PD unit you’ll be ok”*  
(Frank 578-581)

Participants all felt there was a focus of helping patients with their problems. One way they seemed to view patients was through the concept of patients being ‘childlike’, which was brought up by most participants. Some referred to themselves as maternal toward them. It was common for language like ‘my lads’ to be used referring to the group of patients. This appeared to be a way for participants to make sense of their experiences of patients such as patients’ actions. It is possible that by seeing them as childlike they felt more warmth and empathy towards them.

*“it can be quite, a very lonely, patient group to work with which is both demanding and draining erm emotionally, psychologically erm on staff erm a lot of childlike behaviour we are dealing with at (NAME – unit) you know you’ve got childlike behaviour but you’re dealing with adults and I find that predominantly more so on this ward erm and they all show traits of that from the youngest to the oldest erm”* (Gina 5-9)

*“I think erm at times it’s like having children in men’s bodies, in a man’s shell,”*  
(Helen 7)

There was often judgement felt regarding patients actions; all participants described patients as ‘demanding’, ‘needy’ or ‘manipulative’. Participants felt all the patients were like this and their emotions relating to this seemed to relate to frustration;



*“You’ve got to be able to stand there, they know better and they could be stood in your face calling you every name under the sun and there’s nothing you can do basically...Yeah I find that very difficult.” (David 177-181)*

*“Demanding, very demanding. Erm can be sort of “now” do you know what I mean, they don’t wanna wait erm if they’re asking for a light it isn’t “can I have a light”, some will “can I have a light please” they will just come up to you and do that (CLICK FINGERS) if its erm, it should happen like that (CLICK FINGERS)” (Christine 63-66)*

Additional consequences of patients being demanding, needy or manipulative for the participants were that it’s very ‘tiring’ and participants often felt ‘bad’.

*“I think it can be very tiring not just physically cos your running around like a blue arsed fly all the time...But emotionally you know very much so” (Alice 469-471)*

*“they can run rings round you and erm make you feel pretty crap really” (Gina 38)*

Some participants explored how they felt towards the patients in general as many have committed crimes. The idea of leaving ‘morals at the door’ when you walk into the ward was a shared experience.

*“Some people when they find out where I work often say how do you do it how do you with your morals but with any job of this type you’ve got to leave your morals at the door you agree or not agree with what’s happened umm in the individuals past life you’ve got to take yourself out of the picture I’m not here for myself I’m not here for my own morals I’m here for them really this is my job and pick your morals back up on the way out, it’s a weird way of looking at it but it works.” (Frank 593-599)*

Participants’ felt strongly that patients were not aware of ‘how good they have it’. Participants described having to worry, and that patients didn’t have to worry about

anything. The level of agreement for this perspective was varying; those with high levels of agreement regarding patients having no worries, felt there were things they would change such as benefits and activities.

*“...they are getting their benefits paid for, they are getting their whole benefits as well as getting their heating, food, everything so that benefit money is going straight to the Bank, they don't have to pay anything, some of these guys are on two hundred plus a week, I'd change that straight away, cos people, there's that many unemployed rate outside of here and these guys have come here, they have been sent here by court, the, until they've been treated, until, the day that they should get their benefits is the day they get released but that's my opinion, I'd change that straight away.” (David 290-295)*

### **Sub-ordinate theme: The Team**

All of the participants' expressed differences within the team, mainly focusing on criticism. This seemed to be on two levels; within the nursing team and outside of that team within the broader MDT. The team is relatively newly established and the process of getting it set up seemed to have created a divide. People talked about having to apply for their own jobs and then getting on the ward and feeling 'they' didn't set it up properly. The split seemed to be nurses, healthcare assistants and Occupational Therapy and then 'others' and there was ambivalence towards each other's sides, opinions and suggestions. Overall, participants seemed to experience their staff team as under pressure and fragmented;

*“I don't think it was set up right (the unit). Obviously there's always going to be teething problems, you've got to think of the positives, we probably did a lot of positive things but things weren't in place correct and it was like a learning curve” (Helen 181-183)*

*“I think the clinical team's quite fractured. I think there's inexperience. I think there's a forensic inexperience level upstairs, erm I think funding is a massive issue because*

*you can look at other medium secure facilities and you go to them and they have just got everything.” (Dennis 566-599)*

*“I think a lot of it in the first eighteen months especially was left down to nursing and O.T’s to sort out which then the MDT was quite fragmented.” (Dennis 594-595)*

There seemed to be an underlying resentment regarding the set up of the unit and the current way the unit runs. For example staff resented not seeing the “Monday-Friday staff with every day feeling like a weekend” this was viewed as negative. Other professionals are also seen as being responsible for the correct things not being in place.

*“psychology is the biggest killer on here, its, it’s the biggest let down, erm so.”*  
*(Emma 97-98)*

*“it gets frustrating cos I feel that sometimes eerrrmn there’s a lot of expectations for the service and we’re expecting nursing staff to do everything we’re expecting the red coat type thing” (Alice 308-309)*

The participants talked about the MDT members’ behaviour describing it as being a cause of problems. There seemed to be a consensus that staff paid for others actions. The meaning of this to participants was that it adds to their frustrations and emotional fatigue.

*“all that happens is in MDT meetings is that who shouts loudest or you know that no decisions made because umm nobody can agree” (Alice 264-265)*

*“you can see why staff are getting burnt out, you know people have done shift after shift after shift after shift but then we pay for it because if someone then comes on that, erm just the way they are with a patient, not because they mean to be, not, they’re just tired and*

*so they might answer in a way and the patient might take that in the wrong way and then it can change the day.” (Helen 117-120)*

Many of the participants described feeling unsupported by the MDT. There seemed to be judgements made about how the ‘MDT’ viewed the staff who were on the ward fulltime.

*“It’s very fragmented it’s very blaming (pause)... it causes a lot of anxiety it’s quite stressful...Because I think we know we all know it’s got to change” (Alice 284-291)*

The consequence of this was that participants were concerned and de-valued MDT members’ input.

*“it’s my concern that there’s certain members of the MDT that impact their views but don’t do any work with him, they don’t know him erm. We have people that listen to that, those people’s views, erm and try and skirt around the fact that there’s myself that worked with him very closely...” (Emma 329-333)*

Participants’ felt within the team things were viewed differently because it was a PD service. This was expressed in a blaming way towards others despite participants themselves reflecting on how they felt the service was different.

*“increased anxiety through self harm erm if staff have arguments in PD services it’s called splitting...they might be just having a disagreement...if it was a normal service it would just be called we’re having a disagreement but because it’s a personality disorder service we’re splitting ...” (Alice 67-73)*

It seems the ward has experienced a loss of staff at the moment. Participants talked about the frustration of being unable to facilitate things for patients due to low staffing levels. This was also linked to the reasoning behind some boundaries becoming blurred

(Alice 279) due to staff being fatigued (Helen 117-120). The impact of this was negative for both patients and staff.

*“I’ll tell you what’s a big difficulty at the moment, we’ve lost most of our nurses” (Helen 144-145)*

*“we try and facilitate as much as we can... say like you’ve had three staff sick and you’ve only got four staff you can’t take somebody out on an escorted leave because you aren’t looking at your risks” (Christine 221, 223-225)*

Within the nursing team expectations of the nurses on the ward seemed to vary between individuals.

*...individual differences as you know, it’s massive and different staff work differently so but that’s life isn’t it, everyone’s different so it can be very difficult cos you work with different... so you can be on one shift and the very next day you can be on with very different people cos you never work with the same people, erm well sometimes you are it depends but you’re never with the same people so you know, (SIGH) I think for me that’s the most difficult I find is working with different staff members because you have to adapt very quickly to how they want to work and fit to the patients as well... (Helen 63-69)*

*“I think we need more work on understanding of how to deal with behaviours so were working as a united front rather than some people are okay with what goes on and other people aren’t okay” (Gina 199-201).*

## **Discussion**

### **Overview of the findings**

The current study explored the experiences of nursing staff working on a medium secure specialist PD ward. The aim of the research was to explore feelings towards and

experiences of participants when working with patients with a diagnosis of PD; specific aspects such as attitudes, stress and burnout were explored. Staff described what they felt were their vulnerabilities and strengths such as managing risk and good levels of interest regarding their PD patients. They identified which actions and emotions in relation to working life on the ward were challenging such as patients distress and hopelessness. Additionally, challenging behaviour incidents (as identified by the participants) were explored in relation to the attitudes and perceptions of staff regarding patients; with staff feeling 'subtle' incidents were as challenging as overt aggression. The impact of the challenging negative emotions on participants actions were discussed in relation to how participants made sense of situations and patients. They described elements of control with the challenges of taking control and they described the challenges of boundaries and managing relationships. Therefore as can be seen from the identified themes staff described issues of control, attributions about patients' behaviours, and aspects of EE such as criticism. Furthermore complex team dynamics and aspects of burnout were identified which will be explored further in the discussion. All participants expressed a desire for further training, supervision and support.

### **Relation to Existing Literature**

Bateman and Tyrer (2003) discuss the importance of a specialist team approach towards treatment of PD, such as specialist personality disorder wards. They identify that patients need to feel the staff responsible for their care communicate effectively, frequently, get on well together and have clear boundaries. Collaboration and consistency within the team is also vital. The multidisciplinary specialist team approach has advantages for patients with severe personality disorders who require frequent risk assessment, demand continual engagement and have multiple needs, as well as, provoking powerful counter-transference reactions (Bateman & Tyrer, 2003). The results from this study suggest that

staff experience their team as incoherent and unsupportive, with communication often being a struggle.

The team in general described feeling there were vast differences between them; participants described the team, in various ways, as 'splitting'. When participants described the team and their experiences of colleagues, morale seemed low, with little confidence in the cohesiveness of the team. Tuckman and Jensions model (1975) of group development proposes sequential stages of group development. The group reportedly will develop through stages of 'forming', 'storming', 'norming', 'performing' and 'adjourning'. It is possible that this staff group are in Tuckman and Jensions 'storming' stage. This entails within group conflicts and hostilities which arise due to struggles with autonomy and leadership. Individuals may exhibit resistance through not completing task demands or finding them to be impositions.

Interestingly, various studies have highlighted potential differences between professional groups, or within teams, with participants feeling colleagues do not understand the difficulties of working with patients with a diagnosis of personality disorder (Kurtz & Turner, 2007; Woollaston & Hixenbaugh, 2008). The effect of this can be isolation. The results from this study suggest nurses feel isolated from the 'other' staff. Furthermore, research suggests that teams can cause considerable emotional turmoil. Nitsun (2006) suggest many people do not experience the team they work in as supportive, but rather rivalrous and on occasions destructive. The participants also described issues within the team, feeling unsupported and blamed and these issues highlighted how there is a threat of burnout for staff working in such settings. There are low staffing levels and participants identified a high-turnover of nursing staff on the ward. Makoto and Masao (1994) relate poor social support is associated with burnout.

Research suggests BPD patients' experiences of sleep disturbance, frustration, hopelessness, despair, agitation and depression are more likely to influence nurses responses to them (O'Brien, 1998). Participants talked at length about their attitudes and perceptions, often expressing negative attitudes towards patients. Nurses found patients' sadness a difficult emotion to deal with feeling sadness also or hopelessness. This was perceived as more challenging than an 'angry patient'. All the participants in this study described patients as demanding and this resonates with previous work. Some of the behaviour associated with BPD such as chronic suicidality can be extremely demanding and draining on staff members working in inpatient care (Gallop, 1992). Kaplan (1986) found that when admitted to an inpatient unit patients frequently communicated a sense of entitlement due to their need for special attention which would elicit angry responses from patients and staff on the unit. The results from this study show that participants feel patients are demanding and needy which may fit with Kaplan's (1986) findings.

One of the sub-ordinate themes identified was risk and safety and within that participants discussed a custodial element to the ward. Additionally, participants within the super-ordinate theme of difficulty and challenges identified frustration at a lack of therapeutic input; participants described themselves as 'red coats'; 'all things to all men' and perceived psychological interventions as a 'let down'. A number of the participants reflected on 'burnout' and the susceptibility of nurses working with a PD client group. Nurses work in an extremely stressful environment and due to this are thought to be highly susceptible to burnout (Maslach, 2003). The participants described a high workload which is thought to be a feature associated with burnout (Duquette et al., 1994).

Staff morale and staff turnover were also explored. Holmes (2002) argues that the shift from the Victorian mental hospitals to the present smaller establishments has not been as ideal as initially thought. Holmes states that today's wards are not 'un-therapeutic' but



potentially 'anti-therapeutic', reflecting staff morale. On the current ward bank staff are heavily relied upon due to the high turnover of permanent staff. This absence of continuity and poor commitment fosters a custodial rather than therapeutic approach (Holmes, 2002). Furthermore, there was also some reflection on staff feeling institutionalised. The Oxford English Dictionary describes this as 'apathetic and dependent after a long period in an institution' (Oxford English Dictionary, 2012). Nursing staff feeling apathetic and dependant may minimise their ability to help others. Participants seemed to be aware of the dangers of institutionalisation, reflecting on the 'dangers' of staying too long. They may also have touched upon this when discussing difference amongst staff and their decisions on when and if to take action. A need for dominance and control on the ward was also expressed. This may be in order to maintain consistency and safety on the ward.

The dilemmas regarding control and responsibility emerged as important for participants within this study. Participants' job roles were viewed as entailing large amounts of responsibility. The idea of needing to exert control was discussed. Ellis and Miller (1993) suggest the need for control (consciously or unconsciously) constitutes a major part of the decision to become a nurse. Control and responsibility was discussed within this participant sample at length and feeling in control was valued as highly important. Participants' felt it was hugely important to be in control and take control when necessary. Although participants did discuss not wanting responsibility and not having to take control all the time. Importantly, Daffern, Tonkin, Howells, Krishnan, Ijomah and Iltons' (2010) research suggests the nature of an inpatient setting can challenge patients' attempts to secure dominance. Staff can respond to subsequent aggression by attempting to gain control and order themselves. This can increase the patients' need for control as their need for dominance is persistent and the patients' aggression can thus increase (Daffern et al., 2010). Therefore at times staff attempts to lower levels of aggression can ultimately

increase them as the patient needs to feel dominant and in control. The results from this study suggest control is given to patients in safe ways such as through communication and patients having opportunities to vent. It appears patients can dominate and control conversation with little risk to staff. Staff viewed reacting to aggression at the wrong time as damaging which supports Daffern, Tonkin, Howells, Krishnan, Ijomah and Iltons' (2010) findings.

The participants all talked about communication and valuing it as a mode for creating a therapeutic relationship with patients. This was seen as a direct goal for the nursing staff to achieve. Research suggests that in therapy the best predictor of outcome is the therapeutic relationship (Roth & Fonagy, 1996). Participants talked about emotional language and the need for this to be able to reflect the communication used is important. Although this research did not measure expressed emotion (EE), components of EE, appear to have been identified. In relation to EE, criticism is an expression of negative attitudes about patients behaviours which are discrete or specific; hostility refers to a generalisation of criticism about the patients as a whole (Barraclough & Hooley, 2003). Participants in this study described negative attitudes towards patients as a whole and towards specifics, such as viewing them as 'demanding'. When a patient is blamed or seen as responsible for their actions this can be due to the staff member seeing patients actions as 'controllable, internal and personal' (Barrowclough & Hooley, 2003). Staff attributions of a person being in control of their challenging behaviour often leads to more negative emotions such as high levels of anger and less sympathy (Sharrock, Day, Qazi & Brewin, 1990). Interestingly, Moore & Kuipers (1992) report that staff are more likely to make negative statements and less likely to make supportive ones during interactions when rated high in criticism and hostility and that staff members with low levels of criticism and hostility tend to focus on positive aspects of patient's lives rather than negative. Thus the approach staff take to

talking about patients or to patients can be indicators of their levels of expressed emotion which can impact the psychosocial environment.

Staff described negative experiences when working with patients with PD and this concurs with the findings of several studies in this field (Bowers et al, 2006; Markham, 2003; Markham and Trower, 2003; Deans & Meocevic, 2006; Grounds et al, 2004; Wollaston & Hixenbaugh, 2008). Wollaston and Hixenburgh (2008) explored the complexity of nursing staffs' interactions with BPD patients. Their unpleasant and difficult interactions with these patients included being demonised, feeling manipulated and threatened. Over time, lead nurses developed stereotypical perceptions and reactions to these patients. The results from this research suggest that staff on this ward view their patients as needy, manipulative and demanding. It is possible they have developed stereotypical reactions to these patients in the face of repeated negative experiences with them. One of the main 'roles' for the participants was managing risk and assessing risk. Participants' reflected on the difficulties in managing risk with this client group seeing patients as risky and manipulative. They reflected on a number of occasions about the risk of things like grooming being equally damaging as physically violent acts. Risk seems to be malleable and must be assessed regularly. Participants at times have not felt safe on the ward; this is seen as a downside to their jobs. These findings concur with those of previous studies. For example, a multinational survey was conducted on nursing staff working in psychiatric facilities across UK, USA, Canada and South Africa. Within the UK sample secure units and psychiatric hospital staff were assessed. The results indicated that staff felt assaults are an event which is expected in their work with psychiatric patients. Despite the vast sample of participants, findings are not generalisable outside of the environments the survey was conducted in as there is vast variance between establishments and a purposive sample was not used (Poster, 1996).

Overall a number of difficulties and challenges were described. There are large differences between the MDTs perspectives currently. The results described high levels of anger being experienced due to colleagues actions but did not explore this in terms of patients actions. Potentially, the patients perceived as ill meant they are considered less accountable for their negative behaviours as found by Markham (2003) research.

Markham (2003) found that Registered Mental Health Nurses were more negative about their experience working with BPD compared to other patient groups (schizophrenia and depression). This, however, is contradictory to the findings in this study as staff expressed that their PD patients were more interesting and 'lively' than patients with other diagnosis. Markham (2003) also found staff were least optimistic towards patients with a BPD diagnosis. Optimism was not explicitly explored in this research although hopefulness was. There was a split amongst participants regarding hopefulness but a consensus in who participants felt hopeless for. Overall therefore, staff on one hand expressed negative experiences and attitudes and at the same time expressed a sense of interest and optimism. This may be accounted for as the staff are working with PD patients only, they may therefore be searching for positives and fulfilment in the area which they work. It may be they are able to do this through maintaining a sense of optimism and interest. Additionally, participants may feel they are specialist and able to do work others can't thus increasing a sense of interest.

Research suggests staff who are less optimistic about BPD patients also express less sympathy (Markham & Trower, 2003). It would be interesting to see if greater sympathy was also found in this study. Participants did express assumptions they held regarding patients upbringings and this was expressed using sympathy. Therefore this staff group may be more optimistic and sympathetic to this PD patient group. However, all participants described patients as needy, demanding and manipulative thus it is difficult to reconcile their sympathy and hopefulness with this view. Previous research has indicated factors

which appear to be associated with better attitude to personality disorder patients, including lower stress, greater mental well being, a more positive perception of managers and improved work performance (Bowers et al., 2006). Many of these factors were not apparent in this study, therefore some scepticism may be used when considering the strength of peoples hopefulness. Moreover, there was greater consensus on who to be hopeless about rather than hopefulness towards individuals.

Kurtz & Turner (2007) explored the needs of staff working with offenders with a PD diagnosis. Their results suggest that staff experience reluctance and little opportunity to explore differences of opinion with each other. Although the generalisability of their findings is limited due to the research being conducted in one unit only, they are congruent with the current findings, where staff expressed high levels of frustration in relation to team working. The communication within the team, particularly regarding debriefing on situations, was difficult for participants, with people reporting feeling 'judged' and 'blamed'. The 'industrial language' described as being used in debriefing may be a way of distancing or depersonalisation. This is significant as research suggests burnout comprises of depersonalisation, emotional exhaustion and lowered personal accomplishment (Maslach et al, 1996).

It is possible the focus and value placed on the label of PD is a way of distancing from the individuality of the patients, instead seeing them as a homogenous group as a coping strategy to deal with the frustrations and negative attitudes experienced daily on the ward. Additionally, distancing may help participants to ensure they maintain boundaries and manage risk. Nurses often reference wanting to help the sick or dying, when asked why they have gone into the profession (Pines, 2000). This might in part explain the universal perspective that the patients needed help and had a difficult upbringing. This perhaps allows the nurses to see the patients in more of a 'sick patient' role.

### **Limitations of the Study**

The present study has a number of limitations. The research was only conducted within one unit. Further studies exploring staff experiences in other units and settings would be of value. Due to the research including a nursing only participant sample, it is not representative of everyone working on the ward. There was a potential bias in the staff who participated as it was a sample selected by convenience, fitting in with who was on their shift and who wasn't assigned to a role they couldn't leave for the duration of an interview. There may also have been some bias due to the researcher having been on placement at the unit the year prior; however, it is also likely this facilitated openness as there was a level of familiarity. Additionally, the researchers' interpretations of the participants' responses may have been influenced by the experience of being an 'other' on the ward when on a work placement. Furthermore, the data analysis and subsequent validity of findings may have been limited due to the researchers' inexperience. The ability of the researcher to interpret meaning beyond the claims of the individual may have been hampered by inexperience. A further issue regarding the interview schedule is that language and communication emerged as a theme but this was not covered explicitly within the schedule. Other dimensions of the participants' experiences may have been missed due to limitations of the schedule. Further research exploring nursing staff experiences would help verify the current findings and / or establish further dimensions to the experiences of nursing staff in relation to PD

### **Clinical Implications and Future Research**

In recent years a campaign has been implemented in an attempt to reduce the marginalisation of services for people with a stigmatising diagnosis of personality disorder (NIMHE, 2003). This has been attempted through guidance on personality disorder (PD) such as '*Personality Disorder: No longer a Diagnosis of Exclusion*' (DoH, 2003). Its aim was to ensure services were developed but that staff would be equipped with the education

and training they need to work effectively with people with a PD (NIMHE, 2003). The findings of this research suggest this has not yet been achieved. Staff suggested they require more training and that they experience difficulties and challenges with this client group, often holding assumptions regarding the patients behaviours, as well as describing experiencing difficult emotions on a daily basis. The participants in this study clearly described decisions, particularly within the MDT, as being governed by “whim, opinion and dogma” (Bateman and Tyrer, 2003).

This research was conducted within a secure mental health setting. Bateman and Tyrer (2003) suggest working in locked environments with PD patients can be associated with the occurrence of challenging, hostile behaviour that professional staff have to manage positively. Significantly, this research identified numerous examples of challenging and hostile behaviour; with staff describing some of the consequences of this such as taking work home, experiencing intense negative emotions and, potentially, burnout. They also tentatively approached the concept of being institutionalised. The negative impact of working within a locked environment on staff appears significant; further research on ways to change staff experiences or help staff cope with their negative experiences could help change the clinical experience of staff and patients. In broader terms the efficacy of services may be increased.

This ward was originally aimed at being a psychology led ward but this is described as not being achieved and the participants felt they were in a ‘limbo land’. Holmes (2002) suggests that a shift in management, culture of the ward and training is required to adopt a psychological approach to in-patient care. Senior medical nursing and management staff must be determined agents of change. Holmes (2002) also suggests a psychological therapies implementation group is required. Research by Holmes (2002) suggests in order to ‘re-discover’ the psychological approach and culture on an inpatient unit and to improve clinical outcomes, increase staff satisfaction and reduce untoward events a sustained effort

from agents of change is required. The service implications of this appear to be that services need cohesive teams in order to implement and sustain change. Research suggests there are a number of actions required for a psychological approach to be sustainable on a ward.

There is currently a gap in studies which intervene with staff negatives attitudes, attributions and burnout when working specifically with a PD client group. A focus of future research on these factors may be valuable. Further exploration of staff experiences working on PD wards may help identify interventions the efficacy of which can then be researched. The implications for staff interventions would be to address issues such as EE, the emotional impact of their work and strengthening team dynamics. By researching effective interventions greater support can be afforded to staff and, in turn, patients' experiences of staff caring for them. After all it has been well established that the psychosocial environment affects patients suffering from severe mental illness (Barrowclough et al., 2001).



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**Part Three****Appendices**

## Appendices

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## Appendix A: Guidelines for authors

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3. Register (if you have not done so already).
4. Go to the Author Center and follow the instructions to submit your paper.
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**Style** . Please follow the stylistic guidelines detailed in the *Publication Manual of the American Psychological Association, Sixth Edition*, available from the American Psychological Association, Washington, D.C. *Webster's New World Dictionary of American English, 3rd College Edition* , is the accepted source for spelling. Define unusual abbreviations at the first mention in the text. The text should be written in a uniform style, and its contents as submitted for consideration should be deemed by the author to be final and suitable for publication.

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- **Research Articles** . Research articles may include quantitative or qualitative investigations, or single-case research. They should contain Introduction, Methods, Results, Discussion, and Conclusion sections conforming to standard scientific reporting style (where appropriate, Results and Discussion may be combined).
- **Review Articles** . Review articles should focus on the clinical implications of theoretical perspectives, diagnostic approaches, or innovative strategies for assessment or treatment. Articles should provide a critical review and interpretation of the literature. Although subdivisions (e.g., introduction, methods, results) are not required, the text should flow smoothly, and be divided logically by topical headings.
- **Brief Reports** . Abbreviated reports will be considered, and are especially encouraged if they involve: 1) replications; 2) replication failures; 3) well-designed clinical trials and other studies with negative findings; 4) potentially interesting serendipitous findings or results obtained by post-hoc hypotheses; or 5) Dissertations in Brief (DIB). DIB is intended to encourage students to submit innovative research conducted during the student's graduate studies. It is expected that DIB manuscripts would be submitted by the student, who would be the first author. All Brief Reports should contain an abstract and provide a concise synopsis (12 manuscript pages or less) of the major findings presented in the study. The format of manuscripts submitted for Brief Reports may adhere to the Research Report or Review Article format as appropriate. Authors of Brief Reports should make available a full description of method and statistical

analyses with a report of all data and information needed for meta analyses. Brief Reports should include explicit statements of limitation, and power analyses may be necessary.

- **Commentaries** . Occasionally, the editor will invite one or more individuals to write a commentary on a research report.
- **Editorials** . Unsolicited editorials are also considered for publication.
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- **News and Notes** . This section offers a vehicle for readers to stay abreast of major awards, grants, training initiatives; research projects; and conferences in clinical psychology. Items for this section should be summarized in 200 words or less. The Editors reserve the right to determine which News and Notes submissions are appropriate for inclusion in the journal.

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informed consent was obtained from the research participants after the nature of the experimental procedures was explained.

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Appendix B: Rationale for the inclusion and exclusion criteria used within the systematic literature review

Inclusion Criteria	Rationale
– Experiences and views of staff working with patients with a diagnosis of personality disorder (PD).	This study aimed to explore the nature of staff attitudes within inpatient settings towards PD, meaning it aimed to explore the varying components such as experiences, views and perceptions of staff working with PD.
– Studies which were investigating the nature of staff attitudes	The nature of staff attitudes meaning the varying components such as experiences, views and perceptions of staff working with PD.
– Studies published after 2003 (Personality Disorder: No longer a diagnosis of exclusion (DoH, 2003)).	As stated in the text the focus on PD and the stigma associated with the diagnosis required a change in services. Within this it was identified staff require suitable training and support. In theory this should have increased research, into staff components such as the nature of staffs attitudes to PD.
– Peer reviewed studies.	Peer reviewed studies cement the methodological soundness and relevance of the research.
– Studies conducted with inpatient staff or including a large sample of staff working in inpatient settings.	The previous research highlights the importance of inpatient environments and thus the impact on patients who are within them.
Exclusion criteria	Rationale
– Studies which did not include a	This was due to this study aiming to

specific focus on personality disorder.	explore the nature of staff attitudes within inpatient settings towards PD, therefore a focus on PD of the research, or within the results section was a necessity.
– Studies which did not include staff working in an inpatient setting	The previous research highlights the importance of inpatient environments and thus the impact on patients who are within them. Therefore studies which included no data on in-patients settings were excluded.
– Literature reviews or other non-empirical papers.	Literature reviews and other non-empirical papers were excluded due to potential biases in the presentation of findings and no new evidence being presented.
– Case studies	Due to case studies being very focused they are therefore likely to be less generalisable.
– Studies not printed in English	It would have been to challenging to translate articles into English due to time constraints.
– Studies which have not been peer reviewed	Peer reviewed studies cement the methodological soundness and relevance of the research.

## Appendix C: Quality checklist for quantitative studies

1. Is the hypothesis/aim/objective of the study clearly described?
2. Are the main outcomes to be measured clearly described in the Introduction or Methods section?
3. Are the characteristics of the participants included in the study clearly described?
4. Are the interventions of interest clearly described?
5. Are the variables clearly defined eg. nature of staff attitudes
6. Are the main findings of the study clearly described?
7. Have the characteristics of participants lost to follow-up been described?
8. Have actual probability values been reported( e.g. 0.035 rather than  $<0.05$ ) for the main outcomes except where the probability value is less than 0.001?
9. Were the subjects asked to participate in the study representative of the entire population from which they were recruited?
10. Were the statistical tests used to assess the main outcomes appropriate?
11. Were the main outcome measures used accurate (valid and reliable)?
12. Were losses of participants to follow-up taken into account?
13. Were the limitations of the study acknowledged in the discuss?

## Appendix D: Quality checklist for qualitative studies

<b>Study identification</b> <i>Include author, title, reference, year of publication</i>			
<b>Checklist completed by:</b>			
<b>Guideline topic:</b>			<b>Key question no:</b>
<b>Criteria:</b>			<b>How well is this criterion addressed?</b> <i>(Circle one option for each question)</i>
<b>1 Aims of the research</b>			
1.1	Are the aims and objectives of the research clearly stated?	Clearly described Unclear Not reported	Comments
1.2	Is a qualitative approach appropriate?	Appropriate Unclear Not appropriate	Comments
<b>2 Study design</b>			
2.1	Is (are) the research question(s) clearly defined and focused?	Clearly defined and focused Unclear Not focused Not defined	Comments
2.2	Are the methods used appropriate to the research question(s)?	Appropriate Unclear Inappropriate	Comments
<b>3 Recruitment and data collection</b>			
3.1	Is the recruitment or sampling strategy appropriate to the aims of the research?		Appropriate Unclear Not appropriate
3.2	Are methods of data collection adequate to answer the research question?	Adequate Not adequate Not reported	Comments
3.3	Are the roles of researchers clearly	Clear	Comments

The guidelines manual (appendices) described			Unclear Not reported
3.4	Have ethical issues been addressed adequately?	Adequate Unclear Not adequate	Comments
<b>4 Data analysis</b>			
4.1	Is the data analysis sufficiently rigorous?	Rigorous Not rigorous	Comments
<b>5 Findings/interpretation</b>			
5.1.	Are the findings internally coherent, credible (valid)?	Valid Unclear Potential bias	Comments
5.2	Are the findings relevant?	Relevant Unclear Limited relevance	Comments
<b>6 Implications of research</b>			
6.1	Are the implications of the study clearly reported?	Clearly reported Unclear	Comments
6.2	Is there adequate discussion of the study limitations?	Adequate Inadequate Not reported	Comments
<b>OVERALL ASSESSMENT OF THE STUDY</b>			
How well was the study conducted? <i>Code ++, + or –</i>			
Are the results of this study directly applicable to the patient group targeted by this guideline?			Yes No

## Appendix E : Quality assessment for quantitative studies

Study no. Author	1	2	3	5	6	7	8	9	10	11	12	13	Total
1. Bowers et al (2006)	1	1	1	1	1	1	1	0	1	1	1	0	10
2. Mason et al (2010a)	1	1	1	1	1	0	0	1	1	1	0	1	9
3. James et al (2007)	0	0	1	1	1	0	0	1	1	1	0	1	9
4. Markham (2003)	1	1	1	1	1	1	1	1	1	1	0	1	11
5. Markham et al (2003)	1	1	1	1	1	1	0	1	0	1	0	1	9
6. Mason et al (2010b)	1	1	1	1	0	0	0	0	1	1	0	1	7
7. El-Adl et al (2009)	1	0	0	0	1	0	0	1	0	0	0	0	3
8. Deans et al (2006)	1	1	0	1	1	0	0	1	0	0	0	1	6
Total	7	6	7	7	7	3	2	6	5	6	1	6	

## Appendix F : Quality checklist for qualitative studies

Study No. Author	1.1	1.2	2.1	2.2	3.1	3.2	3.3	3.4	4.1	5.1	5.2	6.1	6.2	Total
1. Woollaston et al (2008)	1	1	0	1	1	1	1	1	1	1	1	1	0	11
2. Kurtz et al (2007)	1	1	1	1	1	1	1	1	1	1	1	0	0	11
3. Fortune et al (2010)	1	1	1	1	1	1	0	0	1	1	1	1	1	11
4. Grounds et al (2004)	1	1	0	1	0	1	0	0	1	1	1	0	1	8

## Appendix G: Data extraction sheet

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**Study no****Title****Authors****Date****Source**

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**Aims****Methodology****Participants****Measures****Attitudes  
identified****Main  
results/findings**

---

**Conclusions****Limitations  
identified****Implications****Recommendations  
for future research****Quality rating**

## Appendix H: Interview Schedule

**What effect does working with patients with a diagnosis of a personality disorder have on nursing staff?**

*In general how do you feel towards patients with PD?*

*What do you think about the term PD?*

*Can you describe the challenges or problems you face?*

**How do nursing staff member's levels of experience, knowledge and training impact upon working life?**

*What is your level of training?*

*What experience do you have of working with PD?*

*How do you feel about the diagnoses PD?*

*How do you think your knowledge, training and experience impact on working in the unit?*

*To what extent does your knowledge and training influence how you react to patient's problems?*

*Does it impact how you think, feel, behave?*

**What effect do staff experiences of 'negative' interactions have on their attitudes and actions towards patients?**

*What patient actions or emotions do you see as most challenging? What have been your experiences of this?*

*Can you describe a time recently when you had an interaction with a patient that you found negative or challenging? What made it negative for you? What was your experience at the time? What did you think and feel? What did you do? Do you look at this any differently now?*

*How do the patient's actions emotions affect working with them?*

*When do your responses feelings towards patients change?*

## Appendix I: Participants demographic form

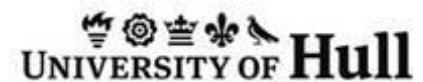


03/02/12 Version 2.0
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**Staff Demographics Sheet**

1. Are you                      Male/ Female
  
2. How old are you?  
 .....
  
3. What is your job  
 title?.....
  
4. How many hours do you work a  
 week?.....
  
5. How many years have you been  
 qualified?.....
  
6. How many years have you worked in specialist PD  
 services?.....
  
7. What additional qualifications do you  
 have?.....
  
8. How long have you worked on swale  
 ward?.....

## Appendix J: Documentation from the Ethical Committee



SRK/GBK

13 February 2012

Mrs S Abel  
Department of Clinical Psychology & Psychological Therapies  
Hertford Building  
University of Hull  
Cottingham Road  
HULL HU6 7RX

Dear Sarah

**Re: A Qualitative Investigation of the Experiences of Nursing Staff working in  
a Secure Personality Disorder Unit**

Thank you for sending me the revised documentation for your research project. I can confirm that these changes are appropriate and I am now able to fully approve your research proposal.

May I once again take this opportunity of wishing you every success with your research.

Yours sincerely

STEPHEN R KILLICK  
Chair – PGMI Ethics Committee

Professor Nicholas D Stafford MB FRCS  
Director - Postgraduate Medical Institute  
Postgraduate Medical Institute, Hertford Building (Room 203)  
The University of Hull  
Hull, HU6 7RX, UK  
T: +44 (0) 1482 465348/464213  
F: +44 (0) 1482 463421  
N.D.Stafford@hull.ac.uk

**Humber**   
 NHS Foundation Trust  
 Research & Development Department  
 Trust Headquarters  
 Willerby Hill  
 Beverley Road  
 WILLERBY  
 HU10 6ED

15/03/2012

Sarah Abel  
 Trainee Clinical Psychologist,  
 Department of Clinical  
 Psychology  
 Hertford Building, Hull  
 University  
 Cottingham Road, Hull  
 Hu6 7RX

Dear Sarah Abel

**Re: R&D N°: 11/12/485                      REC N°: N/A**

**A Qualitative Investigation of the Experiences of Nursing Staff working in a Secure Personality Disorder Unit**

I am please to notify you formally that NHS permission for research has been granted for this study by Humber NHS Foundation Trust.

**Date of commencement of NHS permission for research: 15/03/2012**

NHS permission for the above research has been granted on the basis described in the application form, protocol and supporting documentation. The documents reviewed were:

- Protocol – v4
- Information Sheet – v1 – 10/12/2011
- Informed Consent Form – v1 – 10/12/2011
- Interview Schedule
- CV – Sarah
- Staff Demographics Sheet

Indemnity for this study is provided by the NHS Indemnity scheme.

Humber NHS Foundation Trust conducts all research in accordance with the requirements of the Research Governance Framework, and the NHS Intellectual Property Guidance. In undertaking this study you agree to comply with all reporting requirements, systems and duties of action put in place by the trust to deliver research governance, and you must comply with the Trust information management and data protection policies. In addition, you agree to accept the responsibilities associated with your role that are outlined within the Research Governance Framework as follows:

- That satisfactory honorary contracts/letters of access are obtained and copied to Humber NHS Foundation Trust Research Governance team prior to the commencement of any research activity (including those required by new researchers joining the study post-approval).
- The study follows the agreed protocol
- All amendments (including changes to the local research team) need to be submitted in accordance with guidance in IRAS.
- All changes in the status of the project should be reported to the Humber NHS Foundation Trust Research Governance team.
- That the PI co-operates with appropriate monitoring activity carried out by the Humber NHS Foundation Trust Research Governance team.
- Participants should receive appropriate care while involved in the study

- The integrity and confidentiality of clinical, other records and data generated by the study will be maintained.
- All adverse events must be reported using the Trust's Adverse Incidents Policy.
- The research sponsor or the Chief Investigator, or the local Principal Investigator at a research site, may take appropriate urgent safety measures in order to protect research participants against any immediate hazard to their health or safety.
  - The R&D office should be notified that such measures have been taken. The notification should also include the reasons why the measures were taken and the plan for further action.
  - The R&D Office should be notified within the same time frame of notifying the REC and any other regulatory bodies.
- Any suspected misconduct by anyone involved in the study must be reported
- Permission is only granted for the activities for which a favourable opinion has been given.

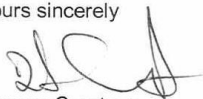
Please note - you must ensure that the protocol is followed at all times. Should you need to amend the protocol, please follow the national research ethics service procedures. You should forward a copy of all amended versions of the protocol and/or documentation together with written confirmation that a favourable opinion has been given by the REC (if applicable), to the R&D office at the trust, and confirmation that there has been no change in the NHS permission status should be obtained prior to further research activity commencing.

You will be required to complete electronic progress reports and a final monitoring form on completion . As part of this requirement, please ensure that you are able to supply an accurate breakdown of research participant numbers for this trust (recruitment target, actual numbers recruited). To reduce bureaucracy, progress reporting is kept to a minimum, however, if you fail to supply the information requested, the trust may withdraw approval.

Please note that the NHS organisation is required to monitor research to ensure compliance with the Research Governance Framework and other legal and regulatory requirements. This is achieved by random audit of research.

I would like to wish you every success with this project

Yours sincerely



Duncan Courtney  
Clinical and Research Governance Manager

### **Participant Information Sheet**

*We would like to invite you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you. **The researcher will go through the information sheet with you and answer any questions you have.** We'd suggest this should take about 5 minutes. Please ask if anything is not clear.*

#### **A Qualitative Investigation of the Experiences of Nursing Staff working in a Secure Personality Disorder Unit - version 1.**

Research has shown that staff working with people with a diagnosis of Personality Disorder (PD) often experience strong negative emotions. Within medium secure environments staff relationships are hugely significant. Within the social networks of clients professional staff have a central role and some clients see staff as their family. How central staff relationships are to clients can be enhanced in a locked environment because of limited contact with family and the community. Staff must maintain a competent, containing approach despite provocation from clients, anxiety and pressure to transgress boundaries.

#### ***What is the purpose of the study?***

The purpose of this study is to investigate the experiences of nursing staff working in a secure PD setting. It is not clear what experiential concerns and understandings there are amongst staff in secure PD settings. Identifying common themes in the experiences of staff members working in this environment could help further focus training and supervisory processes.

#### ***Why have I been invited?***

You have been invited to take part because you are a member of nursing staff working on Swale. We are hoping to recruit around 10 nursing staff members in total.

#### ***Do I have to take part?***

No, it is up to you to decide to take part. We will describe the study and go through this information sheet. If you agree to take part, we will then ask you to sign a consent form. You are



free to withdraw at any time, without giving a reason. Whether or not you take part would not affect your job.

***What will happen if I decide to take part?***

After you sign the consent form an appointment will be booked for you to meet with the researcher. Then you will meet with the researcher in a quiet room, which can be off or on the unit, depending on your preference.

You will be asked to fill out one questionnaire concerning general information about you. You will then have a 60-90 minute conversation with the researcher who will ask you some questions about your experiences of working with people who have a diagnosis of personality disorder.

A few months later the researcher will ask you to complete a short questionnaire to validate the research themes found,

***What are the possible disadvantages and risks of taking part?***

Taking part in this study requires some of your time, which may be inconvenient for you. Although unlikely, if sensitive information is divulged or any emotional distress experienced the researcher will support you in the interview. They will also offer information on who you could contact for further assistance such as your GP, occupational Health, your supervisor and/or line-manager.

If anything should be divulged regarding your job role or actions at work which is of concern to the researcher they will take this information to their researcher supervisor Drew McAnespie. He will then make a decision on what action, if any, to take.

***What are the possible benefits of taking part?***

We cannot promise the study will help you directly but we hope that the information we gain from this study could help us in the future to identify and work with effective training programmes and support for staff as well as having service implications for patients.

Taking part will give you the opportunity to think and talk about some of your experiences in working with people with PD.

***What will happen if I decide I no longer wish to take part?***

After signing the consent form, you can still change your mind about taking part in the study. Even if you have already taken part you can notify the researcher if you wish to withdraw.

***What if there is a problem?***

If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions [07862799540].

***Will my taking part in this study be kept confidential?***

All information which is collected about you during the course of the research will be anonymised. The coded data will be stored securely on University Departmental premises for five years after completion of the study.

***What will happen to the results of the study?***

The results will be written up as part of a doctoral qualification and are intended to be published in a scientific journal. *You will not be personally identified in any of the results.* Information about the results will be available from your manager upon completion of the study in Summer 2012.

***Who is organising and funding the research?***

This research is being undertaken as part of a doctoral research project in Clinical Psychology. The research is funded through the University of Hull.

***Who has reviewed the study?***

All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by Post Graduate Medical Institute and NHS research governance.

***Further information and contact details***

If you have any further questions or queries, please contact Sarah Abel either in person or on 07862799540 between the hours of 9:00am and 8:30pm.

## Appendix L: Participant informed consent form

Date: 10/12/2011 Version Number: 1.0

**CONSENT FORM**

**Title of project:** A Qualitative Investigation of the Experiences of Nursing Staff working in a Secure Personality Disorder Unit.

**Name of Researcher:** Sarah Abel

**Please initial the**

1. I confirm that I have read and understand the information sheet dated 10 <sup>th</sup> December 2011 (version 1.0), for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	<input type="checkbox"/>
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without any legal rights being affected.	<input type="checkbox"/>
3. I understand there will be a questionnaire approximately two months after my initial participation, regarding the findings of the research and I agree to complete this, if I am available.	<input type="checkbox"/>
4. I am aware of the potential risks and benefits of taking part.	<input type="checkbox"/>
5. I agree to take part in the above study	<input type="checkbox"/>

\_\_\_\_\_

Name of participant

Date

Signature

\_\_\_\_\_

Name of person  
Taking consent

Date

Signature

## Appendix M: Reflective Statement

### **Reflective Statement**

This reflective statement is a combination of summaries from my reflective diary and my current reflections. The writing of it has been an emotional and cathartic experience for me, covering the different stages of my research journey and my overall reflections on what I have learnt.

### **Beginning the journey**

My previous academic experience of conducting research had been mixed. I had generated a list of “What not to do this time around”. I had also thought about the enjoyment and sense of achievement I had from designing, conducting, analysing and writing up a piece of research from scratch. Despite the difficulties with the recruitment process from my undergraduate degree I came to my clinical psychology doctorate degree enthusiastic about the research element of the course.

### **Finding a gap**

I knew there were some elements of interest I had developed from clinical experience and in general, mainly with staff groups and staff dynamics. I took this interest and looked for gaps, a peers presentation on their research had talked about expressed emotion (EE) the concept of EE fascinated me so this is where my reading began. I was also developing an interest in severe and enduring mental health difficulties. I quickly met difficulties not knowing how to focus my searches feeling like everything was very interesting. I met with a member of the department whose interests were in forensic and inpatient settings. This really helped to focus my searches and their enthusiasm and guidance influenced me greatly. My first proposal reflected my broad interests and lack

of focus, the feedback from this work highlighted my next steps for me which were to focus in a little more and become more practical.

### **Reviewing the literature and forming an idea.**

I continued to review the literature and the idea of looking at personality disorder wards and staff groups formed. At this time the member of staff I was talking to left the department. I was initially quite worried as I didn't know who my new research supervisor would be. My first meeting with Chris put all those worries to bed. He was enthusiastic and added ideas to my research such as thinking about attributions. When I started researching this, a vast amount of new literature was at hand and I went back to unfocussed searching and reading. I feel I learnt a lot from what I read but much was not applicable to my research. This is a weakness of mine I must be aware of for any future research as again and again I fell into this pitfall. I found discussing with my supervisor my difficulties of focusing was very helpful. He consistently prompted me and helped me reflect on what work I had done and if it was useful.

### **Choice of design**

My previous research experience was a mixed design. This time I thought I would use a quantitative design thinking it would allow me to use some of the measures I had read about particularly regarding EE. I stuck with this methodology and tried to develop a piece of research which would work. After almost a year of this journey writing and re-designing it became apparent that a quantitative design was not appropriate. I needed to go back to the drawing board.

### **Reviewing, letting go and moving forwards**

Reviewing the impracticalities of my proposal from a quantitative design led to me at a very late stage (November 2011) starting over. My passion for the concepts I wanted to review meant I wanted to stick with some of what I had. The difficulty was then turning off a cause and effect mindset and switching to being more explorative and curious. It surprised me how difficult this was. My supervisors support at this time was vital and I think every time I met with them my panic was obvious. A big change at a late stage was a very difficult decision. Reflecting on it now I feel proud and pleased that I made this decision when I did. If I had waited any longer it would have been even more of a challenging process. Around this time I was trying to 'pin down' my SLR questions the wording of which I am still not happy with even after writing it.

The difficulty for me at this stage was writing a new proposal and trying to get through ethics. Once again this process took longer than expected. When I finally had all the necessary permissions in March I was hugely relieved. There was also a part of me which felt very nervous, it was so difficult to become a researcher I worried I would be a therapist in the room when interviewing and not a researcher. Thus, I had lots of practice runs with my husband who was a willing guinea pig. I also scheduled reflection time between interviews.

### **Transcribing and analysing data**

Upon completion of interviews I had to begin transcribing. This was the most painful experience of all, my initial enthusiasm waned after my first ten hours of transcribing and I felt hugely frustrated throughout this time. I also felt a split of responsibilities with the huge undertaking of my SLR dawning on me. On reflection I could have used transcribing as a more thorough way of immersing myself in the text.

The process of identifying themes was one which I could only undertake with annual leave. I found it challenging when trying to manage placement and analysis. I therefore spent two weeks with the text ending up with huge paper mind-maps, reams and reams of paper and a beginning of an understanding. I then needed time away from the text, distance to see the information with new perspective. Therefore the challenge of writing my SLR began. This took a long time and some very strange living hours, ultimately, on reflection this helped build my confidence in my research skills and my empirical study. I think my confidence crisis which I experienced at many points in this process allowed me to be more reflective but also probably bought out the procrastinator in me.

### **Write-up**

When trying to write this information up I have struggled. My meetings with my supervisor have been invaluable including the ‘do you need an extension’ conversation. This struck fear into me, I’m not sure why, but I wanted to be able to achieve my research in the ‘normal’ timeframe. Personally, on reflection more time with the data, one more iteration, may have helped. I feel at times the disparity between my verbal expression of my research and my written expression, which may relate to my dyslexia has seriously affected the quality of what I have produced. My supervisors’ patience with this has been comforting. The lack of speed I have when writing has been particularly frustrating when trying to edit.

### **Finally**

Overall this experience has left me feeling research is not a thing to leave behind but instead something I wish to embrace. I have been thinking of parents’ experiences of conduct disorder, I don’t know if there is a gap here but I aim to find out. I think with

time I will hopefully become more confident with the research process. The difficulties with methodology and timing has been extremely stressful and at times, felt like more than I could handle, but I have and I think my pride in this work is all the richer from these challenges. Ultimately, I think the amazing staff who took time to speak with me will always stay with me. What they had to share has enriched my understanding of other professionals roles and I have considered them in my clinical work a number of times already.