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Weight, Emma Jane and Kendal, Sarah

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Staff attitudes towards inpatients with borderline personality disorder

Emma Jane Weight and Sarah Kendal

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Emma Jane Weight

Nursing student Staff nurse. University of Manchester and Greater Manchester West Mental Health NHS Foundation Trust

Sarah Kendal

Researcher and lecturer. School of Nursing and Midwifery, University of Manchester

Correspondence to: Emma.weight@hotmail.co.uk

Read More: <http://journals.rcni.com/doi/abs/10.7748/mhp2013.11.17.3.34.e827>

Staff attitudes towards inpatients with borderline personality disorder

Abstract: This paper discusses negative attitudes of mental health nurses towards inpatients with borderline personality disorder (BPD), from the perspective of a third year mental health student nurse. Possible causes are presented, including the stigma towards BPD, patients being seen as manipulative and nurses lack of optimism for recovery. Pressure of work, poor communication skills and time restraints contribute to the poor care being delivered by some nurses. It is also possible that negative attitudes are caused by the parallels between BPD and self harm. Some suggestions for a way forward are made, based on recommendations in the literature. Further education relating to BPD is discussed, as well as the need for increased supervision and time for effective communication between nurse, patient and the multidisciplinary team.

As a third year student mental health nurse, experiencing negative attitudes of staff towards patients with borderline personality disorder (BPD) is something I have seen regularly throughout my training. I have felt shocked by what I have seen as I feel it is a nurse's duty to care for a patient no matter what their diagnosis is. I feel some members of staff have a pessimistic view of people with personality disorder, especially as in mental health nursing it is important to see the individual nature of each patient and diagnosis. I have been disheartened when nurses whom I believed to be competent and caring members of the multidisciplinary team have shown negative attitudes. For me, these incidents have highlighted the importance of reflective practice and being able to debrief under clinical supervision.

The International Classification of Diseases Version 2010 (ICD-10) (WHO 2010) defines personality disorders (PD) as a group of conditions in which behaviors express the individual's characteristic lifestyle and method of relating to themselves. These disorders sometimes manifest as responses to personal and social situations which differ greatly from how the average person perceives, thinks, feels and relates to others. Behaviour patterns can be associated with a significant level of distress and problems for the individual, caused by the following symptoms:

- Unstable emotions.
- Feelings of emptiness and anger.
- Trouble creating and maintaining relationships.
- Having a changeable and unsteady sense of identity.
- Self harm.
- Being scared of rejection or being alone
(NICE 2009)
- Episodes of psychosis
- Impulsivity
(Mind 2007 (A))

The diagnostic criteria for BPD set out in the Diagnostic and Statistical Manual of Mental Disorders Version 4 (DSM-IV) are that the patient must meet five of nine criteria, as shown in Table 1 below (American Psychiatric Association 1994).

Table 1: The nine characteristics of borderline personality disorder outlined by the DSM-IV (American Psychiatric Association 1994).

Criterion - Borderline Personality Disorder
1. Frantic efforts to avoid real or imagined abandonment.
2. A pattern of unstable and intense interpersonal relationships characterised by alternating between extremes of idealisation and devaluation.
3. Identity disturbance: markedly and persistently unstable self-image or sense of self.
4. Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating).
5. Recurrent suicidal behaviour, gestures, threats or self-mutilating behaviour.
6. Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability or anxiety usually lasting a few hours and only rarely more than a few days).
7. Chronic feelings of emptiness.
8. Inappropriate, intense anger or difficulty controlling anger (e.g. frequent displays of temper, constant anger, recurrent physical fights).
9. Transient, stress-related paranoid ideation or severe dissociative symptoms.

Despite established diagnostic criteria, it appears that further research is needed to determine whether some criteria should be given more weight than others. For instance, self harm and suicide attempts along with unstable relationships may be the most useful indications for a correct diagnosis (Leichsenring et al. 2011).

It has been estimated that the number of inpatients with BPD in the UK is between 15% and 25% (Leichsenring et al. 2011). With such a high prevalence, it might be expected that there would also be a large amount of research into this condition. However, despite the fact that personality disorders may be the most common type of psychiatric disorder when compared with other mental health conditions, the number of scientific papers about this diagnosis is disproportionately low (Winship and Hardy 2007).

BPD is often seen as 'not being a genuine illness' due to it being widely accepted that the condition has no significant biological causal pathway (Kendell 2002). In addition, it has been suggested that patients with PD symptoms are sometimes given other diagnoses (Eskedal 1998). Potentially, this reflects the complexities of diagnosis, but it may also be a factor in negative attitudes seen amongst mental health nurses. Arguably, where diagnosis is unclear it is easier to adopt a view that the condition is less valid.

BPD is characterised by a high risk of suicide and deliberate self harm. The death rate from suicide is 50 times higher in these patients than in the general population with a prevalence of between 8% and 10% (Leichsenring et al. 2011). Having a diagnosis of PD also significantly increases the likelihood of a person having life complications such as housing, alcohol, drugs and abuse (Haw and Hawton 2008). It has been hypothesised that these problems are what cause patients to self harm. However, it is also possible that the diagnosis of a PD and the stigma which comes with it has led to the problems (Haw and Hawton 2008). Negative attitudes of health care professionals surely only contribute to this stigma.

A policy by the National Institute for Mental Health in England (NIMHE) (2003) argued that patients with a diagnosis of PD have long been described as 'the patients psychiatrists dislike (pp. 20). Studies have found words such as time-wasters, manipulative, difficult or attention-seeking are used to describe these patients. Some staff believe that patients with BPD are in control of their behaviour and are therefore manipulative and dangerous (Woollaston and Hixenbaugh 2008). Health care professionals working in mental health settings are more likely to have negative attitudes and perceptions of people with PD than any other diagnosis, which may influence the standard of care this patient group receives (Fraser and Gallop 1993; Markham 2003). These findings were reflected in the views of service users who reported feeling stigmatised by their community (NIMHE 2003). Some patients felt that health care professionals had a poor understanding of the diagnosis, and often linked it with untreatability. They also expressed the view that they received poorer care from the NHS due to having PD. Service users frequently perceived they were being blamed for their diagnosis and were considered 'not to be mentally ill' (NIMHE 2003 pp. 20).

This information is consistent with the views of mental health nurses experienced by students such as myself. It suggests that cynical attitudes may not be uncommon among nursing staff. This is a

concern, due to the negative effect it could have on clinical practice and patients. However, there are some research papers which convey positive attitudes of nurses towards patients with PD (James and Cowman 2007). Nurses in this study believed that they had a key role to play in the treatment of clients with borderline personality disorder and in supporting their carers. The paper also found that services for clients with this diagnosis were felt to be inadequate (James and Cowman 2007). The James and Cowman (2007) study has limited validity due to poor response rates (41.4%). Nonetheless, it is positive that some health care professionals are reporting a caring attitude towards this client group.

Mental health nurses working in acute care demonstrate a greater extent of social distance towards BPD patients (Westwood and Baker 2010). A suggested reason for this is that these clients are seen as healthier than other patients, therefore when they display challenging behaviours such as self harm or anger, nurses become less empathetic and withdraw (Fraser and Gallop 1993). Further research supports this theory by proposing that BPD patients have greater control over their behaviours than patients with other diagnoses, with the result that any negative behaviour is seen as deliberate (Markham and Trower 2003; Forsyth 2007). Markham and Trower's (2003) study was limited because participants were aware they were being asked about attitudes to different groups of patients so may have changed their answers accordingly (Westwood and Baker 2010), but these findings do resonate with the literature around this topic.

Some studies have identified behaviours associated with BPD as a reason for negative attitudes of staff. Nurses in acute mental health settings link the diagnosis with dangerous and powerful behaviours (Woollaston and Hixenbaugh 2008); this had resulted in the phrase 'destructive whirlwind' being used to describe such patients (Woollaston and Hixenbaugh 2008: pp. 703). This is backed up by Ma et al. (2008) who argued that a chaos stage is sometimes experienced by nurses, where they become intolerant and irritated with the patient. At this point, some nurses will distance themselves from the patient, becoming withdrawn and providing poor care (Fraser and Gallop 1993). Health care professionals have also been known to describe clients with BPD as 'manipulative' (pp. 660). This stems from the belief that their behaviour is calculated and dishonest rather than being part of their illness (Westwood and Baker 2010). A view of this nature could effect the calibre of care a nurse delivers and will lead to the patient feeling rejected and devalued; a feat which will cause further deterioration of their illness (Woollaston and Hixenbaugh 2008). These findings can be related to the experiences of student nurses in order to appreciate the thought process of the nurses involved. They may have experienced dishonest or threatening behaviour from a patient in the past which has led them to believe such patients are manipulative and dangerous. However, further research is needed to determine where these ideas originate from (Westwood and Baker 2010).

The nursing literature suggests that nurses working in acute mental health care settings will have had many negative experiences with patients diagnosed with BPD, resulting in more cynical attitudes and lower levels of optimism towards these patients (Markham 2003; Markham and Trower 2003). Nurses feel unable to help which can lead to frustration and consequently poor care (Filer 2005). On the other hand, James and Cowman (2007) suggest that nurses are starting to see that BPD is a treatable illness, leading them to become more optimistic. Potentially, this could support more positive attitudes towards patients.

NICE guidelines (2009) state that when working with patients with BPD, health care professionals should convey hope and optimism; recovery is possible. Service users have supported this view; NIMHE (2003) reports the need for health care professionals to acknowledge that PD is a real and treatable condition. Patients are less likely to engage with services if they have had a negative experience on initial referral, and studies have shown the need for support to continue long term in order for patients to prevent relapse (NIMHE 2003). Debatably, this information could encourage nurses to adopt a caring and respectful attitude towards people with BPD.

It is possible that the negative attitudes expressed by nurses are due to the fact that patients have deliberately self harmed. There appear to be parallels between patients who self harm and patients who have BPD. Studies have shown a high percentage of patients who self harm have a diagnosis of PD; 40% (Suominen et al. 1996) and 46% (Haw et al. 2001). However, some of these studies also looked at patient's intent to die using the Suicidal Intent Scale (SIS) (Beck et al. 1974). Haw et al. (2003) found that patients presenting to a general hospital having self harmed were more likely to have a high intent to die if they had a diagnosis of depression, and a low intent to die if they had a diagnosis of PD. Findings like these may be a basis to the negative attitudes due to clients being seen as wasting the time of health care professionals (Jeffery 1979). However, the Haw et al. (2003) study consisted of a small sample size which may not be representative of the population as a whole. The study also only contained a very small number of patient's who had seriously self harmed; this may have caused a bias in the results (Haw et al. 2003). Mind (2007) (B)) recognises that self harm may not always be done with the intent to die; it is often used as a mechanism to cope with emotions and release stress.

There are many factors which could lead to the negative perceptions of nursing staff towards patients with PD and those who self harm. A lack of training and supervision means nursing staff have less knowledge and poor understanding of the condition (Cleary et al. 2002). Studies have identified training needs in the areas of control, sympathy and management which could improve relationships between nurses and patients (Cleary et al. 2002; Markham 2003; James and Cowman 2007). The benefit of education was demonstrated in a study which used the self harm antipathy scale as a tool to show that after attending a twelve week course about self harm, negativity was reduced (Patterson et al. 2007). However, in this study the course was optional which shows that those attending were already interested in the subject. It has also been found that staff felt that being able to debrief about a situation helped them to understand it better and stopped them forming negative attitudes. This highlights the need for increased clinical supervision in practice (Mchale and Felton 2010).

The studies above have called attention to the need for knowledge relating to PD and self harm. It is thought that personal experience with suicide or self harm will result in a better attitude towards it (Brunero et al. 2008). It is possible that the attitude of nurses could be due to the inevitable stress of working on a high intensity ward for a long period of time. However, this is contradicted by Dickinson and Hurley (2011) who found that nurses who had had long careers of working with patients who self harm had more positive attitudes. The emotional impact of working in mental health care must be considered in relation to staff attitudes. Alexander and Atcheson (1998) reported that 48% of staff working on high trauma wards had found the emotional element of their role significantly distressing during their career. A popular way for nurses to cope with these

feelings is by using black humour, with 84% of health care professionals in the study finding it helpful. Whilst negative attitudes of nurses are unprofessional, it cannot be ruled out that they are not necessarily true feelings, but instead a defence mechanism and well recognised coping strategy (Alexander and Atcheson 1998). Although this paper focuses on a physical health setting, the same principles surely apply to a mental health ward. Studies on this topic appear unclear which suggests more research is needed.

O'Donovan (2007) explored the way in which differences between nurses' expected and actual roles lead to the development of negative attitudes towards patients who require a lot of therapeutic input. Staff disclosed that they felt their role was focused more towards medication than developing therapeutic relationships. This prevents them from spending time trying to engage with and understand the patient and so prevents them from giving high quality care. This will inevitably cause frustration when the patient's condition fails to improve and the nurse may start to withdraw and believe that personality disorders are not treatable (O'Donovan 2007). A similar speculation is made by Crowley (2000) who examines how time pressures lead to cynical attitudes of staff. Crowley (2000) argues that nurses do not have the communication skills required to treat patients with complex and sensitive issues. However, it could also be that although they do possess these skills, staff simply do not have the time to utilise them when dealing with patients and their carers.

A key aspect of good health care is communication between nurse and patient (Hemsley et al. 2011). It is also essential for there to be an excellent level of communication between members of the multidisciplinary team in order for practice to remain safe and consistent. Staff often feel as if the message heard at the end of the communication process is very different from the message sent out to start with (Baird et al. 2012). A major hurdle for nurse and patient communication is disclosure. Patients can begin to feel shame and weakness associated with talking to health care professionals. This is made worse by the stigmatising image of mental health portrayed by the media and society in general (Lipczynska 2011). Nurses must expect to meet resistance from patients in disclosing their true thoughts and feelings (Lipczynska 2011). Tejero (2010) conducted a study which observed nurses communicating with patients and found that longer interactions produced higher levels of bonding and allowed the nurse to gather more information about the patient which could ultimately be used to improve their care. The Radtke et al. (2012) study found that nurses who valued communication more highly were most likely to set time aside for it. This increased both patient care and satisfaction. Significant barriers of high quality communication were found to include lack of training, the unwillingness of patients to engage and time constraints. Despite this study focusing solely on a general ward, the same principles apply to a mental health ward.

Hemsley et al. (2011) identified time as both a barrier and facilitator of effective communication. Time as a barrier was associated with nurses either avoiding or simply not having the time to engage in successful therapeutic relationships. It is possible that nurses with negative attitudes don't realise the value of communication in patient care. They therefore don't set time aside to build a relationship with the patient and so the patient finds it difficult to disclose information. Time as a facilitator was associated with the nurse realising the value of communication and investing time in it. The views of nurses were considered by Baird et al. (2012) who reported that nurses who believed communication between staff was efficient had higher job satisfaction than those who did

Authors' version

not. Facilitators of communication between nursing staff included an organisational email and effective handovers between shifts.

Negative attitudes of nurses can lead student nurses to believe that there is a lack of professionalism shown by some nurses working in mental health settings. The Nursing and Midwifery Council (NMC) (2008) lay out a code of conduct for all nurses which covers the issue of professionalism. Nurses are told that they should treat each patient as an individual, not discriminate against patients in any way and listen and respond to people in their care. There are also a variety of guidelines set out to ensure patients with the diagnosis of personality disorder receive fair and individualised care without prejudice (Department of Health 2009; NIMHE 2003). It is inappropriate for nurses to portray negative attitudes in front of students. It is fundamental that nursing staff behave in a way that enables students to see them as positive role models. This will prevent students acquiring poor attitudes before they can make decisions of their own (Cameron et al. 2001).

Some student nurses consider a high proportion of nursing staff appear to have inappropriate and negative attitudes towards patients diagnosed with borderline personality disorder. Previous negative experiences, time constraints, lack of training and poor optimism have all been highlighted as components contributing to these negative attitudes of nursing staff. Some staff also hold the belief that patients with borderline personality disorder are in control of their behaviour and so are calculating and threatening. It has been seen that service users can feel labelled by the staff and as a result receive poorer care due to their diagnosis. However, there is some research which conveys positive attitudes of nurses towards patients with PD, although the validity of these studies is questionable. Not all nursing staff appear to be adhering to the NMC code of conduct, or using their clinical experience to the best of their ability. These issues highlight the need for further education and training into the diagnosis of BPD and communication skills. This could increase staff understanding and empathy as well as providing them with key skills necessary to engage in therapeutic relationships with patients. By reflecting on incidents we have experienced in practice, students should enable themselves to distinguish between positive and negative attitudes of nurses. This will prevent us from adopting a cynical viewpoint of patients in the future and feel prepared to challenge poor attitudes in the world of nursing in a professional manner.

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