The history of the borderline personality disorder nursing essay

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This chapter examines the specific characteristics of borderline personality disorder (BPD). I will look at how BPD is understood by staff, the behaviours associated with BPD and how education can be advantageous in changing staff's understanding of BPD. Cleary et al (2002) explored the experiences, knowledge and attitudes of staff with the aim of assessing future training needs. They looked at staff’s understanding of BPD and indicated that it is a complicated disorder with complicated treatment issues. The study also acknowledges that the nature of the disorder can have a major impact on services and the potential to polarise staff. This study had a poor response rate which may pose questions surrounding its generalisability to other areas. However, it indicates that 67% of staff consider themselves knowledgeable in the management of BPD despite 76% of staff expressing that more workshop training would be advantageous with 74% discussing the need for " regular education…to aid in the management of patients with BPD" (Cleary 2002: 189). Overall 95% of staff expressed a willingness to dedicate up to two hours a month towards education should their health authority provide it. This is reflected in similar studies that also consider education that improves staff understanding BPD can lead to better treatment and treatment planning (Krawitz 2004) therefore producing " the best possible care for their clients" (Cleary et al 2002: 190). In their study, Woollaston & Hixenbaugh (2008) noted that the negativity staff feel, such as guilt, anger and hopelessness when interacting with BPD patients can be attributed to the overuse of defence mechanisms such as team-splitting and projection. These behaviours can impact on the nurse’s cognitions, thus negatively affecting their behaviour. An important implication of this study is

the need for services to both recognise and provide training to nursing staff (Woollaston & Hixenbaugh 2008). The study advocates education using a cognitive-behavioural approach to provide staff with a framework in which to understand BPD behaviour, nurses' reaction to this and how negative interactions have an impact on the patients affect, and behaviour (Woollaston & Hixenbaugh 2008). However as the researcher had previously worked with the participants, thus possibly affecting their inclination to express themselves freely, the validity of the results are questionable. In a similar study self-harming, staff-splitting and manipulative behaviours were cited as being both complex and challenging (McGrath & Dowling 2012). Participants associated BPD patients as having some form of ' hidden agenda', describing BPD behaviours as " superficial and calculated in order to get their needs met" (McGrath & Dowling 2012: 5). However BPD patients report living with a pejorative label, where self-destructive behaviours, such as self-harm, are perceived as manipulative as opposed to a release of inner tension. Whether the study has good generalisability is however questionable due to only one ward being used within the study. The study advises brief training workshops in helping nursing staff develop the skills needed to carry out treatment plans (McGrath & Dowling 2012), thus improving positivity when working with BPD. Appropriate training would provide a better understanding of the complexity of BPD and educate nursing staff about " realistic expectations of treatment outcomes to counter later pessimism" (McGrath & Dowling 2012: 8). This would allow for the modification of negative nursing responses towards a more therapeutic level and alleviate negative interpersonal working experiences (McGrath &

Dowling 2012) for both staff and patients. Commons-Treloar (2009) supports this view in her research on the effectiveness of education on attitudinal changes towards BPD. She discusses staff views of behavioural disturbance within BPD as having some level of consciousness in the use of self-harm to relieve distress. As such, repeated presentations of self-harming behaviour do not tend to generate compassionate responses " with many evaluating the behaviour as manipulative" (Commons-Treloar 2009: 1131). Although a validated questionnaire was used in this study, it only allowed for positive or negative answers. Having no neutral response may apply some restrictions to the results. Education was used to help staff recognise that the need to self-harm was not due to an immediate environmental stressor but lay in some past trauma event, therefore the result of an unconscious sense of guilt (Commons-Treloar 2009). This suggests BPD patients who unconsciously engage in self-harm display a reduced responsibility for their behaviours (Commons-Treloar 2009). Education here provided a greater empathetic response from staff and helped to improve the interpersonal relationship. Working with personality disordered (PD) inmates who display negative behaviours is cited the main stressor for prison officers (Bowers et al 2005). Due to prisoners coming into contact with the healthcare system via sections 47 and 48 of the Mental Health Act (GB 2007) and nursing staff working closely with prison officers, this study is valid in providing a comparative view of other staff disciplines’ working with BPD. However, the semi-structured interviews reflected on the previous eight month period which may have introduced some recall bias into the study. Behaviours such as self-harm, consistent complaints, manipulation and " attention-seeking"

(Bowers et al 2005: 177) are noted to be the most prominent behaviours that elicited negative responses from staff. These characteristics were associated with staff feeling less confident and having a lower tolerance for working with prisoners with a diagnosis of BPD. Education in knowledge, skills and understanding surrounding PD is cited as having a positive impact (Bowers et al 2005: 178). The study shows that getting to know the prisoners' past lived experiences and education on aetiology helped staff to understand the behaviours. This provided staff with the ability to use new educational knowledge to help them interact with prisoners more productively by increasing their tolerance of negative behaviours (Bowers et al 2005). The results for this study are comparative to studies undertaken in mental health units and show a clear correlation between the understanding of BPD within both mental health and custody institutions. Due to the inappropriate and intense anger that BPD patient have difficulty managing (Bland et al 2007), verbal abuse and threatening language is commonly experienced by staff. This had led staff into perceiving BPD patients as powerful and dangerous, " an unstoppable force that leaves a trail of destruction" (Westwood & Baker 2010: 660). In these cases education can help staff understand how their own frustrations and anger can lead to unprofessional responses, which Woollaston & Hixenbaugh (2008) explain serve to reinforce the patient's negative beliefs about themselves, therefore increasing the negative behaviours displayed. Training and supervision have been reported by many studies as being a vital aid to helping staff to navigate these transference/counter-transference behavioural issues (James & Cowman 2007, Commons-Treloar 2009, Woollaston & Hixenbaugh 2008, McGrath &

Dowling 2012) where staff can discuss openly their concerns, gain an understanding of the origins of BPD behaviours and learn better ways to manage (Bowers et al 2005).

3. 2 CHAPTER TWO. Staff attitudes; education challenging the cycle of rejection.

In this chapter I will examine the specific attitudes displayed by staff working with borderline personality disorder (BPD). I will look at both negative and positive attitudes, how these attitudes can either promote or deny fair access to services and how education can be beneficial in changing staffs attitudes towards BPD.

Attitude is constructed from past experience, feelings, behavioural responses and knowledge on a particular... [subject or]...object. Holding a particular attitude will increase the probability that a person will act in a certain way. Commons-Treloar & Lewis 2008b: 982. The tendency of people with BPD to reject therapeutic care and engage in behaviours that are difficult to manage can leave staff feeling unhappy, frustrated and negative (Cleary et al 2002). All staff working with BPD patients are vulnerable to these negative emotions, which in turn can lead to derogatory terms and negative attitudes being attached to the patient (Krawitz 2004, McGrath & Dowling 2012). In their study, Bowers & Allen (2006) make a clear connection between staff attitudes, staff morale and emotional self-management. Their study discusses the negative influence on attitude being a lack of knowledge in working with personality disorder (PD) causing difficulty in staff managing their own responses to the patient. One of the largest influences in changing negative and derogatory attitudes into positivity is cited as being the

introduction of targeted education on PD and related issues, producing " a more purposeful and optimistic outlook" (Bowers & Allen 2006: 288) amongst staff. Studies suggest that health professionals often avoid having contact with patients with a diagnosis of BPD (Commons-Treloar & Lewis 2008a, b, McGrath & Dowling 2012) and fail to enter in any meaningful dialogue surrounding reasons for negative behaviours. Many staff report that they would only provide the minimum level of care, at the end of the shift, unless completely necessary (McGrath & Dowling 2012), therefore demonstrating a higher level of social rejection towards patients with BPD than other mental health illnesses (Cleary et al 2002, James & Cowman 2007, McGrath & Dowling 2012). However the study also suggests that improved education on BPD can help staff to respond to negative patient behaviours " consistently without anger, frustration and fear" (McGrath & Dowling 2012: 8) therefore providing more positive therapeutic input. However, poor representation of unqualified staff within the study disregards a large portion of the workforce and introduces some questions around the generalisability of theses results to all staff grades. Some studies discuss the differences in attitudes between male and female staff. Female staff have been shown to have more positive attitudes towards BPD (Bowers & Allan 2006, Commons-Treloar & Lewis 2008a, b) and show more optimism and enjoyment when working with BPD patients (Bowers & Allan 2006) than male staff. This is hypothesised as being due to " the traditional sex role of the female being able to nurture patients with significant emotional difficulties" (Commons-Treloar & Lewis 2008a: 582). It is suggested that along with the standard biopsychosocial factors being taught, different educational approaches may be needed to help

improve male attitudes such as the provision of case vignettes using male BPD patients as opposed to female (Commons-Treloar & Lewis 2008a, b). Studies comparing mental health nurses and emergency medical nurses' attitudes toward BPD and self-harm (Commons-Treloar & Lewis 2008a, b) demonstrate that 75% of staff reported that BPD behaviours, such as self-harming, are difficult to manage and 65% of staff found it difficult to build up a therapeutic relationship. They also report emergency medical nurses' frustrations at being unable to ' cure' the patient and feeling care is ineffectual in the context of repeated presentations with similar injuries (Commons-Treloar & Lewis 2008a, b). These negative attitudes surrounding the disorder, cause distress and inner conflict, therefore leading to an absence of empathy. However, both studies show a non-representation of unqualified staff which disregards a large portion of the workforce and affects generalisability to the entire workforce. Mental health workers showed higher levels of positivity towards working with BPD patients than emergency medical nurses' mainly due to the increased level of educational knowledge surrounding the disorder (Commons-Treloar & Lewis 2008b). This demonstrates that providing education surrounding the aetiology and prevalence of BPD to nurses, in all clinical areas, helps staff to respond in a more therapeutic manner without feelings of futility and frustration (Cleary et al 2002, Krawitz 2004, Commons-Treloar & Lewis 2008a, b, McGrath & Dowling 2012). Nurses have been described as perceiving BPD patients as " a destructive whirlwind" (Woollaston & Hixenbaugh 2008: 703). Nurses perceive patients as a powerful, dangerous and unrelenting force, which leaves an aftermath of destruction. They found BPD patients to be hugely

disruptive, demanding and draining of both staff and resources (Woollaston & Hixenbaugh 2008, Maltman & Hamilton 2011). These feelings of being disheartened and frustrated have been quoted as one of the main reasons staff perceive BPD patients in a negative light and lead to the perception of them being " untreatable and undeserving of care" (Woollaston & Hixenbaugh 2008: 708). Interestingly, this paper also suggest that some staff do consider BPD patients as deserving of care and display a sense of optimism surrounding the treatment of BPD. This supports the notion that staff can project positive attitudes towards BPD patients as well as negative (Bowers & Allan 2006, Commons-Treloar & Lewis 2008a, b, Maltman & Hamilton 2011). Positive attitudes were noted to be predominantly present in newly qualified staff which could lead to the hypothesis that undergraduate training on BPD is an effective tool in building positive attitudes. However, further targeted training by specific services would help to enhance clinical skills and would improve the nurse’s confidence in working with BPD (Cleary 2002, Woollaston & Hixenbaugh 2008). This view is endorsed by James & Cowman (2007) who demonstrated that the majority of staff reflected reasonably positive attitudes towards patients with BPD, a view which tends to be inconsistent with other studies within this area (Purves & Sands 2008, McGrath & Dowling 2012). This study suggests that " given the evidence of the positive benefits of training on knowledge and attitude" (James & Cowman 2007: 647), the lack of education on BPD needs to be addressed especially as it helps to maintain an enthusiastic, positive workforce that is confident in its abilities (James & Cowman 2007) in managing BPD patient’s safely. Studies on staff attitudes within prison settings displayed similar

results to that of nursing environments, with staff displaying both positive and negative attitudes towards prisoners with personality disorder (PD) (Bowers et al 2005, Maltman & Hamilton 2011). Interestingly, where Bowers et al (2005) found approximately equal numbers of positive and negative attitudes with moderate improvements in attitude following targeted clinical education, Maltman & Hamilton (2011) found that, although attitudes were relatively equal, there was only a small increase in post-educational attitudes towards BPD. However, both studies (Bowers et al 2005, Maltman & Hamilton 2011) showed that education on PD provided a better knowledge base, which in turn helped officers to interact more productively with patients and increased the tolerance of negative behaviours. Education for this staff group provided an increased awareness of the prisoners as victims themselves, therefore allowing staff to connect the prisoner's current behaviours to childhood invalidation resulting from childhood abuse. This led on to staff seeing the prisoner as individuals, requiring care tailored to their needs (Bowers et al 2005). As a result the study showed that staff displayed a more positive attitude when interacting with prisoners. Maltman & Hamilton (2011) also found significant improvements in staff's feelings of vulnerability. Officers reported feeling " less fearful, anxious, manipulated... outmanoeuvred and exploited" after educational input (Maltman & Hamilton 2011: 252). These changes were still present at the studies two month follow-up and correspond to Bowers et al (2006) findings on the influence of education on changing staff attitude.

4. DISCUSSION.

4. 1 Statement of findings.

The aim of this dissertation was to answer the question " Is targeted clinical education helpful in improving staff attitudes towards patients with a diagnosis of borderline personality disorder?" The papers examined within this dissertation have established a clear link between negative behaviour and negative staff reactions, leading to ongoing negative staff attitudes towards borderline personality disorder (BPD) patients (McGrath & Dowling 2012, Commons-Treloar 2009). These studies suggest that an exposure to such behaviours can lead to a decline in staff confidence about working with BPD patients, polarisation of staffing and negative stereotypical perceptions being fostered by the staff groups (Woollaston & Hixenbaugh 2008, Bowers et al 2005, Cleary et al 2002). Attitudes towards people with a diagnosis of BPD tend to be more negative than those towards other mental health illnesses such as schizophrenia, depression and bi-polar disorder which is consistent with other studies carried out within this area (Markman & Trower 2003, Bland 2007, Mason et al 2010, Winship 2010). These pessimistic attitudes can act as a barrier to effective care services for people with BPD (James & Cowman 2007, Cleary et al 2002). However not all staff display negative attitudes; some positive attitudes and willingness to help do exist (Maltman & Hamilton 2011, Bowers et al 2006) These positive attitudes derive from a number of sources, namely education on BPD, staff support structures, getting to know the client’s psychosocial history and staff’s willingness to help (Commons-Treloar 2009, Bowers et al 2006, Krawitz 2004)This literature review has revealed a positive correlation between

attitudinal change and education supported in literature. Cleary et al (2002) provided useful evidence which demonstrated staff willingness to attend further education and training on BPD to help facilitate effective treatment and management. This is further supported by studies that endorse the use of education and training to provide a greater understanding of BPD (Woollaston & Hixenbaugh 2008, Bowers et al 2005) ergo, staff using the increased knowledge in the context of more productive client to staff interactions and tolerance (James & Cowman 2007, Bowers et al 2005). Providing staff with a better understanding of the complexities of BPD will allow them to respond both therapeutically and with reduced negativity in times of crisis (McGrath & Dowling 2012).

4. 2 Critique of my literature review process.

Due to both time and monetary restraints, some articles that would have aided in this dissertation could not be accessed. My literature was limited to English language articles due to my only speaking this language. Although this limitation is not uncommon (Aveyard 2010), it should be noted that non-English papers were available which may have contributed to a better understanding of the issues within this dissertation but which could not be translated within the timeframe of this dissertation project. My electronic database searching was thorough by use of cutting and pasting my search terms into each database, thus negating the chance of typing errors occurring and increasing the reliability of my results. My choice of databases was comprehensive and allowed for the collection of all relevant articles. However my hand searching of journals was compounded by time, as such I

only had time to read the abstracts of some articles as opposed to the full paper. This could have resulted in the rejection of articles that may have been relevant to this dissertation.

5. CONCLUSION.

5. 1 Conclusion.

Borderline personality disorder (BPD) is a difficult diagnosis for both patients and staff. The behavioural difficulties encountered within BPD can be damaging to the therapeutic relationship, which in turn can directly impact on recovery. The issue of negative attitudes and behaviours amongst healthcare professionals is an unpalatable thought, where the negativity displayed works against the principles of beneficence, nonmaleficence and equality, principles that the nursing profession as a whole consider highly. Targeted education surrounding aetiology, understanding and awareness of treatment and management options has been shown to combat existing negative and stigmatising attitudes towards BPD. However the findings of this dissertation indicate that, although education has been shown to improve attitudes towards BPD, there is no clear style of education that provides the best outcomes. It is therefore hypothesised that a multifaceted approach to clinical education and ongoing training needs should adopted in order to maintain positive attitudes and provide the best overall results. Different staff populations need different forms of training; therefore targeting educational needs to specific staff groups will provide better outcome measures in respect of attitudinal change. Despite the clear recognition of this particular group of patients' need for care, the diagnosis

of BPD and its treatability is still a hotly contested area. However this is slowly changing with policy and guidance surrounding the care of personality disorders having grown exponentially over the years, culminating in NICE producing guidelines on the care and treatment of BPD in 2009. Since then we have seen the rise of good comprehensive and integrated services that are based on sound multi-disciplinary and multi-agency teamworking being developed. In answering my research question of Is targeted clinical education helpful in improving staff attitudes towards patients with a diagnosis of borderline personality disorder? I can now say that I believe that it is. However this dissertation has only uncovered the tip of the iceberg when looking at attitudes and training needs.

5. 2 Recommendations

The use of education as a means of changing negative staff attitudes towards BPD needs to be core to any service dealing with this difficult and demanding patient group. Services need to see training as an essential component. As such they need to invest in structured training for both non-qualified and post-graduate staff in order to maintain positive, empathetic and person-centred care. Training can take many forms but should provide debate surrounding the concepts of BPD, psychopathy and the negative impact of pejorative labelling. Staff should be educated in the complexity of causal models for BPD problems and behaviour. More research needs to be conducted into why female staff have a more empathetic attitude to BPD behaviours.

5. 3 Implications for practice.

The implications for practice on providing targeted clinical education are that newly learned skills and positive attitudinal change towards BPD patients can alleviate the negative experiences of working with BPD patients, hence influence the quality of care. When staff feel more empathy and optimism towards patients with a diagnosis of BPD they will be able to provide better holistic care that is focused towards recovery.

5. 4 Reflection.

Completing this dissertation has been challenging, mainly due to my experience as a novice researcher, resulting in the literature review being less than perfect. However, the process of the literature review taught me the importance of finding and applying the most up-to-date evidence to my practice and has made me more confident in about appraising evidence in my future career. I feel that I have benefited from the writing of this dissertation as it has greatly helped me in consolidating my mental health nursing practice as well as challenging some of my own preconceived ideas surrounding staff’s negative feelings, making me realise that they are borne out of feelings of frustration, hopelessness and helplessness as opposed to feelings of dislike for the patient. This will greatly benefit me in the future when working with BPD patients and the staff who regularly look after them.