Staff attitudes towards inpatients with borderline personality disorder

Further education in the diagnosis of borderline personality disorder and better communication with service users is needed to change negative staff attitudes towards patients with the condition, argue Emma Jane Weight and Sarah Kendal.

Abstract

This article discusses the negative attitudes of some nursing staff towards inpatients diagnosed with borderline personality disorder (BPD), from the perspective of a third-year mental health nursing student. Factors to support underlying nurses’ attitudes are considered, including stigma associated with BPD, the relationship between BPD and self-harm, clients being viewed as manipulative and nurses’ lack of optimism for client recovery. Work pressures, poor communication skills and time restraints also contribute to the poor care being delivered by some mental health nurses.

The authors suggest ways to improve staff attitudes, based on recommendations in the literature. Further education relating to BPD is discussed, as well as the need for increased supervision of mental health nurses and more time for effective communication between nurse, client and the multidisciplinary team.

Keywords
Borderline personality disorder, mental health patients, negative nursing attitudes, self-harm

As a third-year mental health nursing student, the first author (EJW) witnessed negative staff attitudes towards service users with borderline personality disorder (BPD). She was shocked by such attitudes because she understands it is a nurse’s duty to care for patients regardless of their diagnosis. Some members of staff appeared pessimistic about the potential for people with BPD to recover, even though it is important, particularly in this specialty, to recognise the uniqueness of each client, diagnosis and prognosis. Observing these attitudes in otherwise competent and caring members of the multidisciplinary team was disheartening for the first author. However, such incidents highlight the importance of reflective practice and the need to debrief during clinical supervision.

Definition and diagnosis
The International Classification of Diseases (ICD-10) (World Health Organization 2010) defines BPD as a condition in which behaviours express the individual’s characteristic lifestyle and method of relating to him or herself. The disorder sometimes manifests as a response to personal and social situations that 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.
- Difficulty creating and maintaining relationships.
- Having a changeable and unsteady sense of identity.
- Self-harm.
- Fear of rejection or of being alone (National Institute for Health and Care Excellence (NICE) 2009).
- Episodes of psychosis.
- Impulsivity (Mind 2007a).
The diagnostic criteria for BPD set out in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (American Psychiatric Association (APA) 1994) are that the patient must meet five of nine criteria, as shown in Box 1 (APA 2000).

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

It has been estimated that between 15 and 25 per cent of inpatients in mental health wards have BPD (Leichsenring et al 2011). With such a high prevalence of BPD, it might be expected that there would also be a large amount of research into this condition. However, despite the fact that BPD may be the most common type of psychiatric disorder, a literature review conducted by Winship and Hardy (2007) showed that the prevalence of research papers about personality disorder was disproportionately low (39 papers) when compared with other conditions, such as depression (379 papers) and schizophrenia (272 papers).

BPD is often seen as not a genuine illness, perhaps because it is widely accepted that the condition has no significant biological causal pathway (Kendell 2002). In addition, it has been suggested that people with BPD symptoms are sometimes given wrong diagnoses (Kendell 2002). This may reflect the complexities of diagnosis, but negative attitudes among mental health workers towards people with BPD may also be a factor; where diagnosis is unclear it can be easier to adopt a view that the condition is less valid.

BPD is characterised by a high risk of suicide and self-harm. The death rate from suicide is 50 times higher among people with this condition than among the general population, with a prevalence of suicide in the UK of between 8 and 10 per cent (Leichsenring et al 2011). BPD also significantly increases the likelihood of a person having life complications in areas such as housing, alcohol, drugs, and being victims of all forms of abuse (Haw and Hawton 2008). It has been hypothesised that these problems may be what cause individuals to self-harm (Haw and Hawton 2008). It is possible that the diagnosis of BPD and the stigma that comes with it have also been factors in self-harming (Haw and Hawton 2008). Negative attitudes among healthcare professionals may contribute to this stigma.

‘Disliked’ patients
Policy implementation guidance produced by the National Institute for Mental Health in England (NIMHE) (2003) warned that clients with a diagnosis of BPD have long been described as ‘the patients psychiatrists dislike’. Terms such as time-wasters, manipulative, difficult or attention-seeking are used to describe these individuals. Some staff think that clients with BPD are in control of their behaviour and are therefore manipulative and dangerous (Woollaston and Hixenbaugh 2008). Healthcare professionals working in mental health settings are more likely to have negative attitudes and perceptions of people with BPD than of those with 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 in the community (NIMHE 2003). Some thought that healthcare professionals had a poor understanding of the diagnosis, often linking it with untreatability. Service users also expressed the view that they received poorer care from the NHS on account of having BPD, and frequently perceived that they were being blamed for their diagnosis and considered ‘not to be mentally ill’ (NIMHE 2003). This is a concern, in view of the negative effect it can have on clinical practice and clients.

Negative attitudes shown by some nurses working in mental health settings can be perceived
by nursing students as unprofessional. The Nursing and Midwifery Council (NMC) (2008) code of conduct applies to all nurses and covers issues of professionalism. Nurses should treat patients as an individuals, not discriminate against them in any way, and listen and respond to all people in their care. More guidelines exist to ensure that people with a diagnosis of personality disorder disorder receive fair and individualised care without prejudice (NIMHE 2003, Department of Health 2009). It is particularly inappropriate for nurses to portray negative attitudes in front of students, and it is fundamental that nursing staff behave in a way that enables learners to see them as positive role models. This prevents students acquiring poor attitudes before they can come to conclusions of their own (Cameron et al 2001).

NICE guidelines (2009) state that when working with patients with BPD, healthcare professionals should convey hope and optimism that recovery is possible. The guidelines are supported by an evidence base that indicates patients are more likely to engage with services if they have had a positive experience on initial referral (NIMHE 2003). Service user views reported by NIMHE (2003) emphasised the need for healthcare professionals to acknowledge that BPD is a real and treatable condition. A tentative suggestion is that greater awareness of the evidence base could encourage nurses to adopt a more caring and respectful attitude towards people with BPD.

Some studies have identified behaviours associated with BPD as a reason for negative attitudes of staff who may 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 clients (Woollaston and Hixenbaugh 2008).

This is supported by Ma et al (2008), who suggested that a ‘chaos stage’ is sometimes experienced by nurses, whereby they become intolerant of, and irritated with, the service user with BPD. At this point, some nurses will distance themselves, becoming withdrawn and providing poor care (Fraser and Gallop 1993). Healthcare professionals have also been known to describe clients with BPD as ‘manipulative’, which may stem from the belief that their behaviour is calculated and dishonest, rather than part of their illness (Westwood and Baker 2010).

A view of this nature could affect the quality of care a nurse delivers and lead to the client feeling rejected and devalued, resulting in further deterioration of their condition (Woollaston and Hixenbaugh 2008). Nursing students may empathise with the thought processes of staff who respond in this way and may acquire the belief that people with BPD are likely to be manipulative, threatening and dangerous. However, further research is needed to determine where these ideas originate (Westwood and Baker 2010).

Westwood and Baker (2010) found that mental health nurses working in acute care demonstrated a greater social distance towards people with BPD, and Fraser and Gallop (1993) suggest that patients with BPD are seen as healthier than others, so when they display challenging behaviours, nurses become less empathetic and withdraw. Other research supports this theory by suggesting that individuals with BPD have greater control over their behaviours than those with other diagnoses, with the result that any negative behaviour is seen as deliberate (Markham and Trower 2003, Forsyth 2007). However, Markham and Trower’s (2003) study was limited because participants were aware they were being asked about attitudes to different patient groups and may have changed their answers accordingly (Westwood and Baker 2010).

Some research studies have reported positive nurse attitudes towards people with BPD. James and Cowman (2007) found that nurses in the study believed that they had a key role to play in the treatment of clients with the condition and in supporting their carers. They also found that services for individuals with this diagnosis were perceived as inadequate. This study has limited validity due to poor response rates (41.4 per cent); nonetheless, it is positive that some healthcare professionals are reporting a caring attitude towards this client group.

However, the nursing literature suggests that nurses working in acute mental healthcare settings will have had many negative experiences with clients diagnosed with BPD, resulting in more cynical attitudes and lower levels of optimism towards these individuals (Markham 2003, Markham and Trower 2003). Nurses can feel unable to help, leading to frustration and consequently poor care (Filer 2005). On the other hand, there may be a growing perception among nurses that BPD is a treatable illness, leading to greater optimism in relation to client care (James and Cowman 2007). This could support more positive attitudes towards such individuals.

**Self-harm**

Parallels between clients with BPD and clients who self-harm may specifically influence nurses’ attitudes. The literature suggests that there is a relationship between the two conditions: Suominen et al (1996) reported a 40 per cent
prevalence of a BPD diagnosis among clients who self-harm, and Haw et al (2001) reported 46 per cent. Some of these studies also looked at intent to die, using the Suicidal Intent Scale (SIS) (Beck et al 1974). Haw et al (2003) found that people 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 BPD.

Findings like these may reinforce negative attitudes, such as the perception that some individuals are wasting health professionals’ time because they do not really intend suicide. However, study findings should be interpreted with caution. The Haw et al (2003) study consisted of a small sample that may not be representative of the population as a whole, and a very small number of people who had seriously self-harmed, which may have caused a bias in the results. It is well documented that self-harm is often used as a mechanism to cope with emotions and release stress, and may not always be carried out with the intent to die (Mind 2007b). However, these actual functional aspects of self-harm may be overlooked by staff who feel frustrated by the resistance of service users to attempts to help them stop self-harming.

Training

Limited training and clinical supervision around self-harm can mean that nursing staff have poor knowledge and understanding of the condition (Cleary et al 2002). Potentially, nurse-patient relationships in this context could be improved by addressing training needs that have been identified in the areas of control, sympathy and management (Cleary et al 2002, Markham 2003, James and Cowman 2007).

The benefit of training was demonstrated in a study that used the Self-Harm Antipathy Scale (Patterson et al 2007) to measure staff negativity before and after a 12-week training course on self-harm. The results showed reduced negativity towards clients who self-harmed among staff who attended the course (Patterson et al 2007). However, in this study the course was optional, which shows that those attending were already interested in the subject and may not have been representative of nurses in general.

Clinical supervision is also relevant. For example, McHale and Felton (2010) found that debriefing about a situation can help staff to understand it better and prevent the development of negative attitudes. Therefore, there is evidence that both training and clinical supervision can support positive attitudes in clinical staff.

The aforementioned studies have highlighted the need to increase nurses’ knowledge in relation to BPD and self-harm. Experience may also be a factor. It is possible that the negative attitude of some nurses could be due to the stress of working on a high-intensity ward for a long period of time. However, Dickinson and Hurley (2011) found that nurses who had worked with people who self-harm over a long period had more positive attitudes, indicating that the emotional impact of working in mental health care may be a factor influencing the attitudes of less experienced staff.

Alexander and Atcheson (1998) reported that 48 per cent of staff working on high-trauma wards had found the emotional element of their role significantly distressing. Whereas negative attitudes of nurses are unprofessional, it cannot be ruled out that they are true feelings, as well as a possible defence mechanism and coping strategy. Although Alexander and Atcheson (1998) focused on a physical health setting, their findings may apply to a mental health ward. The evidence around this topic appears unclear, which suggests more research is needed.

O’Donovan (2007) explored the way in which differences between nurses’ expected and actual roles led to the development of negative attitudes towards clients who require high levels of therapeutic input. Staff disclosed that they felt their role was focused more towards medication than developing therapeutic relationships. This prevented them from engaging with and understanding the person and hence providing high quality care. If the person’s condition failed to improve, the nurse might conclude that BPD was not treatable (O’Donovan 2007) and start to withdraw.

The role of time pressures on staff attitudes and engagement was also explored by Crowley (2000), who argued that nurses do not have the communication skills required to relate to and treat people with complex and sensitive issues. Therefore, both a lack of skills and stressful ward environments may be contributing to negative attitudes among staff.

Another major obstacle to nurse and client communication is the issue of disclosure. Service users can feel shame and weakness when talking to healthcare professionals. This is made worse by the stigmatising image of mental ill-health portrayed by the media and society in general (Lipczynska 2011). Nurses must expect to meet resistance from clients to the disclosure of true thoughts and feelings (Lipczynska 2011). Hemsley et al (2011) identified time as both a barrier and a 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, while time as a facilitator included nurses’ willingness to take extra time to work on difficult communication situations. It is possible that nurses with negative attitudes do not realise the value of communication in patient care. Therefore, they do not set time aside to build a relationship and so the person finds it difficult to disclose information.

Conclusion

The first author (EJW) observed inappropriate responses and negative attitudes towards people diagnosed with BPD among some mental health workers. Previous negative experiences with service users, time constraints, lack of training and low levels of optimism in terms of recovery have been identified as factors contributing to these attitudes among nursing staff, some of whom believe that clients with BPD are in control of their behaviour, and are calculating and threatening. Although research recording positive approaches exists, the evidence base for these is limited.

Nurses are required to apply the NMC code of conduct (NMC 2008) and follow NICE (2009) and NMHCE (2003) guidance in using of their clinical skills, knowledge and experience in their clinical practice.

This article highlights the need for further education and training in the diagnosis of BPD among healthcare professionals and on improving nurses’ communication skills. This could increase staff understanding and empathy, as well as provide them with competence to engage in therapeutic relationships with service users. By reflecting on incidents we have experienced in practice, students can learn to distinguish between positive and negative attitudes of experienced nurses. This will help us to develop as professionals, challenge poor attitudes and nurture positive approaches towards client care in the nursing of the future.

References


Mind (2007a) Understanding Personality Disorders. tinyurl.com/3xpo77s (Last accessed: August 30 2013.)


