

Attitudes to Personality Disorder of Staff Working in High and Medium Secure Hospitals

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Abstract

The discourse surrounding personality disorder is largely negative, and the diagnosis is considered to be associated with a degree of stigma. This study aimed to investigate current staff attitudes to personality disorder in a high and a medium secure forensic-psychiatric hospital in the UK. Staff attitudes were assessed using the Attitude to Personality Disorder Questionnaire (Bowers & Allan, 2006). The questionnaire was completed electronically by 132 staff. Attitudes to personality disorder in the current study were significantly less positive than in comparable studies in similar settings. Having completed staff training surrounding personality disorder, and being from a non-nursing professional background, were the best predictors of positive attitudes to personality disorder. The findings of this study offer support to the pursuit of improving access to training in personality disorder in forensic settings.

Key words: Personality disorder, attitudes, forensic, staff, psychiatric.

Introduction

Personality disorder long received less recognition or research attention than other mental disorders; however, in recent years this trend has altered and personality disorder is now widely considered a clinically relevant disorder (Tyrer et al., 2010). Personality disorder is thought to affect approximately 6% of the general population (Huang, Grant, & Dawson, 2006), with prevalence rates typically far higher in clinical/psychiatric (Beckwith, Moran, & Reilly, 2014; Lezenweger, 2008) and forensic settings (Fazel & Danesh, 2002). Comorbidity is common, and the presence of personality disorder is often associated with poorer outcomes in the treatment of other disorders (Colom et al., 2000; Newton-Howes, Tyrer & Johnson, 2006; Tyrer et al., 2010); indeed, the diagnosis of personality disorder has often been associated with a degree of therapeutic pessimism. Patients with personality disorder are considered by clinicians to be more difficult to manage (Newton-Howes, Weaver & Tyrer, 2008), less deserving of care (Lewis & Appleby, 1998; Brody & Farber, 1996) and more in control of their behaviour (in comparison to individuals with other treatment needs, e.g. mental illness); thus these patients are viewed in a more judgemental manner than those with other mental disorders (Markham & Trower, 2003). Indeed the discourse surrounding personality disorder appears to be largely negative, with much of the literature focused on the pessimism, rejection and hostility that appears to surround this patient group (Bowers et al., 2006; Gallop, Lancee, & Garfinkle, 1989; Lewis & Appleby, 1988). Much of this research has specifically focused on Borderline Personality Disorder (Black et al., 2011; Markham & Trower, 2003; Woollaston & Hixenbaugh, 2008; Nehls, 1999; Sheehan, L., Nieweglowski, K. & Corrigan, 2016).

Working with patients with personality disorder is understood to be challenging and emotionally demanding (Moore, 2012; p.194; Adshead, 2002) and can evoke feelings of

helplessness, therapeutic failure, and anger in staff (Gallop et al, 1989), and desires to maintain social distance (Markham, 2003). These challenges may arguably be amplified within forensic settings where patients may present as both “distressed and highly distressing in the actions they undertake” (Adshead, 2002) and staff are required to manage both the risk and the vulnerability of patients. Patients in forensic-psychiatric settings typically have multiple complex and often co-occurring needs, with one prominent treatment need being personality disorder (Maden et al, 1995; Davison, 2002; Blackburn, Logan, Donnelly & Renwick, 2003).

The attitudes that staff hold in relation to personality disorder, including the attributions that they make regarding challenging presenting behaviours, has important implications for the way they manage these challenges (Moore, 2012). Positive attitudes to personality disorder, as measured by the Attitude to Personality Disorder Questionnaire (APDQ; Bowers & Allan, 2006), have been demonstrated to correlate with more positive outcomes in terms of general health, job performance, sickness rates and staff burnout (Bowers et al., 2003). Negative attitudes contribute to a sense of stigma, which can impact on therapeutic relationships, as well as hindering management efforts and negatively impacting on clinical outcomes (Newton-Howes, Weaver & Tyrer, 2008). Additionally, negative attitudes held by staff can influence the propensity for those diagnosed to seek help (Lewis & Appleby, 1998). Thus, the measurement of attitudes towards personality disorder has important clinical and organisational implications, justifying the pursuit of new research to present the current status of staff attitudes within this setting, and to explore what factors are predictive of these attitudes in the current context; aims which this study addresses.

In the United Kingdom, personality disorder was until recently generally considered ‘untreatable’, and the diagnosis often led to exclusions from treatment (NIMHE, 2003). Since this time there have been numerous efforts to improve the care received by patients with

personality disorder, for example with the development of a National Personality Disorder Development Programme which promoted policy implementation guidance (e.g. ‘Personality disorder: No longer a diagnosis of exclusion’ (NIMHE, 2003); ‘Breaking the Cycle of Rejection (NIMH, 2003b) and government commissioned training initiatives (DoH & MoJ, 2007) and alterations to service provision (Joseph & Benefield, 2012; DoH, 2009). Given the emphasis on inclusion and compassionate understanding that underpinned efforts to effect change in way personality disorder is viewed and addressed, (i.e.), (including investment in improving the services provided to individuals with personality disorder), it could be hypothesised that attitudes to personality disorder would be improved in comparison to earlier studies. The present study therefore aims to examine the attitudes of forensic psychiatric hospital staff toward those with personality disorders, and examine what variables predict positive attitudes towards personality disorder. We hypothesise that training in personality disorders will predict more positive attitudes and that current attitudes will be more positive than those identified in earlier research in similar settings.

Ethical considerations

This project received ethical approval from the Research and Development department for the NHS Trust involved. Participants were directed (within the initial advertisement email, and again in the online questionnaire) to a Participant Information Sheet and were invited to contact the researcher for further information if required, prior to participating in the study. It was made clear to participants that their data was collected anonymously and was not personally identifiable, and their continued participation in the questionnaire implied their informed consent to participation in the research project. There were no forms of reimbursement or incentives offered for participation in this research.

Method

Setting

This study was conducted with employees of two forensic psychiatric hospitals in the United Kingdom; one High Secure and one Medium Secure Hospital within the same NHS Trust. At the time of sample recruitment, approximately 1100 staff worked at the High Secure Hospital, and approximately 300 staff worked at the Medium Secure Hospital.

Procedure

Participants were recruited using an advertisement email that was sent to all employees of both sites. All staff with some level of patient contact in their professional roles were invited to take part. The advertisement email included a link to further study information and also a link to the online questionnaire (using 'SurveyMonkey'). All participants were invited to complete the demographic section of the questionnaire, but only participants who had indicated in the questionnaire that they had some prior or current experience of working with patients with personality disorder(s) were invited to complete the APDQ (Bowers and Allan, 2006) section of the questionnaire.

Measures

Demographic questionnaire: The first section involved questions relating to the participants' personal characteristics (e.g. age, gender, ethnicity) and occupational information (e.g. occupational role, years working in setting, and experience working with patients with personality disorder).

Attitude to Personality Disorder Questionnaire (APDQ; Bowers & Allan, 2006): The APDQ is a 37-item questionnaire which measures global attitudes held by staff in relation to

individuals with personality disorder, and the experience of working with these individuals. The scale has been used within a variety of occupational settings, for example psychiatric (Bowers & Allan, 2006), correctional (Carr-Walker, Bowers, Callaghan Nijman & Paton, 2004) and secure forensic hospitals, including the High Secure Hospital involved in the current study (Carr-Walker, Bowers, Callaghan Nijman & Paton, 2004). The items of this scale are statements relating to one's feelings and attitudes towards patients with personality disorder(s), for example: "I feel able to help PD people"; "PD people make me feel irritated". When completing the questionnaire, participants are invited to rate the items by frequency on a six points scale: 1 = Never, 2 = Seldom, 3 = Occasionally, 4 = Often, 5 = Very Often, 6 = Always. A simple scoring procedure is applied to the responses to create a total score and factor scores. The questionnaire produces five factors (quotations taken from Bowers & Allan, 2006; p.287-288):

1. Enjoyment/Loathing: Represents "warmth and liking for, and interest in contact with PD patients"
2. Security/Vulnerability: Represents the "fears, anxieties, and helplessness in relation to PD patients"
3. Acceptance/Rejection: Represents "anger towards PD patients [and]...a sense of difference from them"
4. Purpose/Futility: Represents a sense of "pessimism" in relation to working with PD patients
5. Enthusiasm/Exhaustion: Represents experience of "enthusiasm" or "exhaustion" in relation to working with PD patients

The APDQ (Bowers & Allan, 2006) has been used in a variety of settings, including secure psychiatric hospitals (Bowers et al., 2000), acute psychiatric wards (Bowers et al., 2008) prisons (Bowers et al., 2003; Carr-Walker et al., 2004; Bowers et al., 2006) and community

teams (Purves & Sands, 2009). The tool is unique in its ability to measure the attitudes of staff in relation to personality disorder and has been found to have excellent internal consistency and a Cronbach alpha coefficient of .94 (Bowers et al., 2000). In the current study the Cronbach alpha coefficient was also .94. The Cronbach alpha coefficients for the individual subscales were as follows: Enjoyment/Loathing: $\alpha = .928$; Security/Vulnerability: $\alpha = .869$; Acceptance/Rejection: $\alpha = .800$; Purpose/Futility: $\alpha = .789$; Enthusiasm/exhaustion: $\alpha = .681$.

Analytic Strategy

Sociodemographic information: Descriptive statistics were calculated for all sociodemographic variables. Due to the small number of participants in some occupational groups, it was necessary to merge groups in order to perform subsequent statistical analyses. Three groups were therefore formed: ‘Nurses and Psychiatrists’; ‘Psychologists and Social Workers’; and ‘Allied Health and Education Professionals (e.g. Speech and Language Therapists, Art Therapists, Music Therapists, Lecturers, etc.)’. Where applicable, trainee or unqualified positions were included within categories. Prior to making the decision to merge occupational groups, statistical analyses were performed to consider whether there were any significant differences in APDQ scores between those groups which were to be merged (as this could have made the merging of groups problematic), however no significant differences were found.

APDQ: Total and factor scores were calculated in Microsoft Excel using the Factors described in Bowers & Allan (2006). Kolmogorov-Smirnov ($KS=.079$, $p=0.06$) and visual inspection of the histograms, normal Q-Q plots and box plots suggested that the APDQ Total scores were sufficiently normally distributed. Outlier labelling and visual inspection of the boxplot was performed, finding four extreme scores; however, the 5% trimmed mean (111.99) was very similar to the mean (110.74), thus all cases were retained for analysis.

Independent samples t-tests were conducted to establish whether there were significant differences in APDQ Total scores according to each dichotomous variable (male/female; nursing/non-nursing; currently/do not currently work with patients with personality disorder; have/have not received training in working with personality disorder; permanent/non-permanent).

A one-way analysis of variance was conducted to test the impact of Occupational Group on APDQ Total scores. For the purpose of this analysis, the three aforementioned merged occupational groups were used (i.e. 'Nursing'; 'Allied Health Professionals'; and 'Psychologists, Psychiatrists and Social Workers'). For each analysis, post-hoc (Tukey HSD) analyses were conducted where significant differences were found in the ANOVA.

The relationship between APDQ Total scores and the continuous demographic variables (years in current role, years in secure settings, years in current level of security, years working with female patients, years working with patients with personality disorders) was investigated with the use of Pearson's Product-moment Correlation.

Standard Multiple Regression Analysis was conducted to establish how much variance in APDQ Total scores can be explained by certain demographic variables. Preliminary analyses were conducted to ensure no violation of the assumptions of normality, linearity, multicollinearity and homoscedasticity. The following factors were all entered as predictor variables: Participant gender; occupational group (nursing or other group, dummy coded as 0 or 1); currently working in Women's Service; currently working with patients with personality disorder(s); completed training on working with personality disorder. The remainder of the demographic variables from the questionnaire were not selected as predictors because prior

analyses found no significant difference or association with APDQ Total scores. The five predictor variables were entered simultaneously, using the Enter method.

In order to consider the current findings within the context of prior research, the APDQ Total and Factor means from the current study were compared to comparable previously published data, with independent sample t-test analyses conducted using summary data (mean, sd and N), using Graph Pad Prism 16 software.

For all statistical analysis, the value of ≤ 0.05 was considered to represent statistical significance.

Results

Participants

One hundred and thirty two participants completed the study. Of those who started the questionnaire (N= 154), 22 were excluded due to substantial incomplete data (i.e. participants had not completed the initial demographic section, and did not complete any later questions). Participants were retained in the sample if they proceeded beyond the demographic section, and where missing data occurs, this is indicated within the analysis.

Demographic Questionnaire Analyses

The majority of the sample was female (69.9%) and of white ethnic origins (89.5%). The majority (58.6%) of participants were over 40 years old. Participants had worked in secure settings for an average of 10 years (Median=10, range=35 (1-36)) and in their current level of security for 8 years (Median=8, range=35 (1-36)). Most participants (82%) were employed in permanent contracts, and the average number of years participants had been working in their

current role for was 7 years (Median=7, range=34 (1-35)). A breakdown of occupational groups is presented in **Table 1**.

[TABLE 1 HERE]

Most participants (94%) had some experience of working with patients with personality disordered patients, and of these participants most (76.3%) reported that they currently worked with patients with personality disorder(s). The average duration of experience working with patients with personality disorder(s) was 7 years (Median=7, 95%, range=31 (1-32)). Nearly half (44%) had received no specific training related to working with personality disorder(s), and of those who currently worked with patients with personality disorder, nearly a quarter (24.5%) had received no such training.

APDQ Analyses

APDQ factor and total scores are presented in **Table 2**. There were no significant differences between male and female participants in their attitudes to personality disorder: $t(120) = 1.874$, $p = 0.06$, $d=0.34$, $r=0.17$.

[TABLE 2 HERE]

A one-way analysis of variance revealed a statistically significant difference in APDQ Total scores for the three occupational groups of ‘Nurses and Psychiatrists’; ‘Psychologists and Social Workers’; and ‘Allied Health & Education Professional’s: $F = (2, 119) = 6.362$, $p < 0.05$, $\eta^2 = 0.097$. Post-hoc comparisons using the Tukey HSD test indicated that the mean APDQ Total score for Nurses and Psychiatrists ($M = 104.03$, $SD = 26.53$) was significantly different (more negative) than the mean APDQ Total score for the Social Workers and Psychologists

group ($M = 117.69, SD = 16.52$), and also significantly different (more negative) than the Allied Health & Education professionals group: ($M = 119.93, SD = 18.76$). There was no significant difference between the Social Workers and Psychologists group and the Allied Health & Education Professionals group. The analysis of Permanent ($M = 110.14, SD = 25.05$) and Non-permanent ($M = 113.17; SD = 19.59$) staff revealed no significant differences: $t(120) = -0.551, p = .583$). Attitudes of nursing staff were significantly more negative ($M = 104.05, SD = 26.91$) than attitudes of the combined non-nursing occupational groups ($M = 117.82, SD = 18.09$), $t(117) = 3.314, p < 0.001$.

Participants who currently work with patients with personality disorder(s) reported significantly more positive attitudes towards personality disorder ($M = 114.68, SD = 22.03$) than participants who do not currently work with patients with personality disorder ($M = 96.12, SD = 25.85$): $t(120) = -3.67, p < 0.001, d = -0.67, r = 0.31$. Participants who had received specific training in relation to working with patients with personality disorder(s) reported significantly more positive attitudes ($M = 116.23, SD = 20.79$) than participants who had never received specific training in relation to working with patients with personality disorder ($M = 99.05, SD = 26.47$): $t(120) = 3.89, p < 0.001, d = 0.71, r = 0.34$.

Total APDQ scores did not significantly correlate with any of the continuous variables (i.e. years working in current role: $r(94) = 0.040, p = .698$; years working in secure settings: $r(94) = -.071, p = .493$; years working in a setting of the same level of security: $r(94) = -.095, p = .356$; years working with patients with personality disorder $r(93) = .049, p = .637$; and years working with female patients; $r(73) = -.092, p = .430$).

Multiple Regression Analysis of APDQ Total Scores: The model of all five entered variables accounted for 22.7% of variance in Total APDQ scores ($R^2 = .227$, $F(5,94) = 5.53$, $p < 0.0005$).

The model is presented in **Table 3**.

[TABLE 3]

‘Training on working with personality disorder’ yielded the strongest unique contribution to explaining the variance in APDQ Total scores when the variance explained by all other variables in the model was controlled for ($\beta = -.214$). Occupational Group yielded the second strongest unique contribution to explaining the variance in APDQ Total scores, when the variance explained by all other variables in the model were controlled for ($\beta = -.196$). The remaining three predictor variables did not make statistically significantly unique contributions to the equation.

Comparison of current and previously published ADPQ data: Participants in the current study self-reported significantly less positive attitudes towards personality disorder (APDQ Total and all Factors) in comparison to the sample of multidisciplinary staff from acute psychiatry (Bowers & Allan, 2006). When compared to Prison Officers from a Dangerous and Severe Personality Disorder (DPSD) Unit (Carr-Walker, Bowers, Callaghan, Nigman & Paton, 2004), the current sample reported significantly less positive attitudes in relation to Total APDQ and each Factor, with the exception of Factor 2 – ‘Security’. When compared to a sample of nursing staff (qualified and unqualified) from all three High Secure Hospitals in England (Carr-Walker, Bowers, Callaghan, Nigman & Paton, 2004), the current sample reported significantly less positive attitudes in relation to Total APDQ and each Factor, with the exception of Factor 1 – ‘Enjoyment’. When a subsample of nursing staff from the current

study was compared with the nursing staff sample of Carr-Walker, Bowers, Callaghan, Nigman & Paton (2004), attitudes in the present study were less positive across all domains.

[TABLE 4]

Discussion

This study sought to investigate staff attitudes towards personality disorder in a high and a medium secure forensic-psychiatric hospital in the UK. The attitudes reported in the current study were significantly less positive than previously reported in studies with samples from high secure psychiatric hospitals (Carr-Walker et al., 2004), acute psychiatry (Bowers & Allan, 2006) and DSPD prisons units (Carr-Walker et al., 2004). The best predictor of positive attitudes was ‘training in personality disorder’.

The overall less positive attitudes towards personality disorder which were found in this study warrant further exploration, in the context of the wider literature. The most closely comparable study was conducted by Carr-Walker et al. (2004), who utilised the APDQ to compare the attitudes held by prison officers within DSPD prisons with nurses (qualified nurses and nursing assistants) in three high-security hospitals in the UK. In this study, the authors found that the attitudes of prison officers were more positive than that of nurses, with prison officers expressing less fear, anger or helplessness and displaying more optimism regarding treatment. Conversely, nurses from high secure hospitals reported less confidence in working with DSPD patients, more concern about caring for and managing them and they reported experiencing feelings of vulnerability. Interestingly, all of the prison officers specifically applied to work in that service, whereas this was only the case with nurses from one of the three hospitals. When

this was considered in the analysis, both prison officers and nurses whom specifically applied to work in that service held significantly more positive attitudes than nurses who had been assigned to work in that service.

In the current study, not all participants were working in specific personality disorder services (i.e. some worked in services where, for example, mental illness was the primary diagnosis and personality disorder a comorbidity), thus it is difficult to know whether they 'chose' to work with patients with personality disorder. Of those participants who were currently working in personality disorder services, some would have been transferred from other areas of the hospital, and thus did not elect to work with patients with personality disorder. Thus, it is not known what proportion of participants elected/specifically applied to work with patients with personality disorder, and therefore a comparison similar to Carr-Walker's (2004) is not possible. What is, however, of note is that those currently working with patients with personality disorder held significantly more positive attitudes, in contrast to those participants who had previously worked with patients with these difficulties but did not at the time of the study. It is possible that this may reflect that those participants who held less positive attitudes to personality disorder had elected to work in another area (where they would anticipate having less contact with patients with personality disorder).

Differences in methodology may be of relevance when considering the less positive attitudes in the current study when compared with previous data. For example, in the current study the use of an online questionnaire format with no additional face-to-face interview component (for example as in Carr-Walker et al., 2004) may have led to a greater sense of anonymity, and perhaps greater openness about negative feelings. Alternatively, the differences across studies may reflect genuine differences in the attitudes held by staff, which could conceivably reflect wider organisational differences or differences across time. The comparison studies were

conducted in 2004 and 2006, shortly following the ‘Personality Disorder: no longer a diagnosis of exclusion’ guidance, and at a time of great investment in research and service development; thus it could be hypothesised that the more positive attitudes may reflect a new optimism surrounding personality disorder treatments, which could perhaps have subsided with time.

It is however not possible to directly compare across time points, due to the absence of earlier studies (e.g. in 1990s) with similar study design and samples; indeed the difference in methodologies across studies, and the inability to identify causative relationships make longitudinal comparisons difficult. Chartonas et al. (2017) also highlight the difficulties in drawing conclusions about any longitudinal change, owing to the disparities in the samples from existing research (e.g. in terms of occupational groups, levels of training and experience, counties, and settings). Nonetheless, given the previously reported association between APDQ based attitudes and measures of general wellbeing, burnout, job performance and sickness rates (Bowers, 2003), greater clarity into the cause of the apparent less positive attitudes would be valuable, but are beyond the scope of this study design.

Within the present study, training in personality disorder was found to be the best predictor of attitudes as measured by the APDQ, thus supporting our hypothesis. The notion that increasing knowledge and understanding in mental health issues will address stigma, is what underpins many anti-stigma campaigns; however improvements in ‘mental health literacy’ (Jorm et al., 1997b; Jorm, 2012) do not always equate to improvements in attitudes towards those mental disorders, and anti-stigma campaigns and attempts to improve ‘mental health literacy’ have rarely included personality disorders (Newton-Howes, Weaver & Tyrer, 2008). There are however numerous examples in the literature of targeted training in personality disorder for clinicians (with the aim of improving attitudes and service provision), with largely positive outcomes. For example, training in personality disorder has been found to promote greater

empathy, ability to identify distress, and reduce the likelihood of voicing dislike towards patients with personality disorders (Shanks et al., 2011), and various other measures of attitudinal change.

Indeed, the positive impact of training in personality disorder on staff positivity and attitudes has been demonstrated in recent research using various outcome measures (Krawitz, 2004; Lamph et al., 2014; Davis, 2014), for example the ‘Personality Disorder Knowledge, Attitudes and Skills Questionnaire’ (PD-KASQ; Bolton, Feigenbaum & Woodward, 2010), which was devised to evaluate a national personality disorder awareness training programme established in the United Kingdom (the Knowledge and Understanding Framework). Lamph et al. (2014) and Davies et al. (2014) evaluated this training programme with healthcare professionals, administering this questionnaire prior to the training, immediately after the training and three months after the training. Davies et al. (2014) reported that on completion of the training, improvements were observed in relation to participants’ levels of understanding and confidence’ in working with personality disorder, with a reduction in negative emotional reactions also evidenced. When tested again in a 3 month follow up, the improvements in understanding and emotional reaction were sustained; however, participants’ self-reported confidence in working with personality disorder diminished to pre-training levels. Similarly, Lamph et al. (2014) found positive improvements immediately post training, with some decline at follow up. In order to encourage the sustainment of any gains from training in personality disorder, Davies (2014) suggests that participants would benefit from “ongoing supervision and/or support to consolidate skills” (Davies et al., 2014; p.161).

In the current study, a significant minority (44%) of participants had received no formal training in relation to personality disorder, and of those currently working with personality disorder, a quarter had received no training. Considering the finding that training predicted

more positive attitudes, greater delivery of training on personality disorder is recommended, and this could contribute to supporting the cultivation of more positive attitudes in staff within this setting. Breeze and Repper (1998) reported that when clinician's sense of competence and control is challenged, the clinician is more likely to define the patient as 'difficult'. Relatedly, Krawitz (2004) highlights how clinician confidence in working with personality disorder may negatively impact on treatment outcomes, which could then in turn perpetuate feelings of therapeutic pessimism. Thus, as well as improving knowledge and understanding, it is also clinically important for clinicians to have opportunities to build their sense of confidence and competence in working with personality disorder. This aim could be incorporated into training attempts, but could also be supported through regular clinical supervision, managerial appraisals and reflective practice sessions and peers support groups.

The decision to merge occupational groups was largely driven by the need to manage the difficulties in comparing groups where some had very few respondents, and it would have been preferable to analyse the professional groups independently if they had been of equal sizes. The groups which were combined did however have similar average ADPQ scores, and arguably shared some similarities in terms of their ideological perspective. The finding that Nurses and Psychiatrists held the most negative views was also consistent with other literature, for example Bodner et al (2015) found that Nurses and Psychiatrists held the most negative attitudes towards patients with Border Personality Disorder, and Black et al. (2011) found nurses to self-report less caring attitudes than other professional groups. The differences in attitudes between occupational groups may explained by a variety of factors, for instance differences in the roles and responsibilities between professional groups, the amount of continuous time spent with patients, the nature of their training and the theoretical/ideological stance of the profession, etc.

It is not possible within this study to draw any conclusions as to the cause of the differences between professional groups, however this would benefit further exploration.

In addition to the provision of training, the promotion of mechanisms for support and reflection are also important (Clarke-Moore & Barber, 2008; NICE, 2009) in order to best support staff to work effectively with patients with personality disorder, and discourage the development of negative or pejorative attitudes. Murphy and McVey (2008) suggest that a 'holistic staff wellbeing strategy' (p.287) is necessary for organisational workforce development and support, in the context of working with personality disorder. The authors propose a range of mechanisms including: counselling, coaching and mentoring, post-incident debriefs, liaising with other similar services and implementing interventions to 'counter parallel processes'. Such interventions are recommended across all levels of the institution – from the individual, to the team, and the wider organisation

Study Limitations

The sample size and response rate are relatively low; however, they are typical for research conducted in similar settings with similar study designs (Bowers et al., 2006; Handerson, Harada, & Amar, 2012). Other methods could be utilised to attempt to improve the response rate and sample size, for example distributing paper-questionnaires at the start of staff meetings and collecting at the end; however, with this method there would likely be a reduction in the participants' perceptions of anonymity, which could conceivably impact on the openness and honesty of their responses, and thus diminish the validity of the findings.

The response rate was also low and it was not possible to access data about non-responders, therefore this negatively impacts on the confidence in the representativeness. It cannot be ruled out that attitudes to personality disorder of respondents influenced their decisions to participate.

For instance, those with more positive attitudes may have been inclined to take part (e.g. due to an interest in personality disorder); alternatively, strong (more negative) views of people with personality disorder (in comparison to non-responders) might have influenced responders to take part.

Due to the low representation within certain occupational groups, it was necessary to merge some groups. Although no significant differences were observed between these occupational groups, the inability to more fully analyse these as separate groups represents an important limitation of the study.

Directions for future research

It would be beneficial for future research to explore additional factors that might predict attitudes to personality disorder. The current study did not explore factors beyond basic demographic variables, and it may be beneficial to explore more complex personal variables of participants, such as their own personality traits, general job satisfaction, or access and quality of clinical supervision.

Clinical Implications

The less positive attitudes to personality disorder in the current study poses further questions due to the inability to explore causative factors within the scope of this study, or study design. However, the association between attitudes to personality disorder and staff health, job performance, sickness rates and burnout (Bowers et al., 2003); and the observed potential impact of stigma on therapeutic relationships, clinical management and treatment outcomes (Newton-Howes, Weaver & Tyrer, 2008), reflect the important clinical implications that negative attitudes towards this group can have.

The finding that training in personality disorder predicted more positive attitudes (and that only 44% of participants had received no formal training in relation to personality disorder) suggests the need for improved training initiatives, perhaps especially for nursing staff who held the least positive attitudes. However, in addition to training, there may be other important mechanisms for cultivating positive attitudes in nursing staff (and indeed across all staff groups), such as systems of support. Multifaceted workplace development initiatives would thus be beneficial, incorporating aspects of education, opportunities for reflection, supervision and support.

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TABLES

Table 1: Participants by Occupational Group

| Occupational Group | Number of participants | Percentage |
|--|-------------------------------|-------------------|
| Nursing | 70 | 52.6 |
| Psychiatrists | 3 | 2.3 |
| Psychologists | 23 | 17.3 |
| Social Workers | 3 | 2.3 |
| Allied Health & Education Professionals | 29 | 21.8 |

NB: Percentages do not sum to 100 due to n=5 missing data.

Table 2: Descriptive statistics for APDQ Data

| | <i>M</i> | <i>SD</i> | 95% CI | | Range |
|------------------------------|----------|-----------|---------------|--------|--------------|
| | | | Lower | Upper | |
| Factor 1 – Enjoyment | 2.31 | 0.82 | 2.17 | 2.46 | 4.27 |
| Factor 2 – Security | 3.74 | 0.62 | 3.63 | 3.85 | 3.10 |
| Factor 3 - Acceptance | 3.95 | 0.69 | 3.83 | 4.07 | 3.10 |
| Factor 4 – Purpose | 3.46 | 0.86 | 3.30 | 3.61 | 4.00 |
| Factor 5 – Enthusiasm | 2.48 | 0.90 | 2.32 | 2.65 | 4.50 |
| APDQ Total | 110.74 | 24.03 | 106.43 | 115.05 | 131.00 |

Table 3: Multiple Regression Model

| | B | SE b | β | t | p |
|--|----------|-------------|----------|----------|----------|
| Training / No training on working with PD | -10.91 | 5.04 | -.214 | -2.165 | .033* |
| Non-nursing / Nursing profession | -9.408 | 4.51 | -.196 | -2.086 | .040* |
| Currently / Not currently working with patients with PD | -8.96 | 5.87 | -.156 | -1.527 | .130 |
| Currently / Not currently working in Women's Service | -6.57 | 4.74 | -.135 | -1.385 | .169 |
| Male /Female | 4.10 | 4.99 | .079 | .824 | .412 |

Table 4: APDQ data from current sample and previously published data

| | Current study (<i>nursing subsample</i>) | | MDT acute psychiatry (N=51) ^a | | | | | DSPD Prison Officers (N=55) ^b | | | | | High Secure Hospital nurses (N=645) ^c | | | | |
|------------------------|---|-----------------------|--|------|-------|-------|----------|--|------|-------|-------|----------------|--|-------|-------|-------|-----------------------------|
| | M | SD | M | SD | T | df | P | M | SD | T | df | P | M | SD | t | df | p |
| FACTOR 1 Enjoyment | 2.31 <i>2.04</i> | 0.82 <i>0.78</i> | 3.04 | 0.34 | 8.273 | 171.0 | < 0.0001 | 3.10 | 0.6 | 87.72 | 54.20 | < 0.0001 | 2.67 | 0.78 | 4.478 | 165.0 | NS (0.4454) <0.05 |
| FACTOR 2 Security | 3.74 <i>3.77</i> | 0.62 <i>0.71</i> | 4.51 | 0.64 | 4.092 | 93.10 | < 0.0001 | 5.16 | 0.48 | 6.503 | 107.4 | NS (0.8038) | 4.66 | 0.76 | 14.46 | 196.6 | <0.05 <0.05 |
| FACTOR 3 Acceptance | 3.95 <i>3.84</i> | 0.69 <i>0.77</i> | 4.78 | 0.67 | 7.357 | 96.04 | < 0.0001 | 5.15 | 0.55 | 13.46 | 144.8 | <0.05 | 4.54 | 0.84 | 8.346 | 196.0 | <0.05 <0.05 |
| FACTOR 4 Purpose | 3.46 <i>3.31</i> | 0.86 <i>0.91</i> | 4.05 | 0.87 | 4.092 | 93.10 | < 0.0001 | 4.64 | 0.71 | 15.71 | 155.1 | < 0.0001 | 3.79 | 1.05 | 3.759 | 195.3 | <0.05 <0.05 |
| FACTOR 5 Enthusiasm | 2.48 <i>2.45</i> | 0.90 <i>1.00</i> | 3.45 | 0.9 | 6.430 | 94.19 | < 0.0001 | 4.01 | 0.7 | 17.12 | 130.7 | <0.05 | 3.45 | 1.05 | 10.54 | 188.3 | <0.05 <0.05 |
| APDQ TOTAL* | 110.74 <i>104.05</i> | 24.03 <i>26.91</i> | - | - | - | - | - | 153.85 | 12.8 | 17.32 | 170.2 | < 0.0001 | 133.73 | 23.30 | 123.0 | 732.6 | < 0.0001 <0.0001 |
| APDQ Total** | 15.94 | 3.0178 | 19.83 | 2.93 | 7.88 | 96.12 | < 0.0001 | 22.05 | 1.78 | 16.80 | 162.5 | < 0.0001 | 19.10 | 3.46 | 10.34 | 186.8 | < 0.0001 |

* calculated across all items

** represents sum of all factor means

^a 51 multidisciplinary staff working in acute psychiatry (Bowers & Allan, 2006)

^b 55 DSPD Prison Officers (Carr-Walker, Bowers, Callaghan Nijman & Paton, 2004)

^c 645 Nursing staff (qualified and unqualified nurses) (Carr-Walker, Bowers, Callaghan Nijman & Paton, 2004)