Borderline personality disorder: The attitudes of mental health clinicians

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Borderline personality disorder: The attitudes of mental health clinicians

Submitted by

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Abstract

According to the literature, borderline personality disorder (BPD) is often viewed negatively by mental health clinicians. The primary aim of this research was to assess the attitudes of clinicians working in mental health continuing care teams (CCTs) in Melbourne. A purpose-designed questionnaire, Attitudes to Borderline Personality Disorder Scale (BPD-APS), was used to gather demographic information from a sample of 91 participants and to assess clinicians' attitudes. Participants were from four main disciplines: 22 nurses (24%), 16 psychologists (18%), 17 social workers (19%), 12 consultant psychiatrists (13%), 11 psychiatric registrars (12%). Clinicians' discipline, years of practice, consultation and training with a specialised service (Spectrum) and level of burnout, measured by the Maslach Burnout Inventory (MBI-HSS), were all factors expected to influence clinicians' attitude towards BPD patients. Fifty-eight per cent of the participants had positive attitudes to BPD patients but a substantial proportion (42%) had negative attitudes. Years of experience in mental health impacted on clinicians' levels of interest in working with BPD patients but were not associated with their attitudes towards such patients. Significant statistical differences were found between the four main disciplines: psychiatrists/registrars and psychiatric nurses had more negative attitudes to patients with BPD. Social workers and clinical psychologists were more positive. Analyses indicated that clinicians (58%) experienced moderate to high levels of emotional exhaustion. Thirty eight per cent of the clinicians reported moderate to high levels of depersonalisation, while 61 per cent rated low to moderate levels of personal accomplishment on the MBI-HSS. The attitudes of the clinicians were correlated with depersonalisation but not with emotional exhaustion. Consistent with recent literature, clinicians with access to consultation and training had more positive attitudes. The findings of this study clearly indicate the need for clinicians working in mental health services to receive specific training, supervision and support for working with BPD patients.

Doctor of Psychology Declaration

"I Hanife Guducu, declare that the Doctor of Psychology Clinical thesis entitled Borderline Personality Disorder: The attitudes of mental health clinicians is no more than 40,000 words in length including quotes and exclusive tables, figures, appendices, bibliography, references and footnotes. This thesis contains no material that has been submitted previously, in whole or in part, for the award of any other academic degree or diploma. Except where otherwise indicated, this thesis is my work".

Signature:

Date: 21/2/2011

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I would like to dedicate my thesis to my father. It was he who initiated my path in education and encouraged me to believe in myself.

I would like to thank my husband for his patience and support. He sacrificed a lot and took care of our son Kaan while I spent hours away from them studying. I thank my mother, who was understanding and supported my endurance. I thank my friends, who at the best of times believed in me more than I believed in myself.

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Table of Contents

ABSTRACT II
DOCTOR OF PSYCHOLOGY DECLARATION III
ACKNOWLEDGEMENTS IV
LIST OF FIGURES VII
LIST OF APPENDICES X
CHAPTER 1 11
INTRODUCTION 11
1.1 Borderline Personality Disorder 12
1.1.1 Historical Perspective *13*
1.1.2 The Diagnosis *14*
1.1.3 Etiology of Borderline Personality Disorder *16*
1.1.4 Borderline Personality Disorder Types I, II and III *19*
1.2 The Mental Health System and the Case Manager 20
1.2.1 The Case Manager *21*
1.3 Spectrum Specialist Consultation Services 24
1.4 Attitudes 25
1.4.1 A Definition *25*
1.4.2 Attitudes of Mental Health Clinicians to BPD Patients *27*
1.4.3 The Attitudes of Nurses and Psychiatrists *27*
1.4.4 Research on CCT Clinicians *30*
1.5 Effects of Working with BPD Patients 36
1.5.1 The Therapist *38*
1.6 Burnout 41
1.7 Factors That May Influence Professional Attitudes 42
1.8 Rationale for the Current Study 44
1.9 Summary 46
1.9.1 Overview of Literature *46*
1.10 Research Questions 47
1.11 Aims of the Study 48
1.12 Hypotheses 48
CHAPTER 2 50
METHOD 50
2.1 Participants 50
2.2 Measures 51
2.2.1 Borderline Personality Disorder: The Attitudes of Mental Health Clinicians: *51*
2.2.2 The Questionnaire Measure *52*
2.2.3 Burnout *58*
2.3 Procedure 59
2.3.1 Ethics Approval *59*
2.3.2 Data Collection *59*
2.4 Data Analysis 62
CHAPTER 3 63
3.1 Descriptive Analysis 63
3.1.1 Sample Characteristics *63*
3.1.2 Variable Characteristics *65*
3.1.3 Experience Working with BPD *67*
3.1.4 Treatment Types *67*

3.1.5 Clinicians' Interest, Anxiety and Confidence in Working with BPD 69
3.1.6 Professions Better Suited to Working with BPD 70
3.1.7 Attitudes and Perceptions 70
3.1.8 Prevalence of BPD in Clinicians' Service and Caseloads 72
3.1.9 Contributing Factors Influencing Clinicians' Work with BPD 73
3.1.10 Spectrum Consultation 74
3.1.11 Maslach Burnout Inventory – Human Services Survey 75
3.2 Attitudes of Mental Health CCT Clinicians 78
3.2.1 Proportion of Clinicians Holding Negative Attitudes to BPD 78
3.2.2 Profession and Attitude of the Clinician 78
3.2.3 Analyses of APS-BPD Total Scores 79
3.3 Intervention Used by Clinicians 80
3.4 Years of Experience and Interest in Working with BPD 81
3.4.1 Preliminary Data Screening 82
3.5 Emotional Exhaustion, Depersonalisation and Attitudes and Perceptions 84
3.5.1 Preliminary Analyses of Depersonalisation and Emotional Exhaustion 84
3.5.2 Bivariate Correlations of Attitudes, Emotional Exhaustion and Depersonalisation 85
3.6 Specialist Consultation and Attitudes to Patients with BDP 87
3.6.1 Attitudes and Perceptions with Specialist Consultation 87
3.6.2 Exploratory Analysis of Variables Relating to Interest in Working with BPD Clients 88
3.7 Summary of Results 89
3.7.1 Attitudes of Mental Health Clinicians 89
3.7.2 Discipline and Attitude of Clinician 90
3.7.3 Intervention Used by Clinicians 90
3.7.4 Years of Experience and Poor Interest Working with BPD 90
3.7.5 Emotional Exhaustion, Depersonalisation and Attitudes 91
3.7.6 Specialist Consultation and Attitudes to Patients with BDP 91

CHAPTER 4 92

DISCUSSION 92

4.1. Summary of the Hypotheses and Main Research Findings 93
4.2 Key Themes and Findings 94
4.2.1 Attitudes of CCT Clinicians Working with BPD 94
4.2.2 Professional Background and Attitudes 96
4.2.3 Psychiatrists/Psychiatric Registrars and Psychiatric nurses 97
4.2.4 Psychologists and Social Workers 100
4.2.5 Professions Most Suited to Working with BPD patients 102
4.2.6. Models of Therapeutic Treatment 102
4.2.7 Years of Work, Interest and Attitudes 105
4.2.8 Burnout Amongst Mental Health Clinicians 107
4.2.9 Professional Development/Consultation with Spectrum 110
4.2.10. Study Findings and the CCT Service Context 112
4.3 Strengths and Limitations of the Research. 114
4.3.1 Research design issues 115
4.3.2 Measurement issues 116
4.4 Conclusions and Recommendations 118

REFERENCES ..... **ERROR! BOOKMARK NOT DEFINED.**

APPENDICES 124

List of Figures

Figure 3.1	Emotional exhaustion by years of experience in mental health	76
Figure 3.2	Emotional Exhaustion by professions	77

List of Tables

TABLE 1.1 15

DSM-IV DIAGNOSTIC CRITERIA FOR 301.83 BORDERLINE PERSONALITY DISORDER: 15

TABLE 3.1 64

PARTICIPANT DEMOGRAPHICS 64

TABLE 3.2 65

FREQUENCIES OF PARTICIPANT PROFESSION BY YEARS OF PRACTICE IN MENTAL HEALTH 65

TABLE 3.3 66

MEANS, STANDARD DEVIATIONS AND RANGE OF SCORES ON MEASURES FROM THE BORDERLINE PERSONALITY DISORDER: ATTITUDE OF MENTAL HEALTH CLINICIANS 66

TABLE 3.4: 67

MEANS, STANDARD DEVIATIONS AND RANGE OF SCORES ON THE MEASURES OF THE MASLACH SUBSCALES 67

TABLE 3.5: 68

FREQUENCIES OF TREATMENT MODELS BY DISCIPLINES 68

TABLE 3.6: 69

FREQUENCIES OF AGREEMENT/DISAGREEMENT WITH STATEMENTS ABOUT THE EXPERIENCE OF WORKING WITH BPD PATIENTS 69

TABLE 3.7: 71

FREQUENCIES OF RAW RESPONSES TO ATTITUDES AND PERCEPTIONS SCALE – BORDERLINE PERSONALITY DISORDER (APS–BPD) 71

TABLE 3.8 *FACTORS PERCEIVED AS DISCOURAGING WORK WITH BPD PATIENTS* 73

TABLE 3.9 74

FREQUENCY (%) DISCIPLINES ATTENDING INDIVIDUAL AND GROUP CONSULTATION WITH SPECTRUM SERVICES. 74

TABLE 3.10 75

FREQUENCIES OF MBIHSS SUBSCALE INDICES FOR PARTICIPANT CLINICIANS 75

TABLE 3.11 79

SAMPLE STATISTICS FOR ATTITUDE AND PERCEPTION RATINGS OF THE DISCIPLINES 79

TABLE 3.12 81

FREQUENCIES OF CLINICIANS' MOST COMMONLY USED TREATMENT TYPES 81

TABLE 3.13 83

SUMMARY OF REGRESSION ANALYSIS FOR THE PREDICTION OF INTEREST WORKING WITH BPD PATIENTS BY YEARS OF PRACTICE 83

TABLE 3.14 *SUMMARY OF REGRESSION ANALYSIS FOR THE PREDICTION OF ATTITUDES CONCERNING BPD PATIENTS BY YEARS OF PRACTICE* 84

TABLE 3.*15* 85

PEARSON'S PRODUCT MOMENT CORRELATION COEFFICIENTS BETWEEN ATTITUDES, EMOTIONAL EXHAUSTION AND DEPERSONALISATION 85

TABLE 3.16 86

SUMMARY OF MULTIPLE REGRESSION ANALYSIS FOR THE PREDICTION OF ATTITUDES AND PERCEPTIONS BY EMOTIONAL EXHAUSTION AND DEPERSONALISATION 86

TABLE 3.17 87

SUMMARY OF STATISTICS FOR SCORES ON ATTITUDES AND PERCEPTIONS BETWEEN CLINICIANS' REPORTED ATTENDANCE TO SPECIALIST CONSULTATION 87

TABLE 3.*18* 88

PEARSON'S PRODUCT MOMENT CORRELATION COEFFICIENTS BETWEEN INTEREST, DISLIKE, ANXIETY, CONFIDENCE IN WORKING WITH BPD CLIENTS AND YEARS OF WORK 88

List of Appendices

Appendix A. Mental Health Research and Ethics Committee Approval Letter to commence study 144

Appendix B. Victoria University Ethics Committee Approval letter 145

Appendix C. Information to Participants 146

Appendix D. Borderline Personality Disorder: The Attitudes of Mental Health Clinicians questionnaire 147

Appendix E. Maslach Burnout Inventory: Humans Services Survey 148

Appendix F. Clinician Data 149

Chapter 1

Introduction

The diagnosis of borderline personality disorder according to research both in Australia and abroad has a history of negative perception. It has been recognised as a very difficult condition to treat and associated with burnout of clinicians (Onyett, Pillinger & Muijen, 1997; Prosser, Johnson, Kuipers, Szmulker, Bebbington & Thornicroft, 1996). This clinical disorder has been identified as having high prevalence, social dysfunction, high usage of public health care and chronicity that make it a clinical disorder as significant as schizophrenia, bipolar disorders or major depression (Gunderson, 2001).

Severely ill borderline personality disorder (BPD) patients have been identified as amongst the most challenging patients to treat in mental health services (Zanarini & Silk, 2004). Serious suicide attempts are made by these patients and anywhere from three per cent to 10 per cent of borderline patients with a history of being hospitalised at least once, go on to commit suicide (McGlashan, 1986; Paris, 2007; Stone, 1990).

Today BPD is a common condition treated by mental health professionals in the public mental health system. The primary aim of this research study is to examine the attitudes of community mental health clinicians to the diagnosis of BPD. Further, the literature relating to BPD and clinicians who work with BPD in CCTs is scarce. There has been more written about the attitudes of psychiatric nurses and psychiatrists in inpatient wards than any other discipline or setting (Deans & Meocevic, 2006; Fraser & Gallop 1993; Lewis & Appleby, 1988; Nehls, 2000; Markham & Trower, 2003).

The clinicians who work in public mental health community care teams in Melbourne, Australia are the focus of the study. Clinicians who work in public mental health settings have caseloads and work most often under a generic model. One question to be investigated is whether the clinicians' discipline impacts on their attitudes. By studying the attitudes of these clinicians, we may be able to understand if and why some disciplines are more prone to negative attitudes than other disciplines.

Given the complexity of the disorder and the presentation and associated impact on clinicians, it is important to understand clinicians' attitudes to this and the determinants of these attitudes.

In this current study the terms "patient" or "client" will be used interchangeably when referring to a person diagnosed with BPD. A reasonable case can be made for the use of either of these terms depending on the discipline using the term. Psychiatrists and nurses may often use the term "patient" when making reference to a person as they tend to follow a medical model; other disciplines may refer to these people as "clients". Then again it may not depend strictly on the discipline but rather the context in which the term is used at that particular time.

This literature review will focus firstly on the nature and diagnosis of borderline personality disorder, will outline the mental health system and the role of case manager, go on to review research examining the attitudes of clinicians to patients with borderline personality disorder and then consider the issue of burnout.

1.1 Borderline Personality Disorder

BPD is a mental health disorder in which individuals often struggle with multidimensional problems. Severely ill borderline patients have been

identified as the most challenging patients to treat (Zanarini & Silk, 2001; Barret, 2000). The following review will focus on the history of the diagnosis, the etiology, and the clinicians working in CCT services, who eventually work with these patients.

1.1.1 Historical Perspective

BPD is reported to be the most common of personality disorders seen by mental health services and the challenges faced are unlike those of other clients (Miller & Davenport, 1996). Approximately 11 per cent of patients seen in outpatient community mental health services have a diagnosis of BPD and up to 20 per cent in inpatient units (Swartz, Blazer, George & Winfield, 1990). The rate of suicide for BPD is comparable to that of schizophrenia and bipolar affective disorder (10%). The suicide rate is stated to quadruple for those BPD patients at the severe end of the spectrum (Krawitz & Watson, 2003).

Psychotherapists and psychoanalysts during the 1950's described a group of patients who could experience primary process material but lacked the capability and capacity for introspection and insight (Kernberg, 1984). These patients from a psychoanalytic perspective were puzzling. Many in the psychoanalytic community of the time believed these patients were suffering from a "borderline group of neurosis" (Stern 1938). Many theorists (Stern 1938; Schmideberg, 1947; Kernberg, 1975) viewed borderline patients as being on the borderline between neurosis and psychosis.

Two prominent theorists who have made an impact on our understanding of BPD patients are Heinz Kohut (1959) and Otto Kernberg (1975). Kernberg's theory addressed important ego deficiencies, especially a deficiency in the degree of identity integration. Kohut proposed a "traumarrest" model: that is, the normal developmental needs of the child were traumatically frustrated by the excessively unempathetic responses of the self-objects, and thus could

not evolve. These two theorists hypothesised pathological development of the self as being at the crux of the disorder.

Stern (1938) and Kernberg (1967) described borderline personality organization (BPO) as an intermediary level of internal personality organization, bordered on one side, by more severe psychotic personality and on the other by less severe neurotic organization. The BPO construct incorporated three intrapsychic characteristics: identity diffusion, primitive defences and impaired reality testing. Gunderson (1981) has been recorded as a strong proponent of the borderline as a valid, separate diagnostic entity, referred to by him as "borderline personality disorders".

1.1.2 The Diagnosis

The efforts to achieve uniformity in the characterisation of these difficult patients have led to a need for more precise definitions of the term "borderline". The term "borderline personality disorder" as defined by the American Psychiatric Association in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III) in 1980 and in its later revision (DSM-III R) and then (DSM-IV) in 1994 is based on descriptive, circumscribed and phenomenological features.

In order to have some understanding of and appreciation for those studies reporting the negative attitudes of mental health clinicians, one needs to have some knowledge of those symptoms and characteristics that make up a patient with BPD. Today the DSM-IV requires five of nine characteristics for the diagnosis of BPD as listed in Table 1.1

Table 1.1

DSM-IV Diagnostic Criteria for 301.83 Borderline Personality Disorder:

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1. Frantic efforts to avoid real or imagined abandonment.
2. A pattern of unstable and intense interpersonal relationships. characterized by alternating between extremes of idealization and devaluation.
3. Identity disturbance: marked 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).
5. Recurrent suicidal behaviour, gestures, or threats or self-mutilating behaviour.
6. Affective instability due to a marked reactivity of mood e.g., intense episodic dysphoria, irritability, or anxiety.
7. Chronic feelings of emptiness.
8. Inappropriate, intense anger or difficulty controlling anger.
9. Transient, stress-related paranoia ideation or severe dissociative symptoms.

Interestingly a study conducted by Treloar and Lewis (2008) highlighted that the use of diagnostic criteria for BPD can vary from one service to another, in particular an emergency services setting and a mental health service. This highlights the point that, with the use of five out of nine criteria, patients can have only one diagnostic criterion in common and yet be diagnosed as having BPD. One may argue that this is indicative of some of the limitations in the current DSM-IV definition of BPD.

1.1.3 Etiology of Borderline Personality Disorder

Clinical research has indicated that childhood trauma has been described as an etiological factor and as an antecedent to the development of BPD. Herman, Perry and van der Kolk (1989) conducted a study that demonstrated a strong association between a diagnosis of BPD and a history of abuse in childhood.

Earlier psychodynamic theorists postulated the aetiology of BPD to be a consequence of two aspects of mother–child interaction and that the disorder was uniquely a consequence of either or both: maternal over-involvement with the child and mismanagement and inappropriateness of maternal guidance and support of the child. Bezirganian, Cohen and Brooks' (1993) study used epidemiological methods to look at mother–child interactions, father–child interactions, maternal personality, and adolescent diagnoses of personality disorders over two and a half years in a random sample of 776 adolescents. The results indicated a maternal inconsistency in upbringing of the child and predicted persistence or an emergence of BPD, but not of any other axis II disorder. In summary, the two child-rearing risk factors hypothesised to be important by psychodynamic models of BPD were found to be pathogenic only when they co-existed.

Some psychoanalytic writers have suggested the etiology of BPD is rooted in a pre-oedipal disturbance in the mother–child relationship (Masterson, 1976; and Masterson & Ridley, 1975). Research based on attachment theory proposed that there is a link between childhood trauma and the capacity to think about oneself and others. According to Patrick et al. (1994) and Fonagy et al. (1996), borderline personality disorder patients are typically preoccupied with their disturbed early relationships.

Some researchers have proposed to explain BPD neurobehavioral hypothesis, separation hypothesis and family dynamic theory. Hoffman and McGlashan (2003) sought to develop an integrated model of BPD. They proposed that neurobehavioural vulnerabilities, such as a genetic predisposition, interact with environmental factors, such as family dysfunction, insecure attachment and maltreatment, which result in maladaptive personality disorder. The second developmental model suggested is the separation hypotheses. This model suggests that early deprivation through real or threatened object loss is a principal pathogenic factor, which results in borderline personality development. With the second model, theorists such as Kernberg (1967) and Masterson (1976) hold the view that borderline personality is a result of developmental failure in separation-individuation due to a loss of maternal constancy. This particular loss they talk of can be due to an actual separation or death of a parent, but most commonly a parental withdrawal of affection between the ages of 18 and 38 months.

Shapiro and Zinner (1984) postulated that borderline personality disorder can develop due to the structure of roles assigned within the family. That splitting and projective identification as family group defences that assign "good" and "bad" part object roles to family members. They argued that independence and separation from the family reflect devaluation and rejection of family values, or that dependant demands represent an overwhelming and dangerous burden on the family.

A study conducted by Golomb, Ludolph and Westen (1994) suggested that stressful environmental circumstances reported by the mothers likely affected the borderline daughters directly as well as mothers' ability to parent effectively and empathetically. What has been noted to be striking by many clinicians is the borderline's powerful fear of separations, which are interpreted by them as abandonment. Psychoanalysts have suggested that borderline's tensions over separations from people who are important to them

result from the interference in the mother–child relationship that Mahler et al. (1975) described as the process of separation-individuation. Soloff and Millward (1983) demonstrated that there was an increase in separation experience and separation sensitivity in borderline patients compatible with a psychodynamic ego developmental hypothesis.

Family aggregation studies suggest some heritability for BPD as a diagnosis, but the genetic basis for this disorder may be stronger for dimensions such as impulsivity/aggression and affective instability than for the diagnostic criteria per se. Family, adoptive, and twin studies also converge to support an underlying genetic component to the disorder (Siever, Torgersen, Gunderson, Livesley & Kendler, 2002).

Some clinical theorists have suggested that disturbed attachments are central to the development and psychopathology of BPD. John Bowlby (1958) observed the behaviour of toddlers. This enabled him to understand the problem of attachment and separation, which has given theorists an understanding of abandonment and its varying forms. More recently the assessment of adult attachments using the Adult Attachment Interview (Main & Goldwyn, 1998) has highlighted elementary aspects of BPD patients' unstable and intense relationships. Together with their problematic relationships their fears of abandonment have been seen to have developed as a result of earlier impairments in their attachments (Levy, Meehan, Reynoso & Clarkin, 2005). The types of attachment found to be most characteristic of BPD patients are those of *unresolved, preoccupied, and fearful* (Agrawal, Gunderson Homes & Lyons-Ruth, 2004). Recent studies have suggested that early insecure attachments may increase an individual's susceptibility to develop BPD.

The exact etiology of BPD has not been found, but as discussed there are multiple theories: one focus is on childhood abuse and the other is on a

biological etiology. Based on the literature reviewed, there appears to be general consensus that the etiology of BPD is multifaceted and that there are a number of important interacting factors namely genetic and environmental components.

1.1.4 Borderline Personality Disorder Types I, II and III

Borderline patients according to Zanarini and Silk (2001) are assumed to be equally disturbed. They argued that clinical experience would suggest that there is a continuum of borderline psychopathology. They proposed that there are three subtypes of BPD traits. Type I borderline patients clearly have dysphoria, cognitive disturbances and the same interpersonal difficulties as Type II and Type III BPD patients. What separates Type I BPD from Type II and Type III is a lack of impulsivity, especially in the area of self-mutilation and suicidal attempts. Type I BPD patients are usually able to use the treatment relationship to better themselves.

Type II borderline patients are sporadically self-destructive, especially if they fear they are going to be abandoned by someone they depend on. Type II patients are viewed as more fragile and are often reliant on their therapeutic relationship to help more with their emotional needs. What separates Type I from Type II patients according to Zanarini and Silk (2001) is that Type I borderlines want to overcome their problems and they want to attain their goals in life. Type II borderline patients are believed to experience very hard life struggles and hence view their treatment as their lifeline to stabilising their lives. They too have a need to understand their problems but may feel that their problems are too difficult to be resolved.

Type III borderline patients use psychiatric treatment often and are prone to give up their struggle and determination to function in their world. Out of the three types of borderlines Type III patients often abandon their school or work

and end up on disability pensions. They are also more prone to abandon their families and live in isolation. They may be able to function for months on end but then there may be years where they will be living dysfunctional lives. According to Zanarini and Silk (2001), research on borderlines has focused most often on the most severe Type II and Type III patients. These are the patients who have the most contact with public mental health clinicians.

1.2 The Mental Health System and the Case Manager

Since continuing care teams (CCTs) have operated, BPD patients have been seen in these public services. But limited research has been conducted to investigate the impact of these patients with BPD on multidisciplinary mental health clinicians.

As a result of the development in the 1950s of antipsychotic treatments for severely psychotic patients a process of patient discharges commenced (Gardner, 1995). Patients who would have previously been institutionalised for long periods of time came to be treated in the acute phase of their illness and then discharged. Subsequently there was a large and growing number of people who did not require the services of a psychiatric hospital but did need some level of care as an outpatient. With the advent of de-institutionalisation in the 1970s and 1980s, the case manager role was developed so these patients could receive a continuum of care from an outpatient community service: Community Continuing Care service (CCT). The advent of "community mental health clinics" meant that people could be followed up in their communities (Dax, 1961), usually by nurses (Nehls, 1994).

In 1993, the Second National Mental Health Strategy in Australia clearly endorsed the right of BPD patients to access public mental health services. Ten years later, the Mental Health Council of Australia released its national review of mental health services in Australia titled "Out of Hospital, Out of

Mind" (Groom, Hickie & Davenport, 2003). This report highlighted deficiencies in care and developed a set of community priorities for further action. Individuals and organizations, including consumers, clinicians, service providers and administrators, were consulted and asked to help identify potential areas for further action. All participants were asked to rank their top 10 preferences for focusing activity for the next five years on mental health. In the top 10 ranking, support for programs that promote attitudinal change amongst mental health workers was recognised as a priority and was ranked seventh on the list.

The effectiveness of the treatment of BPD according to Clarke et al. (1995, cited in O'Brien, 1998) was generally poor and ineffective. Furthermore, follow-up treatment in the community after discharge from hospitalisation was not often carried out. O'Brien (1998) found that community staff were frequently at a loss about how to deal with the crises of patients with a diagnosis of BPD. Nehls (1994) reported that community nurse clinicians did not have the necessary resources to care for patients with a diagnosis of BPD.

1.2.1 The Case Manager

The origins of the case manager when traced back to the public health nursing model provided a transition from the health care institution to home (Bienkowski, 2001). It was about coordinating resources and assisting the patient back into community life. The role of the case manager was to "create and manage a matrix network of services for their patient" (Zander, 1995).

Within mental health services, the scope of case management has expanded to include working with people with chronic, non-psychotic disorders and in particular people with BPD disorder. Today, many BPD patients are seen in CCT mental health-type services and under the case management model.

There are various models of case management. The model implemented and encouraged by any one service is dependent on the philosophy of that organisation, which impacts on the case manager's service delivery (Nehls, 2000). Increasingly today, case managers come from a range of disciplines: nurses, social workers, clinical psychologists and occupational therapists. Depending on the clinician's discipline and work experience history, each member of the case management team also has their specific role to maintain. For example, a nurse will give her patients their injections but will normally be rostered to give injections to other case managers' patients also. Clinical psychologists have specialised training to provide psychological assessments and psychotherapy while occupational therapists conduct tests to assess clients' abilities to cook and clean for themselves. The case manager will act as a broker and liaise with various services and agencies, as well as providing ongoing support. Case managers may also arrange meetings with members of the patient's family to aid and educate them about their family member's mental illness. But together with their case management role they will also tend to perform their own discipline specific roles: the case manager can be involved with these and many other areas in their aim to assist their client to live independently in their community.

According to Bachrach (1993), there are nine principles of continuity of care:

- a supportive administrative climate
- supports services for mentally ill patients
- the service is accessible by the population of patients
- it provides the services needed by the patients i.e. psychiatric, housing rehabilitation, leisure, crisis service, and asylum; must be tailored for the patients' needs
- the service is flexible, dependent on patients' needs and not on arbitrary rules
- the various agencies and organizations be linked together to be more productive
- each patient has the opportunity to establish a continuing relationship with his caregiver who will help navigate him through the service
- the patient be encouraged to take an active part in his care with decision making and service planning
- finally, that the service contains programs that relate to the cultural realities of the individuals enrolled in it

Bachrach (1993) raised the point that the continuity of care is a dynamic and ongoing process and that the consensus of what defines a case manager had not yet been reached.

Nehls (1998, 1994, 2000) in the USA has written extensively on case management and what it is like to case manage BPD patients. Nehls (2000) argued that amongst one of the many issues for case managers one is about how much power they gave up and how much power they retained when they saw persons with BPD. In other words, how were the boundaries going to be divided between a case manager, a professional, and a client? Could a case manager visit a suicidal patient off duty and could a client view her clinician as a friend?

Most recently, Joanne Ebert (2008) saw the role of the case manager as having become "diluted", in that she saw the case manager's role as having the responsibility for financial outcomes and resource utilisation to the detriment of an advocate role. She went on to state that the case manager's role had become "cost-centred rather than patient-centred" (p. 294). The literature remains highly uncertain as to what case management actually provides in practice and how it meets client's needs. Further research needs to be conducted to achieve a standard practice of case management service equity and quality (Hennessy, 1993).

In the past there was an awareness of the need for research that could look at the impact of BPD patients on psychiatric nurses working in inpatient wards. This interest has continued today and in particular, the focus of attention has expanded to include other disciplines that work with BPD in CCTs (Nehls 2000).

1.3 Spectrum Specialist Consultation Services

In 1993, the Second National Mental Health Strategy clearly endorsed the right of BPD clients to access public mental health services. The Victorian Government allocated funds to agencies to assist clinicians working with BPD. One of these services in Victoria was Spectrum. Spectrum was established in 1998. It is a service that specifically works with clients with a personality disorder and it has two major aims: (a) provision of support to state mental health services in the process of change towards new treatment strategies and (b) provision of specialised intensive assessment and treatment services for clients with particularly complex needs.

Spectrum provides a number of programs for clinicians in the area of mental health services and their clients with severe or borderline personality disorder.

All programs are accessed via a referral from a clinician working in a Victorian area mental health continuing community treatment team.

Spectrum as a service has a variety of tasks and one of these is to provide education, consultation/support and training for case managers in their work with BPD. One of the hypotheses of this present study was to examine what impact Spectrum had on the management of BPD for CCT clinicians, whether case managers had utilised the service in their work with BPD patients, and if so, whether this support had any impact on clinicians' attitudes to BPD patients.

1.4 Attitudes

1.4.1 A Definition

The definition of attitude is an area that has been of interest to social psychologists for many years, going far back to Allport (1935) and earlier. Attitudes have been defined in general to have three components including cognitions (thoughts, opinions and beliefs) and an affective component (feelings) as well as a behavioural domain, which is interpreted to be triggered as an outcome of contact with an object (Sears, Peplau & Taylor, 1998).

According to Rokeach (1972) and later Ajzen and Fishbein (1980), an attitude is an organisation of beliefs that are evolved around an object or situation that predisposes one to act in a certain manner. According to other attitude theorists Eagly and Chaiken (2007), an attitude is inside the individual; it is not observable but can be apparent by covert or overt responses. For example, attitudes towards fearful objects such as snakes or spiders have an inborn origin. Eagly and Chaiken's (2007) definition of attitude is:

"a psychological tendency that is expressed by evaluation of a particular entity with some degree of favour or disfavour" (Eagly & Chaiken's 1993, p. 1).

Attitude theorists have proposed that attitude formation can be *explicit* or *implicit*. According to Fiske, Lin & Neuberg (1999), explicit attitudes are those evaluations of others that people report and for which expression can be consciously controlled. Implicit attitudes are those evaluations to which people may not initially have conscious access and activation of which cannot be controlled. There is considerable controversy about how to conceptualise these two forms of attitudes. Researchers in this area investigate how these two different forms of attitudes are processed and formed by an individual and how they affect behaviour.

Rydell and McConnell (2006) supported the view that explicit attitudes are shaped in a way that suggests fast changing processes. Explicit attitudes are believed to carry more deliberate behavioural intentions by the individual. Implicit attitudes on the contrary reflected an associative system, developed more slowly through repeated pairings between an evaluation and an object and believed to be unaffected by explicit processing goals.

A study conducted by Rydell, McConnell, Strain, and Mackie (2008) highlighted that the formation of implicit attitudes towards people or social groups may be a reflection of the association the individual makes to that particular group and not a reflection of what he or she is observing. Explicit attitudes on the other hand were found to be less influenced by these associations, but determined by descriptions of the behaviour of the individual concerned. Interestingly what it highlighted was that people who are already stigmatised may face challenges in changing others' implicit attitudes towards them, even if they behave well. But those who are valued in a more positive way can behave inappropriately and still be considered to be implicitly approved. The implication of this for those with mental disorders and in particular for those who are behaviourally more challenging, namely those with BPD, may have considerable consequences. It suggests that the perception one has of this group of patients may in fact make it harder for

them to change the perceptions of them. Therefore people who have a mental illness and in particular in our study those with BPD who are already stigmatised and viewed as "difficult" (Gallop, Lancee & Garfinkel, 1989) may have further challenges in changing their service providers' attitudes toward them.

1.4.2 Attitudes of Mental Health Clinicians to BPD Patients

Most of the psychotherapy literature in this area has suggested that there may be no other psychiatric label more loaded with stereotypes and stigma than that of BPD (Nehls, 1998). Swenson, Sanderson, Dulit and Linehan (2000) stated that inpatient treatment of individuals with BPD is often faced with difficulty and most often fails expectations of the clinician.

1.4.3 The Attitudes of Nurses and Psychiatrists

Much of the research in this area has focused on nurses and psychiatrists in inpatient units and at mental health hospitals, as BPD patients were believed to be warranting an inpatient admission. The literature that has been accessible suggests that the view and attitudes of nurses and, in general, the psychiatric profession have been found to be negative to those patients diagnosed with a personality disorder: in particular those patients with a diagnosis of BPD (Bowers & Allan, 2006).

A study conducted by Fraser and Gallop (1993) examined the attitudes of 17 psychiatric nurses in an inpatient unit. There were 164 patients in the study. They had varied diagnoses: schizophrenia, affective disorders, BPD and others. The patients were divided into groups of 20 randomly and there was at least one patient in each group with a diagnosis of BPD. The researcher who observed them was not aware of the diagnosis of the patients. The researcher observed the groups and rated the nurses facilitating the group

based on their confirming and disconfirming responses and interactions with each patient in the group. Their results indicated that the nurses were less empathetic and confirming to those patients with a diagnosis BPD compared to other patients with different diagnoses.

Lewis and Appleby (1988) studied the attitudes of 240 psychiatrists in the United Kingdom towards clients with a diagnosis of "personality disorder". They concluded that a previous diagnosis of personality disorder led to more critical attitudes on the part of the psychiatrists. Munro (1999) described personality disorder as a "dustbin diagnosis" for patients seen to be different or difficult, and the borderline disorder as drawing "unique criticism" (James & Cowman, 2007). Becker and Lamb (1994) found that professional clinicians often diagnosed women more than men with BPD and that angry and promiscuous women were diagnosed with BPD but men with similar features were diagnosed with antisocial personality disorder (Simmons, 1992).

A study by Gallop, Lancee and Garfinkel (1989) sought to address psychiatric nurses' responses to the diagnostic labels "schizophrenia" and "borderline personality disorder". They examined nurses written responses to a series of hypothetical statements on these patients. In summary, their results indicated that psychiatric nurses were more likely to demonstrate supportive responses to schizophrenic patients than BPD patients. They concluded by stating that the label BPD had become a pejorative label for the difficult patient and that nursing staff may respond to these patients in less empathic ways than they would to other patients. The researchers concluded with a concern of whether their findings were reflective of actual behaviours. If that was the case then a diagnosis of BPD had become a negative stereotypic category that preceded any meeting with the patients. This they felt would set the tone for their subsequent interaction with their clinician, the nurse. Frances (1993) reported that clinicians felt deskilled and bewildered by borderline patients.

Similarly, a study was undertaken by Markham and Trower (2003) where all participants were mental health nursing staff. They found that nursing staff considered patients diagnosed with BPD as having more control of their negative behaviour than those patients with the labels of schizophrenia or depression. The questionnaires contained descriptions of patients' challenging behaviours. Participating nurses were requested to identify the likely cause of the behaviour in question and then on a Likert scale they were asked to rate their attributions of internality, stability, globality and controllability. All participants were requested to record their level of sympathy towards the patient together with their optimism for change.

An Australian study by Deans and Meocevic (2006) conducted a survey to assess the attitudes of psychiatric nurses (65) working in both community and inpatient settings. Their results indicated that a high proportion of psychiatric nurses experience negative emotional reactions and attitudes towards people with BPD. Furthermore, nurses perceive these patients as manipulative. Of the responses gathered, 89%of the nurses perceived BPD patients as "manipulative". One third of the nurses saw these patients as "nuisances". But most importantly 32% of the nurses studied reported that the people with BPD made them feel angry and 44% of them reported not knowing how to care for people with BPD.

An international research study conducted in Dublin, Ireland, by James and Cowman (2007) used questionnaires, consisting of multiple choice questions and Likert scales to study the attitudes of nurses in an adult inpatient unit. Nurses in the inpatient unit reported to have more contact with BPD patients compared with nurses in the community service. Eighty-one per cent of the nurses believed that the services these clients received were inadequate and 80 % of nurses viewed BPD clients as most difficult. The study concluded that the factors that contributed to the inadequate care of these clients were due to the lack of services and in particular specialist services.

It is evident that there is a substantial body of literature reporting that attitudes of clinicians (most often hospital-based nurses and psychiatrists) who work with this clinical population are most often negative. However, there have been minimal studies that have sought to investigate the attitudes of CCTs and the attitudes of the different disciplines that make up a CCT service.

1.4.4 Research on CCT Clinicians

In the last few years, researchers have begun to focus their efforts on highlighting the attitudes of public mental health clinicians who work in multidisciplinary CCTs. One of the main reasons has been that these clinicians have a tendency to burn out. But also as the challenges of working with BPD patients has been acknowledged more widely the focus of attention has been on the professionals who work with them (Nehls, 2000).

BPD patients have been identified to be major users of mental health services and have become challenging for CCT clinicians (Treolar & Lewis, 2008). The multidimensional problems of these patients have become more apparent and thus the literature on these patients and the clinicians who work on CCT services has gradually become more evident.

Significantly more international studies have concentrated their efforts on researching the attitudes of clinicians to patients with a diagnosis of BPD. A study in the US (Pfohl et al. 1999, cited in Krawitz, 2004) demonstrated that many clinicians found it difficult to find empathy for or optimism towards those patients who had a diagnosis of BPD. One of the reasons that has been suggested in the literature is that clinicians start to lose their capacity for effective interventions through emotional exhaustion (Maslach & Schaufeli, 1992).

Subsequently others have identified a link between internal and stable causal attributions of negative behaviour and have suggested that this can increase one's criticism of that particular behaviour (Greene,1998), thus highlighting a relationship between causal attributions, negative attitudes and the perpetuation of negative symptoms. This relationship may have relevance for attitudes of clinicians as well as family members.

According to Zanarini (2001), many clinicians use the terms "difficult" and "borderline" synonymously. Due to the life and death struggles these patients live with and the powerful transference and countertransference interactions, clinicians are said to be reluctant to engage with these patients. It has been suggested that the label of BPD is the most abused and least understood diagnosis, which often causes mental health workers to view BPD patients as enemies rather than clients (Kottler,1994).

Similarly clinicians' attributions about the causes of abnormal behaviour are believed to be an important determinant of their subsequent helping behaviour towards the client. A study conducted by Brickman, Rabinowitz, Karuza, Coates, Cohen and Kidder (1982) and Royce and Muehlke (1991) found that clinicians' behaviour towards a client can be a result of their understanding of how that behaviour is formed. Studies have indicated that counsellors are vulnerable to attribution bias, leading them to infer that clients' problems are based on dispositional rather than situational factors (Hattan, 2001).

According to one empirical study by Barrowclough, Haddock, Lowens, Connor, Pidlidwyj and Tracey (2001), a correlation between mental health workers' emotional reactions to patients and their causal attributions for behaviour existed. Their results indicated that staff tended to feel less positively inclined towards patients whose behaviour they considered to be self-controllable. This study found that patients seemed to be sensitive to staff's feelings for them: patient ratings of perceived feelings and thoughts

from staff were significantly correlated with staff-expressed feelings. Staff tended to view the behaviours of patients they felt less positively disposed towards as more controllable, and there was an association between less benevolent explanations of behaviour and a more critical attitude. The more negatively perceived patient group was found to be more likely to have behavioural disturbances.

Barrowclough et al (2001) concluded that the attitude of staff was very much related to their sympathy for the patient. Hence they proposed that by addressing staff attitudes one could try in essence to alter or change staff sympathy towards those patients diagnosed with BPD.

A phenomenological study was conducted by an international researcher (Nehls, 2000) whereby she assessed video recordings and data of 17 case managers addressing their work experience and attitudes to patients with the diagnosis of BPD. All the case managers had a minimum of six months' work experience with a patient diagnosed with BPD. Some of the case managers worked in rehabilitation, crisis assessment services and others in units that offered counselling. All 17 case managers were interviewed privately about their experience in working with BPD. The questions were about being a case manager and each participant was asked to respond to the following statement: "Tell me about a situation that you have experienced as a case manager for a client with a BPD – one that really stands out in your mind".

The case managers were recorded to have used terms such as "chronically suicidal", "manipulative" or "pushing limits". One cannot construe from these terms alone that these case managers reflected negative attitudes towards these patients but one may be able to hypothesise that the case managers portrayed their very intense relationships with their BPD patients choosing to reflect and highlight the difficulties they face when working with this group of patients.

Nehls' (2000) research findings indicated that these case managers had issues around establishing and maintaining a relationship with a person whose diagnosis was BPD and having to find a balance between relinquishing and retaining power and control. Some of the common terms case managers expressed about these patients were "gamey", "pushing limits" and "manipulative". The researcher concluded that regardless of the specific type of service delivered to patients with BPD, clinicians had the same concerns: self-harm and setting boundaries.

Results from Nehls' study highlighted that case managers were often deliberating about how to be concerned about their patients' intentions of self-harm. Case managers also reported to be concerned about the legal, clinical and interpersonal implications of decisions about suicide risk.

After a thorough literature search the author located only a few studies other than those with nurses that sought evidence for the claims that mental health clinicians had negative attitudes to patients with a BPD. The majority of the literature examining BPD patients has been conducted internationally. One of the few, earlier Australian studies was by Cleary, Siegfried and Walter (2002). They conducted a study to assess the attitudes of clinicians working within public mental health services in New South Wales. Their aim was obtaining baseline data to provide direction for developing planned education and determining staff willingness to participate in such training. A total of 229 staff completed the questionnaires. Eighty per cent of respondents reported feeling the work they did with BPD was moderately to very difficult, 84% of the respondents reported finding that dealing with BPD was more difficult than dealing with other client groups. But 95% of respondents indicated their willingness to gain further education and training.

Interestingly, a change of attitudes amongst CCT clinicians came to be identified. One of the earliest Australian studies that reported this change of attitude was in Melbourne, by Krawitz (2004). This study assessed the effects of a two-day educational workshop that aimed at informing case managers on current concepts, diagnosis, etiology, prognosis and treatment of BPD. The aim of the study was to evaluate any change in the attitudes of the clinicians. Krawitz's study measured clinicians' attitudes, pre and post a two-day educational workshop, to their work with people with BPD. Changes in attitudes (optimism, enthusiasm, confidence and willingness to work with people with BPD) and self-perceptions of knowledge and skills amongst staff working with BPD patients were assessed for 418 participants from public mental health.

What is interesting in terms of this present study is that the clinicians were asked to rate themselves on a scale of 1=very poor to 5=very good their "willingness", "optimism", "enthusiasm", "confidence", "clinical skills" and "theoretical knowledge" in relation to working with BPD pre-workshop. Clinicians' pre-workshop attitudes mean score was about 3 on the scale. The clinicians were administered the same questionnaire post-workshop and again after a six-month follow-up.

A change toward more positive attitudes occurred after the workshop and remained stable after a six-month follow-up. The study found that there was no relationship between the attitude of the clinician and their age, work setting or the discipline/professional group he or she came from.

Another Australian study, conducted in New South Wales by Hazelton, Rossiter and Milner (2006), also examined attitude change. Ninety-four mental health clinicians were given a two-day introductory workshop on dialectical behaviour therapy, a therapeutic treatment model for BPD patients devised by Marsha Linehan (1993). Pre and post-workshop comparisons

were conducted. Their results concluded that participants' attitudes to BPD patients shifted from pessimistic to a more optimistic understanding and general attitude.

Australian researchers Treloar and Lewis (2008) explored the attitudes of both mental health and emergency clinicians' attitudes towards patients with BPD who self-harmed. BPD patients' impulsivity, issues of abandonment, and feelings of emptiness may lead to self-harming behaviours that are not understood by clinicians (Haswell & Graham,1996). Treloar and Lewis's results indicated that there were significant differences between the attitudes of emergency and mental health staff towards BPD patients. The strongest predictor of attitudes was whether the clinician worked in mental health or emergency services. Another significant factor that contributed to clinicians' attitudes was whether they had received specific training in personality disorders. A randomised controlled trial study (RCT) on the attitudes of clinicians towards deliberate self-harm in BPD patients (Treloar & Lewis 2008) found that education and training ultimately improved the attitude ratings of clinicians across disciplines.

The literature reviewed has described the difficulties experienced when working with a client with a diagnosis of BPD. Furthermore, there is limited empirical research that describes the level of stress that may develop as a result of working with these clients compared to other clients with other diagnoses. In effect Australian researchers, Younis and King (2007), looked at how case management of BPD patients may contribute to burnout in clinicians. Clinicians seeing BPD patients usually are aware of those labels that come with these clients. They are often pejorative and intense with negative character (Stone, 1993). But interestingly it appears that health staff who have been researched continue to report highly negative dismissing and stigmatising accounts towards persons with personality disorder even today (Deans & Meocevic, 2006; Hickie, 2006).

In summation the researcher of this current study set out to conduct an empirical investigation that could establish what the attitudes of the various professions working in CCT services: psychiatrists, nurses, psychologists, social workers and occupational therapists are. As discussed above more research on the attitudes of clinicians needs to be conducted to understand what the attitudes of clinicians are, and what factors contribute to their attitudes towards BPD patients.

1.5 Effects of Working with BPD Patients

There has been minimal research that addresses the work case managers do with BPD patients (Nehls, 2000) and, in particular, about the strategies that may prevent clinician's attitudes from declining towards patients with BPD.

Most of the literature in this area has reiterated that BPD patients are a real challenge for clinicians working in mental health services. To understand more clearly why BPD patients have such an effect on clinicians it would be worthwhile to refer to what earlier writers have said about the BPD.

Margaret Mahler (1972) looked at the attachment behaviours of toddlers and their mothers. She looked at the separation process and described a normal period of separation from the mother and a process whereby the child becomes to be an individual. A process she called separation and individuation. She described a third phase which she termed rapprochement. This was described as a process whereby the child alternates between closeness and separation from the mother. This in Mahlers theory is how a child can have a secure sense of self and be confident with his mother. According to Mahler the problem that BPD have is that this process in the rapprochement phase was not achieved successfully and therefore the child

did not develop independence and was not able to reconnect successfully with his mother and separate again (Summers & Barber 2010).

Earlier psychodynamic writers described the challenging behaviours of BPD patients as stemming from their childhoods and from their inability to form strong attachments. Kernberg (1967) explained that some BPD patients rely on more primitive forms of defence mechanisms such as splitting and projective identification to cope with their emotions and anxiety. Projective identification is when the individual projects a drive and usually an aggressive drive, onto another person. But not only does he/she fear an attack but at the same time has some feelings of empathy for that person. According to Melanie Klein, (1930) projective identification and splitting shape the ego of the infant. This she explained was due to their need to escape from the anxiety they experienced caused by the innate conflict between the life and death instinct. Klein (1930) described the infant as splitting off these feelings onto the mother who is seen as either good or bad.

Later on research in this area reported on the personality characteristics of the BPD patient and the difficulties experienced by staff working with them (Gallop, 1985). He stated that the primitive defence mechanisms such as "splitting", utilized by this group of patients was one of the precipitators of the countertransference experienced by hospital staff working with this group of patients more than patients with other clinical disorders such as schizophrenia (Gallop et al., 1989). In psychodynamic terms "splitting" is recognized as a defence mechanism. It is an attempt to manage intense negative and positive emotions by organising and perceiving one's experience as either all good or all bad (Kernberg, 1984).

A study by Pontenza and Carty (2001) suggested that borderline patients engage in treatment in a way that does cause health care providers to respond reactively and regressively. More recent researchers McIntyre and

Schwartz (1998) proposed that therapists do find it difficult working with BPD patients and in order to cope some therapists may be either overly sympathetic with borderline patients or overly harsh. Other researchers have considered how clinicians feel about their skill base (Frances, 1993) and have found that clinicians often feel deskilled and bemused by borderline patients.

Most recent studies highlight how the behaviour of a BPD patient influences the clinicians' working with them interpersonally (Treloar & Lewis 2007). Most importantly all the studies to date all support the view that the BPD patients are a challenge for clinicians working with them, much more then other clinical disorders. But what is important to know is that BPD according to earlier theorists is that BPD patients develop defence mechanisms much more than other patients and rely on these defence mechanisms to make sense of their world by separating good and bad and to protect themselves from aggressive impulses. Kernberg (1967).

1.5.1 The Therapist

The relationship that commences between a therapist and the patient in the context of the therapy has been of topic of theory and research for many years. The relationship that evolves can become a complex and intimate relationship (Lemma-Wright, 1995). Literature in this area proposes that BPD patients come from families where parenting has been problematic (Frank & Hoffman, 1986; Paris and Frank, 1989) and more importantly that these patients have had problems with their earlier attachments. Most prominently this line of thought has its origins from the works of John Bowlby (1973) and from his observations of young children and their mothers. Bowlby studied the process of attachment and separation and concluded that our earlier attachments with our caregivers significantly influence our relationships with others, and that forming secure attachments early on is important (Sroufe & Fleeson, 1998).

According to Fonagy and Bateman (2007), BPD is a result of bad or failed attachments in childhood (Paris, 2008). Fonagy and Batemen (2007) proposed a Mentalization-based therapy. This model of therapy is based on the premise that BPD individuals can mentalize but they abandon their ability to do so at times of high emotional arousal. More recently Fonagy & Batemen (2007) described the therapeutic relationship as one where the BPD patient has an opportunity to play out their own attachment experiences.

The therapeutic relationship commences and perhaps for the BPD patient it is a difficult one at the onset as he or she, according to earlier psychodynamic writers, has had problems in forming relationships. According to Linehan (1993) the strength of the therapeutic relationship is what keeps the patient in therapy which can be successful if the therapist can be compassionate, sensitive and non-judgemental. A patient's feelings towards the therapist are termed "transference" a term that was first used by Freud (1927). He introduced this term very early in his writings and viewed transference as a "resistance" to recovery of the past (Moore & Fine, 1995). Transference feelings can be positive or negative. According to Melanie Klein or Kleinian psychoanalysis transference is an expression of unconscious phantasy, which becomes active in the analysis. The transference seen in analysis is believed be moulded by the individual's earlier experiences, that is by his past (Hinshelwood, 1991).

Borderline personality disorder has been referred to as one of the diagnostic categories which has provoked the strongest emotional response amongst mental health workers (Barret, 2000; Linehan, 1993; McIntyre & Schwartz, 1998; Vuksic-Mihaljevic, Mandic, Barkic & Mrdjenovic, 1998). One may need to consider how a clinician's attitude may be partially based on his or her own countertransference reactions. The issue here is whether the attitudes of clinicians are a result of their own personal experiences with their BPD

patient, or are developed prior to meeting their BPD patient due to their interactions with their peers. It may be that clinicians come with formed attitudes before starting their work with their BPD patient.

"Countertransference" refers to all the feelings and thoughts coming from the therapist to the patient. Freud (1912) first wrote about countertransference. There is a spectrum of countertransference reactions from the internal such as feelings of discomfort to the more obvious such as not listening to the more extreme such as ending the session prematurely. Ultimately both individuals in the therapy setting are believed to be reacting to each other. Very early analysts held the view that countertransference was to be avoided as it interfered with the therapy. But it was soon felt that this was impossible as they were affected by their patients, and more importantly they could utilize their own countertransference feelings to understand their patients (Hinshelwood, 1991).

Furthermore, it may be that clinicians come with formed beliefs and perceptions about BPD patients that, as a result, impact on their relationship and ultimately their attitude (Flier, 2005). But most evidently the literature review highlights that the attitude of clinicians is an important area of research, as BPD patients have multidimensional problems and are a challenge both mentally and emotionally to those clinicians and therapists working with them.

A study by McIntyre and Schwartz (1998) examined psychotherapists' countertransference reactions towards clients diagnosed with either major depression or BPD. Their results indicated that clients with BPD were perceived as significantly more dominant and hostile, whereas the clients with major depression were considered significantly more submissive, friendly and important. Their results suggest that countertransference reactions are evoked towards clients but more importantly their study highlights how a

patient's clinical diagnosis has a bearing on the therapist's countertransference reactions.

1.6 Burnout

Research on clinicians' burnout was initially reported in the 1970s by Freudenberger (1974) and Maslach (1976). While Freudenberger, a psychiatrist, was working in a clinic he noticed that many of his volunteers began to experience a gradual emotional depletion and a loss of motivation.

Around the same time Christina Maslach, a social psychologist, was interested in the ways people coped with emotional arousal on the job. She was interested in highlighting the cognitive strategies such as "detached concern" and "dehumanisation in self defence". While talking to some attorneys about professional identities and job behaviour she learnt that poverty lawyers termed this particular phenomenon as "burnout". So originally "burnout" was a colloquial term used to describe workers' exhaustion and declining ability to describe the effects of mental state and exhaustion.

Today the definition of the term "burnout" is notably taken from Maslach and Jackson (1986). Burnout is a syndrome of emotional exhaustion, depersonalisation and reduced personal accomplishment that is said to occur amongst people who do "people work" (Maslach et al., 1953). According to Maslach and Jackson (1981, 1986), burnout was characterised as a three-dimensional syndrome of emotional exhaustion, depersonalisation and reduced personal accomplishment. They believed that the burnout syndrome was constrained to professionals who work with care/service recipients. Golembiewski, Munzenrider and Carter (1986) proposed a phase model, which workers pass through including sequences of depersonalisation, which leads to a decrease in personal accomplishment and then emotional

exhaustion, which in this model is the final stage of burnout (Taris, Le Blanc, Schaufeli & Schreurs, 2005).

There is limited empirical research that describes the stress that may develop as a result of working with BPD clients compared to other clients with other diagnoses. According to research in this area clinicians working as case managers are vulnerable to burnout (Onyett, Pillinger & Muijen, 1977). The literature reviewed has also described the difficulties experienced when working with a client with a diagnosis of BPD. But more importantly it appears that the pressures of case management of BPD patients, who are widely acknowledged as challenging clients to work with, may contribute to burnout (Younis & King, 2007).

1.7 Factors That May Influence Professional Attitudes

While it may be important to acknowledge the difficulties and challenges of working with BPD patients, it may also be pertinent to consider the characteristics of clinicians working with BPD patients. This may also have a bearing on how the attitude of the clinician is formed: for example, the number of years of work experience, qualifications and the discipline in which the clinician was originally trained. Very few studies have examined the influence of the demographic factors of clinicians in relation to their work in mental health services. As early as 1971 Carbajzl de Carozzo found that attitudes towards mentally ill patients varied according to occupational level. She compared staff at a psychiatric clinic with staff at a neurological clinic. Victor Diaz (1998) investigated three demographic variables of clinicians' age, education and years of work experience and these were found to be related to their attitudes towards mentally ill patients. Other Australian researchers (Bowers & Allan, 2006; Cleary, Siegfried & Walter, 2002) who have reported the attitudes of nurses and psychiatrists were not found to be representative of all those other disciplines working in mental health CCT services.

Baik, Bowers, Oakley and Susman (2008) found that clinicians' level of work experience was important to the care of depressed patients. These researchers suggested that a greater number of years' work experience actually enhances the clinician's understanding and approach to patients. However, they did not investigate was whether time in the workplace led to any change in interest in working with BPD patients or whether clinicians experienced burnout with BPD patients over time. Another study (Rosenberg, 2006) hypothesised that years of experience should curtail the symptoms of burnout and the onset of depersonalisation. However, it was found that depersonalisation varied with level of education and gender varied rather than with years of experience. For example, females reported lower levels of depersonalisation than males, and masters students were more likely to experience burnout than doctoral students (Rosenberg, 2006).

On the other hand, Marriage and Marriage (2005) found that clinicians with a discipline training background in psychiatry, psychology and social work were likely to experience a form of "vicarious traumatisation" (permanent changes in the clinician's frames of reference, e.g., identity, tolerance, beliefs and attitudes) after 10 to 25 years of work experience. These researchers found that the most vulnerable clinicians had extensive experience, were practising full-time, and were aged between 40 and 60 years (Marriage & Marriage, 2005). There appears again to be mixed findings in the literature regarding the information available on the experience of clinicians and the factors associated with their capacity to work in mental health services.

A further question was whether clinicians had received specialist education in working with patients with complex conditions. If it could be shown that professional development may alleviate the symptoms of burnout over time, then it may be recommended for clinicians working with BPD patients. However Rosenberg (2006) did not find differences between those clinicians

who attended and those who did not attend professional education consultation. Perhaps a mediating factor would be the attitude of the clinician because if it is positive, then it may offset the effects of burnout during the course of a clinician's career. If the attitude of the clinician is negative, then demographic factors may have also determined that outcome.

1.8 Rationale for the Current Study

The gap in literature around this topic, especially the limited research in Australia, provided the impetus for this study. The overall impression from reviewing the literature is that mental health clinicians have negative attitudes towards patients with a diagnosis of BPD. The factors associated with these negative attitudes are poorly understood. An understanding of the role of attitudes in professionals treating people with BPD is important as CCT clinicians have a major role in the care of BPD patients.

The mental health clinician in a CCT has a potentially challenging task working with a patient frequently acknowledged in the literature as "difficult" (Zanarini & Silk, 2001) while other service-related factors may impinge on their role. Earlier studies had sought to verify those attitudes of mental health nurses and psychiatrists, which were recorded as negative. To substantiate what the current attitude of mental health clinicians is the author of this study has concentrated on those clinicians who most often work with BPD patients in public mental health services.

Clarke, Hafner and Holme (1995) sought to address amongst other things the effectiveness of treatment of BPD in psychiatric hospital populations. They concluded from their findings that treatment for BPD patients was haphazard and ineffective. In both past and current literature, authors have noted that clinicians, in particular nurses, have identified BPD patients as the "difficult patient" (Gallop et al., 1989). Gunderson (1984; cited in Linehan, 1993, p. 7)

identified the way in which borderline patients engendered intense anger and helplessness on the part of the clinicians. He also acknowledged how borderline patients tended to deteriorate behaviourally within supportive, inpatient treatment programs.

As discussed above there have been many studies on the attitudes of psychiatric nurses working in an inpatient context and some studies have also looked at the attitudes of psychiatrists. There have been fewer studies that have examined the attitudes of mental health continuing care clinicians and their attitudes towards the patients with a diagnosis of BPD. Responsibility for the care of BPD patients changed with the progression from hospitals with inpatient wards to outpatient clinics, that is, CCT clinics. Case managers commenced to see patients with varying mental illnesses from schizophrenia, depression, and personality disorders such as BPD.

The work of case managers and the efficacy of their work with BPD patients have been highlighted as a growing area of concern (Taris et al., 2005). One of the factors considered very important to the clinicians was their level of emotional exhaustion and burnout.

According to Collings et al. (1996) in a study they conducted in the UK with social workers, stress was very much related to pressures in planning and reaching work targets, having no answer to a client's problem, age (being older), marital status, grade level of the social worker, having high workloads, and being dissatisfied with supervision arrangements. It could be argued then that the reduced efficacy of treatment of BPD patients could be a result of already existing emotional exhaustion. Furthermore, the impact of high caseloads, minimal resources, the lack of specific education and training, and supervision to work with BPD patients may increase clinicians' level of burnout, which in turn may result in negative attitudes.

The challenges of working with BPD patients revolve particularly in working with highly emotional individuals who have difficulties in regulating their emotions. The current study will focus on the aspects of clinician response/burnout that relate most closely to these particular challenges, namely emotional exhaustion and depersonalisation.

The attitude of clinicians especially in earlier studies and studies in inpatient units (Bowers & Allan, 2006; Fraser & Gallop 1993; Gallop, Lancee & Garfinkel 1989) indicated that clinicians held explicit negative attitudes. The approach taken by this current study to investigate the explicit attitudes of mental health clinicians towards BPD was influenced by the findings of earlier studies. It was considered important to determine whether such attitudes were still common and found in community care settings, and if so, to investigate some of the factors that may be associated with these explicit attitudes.

1.9 Summary

1.9.1 Overview of Literature

Since the de-institutionalisation of mental health patients in the 1980s there has been a demand placed on mental health services to provide outpatient care. BPD patients have a history of being seen as "difficult and borderline" synonymously (Zanarini, 2001). There has been a general consensus amongst researchers that mental health clinicians have negative attitudes towards those patients with a diagnosis of BPD. Unfortunately, there is limited research found to substantiate this suggestion. Most often, the research that has been available has been research on psychiatric nurses and psychiatrists (Lewis & Appleby, 1988) in inpatient units. An important study (Pfohl et al. 1999, cited in Krawitz, 2004) evaluated the attitudes of mental health clinicians to be negative and less empathetic towards those with a diagnosis of BPD. However, there is very limited research on mental health

professionals who work in CCTs, that is, outpatient community services (Nehls, 2000).

Mental health clinicians have become a focus of research due to the type of work they conduct. An area that has been examined extensively has been the effects of burnout (Maslach, 1998) on clinicians who work in human services but attitudes have not been investigated in conjunction with mental health clinician burnout.

By investigating the relationship between burnout and attitudes towards working with BPD patients, and if the factors that affect attitudes are better understood, efficacy in treatment could be enhanced. Krawitz's (2004) study indicated that after a two-day workshop on BPD clinicians, attitudes had shifted and were more positive. This points to training or consultation for clinicians as one relevant factor.

1.10 Research Questions

1. What are the attitudes of public mental health clinicians to patients with a diagnosis of borderline personality disorder?

2. Does the clinician's discipline impact on his or her attitude to the diagnosis?

3. Does the number of years experience in mental health service impact on the attitude of the clinician?

4. What types of interventions do case manager's use in working with this clinical group?

5. Does the diagnosis of the client impact on how the clinician works with them?

6. Is there an interest in working with this clinical group?

1.11 Aims of the Study

The aims of this study are firstly to provide a profile of the attitudes of those clinicians working with BPD. The profile will cover demographics, discipline background, level of interest in working with BPD, preferred treatment type, professional development and consultation, levels of emotional exhaustion, depersonalisation and personal accomplishment.

The aims are further to examine the relationships between clinician factors, that is, discipline or profession, years of experience, burnout, attendance at professional consultation, and clinicians' attitudes to BPD patients.

1.12 Hypotheses

The following predictions were made:

H1: A majority of mental health clinicians will have negative attitudes to patients with a diagnosis of BPD.

H2: The attitude of the clinician will vary according to his or her discipline/profession.

H3: A majority of clinicians working with this group will have a focus on containment rather than therapy.

H4: (a): Greater number of years of work in mental health services will be associated with less interest in working with patients with BPD.

H4: (b): Greater number of years of work in mental health services will be associated with more negative attitudes and perceptions concerning BPD patients.

H5: Higher levels of emotional exhaustion and depersonalisation will predict more negative attitudes and perceptions concerning BPD patients.

H6: Mental health clinicians who have received specialist consultation will have more positive attitudes to patients with BPD than those who have not received specialist consultation.

Chapter 2

Method

2.1 Participants

One hundred and twenty questionnaires were distributed to the staff of six Adult mental health continuing care team (CCT) services. Of these, 91 (72.8%) were completed and returned. Thus the final sample consisted of 91 participants. The participants were practising clinicians from various disciplines: 22 nurses (24%), 16 psychologists (18%), 17 social workers (19%), 12 consultant psychiatrists (13%), 11 psychiatric registrars (12%), eight occupational therapists (9%), one trainee psychologist (1%), and finally, four trainee mental health workers (4%). All participants had some contact with patients diagnosed with Borderline Personality Disorder (BPD).

An attempt was made to locate workforce data that would enable a comparison of the study sample and the mental health workforce for the State or region. Unfortunately workforce data was not available for the CCT services from which participants were recruited. In September 2009, the Victorian Government released a report "Shaping the future: The Victorian mental health workforce strategy. Final report". This document provided some data on the number of effective full time (EFT) staff employed in the clinical mental health system in Victoria but noted 'substantial variations in the proportions of medical, nursing and allied health staff between service types and settings' (p.14). Unfortunately the report did not provide any breakdown of inpatient staff compared to community-based staff. Furthermore an EFT was provided for "diagnostic and allied health professionals" as a group but not for psychologists as a specific profession. It is clear however that nurses, psychiatrists, psychologists and social workers are the main clinical professions working within the mental health system, just as they are the main

professions sampled in the current study. Beyond that however, given the way workforce data is presented in the report, it was not possible to use it as a basis for a more detailed examination of the representative nature of the current sample.

2.2 Measures

2.2.1 Borderline Personality Disorder: The Attitudes of Mental Health Clinicians:

Development of the Questionnaire

An exhaustive search for an existing questionnaire that measured mental health clinicians' attitudes to borderline personality disorder was conducted and was unsuccessful. The researcher decided to develop a questionnaire that measured clinicians' attitudes to BPD: Clinicians Attitudes to Borderline Personality Questionnaire (BPDAMHC) (see Appendix D). Several question formats and structural designs were considered.

The researcher's main aim was to design a measure that would facilitate optimal exposure of participants' underlying reasoning behind their perception and attitudes to this clinical group of patients. This would provide the researchers with the best possible account for their developed attitudes.

The researcher incorporated some ideas about questions and structure of the statements from another Australian measure developed by Leonard, Brann and Tiller (2005). In December 2006, Dr Leonard granted verbal permission for his questionnaire or parts of it to be used on the condition that it was acknowledged. Leonard and colleagues' questionnaire provided a structural model for the current measure. However, Leonard et al.'s (2005) measure was developed only for psychiatrists as participants to the exclusion of other practising clinicians. His study was also targeting responses about patients with dissociative disorders. Most of the content of the present measure was

designed by the author based on current practices of multi-disciplinary mental health services in Melbourne.

In order to help guide the content of questions on the Borderline Personality Disorder: The Attitudes of Mental Health Clinicians Questionnaire (BPDAMHC), the researcher conducted unstructured preliminary interviews with three senior clinicians of CCT teams to discover some of the common attitudes and thoughts that were prevalent among case managers in adult mental health CCT. For instance, some of these thoughts and attitudes were incorporated as statements in the questionnaire designed. For example: Do BPD patients: "Create problems among staff?" and "Are they not mentally ill, but just manipulating the system?". The three clinicians who were initially interviewed did not participate in the final study.

Other sources for the content of the questionnaire included constructs developed in previous research on attitudes of clinicians toward validity of patient diagnosis (Leonard et al., 2005), attitudinal change in clinicians after professional development (Krawitz, 2004) and clinicians' attitudes to personality disorders (Bowers & Allan, 2006). For example, the above-mentioned item, "[BPD patients] are not mentally ill, but just manipulating the system" was modelled on Bowers and Allan's questionnaire (2006, p.287) item: "I feel manipulated or used by PD (Personality Disorder) patients".

The process of developing the questionnaire for this current study took about six months.

2.2.2 The Questionnaire Measure

The researcher of this study developed a 41-item questionnaire for CCT staff of adult mental health services. The questionnaire utilised three separate sets of Likert items on a one to four-point scale, multiple-choice answers and short-

answer questions, which aimed to draw general statement responses. The items are based on the experience of clinicians with BPD patients, including their perceptions, their likes and dislikes. The emphasis of this study is to highlight what impact a clinician's working environment, caseloads, training or lack of training, discipline, age, gender and years of practice has on their attitude to BPD. The author's intention was to provide a profile of clinicians' attitudes to this clinical group of patients in the context of their workplace.

The survey required clinicians to respond to items about their attitudes to patients with a diagnosis of BPD, as well as providing their demographic details, which included their discipline and general work experience in mental health. Each participant was asked to rate their response to statements about BPD on a Likert rating scale of one to four. The statements were to address their level of understanding, attitudes toward and perceptions of BPD, willingness to work with this clinical group, and factors that may impede such work. The questionnaire aimed to assess the participants' level of experience, willingness and confidence in working with this client group, and the treatments they utilised.

The current questionnaire contained four sections (see Appendix C).

1. Experience Working with Borderline Personality Disorder: 9 items
2. Attitudes and Perceptions: 12 items
3. Work Environment: 16 items
4. Clinician's Data (demographics): 4 items

These are discussed below:

Section One: Experience working with Borderline Personality Disorder

These questions aimed to elicit responses related to participants' working experience with patients diagnosed with BPD. For example, item 1: "How many patients have you seen with a diagnosis of BPD during your

professional career?" Participants were asked to indicate their response by selecting from four categories: 0, 1–5, 6–10 and greater than 10.

The second question was in two parts, "a" and "b", and it aimed to elicit responses about the types of treatment the clinician utilised when they saw a BPD patient. The participants had a choice of nine items:

- Cognitive behaviour therapy
- Psychodynamic therapy
- Medication
- Eclectic therapeutic approach
- Case management
- Containment
- Dialectical behaviour therapy
- Other*
- Have not worked with BPD patients

*This item made provisions for participants to state their own treatment of choice that they most commonly used.

Question three of this section aimed to encapsulate clinicians' general thoughts and views when working with BPD patients. They were required to indicate on a four-point Likert scale whether they strongly agreed to strongly disagreed with four statements. The researcher's rationale for using an even number of response options was to avoid middle answers indicating uncertainty. Previous research has found that using odd numbers of response options leads to indecisive responses that are non-committal (don't know) and are likely to lead to results that are possibly too close to the mean. Forcing participants to choose has been found to be a more effective method of eliciting a clearer set of results and also helps avoid participant resistance in responding to statements (Goldberg, 1978). Uncertain responses would

not have been meaningful given that the participants were asked for their opinion regarding their interest.

For example, one statement was "I have an interest in working with this client group". If the participant had an interest in working with BPD patients, then they would respond "agree". If they felt they enjoyed working with this clinical group of patients a lot more strongly, they would indicate this by responding "strongly agree". If they felt that they disagreed with the statement, then they would respond with "disagree" or "strongly disagree".

Item four of this section requested a Yes/No response to a question about whether there was a profession the participant felt was better suited to working with BPD patients. If they felt there was a profession better suited to working with BPD patients then they would indicate this by circling the response "Yes". This item had a second part for those who had responded with "Yes". If a "Yes" was indicated they were asked to specify which profession they felt was better suited to working with BPD.

Section Two: Attitudes and Perceptions.

In this section questions aimed to get participants to disclose their attitudes and perceptions to 12 items that were in a four-point Likert scale ranging from (1) strongly disagree to (4) strongly agree. Half the questions were phrased as negative and half as positive attitudes. For example, BPD patients: "Will not get better and are just using scarce resources" and "Are likely to benefit from therapy".

These 12 statements were about common thoughts and feelings related to patients diagnosed with BPD . If the respondent agreed with the statement on BPD patients: 1. "Will not get better and are just using scarce resources", they would then indicate this by marking the number 3. But if they strongly agreed with this statement then they would circle number 4.

Where appropriate items were reverse scored such that a higher score indicated a more positive attitude. Scores on the 12 items were added, with a minimum possible score of 12 and a maximum possible score of 48. This score is referred to as the total attitude and perceptions score or the total score on the Attitudes and Perceptions Scale (APS-BPD). The researcher aimed to develop a scale that could be used as a measure of overall positive/negative attitudes. Reliability analysis is reported in the Results chapter.

Section Three: Work Environment

The first item required participants to indicate an understanding of the prevalence of people diagnosed with BPD in their community mental health service. They had a choice of four items ranging from very rare to very common and a last item if they did not know.

Question 2 of this topic requested participants respond to a question related to

their own caseload numbers. The respondents needed to indicate from a four-item selection from zero to more than 10 clients on their caseload. Question 3 required participants to indicate a "Yes" or "No" response to their thoughts about whether BPD patients were evenly distributed in their CCT.

Question 4 was a four-item Likert scale. Participants were required to respond to 9 statements about what discourages them from working with BPD clients, and their belief in the relevance of the statements listed. Two such statements were: Lack of supervision, and heavy caseload. Statements 4 and 5 queried participants about their caseload numbers.

Question 5 was a qualitative question that required participants to write down their response to what would encourage them to work with this client group.

Item 6 of this section required a "Yes/No" response about whether they received consultation from Spectrum, the Victorian specialist body in managing personality disorder patients. Part (b) of this question required participants to respond to a "Yes/No" item about whether they as clinicians had attended any group consultation or education sessions run by Spectrum staff. With all above items, provision was made for participants to indicate a response other than those provided to them.

Section Four: Clinicians' Data

The final page recorded participants' demographic information. All participants were asked to indicate their profession and gender. An item for their age was also provided with a selection of five items ranging from less than 21 years to more than 50 years. The last item required participants to indicate from a selection of five items the number of years they had worked in mental health, which ranged from less than 5 years, 5–10 years, 10–15 years and 15–20 years and then greater than 20 years. The survey questionnaire on attitudes

had not been tested prior to administration with the current sample for reliability and validity.

2.2.3 Burnout

Burnout was measured by Maslach Burnout Inventory (MBI) [Maslach & Jackson, 1986] (see Appendix E) was designed by authors Christina Maslach and Susan E. Jackson. It is a widely used instrument, which consists of a 22-item scale; items are responded to on a six-point frequency scale (0 = never to 6 = every day). It is a self-administered questionnaire and takes participants approximately 10–15 minutes to complete.

The most persuasive and competent author of burnout has been the American social psychologist Christina Maslach and colleagues (1996) who defined burnout as a syndrome of emotional exhaustion, depersonalisation/cynicism and reduced personal accomplishment/efficacy. Burnout is a process that begins with excessive and prolonged levels of job tension. This stress produces strain in the worker. The process is completed when the workers defensively cope with the job stress by psychologically detaching themselves from the job and becoming apathetic, cynical, and rigid. (Cherniss, 1980)

The original MBI measure (Maslach & Jackson, 1981) was developed for usage in the social service sector to examine burnout in many different occupational groups, including teachers (Gold, 1984), business employees (Golembiewski, Munzenrider, & Carter, 1983) and legal aid employees (Jackson et al., 1985). However, later alternate and more population-specific versions were designed such as the MBI-General Survey (Maslach, Jackson, & Leiter, 1996) and the MBI-Human Services Survey (Maslach et al., 1996), the latter being used in the current study. This version has three subscales, which include Emotional Exhaustion, Depersonalisation and Personal Achievement.

Christina Maslach explained emotional exhaustion as feelings of being overextended and exhausted by the emotional demands of one's work (Perseius, Kaver, Ekdahl, Asberg, & Samuelsson, 2007). Depersonalisation/cynicism is characterised by a detached and cynical approach to other people in the context of work. Personal accomplishment/efficacy is the report of self-evaluated feelings regarding the extent to which one believes one is effective in one's work (Maslach & Jackson, 1981; Maslach et al., 1996; Maslach & Leiter, 1997).

Perseius and colleagues (2007) had used the MBI-GS, which has three similar subscales to the MBI-HSS, and satisfactory reliability was obtained with Cronbach's alpha values of .89 (exhaustion), .68 (cynicism) and .77 (personal efficacy). The factorial validity of the MBI has been established in previous studies Shutte, Toppinen, & Kalimo, (2000) Perseius, Kaver, Ekdahl, Asberg, & Samuelsson, (2007) on Swedish samples of professional clinicians.

2.3 Procedure

2.3.1 Ethics Approval

This present research was considered by two ethics committees. Victoria University Research and Ethics Committee granted their approval initially (see Appendix B). Then Melbourne Health Ethics Committee and Research Advisory Committee for each participating Mental Health Continuing Care Team approved this study (see Appendix A).

2.3.2 Data Collection

All 91 participants in the sample were recruited between May 2007 and November 2007 from six adult mental health service CCT's serving the west

and north-west areas of metropolitan Melbourne: Broadmeadows CCT, Moreland CCT, Darebin Mental Health Service CCT, Whittlesea CCT, Sunshine Mental Health CCT and Waratah Mental Health CCT.

All six CCT site managers were initially contacted by telephone. The managers were informed of the project's ethical approval by the Melbourne Board of Ethics (see Appendix A) and their services' Research Advisory Committee. The researcher then arranged with each site manager for a suitable day to attend the respective services to present a brief presentation on the project and to distribute the surveys. The presentation date for all six CCT sites was a day on which the CCT service had their business meeting (and the day of the week changed according to the service). Because the current research required clinicians from various training backgrounds, the reason for choosing a CCT's business meeting day was to have the highest number of clinicians from the multi-disciplinary team present.

The researcher attended the CCT service on the day and presented a brief presentation that covered the nature of the study, and explained why such a study was needed, for example, for exploratory reasons in order to understand what the various disciplines' attitudes were to BPD and to look at what impacted on these attitudes. The researcher also highlighted some of the reasoning behind the study, for example, the cost to services, the growing number of patients with this diagnosis, and acknowledgment of the difficulties experienced by clinicians working with this group of patients.

The researcher explained the format of the survey to the CCT staff. She informed them of the importance of completing the questionnaires on their own without consulting other staff members. CCT staff were given the opportunity to ask questions about the study, but the discussion about the researched area was restricted so as not to influence staff and their attitudes. The participants' information handout (see Appendix C), the measures used.

All participants were informed that the study was voluntary, and they would give implied consent by taking part in responding to the items and returning the completed survey. All participants were informed that their names were not requested. Confidentiality would be maintained and all possible identifiers of the participants would be avoided. Participants were informed on how to contact the researcher if they had any queries following their participation. At the conclusion of the presentation, the clinicians were welcome to ask questions.

Participants were asked to complete a questionnaire developed for the study and the established questionnaire, The Maslach Burnout Inventory (MBI, 2002) (see Appendix D). The clinicians data survey was completed at the end (see Appendix F).

The researcher discussed with all CCT managers about leaving an empty box near their site receptionist for collections. Participants completed the surveys at their service clinics and were requested to complete and return them to the collection box in the same week of receiving the questionnaire. The researcher requested a designated person from each CCT site to address queries about completed surveys. The researcher later made pickups. For some sites, the researcher visited on average three to five times to pick up completed surveys from the collection box. With some CCT teams, the researcher had to send emails and contact nominated staff to remind staff to complete their questionnaires. Completion of the survey was expected to take participants approximately 15 to 20 minutes.

In the survey package, questionnaires were presented in the following order:

- Borderline Personality Disorder Attitudes questionnaire (BPDAMHC)
- Maslach Burnout Inventory – Human Services
- Clinicians' Demographics survey

2.4 Data Analysis

The research design was cross-sectional including clinicians from six adult mental health services in Melbourne. The Statistical Package for the Social Sciences (SPSS version 14.0) for Windows was used for all data analysis. There were some analyses using descriptive statistics including means, standard deviations and frequencies. Correlations were used to analyse some relationships: for example, number of years' experience, burnout and attitudes of participants. T-tests or analyses of variance were used to look at differences between groups, for example, between clinical disciplines and between those who had consultations with Spectrum and those who did not.

Statistical Power Analyses: As indicated above no research up to the present has looked at the attitudes of CCT clinicians to the diagnosis of BPD. Furthermore, the findings of research studies that have investigated attitudes of different professionals or specialists groups have been inconsistent. But in order to obtain some framework for an appropriate sample size, other studies that have considered investigating attitudes have been sought. Such studies were those that looked at nursing attitudes (McAllister, Higson, McIntosh,, et al. 2001).

Two studies that examined the attitudes of emergency department (ED) nurses to patients who self-harm (Anderson, 1997), had a sample of 33 staff. Suokas and Lonnqvist (1989) conducted a similar study and had a sample size of 64. Another study by McLaughlin (1995) investigated nursing staff attitudes to patients who self-harmed and had 95 participants. In order to obtain an appropriate sample size using a small to medium (0.26) estimate of effect size, with an alpha level set at .05 using a one-tailed test of significance, and a beta set at .20 (power 0.80), the minimum required sample size would be 89 participants (Kraemar & Thieman, 1987).

Chapter 3
Results

The purpose of this study was to examine the attitudes of mental health clinicians in community mental health care services to patients with a diagnosis of BPD. The researcher's aim was to investigate which factors may be related to their attitudes: years of work in mental health, level of burnout, caseloads, and experience of specialist consultation support for work with BPD patients. This chapter presents firstly a descriptive analysis of the data followed by an examination of the research hypotheses.

3.1 Descriptive Analysis

Data from all questionnaires were analysed using the standard statistics program for psychological research, SPSS/PC for Windows, Version 15.0. Descriptive statistics on sample characteristics, variable characteristics and reliability analyses of the various components of the measures used in the current study were considered. Levels of severity are shown for the Maslach Burnout Inventory: Human Services Survey (MBIHSS). Cronbach's alpha coefficient was calculated as an indication of internal consistency for both of the measures. The MBIHSS results are compared with normative data (Maslach et al., 1996).

3.1.1 Sample Characteristics

There were 57 female participants and 34 male participants in the sample (N=91).

Table 3.1

Participant Demographics

Demographics	Number	Percentage
Gender		
Female	57	62.6
Male	34	37.4
Age Group		
<21	2	2.2
21-30	26	28.6
31-40	24	26.4
41-50	23	25.3
>50	16	17.6
Profession		
Consultant Psychiatrist	12	13.1
Psychologist	16	17.6
Nurse	22	24.2
Social Worker	17	18.7
Occupational Therapist	8	8.8
Psychiatric Registrar	11	12.1
Trainee Psychologist	1	1.1
Trainee Mental Health Worker	4	4.4

Table 3 shows that of the 91 clinicians participating, a high proportion of respondents (63%) were females. Twenty-six of the participants fell between the ages of 21 and 30 years (29%), 24 of the participants were aged 31-40 years (26%) and then another 23 were between the years 41 and 50 years (25%). Approximately two thirds of respondents fell between the ages of 21 and 50 years, and the largest number of respondents came from nursing backgrounds (24.7).

Table 3.2

Frequencies of Participant Profession by Years of Practice in Mental Health

	Years of Practice					
Profession	<5	5–10	10–15	15–20	20+	Total
Psychiatrist	0	5	3	1	2	11
Psychologist	11	2	0	1	2	16
Nurse	3	1	4	6	8	22
Social Worker	5	5	5	1	1	17
Occupational Therapist	5	1	2	0	0	8
Psychiatric Registrar	5	5	1	0	0	11
Trainee Psychologist	1	0	0	0	0	1
Other (Student)	4	0	0	0	0	4
Total	34	19	15	9	13	90

As shown in Table 3, the professional subgroup with the most years of work experience in mental health services was nurses (n=8: 20+yrs). Several subgroups had most participants in the below 5-years category of work experience such as Psychologists and Occupational Therapists. The Social Workers were spread over 15 years. Psychiatrists had a more even spread of years' experience within this group. It was considered that Psychiatric Registrars, Trainee Psychologists and Students reported the least amount of work experience in a mental health service compared with the rest of the sample of participants (n=5, n=1, n=4: <5 yrs). Most participants had less than 10 years' experience (n=54; 59%)

3.1.2 Variable Characteristics

Tables 5 and 6 below show descriptive data on components of the BPDAMHC and the established measure, MBIHSS respectively.

Table 3.3

Means, Standard Deviations and Range of Scores on Measures from the Borderline Personality Disorder: Attitude of Mental Health Clinicians

Variables	Total: n	M, SD (Range)
Interest working with BPD client group	88	2.7, .78 (1–4)
Anxious working with BPD client group (BPDAMHC)	89	2.6, .78 (1–4)
Confident with intervention used with BPD client group (BPDAMHC)	87	2.6, .63 (1–4)
Dislike working with BPD client group (BPDAMHC)	87	2.0, .81 (1–4)
Attitudes and perceptions total (BPDAMHC)	90	34.8, 4.55 (17–45)

Table 3.3 displays descriptive data on some of the items of the BPDAMHC, and the Attitudes and Perceptions total scores. While all participants responded to the Attitudes and Perceptions questions, some did not respond to the items on the experience working with the BPD client group. The first three item variables showed means of close to three, which meant agreement with the statement. The fourth variable was around two, which meant disagreement with the statement of dislike working with the BPD client group. The mean of 34.8 on the Attitudes and Perceptions Scale corresponds to a somewhat positive attitude (with 30 being the neutral mid-point of the scoring range).

Table 3.4:

Means, Standard Deviations and Range of Scores on the Measures of the Maslach Subscales

Variables	Total: n	M, SD (Range)
Emotional exhaustion (MBIHSS)	90	20.1, 9.69 (1–46)
Depersonalisation (MBIHSS)	90	5.7, 4.10 (0–20)
Personal accomplishment (MBIHSS)	90	36.5, 6.39 (19–48)

Table 3.4 displays some wide-ranging scores obtained on the Emotional Exhaustion and Depersonalisation subscales for the MBIHSS. In terms of categorisation according to Maslach and Jackson (1986), the mean scores for Emotional Exhaustion and Personal Accomplishment were within the moderate range, while the mean score for Depersonalisation fell within the low range.

3.1.3 Experience Working with BPD

The majority of the current sample (63%) reported having seen more than 10 patients with BPD. Thirty of the participants (33%) reported having seen between one and 10, and only four participants (4%) reported having seen no BPD patients. Overall, almost all participating clinicians (96%) had worked with several patients in this client group.

3.1.4 Treatment Types

The 91 clinicians from this study indicated their individual preference for treatment among a wide range of treatment types listed: that is, CBT, psychodynamic, medication, eclectic, case management, containment, and Dialectical Behaviour Therapy (DBT). Of the therapy types, CBT was reported to be a more commonly used treatment (22%) than the others. The

other therapy treatments most frequently used were case management, containment, DBT, eclectic and medication. The clinicians in their work with BPD in the study equally applied these types of treatment.

Table 3.5:

Frequencies of Treatment Models by Disciplines

	Type of Discipline			
Type of treatment	Psychiatrists/ Psychiatric Registrars	Psychologists	Nurses	Social workers
	N=22	N=16	N=22	N=17
DBT	3	5	2	1
CBT	1	6	9	3
Psychodynamic	1	1	0	0
Medication	7	0	1	1
Eclectic	4	0	3	4
Case management	1	1	4	3
Containment	3	1	3	4
Other or N/A	2	2	0	1

Table 3.5 shows that 32% (7 of 22) psychiatrists/psychiatric registrars commonly employ medication with BPD patients, psychologists' preferred treatment type is most often CBT (38%, 6 of 16) and also DBT (31%, 5 of 16). Interestingly 41% (9 of 22) nurses report employing CBT, and social workers have a spread of preferred treatment models, with most preferring eclectic and containment models of treatment. Interestingly one nurse and one social worker selected medication as a preferred treatment.

3.1.5 Clinicians' Interest, Anxiety and Confidence in Working with BPD

Frequencies of agreement/disagreement for each statement about the experience of working with BPD patients are shown below for the current sample of clinicians.

Table 3.6:

Frequencies of Agreement/Disagreement with Statements about the Experience of Working with BPD Patients

Statement	Strongly disagree N (%)	Disagree N (%)	Agree N (%)	Strongly agree N (%)	Totals N (%)
I have an interest in working with this client group	4 (4.5)	30 (34.1)	40 (45.5)	14 (15.9)	88 (100)
I get more anxious working with this client group than with others	10 (11.2)	24 (27.0)	49 (55.1)	6 (6.7)	89 (100)
I am confident with the type of intervention I use with this client group	1 (1.1)	36 (41.4)	44 (50.6)	6 (6.9)	87 (100)
I dislike working with this client group	22 (25.3)	46 (52.9)	14 (16.1)	5 (5.7)	87 (100)

Table 3.6 demonstrates that 61% of 88 participants who responded to the first item agreed that they had an interest in working with this client group. But interestingly 62% of clinicians stated they were anxious when working with BPD patients. Fifty-seven per cent of the clinicians reported being confident with their treatment type. A large proportion of participants (78.2%) disagreed with the statement regarding "dislike working with this client group". Many cases fell into the Agree or Disagree response categories for the first and third

items on interest and confidence respectively, which indicated a lack of endorsement of strong responses.

3.1.6 Professions Better Suited to Working with BPD

The current sample (N=91) was divided approximately in half with their responses to the question of whether they believed there is a profession better suited to working with BPD. Slightly more than half of the participants (53%) stated that there was a profession better suited, while slightly less than half (47%) stated that there was not one profession better suited to working with BPD. Of the 53% who thought one profession better suited, 87% rated psychologists as best suited to working with BPD patients. Interestingly of the psychologists who thought there was a specific discipline better suited to working BPD, all (100%) thought psychologists were better suited. Of the other disciplines who thought there was one discipline better suited, 82% nominated psychologists.

3.1.7 Attitudes and Perceptions

Of the total scores on the Attitudes and Perceptions Scale – Borderline Personality Disorder (APS–BPD), slightly more than half of the sample (N=90) rated high scores (58%), which meant that the participating clinicians reported a positive attitude to working with BPD. The participants who rated negative attitudes comprised 42% of the current sample. Table 3.7 shows the responses to items on the APS-BPD in terms of agreement or disagreement with each statement.

Table 3.7:

Frequencies of Raw Responses to Attitudes and Perceptions Scale – Borderline Personality Disorder (APS–BPD)

BPD patients:	Disagree N (%)	Agree N (%)
1. Will not get better and are just using scarce resources	79 (87%)	12 (13%)
2. May be ambivalent at first but develop a commitment to treatment	20 (22%)	71 (78%)
3. Should be discharged from inpatient units earlier as there are more seriously ill patients	55 (60%)	36 (40%)
4. Engage in distressing behaviour, which is understandable given their history	17 (19%)	74 (81%)
5. Create problems among staff	27 (30%)	64 (70%)
6. Are likely to benefit from therapy	9 (10%)	82 (90%)
7. Are not suicidal but just fake it	82 (90%)	9 (10%)
8. Can form a working relationship with staff	6 (7%)	85 (93%)
9. Are not really mentally ill, but just manipulating the system	86 (95%)	5 (5%)
10. Need more access to inpatient units when they are at risk	31 (34%)	60 (66%)
11. Are a burden to the service	60 (66%)	31 (34%)
12. Appreciate help given	26 (29%)	65 (71%)

The table above shows several endorsements for positive attitudes towards BPD patients. For example, in item 9: "Are not really mentally ill, but just manipulating the system", 95% of the sample disagreed, indicating participants' attitudes were overall positive in stating the opposite to this statement. Participants also indicated their positive attitude when they responded to item 7: "are not suicidal but just fake it". Item 6: "Are likely to benefit from therapy", showed that most participants (90%) agreed with this statement. Responses to item 8: "Can form a working relationship with staff", showed that participants also agreed with this statement (93%), indicating an overall positive attitude.

Some items drew more mixed responses. For item 3 regarding early discharge from inpatient units because there are more seriously ill patients, 40% of participants were in favour of early discharge, while 60% were not in favour of early discharge. Three other statements that obtained varied responses across agreement and disagreement were, firstly, item 5: "Create problems among staff", where 30% disagreed and 70% agreed. Secondly, item 10: "Need more access to inpatient units when they are at risk", showed further mixed responses, where 66% agreed and 34% disagreed. The third set of mixed responses noted were for item 11: "Are a burden to the service", which indicated that although 66% of the current sample disagreed, a sizable minority (34%) did agree with the statement.

3.1.8 Prevalence of BPD in Clinicians' Service and Caseloads

Participants in the current sample (N=91) reported the prevalence of BPD patients in their service as being more "common" (6–15% and over) than "rare" (below 6%). This was in line with Swartz and colleagues (1990), as they had reported about 11% of borderline patients were seen in outpatient community mental health services. In the current sample, 65% rated the prevalence of BPD patients as common, and 19% rated the prevalence as rare. Some participants were not sure of the number of BPD patients in their service (16%). Of the sample, 71% of clinicians reported a current caseload of between one and five patients with a diagnosis of BPD. Nine participants had six or more BPD patients in their caseload. Seventeen participants reported having no patients with a diagnosis of BPD in their current caseload.

Slightly more than half (53%) of the participants in the current study stated that they did not feel that patients with a diagnosis of BPD were evenly distributed among their team. Of the 91 participants, 47% indicated that BPD patients were evenly distributed.

3.1.9 Contributing Factors Influencing Clinicians' Work with BPD

Table 3.8 below displays the results of responses to whether certain factors listed on the questionnaire discourage the participant from working with BPD patients.

Table 3.8 *Factors Perceived as Discouraging Work with BPD Patients*

Potentially relevant factors (N=91)	Not relevant N (%)	Relevant N (%)
1. Lack of education/training for working with BPD	23 (25%)	68 (75%)
2. Lack of supervision in general	30 (33%)	61 (67%)
3. Lack of supervision with specialist expertise	23 (25%)	68 (75%)
4. Heavy caseload (in total)	11 (12%)	80 (78%)
5. Significant caseload of BPD patients already	38 (42%)	53 (58%)
6. Patients unlikely to benefit	54 (59%)	37 (41%)
7. Work with BPD not valued by colleagues	51 (56%)	40 (44%)
8. Work with BPD not valued by management	54 (59%)	37 (41%)

Table 3.8 shows that item 4: "Heavy caseload (in total)" was a relevant factor to a large majority of participants (78%) as to whether they worked with BPD patients. Lack of education and training, lack of specialist supervision and lack of supervision in general were three other factors that clinicians felt were relevant reasons for their work with BPD patients. Clinicians did rate their work with BPD patients as being valued by colleagues and management overall although a substantial subgroup was concerned that it was not valued.

3.1.10 Spectrum Consultation

Of the whole sample (N=91), 52 participants (57%) stated that they had not received an individual consultation from Spectrum in managing one of their clients. In response the question regarding whether they had attended a group consultation or education session, 41 participants (45%) had not received any specialist education from a Spectrum clinician. However, 55% (50 participants) in the current sample reported having had group consultation with Spectrum.

Table 3.9

Frequency (%) Disciplines attending individual and group consultation with Spectrum services.

Profession	Individual Consultation	Group Consultation
Psychiatrists/Registrars (N=22)	31%	31%
Psychologists (N=16)	81%	88%
Nurses (N=22)	46%	59%
Social Workers (N=17)	47%	71%

Table 3.9 shows the total participants and their disciplines that have attended both individual and group consultation with Spectrum services. The discipline that has attended both individual and group consultation the most has been psychologists. Psychiatrists/psychiatric registrars are the discipline who has attended the least number of consultations with Spectrum services.

3.1.11 Maslach Burnout Inventory – Human Services Survey

Frequencies of cases in each severity category of the MBIHSS subscale indices (Maslach et al., 1996) are shown below for the current sample of clinicians.

Table 3.10

Frequencies of MBIHSS Subscale Indices for Participant Clinicians

MBIHSS Categorisation:	Emotional exhaustion N (%)	Depersonalisation N (%)	Personal Accomplishment N (%)
Low	38 (42.2)	58 (64.4)	22 (24.4)
Moderate	29 (34.5)	27 (30.0)	33 (36.7)
High	23 (23.3)	5 (7.6)	35 (38.9)
Totals	90 (100)	90 (100)	90 (100)

As indicated in Table 3.10 a substantial proportion of participants (23%) rated high scores on Emotional Exhaustion and 30% were in the moderate category for Depersonalisation. This suggests a level of burnout within the sample. At the same time, however, 39% of the sample reported a high sense of Personal Accomplishment.

The current descriptive analyses were compared to normative data (Maslach et al., 1996) on the original North American sample (N=3727) of workers in a variety of occupations. The current results were similar to group norms for each subscale; for example, Emotional Exhaustion (M=20.1) was only slightly lower than norms (M=21.0), and this comparison was also found in a Polish sample of nurses (M=20.0: Golembiewski et al., 1983). Examination of the other two subscales showed that Depersonalisation was just below the cusp of the low severity level as determined by Maslach and colleagues (1996) in

the current sample (M=5.7) compared with norms (M=8.7). Personal accomplishment was higher (M=36.5) in this sample than norms (M=34.6: Maslach et al., 1996). Reliability coefficients were similar between the current sample and the original study; that is, Cronbach's alpha (a) for the current sample was .75, and therefore adequate consistency was obtained.

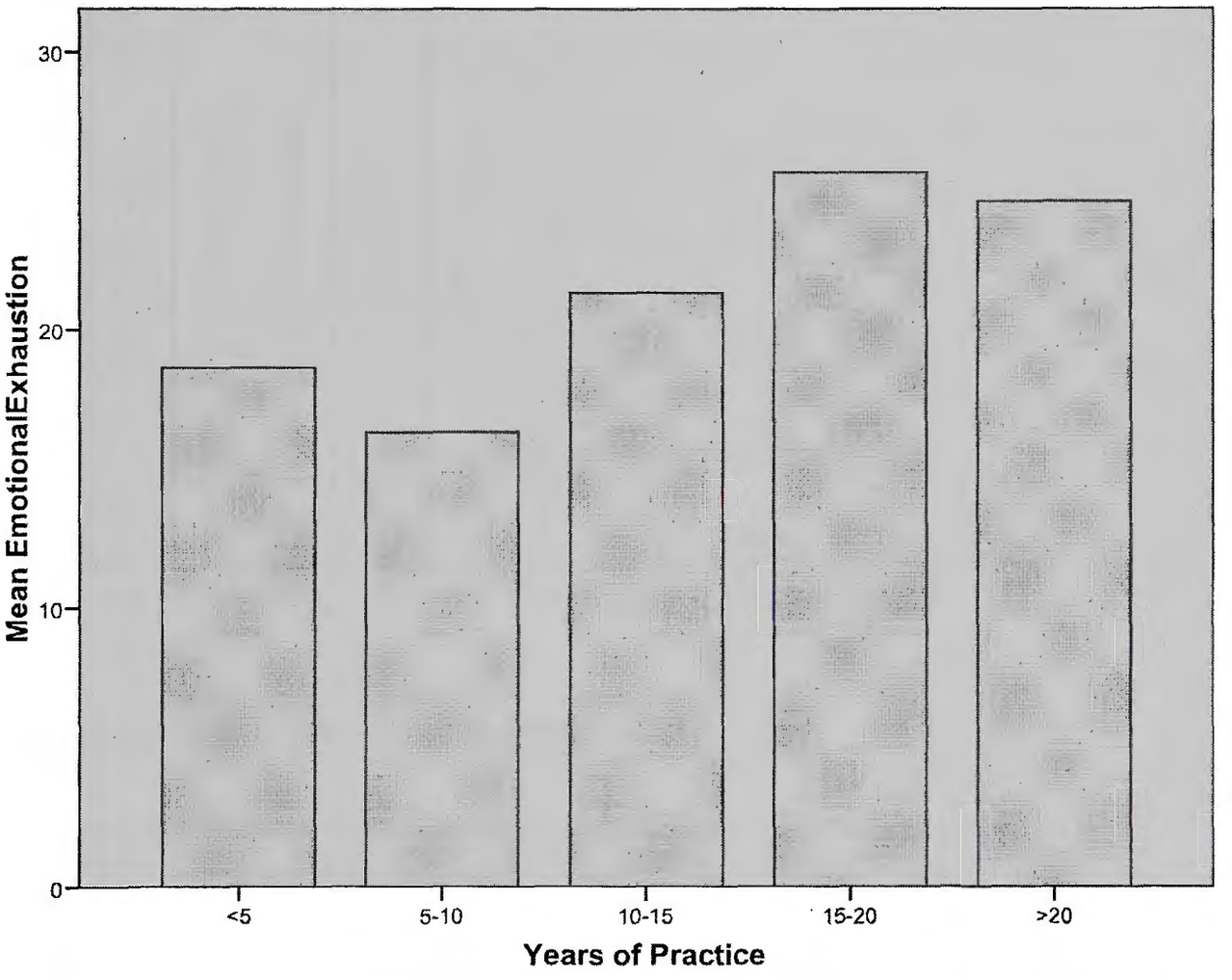

Figure 3.1 *Emotional exhaustion by years of experience in mental health*

As shown in Figure 3.1, clinicians with more than 10 years of work experience in a mental health service reported higher scores on the Emotional Exhaustion (EE) subscale of the Maslach Burnout Inventory – Human Services Survey

(MBIHSS). There was a tendency for scores to increase with years of experience; however, those participants in second category of 5–10 years' clinical experience showed a lower level of Emotional Exhaustion.

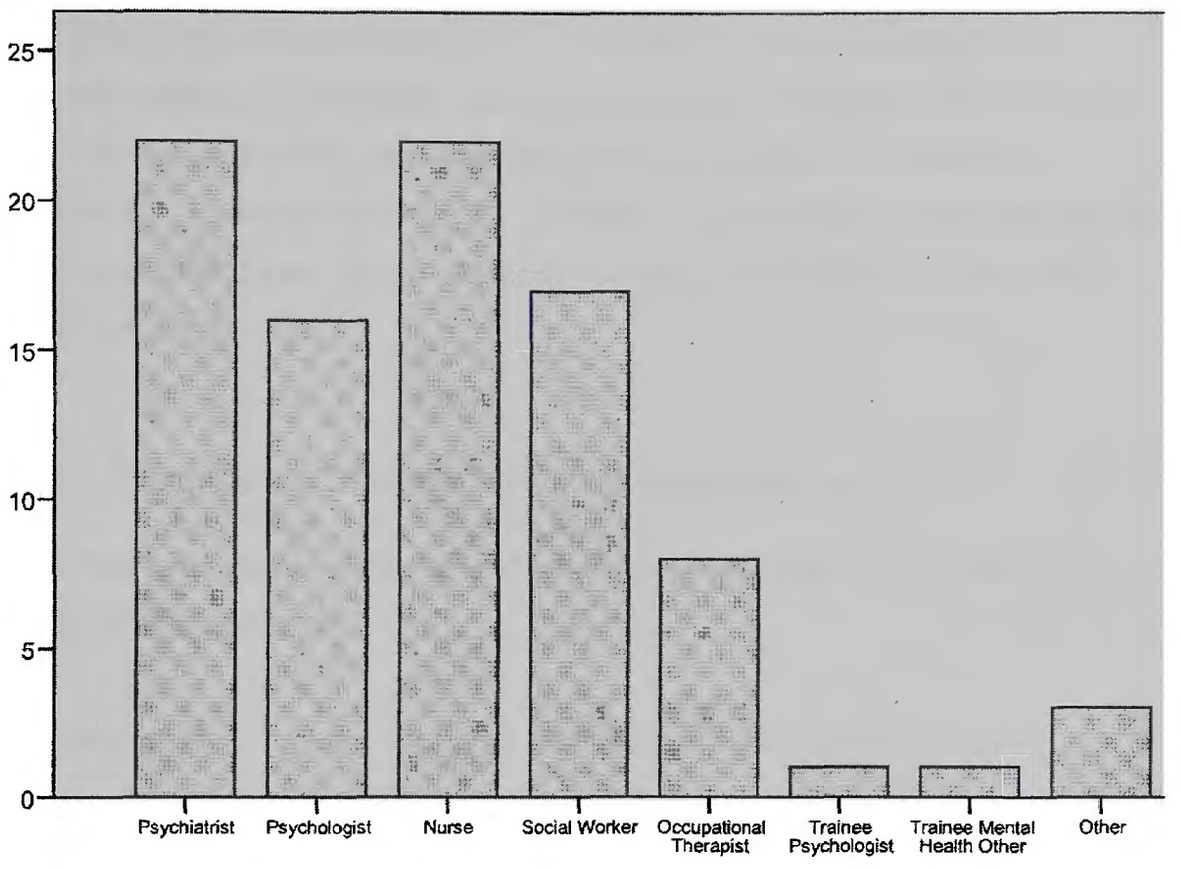

Figure 3.2 *Emotional Exhaustion by professions*

Note: Categories of clinicians' professional background, including students under "Other"

Figure 3.2 shows the highest scores on the Emotional Exhaustion scale for Psychiatrists and Nurses in the sample, which placed their results within the moderate range of EE (17–26). Psychologists and Social Workers were near the cusp of the low to moderate range of EE. Of the fully qualified professionals, Occupational Therapists reported the lowest EE scores. It was noted that trainees and students reported the lowest levels of EE in the current sample.

3.2 Attitudes of Mental Health CCT Clinicians

Seven hypotheses were tested for the purpose of investigating factors associated with the attitudes of CCT clinicians to the diagnosis of BPD. Mental health CCT clinicians' overall attitudes to BPD were examined using the total score from the Attitudes and Perceptions Scale – Borderline Personality Disorder (APS-BPD). Cronbach's alpha coefficient for this scale was calculated to be .81, which indicated very good reliability for the APS-BPD measure.

3.2.1 Proportion of Clinicians Holding Negative Attitudes to BPD

The first hypothesis predicted that clinicians would hold negative attitudes towards BPD patients.

Hypothesis 1: A majority of mental health clinicians will have negative attitudes to patients with a diagnosis of BPD.

Of the total sample (N=91), 38 participants rated low scores on the APS-BPD, which was 42%. Therefore, 53 participants rated high scores on the APS-BPD, which comprised 58% of the current sample. The first hypothesis was not supported, as the majority of clinicians reporting negative attitudes was less than the proportion of clinicians reporting positive attitudes.

3.2.2 Profession and Attitude of the Clinician

This section reports on analyses of the various subgroups of disciplines among the participants, including psychiatrists, psychologists, nurses and social workers (N=91) in relation to the second hypothesis:

Hypothesis 2: The attitude of the clinician will vary according to his or her discipline/profession.

3.2.3 Analyses of APS-BPD Total Scores

Tests of normality on the APS-BPD total scores showed a slightly negatively skewed curve (-.706) (Thorne, 1989), but the size of the skewness was very small, which indicated a relatively normal spread of scores. Kurtosis was slightly peaked at 2.159, which meant that several scores were clustered around the mean. Nevertheless, the data were considered normal, and did not violate the assumption of normality.

Only four main professions/disciplines will be considered for analyses.

Table 3.11

Sample Statistics for Attitude and Perception Ratings of the Disciplines

Discipline	N	M	SD	SE
Psychiatrist/Registrar	22	32.91	4.450	.949
Psychologist	16	36.75	5.639	1.410
Nurse	22	34.41	4.574	.975
Social Worker	17	36.88	2.977	.722
Total	77	35.01	4.711	.537

As shown in Table 3.11, the four disciplines of the current sample had different mean scores for their attitudes and perceptions to working with BPD patients. On inspection Psychologists (M=36.75) and Social Workers (M=36.88) had higher scores than Nurses (M=34.41) and Psychiatrists and Registrars (M=32.91), which suggests a difference between means. The

difference between groups was significant according to the One-way Analysis Of Variance (ANOVA), where F=3.518 (3, 73), p=.019. The results of the between groups comparison showed that the attitude of the clinician did vary significantly according to their discipline. It was noted that of the four main disciplines, Psychiatrists and Psychiatric Registrars had the lowest mean score (M=32.91). The largest difference in attitudes was between psychiatrists and Social workers. The Social worker had less negative attitudes towards people with BPD. However a Tukey post hoc test revealed only a trend toward a significant difference between Social workers and Psychiatrists, p=.06

3.3 Intervention Used by Clinicians

This section reports the sample of participants in terms of their most commonly used treatment in working with BPD patients in relation to the third hypothesis:

Hypothesis 3: A majority of clinicians working with this clinical group will have a focus on containment rather than therapy.

Table 3.12

Frequencies of Clinicians' Most Commonly Used Treatment Types

Treatment Types	Frequency (n)	Percentage
Cognitive Behavioural Therapy (CBT)	20	22.0
Psychodynamic Therapy	2	2.2
Medication	11	12.1
Eclectic Therapeutic Approach	11	12.1
Case Management	13	14.3
Containment	13	14.3
Dialectical Behaviour Therapy (DBT)	12	13.2
Other (e.g. Narrative)	6	6.6
Not Worked with BPD	3	3.3
Total (N=91)	91	100.0

Table 3.12 shows that in the current sample of mental health clinicians at CCT teams the most commonly used treatment choice was CBT (n=20), with containment (n=13) and case management treatment types (n=13) the next most common. DBT (n=12) and medication (n=11) were the next largest subgroups. As only 13 of 91 clinicians selected containment as their most commonly used treatment type, Hypothesis 3 was not supported.

3.4 Years of Experience and Interest in Working with BPD

This section presents analyses using the whole sample (N=91) of mental health clinicians that administered the Borderline Personality Disorder: The Attitudes of Mental Health Clinicians (BPDAMHC). More specifically, the demographic data on years of experience and the results on the statement

regarding clinicians' interest in working with BPD are used to test part (a) of hypothesis 4.

Hypothesis 4 (a): Greater number of years of work in mental health services will be associated with less interest in working with BPD patients.

3.4.1 Preliminary Data Screening

Tests of normality on the statement of the BPDAMHC regarding interest in working with BPD patients showed almost no skewness in the data (-.061). The other items in this section were similarly low in skewness. Years of work experience showed a small positive skewness (.627); this was considered within the normal range. The tests of normality showed that the assumptions were not violated.

3.4.2 Regression Analysis of Years of Work and Interest in Working with BPD

"Years of practice" was the variable entered for the prediction of clinicians' interest in working with BPD patients. Results of the regression analysis are presented in Table 3.13.

As a set, the variable of years of practice explained a significant proportion of the variance in clinicians' interest in working with BPD patients (R^2=.08; F (1, 86)=7.526, p=.007). There was support provided for the hypothesis that the independent variable, years of practice, predicted interest in working with BPD patients, accounted for 8% of the variance.

Table 3.13

Summary of Regression Analysis for the Prediction of Interest Working with BPD Patients by Years of Practice

Predictor Variable	B	SE.B	Beta	t	p
Years of Practice	-.155	.056	-.284	-2.743	.007

The variable years of practice was significantly correlated with clinicians' interest in working with BPD patients. The regression analysis found a result that was significant (Beta=-.284, $p<.01$) indicating there was a tendency for years of practice to be negatively correlated with interest in working with BPD patients.

Hypothesis 4 (b) Greater number of years of work in mental health services will be associated with more negative attitudes and perceptions concerning BPD patients.

3.4.4 Regression Analysis of Years of Work and Attitudes Concerning BPD

"Years of practice" was the variable entered for the prediction of clinicians' attitudes and perceptions concerning BPD patients. Results of the regression analysis are presented below in Table 3.14.

As a set, the variable of years of practice did not explain the variance in clinicians' attitudes and perceptions concerning BPD patients (R^2=.003; F (1, 86)=.216, p=.643). There was no support provided for the hypothesis that the independent variable, years of practice, predicted negative attitudes and perceptions concerning BPD patients.

Table 3.14 *Summary of Regression Analysis for the Prediction of Attitudes Concerning BPD Patients by Years of Practice*

Predictor Variable	B	SE.B	Beta	t	p
Years of Practice	-.157	.339	-.050	-.464	.643

The variable years of practice was not significantly correlated with clinicians' attitudes and perceptions concerning BPD patients. The regression analyses found a result that was not significant (Beta=-.050, p>.01) indicating there was no tendency for years of practice to be correlated with attitudes and perceptions concerning BPD patients.

3.5 Emotional Exhaustion, Depersonalisation and Attitudes and Perceptions

In relation to the fifth hypothesis this section shows an analysis using the participant clinicians' self-reports of Emotional Exhaustion and Depersonalisation on the Maslach Burnout Inventory for Human Services (MBIHSS) and Attitudes and Perceptions on the BPDAMHC scale.

Hypothesis 5: Higher levels of Emotional exhaustion and Depersonalisation will predict more negative attitudes and perceptions concerning BPD patients.

The two subscale scores of the MBIHSS, Emotional Exhaustion and Depersonalisation, were entered into multivariate analyses as independent variables in order to test their contribution to the dependent variable, Attitudes and Perceptions of BPDAMHC.

3.5.1 Preliminary Analyses of Depersonalisation and Emotional Exhaustion

The scores of the Depersonalisation subscale of MBIHSS were normally distributed because of the slight positive skew to the right (.873), and kurtosis

was 1.011, which was relatively low (Gravetter & Wallnau, 2000). Overall, it was assumed that linearity and homeoscedasticity were satisfactory for the regression analyses.

Scores of the Emotional Exhaustion subscale of MBIHSS were also normally distributed. The slight positive skew to the right (.526), and kurtosis was -.235, which was relatively low (Gravetter & Wallnau, 2000). It was assumed that linearity and homeoscedasticity were satisfactory for the regression analyses.

3.5.2 Bivariate Correlations of Attitudes, Emotional Exhaustion and Depersonalisation

Pearson's r product moment correlation coefficients were computed between the variables of attitudes and perceptions, Emotional Exhaustion and Depersonalisation, which included the scores on the Attitudes and Perceptions Scale (APS) of the BPDAMHC and two subscales of the MBIHSS, Emotional Exhaustion and Depersonalisation. The results in Table 3.15 below display associations between these variables.

Table 3.*15*

Pearson's Product Moment Correlation Coefficients between Attitudes, Emotional Exhaustion and Depersonalisation

Variables	1.	2.	3.
1. Attitudes and Perceptions	1	-.183	-.25*
N	91	90	90
2. Emotional Exhaustion -		1	.45**
N		90	90
3. Depersonalisation -	-		1
N			90

*p<.05 **p<.01

Table 3.15 shows two significant correlations. The total score for Attitudes and Perceptions was correlated negatively with that of Depersonalisation (r=-.25). There was a moderate positive correlation between Emotional Exhaustion and Depersonalisation (r=.45).

3.5.3 *Multivariate Analysis of Attitudes and Perceptions, Emotional Exhaustion and Depersonalisation*

Emotional Exhaustion and Depersonalisation were the variables entered for the prediction of Attitudes and Perceptions of clinicians working with BPD patients. Results of the regression analysis are presented in Table 3.16.

As a set, the two variables of Emotional Exhaustion and Depersonalisation together explained a significant proportion of the variance in clinicians' attitudes and perceptions (R_2=.066; F (2, 87)=3.098, p=.05), accounting for 7% of the variance. There was support provided for the hypothesis that the independent variables, Emotional Exhaustion and Depersonalisation, predicted the Attitudes and Perceptions of clinicians.

Table 3.16

Summary of Multiple Regression Analysis for the Prediction of Attitudes and Perceptions by Emotional Exhaustion and Depersonalisation

Predictor Variable	B	SE.B	Beta	T	p
Emotional exhaustion	-.041	.053	-.091	-.779	.438
Depersonalisation	-.221	.126	-.204	-1.753	.083

In contrast to the bivariate analyses in which Depersonalisation was significantly correlated with attitudes and perceptions of clinicians, the regression analyses found a weaker result, which was significant, but not in terms of the independent contribution of Depersonalisation (Beta=-.091,

p>.05). In both analyses, there was no tendency for Emotional Exhaustion to be correlated with Attitudes and Perceptions, except when tested with Depersonalisation.

3.6 Specialist Consultation and Attitudes to Patients with BDP

The sixth hypothesis is analysed in this section. It considers mental health clinicians' attendance at or participation in specialist consultation with Spectrum: Personality Disorder Service for Victoria (SPDSV), together with clinicians' scores on the Attitudes and Perceptions Scale (APS):

Hypothesis 6: Mental health clinicians who have received specialist consultation will have more positive attitudes to patients with BPD than those who have not received specialist consultation.

3.6.1 Attitudes and Perceptions with Specialist Consultation

Table 3.17 below shows the sample number, means, standard deviations and standard errors of the descriptive analysis of two groups within the total sample (N=91) that reported whether they attended a Spectrum specialist consultation as part of their professional development.

Table 3.17

Summary of Statistics for Scores on Attitudes and Perceptions between Clinicians' Reported Attendance to Specialist Consultation

	N=91	Attitudes and Perceptions scores		
Spectrum consultation	N	M	SD	SE
Attendance	39	35.90	4.012	.642
Non-attendance	52	33.90	4.770	.662

Table 3.17 shows the means (M=35.90) of attitudes and perceptions to working with BPD patients for clinicians who have attended a Spectrum specialist consultation as higher than the means (M=33.90) of those clinicians who have not attended specialist consultation. The mean difference between the two sub-groups was found to be significant in the one-way ANOVA on the Attitudes and Perceptions Scale total score, F (1, 89)=4.448, p=.038. There was no significance on Levene's statistic (p=.613), which meant that the variance was not violated.

3.6.2 Exploratory Analysis of Variables Relating to Interest in Working with BPD Clients

Table 3.*18*

Pearson's Product Moment Correlation Coefficients between Interest, Dislike, Anxiety, Confidence in Working with BPD Clients and Years of Work

Variables	1.	2.	3.	4.	5.
1. Years of work in mental health	1.00	.07	-.28**	-.09	.17
N	91	87	88	89	87
2. Dislike working with BPD	-	1.00	-.67**	.40**	-.42**
N		87	87	86	86
3. Interest in working with BPD	-	-	1.00	-.21	.36**
N			88	87	87
4. Anxious working with BPD	-	-	-	1.00	-.32**
N				89	87
5. Confidence in type of intervention	-	-	-	-	1.00
N					87

*p<.05 **p<.001

Table 3.18 shows several significant correlations between the interest in working variables. Those who were confident working with BPD patients were also more interested in this work. Those who lacked confidence tended to be anxious and to dislike working with BPD patients. Furthermore, the more years' experience the participants had, the less interest they had in working with BPD patients.

3.7 Summary of Results

Two main types of analyses were utilised to examine the data gathered for this current study. The first was based on a description of the differences between and within subgroups. Descriptive analyses of clinicians' attitudes and perceptions to BPD patients revealed that less than half of the current sample had negative attitudes. Analysis of Variance (ANOVA) was used to test the difference between groups in the whole sample (N=91) depending on their profession, years of experience and specialist consultation by Spectrum. Attitudes were more negative in clinicians who had not attended specialist consultation and in particular professions.

The second type of analysis used correlations and regression to examine the relationships between variables. Clinicians with the most work experience indicated the least interest in working with BPD patients. Other results are summarised for each hypothesis in the following sections.

3.7.1 Attitudes of Mental Health Clinicians

In the first hypothesis, a majority of mental health clinicians would report negative attitudes and perceptions to working with patients with BPD was therefore not supported in the current analyses.

3.7.2 Discipline and Attitude of Clinician

The results supported the second hypothesis. The attitude of the clinician did depend on their profession. As demonstrated in the ANOVA between professional subgroups, there was a significant difference between attitude and perception ratings of clinicians according to their discipline or profession. The second hypothesis was therefore supported in the current analyses. It was noted that Psychologists and Social Workers had the two highest mean scores on the Attitudes and Perceptions Scale (APS), while Psychiatrists and Nurses had lower mean scores in their subgroups.

3.7.3 Intervention Used by Clinicians

In this study the third hypothesis was not supported and the findings were contrary to expectations: mental health clinicians working with BPD patients most commonly used CBT as their intervention of choice. When participating clinicians compared their treatment of choice in the current study, containment and case management were not endorsed more often than other treatments in the sample, although they were the next largest subgroups.

3.7.4 Years of Experience and Poor Interest Working with BPD

As predicted by the fourth hypothesis, greater number of years of work in mental health services was correlated with poorer interest in working with BPD patients to a small but significant extent, where Pearson's r=-.28. The relationship was negative in the bivariate analyses, which meant that the more experience the clinician had gained, the poorer their interest was in working with patients with BPD.

The first part of the fourth hypothesis was therefore supported; however, the second part was not. Greater number of years of work in mental health

services was not correlated with negative attitudes and perceptions concerning BPD patients in the bivariate and multivariate analyses.

3.7.5 Emotional Exhaustion, Depersonalisation and Attitudes

In relation to the fifth hypothesis, clinicians' reported levels of Emotional Exhaustion and Depersonalisation, considered together, did predict their attitudes and perceptions (as measured by the APS) of BPD patients. Emotional Exhaustion and Depersonalisation levels were related to attitude in clinicians in the multivariate analyses. However, in the bivariate analyses, only the scores on the Depersonalisation subscale were inversely correlated with scores on the attitudes measure (APS) to a significant degree. Emotional Exhaustion and Depersonalisation were found to influence attitudes and perceptions but this effect was mainly due to the contribution of Depersonalisation.

3.7.6 Specialist Consultation and Attitudes to Patients with BDP

As expected in the sixth hypothesis, mental health clinicians who had reported receiving specialist consultation were found to have more positive attitudes to patients with BPD than those who had reported no specialist consultation. Ratings on attitudes and perceptions (APS) varied significantly between those who had participated in education by Spectrum and those had not participated in this education. Therefore the sixth hypothesis in these current analyses was supported.

Chapter 4

Discussion

Borderline personality disorder (BPD) patients have been perceived as more stressful to work with than those with other disorders (Lieb, Zanarini, Schmahl, Linehan, & Bohus, 2004; Nehls, 2000). Furthermore, the diagnosis of Borderline Personality Disorder (BPD) has often been associated with a pejorative meaning. The primary aim of this present study was to examine mental health clinicians' attitudes towards the diagnosis of BPD. These clinicians were working in Melbourne public mental health services Continuing Care Teams (CCTs).

The present study investigated the relationship between clinicians' years of experience, their profession/discipline, the treatment model employed, the level of burnout, and consultation with a specialised service. All these variables were explored in order to substantiate whether they contributed to clinicians' attitude toward BPD patients. Very few studies (Krawitz 2004; Younis & King 2007) have examined the factors contributing to mental health clinicians' attitudes towards BPD patients. This current study is the first research of its kind, in that clinicians' profiles, specialist consultation and burnout have been studied concurrently and therefore comparisons between this study and previous studies are limited.

According to the results of this study, clinicians' attitudes are influenced by their profession/discipline, and the level of consultation and training, while clinicians who felt emotionally exhausted withdrew from BPD patients, retreating to depersonalisation, in an attempt to cope.

In this chapter the main findings are first briefly summarized, in terms of support for the hypotheses, and then discussed in relation to the literature and

implications for practice. Limitations of the study are identified and finally recommendations for future research are presented.

4.1. Summary of the Hypotheses and Main Research Findings

The statistical analyses provided mixed support for the six hypotheses. As seen, there were some interesting relationships between variables, in particular:

The attitudes of the majority of clinicians working in Community mental health services CCTs were not negative. Of the total sample, 58% of the participants reported positive attitudes. However, 42% of the participants reported negative attitudes.

Attitudes did differ according to clinicians' discipline/professional background. In particular, psychiatrists and nurses tended to have more negative attitudes compared with social workers and psychologists. Social workers had the most positive attitudes to patients with a diagnosis of BPD.

The more years of work experience a clinician had the less interested they were in working with BPD patients but years of work did not have an association with attitude towards BPD patients.

Attitudes of the clinician were not significantly correlated with emotional exhaustion. Overall, the results suggested a significant, but weak relationship between depersonalisation and negative attitudes towards BPD. Clinicians with high levels of emotional exhaustion engaged in depersonalization in an attempt to distance themselves from their patient.

Clinicians who received specialist consultation services had more positive attitudes towards BPD patients.

The relationships identified between clinicians' attitudes and the factors that contribute to these attitudes will be discussed.

4.2 Key Themes and Findings

4.2.1 Attitudes of CCT Clinicians Working with BPD

The diagnosis and treatment of BPD patients have been challenging for mental health professionals for a long time (Akiskal et al., 1986; Spitzer, Endicott, & Gibbon, 1979). Previous research has revealed that service providers hold negative attitudes towards BPD patients (Bowers & Allan, 2006; Fraser & Gallop, 1993; Gallop et al., 1989; Lewis & Appleby 1988; Markham & Trower, 2003). Past research has reported that clinicians do find this group of patients the "most difficult" to work with (Zanarini, 2001).

Mental health workers, in particular nurses (Markham & Trower, 2003), have been reported to be less sympathetic towards patients with a diagnosis of BPD as compared to those with depression or schizophrenia. Nehls (1994), emphasised that the range of clients' emotional responses may contribute to the difficulties faced when treating BPD patients.

Furthermore, difficult behaviours such as chronic suicidality and self-destructive tendencies have been reported as draining on mental health nursing staff (Gallop, 1985). Mental health workers in New South Wales (Australia) reported the difficulty of working with BPD patients as being between moderately to very difficult (Cleary, Siegfield, & Walter, 2002).

The attitude of the clinicians in this current study was measured based on the: The Attitude and Perceptions Scale (APS). This was a purpose-designed measure for this study. The questionnaire consisted of 12 "positive" and "negative" statements that were set on a 5-point Likert scale. "Positive" attitude statements towards BPD were based on items such as: "Are likely to benefit from therapy" and "Can form a working relationship with staff". Some of the "negative" items were: "Are not really mentally ill, but just manipulating the system" and "Create problems among staff". Where appropriate items were reversed scored. The range of possible scores on the APS is 17-45, with high scores indicating more "positive" attitudes

In this present study a shift of attitudes was an important finding, but a substantial proportion of participants (42%) in the current study continue to hold negative attitudes towards BPD patients. This was consistent with earlier research in this area (Bowers & Allan, 2006; Fraser & Gallop, 1993; Gallop et al., 1989; Lewis & Appleby, 1988; Markham & Trower, 2003). These findings are crucial in that mental health clinicians working in public mental health services are seen to be the first point of call for these patients.

As discussed a majority of past research (Fraser & Gallop 1993; Gallop, Lancee, & Garfinkle 1989; Krawitz & Watson, 2003; Linehan 1993) has reported on the difficulties experienced by those working with this group of patients. Only recently have studies pointed to possibly changing attitudes of clinicians, and in particular nurses (James & Cowman 2007). James & Cowman (2007) found that inadequate care of BPD was not the result of being categorised as a mental illness or that BPD was untreatable, but rather a consequence of clinicians' lack of belief in their own ability to treat BPD patients. Interestingly, it was found that nurses also believed that it was within their role as clinicians that patients with BPD receive assessment, treatment and education.

Analyses of the data on the APS indicated that a majority of clinicians (58%) hold positive attitudes towards BPD clients. While this is not a longitudinal study and hence cannot clearly document change, the results stand in contrast a lot of the earlier literature on clinician attitudes towards BPD. The results of the current study are consistent with the findings of more recent studies, which suggest a shift of attitudes towards a more positive view of BPD patients (Deans & Meocevic, 2006; Hazelton, James & Cowman 2007; Krawitz, 2004; Rossiter et al., 2006). The review of the means from the APS-scale supported a recent Australian study (Treloar & Lewis, 2008), that clinicians who come from nursing and psychiatric professions have more negative attitudes than those who come from allied health professions

4.2.2 Professional Background and Attitudes

Borderline personality disorder patients represent as significant a cohort in mental health services as patients diagnosed with schizophrenia or bipolar disorder. Unfortunately there is only a limited amount of literature that focuses on the multidisciplinary group that constitutes CCT clinicians, while more studies have explored the attitudes of specific professions, notably psychiatric nurses and psychiatrists, towards BPD patients.

It was expected that clinicians' discipline/professional background would influence their attitude to BPD patients. Attitudes of psychiatrists/psychiatric registrars and registered psychiatric nurses differed from those participants who came from allied health: psychology and social work professions. This was consistent with Treloar and Lewis' (2008) research where allied health professionals working in both mental health and emergency services held more positive attitudes towards BPD patients who self-harmed than did nurses and psychiatrists/psychiatric registrars.

4.2.3 Psychiatrists/Psychiatric Registrars and Psychiatric nurses

In this current study, psychiatrists/psychiatric registrars had the lowest mean scores in the attitude and perception scales of BPD. That is they held the most negative attitudes to BPD patients amongst all the other disciplines represented. Nurses also held relatively negative attitudes, which was consistent with previous research (Fraser & Gallop 1993; Gallop, et al., 1989).

There has been limited research whereby psychiatrists' attitudes to BPD patients have been compared with other professionals' attitudes. While not a direct focus of this study the relationship between mental illness and the social stigma has found a lot of research interest over the past years. In one Australian study (Jorm et al,1998), the general public's attitude towards people with depression and schizophrenia was compared with that of GP's and clinical psychologists. There was no major difference between the attitudes of the health practitioners as a whole and the general public. However, the attitudes of general practitioners and psychiatrists were the most negative. Psychiatrists in this current study were analysed to have negative attitudes to those patients diagnosed with BPD also.

In another study, Lewis and Appleby (1998) in the United Kingdom found that psychiatrists were less sympathetic towards patients with a personality disorder than toward other patients. They found that psychiatrists saw patients with a diagnosis of BPD to be "harder to work with", "less worthy of care" and as "manipulative".

Other studies have found that nursing staff hold more negative attitudes towards BPD patients than to those patients diagnosed with depression or schizophrenia (Markham & Trower, 2003). Mental health nursing staff also perceived patients with a BPD label to be in more in control of their behaviour than other patients. Other Australian research (Deans & Meocevic, 2006) has

found that psychiatric nurses in inpatient wards and also CCT services have reported holding negative attitudes and emotions towards BPD patients. These results are consistent with the current findings that psychiatric nurses hold relatively negative attitudes towards BPD.

Significantly, research on psychiatric nurses has highlighted that the patient's diagnostic label does influence the level and quality of service the patient receives (Gallop et al., 1989). The patients' diagnostic label may be an important determinant of the interaction and care given by a psychiatric nurse. In this present study 41% of nurses indicated that they employed CBT in working with BPD patients. Even though a high proportion of nurses employed a therapeutic mode of intervention with their patients they remained one of the two professions that had more negative attitudes towards BPD patients.

The question arises as to what factors might account for the relatively greater negative attitudes of psychiatrists/psychiatric registrars and psychiatric nurses. It is possible that an explanation for this outcome may be related to the tasks of nurses and psychiatrists in inpatient wards. According to Bowers and Allan (2006), not only does previous experience with patients with personality disorders influence one's attitude to them but also the culture of the organization one finds oneself in. For many years, these professionals have been exposed to BPD patients during their most critical and behaviourally challenging times. That is, they see them at their most disturbed and therefore health professionals' attitudes to BPD patients may be a reflection of their practical experience with them. The patients who are admitted to inpatient wards are most often actively suicidal and are at the severe end of the BPD spectrum.

Another explanation for the negative attitudes of psychiatrists could be as a result of the length of contact psychiatrists have with the mentally ill.

Psychiatrists oversee patients' care over a long period of time that is, in inpatient wards or outpatient clinics. They monitor their reactions to the prescribed medication and their level of stability. Hence, their length of involvement may also be contributing to their attitudes towards BPD patients. This study found a significant association between clinicians' years of experience and their interest in working with BPD patients, that is, the more years of experience the less interest in working with BPD patients. However, interest in working with BPD patients was not correlated with attitude towards BPD.

Psychiatric nurses were the professional subgroup with the most years of work experience in mental health. Eight of the 22 nurses in the current sample had more than 20 years of work experience. Psychiatrists had less years of experience than nurses.

Furthermore, the attitudes of psychiatrists and nurses towards BPD may have been shaped as part of a particular historical development within a discipline. Historically, one major distinguishing feature of the psychiatric and nursing profession compared to allied health professionals is their training and adherence to the "medical model" which relies on pharmacology and perhaps cannot readily accommodate this clinical group of patients. This may be one of the major contributing factors that divide the two groups of disciplines. Literature on the treatment of BPD appears to highlight the limited efficacy of the use of the medical model within the psychotherapeutic treatment of BPD patients (Bateman & Fonagy, 2007). The professions' choice of therapy/treatment may be contributing to the difference of attitudes between these disciplines. Of the 19 psychiatrists/psychiatric registrars represented, 64% indicated that they adhered to the medical model in treating BPD patients. In contrast the nurses in this study reported applying more psychotherapeutic treatments.

Finally, another possible explanation why these professions might have more negative attitudes could relate to their level of training and supervision in working with this particular group of patients. Krawitz (2004) and Younis and King (2007) have highlighted the significance of supervision for those clinicians seeing BPD patients. The length of involvement, the intensity of working with this group of patients as compared to other diagnostic groups is also important to consider. Most of the literature reviewed (Deans & Meocevic, 2006; Fraser & Gallop 1993; Goldner & Ross, 2009; Lewis & Appleby, 1988; Markham & Trower, 2003; Nehls 2000) has emphasised the need for specific training, and support and educational programmes in the area of BPD because of the multidimensional problems these patients experience, and so clinicians working with these have greater empathy and tolerance (Treloar & Lewis, 2008).

4.2.4 Psychologists and Social Workers

In the current study psychologists and social workers were found to hold significantly more positive attitudes than nurses and psychiatrists. Interestingly social workers and psychologists had similar mean scores on the APS.

One international study conducted by Domingo and Baer (2003) in Switzerland found that case managers and in particular social workers reinforced "normality". They concluded that social workers had a different outlook on mental illness. Interestingly and in accordance with Domingo and Baer's (2003) study, social workers were amongst the two disciplines with the most positive attitudes towards BPD patients. This may be due to their education and training backgrounds. The training of psychologists and social workers is more likely to focus on a psychotherapeutic approach and their work with patients is generally not based on the medical model approach. Analyses in this current study indicated that 47% of the social workers

employed a model of psychotherapy, with eclectic psychotherapy ranked (23%) as the model most employed by social workers. A majority of the psychologists employed CBT (38%), and DBT (31%) respectively.

In the *Australian Association of Social Workers Competency and Standards Manual (1999)*, the principles for mental health treatment are outlined for social workers. Social workers are encouraged to look beyond the limits of their patients' diagnosis and to see the person beyond the illness. Another principle they are urged to adhere to is to recognise the "personhood" rather than the "patient hood"(Australian Association of Social Workers, 1999, p. 28).

Demographics were analysed with respect to a possible relationship with ones' profession/discipline and the level of emotional exhaustion. Our results indicated that there was a strong association between a clinician's profession/discipline and their level of emotional exhaustion. Psychiatrists and nurses reported a moderate degree of emotional exhaustion, while psychologists and social workers scores were low to moderate.

Social workers' and clinical psychologists' educational backgrounds may influence their attitudes and perceptions of the "mentally ill" including the BPD patient. The four main professional disciplines investigated appear to have different discipline-specific training and educational backgrounds. This in itself may have been a contributing factor to the differences between professional groups in this present study. As previously discussed, a lack of specific training in the area of BPD and outcomes of therapy/treatment leave clinicians susceptible to developing negative attitudes towards BPD patients (Younis & King, 2007). However the variability amongst the disciplines could be accounted for by not only their varying education and training backgrounds, but also by the overall culture of their professional subgroup.

Furthermore the findings of the current study suggest that clinicians in an attempt to reduce their levels of emotional exhaustion may have depersonalised themselves. It may be that both psychologists and social workers feel better equipped to work with this client group and thus feel less frustration or disappointment, which otherwise may contribute to emotional exhaustion and depersonalisation.

4.2.5 Professions Most Suited to Working with BPD patients

The descriptive statistics of this current study highlighted that most of the participants (96%) had worked with several BPD patients. Participants of this current study were also asked who they considered most suited to working with BPD patients. Fifty-three per cent considered one profession being better suited than others, and of these, 87% rated psychologists to be the profession most suited to working with BPD patients. While this view was particularly widespread among psychologists, of the other professionals who thought there was one discipline better suited 82% nominated psychologists. Psychologists are considered as the "discipline of choice" and to be better suited to working with BPD clients.

4.2.6. Models of Therapeutic Treatment

It was expected that mental health clinicians in this current study would utilize containment as their primary clinical intervention. However, the hypothesis that CCT clinicians primarily utilised containment over psychotherapeutic models was not supported. Approximately half of the sample of clinicians (45) nominated therapies such as CBT, eclectic, psychodynamic and dialectic behaviour therapy as their primary interventions with BPD patients. In comparison 13 participants indicated they focused on containment. Interestingly, another 13 participants indicated that they practised primarily case management with their BPD patients. The author would argue that the terms "containment" and "case management" are used interchangeably, or

that their meanings overlap. If so, 26 participants (approximately one third of the sample) preferred an intervention approach variously described as containment or case management.

Overall approximately 50% of the participants indicated that they utilized at least one type of therapeutic model. Cognitive behaviour therapy (22%) was the therapeutic model most often favoured. Dialectical behaviour therapy (Linehan, 1993), a model of therapy originally developed for suicidal patients, also utilizes cognitive behavioural treatment and was one of the three psychotherapeutic models chosen (13%).

There were some differences between disciplines in the pattern of preferred intervention for BPD. Clinical psychologists clearly preferred a psychotherapeutic mode of intervention, in particular DBT or CBT. Psychiatric nurses also preferred psychotherapeutic approaches, notably CBT, although a substantial minority favoured case management and/or containment. Social workers reported greater use of case management/containment than the other disciplines but were fairly evenly divided between this and psychotherapeutic approaches. Psychiatrists/psychiatric registrars employed medication. But in terms of therapeutic models their preferences ranged between DBT to eclectic therapy.

Interestingly 42% of study participants indicated that they were not confident with their chosen model of intervention. In a recent study Hazelton, Rossiter and Milner (2006) conducted a two-day workshop, introducing DBT to 94 mental health staff. Data collected one month prior and six-months following the completion of the training program indicated that a majority of participants had reported that their knowledge, treatment and attitudes towards patients with BPD had improved with the workshop training and experience in DBT. It is worth noting that attitudes improved in parallel with therapy training, suggesting that confidence in intervention is an important issue.

While the current findings suggest that CCT clinicians are employing some type of therapeutic treatment more often than "containment" we are unable to substantiate how reliably these clinicians are actually implementing the therapies they nominated. In addition we may ask whether the therapies are suitable to be employed with BPD patients. In other words are they evidence-based practice therapies to be employed with BPD patients? The importance of evidence-based practice has come to the fore in public mental health services in recent years (Ahrens, 2005). While some models of therapy such as psychotherapy (DBT, CBT) have been considered as important treatment models, it is emphasised that they should be scientifically evaluated to demonstrate their efficacy within randomised clinical controlled trials (Paris, 2007). Although outcome of treatments is not a core area of interest in this current study, it is interesting to find that in recent years, an increasing number of studies in Australia have implemented DBT with BPD patients and found increasing evidence of successful outcomes (Davenport, Bore & Campbell, 2009).

Several conclusions can be drawn from the results derived from this present study. The challenges of working in community-based case management teams alone are reported to encourage clinicians to become vulnerable to burnout (Onyett, Pilinger, & Muijien, 1997; Prosser et al., 1996). Empirical research in the field of BPD patients (Linehan, 2000) has reported on the difficulties experienced in working with this group of patients. One can speculate that maybe irrespective of therapeutic orientation clinicians can have negative attitudes to patients with BPD. It may be more about the specific characteristics in BPD patients or about the clinician's level of confidence in working with these patients. Even so it appears paramount that CCT services focus increasingly on therapeutic treatments for BPD, which also requires adequate training of staff. Future research should consider treatment models as it is an important area that is likely to assist clinicians

(Hazelton et al. 2006) and is important in the context of education, training and supervision.

4.2.7 Years of Work, Interest and Attitudes

In this current study it was expected that an association between a clinician's years of work experience and their level of interest in working with BPD patients would provide some insight to their attitudes towards BPD patients. A post-hoc exploratory analysis was conducted which assessed a number of factors. The main factors assessed were years of work, level of interest, dislike working with BPD and anxious working with BPD. These variables were considered so as to ascertain if they contributed to clinicians' attitude towards BPD patients.

The more years of work experience a clinician had the less interested they were in working with BPD patients but years of work did not have an association with attitude towards BPD patients. More specifically, the more years of practice a clinician had, the less interest they reported in working with BPD patients. Interestingly nurses were the discipline with the longest years of work experience but had more negative attitudes towards BPD patients. Furthermore longevity of years of experience as analysed from this current study is not a factor that encourages a clinician to have a positive attitude towards BPD patients.

One explanation could be that, as a clinician becomes more experienced in working with BPD, their interest in working with BPD declines. Furthermore it may be that the more experienced clinicians in this current study entered CCT mental health services at a time when BPD was not such a controversial issue, and BPD patients did not receive as much attention. As a result, these clinicians with more years of experience have remained less interested. Similarly, another Australian study by Treloar and Lewis (2008), had also

considered years of experience as a factor that could be affecting a clinicians' attitude. Although their study had a specific focus on BPD patients who self - harm, they found similar results in that years of clinical experience were not associated with a negative attitude towards these patients.

A large majority of participants (59%) had less than 10 years of work experience in mental health services. This can be interpreted in a number of ways: 1. Less experienced clinicians chose to work with BPD patients because other more experienced clinicians prefer not to work with them, as they know that they may be more complicated and demand more time. Our findings indicated that those clinicians with more than 10 years experience did loose interest in working with this client group. It may be that new clinicians to CCT are likely to take on BPD clients due to the challenges they present. A further explanation may be team pressure: a new team member may feel obliged and more receptive to suggestions by management or the team and, as a consequence, take these patients others do not want to work with. But also, for some disciplines, having worked with BPD patients may be interpreted as being experienced and skilled.

Whilst clinicians' interest in working with BPD was lower in those with more years of practice, there was no significant relationship between years of practice and attitude and perceptions towards BPD. It may be that the more experience (conceptualised in terms of years practice) a clinician has the more realistic they are about the difficulties and challenges involved when working with BPD patients. Understanding the practical difficulties also means being aware of the skills, and the amount of time one needs to allocate for these patients. Those clinicians who had more years of experience were less interested in BPD though they were not more negative towards BPD patients.

Furthermore, another reason why clinicians with more years of experience could be less interested in working with BPD patients could simply be because they are reluctant to work with patients with multidimensional problems. These patients tend to need more time and have many other agencies involved with their care (Nehls, 2000).

Our research finding that clinicians who had less than five years experience indicated more interest in working with BPD may be related to recency of training. University graduates are considered to have acquired the most current research, education and training. Therefore, they may be more familiar with the latest therapeutic models of treatment including therapeutic approaches specifically tailored to BPD patients.

Additional analysis highlighted that there was an association between disliking working with BPD patients and being anxious working with BPD. It was interesting to note that 61% of participants stated their interest in working with BPD, but 62% had expressed that they were more anxious when working with this client group. In other words, those feeling anxious did not like working with BPD patients. Furthermore, there was an association between one's interest in working with BPD patients and a clinician's' level of confidence.

In conclusion, the number of years work experience is associated not with clinicians' attitude but with lack of desire to work with this client group. A clinician who has worked for many years may be of the mind that they have already worked for so many years in mental health. This may encourage them to perhaps select those patients who are not as complicated or time consuming.

4.2.8 Burnout Amongst Mental Health Clinicians

Burnout is a syndrome comprised of emotional exhaustion, depersonalisation and reduced personal accomplishment (Maslach et al., 1996). Emotional

exhaustion has been described (Maslach, Schauleli & Leiter, 2001) as being the core feature of an individual's stress dimension in burnout. This means that an individual's emotional and physical resources are exhausted. Depersonalisation represents the interpersonal dimension of burnout and involves negative, cynical, overly detached and impersonal attitudes and feelings towards people. Personal accomplishment represents the individual's understanding or thoughts towards their own achievement or productivity in their work.

The current study revealed that a large proportion (58%) of clinicians working in adult mental health CCT had a moderate to high range of emotional exhaustion. Furthermore, approximately 38% of the clinicians reported moderate to high levels of depersonalisation, while 61% of the participants rated low to moderate levels of personal accomplishment on the MBIHSS subscale. Hence, it appears that the sample showed both significantly high levels of emotional exhaustion and low to moderate levels of personal accomplishment. These findings provide support for a study by Younis and King (2007), who reported that mental health clinicians suffered high levels of emotional exhaustion and moderate to high levels of depersonalisation. In the current study, emotional exhaustion was correlated with depersonalisation, which is consistent with burnout theory (Maslach et al., 1996).

In the current study, it was expected that high levels of emotional exhaustion and depersonalisation would be correlated with the attitude (APS-BPDAMHC) scale, in that clinicians with high levels of emotional exhaustion and depersonalisation would be holding negative attitudes and perceptions towards BPD patients. This fifth hypothesis was only partially supported.

Overall, the results suggested a significant, but weak relationship between depersonalisation and negative attitudes towards BPD. Furthermore, the attitudes of the clinician were not correlated with emotional exhaustion. The

regression analyses revealed that depersonalisation and emotional exhaustion together predicted attitudes but only accounted for a limited amount of the variance.

The results also confirm that clinicians who develop high levels of emotional exhaustion are most likely to also to show depersonalisation tendencies. From this perspective negative attitudes towards BPD patients may develop as a result of clinician's depersonalising. In the current study only depersonalisation was found to be significantly associated with the attitude of the clinician, but not their level of emotional exhaustion per se.

Alternately, clinicians who have negative attitudes may distance themselves from their patient in order to protect themselves. By doing this they may reduce their sense of frustration and hence their feelings of accountability to engage with their client. By distancing themselves from these patients they would be reducing these feelings of inadequacy, which would ultimately weaken their responsiveness.

The above findings may be interpreted to suggest that those with negative attitudes probably utilise depersonalisation as a coping mechanism. It is commonly known that BPD patients have intense problems in regulating their emotions and behaviours, yet the clinician may feel that they lack the understanding, knowledge and skills and resources in working with this client group of patients who require intense involvement from them. (Linehan, Cochran, Mar Levensky & Comtios, 2000).

A study by Linehan (2000) assessed the stress levels of clinicians and also BPD patients over a period of four months. Clinicians providing therapy for BPD patients became emotionally exhausted, did depersonalise their clients and had lowered levels of personal accomplishment.

Similarly, our results indicated that the more years of experience a clinician had, the more likely they were to become emotionally exhausted and were also less interested in having BPD patients on their caseloads. But this did not necessarily affect their attitude towards BPD patients. There appears to be an association between a clinicians' level of burnout and their years of work experience. That is, the more years of work experience they have, the more susceptible they are to burnout. This can also be interpreted to be a contributing factor to their disinterest in taking those patients with a diagnosis of BPD.

In summary the current study found that 58% of the clinicians reported suffering from moderate to high levels of emotional exhaustion. Emotional exhaustion and depersonalisation were strongly associated with each other and depersonalisation was associated with negative attitudes. This relationship can be interpreted in two ways: depersonalisation can lead to negative attitudes or another explanation would be that negative attitudes lead to depersonalisation. According to Linehan (2000), a therapist's negative attitude towards patients is not only likely to erode the alliance, but can also lead to emotional exhaustion and burnout in both the therapist and their client.

4.2.9 Professional Development/Consultation with Spectrum

This current study addressed whether professionals who attended a specialised consultation service focussed on BPD had significantly more positive attitudes and perceptions towards BPD patients, as compared to those who did not attend such a service. As predicted, mental health clinicians who had received specialist consultation had more positive attitudes towards patients with BPD than those who had reported no specialist consultation.

Descriptive data from the present study highlighted what participants considered relevant factors discouraging clinicians from working with BPD

patients. Three of the four main factors related to training and supervision: lack of education and training for working with BPD patients (nominated by 75% of sample), lack of supervision with specialist expertise (75%), and lack of overall supervision (67%). The other main factor was heavy caseloads.

The results of this study were in line with previous research (Krawitz, 2004; Younis & King, 2007) in that clinicians' attitudes to BPD patients were significantly more positive if they received specialist consultation, training or supervision. As discussed earlier one Australian study by Krawitz (2004), reported on the change of clinicians' attitudes after a workshop, which provided educational knowledge, training in supportive psychotherapy and skill training. He reported on how the attitudes of clinicians changed when they developed and increased their knowledge and skills in working with this group of patients.

In further support of this finding an Australian study by Cleary et al. (2002), described that participants felt there was a shortage of services for BPD and that a specialist service for patients with BPD would improve their care for them. Ninety per cent of the participants indicated that they would be interested in further education and training on BPD. Similarly an international study by James and Cowman (2007) in Ireland highlighted that 80% of psychiatric nurses saw education as essential for their professional development and involvement with BPD patients.

Given that there is evidence suggesting that BPD patients are more difficult to treat, (Gallop, et al., 1989; Suokas, & Lonnquvist, 1989) it seems that clinicians working with them need to have specialised education and training. In support of this factor another Australian study by Younis & King (2007) revealed that clinicians who received supervision or focused training were able to reduce their negative attitudes towards BPD patients. This lends

further support to the conclusion that clinicians who receive specialised training on BPD develop more positive attitudes.

4.2.10. Study Findings and the CCT Service Context

The number of BPD patients seeking services at CCT was described earlier (Swartz et al., 1990) as being 11% in community settings and 20% in inpatient units. These numbers make it highly likely that CCT clinicians will be required to see this group of patients.

Clinicians in CCTs teams often work in teams that implement a "case management approach". But one may need to question what case management actually provides. More critical attention could be given to defining and measuring what case management is (Angell & Mahoney, 2006) and whether it is suitable for BPD patients. Unfortunately the effectiveness of a case management model, and whom it serves (i.e. client or service needs) may be considered to be obscure (Hennessy, 1993). In this current study CCT clinicians perceived that their work with BPD patients was not valued by their colleagues (44%) and that their work with BPD patients was not valued by their management (41%). But working as CCT clinicians they felt that they were not getting the resources they required to work with BPD patients. The heavy caseload (78%), lack of general supervision (67%), lack of specialist supervision (75%), and lack of education to work with BPD (75%) were very strong factors that discouraged them from working with BPD patients in their services.

The current study explored what treatment models CCT clinicians employed when treating BPD patients. Contrary to our hypothesis clinicians did not report containment as the model most often employed. The treatment model shown to be employed the most was cognitive behaviour therapy (CBT) indicated by 22% of the sample. Interestingly, the results of this current study found that case management (13%) and containment (13%) were equally

indicated as being as important in describing the work clinicians did with BPD patients. The fact that half the participants indicated they employed a type of psychotherapy as their preferred intervention may seem somewhat at odds with what is most often associated with CCT services, and the use of the case management model (Bachrach, 1993; Nehls, 2000).

The complexity of working with BPD patients has been presented extensively in literature. One author who has considered both case management and the difficulties experienced in working with BPD patients, is Nehls (1993, 1994, 1995, 1998,1999 & 2000). In particular, Nehls (1994) examined the work of nurses and the difficulties they face when working with this group of patients. The results of this present study support Nehls' (1994) view that services for BPD need to be improved. An important factor seems to be that of clinicians' choice of treatment models, supervision and training. In summary there is a need to increase clinicians' skills in working with BPD patients.

Clinicians who reported negative attitudes may have done so due to their lack of resources and understanding of effective therapies, which would otherwise assist them in their work with BPD and allow them to shift their negative attitudes. It appears that a therapeutic model that integrates sound evidence-based practice standards and meets the needs of this client group is what is required. Krawitz's (2002) study reported that clinicians' attitudes towards BPD changed and remained stable over a period of six months when they received theoretical knowledge and skills training, using psychodynamic, cognitive-behavioural, rehabilitation, and crisis treatments.

Furthermore the findings in this current study support the view that there appears to be a lack of clarity and consistency regarding the use of therapeutic models amongst this sample of CCT services. This may be one contributing factor to the negative attitudes of close to half (42%) of the sample of participants in the present study. Clinicians may be disillusioned

about what actually works when treating BPD patients. At the very least a substantial proportion of clinicians lack confidence in employing interventions. The above findings provide support to suggest that there appears to be a lack of uniformity and direction in which treatment models can be employed by those clinicians working in CCT services.

4.3 Strengths and Limitations of the Research.

This section analyses the strengths and limitations of the research. Sampling and design issues are discussed as well as measurement issues. One measure was developed for this study: Borderline Personality Disorder: The Attitudes of Mental Health Clinicians (BPDAMHC). The second measure, the Maslach Burnout Inventory (MBI: Linehan, 1986), is also discussed in terms of its applicability to the current study.

The study sample comprised 91 participants across five mental health CCT sites in the north-west area of Melbourne. Unfortunately no data was available on precise number of clinicians working in each of the CCT services that took part in this study. Nonetheless there was a high level of interest, and the overall number of clinicians who did participate appears to be a substantial sample of staff in these five CCT services. Of the 120 questionnaires distributed 91 were returned. The sample is representative in the sense that it includes significant representation from each of the professions working in the CCT multidisciplinary teams, and this is a strength of this study. Most often previous research has investigated a homogeneous group of clinicians only, such as psychiatric nurses (McAllister et al., 2002), whereas a broader range of clinical backgrounds has been examined less often (Leonard et al., 2005). Furthermore, whether or not a clinician had a special interest in this clinical group of patients was not assessed. Although confidentiality was emphasized, social desirability bias may have operated, influencing participants' responses.

4.3.1 Research design issues

A longitudinal rather than a cross-sectional study could have provided more comprehensive information around those issues pertinent to caring for patients with BPD. A longitudinal design would have made it possible to track shifts in attitudes. Sample size and the diversity of preferred interventions meant it was not possible in the current study to examine the relationship between attitudes and types of treatment models. A larger sample and/or a longitudinal study looking at a limited number of treatments could have permitted this. Furthermore a qualitative approach may have yielded richer data.

Though a relatively good representative sample of clinicians working over these five mental health CCT sites was achieved, the size of the current sample reduces the level of applicability to other clinicians working at different sites. An even greater sample size would be required to do this. While the results of this current study indicate associations between attitudes, professions, levels of burnout, training and consultation, a bigger sample may have yielded more interesting results.

Another limitation with regards to the study design: the absence of a comparison group. A comparison group of clinicians that did not work in CCT services but worked with BPD patients in a private setting could have been compared with the current sample of clinicians. This would have clarified whether the findings in this study are in some ways specific to the particular circumstances of CCT services.

4.3.2 Measurement issues

Measures of burnout have been used previously to examine clinicians from a particular professional group such as nursing staff (Kanste et al., 2006), but only few studies have focused on clinicians working with patients with BPD (Linehan et al., 2000). The questionnaire Borderline Personality Disorder: The Attitudes of Mental Health Clinicians (BPDAMHC) was designed for use in this study. This multi-faceted questionnaire included many items to assess experience treating BPD patients, treatment approach, attitudes toward BPD patients, interest in working with BPD patients and impediments to this work. An important consideration is whether the BPDAMHC is a valid instrument for the measurement of clinician factors in their experience of working with BPD patients. Because there are no previous data available it is difficult to make a psychometric evaluation as to the extent that it measures what it purports.

Much of the data from this questionnaire was used descriptively with two variables used in quantitative analysis: interest in working with BPD (single item score) and APS-BPD attitude total score (based on 12 items). The 12 item Attitudes and Perceptions Scale (APS) was found to have good internal consistency between items as indicated by Cronbach's alpha.

The study relied on self-report and did not control for the actual treatment components used, for example, nurses indicated they used CBT but it was not defined as to what they actually did with this therapy approach. The treatment label may not always reflect the actual treatment activities (especially given the substantial number of clinicians who indicated a lack of confidence in the intervention). As we did not control for this it may also be a variable contributing to the negative attitude of the clinician and levels of emotional exhaustion, but also less interest in working with this group of patients.

The inclusion of trainees (5) from various backgrounds with very little experience in working with BPD patients may have also contributed to scores on the APS.

Given the self-report nature of the questionnaire, social desirability is an issue that needs to be considered. Social desirability bias is defined as a response bias caused by participants desire to answer in a socially acceptable manner (McBurney, 1994). The design and format of the questionnaire (BPDAMHC) aimed at maintaining participants anonymity and did not request names of the participants or any other identifiable details such as their CCT service location.

Despite this it is likely that social desirability has affected participants' responses. If social desirability is impacting on clinicians attitudes we would need to be cautious in our interpretation of our results. At this stage we can only base our information on the data analysed but future studies may need to work effectively in an attempt to make some changes and consider designing their measurement or procedure of implementing their research to consider the impact of social desirability on clinicians. If it is true that the attitudes of clinicians are influenced by their peers, it may be that this can also play a role in them going along with the view that BPD patients are very difficult and cannot be treated.

Another variable that could influence the results of our study is that a comparatively young group of clinicians may want to demonstrate eagerness by portraying an attitude of openness and willingness. This could also result in a social desirability bias, although confidentiality was assured.

Overall, the BPDAMHC was found to be useful to identifying the various aspects of clinicians' experience in working with BPD patients. Some of the

methodological issues mentioned have included consistency of variables in the format and presentation of the questionnaire and the complexity of measuring a group of clinicians with a wide range of demographics and experience in the field of mental health.

4.4 Conclusions and Recommendations

This thesis examined the attitudes of 91 public mental health clinicians working in the north-west area of Victoria towards patients with a diagnosis of BPD. Borderline personality disorder remains a diagnosis that elicits controversy amongst professionals (Akiskal et al., 1986; Briere, 1989; Spitzer et al.,1979; Widiger, Miele, & Tilly, 1992). The current study found that a majority of adult mental health (CCT) clinicians hold positive attitudes to BPD patients. But there is also a substantial and significant number of clinicians working in mental health services who hold negative attitudes to BPD patients.

Most case managers working in public mental health services have to work with patients meeting criteria for BPD. Case managers who work in public mental health CCT services have been reported to be susceptible to burnout (Onyett, Pililinger & Muijen, 1997; Prosser et al., 1996) with an even a greater risk for those working with BPD patients (Younis & King, 2007).

As discussed earlier, this particular client group may constitute a challenge for some clinicians. Yet for others, working with BPD clients may signify experience and skills. These factors may influence the views and attitudes of clinicians working with patients with a diagnosis of BPD. Furthermore it may be desirable for clinicians to adhere to accepted trends within their own disciplines, and in their CCTs

The attitude of clinicians varied according to their discipline. Psychiatrists and nursing staff tended to hold more negative attitudes than social workers and

psychologists. There was no significant relationship between a clinician's years of practice and their attitude to BPD. But increased years of practice was associated with reduced interest in working with this group. More than half of the participants (58%) reported moderate to high levels of emotional exhaustion and low to moderate levels of personal accomplishment, which lends support to a recent study by Younis & King (2007). But contrary to expectation, emotional exhaustion was not associated with the attitude (APS-BPDAMHC) scale. There was, however, a significant, but weak relationship between a clinician's level of depersonalisation and their negative attitude towards BPD.

This present study was conducted in one region of Melbourne, covering the north-west catchment area. Future studies should look at comparing northwest mental health services (CCT) clinicians with those working in southern or eastern mental health services. Such a study may assist to understand if clinician's attitudes to BPD vary across catchment areas. If clinician's attitudes do vary across CCT sites it would be important to know what factors contribute to their attitudes towards BPD patients.

A majority of participants in this current study indicated that further education/ training and supervision could assist them in their work with BPD patients, which is well supported by research (Younis & King, 2007). In the current study the use of specialist consultation/supervision was associated with more positive attitudes to BPD patients. Hence, in Australia, mental health services need to assist and make these resources available to clinicians. The cost of patients entering inpatient wards is reported to be substantially higher than the cost of preventative measures such as more education/training and supervision for clinicians (Krawitz & Watson, 2004). Furthermore case managers need to be guided to adhere to current evidence-based practice models, and to consider perhaps those therapies that have been researched to be optimal for this patient group.

Furthermore, if clinicians who have received more education/training and supervision hold more positive attitudes and have lower levels of burnout (emotional exhaustion and depersonalisation), then more emphasis should be placed on training programs. Those clinicians with less experience may also benefit from supervision and support particularly when working in public settings. Therapists, clinicians that is, psychologists, social workers or other clinicians who opt to work with this group of patients, have more opportunities to broaden their skills by applying therapies that are considered the best suited to these patients. This may assist clinicians working with BPD patients and can reduce the likelihood of developing fatigue and burnout.

More than half of the sample of participants in this current research reported positive attitudes towards BPD patients. One important contributing factor for this result may be due to demographic factors. The majority of the sample (59%) had less then 10 years of professional experience. In addition they were, a comparatively young group of clinicians: more than a quarter (31%) were below the age of 30. More positive attitudes and younger clinicians may reflect current training programs espousing more optimism about treatment for BPD. Interestingly, the two disciplines that tended to have the most positive attitudes towards BPD patients (social workers and psychologists) did not have as many years of work experience in mental health. Furthermore, whether the attitude of a clinician was due to the model of therapy they employed, was not able to be examined in this study. For example, observing patients improve may encourage clinicians' level of confidence and hence assist in shifting their attitudes.

The current study revealed that some disciplines were less likely to hold negative attitudes than others. It may be that some disciplines are better suited to work with BPD patients than other disciplines, which should be acknowledged by CCT services. However, there may be a risk in that

professionals who work less with these patients will not gain the skills needed in order to work with these patients. Hence, professionals in inpatient wards should be provided with training and education in order to continue the work of CCT clinicians. It would be optimal if the same clinician could continue the work while his or her patient is on the ward.

Another question that needs to be raised is whether public mental health (CCT) services are indeed the best services for these clients? Case managers have reported difficulties due to the lack of resources (Nehls, 2000). Working with BPD patients involves having to set limits and boundaries, and structured programmes can have good outcomes (Linehan, 2000). Borderline patients require specific and specialised care from clinicians who have the resources to care for them.

The current sample comprised of clinicians working in public mental health services (CCT). Private mental health services or private practitioners were not included. A comparison between private and public mental health clinicians should be conducted. This could be an area of interest for future studies. It would also be interesting to research, which variables contribute to potential differences between their attitudes. This could assist future policies and planning in public mental health services for both their education and training.

In the present study, results highlighted that years of experience was not associated with negative attitudes towards BPD patients. Yet, it would be interesting to explore how attitudes change over time. By conducting a longitudinal study one could assess the attitudes of clinicians pre and post commencement of therapy. One Australian longitudinal study (six months post workshop) by Krawitz (2004) highlighted that attitudes of clinicians did improve with education and training.

Further empirical research needs to be conducted investigating the attitudes of clinicians towards BPD. First an extensive review of the BPDAMHC questionnaire should be conducted incorporating more variables impacting on clinicians' attitudes. Secondly, longitudinal research is required with a focus on the benefits of education/training and supervision and how they relate to particular therapeutic models for BPD patients.

Given that a considerable proportion (42%) of clinicians working in public mental health services do hold negative attitudes towards BPD, it is important to consider what strategies can be implemented to assist them. The current study, when compared with earlier studies, suggests a shift of attitudes towards BPD patients may have commenced. In order to sustain this apparent shift of attitudes, it has become clear that more can be achieved with the provision of more resources. Thus, it would be most valuable to consider the following areas of support: education/training, supervision, specialized supervision and support from staff and management in their work with the "difficult" patient. Future research must continue to adopt an investigative perspective with a focus on researching what factors could positively contribute to more clinicians working with and developing positive attitudes towards patients with BPD. An interesting area to focus on, could be the strategies or techniques clinicians employ in their treatments of BPD patients.

Much still needs to be learned about working with BPD. Importantly, more supervision and training for clinicians in CCTs in Australian mental health services are needed. Supporting clinicians in their work will ultimately assist patients with a diagnosis of BPD. The current research highlights a potentially important role for policy makers regarding the inclusion of supervision and training as being pertinent. Providing these resources to clinicians working in CCT services will ultimately help the consumers, that is, the patients, who suffer from BPD.

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Appendices

Appendix C

NorthWestern Mental Health

VICTORIA UNIVERSITY | A NEW SCHOOL OF THOUGHT

Information for Participants
Project Title: **Borderline Personality Disorder: The attitudes of Mental Health Clinicians**

Principal Researcher: Anne Graham
Student Researcher: Hanife Guducu

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1. **Invitation to participate and your consent.**
You are invited to take part in this research project. This Participation Information contains information about the project. Its aim is to explain to you clearly and openly procedures involved in this project, before you consent to take part in it.

Please read it carefully, if you have any questions please contact the student researcher Hanife Guducu at the first instance or the principal researcher Anne Graham.

Once you have read and understood the project's intentions and if you agree to take part, the project uses an implied consent procedure and there is no Consent form. By completing and returning the project questionnaire you will indicate to the researchers that you have understood the information and that you give your consent to be a participant in the research project.

2. **Purpose of the Study/Background Information**
The aim of the research is to examine the attitudes of clinicians in Community Mental Health Care services to clients diagnosed with Borderline Personality Disorder, and to investigate factors which may be related to attitudes, including years working in mental health, level of burnout, and experience of specialist consultation support with BPD clients.

A total of 100 clinicians will participate in this project.

This study is focused on Borderline Personality Disorder because patients with this diagnosis have been found to be among the most challenging patients that mental health clinicians work with. We are interested in finding out how clinicians view this work and what factors are related to clinicians' attitudes towards, and interest in working with, this diagnostic group.

3. **Procedures**
Participation in this project will entail completing a questionnaire consisting of:

- Part A: A questionnaire about clinicians' experience, attitudes and perceptions in relation to Borderline Personality Disorder, and aspects of the clinicians' work environment. Brief background (demographic) information is also sought. Time to complete this takes approximately 30mins.

- Part B is the Maslach Burnout Inventory (MBI)which will take approximately 15 minutes

4. **Possible Risks**
The project involves completing questionnaires. There are no known risks or side effects associated with completing this task. It is possible however that answering some questions may bring to mind distressing or stressful aspects of your work. If this is the case you have the option of ceasing your participation. In addition the researcher can help you to access some assistance, if required

5. **Privacy, Confidentiality and Disclosure of Information.**
No names or contact details will be requested. All information obtained from you will remain confidential.

The data will be placed in locked cabinets at Victoria University for a period of five years.

The research will be written up as a Doctor of Psychology thesis and may be published in an academic journal. No individual data will be reported, only group data.

6. **Results of Project**
All CCT managers will receive an outline of results of the project, and will be requested to make these available to staff. The student researcher would be available to present findings at the request of services who participated in the study.

7. Participation Is Voluntary
Participation in this research is voluntary. If you do not wish to take part you are not obliged to. Non-participation will not effect you or your workplace in any way.
If you have any questions that will help you to make your decision about whether to take part in the study please free to contact the student researcher or the principal researcher.

8. **Ethical Guidelines**
This project will be carried out according to the *National Statement on Ethical Conduct in Research Involving Humans (June 1999)* produced by the National Health and Medical Research Council of Australia. This statement has been developed in order to protect the interest of those people who agree to participate in human research studies.

9. **Further information or any problems**
You may contact the student researcher or the principal researcher or if you have any questions or concerns regarding the research project.

Student Researcher:
Hanife Guducu
School of Psychology
Victoria University
Mobile: 0413 020 295

Principal researcher and supervisor:
Anne Graham,
School of Psychology,
Victoria University
Phone: 9919 2159.

If you have any queries or complaints about the way this research is conducted you can contact:
The Secretary, University of Human Research Ethics Committee,
Victoria University
PO Box 14428 MCMC
Melbourne 8001
Phone: 03 9919 4710

Appendix D

Borderline Personality Disorder: The Attitudes of Mental Health Clinicians.

Principal Investigator : Anne Graham
Student Investigator: Hanife Guducu

School of Psychology
Victoria University

Please complete all sections of the questionnaire and return in the envelope provided.

School of Psychology, Victoria University
Principal Research and Supervisor

Experience working with Borderline Personality Disorder (BPD)

1. How many patients have you seen with a diagnosis of BPD during your professional career? (Please tick)

- ☐ 0
- ☐ 1-5
- ☐ 6-10
- ☐ >10

2. (a) Type(s) of treatment you use in working with people diagnosed BPD . Please tick as many as relevant.

- ☐ Cognitive Behaviour Therapy
- ☐ Psychodynamic Therapy
- ☐ Medication
- ☐ Eclectic Therapeutic approach
- ☐ Case management
- ☐ Containment
- ☐ Dialectical Behaviour Therapy
- ☐ Other (please state)

  .....
- ☐ Have not worked with BPD patients

(b) Which type of treatment do you <u>most commonly</u> use in working with people with a diagnosis of BPD ? Please name one:

.....

3. In relation to your experience working with borderline personality disorder, to what extent do you agree with the following statements? Please indicate by circling the number 1 2 3 or 4:

	Strongly disagree	Disagree	Agree	Strongly agree
I have an interest in working with this client group	1	2	3	4
I get more anxious working with this client group than with others	1	2	3	4
I am confident with the type of intervention/therapy I use with this client group	1	2	3	4
I dislike working with this client group	1	2	3	4

4. Would you say that there are some professions better suited to working with this client group than others? (please circle) Yes No

If Yes, please name professions more suited .....

.....

Attitudes and Perceptions

To what extent do you agree with the following statements about patients diagnosed with borderline personality disorder? Please indicate by circling the number 1 2 3 or 4:

BPD patients:	Strongly disagree	Disagree	Agree	Strongly agree
1. Will not get better and are just using scarce resources	1	2	3	4
2. May be ambivalent at first but develop a commitment to treatment	1	2	3	4
3. Should be discharged from inpatient units earlier as there are more seriously ill patients	1	2	3	4
4. Engage in distressing behaviour				

which is understandable given their history	1	2	3	4
5. Create problems among staff	1	2	3	4
6. Are likely to benefit from therapy	1	2	3	4
7. Are not suicidal but just fake it	1	2	3	4
8. Can form a working relationship with staff	1	2	3	4
9. Are not really mentally ill, but just manipulating the system	1	2	3	4
10. Need more access to inpatient units when they are at risk	1	2	3	4
11. Are a burden to the service	1	2	3	4
12. Appreciate help given	1	2	3	4

Work Environment

1. Prevalence of people diagnosed with BPD in your community mental health service

- ☐ Very rare (<1%)
- ☐ Rare (1-5%)
- ☐ Common (6-15%)

Very Common (>15%)
Don't Know

2. How many clients with a diagnosis of BPD are on your current caseload?

- ☐ 0
- ☐ 1-5
- ☐ 6-10
- ☐ >10

3. Do you feel those patients with a diagnosis of BPD are evenly distributed amongst your team members? (please circle) **Yes No**

4. How relevant are the following factors in discouraging you from working with borderline personality disorder patients (or from working with more BPD patients)? Please indicate by circling the number 1 2 3 or 4:

Appendix E

Christina Maslach • Susan E. Jackson

MBI Human Services Survey

The purpose of this survey is to discover how various persons in the human services or helping professions view their jobs and the people with whom they work closely. Because persons in a wide variety of occupations will answer this survey, it uses the term *recipients* to refer to the people for whom you provide your service, care, treatment, or instruction. When answering this survey please think of these people as recipients of the service you provide, even though you may use another term in your work.

On the following page there are 22 statements of job-related feelings. Please read each statement carefully and decide if you ever feel this way *about your job*. If you have *never* had this feeling, write a "0" (zero) before the statement. If you have had this feeling, indicate *how often* you feel it by writing the number (from 1 to 6) that best describes how frequently you feel that way. An example is shown below.

Example:

HOW OFTEN:	0	1	2	3	4	5	6
	Never	A few times a year or less	Once a month or less	A few times a month	Once a week	A few times a week	Every day

HOW OFTEN
0 - 6 Statement:

_____ I feel depressed at work.

If you *never* feel depressed at work, you would write the number "0" (zero) under the heading "HOW OFTEN." If you *rarely* feel depressed at work (a few times a year or less), you would write the number "1." If your feelings of depression are fairly frequent (a few times a week, but not daily) you would write a "5."

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MBI Human Services Survey

HOW OFTEN:	0	1	2	3	4	5	6
	Never	A few times a year or less	Once a month or less	A few times a month	Once a week	A few times a week	Every day

HOW OFTEN 0 - 6	Statements:
1. _____	I feel emotionally drained from my work.
2. _____	I feel used up at the end of the workday.
3. _____	I feel fatigued when I get up in the morning and have to face another day on the job.
4. _____	I can easily understand how my recipients feel about things.
5. _____	I feel I treat some recipients as if they were impersonal objects.
6. _____	Working with people all day is really a strain for me.
7. _____	I deal very effectively with the problems of my recipients.
8. _____	I feel burned out from my work.
9. _____	I feel I'm positively influencing other people's lives through my work.
10. _____	I've become more callous toward people since I took this job.
11. _____	I worry that this job is hardening me emotionally.
12. _____	I feel very energetic.
13. _____	I feel frustrated by my job.
14. _____	I feel I'm working too hard on my job.
15. _____	I don't really care what happens to some recipients.
16. _____	Working with people directly puts too much stress on me.
17. _____	I can easily create a relaxed atmosphere with my recipients.
18. _____	I feel exhilarated after working closely with my recipients.
19. _____	I have accomplished many worthwhile things in this job.
20. _____	I feel like I'm at the end of my rope.
21. _____	In my work, I deal with emotional problems very calmly.
22. _____	I feel recipients blame me for some of their problems.

(Administrative use only)		cat.		cat.		cat.
EE:	_____	_____	DP: _____	_____	PA: _____	_____

Appendix F

Clinician Data:

Please indicate the following:

Discipline/Profession

- ☐ Psychiatrist
- ☐ Psychologist
- ☐ Nurse
- ☐ Social Worker
- ☐ Occupational Therapist
- ☐ Psychiatric Registrar
- ☐ Trainee Psychologist
- ☐ Trainee in another mental health profession
- ☐ Other (please state)

Gender

- ☐ Male
- ☐ Female

Age

- ☐ <21
- ☐ 21-30
- ☐ 31-40
- ☐ 41-50
- ☐ >50

Years of Practice in Mental Health

- ☐ <5 years
- ☐ 5 -10 years
- ☐ 10-15 years
- ☐ 15-20 years
- ☐ >20 years

Thankyou for your participation
Please return in the envelope provided