

Thesis
The Effects of the Label Borderline Personality Disorder on Staff
Attributions and Intended Behaviour

Sophie Strong

July 2010

Thesis submitted in part fulfilment of the degree of
Doctorate in Clinical Psychology
University of East Anglia

© This copy of the thesis has been supplied on condition that anyone who consults it is understood to recognise that its copyright rests with the author and that no quotation from this thesis, nor any information derived therefrom, may be published without the authors prior, written consent.

ABSTRACT

Objectives

Reactions of a sample of mental health staff towards service users with borderline personality disorder (BPD) were investigated using the theory of causal attributions and the attribution model of public discrimination. The relationships between staff knowledge about BPD and attributions, emotions and intended behaviours were also investigated.

Method

A between participants vignette and questionnaire design investigated staff attributions of controllability, and dangerousness and intended behaviours of helping, social distancing and coercion towards a service user labelled with either BPD and depression (n=42) or depression alone (n=41). Staff knowledge about BPD was also assessed.

Results

Staff did not make more attributions of controllability and dangerousness towards service users with BPD but were significantly less likely to help them and more likely to intend to socially distance themselves. A number of staff attributions were significantly associated with their intended behaviours in the depression group but not in the BPD and depression group. Anger was significantly associated with intended behaviour in both groups whilst fear was only associated with staff intended behaviour in the BPD and depression group. Higher staff knowledge about BPD was significantly associated with more positive intended behaviours and attributions; higher treatment knowledge was associated with lower levels of intended coercive behaviour and attributions of controllability and higher levels of intended helping behaviour. In addition, higher

knowledge about the diagnostic criteria for BPD was associated with lower intended social distancing.

Conclusion

The results indicate that emotions of fear and anger and knowledge about treatment and diagnosis of BPD are important when thinking about staff reactions towards service users with BPD whilst controllability and dangerousness attributions are not. However, the lack of significant difference between the groups' attributions might have been a result of the limitations with the attribution measures used in this research. Future research should improve on the measures of attributions to answer these concerns.

CONTENTS

	Page
ABSTRACT	2
LIST OF APPENDICES	11
LIST OF TABLES	12
LIST OF FIGURES	13
ACKNOWLEDGEMENTS	14
CHAPTER ONE: INTRODUCTION	15
1.1 Aims of the Study	15
1.2 Chapter Overview	16
1.3 Borderline Personality Disorder	16
1.3.1 History of Borderline Personality Disorder	16
1.3.2 Diagnostic Concerns	19
1.4 Mental Health Staff and Service Users with Borderline Personality Disorder	21
1.4.1 The Challenges Staff Face	21
1.4.2 Staff Attitudes Towards Borderline Personality Disorder	22
1.4.2.1 Historical Attitudes of Mental Health Staff	22
1.4.2.2 Development of Effective Strategies	23
1.4.2.3 Current Staff Attitudes	24
1.5 The Impact of Negative Staff Attitudes	24
1.6 Theoretical Models	27
1.6.1 Early Models of Stigma and Labelling	27

1.6.2 Social Cognitive Model of Stigma	27
1.6.3 Attribution Theory	28
1.6.3.1 Weiner's Theory of Causal Attributions (1980, 1985, 1986)	30
1.6.3.2 Attribution Model of Public Discrimination towards a Person with a Mental Illness (Corrigan et al., 2003)	34
1.6.4 The Importance of using Labels as Signals for Stigma	35
1.7 Review of the Current Literature	36
1.7.1 Method	37
1.7.1.1 Search Protocol	37
1.7.1.2 Selection Criteria	38
1.7.2 Results	38
1.7.3 Review of the research	41
1.7.3.1 Staff Experience	41
1.7.3.2 Staff Responses	44
1.7.3.3 Staff Attitudes	46
1.7.3.4 Factors that influence staff attitudes	50
1.7.3.4.1 Psychoanalytic explanations of staff views of service users with BPD	50
1.7.3.4.2 Staff knowledge levels and training	53
1.7.3.5 The Relationship between Staff Attitudes and Responses	59
1.7.3.5.1 Weiner's theory of causal attributions	59
1.7.3.5.2 Dangerousness and social distancing	64

1.7.4 Conclusion	66
1.8 Rationale for the Current Research	69
1.9 Research Hypotheses	71
CHAPTER TWO: Method	73
2.1 Overview	73
2.2 Design	73
2.3 Participants	74
2.3.1 Inclusion Criteria	75
2.3.2 Rationale for Selection of Participants	75
2.3.3 Sample Size	75
2.3.4 Recruitment	77
2.4 Materials and Measures	78
2.4.1 Overview	78
2.4.2 Vignettes	78
2.4.3 Perceived Dangerousness Scale (Angermeyer, Matschinger & Corrigan, 2004)	80
2.4.4 Adapted Attribution Questionnaire 27 (AQ-27)	81
2.4.5 Social Distance Scale (Link, Cullen, Frank & Woznaik, 1987) as adapted by Hay, (2007)	83
2.4.6 Knowledge Questionnaire (James & Cowman, 2007)	84
2.5 Ethical Considerations	85
2.5.1 Ethical Approval	85
2.5.2 Consent	85

2.5.3	Deception	85
2.5.4	Confidentiality	87
2.6	Procedure	87
2.6.1	Data Collection Procedure	87
2.6.2	De-brief and Feedback Procedure.	88
2.7	Plan of Analysis	89
2.7.1	Preliminary Analyses	89
2.7.2	Statistical Analyses of Research Hypotheses.	90
CHAPTER THREE: RESULTS		94
3.1	Overview	94
3.2	Sample Composition	94
3.2.1	Response Rate	94
3.2.3	Demographics of the Sample	95
3.3	Preliminary Analysis	97
3.3.1	Internal Reliability of Measures	97
3.4	Hypothesis Testing	99
3.4.1	Hypothesis 1	99
3.4.1.1	Dangerousness	99
3.4.1.2	Controllability	100
3.4.2	Hypothesis 2	101
3.4.2.1	Helping behaviour	101
3.4.2.2	Coercion	102
3.4.2.3	Social distancing	103

3.4.3 Hypothesis 3	103
3.4.3.1 Depression alone group	103
3.4.3.2 BPD and depression group	105
3.4.4 Hypothesis 4	106
3.4.5 Hypothesis 5	107
3.5 Additional Analyses	108
3.5.1 Anger	108
3.5.2 Pity	109
3.5.3 Fear	110
3.6 Summary of results	111
CHAPTER FOUR: Discussion	114
4.1 Chapter Overview	114
4.2 Summary of Research Aims	114
4.3 Summary of Findings and Previous Research	115
4.3.1 Attributions	115
4.3.1.1 Dangerousness	115
4.3.1.2 Controllability	119
4.3.2 Intended Behaviour	122
4.3.2.1 Helping Behaviour	123
4.3.2.2 Coercion	123
4.3.2.3 Social Distance	125
4.3.3 Relationships between Attributions, Emotions and Intended Behaviours	125

4.3.3.1	Depression Alone Group	126
4.3.3.2	BPD and Depression Group	126
4.3.3.3	Comparison of the Two Groups	126
4.3.4	Knowledge Levels	131
4.3.4.1	Association with Attributions	131
4.3.4.2	Association with Intended Behaviour	131
4.4	Additional Analyses	133
4.5	Strengths and Limitations	134
4.5.1	Measures	134
4.5.1.1	Dangerousness	134
4.5.1.2	Controllability	135
4.5.1.3	Helping and coercion	136
4.5.1.4	Social distance	137
4.5.1.5	Knowledge	138
4.5.2	Methodology	138
4.5.2.1	Deception and Socially Desirable Responding	138
4.5.2.2	Order Effects	139
4.5.2.3	Use of Vignettes	139
4.5.2.4	Comparison of Two Labels	142
4.5.2.4	Measuring Intended Behaviour	143
4.5.2.6	Forced Choice	145
4.5.2.7	Sample	146
4.5.2.8	Design	147

4.6	Theoretical Implications	148
4.6.1	Attribution Theory	148
4.6.1.1	The Importance of the Signalling Event	149
4.6.2	Factors Associated with Intended Behaviour	151
4.6.2.1	Knowledge Levels	151
4.6.2.2	Emotions	152
4.6.2.3	Aspects of Attributions Theory that were not Explored	153
4.6.2.4	Specificities of Service User, Staff and Situations	154
4.6.3	Theoretical Conclusions	156
4.7	Clinical Implications	157
4.7.1	Attributions and Intended Behaviours	157
4.7.2	Importance of Emotions	158
4.7.3	Intended Behaviours	159
4.7.3.1	Importance of Knowledge	160
4.7.4	Labels as Signals	160
4.8	Future Research	161
4.8.1	Attributions, Emotions and Intended Behaviours	161
4.8.2	Additional Factors	163
4.8.3	Method	164
4.9	Conclusion	165
	REFERENCES	169
	WORD COUNT	39,969

LIST OF APPENDICES

Appendix A: Vignette for the BPD and Depression Group

Appendix B: Vignette for the Depression Alone Group

Appendix C: Adapted Attribution Questionnaire-27

Appendix D: Knowledge Questionnaire

Appendix E: Adapted Social Distance Questionnaire

Appendix F: Perceived Dangerousness Scale

Appendix G: Participant Information Sheet

Appendix H: Original Attribution Questionnaire-27.

Appendix I: Letter of Ethical Approval

Appendix J: Letter of Research and Development Approval

Appendix K: Informed Consent Form

Appendix L: Participant De-brief Sheet

Appendix M: A Sample of Boxplots and Histograms

Appendix N: A Sample of Scatterplots

LIST OF TABLES

Table 1.	Studies investigating staff attributions and behaviour towards service users with borderline personality disorder	38
Table 2.	Age range of participants within each group	95
Table 3.	Summary of participants' professions within each group	96
Table 4.	Number of items and the cronbachs alpha value for each scale used in this study	98
Table 5.	Means and standard deviations on the dangerousness measure	99
Table 6.	Mean, median and quartile scores of controllability attributions for both groups	100
Table 7.	Mean and standard deviations for the controllability question alone	101
Table 8.	Mean, median and quartile scores of helping behaviour for both groups	102
Table 9.	Mean and standard deviation scores for the two groups on the coercion measure	102
Table 10.	Means and standard deviations of both groups' social distance score	103
Table 11.	Spearman's rho correlations between participants attributions, emotions and intended behaviour scores in the depression alone group	104

Table 12.	Spearman's rho correlations between participants attributions, emotions and intended behaviour scores in the depression and the BPD group	105
Table 13.	Spearman's rho correlations between scores on the knowledge questionnaire and the controllability and dangerousness measures	107
Table 14.	Spearman's rho correlations between scores on the knowledge questionnaire and the social distance, helping and coercion measures.	107
Table 15.	Mean, median and quartile scores for both groups on the anger scale	109
Table 16.	Mean and standard deviation scores for both groups on the pity scale	110
Table 17.	Mean, median and quartile scores for both groups on the fear scale.	111

LIST OF FIGURES

Figure 1.	The Aviram, Brodsky and Stanley (2006) model	25
Figure 2.	The social cognitive model of stigma (Corrigan, 2000)	28
Figure 3.	A path model between attributions, affect and behavioural response (Willner & Smith, 2008b) based on Weiner's theory of causal attributions (1980, 1985, 1986)	30
Figure 4.	The path model within the model of public discrimination Towards a person with a mental illness (Corrigan et al., 2003)	34

ACKNOWLEDGEMENTS

Firstly, I would like to thank all of the Cambridgeshire and Peterborough NHS Foundation Trust mental health staff who took time out of their busy days to take part in this research; without them it would not have been possible. I would also like to thank Professor Malcolm Adams whose knowledge, advice and support helped put this thesis together. My thanks also go to my family and friends who supported me whilst I was conducting this research. Finally, I would like to thank my partner Christian who always listened and offered me endless support and encouragement at all stages of this project.

CHAPTER ONE: INTRODUCTION

1.1 Aims of the Study

This study aims to explore whether there are differences between the attributions and intended behaviours secondary mental healthcare staff make towards service users with the labels borderline personality disorder (BPD) and depression. Attribution theory (Heider, 1958) provides an explanation of the way people attempt to understand others by using previously existing knowledge structures to make internal or external attributions about their situation or behaviour. It suggests that a signalling event leads people to make attributions about another's behaviour or situation and these trigger emotional reactions and behavioural responses. Attribution theories have previously been used when exploring mental health staff stigma towards service users because they help explain the link between signals, stereotypes, affective reactions and behavioural responses. However, they have previously focused mostly on others' behaviour as the signalling event. The social cognitive model (Corrigan, 2000) suggests the signalling event can be a range of factors, including symptoms, behaviour, appearance and labels. This research uses the label of BPD as the signalling event. It is important to explore this because a label can often be one of the first pieces of information staff have about a service user before they have had any face-to-face contact. It could be very damaging if mental health staff form negative attributions about service users with BPD before they have met or experienced any difficulties with them. Aviram, Brodsky and Stanley (2006) highlight the damaging effects of this through their cyclical model that suggests negative staff attitudes can lead to them withdraw from service users with BPD and that the service users respond to this by increasing their difficult behaviour. This cycle highlights how

important it is to attempt to identify factors that are associated with staff behaviours towards service users with BPD. Identifying these factors will help to develop targeted strategies for improving staff reactions towards service users with BPD. As a result this research investigates whether staff attributions and emotions are associated with their intended behaviour. It also explores the associations between staff knowledge levels about BPD and their attributions and intended behaviour towards service users with BPD.

1.2. Chapter Overview

This chapter will begin by briefly discussing the diagnosis of BPD and how it has previously been perceived in the mental health system. Following this, attitudes of staff towards this disorder and the impact of these attitudes are considered. Theories of stigma will then be considered to provide a theoretical framework for exploring staff attitudes and attributions. Finally, a review of the literature on staff attitudes, attributions and stigma towards service users with BPD will be conducted before providing a rationale for the present study.

1.3 Borderline Personality Disorder

1.3.1 History of Borderline Personality Disorder

The term 'borderline' was introduced by Adolf Stern (1938). He used it to describe patients whose difficulties could not be explained by the existing diagnostic categories 'psychotic' and 'neurotic' and who would make attempts to cross therapeutic boundaries or reject the therapeutic relationship. The term continued to be used to describe patients whose behaviour, emotional states and thought processes rapidly shifted between psychosis and neurosis when under pressure, to relatively healthy when not (Schmideberg 1947). In the following years, the term 'borderline' developed from being

considered a personality organization, to a syndrome, then to a disorder, with the term borderline personality disorder (BPD) first being introduced in the Diagnostic & Statistical Manual III (American Psychiatric Association [APA],1980). The most recent definition of BPD comes from the Diagnostic Statistical Manual IV-Text Revision (DSM IV-TR) (APA, 2000). The diagnostic criteria are “a pervasive pattern of instability of interpersonal relationships, self image, affects and control over impulses beginning by early adult hood and present in a variety of different contexts, as indicated by at least 5 of the following”

- 1) Frantic efforts to avoid real or imagined abandonment. Note: Do not include suicidal or self mutilating behaviour covered in criterion 5.
- 2) A pattern of unstable and intense interpersonal relationships characterised by alternating between extremes of idealization and devaluation
- 3) Identity disturbance: Persistent and markedly disturbed, distorted or unstable, self image or sense of self
- 4) Impulsivity in at least two areas that are potentially self damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). Note: Do not include suicidal or self mutilating behaviour covered in criterion 5.
- 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 usually lasting only a few hours and only rarely more than a few days)
- 7) Chronic feelings of emptiness

- 8) Inappropriate intense anger, or lack of control of anger (e.g., frequent displays of temper, constant anger, recurrent physical fights)
- 9) Transient, stress related paranoid ideation or severe dissociative symptoms.

BPD is categorised as an Axis II, rather than Axis I, disorder because of the aetiological factors and long standing nature of the difficulties associated with it. Axis II disorders in the DSM IV-TR (APA, 2000) are characterised by long standing traits resulting from mainly psychological causes that have an unchangeable course. This is different from Axis I disorders, which are considered clinical syndromes defined by symptoms resulting from mainly biological causes that have an unstable, changeable course (Ruocco, 2005).

The prevalence rates of BPD were investigated by Coid, Yang, Tyrer Roberts and Ullrich (2006) who carried out one of the largest surveys of prevalence rates of personality disorder in Great Britain to date. They conducted a survey of a representative sample of adults aged between 16 and 74. They found 10.7% of the sample (628 participants) met criteria for any personality disorder. They also explored the prevalence rates of each of the DSM IV (APA, 1994) personality disorders; they found 0.7% of a sample of 628 people met criteria for BPD. Although BPD was not the most prevalent of the personality disorders they found that those with BPD were significantly more likely to use psychotropic medication and counselling. This makes it unsurprising that recent research indicates that a large number of service users receiving treatment from community mental health teams (Burns, 2006) and acute care services (Moran, 2002) in England are diagnosed with BPD.

1.3.2 Diagnostic Concerns

Despite the 'borderline' concept having been used by mental health professionals for many years, there are concerns about the current diagnosis of BPD. Firstly, there are concerns that it is a categorical diagnosis, whilst 'healthy' personality is explained as a collection of traits on a graded continuum (Haslam, 2003). This can lead mental health staff to consider BPD as a sign there is something fundamentally wrong with the service user's personality, as opposed to it being an extreme end of 'normal' personality. Furthermore, Widiger and Costa (1994) argue that a categorical diagnosis of BPD is too simplistic because it does not allow professionals to think about BPD in terms of differing presentations and levels of severity.

There are also concerns that BPD is not valid as a diagnosis because of the high co-morbidity rates and indistinct boundaries with other diagnoses (Preskorn & Baker, 2002). This is the case with disorders on both Axis I (for example, bipolar disorder) and Axis II (for example, histrionic personality disorder) of the DSM IV-TR (APA, 2000). Indistinct boundaries make it harder for mental health professionals to be confident that the symptoms a service user is experiencing are related to BPD rather than to a co morbid disorder.

In addition to the above concerns, there is the view that the label is simply not very helpful. McMurrin (2002) suggests the label is not helpful because the combination of psychological traits and difficult behaviours that are a large part of the diagnostic criteria make it difficult for people to differentiate between personality disorders and 'social deviance'. Furthermore, its placement on Axis II of the DSM IV-TR (APA, 2000)

could be contributing to the view that the disorder is ‘untreatable’ because of the nature of disorders on this axis being stable and enduring.

This lack of clarity and agreement about the diagnosis is one of the factors that increases staff disagreement about service users labelled with BPD and makes it harder to devise appropriate treatment plans. This can leave staff feeling as though they do not have the appropriate skills or support to manage these service users and that secondary mental health services are not specifically designed for treating or managing service users with BPD (Sampson, 2006; Webb, 2005).

The APA acknowledges the difficulties with the current diagnosis of BPD (APA, 2010) and a working group has been tasked with making changes to the criteria and diagnosis of BPD in the forthcoming DSM V. The most recent communication from this working group (APA, 2010) suggests the following changes are likely. Firstly, the label BPD will be changed to ‘borderline type personality’. This will be one of only five personality types and will be measured on a dimensional rating scale that indicates how well a person matches the ‘borderline type personality’. This will be rated from 1 (no match: description does not apply, to 5; very good match: patient exemplifies this type). In addition to this, the personality traits most commonly associated with the ‘borderline type personality’ will be measured on dimensional scale so individual trait profiles can be developed. The severity of the ‘borderline personality type’ will also be measured on a separate scale that measures the severity of impairment of both self and interpersonal functioning from 0 (no impairment) to 5 (extreme impairment).

It is hypothesised that these changes will reduce the lack of clarity and disagreement amongst staff surrounding this diagnoses and help them work with service

users with borderline difficulties more effectively. This is because fewer personality types along with more detailed trait profiles will reduce the co-morbidity with other personality disorders and help the diagnosis become more valid. It will also highlight how different people with 'borderline personality type' can be. In addition to this, the dimensional nature of the diagnosis and traits communicates that the 'borderline personality type' is on a graded continuum with 'normal' personality and enables staff to create an individual 'trait profile', even if a person does not meet criteria. Finally, a severity rating acknowledges that a 'borderline personality type' can impact on the way a person functions in different ways which will help individualise treatment and management plans.

1.4 Mental Health Staff and Service Users with Borderline Personality Disorder

1.4.1 The Challenges Staff Face

However, it is not only difficulties with the diagnosis that cause staff to experience difficulties when working with service users with BPD. It is widely acknowledged that service users with BPD can be a challenging to work with (Cleary, Siegfried, & Walter, 2002; Horsfall, 1999; Tredget, 2001). Gallop (1985) suggested that this was because their emotional instability can lead them to display impulsive and disturbing behaviour towards themselves and others. Despite this, a review of the literature indicates that nurses are not provided with adequate education, support and supervision to manage them effectively (O'Brien, 1998). O'Brien also reports that this lack of support and training results in nurses experiencing significant occupational stress when working with service users with BPD.

It is important to acknowledge that it is a reality that service users with BPD are often difficult for mental health staff to work with. Acknowledging this view as realistic is helpful because it strengthens the argument that adequate education, training and supervision are needed to reduce the impact of the difficulties staff experience.

1.4.2 Staff Attitudes Towards Borderline Personality Disorder

1.4.2.1 Historical Attitudes of Mental Health Staff

Although it is important to acknowledge that service users with BPD can be challenging to work with, there are also many rewarding aspects of working with them. However, there is no research that highlights these rewarding aspects. This reflects the general opinion that appears to focus on the difficulties staff have when working with this group of service users, whilst ignoring the positive aspects, and raises concerns that there is a stigma attached to the label of BPD.

Reber (1995) defined stigma as a 'blemish' or 'mark' on a person's reputation. Stigmatization is the process that identifies, labels, and attaches undesirable characteristics to those perceived as different. Stigmatised groups or individuals are often separated from the majority group and discriminated against. As a result, a label with stigma attached to it can be very damaging for service users, particularly if it is mental health staff who hold that view.

As early as the 1950s, Robert Knight (1953) raised concerns that the term 'borderline' was used by mental health professionals as a 'dustbin' term for service users who displayed difficult behaviours. There is evidence that this attitude has continued, as more recent research found that service users with BPD have traditionally been labelled as 'bad' as opposed to 'mentally unwell' (Reiser & Levenson, 1984). This attitude can be

considered stigmatizing because it attaches an undesirable characteristic to them rather than highlighting the difficulties staff might experience.

1.4.2.2 Development of Effective Strategies

The research above is relatively old. This is significant because over the last 15 years (Sperry, 2003), a paradigm shift has occurred that has begun to challenge some of the historical views. The development of therapeutic models such as Mentalization based treatment (Bateman & Fonagy, 2004), Dialectical Behavioural Therapy (Linehan, 1993) and Schema Focused Therapy (Young, 1999) has provided a basis for focused strategies and therapies that enable practitioners to work successfully with these individuals (Bateman & Fonagy, 2000). The development of these strategies does appear to have led to a greater understanding of the diagnosis and of the associated behaviours and difficulties people who have BPD experience at a national level. This is evidenced by new policy guidance for people with BPD: this guidance is found in the paper 'Personality Disorder: No longer a diagnosis of exclusion' (National Institute for Mental Health in England [NIMHE] 2003a) and in 'Breaking the cycle of rejection: The personality disorder capabilities framework' (NIMHE, 2003b). The most recent development is the recommendation for increased service provision for people with BPD (National Institute of Health and Clinical Excellence [NICE], 2009).

Furthermore, it is acknowledged that the diagnosis, although still presenting certain difficulties, also has helpful aspects. Gunderson (2008) argues that the diagnosis of BPD is vital because it helps mental health professionals be aware of the difficulties a service user with BPD might experience. This awareness means they can select evidence based interventions and strategies that are available to pre-empt or manage these

difficulties. Having a common label for a disorder also means mental health professionals can share a common understanding of the difficulties associated with it. This allows for easier communication between team members and services about individual service users. Service users also report the label can be helpful by helping to establish an alliance between them and mental health staff by helping them feel understood and by validating their distress and difficulties (Fallon, 2003). The label also means researchers can research a known construct. This increases the level of research and the amount of evidence-based treatment available, which encourages the implementation of specialist services.

1.4.2.3 Current Staff Attitudes

As a result of an increase in effective treatment strategies and more positive legislation about BPD, it could be assumed that staff attitudes towards these service users have also improved. However, research continues to find that staff working within mental health services view service users with BPD negatively. James and Cowman (2007) surveyed mental health staff attitudes and found they were less favourable towards those diagnosed with BPD than towards other diagnoses. Staff attitudes remain negative despite developments in effective strategies and treatment; this indicates there might be an element of stigma associated with this label.

1.5 The Impact of Negative Staff Attitudes

Research suggests that it can be damaging for mental health staff to hold stigmatizing attitudes about service users with BPD because the service users are often aware of them. Although some service users with BPD report having good experiences of mental health services (Fallon, 2003), many report having experienced mental health staff

as being unhelpful, hostile, unsympathetic and socially rejecting (Castillo, 2003; Nehls, 1999). Fallon (2003) also found that service users with BPD were aware of the negative attitudes of mental health staff, including staff thinking they were undeserving of care. As one of the diagnostic criteria for BPD relates to sufferers being more sensitive to rejection (APA, 2000), negative attitudes from mental health staff are highly likely to have a negative impact on their experience with mental health services. The cycle by Aviram et al. (2006) (Figure 1) highlights how this happens. They suggest that staff distance themselves from BPD service users due to their expectation that BPD service users will self-harm or refuse to engage in treatment. However, as BPD service users are sensitive to rejection, this often leads to self-harm and a refusal to engage in treatment. This confirms staff attitudes, leading them to withdraw further.

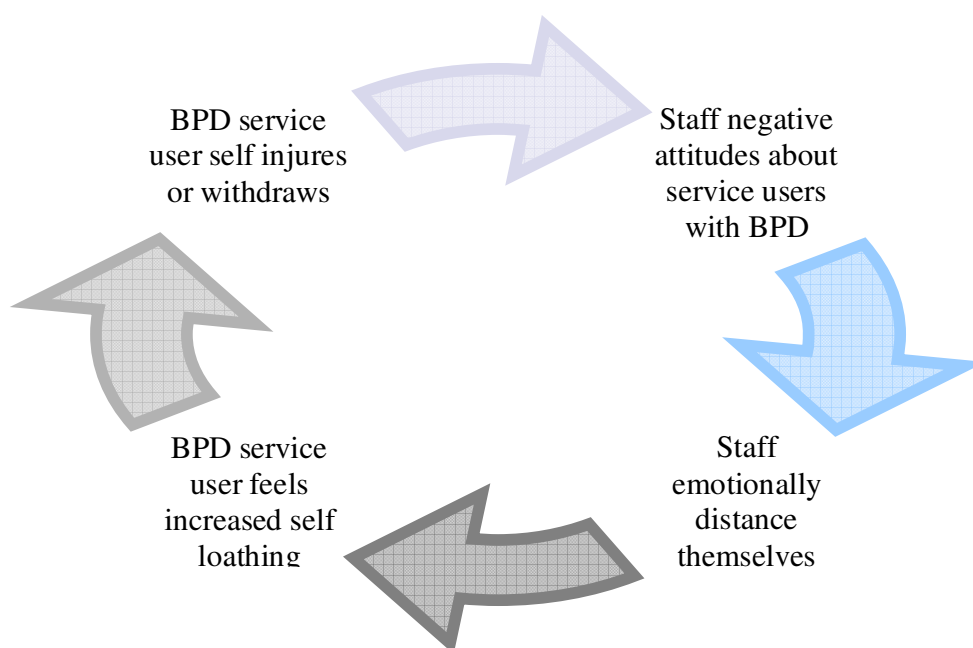


Figure 1. *The Aviram, Brodsky and Stanley (2006) model*

This model is supported by earlier research by Chessick (1990). He argued that the cause of difficult behaviour related to BPD does not lie with the service user, but is a result of the interaction between mental health professionals and the service user. This suggests that the behaviour and reactions of staff can have an impact on BPD service users' behaviour. Sherin and Linehan (1992) also support this theory; they found that non-judgemental attitudes in therapists were associated with less suicidal behaviour in BPD service users.

The Aviram et al. (2006) model also explains how mental health staff stigma towards the BPD label has been maintained. For example, service users with BPD have historically been marginalised within secondary care mental health services; community mental health teams did not feel it was appropriate to treat them (NIMHE, 2003a). Instead, they were often treated through accident and emergency departments and given inappropriate short-term admissions to psychiatric hospitals (NIMHE, 2003a). This resulted in service users finding it increasingly difficult to engage with mental health services and becoming what is known as 'revolving door patients,' which further reinforced their bad reputation.

This negative attitude might also be preventing service users from being diagnosed with BPD despite research suggesting the diagnosis is important and can be helpful. Research suggests BPD is currently under diagnosed. Zimmerman and Mattia (1999) found 0.4% of the patients in an inpatient clinic in America were diagnosed with BPD. Following this, they conducted the structured interview for DSM IV (APA, 1994) personality disorders with all service users and diagnosed 14.4% of patients. It could be argued that the difference in the rate of diagnoses is due to differences in research and

clinical interviews, and that researchers have time to diagnose this disorder whereas clinicians may be focusing on other issues. However, Gunderson (2008) argues that the diagnosis is underused because staff are worried that service users will be discriminated against if they receive a diagnosis of BPD.

1.6 Theoretical Models

1.6.1 Early Models of Stigma and Labelling

Staff attitudes remaining negative despite an evidence base of effective treatment strategies suggests that stigma might be playing a role in maintaining the negative attitudes of staff.

Early concepts of stigma, such as Goffman's (1963), suggest that certain individuals have attributes others considered deeply discrediting and indicate the stigmatised person is 'tainted'. Link, Cullen, Struening, Shrout, and Dohrenwend's (1989) modified labelling approach explains this in relation to psychiatric labels. They argue that psychiatric labels elicit existing beliefs about mental illness that affect people's attitudes towards those who are given those labels. Both these models explain how people can form stigmatizing attitudes towards others because of particular attributes or labels. However, neither attempts to explain how stigma can lead people to behave in a discriminatory manner. Given the negative impact staff stigma can have on BPD service users, it is important to think about models that help identify what triggers staff stigma, what form the stigma might take and the effect this might have on their behaviour.

1.6.2 Social Cognitive Model of Stigma

Social cognitive models help do this because they explain the relationship between attitudes and behaviour. Corrigan's (2000) social cognitive model specifically

explains the process of stigmatization towards people who are mentally ill. The model in Figure 2 explains how signals that indicate a person is mentally ill can lead to stereotypes and these stereotypes lead to discriminatory behaviour.

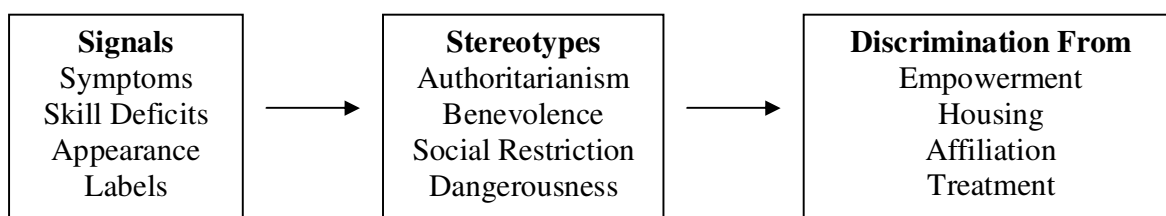


Figure 2. *The social cognitive model of stigma (Corrigan, 2000)*

This model, which highlights the relationship between stigma signals stereotypes and discrimination, was originally developed to further understanding about the process of stigmatization within communities. However, it is not only wider society that holds stigmatizing attitudes towards people with mental health problems. Björkman, Angelman and Jonsson, (2008) found mental health staff stigmatize certain groups of service users. The above model is useful for thinking about stigma within mental health professionals because it provides a framework that helps identify the signals and stereotypes that lead staff to stigmatize particular groups of service users as well as the discriminatory behaviour they might display. However, although the above model is useful for highlighting the path between signals, stereotypes and discrimination, it does not give a clear explanation of why particular signals lead to particular stereotypes and discrimination.

1.6.3 Attribution Theory

A cognitive theory that further explains the relationship between stigmatizing attitudes and discriminatory behaviour is attribution theory. Attribution theory was first

described by Heider, (1958). He argued that people have an innate desire to understand themselves and their surroundings. As such, they constantly attempt to make sense of themselves and the people they interact with by making internal or external attributions about their own and others' behaviour. Making an internal attribution means a person believes the cause of a behaviour is within a person (for example a result of temperament of personality) whilst external attributions suggest circumstances are the reason behind another's a behaviour. Since the 1950's there has been much research and interest in attribution theory. This has helped developed the theory into a model that helps explain the link between signals, stereotypes, affective reactions and behavioural responses. Kelley (1973) was the first to develop Heider's theory further. Kelley suggested three factors that cause people to make internal (to the person) or external (to an object or environment) attributions. These were distinctiveness (the way a person behaves in different situations), consistency (if a person repeats the same behaviour) and consensus (if many people would behave the same way). For example, if a person considers behaviour to have low distinctiveness and consensus but high consistency, their attributions are more likely to be internal; if they consider behaviour to have high distinctiveness and low consistency and consensus, the behaviour would be externally attributed (Orvis, Cunningham & Kelley, 1975). However, there are several limitations with this theory. Firstly, it often requires a person to have witnessed behaviour more than once. Secondly, it does not include any inferences about the intentionality of the behaviour of another. This is a particular weakness because it is this intentionality that is thought to create the link between the attributions, emotions and behaviour (Weiner, 1980).

1.6.3.1 Weiner's Theory of Causal Attributions (1980, 1985, 1986)

Weiner's causal attribution theory does include inferences of intentionality. The theory outlines a cognitive emotional process that explains how people make attributions about the controllability (whether a person has control over the causes of their behaviour), stability (whether there will be change over time) and locus of control (whether the cause of the behaviour is internal or external). He went on to argue that these attributions result in emotional reactions, such as anger and pity or feelings of optimism, which affect the likelihood of helping or punishing behaviours as shown in Figure 3.

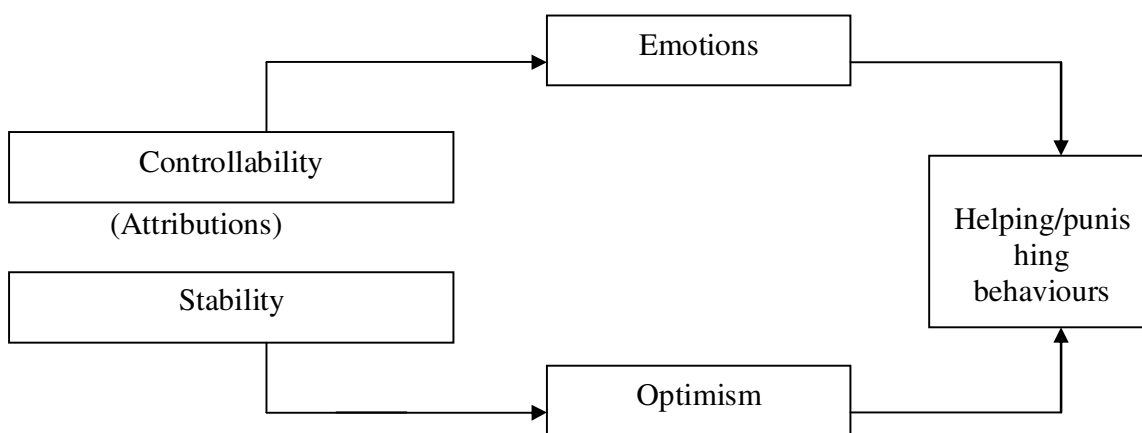


Figure 3. A path model between attributions, affect and behavioural response (Willner & Smith, 2008b) based on Weiner's theory of causal attributions (1980, 1985, 1986)

Weiner's attribution theory (1980, 1985, 1986) is also helpful for thinking about mental health stigma. Applied to mental illness, attribution theory suggests that when a person attributes another's mental illness to internal factors, they perceive a person's mental illness to be caused and maintained by factors that are internal and controllable. This means they think the person with the mental illness has control over their illness and

behaviour. These attributions subsequently lead to negative emotions and behaviour towards the person with the mental illness. In contrast, when people attribute another's mental illness to external factors, their perception is that the person does not have any control over their mental illness and therefore cannot be held responsible for the cause or maintenance of it. This view leads to a more positive and sympathetic view of the person with the mental illness. It can also be considered helpful for examining mental health staff stigma because they also make stigmatizing attributions about service users' behaviour as a result of knowledge structures built on previous experience and peer attitudes (Miller & Davenport, 1996). This is evidenced as it has been used in previous research about mental health professionals' views of the service users with whom they work. For example, it has been widely used within the literature to investigate professionals' views of challenging behaviour displayed by service users with intellectual disabilities (Willner & Smith, 2008a).

Finally, Weiner's theory (1980, 1985, 1986) is more specific than the social cognitive model of discriminatory behaviour described in section 1.6.2 because it suggests that attributions of controllability, stability and internality are the underlying causes of the path between signals, stereotypes and behaviour. As such it can be considered a helpful model for thinking about the relationship between stigma and discriminatory behaviour (Corrigan et al., 2001; Sharrock, Day, Qazi, & Brewin, 1990). Having a specific theoretical construct linking the path between signals, stereotypes and behaviour helps develop specific research questions about why certain stereotypes are held about certain signals and subsequently what could be done to change them. This could lead to more effective anti-stigma campaigns.

However, some aspects of this model suggest it is only of limited use when looking at the process of stigmatization with mental health professionals. Firstly, it focuses on signalling events as behaviours whereas other social cognitive models suggest signalling events can be a range of factors, such as symptoms, behaviour, appearance and labels. Secondly, a literature review of ten studies by Willner and Smith (2008a) that looked at how well attribution theory explains a carer's intention to help found inconsistent results that only partially supported Weiner's (1980, 1985, 1986) theory. One possible explanation for this is that none of the research in this review explored beliefs about personal responsibility and blame. Weiner's (1995) later work argued that attributions of controllability led to judgements of personal responsibility that led to blame. It could be argued that these concepts are very similar to controllability (Tennan, Affleck & Gershman, 1986). However, Weiner (1995) argued the difference was important because people could be in control of their behaviour and not held responsible or blamed. An example of this is a person who purposely kills another to defend themselves or a loved one; they are considered in control of their behaviour, but not held personally responsible or blamed because they were forced to act in defence. Weiner goes on to argue that in these cases it is the inferences of responsibility that lead to the emotional reactions and subsequent behaviours, not the controllability attributions. However, a number of studies in Willner and Smith's (2008a) literature review found that controllability attributions are enough to form a path to feelings of anger or pity and helping and punishing.

In addition to this, research into social stigma suggests that controllability is not the sole attribution people make about those with a mental illness (Corrigan et al., 2001).

It has been found that people also make attributions of dangerousness, which can lead to the view that those with a mental illness should be avoided, coerced into treatment and segregated (Link, Phelan, Bresnahan, Stueve & Prescosolido, 1999). Research has found that mental health professionals also hold attributions of dangerousness about certain service users (Cohen & Struening, 1962). Furthermore, Bowers (2002) found that staff with a less positive attitude towards service users with an unspecified personality disorder favoured management strategies that involved coercion, such as stricter rules and more use of containment methods, such as seclusion. They also considered containment measures appropriate 'punishments' for difficult behaviour. This suggests that staff stigmatization of those with mental illness cannot be explained using only Weiner's (1980, 1985, 1986) theory of causal attributions.

Furthermore, use of Weiner's (1980, 1985, 1986) theory of causal attribution could be considered less appropriate when exploring mental health staff stigmatization because the discriminatory behaviour in this model is based on helping or punishing; mental health staff are paid to help those with mental illness so this will bias their behaviour regarding this at work. The model by Aviram et al. (2006) suggests the impact of negative staff attitudes is not specifically about not helping the person, but about withdrawing from them. This suggests that staff withdrawing behaviour should also be investigated.

As a result of the above concerns, other attribution models that help explain stigmatizing attitudes and discriminatory behaviour should be explored. One attributional model that looks at withdrawal from people with mental illness is the Corrigan,

Markowitz, Watson, Rowan, and Kubiak (2003) attribution model of public discrimination towards persons with a mental illness.

1.6.3.2 Attribution Model of Public Discrimination towards a Person with a Mental Illness (Corrigan et al., 2003)

The model, which is depicted in Figure 4, is a more recent attribution model that attempts to explain public discrimination towards those with a mental illness.

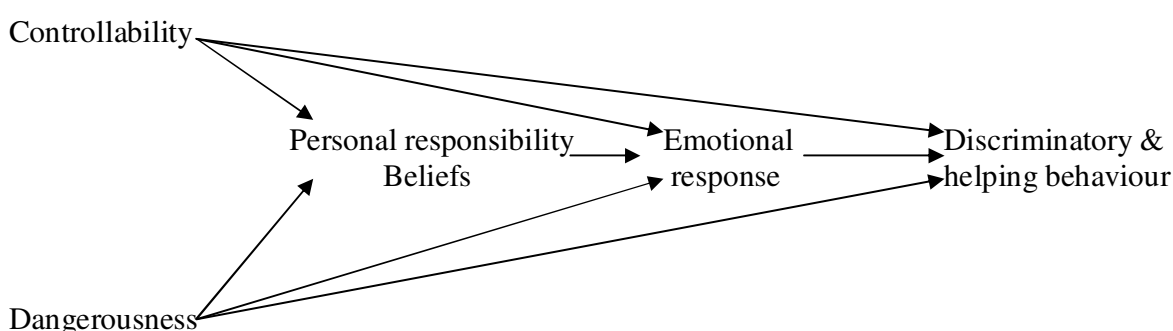


Figure 4. The *path model within the model of public discrimination towards a person with a mental illness (Corrigan et al., 2003)*

As Figure 4 shows, the model suggests that attributions of controllability and dangerousness explain the relationship between stigmatizing attitudes and discriminatory and helping behaviour. The discriminatory behaviours include coercion and social distance. Although there are certain characteristics of this model that are shared with Weiner's (1980, 1985, 1986) earlier attribution theory, such as the attributions of controllability, and his later theory that includes beliefs about personal responsibility (Weiner, 1995), there are also important differences. Firstly, this model was developed to explore people's reactions to a mental illness label. As such, much of the research that has been conducted using this model has used mental health labels as the signal for attributions (Corrigan et al., 2001; Corrigan et al., 2003, Corrigan et al., 2004; Corrigan

2005). Previous attribution theory mainly focused on others behaviours as cues for attributions. Secondly, this model also argues that people make attributions of dangerousness based only on a person's mental health labels. This is important because it suggests that dangerousness attributions are made before any dangerous behaviour has been witnessed and that these attributions lead to behaviour such as avoidance and segregation (Link et al., 1999). Finally, in addition to helping, this model specifically names coercion, segregation and avoidance as behaviours that result from the attributions and emotions. Whilst it could be argued that the 'punishing behaviours', named in earlier attribution theory (Weiner, 1980, 1985, 1986, 1995) include these behaviours they did not name them specifically.

Previous research suggests that this model helps explain the process of stigma towards those who are mentally ill within the general population (Corrigan et al., 2003). It has also found that some mental health staff consider service users labelled with a personality disorder to be more dangerous than service users with other mental health labels and that this causes them to be more coercive in their treatment of them (Bowers, 2002). This suggests that the Corrigan et al. (2003) attribution model of public discrimination towards persons with a mental illness could also be a useful framework to use when exploring staff reactions towards the label of BPD. This particularly includes the attributions they might hold about service users with BPD and the discriminatory behaviour that they may display towards them.

1.6.4 The Importance of using Labels as Signals for Discriminatory Behaviour

Weiner's (1980, 1985, 1986) attribution theory and the Corrigan et al.(2003) attribution model both share the same path as that described in the Corrigan (2000) social

cognitive model; they all begin with a signalling event that leads to stereotypes or attributions being held about a person or event that affect behaviour. The attributions are at the stereotyping stage of the social cognitive model (Corrigan, 2000). However, specific elements of them are different. For example, attribution theory ordinarily focuses on signalling events that are a behaviour or event, whilst the social cognitive model considers the class of signalling events to be much wider. If considering attribution models in the context of the social cognitive model, then attributions can arise from signals other than behaviour, such as labels. To explore mental health labels would be particularly relevant to mental health professionals because diagnostic labels have previously been found to increase mental health staff attributions of responsibility towards service users and that these attributions influence the decisions they make about them (Grossman, 2004). Furthermore, mental health professionals are often provided with a service users' mental health label within referral information which they receive before they meet them. In line with a path model of attribution theory, if mental health staff hold negative attributions about a service user based on their label, this could lead them to behave in a discriminatory manner before the service user has behaved in a difficult manner.

1.7 Review of the Current Literature

The current evidence that explores staff reactions towards service users with BPD was reviewed. This was done by systematically searching the literature for studies that investigated staff attitudes, attributions and behaviour towards service users with BPD.

1.7.1 Method

1.7.1.1 Search Protocol.

Review studies were sourced from four computer databases: PsycINFO (1887 to present) Medline (1950 to present) through First Search, Embase (1980 to present) through Ovid SP, and EBSCOH was used to search CINAHL plus. The search terms and Boolean connectors used were as follows:

Stigma OR attributions OR attitudes

AND

'Personality disorder' OR 'Borderline personality disorder'

AND

Staff OR Nurses

AND

Behaviour OR reactions

The databases were searched for summary terms. The search was limited to abstracts, documents in English and those that used human participants. Reference lists from obtained articles were hand-searched to retrieve relevant studies not already identified.

PsycINFO yielded 60 articles, Embase produced 1 article, Medline produced 7 articles and CINAHL plus produced 7 articles. Combining these searches and removing duplicates resulted in 62 articles, 21 of which were directly related to BPD. The reference lists of these articles were searched manually and produced 12 additional articles. This gave a total of 33 articles.

1.7.1.2 Selection Criteria

The 33 articles were examined for the following inclusion criteria: The research had to focus on clinical staff currently working in mental health settings, and their views on service users with BPD, or the label of BPD (author defined), and the articles had to be from peer reviewed journals. The following exclusion criteria were also used: Research that investigated staff views about mixed populations was excluded, for example, research looking at BPD amongst other diagnoses of personality disorder. Articles exploring BPD service user views of staff attitudes were also excluded.

1.7.2 Results

After examination, 19 studies met the inclusion criteria; these are included in this review and are summarised in Table 1.

Table 1. Studies investigating staff attitudes, attributions and behaviour towards service users with borderline personality disorder.

<i>Reference</i>	<i>Participants</i>	<i>Objective</i>	<i>Design</i>	<i>Outcome</i>
Cleary, Siegfried and Walter (2002)	229 mental health staff	Exploring attitudes towards and knowledge and experience of BPD	Descriptive survey	The majority of participants found it difficult to deal with service users with BPD
Commons-Treloar (2009)	65 medicine and mental health staff	Examining cognitive behavioural and psychoanalytic education programmes on staff attitudes towards deliberate self-harm in BPD service users	Quantitative	Participants in the cognitive behavioural and psychoanalytic education programmes showed significantly improved attitudes when compared to participants in the control group.

Table 1 continued

Commons-Treloar, and Lewis (2008a)	140 mental health and emergency medical practitioners.	Investigating attitudes towards self-harm in BPD	Quantitative	Emergency staff attitudes are more negative than those of mental health staff.
Commons-Treloar, and Lewis (2008b)	99 mental health and emergency medical practitioners.	Investigating the impact of education on staff attitudes towards self-harm in BPD	Quantitative	Targeted education improved all staff attitudes.
Deans and Meocevic, (2006)	65 registered community and inpatient Psychiatric Nurses	Measuring participants' attitudes towards service users with BPD	Descriptive survey	The majority of participants reported negative reactions and attitudes towards BPD service users.
Forsyth (2007)	26 psychiatric nurses and support workers	Comparing mental health staff attributions towards clients with BPD or MDD	Quantitative	Staff were more helpful to MDD patients than to BPD patients.
Fraser and Gallop (1993)	17 nurse leaders and 164 service users	Comparing nurses' responses towards service users with BPD and other diagnoses	Quantitative	Nurses respond in a less empathic manner to BPD service users than to those with other diagnoses.
Gallop, Lancee, and Garfunkel (1989)	113 inpatient Psychiatric Nurses	Investigating expressed empathy towards the labels BPD and schizophrenia	Quantitative	Nurses offered less empathy and more belittling responses to BPD patients.
Hazelton (2006)	94 mental health staff	Exploring the effect of training staff in the use of Dialectical Behaviour Therapy for BPD	Quantitative/ Qualitative	The training improved the therapeutic outlook.

Table 1 Continued

James and Cowman, (2007)	65 clinical nurses	Exploring nurses knowledge, experience and attitudes towards service users with BPD	Descriptive survey	The majority of participants reported that BPD service users were more difficult to care for than other service users
Krawitz, (2004)	418 mental health and substance abuse staff	Assessing the impact of a brief training event on attitudes towards BPD service users	Quantitative	The training caused positive change in participants' attitudes
Markham (2003)	71 psychiatric nurses and health care assistants	Investigating the effects of BPD on staff attitudes	Quantitative	Staff were least optimistic about BPD patients.
Markham and Trower (2003)	48 psychiatric nurses	Examining how BPD affects staff perceptions and causal attributions about patient's behaviour	Quantitative	Patients with BPD attracted more negative responses from staff.
Martin-McIntyre and Schwartz (1998)	155 licensed psycho-therapists	Examining counter-transference reactions towards clients with major depression and BPD	Quantitative	Those with BPD were seen as more hostile and dominant than those with major depression.
Miller and Davenport (1996)	32 psychiatric nurses	Examining the effects of a self-instructional programme on attitudes towards BPD	Quantitative	The programme significantly improved attitudes.
O'Brien and Flote, (1997)	6 psychiatric nurses	Exploring participants' experiences of caring for BPD service users	Qualitative	Nurses often felt unsure and in conflict about service users' behaviour.

Table 1 continued

Rosenkrantz and Morrison (1992a)	158 members of the American Psychological Association (APA) division of psychology	Investigating psychotherapists' reactions to patients with BPD	Quantitative	Therapists responded more positively to BPD clients in the rewarding object relations vignette
Rosenkrantz and Morrison (1992b)	155 members of the APA division of psychology	Examining influence of therapist's personality characteristics on their reactions to BPD patients	Quantitative	High boundary therapists evaluated themselves more positively and devalued BPD patients less.
Woolaston and Hixenbaugh (2008)	6 psychiatric nurses	Investigating perceptions of service users diagnosed with BPD	Qualitative	Nurses have negative experiences of service users with BPD as a result of negative interactions and a lack of skills.

1.7.3 Review of the Research

Overall, the studies indicated that staff attitudes, experiences and responses towards service users with BPD were more negative than they were towards other service users, regardless of whether they were compared to a control group without a diagnosis or one diagnosed with depression or schizophrenia. The causes for this in the separate studies will be discussed in detail below.

1.7.3.1 Staff Experience

O'Brien and Flote (1997) used a phenomenological framework to explore the experiences of six nurses who were providing nursing care to a service user with BPD

displaying severe and life threatening behaviours on an inpatient unit. The phenomenological framework used in this research is a strength because it provides a holistic understanding of the situation being discussed. This enabled the researchers to develop ideas about how a lack of systemic support was contributing to the nurses' experience of working with this individual as opposed to focusing solely on their behaviour. Conflict was identified as an important theme, with nurses reporting that they had conflicting feelings towards the service user, particularly empathy and anger. They also reported conflict between staff members; this arose mainly when some nurses were treating the service user differently.

A further theme all nurses agreed on was feeling frightened. They reported feeling frightened because situations with the service user could quickly become out of control and could become personally and professionally damaging. They considered this particularly frightening because they felt that the organisations they worked for held them personally responsible for the safety of individuals.

This research focused on the detailed experience of a small number of participants and is about one individual service user with BPD who was acutely unwell and exhibiting severe and life threatening behaviour. Exploring participants' experiences in detail is a strength of this research because it highlights how difficult it can be to care for BPD service users when they are actively engaged in attempts to end their life. However, a drawback of this method is that the findings cannot be generalized. Furthermore, it would have been useful to explore nurses' experiences of providing care to a service user displaying severe and life threatening behaviours who did not have a diagnosis of BPD;

this would have helped clarify if the diagnosis of BPD affected their experiences and attitudes.

Woolaston and Hixenbaugh (2008) also conducted a piece of qualitative research exploring six nurses' perceptions and experiences of service users diagnosed with BPD. A thematic analysis was used to explore the data and identify themes. A thematic analysis was helpful because it allowed participants' responses to influence the direction of the analysis and the subsequent themes that emerged. This means it can be considered a true reflection of their experiences.

The core theme highlights how difficult it can be for nurses to work with BPD service users and was named 'the destructive whirlwind'. This name reflects the nurses' experience of BPD service users as a 'powerful, dangerous and unstoppable force' who leave 'a trail of destruction' behind them. Other themes that were identified also demonstrated the difficulties nurses experience when working with BPD service users. These included BPD service users being threatening towards themselves, others or property if their demands were not met. Nurses also said they thought that service users with BPD were often 'manipulative' and 'dishonest' when interacting with them. This resulted in nurses feeling as though they had to be particularly guarded and careful in their interactions with BPD service users.

Care giving was also named as a theme. This theme highlighted nurses' beliefs that BPD service users were untreatable so would not get better. This left them feeling hopeless and de-skilled.

The research by Woolaston and Hixenbaugh (2008) highlights how difficult it can be for nurses to work with BPD service users and supports the findings from O'Brien and

Flote's (1997) research. This is important because the research by Woolaston and Hixenbaugh does not focus solely on BPD service users who are displaying serious life threatening behaviour. This suggests that it is not only the serious and life threatening behaviour BPD service users display that cause nurses to experience difficulties working with them; it is also other aspects of the service users behaviour, such as thinking they are being manipulative, the way they can idealize and demonize staff, and the hopelessness that nurses feel about these service users getting better. However, a drawback of this research is that it cannot be generalized to other settings or staff groups due to the small number of participants, all of whom were psychiatric nurses.

1.7.3.2 Staff Responses

Gallop, Lancee, and Garfunkel (1989) ensured their research could be generalized to a certain extent because they used a large number of participants (N=113). They compared how the labels 'BPD' and 'schizophrenia' affected psychiatric nurses' empathic responses to patients using a within participants experimental design. The staff-patient interaction response scale (SPIRS) was completed by all participants. The scale describes the demographics of four hypothetical service users and several statements they might make. Participants wrote hypothetical responses to these statements. For analyses, the responses were split into four categories (no care, solution focused, affective involvement, and total empathy) developed using semantic analyses of pilot study data. The scale had high test-retest reliability and a significant correlation with a questionnaire measure of emotional empathy, suggesting good criterion validity.

Results indicated higher levels of empathy towards those labelled with schizophrenia than towards those labelled as BPD. Staff also showed warmer responses

to service users labelled with schizophrenia whilst giving more belittling or contradicting responses towards those labelled as BPD. This suggests that the label 'BPD' leads to negative responses from staff.

The research by Fraser and Gallop (1993) also supports this finding. This is interesting because Gallop et al. (1989) focused on hypothetical situations whereas the research by Fraser and Gallop focused on measuring nurses' actual responses to service users in a group situation. Participants were 164 in-patients (group members) and 17 nurses (nurse leaders) who facilitated the groups. All participants took part in one or more of the 20 nurse-led groups that the author observed. The nurse leaders selected the patient sample and ensured that at least 20 of them had a diagnosis of BPD. One drawback of this research was having the nurse leaders responsible for ensuring 20 of the group members had BPD because they may have selected service users with BPD that they liked, or who were known to manage well in groups. The diagnoses being used as comparisons were schizophrenia, affective disorder and 'other diagnosis'. All diagnoses were recorded from the in-patients' clinical notes. This was also a potential drawback, as the authors were not able to ensure that the diagnosis of BPD was correct, and were unable to account for dual diagnoses, which might have biased the results.

The first author observed the groups to measure the nurse leaders' responses to group members using Heineken's (1992) confirmation/disconfirmation response rating instrument. The author remained blind to the diagnoses of participants to ensure they were not biased when completing the rating scales. This suggests we can be confident that the ratings were a true reflection of the nurse leaders' responses.

The research concluded that staff responses were significantly more disconfirming towards BPD service users than towards service users labelled as 'other diagnosis' and those diagnosed with affective disorders. There was no difference in nurses' responses towards those labelled with BPD and those labelled with schizophrenia. Positive feelings towards the group members were also assessed using the Colson hospital treatment rating scale (Colson et al., 1985). The results suggested that nurses experienced significantly more positive feelings towards patients with diagnoses of schizophrenia, affective disorder and 'other diagnosis' than to those diagnosed with BPD. They also revealed that they experienced significantly more negative feelings to those group members diagnosed with BPD.

The above research by Gallop et al. (1989) and Fraser and Gallop (1993), highlights that both hypothetical and actual staff verbal responses to service users with BPD are more negative than those towards service users with other diagnoses. However, as both studies focused solely on the responses of psychiatric nursing staff, we can draw conclusions only about psychiatric nurses' responses towards service users with BPD. It would be helpful for future research to include a range of mental health professionals, particularly as mental health teams are currently multi disciplinary in composition. Furthermore, there is no exploration into what might be causing the more negative responses towards these service users, meaning it is not possible to think about what could be done to make these responses more positive.

1.7.3.3 Staff Attitudes

Negative attitudes could be considered to be one of the factors that cause nurses to respond more negatively towards service users labelled with BPD. Cleary, Seigfried and

Walter (2002) conducted a piece of descriptive survey research about mental health staff knowledge, experience and attitudes towards BPD. Participants were a selection of psychiatric nurses, psychiatrists, psychologists, social workers and occupational therapists. Although this sample of 229 participants included a selection of mental health professionals, 62% of the members of the sample were registered psychiatric nurses so the results remain biased towards this group. Participants were recruited from both community mental health teams and acute inpatient wards. Results indicated that 85% of staff reported having at least monthly contact with a service user with BPD. In terms of their management, 80% of staff reported that dealing with service users was difficult whilst 84% said it was more difficult than dealing with service users who had other diagnoses. Two thirds of staff also reported that they believed the management of service users with BPD was inadequate. This suggests that although they found it difficult to care for them they did not consider them to be undeserving of care.

James and Cowman (2007) also completed a piece of descriptive survey research of psychiatric nurses' attitudes and experience of working with BPD service users in Ireland. They used the questionnaire developed by Cleary et al. (2002). Participants were 65 qualified psychiatric nurses recruited from acute and rehabilitation inpatient wards and community mental health settings. Their results were similar to the findings from Cleary et al. They reported that 75% of participants reported that service users with BPD were difficult to work with and 85% believed they were more difficult than service users with a different diagnosis. Again, similar results were reported for staff thinking BPD service users were deserving of care with 79% agreeing they had a role in the assessment and 87% agreeing they had a role in the management of service users with BPD. It is

interesting that such similar results have been obtained for mental health professionals in Australia and Ireland.

Deans and Meocevic (2006) also conducted a piece of descriptive survey research; this focused specifically on registered psychiatric nurses' attitudes towards service users with BPD. They recruited 65 registered nurses from both community and in-patient settings in Australia. The inclusion criteria indicated participants had to be registered psychiatric nurses who had been working within their setting for a year to ensure they had experience of working with this group of service users. Results indicated that 89% of participants stated that they thought BPD service users were 'manipulative'. Furthermore, 79% thought they were responsible for their own actions including breaking the law and suicide (64%). However, when asked if they thought it would be the service users' own fault if they committed suicide, only 8% agreed. This indicates that staff attitudes might be different when asked about a specific behaviour (i.e., the specific act of a person committing suicide) than a more general one (i.e., a more general question about service users breaking the law and committing suicide). It is also interesting that one question asks about fault whereas the other asks about responsibility. This highlights the importance of thinking about the wording when using questionnaires with staff because different words can mean different things to different people. Furthermore, the authors did not compare attitudes to another label so it is not possible to be confident that the responses are about BPD service users who attempt suicide and break the law or just those two behaviours in all service users.

All the above research into staff attitudes towards service users with BPD was descriptive survey data research. Although these studies provide a useful account of

mental health staff attitudes towards this group of service users, there is no investigation of the possible underlying reasons for these, or of if the attitudes differ towards other service users. Future research should focus on looking at comparing staff attitudes towards BPD and other mental health labels and diagnoses. Furthermore, although one study does include other mental health professionals' attitudes, the research focuses heavily on psychiatric nurses' attitudes towards BPD service users. It will be important for future research to focus on recruiting a wider range of mental health staff.

Commons-Treloar and Lewis (2008a) researched the attitudes of a range of professionals towards deliberate self harm (DSH) in BPD service users. They used a between participants design to compare emergency medicine and mental health clinicians' attitudes. They recruited 140 participants from two Australian health services and one New Zealand health service; 50 participants were emergency medicine clinicians and 90 participants were mental health clinicians. Participants were asked to complete the Attitudes towards Deliberate Self Harm Questionnaire (ADSHQ) in relation to BPD patients they had previously worked with. It was found that mental health staff had significantly more positive attitudes towards DSH in BPD than had emergency staff. However, although it is clear that mental health staff attitudes are more positive than those of emergency medicine staff, it is not possible to ascertain if the attitudes of participants are negative, neutral or positive based on their scores. This is because the scores on the ADSHQ have a wide range (33-132), with higher scores indicating more positive attitudes, but no cut off values to indicate if these attitudes are negative, neutral or positive.

It is also difficult to be certain that the responses on the questionnaires were about BPD service users who self harm as opposed to self harm in general. Firstly, because there is no way of knowing that the service users about whom staff were thinking were diagnosed with BPD and, secondly, because participants were not asked to think about a service user who had self harmed and did not have BPD. It is also not possible to be confident that the type of self harm emergency medicine clinicians and mental health staff witness is similar. It is likely that it would be different because the nature of their jobs is different. For example, emergency medicine clinicians might be more likely than mental health nurses to see people with severe self harm who have just carried out the act. The severity of self harm that staff witness might contribute to their responses on the questionnaire.

Again this research is valuable for providing evidence of what the attitudes of mental health professionals are towards service users with BPD, but does not provide any information about what might cause these attitudes.

1.7.3.4 Factors that Influence Staff Attitudes

Some previous research has explored what influences staff attitudes in an attempt to offer suggestions about improving staff attitudes towards this group of service users. The research that has been conducted about factors that influence staff attitudes towards service users with BPD includes research about the impact of countertransference reactions, therapist characteristics, knowledge levels and training.

1.7.3.4.1 Psychoanalytic explanations of staff views of service users with BPD.

A factor that affects the way staff view service users with BPD is highlighted within psychotherapeutic research into countertransference. McIntyre and Schwartz

(1998) investigated licensed psychotherapists' countertransference reactions towards clients with diagnoses of either BPD or major depression (MD). Tapes of diagnostic sessions, instead of written vignettes, were used to manipulate the independent variable. Using tapes might increase the external validity, as tapes can be used routinely in supervision as aids to exploring therapists' reactions and attitudes towards service users. A further strength of this study is the large sample size (N=155).

Results indicated that therapists considered service users with BPD as more hostile and dominant whereas service users with MD were considered submissive and friendly. Therapists also thought counselling those with MD was more beneficial and would lead to more positive outcomes than counselling those with BPD. This suggests that the countertransference feelings that therapists experience towards service users with BPD may have an impact on their views towards them and their optimism about the outcome of therapy.

Rosenkrantz and Morrison (1992a) investigated psychotherapists' perceptions of themselves and service users with BPD using a within-participants design. Two vignettes representing BPD clients presenting in a rewarding object relations unit (patient believes the therapist will be supportive and approving and behaves accordingly) or a withdrawing object relations unit (patient believes the therapist will be critical and hostile and behaves accordingly) were provided to 158 licensed psychotherapists. The vignettes included higher functioning (having intense and unstable relationships) and lower functioning (having socially withdrawn relationships) BPD clients. In the rewarding condition, the therapist evaluated higher functioning clients more positively than they did lower functioning clients, with no difference in the withdrawing condition.

Importantly, an order effect was found. When the lower functioning BPD patient was presented in the withdrawing condition first, therapists did not rate them as positively as in the rewarding condition. When the rewarding condition was presented first, therapists valued themselves as more positive throughout both conditions. This suggests that if a therapist's interaction with a borderline patient is firstly positive, it could help attitudes and views of staff.

Further research by Rosenkrantz and Morrison (1992b) looked at psychotherapists' tendency to have depressive experiences, their personal boundary preferences and their attitudes to clients with BPD. Participants were 155 licensed psychotherapists. It was a between participants design with participants reading a vignette representing one of two therapy sessions with a BPD client who was either in rewarding or withdrawing object relations units. Results indicated that more boundaried therapists evaluated themselves more positively regardless of condition, and showed less of a tendency to devalue themselves and the patient with lower functioning BPD. Furthermore, therapists who scored higher for analytic depression and fusion tendencies evaluated themselves as less positive than other therapists and evaluated the patient less positively regardless of condition.

The above research suggests that psychotherapists' personality characteristics and perceptions of themselves can affect their perceptions of and attitudes towards service users with BPD. This is important research and valuable to psychotherapists and their supervisors when working with service users with BPD. However, within modern mental health services there is less focus on staff countertransference, so whereas this could be used in individual supervision, it might not be a useful way to frame reactions to BPD

service users for the majority of mental health staff. Furthermore, as the research was conducted using only qualified psychotherapists, it cannot be assumed that the results would be true of other mental health professionals. This is a particular weakness when thinking about staff within the National Health Service, as psychotherapists do not regularly work in inpatient or community mental health settings in England.

1.7.3.4.2 Staff knowledge levels and training.

Staff knowledge levels about BPD have also been the focus of previous research investigating what is associated with staff attitudes towards service users with BPD. Cleary et al. (2002) completed a piece of descriptive survey research that explored staff knowledge levels about BPD. Participants were 229 multidisciplinary mental health staff, who were asked to complete 10 questions relating to BPD. Results indicated that staff knowledge levels were good about certain aspects of the disorder; for example, 77% of the participants correctly identified that impulsive behaviour was part of the DSM IV (APA, 1994) diagnostic criteria for BPD. However, there were also some aspects of the diagnosis with which staff were not familiar; for example, over half the participants incorrectly reported that a grandiose sense of self importance was part of the diagnosis of BPD. This research is a helpful exploration into mental health staff knowledge levels about BPD. However, 62% of the participants were nurses, making it difficult to be confident these results can be generalised to other mental health professionals.

James and Cowman (2007) also conducted descriptive survey research about staff training and knowledge levels about BPD using 65 registered psychiatric nurses. They reported that only 3% of nurses had received specific training about BPD. They also found knowledge levels to be lower than expected. They asked participants 10 questions

to assess their knowledge about the DSM IV (APA, 1994) criteria for BPD, the treatment for BPD and general knowledge about BPD. Participants got a mean of 5.8 questions correct (SD=1.8; range 2-9). This suggests that nurses' knowledge levels about BPD vary widely depending on the individual and could be improved.

Both of the above studies are useful because they highlight that mental health staff knowledge levels about BPD could be improved. This is particularly important in light of previous research, which suggests low levels of knowledge about particular groups of people may lead to negative attitudes towards them (Wolff, Pathare, Craig & Leff, 1996). Furthermore, neither of the above studies attempted to explore the relationship between knowledge levels and mental health staff attitudes or behaviour towards service users with BPD. This means no conclusions about the impact these knowledge levels have on clinical practice can be made with any confidence.

Research has been conducted that aims to explore the impact mental health staff knowledge levels have on their attitudes towards service users with BPD. Miller and Davenport (1996) investigated the effects of increasing staff knowledge on staff attitudes towards patients with BPD using an adapted version of the Reeces questionnaire about BPD (unpublished study, 1988). The experimental manipulation was self administered educational material about BPD. It was a between groups experimental design using psychiatric nurses with the independent variable being the access to the educational material. There were 19 participants in the experimental group, who had access to the self-taught educational material about BPD, and 13 in the control group, who received no information about BPD.

Results indicated that knowledge and attitudes significantly improved post education in the experimental group, whilst no significant difference was found in the control group across the two time points. This suggests that increasing staff knowledge has a positive impact on staff attitudes towards those with BPD. However, a heavy emphasis was placed on the importance of staff responses in the effective treatment of BPD in the educational material. This increases the risk that staff responded in a socially desirable manner post education and that this was what caused the significant difference.

Despite this, the presence of a positive correlation between knowledge and attitudes pre and post teaching suggests that further research should be conducted into staff knowledge of, and attitudes towards, service users with BPD.

Further to their study on the attitudes of professionals to BPD service users who self harm, Commons-Treloar and Lewis (2008b) conducted a study that investigated the impact of targeted staff training about BPD service users who deliberately self harm (DSH) on emergency medicine and mental health clinicians. Type of employment was the between groups element with 33 participants in the emergency medicine clinician group and 66 in the mental health clinician group. The outcome measure was the ADSHQ, which participants completed whilst thinking about service users with BPD.

The training provided factual information about the diagnoses, prevalence rates and aetiological factors of BPD. It provided information about the rates of DSH and suicide within BPD service users and helped attendees think about staff attitudes and therapeutic responses to BPD service users. Time for reflection on and discussion of these issues was provided, and case material was used to facilitate this.

When using the total score on the ADSHQ, statistically significant improvements, with a small to medium effect size ($d=.43$), were found in attitudes to DSH in BPD that were equivalent across emergency medicine and mental health clinicians. Analyses of the subscales on the ADSHQ indicated that the greatest improvements were in staff confidence about effectively managing the assessment and referral of BPD service users who have self-harmed. Importantly, the scores on the factor that assesses staff having an empathic approach indicated that there was only a minimal increase in staff feeling empathy towards service users with BPD who self-harm.. Furthermore, comparing gender groups revealed that only females significantly improved their attitudes after training. This is interesting because the case studies provided in the training were all about female service users.

Currently, it is not possible to rule out the possibility that the training merely changed attitudes towards DSH. In future research, it will be important to include a measure of participants' attitudes to BPD. This would help identify if the training targeted attitudes to both the label of BPD and DSH or just to DSH.

Commons-Treloar (2009) has also investigated if the type of training is more likely to improve staff attitudes towards deliberate self harm in BPD service users. The two types of training were cognitive behavioural and psychoanalytic, and there was a control group with no education programme. Participants were 65 emergency medicine and mental health clinicians from two Australian and one New Zealand health authority. The participants were randomly assigned to one of the two training groups or the control group. The psychoanalytic education group had 25 participants, the cognitive behavioural

education group had 18 participants and the control group, which received no education, had 22 participants.

There were significant improvements in the attitudes as scored on the ADSHQ immediately after the cognitive behavioural and psychoanalytic education programmes. At the 6-month follow up, only the participants who had been in the psychoanalytic education programme continued to display a significantly more positive attitude. The control group had no significant differences in their attitudes across the two time points. This suggests that training can improve staff attitudes for a period of at least 6 months. However, as with the other research that Commons-Treloar has conducted, it is difficult to draw conclusions about staff attitudes towards BPD service users because the research and training focuses specifically on DSH in BPD service users. Furthermore, whilst the difference is statistically significant, it is not possible to be confident that it is clinically important; the psychoanalytic group mean score on the ADSHQ before training was 92.3 compared to 94.5 at the 6-month follow up. This is a difference of only 2.2. As the scores on the ADSHQ range between 33 and 132, a difference of 2.2 might not translate to a noticeable difference in staff attitudes in a clinical setting.

Krawitz (2004) conducted research that looked at attitudes towards service users labelled with BPD rather than the specific behaviours they display. The research assessed the impact of a two day training workshop on mental health staff attitudes. The workshop informed clinicians about the aetiology, diagnosis and prognosis of treatment of BPD. They looked specifically at whether this training improved clinicians' optimism, enthusiasm, confidence and willingness regarding working with service users with BPD, as well as their theoretical knowledge and clinical skills. Clinicians self reported this on a

questionnaire developed for this research. It was a within participants repeated measures design. All 418 participants completed the questionnaire at three points in time: before attending the workshop, immediately following the workshop and at a 6-month follow up period. One-way repeated measures analyses of variance revealed that all six factors being assessed significantly improved after training and remained significantly improved at the 6-month follow up. It is clear that participants reported not only an improvement in their attitudes, but also in their knowledge and clinical skills. This suggests that staff training can improve staff attitudes and increase their knowledge and skills. However, staff knowledge and clinical skills were assessed only by self-report ratings. It would have been helpful for the researchers to include an assessment of their knowledge and skills to ensure they could be confident that the training had improved these aspects of treatment. Furthermore, the research does not explore if improved knowledge levels led to improved staff behaviour towards service users with BPD. This limits how useful these results can be in informing future clinical practice.

Hazelton (2006) also assessed the impact of a two day training workshop on the attitudes, knowledge and experience of mental health staff towards BPD. Participants were 94 multidisciplinary staff working in community mental health teams, drug and alcohol services and accident and emergency departments.

The two day training workshop focused on training the participants to use the principles and practice of dialectical behaviour therapy with BPD service users as opposed to training about the aetiology and treatment of the disorder. The analysis was both quantitative and qualitative, allowing for rich information about the change in attitudes and a detailed exploration of the meanings staff associate with BPD. Results

from the quantitative analyses indicated that staff knowledge about the detection and treatment of BPD had improved. Staff continued to think that BPD service users were more difficult to manage than were other service users, but this perhaps reflects the reality of the situation. However, the discourse analyses results from the qualitative groups suggested that there had been a shift towards a more positive view of service users with BPD. For example, the discourse changed from staff viewing service users with BPD as impossibly difficult to work with to no longer considering them treatment resistant, and more staff being confident in engaging them. It is particularly positive that whilst the staff maintained a realistic view that BPD service users are challenging to work with, they also developed a more positive attitude towards them.

1.7.3.5 The Relationship between Staff Attitudes and Responses

Although it is positive that there has been research that looks at what affects negative staff attitudes and how these might be improved, this research does not provide evidence to indicate if there is an association between negative staff attitudes and negative behaviour. Nor does it indicate other factors that might influence staff behaviour towards service users with BPD. This is important in light of the Aviram et al. (2006) model, which suggests BPD service users are sensitive to negative staff reactions. Previous research that has investigated the process of stigma and negative behaviour from staff towards service users with BPD has focused on the relationship between attributions and behaviour.

1.7.3.5.1 Weiner's theory of causal attributions (1980, 1985, 1986).

Markham and Trower (2003) used Weiner's (1980, 1985, 1986) causal attribution theory to investigate the effects of the labels of BPD, depression and schizophrenia on

registered mental health nursing staff perceptions of service users with BPD. A within participants design was employed, meaning all 48 participants completed the three questionnaires about each diagnostic label.

The results from Markham and Trower (2003) indicated that staff did not make more internal attributions towards service users labelled with BPD. However, the results did suggest that staff rated the causes of challenging behaviour as more stable and service users were considered more in control of their behaviour and the causes of it when labelled with BPD as opposed to being labelled with depression and schizophrenia. Furthermore, staff reported less sympathy and optimism towards BPD patients.

Correlations were also conducted to investigate the relationship between staff attributions of controllability and their emotional reaction of sympathy. Significant negative correlations were found between controllability and sympathy within all three label conditions. Whilst judgements cannot be made about the direction of this relationship, it does suggest that staff who hold higher attributions of controllability feel less sympathy towards service users with BPD, depression and schizophrenia. A correlation was also conducted to explore the relationship between previous negative experiences of staff, and the attributions they held. There were no correlations between previous negative experience and attributions, suggesting that previous experience is not related to staff attributions. It would be helpful for future research to investigate other factors that might be related to staff attributions. This would enable strategies to be developed to help staff form more positive attributions towards service users with BPD.

The above results suggest that staff make more attributions of controllability and have fewer feelings of sympathy towards service users with BPD than they do towards

those with depression and schizophrenia The attribution of controllability was also found to be significantly negatively associated with staff sympathy suggesting there was a relationship between them. This indicates that Weiner's (1980, 1985, 1986) causal attribution theory can be a useful framework when investigating how staff view service users with BPD. However, although Markham and Trower (2003) investigated the attributions and emotions in Weiner's theory, they did not investigate the behaviours. As a result, although it can be suggested that these attributions and emotional reactions will lead staff to be less likely to help service users with BPD based on Weiner's theory, this cannot be stated with confidence. This is a drawback of this research because, although it is important to know about staff attributions and emotions, their behaviour is particularly important because this is what service users will notice. It would be interesting for future research to investigate the behaviour of staff as well as their attributions and emotions.

In addition, it is important to highlight that not all attributions in Weiner's theory have been shown to be important. There was no difference in the internal attributions staff made about the service users with BPD, depression or schizophrenia. However, it is not possible to be confident that a lack of any significant difference between staff attributions of internality was not because of the method used in the study. Participants in this research completed the attribution questionnaire based on general diagnostic labels rather than on a specific character in a vignette. Previous research suggests that measuring participants' attributions about general diagnostic labels does not measure attributions as sensitively as does asking them about a character in a vignette (Corrigan et al. 1999).

Forsyth (2007) protected against the above difficulty when he used vignettes to explore the intended behaviours and emotional reactions of registered mental health nurses and support workers towards a service user, labelled with either BPD or major depressive disorder (MDD), who had not completed a therapy task. He used four vignettes that depicted that the reason for this behaviour was either, controllable and unstable, controllable and stable, uncontrollable and stable or uncontrollable and unstable. This was a repeated measures design so the four vignettes were read by each participant twice, that is, once in relation to the service user with MDD group and once in relation to the service user with BPD. After reading each of the vignettes, staff rated their emotional reactions of empathy and anger and the likelihood that they would be willing to help the service user in the vignette. Although vignettes have less external validity (Lucas, Collins, & Langdon, 2008), their strengths, such as being easily manipulated and being able to control for confounding variables (Hughes & Hubey, 2001) often outweigh the concern about their lack of external validity. For example, the internal validity vignettes provide can be seen as a particular strength when comparing this design to the descriptive survey research above. In the survey, research staff were asked about their experiences and attitudes towards clients they had worked with, which made them externally valid. However, there was little internal validity because researchers were unable to control for confounding variables, such as severity of behaviour or sex of the service user. This makes it difficult to be confident that the results are specifically about BPD as opposed to other variables that were not controlled.

Results indicated that staff report feeling more anger towards service users whom appear to be in control of the reasons for not completing a therapy task in both the MDD

and BPD condition. This supports Weiner's theory of causal attribution (1980, 1985, 1986). A significant difference was also reported in staff helping behaviour, with staff significantly less likely to display helping behaviour towards those labelled with BPD than towards those labelled with MDD. However, this was regardless of whether the service user was depicted as being in control of their behaviour or not. This suggests that it was not attributions of controllability that were associated with staff helping behaviour towards this group of service users. In addition, staff did not report feeling more sympathy to the service user with BPD, who was depicted as having no control over not completing the therapy task. This suggests that although Weiner's theory can help explain what makes it less likely for staff to offer helping behaviour towards some groups of service users, it does not explain staff helping behaviour towards service users with BPD so well.

However, this cannot be stated with confidence because this study was underpowered. Forsyth (2007) reported that 68 participants were required to meet power of .8, medium effect size ($f=.025$) and an alpha level of .05; however, only 28 participants were recruited. The authors reported that they reduced the impact of this by increasing the power by using measures of anger, helping and empathy with five items, as opposed to the one-item scales that were used in previous research (Markham and Trower, 2005). Hallahan and Rosenthal (1996) reported that where participants are difficult to recruit, power can be increased by making the measure more reliable. Although it is possible that increasing the number of items might make the measure more reliable, Forsyth does not report the internal consistency for the scales in his research, so it is not possible to make a judgement about how reliable the scales are. In addition, he was 40 participants short of

the number he needed to meet the power of .8 with a medium effect size and alpha level of .05. As a result, it is possible that the lack of a significant relationship between controllability and helping behaviour was a result of inadequate power.

The findings from the above research indicate that further investigation into staff attributions towards BPD service users is required. This is because results from both pieces of research indicate that the attributions and emotions in Weiner's causal attribution theory (1980, 1985, 1986) cannot fully explain staff reactions towards service users with BPD. In addition, methodological difficulties in both studies mean it is difficult to be confident that their results are a true representation of staff attributions, emotional reactions and intended behaviours. Furthermore, both pieces of research only included registered mental health nurses or support workers on mental health in-patient units. This means it is not possible to be confident that other mental health staff in the community would share these views. More research is particularly needed with a wider range of mental health professionals and settings.

1.7.3.5.2 Dangerousness and social distancing.

Markham (2003) based his research on the Corrigan et al. (2003) model of public discrimination and compared staff attributions of dangerousness and their intended social distancing towards service users labelled with BPD, depression and schizophrenia. A within and between participant design was used. Participants were 50 registered mental health nurses (RMNs) and 21 health care assistants (HCAs). Participants' job role was the between groups variable, which is advantageous because it allows an investigation of different staff groups' opinions.

Vignettes were not used in this research. Instead, staff were asked to base their answers on the diagnostic labels of BPD, schizophrenia, and depression. Although this increases the external validity of the results, it does not control for confounding variables because participants will base their answers on BPD service users with whom they have worked previously, who will have displayed a range of different symptoms and levels of severity. For example, if participants base their answer about BPD on previous experience of working with a service user who displayed high levels of risky behaviour and aggression towards staff, their attributions of dangerousness are likely to be higher than those of the participant who is thinking of a service user who displayed no risky behaviour.

Results indicated that all staff were less optimistic about service users with BPD and had more negative experiences of working with them than working with service users labelled with schizophrenia and depression. Results also indicated that all staff made significantly higher ratings of dangerousness and social distancing towards the label of BPD when comparing it to depression. However, a between groups difference emerged when comparing BPD and schizophrenia. RMNs viewed service users with BPD as more dangerous and expressed more social distancing towards them than towards those with schizophrenia, whilst HCAs made no such distinctions. Importantly, no significant difference in the level of social distancing and dangerousness was found between groups in relation to BPD clients. However, RMNs scored significantly lower on social rejection towards service users labelled with schizophrenia than did HCAs. It could be hypothesised that RMNs have more training about schizophrenia than have HCAs and more training about schizophrenia than about BPD, suggesting it is knowledge that

affects attitudes towards BPD clients. However, as the causes of the difference were not investigated, conclusions about this cannot be made.

Social distancing and dangerousness were correlated within the RMN group. This suggests that future research should investigate staff attributions of dangerousness and subsequent social distancing towards service users with BPD. As this research used only registered mental health nurses and healthcare assistants on an in-patient unit, it will also be important to research community mental health staff attributions of dangerousness and reactions of social rejection. In addition, the Corrigan et al. (2003) model of public discrimination suggests that fear is associated with attributions of dangerousness and intended behaviour of social rejection. It is a drawback of this research that participants' fear was not measured.

1.7.4 Conclusion

The review of the literature suggests that mental health professionals hold negative attitudes towards service users with BPD (Cleary, Seigfried & Walter, 2002; Deans & Meocevic, 2006; James & Cowman, 2007). Staff responses towards service users with BPD have also been found to be more negative than those towards service users with other mental health diagnoses (Gallop et al., 1989; Fraser & Gallop, 1993). Previous research has also explored the factors that are associated with staff attitudes towards BPD service users; these include knowledge levels about BPD (Commons-Treloar & Lewis., 2008 a,b; Cleary et al., 2002; Hazelton, 2006; James & Cowman, 2007; Krawitz, 2004; Miller & Davenport, 1996) and countertransference reactions (McIntyre & Schwartz, 1998; Rozenkrantz & Morrison, 1992a, 1992b). This is positive because it helps to develop strategies to begin to improve negative staff attitudes. However, there

has not been any research that investigates how negative staff attitudes are related to their responses. This makes it difficult to draw conclusions on what effect these attitudes are having on the way staff respond to BPD service users.

A number of studies (Forsyth, 2007; Markham & Trower, 2003) have attempted to bridge this gap in the literature by using Wiener's (1980, 1985 & 1986) attribution theory to help explore fully staff reactions towards service users with BPD as opposed to exploring one aspect, such as attitudes. This model is helpful because it provides a framework that suggests attributions and emotions affect staff intended behaviour. However, whilst this was an important step forward in terms of understanding staff reactions towards service users with BPD, the research has a number of drawbacks that make it difficult to be confident that this is the most suitable theory to use to help explore staff reactions.

Firstly, the questions the research asks do not cover all aspects of the model. An example of this is that Markham and Trower (2003) investigated the attributions and emotional reactions of staff, but did not specifically measure their intended behaviour. Whilst Wiener's attribution theory suggests increased attributions of controllability indicate that staff would be less likely to offer help towards service users with BPD, it is not possible to be confident that this is the case from this research. The research that did investigate staff intended helping behaviour towards service users with BPD (Forsyth, 2007) found that, although staff were less likely to help service users with BPD, this was regardless of their attributions of controllability. This research was underpowered, suggesting the lack of significant association between controllability and helping behaviour could have been due to this. However, it does raise the possibility that other

factors might be associated with helping behaviour. In addition, Weiner's theory of causal attribution (1980, 1985, 1986) is limited for exploring staff reactions to service users with BPD. This is because it is helpful only for explaining staff helping responses towards service users with BPD, and intending to offer or withhold help is not the only intended behaviour that mental health staff display towards service users with BPD. Previous research (Bowers, 2002; Markham, 2003) has found that staff also indicate intentions to coerce and socially distance themselves from service users with a personality disorder and BPD.

The research by Markham (2003) uses a different attribution model. He used the Corrigan et al. (2003) model of public discrimination to investigate staff responses towards service users with BPD. He found it might also be appropriate for helping understand staff stigma towards service users with BPD. He found staff made significantly more attributions of dangerousness and intended behaviours of social distancing to service users with BPD than to those with depression. This suggests that this model might also help explain staff responses to service users with BPD.

It appears that both attributions of controllability and dangerousness are related to helping and social distancing behaviour in some studies. However, this is dependent on the staff group and measurement used. In addition, both Weiner's theory (1980, 1985, 1986) and the Corrigan et al. model (2003) suggest that emotions appear to be associated with staff intended behaviour. Thus, further research should be conducted that explores staff attributions, emotional reactions and intended behaviour towards service users with BPD. Exploring this is important because BPD service users are sensitive to staff responses (Aviram et al., 2006) and having an increased understanding of staff reactions

to service users with BPD will help to begin to develop strategies that will help make them more positive.

1.8 Rationale for the Current Research

Previous research indicates that mental health staff attitudes are more negative towards service users with BPD than towards other groups of service users. However, there has been less research into staff attributions towards this group of service users. Attributions are a helpful concept to explore because both Weiner's theory of causal attributions (1980, 1985, 1986) and the Corrigan et al. (2003) attribution model of public discrimination provide an explanation of how attributions are associated with discriminatory behaviour. The attributions of controllability and dangerousness are particularly interesting because the Corrigan et al. model of public discrimination suggests they are associated with intended behaviours of increased social distancing and coercive behaviours and with decreased helping behaviours. Thus, this research will focus on staff attributions of controllability and dangerousness towards service users with BPD.

In addition, rather than rely on the previous evidence, which suggests attributions lead to staff behaving in particular ways, this research will also investigate the intended behaviours of helping, coercion and social distancing towards service users with BPD and depression. This is particularly important because much of the previous research has either not investigated intended behaviour (Markham and Trower, 2003) or has not reached adequate power to allow meaningful conclusions to be drawn (Forsyth, 2007). It is also important to investigate intended behaviour because BPD service users are particularly sensitive to rejection and to being treated harshly. Previous research has

found that the rejecting behaviour of staff has a negative impact on the engagement of BPD service users (Aviram et al., 2006).

Both the Weiner (1980, 1985 & 1986) theory of causal attributions and the Corrigan et al. (2003) attribution model indicate that attributions are associated with emotions and intended behaviours. However, previous research has not fully explored the association between attributions and intended behaviours and emotions and intended behaviours. As a result, this research will investigate the association between staff attributions of controllability and dangerousness and their intended behaviours of helping coercion and social distancing, as well as the association between staff emotions of fear, anger and pity and their intended behaviours of helping, coercion and social distancing.

In addition, it is important for the current research to explore a range of multidisciplinary staff attributions and intended behaviours towards service users with BPD because much of the previous research focuses on psychiatric nurses and support workers. Exploring a range of multidisciplinary staff attributions is currently particularly important because modern day community mental health teams are expected to have a role in the treatment of service users with BPD (NICE, 2009).

Furthermore, it is important to continually explore the processes that underlie staff stigma towards BPD service users because stigma is a fluid concept that can change with new experiences and knowledge (Arboleda-Flórez, 2008). This suggests that the attributions of mental health staff might have changed recently as a result of guidance such as 'Personality Disorder: No longer a diagnoses of exclusion' (NIMHE, 2003b) and the NICE guidelines for BPD (2009). If new research were to find that mental health staff no longer stigmatize people with this label, then psychiatrists and mental health

professionals might begin to feel more confident about using the diagnosis of BPD. Alternatively, if staff attributions and intended behaviours towards this group of service users remain negative, then it is important to think about what might help improve them. As a result, this research also explores possible relationships between staff knowledge levels about BPD and their attributions of controllability and dangerousness, and intended helping, coercion, and social distancing behaviours. Knowledge was chosen because previous research has found that knowledge improved staff attitudes. It was decided it would be interesting to explore whether it is also associated with staff attributions and intended behaviour.

Therefore, this research uses vignettes to investigate whether secondary care mental health staff attributions and intended behaviour differ towards clients labelled with BPD and depression. In addition to this, it also explores the association between staff knowledge levels about BPD and their attributions of controllability and dangerousness and the associations between their knowledge levels and intended behaviours.

1.9 Research Hypotheses

1. Staff will make more attributions of dangerousness and controllability towards service users labelled as depressed and BPD than those labelled with depression alone.
2. Staff will be less willing to help and more likely to coerce and socially distance service users labelled as depressed and BPD than those labelled with depression alone.

3. Staff attributions and emotional reactions will be associated with their intended behaviour.
4. Higher staff knowledge levels about BPD will be associated with lower staff attributions of dangerousness and controllability towards service users labelled with BPD.
5. Higher staff knowledge levels about BPD will be associated with lower staff intended social distancing and coercive behaviour and higher staff intended helping behaviour towards service users labelled with BPD.

CHAPTER TWO: METHOD

2.1 Overview

This section outlines the methods that were used to investigate the research hypotheses outlined in Chapter One. Firstly, the design of the study is outlined. Next, the characteristics of the participants and the methods used to recruit them are described. Following this the measures and their psychometric properties are discussed and the relevant ethical issues for this study are considered. Finally, the procedure of the research is outlined before the statistical methods are introduced.

2.2 Design

To investigate hypotheses 1 and 2, an independent groups design was employed. Two groups read a vignette in the form of a referral from a general practitioner (GP). Each vignette contained identical information about a female service user who had self harmed before seeking help from her GP. The only difference between the vignettes was the previous diagnoses of the service user; in one vignette, the service user had a diagnosis of BPD and depression (Appendix A) and in the other vignette, the service user had a diagnosis of depression alone (Appendix B). The diagnosis of depression was chosen as the control variable because there are high co morbidity rates between BPD and depression (Zanarini et al., 1998). Prior to starting data collection, the BPD and depression and depression alone vignettes were ordered alternately. Participants were given the vignettes in that alternate order. This was to ensure an equal number of the BPD and depression and depression alone vignettes were read within each team. After reading the vignettes, participants completed an adapted version of the Attribution Questionnaire-27 (AQ-27) (Corrigan, Markowitz, Watson, Rowan & Kubiak, 2003) (Appendix C), a

knowledge questionnaire about BPD (James & Cowman, 2007) (Appendix D) a social distancing measure (Link, Cullen, Frank & Woznaik, 1987), which was adapted by Hay (2007) to make it more appropriate for a British population (Appendix E), and a perceived dangerousness scale (Angermeyer, Matschinger & Corrigan, 2003).(Appendix F).

The independent variable was the diagnoses within the vignettes (BPD and depression, and depression alone). The dependent variables were factors on the revised AQ-27, the perceived dangerousness scale and the social distance scale. The knowledge questionnaire (James & Cowman, 2007) was used to consider relationships between staff attributions and knowledge levels.

To investigate hypothesis 3, a correlational design was used to explore possible relationships between staff attributions, emotions and intended behaviours in both the depression and BPD group and the depression alone group.

A correlational design was also used to investigate hypotheses 4 and 5; this was to explore possible relationships between participants' knowledge levels about BPD, as measured by the James and Cowman (2007) knowledge questionnaire, and attributions and intended behaviours.

2.3 Participants

The participants in this study were 83 staff members from the secondary care mental health services within the Cambridgeshire and Peterborough NHS Foundation Trust. A breakdown of the demographics of the participants is provided in the results section.

2.3.1 Inclusion Criteria

All clinical staff within a secondary mental healthcare multi-disciplinary team within the Cambridgeshire and Peterborough NHS Foundation Trust were eligible for inclusion in this research. Those participants who did not complete all the questionnaires in the research were excluded from the study.

2.3.2 Rationale for Selection of Participants

Both practical requirements and previous research were considered when selecting the staff who would be invited to participate in this research.

Much of the previous research has focused on in-patient psychiatric nurses' and nursing assistants' attributions and attitudes towards service users with BPD (Markham & Trower, 2003; Forsyth, 2007; Markham, 2003). However, service users with BPD present across a range of mental health services (Fahy, 2002) and it will become more common for all staff to work with this group. This is because the new National Institute of Health and Clinical Excellence (NICE) clinical guidelines for BPD (NICE, 2009) recommend service users with BPD should be treated within community mental health teams. Furthermore, as all qualified mental health staff are required to coordinate the care of a number of service users within the role of 'care coordinator', it will not only be nurses who work with this group of service users. As a result, it was decided that all clinical multidisciplinary staff within the secondary mental health services would be invited to participate.

2.3.3 Sample Size

A power calculation was conducted to estimate the number of participants that would be required to ensure hypotheses 1 and 2 achieved 80% power at a 5% significance

level. This was calculated using G power 3 (Faul, Erdfelder, Lang, & Buchner, 2007). It was estimated that 72 participants (36 in each group) would be needed to conduct a one-tailed independent t-test. This was based on an effect size ($d = .6$), a power level of 0.8 and a significance level of 0.05. The effect size used in this power calculation was based on the following previous research. Markham (2003) found a large effect size when comparing registered mental health nurses' social distance ($r=.83$) and dangerousness ($r=.81$) scores towards service users with BPD to service users with depression. He also found a large effect size when comparing health care assistants' social distance ($r=.79$) and dangerousness ($r=.77$) scores towards service users with BPD to those labelled with depression. In addition to this, Markham and Trower (2003) found effect sizes to be large when comparing nurses scores of controllability ($r=.71$) and sympathy ($r=.63$) towards service users with BPD or depression. However, despite the previous research finding large effect sizes, it was decided a more conservative effect size of $d=.6$ would be used in the current research. This is because the current research is using vignettes, which are acknowledged to be less powerful at eliciting attributions and emotions (Lucas et al., 2008; Wanless & Jahoda, 2002). In addition to this, the previous research that has found a large effect concentrated solely on staff who work on in-patient units. This research is looking at a wider group of staff who work across a range of settings.

In total, 83 participants were recruited during the study: 42 in the BPD and depression group and 41 in the depression alone group

A power calculation was also conducted to ensure hypotheses 3, 4 and 5 achieved 80% power at a 5% significance level. This was calculated using G power 3 (Faul, Erdfelder, Lang, & Buchner, 2007). It was estimated that 37 participants would be needed

in the depression and BPD and the depression alone groups to conduct Pearson's r correlations for these hypotheses. This was based on an effect size ($r = 0.4$), a power level of 0.8 and a significance level of 0.05. Again, the effect size was estimated to be slightly higher than medium for the reasons outlined above; 42 participants were recruited into the BPD and depression group and 41 into the depression alone group.

2.3.4 Recruitment

Participants were recruited from the population of multidisciplinary clinical staff working in secondary care mental health services within the Cambridgeshire and Peterborough NHS Foundation Trust (CPFT).

First, the researcher contacted the team managers of 35 Secondary Care Mental Health teams within CPFT to request their permission to invite the staff in their teams to participate in the research. To help them make an informed decision, team managers were provided with the participant information sheet (Appendix G) at this point. If the team manager agreed for their staff to be approached, the researcher arranged a convenient time to visit the team and invite staff to participate. Two weeks prior to the date of the researcher's visit, the team manager was asked to distribute the participant information sheet to their staff team. This provided potential participants time to understand the aims and procedure of the research and make an informed decision about participating. It also ensured that staff who could not attend the research meeting had an opportunity to consider participating.

When visiting each staff team, the researcher addressed the team as a whole to outline the research aims, objectives and methods, and to answer any questions the staff

had. Following this, the researcher arranged to visit the team at a time convenient for the staff who had agreed to participate.

In total, 35 teams were invited to participate. Of these, 21 managers agreed for the researcher to invite staff within their team to participate. However, six of the teams were unable to offer an appointment within an appropriate time frame, so staff within these teams were not invited to participate. The teams who accepted included nine community mental health teams and three acute care services. From these teams, 205 participants were approached directly and 83 agreed to participate.

2.4 Materials and Measures

2.4.1 Overview

The measures used in this research were chosen using previous research literature on BPD as well as considering practical requirements. During the literature search, it became apparent that there was no single measure that was appropriate to measure the staff attributions being measured in this study. This meant that some modification of the measures was required. This is discussed below. Permission to use the questionnaires has been sought from the authors where required.

2.4.2 Vignettes

The two vignettes (Appendix A and B) were developed for this research and are identical except for the diagnoses of the service user; these were BPD and depression or depression alone. The characteristics and behaviour of the service user in the vignette is based on previous research literature about common characteristics and behaviours of service users with BPD. This was to ensure the vignettes represented a real life service user.

It was decided that the service user in the vignette would be female. Although research suggests there are comparable levels of BPD in men and women (Golomb, Fava, Abraham & Rosenbaum, 1995), rates of co-morbid BPD and depression are significantly higher in women (Zanarini et al., 1998). Furthermore, research suggests staff are more likely to recognise BPD in female service users (Adler, Drake & Teaque, 1990). It was also decided that the service user would be in her 20s because the NICE guideline for BPD suggests that BPD is most common in early adulthood (NICE, 2009).

The vignette was based on an incident of self harm, as this is a common symptom of depression (Houston, Haw, Townsend & Hawton, 2003) and one of the DSM IV (APA, 1994) diagnostic criteria for BPD.

It is acknowledged that vignettes may have low external validity because they cannot reflect all the complexities of real life (Kinicki, Hom, Trost & Wade, 1995). However, Hughes and Huby (2002) suggested that vignettes are a useful tool when researching people's attitudes and perceptions. This is because they provide a standardized description of a person or situation and so increase the internal validity of research. The vignettes used in this research were also developed as simulated referral letters to ensure the research mirrored the way that staff teams receive information about service users before they meet them. Furthermore, this research is looking at the effect the label of BPD has on staff views about service users. Vignettes are considered advantageous for doing this because they are able to give little information about the person other than their label. This helps ensure the attributions and intended behaviours are a result of the label. Asking participants to base their answers on a character in a vignette was decided on because previous research suggests asking participants to

comment on an individual with a label, as opposed to the label itself, or people with a label, results in more sensitive measures of participants' attributions and intended behaviours (Corrigan et al., 1999).

2.4.3 Perceived Dangerousness Scale (Angermeyer, Matschinger & Corrigan, 2004)

This was used to assess how dangerous participants considered the person in the vignette to be. It was developed by Angermeyer, Matschinger and Corrigan (2004) using previous findings from stigma research, in which a list of nine personal attributes that represent two common stereotypes of mental illness was generated. These stereotypes were dangerousness and dependency.

Only the dangerousness scale is used in this research. Angermeyer et al. (2004) previously used only the dangerousness scale with a lay population and reported good internal consistency (Cronbach's alpha 0.88). Hay (2007) also reported good internal consistency for the dangerousness scale (Cronbach's alpha 0.81) in an English general population sample.

There are measures of dangerousness that have demonstrated reasonable reliability when measuring mental health staff attitudes of dangerousness towards BPD. For example, Markham (2003) investigated mental health staff attitudes of dangerousness towards service users with BPD using the Beliefs about Dangerousness Questionnaire (Link, Cullen, Frank & Woznaik, 1987) and reported a Cronbach's alpha of 0.79. However, this questionnaire asks respondents to base their answer on a 'man or woman with Borderline Personality Disorder'. The current research did not want to ask staff about their attitudes towards a general person with BPD because previous research has indicated that this does not measure attributions as sensitively as does asking participants

about a character in a vignette (Corrigan et al. 1999). As a result, although the Perceived Dangerousness Scale (Angermeyer et al., 2004) does not have previous reliability data when used with mental health staff, it is considered to be more appropriate for this research.

The scale has six items that are attributes of dangerousness: aggressive, unpredictable, strange, frightening, dangerous and appearing to lack control. Participants are asked to indicate the extent to which they believe these six attributes apply to the service user described in the vignette. They rate this on a five-point Likert scale. The scale ranges from 1 (definitely true) to 5 (definitely not true). As Angermeyer et al. described in their 2004 research, the scoring is reversed for interpretation. As a result, higher scores represent a greater belief that the service user depicted in the vignette is dangerous.

2.4.4 Adapted Attribution Questionnaire 27 (AQ-27)

This questionnaire was used to assess staff attributions of controllability, emotions of fear, anger and pity and intended behaviours of helping and coercion. Corrigan et al. (2003) developed the original AQ-27 (Appendix H) to assess the attribution model of public discrimination towards a person with a mental illness. This model is a nine factor path model that helps explain the relationship between public attributions, emotional responses, and intended behaviours about and towards people with mental illness.

The original AQ-27 has 27 items with nine factors that measure attributions, emotions and intended behaviours towards a hypothetical person with a mental illness in a vignette. These nine factors are: blame (which is used to measure controllability in this research), anger, pity, help, dangerousness, fear, avoidance, segregation and coercion.

Each factor is composed of three statements. Respondents rate how much they agree with the statements on a semantic differential scale from 1 (not at all) to 9 (very much). The higher the factor score, the more the respondent agrees with it.

The AQ-27 has previously been used successfully to identify attributions that lay people hold about a person with a mental illness in a vignette (Corrigan, Markowitz, Watson, Rowan and Kubiak, 2003). However, some items appear to measure fairly extreme views such as 'If I were in charge of Harry's treatment, I would force him to live in a group home'. There were concerns that statements such as this would be too extreme for mental health professionals to support. Therefore, the original AQ-27 was adapted in several ways in order for it to be appropriate for this research. A copy of the adapted AQ-27 can be seen in Appendix C.

The avoidance, dangerousness and segregation factors were removed. Instead, the social distance scale (Link et al., 1987; Hay, 2007) and the perceived dangerousness scale (Angermeyer et al., 2003) were used to assess participants' desire for social distance from the character in the vignette and their attributions of dangerousness. In addition, two items from the coercion factor were adjusted to ensure they do not measure extreme views of coercion. Using individual factors from the AQ-27 to assess staff attributions, emotions and intended behaviours as opposed to the whole questionnaire should not have an impact on the reliability of the factors. Corrigan, Markowitz, Watson, Rowan, Kubiak (2003) used individual items on the AQ-27 when investigating community college students' attributions, emotional reactions and intended behaviour towards people with a mental illness. They reported high reliability for several factors; the Cronbach's Alpha

scores for the items are as follows: blame=.70, pity=.74, anger=.89 fear=.96, helping=.88, and coercion=.89.

The AQ-27 originally focused on a man named 'Harry'; this was changed to 'Mary' to relate to the female service user being depicted in the vignette.

2.4.5 The Social Distance Scale (Link, Cullen, Frank & Woznaik, 1987) as adapted by Hay, (2007)

This scale was used to measure the participants' desire for social distancing from the service users depicted in the vignettes. It was used in place of the avoidance factor on the AQ-27. It is more appropriate for use than the avoidance factor on the AQ-27 because it was devised for use with a vignette and assesses less extreme views than the AQ-27. It includes seven items representing a range of social relationships in which people can engage, for example, renting a room to the person or allowing the person to care for their child. Respondents indicate how willing they would be to enter into each particular social relationship with the person in the vignette, with willingness being rated on a five-point Likert scale from 1 (definitely willing) to 5 (definitely not willing). A higher score indicates a greater desire for social distancing.

Link et al. (1987) report an internal consistency of .92 (Cronbach's alpha), and with a modified version using more appropriate language for an English population sample, Hay (2007) reported a Cronbach's alpha of 0.87. It is this modified version that was used in this research.

There are measures of social distance that have demonstrated good reliability when used with mental health staff. For example, Markham (2003) used the Social Distance Questionnaire (Ingamells, Goodwin & John, 1996) to measure mental health

staff desire for social distance from a person with BPD and reported a Cronbach's alpha of 0.80. However, this questionnaire requires respondents to base their answer on a 'man or woman with borderline personality disorder'. The current research did not want to use this method because previous research has indicated that asking participants about a person with BPD does not measure attributions as sensitively as does asking them about a specific character in a vignette (Corrigan et al. 1999). As a result, although the Social Distance Scale (Link et al., 1987; Hay, 2007) does not have previous reliability data when used with mental health staff, it was considered to be more appropriate for this research.

2.4.6 The Knowledge Questionnaire (James & Cowman, 2007)

This was used to measure participants' knowledge about BPD. It is based on a previous questionnaire developed by Cleary, Seigfried and Walter (2002).

The questionnaire has five sections. The first contains demographic information and was adapted to obtain demographic information appropriate to this research. The second section assesses how much contact a staff member has with BPD service users and if they believe they receive adequate care. The third section assesses knowledge levels of BPD. It contains 10 statements relating to BPD diagnosis, treatment and prognosis. Respondents are asked to rate if statements are true, false or to state that they do not know. Statements are based on the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM IV) (APA, 1994) diagnoses and common myths about BPD found in the literature by Cleary et al. (2002). This section is scored out of 10, with a higher score indicating a higher level of knowledge. The fourth section asks respondents about assessment information they gather from BPD service users and their levels of confidence and difficulty when working with them. The final section asks

respondents if they believe they have a role in working with BPD service users and resources that would be useful in improving care.

James and Cowman (2007) ensured construct validity by piloting the questionnaire with mental health professionals. They also reported the internal consistency in their sample to be high (Cronbach's alpha .79)

2.5 Ethical Considerations

2.5.1 Ethical Approval

This research was given a favourable ethical opinion by the Cambridgeshire 3 Research Ethics committee (Appendix I). It was also given approval by Cambridgeshire and Peterborough NHS Foundation Trust research and development department (Appendix J).

2.5.2 Consent

To enable participants to give informed consent to participate, an informed consent form and participant information sheet was provided. The information sheet (Appendix G) contained information about the procedure of the research and explained that participants' data would be anonymous and confidential. The complaints procedure was also outlined, and participants were informed they could withdraw from the study at any time. After reading this, participants were asked to sign the informed consent form (Appendix K) stating that they had read the information sheet, understood the research and were happy to take part before completing the questionnaires.

2.5.3 Deception

The British Psychological Society Code of Ethics and Conduct (2006) document states that psychologists undertaking research should only withhold information from

participants or intentionally deceive them in 'exceptional circumstances' where it is 'necessary to preserve the integrity of research'. The researcher decided that this research required a limited amount of deception and withholding of information due to concerns that participants would respond in a socially desirable manner if they were aware of the detailed and accurate aims of the research before they completed the questionnaires. Thus, steps were taken to ensure they only had access to a vague and general research outline. The participant information sheet did not inform participants that the research was aiming to compare staff attributions and intended behaviours towards service users diagnosed with BPD and depression. Instead, it stated that the aim of the research was to investigate the relationship between staff and service user characteristics. Furthermore, the information sheet only gave limited information about the measures that were to be used. This was to ensure participants did not know the questionnaires were measuring knowledge about BPD, attributions of dangerousness and intended behaviour of social distancing. Instead, it said the research was examining the familiarity and awareness of certain mental health labels, level of risk and social relationships. As a result, the knowledge questionnaire, the social distancing scale and the perceived dangerousness scale were given false names for the purposes of data collection. They were called the familiarity and awareness questionnaire, the social relationships scale and the perceived risk scale.

The British Psychological Society Code of Ethics and Conduct (2006) document also states that if deception is used or information is withheld from participants that 'the nature of the deception is disclosed to clients at the earliest feasible opportunity'. In accordance with these guidelines, participants were sent the participant de-brief sheet

(Appendix L) two weeks after the data collection had been completed in their team. This informed them of the specific aims of the research and the real names of the measures. It also reiterated that participants could withdraw their data if they wished. If participants requested to withdraw from the study their data was destroyed.

2.5.4 Confidentiality

Once a participant had agreed to take part, confidentiality was guaranteed by the following means:

- During the data collection and analysis stages of the research, participants' data was stored in a locked filing cabinet
- Participants' consent forms and questionnaires were stored separately.
- After completion of the research, the data will be stored securely at the University of East Anglia for five years.

2.6 Procedure

2.6.1 Data Collection Procedure

The researcher firstly checked that participants had read and understood the participant information sheet before asking them to complete the consent form. The consent form was taken and stored separately from their data. Before participants completed the research, it was explained to them that they should not discuss their real cases with the researcher, as the research was focusing on the character in the vignette. This ensured participants would not disclose anything about their working practice that the researcher would need to report, so they could be guaranteed confidentiality. Following this, the participant was given one of the two vignettes and corresponding questionnaires from the researcher's ready ordered pack of vignettes and questionnaires.

They were instructed to read the vignette and complete the questionnaires in the order in which they were provided. It was reiterated that participants should not move onto the next questionnaire before completing the previous one. This was to make sure the participants did not see the knowledge questionnaire before completing the adapted AQ-27, the dangerousness scale and the social distancing scale. This was because the researcher was concerned that completing the knowledge questionnaire first would indicate the true aims of the study and influence participants' responses on the other measures. The adapted AQ-27, the social distance and the dangerousness scales were randomly ordered within the packs to control for order effects. Participants took, on average, 20 minutes to read the vignettes and complete the questionnaires. The researcher was present throughout the time it took participants to complete the research.

As the research was an independent groups design, the vignettes containing the different labels were read by different staff. The vignettes were not randomly allocated. This was to minimize the effect of team attitudes towards the labels by ensuring an approximately equal number of questionnaires were answered about both vignettes in each team. However, to ensure the researcher had no choice about which staff members would receive which vignettes the vignettes and their questionnaires were pre ordered prior to data collection commencing. They were arranged so that the depression alone and the BPD and depression vignettes were alternated. Vignettes and their corresponding questionnaires were then given to participants in that order.

2.6.2 De-brief and Feedback Procedure

Two weeks after the data collection had finished in each team, the participant de-brief sheet was sent to participants. This contained a detailed rationale for the research

and the authentic names of the measures. Participants were also provided with the opportunity to opt out at this point. If they wished to do so, they informed the researcher of this and their data was destroyed. No participant requested that their data be removed. This suggests that the BPS guidance on deception (BPS, 2006) had been appropriately followed.

Following the completion of this research, a report summarising the research findings and implications will be sent to each team manager to distribute to the staff within their team. The researcher's contact details will be on this and participants will be informed they can contact her should they have any questions or concerns. In addition, if the team request it, an individual and anonymous report summarising staff opinions and development needs in relation to working with service users with BPD in their team will be provided. However this has not yet been requested by any of the team managers.

2.7 Plan of Analysis

Overall, this study employed an independent groups design comparing the differences in staff attributions about service users labelled with BPD and depression, and depression alone.

2.7.1 Preliminary Analyses

Descriptive statistics were used to summarise demographic information. This included the participant's age, sex, and job role and whether the participant works in the community or acute care services. Descriptive statistics were also used to ascertain whether data met parametric test assumptions. The exploratory analysis and subsequent plan of analysis of the research questions is outlined below.

2.7.2 Statistical Analyses of Research Hypotheses.

- 1) Staff will make more attributions of dangerousness and controllability towards service users labelled as depressed and BPD than those labelled with depression alone.

Histograms (Appendix M) and Wald statistics were used to ascertain that the data on the dangerousness scale were normally distributed in both the BPD and depression and depression alone group. In addition, boxplots (Appendix M) were conducted and no outliers were identified. Histograms and Wald statistics were also used on the data from the controllability scale. These indicated that whilst the data in the BPD and depression group were normally distributed, it was negatively skewed in the depression alone group. As only one group was negatively skewed, the data were not transformed. Although boxplots identified two outliers in each group, they will not be adjusted because a non-parametric test will be used. As a result, the following statistical tests will be used to investigate hypothesis 1.

A One-tailed independent t-test will be used to investigate the difference between the group's dangerousness scores. The independent variables are the labels in the vignettes (BPD and depression and depression alone) and the dependent variable is the dangerousness score, as measured by the perceived dangerousness scale (Link et al. 1987).

A Mann Whitney U test, the non-parametric version of the t test, will be used to investigate the difference between staff attributions of controllability. The independent variables are the same as above and the dependent variable is the controllability score, as measured by the adapted AQ- 27 (Corrigan et al. 2003),

- 2) Staff will be less likely to help and more willing to coerce and socially distance service users labelled as depressed and BPD than those labelled with depression alone.

Histograms and Wald statistics revealed a normal distribution on the coercion and social distance scales within both groups. Although boxplots identified four outliers within the depression alone group they were not adjusted or excluded. This is because the 5% trimmed mean was 16.9 whilst the mean was 17 suggesting the outliers did not have a significant impact on the mean. On the helping scale, histograms (Appendix M) and Wald statistics indicated that the data for the BPD and depression group were normally distributed whilst the data for the depression alone group were negatively skewed. The data were not transformed because only one group was negatively distributed. As a result of the above analyses the following statistical analyses will be used.

One-tailed independent t-tests will be used to investigate differences between the groups' intended coercion and social distance behaviour. Independent variables are the labels in the vignettes (BPD and depression, and depression alone). Dependent variables are staff intended behaviour, as measured by the coercion factor on the adapted AQ-27 (Corrigan et al., 2003), and the score on the social distance scale (Link et al., 1987; Hay, 2007).

A Mann Whitney U will be used to investigate differences between the groups' intended helping behaviour. Independent variables are as described above and the dependent variable is staff intended helping behaviour as measured by the help factor on the adapted AQ-27 (Corrigan et al., 2003)

- 3) Staff attributions and emotional reactions will be associated with their intended behaviour.

As reported for hypothesis one and two, a number of the attribution and intended behaviour scales within both the BPD and depression group and the depression alone group were normally distributed whilst a number were not. Additional Histograms and Wald statistics showed that the data on the anger and pity scales were negatively skewed in both groups whilst the data for pity was normally distributed. In addition to this a series of scatter plots (Appendix N) revealed that several of the variables did not meet the assumption of linearity for both the BPD and depression group and the depression alone group. As a result a Spearman's r correlation was performed on both the BPD and depression group and the depression alone group to measure the strength of the relationship between staff attributions, emotional reactions and intended behaviours. The significance of the correlation was considered using a 0.05 significance level.

- 4) Higher staff knowledge levels about BPD will be associated with lower staff attributions of dangerousness and controllability towards service users labelled with BPD.

As reported previously, the data in the BPD and depression group were normally distributed for the dangerousness variable and positively skewed on the controllability variable. Additional Histograms and Wald statistics revealed that the data for the participants' DSM IV (APA, 1994), treatment and general knowledge scores and their total knowledge scores were not normally distributed. The assumption of linearity was also assessed; scatterplots revealed that this had been violated between all variables. As a result, a Spearman's r correlation was performed on the BPD and depression group to

measure the strength of the relationship between staff knowledge levels and their attributions about BPD. The significance of the correlation was considered using a 0.05 significance level.

- 5) Higher staff knowledge levels about BPD will be associated with lower staff intended social distancing and coercive behaviour and higher staff intended helping behaviour towards service users labelled with BPD.

As previously reported, the data within the BPD and depression group were normally distributed for the social distancing, helping and coercive behaviour variables with no outliers being identified. However, the data for the participants' knowledge scores were not normally distributed. In addition to this, the assumption of linearity had been violated between all variables. As a result, a Spearman's r correlation was performed on the BPD and depression group to measure the strength of the relationship between staff knowledge levels and their intended behaviour towards the service user with BPD. The significance of the correlation was considered using a 0.05 significance level.

CHAPTER THREE: RESULTS

3.1 Overview

This chapter begins by describing the sample that was recruited, before moving on to explain the analyses of the data. The analyses of the data are presented in two sections. The first section outlines the reliability of the self report measures whilst the second section describes the analyses and results for each of the hypotheses. Following this, there is a section that describes the rationale and results of two additional analyses. To conclude the chapter, a short summary of the results is presented.

3.2 Sample Composition

3.2.1 Response Rate

The recruitment method used in this study makes it difficult to accurately calculate exact participant response rates. This is because not all members of staff within each team were able to attend the pre arranged meetings where they were invited to participate. Although information sheets were left for staff who were unable to attend the meeting, it is not possible to be confident that they received them.

In total, 35 mental health teams within the Cambridgeshire and Peterborough NHS Foundation Trust were invited to participate from both community mental health and acute care teams. Of these, 21 managers agreed for the researcher to invite staff within their team to participate. However, six of the teams were unable to offer an appointment within an appropriate time frame, so staff within these teams were not invited to participate. The teams who were visited included 12 community and 3 acute care teams. From these teams, 205 staff were approached at meetings and a further 60

information sheets were left with the team managers. Of this number, 83 staff agreed to participate, giving an estimated response rate of between 31%-40%.

Out of the 83 participants who responded, all met the inclusion criteria and all questionnaires were completed appropriately. As a result, no participants were excluded from this study.

3.2.3 Demographics of the Sample

The 83 participants in this study are staff members from the secondary care mental health services within the Cambridgeshire and Peterborough NHS Foundation Trust. Overall, 18 of the participants were male and 65 were female. For the two groups, the BPD and depression group had 7 males and 35 females and the depression alone group had 11 males and 30 females. Their age was recorded using categories. Table 2 shows the number of participants in each age range for both groups.

Table 2 Age range of participants within in each group

<i>Participant's Age</i>	<i>BPD and Depression</i>	<i>Depression alone</i>
25 or less	3	5
26-29	4	5
30-39	14	11
40-49	8	13
50 or over	13	7
Total	42	41

The participants were recruited from multidisciplinary teams. As a result, there were participants from a range of different professions within each group; these are summarized in Table 3.

Table 3. Summary of participants' professions within each group

<i>Participant's Profession</i>	<i>BPD and Depression</i>	<i>Depression alone</i>
Community Psychiatric Nurse	19	13
Trainee Clinical Psychologist	5	5
Occupational Therapist	4	5
Support Worker	3	6
Social Worker	5	2
Clinical Psychologist	2	3
Nursing Student	1	3
Psychiatric Nurse	2	1
Nursing Auxiliary	1	2
Psychiatrist	0	1
Total	42	41

As Table 3 shows, both qualified (n= 57) and nonqualified (n=26) members of staff were included in this study to ensure the sample represented all staff members in mental health teams; the BPD and depression group contained 10 nonqualified and 32 qualified participants and the depression alone group contained 16 nonqualified and 25 qualified participants.

The sample was heavily dominated by staff who worked within community mental health teams; they accounted for 92.8% of the sample. This is reflected within both groups. A greater number of participants worked within a community mental health team (n=34) than in an in-patient setting (n=3) or more intensive support team working in

the community (n=5) within the BPD and depression group. Similar numbers were found in the depression alone group; 35 participants were from community mental health teams, three were from an in-patient ward and three from the intensive support teams within the community.

3.3 Preliminary Analysis

3.3.1 Internal Reliability of Measures

Cronbach's alpha (α) was calculated to assess the internal consistency of all variables. It is widely accepted that a Cronbach's alpha of .7 or above is indicative of a reliable scale whilst anything below that indicates a lack of reliability (Field, 2006). As Table 4 shows, several of the scales used in this research have an α between .598 and .673 which suggests they have low internal reliability. However, Cortina (1993) argues that this rule should not be applied in this general manner. In addition, Cronbach (1951) recognised that α is affected by the number of items within a scale: the more items a scale has, the more likely it is to have a larger α value. Therefore, because the above mentioned scales have a small number of items, they are considered to be adequately reliable

The scale with the lowest α value ($\alpha=.472$) in the current study is the controllability factor on the adapted AQ-27. An α of this value would ordinarily indicate that a scale has an unacceptable level of internal consistency (George & Mallery, 2003). However, Voss, Stem and Fotopoulos (2000) suggest that when a scale is particularly short, the mean inter item correlation can be used to assess whether the small number of items has reduced the coefficient alpha. This is because the mean inter item correlation is independent of the scale length. The mean inter item correlation for the controllability factor in this study is .2. Clark and Watson (1995) state that mean inter-item correlations

of between .15 and .20 are acceptable in social science research. As a result, the controllability factor continued to be used as a measure of controllability within this study. However, to increase confidence in the results, the analysis that compares attributions of controllability between the two groups was repeated using only the item that asks specifically about controllability.

Table 4. Number of items and Cronbach's alpha value for each scale used in this study.

<i>Scale</i>	<i>Number of Items</i>	<i>Cronbach's Alpha (α)</i>
Social Distance Scale (Link et al., 1987)	7	.817
Perceived Dangerousness scale (Angermeyer et al., 2004)	5	.765
Adapted Attribution Questionnaire 27 (Corrigan et al., 2003)		
Controllability	3	.472
Anger	3	.899
Pity	3	.612
Fear	3	.943
Help	3	.633
Coercion	3	.672
Knowledge Questionnaire (James & Cowman, 2007)		
Knowledge of DSM IV	3	.735
Knowledge of treatment	3	.598
General Knowledge	4	.673
Total Knowledge score	10	.824

3.4 Hypothesis Testing

3.4.1 Hypothesis 1: Staff Will Make More Attributions of Dangerousness and Controllability towards Service Users Labelled as Depressed and BPD Than Those Labelled with Depression Alone

3.4.1.1 Dangerousness

A one-tailed independent t-test was used to investigate if there was a significant difference in mean dangerousness scores between the groups; the summary data are displayed in Table 5. The t statistic that assumed variances were not equal was used. This is because Hayes and Cai (2007), who reviewed 49 data sets, found that using the t statistic when equal variances are not assumed is as good, and sometimes better, at protecting from a type 1 error than when a conditional procedure testing for equal variances, followed by a t-test based on the outcome of this test, is used. As a result, all t-tests that are used within this research used the t statistic that has been calculated based on equal variances not being assumed.

The one-tailed independent t-test indicated there was not a significant difference between the dangerousness scores of the two groups ($t(72.9)=1.37, p=.86$), suggesting staff members do not consider service users with BPD to be more dangerous than service users with depression only. The magnitude of the difference between the means (mean difference=1.4, 95% CI: -.61-3.30) was small (eta squared .02).

Table 5. Mean and standard deviation scores on the dangerousness measure

	<i>Number of Participants</i>	<i>Mean</i>	<i>Standard Deviation</i>
BPD and Depression	42	15.8	3.7
Depression Alone	41	14.4	5.1

3.4.1.2 Controllability

The Mann-Whitney U test revealed no significant difference in the levels of controllability attributions of staff who read the vignette depicting a service user with BPD and depression and those who read the vignette depicting a service user with depression alone ($U=835.5$, $z=.234$, $p=.408$ (one tailed)). Table 6 shows the mean, median and quartile scores for both groups. The magnitude of the difference between the two groups was medium, $r=.3$.

Table 6. Mean, Median and quartile scores of controllability attributions for both groups

	<i>Number of Participants</i>	<i>Mean</i>	<i>Median</i>	<i>Quartiles</i>	
				<i>20</i>	<i>75</i>
BPD and Depression	42	11	10	7	13
Depression Alone	41	10	11	9	12

As discussed previously, the controllability scale had low reliability ($\alpha=.472$). As a result, the analysis was repeated with a single item from the controllability scale that asks specifically about controllability.

Histograms and boxplots were viewed to ascertain whether there were any outliers and that the data were normally distributed. They revealed a normal distribution in both groups. To ensure the distribution was truly normal, Wald statistics were calculated for each group. All Wald statistics fell between 1.96 and -1.96 suggesting a normal distribution. Boxplots were also used to search for outliers within both groups and none was identified.

A one-tailed independent t-test was used to test the difference between the two groups. The t-test revealed that there was no significant difference detected between the groups ($t(80.6) = .310, p = .76$.) As seen in Table 7, there was a very small difference between the means. The magnitude of the difference between the means (mean difference = 0.1, 95% CI: -.817-.597) was also very small with an eta squared value of .00.

Table 7. Mean and standard deviation scores for the controllability question alone

	<i>Number of Participants</i>	<i>Mean</i>	<i>Standard Deviation</i>
BPD and Depression	42	4.5	1.6
Depression Alone	41	4.6	1.7

3.4.2 Hypothesis 2: Staff will be Less Willing to Help and More Likely to Coerce and Socially Distance Service Users Labelled as Depressed and BPD than those Labelled with Depression Alone

3.4.2.1 Helping Behaviour

The Mann-Whitney U test revealed a significant difference between the groups' intended helping behaviour. The group who read the depression alone vignette indicated they were significantly more likely to offer helping behaviour than were participants who read the vignette depicting a service user with BPD and depression. ($U = 533, z = 3.01, p = .002$). Table 8 shows the differences between the groups' means, medians and quartiles.

Table 8. Mean, Median and quartile scores of helping behaviour for both groups

	<i>Number of Participants</i>	<i>Mean</i>	<i>Median</i>	<i>Quartiles</i>	
				<i>20</i>	<i>75</i>
BPD and Depression	42	22	22	19	24
Depression Alone	41	24	24	22	27

This suggests that staff are significantly less likely to intend to help service users who have a diagnosis of BPD.

3.4.2.2 Coercion

The hypothesis was not supported with a one-tailed independent t-test, showing that the difference between groups was not significant ($t(70.2) = 2.61, p = .106$). Table 9 shows the mean and standard deviation scores between the two groups. The size of the difference between the two groups (mean difference = 1.5, 95% CI: -3.70-.834) was found to be small (eta squared = .07). This suggests that staff are equally likely to intend to be coercive towards service users with a diagnosis of depression alone and depression and BPD.

Table 9. Means and standard deviation scores for the two groups on the coercion measure

	<i>Number of Participants</i>	<i>Mean</i>	<i>Standard Deviation</i>
BPD and Depression	42	11.8	3.1
Depression Alone	41	13.3	6.1

3.4.2.3 Social Distance

Table 10. Means and standard deviations of both groups' social distancing scores.

	<i>Number of Participants</i>	<i>Mean</i>	<i>Standard Deviation</i>
BPD and Depression	42	20.4	3.3
Depression Alone	41	17.0	4.4

A one-tailed independent t-test ($t(73.1)=3.97, p=.000$) revealed the hypothesis was supported. The group who read the vignette about a service user with BPD and depression indicated they would intend to display significantly higher levels of social distancing behaviour than the group who had read about a service user with depression alone.

3.4.3 Hypothesis 3: Staff Attributions and Emotional Reactions will be Associated with their Intended Behaviour

3.4.3.1 Depression Alone Group.

A Spearman's rho, the non parametric version of the Pearson's r correlation, was used to investigate the relationship between participants' attributions, emotional reactions and intended behaviours within the depression group. Table 11 highlights the significant associations between staff emotions and intended behaviours and attributions and intended behaviours that were detected.

Table 11. Spearman's rho correlations between participants' attribution, emotion and intended behaviour scores in the depression alone group

	<i>Help</i>	<i>Coercion</i>	<i>Social Distance</i>
Controllability	-.319*	.136	.117
Dangerousness	-.094	.427*	.330*
Anger	-.270*	.060	.031
Pity	.205	.051	-.001
Fear	-.129	.227	.183

*p<0.05 N=41

A number of significant correlations were detected between attributions and intended behaviours. A medium strength positive correlation was found between staff attributions of dangerousness and their intended behaviours of coercion. A medium strength positive correlation was also found between staff attributions of dangerousness and their intended social distancing behaviour. This suggests that higher staff attributions of dangerousness are associated with staff having higher intentions to behave in a coercive and socially distant manner towards service users with depression. A medium strength negative correlation was found between controllability and intended helping behaviour suggesting lower levels of intended helping behaviour are associated with higher levels of controllability attributions. Only one emotion was significantly associated with staff intended behaviour in this group. There was a small but significant negative correlation between staff anger and their intention to help. This suggests that higher levels of staff anger are associated with them intending to offer less help towards service users with depression alone.

3.4.3.2 BPD and Depression Group

The non-parametric Spearman's rho was used to explore the relationships between participants' emotional reactions and their intended behaviours within the BPD and depression group.

As Table 12, displays, there were no significant associations between staff attributions and their intended behaviour within this group. This is interesting because staff attributions of controllability and dangerousness were significantly associated with their intended behaviour within the depression alone group

Table 12 Spearman's rho correlations between participants' attributions, emotions and intended behaviour scores in the BPD and depression group

	<i>Help</i>	<i>Coercion</i>	<i>Social Distance</i>
Controllability	-.151	.143	.070
Dangerousness	-.157	.138	.159
Anger	-.306*	.113	.099
Pity	.010	.026	.212
Fear	-.345*	.238*	.212

*p<0.05 N=42

Whilst there were no significant associations between staff attributions and their intended behaviour within this group Table 12 shows that there were three significant associations between staff emotions and their intended behaviour. Fear appears to be a particularly important emotion within this group. A small but significant positive correlation between fear and coercion was detected within this group. This suggests that higher levels of fear in staff are associated with higher intentions to be coercive towards

service users with BPD. A medium strength negative correlation between staff fear and intended helping behaviour suggests that there is also an association between higher levels of staff fear and staff expressing a lower intention to help service users with BPD. Staff intended helping behaviour has a medium strength negative correlation with their levels of anger. This suggests that higher staff anger levels are related to staff having a lower intention to help service users with BPD and depression.

3.4.4 Hypothesis 4- Higher Staff Knowledge Levels about BPD will be Associated with Lower Staff Attributions of Dangerousness and Controllability towards Service Users Labelled with BPD.

Spearman's rho, the non parametric version of the Pearson's r correlation, was used to investigate the relationship between participants' knowledge levels and their attributions of dangerousness and controllability.

Table 13 shows there are no significant correlations between participants' total knowledge scores and their attributions of dangerousness and controllability. However, there is a medium strength significant negative correlation between participants' treatment knowledge scores and their attributions of controllability. This suggests that staff who have higher levels of treatment knowledge about BPD have lower levels of controllability attributions towards service users labelled with BPD.

Table 13 Spearman's rho correlations between scores on the knowledge questionnaire and the controllability and dangerousness measures

	<i>Dangerousness</i>	<i>Controllability</i>
DSM IV knowledge	-.140	.137
Treatment knowledge	.043	-.310*
General knowledge	.089	-.008
Total knowledge	.004	-.006

*p<0.05

N=42

3.4.5 Hypothesis 5 Higher Staff Knowledge Levels About BPD Will be Associated With Lower Staff Intended Social Distancing and Coercive Behaviour and Higher Staff Intended Helping Behaviour Towards Service Users With BPD.

A Spearman's rho, the non parametric version of the Pearson's r correlation, was used to explore the relationship between participants' knowledge levels and their intended behaviours of social distancing, coercion and helping. The results of which can be found in Table 14.

Table 14. Spearman's rho correlations between scores on the knowledge questionnaire, the social distance, helping and coercion measures

	<i>Helping</i>	<i>Coercion</i>	<i>Social Distance</i>
DSM IV Knowledge	.706	-.170	-.323*
Treatment Knowledge	.437*	-.272*	-.233
General Knowledge	-.019	-.082	.058
Total Knowledge	.181	-.151	-.164

*p<0.05

N=42

Table 14 shows there are no significant associations between participants' total knowledge levels and their scores in the helping, coercion and social distance measures. However, a significant medium strength positive correlation was found between treatment knowledge and intended helping behaviour, suggesting that higher levels of knowledge about the treatment of BPD are associated with greater intention to help BPD service users.

Two negative correlations were also detected when investigating the separate factors on the knowledge questionnaire. A medium strength negative correlation was found between levels of knowledge about the DSM IV (APA, 1994) criteria for BPD and levels of social distance scores. This suggests that higher levels of staff knowledge of symptoms of BPD are associated with a lower wish to socially distance themselves from service users with BPD. A small but significant negative correlation was also detected between treatment knowledge levels and scores on the coercion measure. This suggests that there is an association between higher staff knowledge levels and their intention to coerce service users with BPD into treatment.

3.5 Additional Analyses

As the results in this research indicated that there is an association between staff emotions and their intended behaviours, additional analyses were conducted that compared the two groups' emotional reactions towards the service users in the vignettes.

3.5.1 Anger

Previous exploratory analyses indicated that the data was negatively skewed on the anger factor in both groups. As a result, a Mann-Whitney U test was used as the non parametric alternative to the t-test. In addition to the exploratory analyses, a Bonferoni

correction was used to protect against a type 1 error. This was because there were multiple analyses within the additional analysis. Following the Bonferoni correction, the significance level was $p=.017$.

The two-tailed Mann-Whitney U test revealed that there was a significant difference between the groups' reporting of anger towards the service user in the vignette who was labelled with depression and the service user in the vignette who was labelled with BPD and depression. Staff were significantly less likely to report feeling angry towards the service user in the vignette labelled with just depression than towards the service user labelled with BPD and depression ($U=578$, $z=-2.67$, $p=.004$). Table 15 shows the differences between the groups' means medians and quartiles.

Table 15. Mean, median and quartiles for both groups on the anger scale

	<i>Number of Participants</i>	<i>Mean</i>	<i>Median</i>	<i>Quartiles</i>	
				<i>20</i>	<i>75</i>
BPD and Depression	42	6.8	5.0	3.0	8.3
Depression Alone	41	4.8	3.0	3.0	6.0

3.5.2 Pity

Previous exploratory analysis of the data on the pity factor revealed it was normally distributed with no outliers in both groups. As a result, a two-tailed t-test was used to assess the difference between the two groups. A Bonferoni correction was used to protect against a type 1 error. Following the Bonferoni correction, the significance level was $p=.017$.

The two-tailed independent t-test indicated that the difference between groups was not significant ($t(80.8) = 2.18, p = .033$). The means and standard deviations from the two groups are shown in Table 16. The magnitude between the means of the two groups (mean difference = 2.08, 95% CI: -4.10--1.78) was found to be small ($\eta^2 = .05$).

Table 16. Mean and standard deviation scores for both groups on the pity scale

	<i>Number of Participants</i>	<i>Mean</i>	<i>Standard Deviation</i>
BPD and Depression	42	14.5	4.5
Depression Alone	41	16.6	4.2

This indicates that staff do not feel higher levels of pity towards service users labelled with just depression than towards those labelled with BPD and depression.

3.5.3 Fear

Previous exploratory analyses for the anger factor indicated that data was negatively skewed in both groups. As a result, a Mann-Whitney U test was used as the non parametric alternative to the t test. As with the anger and pity data, a Bonferroni correction was used to protect from a type 1 error making the p value .017.

The Mann-Whitney U test revealed there was not a significant difference between the groups' reporting of fear ($U = 773.5, z = -.903, p = .367$ (two tailed), $r = .01$). This suggests that staff report equal amounts of fear towards service users with BPD and depression and those with depression alone. Table 17 below shows the differences between the groups' means and medians and quartiles.

Table 17. Mean, median and quartile scores for both groups on the fear scale.

	Number of Participants	Mean	Median	Quartiles	
				20	75
BPD and Depression	42	5.0	3.0	3.0	6.0
Depression Alone	41	4.2	3.0	3.0	5.5

3.6 Summary of Results

Hypotheses 1 and 2 investigated whether staff held different attributions and intended to behave differently towards service users labelled with BPD than towards those labelled with depression. No differences in the attributions of dangerousness and controllability were detected between the groups. However, a number of differences were found between staff intended behaviours towards the service user in the vignette with BPD and depression as opposed to the service user with depression alone. Staff were significantly more likely to socially distance themselves from and less likely to help those service users with the label of BPD.

Hypothesis 3 focused on exploring the association between staff attributions, emotional reactions and intended behaviours. Within the depression alone group, several correlations were detected between attributions and intended behaviours. Positive correlations were found between staff attributions of dangerousness and their intended behaviours of coercion and social distance whereas a significant negative correlation was found between controllability and intended helping behaviour. Anger was significantly negatively correlated with staff intended helping behaviour and was the only emotion significantly associated with intended behaviour in this group. It is not possible to

ascertain the direction of the above relationships because the analysis was using correlations.

Within the depression and BPD group, fear was an important emotion; a significant positive correlation between fear and coercion was found. There was also a significant negative correlation between fear and intended helping behaviour. Another emotion that was significantly associated with intended behaviour was anger; a significant negative correlation between staff intended helping behaviour and anger was found. Again, it is not possible to ascertain the direction of these relationships because a correlation was used. Interestingly, and in contrast to the results in the depression alone group, no attributions were found to be significantly associated with staff intended behaviours.

Hypotheses 4 and 5 explored the association between staff knowledge levels and their attributions and intended behaviours towards service users labelled with BPD. Whilst total knowledge scores were not associated with participants' attributions or intended behaviours, treatment knowledge scores were significantly associated with lower levels of intended coercive behaviour and higher levels of intended helping behaviour. Treatment knowledge was also associated with lower attributions of controllability. Higher knowledge levels about the symptoms of BPD as measured by the DSM IV (APA, 1994) were associated with lower intended social distancing.

Finally, as emotions were found to be significantly associated with staff intended behaviours, particularly in the BPD group, additional analyses were conducted to explore the difference of the staff emotional reactions between the groups. Significant differences were found between staff reporting of anger. They reported feeling significantly more

angry towards the service user with BPD and depression than towards the service user with depression alone. There was no significant difference between the levels of fear and pity in each group.

CHAPTER FOUR: DISCUSSION

4.1 Chapter Overview

This chapter begins by briefly revisiting the aims of the research. Following this, a summary of the main findings and additional analyses are presented along with how these compare with previous research. The strengths and the limitations of the research are then discussed before moving on to discuss the theoretical and clinical implications. Finally, ideas for future research are outlined before an overall conclusion is drawn.

4.2 Summary of Research Aims

The aim of this study was to explore whether there are differences in the attributions and intended behaviours of secondary mental healthcare staff towards service users with the label of BPD and depression compared to those with the label of depression only. It also explored whether knowledge levels are associated with staff attributions and intended behaviours towards service users with BPD. It is important to explore the effects mental health labels have on staff attributions and intended behaviours because a service user's label can be one of the first pieces of information staff have about them. If their label is found to be associated with negative staff attributions and intended behaviours, it could be detrimental to their early interactions (Aviram, Brodsky & Stanley, 2006).

The research used a between participants design. Participants were allocated to one of two groups, with one group reading a vignette about a service user with BPD and depression and the other group reading an identical vignette about a service user with depression only. After reading the vignette, participants completed four questionnaires that measured their attributions, intended behaviours and knowledge about BPD.

Correlations were also used to assess possible associations between staff attributions and their intended behaviours and staff emotions and their intended behaviours BPD

4.3 Summary of Findings and Previous Research

4.3.1 Attributions

Research hypothesis 1 suggested that staff would make more attributions of dangerousness and controllability towards service users labelled with BPD and depression than those labelled with depression alone. The attributions were chosen based on Weiner's theory of causal attributions (1980, 1985, 1986) and the Corrigan et al. (2003) model of public discrimination towards a person with a mental illness. These models were used because they have previously been found to be helpful frameworks for exploring attributions and intended behaviours in a variety of different groups. Weiner's theory suggests that the causal attributions of internality, stability and controllability, along with emotional reactions, influence behavioural responses of helping and punishing. Corrigan's model suggests that attributions of controllability and dangerousness, along with emotional reactions, influence the behaviours of helping, social distancing and coercion.

4.3.1.1 Dangerousness

Hypothesis 1 was not supported; no significant difference was found between staff attributions of dangerousness towards the service user labelled with BPD and depression and the service user labelled with depression alone. This suggests that multidisciplinary secondary care mental health staff do not make higher attributions of dangerousness about a service user with BPD than about a service user with just depression based on referral information. However, these findings are not supported by

previous research. Markham (2003) explored health care assistants' (HCAs) and qualified nurses' (RMNs) attributions of dangerousness towards service users with BPD, depression and schizophrenia on psychiatric in-patient units. He found staff reported significantly higher levels of attributions of dangerousness about service users with BPD than about those with depression.

Although Markham (2003) did not report a pre or post hoc power calculation, which makes it difficult to accurately report the power for his study, it is important to highlight that the difference in the findings of Markham and the current research could be a result of higher power in Markham's study. Markham used a mixed within and between participants design to investigate the difference between staff attributions of dangerousness towards the labels of BPD, depression and schizophrenia. He used a two-way analysis of variance to investigate the main effect followed by individual t-tests to explore the difference between the three labels within the RMN (n=50) and HCA groups (n=21). The present research used a between participants design to investigate differences between two groups' attributions of dangerousness to service users labelled with either BPD and depression or with depression alone, with 41 participants in one group and 42 in the other.

The different designs and number of participants in each piece of research suggests that Markham's (2003) research is likely to have more power than the current research because Markham used a within subjects design to investigate the main effect. However, the design used in the current study ensured the participants were not aware that they were being asked about their attributions towards the label of BPD. This reduced the likelihood that the results would be confounded by participants responding in

a socially desirable manner, which increases the power. Markham was unable to do this because of the within participants, repeated measures design. In addition, Markham had three conditions within each of the two groups to investigate using post-hoc tests. When he investigated these he did not adjust the significance level to protect from the family-wise error rate. This increases the chance of a type 1 error and decreased the power.

Thus, although it is important to emphasise that the difference between the results of the two studies might be a result of Markham (2003) having more power, it is not possible to state this with confidence. As a result, it is important to explore other factors that might have influenced the difference between the results in each study. These will be discussed below.

The difference in results between Markham's (2003) research and the current research might reflect the difference in participants. Markham asked psychiatric nurses on an in-patient unit to be part of his research. In contrast, the sample in this research consisted of multidisciplinary secondary care mental health staff, 92.8% of whom worked within a community mental health setting. These two groups of staff will have had different experiences of working with service users with BPD, which is likely to have affected their attributions towards them.

There were also several differences in the methods. Markham asked participants to base their answers on previous experience of working with service users with each of the labels, whereas the current research asked staff about their attributions based on limited information in the form of a vignette. As participants were nurses on an in-patient unit, it is possible that they were thinking about more extreme cases of service users with BPD than those depicted in the vignette in this research.

Findings from previous qualitative research also supports the Markham (2003) findings rather than the current research. Woolaston and Hixenbaugh (2008) conducted a piece of qualitative research interviewing six nurses about their experiences of working with BPD service users. As discussed in section 1.7.3.1, they described the core theme as nurses experiencing BPD service users as a ‘powerful, dangerous, unstoppable force’ who leave ‘a trail of destruction’ behind them. Interestingly, this sample consisted entirely of nurses as opposed to the multidisciplinary staff on whom the current research focuses. In addition, the sample in Woollaston and Hixenbaugh was heavily biased towards in-patient staff, with four of the participants working on an in-patient unit. It is interesting that Woollaston and Hixenbaugh’s research supports Markham’s findings as opposed to the findings in the current research, because the samples in these two pieces of research are more similar to each other than to this research. This suggests it might be their place of work that influences staff attributions of dangerousness.

O’Brien and Flote (1997) also conducted a piece of qualitative research. They interviewed six psychiatric nurses about a service user with BPD on their in-patient unit who was displaying severe and life threatening behaviour. They reported that all the nurses agreed that they felt frightened when working with the service user with BPD suggesting that they might make attributions of dangerousness towards them (Corrigan, 2003). They said they felt frightened because situations could become quickly out of control and could be both personally and professionally damaging. They considered this particularly frightening because they felt that the organisations they worked for held them personally responsible for the safety of individuals. It is acknowledged that this is a very different scenario from the one depicted in the vignette used in this research. Again, it

used in-patient nurses as participants, which is different from the current research. It also focused on one BPD service user who displayed serious and life threatening behaviour; thus, it could be the seriousness of the behaviour that caused the fear in the staff.

However, the research raises an interesting issue because staff also reported that they feared being professionally damaged. This suggests that it is professional, as well as physical, harm that staff fear when working with BPD service users. The measure used to assess dangerousness in this research focused purely on physical harm, which might not have been as important to staff in this study, particularly as their attributions were based on referral information in the form of a vignette as opposed to a real life situation. Future research should explore the differences between personal and professional danger staff perceive from service users with BPD.

4.3.1.2 Controllability

Hypothesis 1 was not supported, with no significant difference found between staff attributions of controllability between the two groups. This suggests that based on referral information, multidisciplinary secondary care mental health staff do not make more attributions of controllability towards service users labelled with BPD than towards service users labelled with depression. This does not support previous research by Markham and Trower (2003), who that found staff made significantly more attributions of controllability towards the diagnostic label of BPD than towards the labels of depression and schizophrenia.

Markham and Trower (2003) used 48 participants to conduct a series of one way within participants ANOVAs followed by t-tests to assess the differences between the labels of BPD, depression and schizophrenia. This research used an independent t-test

with 83 participants (41 in one group and 42 in the other) to assess the difference between the groups attributions of controllability. Within participants designs have more power than between participants designs, which suggests the difference between the two pieces of research could be a result of Markham and Trower having higher power than the current study. However, it is not possible to state this with confidence because there are several factors that increase the power in the current research. Firstly, this research had more participants than the research by Markham and Trower. In addition, the design used in the current study ensured that participants were not aware that their attributions towards the label of BPD were being measured. This reduced the likelihood that the results were confounded by participants responding in a socially desirable manner, which increases the power of this study. Markham and Trower were unable to do this because of their within participants, repeated measures design. As a result, whilst the difference in results could be a result of Markham and Trower's study having higher power, the possibility that the difference in the findings reflects a genuine difference cannot be discarded. As such, it is important to explore other factors that might explain this difference between the results.

Firstly, the difference between the current and previous research findings could indicate that staff attributions have changed since Markham and Trower's (2003) research was conducted. Since 2003, there has been an increased understanding of BPD, for example, the development of the NICE guidelines for BPD (NICE, 2009). There has also been an increase in the number of therapeutic models that provide focused strategies that enable practitioners to work successfully with these individuals (Bateman & Fonagy, 2000). A lack of any significant difference between the groups in the current research

might reflect how mental health staff have increased their understanding and developed a more positive attitude towards BPD, which means they make fewer attributions of controllability.

It might also reflect the difference in the sample used in the current research and the research by Markham and Trower (2003). Markham and Trower's sample consisted of qualified psychiatric nurses who worked on a psychiatric in-patient unit. As previously discussed the participants in this research were from a different group. They were multidisciplinary qualified and non-qualified staff working within secondary mental health care, 92.8% of whom were working in community mental health teams. This suggests that the difference in the results might reflect the difference in the attributions in-patient nurses make towards service users labelled with BPD than a more diverse sample from secondary mental health care.

However, the lack of a significant difference between the groups in the current research might also reflect the method that was used. This research used vignettes, as opposed to real life situations, to elicit staff attributions of controllability. Previous research has reported that vignettes are not as sensitive at eliciting attributions of controllability as real life situations (Lucas, Collins & Langdon, 2008). This suggests that the use of the vignette might have reduced staff attributions of controllability in both groups making it less likely a difference would be detected.

The above highlights the way different methods of eliciting attributions have the potential to influence how much participants report the attribution of controllability. This is interesting because although Markham and Trower (2003) did not use real life situations to elicit participants' attributions, they did use a different method from the one

used in the current research. Markham and Trower asked participants about their attributions based on the labels of BPD and depression whilst the current research asked staff about their attributions towards a service user in a vignette with the labels of BPD and depression. This suggests that the difference between the methods of the current research and Markham and Trower's research might have contributed to the difference in the findings. However, this is unlikely because although there is concern that vignettes are less sensitive at eliciting attributions, they are considered to be more sensitive than asking participants to report their attributions based on a label alone (Corrigan et al., 1999). It is interesting that although this research used what is considered to be a more sensitive way of measuring staff attributions, it was Markham and Trower's study that detected a difference between the groups. This suggests that the differences in the results from the two pieces of research reflects that the different groups of staff hold different levels of attributions of controllability towards service users with BPD, or that staff attitudes have changed over time, rather than because of the differences in their methods. Future research should focus on measuring attributions of different staff groups to explore this further.

4.3.2 Intended Behaviour

Research hypothesis 2 suggested that staff would be less willing to help and more likely to coerce and socially distance themselves from service users labelled with BPD and depression than they would those labelled with depression alone. These intended behaviours were chosen because they are the behaviours within Weiner's helping behaviour (1980) and Corrigan's (2003) attribution model of controllability and dangerousness in mental illness stigma and discrimination. Both these models have

previous evidence of being helpful when exploring staff intended behaviour and have also been used to think about staff intended behaviours towards service users with BPD previously.

4.3.2.1 Helping Behaviour.

Hypothesis 2 was supported; there was a significant difference between the two groups. The group of staff who read the vignette about a service user with BPD and depression were significantly less likely to intend to offer help than those who had read about a service user with depression alone. This suggests that staff have less intention of helping a service user with BPD and depression than one with depression, prior to meeting them. This supports previous research by Forsyth (2007), who found that staff were less likely to offer help to a service user depicted in a vignette with BPD than one with a Major Depressive Disorder.

4.3.2.2 Coercion

Hypothesis 2 was not supported; there was no difference between the two group's coercion scores, suggesting staff did not report greater intentions to be coercive towards service users with BPD than towards those with depression. This research is the first research to investigate coercive treatment intentions specifically about the label of BPD. It is positive that there is no difference between this label and the label of depression.

No previous research has investigated coercive behaviour towards service users with BPD. However, Bowers (2002) explored the coercive treatment intentions of psychiatric nurses working in high security hospitals towards patients labelled with an unspecified personality disorder. He found that staff with a less positive attitude towards service users with a personality disorder favoured management strategies that involved

coercion, such as stricter rules and a greater use of containment methods, for example seclusion. The current research looked at intended coercive behaviour between two groups based on the labels of BPD and depression whilst Bowers used correlations to explore the association between negative attitudes and the endorsement of coercive methods towards those with a personality disorder in high security hospitals. The differences in these pieces of research mean it is not possible to compare the research findings directly. However, it does raise some interesting questions.

The coercive methods that were investigated in Bowers (2002) research were under the participants' control whilst two of the three items measuring intended coercive behaviour in the current study were perhaps seen by participants as being out of their control. This is because two of the three items that made up the coercive intentions measure focused on compliance with medication and seeing a psychiatrist. Perceiving the coercive action was not under their control might have influenced participants in the current research to disagree with those items because they did not feel they would have the power to enforce them. In addition, the two statements on the coercion measure in this research that related to requiring Mary to take her medication and that she should be treated by a psychiatrist might have been endorsed more strongly by the participants in the depression group. This is because the NICE guidelines for depression (2007) state that medication should be used when treating depression.

A lack of increased intentions to behave coercively towards BPD service users is positive. However, this is the first research exploring staff intentions to coerce BPD service users when treating them, so further research is needed to be confident that this result was not influenced by the methodological limitations.

4.3.2.3 Social Distance

Hypothesis 2 was supported; participants who read the vignette about a service user with BPD and depression reported significantly higher intentions to socially distance themselves from them than those who read about a service user with depression alone. A wish to maintain a social distance from service users labelled with BPD suggests that staff are likely to behave in a more distant manner, which could have damaging effects for the development of the relationship between staff and service users with BPD (Aviram et al., 2003).

The findings in the current research support findings from previous research by Markham (2003). He found nurses and health care assistants working on a psychiatric in-patient unit gave higher ratings of social distancing towards service users labelled with BPD than those labelled with depression. It is important that the two samples in this research were different; this suggests that mental health staff's wish to socially distance themselves from service users with BPD, as opposed to those labelled with depression, is found both in the community and in-patient settings.

4.3.3 Relationships between Attributions, Emotions and Intended Behaviours

Hypothesis 3 used correlations to explore possible associations between staff attributions and intended behaviours and staff emotions and intended behaviours within both the depression alone group and the BPD and depression group. This provides the opportunity to consider whether the association between staff attributions, emotions and intended behaviours are different when staff are thinking about working with a service user with BPD to a service user with depression.

4.3.3.1 Depression Alone Group.

When the associations between attributions, emotions and intended behaviour were examined within the depression alone group, a number of significant correlations were detected between attributions and intended behaviours. Higher staff attributions of dangerousness were associated with a higher intention to behave in a coercive and socially distant manner towards service users with depression. Staff attributions of controllability were also significantly negatively correlated with their intention to help. This suggests that as staff report higher attributions of controllability, they also report lower levels of intention to help. Only one emotion was significantly associated with staff intended behaviour in this group; staff anger was significantly negatively correlated with their intention to help. This suggests that higher levels of staff anger are associated with a lower intention to help.

4.3.3.2 BPD and Depression Group

In contrast to the depression alone group, no significant associations between staff attributions and their intended behaviours were detected in the BPD and depression group. There were however, several significant associations between staff emotions and their intended behaviours; lower intended helping behaviour was significantly associated with higher levels of both anger and fear. Higher levels of staff fear were also significantly associated with them expressing higher intentions to behave in a coercive manner towards the service user labelled with BPD and depression.

4.3.3.3 Comparison of the two groups

It is interesting that different associations were detected in the BPD and depression and depression alone groups. Although there were methodological limitations,

such as limitations with the attribution measures (discussed in section 4.5.1) and the use of vignettes (discussed in section 4.5.2.3), these differences can be considered genuine. This is because the presence of a significant association in the depression alone group suggests that it is unlikely the methodological limitations were responsible for the lack of significant association in the BPD and depression group, because both groups used the same method. In addition, the differences between the associations within each group can be considered to be genuine differences, rather than a result of a lack of power in one group. This is because both groups had enough participants to reach a power of .8. In addition to this, the numbers of participants were almost equal in both groups (BPD and depression group n= 42 depression alone group, n=41).

The most noticeable difference was the different associations between attributions and intended behaviours in each group; in the BPD and depression group, no staff attributions were significantly associated with their intended behaviours whilst in the depression alone group, staff attributions of controllability were significantly negatively correlated with their intended helping behaviour and their attributions of dangerousness were significantly positively correlated with their intended coercive and social distancing behaviour. This suggests that when staff are thinking about working with a service user with BPD, their attributions are less likely to be associated with their intended behaviour than when thinking about working with a service user with depression. In contrast, the results suggest that staff emotions are more likely to be associated with their intended behaviour when thinking about working with a service users with BPD than one labelled with depression. In both groups, there was a significant negative correlation between staff anger and their intention to help whilst fear was only significantly negatively correlated

with helping behaviour in the BPD and depression group. This suggests that higher levels of staff anger are associated with lower intentions to help regardless of the label of the service user, whereas higher levels of fear are only associated with lower intentions to help those service users labelled with BPD. Fear was also associated with intended coercive behaviour in the BPD and depression group but not in the depression alone group, whilst pity was not associated with any helping behaviour in either group. This suggests that emotions might play more of an important role when staff are thinking about working with service users with BPD and depression than depression alone. Interestingly, within the BPD and depression group, neither attributions nor emotions were significantly associated with staff intentions to socially distance themselves from service users.

Previous research that investigated the association between controllability and helping behaviour in staff towards service users with intellectual disabilities supports the results within the depression alone group. Dagnan et al., (1998) and Hill and Dagnan (2002) found controllability to be strongly associated with staff intended helping behaviour. Previous research that investigated staff attributions towards service users with BPD also found controllability to be significantly negatively associated with staff intended helping behaviour (Friday, 2006). Forsyth (2007) found that indicating a service user was in control of their behaviour did not influence the amount of help staff intended to offer service users with depression or BPD; however, he was not able to recruit enough participants to reach adequate power of 0.8. This means the lack of any significant result could have been a result of the study being under powered.

There is less previous research into the association between dangerousness and social distancing behaviour with mental health staff. Interestingly, it supports results within both groups. Markham (2003) found a significant positive correlation between dangerousness and intended social distance when RMNs were measured, but not HCAs. This suggests that the association between staff attributions of dangerousness and their intended social distancing behaviour is affected by the characteristics of the staff members.

The differences in the samples and methods of the previous and current research also suggests that the characteristics of the service user and staff group and the type of behaviour are causing the difference in results. For example, the previous studies by Dagnan et al. (1998) and Hill and Dagnan (2002) were both based on staff attributions towards service users with intellectual disabilities. It is possible that there is not the same association between attributions of controllability and intended helping behaviour from staff towards service users with BPD. In addition, although Friday's (2006) research was exploring the association between staff attributions and helping behaviour towards service users with BPD, the study used in-patient nursing staff whereas this research explores all secondary mental health staff. Previous research has found that different groups of staff do hold different attributions (Markham, 2003). This suggests that Weiner's and Corrigan et al. (2003) attribution theories might explain reactions of some staff groups better than others. However, it is also important to highlight that previous research has found other factors to be associated with intended behaviour.

Previous research suggests several factors that might be associated with intending helping behaviour of mental health staff. Todd and Watts, (2005) found that whilst

clinical staff are likely to have attributions of controllability towards service users with dementia, the thoughts they have about their own role, the effectiveness of the treatment they are offering and their position in the organisation they work in, are also associated with their helping behaviour. Although this research measured staff intentions to help towards a different client group, it does highlight that there are other factors that are associated with staff intended helping behaviour. This provides a possible explanation for why the current research detected a significant difference in the groups' intended helping but not their attributions. In addition to this, Markham (2003) looked at other factors that were associated with staff intention to socially distance themselves from service users with BPD. He found that previous negative experiences of service users with BPD were significantly positively correlated with an increased wish to socially distance themselves. He also found that nurses who expressed higher levels of optimism about working with service users with BPD expressed lower social distance intentions.

The current research also found that staff emotions were associated with their intended helping and coercive behaviour. This suggests that, at the referral stage, one of the factors that is associated with staff intending to help or coerce service users with BPD is their feeling of anger. In contrast the current research did not find any significant associations between social distancing and emotions within the BPD group. This suggests that whilst emotions might be a factor that impact on certain aspects of intended behaviour, they cannot explain it fully.

4.3.4 Knowledge Levels

4.3.4.1 Association with Attributions

Research hypothesis 4 suggested that higher staff knowledge levels about BPD would be associated with lower attributions of dangerousness and controllability towards service users labelled with BPD. This hypothesis was not supported when the overall knowledge scores were used. The overall knowledge scores were not significantly correlated with any attributions staff made towards the service user with BPD and depression in the vignette. However, an examination of the individual subscales of the knowledge questionnaire shows that there is a significant relationship between higher staff knowledge about the treatment of BPD and lower attributions of controllability. Although it is not possible to draw conclusions about the direction of this relationship, the presence of the relationship suggests it is important for staff to have knowledge about the treatment of BPD to help ensure their attributions of controllability remain low.

Although previous research has not explored the impact of knowledge on specific attributions it has found that increased knowledge levels about BPD significantly improves staff attitudes towards service users with BPD (Hazelton, 2006; Miller & Davenport, 1996; Krawitz, 2004). Commons-Treloar and Lewis (2008) also found a significant positive correlation between increased knowledge levels following training and improved attitudes towards deliberate self-harm in BPD service users for both emergency medicine and mental health clinicians.

4.3.4.2 Association with Intended Behaviour

Research hypothesis 5 suggested that higher staff knowledge levels about BPD would be associated with lower social distance and coercion and greater helping

behaviour. When using the overall knowledge score this hypothesis was not supported. The overall knowledge scores were not significantly correlated with any staff intended behaviours towards the service user with BPD and depression in the vignette. However, when the individual subscales of the knowledge questionnaire were examined, several significant relationships were discovered.

There was a significant negative correlation between treatment knowledge and staff intended coercive behaviour. This indicates that higher staff knowledge levels about treatment of BPD are associated with lower staff intentions to coerce BPD service users into treatment. Higher treatment knowledge levels were also significantly positively correlated with higher intended helping behaviour of staff. In addition, higher knowledge levels about the DSM IV (APA, 1994) criteria of BPD were significantly associated with lower levels of staff intended social distancing behaviour. This suggests that the more knowledge staff have about the symptoms of BPD, as measured by the DSM IV diagnostic criteria, the less likely they are to socially distance themselves from service users labelled as such. This association is particularly interesting because emotions and attributions did not have any association with staff intentions to socially distance themselves from service users with BPD.

Previous research has also found increased knowledge levels about BPD has a positive influence on staff behaviour towards service users with BPD (Krawitz, 2004). However, Krawitz assessed participants' knowledge levels by asking them if they considered their knowledge levels about BPD to have increased. This research used a measure that actually assessed different aspects of staff knowledge levels about BPD. It is positive that this research supported the findings from Krawitz whilst using a more

powerful measure of staff knowledge. This provides further evidence that there is a relationship between staff knowledge levels and their intended behaviour. In addition, the knowledge questionnaire used in this research was a brief and measure that assessed basic knowledge levels about the diagnostic criteria and treatment of BPD and some general knowledge about BPD. This suggests that even a basic knowledge about the DSM IV (APA, 1994) criteria and the treatment of BPD is associated with more positive staff behaviour.

4.4 Additional Analyses

This research did not plan to explore the differences in staff emotional reactions towards the service users labelled with BPD and depression and the service users labelled with depression alone. However, the results from hypothesis 3 indicate that whilst staff emotions of anger and fear are associated with their intended helping and coercive behaviours towards service users with BPD, only the emotion of anger was associated with helping behaviour within the depression alone group. This indicated that staff emotions might be more important when considering their reactions towards service users with BPD than those with depression. As a result, additional analyses were conducted to investigate if there were differences in the two groups' emotional reactions.

These revealed that there was a significant difference in the emotions of anger, with staff indicating they feel higher levels of anger towards service user with BPD and depression than towards service users with depression alone. This is important in light of the significant association between anger and lower levels of intending to help service users with BPD.

There were no significant differences between the groups' emotions of fear and pity. The only previous research that has compared staff emotional reactions to service users with BPD and depression is Markham and Trower (2003). They compared the emotion of sympathy towards service users with BPD, depression and schizophrenia. They found staff to have less sympathy towards service users with depression than service users with BPD.

4.5 Strengths and Limitations

4.5.1 Measures

It is acknowledged that there are some drawbacks to the measures that were used in this research. The strengths and limitations of each measure will be discussed below.

4.5.1.1 Dangerousness.

The measure of perceived dangerousness had a Cronbach's alpha of .765 in this study. This suggests the scale reached adequate internal consistency and is an appropriate measure of dangerousness within this sample. This is positive because this measure had not previously been used as a measure to assess mental health staff attributions of dangerousness.

One drawback of the measure was that it focused too heavily on aspects of physical dangerousness, such as being aggressive, unpredictable and frightening and lacking in self control. Although it is useful to measure staff attributions of dangerousness based on physical harm, the measure may not capture all aspects that mental health staff consider to be dangerous about BPD service users. Previous qualitative research suggests that nurses not only make attributions about BPD service users being physically dangerous, but also about them being professionally dangerous

(O'Brien and Flote, 1997; Woolaston & Hixenbaugh, 2008). Future research could include a measure of dangerousness that measured danger to staff professionally, for example, measuring such behaviours as making complaints. This might be more relevant to staff working in the community with service users with BPD who are less physically risky than those on in-patient units.

4.5.1.2 Controllability

The measure of controllability had a Cronbach's alpha of .472 within this study. It is widely accepted that a Cronbach's alpha of below .7 indicates a lack of reliability (Field, 2006). An alpha of .472 would ordinarily be considered an indication of unacceptable internal consistency (George & Mallery, 2003). However, Cortina (1993) argued that this rule should not be applied in such a general manner because alpha scores are affected by the number of items within a scale. Cronbach (1951) recognised that the more items a scale has the more likely it is to have a larger Cronbach's alpha. The controllability scale in this research consisted of three items, suggesting that a Cronbach's alpha value lower than .7 would be adequately reliable.

However, it is acknowledged that .472 does reflect a low internal consistency so several options were considered. Firstly, when the item 'I would think it was Mary's own fault that she is in her present condition' was removed, the alpha increased to .503. However, this was considered to be a sufficient enough increase to support a claim of adequate internal consistency, so it was decided that all items in the scale would be used.

Instead, the inter-item correlation for the scale was calculated. Voss, Stem and Fotopoulos (2000) suggest that when a scale is particularly short, the mean inter item correlation can be used to assess if the small number of items has negatively biased the

coefficient alpha. This is because the mean inter-item correlation is independent of the scale length. The mean inter item correlation for the controllability factor in this study is .2. Clark and Watson (1995) state that mean inter-item correlations of between .15 and .20 are acceptable in social science research. As a result, the factor on the AQ-27 was continued to be used as a measure of controllability within this study.

However, due to the concerns about the scale, the analysis was repeated using only the item that specifically referred to controllability. This was 'How controllable, do you think, is the cause of Mary's present condition?' This was to ascertain if different results were produced. The additional analyses revealed no significant differences between the groups. Obtaining the same results with different methods suggests that the lack of any significant difference between the two groups was not a result of the lack of internal reliability of the scale. However, it is not possible to state this with confidence. Future research should attempt to use a more appropriate measure of controllability to ensure the results are not affected by difficulties with the measures.

4.5.1.3 Helping and Coercion

The factors from the AQ-27 that were used to measure staff intended behaviours reached adequate internal consistency as measured by the Cronbach's alpha (coercion $\alpha=.672$; helping $\alpha=.633$). Although the alpha for each is below .7, they can be considered to have adequate reliability, as each scale consists of three items (Cortina 1993). This is positive, as although they achieved adequate internal reliability when used to measure intended behaviours in the general population in previous research (Corrigan et al., 2004), they had not been used previously with mental health staff.

It is important to note that two of the items on the coercion factor on the original AQ-27 scale reflected extreme intended behaviours that were not appropriate for use when measuring mental health staff intended behaviour. Ideally, a separate measure of coercion, which had been used previously with mental health staff to ensure its reliability, would have been used. However, this was not possible because there was no such measure available at the time. As a result, one of the original statements was simply adjusted to reflect a less extreme behaviour; it was changed from 'How much do you agree that Mary should be forced into treatment with her psychiatrist even if she does not want to?' to 'How much do you agree that Mary should be treated by a psychiatrist, even if she does not want to?'. However, the second item 'I think it would be best for Mary's community if she were put away in a psychiatric hospital' reflected a more extreme form of intended behaviour. As a result, it was removed and replaced with 'If I were in charge of Mary's treatment, I would expect her to comply with all my recommendations'. The Cronbach's alpha of .672 suggests that the adjustment to these items did not affect the internal reliability of this scale.

4.5.1.4 Social Distance

As a result of a lack of appropriate measures to measure intended social distancing behaviour in mental health staff, the social distance measure used in this research (The Social Distance Scale (Link et al., 1987; Hay, 2007) had not previously been used with mental health staff. Despite this scale not having previous reliability data for use with mental health staff, it reached adequate internal consistency as measured by Cronbach's alpha ($\alpha=.817$). As such, it can be considered appropriate for use within this research.

4.5.1.5 Knowledge.

The knowledge questionnaire that was used in this research was originally developed by Cleary et al. (2002) and was adapted by James and Cowman (2007) specifically for use with mental health staff. James and Cowman ensured construct validity by piloting the questionnaire with mental health professionals. They also reported the internal consistency in their sample to be high for the total knowledge score (Cronbach's alpha .79). The internal consistency within the current study was also found to be good for the total knowledge score (Cronbach's alpha .824) and the three factors were also adequate with a Cronbach's alpha of .732 for knowledge of DSM IV (APA, 1994) criteria, .598 for treatment knowledge and .673 for general knowledge. This suggests that it is an appropriate measure to have used in this research.

4.5.2 Methodology

4.5.2.1 Deception and Socially Desirable Responding

As discussed in section 2.5.3, a limited amount of deception was used within this study. This was to ensure that participants did not know that the aim of the research was to compare mental health staff reactions towards a service user labelled with BPD and a service user labelled with depression. It was also to ensure that they were not aware that their attributions of dangerousness and their intended behaviours of social distancing were being measured. This was to reduce the likelihood that participants would respond in a socially desirable manner. To guarantee this was done in an ethical manner, the British Psychological Society Code of Ethics and Conduct (2006) was consulted and followed.

Managing to use deception in an ethical and effective manner is considered a strength of this study. This is because staff responding in a socially desirable manner could have biased the results. However, although steps were taken to reduce the chance of participants responding in a socially desirable manner, no social desirability measure was used. This means it cannot be stated with confidence that the participants did not respond in a socially desirable manner. Despite this, the significant difference between the groups' helping and social distancing behaviours suggests that staff were not responding in a socially desirable manner that affected the results.

4.5.2.2 Order Effects

It is a strength of the current research that the measures were presented to each participant in a random order to ensure there were no order effects. As discussed in the section on data collection, the researcher sat with participants while they completed the questionnaires to ensure they completed them in the order in which they were provided and instructed them not to look at the questionnaires out of order. The knowledge questionnaire (James & Cowman, 2007) was not included in this random presentation and was always presented to the participants last. This was because the measure focused heavily on staff views and knowledge of BPD, which would have been a strong indicator that BPD was one of the factors being focused on in the research.

4.5.2.3 Use of Vignettes

Another strength of this research is that the character in the vignettes was based on previous research to ensure the service user being depicted accurately represented a service user with BPD and depression. However, it is acknowledged that the face validity of the vignettes as a whole could have been strengthened by conducting a small survey.

This could have been in the form of asking several general practitioners, psychiatrists and team managers if the vignettes were an accurate reflection of a common referral letter secondary care mental health teams receive.

Vignettes were considered an appropriate method to use in this research because staff attributions and intended behaviours were being measured towards a service user with the label of BPD based on referral information only. However, there has previously been some debate about the usefulness of vignettes as a method in research because they can have a low external validity (Grey, McClean & Barnes-Holmes, 2002). The strengths and limitations of using vignettes in this research are discussed below.

Previous research has found that vignettes do not reflect the attributions and intended behaviours a staff member would have in response to an actual act of challenging behaviour. Lucas et al. (2008) investigated the difference between staff attributions, emotional reactions and intended behaviours of teachers towards children with intellectual disabilities who had actually displayed a challenging behaviour and a child they depicted in a vignette displaying the same challenging behaviour two weeks later. They found that the staff members made significantly higher attributions of control towards the child after witnessing the real incident of challenging behaviour compared to when they read about it in vignette format. Intended behaviours were also different in the two conditions. Staff reported increased helping behaviour towards the child described in the vignette compared with the child displaying the real challenging behaviour. However, a drawback of the design of the Lucas et al. research was that the participants completed the vignette 2 weeks following the incident of real challenging behaviour and the vignette was matched to the incident of challenging behaviour. This might have caused the

participants' to respond in a more socially desirable manner because they knew they were being questioned about the event again. This result was also supported in previous research by Wanless and Jahoda (2002) who compared the attributions and emotions staff had towards a real person who had behaved in a challenging manner with the attributions and emotions they said they had towards a character in a vignette. They found that staff emotional responses to the real incident were more intense than to the character in the vignette. They also found that the association between attributions and helping behaviour was significantly stronger when reporting from a real event than a vignette. This suggests that vignettes are a less powerful method of eliciting attributions than real incidents of challenging behaviour. However, although staff attributions and emotions were significantly stronger in relation to the real incident, the direction of the relationships and type of emotion felt were the same in both groups. This suggests that whilst vignettes are certainly less powerful, they do not elicit attributions, emotions or relationships between the two that are qualitatively different to research using real situations.

In addition, vignettes can be a helpful method of assessing staff attributions and intended behaviours because they are easily manipulated and can control for confounding variables (Hughes & Huby, 2001). Furthermore, Lewis and Appleby (1998), who used vignettes in their research measuring psychiatrists' views of service users with BPD, argued that whilst vignettes are less externally valid, they cannot create attitudes that are not already present. This suggests that although the method has its difficulties, there are also strengths that can outweigh the concern about vignettes' lack of external validity.

Finally, as the current research focuses on exploring staff attributions and intended behaviours based on referral information, it seems that the use of vignettes in

this research is an appropriate method. However, future research could focus on attributions and behaviours based on real life events with service users with BPD in order to ascertain if the results might be different.

4.5.2.4 Comparison of Two Labels

Although it is positive that this research compared the label of BPD to one other mental health diagnosis (depression), it would have been interesting to include a third diagnostic label. Depression was chosen because of the high rates of co morbidity in women (Zanarini et al., 1998) and because self harm is a common symptom of depression (Houston, Haw, Townsend & Hawton, 2003) and is one of the DSM IV-TR (APA, 2000) diagnostic criteria for BPD. However, there are also differences between the diagnoses; depression is a frequently used diagnosis that has a strong evidence base for effective treatment (NICE, 2007) whereas BPD is diagnosed less frequently and has only an emerging evidence base for effective treatment (NICE, 2009). The fact that these disorders do have these differences might mean mental health staff view them very differently. It would have been helpful to use a diagnosis that is also considered to be a more severe and enduring mental health diagnosis, as Markham and Trower (2003) did in their research. They found that staff held more attributions of controllability towards service users with BPD than towards those labelled with depression or schizophrenia. Using both labels gives more of an idea about the level of controllability attributions staff make towards service users with BPD compared to other labels.

To illustrate this point further, we can look at previous research by Markham (2003). Markham found that both health care assistants and nurses held significantly higher attributions of dangerousness and indicated they were more likely to socially

distance themselves from service users labelled with BPD than from those labelled with depression. However, this was not the case when comparing the label of BPD to that of schizophrenia. When comparing these two labels, the nurses continued to report significantly higher attributions of dangerousness and an increased desire for social distance towards those labelled with BPD whereas there was no significant difference in the health care assistants' attributions or intended behaviours. This information helps explore the way different staff groups make different attributions towards different labels. The current research opted for a simpler design to ensure adequate power was achieved; given the time constraints, focusing on the differences between only two diagnoses was preferable to not achieving the required statistical power. However, future research should compare BPD to other mental health diagnoses to explore if it is compared more negatively to some diagnoses than to others.

4.5.2.5 Measuring Intended Behaviour

The measures used to measure behaviour in this research are self report scales that measure intended behaviours as opposed to measuring actual behaviours. Measuring intended behaviours was appropriate in this study because the research was exploring the behaviours and attributions staff make towards service users labelled with BPD based on referral information. However, it is also important to highlight that intended behaviours might not accurately reflect how staff would behave in a real life situation. Much of the research that explores the extent to which intention to act explains actual action is based on health-related research. Godin and Kok (1996) reported that intention to act explained 34% of the variance in actual behaviour but that this reduced to 16% when they explored behaviours that were considered more difficult to implement. Young (2008) found similar

results when she investigated intended behaviours of staff towards service users diagnosed with a personality disorder, with the intention of helping accounting for 19% of the variance of actual helping behaviours. This means that whilst we can be sure that staff significantly intend to offer more help to service users with depression than those with BPD, it is not possible to establish with any accuracy how this would translate into their actual behaviour.

Social distancing was also measured in this research. A difference between the groups was found with staff more likely intend to behave in a socially distant manner towards service users with BPD than depression. However, the measure was not entirely appropriate because it asked staff about specific social relationships that professional boundaries would prevent them from entering into. This suggests the results might not be as clinically relevant as they could have been if a more appropriate measure of social distance was used. Despite this, the fact that there was a difference is particularly important in light of the counter transference research that suggests boundary preferences have an impact on service user and therapist interactions (Rosenkrantz and Morrison, 1992b) and the Aviram et al. model (2006) that highlights the damaging effect of staff distancing behaviour. In future, a more appropriate measure aimed at social or emotional distancing should be used with staff to ensure the results are clinically relevant.

It would have been interesting to include a measure of actual behaviour in the current research, but the design and method would not have allowed it. It will be interesting for future research to explore staff actual behaviour and compare this to their intended behaviour to ascertain if this is different. This is particularly the case for the association knowledge levels with actual staff behaviour. Although this research found

that higher knowledge levels about the DSM IV (APA, 1994) criteria of BPD were significantly associated with lower levels of intended social distance, and higher treatment knowledge was associated with lower intended coercive behaviour and higher intended helping behaviour, it is not possible to be confident that these associations will translate into actual behaviour. Looking at the association between staff knowledge levels and their intended behaviour is a positive first step, but future research needs to explore the impact of knowledge levels on the actual behaviour of mental health staff towards this group of service users. It would also be useful for future research to explore the direction of the relationship between knowledge levels and staff behaviour to see if it is influencing their behaviour as opposed to simply related to it.

4.5.2.6 Forced Choice

Participants were forced into basing their answers on very little information. This was to ensure that it was the labels that were influencing their attributions and intended behaviours. However, when completing the questionnaires, several staff reported that they did not feel as though they had enough information on which to base their answers, particularly on the dangerousness measure. This suggests that the limited amount of information might have caused participants to be more neutral with their responses about dangerousness in both groups, which might have reduced the chance of finding a difference between the groups. However, this is not considered a weakness of the current study because many referral letters to mental health teams are brief and as such staff are put in a position of making judgements based on little information in their daily working practice. As such, it is important for research to explore their attributions and intended

behaviours in this context. It is positive that in the current research no difference was found between staff attributions of dangerousness towards the two diagnoses.

4.5.2.7 Sample

The diversity of the sample in this research can be considered a strength. It included a range of qualified and non-qualified staff working on both psychiatric in-patient units and community mental health teams. This was to ensure the diverse nature of multidisciplinary mental health staff within secondary care mental health services was represented. This was particularly important, as the NICE guidelines for BPD (2009) state that BPD should be managed in community mental health teams. In addition, previous research has mainly used nurses working on acute in-patient units (Markham 2003; Markham & Trower, 2003; Forsyth, 2007).

A drawback of the sample was that only one psychiatrist agreed to take part in the research. Psychiatrists are important figures in the diagnosis and treatment of BPD so it is important that future research represents their attitudes towards these service users. A further drawback of the sample was that it comprised mainly of community mental health staff; they made up 92.8% of the sample. This reflects the difficulty that the researcher had recruiting from in-patient units. This might be because the nature of their work may make it more difficult for staff to make space in their working day to complete research. It appears that previous research that attempted to recruit staff from in-patient units also experienced difficulties obtaining enough participants. Forsyth (2007) estimated that he needed 68 participants; he distributed 120 questionnaires and received 26 back making a response rate of 22%. It was not possible to calculate the response rate for the participants who were recruited from in-patient units in the current research. It would have been

interesting to do this to enable a comparison to be made between the response rate from in-patient and community mental health staff in the current research and previous research response rates. These comparisons might have highlighted that it is difficult to recruit staff who work on in-patient units. Future research that investigates attributions and intended behaviours of mental health staff that work in acute care services should focus on ways to improve recruitment.

4.5.2.8 Design

The design used to assess the difference between attributions and intended behaviours towards service users with BPD and depression was a between participants design. The strength of this design was that it reduced the likelihood that participants would know that the aim of the research was to compare mental health staff attributions and intended behaviours towards service users labelled with BPD and depression. This is important because of the increased risk that participants would respond in a socially desirable manner if they knew the true aims of the research.

However, the weakness of a between participants design is higher rates of unsystematic variance. Higher unsystematic variance increases the likelihood that the differences between the groups are influenced by variables other than the independent variable. Several steps were taken to ensure that the unsystematic variance was kept to a minimum. Firstly, the randomisation process was limited to each team to ensure that there was an equal number of participants from each team in each group. This protected against team attitudes affecting the results. Secondly, the characteristics of the staff were similar in both groups, as the distribution of staff working in the community and in-patient settings was the same in each group. Both groups also had a range of qualified and non-

qualified staff: in the BPD and depression group there were 10 non-qualified staff and 32 qualified staff and in the depression alone group there were 16 non-qualified staff and 25 qualified staff. It is important that there was a range of qualified and non-qualified staff in each group because previous research has found staff qualification to affect their attributions of dangerousness and intended social distancing behaviour towards service users with BPD (Markham and Trower, 2003).

A correlational design was used to explore the association between staff attributions, emotions and intended behaviours. This design was also used to explore the association between staff knowledge levels and their attributions and intended behaviours towards service users with BPD. A limitation of using this design is that it is not possible to detect the direction of the relationship between the factors being explored. This makes it impossible for this research to make judgements about which factor is influencing the other. For example, whilst the research can state that there is an association between higher levels of staff knowledge about BPD treatment and higher intentions to help service users with BPD, it cannot state that the knowledge levels lead to higher intentions to help. Future research should use designs that would ascertain the direction of relationships between the significant associations found in this research.

4.6 Theoretical Implications

4.6.1 Attribution Theory

The results of this research raise important questions about how useful the attribution theories by Corrigan et al. (2003) and Weiner (1980, 1985, 1986) are for understanding staff reactions towards service users with BPD when they have limited referral information. Although it does not assess the path models of Weiner's (1980,

1985, 1986) and Corrigan et al. (2003) models, the results do indicate that these models are not able to fully explain staff reactions to service users with BPD at the point of referral. This is because whilst there was no significant difference between staff attributions of controllability and dangerousness towards the service users in the two groups, staff were significantly less likely to help and more likely to socially distance themselves from service users with BPD and depression than depression alone. This suggests that staff attributions are not associated with their intended behavior towards service users with BPD at the point of referral. Further evidence of this was the lack of significant association between staff attributions and their intended behaviors within the BPD and depression group; it was their emotions of anger and fear, and knowledge levels about the treatment and DSM IV criteria (APA, 1994) of BPD that were associated with their intended helping, coercive and social distancing behaviour.

4.6.1.1 The Importance of the Signaling Event

One of the differences between the current and previous research that explores staff attributions and intended behaviours towards service users with BPD was that the current research explores these factors towards service users at the point of referral. It could be that staff do not make attributions about service users when they only have access to their mental health label and other limited referral information. Weiner (1986b) would argue that this is because it would not be necessary for staff to make a causal attribution at this time. This is because attempting to attribute causality to all situations would be time consuming, tiring and unnecessary (Weiner, 1986b). As such, people only do such a thing when they need to understand something, for example when they fail where they expected to succeed, or when they have been hurt or rejected. This is why

Weiner's attribution theory (1980, 1985, 1986) has traditionally used a behaviour that challenges as the signal that triggers the path between attributions and intended behaviour. The decision to look at staff attributions and intended behaviours towards service users as a result of their label in this research was based on The Corrigan et al. (2003) model of public discrimination towards a person with a mental illness. This model argues that signalling events are of a much wider class than others behaviour and that mental health labels can be the signalling event for attributions of controllability and dangerousness. However, this research found that the label BPD and limited referral information does not have a significant impact on staff attributions towards service users with BPD. Although the lack of controllability attribution could be explained by Weiner's (1986b) argument, dangerousness is not a causal attribution. However, Weiner's argument could still stand because a hypothetical situation is also less likely to elicit dangerousness attributions from staff because they will not need to do so to ensure their safety. In addition to this, the Corrigan et al. model has support as an attribution model to explain reactions of the general public (Corrigan, 2000) but not with mental health staff. As a result it cannot be ruled out that mental health staff simply do not form attributions about mental health labels in the same way as the general public.

Although the results from this research suggest that the label BPD does not affect staff attributions of controllability and dangerousness towards service users, it is nonetheless associated with their intended behaviour. This suggests that, prior to mental health staff meeting service users with BPD, additional factors are associated with their intended behaviour towards service users with BPD. It is important to think about what might be associated with staff intended behaviour towards service users with BPD. This

is because the current and previous research has consistently found that staff are less likely to intend to help (Forsyth 2007) and more likely to intend to coerce and socially distance (Markham, 2003) themselves from service users labelled with BPD than those labelled with other mental health labels. The results in this research identified several factors, other than attributions, that were associated with staff intended helping coercive and social distancing behaviour.

4.6.2 Factors associated with intended behaviour

4.6.2.1 Knowledge Levels

Higher treatment knowledge levels were associated with staff indicating higher intentions to help and lower intentions to coerce service users with BPD. This is interesting because it could be argued that higher treatment knowledge would help staff feel more confident that they can work more effectively with service users with BPD. The reasoned action approach (Fishbein, 2008) argues that the perceived future outcome is one aspect that will influence how a person intends to behave. Specifically, it suggests that if a person believes their behavior will encourage a good outcome and prevent a bad one, they are more likely to engage in it (Fishbein, 2008). The significant association between higher staff knowledge about the treatment of BPD and higher intention to help service users with BPD in this research supports this theory. As such, it could be argued that this theory would better explain staff intended behavior helping behavior towards service users based on information about their label. However, it is important to highlight that this research did not explore all aspects of the attribution theories. This will be discussed fully in section 4.6.2.3.

Interestingly, knowledge about the DSM IV (APA, 1994) criteria of BPD was the only factor associated with higher staff intentions to socially distance themselves from service users with BPD. This suggests that the Corrigan et al. (2003) attribution model of public discrimination does not help explain staff intended social distancing towards service users labeled with BPD at the time of their referral. Instead, the Aviram et al. (2006) model may help think about the reasons for this. Aviram et al. argue that negative beliefs staff hold about service users with BPD cause them to believe that a service user's difficult behavior is guaranteed and deliberate. As a result they protect themselves from the negative consequences of failing to help and being rejected by distancing themselves from service users with BPD. This would suggest that higher knowledge about the symptoms and behaviours associated with BPD would reduce the likelihood that staff would have negative thoughts about BPD service users and their behaviour and in turn reduce the distance they intend to place between them. This suggests that it is not attributions of controllability and dangerousness that would be associated with staff distancing behaviour but beliefs about how personally responsible a service user is over their behaviour. These beliefs were not investigated in this research; this will be discussed further in section 4.6.2.3.

4.6.2.2 Emotions

This research also found that emotions were associated with staff intended behaviour towards service users with BPD. Higher levels of staff anger were associated with less intention to help; higher staff fear was associated with lower intention to help and higher intention to coerce. These results highlight that there is an interaction between higher levels of staff fear and their intention to behave in a negative way towards service

users with BPD before they have met them. This supports the Aviram et al. (2006) model that argues staff are ready to behave in a negative manner towards service users with BPD before they have displayed challenging behaviour. It is not possible to draw conclusions about whether these results also suggest attribution theory might be a helpful framework for understanding staff reactions to service users with BPD. This is because the association between emotions and attributions were not explored.

4.6.2.3 Aspects of Attribution Theory that were not Explored

However, the knowledge and emotions that were found to be significantly associated with staff intended behaviours in this research do suggest that some aspects of attribution theory, which were not explored in this research, could be important. The Corrigan et al. (2003) model and Weiner's (1995) later attribution theory highlight the importance of beliefs about personal responsibility in the path between attributions, emotions and behavior. This is because a person can be in control of their behaviour (i.e. hitting another person) but not be held personally responsible (they acted in self-defence). Although the Corrigan et al. (2003) and Weiner (1980, 1985, 1986) model along with previous research (Markham and Trower, 2003) suggests that controllability does not have to be mediated by personal responsibility in order to lead to helping or punishing behaviours, Weiner (1995) later argued that it was personal responsibility beliefs that were important in leading to negative emotions rather than attributions of controllability. This research did find differences in the emotions of anger between the groups and also that anger was associated with decreased helping behavior and increased coercive behavior. A further result from this research that indicates personal responsibility beliefs might be important is the association between staff having higher knowledge levels about

the DSM IV (APA, 1994) criteria for BPD and lower intentions to socially distance themselves from service users labeled with BPD. This is because it is the belief that service users are being difficult on purpose that leads to staff withdrawal (Aviram et al., 2006) and knowledge of symptoms might reduce this. It would be interesting to use future research to look at the association between personal responsibility beliefs, staff emotions and their intended behaviour to see if it is specifically these beliefs that lead to the path model and the attribution of controllability are just necessary precursors to this belief.

An additional aspect of attribution theory that was not explored was attributions about internality and stability (Weiner, 1980, 1985, 19860). Weiner argued that both of these attributions are linked to feelings of optimism about change and therefore linked to helping or punishing behavior. It might be that limited referral information based on the label BPD elicits more attributions of internality and stability than controllability and dangerousness. The significant associations that were found between higher staff treatment knowledge and higher staff intentions to help, in this research, support this argument. Previous research also supports this argument; Forsyth (2007) found mental health workers to be significantly more likely to help service users with BPD and depression when the cause of their difficult behaviour was depicted as unstable rather than stable.

4.6.2.4 Specificities of Service Users, Staff and Situations

When discussing the theoretical implications of this research it is important to highlight that the associations found between attributions, emotions and intended behaviours were different within the depression alone and the BPD and depression

groups. As previously discussed, in the BPD and depression group no attributions were associated with staff intended behaviour. However, in the depression alone group staff attributions of controllability and dangerousness were associated with their intended behaviours of helping, coercion and social distancing. This suggests that when thinking about service users with depression, based on limited referral information, staff attributions are associated with their intended behavior. This suggests that the characteristic of the service user is also important in understanding staff reactions towards them. Furthermore, the previous research that does not support the current research was conducted with different staff groups who worked on in-patient units. It is also at different point in time to the point of referral. This suggests that circumstances, people and the signals that lead to attributions all impact on how well attribution theory can explain staff reactions towards service users. It also suggests that it is not always attributions that cause staff to intend to behave in a less helpful or more socially distant manner towards service users with BPD. This reflects the previous research into the usefulness of attribution theory for explaining staff reactions towards service users. It has helped draw conclusions about how helpful attribution theory is when explaining staff reactions to certain groups of service uses or behaviours. However, there have been very different conclusions about how useful the model is overall (Willner and Smith, 2008a). This might reflect the reality that attribution models are more useful in some circumstances than others, as opposed to being universally helpful in understanding intended behavior.

4.6.3 Theoretical Conclusions

The results of this research indicate that the Corrigan et al. (2003) and Weiner (1980, 1985, 1986) theories of attribution are not useful when thinking about staff intended behaviour towards service users with BPD at the point of referral. This is because the attributions from both Wiener's theory and the Corrigan et al. model were not associated with staff intended behaviour. Instead, staff knowledge about treatment and DSM IV (APA, 1994) criteria for BPD was associated with them indicating a higher intention to help and lower intention to coerce and socially distance themselves from service users with BPD. Higher levels of staff anger and fear were also associated with them intending to offer less help and more coercion. Firstly, this might suggest that other theories, such as the theory of reasoned action (Fishbein, 2008), may help explain staff intention to help service users with BPD better than attribution theory. It also suggests that higher staff intentions to socially distance themselves from service users with BPD could be better explained by the Aviram et al. (2006) model. However, it is important to highlight that not all aspects of attribution theory were explored in this research. Beliefs about personal responsibility were perhaps the most important aspect that were not looked at because it is these beliefs that often mediate between the controllability attributions, negative emotions and helping and punishing behaviours (Weiner, 1995). In addition, staff beliefs about stability and optimism were not assessed. This is important in the light of the previous research that suggests previous negative experience impacts on wish to help and also the reasoned action approach to behaviour.

Finally, it is important to acknowledge that results from previous research and the depression alone group in this research suggest that both Weiner's (1980, 1985, 1986)

theory and the Corrigan et al. (2003) model of attribution are a helpful way to understand staff reactions to service users with and without the BPD label. This indicates that the individual characteristics of the staff group, service users and situation influence how useful attribution theory can be for understanding staff reactions towards mental health service users.

4.7 Clinical Implications

4.7.1 Attributions and Intended Behaviours

Despite the methodological limitations of this research, it is possible to draw several important clinical implications from the findings.

Firstly, the lack of any significant difference between the groups indicates that when staff have access to referral information only, the label of BPD does not lead them to make more attributions of controllability and dangerousness towards service users than does the label of depression. This might reflect a change in attitudes because previous research that explored mental health staff attributions towards service users with BPD was conducted in 2003. It might also reflect a difference in the job roles of the participants used in the research; the current research used multi disciplinary staff whilst the previous research used psychiatric nurses from in-patient units. However, in order to be confident that either of the above reasons for the differences is true, future research should explore this further. Being aware of the groups of staff that are continuing to hold attributions of controllability and dangerousness towards service users with BPD could influence targeted training in those areas.

4.7.2 Importance of Emotions

The findings from this research suggest that staff emotions of fear and anger play an important role in their reactions towards service users with BPD. The findings also indicate that staff emotions might have more of a role in the reactions of staff towards service users with BPD than towards those with depression. This is because the only emotion to be associated with intended behaviour within the depression alone group was anger, with higher levels of anger being associated with lower intentions to help. Furthermore, the additional analyses revealed that there was a significant difference in the amount of anger staff reported, with staff indicating they felt higher levels of anger towards service users with BPD than towards service users with depression.

It is particularly important that these findings were based on staff having limited information about a service user in the shape of a referral letter that indicated they had a label of either depression alone or BPD and depression because it suggests staff can experience feelings of anger and fear prior to meeting a service user.

In addition, these feelings are associated with staff intending to offer less help and increased coercion towards service users with BPD. An intention to behave in this manner prior to meeting a service user with BPD could increase the likelihood that the cycle Aviram et al. (2006) describes could be initiated. If mental health services are aware of this, they could help prevent it by offering increased routine supervision, training or support to staff working with service users with BPD, rather than offering post hoc supervision when staff indicate they are finding it difficult to work with an individual service user. Based on the Aviram et al. model, helping staff moderate their reactions to

the service user at the earliest opportunity will reduce the likelihood the service user will feel rejected, and will help develop a more stable working alliance.

4.7.3 Intended Behaviour

Previous research has highlighted how important it is for staff to behave in a helpful and accepting manner towards service users with BPD because such service users are so sensitive to rejection (Aviram et al., 2006). Aviram et al. go on to argue that rejecting behaviour increases the likelihood that a BPD service user will resort to using difficult behaviours, such as self-harm, to manage feelings of rejection and attempt to elicit care. This in turn confirms staff beliefs about how they need to remain distant and not help, thus maintaining the cycle of stigma and exacerbating the client's difficult behaviours. Knowing that staff behaviour might contribute to this cycle enables clinicians to think about what might help reduce this and to work with these service users in a more effective manner. Previous qualitative research has also reported that BPD service users notice if staff behave in a socially distancing manner (Nhels, 1999; Costello, 2003). They also notice when staff behave in a helpful manner towards them and have talked about how their relationship with staff is one of the most important aspects of their contact with services (Fallon, 2003).

In light of this, it is clinically important that this research found staff to be significantly less likely to intend to help and more likely to socially distance themselves from service users with BPD than those with depression alone. Knowing this allows teams to offer training for staff to enable them to behave in a more helpful manner towards service users with BPD.

4.7.3.1 Importance of Knowledge

The results of this research suggest that training for staff will be particularly helpful, because it also found knowledge levels to be significantly associated with more positive staff intended behaviour, particularly knowledge about treatment and the DSM IV criteria of BPD. It is also important to highlight that the knowledge was basic facts rather than in-depth knowledge about treatment. This suggests that training could be done by providing staff with information leaflets. Alternatively, knowledge could be provided by ensuring that clinical staff with knowledge about BPD regularly provide information about effective treatment for BPD and the DSM IV criteria when having team discussions about service users with BPD.

4.7.4 Labels as Signals

The fact that this research used a vignette design that replicated a referral letter is also clinically important. Previous research that has investigated attributions and intended behaviours focus either on labels (Markham & Trower, 2003, Markham, 2003), or vignettes about a therapy situation (Forsyth, 2007). To have information about the attributions staff form and how they intend to behave towards service users with BPD before they have had the chance to meet them is important because this might influence the relationship they develop with that service user. Aviram et al. (2006) highlights how damaging it might be if staff are less helping and more distant from service users when they first meet them because it could begin the cycle that ultimately leads BPD service users to behave in ways that staff find difficult. It will be helpful for mental health staff and services to have an awareness that staff can intend to behave in a less helpful, more distant manner towards service users with BPD. This awareness could help them use

supervision to explore and change this intended behaviour prior to meeting the service user. This would help prevent the cycle that Aviram et al. argue can be so damaging.

4.8 Future Research

4.8.1 Attributions, emotions and intended behaviours

There has been no previous research exploring multidisciplinary staff attributions and intended behaviours towards service users with BPD within secondary mental health care. As such, it will be important to conduct similar research to ascertain if the lack of significant differences found in the current research truly reflects the fact that staff attributions are no different towards BPD service users and service users with depression. In contrast to the mixed results about the importance of attributions, the current and previous research find consistent results in terms of the intended behaviours staff report they would display towards service users with BPD compared to those labelled with other mental health diagnoses. It has consistently found that staff are less likely to intend to help service users with BPD and more likely to socially distance themselves. This is across staff groups and regardless of the method of the study. Despite this, there has not been a consistent finding about what might be associated with these intended behaviours. For example, the current research found staff emotions were associated with their intended behaviours towards service users with BPD whilst previous research found that staff attributions were associated with their intended behaviours (Markham & Trower, 2003; Markham, 2003). As a result, future research should focus on exploring what is associated with staff intended behaviours.

As the results of the current research indicate that staff anger and fear are associated with their intended helping and coercive behaviour towards service users with

BPD,, future research should further explore the influence staff emotional reactions have on their intended behaviour towards this group of service users. Specifically, what might be underlying these emotions and how they are associated with their behaviour.

This research also found that higher staff knowledge levels about treatment and the DSM IV (APA, 1994) criteria for BPD were significantly associated with higher intended helping behaviour and lower intended social distancing behaviour. However, the correlational design of this research means it is not possible to assess the direction of this relationship. Future research should focus on exploring whether staff knowledge levels influence their intended and actual behaviour towards service users with BPD. The outcome of this research will help determine how useful training will be for helping staff work with service users with BPD more effectively. Finally, this research suggests that basic knowledge levels are associated with more positive staff intended behaviours towards service users with BPD. As such, it will be important for future research to explore the effectiveness of short, cost-effective training materials.

Further research is also needed to further clarify which characteristics of the staff member and service user impact on the attributions staff make towards service users with BPD. This is because previous research has found a difference in the dangerousness attributions of qualified and non-qualified staff towards service users with BPD (Markham 2003). It has also found that staff who work on in-patient units report different attributions towards BPD service users (Forsyth, 2007; Markham, 2003; Markham & Trower, 2003) than the current research which used a range of secondary mental health care staff. Determining which staff and service user characteristics have an impact on the attributions they make will enable training to be offered to the right staff groups.

4.8.2 Additional Factors

In addition to furthering the research about aspects of the attribution models that were explored in this research it will also be important to explore aspects of the models that were not. This is because previous research (Forsyth, 2007) and the results from this research, indicates that stability attributions and feelings of optimism might be important when trying to understand staff intended behaviour towards service users with BPD. In addition to this, it will be important to explore staff beliefs about personal responsibility, and the impact these have on their emotions and intended behaviours. Both Weiner (1995) and Aviram et al. (2006) argue that beliefs about personal responsibility have an impact on helping and distancing behaviour. This could be achieved by assessing how well the path models in both Weiner's theory of causal attributions (1980, 1985, 1986) and the Corrigan et al. (2003) model of public discrimination towards a person with a mental illness explain staff intended behaviour. However, other models, such as the reasoned action approach to behaviour would also be useful to think about when exploring staff reactions to service users with BPD.

The intended coercive behaviour of staff was also measured during this research. No significant difference in the amount of intended coercive behaviour was found between the groups. This was the first research that measured coercive behaviour towards those with BPD. Although the lack of difference between the groups might indicate that staff are no more likely to intend to coerce BPD service users than ones labelled with depression it might also reflect a limitation with the measure of coercion. This limitation was that the measure focused strongly on psychiatric treatment. It would be interesting to

see if these results were replicated when using a measure of intended coercive behaviour that did not revolve so strongly around psychiatric treatment.

4.8.3 Method

It will also be important for future research to focus on answering some of the methodological questions raised in this research. For example, how effective vignettes are as a method to elicit staff attributions and intended behaviours towards service users with BPD. This question has previously been researched within the intellectual disability research (Lucas et al., 2009; Wanless & Jahoda, 2002), but not when exploring attributions and intended behaviours towards service users with BPD. As such, future research could use both within and between participants designs to compare mental health staff attributions and intended behaviours towards real incidents and vignettes.

Furthermore, the current and previous research (Markham, 2003, Forsyth, 2007) that explores staff behaviour towards service users with BPD all use measures of intended behaviour. This is a positive first step because measuring intended behaviour is a good indication of actual behaviour. However, it would be helpful for future research to explore actual behaviour of staff towards service users to ascertain if the results from previous and the current research are replicated. It will be particularly important for future research to use a more appropriate measure of staff distancing behaviour; not only was this a measure of intended behaviour but it also required staff to answer questions about social relationships that would have not been allowed according to their professional boundaries. Perhaps using a method that has been used previously by Fraser and Gallop (1993), who used Heineken's (1992) confirmation/disconfirmation response

rating instrument to rate actual responses to service users with BPD, could be used to assess staff responses about real referrals they receive about service users with BPD.

Finally, for future studies to improve on the method from this research and be confident about the results, they should use a more suitable measure of controllability. It would also be helpful if the research included a measure of dangerousness that reflected both physical harm and any professional damage a service user with BPD might do. This is because previous qualitative research (O'Brien & Flote, 1997; Woolaston & Hixenbaugh, 2008) suggests that it is both personal and professional damage that concerns staff when working with BPD service users. This would ensure that a non-significant result could be interpreted, with confidence, as a genuine lack of difference between two groups' attributions, as opposed to a difficulty with the measurement.

4.9 Conclusion

This study used vignettes in the form of referral letters from a GP to compare staff attributions and intended behaviours towards service users labelled with BPD and depression. In addition to this, it investigated possible relationships between staff attributions, emotions and intended behaviours. The association between staff knowledge levels and their attributions and intended behaviours was also explored. Between groups comparisons were used to assess the difference between the groups' intended behaviours and attributions whilst correlations were used to explore associations between staff attributions, emotions and intended behaviours. Correlations were also used to explore the relationships between staff knowledge levels and their intended behaviours and their knowledge levels and attributions.

The current research did not support the findings of previous research as it did not find significant differences between staff attributions of dangerousness and controllability towards service users with BPD and depression. It was suggested that the lack of significant difference between the two groups attributions in the current research was a result of the current research being conducted 6 years after the previous research (Markham & Trower, 2003; Markham, 2003); within 6 years, the attributions staff hold about service users with BPD may have changed, particularly because of the new strategies available for working with them. It was also suggested that the lack of support for previous research might reflect the different samples in each of the studies. Previous research used in-patient staff (Markham & Trower, 2003; Markham, 2003; Forsyth, 2007) whereas the sample in this research comprised mostly community mental health staff. As a result, it was highlighted that the characteristics of the staff group, service users and the situation may have an impact on how useful attribution theory is at explaining staff reaction towards service users with BPD. However, it was also acknowledged that the lack of any significant difference between the groups' attributions in this research might have been a result of the limitations with the attribution measures. The comparison of the results from this research and previous research raised some important questions for future research. It was suggested that future research could help answer these questions by comparing staff groups and improving on the measures of controllability and dangerousness that were used in this research.

The findings in this research did support findings from previous research in terms of staff intended behaviours. It found that staff were less likely to intend to help and more likely to intend to socially distance themselves from service users labelled with BPD than

those labelled with depression. Clinical implications about this were discussed in the context of the Aviram et al. (2006) model of stigma. However, it was acknowledged that this research was investigating intended behaviour rather than actual behaviour and suggested that future research needs to explore actual staff behaviour in order to move these findings forwards.

This research also explored the associations between staff attributions and emotions and staff attributions and intended behaviours within both groups. It was interesting that whilst attributions were found to be associated with intended behaviours of staff within the depression alone group, this was not the case in the BPD group. In this group, it appeared that anger and fear were more important; they were both significantly associated with lower intentions to help service users with BPD. Fear was also associated with higher intentions to coerce service users. Additional analyses were conducted that found staff report higher levels of anger towards service users with BPD than towards those with depression.

As a result, whilst Weiner's (1980, 1985, 1986) attribution theory and the Corrigan et al. (2003) attribution model have provided a useful framework to think about staff reactions to service users with BPD, the results from this research suggest other factors are perhaps more important when thinking about their reactions towards service users with this group; particularly staff emotions and levels of knowledge about the treatment and DSM IV (APA, 1994) criteria for BPD., However, it is not possible to rule out the usefulness of attribution theory for explaining staff reactions to service users with BPD as only limited aspects of the models were explored within this research. Perhaps most importantly beliefs about personal responsibility, attributions of stability and

feelings of optimism were not explored. The findings from the current and previous research (Forsyth, 2007) suggest that these might be important factors and should be explored in future research. Other theories were also considered, such as the reasoned action theory (Fishbein, 2008) and the Aviram et al. (2006) cycle of stigma and should also be researched further.

An additional important point for discussion was that there was no association between staff intentions to socially distance themselves from service users with BPD and their emotions or attributions. This suggests that other factors are associated with staff intentions to socially distance themselves from service users with BPD. This is particularly important because staff were found to intend to socially distance themselves from the service user with BPD significantly more than from the service user with depression. Factors that are associated with staff social distance should be explored in future research.

Finally, the clinical implications of the research were discussed with a particular focus on cost effective strategies of increasing staff knowledge levels about the treatment of BPD and the DSM IV (APA, 1994) criteria of BPD. The research also highlighted that staff emotions of fear and anger are associated with lower intentions to help service users with BPD. Thus, it will be important for services to provide good supervision for staff working with these service users, particularly at times when they are indicating lower intentions to help service users with BPD because this might reflect underlying feelings of anger and fear that could be addressed within their regular supervision.

REFERENCES

- Adler, D., Drake, R. & Teague, G. (1990). Clinician's practices in personality assessment: Does gender influence the use of DSM III Axis II? *Comprehensive Psychiatry*, 31, 125–133.
- American Psychiatric Association (1980) *Diagnostic and Statistical Manual of Mental Disorders*. (3rd Ed.). Washington, DC: Author.
- American Psychiatric Association (1994). *Diagnostic and Statistical Manual of Mental Disorders*, (4th Ed). Washington, DC: Author.
- American Psychiatric Association (2000). *Diagnostic and Statistical Manual of Mental Disorders*, (4th Ed), *text revision*. Washington, DC: Author.
- Angermeyer, M. C., Matschinger, H., & Corrigan, P. W. (2004). Familiarity with mental illness and social distance from people with schizophrenia and major depression: Testing a model using data from a representative population survey. *Schizophrenia Research*, 69, 175-182
- Arboleda-Florez, J., & Sartorius, N (2008). *Understanding the stigma of mental illness: Theory and interventions*. Chichester: John Wiley & Sons
- Aviram, R. B., Brodsky, B. S., & Stanley, B. (2006). Borderline personality disorder, stigma, and treatment implications. *Harvard Review of Psychiatry*. 14, 249-256.
- Bateman, A., & Fonagy, P. (2000). Effectiveness of Psychotherapeutic treatment of personality disorder. *British Journal of Psychiatry*, 177, 138-143.
- Bateman, A.W. & Fonagy, P. (2004) *Psychotherapy for borderline personality disorder: Mentalization based treatment*. Oxford: Oxford University Press.

- Bjorkman, T., Angleman, T., & Jossen, M. (2008). Attitudes towards people with mental illness: a cross-sectional study among nursing staff in psychiatric and somatic care. *Scandinavian Journal of Caring Sciences*, 22, 170-177.
- Bowers, L. (2002). *Dangerous and Severe Personality Disorder: Role and responsibilities in of the psychiatric team*. Routledge: London.
- Burns, T. (2006) An introduction to community mental health teams (CMHTs): How do they relate to patients with personality disorders? *In Personality Disorder and Community Mental Health Teams: A Practitioner's Guide*. Edited by M. J. Sampson, R. A. McCubbin and P. Tyrer. Chichester: John Wiley & Sons, Ltd.
- Castillo, H. (2003). A dangerous diagnosis. *Mental Health Today*. February, 27-30.
- Chessick, R. D. (1990). Hermeneutics for psychotherapists. *American Journal of Psychotherapy*, XLIV, 256-273.
- Clark, L.A., & Watson, D. (1995). Constructing validity: Basic issues in objective scale development. *Psychological Assessment*, 7, 309-319.
- Cleary, M., Siegfried, N., & Walter, G. (2002). Experience, knowledge and attitudes of mental health staff regarding clients with a borderline personality disorder. *International Journal of Mental Health Nursing*, 11, 186-191.
- Cohen, J., & Stuenkel, E. L. (1962). Opinions about mental illness in the personnel of two large mental hospitals. *Journal of Abnormal and Social Psychology*, 64, 349-360.
- Coid, J., Yang, M., Tyrer, P., Roberts, A., & Ullrich, S. (2006). Prevalence and correlates of personality disorder in Great Britain. *British Journal of Psychiatry*, 188, 423-431.

- Colson, D., Allen, J., Coyne, L., Dexter, D., Jeha, N., Kearns, W., et al. (1985). Patterns of staff perceptions of difficult patients in a long-term psychiatric hospital. *Hospital and Community Psychiatry, 36*, 168-172.
- Commons-Treloar, A. J. (2009). Effectiveness of education programs in changing clinicians' attitudes toward treating borderline personality disorder. *Psychiatric Services, 60*, 1128-1131.
- Commons Treloar, A. J., & Lewis, A. (2008a). Professional attitudes towards deliberate self harm in patients with borderline personality disorder. *Australian and New Zealand Journal of Psychiatry, 42*, 578-584.
- Commons Treloar, A. J., & Lewis, A. (2008b). Targeted clinical education for staff attitudes towards deliberate self-harm in borderline personality disorder: Randomized controlled trial. *Australian and New Zealand Journal of Psychiatry, 42*, 981-588.
- Corrigan, P. W. (2000). Mental health stigma as societal attribution: Implications for research methods and attitude change. *Clinical Psychology: Science and Practice, 7*, 48-67.
- Corrigan, P. W. (2005). *On the stigma of mental illness: Practical strategies for research and social change*. Washington DC: American Psychological Association.
- Corrigan, P. W., Markowitz, F. E., Watson, A., Rowan, D., & Kubiak, M. (2003). An attribution model of public discrimination towards persons with mental illness. *Journal of Health and Social Behaviour, 44*, 162-179.

- Corrigan, P. W., River, P. L., Lundin, R. K., Penn, D. L., Uphoff-Wasowski, K.,
Campion, J., et al. (2001). Three strategies for changing attributions about severe
mental illness. *Schizophrenia Bulletin*, *27*, 187-195.
- Corrigan, P. W., River, L. P., Lundin, R., Wasowski, K. U., Campion, J., Mathisen, J., et
al. (1999). Predictors of participation in campaigns against mental illness stigma.
Journal of Nervous & Mental Disease, *187*, 378-380.
- Corrigan, P. W., Watson, A. C., Warpinsky, A. C., & Garcia, G. (2003). Stigmatising
attitudes about mental illness and allocation of resources to mental health
services. *Community Mental Health Journal*, *40*, 297-307.
- Corrigan, P. W., Watson, A. C., Warpinsky, A. C., & Garcia, G. (2004). Implications of
educating the public on mental illness, violence, and stigma. *Psychiatric Services*,
55, 557-580.
- Cortina, J. M. (1993). What is coefficient alpha? An examination of theory and
applications. *Journal of Applied Psychology*, *78*, 98-104.
- Dagnan, D., Trower, P., & Smith, R. (1998). Care staff responses to people with learning
disabilities and challenging behaviour: A cognitive emotional analysis. *British
Journal of Clinical Psychology*, *37*, 59-68.
- Deans, C., & Meocevic, E. (2006). Attitudes of registered psychiatric nurses towards
patients diagnosed with borderline personality disorder. *Contemporary Nurse*, *21*
43-49.

- Electronic reference for the proposed changes to borderline personality disorder in the DSM V by the American Psychiatric Association (2010).. Retrieved October 10, 2010, from <http://www.dsm5.org/ProposedRevisions/Pages/proposedrevision.aspx?rid=17>
- Fahy, T. (2002). Organisation of personality disorder services in general adult psychiatric services. Key text listed in appendix 1 of: National Institute of Mental Health in England, (2003), *Personality Disorder: No longer a diagnosis of exclusion*. Retrieved August 14, 2009, from http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset?dh4130849.pdf
- Fallon, P. (2003). Travelling through the system: The lived experience of people with borderline personality disorder in contact with psychiatric services. *Journal of Psychiatric and Mental Health Nursing*, 10, 393-400.
- Faul, F., Erdfelder, E., Lang, A.G., & Buchner, A. (2007). G*Power 3: A flexible statistical power analysis program for the social, behavioural, and biomedical sciences. *Behaviour Research Methods*, 39, 175-191.
- Field, A. (2005). *Discovering statistics using SPSS*. (2nd ed.). London: Sage Publications Ltd.
- Fishbein, M. (2008). A reasoned action approach to health promotion. *Journal of Medical Decision Making*, 28, 834-844.
- Forsyth, A. (2007). The effects of diagnosis and non-compliance attributions on therapeutic alliance processes in adult acute psychiatric settings. *Journal of Psychiatric and Mental Health Nursing*, 14, 33-40.

- Friday, C. (2006). *Nursing staff attributions towards clients with a personality disorder*. Unpublished doctoral Thesis. University of East Anglia.
- Fraser, K., & Gallop, R. (1993). Nurses' confirming/Disconfirming responses to patients diagnosed with borderline personality disorder. *Archives of Psychiatric Nursing*, 8, 336-341.
- Gallop, R. (1985). The patient is splitting, everyone knows and nothing changes. *Journal of Psychosocial Nursing*, 23, 7-10.
- Gallop, R., Lancee, W. J., & Garfunkel, P. (1989). How nursing staff respond to the label borderline personality disorder. *Hospital and Community Psychiatry*, 40, 815-819.
- George, D., & Mallery, P. (2003). *SPSS for Windows step by step: A simple guide and reference. 11.0 update* (4th ed.). Boston: Allyn & Bacon.
- Goffman, E. (1963) *Stigma: Notes on the Management of Spoiled Identity*. Englewood Cliffs, NJ: Prentice Hall.
- Golomb, M., Fava, M., Abraham, M. & Rosenbaum, J. (1995). Gender differences in personality disorder. *American Journal of Psychiatry*, 152, 579-582.
- Grossman, C. I. (2004). Labels and Language: Implications for prevention of the DSM definition of mental disorder. *The Journal of Primary Prevention*, 24, 513-522.
- Grey, I. M., McClean, B., & Barnes-Holmes, D. (2002). Staff attributions about the causes of challenging behaviour. *Journal of Learning Disabilities*, 6, 297-312.
- Gunderson, J. G., & Links, P.S. (2008) *Borderline Personality Disorder a Clinical Guide*. (2nd Ed.). Washington, DC: American Psychiatric Association.
- Hallahan, M., & Rosenthal, R. (1996). Statistical Power: concepts, procedures and applications. *Behaviour Research and Therapy* 34, 489-499.

- Haslam, N. (2003). The dimensional view of personality disorders: A review of the taxometric evidence. *Clinical Psychology Review, 23*, 75-93.
- Hay, K. A. (2007). *Factors that influence a desire for social distancing from people with schizophrenia in an English general population sample*. Unpublished doctoral dissertation, University of East Anglia, Norwich.
- Hayes, A. F., Cai, L. (2007). Further evaluating the conditional decision rule for comparing two independent means. *British Journal of Mathematical and Statistical Psychology, 60*, 217-244.
- Hazelton, M., Rossiter, R., & Milner, J. (2006). Managing the unmanageable: Training staff in the use of dialectical behaviour therapy for borderline personality disorder. *Contemporary Nurse, 21*, 120-130.
- Heider, F. (1958). *The Psychology of Interpersonal Relations*. New York: John Wiley & Sons
- Heineken, J. (1992). Disconfirmation in dysfunctional communication: A new way to teach communication skills. *Nurse Educator, Spring*, 33-42.
- Hill, C., & Daggan, D. (2002). Helping, attributions, emotions and coping style in response to people with learning disabilities and challenging behaviour. *Journal of Learning Disabilities, 6*, 363-372.
- Horsfall, J. (1999). Towards understanding some complex borderline behaviours. *Journal of Psychiatric and Mental Health Nursing, 6*, 425-432.
- Houston, K., Haw, C., Townsend, E., & Hawton, K. (2003). General practitioner contacts with patients before and after deliberate self harm. *British Journal of General Practice, 53*, 365-370.

- Hughes R., & Huby, M. (2002). The application of vignettes in social and nursing research. *Journal of Advanced Nursing* 37, 382-386
- Ingamells, S., Goodwin, A. M., & John, C. (1996). The influence of psychiatric hospital and community residence labels on social rejection of the mentally ill. *British Journal of Clinical Psychology*, 35, 359-367.
- James, P. D., & Cowman, S. (2007). Psychiatric nurses' knowledge, experience and attitudes towards clients with borderline personality disorder. *Journal of Psychiatric and Mental Health Nursing*, 14, 670-678.
- Kelley, H. H. (1973). The process of causal attribution. *American psychologist*, 28, 107-128.
- Kinicki A.J., Hom P.W., Trost M.R. & Wade K.J. (1995) Effects of category prototypes on performance-rating accuracy. *Journal of Applied Psychology* 80, 354-370.
- Knight, R. P. (1953) Borderline states. *Bulletin of the Menninger Clinic*, 17, 1-12.
- Krawitz, R. (2004). Borderline personality disorder: Attitudinal change following training. *Australian and New Zealand Journal of Psychiatry*, 38, 554-559.
- Linehan, M. M. (1993). *Cognitive behavioral treatment of borderline personality disorder*. New York: Guilford.
- Link, B.G., Cullen, J. F., Frank, J., & Woznaik, J. F. (1987). The social rejection of former mental patients: Understanding why labels matter. *The American Journal of Sociology*, 92, 1461-1500.
- Link, B. G., Cullen, F. T., Struening, E., Shrout, P. E., & Dohrenwend, B. P. (1989). A modified labelling theory approach to mental disorders: An empirical assessment *American Sociological Review*, 54, 400-423.

- Link, B.G., and Phelan, J.C. (2001). Conceptualizing stigma. *Annual Review of Sociology*, 27:363-385.
- Link, B. G., Phelan, J. C., Bresnahan, M., Stueve, A., & Pescosolido, B. A. (1999). Public conceptions of mental illness: Labels, causes, dangerousness and social distance. *American Journal of Public Health*, 89, 1328-1333.
- Link, B. G., Yang, L. H., Phelan, J. C., & Collins, P. Y. (2004). Measuring mental illness stigma. *Schizophrenia Bulletin*, 30, 511-541.
- Lucas, L. L., Collins, S., & Langdon, P. (2008). The causal attributions of teaching staff towards children with intellectual disabilities: A comparison of 'vignettes' depicting challenging behavior with 'real' incidents of challenging behavior. *Journal of Applied Research in Intellectual Disabilities*, Digital object identifier, 10.1111/j.1468-3148.2008.00428.x. Retrieved November 22, 2008, from <http://www3.interscience.wiley.com/cgi bin/fulltext/120124984/PDFSTART>.
- Markham, D. (2003). Attitudes towards patients with a diagnosis of 'borderline personality disorder': Social rejection and dangerousness. *Journal of Mental Health*, 12, 595-612.
- Markham, D., & Trower, P. (2003). The effects of the psychiatric label 'borderline personality disorder' on nursing staff's perceptions and causal attributions for challenging behaviors. *British Journal of Clinical Psychology*, 42, 243-256.
- McIntyre, M, S., & Schwartz, R. C. (1998). Therapists' differential countertransference reactions toward clients with major depression or borderline personality disorder. *Journal of Clinical Psychology*, 54, 923-931.

- McMurran, M. (2002). *Expert paper: Personality disorders*. NHS National Programme on Forensic Mental Health Research and Development.
- Miller S, A., & Davenport, N. C (1996). Increasing staff knowledge of and improving attitudes towards patients with borderline personality disorder. *Psychiatric Services, 47*, 533-535.
- Moran, P. (2002). The epidemiology of personality disorders. *Psychiatry, 1*, 8–11.
- National Institute for Health and Clinical Excellence. (2007). Clinical guideline 23: Depression: Management of depression in primary and secondary care. London: The British Psychological Society and Gaskell. Retrieved April 12, 2009, from www.nice.org.uk/CG023NICEguideline).
- National Institute for Health and Clinical Excellence. (2009). Clinical guideline 78: Borderline Personality Disorder: Borderline personality disorder: Treatment and management. London: National Collaborating Centre for Mental Health Retrieved February 8th, 2009, from <http://www.nice.org.uk/Guidance/CG78/NiceGuidance/pdf/English>
- National Institute for Mental Health in England. (NIMHE). (2003a) Breaking the cycle of rejection: The personality disorder capabilities framework, policy implementation guidance for the development of services for people with personality disorder. London: Department of Health.
- National Institute for Mental Health in England (NIMHE). (2003b). Personality disorder: No longer a diagnosis for exclusion, policy implementing guidance for the development of services for people with personality disorder. London: Department of Health.

- Nehls N (1999) Borderline personality disorder: The voice of patients. *Research in Nursing & Health*, 22, 285-293.
- O'Brien, L. (1998). Inpatient nursing care of patients with borderline personality disorder: A review of the literature. *Australian and New Zealand Journal of Mental Health Nursing*, 7, 172-183.
- O'Brien, L., & Flote, J. (1997). Providing nursing care for a patient with borderline personality disorder on an inpatient unit: A phenomenological study. *Australian and New Zealand Journal of Mental Health Nursing*, 6, 137-147.
- Orvis, B.R., Cunningham, J.D. & Kelley, H.H. (1975). A closer examination of causal inference: The roles of consensus, distinctiveness, and consistency information. *Journal of Personality and Social Psychology*, 32, 605-616
- Preskorn, S. H., & Baker, B. (2002) The overlap of DSM IV syndromes: Potential Implications for the Practice of Polypsychopharmacology, Psychiatric Drug Development, and the Human Genome Project. *Journal of Psychiatric Practice*, 8, 170-177.
- Reber, A. S. (1995). *The penguin dictionary of psychology*. (2nd Ed.). London: Penguin
- Reiser, D., & Levenson, H. (1984). Abuses of the borderline diagnosis: A clinical problem with teaching opportunities. *American Journal of Psychiatry*, 126, 983-988.
- Rosenkrantz, J., & Morrison, T. L. (1992a). Psychotherapist personality characteristics and the perception of self and patients in the treatment of borderline personality disorder. *Journal of Clinical Psychology*, 48, 544-553.

- Rosenkrantz, J., & Morrison, T. L. (1992b). Psychotherapist perceptions of self and patients in the treatment of borderline personality disorder. *Journal of Clinical Psychology*, 48, 553-560.
- Ruocco, A. C. (2005). Reevaluating the distinction between axis I and axis II disorders: The case of borderline personality disorder. *Journal of Clinical Psychology*, 6, 1509-1523
- Sampson, M. J. (2006) The Challenges Community Mental Health Teams Face in Their Work with Patients with Personality Disorders. In *Personality Disorder and Community Mental Health Teams: A Practitioner's Guide*. Edited by M. J. Sampson, R. A. McCubbin and P. Tyrer. Chichester: John Wiley & Sons, Ltd.
- Schmideberg, M. (1947). The treatment of psychopaths and borderline patients. *American Journal of Psychotherapy*, 1, 45-70.
- Sharrock R., Day A., Qazi F. & Brewin C. (1990) Explanations by professional care staff, optimism, and helping behaviour: An application of attribution theory *Psychological Medicine* 20, 849-855.
- Shearin, E. N., & Linehan, M. M. (1992). Patient-therapist ratings and relationship to progress in dialectical behaviour therapy for borderline personality disorder. *Behaviour Therapy*, 23, 730-741.
- Sperry, L. R., (2003). *Handbook of diagnosis and treatment of DMS-IV-TR personality disorders*. (2nd ed.). New York and Hove: Brunner-Routledge.
- Stern, A. (1938). Psychoanalytic investigation of and therapy in the borderline group of neuroses. *Psychoanalytic Quarterly*, 7, 467-489.

- Swift, E. (2009). Borderline personality disorder: Aetiology, presentation and therapeutic relationship. *Mental Health Practice, 13*, 22-25.
- Tennen, H., Affleck, G., & Gershman, k. (1986). Self-blame among parents of infants with perinatal complications: The role of self protective motives. *Journal of Personality and Social Psychology, 50*, 690-696.
- The British Psychological Society. (2006). *Code of Ethics and Conduct*. Leicester: Author.
- Todd, S. J., & Watts, S. C. (2005). Staff response to challenging behaviour shown by people with dementia: an application of an attribution-emotion-action model of helping behaviour. *Aging and mental health, 9*, 71-81.
- Tredget, J. E. (2001). The aetiology, presentation and treatment of personality disorders. *Journal of Psychiatric and Mental Health Nursing, 8*, 347-356.
- Unpublished study. (1998). In Miller S, A., & Davenport, N. C (1996). Increasing staff knowledge of and improving attitudes towards patients with borderline personality disorder. *Psychiatric Services, 47*, 533-535.
- Voss, K. E., Stem, D. E., Fotopoulos, S. (2000). A Comment on the relationship between coefficient alpha and scale characteristics. *Marketing Letters, 11*, 177-191.
- Wanless, L. K., & Jahoda, A. (2002). Responses of staff towards people with mild to moderate intellectual disability who behave aggressively: A cognitive emotional analysis. *Journal of Intellectual Disability Research, 46*, 507-516.
- Webb, C. E. (2005). A focus group survey of CMHT staff views on the meaning of personality disorder. *Clinical Psychology, 48*, 3-7.

- Weiner, B. (1980). A cognitive (attribution)-emotion-action model of motivated behavior: An analysis of judgments of help giving. *Journal of personality and Social Psychology*, 39, 186-200.
- Weiner, B. (1985). An attributional theory of achievement motivation and emotion. *Psychological Reviews*, 92, 3-25.
- Weiner, B. (1986). *An attributional Theory of Motivation and Emotion*. Berlin: Springer
- Weiner, B. (1995). *Judgements of responsibility: A foundation for theory of social conduct*. New York: Guildford.
- Widiger, T. A., & Costa, P. T. (1994). Personality and personality disorders. *Journal of Abnormal Psychology*, 103, 78–91.
- Willner, P., & Smith, M. (2008a). Attribution theory applied to helping behaviour towards people with intellectual disabilities who challenge. *Journal of Applied Research in Intellectual Disabilities*, 21, 150-155.
- Willner, P., & Smith, M. (2008b). Can Attribution theory explain carers' propensity to help men with intellectual disabilities who display inappropriate sexual behaviour? *Journal of Intellectual Disability Research*, 52, 79-88.
- Wolff, G., Pathare, S., Craig, T., & Leff, J.(1996). Community knowledge to mental illness and reaction to mentally ill people *British Journal of Psychiatry*, 168, 191-198.
- Woollaston, K., & Hixenbaugh, P. (2008). 'Destructive whirlwind': Nurses' perceptions of patients diagnosed with borderline personality disorder. *Journal of Psychiatric and Mental Health Nursing*, 15, 703-709.

- Young, C. (2008). *Clinical helping behaviour towards clients diagnosed with a personality disorder who display difficult and challenging behaviour*. Unpublished doctoral thesis. University of East Anglia.
- Young, J. E. (1999) *Cognitive therapy for personality disorders: A schema-focused approach*. (3rd Ed). Florida: Professional Resource Press.
- Zanarini, M. C., Frankenburg, F. R., Dubo, E. D., Sickel, A. E., Trikha, A., Levin, A., et al. (1998). Axis I co-morbidity of borderline personality disorder. *American Journal of psychiatry*, *155*, 1733-1739.
- Zimmerman, M., Mattia, J. I. (1999). Differences between clinical and research practices in diagnosing borderline personality disorder. *American Journal of Psychiatry* *156*, 1570–1574.

Appendices

Appendix A: Vignette for the BPD and Depression Group

Appendix B: Vignette for the Depression alone Group

Appendix C: Adapted Attribution Questionnaire-27

Appendix D: Knowledge questionnaire

Appendix E: Adapted Social distance questionnaire

Appendix F: Perceived Dangerousness Scale

Appendix G: Participant Information Sheet

Appendix H: Original Attribution Questionnaire-27.

Appendix I: Letter of ethical approval

Appendix J: Letter of research and development approval

Appendix K: Informed consent form

Appendix L: Participant De-brief sheet

Appendix M: A sample of Boxplots and histograms

Appendix N: A sample of Scatterplots

Appendix A

Vignette for the BPD and Depression Group

Dear Team,

RE: Mary Smith

I would be grateful if you could assess this 25 year old lady who presented to me this morning and revealed a cut on her left forearm. She moved to the area a month ago and said her mood had been deteriorating since she arrived. She began cutting her arm the day before she came to see me. She has scars from previous instances of self harm but said she had not done this in the year preceding this most recent episode.

She informed me she had input from mental health services where she used to live. I have contacted them and they informed me that she is known to them and has a diagnosis of Borderline personality disorder and Depression.

Yours sincerely

Dr GP

Appendix B

Vignette for the Depression Alone Group

Dear Team,

RE: Mary Smith

I would be grateful if you could assess this 25 year old lady who presented to me this morning and revealed a cut on her left forearm. She moved to the area a month ago and said her mood had been deteriorating since she arrived. She began cutting her arm the day before she came to see me. She has scars from previous instances of self harm but said she had not done this in the year preceding this most recent episode.

She informed me she had input from mental health services where she used to live. I have contacted them and they informed me that she is known to them and has a diagnosis of Depression.

Yours sincerely

Dr GP

The AQ-27 Score Sheet

Name or ID Number _____ Date _____

The adapted AQ-27 consists of 6 stereotype factors; scores for each factor are determined by summing the items as outlined below: The higher the score, the more that factor is being endorsed by the subject.

_____ Controllability = AQ7 + AQ8 + AQ15

_____ Anger = AQ1 + AQ3 + AQ9

_____ Pity = AQ6 + AQ14 + AQ18

_____ Help = AQ5 + AQ12 + AQ13

_____ Fear = AQ2 + AQ11 + AQ16

_____ Coercion = AQ4 + AQ10 + AQ17

Appendix D

Knowledge Questionnaire

**STAFF EXPERIENCE, KNOWLEDGE AND ATTITUDES
REGARDING CLIENTS' WITH A BORDERLINE PERSONALITY
DISORDER (James and Cowman 2007)**

PLEASE INDICATE YOUR ANSWERS BY TICKING THE APPROPRIATE BOX

1. Are you

Male

Female

2. In what age group are you?

25 years or less

26 - 29 years

30 - 39 years

40 - 49 years

50 years or more

3. What is your current job title?

Community Psychiatric Nurse

Occupational Therapist

Psychologist

Psychiatrist

Support worker

Other - please specify.....

4. What is your usual place of work?

In-patient Ward

Crisis Team

Community Mental Health Team

Other - please specify.....

5. How long have you been working in this Clinical Area?

Less than 2 years

2 - 5 years

6 - 10 years

11 - 15 years

More than 15 years

6. How long have you been qualified in your profession?

Less than 2 years

2 - 5 years ago

6 - 10 years ago

11 - 20 years ago

21 years or more

7. Have you ever received any specific training in relation to care of people with a diagnosis of Borderline Personality disorder (BPD)?

No

Yes - *Please describe the type of training received in space below:*

.....

8. How often do you come into contact with a client who has a diagnosis of BPD?

Daily

1 - 2 times per week

1 - 2 times a month

5 - 6 times a year

Once a year or less

Never

9. Do you consider that your clients who have a diagnosis of BPD are managed:

Adequately - *go to question 11*

Inadequately

10. If you thought management of your clients with BPD was inadequate do you believe this is because: (please answer for each option)

	Strongly Agree	Agree	Don't Know	Disagree	Strongly Disagree
You lack training and/or expertise					
There is a shortage of services to treat this client group					
The clients themselves are difficult to treat					
The clients are untreatable					
The clients do not have a mental illness					
Clients are often not told their diagnosis and therefore cannot learn to cope with it					
There are frequent disagreements with the multidisciplinary team as to how to best treat these clients					
BPD has been overly medicalised and therefore the treatments used are inappropriate, e.g. medication					

Any other reasons:

11. For each of the following statements please state whether you agree, disagree or don't know. The DSM-IV diagnosis of BPD is characterized by:

	Agree	Disagree	Don't know
1. Unstable mood with rapid shifts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Grandiose sense of self-importance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Impulsive behavior particularly self-destructive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

12. The following statements refer to the treatment of people with a BPD. Please state whether you agree, disagree or don't know for each statement.

	Agree	Disagree	Don't know
1. Patients with BPD should not be hospitalized	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Short-term psychotherapy can be useful to manage crises in patients with BPD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Antidepressant medication is of no benefit to depression experienced by people with BPD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

13. For the following statements please indicate whether you believe it to be True or False of people with BPD:

	True	False	Don't Know
1. A significant number attain some stability in their 30s and 40s	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. People with a BPD have a high incidence of depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. BPD can progress to schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. May have short-lived psychotic Episodes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

The following questions will help determine staff needs in relation to their dealings with clients with BPD.

14. When taking a history from clients, do you obtain information for each of the following:

	Always	Usually	Occasionally	Rarely/never
1. Drug and alcohol history	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Family history	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Sexual history	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Relationship history	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Contact with police	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. History of self-harm and suicide attempts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. History of aggression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

8. History of abuse or rape

15. How confident are you in undertaking the following:

	Very	Moderately	Only a little	Not at all
1. Identification of BPD in clients who have not been diagnosed with the disorder.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Assessment of the severity of difficulties in clients diagnosed with BPD.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Day to day management of BPD.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Developing care plans for those with BPD.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

16. How difficult do you find dealing with clients who have a BPD?

1. Very difficult
2. Moderately difficult
3. Slightly difficult
4. Neither difficult nor easy
5. Easy

17. Do you find dealing with clients who have a BPD compared to other clients?

1. More difficult
2. The same
3. Less difficult

18. As a mental health professional do you see yourself as having a role in:

	Yes	No	Unsure
1. The assessment of clients with BPD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. The management of clients with BPD.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Educating the families and carers of clients with BPD.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Educating and providing information to clients with BPD.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

19. Please rank the following resources in order of which you believe would be the most helpful, in order to improve the care received by clients with a diagnosis of BPD: (please place 1 next to the most helpful, 2 to the next most helpful, 3 to the next most helpful etc.)

- ___ Information for distribution to clients
- ___ Information on where to refer clients
- ___ Regular in-services training
- ___ Skills training workshop
- ___ Increased education during undergraduate education/training
- ___ A specialist service for those clients who have a BPD
- ___ Training in Dialectic Behavioural Therapy
- ___ Standard protocols for management of BPD
- ___ A liaison psychiatric service in Accident and Emergency
- ___ Supervision / Team support
- ___ Other – please specify

.....
.....
.....
.....

20. If further education or training regarding clients with BPD were provided, would you be interested in undertaking the training?

- 1. Yes
- 2. No

21. Are there any other comments you would like to make about this subject?

.....
.....
.....
.....

Thank you again for your time.

Appendix E

Social Distance Scale (Link, Cullen, Frank and Woznaik, 1987) Adapted by Hay (2007)

	Definitely not willing	Not Willing	Neutral	Willing	Definitely Willing
Would you be willing to start work with a person like Mary?					
Would you like to move next door to a person like Mary?					
Would you make friends with a person like Mary?					
Would you rent a room to a person like Mary?					
Would you recommend a person like Mary for a Job					
Would you like your child to marry a person like Mary?					
Would you trust a person like Mary to take care of your child?					

Appendix F

Perceived Dangerousness Scale. (Angermeyer+Matschinger Corrigan, 2003)

To what extent do you think the following descriptions apply to Mary?

	Definitely True	Somewhat True	Neutral	Somewhat Untrue	Definitely Untrue
Aggressive					
Lacks self control					
Dangerous					
Unpredictable					
Frightening					
Strange					

Appendix G

Participant information sheet.



Research title: An Investigation into Factors That Affect Secondary Mental Health Care Staff and Service User Interactions.

I would like to invite you to take part in a research study. Before you decide it is important that you understand why the research is being done and what it will involve. Please take the time to read the following information carefully and talk to others about the study if you wish.

Part 1 tells you the purpose of this study and what will happen to you if you take part. Part 2 gives you more detailed information about the conduct of the study.

PART 1

What is the purpose of this study?

This research aims to explore possible relationships between service user and staff characteristics. Information about how these characteristics interact can help inform training programmes for staff and individualised treatment approaches for service users.

Why have I been invited to take part?

You have been invited because you are a member of clinical staff working within a secondary mental health care multidisciplinary team. Every member of staff who works within these teams in CPFT has been invited to take part.

Do I have to take part?

No. Participation in this research is completely voluntary. This sheet will give you the information you need to make an informed decision about whether you want to take part. Talk to others about taking part in this study if you wish. If you do decide to take part, you are free to withdraw at any time, without giving a reason and without penalty.

What will happen to me if I take part?

You will be asked to meet with me at your own convenience for 15-20 minutes. During this time you will be asked to read one of two short vignettes about a service user with a

particular mental health diagnosis and complete four questionnaires. Here is a brief description of the four questionnaires:

1. Attribution Questionnaire 27. (AQ-27)

A modified version of the AQ-27 looks at different attributions, emotional reactions and intended behaviours towards a service user described in a vignette. It consists of 18 statements about the service user you will read about in the vignette. You will be asked to read these statements and indicate how much you agree with the statement on a scale of 1 (not at all) to 9 (very much)

2. Social Relationships Scale

This scale measures your views about what sort of social relationship you would be happy to have with the service user described in the vignette. It consists of 7 statements describing a number of social relationships. You will be asked to read these statements and indicate how willing you would be to have a relationship of this sort with the service user. The ratings are from 1 (definitely not willing) to 5 (definitely willing).

3. Risk scale

This scale measures how risky you think the person described in the vignette is. It lists 8 attributes that indicate risk. You are asked to indicate to what extent these attributes apply to the person in the vignette on a five-point Likert scale ranging from 1 (definitely true) to 5 (definitely not true)

4. Familiarity and Awareness Questionnaire

This contains demographic questions such as your gender, job role and time in job. It also asks you about your views about the treatment and assessment of particular mental health diagnoses and your familiarity and awareness about these.

Once you have read the vignette and completed the questionnaire, you will not be asked to meet with me again, or complete any further questionnaires.

What will happen to my information if I choose to take part?

During the study, your information will be kept in a locked filing cabinet at the University of East Anglia. When the research is finished, it will be kept for 5 years in a locked filing cabinet at the University of East Anglia. Your consent forms will be kept separately from your questionnaires to ensure your details remain anonymous.

What are the possible benefits of taking part?

I cannot promise the study will help you personally. However some of the information about your views of working with service users with particular mental health disorders will be given as general feedback to your team managers (your personal responses will

not be identifiable or shared with your team managers). This will help raise awareness within the service about staff views of working with these service users.

What happens when the research stops?

I estimate that it will take 9 months to analyse the results and produce the reports. I will be circulating the findings to team managers so they can pass them out to you.

What if there is a problem

Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be addressed. The detailed information on this is given in Part 2.

Will my taking part in this study be confidential?

Yes, taking part in this study is confidential. We will follow ethical and legal practices and all information about you will be handled in confidence. The details of this are included in Part 2

PART 2

What if I participate and then change my mind?

You may withdraw from this study at any time, and your data will be removed.

What if there is problem?

If you are concerned about any part of this study, contact details of the researchers are listed below and we encourage you to contact us with any concerns. If you wish to formally complain, you can do this through the NHS complaints procedure, details of which can be obtained from the NHS website www.nhs.uk.

Will my taking part in this study be kept confidential?

Your data will be kept strictly confidential. Your informed consent forms and questionnaires will be kept separately to ensure anonymity.

What will happen to the results of the research study?

A summary report of the finding will be passed to your team managers to circulate within your team. I anticipate that this will be in July 2010. A report will also be submitted as part of the academic requirements for the principal researcher's Doctoral Course in Clinical Psychology.

Who is organising and funding the research?

This research has been developed as part of the course requirements for the principal researcher's Doctoral Course in Clinical Psychology at the University of East Anglia. The minimal administration costs will be absorbed by the budget given by the University of East Anglia

Who has reviewed the study?

All research in the NHS is looked at by independent group of people, called a Research Ethics Committee to protect your safety, rights, wellbeing and dignity. This study has been reviewed and given a favourable opinion by The Cambridgeshire 3 Research Ethics Committee.

What are the possible disadvantages and risks of taking part?

It is unlikely that participation in this study will cause you any distress. However, some of the questions might raise concerns about a service user on your current case load. You will be encouraged to take this to your regular supervision if this happens.

Contact for further information

If you have any questions or wish to speak to me about this study for any reason, please do not hesitate to approach me when I visit your service or to get in contact through the address or email below:

Researchers:

Sophie Strong
Doctoral Programme in Clinical Psychology
School of Med Health Policy and Practice
University of East Anglia
Norwich, Norfolk
NR4 7TJ
Email: Sophie.strong@uea.ac.uk

Educational Supervisor:

Professor. Malcolm Adams
Doctoral Programme in Clinical Psychology
School of Med Health Policy and Practice
University of East Anglia
Norwich, Norfolk
NR4 7TJ
M.Adams@uea.ac.uk
Tel: 01603 593600

6. I think Harry poses a risk to his neighbors unless he is hospitalized.

1	2	3	4	5	6	7	8	9
none at all							very much	

7. If I were an employer, I would interview Harry for a job.

1	2	3	4	5	6	7	8	9
not likely							very likely	

8. I would be willing to talk to Harry about his problems.

1	2	3	4	5	6	7	8	9
not at all							very much	

9. I would feel pity for Harry.

1	2	3	4	5	6	7	8	9
none at all							very much	

10. I would think that it was Harry's own fault that he is in the present condition.

1	2	3	4	5	6	7	8	9
no, not at all							yes, absolutely so	

11. How controllable, do you think, is the cause of Harry's present condition?

1	2	3	4	5	6	7	8	9
not at all under personal control							completely under personal control	

12. How irritated would you feel by Harry?

1	2	3	4	5	6	7	8	9
not at all							very much	

13. How dangerous would you feel Harry is?

1	2	3	4	5	6	7	8	9
not at all							very much	

The AQ-27 Score Sheet

Name or ID Number _____ Date _____

The AQ-27 consists of 9 stereotype factors; scores for each factor are determined by summing the items as outlined below: **Note:** items are reversed score prior to summing up for the Avoidance scale.

_____ Blame = AQ10+ AQ11 +AQ23

_____ Anger = AQ1 + AQ4 + AQ12

_____ Pity = AQ9 + AQ22 + AQ27

_____ Help = AQ8 + AQ20 + AQ21

_____ Dangerousness = AQ2 + AQ13 + AQ18

_____ Fear = AQ3 + AQ19 + AQ24

_____ Avoidance = AQ7 + AQ16 + AQ26 (Reverse score all three questions)

_____ Segregation = AQ6 + AQ15 + AQ17

_____ Coercion = AQ5 + AQ14 + AQ25

The higher the score, the more that factor is being endorsed by the subject.

Letter of Ethical Approval

Appendix I



National Research Ethics Service

Cambridgeshire 3 Research Ethics Committee

Victoria House
Capital Park
FULBOURN
Cambridge
CB21 5XB

Telephone: 01223 597597
Facsimile: 01223 597645

20 August 2009

Miss Sophie Strong
14 Clement Drive
Peterborough
PE2 9RQ

Dear Miss Strong

Study Title: An Investigation into Factors That Affect Secondary
Mental Health Care Staff and Service User Interactions.
REC reference number: 09/H0306/59

Thank you for your letter of 18 August 2009, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Vice-Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

For NHS research sites only, management permission for research ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

This Research Ethics Committee is an advisory committee to East of England Strategic Health Authority
*The National Research Ethics Service (NRES) represents the NRES Directorate within
the National Patient Safety Agency and Research Ethics Committees in England*

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Questionnaire: Adapted Social Distance Scale with title participants will see	1	29 April 2009
Questionnaire: Social Distance Scale		
Questionnaire: Knowledge Questionnaire		
Questionnaire: Modified Attribution Questionnaire 27	1	29 April 2009
Questionnaire: Attribution Questionnaire 27		
Questionnaire: Perceived Dangerousness Scale adapted with the title participants will see	1	29 April 2009
Questionnaire: Perceived Dangerousness Scale		
Questionnaire: Knowledge Questionnaire adapted with title that participants will see	1	29 April 2009
Compensation Arrangements: Letter from University of East Anglia		03 July 2009
Peer Review: Letter from Professor Adams		01 July 2009
Depression Vignette	1	29 April 2009
Peer Review: Email from Anna Vizer		18 June 2009
Borderline Personality Disorder and Depression Vignette	1	29 April 2009
Participant Information Sheet	2	18 August 2009
Participant Consent Form	2	18 August 2009
Response to Request for Further Information		18 August 2009
Supervisor CV: Malcolm Adams		
Applicant's checklist		
Covering Letter		08 July 2009
Research Proposal	1	29 April 2009
Investigator CV: Sophie Strong,	1	29 April 2009
REC application (Submission code 18289/48201/1/947)		
Participant debrief sheet	1	29 April 2009

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Service website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document "*After ethical review – guidance for researchers*" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments

This Research Ethics Committee is an advisory committee to East of England Strategic Health Authority
The National Research Ethics Service (NRES) represents the NRES Directorate within the National Patient Safety Agency and Research Ethics Committees in England

- Adding new sites and investigators
- Progress and safety reports
- Notifying the end of the study

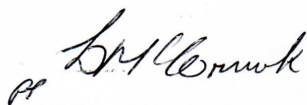
The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

09/H0306/59

Please quote this number on all correspondence

Yours sincerely



Mr Stuart Kent
Vice-Chair

Email: lynda.mccormack@eoe.nhs.uk

Enclosures: "After ethical review – guidance for researchers"

Copy to: *Mrs Tracy Moulton*
The Registry
University of East Anglia
Norwich
NR4 7TJ

Malcolm Adams
Doctoral Programme of Clinical Psychology
Elizabeth Fry Building
University of East Anglia
Norwich
NR4 7TJ

Natercia Godinho
R&D Manager
R&D Office
CPFT
Douglas House
18 Trumpington Road
Cambridge
CB2 8AH

This Research Ethics Committee is an advisory committee to East of England Strategic Health Authority
The National Research Ethics Service (NRES) represents the NRES Directorate within
the National Patient Safety Agency and Research Ethics Committees in England

Appendix J

Letter of research and development approval

Cambridgeshire and Peterborough

NHS Foundation Trust

Understanding mental health, understanding people

Please reply to:
 Natercia Godinho
 R&D Manager
 R&D Office
 Douglas House
 18 Trumpington Rd
 Cambridge CB2 8AH

R&D ref: M00374
 Ethics ref: 09/h0306/59
 Date: 01/10/2009

Tel: 01223 746145
Fax: 01223 746162
E-Mail: natercia.godinho@cpft.nhs.uk
Website: www.cpft.nhs.uk

Miss Sophie Strong
 14 Clement Drive
 Peterborough
 PE2 9RQ

Dear Miss Strong

Study title: An investigation into factors that affect secondary mental health care staff and service user interactions

Thank you for applying for NHS permission to Conduct Research for the above named project. A site specific assessment has been conducted by the R&D based on the information provided on the site specific information and in accordance to the Research Governance Framework For Health and Social Care for research appraisal. The study therefore has been granted full approval on the basis described in the application form, protocol and supporting documentation.

Trust approval of the above research applies to the research sites listed on the application form. Any changes to the above research should be communicated to this Trust and to the relevant Ethics Committee, and protocols followed accordingly.

Sponsor: University of East Anglia

End date of Sponsorship: 30/09/2010

Funder: No external funding – student funding

Protocol: version 1 dated 29 April 2009

Ethics

In accordance with the Department of Health's Research Governance Framework for Health and Social Care, all research projects taking place within the Trust must receive a favourable opinion



HQ Elizabeth House, Fulbourn Hospital, Cambridge CB21 5EF.
 T 01223 726789 F 01480 398501 www.cpft.nhs.uk

In partnership with the University of Cambridge

from the ethics committee and approval from the Department of Research and Development (R&D) prior to commencement.

Honorary Research Contracts (HRC)

All researchers with no contractual relationship with any NHS body, who are to interact with NHS patients in a way that directly affects the quality of their care, should hold honorary NHS contracts (Access Letter or Research Passport). For more information on whether you or any of your research team will require an HRC please liaise with the R&D office. **It is your responsibility to inform us if any of your team does not hold NHS contracts.** Any additional researchers who join the study at a later stage must also hold a suitable contract.

Risk and Incident Reporting

Much effort goes into designing and planning high quality research, which reduces risk; however untoward incidents or unexpected events (i.e. not noted in the protocol) may occur in any research project. Where these events take place on trust premises, or involve trust service users, carers or staff, you must report the incident within 48 hours via the Trust incident reporting system on www.cpft.nhs.uk.

Research Governance, Confidentiality and Information Governance

Whilst conducting this study, you must fully comply with the Research Governance Framework. This can be accessed at <http://www.dh.gov.uk> website then use the DH search facility. All personnel working on this project are bound by a duty of confidentiality. All material accessed in the trust must be treated in accordance with the Data Protection Act (1998).

All parties involved in this research to familiarise themselves and comply with the Trust's policies and procedures available on the Trust website:
<http://www.cpft.nhs.uk/Publications/DocumentsThatGuidePractice/DtGP/tabid/486/language/en-US/Default.aspx>

Protocol / Substantial Amendments

You must ensure that the approved protocol is followed at all times. Should you need to amend the protocol, please follow the Research Ethics Committee procedures and inform all NHS organisations participating in your research.

Monitoring / Participant Recruitment Details

You will be required to produce a short electronic progress report annually and at completion. You can obtain these forms from the R&D office. If your study has been adopted onto the Portfolio it is the responsibility of the Accrual Data Contact (ADC) to upload any and all accrual data

(recruitment data) relating to this Trust to the NIHR and to liaise with the local Principal Investigator and the R&D Office on such accrual.

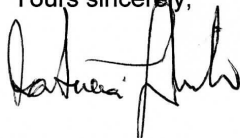
Final Reports

At the end of your research study, we will request a final summary report so that your findings are made available to local NHS staff. The details from this report may be published on the Trust intranet site to ensure findings are disseminated as widely as possible to stakeholders.

Failure to comply with any of the above may result in withdrawal of Trust approval.

On behalf of this Trust, may I wish you every success with your research.

Yours sincerely,

A handwritten signature in black ink, appearing to read 'Natercia Godinho', written in a cursive style.

Natercia Godinho
R&D Manager

Appendix K

*Informed Consent Form***Consent Form**

TITLE: An Investigation into Factors That Affect Secondary Mental Health Care Staff and Service User Interactions.

Researcher: Sophie Strong, Trainee Clinical Psychologist

Research supervisors: Professor Malcolm Adams, Course Director in Clinical Psychology, UEA
Dr Naz Keval, Senior Clinical Tutor in Clinical Psychology, UEA

I

.....
consent to take part in the study named above.

1. I have received and read the information sheet dated 18.08.09 (version 2) regarding the above study.
2. I have had the opportunity to consider my participation fully, ask any questions and had them answered satisfactorily.
3. I understand that my participation in this research is completely voluntary and that I can withdraw at any time without giving a reason and without penalty.
4. I understand that information will be treated as completely confidential unless I disclose anything illegal or harmful to myself or others.
5. I agree to participate in this study.

Name of Participant

Date

Signature

Name of Researcher

Date

Signature



Research title: An Investigation into Factors That Affect Secondary Mental Health Care Staff and Service User Interactions.

Dear Participant

Thank you for participating in the above research. This letter is a de-briefing letter that aims to give you some of the information I was unable to provide you with prior to you reading the vignettes and completing the questionnaires. I was unable to provide this information because giving you it may have changed the way you answered the questionnaires about the service users depicted in the vignettes.

The research focused on staff attributions and intended behaviour towards the label borderline personality disorder (BPD). Research suggests that service users with BPD can be challenging to work with. The research you participated in is important because it aims to help identify what it is about clients with BPD that staff can find difficult to work with and if that results in any particular behaviours such as social distancing. It is looking specifically at whether staff hold different attributions towards service users labelled with BPD and those labelled with depression. It also aims to investigate if there is a difference between intended behaviours towards these client groups and if increased knowledge of BPD is associated with lower attributions of dangerousness and controllability.

To assess this I used three scales which I did not provide you with the name of. These were the social distance measure, the perceived dangerousness measure and the staff experience, knowledge and attitudes regarding clients' with a borderline personality disorder. I labelled them the social relationships scale, the perceived risk scale and the familiarity and awareness Questionnaire as I was worried the names of them may have influenced the way some people responded to them.

As this research also collected staff views about working with service users with BPD and their views about how adequately they are prepared to do so, it could help

identify concerns staff might have when working with this client group. It could also improve training and support systems for secondary care mental health staff who work with service users diagnosed with BPD.

If after reading this you wish to withdraw from the above study do not hesitate to contact me on the details provided below. I will ensure your data is removed and destroyed.

Many thanks for your time

Researchers:

Sophie Strong
Doctoral Programme in Clinical Psychology
Psychology
School of Med Health Policy and Practice

University of East Anglia
Norwich, Norfolk
NR4 7TJ
Email: Sophie.strong@uea.ac.uk

Educational Supervisor:

Professor. Malcolm Adams
Doctoral Programme in Clinical

School of Med Health Policy and
Practice

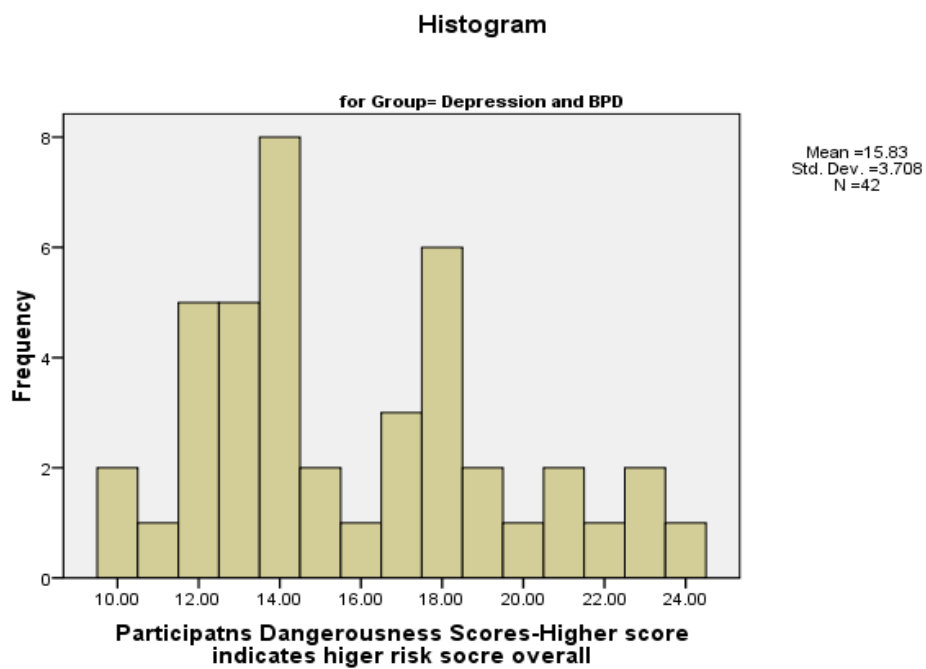
University of East Anglia
Norwich, Norfolk
NR4 7TJ
M.Adams@uea.ac.uk
Tel: 01603 59360

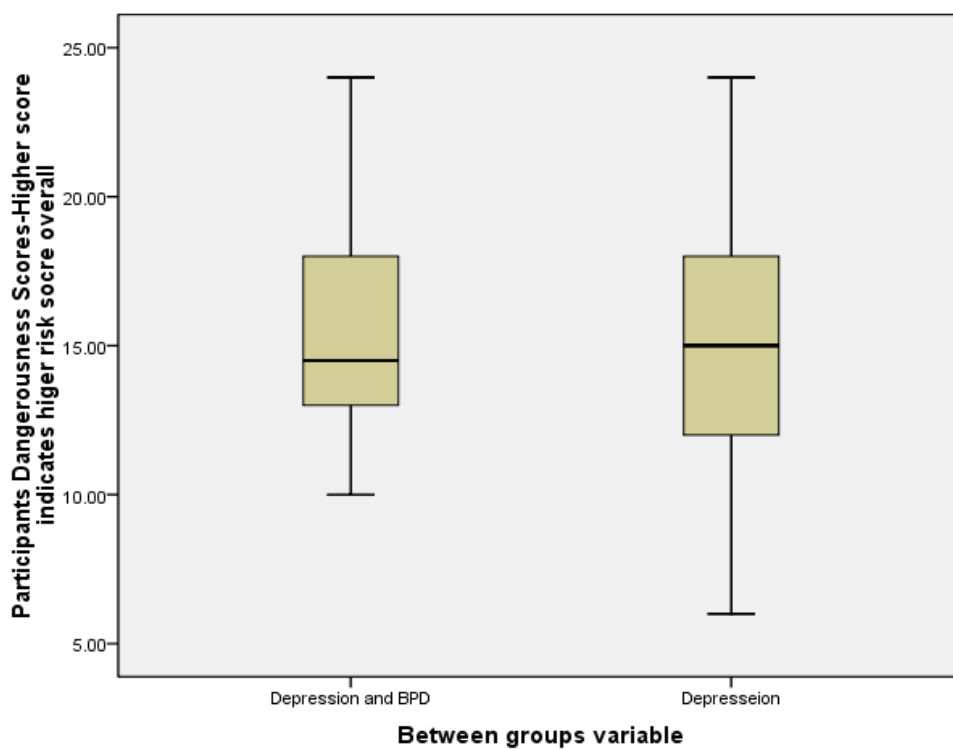
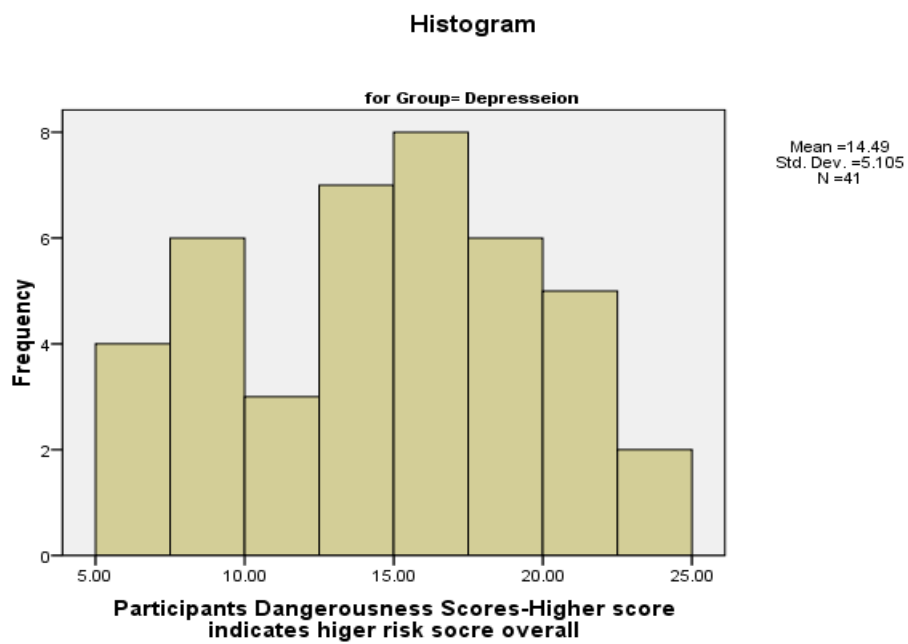
Appendix M

A sample of Boxplots and histograms

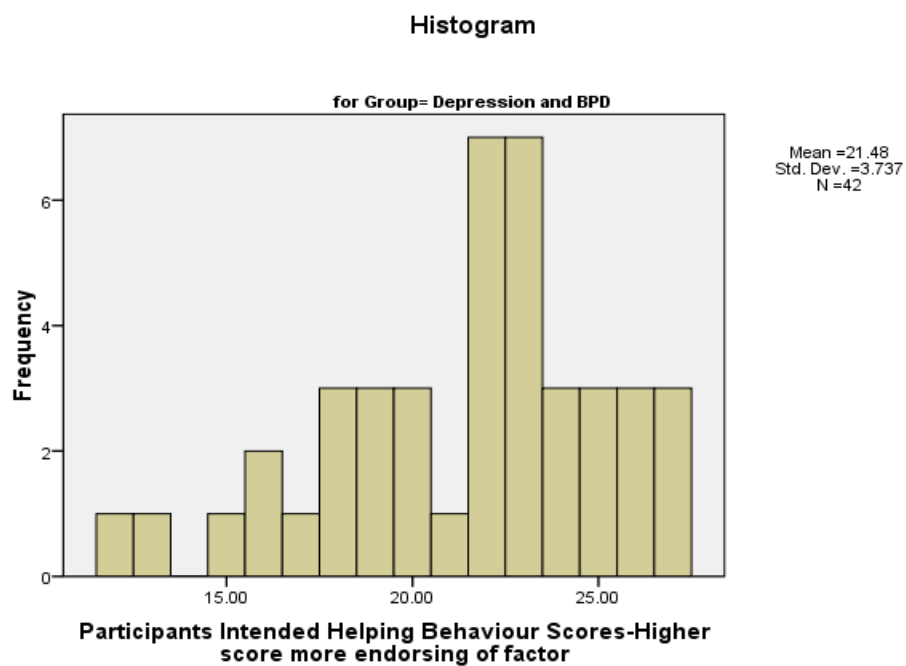
This is a sample of the boxplots and histograms that were used to assess the distribution of the data and the presence of outliers. All the histograms and boxplots are available on request

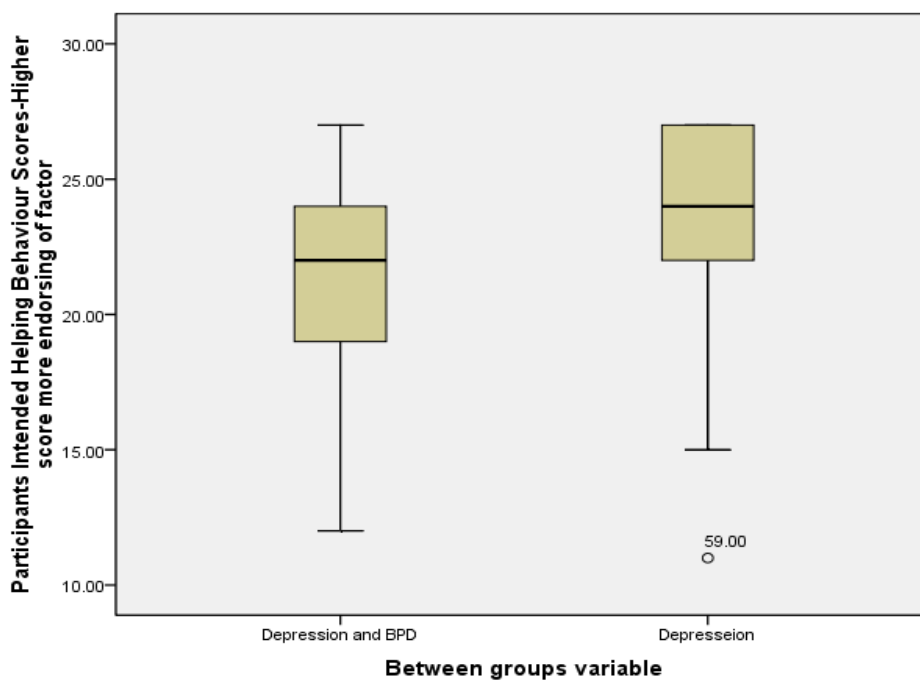
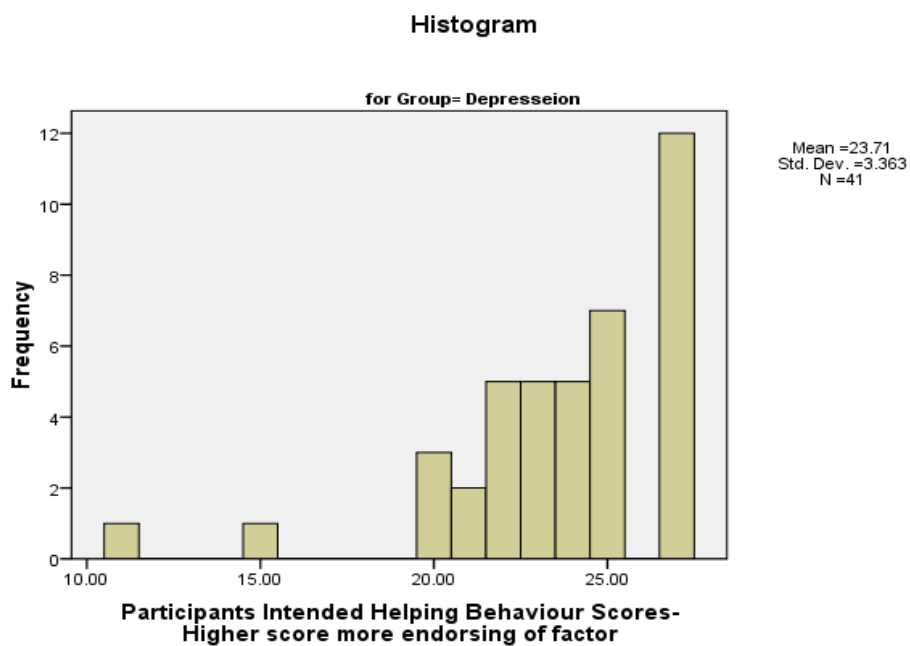
Boxplots and Histograms for data on the dangerousness factor for both the BPD and depression and depression alone groups in hypothesis 1



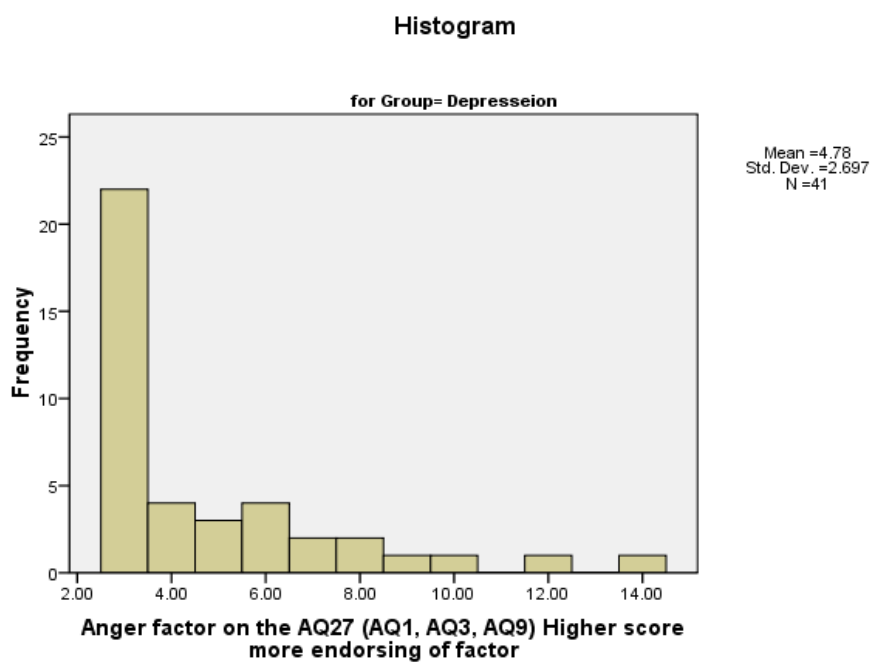
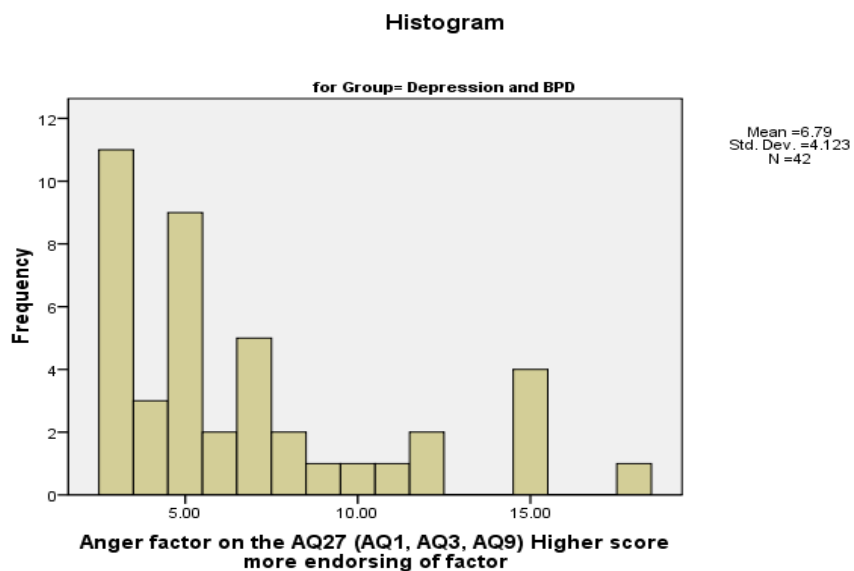


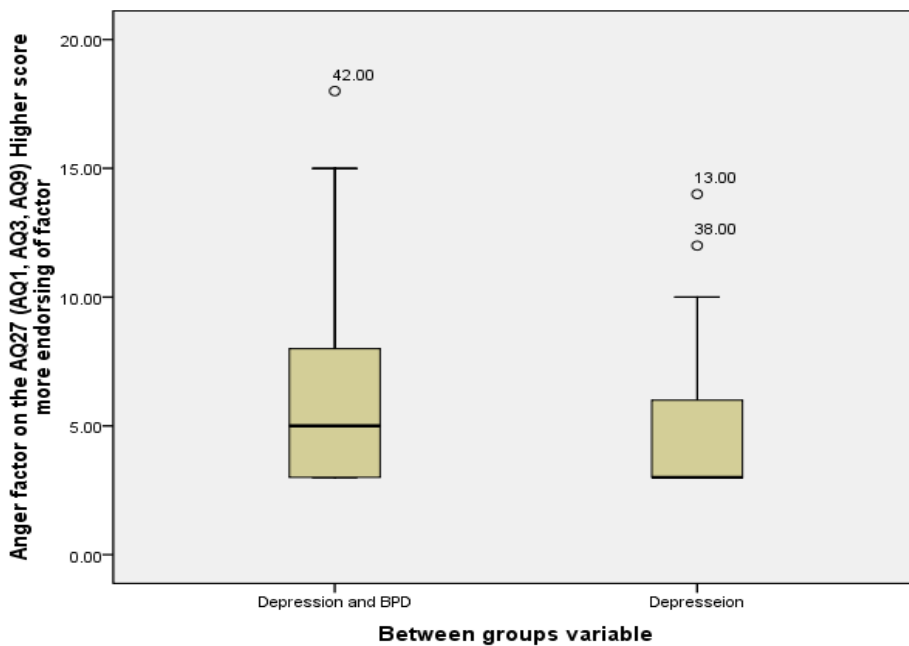
Histograms and box plots for the data on the helping behaviour factor for the BPD and depression and depression alone group in hypothesis two.



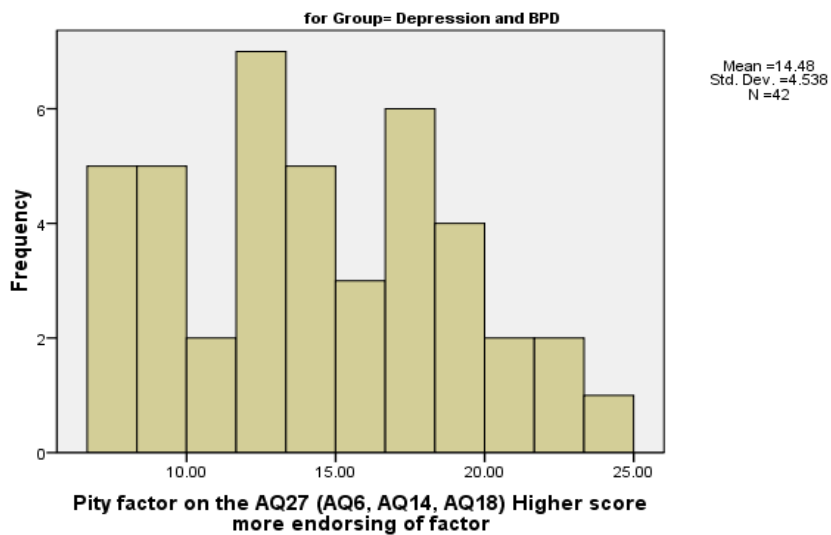


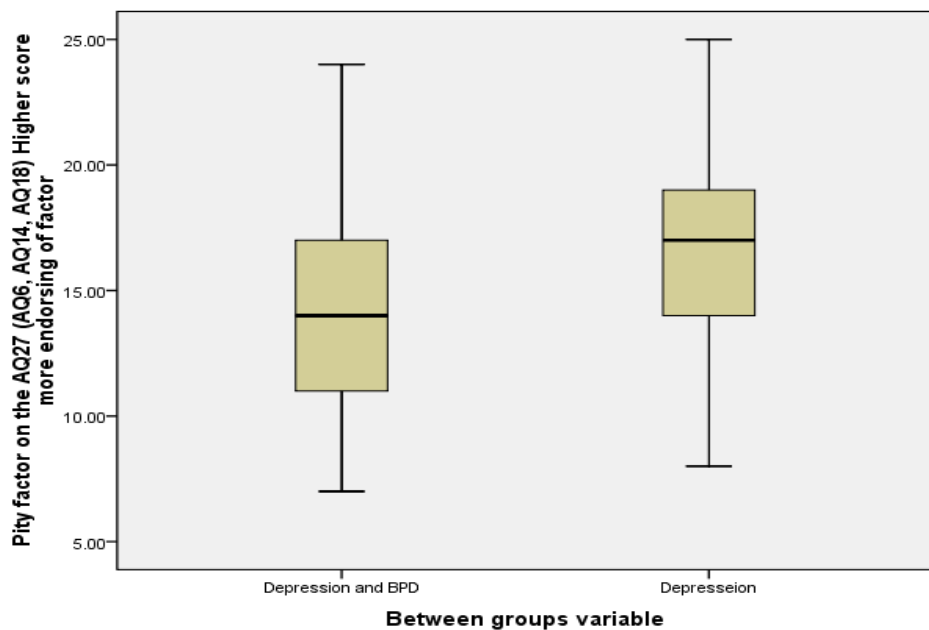
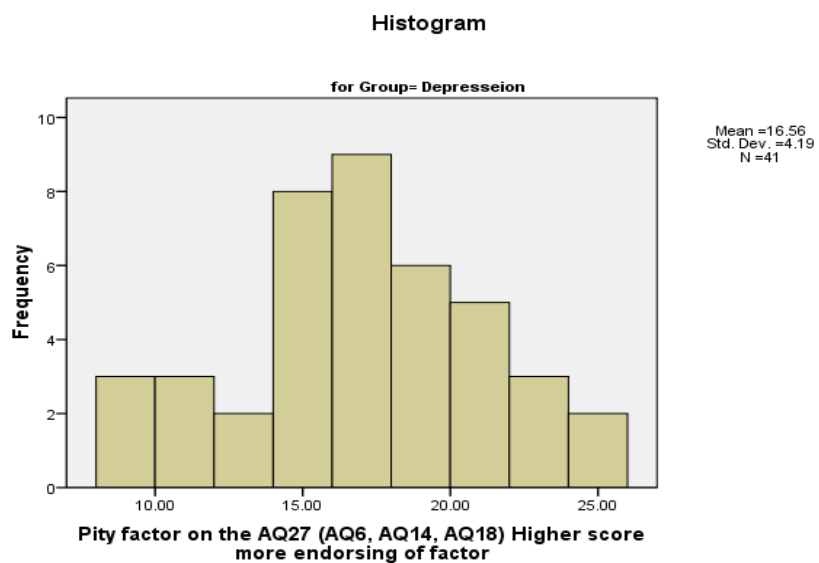
Histograms and box plots for the data on the fear, anger and pity factors within the depression group



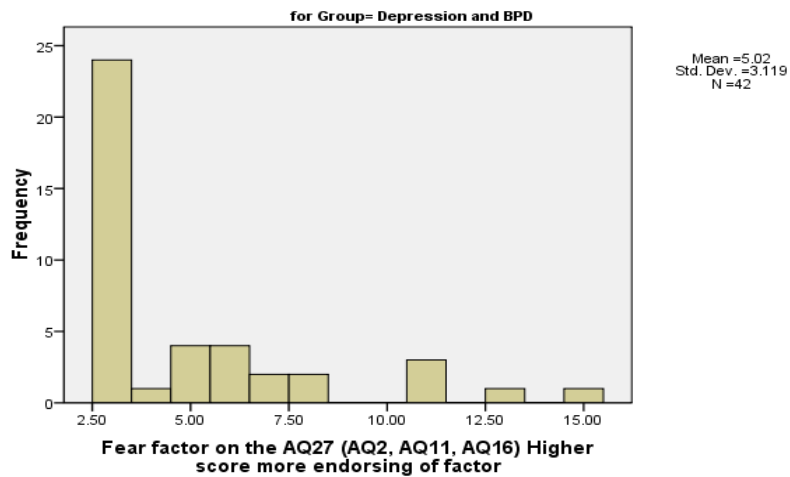


Histogram

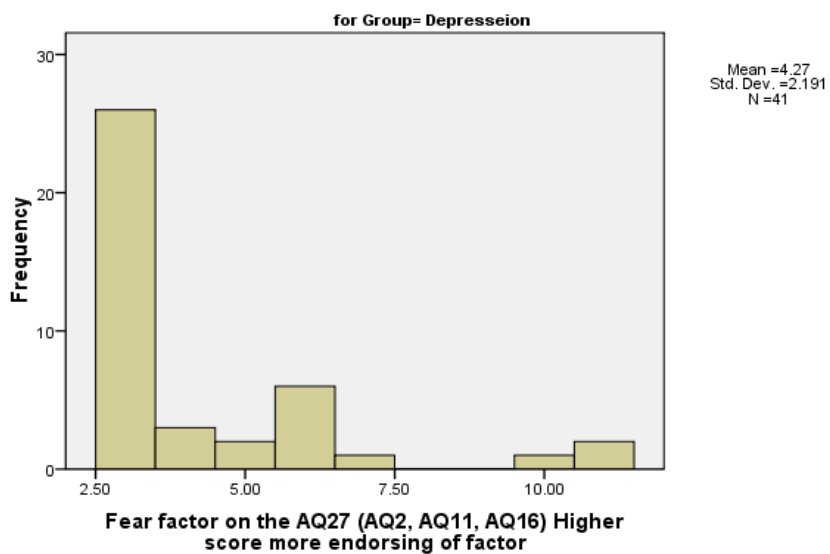


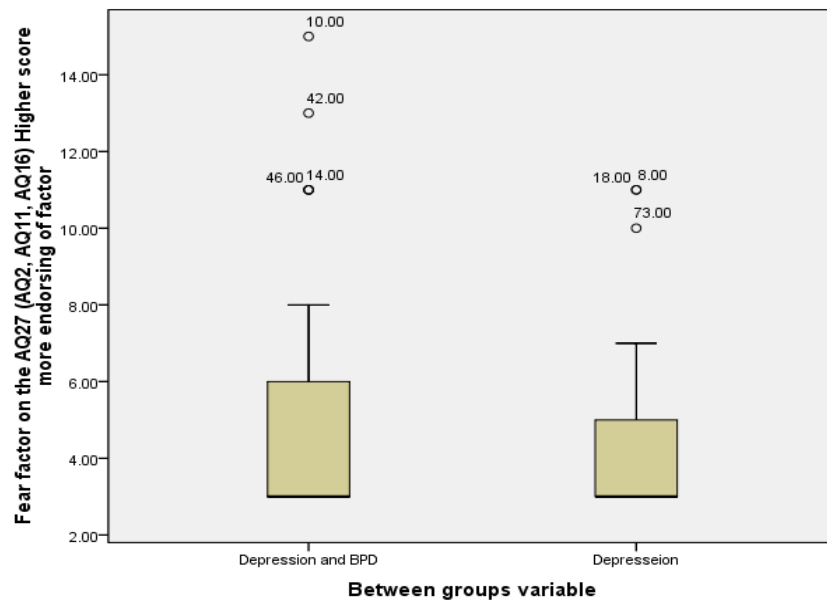


Histogram



Histogram





Appendix N

A sample of Scatterplots

This appendix is a sample of the scatterplots that were used to assess linearity of the data on all factors in hypothesis three within the depression alone group. All the scatterplots that were used in this research are available on request

