Finding Meaning in Chaos: *understanding mental health workers attitudes in relation to personality disorder*

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Introduction

The link between a diagnosis of mental illness and stigma has long been established and in recent years there has been an acknowledgment that, for personality disorder, this stigma is most evident within the mental health community (e.g. King,2014). Despite the development of policies and initiatives to combat this stigma; and the exclusion associated with this diagnosis, negative attitudes persist. This is acknowledged in current literature, but there are few studies that explore the meaning for this apparent 'stickiness'. There are important implications for service users as stigmatising behaviours can become intertwined with symptoms, and therefore amplify the distress experienced by service users (Aviram, 2006).

Methods

This research was conducted within a local mental health trust. Eight participants were recruited from a range of mental health settings and of various levels of seniority.

A semi-structured interview schedule was developed with the aim of answering the following two research questions:

(i) How mental health workers construct their knowledge and understanding of Personality Disorder?

(ii) How mental health workers experience working with personality disorder?

In depth interviews were conducted which were audio recorded and transcribed. A qualitative thematic approach was used to analyse these data, using a reiterative process.

References

Aviram, R. B. Brodsky, B. S. & Stanley, B. (2006) Borderline Personality Disorder, Stigma and treatment implications. *Harvard Review of psychiatry, 14 (5), 249-256*

King. G. (2014) Staff Attitudes towards people with borderline personality disorder. Mental Health Practice, 17 (5), 30-34

Findings and Discussion

All participants cited early traumatic experiences as a precursor for the development of a personality disorder. Some saw social class as a significant risk factor with the disparity between 'middle class' professionals and 'working class' patients seen as a barrier to understanding.

"…And some people don't understand how other people live … and that creates, like a divide. How can you overcome that?"

Participants spoke of inadequate training regarding PD and only those from a social work background felt that their training had equipped them adequately. Frequently, understanding of personality disorder and how to respond to, and manage patients was passed on by word of mouth - risking negative attitudes percolating within teams, allowing stigmatising cultures to be encouraged

"I never had any formal training about it, dealing with people with personality disorder, it just wasn't there"

Participants indicated that those undertaking further training often became 'go to' people for advice. Notably, an experiential training programme run from a PD Therapeutic Community was frequently referred to as a helpful resource, despite no longer running.
Opportunities to visit specialist services and see their work in action were also seen to be helpful.

Only those within specialist serives referred to the KUF PD awareness course.

Those who had training post qualification and clinical supervision appeared to have greater therapeutic optimism about the treatability of personality disorder and were more likely to cite the 'system' as a major barrier to positive outcomes rather than blaming the patient. A fragmented system was seen to compound the symptoms experienced by patients.

" … If you're distressed and you get a response from services that makes that distress worse then the service says your untreatable; but actually it's the service design'

For those who felt they had inadequate support and training the emotional impact of working with severely distressed patients could be experienced as overwhelming. These participants more frequently used negative words to describe their experience and had less therapeutic optimism.

Some participants did not fully understand the aims of specialist teams and expressed pessimism about the ability of other services to facilitate positive outcomes for service users. Although it was acknowledged by some that they saw service users within a specific time limited context.

"'… you know obviously people can recover and we have to remember that, but the point we are working we don't always see that."

Conclusions

This small study begins to show the importance of understanding the meaning behind negative attitudes in relation to personality disorder within mental health teams. Both the quality of support offered and the way mental health workers construct their knowledge of personality disorder can influence the development of either positive or negative attitudes. Inadequate training and support to make sense of their experiences may leave mental health workers feeling overwhelmed, and vulnerable to developing negative attitudes. Improvement in these areas and increased sharing of best practice between services, are essential ingredients if negative attitudes are to become 'unstuck' and a more hopeful experience is to be offered to service users.

Implications

- Professional training needs to include a greater focus on personality disorder.
- Provision of focused support and supervision for all mental health workers is needed, not just for those who work in specialist teams,
- Improved awareness of resources, and sharing best practice between and within services could help create more informed and hopeful teams.
- Increased use of experts by experience; or developing a role for personality disorder ambassadors, could contribute to informing mental health workers on the experience they provide for service users.