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Title

Staff Nurse Perceptions of the impact of Mentalization-Based
Therapy Skills Training when working with Borderline Personality
Disorder in Acute Mental Health – A Qualitative Study

Acronyms

BPD – Borderline Personality Disorder

FG – Focus Group

MBT – Mentalization Based Therapy

MBT-S – Mentalization-Based Therapy Skills Training

P - Participant

RMN – Registered Mental Health Nurse

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Abstract

Introduction

People diagnosed with borderline personality disorder (BPD) are highly prevalent in acute mental health wards, with staff nurses identifying a challenge in working with people who can be significantly distressed. This has contributed to a negative stereotype verging on stigmatization. Mentalization-based therapy (MBT) is a psychological therapy which has been shown to be of benefit to people with a diagnosis of BPD, but as yet it has been utilised and evaluated only in partial hospitalization and outpatient settings. Despite this, most people diagnosed with BPD will continue to be treated in generic inpatient settings such as acute mental health. Mentalization-based therapy skills training (MBT-S) is a new and cost-effective 2 day workshop aiming to provide generalist practitioners with MBT Skills for use in generic settings.

Aim/Question

This study aimed to capture staff perceptions of the impact of MBT-S on their practice when working with people with a diagnosis of BPD in acute mental health.

Method

Through 2 focus groups this study assessed the perceptions of 9 staff nurses. An interpretive phenomenological approach was utilised in data analysis.

Results

Participants found the approach easy to grasp, improving of consistency between staff and flexible in its use in planned or 'off the cuff' discussions. MBT-S promoted empathy and humane responses to self-harm, impacted on participants ability to tolerate risk and went some way to turning the negative perception of BPD through changing the notion of patients as 'deliberately difficult'. Staff felt empowered and more confident in working with people with a diagnosis of BPD.

Discussion/Implications for practice

The positive implication for practice was the ease in which the approach was adopted and participants perception of MBT-S as an empowering skillset which also contributed to attitudinal change. In acute mental health environments, which may not have the resources to provide long-term structured treatments to patients, MBT-S could be viewed as ideal as participants applauded its flexibility. The promotion of empathy also sees a move away from iatrogenic damage caused by unhelpful responses to self-harm. In the context of wider research, this study shows that staff nurses find the MBT-S skillset valuable in the generic inpatient setting of acute mental health.

Keywords

Acute Mental Health, Borderline Personality Disorder, Mentalization-Based Therapy, Mentalization-Based Therapy Skills Training, Staff Nurse Perceptions

Accessible Summary

What is known about the subject?

- People diagnosed with borderline Personality Disorder (BPD) can raise anxiety in health professionals and constitute a high proportion of psychiatric inpatients in generic settings.
- Mentalization-Based Therapy (MBT) is an evidence-based psychological treatment effective in the treatment of people diagnosed with BPD, but this has been used and evaluated only in specialist settings.

What this paper adds to existing knowledge?

- Mentalization-Based Treatment Skills Training (MBT-S) is a new and compact 2 day workshop which aims to provide mental health professionals with MBT skills for use in generic healthcare settings and has never been evaluated.
- This study assesses staff nurse perceptions of the impact of MBT-S on their practice when working with people with a diagnosis of BPD in the generalist setting of acute mental health wards.

What are the implications for practice?

- Staff nurses perceived MBT-S as a straightforward but empowering skillset which also contributed to attitudinal change to people diagnosed with BPD. MBT-S promoted empathy as a response to instances of self-harm which removes the potential of a vicious cycle of iatrogenic harm.
- Staff found MBT-S to be flexible in its structured or 'off the cuff' usability, a desirable attribute in acute mental health where people diagnosed with BPD primarily present in crisis and not for long-term structured treatment.

Introduction

Borderline Personality Disorder (BPD) is characterised by instability in interpersonal relationships, self-image and mood, a rapid fluctuation between emotional states, impulsive behaviour and a tendency towards self-harm and suicidal thinking (NICE, 2009). The many challenges that come with treating people diagnosed with BPD are felt intensely by staff nurses working in acute mental health settings, who often feel impotent in their ability to make progress and confused as to a clear purpose of admission (Markham and Trower, 2003, Woolaston and Hixenbaugh, 2008, McGrath and Dowling, 2012). Whilst psychological therapies such as Mentalization-Based Therapy (MBT) have been shown to have a positive effect on outcomes such as self-harm and suicidality, they have been delivered

in specialised partial hospitalization or outpatient settings (Bateman and Fonagy 1999, 2001, 2008, 2009, Bales, 2012). Mentalization-Based Therapy Skills Training (MBT-S) presents generalist practitioners such as registered mental health nurses (RMN's) with the skills used in MBT, intending a psychological focus to treatment, deliverable in a generic environment.

People with a diagnosis of BPD often find themselves in crisis, with an estimated prevalence within mental health inpatient services at up to 20% (Zanarini et al, 2001). These crises often manifest as episodes of self-harming, self-destructive and suicidal behaviour, and health professionals can feel apprehensive regarding what may happen without intervention (Fagin, 2004). Therefore, people are often admitted to acute mental health wards for 'crisis admissions', designed to manage any immediate risk of harm whilst promoting recovery (Borschmann et al, 2012). However, these admissions can be both frequent and lengthy (Dasgupta and Barber, 2004), proving to be a serious financial burden on the NHS whilst lacking a clear purpose or measure of effectiveness. Although hospital admission is common, expert opinion remains unconvinced, in its current state, that it holds any value (Paris, 2008, Bateman and Krawitz, 2013).

Unstable interpersonal relationships in BPD are sometimes rooted in reactions triggered by misunderstanding and misinterpreting the motives of others. Given that this challenge in interpersonal relations may be a contributory factor to impulsive and self-destructive behaviour, the acute mental health environment itself

can be counterproductive. Whilst hospital admission may contain any immediate risk, the underlying issues are often not addressed. Wards which have 28 patients aged between 18 and 65, mixed sex, all presenting as acutely unwell with a variety of disorders can foster a web of misunderstandings. A patient can move from a crisis in the community to further and 'fresh' crises within the hospital setting, as they misinterpret the motives of a multitude of doctors, nurses and patients, potentially all of whom they will be meeting for the first time. A patient's self-harming and suicidal behaviour can potentially increase to a malignant regression (Dawson and McMillan, 1993), where the patient becomes more suicidal in hospital. This process sees the patient met with a response to suicidality and self-harm that they have not received out-with the hospital environment, and thus acts to reinforce the patient association between self-destructive behaviour and the time and attention they receive. The continued desire for the caring response, or the perception that there has been no caring response (Watts and Morgan, 1994), can see an escalation in suicidality.

Literature

Often disputed in their status as true mental illness (Kendell, 2002), personality disorders have been burdened with the notion that patients have complete control over their behaviour. This can therefore reduce the seriousness at which symptoms are viewed by clinicians (Lewis and Appleby, 1988, Adshead, 2001). BPD in particular suffers from the 'mad or bad' dilemma, with dispute over

whether presentations are genuinely psychiatric in nature, or simply a deviation from the social norms we take for granted (Nyquist Potter, 2009). Debate aside, the significant distress experienced by people diagnosed with BPD being on a par with that of 'typical' mental illnesses dictates an appropriate empathetic response (Nyquist Potter, 2009). Moreover, arguments over whether BPD exists as a true mental illness or a social condition should not distract from increasing understanding, and putting effective treatments in place (Bateman and Krawitz, 2013).

In terms of inpatient care, studies have shown staff frustration as RMN's experience personal distress in working with people diagnosed with BPD, seeing their patients as demonizing, threatening, manipulating, time consuming (Woolaston and Hixenbaugh, 2008, McGrath and Dowling, 2012) and deliberately difficult (Markham and Trower, 2003). This can lead to a negative attitude towards the disorder, with sustained experiences of patients in acute distress developing into a stigmatization. This worryingly moves back towards a time when BPD was pessimistically viewed as untreatable (Bateman and Tyrer, 2004).

MBT is a psychological therapy designed specifically for the treatment of persons diagnosed with BPD (Bateman and Fonagy, eds, 2012). Mentalizing refers to the implicit and explicit process by which we make sense of ourselves and each-other through awareness of subjective mental states (Bateman and Fonagy, 2010). People diagnosed with BPD may have a reduced capacity to

mentalize, which might contribute to to problematic impulsive behaviour and unstable interpersonal relationships (Bateman and Fonagy, 2010). MBT is delivered in specialised settings in a structured programme which also provides integral clinical supervision (CS) for staff. CS is specifically recommended for staff working with this patient group (Bland and Rossen, 2005).

MBT's key principles include an inquisitive approach to mental states, support and empathy, clarification, exploration and the discussion of alternative perspectives (Anna Freud Centre, 2014, p.20). The aim is to promote self-reflection through exploration of the mental states of self and others. It is cost-effective in that it can be delivered by generalist practitioners without extensive training. The treatment is evidence based through randomised control trials and follow up, having shown positive progress in many outcomes, particularly expressions of crisis such as self-harm and suicidality (Bateman and Fonagy, 1999, 2001, 2008, 2009, Bales et al, 2012). It is acknowledged however that most of these studies on MBT have been conducted by those who have manualised it. This raises the question of a potential bias which can only be addressed by further independent research. MBT is delivered in specialised settings, such as partial hospitalization and outpatient programmes. However, most people with BPD will continue to be treated in generalist mental health settings (Bateman and Krawitz, 2013, p.36), such as the inpatient environment of acute mental health.

Addressing this imbalance, MBT-S is a 2 day workshop which presents generalist practitioners with MBT skills for use in generic settings.

Whilst practitioners are not trained to deliver a structured programme of MBT, MBT-S aims to provide staff with the key skills and principles for utilisation in their clinical practice (T1).

T1: Mentalization Based Therapy Skills Training (MBT-S)

(Adapted from The Scottish Personality Disorders Network, 2015 and The Anna Freud Centre, 2014)

Description

MBT-S is a 2 day workshop which aims to provide generalist mental health practitioners with the skills utilised within the full MBT programme. It is appreciated that many people diagnosed with BPD will present to generic settings such as acute mental health and as such these specialist skills have been made available within an accessible format. Attendees do not become qualified MBT therapists, but can develop the skills for more effective therapeutic relationships. MBT-S is differentiated from MBT, as delivery of MBT would be within the defined setting of a specialist intervention. In Scotland, completion of MBT-S is a pre-requisite to continued development through MBT Basic Training.

Delivery

MBT-S is delivered over 2 separate days preferably separated by a couple of weeks to allow participants to practice their skills and complete allotted tasks. The format is a combination of didactic

teaching, role play and DVD clips. To maximise the small group experience, the training is preferred with a ratio of 1 trainer to 10 participants.

Key Principles

- Understanding mentalizing, recognising non-mentalizing and having an awareness of approaches to restore mentalizing.
- Distinguish four types of mentalizing problems: concrete understanding, context-specific non-mentalizing, pseudo-mentalizing and misuse of mentalizing.
- Adoption of the not-knowing stance, whereby practitioners make a genuine inquisitive and curious approach to patient mental states.
- Understanding support and empathy as key to establishing and maintaining effective therapeutic relationships.
- An ability to clearly re-state, clarify and elaborate for the client the practitioners understanding of thoughts, feelings, beliefs and other mental states described by the client and to do so in a way that opens discourse about these rather than closing it off.
- Able to use basic mentalizing interventions: 'stop and stand', 'stop, listen, look', 'stop rewind explore' and 'labelling with qualification'.
- An ability to offer alternative perspectives for consideration.

- An ability to make use of the here-and-now relationship with the practitioner to help the client identify failures of mentalization and explore their consequences.

This study provides new insights given MBT-S is a new incarnation and remains unexplored in terms of nurses subjective assessment of its value. Furthermore, the MBT approach has been untested in the acute mental health setting, where patients often present in crisis and distress. Finally, there have been no studies on staff perceptions of the MBT approach.

Aim / Question

The aims of the study were to provide a contextual staff perception of issues arising from working with people with a diagnosis of BPD in acute mental health, and explore staff perceptions of any subsequent impact MBT-S had on their clinical practice. The study aimed to capture the lived experience of staff working with people diagnosed with BPD presenting in times of crisis, assessing staff perceptions of MBT-S through its 'usability', the value of the associated clinical supervision, and addressing any impact on their attitudes and negative stigma associated with the disorder.

Methods

Design

The phenomenon under investigation were the experiences and perceptions of staff nurses, therefore a qualitative phenomenological approach was adopted. Husserl (1960) is credited with the founding

of phenomenology, an approach which aims to capture descriptions of lived experiences. Husserl (1960) advocated a phenomenological reduction, a complete suspension of the researchers' beliefs and preconceptions in order that participants' views could be represented accurately. Whilst the merits of this approach were clear in terms of accuracy, it was obvious to the researcher that this neutrality would not be possible. The researcher had worked as a staff nurse in acute mental health in the hospital setting under study. Furthermore it had been experiences of working with people diagnosed with BPD, and attendance at MBT-S and MBT basic training, that had inspired and shaped interest in this study.

Heidegger (1962) and Gadamer (1976) expanded on the phenomenology of Husserl, although refuted the value placed on the phenomenological reduction. Moving from description to interpretation, and away from the idea of research validity requiring detachment, they instead promoted the idea that we necessarily require our own experience as a contextual foundation for making sense of any phenomena. Heidegger's (1962) hermeneutics were an interpretation of the Dasein, his term to illustrate 'being there'. His assertion was that we could not make sense of 'being there' if detached from the world. Gadamer (1976) built on this foundation, introducing the useful concepts of prejudice, the hermeneutic circle, and fusion of horizons.

Prejudice (Gadamer, 1976) refers to pre-existing knowledge and preconceived ideas which Gadamer (1989) insists are integral to how

we make sense of the world. The notion is that a true understanding can only take place within our prejudice, not from outside. Therefore previous knowledge and experience is seen as a benefit to, and not contaminant of, research.

The hermeneutic circle (Gadamer, 1989) refers to the connection between the whole and sum of its parts. The circular process is that the thing being studied cannot be understood without examination of each of its parts, with each part meaningless if examined outside the context of the whole. The researcher is placed within this circle, which is described as the fusion of horizons (Gadamer, 1989). The fusion of horizons, with horizon referring to all that can be seen from a particular perspective (Gadamer, 1989), involves the furthering of understanding and an evolution of that which is already known. The idea is that we remain open to the meanings presented within a study, with an acute awareness of researcher prejudice. Any unique and hidden meanings are highlighted through utilising prejudice as a backdrop. Through fusing researcher prejudice with the findings of the study, the phenomena benefits from a new and unique perspective, and therefore creates a new horizon.

In order to learn something new, the previous experience of the researcher was seen as an asset rather than a burden, and the approach deemed most appropriate was an interpretive phenomenology founded on the ideas of Gadamer. Whilst the exploration of the question required a description of the participant's voice, it was clear that only through an interpretation of this within

the context of the study and researcher prejudice that new understanding could emerge.

Sample and Setting

9 staff nurses participated in the study. A purposive sample was identified as RMN's, working across 4 acute mental health wards in 1 hospital, having completed MBT-S with at least 6 months to use the approach in clinical practice. Of the 18 RMN's who had completed MBT-S, 9 participated in the study, giving a participation rate of 50%. Reasons for non-participation varied, with some potential participants having left the acute mental health area post MBT-S, some being unable to leave clinical areas to participate if allocated to be on shift, and others being unwilling to participate if on a day off.

Data Collection

Data was collected using 2 focus groups. Given the author had a previous working relationship with many of the participants, a neutral party, a member of the practice education team, was recruited as facilitator to limit potential bias. Whilst researcher prejudice was seen as an asset for the interpretation of data, it was felt that during data collection this should be minimised. Allocation of participants to each focus group was based on availability, with a split of 5 in the first group and 4 in the second. The focus groups were facilitated within the hospital, in seminar rooms away from clinical areas. Data collection was aided by a semi-structured topic guide, which framed the discussion in a timeline of 'before' and

'after' the MBT-S training. The guide was used to provide the facilitator with a plan whilst still allowing any interesting unforeseen data to be explored, also giving a timeline and narrative structure to findings. The facilitator ensured to clarify participants views throughout each group to avoid misrepresentation in the findings. Each focus group was audio recorded and manually transcribed verbatim by the author. Focus groups were 60 minutes in length.

Data Analysis

Transcriptions were analysed as a group opposed to focusing on individuals, and coded by the author using an exploratory thematic analysis. There were three cycles of coding. The first cycle saw the topic guide used to order the discussion into a narrative, whilst the second cycle saw a detailed analysis and interpretation of the transcription, with a labelling of major themes. The third cycle re-explored participants views and researcher interpretation, capturing specific examples and quotes representative of these perspectives.

A single narrative comprising 4 primary themes (T2) captured 7 secondary themes directly relevant to MBT-S (T3). All are presented in the results section. Besides the first cycle, all themes were derived from the data. No computer software was used.

T2 - Primary Narrative Themes

1. Contextual Baseline
2. The Impact of MBT-S

3. Clinical Supervision
4. Change in Staff Perceptions of BPD

T3 - Secondary MBT-S Themes

- Common Sense Approach
- Consistency of Approach
- Empathy
- Flexibility
- Empowerment of Staff
- Tolerating Risk
- Limitations

Ethical Considerations

Ethical approval was sought from the local Research and Development office and the North of Scotland Research Ethics Service. This process included committee review of the research protocol, participant information sheets, consent forms and focus group topic guide. A site-specific form was completed to allow the study to take place in NHS premises. Approval was granted before beginning recruitment to the study. Informed consent was assured by allowing participants 4 weeks to read the information sheet and ask questions. Written consent was obtained immediately prior to each focus group. Participants were assured of their right to withdraw, and anonymity in presentation of the findings.

Results

1 - Contextual Baseline

To provide a baseline context for exploration of MBT-S and participants perception of its impact, the first question was aimed at the 'inpatient care of patients with a diagnosis of BPD', with a necessary additional theme of the 'impact on staff' prior to training. The inpatient environment was noted as extremely busy and not conducive for working therapeutically.

FG2 P4 "I just think that the specific management of people with borderline personality disorder is not very suited to a very busy acute psychiatric ward to be honest... the environment is not always conducive".

Working with people diagnosed with BPD was described as tiring and draining, frustrating and personally distressing. Participants described an uncertainty in how to approach patients and confusion as to the purpose of admissions which were recognised to be both frequent and lengthy.

FG1 P3 "Sometimes we get people in and they come in for two days, then they go home for a week, then they come in for three days and it's just back forth back forth back forth back forth, that you just, you don't know what you're doing with them anymore".

Participants described the "back, forth" admission cycle, and one patient who had remained in hospital for:

FG2 P2 “three or four years”.

These ideas were consistent with related literature, finding significant personal distress and negative staff perceptions towards patients with BPD (Markham and Trower, 2003, Woolaston and Hixenbaugh, 2008, McGrath and Dowling, 2012). One participant captured this negativity, stating:

FG1 P3 “I think they suck the life out of you to be perfectly honest...”

2 - MBT-S Themes

Common Sense Approach

MBT has been described as a “common-sense view of the mind” (Bateman and Fonagy, 2009, p.1363), and participants explained their smooth transition in adopting the approach. Participants recognised the implicit nature of mentalizing, a participant stating that:

FG1 P4 “a lot of it is kind of natural anyway” and “before we had any mentalization, we probably did the same sort of techniques”.

This required minimal adjustment from ordinary practice. However, beyond participant’s implicit mentalizing abilities was a recognition that they could approach things differently and more explicitly.

FG2 P2 “In the training there was things that you recognised that you think, oh actually we do do that, but we never had any formal training on it, so it was, so we’re doing that right, but maybe there’s something else we could do differently”.

Consistency of Approach

Participants felt that between staff who had completed MBT-S, there was an improved consistency in approach to patients. Given that people diagnosed with BPD have been described as splitting staff teams into contrastingly firm and controlling versus over-tolerant and overprotective approaches (Fagin, 2004), consistency is integral.

Participants had agreed that between those who had attended MBT-S:

FG1 P2 “we all kind of work to the same goal and with the same purpose”.

This provides an element of structure in a chaotic environment through a shared approach where, a participant described:

FG1 P2 “it’s not somebody saying one thing and somebody says something else”.

Empathy

Participants understood empathy, a key component of the MBT approach, as a building block of any therapeutic relationship. A positive aspect of this was its ability to push nurses away from the idea of self-harm as a behaviour which required only a pragmatic physical response.

FG1 P1 “When somebody self-harmed... you just kind of dealt with it... cleaned it up give them a plaster, but I think they were saying at the training it’s, that’s not a normal thing to do. Why should you just go and clean it up and that’s it done with? You should kind of act

like, 'oh my goodness what have you done there', then sit down with them and speak about it."

Here the participant had adjusted their approach to a more natural and indeed humane response. There was an understanding that before any therapeutic engagement could take place, nurses needed to as fully as they can, get alongside their patients and their emotional states.

Flexibility

MBT skills were used in both structured 1-1 sessions with patients, as well as in immediate response to ward based crises such as self-harm.

FG1 P4 "You can focus on a little problem, whatever's triggered the crisis... you can actually go in and say ok what's upset you today and you can start the process that way... or actually having a long one to one with somebody, and actually using it as like a fixed process, that's the structure of your one to one... you can... you vary it."

MBT-S was used to promote recovery through self-reflection. In its structured or 'off the cuff' state, the flexible use of MBT-S was seen as a valuable property in the unpredictability of acute mental health.

Empowerment of Staff

Participants described a move away from the uncertainty marked at baseline. One nurse stated:

FG1 P3 "I just feel like I know what I'm doing a little bit more"

Whilst another stated:

FG1 P5 “It’s almost like having a secret weapon that you can actually use, and you can actually see a difference with it”

This asserts the view of MBT skills as a useful tool which has a visible impact on patients. Although “secret weapon” is a combat metaphor, it appeared to reflect staff feeling empowerment in the difficult ‘trenches’ of acute mental health as opposed to representing people with a diagnosis of BPD as ‘the enemy’.

Tolerating Risk

Another positive aspect of the approach came in giving staff the self-confidence to discuss self-harm and suicidality without making risk-specific measures, such as constant observation of patients, inevitable. One participant described the impact of MBT-S on their ward’s ability to tolerate risk:

FG2 P1 “I think as a ward we feel that we’re less likely to put somebody with a borderline personality disorder on an ob (constant observation)... at the weekend we had somebody that cut really quite badly it was a 999 job, bloodbath basically... now before I think, as a ward, as nurses we would have said right ob. But no, we knew she was heading towards discharge and we kind of thought ok, so she’s anxious. This is why she has cut... she’s anxious about going home this week, this is her way of telling us she’s anxious. So we took her up to A&E and got it dealt with, came back down and we didn’t put her on, we sat with her and we spoke through it, and we empathised

with her you know you're anxious you're going home, but we didn't put her on an ob."

The participant felt that following MBT-S, they could discuss the patient's thoughts and feelings without having to react through putting the patient on constant observation. Tolerating risk in this way allows the patient the opportunity to understand their own mind and behaviour without having their personal responsibility removed through overly restrictive responses to risk. This sees a move from pragmatic reactions to behaviour to a psychological and empathetic response to distress.

MBT Skills Limitations

Whilst there were no direct criticisms of the approach, it was noted that the time spent with patients did not lessen, and the notion of people diagnosed with BPD as time consuming remained.

Furthermore participants again raised the issue of the acute mental health environment, suggesting that in order to use MBT-S effectively they needed more time to speak to patients. Barriers to this were noted as ongoing staffing issues and level of clinical activity. As one participant explained:

FG1 P3 "Last time I would say I was probably having quite a good one to one with somebody and I felt like I was using my skills, another member of staff came into the interview room and pretty much in a polite way told me to kind of get back, that they needed me out on the floor".

3 - Clinical Supervision

Following MBT-S training, all participants had been offered the opportunity to attend group clinical supervision (CS). Given that only 3 of the 9 participants had been able to attend, the overall perception of this was difficult to measure. However, the fact that two thirds of the sample had not been able to attend spoke volumes as to the activity in clinical areas, and the lack of protected time. Those participants who had not experienced CS did voice a willingness and enthusiasm to attend.

Of the 3 participants that had attended, all found it to be extremely useful. Key themes emerged as consolidating the MBT model, providing reassurance and peer support, increased self-confidence in nurses, ensuring consistency and adherence to MBT-S, and strategies for moving forward with severely distressed patients. As one participant explained:

FG1 P1 “Yeah, it gives you a bit more confidence... a bit more ammunition as well, from the advice... you do go away with... an improved sense of ‘well ok you know, I’m not doing it completely wrong’”.

‘Ammunition’ is another combat metaphor, which interestingly was raised by a different participant within the alternate focus group. This echoed the view of the acute mental health environment as a ‘battlefield’, and did not appear to mark people diagnosed with BPD as ‘the enemy’. ‘Ammunition’ reflected the participants feeling of

empowerment in their ability to make positive changes to patient mental states.

4 - Changed Staff Attitudes to BPD

Given the negativity around staff perceptions of people with a diagnosis of BPD at baseline, participants were asked whether their perceptions had changed. The primary change following MBT-S was the perception of intent. Participants had more of an understanding of the reasons behind behaviour, and no longer saw patients as being deliberately difficult. This saw improvements in levels of frustration, and therapeutic relationships through an increased capacity for empathy.

FG2 P2 "I think it makes it less frustrating, if you can kind of sit back and think about why the person is doing it... and maybe it helps you be a bit more empathetic"

Discussion

This small study explored staff perceptions of the impact MBT-S had on their practice and attitudes when working with people diagnosed with BPD in acute mental health. There was overall more hope and optimism compared to baseline. Finding the approach easy to grasp, participants found increased consistency between them and their colleagues. Further changes included the understanding of empathy as the foundation of the therapeutic relationship and an appropriate response to self-harm. Staff felt less impotence, describing empowerment in their perception of their acquired ability to make a

visible difference to patients in structured or 'off the cuff' discussions. Participants also felt they had a greater ability to tolerate risk, essential given the chronic risk of suicide and self-harm in some patients. Finally, MBT-S had a positive impact on changing staff attitudes towards people diagnosed with BPD, with participants noting a change to the notion of intentionally difficult behaviour as conducive to greater understanding and empathy. Clinical supervision was thought to be beneficial though staff were not provided with protected time to attend.

The fundamental progression fulfilled by this paper is staff nurse perceptions of the MBT approach within a generic inpatient mental health setting. Whilst MBT has been proven an effective treatment method, this has been done so in randomised controlled trials in partial-hospitalization and outpatient settings following a structured programme of care (Bateman and Fonagy, 1999, 2001, 2008, 2009, Bales et al, 2012). The challenge in evaluating these existing studies includes assessing not only the value of MBT, but taking into account any hidden value of the milieu and structure. MBT-S aims to provide professionals with MBT skills, but lacks the specific environment or structured programme. As such this paper not only provides a new insight into staff nurse perceptions of the value of MBT-S, but also examines perceptions of the MBT approach in a generic and unstructured environment.

This paper measures the MBT approach through the lived experience of staff nurses in acute mental health, where existing literature did

not prioritise the nurse experience as an outcome measure. The value in assessing staff perceptions is marked by existing studies which detail significant issues for staff nurses working with this client group (Markham and Trower, 2003, Woolaston and Hixenbaugh, 2008, McGrath and Dowling, 2012). This study, which shows overall positivity through the 7 MBT-S themes, addresses many of the issues described in these studies. In particular the progress surrounding participants empathy for people diagnosed with BPD directly contributed, within this small study, to a reduction in negative stereotyping and stigma. Although it may sound absurd to have to 'teach' empathy to mental health nurses, this process is more complex. MBT-S promotes empathy through an increased understanding of BPD and explains the inherent value of not only having empathy, but making it explicit as a base for effective therapeutic relationships. The iatrogenic harm done to people diagnosed with BPD has often been described as stemming from health professionals responses to self-harm, with patients viewed as 'attention seeking' and feeling as if they are wasting staff time (Pembroke ed, 1996, Baker, Shaw and Biley eds, 2013). This perpetuates a vicious cycle whereby the patient's self-harm may increase as a result of the self-loathing induced by non-empathetic responses to their distress (Pembroke ed, 1996, Baker, Shaw and Biley eds, 2013). The promotion of empathy within MBT-S moves away from this damaging response, towards a more person-centred, and non-judgemental approach.

The necessity of training such as MBT-S is emphasised by the prevalence of people diagnosed with BPD in acute mental health environments. However, MBT and MBT-S are not the only psychological interventions. Dialectical behavioural therapy (DBT) (Lineham, 2014) for example, based on cognitive behavioural therapy (CBT), has the most extensive evidence base for working effectively with people diagnosed with BPD (Stoffers et al, 2012). DBT is fundamentally a problem solving behavioural approach which is founded on the idea that the root of BPD is in a predisposition to emotional dysregulation (Swenson et al, 2001). MBT and MBT-S differ from DBT in being psychodynamic in nature and based on the notion that BPD is characterised by a failure to mentalize which stems from disorganised attachments (Bateman and Fonagy, 2010). Despite this, there is significant overlap between both the MBT and DBT therapeutic stances, though as yet the two approaches have yet to be directly compared through treatment trials.

Whilst there have been examples of DBT fully implemented into inpatient units (Bohus et al, 2004, Kroger et al, 2006, Soler et al, 2009) these have been for a set period of three months. This would not appear to fit the philosophy of the acute mental health unit studied, in which persons diagnosed with BPD are primarily admitted for crisis admissions which should not last longer than a month (Borschmann et al, 2012). The acute mental health unit caters to managing immediate crisis, and does not provide a structured programme of treatment.

Nursing in acute mental health environments has sometimes been described as fire-fighting (McGeorge and Rae, 2007), referring to a reactive process of nursing where care and treatment is not so much planned, as a responding to incidents and situations as they arise. Some people with a diagnosis of BPD can be impulsive, particularly when in periods of crisis which may be associated with hospitalization. As such the flexible and 'off the cuff' approach of MBT-S is ideal.

Furthermore it has to be stressed that MBT-S is not therapy, but a toolbox of the skills used in its parent therapy. As such it is not a format to a structured programme, but a skillset which it could be argued is more appropriate to the acute environment. However, this paper makes no judgement on the suitability or likelihood of success DBT may have in acute mental health were it implemented in its similar skillset simplification.

Attitudinal change within participants was positive, this had however been achieved previously within other brief BPD education workshops (Krawitz, 2004, Commons Treloar and Lewis, 2008, Shanks et al, 2011). MBT-S however showed, in this small study, both an attitudinal change, and a feeling of empowerment in staff. Whilst a changing of attitudes is a necessary foundation for working with people with the diagnosis, a skillset is also required. MBT-S was perceived to provide both the positive attitude and skillset necessary for working with people at their most distressed.

It is essential that staff nurses have the appropriate knowledge and skills to work with people with BPD effectively. MBT-S is valuable in its accessible and cost-effective set-up. The 2 day workshop is feasibly deliverable to all RMN's, not requiring significant leave from clinical areas, and not incurring the significant expense of many psychological therapies. With the key aim of this study the assessment of MBT-S through staff perceptions, there was a positive take on the value of the training in attitudinal change and it's usability in working with people diagnosed with BPD in the acute mental health environment.

Limitations

The limitations of the study are in its small sample size, limited to 9 staff nurses in 1 hospital. Moreover, given 6 of the 9 participants had not attended the CS, there could be questions raised over whether they were delivering a 'true' MBT approach.

The researchers position as former staff nurse within the acute mental health environment, as well as attendance at both MBT-S and MBT basic training has to be acknowledged. To limit bias, the focus groups were guided by a neutral facilitator who utilised a semi-structured topic guide, allowing the covering of key themes whilst capturing anything else participants wanted to raise.

Participants were encouraged to be honest, with no pressure to indicate one way or another whether MBT-S had made a difference to them. The facilitator was given no agenda for the capture of a

particular opinion. Whilst the interpretation was entirely subjective and carried out by the lead researcher, the emic position was seen to be of benefit to the study. The emic position was used to pull out further detail whilst remaining true to the voices of individual participants. As such, analysis was completed without a preconceived dataset.

Finally it is acknowledged that any phenomenological research is limited in its generalizability. This study does not claim to represent a universal lived experience of the issues examined through the perceptions of staff nurses. However it is seen as a valuable snapshot of a particular environment, and a potential catalyst for further research.

Implications for Practice

Given the prevalence of people with BPD in acute mental health settings, an accessible workshop such as MBT-S is ideal to provide nurses with the attitude and skills needed to maintain a therapeutic alliance. MBT-S is easy to grasp, allowing a straightforward implementation as nurses have little adjustment from their ordinary practice. Moreover, MBT-S is perceived as a staff empowering skillset which contributes to attitudinal change, and could be said to be ideal for the acute environment where long-term treatment plans are unsuitable, and the potential for 'fire-fighting' requires an 'off the cuff' flexibility.

Tolerating risk is essential given that some persons diagnosed with BPD can be at chronic risk of suicidality and self-harm, and in equipping nurses with psychological therapies they can move away from overuse of restrictive and potentially counterproductive measures such as constant observations. Empathy is the key to any therapeutic alliance, and MBT-S encouragement of this characteristic promotes more person-centred care, avoiding the iatrogenic harm attributed to unhelpful responses to self-harm. Further research is necessary both on staff perceptions on MBT-S, and on its impact on specific clinical outcomes such as frequency and length of admission. It would also be useful to see similar studies on staff perceptions of the DBT approach in acute mental health environments, allowing a gauge of the similarities and differences of BPD specific training on attitudes and feelings of staff empowerment.

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