CNS Spectrums

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Psychiatric providers' attitudes toward patients with borderline personality disorder and possible ways to improve them

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Original Research

Cite this article: Ukwuoma DU, Ajulu KA, Wang D, Golovko S, Marks J, and Leontieva L (2024). Psychiatric providers' attitudes toward patients with borderline personality disorder and possible ways to improve them. *CNS Spectrums* **29**(1), 65–75.
https://doi.org/10.1017/S1092852923006326

Received: 23 May 2023
Accepted: 25 September 2023

Keywords:
Borderline personality disorder; positive transference; negative transference; health professionals; attitudes

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Abstract

Objective. Tending to patients with a diagnosis of borderline personality disorder (BPD) is a challenging task for clinicians due to stigma and differences in opinion within the psychiatric community. Various symptoms of BPD including affective instability, mood reactivity, and extremes of idealization are associated with challenging emotions toward patients with BPD. This observational research study utilized an adaptation of the 37-question Attitude to Personality Disorder Questionnaire (APDQ) to assess the attitudes of clinicians toward patients with BPD.

Methods. This questionnaire was distributed to 139 clinicians including psychiatry attendings, psychiatry residents, registered nurses, nurse practitioners, social workers, recreation and art therapists, and psychologists who worked with patients diagnosed with BPD on an inpatient unit. Responses of participants were compared based on occupation, gender, and duration of years worked on an inpatient psychiatric unit.

Results. Results show that individuals employed in occupations under the "other health professionals" category had more positive transference (which included feelings of respect toward BPD patients along with feelings of closeness and warmth) toward patients with BPD, and nurses had an increased total score for lack of valid difficulties compared with other health professionals. When grouping by gender and duration of year spent working on an inpatient unit, there were no significant differences in the response toward patients with BPD in affective situations.

Conclusion. Clinical implications are discussed, as well as the need for training to help improve staff attitudes toward this patient population.

Introduction

Personality is defined as a combination of characteristics or qualities that form an individual's distinctive character. The psychoanalyst, Adolf Stern, first coined the term borderline personality disorder (BPD) in 1938 to describe a group of patients who did not respond to early psychoanalytic treatment. He found that these patients could neatly fit into a psychotic or neurotic group and used the term "borderline" to denote individuals who were on the perimeter of these conditions.[1] In the early 1940s, this group of patients were considered pseudo-neurotic schizophrenics, and further research done by psychiatrist Robert Knight would shine new light on ego psychology and "the borderline state[1]." Otto Kernberg introduced the term "borderline level of organization" in the 1970s and detailed this as a consistent level of functioning and behavior characterized by instability and reflecting a disturbed psychological self-organization.[1] It wasn't until the 1980s, roughly 30 years after personality disorder (PD) was included in the DSM, that BPD was recognized in the DSM 5.[2]

The psychological makeup and development of BPD is an ongoing subject of research. The *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition, defines BPD as a pervasive pattern of instability of interpersonal relationships, self-image, affects, and marked impulsivity beginning in early adulthood and present in a variety of contexts. Diagnostic criteria for BPD include efforts to avoid abandonment, patterns of unstable personal relationships, identity disturbance, impulsivity, affective instability, and suicidal behavior.[2]

The prevalence of BPD is 1.6% in the general population and as high as 43% in inpatient psychiatric settings.[3,4] There has been no significant difference in rates of BPD between males and females.[3,4] BPD can also be difficult to diagnose due to co-occurring symptoms of other psychiatric disorders mimicking the symptoms of BPD leading to misdiagnosis. In a recent study, over 40% of people were previously diagnosed with other psychiatric illnesses including bipolar or major depressive disorder.[3,4] Patients with BPD are also likely to have a co-occurring substance use disorder which contributes to enhancing stigma.

BPD has been a subject of interest at academic facilities for several years. For example, dynamic deconstructive psychotherapy (DDP), a new evidence-based treatment model for the treatment of BPD, was created.[5–7] In addition, the Upstate Psychiatry High-Risk Program, a program geared toward suicide prevention in high-risk populations including BPD patients, is nationally recognized with high success rates.[5–7] These treatments rely on educated, responsible, and open-minded clinicians who are well-equipped to support and treat this patient demographic.

The goal of the present study was to assess the attitudes of psychiatric providers toward patients with BPD with the hope of improving patient outcomes by creating appropriate staff training, education, and support. Several studies have shown widespread antagonism, feelings of frustration, and limited empathy toward patients with BPD, particularly among healthcare professionals, with some variance among healthcare occupations.[8–10] While these and other studies have described the attitudes of health professionals toward patients with BPD, specific training programs have not been recommended in most cases. This study surveys the attitudes of healthcare professionals at our clinical sites, and proposes a specific training program to address shortcomings noted.

Methods

Study flow, design, and setting

The survey was distributed throughout two facilities: a state psychiatric hospital and an acute care psychiatric unit in an academic hospital. The study was approved by an institutional review board in both hospitals (IRB approval #1813497-2). The project was conducted over a number of years: started in 2009 in the state psychiatric hospital. At that time 76 surveys were distributed to staff, however, only 12 were returned (16% return rate). The project was re-started in 2016 in an academic facility, it was given to all staff on the unit plus rotating residents, students, and psychology interns. At that time, 28 surveys were collected. The project continued in 2019 in the state psychiatric hospital facility with 40 surveys distributed and none returned. The project continued in 2021 during which 55 surveys were distributed with almost 100% return rate in an academic facility. In the same year, 100 surveys were distributed in the state facility with the incentive of receiving Dunkin Donuts gift card ($5 value) for returned survey envelope. This incentive yielded a 44% return rate. Overall, a total of 139 surveys were collected from psychiatry attendings, psychiatric residents, registered nurses, psychologists, nurse practitioners, social workers, and mental health technicians. Out of the total collected surveys, 81 were from the academic facility and 58 from the state psychiatric hospital.

Study measures

A 47-question survey was utilized which graded responses to affective situations on a six-point Likert scale. On this scale, answers ranged from never (1) to always (5). The survey used was an adaptation from The Attitude to Personality Disorder Questionnaire (APDQ; 37 questions) with 10 additional questions included to expand the staff's attitude and knowledge.

Four questions from the original APDQ (Bowers and Allan, 2006) were removed/substituted by 10 new questions after consultation with an expert in this area (R. Gregory, based on personal communication in 2009), and after considering staff feedback regarding care or patients with this condition. The PD from the original Bowers and Allan questionnaire was substituted by BPD in our survey. The grouping of questions was conducted in consultation with an expert (R. Gregory, email communication) to reduce the number of variables for analysis and create meaningful subscales reflecting staff attitudes based on transference reaction (Table 1).

The APDQ psychometrics are as follows: internal consistency measured by Cronbach's alpha is 0.94; test–retest reliability is $r = 0.71$.[11] Participants in this study were grouped based on occupation (Table 2), gender (Table 3), and years worked on an inpatient unit (Table 2). Occupations included physicians (and nurse practitioners), nurses, and other health professionals (psychologists, mental health technicians, social workers, occupational therapists, and recreational therapists; Tables 2 and 4).

With the survey, the cover letter was given to the participants with explanation of the study, date, years working on inpatient units, gender, and profession. An envelope was provided to the participants with instructions to place the survey into the envelope and then seal the envelope once the survey was completed. The participation was voluntary and anonymous. After completing the survey, participants put the sealed envelope into survey-collecting boxes.

Statistical analysis

Descriptive analysis was used to evaluate the survey responders, with the number of non-missing values, mean (standard deviation), interquartile, and minimum and maximum values. For the analysis of the survey responses, the survey's questions were grouped into categories based on positive transference (17 items), negative transference (26 items), neutral items (4 items), lack of valid difficulties (6 items), hopelessness (5 items), fear (6 items), maternal instinct (10 items), irritation (3 items), curiosity (2 items), and respect (2 items) for this patient population. Please see the grouping items in Table 1.

An analysis of variance (ANOVA) was used to compare the responses by gender (females, males, and others), by profession (nurses, physicians [including nurse practitioners], and other health professionals) and number of years inpatient (<1 year, 1–3 years, 3–10 years, >10 years). Given the reasonably large sample sizes, the type I error rate of the ANOVA test should be well maintained by the central limit theorem.

Given the data were collected from surveys with a Likert scale, no special data cleaning or imputation methods were used. We did not analyze the data by the time points when the data were being collected.

SAS 9.4 was used for analysis.

Results

Demographic characteristics of the study participants are presented in Table 2. Briefly, they consisted of 32% nurses, 30% physicians (including nurse practitioners), and 37% other health professionals (psychologists, mental health technicians, social workers, occupational therapists, and recreational therapists). The average time of working in psychiatry was 6 years, however, the range was from 0 to 36 years, with a standard deviation of 7.

ANOVA testing was used to generate 10 comparison scores (Table 1 for grouping and Table 4 for scores). The total score of positive transference was highest among other health professionals (60 [11.2]), followed by physicians (including nurse practitioners;

https://doi.org/10.1017/S1092852923006326 Published online by Cambridge University Press

Table 1. Grouping Items

Grouping category	Survey questions
Items indicating positive transference	I like patients with BPD.
	I respect patients with BPD.
	I feel fondness and affection for patients with BPD.
	I have a feeling of closeness with patients with BPD.
	I am excited to work with patients with BPD.
	I admire patients with BPD.
	I enjoy spending time with patients with BPD.
	I feel warm and caring toward patients with BPD.
	I feel protective toward patients with BPD.
	I feel understanding toward patients with BPD.
	I feel happy and content in patients with BPD company.
	Caring for patients with BPD makes me feel satisfied and fulfilled.
	I feel that patients with BPD have reasons they behave in certain ways which needs to be understood first in order to help them.
	I think that patients with BPD need to be hugged.
	I feel patient when caring for BPD people.
	I feel able to help BDP people.
	I feel interested in BPD people.
Items indicating negative transference	I feel frustrated with patients with BPD.
	I feel drained by patients with BPD.
	I feel vulnerable in company of patients with BPD.
	I feel manipulated or used by patients with BPD.
	I feel uncomfortable or uneasy with patients with BPD.
	I feel I am wasting my time with patients with BPD.
	I feel pessimistic about patients with BPD.
	I feel helpless in relation to patients with BPD.
	I feel frightened of patients with BPD.
	I feel angry toward patients with BPD.
	I feel provoked by patients with BPD behavior.
	Patients with BPD make me feel irritated.
	I feel oppressed or dominated by patients with BPD.
	I feel powerless in the presence of patients with BPD.
	I feel cautious and careful in the presence of patients with BPD.
	I feel outmaneuvered by patients with BPD.
	I feel problems that patients with BPD have, are all behavioral.
	I think patients with BPD are always aware what they are doing and in control of their actions.
	I feel patients with BPD act the way they do because of lack of discipline they got in their childhood.
	I think that patients with BPD need to be shown “tough love” in order for them to straighten up their actions.
	I feel exploited by BPD people.
	I feel unable to gain control of the situation with BPD people.
	I feel that no matter what I do for a person with BPD, it is not enough.
	Person with BPD tend to over dramatize their problems.
	I feel that patients with BPD spilt staff.
	I would not take it too seriously when a person with BPD threatened self-harm because they are manipulative.

https://doi.org/10.1017/S1092852923006326 Published online by Cambridge University Press

Table 1. *Continued*

Grouping category	Survey questions
Neutral items	I know how to work with patients with BPD on the unit.
	I think it is important to maintain firm limits when dealing with person with BPD.
	If a patient with BPD expresses dislike for an assigned staff person, I believe the staff assignment should be changed.
	I feel I have adequate training to work with BPD patients.
Fear	I feel vulnerable in company of patients with BPD.
	I feel uncomfortable or uneasy with patients with BPD.
	I feel frightened of patients with BPD.
	I feel oppressed or dominated by patients with BPD.
	I feel powerless in the presence of patients with BPD.
	I feel cautious and careful in the presence of patients with BPD.
Lack of valid difficulties	I feel manipulated or used by patients with BPD.
	I feel I am wasting my time with patients with BPD.
	I feel outmaneuvered by patients with BPD.
	I feel problems that patients with BPD have, are all behavioral.
	I think patients with BPD are always aware what they are doing and in control of their actions.
	I feel patients with BPD act the way they do because of lack of discipline they got in their childhood.
Helpless/hopeless	I feel frustrated with patients with BPD.
	I feel drained by patients with BPD.
	I feel I am wasting my time with patients with BPD.
	I feel pessimistic about patients with BPD.
	I feel helpless in relation to patients with BPD.
Irritated	I feel angry toward patients with BPD.
	I feel provoked by patients with BPD behavior.
	Patients with BPD make me feel irritated.
Maternal	I like patients with BPD.
	I feel fondness and affection for patients with BPD.
	I have a feeling of closeness with patients with BPD.
	I enjoy spending time with patients with BPD.
	I feel warm and caring toward patients with BPD.
	I feel protective toward patients with BPD.
	I feel understanding toward patients with BPD.
	I feel happy and content in patients with BPD company.
	Caring for patients with BPD makes me feel satisfied and fulfilled.
	I think that patients with BPD need to be hugged.
Curiosity in the work	I am excited to work with patients with BPD.
	I feel that patients with BPD have reasons they behave in certain ways which needs to be understood first in order to help them.
Respectful	I respect patients with BPD.
	I feel patients with BPD act the way they do because of lack of discipline they got in their childhood.

https://doi.org/10.1017/S1092852923006326 Published online by Cambridge University Press

Table 2. Demographic Characteristics of Study Participants

	N	%		
Gender				
Males	36	25		
Females	97	70		
Other	6	5		
Occupation				
Nurses	45	32		
Physicians (and nurse practitioners)	42	30		
Other health professionals[a]	52	37		
Facility				
Academic	81	58		
State hospital	58	42		
	N	Mean	SD	Range
Years of working on inpatient units				
Males	36	7	7	0–32
Females	97	6	7	0–36
Other	6	6	6	2–16
Physicians (and nurse practitioners)	42	5	7	0–20
Nurses	45	6	7	0–36
Other health professionals	52	7	7	0–32

[a]Psychologists, mental health technicians, social workers, occupational therapists, and recreational therapists.

53.8 [11.4]), then nurses (53.8 [11.3]; Table 4). The difference among the groups was statistically significant ($p = 0.014$; Table 4).

The total score of "lack of valid difficulties" was highest among nurses (17.1 [4.5]), followed by physicians (including nurse practitioners; 15.9 [4.1]), then other health professionals (14.6 [4.9]; Table 4). The difference among the groups was statistically significant ($p = 0.035$; Table 4). The total score of "irritated" showed a trend ($p = 0.052$) toward being highest among physicians (including nurse practitioners; 8.0 [2.4]), followed by nurses (7.0 [2.6]), and then other health professionals (6.9 [2.4]; Table 4).

The total score of "respectful" was highest among other health professionals (7.5 [1.9]), followed by nurses (6.9 [1.7]), and then physicians (including nurse practitioners; 6.4 [2.1]; Table 4). The difference among the groups was statistically significant ($p = 0.018$; Table 4). The rest of the comparison variables did not yield statistical significance.

ANOVA/*t*-test (for comparison by gender) was used to generate the same 10 comparison scores noted above and none of the gender differences in the scores were statistically significant (Table 3). ANOVA/*t*-test (for comparison by years inpatient) was used to generate the same 10 comparison scores noted above and none of the years inpatient's differences in scores was statistically significant (Table 5). Regression analysis was also applied to comparison by years inpatient in relation to the 10 scores as above and the results were not statistically significant.

Discussion

This present study assessed attitudes toward patients with BPD with results analyzed based on occupation, gender, and years worked on an inpatient psychiatric unit. Our main findings suggest that nurses and physicians (including nurse practitioners) were less likely to have positive transference toward BPD patients compared to other health professionals. Positive transference included feelings of respect toward BPD patients along with feelings of closeness and warmth (Table 1). Feelings of negative transference included but were not limited to, feelings of pessimism, oppression, and manipulation (Table 1). When grouping by gender and duration of years spent working on an inpatient unit, there was no significant difference in the response toward patients with BPD in affective situations (Table 3).

When comparing attitudes to PD by occupation, other health professionals had the highest total score of positive transference and the highest score of curiosity in the workplace (Table 4). In contrast, nurses had the lowest total score of positive transference. In similar studies, it has been found that psychiatric nurses have acknowledged negative emotions involving anger and irritation when working with this patient population. In a large-scale 2011 study performed by Black et al., more than 700 clinicians were surveyed to assess their attitudes toward patients with BPD.[12] Like our study's findings (Table 4), psychiatric nurses scored lowest in terms of caring attitudes toward patients with BPD as well as feelings of empathy toward patients with BPD.[12] The negative feelings of nurses toward patients with BPD may be attributed to the perception that the mood reactivity and impulsivity of these patients are within their control rather than uncontrollable.[13] A common trait of patients with BPD is their perceived manipulative behavior, which could lead to the splitting of nursing staff who have the most direct contact with these patients while on an inpatient unit. In a 1986 study conducted by Lansky and Rudnik, it was found that nurses' attitudes that patients with BPD do not have valid difficulties and physician irritation may lead to invalidating comments, increased splitting, and a worsened course of inpatient stays.[14] Physicians (including nurse practitioners) showed a trend toward an increased total score of irritation compared to nurses and other health professionals (Table 4). Increased feelings of irritation from psychiatrists may be attributed to BPD generally being considered as difficult to treat due to overlapping of symptomatology with different psychiatric disorders such as depression, anxiety, and bipolar disorder. In addition, patients with BPD frequently may present with suicidal behavior/ideation and self-injurious behavior, and these clients are high utilizers of mental health services. These factors alone would decrease feelings of hope or optimism about recovery. It should also be considered that BPD patients may be able to sense this displeasing attitude from psychiatrists which could precipitate feelings of rage in these patients. These interactions undoubtedly will precipitate troublesome outcomes including the use of restraints and medications for agitation and well as prolonged hospitalizations. This study showed the highest statistically significant score of positive transference among other health professionals (psychologists, social workers, occupational therapists, etc.), followed by physicians (including nurse practitioners), then nurses. This could be due to a higher degree of empathy expressed by staff in other health professionals as they possibly relate to patients with BPD in the context of real-world functioning and not primarily as patients. For instance, social workers and occupational therapists focus on social interactions and relationships primarily and not on addressing the "disease process" of BPD, per se.

In our sample, although not statistically significant, the other health professionals had the longest average years of experience working in inpatient psychiatry settings—7 years compared to

https://doi.org/10.1017/S1092852923006326 Published online by Cambridge University Press

Table 3. Comparisons by Gender—*t*-Test

		F	*M*	*O*	*p*-Value
Total score of positive transference	*n*	92	31	6	0.322
	Mean (SD)	57.0 (12.0)	53.5 (11.3)	54.0 (4.6)	
	Median	56	49	52	
	Q1, Q3	48.0, 65.0	46.0, 64.0	51.0, 57.0	
	Min., max.	34.0, 84.0	35.0, 75.0	50.0, 62.0	
Total score of negative transference	*n*	84	30	5	0.476
	Mean (SD)	69.6 (17.3)	73.6 (14.0)	73.4 (9.5)	
	Median	69.5	74.5	70	
	Q1, Q3	56.0, 79.5	66.0, 87.0	69.0, 72.0	
	Min., max.	34.0, 141.0	42.0, 97.0	66.0, 90.0	
Total score of neutral items	*n*	97	35	6	0.643
	Mean (SD)	14.1 (2.6)	13.7 (2.8)	13.7 (1.9)	
	Median	14	14	13.5	
	Q1, Q3	12.0, 16.0	12.0, 16.0	12.0, 14.0	
	Min., max.	8.0, 20.0	8.0, 18.0	12.0, 17.0	
Total score of fear	*n*	95	36	6	0.965
	Mean (SD)	15.0 (4.3)	14.9 (3.9)	15.3 (3.1)	
	Median	15	14.5	15	
	Q1, Q3	12.0, 18.0	12.5, 17.0	13.0, 17.0	
	Min., max.	7.0, 30.0	7.0, 26.0	12.0, 20.0	
Total score of lack of valid difficulties	*n*	94	35	6	0.507
	Mean (SD)	15.5 (5.0)	16.5 (3.5)	16.2 (3.3)	
	Median	15	17	16.5	
	Q1, Q3	12.0, 19.0	14.0, 19.0	14.0, 19.0	
	Min., max.	6.0, 35.0	9.0, 23.0	11.0, 20.0	
Total score of helpless/hopeless	*n*	96	35	6	0.414
	Mean (SD)	14.5 (4.5)	15.5 (3.7)	13.8 (2.9)	
	Median	14	15	13.5	
	Q1, Q3	11.0, 17.5	13.0, 17.0	12.0, 16.0	
	Min., max.	5.0, 28.0	10.0, 24.0	10.0, 18.0	
Total score of irritated	*n*	96	36	6	0.110
	Mean (SD)	7.0 (2.5)	8.0 (2.6)	7.7 (1.5)	
	Median	7	8	8	
	Q1, Q3	5.0, 9.0	6.0, 9.0	7.0, 9.0	
	Min., max.	3.0, 15.0	3.0, 14.0	5.0, 9.0	
Total score of maternal	*n*	93	32	6	0.339
	Mean (SD)	31.5 (7.8)	29.4 (6.6)	29.5 (3.5)	
	Median	31	27	29	
	Q1, Q3	25.0, 37.0	24.5, 35.0	26.0, 32.0	
	Min., max.	16.0, 51.0	17.0, 41.0	26.0, 35.0	
Total score of curiosity in the work	*n*	97	36	6	0.616
	Mean (SD)	7.2 (1.9)	6.9 (1.9)	7.0 (1.1)	
	Median	7	7	7	
	Q1, Q3	6.0, 9.0	5.0, 8.0	7.0, 8.0	

https://doi.org/10.1017/S1092852923006326 Published online by Cambridge University Press

Table 3. *Continued*

		F	*M*	*O*	*p*-Value
	Min., max.	3.0, 11.0	3.0, 11.0	5.0, 8.0	
Total score of respectful	*n*	96	35	6	0.664
	Mean (SD)	7.0 (2.0)	6.8 (2.1)	6.5 (0.8)	
	Median	7	7	7	
	Q1, Q3	6.0, 8.0	5.0, 8.0	6.0, 7.0	
	Min., max.	2.0, 11.0	2.0, 11.0	5.0, 7.0	

Table 4. Comparisons by Profession—ANOVA

		Nurses	Other health professionals	Physicians (and nurse practitioners)	*p*-Value
Total score of positive transference	*n*	42	47	40	0.014^
	Mean (SD)	53.8 (11.3)	60.0 (11.2)	53.8 (11.4)	
	Median	52	62	52	
	Q1, Q3	46.0, 61.0	50.0, 66.0	46.0, 58.5	
	Min., max.	34.0, 82.0	34.0, 82.0	35.0, 84.0	
Total score of negative transference	*n*	36	44	39	0.174
	Mean (SD)	72.6 (15.6)	67.1 (18.4)	73.2 (13.7)	
	Median	72	64	73	
	Q1, Q3	67.5, 81.5	54.0, 79.0	66.0, 80.0	
	Min., max.	34.0, 107.0	42.0, 141.0	46.0, 108.0	
Total score of neutral items	*n*	44	51	43	0.275
	Mean (SD)	14.5 (2.6)	13.6 (2.8)	14.0 (2.3)	
	Median	14	14	14	
	Q1, Q3	12.0, 16.5	11.0, 16.0	12.0, 16.0	
	Min., max	10.0, 20.0	8.0, 19.0	9.0, 18.0	
Total score of fear	*n*	44	50	43	0.514
	Mean (SD)	15.1 (4.4)	14.5 (4.6)	15.4 (3.3)	
	Median	14	14	16	
	Q1, Q3	12.0, 17.5	11.0, 17.0	13.0, 17.0	
	Min., max.	7.0, 30.0	7.0, 30.0	9.0, 24.0	
Total score of lack of valid difficulties	*n*	42	51	42	0.035^
	Mean (SD)	17.1 (4.5)	14.6 (4.9)	15.9 (4.1)	
	Median	17	14	17	
	Q1, Q3	15.0, 20.0	11.0, 18.0	13.0, 18.0	
	Min., max.	7.0, 31.0	6.0, 35.0	8.0, 29.0	
Total score of helpless/hopeless	*n*	43	51	43	0.140
	Mean (SD)	14.9 (4.7)	13.9 (4.2)	15.6 (3.6)	
	Median	16	13	16	
	Q1, Q3	11.0, 18.0	11.0, 15.0	13.0, 18.0	
	Min., max.	5.0, 28.0	6.0, 25.0	7.0, 23.0	
Total score of irritated	*n*	43	52	43	0.052
	Mean (SD)	7.0 (2.6)	6.9 (2.4)	8.0 (2.4)	
	Median	7	7	8	
	Q1, Q3	5.0, 9.0	5.0, 8.5	6.0, 9.0	
	Min., max.	3.0, 14.0	3.0, 15.0	3.0, 14.0	

https://doi.org/10.1017/S1092852923006326 Published online by Cambridge University Press

Table 4. *Continued*

		Nurses	Other health professionals	Physicians (and nurse practitioners)	*p*-Value
Total score of maternal	*n*	42	48	41	0.103
	Mean (SD)	29.8 (7.6)	32.8 (7.0)	30.0 (7.4)	
	Median	28.5	33	28	
	Q1, Q3	24.0, 35.0	26.0, 38.0	25.0, 34.0	
	Min., max.	17.0, 48.0	17.0, 45.0	16.0, 51.0	
Total score of curiosity in the work	*n*	44	52	43	0.116
	Mean (SD)	6.9 (1.8)	7.5 (2.1)	6.9 (1.5)	
	Median	7	8	7	
	Q1, Q3	5.0, 8.0	6.0, 9.0	6.0, 8.0	
	Min., max.	4.0, 11.0	3.0, 11.0	4.0, 11.0	
Total score of respectful	*n*	44	51	42	0.018^
	Mean (SD)	6.9 (1.7)	7.5 (1.9)	6.4 (2.1)	
	Median	7	7	6.5	
	Q1, Q3	6.0, 8.0	6.0, 9.0	5.0, 8.0	
	Min., max.	3.0, 11.0	2.0, 11.0	2.0, 11.0	

6 years among nurses and 5 years among physicians (including nurse practitioners; Table 5). It is unclear if this would have a significant bearing on the differences in attitudes.

Our study also showed statistically significant differences in measured outcomes including "lack of valid difficulties"—highest among nurses, followed by physicians (including nurse practitioners), then other health professionals (as above); and "respectful"—highest among other health professionals, followed by nurses, then physicians (including nurse practitioners). Similarly, another study showed the exact same distribution of positive transference scores, with a statistically significant difference in empathy scores among clinicians.[8] In that study, psychologists displayed the most empathy, followed by psychiatrists, and then nurses. The same study also showed statistically significant differences in antagonistic judgments, with psychologists showing the least antagonism, followed by psychiatrists, then nurses. Another study showed some differences in antagonism scores, with the most antagonistic attitudes demonstrated among nurses, followed by social workers, then psychologists and finally, psychiatrists.[9] Another study showed 89% of respondents among psychiatric nurses thought of BPD patients as "manipulative" but only 44% of the nurses reported knowing "how to care for people with borderline personality disorder."[10] Another study among nursing staff showed that nurses were "more negative" and had the least optimism toward patient with BPD as compared to patients with schizophrenia or patients with depression.[15] Thus, in line of previous findings, our study showed a pattern of limited empathy and a high degree of negative affect toward patients with BPD among staff in inpatient psychiatric units. They also reveal the likelihood of limited specific training on caring for this patient population, which constitutes a significant portion of patients on psychiatric units. Some studies have shown a positive correlation between specific training regarding management of people with BPD and positive caring attitudes toward this patient population.[16–18]

An example of such an intervention based on this study's finding of negative transference of the front-line inpatient staff could be an interactive role-play. For such training, we propose educating staff regarding BPD patients' most common state of being that creates conflicts and negative interactions, that is, the "angry victim state."[6,19] In the angry victim state, the patient's behavior is demeaning, intrusive, and controlling; their mood is angry. Countertransference reactions from staff are commonly feeling irritated, used, and manipulated by the patient. This can lead to staff retaliating through invalidating comments, control struggles, and limit setting. Such countertransference-driven behavior enacts the patient's expectations of humiliation and rejection in this state of being. Alternative responses from staff include mirroring the patient's grandiosity and experiential acceptance. Such mirroring helps reduce grandiosity, entitlement, and defensiveness and, consequently, change manipulative and demanding behaviors. A role-play example could be: The patient is at the nurse's station demanding immediate medication, raising their voice, stating that "no one cares here." The training identifies the staff's countertransference response of being unjustly criticized by the patient, and of wanting to give the patient a reality check by pointing out how much they have done for the patient. Instead of a reality check, it is rather more helpful to listen and reflect with the following experiential acceptance: "What is it like for you to be on a unit where you believe staff do not care?" This unexpected response helps to break the destructive enactment of the angry victim state and reduce agitation. In short, educating staff on recognizing and not acting on their initial countertransference urges but instead, giving a paradoxical accepting response will help to reduce the tension between the staff and the patient and increase the therapeutic alliance.

Limitations

As with other studies regarding this topic, the findings need to be analyzed considering some possible limitations. The findings in this observational research study did not yield many statistically

https://doi.org/10.1017/S1092852923006326 Published online by Cambridge University Press

Table 5. Comparisons by Years Inpatients—ANOVA

		<1 year	1–3 years	3–10 years	>10 years	p-Value
Total score of positive transference	*n*	40	35	32	21	0.794
	Mean (SD)	56.5 (12.4)	55.9 (9.3)	57.3 (13.9)	54.0 (10.2)	
	Median	55.5	56	54.5	55	
	Q1, Q3	46.0, 65.5	49.0, 64.0	48.0, 69.0	47.0, 58.0	
	Min., max.	34.0, 82.0	34.0, 79.0	34.0, 84.0	39.0, 75.0	
Total score of negative transference	*n*	37	33	29	19	0.938
	Mean (SD)	70.2 (15.9)	71.6 (17.8)	69.1 (15.9)	71.1 (13.8)	
	Median	68	70	71	72	
	Q1, Q3	61.0, 80.0	62.0, 79.0	58.0, 81.0	56.0, 81.0	
	Min., max.	41.0, 108.0	42.0, 141.0	34.0, 92.0	52.0, 95.0	
Total score of neutral items	*n*	40	36	35	26	0.775
	Mean (SD)	13.7 (2.5)	14.1 (2.6)	14.3 (2.4)	14.2 (3.1)	
	Median	14	14	15	14.5	
	Q1, Q3	12.0, 15.0	12.0, 16.0	12.0, 16.0	12.0, 17.0	
	Min., max.	8.0, 20.0	9.0, 19.0	8.0, 19.0	8.0, 19.0	
Total score of fear	*n*	39	36	34	26	0.887
	Mean (SD)	14.5 (4.1)	15.1 (4.6)	14.7 (3.7)	15.1 (3.4)	
	Median	15	15	14.5	14	
	Q1, Q3	11.0, 17.0	11.0, 17.5	12.0, 17.0	13.0, 18.0	
	Min., max.	7.0, 30.0	8.0, 30.0	7.0, 22.0	7.0, 21.0	
Total score of lack of valid difficulties	*n*	40	34	35	24	0.633
	Mean (SD)	16.4 (4.6)	15.4 (5.1)	15.6 (4.3)	15.0 (4.1)	
	Median	16	15	16	15.5	
	Q1, Q3	13.0, 19.0	12.0, 17.0	12.0, 19.0	12.0, 18.0	
	Min., max.	9.0, 31.0	7.0, 35.0	7.0, 22.0	6.0, 23.0	
Total score of helpless/hopeless	*n*	39	36	35	25	0.847
	Mean (SD)	14.9 (4.6)	14.5 (3.8)	14.1 (4.3)	14.7 (3.5)	
	Median	14	15	14	15	
	Q1, Q3	12.0, 19.0	12.0, 17.0	11.0, 17.0	12.0, 17.0	
	Min., max.	5.0, 24.0	6.0, 25.0	6.0, 22.0	10.0, 24.0	
Total score of irritated	*n*	39	36	35	26	0.143
	Mean (SD)	7.1 (3.0)	7.9 (2.2)	6.5 (2.0)	7.4 (2.3)	
	Median	7	8	7	8	
	Q1, Q3	4.0, 9.0	7.0, 9.0	5.0, 8.0	5.0, 9.0	
	Min, max	3.0, 14.0	4.0, 15.0	3.0, 11.0	3.0, 12.0	
Total score of maternal	*n*	40	35	32	22	0.746
	Mean (SD)	31.4 (7.6)	30.9 (5.6)	31.8 (9.0)	29.6 (7.4)	
	Median	31	30	29.5	31	
	Q1, Q3	25.0, 38.0	28.0, 35.0	25.0, 39.0	24.0, 35.0	
	Min., max.	17.0, 45.0	17.0, 48.0	17.0, 51.0	16.0, 41.0	
Total score of curiosity in the work	*n*	40	36	35	26	0.242
	Mean (SD)	7.5 (1.8)	7.2 (1.8)	7.2 (1.9)	6.5 (2.0)	
	Median	7	7.5	7	6	
	Q1, Q3	6.0, 9.0	5.5, 8.0	6.0, 9.0	5.0, 8.0	

https://doi.org/10.1017/S1092852923006326 Published online by Cambridge University Press

Table 5. *Continued*

		<1 year	1–3 years	3–10 years	>10 years	p-Value
	Min., max.	4.0, 11.0	4.0, 11.0	3.0, 11.0	3.0, 10.0	
Total score of respectful	*n*	40	36	35	25	0.463
	Mean (SD)	6.7 (2.0)	6.7 (1.9)	7.3 (2.1)	7.2 (1.7)	
	Median	7	7	7	7	
	Q1, Q3	5.0, 8.0	5.0, 8.0	6.0, 9.0	7.0, 8.0	
	Min., max.	3.0, 11.0	2.0, 11.0	3.0, 11.0	2.0, 10.0	

significant results. This could be due to several factors, one of which is the smaller sample size. Our study included 139 participants, most of whom were in the other health professionals grouping and did not have frequent interactions with this patient demographic. In addition to this, the experience of the clinicians that were sampled was also limited with the average duration of years worked among all participants being 6.5 years. The timeline of sampling was also prolonged as this project was first conducted in 2009 and was halted several times due to a low return rate of the Adults with Personality Disorder Questionnaire. Despite these limitations, our findings do accurately reflect the population of clinicians at SUNY Upstate based on review of similar studies at our institution. However, the extent at which our results can be generalized to other contexts remains unclear without the utilization of a larger sample size including more adept clinicians with responses collected over a shorter period of time.

Conclusions

These studies show a pattern of limited empathy and a high degree of negative affect toward patients with BPD among staff in inpatient psychiatric units. They also reveal the likelihood of limited specific training on caring for this patient population, which constitutes a significant portion of patients on psychiatric units. Some studies have shown a positive correlation between specific training regarding the management of people with BPD and positive caring attitudes toward this patient population.

Future directions

We propose an intervention among our study population involving targeted training on management of people with BPD, frequent supervision, education, and an attitudes reassessment in the future to compare the effect of such training.

Supplementary material. The supplementary material for this article can be found at https://doi.org/10.1017/S1092852923006326.[11]

Author contribution. Conceptualization: S.G., J.M., L.L.; Supervision: S.G., J.M., L.L.; Writing – original draft: K.A., L.L., D.U.; Writing – review & editing: K.A., J.M., L.L., D.U.; Data curation: D.W.; Formal analysis: D.W.

Competing interest. The authors have no potential competing interest or relevant financial relationships with ineligible companies.

References

1. Bateman AW, Krawitz R. *Borderline Personality Disorder: An Evidence-Based Guide for Generalist Mental Health Professionals*. Oxford: Oxford University Press; 2013.
2. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders: DSM-5*. American Psychiatric Association; 2013.
3. Leontieva L, Gregory R. Characteristics of patients with borderline personality disorder in a state psychiatric hospital. *J Pers Disord.* 2013;**27**(2): 222–232. https://doi.org/10.1521/pedi.2013.27.2.222
4. Gregory R, Sperry SD, Williamson D, Kuch-Cecconi R, Spink GL. High prevalence of borderline personality disorder among psychiatric inpatients admitted for suicidality. *J Pers Disord.* 2021;**35**(5):776–787. https://doi.org/10.1521/pedi_2021_35_508
5. Thomas JG, Sperry SD, Shields RJ, Gregory RJ. A novel recovery-based suicide prevention program in upstate New York. *Psychiatric Serv.* 2022;**73** (6):701–704. https://doi.org/10.1176/appi.ps.202100162
6. Gregory RJ, Remen AL. A manual-based psychodynamic therapy for treatment-resistant borderline personality disorder. *Psychotherapy.* 2008; **45**(1):15–27. https://doi.org/10.1037/0033-3204.45.1.15
7. Gregory RJ, Remen AL, Soderberg M, Ploutz-Snyder RJ. A controlled trial of psychodynamic psychotherapy for co-occurring borderline personality disorder and alcohol use disorder: six-month outcome. *J Am Psychoanal Assoc.* 2009;**57**(1):199–205. https://doi.org/10.1177/0003065109570011006
8. Bodner E, Cohen-Fridel S, Iancu I. Staff attitudes toward patients with borderline personality disorder. *Compr Psychiatry.* 2011;**52**(5):548–555. https://doi.org/10.1016/j.comppsych.2010.10.004
9. Bodner E, Cohen-Fridel S, Mashiah M, et al. The attitudes of psychiatric hospital staff toward hospitalization and treatment of patients with borderline personality disorder. *BMC Psychiatry.* 2015;**15**(2). https://doi.org/10.1186/s12888-014-0380-y
10. Deans C, Meocevic E. Attitudes of registered psychiatric nurses towards patients diagnosed with borderline personality disorder. *Contemp Nurse.* 2006;**21**(1):43–49. https://doi.org/10.5172/conu.2006.21.1.43
11. Bowers L, Allan T. The attitude to personality disorder questionnaire: psychometric properties and results. *J Pers Disord.* 2006;**20**(3):281–293. https://doi.org/10.1521/pedi.2006.20.3.281
12. Black DW, Pfohl B, Blum N, et al. Attitudes toward borderline personality disorder: a survey of 706 mental health clinicians. *CNS Spectr.* 2011;**16**(3): 67–74. https://doi.org/10.1017/S109285291200020X
13. Forsythe VA. *Choosing Emotion Regulation Strategies: The Effects of Interpersonal Cues and Symptoms of Borderline Personality Disorder*. Columbus, OH: Ohio State University; 2014.
14. Lansky MR, Rudnick A. Right on the money: disability forms and the hospitalized borderline patient. *Hillside J Clin Psychiatry.* 1986;**8**(2):132–143.
15. Markham D, Trower P. The effects of the psychiatric label 'borderline personality disorder' on nursing staff's perceptions and causal attributions for challenging behaviours. *Br J Clin Psychol.* 2003;**42**(3):243–256. https://doi.org/10.1348/01446650360703366

16. Commons Treloar AJ, Lewis AJ. Professional attitudes towards deliberate self-harm in patients with borderline personality disorder. *Aust N Z J Psychiatry*. 2008;**42**(7):578–584. https://doi.org/10.1080/00048670802119796
17. Krawitz R. Borderline personality disorder: attitudinal change following training. *Aust N Z J Psychiatry*. 2004;**38**(7):554–559. https://doi.org/10.1080/j.1440-1614.2004.01409.x
18. Lanfredi M, Elena Ridolfi M, Occhialini G, et al. Attitudes of mental health staff toward patients with borderline personality disorder: an Italian cross-sectional multisite study. *J Pers Disord*. 2021;**35**(1):41–56. https://doi.org/10.1521/pedi_2019_33_421
19. Gregory RJ. Borderline attributions. *Am J Psychother*. 2007;**61**(2):131–147. https://doi.org/10.1176/appi.psychotherapy.2007.61.2.131

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