Factors underlying and maintaining nurses' attitudes to patients with severe personality disorder

Final report to National Forensic Mental Health R&D

Len Bowers RMN PhD
Professor of Psychiatric Nursing

Linda McFarlane BSc
Research Assistant

Frank Kiyimba RMN
Research Assistant

Nicola Clark MA MSc
Research Assistant

Jane Alexander
PhD Student

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Department of Mental Health Nursing
City University
London E1 2EA
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Chapter I
Executive summary

1. Aim of the project

To identify the factors underlying and maintaining nurses’ positive therapeutic attitudes to patients with severe personality disorder, to inform a support and training strategy to nurture such attitudes.

2. Literature review

The literature describing the nursing care of patients with severe personality disorder in secure settings is more notable by its absence than its presence. Clearly there exists a vacuum of practical guidance and of research results. Work on developing valid and reliable diagnostic categories underscores the variety of behaviours currently classified under the rubric personality disorder, and implies that many differing nursing strategies are needed to provide care and treatment. Theoretical thinking on the causes of personality disorder is also enormously varied, and is likely to shape the way that nurses interpret and respond to the behaviour of personality disordered patients on the wards. However literature that explores this implied diversity of psychiatric nursing care does not currently exist. The literature which is available indicates that nurses find personality disordered patients difficult to care for and can have profoundly negative attitudes towards them.

3. Methodology and analysis

3.1. Attitude to Personality Disorder Questionnaire (APDQ) survey

The APDQ was developed specifically for this study, and consisted to two sections. The first 37 items consisted of affective statements regarding personality disorder patients and were Likert scaled, the remaining 8 items asked respondents to rate their attitudes to key treatment variables. Following piloting the questionnaire was distributed to all nurses working in the three English High Security Hospitals (Ashworth, Broadmoor and Rampton) via the internal mail systems during 1998. Reply paid envelopes were included and a 26% response rate obtained. Data was entered onto SPSS and analysed using t tests, chi squared tests, pearson correlations, principal components analysis, and ANOVA.

3.2 Interview survey

Semi-structured interview schedules on the nursing care and treatment of personality disorder were developed, based upon a literature review and the theoretical thinking of the research team. Following piloting these interviews were conducted with a random sample of 121 nurses in the three hospitals, stratified by grade and by PD unit vs. non PD unit. Random selection was conducted from full staff lists for the hospitals by computer. Interviews took place on the wards during 1998, all were tape recorded and fully transcribed. Following transcription, each
tape/transcript was listened to again by members of the research team to clean out any inaccuracies and errors. In order to facilitate coding and analysis of the data, all transcripts were imported into qualitative data analysis software (QSR.NUD.IST version 4). Preliminary exploration of the data took place using text and string searches.

4. Key findings

1. Nurses attitudes to personality disordered patients are made up of six components or independently varying dimensions:

   Enjoyment................................................................. Loathing
   Security.................................................................... Vulnerability
   Acceptance............................................................ Rejection
   Purpose................................................................... Futility
   Enthusiasm............................................................ Exhaustion
   Spontaneity............................................................. Caution

2. PD unit nurses have a more positive attitude to PD patients than nurses in non PD wards and units. This is most marked for enjoyment and security.

3. Individual Hospital culture has the largest impact on attitude to PD, followed by gender and nursing grade.

4. Nurses consider PD patients to be difficult to treat and are pessimistic about the efficacy and outcome of treatment. They consider themselves to be, on balance, poorly trained to care for these difficult patients. Nurses find it easier to endorse negative feelings and more difficult to admit to positive feelings about PD patients and their care. There is no consensus at all among them as to whether PD patients should be within the healthcare system or detained in prison, although there is majority support for specialist PD units.

5. There is considerable concern at Rampton about the negative impact of the complaints procedure on staff.

6. The interviews have allowed the identification of a range of variables that have a relationship to overall attitude to PD patients. These variables exist at the level of organisational systems (the operations of the complaints system, multidisciplinary relationships, management methods etc.) and at the level of the individual nurse. For the nurse, what influences attitude to PD are their beliefs (e.g. on cause), knowledge (e.g. psychological understanding of PD behaviour), moral commitments (e.g. to nursing professionalism), who they identify with (e.g. patient or victim), and the self management methods they use to contain their emotional reactions to patients (e.g. separating the person from the behaviour). In the development of and change of attitude over time, there are key events that have a profound influence upon the individual nurses point of view, e.g. reading case notes, being verbally abused, suffering or witnessing a violent attack, etc.
5. Recommendations

Analysis of the interview data is not yet complete, but the following early recommendations should be considered.

1. Adequate training for all staff working with PD patients should be initiated. Due to the small size of the PD units, it might be feasible to hold specialist induction training at a central location. This would be easier and more efficient if the three High Security Hospitals took new staff onto the PD units at specific times each year. Efforts should also be made to make sure a similar package of training is incorporated into basic psychiatric nurse education.

2. A structured package of training should be devised and evaluated for this purpose. It should contain material emphasising nurture theories of PD, develop empathy by the study of in depth case examples, prepare nurses to deal with the feelings aroused by index offences, train nurses how to use clinical supervision to deal with their feelings, raise awareness of manipulative behaviour and train nurses how to practically deal with it, promote evidence of treatability, and training in treatment methods which nurses can incorporate into their everyday care. Additional recommendations will be made as the analysis proceeds.

3. Staff support mechanisms should be strengthened for those nurses working with PD patients. The work causes strong emotional stress that overflows into nurses personal lives and creates fears for their families. Services may wish to consider how they will provide external clinical supervision, support during and after the complaints process, and if there is any way to promote nurses' feelings of security at home with their families.

4. Better efforts could be made to encourage staff morale in the treatment of PD. Services may wish to consider how they can give feedback to nurses on the progress of patients who have been successfully treated and have left the High Security Hospital system. Under the current situation nurses are more likely to hear about treatment failures than treatment successes. Information on treatment success will strengthen nurses belief in treatability and improve positive attitudes to existing PD patients.

5. The managers of the complaints systems at Ashworth, Broadmoor and Rampton should meet to share comparable data on the type, nature, process and duration of their complaints procedures, and endeavour to discover if there is any obvious reason for the negative views of staff at Rampton.
Chapter II
Introduction and review of the literature

1. Introduction

The evidence that effective treatment can be given to patients with personality disorders is limited and inconclusive (Dolan & Coid 1993). Partly due to this, nurses caring for personality disordered patients run the risk of adopting therapeutic nihilism, rejecting patients bearing this diagnosis, distancing themselves from them, and considering them illegitimate users of health service resources. In non forensic settings alienation between patients and professional staff has been shown to be linked to completed suicide (Morgan & Priest 1991) however in forensic settings the process has received little attention, although Robertson (1987) has shown that mentally disordered offenders have a very high risk of 'unnatural death'. Palmer (1992) has described how the collapse of a rehabilitative ideal with such patients can lead to an emphasis upon incapacitation and deterrence which in turn may promote negative and punitive approaches.

The study reported here was therefore designed to investigate how nurses maintain a positive therapeutic relationship with patients with severe personality disorder (PD). This study aimed to identify the factors that allow and encourage nurses to foster such a relationship, by interviewing the nurses themselves, and by surveying all of the High Security hospital nurses about their feelings about PD patients. One hundred and twenty nurses in the three English High Security hospitals were interviewed about their experiences with PD patients and what they have been told about them. Analysis has identified positive attitudes, thoughts and judgements about patients with PD, and their linkages to the beliefs, organisation and culture of nursing at the different hospitals.

The review of the literature provided below gives a brief overview of the issues that surround the identification, aetiology and treatment of PD. Although volumes could and have been written on these subjects, the review provided below is cursory and aims to give just enough information for the general reader to understand the context of the research. The review that follows on nursing attitudes, and the nursing care and treatment of personality disorder is more comprehensive. However the literature on nursing and personality disorder is scant, and little of what does exist is based on systematic empirical research.

2. Definition and diagnosis of personality disorder

Diagnostic systems and their validity in the area of personality disorder are hotly contested and contentious issues Many personality disordered patients fulfil criteria for more than one of the personality disorders listed in the systems of classifications (Fuer et al 1988). Although the diagnosis of personality disorder remains complicated, unclear, and very loose, Dolan & Coid (1993) suggest the following clinical classification of personality disorders according to four different contemporary diagnostic frameworks.
2.1 ICD-10

The ICD-10 (World Health Organisation, 1989) includes a variety of conditions which indicate that the person’s characteristic and enduring patterns of inner experience and behaviour deviate markedly form the culturally expected and accepted range. It is recommended that clinicians should generally record as many diagnoses as necessary to cover the clinical picture, but, if recording more than one, then the main diagnosis should be specified. Coid and Dolan (1993) however, observe that it remains unclear whether the emphasis on personality characteristics such as unconcern, specific attitudes, low tolerance, incapacity to experience certain feelings rather than behaviour will be an improvement on previous categorisation systems.

The ICD-10 categories are: paranoid; schizoid; dyssocial; emotionally unstable; histrionic; anxious (avoidant); dependent; anankastic (obsessive-compulsive); other.

2.2 DSM - IIIR

The classification includes 11 categories divided into three “clusters” and are diagnosed along axis II from the major mental disorders.

Cluster A: paranoid; schizoid; schizotypal. Cluster B: antisocial; borderline; histrionic; narcissistic. Cluster C: avoidant; dependent; obsessive-compulsive; passive-aggressive.

2.3 Hare’s Psychopathy Check list

This is a unidimensional scale of personality disorder including both personality traits and antisocial behaviour. A list of 20 characteristics considered by Cleckley (1976) were initially taken by Hare to be typical of psychopathy and he applied them to a series of prisoners (Hare 1980).

1. Glibness / superficial charm.
3. Need for stimulation/proness to boredom.
4. Pathological lying.
5. Cunning/Manipulative.
6. Lack of remorse or guilt.
7. Shallow affect.
8. Callous/lack of empathy.
10. Poor behaviour controls.
11. Promiscuous sexual behaviour.
12. Early behaviour problems.
13. Lack of realistic, long term goals.
15. Irresponsibility.
16. Failure to accept responsibility for own actions.
17. Many short term marital relationships.
2.4 Blackburn’s typology derived from MMPI profiles.

Models using a broad range of personality traits have been employed with personality disorders using the Minnesota Multiphasic Personality Inventory (MMPI). Studies using this typology have been reported in both forensic psychiatric hospital populations and in prisons. Cluster analysis of the MMPI results in the identification of four groups:

Type 1: Primary: Individuals are highly extroverted, non-neurotic and guilt free, have a high level of impulsivity and are more violent in terms of previous convictions.
Type 2: Secondary or neurotic: Individuals are withdrawn, hypochondriacal, suspicious, prone to depression, tension, disruptive thoughts; resentful, aggressive, anxious, undersocialised, impulsive, introverted. Individuals have highly abnormal MMPI profile suggestive of paranoid and psychotic disorder.
Type 3: Controlled: Individuals tend to show defensive denial about psychological problems, are sociable, slightly extrovert and highly controlled, they deny experiencing anxiety and other negative affect.
Type 4: Inhibited: Individuals show defensive denial, less controlled and more suspicious but not notably aggressive. Characters include social withdrawal and extreme introversion. They show profile of depression and social avoidance, tend to have committed more sex offences.

2.5 Application in the High Security Psychiatric Services

The confusions over diagnosis are further complicated by the legal system in the UK. A significant number of patients within the High Security Hospital system are legally detained under the category of “psychopathic disorder”, however not all of these patient fit any or all of the criteria described above. Tennant & Hughes (1997) report, for example, that three out of four “psychopathic” High Security Hospital patients fail to meet the Hare Psychopathy Checklist criteria for personality disorder. Overlaid upon this problem is that some patients have dual or multiple diagnoses, fitting the some criteria for personality disorder and yet in addition having mental illnesses such as schizophrenia. The only thing the literature does seem to agree upon is that those currently called personality disordered within the forensic psychiatric system are by no means a homogenous group. The medical and therapeutic literature deduces that these different patients will need different treatment approaches. The obvious conclusion for psychiatric nurses is that these patients will require differences in nursing care and management.
3. **Cause of personality disorder**

As the diagnostic taxonomies are diverse and without any consensus, it comes as no surprise that there is little agreement as to the cause of personality disorder, and the evidence base for such theorising is weak. Aetiological theories can be broadly categorised into two groups, those emphasising nature and those stressing nurture. It is important to realise that these two bodies of theorising are not necessarily mutually exclusive. Cognitive behavioural approaches offer no theory as to the cause of personality disorder, only an analysis of its underlying belief system and the means by which it can be changed.

3.1 **Nature**

1. Genetic causes of antisocial personality: some twin studies and some adoption studies have shown evidence for a genetic cause of criminal behaviour. By extrapolation this may mean that antisocial personality (which is associated with criminal behaviour) may also have a genetic component.

2. Genetic causes of other personality disorders: studies of the relatives of existing patients have yielded inconsistent results, with some offering support for a genetic cause to specific subgroups and others finding no link. Evidence for a link between personality disorder and schizophrenia is also contradictory.

3. Chromosomal abnormalities: It has been argued that these are an occasional cause of abnormally aggressive behaviour, in particular the XYY Karyotype.

4. Cerebral pathology: the behaviour of some brain damaged patients is similar to those with personality disorder. This link has led to speculation that personality disorder is caused by brain damage in childhood or delayed brain maturation.

5. Serotonin depletion: a variety of neurobiological studies on animals and humans have shown an association between low serotonin levels and impulsive and aggressive behaviour.

3.2 **Nurture**

1. Psychodynamic: these theories locate the cause of personality disorder in incomplete or faulty transitions in the early (speculated) stages of child development.

2. Attachment: derived from the work of Bowlby, this theory suggests that early separation of the child from its mother, or poor attachment/bonding leads to an inability to form close relationships and antisocial behaviour.

3. Social learning: this theory argues that the development of personality disorder may arise in those who condition slowly and who therefore imperfectly learn social norms. Alternatively, antisocial behaviour may be learned from and modelled by parents.

4. Physical and sexual abuse during childhood: some retrospective studies have reported an excess of abuse in the childhood's of those with personality disorder.
3.3 Consequences for psychiatric nursing

It is important to realise that aetiological theorising about personality disorder is not only important for clinical research and the choice of formal psychiatric treatments. For nurses, these theories can guide how they interpret and respond to the patients’ daily behaviour and interactions on the ward. How these theories influence nursing care has not before been a topic for investigation, however it may readily be seen that a ward in which the nursing team is strongly and coherently viewing all patient behaviour in psychodynamic terms will be a very different environment from another that has a strong commitment to organic theories.

4. Personality disorder in the English High Security Hospitals

4.1 Descriptive research

Little exists in the way of systematic descriptive research about the care of personality disordered patients in the High Security Hospitals. Richman (1998) reports an ethnographic, participant observation study, conducted on one PD ward at Ashworth Hospital during 1988. This provides the sole empirically derived piece of work conducted by an objective observer into the daily life and functioning of this type of ward, usefully describing the patients’ as well as the staff's point of view. Richman tells us how the patients believed both themselves and their ward to be "special", a place where they had privileges in accord with this enhanced status. Thus patients believed that they had been able to block some admissions and transfers in to the ward, and kept themselves together as an exclusive group within the hospital as a whole. They were willing and able to challenge the authority of the staff at every turn, whether this was in an attempt to stretch the ward regulations or assert their moral superiority over the staff. Staff were regarded by patients as being there for their benefit, and were made to work hard. For example any attempt by staff to stretch their meal breaks would be met with urgent requests or a manufactured incident that demanded the nurses’ presence. Nurses’ loyalty and trustworthiness were tested by patients, who fed them confidences to see if they were maintained or not. A clear patient hierarchy was visible with two pairs of patients competing for leadership, with symbolic displays of power and status being regular events. According to Richman, nurses were valued by the personality disordered patients not for their professional expertise, but because of their personal characteristics (e.g. openness, humour, non-judgemental attitude, physical prowess, honesty, etc.). Through Richman's eyes we gain an insight into the realities of daily life for nurses and patients on a PD unit, thus his account is rare and extremely valuable.

Details about the demography and diagnostic mix of patients in the High Security Hospitals have been published. Coid (1992) compared male and female patients detained in these hospitals with prisoners detained in special units due to dangerousness, using the Hare PCL and the DSM-III criteria. At that time 179 patients were legally classified as "psychopaths" within the hospitals. Using the Hare PCL 77% of the male psychopaths did not meet the criteria for that diagnosis, in contrast to the male prisoners where 77% did. Using the DSM-III criteria, most patients were found to fit multiple diagnostic categories. Borderline and avoidant personality disorder were more prevalent in the female psychopaths, with borderline,
antisocial and narcissistic being the most frequent diagnoses for male psychopathic patients. By these criteria, far fewer male patients (7%) failed to meet the criteria for a diagnosis of personality disorder. Interestingly, the male prisoners were still the most pathological group.

4.2 Ashworth Hospital

Late in 1993, as part of the response to the Blom-Cooper (1992) report, this Hospital re-organised and opened a special unit for patients with personality disorder. This was composed of six wards catering for 130 patients, and is said by Storey et al (1997) to be the largest single unit of its type in Europe. Nurses were allocated to work on this unit regardless of their wishes and desires. As this was the first such unit in High Security Hospitals, the staff had little specific experience upon which to draw, and the necessity for training input was identified at an early stage. Given the paucity of literature on the practical psychiatric nursing care of this difficult group of patients, staff had to create the regime and culture by themselves. The downside of this situation has been a number of untoward events resulting in internal and external inquiries. Among the benefits has been the development by trial and error of psychiatric nursing expertise in dealing with the personality disordered individual, which is now being shared via the literature by nursing staff from Ashworth Hospital (e.g. Melia et al 1999, Moran & Mason 1996).

4.3 Broadmoor Hospital

Unlike the other two hospitals, Broadmoor does not have a defined and separate personality disorder unit. However it does have several wards where patients with personality disorder tend to be concentrated. The first is Glastonbury ward, an addictive behaviours unit using a very broad definition of addiction and well described by McKeown et al (1996a). The second is Woodstock ward which specialises in the care of young male patients (Brett 1992). The third is Leeds ward, a female ward where the dominant diagnosis is that of personality disorder. These three wards have been running in accord with their current philosophy for some years.

4.4 Rampton Hospital

The PD unit at Rampton Hospital is of fairly recent origin, being founded as a single ward in 1996 and now consisting of a three ward unit consisting of admission, treatment and pre-discharge wards. Although planned on a remarkably short time scale (8 weeks), the unit has followed a policy of only recruiting staff who actively apply to work there (in contrast to Ashworth). The unit has defined admission criteria, prefers to take transfers of sentenced prisoners, and the primary diagnoses of most patients are antisocial and/or Borderline personality disorder. Treatment is mainly cognitive-behavioural in emphasis, although some therapeutic community principles are followed.
5. Nurses attitudes to personality disorder

It is almost a truism to state that psychiatric nurses (and psychiatrists, Lewis & Appleby 1988) tend to dislike personality disordered patients. Moran & Mason (1996) write about the care of personality disorder within the High Security Hospitals, that "Few psychiatric nurses prefer to care for this patient group and tend to dislike this population." p189.

In the psychiatric literature, a link between difficulties in inpatient management and subsequent suicide has been made, mostly in relation to those patients considered to be suffering from Borderline Personality Disorder (BPD). Adler (1973), Friedman (1969), and Gunderson (1984) all describe increasing malfunctioning and suicidal behaviour of patients within the context of negative reactions by staff, in a form very similar to that which Morgan and Priest have termed malignant alienation. Kullgren (1985), in a retrospective analysis of 11 cases of BPD who committed suicide during inpatient treatment, showed that in more than half the cases rejecting or repressive characteristics could be found in the treatment given. Using a similar methodology, but adding a matched control group of BPD sufferers who did not commit suicide, Kullgren (1988) showed that for 5 of 11 completed suicides, discharge was being planned due to perceptions that the patients were manipulative, or that they were not suffering from serious psychiatric disorder.

Many mental health professionals feel particularly alienated to patients diagnosed as having a borderline personality disorder (Gallop et al, 1989). Although there is considerable controversy about the nosological status of this disorder, most mental health professionals agree the term is useful (Spitzer et al, 1979). Such patients are likely to repeatedly harm themselves (Brodsly et al, 1995) and commonly induce strong counter-transference reactions in staff (Rosenbluth, 1991).

Two reviews of the nursing literature (May and Kelly1982, Ganong et al 1987) on "good" and "bad" patients show that nurses tend to express negative judgements about patients who are (a) perceived as hostile, uncooperative, complaining and manipulative; (b) suffering from chronic or stigmatised illnesses; (c) making staff feel ineffective. Personality disordered patients fit several of these characteristics, and studies of nurses show that they also have negative responses to patients who self-harm (e.g. Sidley and Renton 1996, Suokas and Lonnqvist 1989).

Plentiful evidence exists that nurses become alienated from disliked patients. Using systematic observation techniques, Hamera and O'Connell (1981) demonstrated reduced numbers and duration of contacts with such patients, as did a study by Podrasky and Sexton (1988). An alternative approach to investigating this issue has been in-depth qualitative interviews with nurses. Using this methodology, Smith and Hart (1994) showed that intense encounters with angry patients could lead to nurses disconnecting and withdrawing from patients, and McCrea and Crute (1991) found that midwives reported avoiding patients who "had no clear needs" in their eyes. Also, Macilwaine (1981) reported that, on acute psychiatric wards, neurotic patients are viewed by nurses as "not really ill", and tend to be ignored. The concept of malignant alienation was first introduced by Morgan and Priest (1984) and was based upon their analysis of 26 unexpected deaths among psychiatric inpatients. They discovered that a significant number of patients who committed suicide lost support
from others in the last few weeks of their lives. Staff became critical of these patients' behaviour, which was perceived to be provocative, unreasonable, and over-dependent. They named this process malignant alienation. They later replicated these findings (Morgan and Priest 1991), showing that out of a further 32 completed suicides of psychiatric inpatients, 15 had become alienated in some degree from others. Although Watts and Morgan (1994) further discussed the phenomenon from a psychodynamic perspective, no further empirical work has been carried out.

In a rare controlled study, Miller and Davenport (1996) demonstrated that an educational programme may help to change negative staff attitudes to such BPD patients. Although the sample for this study was small, and was based upon a self administered learning package, improvements in both knowledge and attitude were demonstrated. This holds out the hope that similar interventions may work with nurses negative attitudes towards personality disorder in general.

The rating of nursing attitude used in the Miller & Davenport (1996) study remains unpublished and it has not been possible to obtain a copy. Lewis & Appleby (1988) also developed their own 22 item semantic differential scale to be used in conjunction with a variety of forms of the same case history. The only other research scale that has endeavoured to assess staff's emotional response to difficult patients is the Hospital Treatment Rating Scale (HTRS, Colson et al 1986). Published psychometric data on this scale is incomplete, and it consists of several subsections with different properties. However it's use in long term psychiatric care settings has revealed that staff consider patients with "character pathology" to be particularly difficult. In short there is no adequately tested scale to assess nursing attitudes to personality disordered patients.

6. Nursing care and treatment of personality disorder

6.1 Nurse-patient relationships

Since the work of Peplau in the 1950s, who brought the neo-Freudianism of Harry Stack Sullivan into the nursing literature, psychiatric nursing textbooks have given a dominant emphasis to the importance of the nurse-patient relationship. This emphasis has been well received by psychiatric nurses in the UK, as it harmonises with the reality of their daily work with the mentally ill. It has been so frequently remarked as to be a truism, that nurses spend the most time with patients and therefore develop strong relationships with them. Nurse-patient relationships are seen in a variety of ways within the psychiatric nursing literature. In their formal derivation by Peplau from neo-Freudianism, such relationships are seen as a psychotherapeutic method in themselves. Others have interpreted them as being a necessary means of delivering nursing care, or a method of humane control of patients, particularly in relation to the prevention of violent incidents. At the very least, good nurse-patient relationships are necessary for a ward to operate harmoniously, making daily life together bearable and reasonably smooth.

Noak (1995) reflects some of these perspectives, and argues that a good nurse-patient relationship enables the nurse to become an advocate of the patient, and allows the nurse to get to know the patient well thus developing empathy. He also argues that
a good relationship assists the patient to become engaged with and committed to therapy, and provides interpersonal continuity and stability. He therefore appears to see the nurse-patient relationship as having a restorative or re-parenting function, as well as a means by which patients ambivalent about treatment may be engaged with the process using the leverage that a relationship supplies. These are laudable goals, but Noak cannot point to any empirical evidence that they can be accomplished, neither does he define in any detail exactly what constitutes an effective nurse-patient relationship with a person suffering from a personality disorder.

Noak (1995) identifies that the main threat to good nurse-patient relationships comes from the manipulative, rule breaking, boundary pushing behaviour of personality disordered patients. He suggests that this needs to be counteracted by nursing team consistency, multidisciplinary team support, and the recognition of manipulative behaviour as manipulative by managers. Neilson (1991) also sees manipulative behaviour as a threat to therapeutic nurse-patient relationships, identifying the remedy as nursing team consistency. However he perceives personality disordered patients as capable of a second means of upsetting and destabilising good nurse-patient relationships: splitting. He conceives of this in its psychodynamic sense as the projection of good and bad aspects of the self onto the nursing team. He goes on to describe how this can have two negative outcomes, (i) the production of sentimentalised and over-dependent good relationships with some staff, and (ii) the production of enmity, hostility and avoidance in and by other staff. Finally he argues that this can result in conflict between the team. His solution is that nurses need to encourage an open and accepting atmosphere for the team, and make good use of conflict resolution strategies.

The daily reality of nursing relationships with personality disordered patients has been described nowhere better than by Melia et al (1999). Due to the characteristics of patients, relationships are highly charged and emotionally intense, with high levels of anger and hostility on the part of patients towards nurses. The patients’ expectation of harm and exploitation leads them to seize upon signs of behaviour indicating this on the part of the nurses, resulting in recriminations, accusations, and loyalty testing behaviours. Thus they alternate between possessive and dismissive attitudes to the nurse. They blame others for their past actions and current predicament, seeking to recruit any sympathetic nurse to this point of view. Melia et al do not cast "splitting" in the same psychodynamic light as Neilson. Instead they view it as a number of related behaviours for which they offer no motivational explanation. The first of these is complaining to one member of staff about the actions of another, and second persuading individual staff to "bend" the rules. The third is when a patient tries to create a special and secretive relationship with an individual member of staff. All produce team conflict that can be further exploited by patients. Melia et al therefore see the nurse-patient relationship as a therapeutic tool whereby patients can learn a different psychosocial world view closer to that of everyday society, primarily via guided reality testing and feedback.

For Melia et al the solution to the problems and tensions generated within nurses' relationships with personality disordered patients lies in the organisation and structuring of nursing care. Ward based nursing care has traditionally been task orientated, i.e. the ward has a set routine and a usual number of tasks to be undertaken during a nursing shift. These tasks are allocated to members of the nursing team by
the nurse in charge who ensures that they are satisfactorily carried out. This method of ward organisation declined in the 1970s and was replaced by primary nursing (Bowers 1989). Under primary nursing, the nursing care of individual patients is allocated to nurses, and such care spans the shift system, thus encouraging the development of individualised nurse-patient relationships. Melia et al consider that this approach isolates individual nurse-patient dyads and may accentuate the difficulties engendered by those with personality disorder. Thus they recommend the introduction of triumvirate nursing: a system whereby nurses work in teams of three, each with equal responsibility for nursing their patients. The three nurses then clinically supervise each other, providing support and objectivity via meetings of the triumvirate. Melia et al do not therefore describe the therapeutic mechanics of using the nurse-patient relationship to achieve change and growth for personality disordered patients. This is a shame as such descriptive nursing care information does not completely exist in the literature, and the authors so obviously do have this expertise. Instead they concentrate on how triumvirate nursing can be used to contain the patient and avoid the potential negative outcomes of their methods of relating to the nurses. Valuable though this is, it is a defensive strategy that implies success is the resistance of manipulation and splitting.

In an earlier paper by some of the same authors (Moran & Mason 1996), an attempt is made to describe what nurses should be "doing" with personality disordered patients. This description is a response to the fact that while debate on the definition of personality disorder and appropriate legal frameworks for care rumbles on, little actual guidance for nurses about "doing nursing" exists. They therefore describe, based upon their own clinical experience, seven principles for nursing care. Some of these can usefully be viewed as ways in which the nurse-patient relationship can be therapeutically exploited to benefit nurses and patients, others may be better perceived as attitudinal and belief prerequisites to the establishment of good relationships:

1. **Usufruct - enjoy their dynamic.** Instead of being threatened by the manipulation of personality disordered patients, nurses should seek to enjoy and appreciate seeing through it. Moran & Mason go even further and hint that this enjoyment should be shared with the manipulating patient, thus allowing nurses and patients to work together constructively rather than antagonistically in defining the ward's rules.

2. **Never be surprised.** Sudden changes in the attitude and demeanour of personality disordered patients should be met in the first instance without surprise or judgement. In fact Moran & Mason recommend no overt emotional reaction whatsoever. They view nurses' immediate emotional reactions (e.g. anger, disgust) as allowing an opening for patients to rush them into unwise decisions and statements. Instead they recommend that nurses' should give themselves time to think carefully and calmly to arrive at a considered response.

3. **Humour.** Moran & Mason argue that humour can be used by nurses in a variety of ways: to tell uncomfortable truths without confrontation, to defuse tense situations, and when used in a self-deprecating way can hinder patients' attempts to dominate nurses through ridicule.

4. **99% honesty.** Moran and Mason recommend that nurses are honest to the point of discomfort with personality disordered patients. Unfortunately they do not specify...
what nurses should be honest about, nor in what situations, while they do assert that patients will not like it in the short term.

5. Destabilising the static. Personality disordered patients on a ward form into a fairly rigid hierarchy or dominance order. Moran and Mason suggest that it is the nurses place to move up and down through different levels of this hierarchy, presumably by supporting patients at different times at different levels of the informal hierarchy, in order to break up entrenched patterns of dominance.

6. Rule flexibility. What Moran & Mason have to say here is ambiguous and difficult to understand. At one level they appear to be saying that nurses should assist patients in the legitimate broaching of rules, with the aim of destabilising the patients' informal hierarchy. The difficulty is in defining what sort of rule bending is "legitimate". The necessity for the strict upholding of security rules, plus the Fallon Inquiry report on the disaster that ensues when they are not, makes this recommendation seem rather suspect.

7. Vulnerability. Nurses should wait for the moment when the personality disordered patient needs them and approaches them with a specific request, then in fulfilling this request they can elicit gratitude and indebtedness from the patient. Moran & Mason suggest that this can then be used to build the relationship and enables the nurse to display altruism.

Interestingly, the nursing literature on personality disorder care, such as it is, fails to mention or discuss core nursing rehabilitative functions. These have been a central part of the nursing role since the publications of Barton, Wing, and Lieberman. Either these approaches are not seen as relevant to the nursing care of personality disorder, or it is not recognised that they require a specific application to patients of this sort. Neither is the use of the nursing process or nursing models discussed. Specific applications of these nursing technologies to the care of personality disordered patients are absent from the literature. Nurses caring for personality disordered patients on the ground are therefore left to grapple with the intricacies of making these things operate in a positively functional way within the context of their particular environment, whether that be acute admission psychiatric ward, medium secure unit, mental illness ward of a High Security hospital, or specialist personality disorder unit in a High Security setting.

The problem with all of the published literature is that it represents the voice of experience, clinical lore, tradition and wisdom, but not empirical evidence. Little exists even in the way of systematic and objective descriptive research to underpin the arguments, assertions and recommendations made in the published body of clinical nursing literature.
6.2 Nursing and the Therapeutic Community

Whilst it would be true to say that therapeutic communities can differ in a number of ways - for example in philosophy, therapeutic interventions and the role of staff (Harris et al, 1994) - they also share certain characteristics, fundamental to which is the use of a democratic rather than an authoritarian regime.

Models set up by founding fathers such as Jones and Main encompass

- community treatment - where patients as well as staff are actively engaged in treatment for the community population
- therapeutic culture - where what takes place in the environment is intended to re-educate and socially rehabilitate
- living-learning confrontation - looking at where and why particular behaviours are unacceptable and at what can replace them (Kernberg, 1984)

Thus as members of the ward community, nurses play a key functional role in providing this active engagement, therapeutic culture, and living-learning confrontation. The nurses presence 24 hours of the day makes them the crucial tools in the production of the therapeutic community process.

Main aims of the therapeutic community are to foster self-esteem, more effective functioning, improved communication and a sense of responsibility in each patient - for themselves and their actions as well as towards others in the community. All of this would take place in group settings of various kinds, though some therapeutic communities do also provide individual therapy for particular patients, a difference noted by Levinson (1996) in a paper comparing the Cassel and Henderson Hospitals, both ‘therapeutic communities’. Provision of individual therapy may also help to counteract a point raised by Kernberg (1984). In a chapter entitled “The Therapeutic Community Model of Hospital Treatment for Severe Psychopathology” he foresees dangers in the proliferation of group settings for treatment, where the development of the individual may take place at the expense of others. He goes on to consider a number of assumptions made about the effectiveness of the therapeutic community model. Whilst agreeing that there are a number of ways in which it can be effective, he points to ways in which there can be negative consequences. By encouraging awareness of potential pitfalls, he hopes to aid avoidance. Included in his list is the assumption that patients can help one another. Whilst agreeing with this view, he also cautions that equally “one can find a psychopath potentially driving another patient to suicide.” Norton (1996) gives an example whereby a patient in crisis is cared for by 2 patients in particular, within a therapeutic community. Such an action meets the TC expectation of being supportive to each other; however in this instance Norton asserts that the carers were motivated in a way considered not uncommon in patients with personality disorder: that the caring was done with the idea in mind that it chalked up a favour to be returned by the recipient at some future date. Nevertheless, Norton suggests that the breaking or misapplying of rules within the clear boundaries of the therapeutic community can then be identified and addressed.

Kernberg (1984) suggests that a further assumption is that an authoritarian regime is anti-therapeutic - an assumption he agrees with where it is taken to mean
being in control of decision making beyond that which is functionally necessary. He also questions the idea that the democratic process per se is therapeutic, suggesting that there may be negative as well as positive effects. He also points out that whilst such a process underpins the aims and objectives of group meetings, for example - where decisions are made openly by the collective of staff and patients making up the community - there is a need to be clear whose responsibility it is to carry out those decisions taken and to be clear whose duty it is to monitor and evaluate how the community is working.

This is further linked to some extent to the need for harmony between the unit taking on the therapeutic community model, and the management of the hospital within which it operates. If that harmony does not exist, conflicts and problems will undoubtedly arise which have the potential to undermine the treatment process. (Kernberg, 1984) He also emphasises the need for consideration to be given to the extent patients are helped to sustain modified behaviour - learned within an ideal environment - in the external world. Certainly this is addressed by the PD service at Rampton High Security Hospital, where some aspects of the TC model have been implemented. Patients progress through an assessment ward, to a treatment unit - the ‘ideal environment’ noted by Kernberg, to a pre-discharge villa, where they need to show they can sustain their modified behaviour in an environment similar to that which they will have to cope with outside.

Finally, Kernberg suggests that staff may deny differences among patients, believing that they all have the same needs and responses, and that this may contribute to the regressive group tendencies mentioned above. Campling (1996) discusses the problems of maintaining a therapeutic alliance using examples from her experience in a therapeutic community for young adults diagnosed as having Severe Personality Disorder. She suggests that characteristically these patients find it difficult to ask for help, so use maladaptive behaviours to draw attention to their needs; however she emphasises that the response to the crisis may overlook the cause, and difficulties with the therapeutic alliance escalate. She suggests that the establishment of trust is crucial. Patients should be encouraged to both take responsibility and understand what staff see as their responsibility; further, they should try and talk about feeling self-destructive, rather than being self-destructive. Nevertheless, acting out can be dealt with by the community, both by role modelling, focusing on roles and boundaries, and understanding what lies beneath the behaviour. Otherwise “Pandemonium, muddle and rocketing anxiety levels [of the staff] will cause patients to feel dangerously omnipotent.”

The issue of difference is further addressed later when looking at outcomes, where some consideration is given to sub-groups within the ‘PD’ category -anti-social personality disorder, borderline personality disorder, severe personality disorder and so on. However, it was also consideration of the treatment needs of patients in specialised areas which led to the opening of Broadmoor Hospital’s Forensic Addictive Behaviours Unit (McKeown et al, 1996a). This unit treats those with behaviours considered to be addictive - misuse of alcohol and drugs, gambling and sexual offences, as well as concurrent clinical diagnoses, whether PD and/or mental illness. Interventions on the unit for these addictive behaviours are based on therapeutic community and group therapy approaches, as well as individual work. A TC approach is used to foster co-operative living and interpersonal skills; group work
tackles general skills such as anger management and problem solving, whilst specialist psychodynamic groups address the specific addictive behaviour. Individual work is provided through support from named nurses, and in some cases, additional work with a therapist working from a cognitive, behavioural or dynamic approach.

A further point raised by the Broadmoor team (McKeown et al, 1996b) in terms of differences between TCs is that it is usually the case that members have opted for treatment and are at liberty to leave when they wish. Obviously this is not an option in a high security hospital, but the Broadmoor team believe that compromise is possible in that patients could transfer from the unit to another ward within the hospital. The authors also point out that there is always some conflict between the need for security and the theoretical ideals of a TC, and the aim in the unit is again to achieve a balanced compromise. Pre-admission screening and initial admission assessments are used to ascertain a patient’s ability to benefit from and contribute to a TC setting, as well as the extent to which he is willing to join in group work (Quayle et al, 1996).

Therapeutic community concepts implemented on the unit include:

- the interaction within the community as treatment, which includes role modelling - of staff and ‘senior members’ with the aim ultimately of being role models themselves.

- that there is an open system of communication where patients talk about their difficulties to all members of the community - both staff and other patients - and all members work with them.

- communal meetings and communal running of the ward

- the unit aims for separateness from other parts of the hospital, though Kerberg’s fear (see above) is confirmed to some extent in that “essential hospital business sometimes intrudes in the therapeutic routine of the ward.” (McKeown et al, 1996b)

Studies pointing to the beneficial effects of this approach are summarised: assessing effectiveness includes looking at changes in how the patient feels and functions, and to what extent readmission and reconviction rates are decreased. An example given is that of Cullen’s work in a therapeutic prison (1994), which seems to indicate that less than 18 months in therapy is not sufficient to prevent re-offending behaviour. Dolan, Evans and Wilson (1992) carried out a study in the Henderson hospital, on therapeutic community treatment for PD adults, looking at changes in neurotic symptomology on follow up. Fifty percent of PD patients in the Henderson have a forensic history. Findings showed a significant reduction in symptomatic distress, with 55% improving reliably.

A study by Harris et al (1994) suggests on the other hand that the particular treatment programme of the therapeutic community they studied was not suitable for psychopaths. The programme was evaluated by comparing post release general and violent reoffending, both of psychopaths and non-psychopaths from the TC as well as control groups. Other variables considered included whether there was greater
supervision of non-psychopaths post-release. From this study, the researchers postulated that PD patients did learn, but used what they had learned to help them re-offend. These patients tended to be in the anti-social PD category and the point is also raised in the literature that perhaps these sub categories make a difference to outcomes and responses to treatment. Some authors write about the treatment of PD in general - Norton (1992) for example is adamant that when talking about treatment at the Henderson, it’s enough to say that patients are PD, without looking at sub-categories. Others are more specific. An earlier PD study at the Henderson (Copas et al, 1984) showed that

“The therapeutic community treatment is effective with selected individuals showing the anti-social behaviour associated with such disorder. In particular this treatment is of benefit to the offenders with only one conviction and who are able to persevere with treatment for a period of 6 months, for treatment to be maximally effective. The variation of psychological types within the broad category of PD was demonstrated and this has a bearing on the outcome of treatment. “

The same attitude is adopted by Linehan (1993) in relation to the efficacy of cognitive treatment, in particular with patients with borderline personality disorder.

In Dolan and Coid’s book “Psychopathic and Anti-Social Personality Disorders” (1993), the point is made that high security hospital patients receive individual packages of care, where different types of treatment may be delivered by a range of professionals. A unit may take on aspects of a therapeutic community for example, but at the same time a patient may be receiving individual psychotherapy, cognitive therapy, skills training and so on. Patients differ in the extent to which various elements are experienced, which also makes measuring outcomes difficult. The majority of studies seeking to evaluate the efficacy of TCs have been conducted outside forensic psychiatry. Some encouraging results have been obtained, but the methodological difficulties of this sort of study means that firm conclusions cannot be made. The extra difficulties involved in studying patients in the High Security hospitals means that we are forced to extrapolate the results from studies on rather different patient populations, making any conclusion of TC efficacy even more frail.

Perhaps more problematic in the High Security Hospital setting is the ability of the nurses to maintain control of the security aspects of care whilst allowing room for the community to set its own rules and allocate its own tasks. The empowerment of patients who have committed serious crimes is bound to raise concerns about safety, and there is evidence that TCs can get this judgement wrong. The Fallon Inquiry reports in detail how lax security and too much patient empowerment led to patients being able to run their own businesses, conduct catalogue fraud, import and store pornography on the ward, etc. Similar events have been reported elsewhere when TC ideals have been imported into the care of personality disordered criminals. Feldbrugge (1992) relates how a culture of drugs, threats, extortion and blackmail spanning eight wards was uncovered on such a unit in the Netherlands. These examples show that although some nursing authorities advise a liberalisation of regimes within secure settings (e.g. Neilson 1992), this should proceed with great caution. Any attempt to introduce a TC within a High Security setting should
therefore give much thought to which areas patients will be given responsibility and accountability for, and should probably come under regular external security review.

6.3 Nurse involvement in other treatments

Noak (1995) lists forensic psychiatric nurses as being involved in the delivery of a number of therapies to personality disordered patients. These include long term psychotherapy, group psychotherapy, cognitive therapy, psychosexual counselling, and behaviour therapy. The literature on these therapies is diverse, and none of the nursing literature takes up the issue of how these are to be applied by nurses within their everyday practice of caring for patients. Thus the published literature makes it appear that nurses jump in and out of the role of “psychotherapist” as group or individual sessions begin and end. How this is managed, how it overflows into daily nursing care, or into the general behaviour of patients, is not considered anywhere as a topic for discussion. Tennant & Hughes (1997) provide a case study that exemplifies a representative mix of therapeutic interventions. Eight are named in the care plan, seven of which are individual or group therapeutic sessions. Only the one remaining has any reference to daily life on the ward, and even that makes no mention as to how the patient is to be managed within the context of the ward community. In a second paper, Tennant & Hughes (1998) describe the use of a "men's group" with violent personality disordered offenders, focusing on dysfunctional concepts of masculinity, and Aiken & Sharp (1997) describe a psychodynamic psychotherapy group. Again the therapy is described separately from daily nursing care. Only the TC literature (e.g Yurkovich 1989) makes clear how, by that model, “therapy” and “nursing” can be an integrated whole. A rare exception to this is a study by Cremin et al (1995) that describes how a psychodynamically informed style of interaction can be incorporated into everyday nursing interaction with impulsive, self harming, personality disordered patients. The study was of an extremely small sample (four cases), but did produce results suggesting that nursing interactions can reduce self harming behaviour.

A number of factors may influence the degree to which psychiatric nurses become involved in formal psychotherapeutic approaches. The constraints of staffing shortages and the shift rotation system may make it difficult for nurses to be involved at all. Secondly, these therapeutic skills are difficult for nurses to acquire, and are not taught in any depth during basic nurse training. Hence only the most keen and dedicated nurses manage to secure sufficient training to play a lead role in formal therapy. Lastly, inter disciplinary conflict and competition between the psychiatric professions may make it hard for nurses to gain access to groups as co-therapists, or for them to gain high quality supervision and/or recognition for their work. None of these practical factors are comprehensively discussed in the nursing literature about personality disorder care, although some are mentioned in descriptive and exploratory research about psychiatric nursing in general. The only paper that addresses the training issues is that by Hughes & Tennant (1996), who describe how three differing levels of training in cognitive behavioural interventions were delivered to personality disorder unit nursing staff at Rampton Hospital. These authors sensibly tackle the practical issues involved in this type of exercise.
6.4 Nursing care and security

In the UK High Security Hospitals psychiatric nurses are responsible for security as well as the therapeutic aspects of care. This has been discussed at length by Burrow (1991, 1998), who describes how nurses keep doors locked, search wards, rooms and patients, monitor mail, telephone calls and visitors, escort patients to different parts of the hospital, and manage parole systems. The requirement to rigorously operate such systems when they are disliked and rejected by patients is a hindrance to the formulation of adult-adult relationships between nurses and patients, and makes it difficult for nurses to act on any way as patient advocates. However it may be that this debate has been overblown in relation to forensic psychiatric nurses, as all psychiatric nurses working in acute care have responsibilities for security, albeit of a lesser intensity in general hospital settings. In any case, Burrow (1998) recommends that therapy and security can be melded in nursing practice if security is stated in terms of patient care.

Recently, variance in security practices between the different High Security Hospitals, plus variance between units within individual Hospitals, has been identified as a source of serious untoward events by the Fallon Inquiry. This variability has been shown to exist at every level, and in the worst cases multidisciplinary teams have been allowed to determine their own security policies with disastrous results. These events indicate that rigorous security procedures within forensic psychiatric settings are a prime duty of the nurses, in order to maintain the safety of patients, others, and themselves.

7. Summary

The literature describing the nursing care of patients with severe personality disorder in secure settings is more notable by its absence than its presence. Clearly there exists a vacuum of practical guidance and of research results. Work on developing valid and reliable diagnostic categories underscores the variety of behaviours currently classified under the rubric personality disorder, and implies that many differing nursing strategies are needed to provide care and treatment. Theoretical thinking on the causes of personality disorder is also enormously varied, and is likely to shape the way that nurses interpret and respond to the behaviour of personality disordered patients on the wards. However literature that explores this implied diversity of psychiatric nursing care does not currently exist. The literature which is available indicates that nurses find personality disordered patients difficult to care for and can have profoundly negative attitudes towards them.
Chapter III
Methodology

1. Aims of the study

To identify the factors underlying and maintaining nurses’ positive therapeutic attitudes to patients with severe personality disorder, to inform a support and training strategy to nurture such attitudes.

Subsidiary questions:
Do beliefs relate to age, experience, gender and grade? Do cynicism and negative beliefs increase in breadth and intensity with experience?
Do individual hospitals have individual and discrete cultures in relation to the care of PD patients?
Is what keeps nurses going with this patient group an ethical imperative?
Is there a third way for nurses, between naïve faith in treatability and cynical punitive attitudes? If so, can it be elicited from nurses who have found this way, what beliefs is it composed of, and how are those beliefs maintained in the face of the rest of the nursing culture?

2. Attitude to Personality Disorder Questionnaire (APDQ) survey

2.1 Piloting of questionnaire

An initial version of the questionnaire was drawn up using the team's knowledge of the relevant literature, a section of the Hospital Treatment Rating Scale, and suggestions/feedback from the Steering Group.

These were distributed to Forensic Psychiatric Nurses on a course at City University, and to a convenience sample of local psychiatric nurses (41 in all). Initial analysis allowed the dropping of some items from the scale, and the rephrasing of others. The final version may be found in appendix 2.

2.2 Distribution

Staff lists were provided by each Hospital's personnel department. Questionnaires were distributed in individually addressed envelopes containing reply paid envelopes to every nurse in each High Security Hospital six weeks prior to the interviews. Returned questionnaires were not individually identifiable, so personalised follow up to non responders could not be conducted. It was decided that ensuring the anonymity of respondents was more critical to the response rate than the potential to send reminders. As an alternative, bundles of duplicate questionnaires were delivered to each of the wards by the research assistants at the same time as they were conducting the interviews.
2.3 Response rate

The overall response rate was 26%. This relatively low response rate is typical for research in the High Security Hospitals. In order to assess for non-response bias, the gender and grade mix of the responders was compared to that of the non-responders. This analysis indicated that the responders were representative with respect to gender, however there was a particularly low rate of response for unqualified staff. PD unit nurses had a much better response rate, but this cannot be precisely calculated because for the survey nurses were asked to define for themselves whether they worked on a PD unit or not. These self-definitions probably do not precisely match those used by the research team. The better response of PD unit nurses means that the survey is well representative of their views. The refusal rates for the interviews was less than 10%, and the range of attitude to PD measured from those interviews matches accurately the variation in questionnaire responses by hospital, grade and gender. This implies that, even though the questionnaire response rate was low, the sample obtained was representative.

3. Interview survey

3.1 Preparation and piloting

Both research assistants recruited to the project had previous training and experience of conducting research interviews. Additional individual training was given. The interview schedule was piloted with 5 members of the University with experience of working with personality disordered clients, in order to perfect the schedule and develop the interviewing skills of the researchers. The senior research assistant, who has considerable experience in fieldworker training, gave individual feedback on style and follow-up questions to the researchers. In order to improve parity of interviewing styles the researchers interviewed each other, and listened to each other’s interviews on tape.

Semi-structured interview schedules were developed, based upon a literature review and the theoretical thinking of the research team. Additional items and changes were suggested by the steering group.

Both research assistants used this preliminary schedule with 4 volunteers from within the Department of Mental Health Nursing at City University, following which additional changes to the schedule were made. Once finalised, the interview schedule has not been changed in order to maintain consistency of responses and comparability between Hospitals. The final version can be found in appendix 3.

Consistency between the two interviewers was attained by:
1. Interviewer training was conducted with the two research assistants together.
2. Pilot interviews were conducted in the presence of the other research assistant.
3. During the data collection period at each Hospital, the research assistants (a) discussed in detail the way their interviews were progressing and how replies to each question were working out, and (b) listened to tapes of each other’s interviews.
4. Following each site visit, interview transcripts were examined by the project leader, who gave feedback to the research assistants together.
3.2 Sample

Following the obtaining of staff lists from the Hospitals it was discovered that standard stratified random sampling for PD unit and non PD unit staff would yield only very low numbers of staff from the PD units - in fact numbers which would be far too small to generalise from. This is because the numbers of staff working in the PD units form only a small percentage of the whole. As the purpose of the research is to identify what factors support positive long term attitudes to PD, it was decided to take roughly half the sample from the pool of PD unit staff. Stratification proportional to grade was maintained.

Full nursing staff lists, as provided by the personnel department at each Hospital, have been used to draw the samples. Both day and night staff are being interviewed. Research Assistants are conducting interviews at night where necessary. Following drawing of the sample, each potential interviewee is contacted by phone to obtain their preliminary consent. Refusals have been very low (7% at Rampton). Where a refusal has occurred, a replacement is drawn from the sample pool.

3.3 Transcription

All 121 interviews were tape recorded and fully transcribed. Following transcription, each tape/transcript was listened to again by members of the research team to clean out any inaccuracies and errors.

3.4 Data analysis

In order to facilitate coding and analysis of the data, all transcripts were imported into qualitative data analysis software (QSR.NUD.IST version 4).

The first seven transcripts were explored separately by the six members of the research team, and an initial coding list drawn up. A further five transcripts from later in the interview series were then inspected by three of the research team to check for completeness and definition of the preliminary coding list. Small adjustments were then made and a strategy for coding created.

All 121 interviews were coded by one researcher (LB) on overall attitude to PD using the dimensions of analysis provided by the factor analysis of the APDQ. A random sample of 30 of these were independently coded by another researcher (blind to the initial ratings) using the same method, yielding an intraclass correlation coefficient of 0.96.

Responses to individual questions were collected and analysed together. As some topics spanned several questions, or material on some topics was spread throughout the interviews, analysis via question responses was supplemented (and in some cases replaced) by text word searches. The material thus gathered was read, and then coded into appropriate categories before being finally analysed and described. Categories of content, or of responses to individual questions, were quantified and related to overall attitude to PD using contingency table analysis.
4. Reception of the project at each of the high security hospitals

Support from each of the Hospitals has been enormous. Each Hospital has devoted time and considerable resources into providing site visits for the induction of the research team. The opportunity for the research team to meet senior staff and nurses on the wards has been absolutely invaluable. Everywhere our team has been we have been met with openness and interest.

All three hospitals have appointed liaison staff who have devoted time to ensuring that the research assistants can access staff for interviews at appropriate times and places. In addition, POA and RCN representatives at these Hospitals have given the project their backing. Without this level of support carrying out this research would have been much more difficult, if not impossible.

5. Support in steering group

The project steering group has met once and contributed to the content of questionnaires, interview schedules, and helpfully advised on the organisation and administration of the project in the High Security Hospitals. A further meeting will be called when interim results are available, in order to advise on interpretation of the data.
Chapter IV
APDQ Survey Findings

1. Response rate

The following table gives the response rates for the different hospitals:

<table>
<thead>
<tr>
<th>Hospital</th>
<th>No. of staff</th>
<th>No. respondents</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ashworth</td>
<td>1044</td>
<td>280</td>
<td>26.82</td>
</tr>
<tr>
<td>Broadmoor</td>
<td>656</td>
<td>176</td>
<td>26.83</td>
</tr>
<tr>
<td>Rampton</td>
<td>803</td>
<td>195</td>
<td>24.28</td>
</tr>
<tr>
<td>All</td>
<td>2503</td>
<td>651</td>
<td>26.01</td>
</tr>
</tbody>
</table>

2. Statistical methods of analysis

The questionnaire consists of three sections. The first is demographic data about the respondent and is nominal, the second (Section A) consists of likert scale responses to affective statements about PD patients and is interval data, and the third (section B) are mainly graded respondent assessments of treatment difficulty and have been treated as ordinal data. All data were analysed using SPSS v7.5.

Sub groups of responders were assessed for differences on section A using $t$ tests, and on section B using chi square. Where appropriate to the nature of the data, Pearson r correlations have been used. Responses to section A were subjected to principal components analysis with varimax rotation. This identified 6 components with eigenvalues greater than one. Mean scores on the factors were then calculated for each respondent, and these were analysed using one way ANOVA.

3. Validity and reliability

The validity of the questionnaire is endorsed by the fact that differences were found between staff who worked on PD units and those who did not, in the expected direction of PD unit staff having a more favourable attitude. Internal consistency of section B of the scale is high, with a Cronbach alpha of 0.94. Test-retest reliability of the scale has not as yet been assessed.

4. First level analysis

4.1 Staff demographics

The largest single group of respondents were in their 30s, with relatively few in their 20s. This would appear to indicate a fairly mature mix of staff, given that entry to nurse training is conventionally in the late teens and early twenties. There were roughly 2 male nurses to every female nurse currently working in the High Security Hospitals. Most nurses had (61%) worked outside the High Security hospital system.
at some stage in their previous career. These hospitals cannot therefore be seen as static closed institutions and must be open to change and influence from outside. Most staff had a relatively small amount of experience of working in the High Security Hospitals (under 5 years). Turnover is highest amongst unqualified staff, with 82% of A grades having less than five years experience, compared to 39% of E grades and 18% of F grades.

4.2 Responses to affective questionnaire items

Principal components analysis with varimax rotation of the responses to the affective statements in section B of the questionnaire revealed six components with eigenvalues greater than one. The results of the KMO and Bartlett's tests were satisfactory, indicating that the analysis was statistically valid.

The six components (and the items upon which they are based) were:

1. Enjoyment/loathing. Like, respect, fondness, closeness, excited, admire, enjoy, warm & caring, protective, understanding, happy, fulfilled, patient, able to help, interested in. 21% of variance.

2. Security/vulnerability. Vulnerable, manipulated, uncomfortable, helpless, frightened, oppressed and powerless, outmanoeuvred, exploited, unable to gain control. 17% of variance.

3. Acceptance/rejection. Angry, shudder, irritated, alien and intolerant. 8% of variance.

4. Purpose/futility. Timewasting, pessimistic, resigned. 6% of variance.

5. Enthusiasm/exhaustion. Frustrated and drained. 6% of variance.

6. Caution. 4% of variance.

Overall, nurses found it harder to endorse positive affective statements about PD patients (e.g. fulfilled, happy, warm) than they did negative statements (e.g. exploited, intolerant). The negative statements that were least likely to be endorsed were feelings of oppression and powerlessness.

4.3 Responses to non-affective questionnaire items

Most nurses viewed PD patients as a difficult patient group to care for and treat. Less than 1 in 10 nurses considered them to pose no or mild difficulties. The large majority of nurses considered that PD patients would not engage with treatment or have a good outcome. Less than 1 in 5 nurses expressed any optimism about the treatment of PD patients.
Although the balance of opinion was that PD patients should continue to be cared for in High Security Hospital settings, there was considerable divergence and little sign of any consensus among nurses on this issue. There was strong support from nurses that PD patients should be cared for in specialist wards (more than 70% of respondents). That this opinion was expressed against the backdrop of the ongoing Fallon Inquiry makes this finding even more striking. It may be that large numbers of nurses simply want PD patients cared for elsewhere - if not in prison then in a separate part of the hospital. However, for answers to this question, the distribution of opinion among nurses working on PD units was identical to that of nurses working on other types of ward. On cross gender care, it was clear that the weight of nursing opinion was that PD patients (of either gender) should be cared for by nurses of both genders (65% supported this).

Most nurses felt unprepared and less well trained to work with PD patients. However the situation was not completely bleak, as 1 in 4 nurses did consider that they had been adequately trained. Those working on the PD units were more likely to indicate that they considered themselves adequately trained (30%), in comparison to those who worked on other types of ward.
5. Second level analysis

5.1 Results by hospital

On nearly all items, section A and section B, including negative affective statements, Rampton staff are the most positive and Ashworth staff the least positive. Significance by chi square tests on these items is in the majority of cases at the p < 0.01 level or higher. A typical result is displayed by responses to the question on whether prison is a more appropriate environment for PD patients than hospital (p < 0.001 by chi square):

One way ANOVA demonstrates that all six factors of the scale follow the same pattern with Rampton being the most favourable and Ashworth the least: enjoyment (factor 1, F = 15.554, p < 0.001), vulnerability (factor 2, F = 18.892, p < 0.001), rejection (factor 3, F = 15.71, p < 0.001), futility (factor 4, F = 18.135, p < 0.001), exhaustion (factor 5, F = 9.628, p < 0.001), caution (factor 6, F = 13.147, p < 0.001).

5.2 Results by age

Simple contingency table analysis of items by age group of respondent leads to only one significant finding: older nurses are more likely to support the assertion that male nurses should be involved in the care of female PD patients (p = 0.005 by chi square).

However one way ANOVA of the mean factor scores by age group shows that factor 4 (futility, F = 2.226, p = 0.05) increases with age, and factor 5 (exhaustion, F = 4.817, p < 0.001) peaks at 30-39 and declines thereafter.

5.3 Results by gender

Female nursing staff are more optimistic about the treatment of PD (p < 0.001 by chi square), less likely to think prison more appropriate (p < 0.001 by chi square), more likely to think they should care for male patients (p < 0.001 by chi square), and believe men should care for females (p < 0.001 by chi square). They also consider
themselves better trained for the care and treatment of PD patients than the male nurses (p = 0.052 by chi square).

One way ANOVA of the factor means shows several significant differences between male and female nurses. Female nurses are more likely to express enjoyment (factor 1, F = 35.632, p < 0.001), less likely to express rejection (factor 3, F = 7.184, p = 0.008), less likely to have a sense of futility (factor 4, F = 12.1, p = 0.001), and less likely to express a feeling of caution (factor 6, F = 4.848, p = 0.028).

Therefore in every case where female nurses show significant differences from male nurses, those differences are in the direction of a more positive, favourable and sympathetic stance towards PD patients. However, they feel just as vulnerable and just as emotionally exhausted as do the male nurses.

5.4 Results by nursing grade

Because 10 categories of nursing grade were used, interpretation of contingency table results is difficult. The nursing grades were therefore split into 3 groups for this analysis: A & B grades (unqualified nurses); C, D & E grades; F, G, H, I & other grades.

A & B grades are least likely to consider the care and treatment of PD patients to be difficult (p < 0.001 by chi square), are less likely to agree that female nurses should care for male PD patients (p = 0.002 by chi square), and are more likely to rate teamwork in caring for PD patients as good (p = 0.007 by chi square).

C, D & E grades are least likely to consider themselves adequately trained to work with PD patients (p = 0.043 by chi square), and are the most pessimistic about care & treatment outcomes (p = 0.012 by chi square).

F, G, H, I & other grades are more likely to be optimistic about the outcome of treatment (p = 0.012 by chi square).

One way ANOVA showed that all factors except factor 2 (vulnerability) vary significantly by grade. However much of the variance seems to be coming from 3 C grade staff. These were therefore excluded and the analysis repeated, resulting in differences on factor 3 (rejection) and 4 (futility) disappearing. Enjoyment (factor 1, F = 4.749, p < 0.001) runs roughly by grade, the higher the grade, the more positive the affect. Exhaustion (factor 5, F = 2.085, p = 0.035) increases as grades go up until above F, when it then falls. Caution (factor 6, F = 2.895, p = 0.004) decreases as grades go up.

5.5 Results by years since qualification (excluding unqualified staff)

One way ANOVA showed that futility (factor 4, F = 2.323, p = 0.042) increases sharply after more than five years experience and then stays high, and exhaustion (factor 5, F = 4.433, p = 0.001) peaks at 5 - 10 years experience and then gradually declines.

5.6 Results by experience outside the High Security Hospitals
Those who have worked as nurses (qualified or unqualified) outside the High Security Hospital system are more likely to regard the care and treatment of PD patients as difficult (p = 0.016 by chi square), are less likely to rate teamwork with PD patients as good (p < 0.001 by chi square), are less likely to support cross gender care (female nurses for male patients p = 0.01 by chi square, male nurses for female patients p = 0.008 by chi square) and are less likely to consider themselves well trained to work with PD patients (p = 0.042 by chi square).

One way ANOVA shows that staff with experience outside also score more highly on exhaustion (factor 5, F = 4.212, p = 0.041).

For all items for which significant differences exist, nursing staff with experience outside the High Security Hospital system feel less confident in their ability to care for and treat PD patients.

5.7 Results by current work area (PD ward vs. Other)

PD unit nurses did not rate the care of PD patients as easier, or approve of cross gender care, or even consider PD units better than conventional wards, to any greater or lesser degree than nurses working on other types of wards and units. However they were more likely to be optimistic about treatment outcomes for PD (p = 0.001 by chi square), rate teamwork as better (p = 0.002 by chi square), and consider hospitals a better environment for care than prison (p < 0.001 by chi square).

One way ANOVA shows that only enjoyment (factor 1, F = 13.9, p < 0.001) is higher among PD unit nurses. Vulnerability, rejection, futility, exhaustion and caution are all shared to the same degree by PD and non-PD unit nurses.

5.8 Multiple regression of demographic variables on mean factor scores

In order to assess the relative contribution of the demographic variables to overall attitude to PD patients, multiple regression of those items on the mean factor scores was undertaken. In order to do this some categorical variables (gender, hospital and grade, experience of working outside the High Security Hospitals, PD vs. non PD unit) were effect coded using dummy variables (Hair et al 1998). The resulting regression equations (without constants) were as follows:

Mean APDQ score (on affective statements only) = 0.31(Hospital) + 0.13(Grade) + 0.12(Gender)
Rampton Hospital, higher nursing grade and female gender result in more positive scores, i.e. the mean APDQ score is determined 31% by hospital, 13% by nursing grade and 12% by nurse gender.

Enjoyment/loathing = 0.25(Gender) + 0.22(Grade) + 0.19(Hospital) + 0.13(PD vs. non PD unit)
Female gender, higher nursing grade, Rampton Hospital and working on a PD unit result in more positive scores on this factor.

Security/vulnerability = 0.29(Hospital)
Hospital alone affects this mean factor score, with Rampton Hospital nurses feeling most secure and Ashworth Hospital nurses the least.

Acceptance/rejection = 0.24(Hospital) + 0.12(Grade)
Rampton Hospital and higher nursing grade mean that nurses are more accepting of PD patients.

Purpose/futility = 0.22(Hospital) + 0.15(Gender) + 0.1(PD vs. non PD unit)
Rampton Hospital, female gender and working on a PD unit result in a more purposeful and optimistic outlook.

Enthusiasm/exhaustion = 0.23(Hospital) + 0.17(Age)
Rampton Hospital and younger age mean that nurses are more energetic.

Caution = 0.21(Hospital) + 0.14(Grade)
Rampton hospital and higher nursing grade result in less expressed caution.

Clearly the largest and most consistent determinant of nurse's positive attitude to PD is the culture of the hospital where they work, followed by their gender and their nursing grade.

6. Third level analysis

6.1 Comparison of results between hospitals

At all three hospitals greater age is partially linked to a less favourable and sympathetic attitude to PD patients. This link is strongest at Ashworth hospital, almost absent at Broadmoor hospital, and equivocal at Rampton hospital.

In every hospital female nurses display a more favourable and sympathetic attitude to PD patients. However these differences are more accentuated in Rampton hospital and at their weakest in Broadmoor hospital. In all three hospitals there is a tendency for higher grades to display more favourable attitudes to PD patients. However Ashworth is dramatically different, in that although enjoyment increases with grade, overlaid on this is high vulnerability, futility and exhaustion among the qualified staff, which is at its most strong among C, D and E grades.

The overall picture of PD unit nurses having a more favourable attitude to PD patients is supported by the data from Rampton and Ashworth. The picture at Broadmoor was less clear and more mixed with some negative attitudes displayed by PD unit nurses compared with non PD unit nurses.
6.1 Comparison of results between PD and non PD unit nurses

PD unit nurses show more cohesion and less variance with age, whereas among non PD unit nurses attitudes generally become more favourable with age, with the most negative age group being 30-39.

The differences in attitudes to PD patients between male and female nurses are the same, regardless of which type of unit they work in.

On all items for which significant differences were found, higher grades mean a more favourable attitude towards PD patients for PD unit staff. For non PD unit staff the picture is more mixed, with negative attitudes more concentrated amongst the middle grade staff.
Chapter V
Preliminary Analysis of Interview Data

One hundred and twenty one interviews were obtained from nursing staff at the three English High Security Hospitals, each lasting approximately one hour. This volume of material takes some time to analyse systematically, even using computer support. Just to read through the interviews carefully took more than three months. Hence at this stage in the study, preliminary results only can be presented. Work on the project continues, presently supported by funds from the Dept. of Mental Health Nursing at City University. Many interesting avenues to explore the data remain, and an outline of these will be given at the close of this chapter.

1. Method of analysis

All transcribed interviews were imported into QSR NUDIST, a qualitative data analysis software package. All demographic data was automatically coded at the time of import to QSR NUDIST. Early transcripts had already been reviewed by the team and a coding strategy devised. However it was discovered that many of the coding categories could be replaced by text and string searches. As there was some pressure to produce results quickly, analysis proceeded by examining those categories that could most readily obtained by substituting text searches for manual coding of the data.

The method of analysis was also guided by the aims of the study, namely: to elicit the differences in thinking between those nurses who could work well and positively with PD patients, and those who could not; and to explore differences in the culture of the three hospitals that may have an impact on nursing attitudes towards PD patients. Therefore for those categories and themes that were examined in the interview data, contrasts were drawn between material from the different hospitals, and between PD unit and other nurses. This latter was used as a rough, imperfect proxy indicator as to whether nurses could work positively with PD patients or not. Later on in the process of analysis, ratings were made of each interview of the overall attitude to PD, based upon the balance of content reflecting the nurse's position on the six factors identified by the APDQ. These ratings were used in the analysis thereafter.

The initial categories were chosen for exploration and analysis because the research team felt from the first reading of the data that these might be the most productive areas for the generation of meaningful findings. A more thorough and systematic picture will emerge at a later stage as the analysis continues. It must therefore be emphasised that the current results are still of a preliminary nature, and their interpretation may be subject to change in the light of new findings which are being generated all the time.
2. First level analysis

2.1 Cause of personality disorder

Nurture theories were the most commonly upheld by nurses (n = 69, 57%). The type of developmental events that nurses cited as leading to PD were physical or sexual abuse, emotional abuse, deprivation, lack of love, parental rejection, lack of stability, food, warmth or good role models. These explanations overlapped and were not clearly distinguished by nurses. Fewer nurses supported a nature only explanation (n = 10, 8%), emphasising genetic heritage. Rather more saw nature causes in terms of an inbuilt predisposition that could be triggered by poor nurturing experiences (n = 30, 25%). The remaining nurses made no comment, said they did not know, or mentioned 'mental illness' without further elaboration.

Emphasis on nurture as a cause correlates with working in a PD unit (chi square = 16.6, p < 0.005).

2.2 Gut feelings

All interviewees were asked what was their gut feeling or innate response to patients with PD. The following categories emerged when this material was considered as a whole:

<table>
<thead>
<tr>
<th>Positive gut feelings</th>
<th>Negative gut feelings</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Job satisfaction</td>
<td>• Untreatable, rejecting</td>
</tr>
<tr>
<td>• Treatment optimism</td>
<td>• Difficult and draining</td>
</tr>
<tr>
<td>• Professionalism</td>
<td>• Waste of time</td>
</tr>
<tr>
<td>• Empathy</td>
<td>• Anger and hatred</td>
</tr>
<tr>
<td>• Seeing positive qualities</td>
<td>• Vulnerability</td>
</tr>
</tbody>
</table>

The themes most prominent for PD unit nurses was professionalism and empathy, for non PD unit nurses untreatability and difficulty.

2.3 Manipulation

Although no specific question was asked about manipulation, nurses had a lot to say about it in the course of answering other questions. Plentiful examples were given of the manipulative strategies used by PD patients, and their targets were named as: nurses, mentally ill patients, other PD patients, the legal system, the treatment system, the complaints system, solicitors, advocates, medical staff, relatives and managers.

PD unit nurses more frequently identified manipulation as a problem, thus giving evidence of their high level and awareness of PD patient management problems. In tandem with this, they were also able to give more examples of the manipulative behaviour of patients. They were also more likely to perceive the remedies to manipulation as teamwork, good communication, and a high level of ward organisation. They were less keen to encourage patients to complain, but were more
comfortable with the idea of giving a degree of leadership and responsibility to patients.

In contrast the non PD unit nurses were less likely to say manipulation was a problem in the nursing management of PD patients, and were less aware that good ward organisation could help to contain that behaviour. They were also much more cautious about the idea of giving responsibilities to PD patients. They were however more likely to voice concern about the potential of PD patients to manipulate the mentally ill, an issue on which they probably have greater experience.

2.4 Complaints

All interviewees were asked whether PD patients should be encouraged to make criticisms and complaints. When the responses were grouped together, the following categories emerged:

<table>
<thead>
<tr>
<th>Positive aspects</th>
<th>Negative aspects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional expression</td>
<td>Manipulation of complaints system</td>
</tr>
<tr>
<td>Human right</td>
<td>Vulnerability of staff</td>
</tr>
<tr>
<td>Promotes therapeutic engagement</td>
<td>Petty complaints</td>
</tr>
<tr>
<td>Improves functioning of nurses, ward,</td>
<td>Diverts attention from treatment</td>
</tr>
<tr>
<td>and hospital</td>
<td></td>
</tr>
<tr>
<td>Learning coping skills</td>
<td></td>
</tr>
</tbody>
</table>

The overall picture of comments on complaints was fairly similar between PD and non PD unit nurses, especially with respect to the perceived negative aspects of the complaints system. However PD unit nurses laid more emphasis upon complaints as a human right, and only PD unit nurses saw the complaints procedure as a potential therapeutic tool to aid patients' progress. Non PD unit nurses laid greater emphasis upon complaints as a form of communication and emotional expression.

2.5 Sex offenders

Attitudes and feelings towards sex offenders, paedophiles in particular, were negative. Very strong feelings were expressed: bad, evil, repugnant, shock, disgust, sickened, scum, etc. It is clear from the words chosen by nurses to express their feelings that they were emotions of anger and rejection. A particular link was made by nurses between having these angry feelings about paedophiles and being a parent. Having children of one's own seems to force an identification of one's children with the victims and elicited strong parental protective feelings. It is clear from some of the nurses that this did influence their behaviour. Certain patients were avoided or ignored, as was work in the sex offenders group etc. Although negative emotional reactions seem to be frequent, avoidance of patients is rather more rare. Many nurses contain their angry feelings by stressing the higher morality of professional and non-judgemental nursing care.
Non PD unit nurses had much less to say about sex offenders and their treatment, presumably due to their lesser exposure to patients who have committed these types of crimes. However despite the lower frequency of comments, the same themes were present as in the comments of PD unit nurses.

2.6 Violence

Well over a half of the nurses (n = 79, 65%) said they had been seriously threatened or attacked by a PD patient, and this number did not differ significantly between those who worked on PD units and those who did not. Having been attacked by a PD patient was associated with an overall negative attitude to PD (Chi square = 8.6, p = 0.089). Attacks could be very severe, involving weapons such as knives, razors, boiling liquids, etc., and injuries were sometimes serious.

Surviving or witnessing a patient attack aroused strong feelings in nurses. Fear and anger were the most common. Fear could be extreme, with nurses feeling terrified, intimidated, and reluctant to come back to work. Sometimes nurses left or retired early as a consequence of attacks. Anger was mainly towards the patient, but could also be displaced onto management. Some nurses expressed desire for a more punitive regime to control patient violence as a consequence, others withdrew from patients, begrudged them things (e.g. visitors), or were less likely to be confident that patients could be treated. Nurses acknowledged that both these sets of feelings could make it difficult for them to work with the patient in future. The emotional impact of the attack depended upon its severity, the perceived vulnerability of the victim, and the nature of the relationship the nurse had with the patient. In the context of what nurses had thought was a good relationship, attacks led to strong feelings of disappointment.

Any attack, but particularly those that were severe, shockingly reminded nurses of the nature of those who they cared for. As a consequence nurses became more security minded, cautious and wary, implying that there is a natural relaxation of security awareness in the absence of negative events.

Nurses with an overall positive attitude to PD laid more emphasis on preventing violence by verbal de-escalation and long-term therapeutic engagement. Those with an overall negative attitude were more likely to blame the nurse's interactional style for stimulating patient violence, or to say that the attack was due to the nurse being disliked by the patient. They laid more emphasis on ward management strategies for prevention (e.g. seclusion, nurses in charge, etc.), and felt that management were not concerned about their safety.

2.7 Reading case notes about the index offence

Reading the case notes of a patient, which frequently contain detailed information about the index offence, can have a dramatic emotional impact, especially on nurses who are new to working in the High Security Hospitals. Just as with attacks on the ward, the two main emotional reactions are those of fear and anger. Being faced with the reality of what patient have done can make nurses feel vulnerable for themselves of their families. They may become more cautious at home and at work. At home they
increase personal and family security measures, become more suspicious of other people, and may become overprotective towards their children. At work this results in greater consciousness of security issues and general wariness about patients. The second main emotional response is a combined feeling of anger and disgust. These can be so acute that nurses have been known to physically vomit and go off sick, and indeed some nurses leave their jobs after such an experience. Nurses acknowledge that to have this feeling makes it virtually impossible to work with or relate to the patient concerned, that in fact they say the combination of fear and anger would make working life in the High Security Hospitals psychologically impossible.

Three methods seem to be used by nurses to cope with the fact that case notes have to be read in order for the patient to be effectively and securely nursed. These are:

1. Getting to know the patient as a person first, before reading the case notes or even finding out the nature of the index offence. This seems to allow nurses to balance the reality of the patient as a fellow human being against the feelings aroused by their index offence.
2. Repress thoughts about the index offence or dissociate (cut off, detach, switch off) from the feelings aroused, concentrating instead on the therapeutic work that has to be done.
3. Become hardened over time. Repeated exposure to the grim details of what people are capable of results in them becoming routine facts without any emotional impact.

Method 1 is reported as a pragmatic strategy, and method 3 as an unintended but generally helpful outcome of the job. Method 2 requires nurses to manage their thoughts and feelings, and they do this through moral justifications for their stance. These are: an identification with a professional stance of objectivity and affective neutrality; and secondly through allegiance to a non-judgemental approach to care.

2.8 Times past

In the course of answering other questions, nurses frequently commented on how the High Security Hospitals had changed in the course of their working lives. Views on these changes were both positive and negative, and the most common dichotomy drawn was that between a strict punitive past, and a lax liberal present. In opposition to the present, the past was characterised as a time of regimented routine, when patients had to use formal terms of address, more punitive approaches to behaviour control were used (especially seclusion), managers were more supportive of staff, and patients had fewer rights and freedoms. There seem to be clear links here between the way things were in the past and a negative attitude to PD overall, especially in terms of managing feelings of vulnerability through authoritarianism. However there is also clearly value in the old style emphasis upon disciplined security measures, as the Fallon report has shown. The benefits of both need to be preserved as we move forward into a new era of PD care.

2.9 Old staff and young staff

There is a great diversity of discourses about the differences between older and younger staff with respect to PD care, some saying the younger staff are more
negative and others the older staff. These discourses are intermingled with those about the perceived past of the special hospitals. There is no uniform perspective. For example, 'dinosaur' is a term given to older staff who have been working in the specials a long time. On the face of it, it appears intrinsically pejorative, with connotations of being ancient, slow, failing to move with the times, extinct, belonging in times before the current era. However the interviewees use the term both positively and negatively. In it’s negative sense it is linked to comments about conservative, security conscious methods of nursing, and resistance to change. Positively it is linked to comments about entertaining and educational/moralistic stories, or useful advice still remembered, followed, and passed on to others. Perhaps the more discerning staff see that there is good and bad to be found in both age and youth, and that in terms of learning younger staff need to filter and select the attitudes, opinions and methods they learn from those who are older. Some nurses clearly commit themselves to one perspective e.g. old school nurses are bad and younger, fresher nurses from outside are better. However buying into this picture robs the nurse of the opportunity to use and learn to good things that may be passed on by older staff. Instead they are written off, labelled as bad, and rejected. A more beleaguered and defensive position may be found among some of the older nurses, where everything in the past was good and none of the new ways are acceptable.

2.10 Parental views of PD patients

A significant number of nurses (n = 37, 30%) mention acting like parents or in a parental role towards PD patients. The way in which nurses felt that they took a parental role towards PD patients broke into four components:

1. **Love.** Nurses felt that they provided parental care, understanding and nurturance, with many linking this to the absence of such care and attention during the patient’s childhood. Others linked this to identification issues. They saw the PD patient as ‘like’ their son or daughter in certain respects. The PD patients exhibited behaviours that reminded them of their children, or caused them to consider that their child might run into similar difficulties.

2. **Trust.** For some of the nurses taking the parental role, whether they expressed this as being motherly or fatherly, meant that patients would trust them, have confidence in them, and confide in them.

3. **Authority.** In this regard nurses talked about the parental role as regards to setting limits, laying down boundaries, applying rules for behaviour, and being a source for the determination of right and wrong. Within this context nurses spoke of the respect that patients were then willing to give in this type of relationship.

4. **Role models.** Nurses connected being parental to the provision of a role model for patients to follow and copy. Again, just as with love and caring, nurses linked this to the things that had been missing in the PD patients’ childhoods.

Expression of a parental role or identification by nurses was very highly associated with a positive overall attitude to PD (chi square = 20.1, p < 0.000).

Nurses also drew similarities between PD patients and children. For some they were like loveable rogues. In these cases the references conveyed a kind, warm appreciation of the patient, coupled with an understanding and sympathetic attitude to their behaviour. For others they were like nasty little brats. In these cases the references were less warm and carried derogatory connotations. Adjectives such as
‘spoilt’, ‘greedy’, ‘childish’, ‘dummy coming out of the pram’, ‘tantrums’, ‘selfishness’, etc. were used. These statements convey a feeling of resentment, anger and rejection. There were insufficient numbers of cases of these analogies being drawn to assess their individual relationship to overall attitude. Grouped together, there was no association.

2.11 Patient hierarchy

An informal patient hierarchy seems to develop naturally on a ward with PD patients. Methods by which patients achieve higher status and power amongst their peers are: exploiting the mentally ill; intimidating and bullying others either through greater verbal fluency physical threat, or actual violence; exploitation of any leadership or responsibility to selectively benefit themselves or others they choose. Although these behaviours are deliberately hidden from nurses, their effects can be seen in deference behaviour of patients to those at the top of the hierarchy, the giving of gifts, copycat behaviour, a high level of ward tension, more frequent fights and arguments, and low patient morale.

Nurses control and break up informal hierarchies by restricting the responsibilities given to patients, having clear open rules for conduct, bringing the fears of weaker patients into the open and dealing with them together with the ward community, and as a last resort transferring out overly dominant patients.

2.12 Multidisciplinary teams

**Doctors:** In the view of nurses, the best way for psychiatrists to operate in order to facilitate the care and treatment of PD patients is to do the following:

1. Give a clear, consistent, enthusiastic and committed lead to treatment content, and express optimism about eventual therapeutic progress.
2. Allow and facilitate nurses taking a role in psychological treatment.
3. Be present on the ward frequently, talking and listening to both nurses and patients.
4. Confer with the nurses and listen respectfully to their views before taking decisions.
5. Uphold the ward rules with patients, be aware of patients’ manipulation and refuse to go along with it.
6. Educate the nurses in the course of your daily clinical work.
7. Show concern and support for nurses in their task of patient management, do what is possible to assist in the resolution of the problems that they face.

Key events can shape the nursing teams views of individual psychiatrists, powerfully impacting upon the subsequent teamwork and working relationships. Nurses described two of these events. In the first a doctor came to the aid of a nurse who was being held hostage, resulting in strong cross-disciplinary commitment and bonding. In the second instance, a doctor behaved in what nurses considered to be an inappropriate manner towards a patient, bringing her a present of videotapes in order to persuade her to accept a depot injection.
Psychologists: Nurses perceive psychologists as having a very significant contribution to make to the treatment of PD patients, with some seeing them as the sole agents of psychological treatment, and others commenting on the scarcity of psychologists and the need for more input. Nurses value psychologists for their one to one work with patients around their index offence, for their leadership of therapeutic groups especially those for sex offenders, and for their ability to carry out cognitive-behavioural interventions with PD patients. Psychologists are also perceived as an important source of education, learning and supervision. All in all, psychologists and their input were well respected by nurses. However this is not to say that there were not isolated areas of conflict. When psychologists fail to communicate and liaise with nursing staff, this is found to be offensive and cause difficulties with patients.

Social workers: Social workers received less comment by the nurses in these interviews. When comments were passed it was usually in relation to dealing with patients relatives and families. No consistent picture emerges of working relationships between nurses and social workers. Their role in liaising with patients relatives is valued, but nurses also criticise them on a variety of grounds. They are said to have too rosy a view of patients and a stereotyped negative attitude to nurses.

2.13 Management

A significant number of nurses (n = 30, 25%) complained that they felt undermined by managers. These events typically arise when nurses "say no" to patient requests, only to find subsequently that they are overruled by those further up the nursing hierarchy. This may be the ward manager, or may be a nurse in a middle management position, or even on occasion the top managers and executives of the Hospital. Nurses find such experiences very disheartening, feeling "trodden upon", "angry", "devalued", "forgotten", "demoralized", "frustrated", "insecure", "helpless", and that their efforts in patient care have been "wasted". Nurses quote these events explicitly as reasons why they have no faith and trust in their managers, why they feel so exposed to criticism, and why they are reluctant to 'say no' in the first place. One example given by a nurse was the desire of female patients to have a 'nought' haircut. The nurse said no and was subsequently overruled by a manager. It is possible to see both sides to this dispute. However in such a situation it is the manager's responsibility to take the final decision. Therefore, nurses must expect to be overruled on occasion, and come to terms with the reality that managers have decision-making responsibilities.

The dynamics of this whole process of "undermining" are of great interest due to the light they shed upon nurse-patient relationships, because, in a sense, the nurse-patient relationship is being mirrored in the manager-nurse relationship. PD patients find being told "no" a difficult experience, one to which they respond with catastrophic feelings of low self esteem, worth, value, and loss of face (the thought that others perceive them as less worthy). The nurses respond in a similar fashion when being told "no" by their managers, and a similar catastrophic reaction materialises. It is neither mysterious nor surprising that this happens. Self-esteem is a primary issue for many PD patients in all their interactions with nurses, a bias possibly acquired through a history of being abused and being made to feel thoroughly worthless. The prominence of the issue probably rubs off on the nurses, who become sensitised to
any slight or implicit criticism from their managers. In addition, nurses are further
sensitised by the volume and frequency of the verbal and physical abuse they receive
from patients. No wonder their reaction to being contradicted by managers is so
emotionally fierce.

Those comments in the interviews that address the manager's role in the complaints
process (n = 27, 22%) are largely critical. The criticisms are twofold, firstly that
managers react too strongly (by means of suspensions and moves) to trivial
complaints; and secondly that they express no concern and give no support to nurses
who are the targets of complaints, who may feel upset, angry, guilty without due
cause, and who are stressed and traumatised. Some nurses, however, express
understanding of the managers point of view, giving reasons why they may be
oversensitive and unrealistic. These include:

1. The high political profile of the High Security Hospitals and their inmates
engendering a sense that everything they do is potentially open to public
scrutiny and criticism.
2. Managers themselves are afraid of what might happen to them if they do not
handle a complaint with absolute objectivity and total adherence to the rules of
the process.
3. It is difficult for them to tell at one remove, without knowing the nurse and
patient concerned in depth, what is a serious complaint and what is truly
trivial.
4. The patient abuse and nursing malpractice of the past makes the allegations of
patients easier to believe, and they are thus taken more seriously.

For those staff who have no appreciation of the external forces within which
managers have to work, the complaints process as endured, or as observed in its
mastication of other nurses, engenders hostility towards and alienation from
managers.

To a great extent, patients manipulation of managers has been covered under
complaints above, and in another section where it was described how PD patients
wield influence outside the hospital, open gaps in policy, and interfere in the nursing
staff hierarchy in order to get what they want. Several examples were given by nurses
of how PD patients seek to subvert senior nurses' trust and confidence in their staff.
The interesting point to observe with these examples is that it is absolutely impossible
for the manager to know what the truth of the issue is. For it is the manager's role to
ensure staff fulfil their duties properly, and everybody knows that employees do on
occasion break rules or seek to cut corners. The manager must choose either to trust
the staff or the patient, and even if they elect to do the former, a seed of doubt has
been sown by the patient, undermining the nursing team cohesion.

Any hierarchical system has the capacity to generate and maintain mistrust and
cynicism. The presence of PD patients within the High Security Hospitals exacerbates
and multiplies this problem because of: the manipulative subversion of the hierarchy
by patients; the harsh and hypersensitive complaints system which is not fully
understood by staff; and the mirroring of PD sensitivity to criticism by nurses and
managers. These three and their associated problems inevitably poison relationships
between nurses and their managers. Thus a picture emerges from the remainder of the
data on management that, outside of nurses who are part of the ward based team,
managers are disparaged and treated with suspicion. As a result the organisation is dysfunctional, and handicapped with internal conflicts.

2.14 The terminology of evil

Nurses were asked whether they considered PD patients to be bad, evil, or monstrous. They were most likely to attract these negative labels if they were not abused as children, their index offence had been serious violence against vulnerable victims, had been planned in advance, involved torture, they refused treatment in hospital, showed no remorse, and appeared to be nice people. Nurses characterised the terminology of evil as an emotional rather than considered and objective response to PD patients, and one in five of them laid most blame on the media for promoting the use of these words. They were clearly seen to be an expression of angry and rejecting feelings towards PD patients. Although many nurses found anger to be an understandable response to what patients had done, they recognised that these feelings could make it impossible to converse with patients. Thus from a purely practical and pragmatic point of view the nurses were motivated to ignore or repress thoughts about the patients' index offences. Nurses also reported that use of the terminology of evil, coupled with angry feelings towards patients for their index offences, perhaps plus judgements that they are not fully human and of a different species to the rest of us, can lead to patients being ignored and degraded. Thus, in their apparently righteous anger towards the patients who have committed horrible crimes, nurses start to mirror PD behaviour themselves in a minor form.

Nurses used a number of different cognitive-moral-emotional self control strategies in order to cope with their natural reactions towards the actions of PD patients in their care:

1. Professionalism and affective neutrality – providing a service which is blind to the nature of the client.
2. An ideology of individualised care, and a reluctance to stigmatise or label anybody. Nurses who advanced this argument challenged themselves to get to know the patient as a person with a rich personal history and unique characteristics, instead of angrily and summarily rejecting them at an earlier stage.
3. Commitment to preventing the recurrence of crime. This provides a justification for ignoring emotional reactions to past offences, putting them to one side and engaging with the patient in order to make therapeutic progress.
4. PD construed as an illness that diminishes responsibility.
5. Bringing to mind and recalling the patients personal history of abuse and suffering.
6. Asserting that PD patients are human beings too, thus deserving of care.
7. Separating the behaviour from the person, condemning the crime without rejecting the person.

These coping methods are mentioned far more often by those with an overall positive attitude to PD (chi square = 12.67, p = 0.013).

Several of the methods nurses use to prevent themselves from falling into angry thoughts and feelings about patients have as their common denominator the necessity to, ignore, repress or deny the patients index offence. The rationale for this varies,
from professional affective neutrality to separating the behaviour from the patient. However this method of coping has its own risks and dangers. Ignoring this index completely means that the nurse may never speak about it to the patients, and therapeutic opportunities are lost. Additionally, because the nature of the index offence is repressed, the patients' apparent dangerousness can lessen in the nurses' eyes. The question arises as to what are the consequences of this repression of emotion? Freudian psychoanalytic theory would suggest that it would return in a changed and hidden form, yet there is nothing in the data that was collected during this study that would suggest that this is the case.

2.15 Personalising it

Nurses made reference to occasions on which it was difficult for them to keep their temper and not take the behaviour of PD patients personally. These were, typically, violence or verbal abuse on the ward, particularly if in the context of what was considered a good nurse-patient relationship. Alternatively nurses could become acutely riled when patients spoke inappropriately about their index offence or behaved in ways that contrasted with it. Nurses can become upset and angry in these circumstances, especially if the patient homes in on their identified emotional vulnerabilities.

Nurses have a range of techniques for containing their emotions and dealing with these situations in a productive manner:

1. Staying calm and reasoning with the patient, giving explanations for why things have happened the way they have, or why they cannot have what they are demanding.
2. Strive to avoid confrontation in the first place by: treating patients with respect; explaining the rules; talking down in advance when someone is seen to be agitated; being pleasant and polite; being diplomatic; being tactful. Avoiding downgrading, judging, dismissing condemning, or destructively criticising patients.
3. Using of honest feedback to the patient about the effect of their behaviour. This is important not just for managing the situation and one's own feelings, but also to provide a role model on how to productively manage and express angry feelings without an emotive argument.
4. Using clinical supervision to ventilate those feelings so that the pressure reduces and they are more easily controlled during nurse-patient interaction.
5. Providing cover and sharing the burden with the nursing team, thus protecting each other from emotional ignition.
6. Striving to keep things in perspective, seeing the big picture rather than get overwhelmed by the moment. In this sense the 'big picture' is the patient's treatment in hospital, the therapeutic work directed towards helping them overcome their problems, and the prevention of re-offending in future.
7. Psychological explanations of the behaviour of patients also help the nurses not to 'take it personally'. The verbal abuse and anger of patients might be: anger displaced from elsewhere; a method learnt from childhood of getting a desired state of affairs; a way of testing out the nurses commitment to them; or a means of provoking an emotional response.
8. Systems level checks assist nurses in containing their own feelings in these situations, e.g. the professional standards of nursing inculcated during training, and the hospital complaints procedures. Nurses with a positive overall attitude to PD were more likely to have insight into their own emotional reactions and express awareness of ways to contain themselves (chi square = 11.52, p = 0.021).

2.16 Trust

More than 1 in 5 of the interviewed nurses avowed that PD patients should either not be trusted at all, or be trusted with extreme caution. These recommendations were coupled in some cases with accounts of 'let down' experiences, or other tales of betrayal of nurse confidence. There was an association between those who made these assertions and an overall negative stance towards PD care (chi square = 7.87, p = 0.097).

The interviewees spoke of two barriers or handicaps to winning the trust of patients. The first is the suspicious and mistrustful stance of the patients themselves. This mistrust was perceived to originate in their past experience of abuse as children, and thus viewed sympathetically. The second barrier to mutual trust was the security function and role of nurses. Some nurses felt that there was an incompatibility between trusting patients and yet showing in all their security actions that the patients were not really trusted at all. Nurses had several methods of overcoming these barriers:

1. Spending time with patients in friendly, chat helps to build trust. It is important to the development of trust that such contact takes place over a long period of time, and that it is carried out in such a way that demonstrates that the nurse considers the patient to be a social equal, and does not judge the patient in any way.
2. Being reliable and dependable, delivering on even the smallest promises. Such is the sensitivity of PD patients to rejection that forgetting the slightest thing can lead to them taking offence. Hence to build trust nurses need to consistently do everything they say they are going to do.
3. Accepting and tolerating criticism from patients is also necessary to build trust with them. It reinforces the mutual respect and demonstrates that nurses are willing to look into their own faults as well as those of patients.
4. Expressing respect for patients by negotiating on treatment plans and ward rules was also said to enhance and build trusting relationships.
5. Some nurses made the point that one cannot expect to be trusted by patients if you do not give some trust to them, typically on minor matters in relation to ward tasks. However doing this can be a risky venture for nurses, as it can lay them open to being manipulated or otherwise taken advantage of. Many nurses expressed caution about this course of action.

The common denominator of these methods of trust building seems to be a non-judgemental approach to relating to patients. If they are not judged for their index offence or other behaviour, then the nurse is willing to spend time with them, treat them as an equal, be attentive to keeping promises, accept criticism, give honesty, negotiate treatment, and give a little trust. All these elements of relating to patients are based upon a fundamental attitude of acceptance.
Two benefits of trust were identified:

1. Nurses found it personally rewarding when they felt they had won the trust of a PD patient. This was regarded as a difficult achievement that was not generally possible with all patients. The key indicator that trust had been established was that patients would approach the staff to talk about intimate matters, or more specifically their feelings.

2. Having the trust of patients makes daily management of the ward a much easier state of affairs, because patients will confide and share their disturbed thoughts and feelings with nurses, instead of expressing them in disruptive behaviour. Forewarning the nurses of their feelings gives the nurses and opportunity to work out alternative solutions with the patient.

2.17 Let down

Some nurses report an emotional experience in their relationships with PD patients that can best be summed up as feelings acute disappointment. Nurses make an emotional investment in their patients, they 'care for them'. Not just neutrally professional care, not a false façade, but a real commitment to other people via their work. That is their value system, and is usually why they entered nursing in the first place - in order to do meaningful, and morally valuable work. Because of this, nurses make really hard effort to develop relationships with patients that express that caring ethic. Over time patients appear to accept this and commit to a genuine, caring, therapeutic relationship. Thus when patients suddenly behave in a completely contrary fashion, nurses are left feeling bewildered, betrayed and confused. So acute are these reactions that some nurses leave the service, others simply make a vow to themselves that they will never trust a PD patient again, lapsing into an angry and negative overall attitude to PD. Typical 'let down' experiences are:

1. Sabotage of treatment progress after long term work with the nurse.
2. Losing their temper with the nurse and being verbally abusive.
3. Using the therapeutic interaction to manipulate the nurse.
4. Physically attacking the nurse for no apparent reason.
5. Making a false allegation about the nurse.

Those that find a productive way forward after such experiences do so by:

a. Persevering with the building a rebuilding of relationships.
b. Holding in mind the expectation that patients will let the nurse down, thus taking the shock out of any eventual disappointment.
c. Developing a psychological understanding and explanation of the 'let down' experience as: displacement of the patient's anger from elsewhere; a defence mechanism against the anxieties provoked by intimacy; repetition of a life-long pattern.

2.18 Responsibility for their deeds

Nurses were virtually unanimous that PD patients are responsible either wholly or to some degree. A number of variant positions were identifiable, but the largest proportion clearly considered that PD patients are responsible for whatever they do.
This span of views sharply contrasts with the location of the High Security Hospitals within the criminal justice system. Patients have largely been sent to the Hospitals because it is considered that they are mentally disordered and not responsible for their actions. Yet it is clear once they arrive within the forensic psychiatric system, they are considered by nearly all the nursing staff to be at the very least partly responsible for their actions. Also notable is the fact that judgements of PD patients' responsibility bear no statistical relationship to overall attitude to PD, whether that is positive or negative. However the arguments nurses use to justify their position on patient responsibility do relate to overall attitude.

Two main reasons were given by nurses as to why PD should be considered responsible for their actions:

1. As a matter of first principle, everybody is responsible for what they do. This judgement was related to age, it being held and expressed more often by those nurses who were younger (Chi square = 7.9, p = 0.019).
2. Because they are cognitively competent. They know what they are doing, are not psychotic, show the ability to plan a reasoned course of action, and can make rational arguments. The use of this type of reasoning is highly related to a negative overall attitude to PD (Chi square = 24.4, p = 0.000).

Nurses gave four reasons as to why PD patients should not be considered fully responsible:

1. Co-morbidity of other mental illnesses, specifically psychosis.
2. PD itself should be considered an illness that excuses.
3. Impulsivity, if contributory to the index offence, is seen as less culpable.
4. PD patients have an incomplete or warped perspective of the world. They don't have a fully informed overview of their own behaviour, or perceive the social world in an altered or different fashion. The use of these type of arguments are highly correlated with an overall positive attitude to PD (Chi square = 14.7, p = 0.005).

The nurses reported that it was a characteristic of PD patients not to accept responsibility, and to blame others. Indeed, not accepting responsibility was seen as part of the disorder. The implication of this is that getting patients to accept responsibility a focus and aim of treatment. The way nurses do this is through a process of daily interaction about events on the ward, which is most often referred to as education. The patient has to learn they are responsible through receiving honest feedback from nurses about the impact of their behaviour. In this sense nurses are striving to alter the patients' world view, reframing every action and the social responses it elicits.
2.19 Respect

Respecting the PD patient means not judging, condemning, deriding, devaluing or otherwise rejecting them as a person. Other nurses express this by saying that PD patients should be treated as equals, in the same way that friends would be treated outside the hospital. Although this can be hard to do in the face of knowledge about the patient's index offence, it is an ethical imperative to try to understand and respect them, one that nurses say they have learnt during their training. Several examples were given by nurses of how they tried not to behave, in fact of behaviour that they considered was disrespectful of patients. These were giving orders in a way that was superior and dismissive, or failing to give a reason why something cannot be done, in an angry and rejecting manner.

There was both consensus and disagreement about what nurses had to do in order to win the respect of patients. There were two areas of disagreement: hierarchy and gender. Some nurses suggested that ward managers and other higher in the hierarchy automatically received more respect from patients, whereas others strongly asserted the opposite, that respect had to be earned whatever the nurse's formal position. The second area of disagreement was gender, with some nurses suggesting that PD patients had more respect for opposite gender nurses, while others said this was not the case.

The consensus views were very clear.

1. In order to get the respect of patients, nurses had to be able and willing to say 'no' and refuse patients their requests on occasion. The essential ingredient to winning respect here seems to be a willingness to openly argue the case for a decision to say no, stating the reasons for the decision. Another way in which nurses express this is by saying it is necessary to be open, honest and straightforward with patients.
2. Although the relationship between nurse and patient is, in the sense of personal value and worth, egalitarian, in order for respect to develop patients have to know that there are limitations on those relationships. From these sources alone it is hard to say precisely in what way this limitation on the relationship exists. Perhaps it consists in keeping a distance, something private, an independent viewpoint that is not effected by what the patient says, a refusal to be taken advantage of by them, or a limit as to what the nurse is willing to do.

The consequences of mutual respect is that it provides a good basis for the nurse-patient relationship, difficult events (e.g. room and personal searches) can be handled whilst keeping the patient much calmer, and patients can learn more easily from the behaviour of nurses.

3. Second level analysis

3.1 Positive vs. negative overall attitude to PD

To summarise the information from the preceding sections, nurses with a positive overall attitude: lay more emphasis upon nurture in their thinking on the cause of PD;
were more aware of manipulation as a problem and had greater command of the ways it could be managed; perceived that the complaints procedure could be used as a therapeutic tool; were less likely to have been attacked or seriously threatened by a PD patient; laid more emphasis on preventing violence by verbal de-escalation and long-term therapeutic engagement; were more likely to see themselves as acting in a parental role towards PD patients; knew better how to cope with and contain their angry feelings towards patients about the index offences; were more likely to have insight into their emotional reactions to PD patient behaviour on the ward and express awareness of ways to contain themselves; were less likely to assert that PD patients are wholly untrustworthy; and were more likely to view PD patients as having diminished responsibility because of their distorted view of the world.

Those nurses with a negative overall attitude: lay less emphasis upon nurture in their thinking on the cause of PD; were less aware of manipulation as a problem and had less awareness of the ways it could be managed; perceived that the complaints procedure as a means of emotional expression by patients; were more likely to have been attacked or seriously threatened by a PD patient; were more likely to blame the nurse's interactional style for stimulating patient violence; were less likely to see themselves as acting in a parental role towards PD patients; did not know how to cope with and contain their angry feelings towards patients about the index offences; were less likely to have insight into their emotional reactions to PD patient behaviour on the ward or express awareness of ways to contain themselves; were more likely to assert that PD patients are wholly untrustworthy; and were more likely to view PD patients as having full responsibility because they were cognitively competent.

3.2 The three hospitals compared

Most findings on differences between the three hospitals mirror those on overall attitude to PD. More nurses had a positive attitude at Rampton, and more had a negative attitude at Ashworth, with Broadmoor being somewhere in between. However the picture varies when complaints and manipulation are considered.

Rampton nurses were more clear about strategies for the nursing management of PD patients, but saw managers and solicitors being more likely to be manipulated, especially via the use of the complaints system. Broadmoor nurses were much less clear on how to manage manipulative behaviour, and were perhaps more conservative in that none viewed giving patients responsibility as potentially positive. More emphasis was placed by Broadmoor nurses on the manipulation of the prison and legal systems by patients. Ashworth nurses were not distinctive in their talk about manipulation, occupying a middle position between Broadmoor and Rampton.
The following table shows the breakdown of themes on complaints by hospital. Some nurses made comments reflecting more than one category:

<table>
<thead>
<tr>
<th></th>
<th>Ashworth</th>
<th>Broadmoor</th>
<th>Rampton</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional expression</td>
<td>15</td>
<td>24</td>
<td>11</td>
<td>50</td>
</tr>
<tr>
<td>Human right</td>
<td>7</td>
<td>15</td>
<td>3</td>
<td>25</td>
</tr>
<tr>
<td>Therapeutic engagement</td>
<td>1</td>
<td>9</td>
<td>1</td>
<td>11</td>
</tr>
<tr>
<td>Improves functioning</td>
<td>2</td>
<td>9</td>
<td>6</td>
<td>17</td>
</tr>
<tr>
<td>Learn skills</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Manipulation</td>
<td>13</td>
<td>12</td>
<td>21</td>
<td>46</td>
</tr>
<tr>
<td>Vulnerability</td>
<td>3</td>
<td>5</td>
<td>29</td>
<td>37</td>
</tr>
<tr>
<td>Petty</td>
<td>7</td>
<td>1</td>
<td>4</td>
<td>12</td>
</tr>
<tr>
<td>Diverts attention</td>
<td>0</td>
<td>6</td>
<td>0</td>
<td>6</td>
</tr>
</tbody>
</table>

It can be seen that negative views on the manipulation of the complaints system are much more prominent at Rampton hospital than elsewhere, and nurses there feel much more vulnerable. Only Broadmoor staff viewed complaints as diverting patients attention from the problems that brought them into hospital.
Chapter VI
Discussion and conclusions

1. Discussion

1.1 Overall findings from APDQ survey

The survey reveals that the High Security Hospitals are staffed by a relatively mature and experienced group of nursing staff. Most are men, although one third are women, and the majority have had experience of working outside the High Security Hospital system. It is intriguing that those nurses who have worked outside the system actually have a less favourable attitude to PD patients. Possibly this indicates that negative opinions have been exported from general psychiatry into the High Security system, not vice versa.

The survey confirms previous research, in that nurses consider PD patients to be difficult to treat and are pessimistic about the efficacy and outcome of treatment. They consider themselves to be, on balance, poorly trained to care for these difficult patients. The means of the affective statement items shows that nurses find it easier to endorse negative feelings and more difficult to admit to positive feelings about PD patients and their care. There is no consensus at all among High Security Hospital nurses as to whether PD patients should be within the healthcare system or detained in prison, although there is majority support for specialist PD units. It should be noted that the survey took place before the publication of the Fallon enquiry report and its recommendations. It is possible that views may have shifted in the aftermath of that report.

There is considerable support among special hospital nurses for ‘cross gender care’, that is, male nurses being involved in the care of female PD patients and vice versa. Results were almost identical for each direction, with a Pearson correlation of 0.8 indicating that nurses who supported cross gender care in one direction were most likely to support it in the other. Unqualified nurses were the least likely to support cross gender care, and older nurses were more likely to express their support. Female nurses were more enthusiastic in their support than men, indicating that they were more willing to be involved in cross gender care than male nurses were to accept them. Thus it might be easier to introduce male nurses to female wards as they are more likely to be well accepted by female staff, in comparison to introducing female staff to male PD wards. However, although there is a gender differential in support, both male and female nurses give majority support to it.

For every item on the scale for which there is a significant difference between male and female nurses, females express a more favourable and sympathetic attitude to PD patients. There are several possible explanations for this. It may be that female nurses simply respond to this questionnaire with more positive emotional responses, without their actual behaviour towards PD patients differing in any way. However if this was the case one would expect female nurses to show differences from male nurses across the board on all items. In fact they only differ on one factor, enjoyment. Alternatively, a large number of female nurses work on the female only wards, and thus their more
positive responses may reflect that it is easier to relate to female PD patients whose
diagnostic mix and index offences differ from male PD patients. Lastly, the more
favourable affect may not be something that female nurses bring to their interactions
with PD patients, but may be elicited by the better behaviour of PD patients with
female nurses.

It needs to be reiterated here that a more favourable attitude is not necessarily better
for the care of PD patients - this remains to be established. The more favourable
attitude of female nurses may make them more vulnerable to exploitation and
manipulation. However more favourable attitudes as assessed by this scale are
associated with working on specialised PD wards, and are thus likely to reflect a
better and more positive therapeutically committed culture among PD unit nurses. If
this is accepted, then whatever the reason, female nurses do have a tendency towards
more favourable attitudes. Thus the decision to involve them in the care of male PD
patients should be judged to be a good one.

The finding that attitudes to PD patients become more positive as one travels up the
nursing grade hierarchy was not unexpected. Recruitment and selection techniques are
deliberately designed to pass those with greater knowledge and enthusiasm. That
attitudes improve as grades go up thus also confirms the validity of the scale.

The concentration of futility and emotional exhaustion amongst the C, D and E
grades, coupled with their perception that they are not well trained, is worrying. It is
possible that there is an accumulation of staff in these grades who have not moved on
up the hierarchy, and whose failure to do so has exacerbated a gloomy and pessimistic
outlook on the care of PD patients - further lessening their chances of career progress.
Alternatively, these are the grades of qualified staff who have the most patient
contact, thus exposing them to more negative experience and interaction with PD
patients.

1.2 Findings from the interview study

The findings so far from the interviews, as they relate to positive and negative
attitudes to PD, are summarized in charts 1 and 2 on the following pages.

1.2.1 Direction of causality

For the variables identified in charts 1 and 2, a statistical association has been found
with attitude to PD. However the direction of causality as portrayed is hypothetical. It
may be, for example, that having a positive attitude overall enables the nurses to
understand and tolerate PD patient behaviour better, rather than vice versa.
Chart 1: Positive attitudes to PD patients

Positive Attitude: Enjoyment, Security, Acceptance, Enthusiasm, Purpose.

- Identification
- Self with patient
- Self with child
- Higher grade
- Hospital Culture
- Female gender
- Managed as therapy
- Understood psychologically
- Sills to contain
- Patient with child

- Team cohesion
- Managed nurses & ward
- Expected
- Manipulation, complaints, abuse

- POSITIVE ATTITUDE
- Systems security
- Therapeutic progress
- Trust achieved
- Incident prevented
- Insight achieved

- Demographics
- Higher morality
- Good seeing
- Big picture
- Individual focus
- Ignore index
- Abuse remind
- Ward nurses
- MDT

- Self management
- Reading case notes
- Split beh./person
- Belief in nurture cause

- Higher grade
- Female gender
- Self with patient
- Hospital Culture
- Higher grade

- Expected
- Manipulation, complaints, abuse
- Understood psychologically
- Sills to contain
- Patient with child

- Team cohesion
- Managed nurses & ward
- Expected
Chart 2: Negative attitudes to PD patients

NEGATIVE ATTITUDE
Loathing, vulnerability, rejection, Futility, exhaustion

- Patient morally judged & condemned
- Let downs
- Identification
  - Self with victim
  - Male gender
  - Hospital culture
  - Lower grade

Demographics
- Hospital culture

Management & workforce split
- Mirroring
- Patient mischief

Belief in nature cause
- Patient mischief
- Management & workforce split

Let downs
- Child with victim

Undermining
Further complexity is added by the high likelihood that some relationships between the studied variables are cyclical. For example, it seems likely that the moral judgementalism identified as being associated with a negative attitude is expressed verbally or non verbally by nurses to patients. As PD patients are highly sensitive to any disrespect, they are likely to respond to this with more difficult behaviour, which itself adds to a negative attitude on the part of nurses. Thus a negative attitude to PD patients is likely to be self confirming and self sustaining. Similar cycles seem likely to occur with positive attitudes also. For example the therapeutic use made of difficult PD patient behaviour by nurses with a positive attitude seems likely to produce more patient progress, which itself generates a greater sense on purpose on the part of the nurse and a strengthened positive attitude.

Only further research can start to disentangle the causal relationships between these many different variables.

1.2.2 Relationship to factor analysis of the APDQ

There are likely to be relationships between the factors identified by the APDQ, and the important variables as identified by the interviews. For example the self management strategies depicted on chart 1 are likely to impact most upon whether nurses are able to accept or reject the PD patient. The team cohesion factors seem likely to impact most on whether nurses feel secure or vulnerable. A multitude of speculative links between the interview variables and the APDQ factors can be drawn. Indeed, this may be a useful way of ordering the presentation of an increasing number of detailed points from the interview study. However this methods of organizing the findings has not been used here because it may be taken to imply that there is empirical evidence to link the interview findings to the APDQ factors. This is not the case, but is instead an issue that requires further investigation and research.

1.3 Attitude and behaviour

There is a longstanding debate about the relationship between attitudes as expressed to researchers, and actual behaviour in real life settings. It is clear that the relationship is not straightforward, and it should not be assumed that the opinions expressed by nurses via the APDQ translate readily into the way they behave in the care of patients.

However one of the strengths of this study is that it brings together a quantitative assessment of attitude and an in depth interview study. In this way the overall attitude of nurses can be linked to their behavioural rationales, to their reasoning about PD patients, and to the ways in which they cognitively manage their own emotional reactions to events and circumstances. What is more, there is evidence in the interviews to link attitude to action, as the nurse respondents give actual examples of how they and others have behaved with patients which illustrate the connection directly. Sometimes these examples are given as paradigmatic illustrations of the nature of PD behaviour, sometimes they are demonstrations of the nurses personal learning and the foundation stones upon which they have built their attitudes. At other times nurses give examples of their own or other nurses behaviour that they now reject as wrong, providing with this a reasoned argument as to why this is the case.
Because the interview data shows how positive and negative attitudes play themselves out in the actions of nurses, a good argument can be made that these attitudes do impact on the everyday behaviour of nurses. However this conclusion would be made tighter still by confirmatory data from an observational or outcome study.

**1.4 Attitude and therapeutic impact**

Although this study has provided good grounds for the assertion that positive and negative attitudes influence nurses' behaviour towards patients, there is unfortunately no hard evidence that these attitudes bear any relationship to treatment outcomes.

A reasoned argument can be made, for example, that nurses who psychologically interpret PD patient behaviours, and work with patients to assist them in changing their view of the social world, are likely to have a beneficial impact. Evidence for the efficacy of therapeutic communities can, of course, be taken as generally supporting the utility of this way of working. However there is, as yet, little specific empirical evidence on this issue.

It would be easy to recommend that more research should be undertaken on the relationship between nurse attitudes and patient outcomes. However there are profound methodological problems with conducting outcome research in the High Security Hospital system. These are well known and relate to the difficulty in assembling control groups, the extreme duration of treatment required to produce any impact, and the measuring of outcomes within the synthetic environment of the Hospital itself. It is therefore more realistic to recommend that research on the relationship of nurse attitudes to patient outcome should take place in lower security settings with patients who have less serious personality problems.

It is, however, possible to construe therapeutic impact in a broader way. The efficacy of nursing is not just about producing changes in the problems which brought PD patients into the High Security Hospitals. It is also about producing a caring environment which maximizes the dignity, enjoyment of life, and freedom of patients whilst ensuring the maximal safety of the patient community and the protection of the general public. It may well be that nurses' positive attitudes enable these process outcomes, that they produce a ward community of patients who are securely held, safe from each other, and whose opportunity to lead a life which is in some form meaningful is maximized. If this were so, it would be no mean achievement. Viewed in this way, nursing outcomes and their relationship to nurse attitudes could be subjected to further research in High Security settings.

Two further questions then arise for consideration. Firstly, is it beneficial for the ward nursing team as a whole to contain nurses with a mix of attitudes. It is possible, for example, that a nursing team needs members who have a high feeling of vulnerability. Such members will continually remind the team of security issues, and will be on the lookout for manipulative behaviours of patients, whereas nurses who feel too secure may be complacent. The ideal mix of attitudes on the nursing team thus becomes an issue for further investigation. Secondly, it is clear that although nurses may possess a measurable overall attitude to PD, their actual attitude to individual patients varies. This is illustrated by nurses' comments on the terminology of evil, where it became
apparent that certain patients were more likely to attract negative labels than others. How these varying attitudes impact upon the dynamic society of the ward community is thus also an issue for study.

1.5 Hospital comparisons

The APDQ survey, confirmed by ratings of nurse attitude from the interviews, demonstrates that the individual hospital has the largest impact on whether nurses are positive or negative towards PD care.

1.5.1 Ashworth

Nursing staff at this hospital have the least favourable attitude overall to PD patients and their care. It is here that greater age is most closely linked to a more negative attitude. The pattern of attitude by grade is also different at Ashworth. While at all three hospitals enjoyment increases as the grades go up, at Ashworth this is overlaid by high vulnerability, futility and emotional exhaustion among the qualified staff. The reasons for this are not certain, but it would seem likely that these results may be the consequence of the Blom-Cooper and Fallon Inquiries, or of the management turmoil which has accompanied them. In the interviews the PD unit staff themselves had the most negative judgements about patients whose index offence was a sex crime. It is difficult to be sure why this was the case, but it may reflect the fact that nurses have in the past been allocated to the PD unit rather than volunteered.

1.5.2 Broadmoor

This is the only hospital where no difference was detected between PD and non PD unit nursing staff. In addition this hospital showed the weakest difference between male and female nurses. This may be linked to lack of clarity and policy for PD patients at this location, where it was subsequently discovered that there was no clear, agreed PD unit which was recognised as such by all staff and all disciplines. From the interview data the views at Broadmoor were more mixed, with differences between PD and non PD unit nurses less prominent, and detailed information on nursing management strategies relatively rare. It seems likely that this reflects the fact that although some wards have large numbers of PD patients, there is no organisationally separate PD unit. What is more, on one ward PD patients are viewed as suffering from addictive behaviours, a substantially different treatment philosophy than is present at either Ashworth or Rampton.

1.5.3 Rampton

Nursing staff at this hospital clearly have the most favourable attitude to PD patients and their care. There appears to be no link between age and attitude at this hospital, but the link between gender of nurse and attitude was at its strongest here. As at Broadmoor, more favourable attitudes are correlated with higher grade. The more positive attitudes at this hospital may be a result of the recent establishment of the PD unit there, and of the clear, coherent, structured approach to the treatment and management of PD patients. The training given to staff prior to the opening of the unit, and the method by which staff were recruited to work on it (by application rather
than allocation) may also have had an impact. Staff at Rampton were more strongly allied to nurture theories of PD than elsewhere. Nurses were clear about how to contain manipulative behaviour, but attitudes to the complaints system were very much more strongly negative than at the other hospitals. This strong result makes it seem likely that the complaints system does not impact upon nurses attitudes to PD. The positive attitude to PD may also be due to the fact that the PD unit at Rampton admits by preference from prison rather than accepting Section 37/41 admissions. Thus they can selectively admit those with better motivation to undergo treatment. The PD unit at Rampton is also significantly smaller than at Ashworth, thus making the maintenance of a coherent treatment philosophy somewhat easier.

1.6 Relationship of findings to the existing literature

1.6.1 Definition and diagnosis of personality disorder

Given that the majority of the medical literature on PD is about diagnostic controversies, it is striking that nurses had little use for diagnostic sub-categories when talking about PD. They did not, for instance, suggest that schizoid PDs required different care from antisocial PDs. They did, however, make the point that all PD patients are individuals, different and with different nursing care needs. However the medical categorization system was not perceived as being useful.

1.6.2 Cause of personality disorder

Although the cause of PD is disputed in the literature, viewed as a group, nurses had a strong commitment to nurture explanations. It is not clear why this is the case, especially given the inconclusive nature of the empirical evidence documented in the literature. Perhaps nursing culture and education engenders sympathy for this type of explanation of PD.
1.6.3 Personality disorder in the English High Security Hospitals

Richman's (1998) descriptive research is largely confirmed by the interview data. The status sensitivity of patients, their need for and testing of the staff's trustworthiness, the crystallization of informal patient hierarchies, are all reflected in the responses of nurses detailed in the interviews from this study.

1.6.4 Nurses' attitudes to personality disorder

This study shows that nurses' attitudes to PD in the High Security Hospitals are similar to those found elsewhere in that they are, on average, very negative. Less than 1 in 10 nurses considered PD patients to pose no or mild difficulties, the majority of nurses considered that they would not engage with treatment or have a good outcome, less than 1 in 5 expressed any optimism about their treatment, and 3 out of 4 nurses felt inadequately prepared to work with them.

Although some of the interview replies indicated that nurses with the most profoundly negative attitudes did withdraw from disliked patients, no nurse drew a link between this and suicide attempts by patients, as found by Morgan and Priest (1984). This does not mean that such processes as malignant alienation do not occur; it simply means that if they do, nurses are not aware of them.

1.6.5 Nursing care and treatment of personality disorder

1.6.5.1 Nurse-patient relationships

Analysis of what the interviews have to say about nurse-patient relationships is not yet complete, however the analysis of trust, respect, personalizing and losing it are all aspects of this topic.

The psychodynamic picture of 'splitting' as portrayed by Neilson (1991) is not described by the nurse interviewees. Neilson (1991) suggested patients project good and bad aspects of themselves onto the nursing team, creating conflicts between nurses. Relationships and team conflict are not described in this way by interviewees. Instead it is the picture portrayed by Melia et al (1999) which is accurately confirmed by the nurse interviewees in this study. Patients relationships with staff are highly charged and patients do test staff as the interview data show. Just as Melia et al locate this behaviour in the abusive backgrounds of patients, so do the study interviewees who have a positive attitude. Furthermore the practical patient management problems that Melia et al describe (e.g. erosion of the rules) are also repeated by the interviewees, and Melia et al's description of the use of the nurse-patient relationship in therapeutic treatment is the same as that described by the most positive of the interviewees.

Moran and Mason's (1996) seven principles for nursing care of PD patients receive varying support from the interview data. No nurses mention enjoying patient manipulative strategies as they suggest, but such enjoyment may be reflected in the humorous description by some interviewees of what some patients have tried to do. Moran and Mason's recommendation never to be surprised does receive support in that the interviewed nurses used expectation of disappointment to counter potential
'let down' experiences, but their recommendations for the use of humor are not mentioned by nurses. Neither destabilizing the patient hierarchy nor rule flexibility are recommended by the nurses interviewed in this study. However Moran and Mason's recommendations for honesty with patients and the generation of indebtedness to build trust are both endorsed.

1.6.5.2 Nursing the Therapeutic Community and other treatments

These aspects of the interviews have not yet been analysed, therefore no comment can be made at present.

2. Conclusions

The current study confirms that the APDQ is a useful instrument for the study of psychiatric nurses attitudes to PD patients. It has demonstrated differences between PD unit and non PD unit staff, by grade, age, gender, experience and individual hospital. Further work is needed to validate the scale and examine its test-retest reliability, and sensitivity to change.

The interviews have allowed the identification of a range of variables that have a relationship to overall attitude to PD patients. These variables exist at the level of organisational systems (the operations of the complaints system, multidisciplinary relationships, management methods etc.) and at the level of the individual nurse. For the nurse, what influences attitude to PD are their beliefs (e.g. on cause), knowledge (e.g. psychological understanding of PD behaviour), moral commitments (e.g to nursing professionalism), who they identify with (e.g. patient or victim), and the self management methods they use to contain their emotional reactions to patients (e.g. separating the person from the behaviour). In the development of and change of attitude over time, there are key events that have a profound influence upon the individual nurses point of view, e.g. reading case notes, being verbally abused, suffering or witnessing a violent attack, etc.

As the analysis of this data is only half complete, more is likely to be discovered and described over the next few months. Attention should soon turn to investigating whether nurse attitudes can be changed by an educational intervention, and do such changes have the predicted impact on nurses' behaviour with patients.
3. Recommendations

Given that the analysis is not yet complete, it is premature to make wide-ranging recommendations at this stage. However the recommendations made at the time of the first report in May 1999 are still appropriate and await a policy response. They are:

1. Adequate training for all staff working with PD patients should be initiated. Due to the small size of the PD units, it might be feasible to hold specialist induction training at a central location. This would be easier and more efficient if the three High Security Hospitals took new staff onto the PD units at specific times each year. Efforts should also be made to make sure a similar package of training is incorporated into basic psychiatric nurse education.

2. A structured package of training should be devised and evaluated for this purpose. It should contain material emphasising nurture theories of PD, develop empathy by the study of in depth case examples, prepare nurses to deal with the feelings aroused by index offences, train nurses how to use clinical supervision to deal with their feelings, raise awareness of manipulative behaviour and train nurses how to practically deal with it, promote evidence of treatability, and training in treatment methods which nurses can incorporate into their everyday care. Additional recommendations will be made as the analysis proceeds.

3. Staff support mechanisms should be strengthened for those nurses working with PD patients. The work causes strong emotional stress that overflows into nurses personal lives and creates fears for their families. Services may wish to consider how they will provide external clinical supervision, support during and after the complaints process, and if there is any way to promote nurses' feelings of security at home with their families.

4. Better efforts could be made to encourage staff morale in the treatment of PD. Services may wish to consider how they can give feedback to nurses on the progress of patients who have been successfully treated and have left the High Security Hospital system. Under the current situation nurses are more likely to hear about treatment failures than treatment successes. Information on treatment success will strengthen nurses belief in treatability and improve positive attitudes to existing PD patients.

5. The managers of the complaints systems at Ashworth, Broadmoor and Rampton should meet to share comparable data on the type, nature, process and duration of their complaints procedures, and endeavour to discover if there is any obvious reason for the negative views of staff at Rampton.
Chapter VII
References

Adler, G (1973) Hospital Treatment of Borderline Patients, American Journal of Psychiatry 130:32-35

Aiken, F. & Sharp, F. (1997) Containment and exploration: group psychodynamic psychotherapy for PD patients in a secure setting Psychiatric Care 4(2) 75-8


Blom-Cooper, L; Brown M; Dr R Dolan; Professor Elaine Murphy (1992) Report of the Committee of Inquiry into Complaints about Ashworth Hospital Vols 1 and 2 HMSO


Coid, J (1992) DSM-111 diagnosis in criminal psychopaths: a way forward, Criminal Behaviour and Mental Health 2, 78-79


Feldbrugge, J.T. (1992) Rehabilitation of patients with personality disorder; Patient staff collaboration used as a working model and a tool, *Criminal Behaviour and Mental Health* 2(2),169-177


Gallop, R., Lancee,W.J., Garfinkle, P. (1989) How nursing staff respond to the label 'Borderline Personality Disorder,' *Hospital and Community Psychiatry* 40, 815-819


Harris,G.T, Rice, M.E., Cormier, C.A. (1994) Psychopaths : Is a Therapeutic Community Therapeutic? Special Issue: Therapeutic Communities for Offenders *Therapeutic Communities International Journal for Therapeutic and Supportive Organisations* 15 (4),Winter,283-299
Hughes, G. & Tennant, A (1996) A training and development strategy for clinically based staff working with people diagnosed as having psychopathic disorders Psychiatric Care 3 (5), November,194-9


Kullgren, G (1988) Factors Associated with Completed Suicide in Borderline Personality Disorder, Journal of Nervous and Mental Disease, 176 (1) 40-44

Levinson, A. (1996) The struggle to keep a culture of enquiry alive at the Cassell Hospital, Therapeutic Communities International Journal for Therapeutic and Supportive Organisations 17(1), Spring, 47-57


MacIlwaine, H (1981) How nurses and neurotic patients view each other in general hospital psychiatric units, Nursing Times 77 (27) 1158-1160


Miller, S and Davenport, N (1996) Increasing staff knowledge of and improving attitudes towards patients with Borderline Personality Disorder, Psychiatric Services 47, No 5, 533-535


Tennant, A. & Hughes, G (1997) Issues in Nursing Care for Patients with Severe Personality Disorder, *Mental Health Practice* 1, No1, Sep 97


## Appendix 1  Literature search methodology

This search was used for PSYCHLIT & CINAHL(journals and books, all period covered by indexes)

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Appendix 2  Attitude to personality disorder questionnaire (APDQ)

Please do not write your name or ward on this form. Your responses will be kept anonymous.

Please tell us a few basic things about yourself (please circle that which applies):

1. Your age in years?
   Under 20 / 20 - 29 / 30 - 39 / 40 - 49 / 50 - 59 / Over 60

2. Your gender?
   Male / Female

3. Your nursing grade?
   A / B / C / D / E / F / G / H / I / Other

4. If a qualified nurse, now many years since qualifying?
   ........................ years

5. Do you have experience of working as a psychiatric nurse outside the High Security Hospitals?
   Yes / No

6. How many years experience of working in the High Security Hospitals?
   ........................ years

7. Are you currently working in a PD Unit?
   Yes / No

8. Have you ever worked in a PD Unit in the High Security Hospitals?
   Yes / No

9. Have you ever worked in a PD Unit outside the High Security Hospitals?
   Yes / No

10. What is your employment status?
    Permanent / Temp. / Fixed term / Bank / Agency / Student / Other
Now please take a moment to reflect upon your experience of nursing patients with personality disorder.

By PD we mean personality disorder by any commonly used diagnostic system, including PD combined with other conditions, e.g. Learning Disability, Schizophrenia, etc. We recognise that PD patients vary a lot, and many people feel that it is not a terribly useful diagnosis. But these difficult patients do exist and psychiatric nurses do have to care for them. The behaviours typical of PD patients are impulsive, histrionic, antisocial, immature and paranoid.

For the purposes of this questionnaire we would like you to think about your feelings towards PD patients overall. We realise that you may have different mixtures of feelings about different PD patients you have cared for in the past. For this questionnaire we would like to you try and average those out and tell us what your responses are in general towards PD patients as a whole.

For each response listed below please indicate the frequency of your feelings towards people with a personality disorder. Please circle your choice quickly, rather than spending a long time considering it. We want to know your honest, gut feelings.

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<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>15</td>
<td>I feel helpless in relation to PD patients</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>16</td>
<td>I feel frightened of PD patients</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>17</td>
<td>I feel angry towards PD patients</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>18</td>
<td>I feel provoked by PD patients behaviour</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>19</td>
<td>I enjoy spending time with PD patients</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>20</td>
<td>Interacting with PD patients makes me shudder</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>21</td>
<td>PD patients make me feel irritated</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>22</td>
<td>I feel warm and caring towards PD patients</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>23</td>
<td>I feel protective towards PD patients</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>24</td>
<td>I feel oppressed or dominated by PD patients</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>25</td>
<td>I feel that PD patients are alien, other, strange</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>26</td>
<td>I feel understanding towards PD patients</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>27</td>
<td>I feel powerless in the presence of PD patients</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>28</td>
<td>I feel happy and content in PD patients company</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>29</td>
<td>I feel cautious and careful in the presence of PD patients</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>30</td>
<td>I feel outmanoeuvred by PD patients</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>31</td>
<td>Caring for PD patients makes me feel satisfied and fulfilled</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>32</td>
<td>I feel exploited by PD patients</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>33</td>
<td>I feel patient when caring for PD patients</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>34</td>
<td>I feel able to help PD patients</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>35</td>
<td>I feel interested in PD patients</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>36</td>
<td>I feel unable to gain control of the situation with PD patients</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>37</td>
<td>I feel intolerant. I have difficulty tolerating PD patients</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>
1. **Overall extent of care & treatment difficulty.** Please indicate your overall sense of the difficulty in treating PD patients as compared to others by circling only one of the numbers below.

<table>
<thead>
<tr>
<th>Number</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>The care &amp; treatment of PD patients is <em>relatively free from difficulty</em></td>
</tr>
<tr>
<td>2</td>
<td>Care &amp; treatment poses <em>some mild difficulty</em></td>
</tr>
<tr>
<td>3</td>
<td>Care &amp; treatment is <em>moderately difficult</em></td>
</tr>
<tr>
<td>4</td>
<td>Care &amp; treatment is <em>very difficult</em></td>
</tr>
<tr>
<td>5</td>
<td>Care &amp; treatment <em>difficulty is extreme</em></td>
</tr>
</tbody>
</table>

2. **Good use of care & treatment.** Indicate your opinion with a rating about whether PD patients make good use of care & treatment. How much do they profit from care & treatment, and how satisfactory will eventual adjustment be? Please ignore financial considerations in making this rating. Please circle only one of the numbers below.

<table>
<thead>
<tr>
<th>Number</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>I am <em>very optimistic</em> about care &amp; treatment outcomes and confident PD patients will make good use of care &amp; treatment</td>
</tr>
<tr>
<td>2</td>
<td>I am <em>optimistic</em> about care &amp; treatment outcomes</td>
</tr>
<tr>
<td>3</td>
<td>I am <em>quite unsure</em> about what kind of care &amp; treatment outcomes to expect</td>
</tr>
<tr>
<td>4</td>
<td>I am <em>pessimistic</em> about care &amp; treatment outcomes but think there is some possibility for good outcomes</td>
</tr>
<tr>
<td>5</td>
<td>I am <em>extremely pessimistic</em> about care &amp; treatment outcomes and have little hope for positive outcomes</td>
</tr>
</tbody>
</table>

3. **Teamwork.** Indicate your opinion with a rating about the extent to which staff members work well together in treating PD patients. Take into account the openness of communication, ability to express and discuss disagreements, ability to reach consensus about treatment of PD patients. Please circle only one of the items below.

<table>
<thead>
<tr>
<th>Number</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td><em>Exceptionally good team work</em>; work very well together</td>
</tr>
<tr>
<td>2</td>
<td><em>Good teamwork</em>; work well together</td>
</tr>
<tr>
<td>3</td>
<td><em>Fair teamwork</em>; work fairly well together</td>
</tr>
<tr>
<td></td>
<td>Poor teamwork; do not work well together</td>
</tr>
<tr>
<td>---</td>
<td>----------------------------------------</td>
</tr>
<tr>
<td>5</td>
<td>Exceptionally poor teamwork; working against each other</td>
</tr>
</tbody>
</table>

* * *
4. Please indicate your opinion in relation to the following statements, by circling the number that applies.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Neither agree or disagree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prison is a more appropriate environment for PD patients than High Security Hospitals</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>A PD unit is a more suitable environment for PD patients than a conventional ward</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Female nurses should <strong>not</strong> care for male PD patients</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Male nurses should <strong>not</strong> care for female PD patients</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I have been well trained to work with PD patients</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

* * *

Thank you for taking the time to complete our questionnaire. Please place it in the envelope provided and send it back to us at:

PD Project  
c/o Linda McFarlane & Frank Kiyimba  
St Bartholomew School of Nursing  
City University  
Philpot Street  
London E1 2EA
Appendix 3

---

**Nursing Patients with Personality Disorder**

**Interview Schedule**

**Interviewer code:**

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Rampton</th>
<th>1</th>
<th>Gender</th>
<th>Male</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Broadmoor</td>
<td>2</td>
<td></td>
<td>Female</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Ashworth</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Interviewer read:**

The findings of this research will be analysed in a number of ways - for example by nursing grade, hospital, whether working on a personality disorder unit or not. In this way we can look at the sort of things which may result in both differences and similarities of experience in nursing patients with personality disorder. If you don’t have any objections therefore, I would just like to ask you a few questions about yourself. Is that all right with you?

1. **To which one of the following age groups do you belong?**

   **Read out:**

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>under 20</td>
<td>1</td>
</tr>
<tr>
<td>20-29</td>
<td>2</td>
</tr>
<tr>
<td>30-39</td>
<td>3</td>
</tr>
<tr>
<td>40-49</td>
<td>4</td>
</tr>
<tr>
<td>50-59</td>
<td>5</td>
</tr>
<tr>
<td>over 60</td>
<td>6</td>
</tr>
</tbody>
</table>

2a. **Are you a full-time permanent member of staff?**

   Yes 1 (now go to Q3)

   No 2 (now go to Q2b)

2b. **What is your actual employment status?**

<table>
<thead>
<tr>
<th>Employment Status</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>permanent PT</td>
<td>1</td>
</tr>
<tr>
<td>temporary FT</td>
<td>2</td>
</tr>
<tr>
<td>temporary PT</td>
<td>3</td>
</tr>
<tr>
<td>fixed term FT</td>
<td>4</td>
</tr>
<tr>
<td>fixed term PT</td>
<td>5</td>
</tr>
<tr>
<td>bank</td>
<td>6</td>
</tr>
<tr>
<td>agency</td>
<td>10</td>
</tr>
<tr>
<td>student</td>
<td>11</td>
</tr>
<tr>
<td>other</td>
<td>12</td>
</tr>
<tr>
<td>(specify).........</td>
<td></td>
</tr>
</tbody>
</table>

3. **How would you describe your ethnic origin?**

   ......................................................................................................................................................
4. Do you live in hospital accommodation?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

I’d like to talk to you now about your nursing experience.

5. Which nursing grade are you at the moment?

<table>
<thead>
<tr>
<th>Grade</th>
<th>Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>A 1</td>
<td>F 6</td>
</tr>
<tr>
<td>B 2</td>
<td>G 10</td>
</tr>
<tr>
<td>C 3</td>
<td>H 11</td>
</tr>
<tr>
<td>D 4</td>
<td>I 12</td>
</tr>
<tr>
<td>E 5</td>
<td>Other 7</td>
</tr>
</tbody>
</table>

6. And how many years is it since you qualified?

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

7. For how long have you worked at ................. (name of hospital) ?

8a. And have you worked anywhere else?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

8b. In which other types of places have you worked? .................................................................

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

9a. Is there anyone else in your family who has worked or is working within any of the high security hospitals?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

9b. In which high security hospitals have they worked?

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

10a. In terms of working with patients with personality disorder, has your experience at ................. (name of hospital) been in  (read out)
both personality disorder units and non-personality disorder units? 1 (go to Q 10b)
personality disorder unit(s) only 2 (go to Q11)
non-personality disorder units only 3 (go to Q11)

10b. In which type of unit do you currently work? personality disorder unit 1
non-personality disorder unit 2

11. Have you ever worked in a personality disorder unit outside of ................. (name of hospital)?

   yes 1 (go to Q 11b)
   no  2 (go to Section1)

11b. Where was that? ..............................................................................................................................

Thank you for agreeing to answer these questions. Now if it’s OK with you, I’ll move on to the questions in the main interview schedule.

==================================================================

Section 1

Interviewer read out:
There are three areas I would like to cover with you in this interview. The first, which I’d like us to look at now, is about the kinds of views and attitudes most commonly found amongst nursing staff here, towards patients with personality disorder.

1. By working here at ................. (name of hospital), what would you say you have learned about nursing people with personality disorder?

2. Can you tell me who or what you found most useful to you during that learning process - and obviously may still be useful?
(Follow up: How were they useful? In what sort of situations did you learn? If not mentioned, ask: What about managerial support? training input? clinical supervision? nursing colleagues?)

3. Would you say there have been particular past events or happenings, or even particular patients, which have influenced nurses’ opinions about patients with personality disorder?
(Follow up: How? Is there anything else you can think of which may have helped to shape opinion?)

- 75 -
4. Can you give me any examples of stories which circulate amongst nurses here, about patients with personality disorder?
(Follow up: Do those come from all over the hospital, or from particular units - for example, do you hear different stories from personality disordered units as opposed to wards which are not specifically for personality disordered patients?)

5. In your opinion - taking into account the sorts of beliefs, views and attitudes we’ve just been talking about - what do nurses here generally think about people with personality disorder?

==================================================================

Section 2

Interviewer read out:
I’m going to move on to the second area now. The aim of this section is to look at your beliefs about personality disorder.

1. First of all, what do you believe to be the origin or cause of personality disorder?
(Follow up where appropriate: Is it something you have any doubts about? Have you always felt that way? What do you think has shaped your opinion?)

2. Do you think that patients with personality disorder can be treated?
(Follow up: If yes - in what sorts of ways? / any other ways?
Ask all: Is that something you have any doubts about? Have you always felt that way? What do you think has shaped your opinion?)

3. What about responsibility? Are patients with personality disorder responsible for their behaviour?
(Follow up: Is that something you have any doubts about? Have you always felt that way? What do you think has shaped your opinion?)

4. How appropriate do you feel words like monstrous, bad, and evil are, in terms of describing patients diagnosed as having personality disorder?
(Follow up where appropriate: Is that something you have any doubts about? Have you always felt that way? What do you think has shaped your opinion?)

5. Given your beliefs about treatability and responsibility, where would you say is the most appropriate environment for patients with personality disorders - in a hospital like this, or prison, or somewhere else?
6a. Are you ever affected in any way by reading the case notes of patients who have a history of violence or injury to others, or who have committed serious crimes?
(Follow up where appropriate: How else does it affect you? Do those kinds of feelings make it harder to work with the patient?
Ask all: Do you know of other nurses who have been affected? What was their experience?)

6b. Do you ever find yourself thinking about the people who have been damaged by patients with this kind of history?
(Follow up where appropriate: How does that make you feel?)

7. I’d like you to take some time now to talk about your experience of nursing patients with personality disorder - what it’s like, what’s rewarding, what’s difficult - that kind of thing.

8. Have you ever been seriously threatened or attacked by a patient with personality disorder?
(Follow up: If yes - how did that make you feel?
Ask all: Do you know of other nurses who have been attacked or threatened? How did that make you feel?)

9. What sort of things would you identify as being important, in order for you to have a good nurse-patient relationship with a patient with personality disorder?
(Follow up where appropriate: Is that something you have any doubts about? Have you always felt that way? What do you think has shaped your opinion?)

10a. I’d like to look now at the effects patient visitors may have. Thinking first about relatives - have visits from relatives ever aroused any feelings in you?
(Follow up: - if yes, what sorts of feelings did you have? Why do you think that was?
Ask all: Do you know of other nurses who have experienced feelings about relative visits? What sort of feelings did they experience?)

10b. Do you ever get a situation where patients react badly to a visit from relatives, thus leaving you to deal with the consequences? How does that make you feel?
(Follow up: Do you know of other nurses who have experienced this? Can you tell me about any incidents?)

11. What about visits from lawyers or other professionals representing personality disordered patients? Do those sorts of visits arouse any feelings in you, or cause you any problems?
(Follow up: Have you heard of other nurses experiencing difficulties with, or feelings about, visits of this kind?)
12a. I’d like you to think now about what it’s like to nurse different sorts of patients with personality disorder, and to describe any problems or difficulties you may have encountered. For example, do you think there are any differences in nursing men with personality disorder as opposed to nursing women?
(Follow up: Do you think your view is influenced by your gender? To what extent? Would other nurses of the same gender feel the same, do you think? What about nurses of the opposite gender?)

12b. Do you think there are any problems within ..................... (name of hospital) itself, which make nursing one gender more difficult than another?
(Follow up: Have you always felt that way? What do you think has shaped your opinion?)

12c. And what about different ethnic groups? For example, are their particular ethnic groups who present specific problems, or perhaps you feel more comfortable working with?
(Follow up: To what extent do you think your view is influenced by your own ethnicity?)

12d. Do you think there are any problems within ..................... (name of hospital) itself, which make nursing one ethnic group more difficult than another?
(Follow up: Have you always felt that way? What do you think has shaped your opinion?)

13a. Thinking about new staff arriving here to start work, and who have no experience of working in this kind of environment. To what extent would you say the induction programme here is useful, in terms of telling nurses the sorts of things they need to know about patients with personality disorder?
(Follow up: Does that apply to both qualified and unqualified staff?)

13b. What sort of things would you want to communicate to a new member of staff, about nursing personality disordered patients?
(Follow up: Again, would that apply to both qualified and unqualified staff?)
Section 3

Interviewer read out:
This is the final section. What I want to find out here is your views on the nursing management of patients with personality disorder. I am going to read out a number of general statements, and in the first instance I would like you to tell me whether or not you think they are a good idea in a ward with personality disordered patients. Depending on your reply I will then ask you some follow up questions. Some of the statements are controversial.

1. When working with patients with personality disorder, part of the nurses’ role is to encourage patients to express their criticisms and complaints.
   If ‘no’ - what do you think the consequences would be? (For patient, staff, ward in general)
   If ‘yes’ - what do you think are the benefits of that approach? (as above).
   Do you have personal experience of that? What have other nurses experienced? Can you give me examples?

2. As part of their treatment schedule, personality disordered patients should be entrusted with responsibilities and leadership.
   If ‘no’ - what do you think the consequences would be? (For patient, staff, ward in general)
   If ‘yes’ - what do you think are the benefits of that approach? (as above)
   Do you have personal experience of that? What have other nurses experienced? Can you give me examples?
3. *Patients with personality disorder need the ward to be very well organised.*
If ‘no’ - what do you think the consequences would be? (For patient, staff, ward in general)
If ‘yes’ - what do you think are the benefits of that approach? (as above)
Do you have personal experience of that? What have other nurses experienced? Can you give me examples?

4. *Rules created by staff which aim to facilitate the smooth running of the ward, need to be understood and accepted by patients with personality disorder.*
If ‘no’ - what do you think the consequences would be? (For patient, staff, ward in general)
If ‘yes’ - what do you think are the benefits of that approach? (as above)
Do you have personal experience of that? What have other nurses experienced? Can you give me examples?

5. *Patients with personality disorder need to acknowledge and respect the fact that the nursing staff are in charge of the ward.*
If ‘no’ - what do you think the consequences would be? (For patient, staff, ward in general)
If ‘yes’ - what do you think are the benefits of that approach? (as above)
Do you have personal experience of that? What have other nurses experienced? Can you give me examples?

6. *Patients with personality disorder should agree to follow the treatment schedule created for them.*
If ‘no’ - what do you think the consequences would be? (For patient, staff, ward in general)
If ‘yes’ - what do you think are the benefits of that approach? (as above)
Do you have personal experience of that? What have other nurses experienced? Can you give me examples?

7. *Part of the role of nurses working with personality disordered patients, is to encourage those patients to express their feelings and discuss their past.*
If ‘no’ - what do you think the consequences would be? (For patient, staff, ward in general)
If ‘yes’ - what do you think are the benefits of that approach? (as above)
Do you have personal experience of that? What have other nurses experienced? Can you give me examples?

*Interviewer read out:*
That was the last statement in this section, but before we finish, I would just like to ask you in what sort of ways - if any- working with personality disordered patients has made an impact on you?
Thank you very much for agreeing to take part, and for taking the time to answer these questions. Is there anything you want to ask me - either about the interview or the research in general?