The Mental Health Nurse's Understanding of the Relationship Difficulties Experienced with Male Patients Diagnosed with Personality Disorder As Defined within DSM-IV.

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The Mental Health Nurse's Understanding of the Relationship Difficulties Experienced with Male Patients Diagnosed with Personality Disorder As Defined within DSM-IV.

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ABSTRACT.

This research study utilised Q-methodology to elicit the shared perspectives of n=40 registered Mental Health Nurses (MHN) who work with men diagnosed with personality disorder (PD), represented from high, medium, and low secure environments. A literature search focused on the understanding of personality disorder, their relationship difficulties and how this is processed, to situate/contextualise the nurse participants' results. The literature highlighted the influences on the nurses' understanding and the therapeutic relationship, particularly concerning diagnosis, risk, role and training, and the components that impede and optimise the therapeutic alliance.

The aim of the study was to explore the nurse participants' shared perspectives regarding (1) what they understand about men diagnosed with personality disorder, (2) how Mental Health Nurses' understand the therapeutic relationship, and (3) how understanding personality disorder and their relationship difficulties inform reflective processes. Two Q-sorts, utilising 70 and 82 statements respectively were used to elicit participants' perspectives and were analysed using a PQ-Method 2.11 factor analysis programme.

The first Q-sort created eight distinct factors for understanding personality disorder: (Factor 1: "Labels are unhelpful - look deeper"; Factor 2: "social groups and difference - gender and ethnicity"; Factor 3: "Personality disorder - a pejorative label for men and women"; Factor 4: "Beyond the mist of the personality disorder label"; Factor 5: "Personality Disorder and relationships"; Factor 6: "Personality disorder, relationships and society"; Factor 7: "Race,

gender, treatment and the non-prejudicial society"; Factor 8: "Personality disorder"?). The second Q-sort created seven distinct factors for personality disorder relationships: (Factor 1: "Processing present relationships"; Factor 2: "The impact on therapeutic relationships"; Factor 3: "Relationships are consciously driven but don't talk about the past"; Factor 4: "Coping with emotional and other responses"; Factor 5: "Coping with the 'relationship' and the utility of labels"; Factor 6: "The relevance of past and present behaviour, and female nursing issues"; Factor 7: "Relationship strategies, the impact and processing") respectively from the nurse participants.

In addition, emerging themes that traversed most factors revealed the following related issues pertaining to Q-sort A: ("Diagnosis and nursing assessment of personality disorder"; "Relationships"; "Features of personality disorder"; "Perceived understanding of society"; "Gender issues"; "Racial issues"; "Treatment") and Q-sort B: ("Relationship patterns"; "The impact of personality disorder relationships on the Mental Health Nurse"; "Nurses coping strategies"; "Nurses role"; "Understanding of self"; "Processing relationship difficulties"; "Reflective practice"; "Training").

The research methodology offered a unique perspective concerning the aims, providing a foundation for a variety of future developments recommended in the discussion chapter. The above factors and the emerging themes have been interpreted, discussed, and the potential recommendations for practice have been examined. The recommendations for future practice consideration involved: functional dimensional diagnostic and nursing assessment models

alongside shared formulation, personality disorder and risk, reflective practice, integrative evidence based interventions, training and support, evaluation of forensic/Mental Health Nurse competency base and role. Final recommendations concerned further research, into the relationship between personality disorder and race, and the provision of a specific reflective practice model underpinned by attachment theory.

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Finally, I would like to dedicate this thesis to my dad

(Frank Sharp 1926-2002)

to thank him for his humour, love, consistency, and friendship.

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CONTEXT AND THE PROBLEM.

Chapter One:

Context and Problem.

1.0 The Context.

This chapter is designed to situate the study at its inception in 2002, which represented a point in time when serious attempts were beginning to be made to understand personality disorder and how best to mobilise resources to manage their challenging needs. However, positive change could not be immediate because the baseline of understanding historically was one of confusion and inconsistency, particularly in relation to assessment/diagnosis, evidence based interventions and best practice guidelines. As one would expect currently improved clarity has been achieved, but arguably many of these issues still require further development. In the midst of the profound and uncertain challenges represented by patients diagnosed with personality disorder (PD) Mental Health Nurses (MHN) who have the longest contact time, yet had limited resources to meet their needs, reflecting the paucity of understanding internationally. Consequently, this chapter will firstly, introduce my role, the development of the Personality Disorder Unit (PDU) in the high secure site, baseline evidence based research and attempts to implement best practice. Secondly, best practice guidelines resulted in nurses processing relationship difficulties through reflective practice groups, providing the impetus for this research study. An anecdotal reflective practice session is described under the title 'The Problem' (1.1), which provided a rich source of understanding to a challenging problem, prompting interest in how nurses understand personality disorder, their relationships and how this could be processed effectively. The final sections in this chapter focus on the

omnipresent: political influences (1.2), the nursing role (1.3), nurses' attitudes to PD (1.4) and understanding through attribution theory (1.4.1), and understanding of self through attachment theory and reflective practice (1.5). Finally, the research aims are stated and an overview of all the chapters is provided.

I embarked upon this study whilst working in a variety of positions within mental health nursing and as a psychotherapist within a high secure hospital, which is one of three high secure psychiatric hospitals in England. The High Secure Hospital provides treatment and care for approximately 400 patients suffering from mental illness and/or personality disorder, who are considered to be a grave and immediate danger to themselves and others. Patients are often referred directly from court and from prison or health care settings because they cannot be managed effectively. All too often they have childhood histories of extreme trauma, neglect and abuse and have developed equally extreme childhood coping strategies which can serve to perpetuate and reinforce negative feelings thoughts and behaviours within their relationships. This often culminates in pathological responses and offending, resulting in it being contextualised within a personality disorder and/or comorbid mental illness diagnosis. Commonly, by the time they are admitted to a high secure setting, a wealth of failed interventions have littered their pathway, reinforcing their negative beliefs and hardening their resolve against trusting or engaging in therapeutic relationships.

The High Secure Hospital was subject to two public inquiries (Blom-Cooper et al, 1992 and the Fallon et al Inquiry, 1999). One of the many recommendations

from the former Inquiry resulted in the hastily constructed Personality Disorder Unit (PDU) in 1994, which in turn became the subject of the latter inquiry. The PDU comprised of six wards for approximately 130 patients diagnosed with personality disorder and represented the largest personality disorder unit in the country. In my opinion the unit was created 'cart before the horse' in the sense that staff were deployed there in most cases without negotiation, assessment of skills, motivation or aspiration, and in an absence of training and support. The majority of patients on the unit had been transferred from various prisons, filling a void within the hospital created by patients diagnosed with Learning Difficulties who had been transferred to conditions of medium security. Prior to the creation of the PDU it was my observation that patients diagnosed with personality disorder were very much in the minority and were 'crisis managed', resulting in their challenging behaviours being responded to by transferring them to a string of different wards, which exacerbated their behaviours due to increased isolation, and inconsistency; resulting in stigma and stereotyping of the patient with its incumbent negative responses.

I was working as a ward manager on the PDU, at this point and I became acutely aware of not only the local/national/international paucity of knowledge surrounding most aspects of the care and management of people diagnosed with personality disorder but also the profoundly challenging therapeutic dilemmas that can be presented. This concern was reinforced by Reed (1994) who commissioned Dolan and Coid (1993) to undertake a 30 year retrospective meta-analysis of assessment and treatment of personality disorder. They concluded that assessments and subsequent treatment had been so

inconsistent and varied that a definitive approach could not be considered better than another. Nevertheless, they were able to recommend what standards should be adhered to in order to inform effective research of assessment and treatment of personality disorder. In addition, Reed (1994) pointed out that most of the available literature pertained to psychodynamic approaches and therapeutic communities. Whilst cognitive behavioural therapy, cognitive analytical therapy, and dialectical behavioural therapy were perceived as being in their infancy in relation to demonstrating an evidence base for the treatment of personality disorder.

Consequently, I negotiated with my nursing team to undertake a patient needs analysis and subsequent treatment interventions based on best available evidence. We undertook community meetings, therapy groups, journal clubs, training, support/reflective practice, and established a host of external links. In addition, aspiration interviews were undertaken with the staff to negotiate and match them with the development of skills required to meet the identified patient's needs, i.e. – allocating specific training for assessments, treatment involved training in America to undertake DBT, and the development of research skills to measure practice efficacy. The process of engaging in the above developments was to enable the creation of a Practice Development Unit under the umbrella of the Kings Fund.

Whilst being conscious of the above difficulties, the PDU was assessed by the Health Advisory Service (2000) who provided many positive conclusions and in their feedback and I was particularly struck by a metaphor they used to

positively describe contemporary understanding of personality disorder and our attempts to progress. They described the PDU as akin to a pilot flying in zero visibility and having to create an artificial horizon. Consequently, in the absence of a recognised efficacious approach to personality disorder it was hardly surprising that I was informed that during the course of a registered mental nurse's three-year training they would be fortunate to have one day's training about personality disorder.

1.1 The 'Problem'.

The importance for nursing staff to have the opportunity to engage in reflective practice emerged as an important necessity to provide mutual support and understanding. This resulted in a social worker and I creating the first reflective practice group in the hospital, providing the catalyst to undertake this research study, through which the following vignette will hopefully exemplify this further:

> The reflective practice group comprised of a variety of non/qualified Mental Health Nurses of differing gender, experience and age. Unless there was an urgent issue to discuss we would normally identify a specific patient to discuss over two meetings within the fortnight period to accommodate their shift pattern. In the first session a background history would be provided followed by group members individual feedback, including perceptions of how the patient made them feel, think, behave, in which attempts were made constructively to contextualise these dynamics. In the second week a specific area of need was identified and processed within a care plan, to be negotiated with the patient care team and patient to enable a strategy to be developed to challenge, support the identified area of need.
>
> On one occasion I was particularly struck by three female nursing assistants who independently and intuitively described the experience of their boundaries being challenged/transgressed. The first described the patient invading her personal space. The second explained how he had subtly physically touched her, whilst the third explained how she could not understand how she had been discussing her husband and children

with him. All three of them had felt unable to express these concerns previously because the patient was able to exert considerable peer pressure and was well-known for his litigious behaviour which they perceived as controlling and disempowering. Compounding their inability to express their concerns was the nature of the hierarchal macho system, in which they felt if they expressed vulnerability it would be seen as weakness and feared that their concerns would be invalidated because of their lack of training. After considerable exploration a wealth of perspectives and a degree of consensus of understanding was achieved. The patient concerned had been diagnosed with antisocial and narcissistic personality disorder with a high percentile score in relation to psychopathy, whose index offence had involved considerable grooming and controlling of his young victim, and resulted in a brutal and sadistic murder. His presentation at ward level had almost made it impossible for him to reflect on his treatment needs. However, following the group contextualisation of the initial intuitive feelings, they provided a tentative understanding of parallel offending behaviour, culminating in a negotiated care plan, validated by the patient care team to enable the patient's behaviour to be challenged whilst providing supportive insightful alternative strategies to be developed.

However the emerging issues highlighted above should also be understood and contextualised in light of the following:

- There was a national evolution taking place in the understanding of the term personality disorder, its treatability, and risk (1.2).
- In the absence of; specific training and National understanding, how and what could nurses effectively manage, understand, whilst protecting their integrity and their therapeutic relationships (1.3).
- What influence did the culture of the environment have on nurses' attitudes (1.4) and the significance of understanding themselves in this dynamic (1.5)?

1.2 Political Influences.

It is important not to underestimate the significance of the political influences upon Mental Health Nurses working with PD patients. This section will describe how the need for the PDU was born out of the high secure site's first public inquiry recommendation, only for the PDU itself to be the subject of an extraordinary second public inquiry. It will also focus on how one crime

crystallised public, media, and government concern over psychopathy/personality disorder culminating in (1) changed legislation arguably confusing diagnosis, detention, and treatability, and (2) the creation of the term Dangerous and Severe Personality Disorder (DSPD), alongside the establishment of a £126 million DSPD research project to assess treatability of psychopathy.

Firstly, predating the 1990s, patients diagnosed with personality disorder within the high secure environment were considered to be so demanding that they were predominantly managed together with patients diagnosed with psychosis, which inhibited the development of specialised interventions and research (Bowers, 2002). Consequently, when The High Secure Hospital became the subject of a public inquiry (Blom-Cooper et al., 1992) it can be considered that one of its recommendations to create a specialised personality disorder unit (PDU) would helpfully address this anomaly. The PDU comprised of six wards for 130 patients, representing the largest personality disorder unit in Europe (Storey et al., 1997). As mentioned earlier, regardless of the nurse's aspirations and abilities they were allocated to this unit with a paucity of experience, training and an absence of available practical psychiatric nursing literature, thus leaving nurses and other staff to create a culture and regime at their own behest. Significant learning and development was undertaken through trial and error (Melia et al., 1999, Moran and Mason 1996), with its inherent benefits but considerable costs. The catalyst Blom-Cooper et al Report (1992) and the subsequent creation of the PDU was undertaken following the critical 'Cutting Edge' television documentary pertaining to allegations that patient's complaints

were not processed adequately. The investigation unearthed demeaning and uncaring attitudes to patients, culminating in bullying and harassment, a poor quality of life, eliciting difficult to manage behaviours, substandard nursing medical and management. The implementation of the 90 recommendations resulted in a transformation of the culture and attitudes, including the ground-breaking development of the PDU in 1994, which was heralded as a positive way forward to provide therapeutic care to this most difficult of diagnostic patient groups. There was a perception that following the swift adherence to the Blom-Cooper et al (1992) recommendations with its focus on care that had dramatically liberalised the rigid culture to the degree that security had been compromised, raising controversy about personality disordered patients care, culminating in the second Inquiry. The Fallon et al Inquiry (1999) was triggered in response to allegations of paedophilic activity, pornography, drugs and alcohol, and financial irregularities, made by a patient who had absconded whilst on escorted leave. Not all the allegations could be proven but there was significant evidence to demonstrate worryingly inconsistent and poorly implemented security rules. Consequently security was significantly increased across all the high secure hospitals, and was increased further following a review by the Tilt Report et al (2000).

At a macro level, critical public perceptions of psychiatry increased further in 1998 following the murder, by Michael Stone, of a woman and her child who had been walking in the countryside. This individual had been diagnosed with a personality disorder but had been deemed untreatable. This political and public concern was translated into the proposal by Mr Jack Straw (MP), the then

Home Secretary, to establish a service for dangerous and severe personality disorder (DSPD) and controversial new Mental Health Act legislation to provide preventive detention prior to a crime being committed by DSPD patients.

This is not the first time that the British State's policymakers have attempted to shape the management of the pathology, but also perceptions of its very nature. The Fallon et al Inquiry (1999) noted that the legal concept of 'psychopathic disorder', was developed to cover patients with personality disorder when they fall within the remit of mental health law and that the term is so unpopular that it is considered a term of 'abuse'. Cavadino (1998) expressed the futility of relating the 19th century concept of 'moral insanity', arguing that 'the more modern term is simply a prime example of moralism masquerading as medical science''. He added that,

> Perhaps we should strip away the mask completely, and for the term 'psychopath' substitute the word 'bastard'. For predominantly aggressive psychopath, read 'stroppy bastard'. For 'predominantly inadequate psychopath': read 'useless bastard'. Would much be lost in the descriptive power of the term? Would not much be gained in the honest expression of the essentially moral judgement and dehumanising contempt with which we view 'the psychopath'? (Cavadino, 1998, p.6).

Historically, antisocial personality disorder and psychopathy have been considered to be resistant to treatment; which has been the dominant understanding of these conditions even into the late 1990s according to Pickersgill (2012). Whilst Murphy and McVey (2010) suggest that mental health service providers have denied personality disordered people access to services on the grounds of 'lack of treatability' without sufficient evidence. Nevertheless, Jasanoff (2005) claims that the UK is not alone amongst other nations to have debated clinical and moral issues in relation to psychopathy, adding that mental

health law is frequently used as a method of managing ‘dangerous’ and ‘risky’ individuals. Consequently, following the Butler review of the 1959 Mental Health Act and the creation of the 1983 Mental Health Act, the introduction of the ‘treatability test’ was introduced for psychopathy (now redefined as antisocial personality disorder) to determine suitability for involuntary legal detention. Raising the contentious issue of whether psychopathy was treatable. Pessimism was exemplified by Grounds (1987):

> The detention of offenders in the legal category ‘psychopathic disorder’ in special hospitals for treatment raises a number of critical issues. There are doubts about the nature of the disorder; what constitutes treatment; who is ‘treatable’; the effectiveness of treatment; and whether evidence of psychological change implies reduced risk of reoffending (Grounds, 1987, p. 474).

Pessimism was not entirely universal but the reality of prejudice against personality disorder was captured by Tyrer et al. (1991) who argued that:

> One of the important consequences of better classification and awareness of personality problems is the recognition that people with personality disorders suffer considerably and merit help, even if it cannot always be given in a reliable and effective form. In the past, many therapeutic disciplines have tended to regard personality disorders as not really part of psychiatry’s province and that they should therefore be separated from ‘real’ mental illness. This view is often implicit and rarely finds its way into print but is unfortunately common in practice. Views of treatment are now changing. Psychotherapy in particular, which has always maintained that personality disorders are part of its territory, has persevered in attempts to understand and modify the harmful attitudes that dominate the personal lives and relationships of people with personality disorders, and has helped to transfer this awareness to others (Tyrer et al., 1991. p. 468).

In the 1990s the concept of evidence-based practice was gaining momentum in psychiatry particularly in the realm of the treatment of personality disorder, exemplified by the Department of Health and the Home Office who commissioned an influential review of treatment of personality disorder by Dolan

and Coid (1993). They concluded with cautious optimism regarding treatability of personality disorder and recommended consistent and rigorous research to determine the effects of treatment. This was particularly timely in light of the proposed review of the 1983 Mental Health Act. This cautious optimism, at the time was exemplified by Adshead (2001) who summarised that:

> Personality disorder still presents considerable conceptual and therapeutic challenges. We still struggle with defining it, diagnosing it and dealing with its more destructive behavioural manifestations. As the behaviours become more dangerous and frightening to others, so we have seen that sections of the public, including government, hope that psychiatry can offer something that will make people not just feel better, but behave better. The clinician/researcher who could do such a thing might get a Nobel Prize (and make a lot of money). The more likely course for psychiatrists is that we will continue to have to manage very difficult people with scarce resources; and somehow avoid falling into either angry despair or mindless optimism. As Kipling suggests, 'triumph' and 'disaster' may both be psychological impostors (Adshead, 2001, p.413).

However, following the murders by Michael Stone and subsequent media constructions of a dangerous individual abandoned by mental health professionals as a consequence of legal constraints sat alongside broader public fears about predatory paedophiles and serial killers. Consequently, policy-makers appeared pressed to respond to these concerns (Freestone, 2005; Manning, 2002; Prins, 2007; White, 2002). In response Straw (1999) introduced the phrase: Dangerous and Severe Personality Disorder (DSPD) which was not a medical diagnosis but a new administrative category for risky individuals, and sought to combine antisocial personality disordered who were believed to represent a clear and enduring danger to the public, to enable powers for indeterminate detention within specific DSPD Units, to reduce the risk they presented with. Bartlett (2003) commented that this recommendation had a

striking similarity to that of the Butler committee recommendations (1975) and the Fallon et al report (1999) and may have been the source of inspiration. Bartlett (2003) noted that concerns were raised that further polarisation from a therapeutic regime towards one of the public protection would be augmented, and would create a situation where health practitioners would be agents of social control.

Nevertheless, in 2001 the government spared little expense in the function and construction by committing £126 million in the development of a DSPD service which was piloted at HMP Whitemoor and Rampton Hospital. A government White Paper was released by the Department of Health (2000 a, b) in an attempt to revise the 1983 Mental Health Act which was poorly received. Raising more questions than answers, with its preoccupation on risk and dangerousness, e.g. how could dangerousness be measured and how would this qualify for admission to a DSPD programme? How did dangerousness and risk relate to treatability? Despite these concerns public spending on personality disorder research and services was building considerable momentum, involving the Medical Research Council (MRC), the Department of Health (DH), the DSPD programme, and the National Forensic Mental Health R&D programme. Manning (2002) also commented on the effectiveness of the highly regarded London based ‘therapeutic communities’ at the Henderson and Cassel hospitals, whom I approached as part of this study. Although the number of randomised controlled trials (RCTs) remained low, therapeutic optimism in the treatment of personality disorder was garnered through the new therapies of

dialectical behavioural therapy (DBT), cognitive behavioural therapy (CBT) cognitive analytical therapy, (CAT), and the adjunct of psychotropic medication. This optimism was exemplified by Gwen Adshead who stated that:

> …there could be 'no justification for global assertions that personality disorder is untreatable' (Adshead, 2001, p. 412).

Continuing the promotion of treatability of personality disorder in the continued face of adversity, the then newly formed National Institute for Mental Health in England (NIHME) published the first of several reports (NIHME, 2003a) arguing that personality disordered individuals were treatable and that the treatability test in the 1983 Mental Health Act should be removed. Several months later they (NIHME, 2003b) published a paper entitled 'Breaking the Cycle of Rejection' which provided a capabilities framework promoting the vision of treatability and challenged the discriminatory link between personality disorder and dangerousness by providing services to reduce vulnerability and promote effective coping. The report also highlighted the fact that the disproportionate emphasis on dangerousness and risk pertaining to the minority obscured the fact that many of the people diagnosed with personality disorder were extremely vulnerable to abuse and violence towards themselves, through self-harm and suicide. Consequently, the capabilities framework had a strong focus on the skills in 'assessing and managing risk to self and others' (NIHME, 2003a). Dolan (2003) built upon her previous review (Dolan and Coid, 1993) concluded that personality disorder was (potentially) treatable. Nevertheless, Warren et al. (2003) lamented that the absence of RCTs, believed treatment of personality disorder was possible but more research was required. It was apparent that the association of policy and clinical goals had gained momentum and by 2005 two

more DSPD units had been created at HMP Frankland and Broadmoor Hospital.

In 2007, after a decade of political wrangling the amended 1983 Mental Health Act was passed, leading to concern that involuntary detention could be augmented irrespective of whether it was the correct type, due to ‘effective’ being replaced by ‘appropriate’ treatment. The ‘treatability test’ was replaced by the ‘appropriate treatment test’ in effect a vague ‘holistic assessment’ in relation to whether treatment was appropriate. Such was the confidence in 2007 regarding the treatability of personality disorder the National Forensic Mental Health R&D Programme officially closed. Despite continued professional scepticism about treatability, and further acknowledgement by Newton-Howes et al. (2006) that personality disordered individuals represent the most difficult groups and psychiatric practice, various highly regarded clinical authors have positively argued for the effectiveness of treatment for personality disorder:

> The evidence base has an edge over the past two decades to indicate that personality disorders are treatable. A range of psychological therapies have been shown to be the most effective treatment for personality disorders, though medication can have some additional effect in reducing the severity of symptoms (Pidd and Feigenbaum, 2007: 8)
>
> Clinicians should ‘celebrate the emergence of effective biological and psychosocial treatments’ (Fonagy, 2007, p. 3).
>
> The literature was now ‘clear that personality disorder can be treated’ (Livesley, 2007, p. 28).

In summary, it is clear that there was a significant complexity of influences that Mental Health Nurses were exposed to, associated with potential uncertainty about their careers, contending with constantly changing policy and management, and compounded by the fact that they had to contain and process

feelings of anxiety, insecurity, demoralisation, whilst being vigilant of how their actions could be interpreted at various societal levels.

1.3 Mental Health Nurses Training/Readiness to Work with Patients Diagnosed with Personality Disorder.

Within the above context of inquiries about caring practice and a decade of significant evolution from a belief that personality disorder was untreatable to a situation where increasing optimism was blossoming, albeit in the absence of a convincing evidence base, how were nurses able to fulfil their role? Consequently, this section will focus on how nurses feel unprepared, ineffective nursing models, attempt to identify the nursing role, attempted models and conclude with strengths and weaknesses of identified competencies.

Research literature provides a consistent theme of nursing staff feeling inadequately prepared to treat and manage patients diagnosed with personality disorder (Krawitz, 2004; Miller and Davenport, 1996). Bowers (2002) reported that high secure psychiatric nurses felt unprepared for their treatment role. Beyond the high secure context other studies echoed this concern evidence by: James and Cowmen (2007) reported that only 3% of Irish nurses in their study claimed to have received training about borderline personality disorder; Deans and Meocevic (2006) identified that 56% of psychiatric nurses felt lacking in training, whilst Cleary et al. (2002) identified 29% of Australian nurses considered themselves lacking sufficient training. Moran and Mason (1996) highlight that the medical model with its focus on biology has dominated historically, whilst the bio-psychosocial model has been favoured in training

Furthermore, nurses who do not have this training tend to use the medical model despite evidence of its poor efficacy with this diagnostic group of patients.

Tarbuck (1994) describes that a central component of nursing theory and practice is its use of models of nursing which were originally aligned to the medical model but with the development of psychiatric nursing, more specific models were used in the form of the Tidal Model (Barker, 2000, 2001, 2003) to the Ego Competency Model (Kerr, 1990). However, in the more specialised forensic nursing arena in which compulsory detention, assessment of risk, custodial concerns, political and media scrutiny is ever present, these models alongside the typical qualification of Registered Nurse for the Mental Handicapped and Registered Mental Nurse can often be ineffective. Possibly compounded by the Common Foundation Programme diluting this training further.

It is further argued that despite the absence of adequate training, the context in which forensic training is provided is also crucial. Woodson (1996) describes the futility of providing training in a context that is operating a dominant custodial ethos. The dilemma for all staff working within a forensic environment is that of maintaining a balance between security and therapy. Carrying out security procedures (e.g. searching belongings and locking doors) which in the UK predominately falls upon nursing staff to undertake (Day, 1993). However, this has the potential of impacting upon the therapeutic relationship due to issues of mistrust (Markham, 2003), and eliciting responses from patients that

they may have reserved for past authoritarian abusive figures. Nevertheless, I would argue that although this situation is not ideal, it can provide an opportunity to explore a patient's negative past evaluation (negative attribution bias) which is triggered in the current circumstances, within a reflective therapeutic relationship. Alternatively, other countries have attempted to split the role of security and therapy by employing security staff to work alongside nurses, but this split historically resulted in other problems (Burrows, 1993a, b). Whilst Peternelj-Taylor and Johnson (1995) suggested from their experience of developing a close relationship between the regional psychiatric hospital and university to enhance assessment, treatment, teaching and research, has in turn demonstrated that custody and caring can coexist despite raising unique challenges for psychiatric nurses.

When exploring the limited amount of literature regarding the nursing role in caring for patients diagnosed with personality disorder, it appears to be generally divided between utilising therapy or management strategies. Barker (1999) argues that the role of nursing in this context is so poorly defined that it has become enmeshed with other disciplines. Moran and Mason (1996) who both had experience of working at The High Secure Hospital focused in this paper on the nursing management on six important elements all of which were roundly criticised by Murphy and McVey (2010). The latter co-authors had experience of both my second site of study (Medium Secure Hospital) and within the DSPD (HMP Whitemoor), both of which I considered cutting edge environments within the context of time. For example: (1) 'use of humour' was criticised for being potentially dangerous due to this diagnostic group proneness

to cognitive distortions, (2) ‘99% honesty’ was criticised for being ill-defined and potentially detrimental to the hypervigilance to deception within relationships, (3) ‘destabilising the static’ (by changing the hierarchal structure within relationships to prevent potential dominance), was considered flawed because it was considered a risky form of ‘game playing’ and a ‘poor substitute for the use of explicit communication’ (Murphy and McVey, 2010, p.180), (4) ‘rule flexibility’ or ‘rule bending’ was considered problematic because this client group, in the absence of clear boundaries, will develop increased anxiety and chaos, (5) ‘creating vulnerability’ was advocated by not intervening immediately to meet patient’s needs, thus prompting the patient to make a request, which in turn would elicit gratitude from the patient, which again could be interpreted as game playing with patients who may have limited capacity for gratitude and in fact may also have a profoundly differing concept of validation (e.g. self-harm as a means of validation), (6) ‘usufruct’ (enjoy the dynamic) in which the nurses are encouraged to explicitly challenge perceived patient manipulation; although this was considered a healthy approach, it could be undermined within the context of the other strategies.

In addition, Murphy and McVey (2010) concludes that the management strategies postulated by Moran and Mason (1996) appear to be synonymous with the very strategies that these specific patients are characterised by within the diagnostic criteria of the psychopathy checklist (PCL-R) and commonly criticised for e.g. ‘glib and superficial charm’, ‘conning and lying’, ‘cunning and manipulative’, ‘impulsivity’ and ‘exploitation of a relationship’, in relation to the

above elements 1-5 respectively. Raising the therapeutic concern of, 'Who is manipulating who? (Murphy and McVey, 2010, p181).

Predating Moran and Mason's (1996) paper, Richman (1989) reported on an ethnographic observational study undertaken on one personality disorder ward at the High Secure hospital in 1988, which described a variety of behaviours performed by both patients and staff. He specifically highlighted that patients valued nurses not necessary for their professional expertise but their personal attributes in the form of e.g. openness, humour, non-judgemental attitudes, physical prowess, and honesty. As a consequence this may have impacted upon Moran and Mason's (1996) conceptualisation of nursing management of personality disordered patients.

Following the creation of the PD unit at The High Secure hospital and prior to the Fallon et al Inquiry and in the absence of a clear model for the nursing care and management, nurses were subject to multiple physical and psychological threats which were often crisis managed, resulting in a rapid and steep learning curve for nurses. Consequently, Melia et al. (1999) recognising a variety of extreme boundary violations in which he considered the nurse-patient relationship as a therapeutic tool that could benefit the patient. To prevent the nurse being isolated in their processing and responses to PD patients he developed 'triumvirate' nursing approach, in which every patient was allocated three nurses with equal responsibility, who would only see the patient whilst in pairs. The aim of which would provide supervision for each other, support, and objectivity and for the patient would enable change and growth. Bowers (2002)

has argued that this system may provide containment for the patient and avoid possible negative outcomes for the nurse, in essence it is,

> ‘a defensive strategy that implies success to be the resistance of manipulation and splitting’ (Bowers, 2002, p. 27).

Murphy and McVey (2010) were even more critical of the model questioning the benefits to the patient by virtue of removing the opportunity to ‘develop a healthy emotional intimate relationship’ (Murphy and McVey, 2010:181), due to the fact that PD patients often have a lack of self-worth and suspiciousness in which they struggle in individual relationships let alone with the intense scrutiny of more than one nurse. They further argued that even if gains could be achieved, the longevity of change would be unlikely due to the ‘behavioural modifications being situationally specific’ (Murphy and McVey, 2010:181) and the ‘unlikely event of the underlying factors of the disorder not being addressed’ (Murphy and McVey, 2010:p181).

Mason et al. (2008a) explored the perceptions of strengths and weaknesses regarding skills and competencies in non-forensic nurses, forensic nurses and other disciplines, utilising 1172 survey responses, in which the majority were forensic nurses. The study suggested that forensic and non-forensic nurses considered ‘life skills’ were required more than traditional psychiatric competencies (Mason and Carton, 2002). However, other disciplines considered that nurse’s main strength resided in the organisational domain, involving the maintenance, adherence and regulation of institutional rules and procedures

In terms of perceived weaknesses forensic nurses identified various forms of frustration e.g. with aggressive patients, or other disciplines, whilst the non-forensic nurses also identified frustration but focussed more on stress. Other disciplines highlighted that nurses' weaknesses related to being punitive in their approach, poor negotiation and risk assessment skills. Forensic nurses identified that the main nursing skill that they required was related to the management of personality disorders but not necessarily to manage their aggression (Paterson et al., 2000). This was also echoed by the other two participant groups comprising of (1) non-forensic psychiatric nurses, and (2) other disciplines, featuring in their top two of areas of difficulty. A broad array of approaches were identified by all groups to resolve perceived deficits, to provide efficacious nursing interventions, which can only be perceived as striving for success in the absence of a research evidence base. In this absence, Holmes and Gastaldo (2002) argued from a Foucauldian position that forensic nursing functions as a form of 'governmentality' in which the 'body' is employed as a site of political power. Foucault situates 'power' in the operationalisation of identity. Nevertheless, Mason. (2008b) argues that it is incumbent upon nurses to clearly delineate their efficacious competencies and skills particularly in the areas of management of personality disorder, violence and aggression.

1.4 Mental Health Nurses Attitudes Towards Patients Diagnosed with Personality Disorder.

The previous sections have focused on the political influence and nursing role difficulties which impact upon nurses when working with PD patients. They also

provided a conceptual background of the array of influences upon nurses understanding of personality disorder and the therapeutic relationship which included the specific context, perceptions of 'the problem', political influences, and the lack of nurse's preparedness. Consequently, it is important to explore how these influences impact upon their attitudes towards these patients.

Consequently this section further explores society's influences, the security/therapy role dilemma, the impact of patients' crimes, negative peer influences, nurses' perceptions of threat from patients' behaviours, and nurses responses ranging from cautiousness, hypervigilance and control.

Arguably, nurses are potentially vulnerable to the influence associated with perceptions of personality disorder being described as bad, evil, traumatic which will likely shape attitudes and judgements/interpretations within the relationship. These perceptions are often perpetuated from the media, society, peers, and learnt experiences. Bowers (2002) reported that largest proportion of nurses (20%) in his study of three high secure hospitals in England, blamed the media for their negative beliefs and acknowledged that some of this was formative prior to undertaking nursing. There was also acknowledgement that the criminal justice system can be guilty of using pejorative labels which are also emotionally laden e.g. parasite to society. The use of stigmatising language was explained by a research participant as follows:

> “It’s easy to label people as - and maybe it’s safer to think that they are a different species, that they are not human beings like us, like me and you. Maybe it’s sort of more comfortable to think that. That they are monsters that they are not like us, but I think maybe people are frightened that maybe we’ve all got that element in, within us, we’re all sort of human beings at the end of the day” (Bowers, 2002, p. 39).

Nurses also need to maintain a fine balance between sustaining an environment conducive to a therapeutic relationship and ensuring the environment is secure. This balance is often referred to as the therapy versus security role, which arguably could and should be one and the same. I would contest that the relationship is a key therapeutic tool/medium in the understanding and shaping of therapeutic change. However, how might attitudes already be tainted and how does this blunt the therapeutic relationship as an effective agent of change?

It is generally recognised that nurses have the longest contact time with patients diagnosed with personality disorder within an institutional setting. This not only raises the possibility of therapeutic engagement but exposes them to the reality and judgements of people who have committed often (1) horrific offences, or are undertaking (2) traumatic behaviour which led the Home Office (1992) to express the concern that nurses have little respite from this ‘contamination’ of negative feelings in the forensic setting. Leading Bowers (2002, p.37, p.53) to summarise that forensic nurses reported:

(1) Patients had been committed for rape with severe violence, murder, torture and mutilation of children (including taking photographs of the event), necrophilia, post-mortem dismemberment, cannibalism etc.

(2) Patients, who inserted pens or wires into themselves, cut themselves with broken crockery or glass creating large wounds, poking things in

> their eyes, swallowing batteries and other items or burning themselves with cigarettes. Repeated episodes over a long period could result in severe scarring, deformity, with limbs becoming ‘a mass of scar tissue’, or burns to ‘every part’ of the body.
>
> Such behaviours were seen by some nurses as manipulative, as a means to achieve individual interaction and other objectives. In addition the nurses felt angry, distressed, traumatised and stressed by the sheer emotional distress. The majority of nurses saw this as an expression of overwhelming negative emotions (e.g. anger, guilt, shame, remorse, disappointment, worthlessness), as a tension relieving device.

Some professionals do not believe that these perpetrators deserve respect and were pessimistic regarding the potential for therapeutic change (Kent-Wilkinson, 1996). Furthermore, certain offences led to socialised values of distaste (Richman et al., 1999). Bowers (2002) reported that anger was the most common emotional reaction (30%) amongst staff about the patients’ crimes. This sometimes led to difficulties in maintaining psychological boundaries. For example, anger was reported in relation to members of staff who have their own young families, when they are working with patients who have undertaken paedophilia or child murder. Others have argued that nurses’ negative views can be dependent upon how little their skills were utilised (Rogers and Topping-Morris, 1997). Negative views can also be understood within the psychodynamic framework of countertransference although this may not be entirely understood without specific training and support (Maier, Van Rybroek., 1995).

Bowers (2002) reported that apart from the crimes PD patients have committed what can cause most difficulty are perceptions of: manipulation, self-harm, violence, complaints, and informal exploitative hierarchy within the ward

context. Consequently, violence and aggression can be understood in various ways. These can include death, rape, taking a hostage and making serious (but fabricated) complaints. Patients occasionally threaten nurses' families and children and say what they will do on release from hospital, with such threats being particularly intimidating. Nurses' perceived that the three main triggers to patient violence included saying 'no', nurses manner or attitude, and destabilising impact from patients' relatives.

As a result nurses tend to be very secretive about personal information that would allow patients some form of leverage. Nurses have been reported to be fearful of the potential for violence associated with working with patients' diagnosed with personality disorder, which can spill over into their personal life, resulting in hypervigilance to perceived threat.

Bowers (2002) also reported nurses' concerns about being manipulated to obtain information/advantage (e.g. information about nurses, their opinions, families, likes and dislikes, interests, foibles, past decisions and actions) to be used within a patient hierarchy to create power. This resulted in nurses' feeling vulnerable and cautious.

The Home Office (1999) observed that a tension can exist between liberation and control, which has led forensic nurses to positively regard control (Mason, Chandley, 1999) as a means to proactively manage a perceived dangerous environment whilst striving to maintain a therapeutic ward atmosphere (Caplan, 1993). However, this tension can be exacerbated due to the fact that nurses in

the United Kingdom have a further responsibility in maintaining security alongside therapy (Burrows, 1991). A tightrope can exist between nurses' containing their own feelings about patients' outrageous offences and maintaining a professional non-judgmental approach and conversely patients' childhood relational patterns being triggered in response to nurses being perceived as controlling/boundaried authoritarian figures or inconsistent nurturing figures. Nurses' perception of danger can be validated by the nature of the patients' compulsory detention often due to extreme acts of violence, resulting in nurses' additional role of managing the ever present potential for violence (Coram, 1993). Various researchers have commented on the nurses' responses to patients' aggression within inpatient psychiatric settings, whether it is is towards others, themselves or property, this potential is often measured in extremes. They reported that there can be a constant violent potential fused with an adherence to a macho culture, that can result in often undisclosed feelings (Morrison, 1990) of fear, adrenaline, relief (Whittington and Wykes, 1992) and subsequent chronic stress (Wykes and Whittington, 1994).

1.4.1 Information Processing That Can Influence Attitudes.

The previous sections highlight the significant influences that can seriously impact upon nurses' attitudes towards PD patients. Consequently, this section will (utilising attribution theory) focus on the equally important understanding of how and why the labels are created, how this relates to 'psychopathy' and 'risk of dangerousness', and the conditions likely to elicit negative labels by nurses. It will conclude with the importance of utilising this understanding as a means to

process the negative attitudes for nurses and patients through the variously recommended mediums of specialist training and supervision practices.

Attribution theory and labelling theory provide an understanding that people can pre-judge others by identifiable attributes or labels. Giddens (2000) described labels as a cluster of interrelated ideas in which the theory attempts to explore how humans respond to this label. These responses can emanate and be reinforced by deeply entrenched normative social beliefs and values from individuals and groups e.g. discriminatory practices. The Huesmann (1998) attribution model highlights the role of cognitive processes and the internal representations of such processes (i.e. cognitions), as mediators connecting "biological, environmental and situational inputs to behavioural outputs" (Huesmann, 1998, p. 73), with further emphasis on the role of affect at each element of information processing. The role of affect within the relationship dynamic of the nurse and patient cannot be underestimated as it not only distorts information processing but also provides a catalyst for understanding.

One of the most important elements of the information processing approach is the concept of a cognitive 'script'. Scripts have been described as 'guides to social actions' e.g. a sequence of actions that correspond to a familiar social situation. Once an individual enters a script, the scripted behaviours proceed relatively automatically (Anderson et al., 2007).

The concept of scripts is important when discussing how human strategies are accessed and selected. Strategy retrieval can either be scripted and automatic

or a conscious and deliberate process Once a strategy has been implemented and is viewed as successful, the social problem-solving process ends, with information about the success of this strategy potentially retained by the individual, affecting where in the future the strategy will fall in the individual's hierarchy of possible responses, resulting in the solution being accessed and implemented sooner in ensuing situations (e.g. Bushman and Anderson, 2002; Anderson et al., 2007; Huesmann, 1998).

Dodge (1986) conceptualised an individual's behavioural responses to a social situation as following a series of information processing steps that generally occur outside conscious awareness. The steps, in order, include:

a. Encoding social cues in the environment
b. Forming a mental representation and interpretation of these cues
c. Searching for a possible behavioural response
d. Deciding on a response
e. Enacting the chosen response

Huesmann updated this model in 1998 and argued for more inclusion of emotions and normative beliefs (i.e. beliefs an individual holds which they feel are representative of society beliefs, one example may be: 'it's okay to smack children'). Emotions were largely neglected in the earlier models, although they are recognised to be key elements that impact negatively on information processing ability (Harper et al., 2010).

The Unified Model (Huesmann, 1998) also places greater emphasis on the role of schema (e.g. organised knowledge about self, events and beliefs), emotions

and the interpretation of environmental responses (i.e. how individuals interpret the responses of others/society influences and how this serves to maintain an negative script). Although other schema patterns exist, the three main types commonly referred to in social information processing literature pertained to: (1) self-schema - organised knowledge about self e.g. competencies, skills, values (how one describes oneself to somebody else); (2) event schema - knowledge about events e.g. the expected pattern of events to complete a task (making tea) and (3) belief schema - organised sets of beliefs e.g. how one would describe a particular context.

Crick and Dodge (1994) argued that individuals make information-processing more efficient by relying on the use of cognitive heuristics (e.g. biases) or schemata to help them to interpret the situational or internal cues that they experience in social situations. They further argue that reliance on particular heuristics or schemata may be responsible in part for problematic social behaviour and social maladjustment e.g. by basing a decision about using aggression on what they can gain from the interaction, as opposed to how it will affect their relationship with others, is more likely to lead to an aggressive response (Crick and Koch, 1992).

Consequently, it is hardly surprising that the pejorative and emotionally laden label of ‘psychopath’ which is a term to describe an individual who is cold, unemotional, callous, and remorseless (Blackburn, 1983) evokes so many responses. The term psychopathy appears to carry many real and imagined attributes, which have been normalised from the media into society, carrying

with it a raft of negative expectations and pre-emptive responses. However, its clinical validity has been questioned to the extent that it has been reported to be a fictitious entity (Mason, 2006). The diagnostic labels of conduct disorder, personality disorder and psychopathy have been demonstrated to influence judges in mock trials involving 326 USA judges (Murrie et al., 2007). Questions have also been raised with regard to the scientific rigour of the two main (DSM and ICD) internationally recognised psychiatric nasological frameworks that underpin the diagnosis of personality disorders (Kendler, 1990). This pejorative labelling concern, during the course of my research investigation resulted in a low secure hospital (and an eminent hospital that I had previously approached to undertake this research study) under using the diagnosis and refusing to use borderline personality disorder respectively.

Other influential labels concerning personality disorder is the often co-assigned label of ‘dangerousness’ which is considered the most influential factor upon professional practice (Gacono, 2000). Despite the development of dynamic and static risk assessment tools, dangerousness can be difficult to predict with certainty (Menzies et al., 1994). This pejorative and potentially nebulous concept raised further concerns by Haddock et al. (2001) who found that the label of Dangerous Severe Personality Disorder created inconsistent understanding in terms of assessment, diagnosis and treatability, among forensic psychiatrist. Mason et al. (2010) reported on the perceptions of diagnostic labels in forensics psychiatric practice, utilising surveys gleaned from 416 nurses and 300 other professionals. This study highlighted the perception that mental illness was more treatable and responsive to treatment than

personality disorder, reinforcing the understanding that labels can impact upon forensic care planning (Murrie et al., 2007). The study also highlighted a lack of confidence in the efficacy of clinical interventions.

In Bowers (2002, p.38) study of nurses' beliefs and attitudes involving 621 survey respondents and 121 semi-structured interviews across three high secure hospitals in England, he reported that patients who were most likely to attract negative labels from nursing staff if:

- they had not been abused as children
- the index offence had been serious violence against vulnerable victims
- the offence had been planned in advance, and involved torture
- they refused treatment in hospital
- they showed no remorse
- they appeared to be nice people.

In the face of many of the above challenges when working with patients diagnosed with personality disorder a significant risk of staff burnout exists (Hampton, 1997). Miller et al. (1994) recognised these concerns and recommended educational programs to help alleviate negative attitudes towards personality disordered patients. Consequently, in 2003, the National Institute for Mental Health in England (NIMHE) published a document entitled Personality Disorder No Longer a Diagnosis of Exclusion which championed the importance of access to specialist training to develop a treatment evidence base, to enhance further training. It was also highlighted the importance of debriefing and clinical supervision to manage and contain feelings often triggered by patients pathology within this diagnostic category, who may have committed incomprehensible offences.

In further recognition of these difficulties the National Institute for Health and Clinical Excellence (NICE; 2009a, 2009b) published guidelines regarding the treatment and management of patients with borderline and antisocial personality disorder, which also highlighted the importance of supervision and support to address negative attitudes. Despite the promotion of the above national advances to address negative attitudes and enhanced advances made by other countries towards providing specialist services, Mason et al. (2010) reflected that personality disorder will always be prone to pejorative labelling even though there is universality/acceptance of the related dangerous behaviours.

1.5 Internal Factors Which May Influence the Therapeutic Relationship.

In the previous sections above I have introduced a variety of external background factors that can impact upon the nurse PD patient relationship, yet a crucial component of nurses' understanding is of themselves and how this can equally impact upon their therapeutic relationship. Consequently this final section will focus upon the importance of understanding oneself, and how attachment theory can enhance understanding of the PD DSM (DSM: Discussed p.34 below) relationship definition. Concluding with how an understanding of attachment styles of the patient and the nurse can enhance the nurse/patient therapeutic relationship, particularly when used in the context of reflective practice (also 8.5.7., 9.5).

As a trained psychotherapist I was fortunate to undertake several years of personal therapy to help me understand the distinction between the factors that belonged to myself and those that belong to the patient, to enable the therapeutic use of a variety of strategies e.g. transference and countertransference (see 3.3.2). Despite this awareness it was also crucial during therapeutic engagement to have reflective supervision for support and continued insightful constructive enlightenment. However, nurses often don't have the benefit of this introspection of the self, or even the possibility of a containing interpersonal reflective space to process challenging interpersonal relationships. Hence, the following statement still demonstrates an important area of treatment deficit:

> 'unless the staff members can clearly understand just what the patients are doing and how it is affecting his own emotions, he will not be able to deal with the patient therapeutically' (Kaplan, 1986, p. 437).

By definition one of the internationally recognised classificatory systems for the diagnosis of personality disorder is Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) published by the American Psychiatric Association (1995) defines personality disorder relationships as, 'patterns of unstable and intense relationships noted by alternating between extremes of idealisation and devaluation'. Welldon (1993: p.487) conceptualises this by stating that, 'an early and severe emotional deprivation is usually found in forensic patients/offenders of both sexes'. It is argued that traumatic, continuous and inconsistent attitudes towards them have effectively interfered with the processes of individuation and separation. There is a basic lack of trust towards the significant carer, which accompanies PD patients throughout their lives. As such some

psychopathological features are evident and can be understood in the light of PD patient's early background' (Sharp, 1995). West et al. (1993) have provided empirical results to support the hypothesised relationship between dysfunctions of the attachment system and personality disorder. Similarly, Sack et al. (1996) utilised a battery of assessment tools to compare two control groups and reported that maladaptive interpersonal relations associated with personality disorder can usefully be understood from an attachment perspective.

To understand the potential unprocessed attachment difficulties within the nurse-patient relationship Dozier et al. (1994) in a seminal study compared the role of attachment organisation between the case manager and their clients who had serious psychopathological disorders, indicating a significant correlation in terms of attachment type and interventions, which will be explored in more detail in sections 8.5.7. and 9.5. As a consequence most reviews of working with patients diagnosed with personality disorder have recommended the importance of a provision for staff to have effective supervision in place to counteract the effects of working with challenging personality disordered patients (NICE, 2009).

In summary patients diagnosed with personality disorder demonstrate enduring patterns of relating that are consistently misunderstood by themselves and those who care for them, leading to serious consequences. It is the researcher's hypothesis that if the patient and carer become more aware of their own patterns of relating, including the socio-cultural context which frames such relationships, this will strengthen both the therapeutic alliance and therapeutic

outcomes. In addition, to analysing current perceptions regarding the interpretation of relationships and the practical utility of attachment theory, an important feature of the research will be to inform understanding of how reflective processes can provide practical utility.

Chapter 2 Aims.

It is with the above background, set in the context of time and crystallised in a variety of vignettes (described in 1.1), that I was motivated to focus on the aims stated below.

Aims:

1. What are Mental Health Nurses' understandings of men diagnosed with personality disorder?
2. What are Mental Health Nurses' understandings of the relationship difficulties that men diagnosed with personality disorder have and how does this influence the nurse-patient relationship?
3. How does the understanding gleaned from aims one and two inform clinical practice?

This thesis will focus on the specific issue of Mental Health Nurses understanding of personality disorder, particularly concerning their relationships and the interface that exists between patient and nurse. The investigation will be empirically operationalised through discursive analysis of the written text, interview data and Q-methodology (Stephenson, 1935).

Following the contextualisation of the issues that formed the studies aims within this chapter (one), chapter two will explore, interrogate and contested understandings in relation to the evolving/dynamic understanding of the term personality disorder which partially represents my first research aim. Within chapter three I will explore and interrogate available literature pertaining to the relationship difficulties patients diagnosed with personality disorder can have, with a particular focus upon the nurse-patient relationship and how this interface is understood and processed. Consequently this chapter will partially address my second research aim. These three introductory chapters, therefore, also functionally locate and frame the empirical investigations which follow. Chapter four builds on and develops the epistemological narrative outlined in the current chapter to specify the methodological concerns in respect of the empirical investigations. Chapter five will focus on the methodological procedure, in particular the data collection and analysis. Chapters six and seven will detail the empirically generated accounts of Mental Health Nurses understanding of (1) personality disorder and (2) personality disorder relationship difficulties. Each of the distinct chapters will utilise the empirically generated accounts as a foundation for interrogation and discussion of related issues.

Finally, chapters eight and nine will function as the tentative and textual closure of this thesis. It will particularly focus on the interpretation of each factor generated from the two Q-sorts, the emerging themes that traverse most of the factors which will be linked to the earlier literature search. Each emerging theme will also be preceded by recommendations for practice.

CHAPTER TWO:

THEORETICAL UNDERSTANDING OF PERSONALITY DISORDER & THE MODELS AND INTERVENTIONS THAT UNDERPIN IT.

Section One: Context & Introduction.

Chapter Two:

Theoretical Understanding of Personality Disorder & the Models and Interventions That Underpin It.

2.0 Introduction.

In the previous chapter a background context was provided, of the shifting, dynamic evolution of the poorly understood concept of personality disorder and how problematic these influences were for the Mental Health Nurse, who often has the most contact time with patients' diagnosed with personality disorder. In this chapter I will aim to explore the research aim (1) What are Mental Health Nurses' understandings of men diagnosed with personality disorder from a variety of theoretical perspectives by interrogating and contextualising the available literature.

Caveat: It is impossible to consider the effectiveness of any treatment modality for patients' diagnosed with personality disorder, let alone the therapeutic interface of the relationship with Mental Health Nurses, without a universal understanding of the traits, behaviours, and intrapsychic structure that comprise of this disorder. As Kendell, (1989, p. 45) crucially highlights:

> In the context of clinical psychiatry statements about diagnostic validity are essentially statements of predictive power, and hence about practical utility.

Additionally, one of the study's major emerging themes concerning Mental Health Nurses' understanding of personality disorder was related to the

diagnostic/assessment issues. Consequently, a comprehensive literature search related to these issues was felt to be essential to situate the understanding within the wider domain. Firstly, this chapter will focus on the legal and clinical classification difficulties (2.1.1) with a particular emphasis on the comparison and efficacy of contemporary diagnostic tools (2.1.1/2), prior to examining the underpinning personality traits (2.1.3-4), culminating in a summary of the assessments (2.1.6). Secondly, the main drivers of understanding of personality disorder are the treatment modalities which are constantly adapting and evolving to demonstrate the best evidence base to not only meet patients' needs but to obtain competitive finite resources. Consequently, it is also essential to introduce their understanding and efficacy (2.3), summarise (2.3.12), and conclude with how a dimensional assessment and an integrative model could demonstrate best practice and understanding (2.4).

2.1 What Is Personality Disorder?

2.1.1 Diagnostic Contradictions.

The conundrum of grouping individuals according to their characteristic approach to life has been an issue dating back to the times of the ancient Greeks. However, Tyrer (2000) has argued that the notion of personality surfaced 100 years ago with the birth of psychoanalytic/Freudian ideas in their attempt to understand normal and abnormal personality. An early debate existed which suggested that personality had more to do with the situation in which people were observed rather than stable characteristics (Mischel, 1968). However, there is now more general agreement that behaviour is influenced by characteristics of both the 'person and situation' (Cervone and Mischel, 2002;

Kenrick & Funder, 1988). In addition, personality disorders are generally understood to be variations or exaggerations of normal personality characteristics (Livesley, 2001; Widiger and Francis, 1994). Nevertheless, Alwin (2006: p.30) concludes that there is no universally agreed definition of personality and that ‘personality is best viewed as an area of scientific enquiry’.

Legal Classification.

The practical clinical utility of the Mental Health Act (MHA) 1983 legal classification of Psychopathic Disorder quoted below is considered very limited. It is a ‘catch all’ statement which pays scant regard to defining the implicit needs of this diagnostic group.

> A persistent disorder or disability of the mind (whether or not including impairment of intelligence) which results in abnormally aggressive or seriously irresponsible conduct on the part of the person concerned (MHA 1983, Classification of Psychopathic Disorder, p.2.).

The above term of Psychopathic Disorder is: ‘the latest in the historical sequence of medical and legal terms dating back 150 years ago to moral diseases of the mind. The legal definition has not changed despite much change in medical and clinical practice.’ (Reed, 1994: p.4.) The Legal definition of "psychopathic Disorder" quoted above, was not created by clinicians and the terms within it – ‘seriously irresponsible’ and ‘abnormally aggressive’ have never been seriously tested. It remains an "elastic and ill-defined category", notes Chiswick (1992; p.107).

Clinical Classifications.

Robins & Guze (1970) created a six phase system which helps to validate clinical syndromes and reduce variables, however when it is applied to personality

disorders as defined by contemporary diagnostic tools (see table 2.1 below), it often fails to meet the criteria, falling outside the definition of a syndrome.

Table 2.1 Validators of clinical syndromes.

- Identification and description of the syndrome, either by 'clinical intuition' or by cluster analysis.
- Demonstration of boundaries of 'points of rarity' between related syndromes to discriminate function analysis, latent class analysis, etc.
- Follow-up studies establishing a distinctive course or outcome.
- Therapeutic trials establishing a distinctive treatment response.
- Family studies establishing that the syndrome 'breeds true'.
- Association with more fundamental abnormality: histological, psychological, biochemical or molecular.

Assessment Procedure.

The methodological considerations for gathering information to inform a personality disorder assessment will be briefly reviewed as follows. Firstly, unstructured assessments are considered unreliable and of questionable validity (Zimmerman, 1994), whereas structured *assessments*, particularly interview-based assessments are considered the ‘gold standard’ for diagnosing personality disorder (Clark and Harrison, 2001). Secondly, self-report questionnaires that are considered more reliable are those that focus on traits which reflect their beliefs about the self or others due to the access to autobiographical memory claims Alwin (2006). However, questions related to traits concerning the undesirable effects on others are better assessed utilising a semi-structured interview (Clark and Harrison, 2001). Thirdly, wherever possible the data should be corroborated from credible multiple sources due the potential for misleading under and over reporting by the respondent. Fourthly, whilst acknowledging the utility of diagnosis for providing a baseline of information, a more enlightened contemporary position is taken by Alwin (2006) who advocated the addition of a formulation. It was

argued that diagnosis can be inflexible and impersonal and that formulation can help individuals to focus their experiences within a context/explanatory dynamic framework which can encourage awareness of their behaviours, thoughts and emotions; linking individualised personality traits, hypotheses and systemic responses to needs.

Contemporary Diagnostic Tools.

Five contemporary diagnostic tools (see section 2.1.2) are considered by clinicians to have a large measure of validity, yet multiple morbidity can still exist within each (e.g. diagnosed with several personality disorder types), which has led Dolan et al. (1993) to suggest that more than one diagnostic tool should be utilised to support or confirm the diagnosis. These diagnostic tools rely heavily on a combination of identifying personality traits and behaviour presentation but evidence supporting the validity of one tool over another is weak. Consequently, Alwin (2006) commented that:

> …choice would appear to be largely a matter of the preference or the theoretical predilection of the clinician (Alwin, 2006, p.30).

Efficacy of Diagnostic Assessments.

A picture is emerging of diagnostic inconsistency which becomes even more confusing when different theoretical treatment modalities are applied, from at times vague and differing assessments. It is hardly surprising that research on treatment outcomes are perceived as ‘generally flawed’ (Dolan and Coid, 1994).

Due to the paucity and poor quality of research based outcomes on personality disorder many experts in the field have questioned the concept, diagnosis and treatability of personality as evidenced below:

> …in answering the question whether personality disorder can be treated by psychological methods the answer must be 'possibly' since more investigation and long term follow-ups are needed before an affirmative answer can be given (Blackburn, 1983, p.34).
>
> The legal concept of psychopathy is logically flawed and does not relate to any single medical, biological, psychological criteria (Butler, 1975, p.84).

In terms of a way forward for the future diagnosis of personality disorder, it is further argued by Livesley et al. (2014) that to improve validity there needs to be consideration of (1) how personality disorders are classified and (2) how classifications are compiled. In terms of classification historically DSM-III personality disorders appear to have been based on the simplified medical model (Klerman, 1978), which may have utility treating infectious diseases but struggles when dealing with,

> 'personality disorders that have a complex multidimensional psychopathology arising from the interplay of multiple genetic and environmental factors' (Livesley et al., 2014, p.213).

The concept of personality disorder was further challenged by Chiswick, et al. (1984) who highlighted that many psychiatrists were unwilling to accept personality disordered patients for treatment because of doubts over the validity of the concept. As Blackburn (1983; p.26) added that, 'Psychopathy - contentious, much literature, many views.' Therefore, as Frosch (1983: p.243) stated that, 'One cannot review the literature on personality disorder without being impressed with how little we know about these conditions.'

In light of the above confusion about the concept of personality disorder it is unsurprising that other authors have challenge its treatability, leading Bluglass

(1988) to remark that he was pessimistic regarding changes in personality disorder and discussed the lack of success in devising methods of treatment or management in medical sociological fields. Cleckley (1964) was also unconvinced satisfactory change can be undertaken with people diagnosed with psychopathy as evidenced below:

> There is no satisfactory means of dealing with them (Psychopaths) that has been presented by any psychiatric authority; meanwhile their status in the eyes of the law has made it impossible to treat them at all (Cleckley, 1941, p. 94).

> There is of course no evidence to demonstrate or to indicate that psychiatry has found a therapy that cures or profoundly changes the psychopath (Cleckley, 1964, p. 478).

Dolan and Coid (1994) in a landmark retrospective thirty year study of treatment efficacy of personality disorder concluded:

> It is impossible to review the literature on the treatment of psychopathy without being impressed by two major features: firstly that research investigations of treatment outcomes of psychopathy are few and poor quality; secondly, and more worryingly that despite several decades of reviewers' commenting to that effect, no obvious improvement has come about to date (Dolan and Coid, 1994, p. 3).

Despite the above confusion Gunn and Robinson (1976) suggested five agreed facts about personality disorder which is relevant now as it was then:

a) Diagnosis is unreliable.
b) Authors disagree about its definition.
c) It is used in the vernacular as a term of derogation.
d) It is a legal term used in England and Wales.
e) Doctors use it to indicate that the patient is incurable or untreatable.

To further highlight the diagnostic discrepancy Coid (1992) utilised Hare's Psychopathy Checklist (PCL-R) and the structured interview for DSM-III-R on a sample group of patients diagnosed with the legal definition of psychopathic

disorder within English Special Hospitals. Results using Hare's PCL-R indicated that 28% of the women and 48% of the men were not psychopaths. The DSM-III-R criteria indicated that 44% of females and 38% of the men met the category of anti-social personality disorder. The most common diagnosis obtained was borderline personality disorder which included 91% of the women and 56% of the men. Interestingly, 17% had an absence of any DSM-III-R personality traits.

2.1.2 Comparing and Contrasting Five Contemporary Diagnostic Assessments Tools.

a) ICD-10.
b) DSM-IV
c) Hare's Psychopathy Checklist.
d) Blackburn's Typology derived from MMPI Profiles.
e) Psychodynamic Classification.

a) ICD-10.

This system subdivides personality disorder into clusters of traits (see table 2.2) that correspond to the most frequent or conspicuous behavioural manifestations. The subtypes are widely recognized as major forms of personality deviation.

Table 2.2 ICD-10 F60 Specific Personality Disorder – diagnostic guidelines.

a)	Markedly disharmonious attitudes and behaviours, involving usually several areas of functioning, e.g. affectivity, arousal, impulse control, ways of perceiving or thinking, and style of relating to others;
b)	The abnormal behaviour pattern is enduring, of long standing, and not limited to episodes of mental illness;
c)	The abnormal behaviour pattern is pervasive and clearly maladaptive to a broad range of personal and social situations;
d)	The above manifestations always appear during childhood or adolescence and continue into adulthood;
e)	The disorder leads to considerable personal distress but this may only become apparent late in its course;
f)	The disorder is usually, but not invariably, associated with significant problems in occupational and social performance.

b) DSM-IV.

This system identifies and subdivides personality disorder into ten subtypes which are clustered into three groups (see table 2.3) providing recognition of the difficulty of incorporating all the traits into one category.

In table (2.3) the growing uniformity between the two main assessment tools can be observed. DSM-IV-R (p.630) defines personality disorder as an:

> …enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment.

To meet a DSM classification of personality disorder the patient also needs to fulfil the following requirements identified in table 2.4.

Table 2.3 Personality disorder clusters identified in DSM-IV-R and ICD-10

ICD-10	DSM-IV-R/DSM-V
	Cluster A
Paranoid	Paranoid
Schizoid	Schizoid
	Schizotypal
	Cluster B
Dyssocial	Anti-social
Emotionally Unstable:	Borderline
impulsive type	Histrionic
borderline type	Narcissistic
Histrionic	
	Cluster C
Anxious (avoidant)	Avoidant
Dependent	Dependent
Anankastic (obsessive-compulsive)	Obsessive-Compulsive
Other.	

Table 2.4 General Diagnostic Criteria for a Personality Disorder – DSM-IV.

a)	An enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture. This pattern is manifested in two (or more) of the following areas:
(a1)	cognition (i.e., ways of perceiving and interpreting self, other people and events.)
(a2)	affectivity (i.e., the range, intensity, lability, and appropriateness of emotional response)
(a3)	interpersonal functioning.
(a4)	impulse control.
b)	The enduring pattern is inflexible and pervasive across a broad range of personal and social situations.
c)	The broad pattern leads to clinically significant distress or impairment in social, occupational, or other important areas of social functioning.
d)	The pattern is stable and of long duration and its onset can be traced back at least to adolescence or early adulthood.
e)	The enduring pattern is not better accounted for as a manifestation or consequence of another mental disorder.
f)	The enduring pattern is not due to the direct physiological effects of a substance (e.g., abuse of drugs, a medication) or a general medical condition. (e.g., head trauma)

DSM & ICD

International and national (legal/clinical) classifications exist alongside assessment tools which are often developed from specific therapeutic modalities. For example: in Britain a legal definition exists under the Mental Health Act 2007 for the classification of personality disorder. However, clinicians and diagnosticians will generally use the World Health Organisation classification system known as ICD-10 (International Statistical Classification of Diseases and Related Health Problems) which is also recommended for classification and codification in the National Health Service (N.H.S. U.K.).

Despite the requirement to use the ICD-10 system in the NHS, many clinicians prefer to use the American Psychiatric Association's (APA) classification system known as DSM-IV (Diagnostic and Statistical Manual of Mental Disorders) possibly due to the wider access to research and publications. Greater harmonisation between the two classification systems is understood to be evolving as they are revised accordingly. The authoritative 'Notable Practice Sites' identified by the National Institute for Mental Health in England (NIMHE, 2003) found the classification systems to be too limiting and pejorative and preferred to use dynamic formulations to guide their practice. Blackburn (1988) argues that the classification of personality disorder needs to be based on personality theory and not antisocial behaviour or moral judgements (Blackburn, 1988). Alwin (2006, p.2) discussed the struggle to understand the notion of personality disorder, believing that classification of personality disorder is unsatisfactory but provides a 'starting point' for clinical application and future research.

DSM-IV

Widespread criticism of DSM–IV was exemplified by Bernstein et al. (2007) who undertook a survey of experts which reported that 80% were dissatisfied with the DSM-IV diagnostic tool. The following problems were identified, (1) Austin and Deary (2000) demonstrated that empirical analysis failed to identify structures resembling DSM-IV diagnosis, (2) Verheul and Widiger (2004), highlighted limited association between diagnostic constructs and clinical presentation and (3) Livesley (2012a) commented on extensive diagnostic co-occurrence, poor inter-rater reliability lack of structural validity and the fact that

evidence demonstrates that personality disorder is continuous with normal personality variations and not discontinuous with its reliance on a categorical system using ten types of personality disorder.

DSM-V

In 2004, following the recognition that there was widespread agreement with regard to the shortcomings of the categorical model and that an alternative means of classifying disorders related to personality was required. This resulted in a Personality and Personality Disorders Working Group was established chaired by Professor Andrew Skodol to address these issues. Consequently, between 2010 and 2013 various prototype models were proposed resulting in a withdrawal and discarding. A second prototype utilising a hybrid categorical and dimensional model which was updated but did not meet with the approval of the American Psychiatric Association (APA). The APA in 2013 chose to continue with virtually the same Axis II/Section 2 categorical system of 10 personality disorder types (with the new edition of personality change due to another medical condition) to maintain continuity. A concession was made to include a new model in Section III entitled ‘Emerging Measures and Models’ to recognise the emerging dimensional diagnosis for further study. Although this was consigned to the ‘emerging model’ section it is not meant to be the main diagnostic tool but it is hoped that it will be used alongside the updated categorical system, in the hope that it will be further evaluated through research, with field trials already identified, and eventually to be included as a validated diagnostic assessment in future updates of DSM.

Livesley (2012) was scorning of the working party for not using this opportunity to create an empirically informed system. The DSM-V proposal had three components: (1) a definition of general personality disorder and an associated scale of impairment; (2) a typal system of six disorders; and (3) a dimensional system with 25 traits organized into five domains. Livesley (2012) concluded that it had resulted in an overcomplicated (for clinical purposes) hybrid system which in effect uses two classification systems in axis II and III of typal and dimensional respectively. Verheul (2012, p.369) commented that the new model 'is a heroic and innovative but nevertheless fundamentally flawed attempt to improve DSM-IV.' In particular, 'it fails to retain user acceptability, accuracy and reliability, it lacks empirical support and is far too complex for the average clinician and does not provide a coherent framework for reliable diagnoses. This lead Pull (2014, p.84) to question whether this new diagnostic system was 'back to the past or back to the future'.

The final version of DSM-V now comprises of a hybrid model which includes the categorical and dimensional systems utilising functional impairment criteria (evidenced by the presence of impairment in self and interpersonal functioning e.g. criterion A[1], severity of these elements is assessed using the LPFS[2]) and dimensional personality traits (evidenced by the presence of pathological personality disorders (antisocial, avoidant, borderline, narcissistic obsessional

[1] Criterion A: relates to the impairment of self (self direction or identity) and interpersonal (intimacy or empathy) functioning.

[2] LPFS: Level of Personality Functioning Scale, which makes distinctions in five levels, ranging from - no impairment (0) to some (1), moderate (2), severe (3), and (4) extreme. For a personality disorder diagnosis the minimum of a moderate level of impairment is required.

compulsive, and schizotypal). A seventh one exists entitled ‘personality disorder personality traits e.g. criterion B[3]) which can be linked to one of six categorical traits specified’ to replace the previous ‘personality disorder not otherwise specified’.

This revision provides an opportunity for clinicians/nurses to utilise a model that is widely recognised by academic practitioners. It not only assist a more accurate contextualisation of personality disorders within assessment and formulations, but also to select a specific evidence-based intervention, whilst demonstrating change on a continuum that measures severity and describes function.

There are 25 personality traits used as descriptors in which each personality disorder has its own individual configuration of personality traits based on the DSM-V Section III facet structure. For example, borderline PD is organised via the facets of Impulsiveness, Risk Taking, Emotional Lability, Anxiousness, Separation Insecurity, Hostility, and Depressivity.

The DSM-V Section III model indicates several significant revisions to address the criticisms to previous versions of the DSM, which resulted in a system that is more consistent with the personality pathology literature (APA, 2013; Skodol, 2012). The model was a result of a significant amount of research that

[3] Criterion B: mandates that a participant should also exhibit maladaptive personality traits based on the model of five dimensional personality domains and include 3 to 7 associated facets. The domains involve antagonism, psychoticism, disinhibition, negative affectivity, and detachment.

consistently identifies four to five broad trait domains within personality psychopathology (Krueger et al., 2011; Livesley et al.; 1998; Tackett et al., 2008). This model has also shown strong associations with other models of personality such as the Personality Psychopathology Five (PSY-5) model (Anderson et al., 2013), and the Five Factor Model (FFM) (Widiger et al., 2013). For instance, Negative Affectivity aligns well with the PSY-5 domain of Negative Emotionality/Neuroticism and the FFM domain of Neuroticism. The Section III model was, in part, designed in order to reflect the extreme range of these normal personality domains (Krueger et al., 2012) and, therefore, these empirical associations establish the important relationship between normal and pathological personality traits.

Nevertheless, Livesley (2013, p.208) remained critical arguing that the APA's final version of DSM-V is described as a 'hybrid model' thus seeking, 'to put a positive spin on the result by claiming that the model is an integrated hybrid classification'. He believes that the typal and dimensional components are incompatible with each other. He postulates that it fails to demonstrate an explicit and coherent conceptual structure evidenced by the Working Group's reluctance to abandon the DSM-IV categorical diagnosis but also felt obliged to include a dimensional classification. In addition, it does not use best available scientific evidence. For Example: (1) the fact that reducing the diagnostic types from 10 to 6 was not based on evidence and appeared to be based on reducing overlap and the prevalence of diagnosis and use, (2) ignoring extensive evidence but also its own conclusions that personality pathology does not 'tend to delineate categories of persons in nature' (Krueger et al., 2011) and (3) lacks

clinical utility (e.g. the discontinuity restricts the evaluation and equally without validity it will lack utility which is the key issue in user acceptability). This system as Leising and Zimmermann (2011, p.317) have remarked, as a classification should not be more complex than necessary however the DSM-V proposal 'leaves much to be desired' in this regard.

Early research has been undertaken by Anderson et al. (2014) whose limited self-report study of nonclinical undergraduates focusing on the assessment of criterion B has provided some support for the inclusion of criterion B in DSM-V. Associations were found with section III traits and their respective DSM-V section II personality disorders, particularly at the domain levels. E.g. narcissistic, histrionic and antisocial personality disorders were best predicted by antagonism. Avoidant, obsessive compulsive, paranoid, dependent, and borderline were best predicted by negative affectivity, whilst schizoid is linked to detachment and schizotypal by psychoticism. However, some additional links that were not included in the model concerned negative affectivity with narcissistic personality disorder, psychoticism and detachment with borderline personality disorder. This study was an attempt to explore the validity of the model and concluded that it requires some revisions and for it to be cross-referenced with a clinical population in future research.

Livesley et al. (2013, p.213) hypothesised that a more practical method of dealing with this complex diagnostic issue could be to ask the questions, 'what diagnostic information do clinicians need to treat personality disorder'? This in turn results in two more questions, (1) 'what diagnostic information best predicts

prognosis and outcome', and (2) 'what information do clinicians need to identify treatment targets and select treatment methods'?

In attempting to answer point (1) Crawford et al. (2011) and Verheul et al. (2008) have provided increasing evidence that the severity of personality pathology is more predictive of outcome than a categorical diagnosis. Subsequently, DSM-V recognised this by using severity of impairment; however it appears that the ICD-11 proposal has gone one step further by making the severity the only mandatory criteria.

With regard to point (2) Livesley et al. (2014) suggest that this could be approached by, 'considering the level at which clinicians typically intervene when treating personality disorder'. However, Livesley further points out that,

> 'Most interventions do not target global construct such as borderline or neuroticism nor are these constructs particularly useful in determining which intervention to use. This is why the five factor model that is so often proposed as an alternative classification is not really a viable option: domains are not linked to treatment methods and many facet traits do not reflect behaviours that clinicians have traditionally found useful in treating personality disorder' (Livesley, 2014, p214).

However, treatment targets are not specifically aimed at global constructs but towards specific traits (e.g. emotional lability, cognitive dysregulation, impulsivity), which Clarke (1990, 1993), and Livesley et al. (2009) have suggested may require the identification of 30 traits arranged in clusters to provide structure and parsimony the process of diagnosis.

The above recognition of at what point clinicians/nurses intervene therapeutically with patients diagnosed with personality disorder is a pragmatic

understanding of the reality that they appear already to intervene at, seemingly regardless of diagnostic criteria. This will be a significant factor in developing understanding associated with the research aims and elucidate further in the treatment efficacy below.

To highlight the similarities and differences that exist between three of the main diagnostic systems in relation to the diagnosis of borderline personality disorder table (2.7) provides a comparison. It can be seen that many similarities exist between DSM-IV and ICD-10 despite some subtle descriptive differences. However, by comparison, the psychodynamic criteria may appear distinctly different due to the parlance but it is consistent, despite being limited due to the requirement for specialist training.

c) Hare's Psychopathy Checklist (PCL-R).

This is a unidimensional scale of psychopathy which includes both personality traits and anti-social behaviour. Hare developed Cleckley's (1976) characteristics of a psychopath and finally revised the list into twenty characteristics (see Table 2.5), which are generally compatible with traditional views of the personality traits and behaviours which are found in psychopathy. Hare (1991) demonstrated a high inter-rater and test re-test reliability using both the PCL and PCL-R on prisoners and forensic psychiatric hospitals in patients. The results using the PCL-R suggested that there is a correlation of core personality traits which corresponded to the then DSM-III narcissistic personality disorder and to the features of chronic, unstable lifestyles in anti-social personality disorder.

Coid (1993) argued that the PCL-R omits a considerable amount of psychopathology. But it is recognised that although it is briefer than DSM-IV-R it does have a higher inter-rater reliability and it obtains information from both

interview and case files - an important factor when one considers that many of these patients can present very favourably at interview.

d) Blackburn's Typology Derived From MMPI Profiles.

The Minnesota Multiphasic Personality Inventory (MMPI) is a trait based dimensional model in which the psychopath is described along a pre-set scale. Blackburn's typology is an empirical conversion to a categorical scheme derived from MMPI. Studies in Special Hospitals (Blackburn 1971, 1975, 1986) and prisons (Holland and Holt, 1975; Widom, 1977; McGurk, 1978; McGurk and McGurk, 1979; Henderson, 1982) reveal similar profiles when it was subject to cluster analysis. This system identifies four groups of which only one and two could be described as psychopathic. (See table 2.6)

Table 2.5 Items in Hare's Revised Psychopathy Checklist.

1) Glibness/superficial charm.
2) Grandiose sense of self-worth.
3) Need for stimulation/proneness to boredom.
4) Pathological lying.
5) Cunning/manipulative.
6) Lack of remorse/guilt.
7) Shallow affect.
8) Callous/lack of empathy.
9) Parasitic lifestyle.
10) Poor behaviour controls.
11) Promiscuous sexual behaviour.
12) Early behaviour problems.
13) Lack of realistic, long term goals.
14) Impulsivity.
15) Irresponsibility.
16) Failure to accept responsibility for own actions.
17) Many short-term marital relationships.
18) Juvenile delinquency.
19) Revocation of conditional release.
20) Criminal versatility.

Table 2.6 Blackburn's Typology (some of the characteristics).

Type 1. Primary (Psychopath)
Highly extroverted
Non-neurotic
Guilt Free
Highly Impulsive
More violent in terms of convictions
Type 2. Secondary or Neurotic (Psychopath)
Withdrawn
Hypochondriacal
Suspicious
Prone to depression
Prone to tension
Disruptive thoughts
Resentful
Aggressive
Anxious
Undersocialised
Impulsive
Introverted
* In Special Hospitals associated with sex offenders.
Type 3. Controlled (non-psychopath)
Defensive Denial
Sociable
Highly extroverted
Highly controlled
Deny anxiety or other negative affect.
Type 4. Inhibited (non-psychopath)
Defensive denial
Less controlled
More Suspicious
Not Aggressive
Social withdrawal/avoidance
extreme introversion
Dysthymic or depression
* have committed more sex offences.

Blackburn (1992) argued that although MMPI identified a rich source of desirable information the personality characteristics could be reduced. The Special Hospitals Assessment of Personality and Socialisation (SHAPS) is a ten scale questionnaire which produced a reduction on the MMPI traits but included a

further two criteria. Unfortunately SHAPS has only been tested in high security settings.

Arguably the emerging dimensional model discussed above within DSM-V, could be considered akin to the work conducted by Sullivan (1953) and Leary (1957) in creating the Interpersonal Circle. Interpersonal Theory was inspired by Harry Stack Sullivan (1953), and made more accessible to research by Timothy Leary (1957), who introduced the circular ordering of variables known as the Interpersonal Circle. Interpersonal theory comprises of three strands associated with complementarity, vector length, and circumplex structure. Complementarity contends that people in dyadic interactions negotiate the definition of their relationship through verbal and non-verbal cues. Thus negotiation occurs along the following dimensions: dominant-friendliness invites submissive-friendliness, and vice versa, while dominant-hostility invites submissive-hostility, and vice versa. Vector length (a measure of statistical deviance) contends that within the diagnosis of personality type on the Interpersonal Circle psychopathy deviance can be indexed. Indicating people with rigid, inflexible personalities will have more problems while people with flexible, adaptive personalities have fewer problems. The circumplex contends that the variables that measure interpersonal relationships are arranged around a circle on oppositional diagonal dimensions. The Interpersonal Circle has dimensions of affiliation (love vs. hatred) and power (dominance vs. submission) which also have symmetry to Blackburn's typology (see Table 2.6). The process of collecting assessment data is undertaken by two clinicians over a set period completing questionnaires based on their observations of the participant, prior to the analysis of data.

e) Psychodynamic Classification.

To understand psychodynamic classification there needs to be an appreciation of its broad evolving theoretical base. A psychodynamic approach can involve long-term psychoanalysis and various shorter psychoanalytic therapies. Psychodynamic theory has moved from focusing on unconscious conflicts arising from instincts and aggressive drives towards a focus on reality orientated ego functions and object relations. Western (1991) explains that object relations are concerned with: patterns of relating to others, their thoughts and emotional processes that guide relationships. Consequently, intimate relationships are understood as external manifestations of internal representations based on early childhood interpersonal relationships with caregivers. Thus, dysfunctional relationships within a personality disorder are considered distortions of internal representations. Object relations theory and concepts of the self are integrated and developed within attachment theory (Ainsworth and Bowlby, 1991), which provides a more eclectic structure However, attachment theory is underpinned by similar principles regarding distorted and replicated relationships in the present, based on challenging developmental interpersonal relationships with significant carers in the past. As examples of how psychodynamic classification is utilised and formulated by clinicians, Fonagy (1998), identifies borderline personality disorder as a disorder of attachment due to their level of separation tolerance and ability to understand others' mental states. Kernberg (1996) uses and develops object relations theory with people diagnosed with personality disorder and believes that it represents a developmental failure in one of the following areas:

- ego identity (integration of self-concept and concept of significant others)

- ego strength (control of affects and impulses)
- an integrated and mature super ego (internalised social values)
- effective management of libidinal and aggressive impulses.

Consequently, Kernberg (1996) would characterise borderline personality disorder as experiencing identity diffusion (confused ego identity), primitive internal defences: idealised object (specific people temporarily perceived as faultless), denial or splitting (people or relationships perceived as all good or bad), alongside various levels of superego disorganisation. These developmental distortions in interpersonal relations, alongside poor emotional impulse control can lead to pathological rage.

The aim of psychodynamic classification is to identify individuals' internalised object relations that lead to repetitive maladaptive cognitions, emotions and behaviour. This is often achieved by identifying the most significant object relations which emerge in the transference within the therapeutic relationship. Therefore, a psychodynamic classification not only provides a static categorisation approach but also a dynamic/fluid continuum understanding to assessing personality disorder traits.

f) In conclusion, the main diagnostic assessments stated above all have difficulties: DSM-IV R and ICD-10 represents a categorical system which does not explain behaviour but represents higher reliability because it uses multiple sources of corroborating evidence; the MMPI relies on potentially unreliable self-reporting and is often recommended alongside other personality disorder assessment tools;

whilst psychodynamic assessment requires specialist training but uses categorical and dimensional approach in formulating and hypothesising the origins of traits and functions of behaviours in the form of formulations. The minimum requirement suggested by Dolan and Coid (1994) recommend the use of the PCL-R in conjunction with either DSM-IV-R or ICD-10. Many other assessments of personality disorder are emerging related to various therapeutic modalities but require further scientific rigour to determine their effectiveness. For example: schema therapy, cognitive analytical therapy, dialectical behavioural therapy, interpersonal cognitive therapy. However, their effectiveness as personality disorder treatment modalities will be discussed in section 2.2.

To contrast the various diagnostic systems the criteria for borderline personality disorder is highlighted below in Table (2.7) utilising three classification systems. It demonstrates considerable similarities between the diagnostic systems pertaining to traits and behaviour. However, traits do have their diagnostic limitations due to their inability to predict and explain behaviour.

2.1.3 What Are Personality Traits?

In the above section diagnosticians and clinicians utilised trait clusters to classify personality disorder but how do we make a distinction between ‘normal’ and ‘abnormal’ and apply those to interpersonal relationships?

Personality refers to that unique and distinct human quality that defines and determines the essence of a person’s character i.e. what he or she is really like. An individual’s personality serves to distinguish him/her from anyone else in the world, yet at the same time reflects qualities that are commonly noted in all individuals.

Traits are defined by DSM-IV-R as:

> …enduring patterns of perceiving, relating to, and thinking about the environment and one self that are exhibited in a wide range of social and personal contexts (p.630).

2.1.4 Assessment of Traits.

Personality traits are viewed as part of a hierarchy within research and are generally interpreted through the person's tendency to behave in a particular way. The categories of personality are defined when certain traits occur together in many individuals. Utilising factor analysis researchers have been able to relate large numbers of normal traits along dimensions indicating predispositions to behaviour, emotions and cognitions. Alwin (2006) believes that is now generally accepted most variations in personality can be accounted for by the 'Big Five' factors in which the dimensions range from the following:

- Neuroticism vs stability,
- extroversion vs introversion,
- Agreeableness vs antagonism,
- Conscientiousness vs lack of self-discipline,
- Openness to experience vs rigidity.

These factors are understood to be biologically derived tendencies which significantly influenced our shaping of attitudes, goals, relationships and the concept of self which combine to affect the way we interact socially (McCrae and Costa (1999). Whilst Clark (1996) reveals that this structure parallels studies of traits defining personality disorder. Consequently Widiger and Frances (1994), believe that it is possible to represent current classification of personality disorder on dimensions related to the extremes on some of the dimensions but insufficient for traditional diagnostic classification.

2.1.5 Trait Ambiguities.

Are traits a feature of behaviour or vice versa? Powell (1984) reviewed several studies that indicated that traits may be individually manifested in one situation but not another. Powell and Stewart (1978) stated that the measurement of traits are weakly predictive of behaviour or attitude and ignore situational factors. Personality is obviously not static and the potential exists for its development throughout life.

DSM-IV defines personality disorder as traits that are inflexible and maladaptive, causing significant functional impairment or subjective distress, consequently Livesley (2001) believes that 'dysfunction' needs to be defined in terms of the basic function of personality. The evolutionary aim would be to obtain the universal life tasks described below whilst working to understand the psychological constraints and resolutions:

- A stable self-system (identity, representations of self and others)
- Satisfying interpersonal functioning (attachment, intimacy, affiliation)
- Societal/group relationships (pro-social, corporative behaviour)

(Alwin, 2006, 42).

Change depends on the individual's capacity to learn. Consequently an interactionist approach should be promoted via a multi-dimensional assessment.

Table 2.7 A Contrast of Borderline Personality Disorder Across Three Diagnostic Systems.

DSM-IV-R	ICD-10	Psychodynamic.
1) Frantic efforts to avoid real or imagined abandonment.	- Efforts to avoid abandonment related to *	6e, f, g) ego weakness; poor super ego integration, instinctual conflict.
2) A pattern of unstable & intense interpersonal relationships characterised by alternating between extremes of idealization & devaluation.	- Involved in intense unstable relationships *	6c) Primitive Defence Mechanisms: e.g.idealisation, splitting, denial, omnipotence etc.
3) Identity disturbance: markedly & persistently unstable self-image or sense of self.	- Disturbed self-image (aims & internal preferences unclear or disturbed).	6b) Lack of integrated identity. 3) Polymorphous perverse sexual trends. 4) Classical Pre-Psychotic personality structure
4) Impulsivity in at least two areas that are potentially self-damaging		
5) Recurrent suicidal behaviour, gestures or threats, or self-mutilating behaviour.	- Suicidal threats & self-harm.	5) Impulse neurosis & addiction: repetition which gratifies instinctual needs.
6) Affective instability due to a marked reactivity of mood	- Emotional instability	6a) Lower level character disorder: chaotic & impulse-ridden.
7) Chronic feelings of emptiness.		6d) Reality Testing
8) Inappropriate, intense anger or difficulty controlling anger.	- Chronic feeling of emptiness	
9) Transient, stress-related paranoid ideation or severe dissociative symptoms.		1) Anxiety - chronic & diffuse. 2) Polysymptomatic Neurosis - Paranoid, hypochondriacal, conversion symptoms etc.

2.1.6 Summary of Personality Disorder Assessment.

Individual diagnostic assessment of personality disorder alone cannot accurately embrace all pathological personality traits even within a cluster framework. This may be refreshing for the sake of individuality but remains a nightmare for diagnosticians, researchers and more importantly those persons labelled with personality disorder.

Theory is a construct of reality and reflects the understanding that exists at the time of social history in which the theory is developed. Any discussion about underlying personality and motivation must take in the wider social context. The concept of personality development is a constructivist view which remains essential. Personality can be seen as a combination of three elements:

- the individual's behaviour,
- the meaning of that behaviour as constructed by other people,
- the meaning of that behaviour as constructed by himself/herself.

The underlying rationale of this constructionist view is that studying personality outside its social context is bound to give an incomplete account. It is only when behaviour is imbued with social meaning that it becomes 'personality'.

In conclusion, there appears to be little evidence from empirical data to suggest that one assessment is superior to another. When considering comorbidity there is considerable evidence that a co-occurrence exists between Axis I and Axis II disorders. It has been demonstrated that between 66% (Dahl, 1986) and 97 percent (Alnaes and Torgersen, 1988) of patients with an Axis II disorder also have a diagnosable Axis I disorder. Regardless of the diagnosis there is general recognition that to improve the treatment efficacy for patients' diagnosed with personality disorder, there is a requirement to place their experience within a context that explains their thoughts feelings and emotions. A formulation of this nature that captures the often complicated dynamic understanding can directly inform interventions and provide a catalyst for positive change. In addition, the

provision of a formulation is an important necessity often due to the understanding that diagnosis will provide a useful baseline of information. However, if the information gathered is only used to demonstrate whether someone achieves diagnostic criteria or not it profoundly limits its utility in terms of accurately describing and understanding the function of the presentation. A functional assessment in the form of a formulation will in turn provide an opportunity for the most effective treatment intervention.

2.2 The Origin of Understanding of Personality Disorder.

Psychological understanding of personality disorder is thought to originate from the perspectives of psychodynamic, behavioural, cognitive, and interpersonal theories of psychopathology. Although these perspectives can be diverse a commonality is associated with memory systems relating to the self and others. Developmental influences are related to learning experiences in early relationships and it is thought that biological factors may limit the extent by which the personality traits can change.

In an attempt to understand the developmental origins Robins (1974), McCord (1982a, b) and Offord (1982) have suggested that the following criteria are early developmental signs of personality disorder:

a) conduct disorder in childhood.

b) poor peer relationships.

c) coming from a disordered or deprived family background, with parents who display mental illness or criminality or abusive behaviour.

Conduct has been defined as a persistent pattern of behaviour, violating basic rights of others and age appropriate social norms. Interestingly, Rutter and Giller (1983) demonstrated that 87% of children with conduct disorder met the anti-social personality disorder criteria within DSM-III-R. Werner et al. (1971) produced an excellent longitudinal research model of interrelations between risk,

stress, source of support and coping which provides an important source of data on development, interaction and biological factors on outcome in adulthood. It is not entirely relevant to personality disorder but highlights predictive factors and preventative measures.

Unfortunately research into the clinical work of therapists who work with personality disorders is considered weak. For example, treatment is rarely chosen in relation to personality traits. Psychological understanding of personality disorder often originates from work undertaken in alternative psychological disorders from the realms of behavioural, cognitive and psychodynamic therapists. Each therapeutic modality comprises of different assumptions about personality, with theoretical integration considered currently unlikely. However, Livesley (2003) argues for the utility of flexibly integrating components for treating different aspects of personality problems.

2.3 Summary of the Main Psychological Approaches That Underpin Current Therapeutic Interventions.

2.3.1 Psychodynamic Understanding pertains to short and long-term psychoanalytical and classic psychoanalysis therapies respectively. In recent years psychodynamic understanding focused more on conscious functions and object relations, moving away from unconscious conflicts arising from instinctual libidinal and aggressive drives. Western (1991) considers that object relations refer to enduring patterns of relating to others and the process of thoughts and emotions that guide these relationships. Consequently, internal mental representations are considered to be formed in early developmental years through interaction with caregivers. However, it is understood that these internal representations, if corrupted by negative uncontained developmental relationships, can become externalised/manifest evidence by dysfunctional, distorted and distressing relationships often characteristic of personality disorder.

Born out of object relations understanding is the theory of attachment (Ainsworth and Bowlby, 1991), which is underpinned by the understanding that mammals are motivated to form secure relationships with caregivers. Hence, the quality of the early attachment with infants' caregiver is considered crucial in the early development of social and cognitive development and the later processing of relationships, mediated through an 'internal working model'. Consequently, as an example a child who has developed an insecure attachment style due to an experience of expecting others not to provide support or sufficient trust, will subsequently recreate this relationship dynamic. Despite this risk adult behaviour will also be influenced by other developmental factors. Nevertheless, Fonagy (1998) has hypothesised that borderline personality disorder should be considered a disturbance of attachment which is characterised predominantly by separation intolerance and difficulties in the ability to understand others' mental states as defined within the 'theory of mind' model. Kernberg (1996) uses and develops object relations theory with people diagnosed with personality disorder and believes that it represents a developmental failure in one of the following areas:

- ego identity (integration of self-concept and concept of significant others)
- ego strength (control of affects and impulses)
- an integrated and mature super ego (internalised social values)
- effective management of libidinal and aggressive impulses.

Consequently, Kernberg (1996) would characterise borderline personality disorder as experiencing identity diffusion (confused ego identity), primitive internal defences: idealised object (specific people temporarily perceived as faultless), denial or splitting (people or relationships perceived as all good or bad), alongside various levels of superego disorganisation. These developmental distortions in interpersonal relations, alongside poor emotional impulse control can lead to pathological rage.

The aim of psychodynamic classification is to identify individuals' internalised object relations that lead to repetitive maladaptive cognitions, emotions and behaviour. This is often achieved by identifying the most significant object relations which emerge in the transference within the therapeutic relationship. Therefore, a psychodynamic classification not only provides a static categorisation approach but also a dynamic/fluid continuum understanding to assessing personality disorder traits.

Psychodynamic Psychotherapy Efficacy.

Utilising a RCT Munroe-Blum and Marziali (1995) combined interpersonal group therapy and individual psychodynamic therapy, to demonstrate an improvement in depression and social functioning on follow-up. However there was a 20% rate of withdrawal.

Bateman and Fonagy (2001) where able to demonstrate significant improvements (reducing self-harm, improving interpersonal and social functioning) and advantages of utilising psychodynamic therapy alongside partial hospitalisation for patients diagnosed with BPD in an 18 month follow-up. Some methodological problems were highlighted concerning, 16% of participants were not being treated in their original group whilst others were continuing to receive treatment at follow-up, and it was difficult to delineate what the specific components of intervention were most effective. Most psychodynamic studies have been regarded as requiring larger sample sizes and generalised across more than one site (Bateman and Fonagy, 2000).

2.3.2 Behavioural and Cognitive Behavioural Understanding.

Behaviourism's origins were developed through observation of human and animal learning, whereas psychodynamic origins have been based on observations of distressed people undertaking therapy. Implicit within behaviourism is the understanding that behaviour is controlled by antecedents and consequences in

the subject's environment, with positive outcomes being reinforced and aversive outcomes reduced. Consequently, following a functional analysis of target behaviour, guided experimental research interventions are provided to develop coping and adaptive social skills.

Follette (1997) argues that behaviourists consider personality disorder and traits as unhelpful labels that describe form but not the function. Furthermore, it is understood that by identifying an individual's grouped shared functional responses (e.g. avoiding emotional intimacy that previously caused painful rejection and demonstrated through withdrawal, substance abuse, aggression to self and others) opportunities can arise for interventions guided by experimental research on behaviour.

2.3.3 Cognitive Behavioural Therapy (CBT) Understanding.

CBT shares similar principles to behaviourism with increased emphasis upon how cognitions control behaviour through the understanding of information processing. Beliefs and expectations are obtained through the processes of social learning (e.g. observation and reinforcement), which in turn impacts upon how an individual interprets and reacts to environmental stimuli/events. The CBT objective is to provide coping strategies to manage maladaptive social and emotional reactions to difficult situations, through the use of education, and behavioural skills e.g. social skills training, self-control techniques, problem-solving, cognitive restructuring, and relaxation techniques. The recognition of personality disorder and traits in CBT is contentious due partly because the therapy focuses on context specific behaviours. Nevertheless, Marshall & Barbaree (1984) have argued that personality disorder should be seen as ineffective/unskilled interpersonal behaviours which can lead to either aversive behaviours from others in the form of social punishment or social isolation due to lack of positive social reinforcement.

CBT Efficacy.

Davidson et al. (2004) was able to demonstrate the cost effectiveness of using a manualised form of CBT (MACT) to reduce repeated self-harm with patients experiencing personality disturbance or disorder. It also highlighted how therapists' competence equated to outcome. Davidson et al. (2005) was able to demonstrate gradual and sustained improvement using CBT versus treatment as usual in random control trials, evidenced on a positive symptoms of stress index, state anxiety, dysfunctional beliefs, and the number of suicidal acts, over a two-year period.

2.3.4 Dialectical Behavioural Therapy (DBT).

DBT integrates CBT with Zen and the dialectical philosophy and synthesising of opposites. The aim of the DBT is to specifically address the needs of individuals diagnosed with borderline personality disorder (BPD) and their specific target hierarchy of needs pertaining to life-threatening behaviours (self and others), therapy interfering behaviours, and quality of life interfering behaviours. Utilising a bio-social model Linehan et al. (1994) conceptualises BPD as a dysfunction of emotional regulation originating from the interaction of an invalidating/rejecting environment and biological irregularities. This in turn can be triggered by for example interpretations of validation, resulting in emotional dysregulation and acting out behaviour (e.g. self-harm) to reduce intolerable painful emotions. A balance between acceptance and change interventions to address the target hierarchy of needs include (1) skills training in distress tolerance, emotional management, mindfulness, and interpersonal effectiveness, (2) therapy utilising functional analysis/chain analysis, skills practice and desensitisation techniques (3) crisis management/additional coaching skills.

DBT Efficacy.

Verheul (2003) was able to demonstrate a reduction of self harm in women during treatment. However, Linehan et al. (1993) reported that in the 6/12 month post-treatment this improvement was maintained, although the number of suicide attempts showed little discernible difference between DBT cohort and the treatment as normal cohort. In addition, Linehan et al. (1994) discovered that there was no difference between the control groups in terms of levels of depression, suicidal ideation, hopelessness, and reasons for living. Koons et al. (2001) study of female military veterans was able to evidence improvements in relation to depression and hopelessness but with no difference in self harm compared with the treatment as usual group. When studying adapted DBT for comorbid (substance abuse) BPD women Linehan et al (2002) showed significant improvements for abstinence from drugs, and parasuicidal behaviour. Finally, Linehan et al. (2002) compared DBT with a comprehensive validation therapy which highlighted no differences on any of the outcome measures.

2.3.5 Cognitive Therapy.

The aim of cognitive therapy is to modify beliefs and develop more adaptive strategies. Beck and Freeman (1990) identified treating personality disorder utilising only skills training reduces effectiveness and argued for a broader theory to include normal and abnormal personality, which would focused on evolutionary survival skills (e.g. attacking, avoiding, freezing, suspiciousness, seeking attention). Consequently, he considered personality strategies to be core beliefs/deep cognitive schemas. Whilst personality disorder and represented dysfunctional beliefs, maladaptive strategies which are overgeneralised, inflexible and resistant to change. Each personality disorder is understood to have a profile of beliefs, attitudes, and emotions related to themselves and others. For example, a general theme of antisocial personalities is a belief that others are vulnerable and exploitative (normative information bias), a self-belief that they are autonomous, strong, entitled regarding rule breaking; resulting in behavioural

strategies of exploiting and attacking others (dysfunctional cognitive schema). Consequently therapy would result in the therapist guiding the individual from unqualified to qualified self-interest, taking account of others' needs. Cognitive therapists focus on development issues, client-therapist relationship, and recognise the need for longer term treatment.

2.3.6 Schema Therapy.

The aim of schema therapy is to creatively find personal meanings and narrative that is adaptive for the individual whilst challenging and invalidating early maladaptive schemas (EMS). Young's (1994) schema therapy is underpinned by cognitive therapy, and although not based on a theory of personality it focuses on EMS. EMS are cumulative consequence of early dysfunctional experiences, pertaining to self and relationships with others, providing a template for processing and activation of later experiences (creating destructive emotions that interfere with core needs important for a sense of self e.g. social validation, interpersonal relatedness). Various EMS identified (e.g. expecting abandonment, failure, subjugation) which are contained within broad domains (e.g. over vigilance and inhibition, impaired limits), often associated with parenting style/attachment. Schema maintenance is often achieved through cognitive distortions and overcompensation styles. The EMS identified through questionnaires, imagery and dialogue. Intervention comprises of CBT techniques to challenge and invalidate EMS.

Schema Therapy Efficacy.

Despite being a reasonably new mode of therapy for personality disorder Nordahl and Nysaeter (2005) demonstrated clinical improvement. They utilised a single case series for six patients diagnosed primarily with borderline personality disorder (BPD). Clinical improvements were noted in five of the six patients whilst significantly three of the six patients ceased to fulfil the BPD criteria.

Whilst Giesen-Bloo et al (2006) compared schema therapy with transference focused psychotherapy, highlighting superiority in terms of cost effectiveness, quality of life, and BPD criteria, utilising a three year multisite study with a 12 month follow-up (n=88). Smaller single case studies have been undertaken by Hoffart et al. (2002) indicated that the early use of schema therapy formulations increased self-understanding and reduced emotional distress in patients with cluster C personality traits. Farnsworth (2005) utilising participants in a forensic environment was able to indicate positive treatment gains in terms of reduction in incidents of aggression, ambivalence over emotional expression, increased self-esteem, and empathetic concern for others.

2.3.7 Cognitive Analytical Therapy (CAT).

CAT aims at disconfirming 'expectations of relationships' referred to as 'reciprocal role procedures' (RRPs) and the integration of dissociated self-states through self-reflection, self-monitoring, and CBT procedures.

CAT is a short-term, integrative therapy, bringing together aspects of psychoanalysis (utilising object relations, particularly actual childhood experiences rather than unconscious fantasy) and cognitive developmental theory (utilising CBT techniques with the exception of information processing models of knowledge and feeling) developed by Ryle (1997). CAT focuses on identifying and understanding reciprocal roles (RRP), which have become characteristic patterns, emanating from the individual's early internalised experiences with caregivers/others which become integrated into their self-concept and behavioural responses. E.g. a needy child may have a satisfying or depriving caregiver and may internalise these roles. Someone with personality disorder may seek to elicit a nurturing RRP by self-harming. They may also enact both roles e.g. abuser and victim. The construct of roles is described as self-states, in BPD there may be a disassociated for state to avoid unmanageable feelings. Failure to achieve or confirm a dominant self-state may lead to disappointment or even rage.

Collaborative sequential diagrammatic representations are created which demonstrate the main recurrent cyclical patterns, to target problems that need to be revised in conjunction with the above aims.

2.3.8 Interpersonal Understanding.

The general aim of interpersonal theory is to break the cycle of negative self-fulfilling prophecy of maladaptive interpersonal behaviour by providing new experiences that will disconfirm distorted expectations of others.

Kiesler (1996) reported that Leary's (1957) first description of an interpersonal approach to personality disorder has been developed by numerous psychotherapists. Although there is a diversity of approaches within this modality a binding feature is the use of the interpersonal context of therapy as a means to change. However, other influences have utilised cognitive social learning theory focusing on dysfunctional beliefs (Carson, 1979) whilst Benjamin (1996) drew upon psychodynamic and attachment theories. The interpersonal circle, which demonstrates dimensional interpersonal characteristics, has been a cornerstone for theoretical developments e.g. hostility/friendliness. Various personality disordered traits can be identified to determine a pathological style. It is understood that complimentary styles are elicited, confirming expectations, often originating from early adverse relationships restricting learning experiences resulting in distorted expectations of how others may react. For example, a friendly presentation involves non/verbal messages prompting a friendly reaction that then provides feedback. People will often behave in ways that extract information from others that confirms expectations. Conversely, a dysfunctional interpersonal style can result in a hostile person expecting hostile reaction and behaves in ways to attract them, often minimising the opportunity to disconfirming this elicited experience.

An alternative to the interpersonal circle is the interpersonal octagon described by Birchnell (2002) which also uses two dimensions to conceptualise interpersonal relationships This includes 'becoming closely involved with others versus being separated from others', whilst the second dimension whether the person tends to be from above or from below. The outcome provides a description of eight types of relationships alongside other descriptors. Personality disorders are understood in terms of types of incompetence in relationships. Birchnell and Shine (2000) provided research to demonstrate how this model could be related to the ten DSM-IV personality types, which was developed further into a model for psychotherapy (Birchnell, 2002).

2.3.9 Therapeutic Communities (TCs).

The concept of the Therapeutic Community was born after the Second World War. The cornerstone of this approach is that the community is democratic, decisions are shared between staff and patients, admissions and treatment are voluntary. Rapoport (1960) suggested that community living, democratisation, permissiveness, reality confrontation, are the four underlying TC treatment principles. It is considered helpful in reducing 'us and them' attitudes, negative behaviour is confronted by each other, and the causes of destructive behaviour are resolved in community meetings.

Within a Therapeutic Community there is 'a culture of enquiry into personal and interpersonal and inter-system problems' including 'the study of impulses, defences and relations, expressed and arranged socially' (Norton, 1992). The aim of the 'culture of enquiry' is that it will lead to a better understanding of the deviant or unhealthy previous behaviour and blossom into positive change.

There appears to be more written about the Therapeutic Community as a treatment modality for psychopaths than any other modality. However, much of

the research is equivocal, lacking in control groups, and utilises recidivism as the main outcome measure.

The Henderson Hospital is the only therapeutic community that specifically treats patients diagnosed as psychopathic. The Henderson treats up to twenty-nine patients, half of which may have a history of convictions (Norton, 1992). Dolan et al. (1992) demonstrated that 61% of the patients met the DSM-III-R criteria for anti-social personality disorder and 87% had borderline personality disorder. An earlier study in 1991 discovered that on average each patient met six DSM-III-R criteria (Dolan et al., 1992).

Therapeutic Community Efficacy.

Many of the studies reviewed have demonstrated an improvement post discharge in terms of employment and/or recidivism (Tuxford, 1961; Taylor, 1963; Whiteley, 1970; Copas and Whiteley, 1976; Copas et al., 1984).

At the Henderson Hospital, Norris (1985) found an improvement on repertory grid measures of rule breaking, independence, self-perception, and self-esteem. Newton (1973) and Miller (1982) demonstrated significant decreases in hostility during treatment at HMP Grendon. Gunn (1978) in a study also at HMP Grendon observed significant decreases in MMPI scales of depression, anxiety and hostility during treatment. There was also a significant increase in extraversion and ego strength. When Gunn used the General Health Questionnaire (GHQ) on admission, and again following nine months, a significant decrease in pathology had taken place. A semantic differential scale also demonstrated improvement in the positive evaluation of authority figures.

A study at Balderton Therapeutic Community unfortunately formed the basis for its closure. The study comprised of two approaches to adolescent psychopaths.

Firstly, a therapeutic community group and secondly an authoritarian group, in which success was determined utilising the following criteria:

a) recidivism

b) employment record

c) clinical recovery

d) residual neurotic symptoms.

In every aspect the authoritarian treated group did marginally better, although it was noted that there was a significant drop out rate in the therapeutic community group.

The likelihood of improvement in recidivism increased if the patient completed his treatment and stayed in treatment longer (O'Brian, 1976; Dolan et al., 1992; Copas et al., 1984).

Due to methodological inconsistencies (regarding participant type, treatment setting, intervention, lack of appropriate control groups and methods negating proper comparison) concerning large-scale studies undertaken by Lees et al. (1999); Warren, et al. (2002) and ethical issues (e.g. participant appropriateness utilising RCT) highlighted by Norton and Warren, 2004; Slade and Priebe, 2001, have resulted in the effectiveness of therapeutic communities not being clear. Nevertheless, outcomes have been perceived as positive evidence by Copas et al. (1984) who demonstrated a 36% absence of hospital admissions and convictions compared to 19% in the non-admitted control groups, which increased to 65% if they remained beyond nine months. Dolan and Warren et al. (1995) replicated this study with similar findings of 42.9% compared with 17.9% of non-treated participants on a Borderline Syndrome Index. Warren et al. (2004) conducted a twelve-month follow up which demonstrated a significant reduction in impulsive behaviour and urges, particularly in relation to self-harm.

2.3.10 'Milieu' Therapy.

Blackburn (1992, p.195.) described 'Milieu' therapy as a "euphemism for an orderly regime within the hospital." 'Milieu' therapy may or may not include a wide variety of treatment interventions by a wide range of differing professionals, to address a single aspect/need. The above understanding highlights, to some extent, a flaw in ascertaining research into the efficacy of this mode of treatment. Its definition is a broad spectrum of treatments which may or may not have been received. Most research into this area can only compare one broad systems of approach with another (e.g. penal). The main indicator or outcome measure is that of recidivism and re-admission. Consequently studies are not assessing treatment but evaluating the appropriateness of the decision to release a patient.

Treatment is ill defined with this mode of therapy. When discharge outcomes are compared between the mentally ill and personality disordered patients, Bailey and MacCulloch (1992) demonstrated that the latter group were more likely to re-offend, be re-admitted or recalled. They highlighted that of the subjects 50% do not re-offend within three years and that 25% of the offences were deemed to be seriously violent. No Special Hospital study including the one above has been able to demonstrate how the actual psychiatric treatment received relates to re-offending.

A note of optimism is achieved by Norris (1984) whose study demonstrates that the longer a patient diagnosed with personality disorder is in treatment the better the outcome in terms of recidivism, re-admission and recall.

Unfortunately very few studies separate the diagnostic groups and worse still no information has been provided that demonstrates which treatment is most effective.

2.3.11 Medication.

Although medication can be helpful in reducing symptoms associated with personality disorder there is no specific medication that treats personality disorder. Markovitz (2001) and Tyrer and Bateman (2004) both summarise that there is insufficient evidence and inadequate research, complicated by poor sample size, significant dropout rates, and placebo effects. Furthermore, because everybody is different it is problematic to determine which is most suitable for each individual. It is also common practice particularly in therapeutic communities that medication should be discontinued before psychological treatment is undertaken.

2.3.12 Summary of Treatment Approaches.

In the past personality disorder was considered untreatable, while this should be considered untrue, treatment is still hampered by inconsistent research methodology. RCTs are considered the 'gold standard' of evidence in medicine, usually because it strives to identify what intervention is better than another for a specific disorder and in its absence, treatment efficacy cannot be definitive. However, Seligman (1995) argues RCTs strength is understood to be its scientific rigour, yet this could be seen as its weakness because it does not reflect what is done in psychotherapies clinical practice. Furthermore, Slade and Priebe (2001) are critical of RCTs because they often group individuals through a diagnosis or a particular problem (e.g. self-harm) and assume that these people will all be the same or conversely RCTs can have highly selective inclusion criteria and could exclude full representation. Consequently, individuals may have the same disorder but an individual may have a set of different problems and psychological issues from that of another. Therapy tends to focus on the individual's presenting problems, and it would be unlikely that an individual would enter therapy asking for their personality disorder to be changed.

Available research does demonstrate that no on treatment is considered better than another in treating personality disorder. Therefore, it may be advantageous to

integrate the diverse models and shape it to the individual's needs. Nevertheless, research indicates that the treatment of personality disorder can be most positive when it is long-term, intensive, well structured, theoretically coherent, and when follow-up is provided post residential care. It can be seen from the evidence above that dropout rates and satisfactory engagement are problematic with this diagnostic group, which leads Bateman and Fonagy (2000) and Rawlings (2001) to suggest the particular importance that care should be taken to engage personality disordered clients in treatment, and keep them engaged. Consequently, it is argued by Luborsky and Auerbach (1985), that the strongest predictor of outcome in psychotherapy is the therapeutic alliance, which will be explored in the following chapter.

2.4 Conclusion.

It can be seen thus far, from the review above, that there is still much to understand about personality disorder in terms of origin, assessment, treatment efficacy, which can be confounded by inconsistent research methodology and the pejorative and categorical nature of the disorder. Placing this 'understanding' within the context of a forensic culture creates yet another level of difficulty in relation to the severity of risk and how this should be managed and treated. Psychiatric nursing and forensic psychiatric nursing roles appear to be ill-defined in relation to the management and treatment of personality disorder. However, despite an emerging improvement in assessment (e.g. dimensional models) and some indications of improvement in treatment efficacy in relation to presenting problems from this diagnostic group, psychiatric nursing does not stand alone in relation to other clinical disciplines in terms of understanding how best to approach their needs. My data collection was initially undertaken at a point in time when it was difficult to identify a clear evidence base to satisfactorily shape the way forward. In fact it was perhaps clearer to say what we didn't want and utilise available and sometimes unproven resources to this end. Consequently, psychiatric nurses working with people with personality disorder should at the

most be able to equitably utilise the therapeutic tools reviewed above alongside other clinicians, whilst at least there should be a satisfactory appreciation of these methods to motivate and support their use systemically throughout the 24 hour a day learning opportunities nurses can provide. Forensic psychiatric nurses should equally be able to use the same therapeutic tools alongside those reviewed in the forensic environment below.

Historically, research into treatment modalities for this client group, has been and continues to be fraught with inconsistency regarding diagnosis, research methodology and long term follow up. It is rare to find research which focuses on the same outcome or which uses the same evaluation tool, ensuring that the validity of the intervention remains inconclusive. Even when evidence is available with regard to efficacy, no one therapeutic intervention has demonstrated superiority over another. A considerable amount of confusion exists regarding: research based treatment outcomes, definition and assessment for personality disorder. The interactive processes of individuals are seemingly complex and chaotic but developmental research has begun to demonstrate that it can actually be coherent and follows certain laws. However, it should be recognised that a treatment intervention along one dimension will not necessarily effect change in an individual without intervention along another. No single type of treatment in an institutional setting has been found to be uniformly successful. Convincing evidence does not exist that personality disorder can or cannot be treated successfully. This led Dolan and Coid (1994, p.266), to suggest that in the past 'nothing works became the accepted wisdom' but today we should ask, 'nothing so far tried works but what does work'? For serious and multiple offenders, multi-model treatment programmes are appropriate which are more intensive and the matching of treatment should be improved.

Many of the research difficulties have already been mentioned above but suffice to say there will be limited progress if the underlying nature of the condition is not

more fully understood. Chiswick (1992), stated that it is unsurprising that an experimental model based upon the concept of the treatment of mental illness has failed to be extrapolated successfully to the treatment of psychopathy, a concept which does not readily fit the illness model. This is a condition which is partially socially defined. It is a condition which requires continued but varied, treatment interventions over the course of life. When research has been evaluated it often appears to appraise the institution e.g. prisons with focus on recidivism, and High Secure Hospitals with focus on risk involved on the decision to discharge. Care providers should not subscribe to failure if we have not tried all the options.

It is with this in mind that following the forensic review below I will explore why an integrated approach may provide further opportunities for Mental Health Nurses to contribute and improve understanding.

Leichsenring and Leibing (2003) report that treatment outcome for personality disorder seems similar across treatments, resulting in the general recognition that no one therapy is better than another. In addition, as discussed above, the diagnosis of personality disorder has been contentious; nevertheless this has been gradually recognised within the new DSM-V to the point that a dimensional model of personality disorder has been included as an emerging model within the system. Leading Livesley to state,

> The theoretical models underlying current therapies do not fully explain either the range of psychopathology of PD or the multiple biological and psychosocial factors implicated in its development. (2012, p.18)

Livesley (2012) has not only argued for a more meaningful way of describing personality disorder (e.g. a dimensional model) but in recognition of an absence of a dominant efficacious therapeutic intervention, he suggests that a more integrated therapy is utilised drawing upon the best components of what works from each intervention.

He proposes a framework that comprising of two main components:

(1) A system for conceptualising personality disorder utilising empirical knowledge; and

(2) A model of therapeutic change founded on specific outcome studies in the treatment of personality disorder.

As highlighted above, treatment is dominated by a few treatments alongside the introduction of a variety of manualised interventions, with the implication that one intervention should be chosen to address PD. To exemplify the utility of an eclectic model, a borderline PD may experience emotional dysregulation, poor impulse control, maladaptive object relationships and cognitions, and impaired mentalising. Utilising DBT Linehan (1993) would address emotional dysregulation by building upon appropriate skills. However, mentalising[4] based therapy (MBT; Bateman and Fonagy, 2004) by utilising mentalising techniques would enhance the functioning of meta-cognitions which in turn would impact upon emotional regulation. Thus by amalgamating DBT skills with MBT processing a more effective intervention could be provided. However, if this also involved self-harm, further approaches could involve cognitive therapy to address maladaptive cognitions and schema therapy (Young et al., 2003), a method of cognitive restructuring and even psychodynamic interventions for interpersonal aspects and avoidance behaviour.

Castonguay and Beutler (2006) and Critchfield and Benjamin, 2006 have identified from the analysis of empirical literature that effective generic principles for therapeutic change include a strong working alliance, an empathetically flexible approach to repairing ruptures in the alliance, a caring attitude, warmth, empathy, positive regard, congruence and authenticity, patient-therapist agreement on treatment goals, strong collaboration between patient and therapist in working

[4] **Mentalization** refers to your ability to recognize your own and others' mental states, and to see these mental states as separate from behavior. Mentalization includes being able to think about thoughts, emotions, wishes, desires, and needs in yourself and other people, and to see that these internal events may have an impact on the actions that you and others take, but are separate from those actions.

towards goals, and a high level of therapist activity. They further suggest that treatment should be organised in relation to change mechanisms universal to all therapies. Consequently, the five principles common to all treatment and are potential transferable to all clinicians include:

(1) Therapy factors (principles for organizing an evidence-based integrated treatment).

Critchfield and Benjamin (2006) highlight that effective PD treatments comprise of a well-defined structure which in turn provides consistency required for a positive outcome. However, Livesley (2012, p.20) argues that an, 'integrated treatment cannot be based simply on eclecticism' and in the absence of an evidence-based personality disorder theory that the clinician should demonstrate a conceptualisation of the personality disordered individual's psychopathology alongside therapeutic principles of change.

(2) Relationship factors (especially alliance factors).

Smith et al. (2006) have identified that from psychotherapy research that the quality of the therapeutic relationship/alliance is key to outcome, particularly because relationship difficulties are a defining characteristic of PD (Cloninger, 2000). Consequently, it is imperative that strategies are developed to enhance collaboration, to manage and model adaptive approaches to resolve deep-seated interpersonal difficulties related to rejection, abandonment, trust and intimacy. Livesley (2012) believe that the alliance can be enhanced by having agreed goals with an understanding of how they will be achieved, which ultimately enhances motivation.

3) Therapist factors.

Important ingredients in supporting the therapeutic relationship and positive outcome involves the therapists' ability to utilise empathy, support and validation, which represent the cornerstone of a Rogerian (Rogers, 1957) 'person centred'

approach and considered a major predictor of outcome. However, there is a sparsity of supporting research directly linking empathy approaches with personality disorder, with the exception of a study of a PD comorbid addictions group indicated by Miller and Rollnick (2002) who linked the significance of empathy with outcome. Nevertheless, the above Rogerian principles are akin to open-mindedness, flexibility and creativity reported by Fernandez-Alvarez et al. (2006) as significant therapist attributes in terms of patient outcome. Providing support, validation, containing limit setting and repairs to ruptures in the relationship (Safran et al.2002) are also key to this relationship, in light of the replication of inconsistent traumatic attachments in childhood. Therapist factors associated with outcome also involve the ability to cope/tolerate with intense psychopathological positive and negative feelings, particularly in relation to counter/transference responses.

(4) Patient factors (variables associated with outcome).

There are a broad array of characteristics that PD patient may display that will potentially hamper the creation of a therapeutic alliance e.g. impaired object relationships, pessimism and hopelessness, poor social skills, poor family relationships, powerful defensive behaviour, hostility, perfectionism, and limited psychological mindedness. Providing initial and ongoing motivational strategies alongside supportive and empathetic approaches are imperative due to high dropout rates in therapy by PD patients (Cottraux et al., 2009), often due to feelings of helplessness, hopelessness, passivity due to adverse developmental experiences.

(5) Technique Factors.

With regard to the integration of effective strategies for the treatment of PD Critchfield and Benjamin (2006) reported on the importance of maintaining, a goal orientated approach, the identification of maladaptive patterns of thinking and feeling and acting, and dealing with presenting problems. This provides an

opportunity to reinforce why therapeutic interventions may be helpful. Maintaining a focus on change is important in effecting outcome, whilst Linehan (1993) promotes this approach within DBT but balances this with acceptance and support as part of the integral dialectical approach.

Any effective model for the treatment of personality disorder should be coherent and include a distinction between common and individual factors related to the perceived disorder, where the disorder is in relation to normal personality functioning, and utilise a social cognitive model to provide structures of cognition and affect derived from adaptive mechanisms.

2.5 Summary.

The above review of the understanding of PD indicates that the construct of PD including psychopathy has considerable relevance for forensic psychiatric nurses. Revisions of diagnostic tools have not resulted in an agreed consensus, however new and hopefully illuminating diagnostic and treatment options which describe origins of PD are being postulated and gradually gaining a degree of acceptance, which will need to be evidenced by future research. However, despite disagreements about assessment, manifestation and treatability of psychopathy, Melia, et al. (1998) comments can be considered equally relevant today (Kirkman, 2008), in that PD causes significant challenges to forensic nurses in terms of high levels of stress, anxiety, and the dilemma arising between care and containment. These difficulties are compounded by assumptions associated with PD patients' level of dangerousness, which potentially could lead forensic nurses to focus on control rather than therapeutic engagement in which the former may seem easier to quantify. In the face of these difficulties nurses need to maintain positive attitudes about their role and contribution to maintain a therapeutic boundaried atmosphere to maximise therapeutic success. Maintaining a contemporary understanding will enable forensic nurses to develop a credible dialogue with other healthcare professionals, thus promoting positive views and attitudes about

their own role (Kirkman, 2002). Whilst it is imperative that research into the understanding of psychopathy and personality disorder needs to continue not least from a clinical perspective but also for the potential risks posed to society.

A key aspect of personality disorder in terms of origin, manifestation and interface for change is that of their relationships, and for forensic nurses the development and maintenance of the therapeutic alliance, which will be the focus of the following chapter.

CHAPTER THREE.

UNDERSTANDING PERSONALITY DISORDER RELATIONSHIPS.

Chapter Three.

Understanding Personality Disorder Relationships.

3.0 Introduction.

In the previous Chapter Two: Understanding Personality Disorder, various difficulties surrounding conceptualising personality disorder were discussed, ranging from categorical diagnostic systems based on pathology, and dimensional diagnostic systems ranging from functional to dysfunctional. The emerging theme from the previous chapter is that the salient feature of understanding personality disorder is that of their relationships, which will be the sole focus of this chapter.

Most authors appear to agree that personality disorder is concerned with relationship difficulties, with origins in childhood and manifestations represented in adulthood. However, it is this relationship interface that Mental Health Nurses need to work with, not only understanding the personality disordered patients interactions but also requiring an awareness of themselves, the physical, psychological, and organisational systems that influence and occupy the space where the 'therapeutic alliance' between patient and nurse needs to take place. The importance of this interface is highlighted by Bowen and Mason (2012, p. 3561) who, following their comprehensive study into skills and competencies of forensic and non-forensic psychiatric nurses, stated that nurses viewed:

> …establishing a therapeutic relationship as the bed-rock for nursing personality disordered patients.

Hence, the relationship between the nurse and patient is essential in understanding personality disorder in terms of origin, manifestation, interface, development and particularly the maintenance of their therapeutic alliance. This

is particularly important due to the fact that the ‘therapeutic alliance’ is a strong indicator of therapeutic outcome when working with patients diagnosed with PD (Luborsky and Auerbach, 1985).

It can be seen from this brief introduction that to understand and to work effectively with patients diagnosed with personality disorder that the relationship is pivotal and as such forms the second and third aims of this study:

2 What are Mental Health Nurses’ understandings of the relationship difficulties that men diagnosed with personality disorder have and how does this influence the nurse-patient relationship?

3 How does the understanding gleaned from aims one and two inform clinical practice?

The Mental Health Nurse participant Q-sort (B) results pertaining understanding PD patients’ relationship difficulties culminated in producing seven factors and a broad array of significant emerging themes. Consequently, this chapter presents a literature search focusing on PD relationship difficulties to enable the results to be conceptualised within the broader domain of understanding.

Essentially, this chapter is divided into firstly, the influences which may impact upon the therapeutic relationship (section 3.1/3.2), and secondly, how nurses can process the relationship difficulties (3.3). More specifically, the first element of exploring the influences on the therapeutic relationship are captured by focusing on, the UK government influences (3.1.1), the origins of PD relationship difficulties (3.1.2), and the role of mental health nursing/forensic nursing (3.2/3.2.1). Furthermore, it will highlight the link between mental health nursing and the therapeutic relationship (3.2.2), focussing on the factors that may hinder and promote its development from both perspectives (3.2.2). In addition, it will explore nurses: training (3.2.3), negative attitudes, defences

that can also influence the relationship. Following this exploration of understanding of the nurse-patient relationship, the means of processing these difficulties will be examined by firstly, briefly introducing the potential problems (3.3.1), secondly, through commonly used theoretical constructs (3.3.2), reflective processes (3.4) and clinical supervision (3.4.4).

3.1.1 UK Government Understanding.

In my role as a psychotherapist working with forensic patients whose criminal status is often in the media, my supervision session led me to adopt the notion that a third person (society) is always represented in the therapy room with the patient. It is with this thought in mind that this chapter will briefly re-introduce the influences affecting the PD relationship in the form of preoccupation with PD risk and dangerousness by the UK government and the media (3.1.1). When not focussing specifically on PD risk and simply exploring personality disorder the cause and effect can be demonstrated, however the diversity of their symptoms cannot be constrained effectively within diagnostic classification resulting in broad eclectic interventions and questions regarding the effectiveness of relationship interventions (3.1.2).

The question of how best to understand and manage individuals with a diagnosis of personality disorder who present a risk to others is a concern for society, government, mental health services, and the criminal justice system. The lack of resources available and sensationalist media reporting of violent incidents involving psychiatric patients have all contributed to a cultural preoccupation with ‘dangerousness’ and mental disorder (Blumenthal and Lavender, 2002; Laurence, 2002).

The UK government responded to the above concerns by proposing substantial changes to the 1983 Mental Health Act, made in the form of a revised draft Mental Health Bill (Department of Health, 2004a, 2004b). This prompted the creation of conditions for the legal detention of mental health patients that did not require them to necessarily engage in 'treatment' but could be detained on the basis of not causing deterioration in their mental health. It placed an emphasis on the resulting psychological dysfunction rather than on classification of an underlying cause in the form of 'psychopathic disorder'. Treatability was removed and replaced instead by a requirement for the availability of appropriate treatment of detained patients. In anticipation of the increased need for services the government directed funding towards the creation of four pilot units (two in hospitals – Rampton and Broadmoor High Secure Hospitals and two in prisons – HMP Franklin and HMP Whitemoor), known as Dangerous and Severe Personality Disorder (DSPD) Units), which included research into the best way of helping these patients. Nevertheless, research suggests that the majority of people detained on the basis of a risk assessment, under these proposals, would not actually go on to do anything dangerous (Cooke et al., 2001; Critical Psychiatric Network, 1999; Taylor, 2002).

Mason (2002) refers to the complexity surrounding the notion of personality disorder, its measurement, classification, therapeutic management and prognosis. The events leading to the Fallon et al Inquiry, and the publication of the report (HMSO 1999), have seriously questioned the professional ability to address this problem. Irrespective of the academics debate surrounding

treatability, no other patient group has caused as much stress, anxiety and frustration as the severely personality disordered patient, particularly in relation to the practical day-to-day management (Melia et al., 1998).

If potential treatability/prevention of deterioration are grounds for detention then it could be interpreted that a deeper clinical understanding appears be absent or not understood, which will be explored through the revisiting of the origin of relationships difficulties.

3.1.2 Understanding of the Origins of PD Relationship Difficulties.

This section provides a couple of examples demonstrating some personality disorder causes and how this can impact on the individual developmentally and manifesting as symptoms. The breadth of symptoms lead to multiple classifications, matched by eclectic interventions, and poor evidence for specific relationship interventions.

Kurtz (2002a) identifies that the quality of parenting emerges as both a direct and indirect influence, and that the aspects that appear to be of most relevance are a hostile family environment and a neglectful style of parenting. The emotional impact of this developmental pattern can lead to the most extreme emotional dysregulation which often characterise borderline personality disordered patients who self-harm. Influential studies have found that people who repeatedly self-injure or have a borderline personality disorder are unable to soothe themselves or have ‘comforting cognitions' (e.g. positive self-talk) (Linehan, 1993; McAuliffe et al., 2002).

Forensic patients have typically had very negative relationships with parental and authority figures (McCann et al., 2000). Disorders of attachment are prevalent, particularly in patients with personality disorders (Frodi et al., 2001). Offending and antisocial behaviour can place additional stress on these already strained family relationships (Tsang et al., 2002). Levels of self-efficacy and self-esteem among these patients can be very poor (Rask and Hallberg, 2000). Impaired social ability may play a more significant role in offending than factors like intellectual ability (Kearns and O'Connor, 1988).

Compounding the above attachment and forensic influences Coid (1992, p. 27), reports that there are high levels of co-morbidity within the population diagnosed with personality disorder and states that, 'many are likely to meet the criteria for Axis I diagnosis, such as anxiety or depression, and for more than one diagnosis of personality disorder.

As a consequence of the above examples which demonstrate some of the multifaceted nature of the difficulties faced by this diagnostic group, interventions are usually eclectic or integrative, combining elements from psychodynamic, cognitive behavioural and systemic therapies. However, specific treatment targeting relational abilities have been shown to be effective (Goodness and Renfro, 2002).

Although personality disorder cause and effect can be understood, conceptualising this within a diagnostic classification and a specific treatment can be problematic. Nevertheless, promising dimensional/functional assessments and evidence based treatment modality components shaped into

an integrative approach are gaining momentum. Consequently, understanding PD relationships for Mental Health Nurses through diagnostic classification and therapeutic modalities can be challenging. These challenges can obviously transfer into difficulties in providing clarity in terms of the nurse's role in the provision of assessment and interventions, but also when identifying efficacious training needs when working with patients diagnosed with personality disorder relationship difficulties.

3.2 Mental Health Nursing.

The key component of a PD patients' difficulty concerns the relationship, whilst the key components of the Mental Health Nurses role is that of developing a therapeutic alliance within the relationship. This section will explore the ill-defined nursing role, the weakness of training to work with PD patients, prior to focusing on recommendations including: utilising NIHME (2004) Skills and Competency Framework, NMC (2010) guidelines, skills enhancement (e.g. therapeutic alliance, self-awareness and reflective practice, and specific management skills) (Holmes, 2002), training about the impact of labelling, and psychosocial interventions. Finally training recommendations will focus on (1) the suggestion of establishing induction programs utilising case study approaches to identify and resolve PD issues with formulations linking PD and risk to self and others, whilst (2) will explore utility of the Recovery Approach.

3.2.1 What Is Forensic Nursing/Mental Health Nursing?

Barker et al. (1997), define psychiatric nursing as a collaborative process based upon 'interactive, developmental human activity more concerned with the future of the person than with the origins or causes of their mental distress' (Barker et

al., 1997, p. 663). Whilst the International Association of Forensic Nurses (IAFN 1999, p.2) defines forensic nursing as:

> The application of the forensic aspects of health care combined with the bio-psychosocial education of the registered nurse in the scientific investigation and treatment of trauma, and/or death of victims and perpetrators of violence, criminal activity, and traumatic accidents. The forensic nurse provides direct services to individual clients, consultation services to nursing, medical, and law related agencies, as well as providing expert testimony in areas dealing with questioned death investigative processes, adequacy of services delivery, and specialised diagnosis of specific conditions as related to nursing.

However, despite the above definition, Mason (2002) questions what constitutes forensic nursing practice is generally considered vague and ambiguous. Yet registered Mental Health Nurses who work within forensic settings represent a significant percentage of this branch of nursing, often working with the most disturbed and dangerous patients in the country. Forensic psychiatric nurses work in a significant number of high, medium and low secure psychiatric hospitals throughout the UK. They can also work within prisons, prison in-reach schemes, community, and court liaison schemes. Nevertheless, wherever nurses work it is widely acknowledged that individuals with a diagnosis of personality disorder who are considered a risk to others are particularly difficult to work with, often find it extremely difficult to make constructive use of help, and can arouse intense negative feelings in staff (Hinshelwood, 2002). Patients with personality disorder are, arguably, among the most problematic of in-patient cases, invariably arousing strong feelings among staff. Expertise in combining responsiveness and limit-setting are often considered more appropriate for this patient group but rarely comes without training and support. Whittington and McLaughlin (2000) argue that unless there is change in ‘organisational’ attitudes supported by a management structure which is committed to psychotherapeutic education, training and supervision aligned to

appropriate clinical placements then the potential of the nurse as a powerful and dynamic therapeutic resource will remain largely untapped.

This nurse training/role concern has also been raised more recently by Bowen and Mason (2012) who analysed the postal responses from 415 forensic nurses and 382 non-forensic nurses. The forensic nurses identified their main 'strengths and skills' (Table 3.2) as: being firm, setting limits and defining boundaries, whilst the non-forensic nurses identified skills in being non-judgemental, listening and risk assessment. In terms of 'nursing weaknesses' (Table 3.3) forensic nurses identified inability to engage, inability to resolve conflict and impatience, whilst the non-forensic nurses identified frustration with the system, fear of aggression and no skills to engage. With regard to the 'skills and competencies most required for nursing' (Table 3.4), forensic nurses rated being nonthreatening, non-judgemental and being able to expect anything, whilst non-forensic nurses identified being open-minded, non-judgemental and forming relationships. Finally, information was gleaned with regard to the 'attributes that were considered least desirable' (Table 3.5) to work with PD patients. Forensic nurses chose not overreacting, being judgemental and over confrontational; whilst non-forensic nurses chose supercilious attitude, cynicism and being judgemental. The clearest distinction between the two groups suggested that forensic nurses focused on challenges concerning active engagement whilst non-forensic nurses focused on the challenges in attitudinal approach.

Table 3.2 Main strengths and skills in rank order.

Forensic nurses	Non-forensic nurses
Firm	Non-judgemental
Ability to set limits	Listening skills
Defining boundaries	Risk assessment
Assessing risk	Setting limits
Honesty	Teamwork
Confidence	Knowledge
Listening skills	Tolerance
Identifying patients' objectives	Patients Disarming manner
Relationship	Formulation
Assertiveness	Fairness

Table 3.3 Main weaknesses of nurses in rank order.

Forensic nurses	Non-forensic nurses
Inability to resolve conflict	Fear of aggression
Impatience	No skills to engage
Frustration	Stress
Lack of tenacity	Cynicism
Showing reactions	Apathy
Lack of understanding	Disengaged
Fear of aggression	Impatience
Fear of litigation	Lack of knowledge
Lack of confidence	Punitive

Table 3.4 Main skills and competencies required in rank order.

Forensic nurses	Non-forensic nurses
Non-threatening	Open-minded
Non-judgemental	Non-judgemental
Expect anything	Relationship formation
Do not over-react	Respect
Do not back them in a corner	Knowledge of patient behaviour
Negotiate limits	Set limits
Agree boundaries	Aware of manipulation
Watch for splitting	Firm but friendly
Establish agreed sanctions	Consistency
Team approach	Listening skills
Respect	Managing aggression
Humour	Communication

Table 3.5 Main attributes not required in rank order.

Forensic nurses	Non-forensic nurses
Over-reaction	Supercilious attitude
Judgemental	Cynicism
Over-confrontational	Judgemental
Staff win – Patient lose	Over-controlling
Bad attitude	Arrogance
Denigration	Disengagement
Backing them into a corner	Rigid personality
Narrow-mindedness	Punitive approach
Over-controlling	Immaturity
Poor risk management	Entrenched views

A further distinction between forensic and non-forensic nurses pertained to the forensic nurses prioritising the creation of robust boundaries (e.g. potential 'management approach') whilst non-forensic nurses focused on non-judgemental listening (e.g. potential 'clinical' approach'). Arguably, this could link to the previous discussion (above, under 'Inadequacy of Training') and may represent further evidence regarding the ideological differences between 'management' and 'clinical' approaches. However, both groups in Table 3 highlight the similar competencies needed to engage with PD patients (e.g. non-threatening and non-judgemental) and in Table 3.4 they both identified and inability to engage within their top three of 'main weaknesses'. The prioritising by Mental Health Nurses of 'establishing a therapeutic relationship' in this study, is consistent with Murphy and McVey's (2003) literature review, and is considered to be the bedrock for nursing personality disordered patients (Bowen and Mason, 2012). This study also supports James and Cowman's (2007) suggestion that preregistration nurse training is inadequate to prepare nurses for this area of work and that different training is required for forensic and non-forensic nurses.

3.2.2 Mental Health Nursing and the Therapeutic Relationship.

A key component of the nursing role is the establishment and maintenance of the therapeutic relationship/alliance with patients diagnosed with personality disorder. Consequently, this section will firstly, consider separately nurse and patient factors which may hinder the development of the therapeutic relationship, and secondly, the significance of how nurses can provide a containing space for patients to support the therapeutic relationship.

Patient Factors Which May Hinder the Therapeutic Relationship.

Within the tradition of the recovery literature, promoting relationships involves the provision of a 'true partnership working' with Mental Health Nurses (Slade 2009). However, this assumes that the creation of a trusting therapeutic relationship is possible in a forensic setting. Ruszczynski (2010) who has facilitated reflective practice and undertaken research within a variety of forensic settings suggests that the creation of a therapeutic alliance is fraught with difficulties due to the attacking and/or neglectful relationship that is manifested in the relationships with Mental Health Nurses. The physical and psychological attacks can often be interpreted as re-enactments of profound disruptions in childhood attachments that were subject to abuse, loss and neglect. These disruptions to secure childhood attachments significantly interfere with the development of an autonomous self which is considered to be key within the recovery model. These insecure attachments can result in dismissing relationships, twinned with a significant lack of understanding concerning the emotional needs of themselves and others, culminating in being less likely to obtain professional help and maintain treatment engagement (Aiyegbusi, 2004). An insecure attachment style can result in an unstable self-structure and reflective function reducing the ability to mentalise [5] and communicate psychological needs in adaptive and non-violent ways (Bateman and Fonagy, 2004). For example, the patient who explicitly expresses his desire to leave hospital but self-sabotages by testing positive for drugs could be

[5] Mentalization refers to your ability to recognize your own and others' mental states, and to see these mental states as separate from behavior. Mentalization includes being able to think about thoughts, emotions, wishes, desires, and needs in yourself and other people, and to see that these internal events may have an impact on the actions that you and others take, but are separate from those actions.

indirectly indicating his anxiety about the outside world and desire for containment.

The recovery approach[6] is further hindered due to the fact that it is likely that PD patients have lived in institutions for a significant part of their adult life leading to difficulties in terms of hope, related to being unable to see beyond illness and achieving a 'non patient identity' (Mann et al, 2014, p.125). For nurses to effectively use the recovery approach a shift the power balance needs to be undertaken as summarised by Repper and Perkins (2003) in which professionals need to be, "on-tap, not ontop". Achieving this balance is potentially problematic due to the nurses' dual roles of security and therapy and the patient who may imbue false abusive authoritarian attributes (related to past experiences) on nurses. Nurses influenced by treatment pessimism may struggle with Perkins (2006) recovery principle that the process of recovery is fuelled by 'hope' and that everyone should strive to be hopeful despite what may seem to be insurmountable practical problems. Furthermore, this can be compounded by long-term rehabilitation resulting in dependency on boundaries, structures and containment, with staff being cast in the role of the caregiver (often their first secure base). Mann et al. (2014) argue that the provision of a secure base whilst instilling a recovery focused notion of hope and personal control can have the potential for eliciting disengagement or destructive behaviour to restore a sense of safety.

[6] Recovery: A deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness.

Peternelj-Taylor and Johnson (1995, p.16) also suggest that ‘the relationships that are formed are dubious at best; offenders regard the professional as a friend and confidant when requests are approved, and as a member of the establishment or the system when requests are denied’. Being seen as part of the ‘system’ of detention is always going to be a difficult to overcome, but essential to avoid patients viewing nursing staff ‘as a dumping ground for their hostility’ (Peternelj-Taylor and Johnson,1995, p.16).

Winnicott (1949) argues that the needs of PD patients are so basic, so great, and so immediate, as to put staff in an intensely demanding position, similar in many ways to that of a parent with a new-born baby. Hence, this group of patients can sometimes be characterised, not only by neediness and vulnerability, but by hostility – particularly towards custodians and carers, who are likely to trigger associations with former figures from childhood. The combination is likely to produce hate and fear, among other feelings in the staff who are in close contact with these patients.

The adversarial nature of the criminal justice process can promote an authoritarian style of therapeutic interaction. In patients who spend long periods in secure settings it can be easy to recreate an authoritarian style of relationship via the process of transference (Felhouse, 1984). Evidenced by patients perceiving that a significant proportion of aggressive incidents are precipitated by interpersonal stressors between themselves and staff (Ellen et al., 2003).

Patients' Capacity to Think Reflectively about Themselves and Others.

Ideas from attachment theory have been used to develop understanding of the aetiology of violence, as well as the vicissitudes in the therapeutic relationship (Adshead, 2002; Bowlby, 1998; Fonagy et al., 1997). Individuals with a diagnosis of personality disorder who are also considered a risk to others have usually experienced inconsistent, neglectful, or abusive behaviour from primary attachment figures. According to the attachment model (Main et al., 1985), these experiences are internalised as a 'working model' of important relationships for the individual. They are likely to rely on models of frustrating, unavailable, or abusive carers, identifying to a greater or lesser extent with the adult position as they grow up. According to research by Troy and Sroufe (1987), they have suggested that children who bully or take up the role of victim in their play with others tend also to be avoidant in their style of relating, defensively minimising the significance of their relationships and finding it hard to ask directly for the love and attention they need (De Zulueta, 1996). In considering the possible lack of a moral sense in some offenders, Fonagy and colleagues postulated that the absence of a responsive and consistent relationship in early childhood thwarts the development of the capacity to think reflectively about oneself and other people (Fonagy et al., 1997).

The perception of emotional interactions in the environment significantly affects brain function, via the amygdala in the limbic circuit which controls and arousal (Philips, 2003). Confrontational relationships can be associated with very high levels of arousal and the re-experience of unpleasant emotions. These relationships can therefore reduce the patient's capacity for logical and sensible thinking and increase the risk of aggressive behaviour (Whittington and Wykes,

1996). In forensic populations there are also elevated levels of Post-Traumatic Stress Disorder (PTSD) (Timmermann et al., 2001), often related to histories of physical and sexual abuse. These traumatic experiences can be exacerbated, should nurses be required to use approved restraining techniques, providing the sense that the trauma is being re-enacted in the present.

Another potential means of misinterpretation of PD patients' needs could be demonstrated in the form of not equating challenging behaviour with their inability to seek help in other ways. Consequently, Gralton et al. (2006, p.26), in their discussion of the utility of a solution-focus model in inpatient secure settings, suggest that this model can be a useful strategy for preventing and managing malignant alienation (e.g. 'equating challenging behaviour with an inability to seek help in other ways') in patients diagnosed with personality disorder. Nevertheless, patients involved in this negative process may have longstanding problems in communicating their needs effectively, attempting instead to have their care needs met in less appropriate ways (e.g. self harm, illicit drug use (Watts and Morgan, 1994). This is reinforced further by Dale and Storey (2004) who also noted how nurses described the tendency of patients to bring with them high levels of emotional need and vulnerability following their past experiences of abuse and manipulation, exacerbated by previous dysfunctional relationships, resulting in predisposition to distort and misinterpret the behaviour and signals from other people.

What Do Patients Want from Nurses?

The lack of a theoretical underpinning to the nurse-patient relationship may appear antithetical to the therapeutic aspirations of patients who increasingly

ask for someone to talk to (Edginton, 1998). Earlier Ley (1988) reinforced this perspective following a literature review and found that the best patient satisfaction indicator on an adult psychiatric ward was satisfaction with nurse communication. Later Rickets (1996) similarly found that the level of satisfaction reported by patients discharged from an adult psychiatric ward was positively associated with nursing staff having time to talk, the availability of named nurses and their feeling sufficiently empowered to be part of the decision-making process.

Nurse Factors Which May Hinder the Therapeutic Relationship.

Given that clinical nursing staff have the longest contact time with patients who have the potential for violence, it is not surprising that Whittington and Wykes (1992) identified the existence of chronic stress in psychiatric nursing staff. In their study, living for long periods with the tension of anticipating violence produced an element of chronic fear. Arguably this tension/anxiety is more profound in forensic mental health services due to the risk related to sex-offending and homicide being intrinsically high. Menzies-Lyth (1960) has suggested that healthcare organisations hold substantial anxiety due to the management of risk, the countertransference of anxiety from patients and the type of defensive techniques that staff used to manage it. Potentially compounding this anxiety/fear could be a sense of powerlessness from junior staff and patients due to hierarchal decision-making (Slade, 2009).

Open communication and avoiding confrontation are key recommendations in relation to prevention of violence in inpatient settings (Royal College of Psychiatrists, 1998). This is still considered a competency requirement by both

forensic and non-forensic Mental Health Nurses to engage with PD patients (e.g. non-threatening, and non-judgemental). However, a high degree of interpersonal skill is required to manage aggressive behaviour (Crowhurst and Bowers, 2002). Unfortunately, a confrontational style of interaction in some forensic settings has been common (Kaye and Franey, 1998; Rask and Lavender, 2001). This has also been referred to as a 'management approach', serving the function of challenging, restricting, and thwarting disruptive and dysfunctional behaviours in patients with PD, thus providing a sense of containment at the expense of a reduced therapeutic optimism (Bowen and Mason, 2012).

Mental Health Nurses, especially those who work in in-patient settings, will often trigger associations with primary attachment figures or become emotionally significant to patients in their own right (Adshead, 1998). In forensic services this is enhanced by the power and control vested in the staff, evoking memories of authoritarian and withholding relationships in childhood.

However, Happell et al. (2003) have argued that the focus on equality of power within the recovery model can in the midst of uncertainty, feel disempowering for Mental Health Nurses, impacting upon their job satisfaction and subsequently fighting for a sense of their own existence and feeling of worth.

Peternelj-Taylor and Johnson (1995, p.16) suggested that therapeutic efficacy may well be related to issues of maintaining control of a population of patients who, by and large, merely wish to disrupt the hated system. They argue that, 'the orientation phase of the therapeutic relationship is frequently long and

tense with patients often perceiving nurses' sincerity and genuineness as qualities to be exploited'. This argument is supported by other researchers in this field (Hufft and Fawkes, 1994). Thus, the formation of a therapeutic relationship in secure psychiatric settings, whilst being a central importance, is fraught with difficulties.

Providing a Containing Space.

A containing space is suggested by Holmes (2001) who highlighted that a prime function of mental health services is to provide a secure base for patients, in an in-patient context. A secure base would represent a familiar person in a familiar place to whom the patient can turn at times of threat or illness, characterised by a combination of responsiveness and sensitivity with the capacity to set limits and help cope with separation.

Unfortunately the creation of the high secure personality disorder unit was undertaken at a time when many professionals considered personality disorder untreatable or at best difficult to treat, alongside many other factors described in Chapter One that potentially negatively influenced Mental Health Nurses' attitudes.

Consequently, organising the system to provide optimism is a simple yet important factor in the creation of a containing space. This view is supported by Kurtz's (2005) literature review of what works with people diagnosed with personality disorder, she concluded that it is important to inform staff about the contemporary state of knowledge in what was considered a new and difficult area. This is to serve as a valuable means to correct historical pessimistic views

about the possibility of achieving positive change with patients diagnosed with PD.

Setting limits or creating boundaries is often considered crucial in creating a containing space, particularly for people who may not have had this consistency developmentally. Dale and Storey (2004), when reporting on their research study on nurses' competency skills, expressed concern about the lack of recognition by nurses of the potential problems of boundary violations in their contact with patients, with some respondents feeling it was not within the role to manage boundary violations. Nevertheless, the vast majority could recognise the importance of monitoring, challenging and managing these boundaries within their role.

Nurses in Dale and Storey's (2004) study, identified different forms of boundary violation including boundary crossing, boundary violation and sexual misconduct, noting that this would occur within secure mental health services because of the complex nature of offending behaviours and the length of stay of the patients, resulting in a potential intensity within the relationships. To provide clarity between the distinction of boundary violations and crossings Gabbard and Myers (2008, p.114) defines,

> boundary crossings as happening when the normal boundaries are crossed in some way, which may be beneficial to the client. Violations are defined as always being harmful, or having the potential to cause harm.

'Splitting' is another potential means of breaching boundaries. Splitting is referred to when individuals or groups are intentionally affected positively or negatively to induce a consistent behaviour to enable the bending of rules or to create conflict (see 3.3.2 for origins of 'splitting'). Concern was expressed

regarding the seductive elements of splitting, due mainly to its covert nature, particularly difficult if this includes maintaining secrets on the basis of confidentiality. To demonstrate this 'splitting' process in a forensic setting Mann et al. (2014) describes the challenges of power-sharing within the 'recovery approach', in which staff may find it difficult to share power with people guilty of violent crimes. Mann et al. (2014, p. 128) added that,

> staff may struggle to accept that they are equal to their patients, as this would mean they need to acknowledge there is nothing distinctly different between them and people who have committed serious crimes, thereby forcing them to face the 'evil' in all of us. It is far easier for staff to create a divide between themselves and those that commit such crimes, splitting off the bad parts of themselves and projecting them onto the patients, thus maintaining a punitive power differential.

3.2.3 Utility of Mental Health Nurse Training.

James and Cowmann (2007) have reflected whether a skills deficit exists due to reports of negative attitudes of staff (Markham, (2003) and reports of poor service experience by PD patients (NIHME, 2003b). This was responded to in the UK by the provision of skills and competencies in the form of the Personality Disorder Capability Framework (NIHME, 2004) and by the National Institute of Clinical Excellence (NICE) guidelines for working with antisocial (2009a) and borderline (2009b) personality disorders which also provided advice for the development of staff.

When exploring these skills and competencies, Ramritu and Barnard (2001, p.49) identify one competency definition as, 'possession of knowledge, skills, attitudes and the ability to perform to a prescribed standard. Yet there is no reference to competencies and skills required for working with patients diagnosed with personality disorder in the Standards for Pre-registration Nurse Education

(NMC, 2010). However, in table 3.1 below the NMC Standards do require specific competence for Mental Health Nurses in the following areas for non-specific diagnostic groups:

Table 3.1 Extracts of Standards of Competence for Pre-registration Nurse Education (NMC, 2010).

They must also engage in reflection and supervision to explore the emotional impact on self of working in mental health; how personal values, beliefs and emotions impact on practice, and how their own practice alliance with mental health legislation, policy and value-based frameworks.
Use skills of relationship-building and can occasion to engage with and support of people distressed by hearing voices, experiencing distressing thoughts or experiences other perceptual problems.
Use skills and knowledge to facilitate therapeutic groups with people experiencing mental health problems and their families and carers.
Be sensitive to, and take account of, the impact of abuse and trauma on people's well-being and the development of mental health problems. They must use interpersonal skills and make interventions that help people disclose and discuss their experiences as part of their recovery.
Use their personal qualities, experiences and interpersonal skills to develop and maintain therapeutic, recovery-focused relationships with people and therapeutic groups. They must be aware of their own mental health, and know when to share aspects of their own life to inspire hope when maintaining professional boundaries.
To be able to apply their knowledge and skills in a range of evidence-based individual and group psychological and psychosocial interventions, to carry out systematic needs assessments, develop case formulations and negotiate goals.
To be able to apply their knowledge and skills in a range of evidence-based psychological and psychosocial individual and group interventions to develop and implement care plans and evaluate outcomes, in partnership with service users and others.
Use recovery-focused approaches to occur in situations that are potentially challenging, such as times of acute distress; when compulsory measures are used; and in forensic mental health settings. They must seek to maximise service user involvement and therapeutic engagement, using interventions that balance the need for safety and positive risk-taking.

Despite the above competencies for preregistration nursing, James and Cowmann (2007) argue that training is inadequate to prepare nurses for work in this area in relation to personality disordered patients.

Holmes (2002: p. 384), states that, 'hostility and withdrawal on the part of staff often accompany a sense of being deskilled and unable to cope. Training in psychological therapy can help overcome this'. He suggested that three key skills are vital. Firstly, the capacity to build a therapeutic alliance with patients

and their relatives. Secondly, self-awareness and reflective practice should be developed, both at the level of the individual practitioner and in the staff team as a whole, thereby lowering expressed emotion and the likelihood of malignant alienation. Thirdly, specific skills are needed in the management of personality disorder. In addition, regular supervision and staff support were thought to be crucial ingredients in improving the quality of psychological care on acute wards.

In response to the revised draft Mental Health Bill (Department of Health, 2004a, 2004b) some welcomed the planned opportunity to increase clinical and academic resources for this patient group. The services for those with a personality disorder diagnosis were characterised by a report on the Personality Disorder Network as extremely limited, as well as uneven in type, quality, and distribution (National Institute for Mental Health in England, 2003). There is widespread acknowledgement that more research is needed on the effectiveness of psychosocial interventions for people with a diagnosis of personality disorder who present a risk to others, and on what education and support should be given to the staff who care for them (Grubin and Duggan, 1998).

Nevertheless, teaching about what treatments work for these individuals is likely to be a valuable corrective to prevailing therapeutic pessimism about intervening effectively with those with a diagnosis of personality disorder (Bowers et al., 2000). This position is supported further by Gallop et al (1989), Mason et al (2009) and Bowen and Mason (2012) who make the distinction between ‘clinical’ and ‘management’ with regard to nursing approaches. They

considered that the clinical nursing application towards resolving a dysfunctional psychological interaction is rooted in therapeutic optimism. Consequently they equated the notion that their optimism is based in the ideological belief that their contribution, mediated through a positive interactive style, would provide the best opportunity for change, growth and development. The nursing 'management' is considered less therapeutically optimistic because it focuses on containment, in which challenging, of dysfunctional and disruptive behaviours are undertaken alongside restricting and thwarting. This ideology is based on the understanding/belief that by not allowing PD behaviour, it prevents the risk of harm to others which is considered a positive endeavour (Ganong et al., 1987).

With regard to staff attitudes, training should be provided on debates surrounding the concept of personality disorder and psychopathy, and the impact of labelling (Blackburn, 2000b). Education of nurses about borderline personality disorder for example has been noted to increase nurses' understanding of the dynamics of the disorder and tolerance for their patients (Miller and Davenport, 1996). Bowers et al. (2000) provides empirical evidence regarding the nursing of PD patients, in which he identifies five dichotomous components to affective elements of nursing attitudes which comprised of (1) enjoyment/loathing (2) security/vulnerability, (3) acceptance/rejection, (4) purpose/futility, and (5) enthusiasm/exhaustion.This report continues the historical theme of general pessimism, in that nurses found it difficult to endorse the positive effect of statements about PD patients, with only one in five nurses expressing optimism regarding the treatment of PD patients.

It is also argued that related training, support and guidance for staff who come from a range of disciplines have not been readily available. Duff (2003), promotes the need for induction programmes with core ingredients which could be supported by a case study approach. She also reported finding the programme useful for staff groups to enable the identification and resolution of issues arising from working alongside people diagnosed with personality disorder (Duff and Meredith, 2001). Within the above approach nurses should focus on developing an understanding of the functional link between personality disorder and the risk patients pose to themselves and others, to help facilitate a safe and therapeutic environment. In addition, she postulated that interventions should be based upon a formulation of the causes for each individual patient's difficulties, and that staff would need substantial resources to enable them to undertake such detailed and thorough assessments. The use of a formulation not only assists in the construction of a care and treatment pathway, but also enables a consistent, sensitive, and considered approach to meeting the needs of a PD patient. This would also demonstrate the NMC (2010) competency requirement identified in point 6 in table 3.1, in which there is expectation of needs being assessed with case formulation and negotiated goals being developed, thus providing clarity of understanding to enhance the therapeutic alliance.

Mental Health Nursing's failure to address, the perceived inadequacies of the Registered Mental Nurses (RMN) and Registered Nurses for Mental Handicap syllabi to skill a nursing workforce to cater for mentally disordered offenders was clearly a major concern in the 1990s (Dale et al., 1995). Furthermore, McCabe (2002) argued that psychiatric nursing was in a precarious position of utilising

an ageing paradigm of practice and suggested a beginning point for the development of a new paradigm, which should embrace contemporary understanding. She states that, 'the giants of our profession such as Peplau (1952), Mellow (1968, 1986), and Lego (1992, 1999), used their knowledge and understanding of their time, together with their vision that was their genius, and inculcated the interpersonal nurse-patient relationship as the central paradigm for psychiatric nursing. Unfortunately, in terms of specific training based on contemporary evidence to meet the needs of personality disorder for nurses the situation does not seem to have changed since the NMC (2010) evidence.

McCabe (2002) suggested that psychoanalytical, developmental theories coexist with neurobiological theories with no clear connection between them, with both leading to distinctly different nursing care practices. This incompatibility she claimed had led to uncertainty about the credentials required for advance practice and which was most reflective of 'true' psychiatric nursing. McCabe (2002) added that the oldest and most embedded knowledge structure pertained to psychosocial knowledge. The psychosocial knowledge structure was believed to be rooted in psychological, developmental theory, was humanistically orientated, and infused the nursing profession with one-to-one nurse-patient relationship as the core of nursing identity and function. The second knowledge structure was believed to pertain to the body of neurobiological knowledge. She proposed a new paradigm in which the interpersonal relationship was not the totality of what the psychiatric nurses do but was the context within which they worked. Arguably, McCabe's evidence is still pertinent today due to a paucity of recent NMC changes specifically with

regard to personality disorder. The following reasoning was provided to demonstrate the need for change (McCabe, 2002, p.59).

> We now understand much of the frontal lobe dysfunction that occurs with schizophrenia for example. We now need to develop interventions that reflect that understanding, reflect the capacity and limitations of individuals with these disorders. We would not ask a paraplegic patient to stand and walk into our clinics because we understand the physiologic deficit of that disorder. In a similar fashion, we need not ask schizophrenic patients to perform executive or cognitive functions which are impossible within their psychological deficit.

McCabe's (2002), understanding of the relational aspects of psychiatric nursing which was often embedded in psychodynamic knowledge should demonstrate its links to neurobiological knowledge concerning people diagnosed with personality disorder through the medium of attachment theory.

Despite difficulties surrounding the notion of personality disorder and Mental Health Nurses contemporary skill base, in psychiatry Mental Health Nurses still form the largest professional discipline providing care on an everyday basis for sustained periods. Nurses therefore are in a pivotal position to establish valued 'therapeutic relationships' (Whittington and McLaughlin 2000, p. 261) from within which they have the potential to use a powerful therapeutic resource.

Historically empirical evidence, suggested that in practice this potential was being greatly under used resulting in a disproportionate amount of nursing time being taken up by administration (Robinson, 1996 a, b) and time spent talking to patients being minimal (Martin, 1992; Gijbel, 1995; Tyson et al., 1995; Robinson, 1996a,b; Whittington and McLaughlin, 2000); and when interactions did occur they were neither purposely therapeutic nor theoretically informed (Robinson 1996a,b, Sullivan, 1998, Whittington and McLaughlin, 2000).

Although, this suggested a marked discrepancy between nursing theory and nursing practice – expectation and reality, it lead Sullivan (1998, p.42) to conclude that there was no 'well-developed concept of nurse-patient interactions based on sound theory'

In contrast with the past, the contemporary recovery approach has been gradually achieving prominence as a guiding principle for mental health services (Department of Health, 2001). Although to date there does not appear to be any significant evidence of its utility specifically with PD patients within high and medium forensic settings. Despite the NMC Preregistration Competency standard (2010) which states that Mental Health Nurses should,

> Use recovery-focused approaches to occur in situations that are potentially challenging, such as times of acute distress; when compulsory measures are used; and in forensic mental health settings. They must seek to maximise service user involvement and therapeutic engagement, using interventions that balance the need for safety and positive risk-taking.

The recovery approach provides a departure from the medical model of pathology, illness and symptoms towards health, strengths and wellness, enshrined with social inclusion. Recovery is defined by Anthony (1993) as

> …'a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness.'

Andresen et al's five stage recovery model focusing on moratorium, awareness, preparation, rebuilding and growth (Andresen, 2003) is similar to the Recovery Star's five stages of stuckness, accepting help, believing, learning, and self-reliance (MacKeith and Burns, 2010), of which the latter has been adapted and is being piloted in 2014/15 within the high secure hospital concerned with my

study . This may present with unique challenges in attempting to utilise and individual/humanistic ethos. For example forensic patients who are detained have real limits imposed upon the capacity for choice and autonomy, alongside their length of stay can result in an erosion of independence and hope. Mezey et al. (2010) using a qualitative approach discovered that the recovery concept pertaining to autonomy, self-acceptance and hope generally appears to be less meaningful for individuals in a medium secure unit. The under elaborated research for forensic patients utilising a 'recovery' approach remains unclear and arguably could be fraught with many difficult challenges (Mann et al., 2014).

In summary, there is considerable uncertainty about the nurse-patient relationship but it remains clear that Mental Health Nursing is mainly defined through the therapeutic relationship and personality disorder is mainly understood in terms of patterns of relationship difficulties, the former point is underlined by Gallop et al. (2003, p. 213), who has stated that,

> Psychiatric/mental health nursing asserts that the therapeutic relationship is central to psychiatric and mental health nursing practice. This relationship is founded upon understandings of the therapeutic use of self, principles of empathy, respect, and attentions to subjective experience of the other.

This relationship is understood as an interpersonal process in which the nurse brings an awareness and understanding of self and the client brings their self-knowledge (Geonellos, 1995; Heifer, 1993; O'Brien, 2000.). Although nurses may also be trained in other therapeutic modalities, evidence suggests that success in a specific modality is dependent upon the relationship and the modality (Burns and Auerbach, 1996; Wright and Davis, 1994; Repper et al. 1994). It has been contended that even Peplau's theory (Peplau, 1952) of interpersonal relationships in nursing is,

> …insufficient for helping the nurse acknowledge the complexity of the human condition, navigate the relationship, and understand how the nurse's own history and interpersonal style influence the relationship (Gallop et al., 2003, p. 214).

Despite the confused picture pertaining to the nurse-patient relationship, optimism should exist in terms of the potential for training, the improving evidence base in terms of transferable skills in relation to assessment and interventions. In addition, the importance of training in relation to negative attitudes and labelling and its impact on the relationship which will be focused upon in the next section.

3.2.4 Mental Health Nurses Negative Attitudes.

Many factors can influence the nurse-patient relationship including the previously discussed society (in the guise of legislation, public, media), inconsistencies in the nursing role, training or generic assessments and treatment. However, the impact of negative attitudes born out of pejorative labels, defensive strategies against perceived threat can severely undermine the foundations of any therapeutic relationship and will be explored in this section.

The interface of understanding between society and service delivery prompted Lavender (2002), to suggest that society's characterisation of attitudes towards people with a diagnosis of personality disorder who are considered a risk to others as conflicted – unsure of whether it wants to treat, punish, or simply to lock away. Lack of certainty about the task of services in dealing with these individuals is demonstrated by the range of terms used to describe them: they are referred to by turns as patients, offenders, or offender-patients, and the

derogatory term ‘dangerous and severely personality disordered’ or ‘D.S.P.D.’ (Home Office, 1999) remains in currency despite the controversy surrounding it (Blackburn, 2000b; Castillo, 2003). Duff (2003), suggests that increase in the public profile of people diagnosed with personality disorder can result from media-led public anxiety, and professional recognition of the need to reduce associated risks, client distress, and the inefficient use of resources.

The term borderline personality disorder has been described as ‘frequently used within the mental health professions as little more than a sophisticated insult’ (Herman, 1992, p.116) and as a ‘pejorative diagnosis that generates a negative and perhaps stereotypical response’ (Fraser and Gallop, 1993, p. 338). A study of nurses’ attitudes to patients with borderline personality disorder revealed that they were more likely to respond with belittling remarks, lack empathy and to provide less care (Gallop et al., 1989). This type of response has been identified as the least effective limit setting style and the one most likely to proceed angry, impulsive or violent outbursts in patients Lancee et al. (1995).

In addition, many people who injure themselves in psychiatric settings who are often diagnosed with personality disorder are often labelled as 'manipulative' or 'attention seeking' (Clarke and Whitaker, 1998. p. 130). As a defence mechanism, this serves to make nurses feel better about themselves, locating the source of difficulty with clients rather than looking at their own knowledge, attitudes or beliefs.

There are well argued problems with the concept of personality disorder, which are relevant to a consideration of the needs of staff. Research suggests that

the problematic behaviours that characterise the disorder are best understood as extremes on certain key dimensions of personality that are common to everybody (Blackburn, 2000a; Eysenck, 1998). But the widely used terms 'personality disorder' and 'PD' communicate a categorical theory of personality, in which disorder exists as a discreet unstable entity within an individual and normal and abnormal personality are seen as separate. This is likely to influence the way in which staff view patients, contributing to widespread pessimism about the possibility of therapeutic change, and increasing the difficulty of establishing points of connection and developing empathetic relationships with patients. It is believed that such terms medicalise what is really a social problem between people, thus obscuring the nature of difficulties and the best ways of addressing them (Kendell, 2002; Koerner et al., 1996). The consistent use of these labels can create a distance between staff and patients. Consequently, it is important to provide training sessions for staff in which the concept of personality disorder and attitudes towards it are subject to critical discussion. It may also be useful to address the issue of the impact of psychiatric diagnosis and labelling on patients and public attitudes with staff to prevent the unthinking use of powerful and value laden terms as argued by several authors (Angermeyer and Matschinger, 2003; Angermeyer, et al., 2004; Hayne, 2003).

3.2.5 PD Effect on Nurses

Nurses have the longest contact time with patients but they also had little respite from the 'contamination' of negative feelings in forensic settings (HMSO, 1992). Kent-Wilkinson (1996, p.25) reported the existence of negative views: 'in cases where the criminal offense is horrific some professionals believe that

respect for the offender is not deserved and that change and growth will never happen'.

Kent-Wilkinson (1996) also argued that maintaining positive views was always difficult, but central to the development of the forensic nursing profession. Unfortunately, positive views are often expressed in relation to the extent to which forensic psychiatric nurses' feel that they are in control of particular situations (Mason and Chandley, 1998). Although control can have both negative and positive connotations in general spheres of life, in terms of forensic psychiatric cultures there is often a tension noted between control and liberation (HMSO, 1999).

As noted above, people who self-injure may often be diagnosed by mental health care professionals as having a personality disorder, or more specifically a borderline personality disorder. Hence, Connors (2000) discussed in the often-negative effects of self-injury has on a therapists' emotional equilibrium. These can include fear, anger, helplessness and feeling a failure. It is for these reasons that responses, thoughts and feelings of those in contact with people who self-injure need to be explored.

3.2.6 Nurses' Defences.

It may be that 'one way to survive in the chaos and mental pain that are very raw materials of mental health work is to batten down the hatches and to retreat into a defensive world of cynicism and mild paranoia, in which exploration of feelings is considered to be destructive and dangerous when it happens' (Holmes, 2002, p.383). Such defensiveness explains the experience of

psychotherapists or reflective practice facilitators being seen as, ‘at best, woolly-minded idealists who have no idea about the reality of acute psychiatric work and, at worst, as sinister agents who are bent on disabling staff by laying bare their weaknesses to be exploited by managers and colleagues’ (Holmes, 2002, p. 383).

> ‘The consequent lack of continuity and commitment means that custodial rather than therapeutic values prevail’.

Another defence process is that of staff splitting which has been recognised as a dynamic during which staff tend to polarise into those who believe that the patient is manipulative, needs more structure or even punishment to prevent acting out behaviour and others who feel that the patient is in need of understanding and empathy, better support and more attention (Kaplan, 1986). Staff responses can be experienced as fear, hostility and rigid controlling interventions, or over protectiveness and tolerance beyond reasonable limits.

Other descriptors which are associated with prefiguring nurses’ derogatory responses to people diagnosed with borderline personality disorder include ‘manipulative’. This often pertains to descriptions of patients’ behaviour when they attempt to control others to have their needs met or control the level of intimacy in a relationship.

In response to perceived ‘manipulation’ nurses may respond in various ways: (1) nurses may feel flattered by the pseudo-intimacy, mistaking it for a therapeutic alliance whilst simultaneously losing a sense of objectivity about the patient; (2) they may distance themselves or judge behaviour pejoratively to ensure that they are not manipulated, resulting in failing to respond

empathetically and avoid opportunities for therapeutic contact; (3) nurses can refuse all requests made by the patient for fear of being manipulated and give in to all requests for fear of confrontation (Chitty and Maynard, 1986). Anecdotally, this avoidance behaviour can sometimes be acknowledged by nursing staff, often in the form of reluctance to engage.

These responses can engender various feelings, particularly exacerbated when the patient may self-harm, resulting in anger and frustration due to a sense of having failed to maintain safety of the patient, raising feelings of professional incompetency (Benham, 1995; Crowe, 1996).

3.3 Nurse/Patient Relationship: Processing Awareness.

The previous sections have highlighted various influences that can exacerbate nurse-patient relationship difficulties, and the profound impact this may have on the nurse and the therapeutic relationship. Consequently, this section will briefly highlight relationship problems (3.3.1), prior to focusing on the crucial components of processing the issues that can arise. Processing relationship difficulties will initially be explored through the commonly used terms/tools in personality disorder practice (particularly psychodynamically informed environments) specifically to prompt recognition and interpretation of splitting, projection, transference and countertransference. The chapter will conclude by focusing on reflective processes and clinical supervision.

3.3.1 Potential Problems.

> ‘The expectation in many societies is that when people are ill they should seek professional help and adhere to the advice received. In health care

> the ‘difficult’ clients are often the ones who do not follow these rules. Self-injury challenges the established rules because the individual deliberately inflicts 'sickness' on the self.’ (Rayner etal, 2005, p.13).

There is often no more an extreme presentation as that of the person undertaking self-injurious behaviour, a behaviour that often characteristic of patients diagnosed with borderline personality disorder (Rayner etal, 2005). However, the unhelpful reactions of helpers as a result of their lack of understanding of those who self-harm have been challenged and extensively documented, particularly by people whom have used health care services following self-injury (Pembroke, 1996). These often extreme reactions may limit the helpers’ ability to maintain a therapeutic relationship and prevent any further aid being given (Connors, 2000). Also, too often rejection of the person occurs, which may reinforce their feelings of lack of self-worth and negative self-beliefs.

This contravention of the norms of the health service culture can result in professionals feeling helpless, due to their inability to offer a remedy. This can also challenge their views of autonomy, competence and role (Fincham and Emery, 1998). Indeed,' good patients' confirm the role of the nurse, whilst 'bad patients' challenge it (Kelly and May, 1982).

The arousal of feelings in the therapist during patient interactions is supported by Herron and Rouskin (1982), who state that the process of therapy 'is an intense, often disturbing mixture of the therapists’ emotional and interpersonal responses to their patients' (Herron and Rouskin.,1982, p.85). The processing of crucial emotions is often neglected for a variety of reasons with staff often

urgently trying to problem-solve at a cognitive level in the face of perceived crisis, thus missing one the most important clues to their behaviour. Delaney and Ferguson (2014) conceptualised the importance of this processing of the relationship with self and others which they describe from an interpersonal neuroscience perspective which they believe is key in integrating adaptive thinking/feeling/remembering and, if processed effectively, can support the individual towards a healthy mind and meaningful life. When powerful feelings, thoughts, behaviours are aroused in a nurse-patient relationship, which may appear alien to themselves, it could be interpreted as transference and the acting upon these experiences is referred to as countertransference. Both of these potential terms/experiences are important to recognise and process and will be explored further under 3.3.2.

Potentially the transference-countertransference exchanges can become intense, powerful and traumatic. Therefore, Mental Health Nurses may lose track of reality within the rational, objective logic of the clinical setting (McCann and Pearlman 1990). Interestingly, it is often only when the nurse has become enmeshed in complex interpersonal dynamics that with the benefit of hindsight through supervision and/or peer support, they are able to consciously, objectively untangle their countertransference responses to prevent acting on them (Kudler et al., 2000). Donna et al. (2004), found it helpful when addressing their countertransference was to have process meetings with the members of the treatment team in order to share their experiences.

3.3.2 Theoretical Understanding of Relationship Dynamics.

Various theoretical constructs use the following terms to explain further the relationship difficulties that might occur when working with patients diagnosed with personality disorder: e.g. splitting, projective identification, counter-transference.

Splitting is often referred to as a psychological defence characterised by a polarisation of good and bad feelings, of love and hate, of attachment and rejection keeping contradictory intrapsychic aspects apart (Gabbard and Wilkinson, 2000). This interpersonal process clearly works to protect a client from anxiety, but often leads to turmoil and confused reactions from nurses. Splitting can be exemplified when a client who self-injures builds a positive relationship with a nurse on a ward. They may begin to idealise the nurse and invest them with strength, love and power. The nurse then finds it hard to resist these feelings. Indeed, most people like to believe that they are good carers and 'special'. Eventually, the staff member betrays the idealised image by behaving in a way that is 'merely human' and the client feels let down. The client may then turn on the nurse and 'attack' (usually emotionally). This can result in the nurse feeling demeaned, humiliated, attacked and a failure.

Projective identification was first introduced by Klein (1946) to describe a defence mechanism that operates in early life and was understood as an activity of pressing unwanted feelings, sensations and associated parts of the self on to an external object (Richards, 2000). Ogden (1992), views projective identification as a process in which the therapist actually becomes involved in the client's 'inner world'. The client's projected material is internalised and fully

experienced by the therapist, who may find it hard to differentiate between feelings that may be projected from the client and emotions linked to their own life experiences. Projective identification can be exemplified by the following relationship vignette between a patient and nurse:

> Over a period of time a nurse and patient had built up a good relationship but after a good session the patient began to feel very close to the nurse, she cuts herself and presented this to the nurse. This resulted in the nurse feeling rejected, a failure and 'not good enough'. The nurse may feel that all their work had been wasted, which paralleled the emotional reaction by the patient regarding the loss of her home whilst in hospital, but had been unable to communicate this verbally as the emotions had been too intense. This could then reinforce the patient's negative belief system, such as: 'I am worthless and a failure' and 'Everyone leaves me in the end'
>
> 'Essentially, projective identification can be understood as a means of coping with negative emotions, and can increase empathy and communication about feelings and self-injury' (Rayner et al. 2005: p. 15).

Transference put simply, 'pertains to the transference of attitudes, emotions and relational-behavioural patterns that belong to a previously significant relationship experience (often the maternal-paternal dyad), onto here-and-now present relationships'. In this sense 'transferential' material provide the metaphorical building blocks for dynamic interpersonal re-enactments of previous significant interpersonal experiences, and the treatment setting or 'therapeutic relationship' is the backdrop onto which these interpersonal experiences are transferred and played out'. (Cameron et al. 2005: 66)

Countertransference reactions pertain to the attitudes, emotions and behavioural-relational patterns that are evoked in the significant other – that is,

in this instance the Mental Health Nurse (Cameron, et al. 2005, p.66) and described in a vignette below.

> ‘Mr. J, a 38-year-old male, was referred for substance abuse. He also had a narcissistic personality disorder. In the initial stage of treatment, he began to talk to me about his recent inpatient drug rehabilitation experience. He boasted that within a week of being in the hospital, he had become somewhat of a self-appointed guru in drug rehabilitation. He was giving other patients advice about how to manage their addiction and depression, and he even had some staff members beginning to listen to him. As he was telling me this, going “on and on” about it, I felt myself bored and distracted, and yet pulled into a mirroring trance like I was interested, listening attentively, and even felt pressure to provide a smiling nod. The session ended with me feeling my interaction with Mr. J was more “false” on my part than helpful or real. The next session he came back angry and disappointed. When I asked him why, he said he was disappointed in me because he had fooled me. He had taken my ostensible smile as evidence that he was smarter than I am and that I couldn’t see through his facade, just like he had fooled the patients at the drug rehabilitation centre. If he was smarter, how could I help him. I had fallen from being a hero to a zero with that one smile, which caused a massive narcissistic injury. Mr. J then talked about how this facade was a cover-up for his profound sense of being defective to the core. He was describing his abandonment depression and how drinking excessively served as a way of numbing out his interior sense of being inadequate and allowed him to inflate his grandiosity.
>
> As I began to acknowledge his inner pain, the impaired real self (Masterson, 1993), he stated, “When I get people to admire my performance, it’s like cotton candy — sweet but empty, versus when my real pain gets acknowledged, it’s like broccoli — it nourishes my body.” This is an example of how my countertransference eventually helped to reveal how active his false narcissistic self was as a cover-up for his impaired real self’.

These countertransference responses can reflect either as unresolved personal conflict or ‘blind spots’ that belong to the nurse These blind spots and clinical nuances provide a possible window of opportunity from which to view and understand the dominant state of mind of the patient (Jackson and Williams, 1994; Garelick and Lucas, 1998; O’Kelly, 1998; Von Klitzing, 1998).

Processing Countertransference Reactions

In relation to borderline personality disorder patients who self-harm, Gabbard and Wilkinson (2000) listed the common countertransference reactions as guilt (i.e. feeling not 'good enough'), rescue fantasies, transgression of professional boundaries, and rage and hatred, helplessness and worthlessness and anxiety and terror.

Nurses may feel guilty about experiencing strong feelings about the patient resulting in either withdrawal or over-involvement. Rescue fantasies can result in nurses attempting to rescue (i.e. mothering) the patient rather than empowering them as adults. With regard to the transgression of professional boundaries nurses may find it difficult to say 'no' for fear of how the client will react. Thus, a fine balancing act occurs between client-centred care and protection of nurses' boundaries.

Nevertheless, it is important to recognise that the nurses' countertransference can be valuable in understanding the emotional intensity of the PD patient's internal world. Specific emotions may occur in different members of the team, for example, one may feel anger, and helplessness. Conversely, the Mental Health Nurse needs to monitor and recognise the processing of the therapeutic relationship from a self-perspective, which, according to Kohut (1984), suggests that the therapeutic effect is mediated through the patient's experience of transmuting internalisation, whereby the patient internalises the therapist's self-object functions for his own use. In schema therapy this could be termed from a positive perspective 'reparenting' or from a psychodynamic perspective 'internalising the good object'.

In summary, much of the literature suggests that it is crucial to have an awareness of the potential relationships that can exist when working with men diagnosed with personality disorder, and an awareness of one's own relationship dynamics, to enable a clear processing of the relationship, culminating in a formulation and a sensitive/reflective approach to the therapeutic relationship.

The ability to process experiences in a non-pathological way is contingent upon the capacity for 'emotional containment', which comes from being able to think and to reflect rather than react in the face of distress (Bion 1957, 1962, Ogden 1992). This capacity evolves developmentally from birth and is crucially dependent on the presence of a consistent, responsive and thoughtful maternal figure, who, in the course of normal 'healthy' development, provides a 'containing' experience that is gradually internalised by the infant (Ogden, 1992). When this experience of emotional containment is either absent, interrupted or obliterated by early traumatic experiences, this capacity to reflect and think about or psychologically process distressing feelings is severely impaired (Fonagy and Target, 1995). This can result in these unbearable feelings being then projected upon others. This in turn can result in the Mental Health Nurse being exposed to unrelenting negative projections, culminating in pressure to react or respond by seeking premature methods to eliminate these behaviours.

In contrast, psychodynamically informed Mental Health Nurses who maintain a thoughtful and reflective therapeutic stance will be less likely to either collapse

or retaliate (Glass et al., 1989; Jackson, 1992, 2001; Jackson and Williams, 1994; Moore, 1998; Van Humbeek et al., 2001). In light of Bowen and Mason's (2012) study regarding the evaluation of skills and competencies in the face of complex challenges in their relationship with PD patients, more training is required. Based upon Bowen and Mason's 2012 study, forensic nurses require an improved ability to provide reflection in action involving negotiation and bargaining skills, whilst non-forensic nurses appear to require skills for providing talking-orientated change. One suggested option was the utilisation of Hinshelwood's (2001) model which utilises a model of action and reflection as a driver for psychological change to enable a fuller integration into a psychologically minded approach to clinical work. This requirement is also made implicit in the NMC Preregistration Competency Standards for Mental Health Nurses (2010) which states that,

> they must also engage in reflection and supervision to explore the emotional impact on self of working in mental health; how personal values, beliefs and emotions impact on practice, and how their own practice aligns with mental health legislation, policy and value-based frameworks (p.23).

3.4 Mental Health Nursing and Reflective Processes.

This chapter has served to highlight the many difficulties associated with working with patients diagnosed with PD, specifically associated with relationship difficulties. Consequently, in this section I will begin to explore how Mental Health Nurses can start to develop methods to safely understand and challenge these relationship dynamics.

The early recognition that a relationship difficulty exists is obviously important to enable early interventions to prevent any exacerbation of the difficulty and thus

support the therapeutic alliance. One of the main types of recognition pertains to countertransference in nurses which has led to a reported improvement in client care (Winship, 1995), enrichment of nursing knowledge (Thompson, 1990), and a sense of professional growth (Hallberg et al., 1994).

Casement (1991) introduced the notion of the 'communication by impact' which he exemplified in the way that a patient will communicate unacknowledged and painful feelings unconsciously to a therapist. This is expanded upon by Aiyegbusi (2004) who explained that projective identification or 'making the others suffer', when a patient causes the therapist to experience something painful, such as rage or abandonment, on their behalf, in an unconscious quest for understanding. Another form is discussed by Casement (1991) and Davies (1996) in their description of 'actualization' when a patient unknowingly brings about a re-enactment of a damaging or abusive aspect of a formative relationship. Consequently, it is important to work on understanding the complex unconscious communication patients' display. In particular, the way in which PD patients interact based on their individual formulation of their personality style, life experiences and how these experiences are interpreted by nurses. In the absence of this informed approach Aiyegbusi (2004) explains that it can create a 'toxic environment,' characterised by conflict and the repetition by staff and patients of their traumatic past relationships, which needs to be avoided. Furthermore, empirical research supports the theoretical literature, which underlines the importance of understanding the dynamics within therapeutic relationships with these individuals in order to prevent destructive re-enactments from occurring (Cox, 1996).

Considerable clarity can be achieved when using an integrated perspective within an object relations framework when attempting to understand how intrapsychic defences have developed in the context of interpersonal and often traumatic early experiences (Kudler et al., 2000). Consequently utilising this approach Mental Health Nurses can provide valuable insight into how shattered personal assumptions about self, others and the world can lead to psychopathology, emotional and relational difficulties (Casey and Long, 2002; Mueser et al. 2002). So, nurses can benefit by early recognition of what is being manifested by PD patients and equally by understanding their own 'self.' they can begin to discern whose relationship dynamic is being re-enacted through transference and countertransference responses. This potential early assessment and identification of a relationship difficulty has prompted Young (1999), Beck and Freeman (1990) and Davidson (2000) to recommend discussing the therapeutic relationship when events trigger a negative schema or belief. Indeed, ignoring the therapeutic relationship when working with people who may self-injure may lead to people being deemed 'untreatable' by professionals.

Searching for meaning are the central tenets of psychodynamic theory and Barker's Tidal Model of Mental Health Nursing (Barker, 2003) which have become important in mediating and/or maintaining factors that have obvious implications for accurate diagnosis and effective treatment interventions (Read et al., 2004). Rather than creating diagnostic categories (PTSD, schizophrenia, borderline personality disorder, etc.), Read and Ross (2003), and Read et al. (2004) suggest it may be more helpful and accurate to reframe the abuse-related symptoms of these 'disorders,' preferring to consider them to be lifelong

processes initiated as adaptive responses to early adverse circumstances. Subsequently they have evolved into a range of maladaptive interacting disturbances in multiple personal and interpersonal domains.

3.4.1 The Importance of Reflective Processes.

Caring for patients with personality disorders results in tension, exhaustion, burnout and high staff turnover (Piccinino, 1990; Bland and Rossen, 2005). Patient suicide and assaults by patients on staff has been associated with staff suffering from loss of self-esteem, loss of trust in themselves and their colleagues and loss of the perceived control of the milieu (Cooper, 1995; Mann et al., 2014)

Hartman (1995) reported that studies focusing on clinicians working with victims of violence in a range of settings suffered from reactions involving autonomic arousal sleep disturbance, agitation and inattention. Various emotional responses that were difficult to contain included rage and despair, depression and hostility (Hartman, 1995). Psychological reactions included intellectualisation, rationalisation, and over-identification with the patient, projection, interjection and denial. Hartman (1995) reviewed and reported that behavioural responses included: forgetting appointments with the patient, numbing, loss of professional boundaries and increased use of drugs and alcohol. Clinicians also became preoccupied with the patient, had dreams about the patient and flashbacks of the patient's traumatisation (Hartman, 1995). Hence, nurses who work with victims of traumatisation, such as those diagnosed with borderline personality disorder, may be at risk of being similarly damaged by the experience.

Crothers (1995) goes further by describing trauma as contagious (vicarious traumatisation or traumatic countertransference) particularly when working closely with patients who have suffered abuse, resulting in the same terror, rage and despair as the patient. Nurses in comparison with other disciplines may find the situation compounded by virtue of remaining with the patients for 6-8 hours per shift/day, in close confinement with very disturbed patients, however there do not appear to be any studies to confirm this distinction.

This process of potentially paralleling the intra-psychic process of patients can render the nurse ineffective in their interventions with the patient as they identify with the patient's feelings of helplessness and hopelessness. O'Brien (1998) suggests that their response to the patients may then be rejecting, as they try to distance themselves from the feelings of helplessness, or they may try to overcompensate with closeness to the patient and distance themselves from colleagues.

High-level team functioning can help specifically with the projections of distressed patients, particularly if facilitated by leadership that is firm but shared and by the maintenance of clear boundaries. In addition, high-level functioning teams will use negotiation, disclosure and use adaptive responses to stress.

Conversely, Kaplan (1986) and Piccinino (1990) suggest that non-functioning teams are marked by underlying conflict, a lack of support for open communication, leadership by control and distancing relationships between team members. Dale and Storey (2004) identified that 10% of high security

respondents, 20% of medium secure respondents, and 25% of low secure respondents did not value teamwork. In addition, they reported that many of the nurses' felt that involvement in teamwork processes were optional or voluntary and that cooperation with members of other disciplines was not an essential part of their work. However, Mason and Chandley (1999) described how their participants within the same high secure environment felt isolated and without sufficient authority or influence to be able to contribute effectively to multi-professional teamwork or to control their own working lives and contribute appropriately to their patients' care. A similar experience was suggested by Slade (2009) who described a constant potential threat from patients with personality disorder in a forensic setting, due to their past offending and current level of risk. This can leave nurses feeling anxious/fearful and experiencing a sense of powerlessness, potentially accentuated for junior staff and patients due to hierarchal decision-making.

Individuals with a diagnosis of personality disorder who are judged a risk to others have almost always suffered extreme forms of abuse or neglect in childhood, and therapy with them often involves listening to these traumatic experiences in some depth (National Institute for Mental Health in England, 2003). There is then a strong possibility that forensic mental health staff are affected by their work in a similar way to those who work with survivors of sexual abuse.

In discussing the importance of a reflective practice model when working with men diagnosed with personality disorder, research literature has long recognised the importance of formal and informal supervision and support

structures for staff working with this client group (Ford et al, 1997; Paine, 1981; Wilkin, 1999). Cameron, et al. (2005), following their review of the literature on the nature of the nurse-patient relationship, concluded that authors suggest that nursing, including psychiatric/mental health nursing, is an interpersonal transaction committed to getting to know and understand the predicament of the patient using reflective practice. Bowers et al. (2000) have further support for this perspective, indicating that staff working with people diagnosed with personality disorder can experience strong emotional stress that overflows into their personal lives. They feel that it is essential, therefore, that there are robust systems in place to support and supervise staff, which ideally should be provided by external services. In addition, Mitchell and Everly (1995) believe that regular debriefing may be required, particularly in environments where there is a propensity for frequent periods of crisis which involves self-harm or aggression. The above responses demonstrate not only the potential difficulties but the importance of reflective practice in such environments.

3.4.2 Self Awareness as an Important Component of Reflection.

Winnicott (1949) recommended that practitioners' working closely with individuals with a diagnosis of personality disorder who are considered a risk to others need to be self-aware in order to think properly about the meaning of feelings and experience within a therapeutic relationship. It is important to be able to distinguish between a patient's feelings of rejection and resentment, for example, and the therapist's anxiety about their potential aggression.

Due to the potential of Mental Health Nurses evoking important early attachment dynamics in men diagnosed with personality disorder, Adshead

(2002) has argued that it is important for them to function as a ‘secure base’. Hence, the necessity for Mental Health Nurses to have an awareness that the following factors will contribute to this sense of emotional safety:

- the creation and maintenance of boundaries between staff and patients to protect the therapeutic space, particularly because nurses have more contact time than most other disciplines;
- the careful management of separation, loss, and the avoidance of abrupt endings;
- and the monitoring, naming, and regulating of affect in the staff and patients to promote the capacity of patients to think about and understand themselves in relation to other people (Kurtz , 2005: 406).

The importance of being self-aware will help the understanding of many of the nurse/patient coping strategies identified above and prevent another example by Kurtz (2002b) who believes that a moralistic attitude towards those diagnosed with personality disorder can be suggestive of a distancing strategy by staff towards patients.

Duff (2003) examines three areas of crucial awareness (self-awareness, awareness of people with a personality disorder, and systems awareness). She states that one of several essential elements is that of providing support for staff working with people diagnosed with personality disorder and should include self-awareness, which is associated with being familiar with one's own responses, blind spots, prejudices and vulnerabilities. This is recognised as a vital component when working with people with a diagnosis with personality disorder given their difficulty in developing and maintaining healthy relationships (American Psychiatric Association, 1994). Experiences of high personal challenge should be expected when working with people with personality disorder and without self-awareness and support they can chip away at people's self-esteem and result in staff feeling that they are unskilled and have

failed. Consequently, self and situational reflection are valuable activities in recognising positive aspects of working with people with personality disorder in what can often be very challenging relationships. In addition, reflection also helps develop and maintain personal coping strategies and support systems that help to prevent staff burnout (Ford et al., 1997).

It is argued that awareness should extend to the issues of risk with which people present, either to themselves or others, including their perspectives and positive attributes, to enable staff to engage with and assist them to build on their strength and enhance existing skills. Awareness of the people with whom staff work must be based on a wide range of detailed sources of information in order to facilitate links between their past behaviour (Davidson, 2000). This awareness should help Mental Health Nurses to manage and treat people with personality disorders safely and effectively.

Looking beyond individual reflection, Duff (2003) discusses systems awareness by acknowledging that interpersonal difficulties are the main problem faced by people with personality disorders, and that it should be unsurprising that these difficulties often manifest themselves in relationships they have with people they work with. She identifies that these difficulties can include the following:

- Splitting the staff team.
- Alienation of the person by the staff group.
- A culture of ‘pull yourself together’ therapy.
- Reduced ability of the staff group to empathise with this client group.
- Inconsistency and erratic responses to the individual by the team.
- Encouraging dependency.
- Differences in the team on how to respond to difficulties presented by this client group.
- ‘Unacceptable’ staff anger towards clients.
- Feelings of failure among the staff team.

- Lack of motivation to continue working with people with personality disorders due to feeling that the care being offered is not good enough. Duff (2003, p.28)

Therefore, a consistent approach and clear communication is imperative in helping to solve some of the problems identified above, particularly in the face of high emotional responses. The interpersonal difficulties highlighted by Duff above raises another imperative which is about understanding these issues in terms of self-awareness, awareness of the meaning for the PD patients and the systems awareness. This ideally should be explored and understood within a reflective space.

3.4.3 Provision of Reflective Space.

Holmes (2002) recommends that staff support groups should be undertaken at a bare minimum of weekly or fortnightly, by a multidisciplinary team, facilitated by a psychotherapist with training in group dynamics. Kho et al. (1998) provide evidence that the existence of such a group serves to reduce the number of violent episodes on a ward, possibly by reducing expressed emotion and enhancing cohesion within the group.

Cox (1996) believes that regular, ongoing supervision is regarded as indispensable in helping practitioners acknowledge the personal impact of contact with these highly distressed and sometimes threatening people, thus supporting the exploration of dynamics that develop in the context of the therapeutic relationship. This sort of supervision aims to promote a reflective approach to practice, and should be distinguished from a more managerial type of supervision, in which clinical activity is monitored and evaluated.

In order to satisfactorily process the above complex dynamics, supervision for individual staff caring for these patients needs to promote a reflective approach to practice. Reflective practice encourages workers to think about the way in which they can be affected at both conscious and unconscious levels by patients, and how, if unexamined, problems can be played out in a therapeutic relationship so that damaging past experiences are re-enacted (Casement, 1991; Cox, 1996; Davies, 1996). If supervision is to enhance reflection, it will need to be explorative in nature, to incorporate an acknowledgement of unconscious functioning in relationships, and to be perceived by staff as supportive and non-critical. This understanding is supported by Proctor's (2008) work on clinical supervision.

However, Mason (1995), in a study of the use of seclusion in the special hospitals in the UK, found that whilst negative views were often apparent, the majority of nursing staff could change to a more positive perspective when facilitated by change strategies. According to Storey and Minto (2000), clinical supervision in secure environments had a low level of acceptance, which is likely to be due to the reluctance to reveal personal feelings in these settings. However, literature clearly indicates high levels of stress found in forensic settings, which suggests the need for high levels of support to provide confidence (Coffey, 2000; Coffey and Coleman, 2001). This position is supported by Asdhead (2004) who suggested that staff should attend regular reflective practice groups, using them to discuss honest appraisals of the impact of interacting with a forensic PD population. This in turn can provide a secure base to reduce violence, and increase affective arousal, thus allowing a more coherent attachment to develop. Further support was provided by Mann et al.

(2014) who have observed that reflective practice in secure settings has enhanced the staff's ability to reflect on problematic countertransference and to distance themselves from re-enacting the patients' insecure attachments.

Nevertheless, Peternelj-Taylor and Johnson (1995), argue that forensic nurses need to be additionally skilled in self-reflective techniques due to the plethora of issues that emerge when caring for mentally disordered offenders. In a study of the training needs of forensic psychiatric staff at a medium secure unit in the United Kingdom, Byrt's (1990, 2013), respondents from a sample of 90 when asked what particular topics they require training in resulted in them producing a list that included nurse-patient relationship, listening skills, personal qualities and self-awareness.

3.4.4 Clinical Supervision

It is recognised that clinical supervision for nurses has been sparse and even absent altogether in many secure services, often the excuse is a lack of resources, both in terms of time and expertise (Dale and Storey, 2004). Nevertheless, working with forensic patients can be anxiety provoking and stressful (Gournay et al., 2000). Dale and Storey (2004, p.177) reported that nurses described their relationship with personality disordered patients as being highly charged and emotionally intense, with high levels of anger and hostility, hence the importance of training which involves learning how to deal with the emotional effects of treating patients. This training need was supported by respondents in Dale and Storey's (2004) study, but maybe undermined by the questionable utility of treatment interventions for patients diagnosed with personality disorder (Dolan and Coid, 1993). Nevertheless, new treatment

models (see 2.3) for personality disorder are emerging in recent years which may support Dale and Storey's findings and recommendations.

The implementation of clinical supervision has been inconsistent in mental health services, with a system often only emanating from practitioners as a desperate response to critical issues and events in their professional life (Butterworth and Faugier, 1992). This sparsity of a clinical supervision framework has culminated in differing practices, resulting in participants being confused and wary of accepting practice that appears to have many definitions and interpretations. Despite the Nursing and Midwifery Council (NMC) (2006) standards for clinical supervision, Cookson et al. (2014), following their questionnaire survey of 191 participants from predominantly nursing and allied professionals, identified that staff were receiving regular, formalised clinical supervision that met their needs but with importance inconsistencies. They suggested that against best evidence clinical and managerial supervision was not entirely separate with limited opportunities to choose their own supervisor, and problems with duration and frequency, and supervision agreements.

3.5 Summary.

In summary, this chapter has attempted to build upon the broad and controversial understanding that continues to evolve about personality disorder, by narrowing the focus of the investigation on the key factor concerning PD relationships. The findings thus far have demonstrated that Mental Health Nurses consider the therapeutic relationship to be the bed-rock for nursing this group of individuals, whilst also representing a strong indicator of outcome. The literature provided considerable evidence of a broad array of influences that can

impact and confuse the interface of this dynamic relationship, yet there are indications that training, supportive models, and supervision/reflection are less than adequate or appropriate, despite professional competency requirements. As alluded to in Chapter Two new and evolving models of treatment are beginning to provide some treatment efficacy with various aspects of personality disorder, culminating in recent suggestions towards the creation of an integrated approach. Many of the factors that have proven to have utility with patients diagnosed with PD, have transferable skills that could support Mental Health Nurses to enhance their role, alongside consistent recommendations for all disciplines to use formulations and reflection. The next chapter will explore the methodology I have utilised in this study to capture the subjective voices represented in Mental Health Nurses in high, medium, and low secure environments, the results of which will be the subject of Chapters Six and Seven.

CHAPTER FOUR:

INTRODUCTION, EPISTEMOLOGY AND CHOICE OF METHODOLOGY

Chapter Four:

Introduction, Epistemology and Choice of Methodology: Q–methodology.

4.1 Introduction

This chapter builds upon the previous chapters which have conceptualised the background, provided contemporary perspectives regarding PD understanding and the interpersonal relationships with PD patients. Within this chapter I will provide: a brief outline of my philosophical position (4.2), rationale for the choice of methodology and epistemological assumptions (4.3), introduction to Q-methodology (4.4). The introduction section will also focus on: methodological choice and type of Q-methodology, and its stages and structure (4.1-8). Whilst chapter five will describe the methodological process, followed by chapters six and seven which will describe the results. To enhance clarity throughout the four chapters many of the research tools and tables have been assembled within the accessible appendices, including a glossary of terms in Appendix 9.

4.2 My Philosophical Position.

By describing my position within the roles of researcher, professional and person I hope to provide a context to the influences that have shaped my methodological and epistemological assumptions within this research.

4.2.1 Personal Perspective

From early childhood onwards my three younger siblings and I adapted and coped with my mother's mental illness. Although she was never diagnosed with a personality disorder, clearly it would impact upon her personality and her relationships. From an attachment and relational perspective we all learnt how

to be sensitive to her needs whilst attempting to develop our own healthy sense of self. Within this relationship dynamic different attachment styles and reflective abilities developed. Ultimately this informed the choice of my professional pathway and the mandatory five years of both individual and group psychotherapy which all students undertake to help explore and resolve issues to enhance the practitioners' reflective capacity and therapeutic abilities. Thus hopefully preventing the corruption of the practitioner/patient therapeutic relationship in terms of what issues belong to which person.

Consequently, Dozier et al (1994) research which compared clinicians and patient's attachment styles and the impact upon the therapeutic relationship raised questions about the importance of nurses understanding of themselves, particularly when working with men diagnosed with personality disorder who often have extreme unresolved attachment issues.

4.2.2 Professional and Researcher Perspective.

Prior to the data collection I had worked as a Ward Manager on a personality disorder Ward and subsequently undertook the role as an Advanced Nurse Practitioner and Integrative Psychotherapist. Although the psychotherapy training was based within the humanistic domain I have also trained in a range of theoretically diverse specialised assessment/formulation and treatment modalities based on evidence-based approaches for personality disorder. These approaches have ranged from cognitive and behavioural schema therapy, dialectical behavioural therapy, solution focused therapy, and offence

focused manualised interventions to name a few. Reflective practice[7] has been enshrined within all my practice both as a facilitator and recipient. This reflection has been both reflection-on-action and reflection-in-action (Schön, 1983).

Working within a high secure environment with patients experiencing extreme psychological needs who are compulsorily only detained can lead to an inevitable power imbalance between patients and practitioner (see 3.2.2). Within the therapeutic relationship a necessary context exists in which an evaluation of risk for self and others is integral and constant. Consequently, relational boundaries between patients and clinicians are imperative for safety and security. However, these boundaries can often be misunderstood and challenged by the patient who can often misconstrue nurses and other clinicians as dominant, abusive and dangerous relating to their own past traumas, which in turn can trigger unhealthy, self-perpetuating 'protective', challenging responses.

Nurses and other professionals are not immune to their own unhealthy protective responses in these circumstances which in the worst-case scenario can either exacerbate a difficult situation or with internal and external reflective support provide insight and potential positive growth within the relationship.

Consequently, I have been a strong advocate of supporting practitioners and patients to learn from these situations utilising reflective practice models which can be powerful tools in attempting to rebalance any perceived inequity. Nevertheless, the very nature of being sectioned under the Mental Health Act

[7] Reflection definition: 'The process of internally examining and exploring an issue of concern, triggered by an experience, which creates and clarifies meaning in terms of self, and which results in a changed conceptual perspective' (Boyd and Fales, 1983: p.100).

and compulsorily detained will always provide an inevitable constant in terms of the shifting power dynamic within the relationships. Therefore, in my opinion, my roles as a researcher and clinician have been enshrined in that of a critically reflexive researcher-practitioner. This in turn hopefully provides me with a position of facilitating marginalised/disempowered/unconscious voices to be heard and understood whilst striving to maintain a non-judgemental boundaried position which I and others constantly evaluate as an integral part of our practice.

4.2.3 Why Use Q-methodology & Epistemological Assumptions.

Within this research I have attempted to use a critical realist approach within a social constructionist paradigm. Throughout this chapter I will introduce and explain how my theoretical philosophy has influenced the methodological process.

Critical Realism and Social Constructionism

Personality disorder is often described by two polarised positions e.g. 'medical naturalism and social constructionism' (Bentall, 1999, p. 261). The first position of medical naturalism assumes that there exists a knowable real external world of natural disease entities and that the more these entities are studied by diagnosticians this will lead to a more accurate description of reality. However, critics have suggested that in the absence of hard signs of psychiatry a functional diagnosis is problematic or mythological (Boyle, 1990). This argument continues with contemporary difficulties concerning DSM-V classification and the more functional dimensional models of assessment.

Functional assessments focus on the meaning of dynamic symptoms within given contexts for an individual where-as predominant psychiatric classification systems focus on grouping symptoms to provide a diagnosis. (This difficulty is discussed in detail throughout chapter two and summarised in section 2.4). The second position, of social constructivism, regards diagnosis as a representation of variegated and ultimately an unknowable condition. Consequently, causal arguments about personality disorder and mental illness are considered problematic and have been replaced by studies to consider how psychopathology is represented or socially constructed. These polarised perspectives are defined further by Moore (2005):

> 'In the first the world is an orderly, law-abiding enduring, fixed and objectively knowable and constant place. In the second the world is indeterminate, disorderly and constantly in flux and thereby ultimately 'unknowable' in any objective sense' (Moore, 2005, p.106).

A third approach is possible in which a regard exists between the two points/poles of debate, which Baskar (1990) refers to as 'critical' or 'sceptical realism' 'sharing with social constructionism the requirement that the scientific and technical concepts be examined in the context of the social with historical conditions which allow them to emerge' (Bentall, 1999, p. 262). Bentall (1999) elaborates further by stating:

> 'In a critical realist account it is not reality which is deemed to be socially constructed rather it is our theories of reality, and the methodological priorities we deploy to investigate it. Our theories and methods are shaped by social forces and informed by interests. These include interests of race, class and gender as well as economic investment and linguistic, cultural and professional constraints in time and space. These forces and interests invite forms of sceptical or critical analysis when we are asked to accept or reject empirical knowledge claims about reality' (Bentall, 1999, p. 262).

Critical realism is understood to be a third way between relativism and positivism (Robson, 2002) and comprises of an 'emancipatory' potential for

healthcare and practice (Williams, 2003). Evidence of this potential can be seen via the 'double inclusiveness' of critical realism, in which the meta-theoretical perspectives can be understood alongside the knowledge that they may harbour bias and be limited in their position. Bhaskar and Danermark (2006) extend this understanding to include multiple reality domains (empirical, actual and real). Foster (2013) explains that critical realism has three layers (1) real - which describes underlying mechanisms or structures that are responsible for what we can observe although it cannot be seen e.g. gravity. (2) Actual - which describes events that are caused by the 'real' e.g. the effect of gravity causes objects to fall at 32 ft.^{2}.

Similarly, human nature cannot be seen and no consensus of agreement can be determined on its attributes of free will, selfishness, altruism but the subsequent effects/events are described as the actual. (3) Empirical - is understood as the observable experience of the person observing the events caused by the real. To further exemplify the above three layers of critical realism, utilising a clinical example of a borderline personality disorder patient who self-harms (1) Real - can be understood as the mechanism that generated the event e.g. the individuals perception of threat which they may or may not be aware of. (2) Actual - can be understood as the events that have been generated e.g. fear/anxiety/anger. (3) Empirical - can be understood as the observable experience of self-harm.

Bhaskar's philosophy was extended following the influence of Buddhism and Hinduism resulting in 'the real' being divided into two additional layers conceptualised as a meta-philosophy or meta-realism (1) the cosmic

envelope/co-presence e.g. co-presence with people. (2) Demi-reality describing disunity, alienation or being cut off from people, culminating in social disorganisation. Foster (2013) argues that Baskar's philosophy demonstrates trans-Marxism with domination/oppression of disunity being replaced by the emancipation/liberation caused by co-presence and the important awareness that everyone is interconnected. Consequently, emancipation is achieved through co-presence in which we are united in our differences and diversity. Achieving emancipation through co-presence (which I understand as recognising difference, validating and integrating understanding) can be seen in the following examples: (1) Dialectical Behavioural Therapy for the treatment of borderline personality disorder will with unconditional positive regard, validate self-harm without reinforcing it because to invalidate the potential meaning of this behaviour (e.g. providing expression for extreme emotions, eliciting support/attachment, gaining control) for the individual could reinforce a familiar negative attribution bias that others are always uncaring, abandoning, triggering anxiety and escalating extreme behaviours. (2) Within a reflective practice group all viewpoints are considered meaningful when exploring a personality disorder issue and can be enhanced when recognising one's own bias and differences. Consequently, through group reflection on all the possible elements for a patient who is self-harming as in the previous example, emancipation could be achieved.

It is with a critical realist philosophical understanding situated within a social constructionist paradigm that I believe I have been able to faithfully represent all perspectives and understandings within the limits of my research aims.

Q-methodology in Context

In Chapter Two the potential difficulties Mental Health Nurses have when working with men diagnosed with personality disorder, within DSM-IV were contextualised. Within this process various theoretical perspectives were offered to provide a degree of general illumination. Nevertheless, this type of description is an objectifying perspective of the situation, a situation that I perceive to be deeply intimate and personal between the nurse and 'patient'. Warner (2003) argued that the terms we use, the questions we ask and how we determine which questions are relevant to ask, shape the assumed reality we wish to address. Consequently, it should be recognised that underpinning this research are a variety of medicalised and gender discourse assumptions through the utilisation of the terms 'hospital', 'diagnosis', and gendered by focusing on 'male' personality disorder. To reduce the dominant discourse assumptions I utilised the term 'relationship difficulties' instead of 'relationship problem' and broadened the context from simply high secure to medium and low secure.

It is also important to acknowledge the background identified in Chapter One, of a high secure context was at the time attempting to address and adjust to the scrutiny of its second public inquiry (Fallon et al Inquiry, 1999), with national ramifications for the care, management and treatment of PD patients and its subsequent influences on the medium and low secure contexts that participated in this study. Warden (1999, p.211) highlighted that the inquiry made 58 recommendations, mainly focusing upon improving security and the 'wider problems dealing with violent criminals with personality disorder'. In addition,

the inquiry identified greater ‘control and management’ as a solution to ‘system failure’. This inquiry alongside high-profile media offences led to the development of the legislative construct of dangerous and severe personality disorder. The above acknowledgement is important in the understanding and development of a research question as it is mediated through individual concerns, within a specific social context of time and place (Slife, 2000).

In addition, it was argued in Chapter Two that there were a myriad of influences upon the Mental Health Nurses’ understanding of PD and their relationships from the macro societal level to the micro interpersonal level which within the context of time, place, subject, and person will be individual and dynamic. It has been demonstrated with the development of DSM-V that a categorical system is not satisfactory in understanding the concept of personality disorder. With the advent of the emerging dimensional model conceptualised within an individualised dynamic context, described within a formulation rather than a category, it is possible to envisage a new framework for understanding an individual’s subjective meaning. In addition, it captures the dimensional range from adaptive to maladaptive functioning in an attempt to normalise and understand experience rather than pathologise and label with potentially limiting consequences. In much the same way the Q-methodology approach does not presume to know but seeks to understand or explore subjectivity. Brown (1997, p. 21) states that,

> ‘Subjectivity is everywhere, from the lofty philosophising and diplomatic negotiating to the street talk of the juvenile gang and self-talk of the daydreamer, and is the purpose of Q-methodology to enable a person to represent his or her vantage point for purposes of holding it constant for inspection comparison’.

Q-methodology's utility in relation to this study is its ability to capture 'representations' of social objects and understandings (Stainton-Rogers et al., 1995). Its purpose is to sample the range and diversity of views expressed and not to place meaning on the percentages of people expressing them (Kitzinger, 1987) and fits those research questions which are concerned to hear 'many voices' and uniquely allows those voices expression (Stainton-Rogers, 1995). This is supported by many authors and exemplified by Khoshgooyanfard (2001, p.482) who highlights that a questionnaire e.g. Likert Scale can only show "pre-specified" thoughts which a researcher has already considered and cannot provide adequate situations for respondents to describe their own thoughts thoroughly and freely.

Q-methodology is situated within a social constructionist understanding in which human values and socio-cultural influences are considered to be pre-structures of all knowledge about the world (Stoppard, 2000). Therefore, meaning can be seen as a consequence of social experience, which challenges the notion of a single reality, and that reality is thus guided by individual experience, belief and social change. Hence, understanding is considered subjective and temporarily driven and particularly relevant to individual Mental Health Nurses' personal beliefs with regard to understanding and relationships with PD.

The social systems created within high, medium and low secure psychiatric facilities are often driven or dominated by a psychiatric/medical ideology representing a 'true' discourse of understanding. Q-methodology is often used to encapsulate a variety of meanings that are not considered absolute but potentially contextual, multiple and often contradictory (Murray and

Chamberlain, 2000, p.45). The multiple accounts/understandings thus challenge the notion of a single ‘truth’ which may represent an oppressive/normative assumption within the given context. This results in enabling diverse subjective meaning to become manifest and universal objective claims to be diminished.

Thus, Q-methodology was considered appropriate in capturing the subjective meaning, in relation to my aims of explicating Mental Health Nurses (1) understandings of men diagnosed with personality disorder, and (2) understandings of the relationship difficulties that men diagnosed with personality disorder have and how this influences the nurse-patient relationship? The next section will discuss Q-methodology.

4.3 Introduction to Q-methodology.

A glossary of Q-methodology terms are available in appendix nine to assist the reader through the remaining chapters.

Q-methodology dates back to Stephenson (1935), and contains more than 1,500 bibliographic entries (Brown, 1986). Q-methodology is a quantitative means of objectively analysing and understanding human subjectivity. Subjectivity within this context is regarded simply as a person’s point of view on any matter of personal and/or social importance.

The method enables the participants to provide their viewpoints through a medium of systematically ranking their statements from those that are 'most characteristic of their viewpoint’ to those that are 'most uncharacteristic of their viewpoint'. The Q-sample is only constrained by the domain of subjectivity in

which the researcher is interested (the domain that Stephenson (1978) has termed a “communication concourse”).

Data analysis of Q-sorts occurs with the intercorrelation of the *N* Q-sorts as variables (hence persons, not traits or Q-sample items, are correlated) and factor analysis of the *N x N* correlation matrix are undertaken. The resulting factors represent points of view, and the association of each participant with each point of view is indicated by the magnitude of his or her loading on that factor. The last step of data analysis involves the calculation of factor scores, whereby each statement in the Q-sample is scored for each factor. Factor scoring helps the task of understanding and interpreting the meaning of factors in two ways: first, through the construction of a factor array (a composite Q-sort, one for each factor), and second, through the statements whose ranks in the arrays are statistically different. The final interpretation of the factors is produced in terms of consensual and divergent subjectivity, with attention given to the relevance of such patterns to existing or emerging theories and propositions (Stainton-Rogers, 1995).

According to Brown (1996), the variables in Q-method are not the Q-sample statements but the people performing the Q-sorts. Therefore, in my study, each participant’s factor loading score indicates the degree of association with another participant. A participant’s positive loading indicates their shared subjectivity with others on that factor, whilst negative loadings indicate a rejection of a factor perspective. For example, in the case of my study, conformity of nurses to a particular attitude to personality disorder (see Tables 6.1, 6.2, 7.1, 7.2).

Interpretation of the factors can be undertaken by referring to the demographic correlates and the factor scores of the participants. This can be seen in my case study, in relation to the hospital context in which Mental Health Nurses work, which has been particularly emphasised within the forensic context. The factor scores equate to the z-scores and can be converted into a factor array corresponding to the plus and negative values used in the scoring grid.

4.3.1 Q Vs R Methodology

The issues that Q-methodology can assess are limited only by the imagination of the researcher (Stainton-Rogers, 1995). Q-methodology does not estimate population statistics but is used for sampling a range and diversity of views without making claims about how many people express them (Kitzinger,1987). This is further endorsed by Stainton-Rogers (1995) who suggests that Q-methodology 'fits' research questions that are concerned to hear 'many voices' and uniquely allow those voices expression.

It has been argued that Q-methodology is generally most suited to discourse and text within the research needs of social disciplines (Stainton-Rogers, 1995), particularly scientific inquiry of attitudes related to health and health beliefs (Dennis, 1986), evidenced by Dennis (1986); Stainton-Rogers (1991); Dennis and Goldberg (1996), Prasad (2001); Coffey et al. (2004). In addition, Prasad (2001) suggest that Q-methodology can be utilised in a variety of settings, with the same individual multiple times and with short inter test intervals.

Q-methodology is distinguished from other conventional measurement strategies in the following ways. When compared with R-methodology it is

understood that a concept does not have an assumed meaning other than that provided by the participant, whereas R-methodology would define a meaning from the beginning, entering into the realm of categorical definitions, hence a breadth of understanding of a pre-conceived concept can be achieved.

Q-methodology is based on the participants' impressions, gleaned from self-reference. Whilst R-methodology is based on measuring expression which is linked to external reference or categorisation, which can exclude increased understanding of the participants' perceptions. To highlight this distinction further Khoshgooyanfard (2011) argues that a questionnaire or scale (e.g. Likert scale) has a "pre-specified" structure comprising of the thoughts that a researcher has already considered, seriously limiting the exploration of an individual's subjectivity and orientating the participant to something different. Resulting in demonstrating or only allowing an understanding of the researchers' structural approach/theoretical framework and not what the respondents really thinks.

Quantitative research traditionally utilises measures to test hypothetical generalisations, focusing on the reliability, validity, accuracy of the measurement tools (Golafshani, 2003). Whereas Q-methodology is speculative rather than hypothetical-deductive, with an absence of a predetermined hypothesis. Thus, Q-methodology 'has the power to surprise because no assumptions about the way understandings are structured are built into the method' (Cross, 2005, p.211).

Consequently, Q-methodology has been preferred within this study to assist the process of understanding of both subjective perspective and ultimately an objective perspective, inside an area of investigation that has dominant systems which strive for categorical understanding but leave so much to be understood. Categorical definitions which exist in psychiatry, mental health legislation, and even in R-Methodology always carry the risk of missing or misinterpreting meaning from participants' own frame of reference. For example, see the self-harm behaviour described in section 4.3 which demonstrates potential misinterpretation. Hence, Q-methodology commences with the notion of finite diversity (Stainton-Rogers, 1995), with the objective not to obtain the 'truth' but the variety of accounts that people construct (Kitzinger, 1987). Therefore, it is not the 'constructors' (participants) who are the focus but the 'constructions' (Stainton-Rogers, 1995).

This study comprises both a qualitative approach utilising semi-structured interviews and quantitative elements within the Q-methodology analysis. It has been argued that Q-methodology actually combines the strengths of both qualitative and quantitative research (Dennis and Goldberg, 1996) and provides a bridge between the two paradigms of enquiry (Sell and Brown, 1984). This was supported by Coolican (1999, p. 198) who argued,

> 'It somewhat over polarises the debate to talk of 'qualitative' researchers opposed to quantification researchers. Many qualitative researchers have no particular objection to quantification in its appropriate place…'

Nevertheless, Q-methodology is not without its critics. Firstly, when Q-methodology is repeated on the same person it may not provide the same result lead to questions about reliability. However, Stainton-Rogers (1991) explained that social psychology does not expect an individual to replicate the same view,

despite Brown (1980) claiming that Q-sort can be replicated with 85% consistency in follow-ups a year later. Secondly, it is argued that participants respond to predetermined statements which are perceived as potentially limiting. However, decisions on the final statements are not made on the sole preserve of the researcher and have often been subject to interviews and focus groups. Thirdly, a risk of bias in regarding the researchers' interpretation at the final stage does rely upon researchers' transparency and analytical skills (Pope et al., 2000). Fourthly, similar to other 'scales' Q-methodology is reliant upon the honesty and openness of the participant, which may be problematic should for whatever reason the participants provide false responses. However, uncertain responses are minimised due to the procedure of forced distribution of the statements.Nevertheless, poor self-reporting would be equally problematic in any other methodology and not specific to Q.

In response Banister et al. (1994) have argued that these types of gaps apply to all scientific enquiries and present themselves in the form of inconcludability, indexicality, and reflexivity.

(1) Inconcludability pertains to the idea that accounts are never conclusive and require further explanation (Johnson, 1999), suggesting that a gap will always be present between the meaning in the research setting and that of the written account in reports, thus, providing a space/opportunity for the reader/researcher for further understanding to be promoted either during or afterwards. This is addressed within this study by providing a comprehensive account of the narratives, alongside underpinning theoretical assumptions.

(2) Indexicality pertains to the notion that a representation is always associated to a specific setting in time and will be subject to dynamic change (Johnson, 1999) and states that with this in mind it 'means that we must reformulate what we understand by validity and reliability' (Banister et al., 1994:10). As a consequence, he believes that influences should be made accountable and visible. Consequently, within this study comprehensive accounts of the narratives are available alongside understandings pertaining to time and place.

(3) Reflexivity concerns the requirements for continual evaluation of the researchers influence on the research process, culminating in Horsburgh (2003) remarking that the researcher is intimately involved in the process and creation of research endeavour. It has been succinctly argued that 'reflexivity involves being aware of the issues influencing the researchers external and internal responses while simultaneously being aware of the researchers association to the research topic and the participants' (Dowling, 2006, p.8).

When reflecting upon my own influence, I am able to acknowledge that I have a part to play within the culture of the high secure organisation, which may elicit influences within the other areas of study. Although my position within the structure of the organisation does not situate me entirely as a neutral or objective observer of the phenomenon being explored, by making the study transparent and open to critical scrutiny, it enhances reflexivity and credibility of the research (Carolan, 2003).

4.3.2 Types of Q-Samples and Best Fit.

There are several methods of processing data that can inform the Q-sample: the ‘naturalistic’ or ‘ready-made’ and by design ‘structured’ and ‘unstructured’ (McKeown and Thomas, 1988).

Naturalistic Q-samples inform their statements from the participants’ oral or written communication, whilst the ready-made Q-statements are drawn from secondary sources other than the participant e.g. the mass media. Combinations of both methods can be used with the ultimate choice determined by the suitability for the research requirements. Within this study the naturalistic method was utilised to expedite the Q-sorting process and the attributions of meaning based upon the participants’ own communications, thus reducing the risk of missing the participants’ meanings or confusing them with alternative meanings obtained from external frames of reference. I considered that sufficient diversity had been created already through the enlisting of participants from a broad spectrum of treatment environments and that by the introduction of ready-made samples it could potentially create an imbalance (McKeown & Thomas, 1988).

Although the naturalistic method relies upon the time-consuming process of interview, the interview can utilise persons, objects, symbols and events, in addition to statements and incorporated in future instructions for the administration of Q-sorts. Nevertheless, this study utilised interviews, in light of the available resources in terms of person, time, and the myriad and quality of personal narratives available compared with the dearth of understanding in the available literature. In the future and out with this thesis, I hope to build upon

this study and use the Q-sort results to inform an action research methodology by identifying appropriate vignettes.

In terms of distinctions between the designs of structured and unstructured, one must first appreciate that Q-samples are always representations of communication contexts that do not include the entire communication possibilities (McKeown and Thomas, 1988). Consequently, it is important to understand the process of selecting and excluding various items.

This study adopted the unstructured approach. The unstructured sampling involves using items presumed to be relevant to the study, and ensuring sufficient coverage of all the possible sub-issues. An example of 'ensuring sufficient coverage' is provided in the 'Interview Schedule' (see appendix two) where I have indicated potential areas of relevance under 'general responses,' which in turn had been created from my literature search. Generally, this is understood to be an accurate method of capturing the positions on particular issues, but awareness is needed to manage the risk of under or over sampling a component, resulting in an inadvertent bias.

The structured sampling tends to promote theory testing by incorporating hypothetical considerations into the sample; this is often undertaken whereby Q-Sample statements are assigned to conditions defined by the researcher. An example of this could be demonstrated if participants had been asked to order their statements based on their response to a previously tested situation or evidence based theoretical perspective. The latter process can either be deductive (based on prior hypothetical or theoretical considerations) or inductive

(based on emerging patterns that are observed when the statements are collected).

In this study, various measures were employed to maintain the integrity of the sampling which is further explained within the section, under: 'Interview Schedule', 'Interview Participants, and 'The Statements'.

4.3.3 Conditions Associated with Q-Sorting

Q-sorting is the process whereby participants rank/order the statements or other stimuli along a continuum defined by the instruction (see appendix 1, for the, 'instructions for completing the Q-sort'). The instructions can be simple requests for agreement and disagreements or operationalisations of theoretical constructs. For example:

- Sort the items according to those with which you most agree (+6) to those with which you most disagree (-6).
- Sort the items according to those that are most like object/person X (+6) to those are most unlike that object/person (-6).

Variations can include:

- What is most like/most unlike your position?
- What you believe is most like/most unlike a 'particular' point of view.
- What you believe is most like/most unlike a 'differing' point of view.

Operationalised hypothetical constructs and categories can be a method of testing theory at the sorting stage by creating a written scenario and instructing the participants to order/rank their perceptions pertaining to the statement cards. This can be repeated utilising the same statements, whilst altering the scenario. Within this study I chose to use the ranking of statements, requesting the participants to rank their statements along a continuum from their statements that they 'most agreed' to those that they 'most disagreed'. The rationale for this approach, as opposed to alternative approaches, was that I

wanted to maximise the diverse subjectivity, which was already constrained by the forced distribution, and if I'd asked participants to rank their statements around a specific scenario I may have excluded important subjective understanding. E.g. a Mental Health Nurse may have had an understanding of PD outside that of a specific scenario. Thus, this relies upon or provides an onus upon an individual's self-reference (Stephenson, 1974). To further highlight the importance of this approach Karim (2001, p. 2) stated that Q-sorting,

> 'Involves an ipsitive approach which means that each item in the Q-sort deck is dependent and interrelated. The participants are less likely to respond to an item which is inconsistent with the previous item because his/her choice is likely to be restricted by the previous response'.

Consequently, Q-sorting is considered subjective due to the fact that the individual will construct their own meaning to statements and how it refers to their own views (Brown, 1997). However, it has been argued that the process of forced ranking is artificial and may not reflect how people would distribute their opinions (Karim, 2001). Nevertheless, this procedure is equally understood to enable careful consideration of participants' feelings and attitudes (Prasad, 2001), and facilitates decision-making by forcing the participant to prioritise which matter most to them (Cordingley et al., 1997, p.40).

This study used cards for the Q-sort although online sorting can now be used (Stainton-Rogers and Dyson, 2012). When undertaking a card Q-sort the participant requires sufficient space to distribute the marker cards from left to right as indicated in appendix 1. The Q-sort cards are separated into three piles, those that they most agree with, those that they most disagree with, and those that are either uncertain/neutral/ambivalent. Turns are then taken, by the participant, between placing the 'most agree' pile of cards in rank order

(commencing with the highest positive column) and the 'most disagree' pile of cards (commencing with the highest negative column) working inwards to the middle. The neutral pile of cards is placed with as much ranking as possible within the vacant middle section. The ranking from 'most to least' does assume that the opposite of a concept is nothing more than the same thing, but to a lesser degree, in perhaps the same way that beautiful is to less beautiful, rather than beautiful is to ugly. Thus, not subscribing to a black and white categorisation but simply holding a differing perspective. Therefore, all Q-sorts, are anchored in the same way, that is, have a point with no meaning where only the dispersion or variation of Q-sample items around it, is dependent upon individual self-reference (Stephenson, 1974).

When considering the statements size it is generally recognised that between 30-80 statements can be used (Stainton-Rogers et al., 1985). In this study, 70 and 82 statements were used in the respective Q-sorts pertaining to 'Understanding' (70), and 'Processing Relationship Difficulties' (82), with men diagnosed with personality disorder. Most attention in Q-methodology is given to the statement samples (Q-samples); however, the person-sample is not unimportant. Due to its intensive orientation (Baas and Brown, 1973; Brown, 1974) Q-method is biased towards small person samples and single case studies, a preference in keeping with the behaviourist dictum that it is more informative to study one subject for 1,000 hours than 1,000 subjects for one hour (Skinner, 1969).

In addition, establishing diversity is central to Q-methodology (Stainton-Rogers, 1995) to enable the exploration a variety of accounts that participants construct

(Kitzinger, 1987), thus providing diverse perspectives without prompting a 'true'/'superior' viewpoint (Kitzinger, 1986). This is a subjectivity that is amenable to empirical analysis, and so too can small person samples sustain meaningful generalisations about behavioural dynamics.

According to McKeown and Thomas (1988) the purpose of Q-methodology is to study intensively, the self-referent perspectives of particular individuals in order to understand the nature of human behaviour, thus enabling the researcher to explore the dynamics of interpersonal subjectivity. For example, if the aim of my research project was to obtain understanding of a situation in the NHS. across a broad span of multidisciplinary health professionals in a patient care team, in quantitative analysis the statistics will often demonstrate the narrative of the majority. However, if the key decision maker was represented by one doctor, this perspective would be underrepresented, which generally would not be the case in Q-methodology. Therefore, for this study, I have chosen a flattened hierarchy in terms of professional disciplines by specifically focusing upon Mental Health Nurses in different contexts of time and place.However; they are bound by the extrapolation pertaining to the understanding of PD and their relationships within the context of their role.

It is argued that, 'what science actually deals with are events, occurrences, and instances- i.e., with discovery and prediction from behavioural units' (Brown, 1974, p.4). There is no reason to argue that the study of such events cannot take place within the confines of one person's 'behavioural universe' (Stephenson, 1985). Hence, the basic law of Q-methodology is the 'transformation of subjective events into operant factor structure' (Stephenson,

1970-1980, p.205). Delprato and Brown (2002) exemplify this further in their study of impoverishment in which the factor analysis provided ‘voices’ in relation to behaviour, which in this case suggested that the previously unempowered individuals may respond to a single formula differently (e.g. in response to the provision of economic opportunities to the impoverished/disempowered group, one subgroup maximised opportunities, whilst another subgroup did not). However, it highlighted it may also be ineffective for unempowered citizens of a certain kind, while successful for others. Consequently, the methodology was able to distinguish a population by functional subtypes providing opportunities to modify strategies by aligning them with indigenous differences.

4.3.4 Statistical Analysis

The data analysis in Q-methodology normally involves the sequential application of three sets of statistical procedures: correlation, factor analysis, and the computation of factor scores. The completed scoring grids are transferred to the computer for Q-factor analysis, the particular procedure utilised is discussed further in this section under ‘Q-factor Analysis.’ Factor analysis is essential to this methodology because it provides a statistical means to identify diverse ‘voices’ through the process of Q-sorting.

4.3.5 Q vs. R Factor Analysis

Some of the distinctions between ‘Q Vs R Methodology’ have been discussed above but some of the issues will be revisited here. Q requires the correlation and factoring of persons as opposed to tests, traits, as would be the case in R-methodology. The person versus traits distinction has led some (Russett, 1971; Rummel, 1970; Nie et al., 1975) to suggest, erroneously, that Q-method is

merely an ‘inverted’ Q-factor analysis, and that it is nothing more than the application of R-method factoring technique transferred onto a data matrix, in which case observation and measures of those cases are exchanged for one another, for the purpose of analysis.

Regarding the above suggestion of transferring and inverting, it is clear that distinctions about the data are processed differently providing different results It is normally assumed in R-methodology that there is an objectifiable world which can be scored on absolute ‘traits’ which people may possess in varying amounts. Whilst in Q, no external reality is assumed because it is understood that the whole Q-sort is self-referential, both in terms of operationalising individuals’ subjectivity (Brown 1980) or operationalising analytical patterns (Curt, 1994). Consequently, within my own study, it is clear that Mental Health Nurses have been subjected to many influences in the form of a medical hierarchy, political concerns with regard to risk of PD, and in the case of the high secure environment major historical inquiries in relation to treatment and security. However, the utility of Q-methodology is that it is not assumed that a dominant (e.g. political/medical) narrative will represent the main outcome/’truth’ but the diversity of narratives that will conceptualise how the individuals make sense of personality disorder and their dynamic relationships.

4.3.6 The Purpose of Factor Analysis in Q

The Q-sort results will be analysed by factor analysis. Factor analysis is essential to Q-methodology since it comprises the statistical means by which subjects are grouped, or more accurately group themselves, through the process of Q-sorting. Factor analysis provides statistical clarity to the

behavioural order within a matrix, by virtue of similarity or dissimilarity, demonstrated by its factor loading and correlations. Factorization simplifies the interpretive task substantially, bringing focus to the typological nature of participants on any given subjective issue.

The significance of the loading of a factor is determined by the eigenvalue criteria, whereby a factors' significance (importance) is estimated by the sum of its squared factor loadings (eigenvalue divided by the number of variates (Q-sorts in Q, traits in R) equals the percentage of the total variance accounted for by a factor). As previously stated, an Eigenvalue greater than 1.00 is considered strong, whilst those with a lesser value are considered weak. Although a statistically weak factor would not always be excluded as Brown (1980, p.40) argues that: 'the importance of a factor cannot be determined by statistical criteria alone, but must take account of the social and political setting to which a factor is organically connected'. However the correlation is often set deliberately low to enable the extraction of the maximum number of factors. Nevertheless, this study has not been required to utilise factors below the conventional statistical threshold due to the amount of factors that exceeded the upper threshold.

4.3.7 Factor Rotation

Q-methodology utilises a considerably complicated statistical mechanism with little requirement for the researcher to comprehend the mathematics involved (Brown, 1991). This study utilised one of several dedicated computerised Q-methodology packages p.c.q. Version 2.0 factor analysis program developed by Stricklin (1992), which in turn used centroid method.

When the Q-sorts have been correlated with each other and factor analysed, in terms of similarities and dissimilarities, the next stage will be factor rotation. ‘Varimax’ is a method of orthogonal (when each factor is independent and at right angles to another) rotation, with the purpose of maximising the purity of saturation of as many variates (Q-sorts) as possible. Thus, rotation provides a change in the vantage point in which the data is viewed.

The analysis of the data indicates how much individuals concur (load) on particular factors. Consequently, the higher the loading more the participant will represent a factor (Shemmings, 2006) the minimum default loading is considered 0.45 which equates to a significance level at 0.01. A 0.01% (1:100) represents the chances that the result would be accidental. McKeown and Thomas (1988, p.17) state that a positive loading above the 0.45 threshold indicates a ‘shared subjectivity’ with others on that factor, with a negative loading signifying a rejection of the factor’s perspective.

It is desirable to rotate the factor axes during factor analysis because unrotated solutions do not have a clean factor structure and therefore are difficult to interpret. On the other hand, rotation changes factor loadings and this may lead to factors with different meanings dependent on the rotation. Regardless of the how the factors are rotated, the abductory principles allow the researcher to probe these analyses exploring any preconceived ideas, vague notions, and/or prior knowledge about the study or participants, while at the same time giving due regard for any obvious contours or patterns in the data themselves (Brown, 1993).

4.3.8 Factor Scores.

Results from the factor analysis will be interpreted according to the significance of the scoring. This will identify those factors with significant relevance/conformity to the participant group.

In most research, factor interpretation is undertaken on the basis of factor loading, however Q is based primarily on factor scores. The aim is to generate a 'factor array' (significant cluster), creating one for each factor. This is achieved by the calculation of factor weights to establish the factor scores, the factor scores in turn are then computed as 'z-scores' but for convenience are converted to whole numbers (+5 to -5) to facilitate comparisons between factor arrays.

Brown (1980, p.242) explains that: 'the Q-sort with the highest loading is given a weight of 10, with all others assigned some lesser whole number in roughly the same ratio as the original weights.' To be significant the loading at 0.01 level, it should then be equal or greater than 0.45, to assist in determining the standard error of the difference. Analysis is considered to generally produce between 3-10 factors (Curt, 1994).

Analysis involves engaging with the numerical pattern/position and the chosen statements that they relate to in order to theorise upon what specific 'story' is being conveyed by each one (Stainton-Rogers et al., 1995). Factor analysis requires more than basically retelling of the position of the statements but to develop propositions it should be meaningfully interpreted using analytical skills (Cross, 2005).

Nevertheless, these emerging accounts should not be considered a finite but provide a medium for making sense of ‘knowledge’, enabling the reader to develop their own meaning, reflections debate and critique. This is a position supported by Watts and Stenner (2005, p.85) who suggest that ‘the process of interpretation is potentially never-ending, there always being different shades of meaning and an emphasis that could be drawn from the data’.

4.4 In Conclusion,

Stainton-Rogers and Dyson (2012, p.199) state that once Q is positioned,

> …within a social constructionist epistemology, it provides a powerful technique for studying inter subjectivity: how argument and truth-claims are deployed within and between the competing positions taken by groups with different stakes to claim, status to defend, values to endorse and realities to construct. It enables us to conduct an analysis of discourse where knowledge is not seen as any way absolute, but multiple and contingent on time and place and purpose.

It is with this in mind that I believe that this chapter has described how this methodological approach and my epistemological position is suited to understanding psychiatric nurses who work with patients diagnosed with personality disorder. In particular because psychiatric nurses consistently engage in intimate and complex shifting dynamics with an array of changing influences, processed and responded to in multiple and diverse ways (highlighted in chapters 2 and 3). Q-methodology has the ability to explore these complex exchanges among and between the various discourses that can be found occupying a variety of discursive niches. Curt (1994) uses a geological analogy to describe the different discourses that can be seen as functioning like tectonic plates, often in flux shaping and moulding each other, in which Q-

methodology enables naming of the discourses, interpreting and mapping the relationships with each other. It is hoped that this chapter has provided a foundation of understanding that will support the following methodological procedure chapter, specifically how the research data was elicited and analysed.

CHAPTER FIVE:

METHODOLOGICAL PROCEDURE

Chapter Five:

Methodological Procedure.

5.1 Introduction

In the previous chapter I provided: an outline of my philosophical position, a rationale and the conditions required for the research methodology and introduced the stages required to undertake Q-methodology.

I have hypothesised in chapter one that due to Mental Health Nurse training deficits various understandings would exist regarding what they understood about the:

A) notion of personality disorder and,

B) personality disorder relationship difficulties and the impact on their therapeutic relationship.

Therefore, two Q-sets were created and utilised with the participants, pertaining to ‘A’ and ‘B’ above.

To obtain a diverse and broad array of understanding, three differing contexts for the treatment of personality disorder were chosen, comprising of (1) a high secure hospital, (2) a medium secure and (3) a low secure hospital which are described in more detail in chapter three.

5.2 Ethical Issues.

Ethical approval was obtained from all three sites in 2000, following rigorous completion of the respective ethical approval forms, supplemented with sample consent forms (see appendix 4) and information sheets (see appendix 3) for

every stage of the research. Although this process was rigorous and daunting, and despite the protracted nature caused by two sites changing their ethics committees in preference to external, neutral local ethics committees which required me to resubmit new applications. Consequently, ethical approval was obtained from the following committees, however to limit deductive disclosure the specific names of the hospitals have been removed,

1. The High Secure Hospital: The North Sefton Local Research Ethics Committee, and the 'High Secure Hospital' Research and Development Department.

2. The Medium Secure Hospital: The York Research Ethics Committee, and 'Medium Secure Hospital' Clinical Development Forum.

3. The Low Secure Hospital: The Lancashire Care NHS Trust Research Governance Sub-Committee.

Participation in the study was on a voluntary basis, with assurances that participants would be provided with anonymity, opportunities to withdraw at any stage, and that their decisions would not be problematic. Consent forms (see appendix 4) and information sheets (see appendix 3) were provided for every stage of the research. Anonymity was ensured by names being coded, audio tapes and Q-sort statements to be erased/safely disposed of on completion of the study, all data pertaining to the participants was stored in a secure cabinet. Additionally, the whole transcripts are not included within this final document.

Accessing the participants was initially protracted in various ways which I will briefly reflect upon.

5.2.1 The High Secure Hospital: once I had obtained managerial and ethical approval (Research Ethical/Governance Committee and Local Ethics

Committee), I found that despite various disruptive influences within the hospital (discussed further in chapter three) the measure of spontaneous support and generosity was very positive. Although, I was conscious of the potential need for cathartic expression in the midst of these difficulties. Despite the fact that I was reasonably well known through my full-time employment over many years within this context, I undertook the process with appropriate sensitivity whilst maintaining a neutral position as possible within the process.

5.2.2 The Medium Secure Hospital was very receptive at every level of engagement with this research, and encouraged me to present this work to numerous training forums, patient care teams, individual professionals, and directed me to obtain formal agreements from: two clinical development committees, the hospital governance/ethics committee, and the newly created Local Ethics Committee based at York University.

The treatment team within the one specialised ward for patients' diagnosed with personality disorder were extremely pleasant, motivated and generous with their time and support. Overall, they utilised a broad raft of evidence based therapeutic interventions and encouraged the use of various reflective processes, which was evident through their feedback.

5.2.3 The Low Secure Hospital: prior to successfully approaching this hospital I had sought to enlist various renowned, low secure environments for the treatment of personality disorder. They are included below because they had the potential for representing a more informed spectrum of diversity within the

study, which ultimately was excluded and are highlighted below as a potential limitation of the study.

The ‘H’ Clinic, London. I had experienced two informative visits to this clinic, only to eventually discover that there was a moratorium on research proposals due to the overwhelming number currently being undertaken at that time.

The ‘C’ Hospital, London. Following two visits and numerous letters over a period of nine months, to this environment. I discovered that the research coordination had been undertaking significant changes which had resulted in delayed and inconsistent responses, culminating in feedback that there was a gender biased towards female patients to the exclusion of males in their environment, that would invalidate the research due to the significantly lower numbers of men diagnosed with personality disorder.

‘W’ House, Reading. This environment was recommended by the above and represented an excellent 'therapeutic community' with strong links to the 'Therapeutic Community Association,’ and a flattened hierarchy of multidisciplinary staff. Following two visits in which I had been very impressed at every level by the skill, motivation, receptiveness and having undertaken all the requirements of the local ethics committee, I was surprised to learn that two members of the nursing team had felt uncomfortable about potentially undertaking the assessment interview (adult attachment interview) which was going to form part of a previously proposed aspects of the research. Consequently, on this basis, and to my surprise, the therapeutic community team felt that they had no choice but to regrettably withdraw their involvement.

Although I respected their decision, there did appear to be an irony that their decision emanated from an environment that seemed so strongly founded and promoted the importance of self-reflection within a safe, shared context. However, their response did prompt some self-reflection within myself pertaining to their perception of my boundaries (e.g. my employment in an environment which had been subject to a public enquiry) or was it simply a concern about discussing potential personal vulnerabilities or other unknown issues. Nevertheless, I concluded that after over 20 years of ethically sensitive, boundaried employment as a nurse and psychotherapist bound by sound ethical standards and my adherence to the best ethical and research protocols (eg. provision of a significant amount of information about the subject matter for informed consent, safety, confidentiality and much more) it is perhaps impossible to account for all variables. Unfortunately, at a later stage, I was to discover that the flattened hierarchy still caused interprofessional difficulties between medical professionals, who thought that nursing professionals should acquiesce to what they believed to be best. Consequently, the research appears to have been inadvertently lost within this dynamic.

The Low Secure Hospital, represented an environment which does not specialise in patients' diagnosed with personality disorder but nevertheless does have considerable involvement with them, both within their in/out-patients' departments. I undertook four visits to orientate staff at various levels of the research and successfully obtained ethical approval in 2000 once 'people diagnosed with personality disorder' were referred to within the documentation as 'people with relationship difficulties'. The rationale for this modification is that

although they obviously use this diagnostic label, they felt that it reduces the stigma associated with it. This environment has also been very supportive and receptive throughout this research process.

5.3 The Interview Schedule.

The interview schedule was created and piloted, based on an analysis of available literature (undertaken in 2001) and the research aims, adhering to the parameters of the 'communication concourse,' described in the 'Introduction to Q-methodology' (4.4). This was presented to the participant as a broad semi-structured interview, functioning to maximise their own diverse, subjective, 'expert' responses. The schedule is available within appendix two, consisting of questions related to their understanding of: 'male personality disorder' and 'their relationships,' providing opportunities for broader discussions to take place.

In 2014 another literature search was undertaken with the same parameters concerning aims one and two, not as part of the Q-methodology procedure but to situate, contextualise and contrast the results.

5.3.1 Interview Participants

In 2000 the ten interviewed participants (see appendix 5: details of interviewees) were diversely ('snowball sample') selected as possible, by three participants from each of the three sites, all of whom were registered Mental Health Nurses. Any similarities identified in the details of the interviewees, reflect the similarities within each of the environmental contexts, but their diversity was maintained through the parameters of the 'snowball' sampling process. This involved identifying a participant and asking this person to identify

another participant who they thought would represent opposing perspectives to themselves in relation to the subject matter or 'communication concourse'. This process was repeated until a sufficient number of participants had been identified. Snowball sampling is defined as follows: 'the researcher identifies one or more individuals from the population of interest. After they have been interviewed, they are used as informants to identify other members of the population, who are themselves used as informants, and so on' (Robson, 1993, p.142). Traditionally, snowball sampling is used to reach 'hidden' populations due to low numbers of potential participants or the sensitivity of the topic to be investigated (Browne, 2005). Snowball sampling is often used in Q-methodology because it favours diversity (Kitzinger, 1987).

5.3.2 The Interviews.

The interviews were undertaken in the privacy of the respective ward interview rooms at the Medium and Low Secure Hospitals due to staff being unable to leave the ward. Whilst at the High Secure Hospital staff members were able to be released from their wards to be interviewed within the privacy of a separate department (Clinical Therapies Department). Nevertheless, there did not appear to be any hindrance associated with any of the interview venues. The interviews lasted one hour with each participant, and did not deviate significantly from the interview schedule (see appendix 2) although I detected expected undertones reflective of each environment, which is discussed further in chapter three. All the interviews were audio taped and transcribed verbatim professionally. The authenticities of the transcripts were accurately validated by myself.

5.4. The Statements.

The transcribed audio-taped interviews were coded for anonymity and subjected to a discourse analysis, with statements being extracted which pertained to the 'communication concourse' e.g. 'understanding' and 'relationships'. All extracted statements were referenced to source e.g. participants' number, page number and line.

Consequently, samples of opinions were drawn from 70 (A sort) and 82 (B sort) (total of 152) statements respectively, collected from ten semi-structured, one hour, audio-taped and transcribed interviews of Mental Health Nurses from diverse forensic sources, and had been refined from a total of 160 statements. The 'refinement' of the original statements did not dramatically reduce the number of statements but did exclude repetition and data outside the 'concourse'. Some minor adjustments were made to statements to resolve potential ambiguity, confusing propositions, and multiple ideas. For example, the following statements were rejected because they appeared not only confusing to participants but even if they were rated it would be difficult to interpret their meaning retrospectively from the participants' perspective:

> 'People diagnosed with personality disorder have difficulty changing because a different approach to situations does not fit in with their value system'.

> 'People with personality disorder have developed a relationship schema through their relationship with childhood attachment figures and despite attempts to compensate or avoid certain things they often reinforce this schema'.

The final stage of refining the statements involved piloting the statements with a number of volunteers who were also Mental Health Nurses from a forensic setting in 2001. One of the important aims of piloting the statements at this stage is to ensure that it is both understood and that methodological integrity is achieved, particularly through the successful balancing of the statements, between those that they 'most agree with' and those that they 'most disagree with.' A bias towards either side could affect the 'integrity'. The outcome of the piloting resulted in a few statements being rewritten to reduce ambiguity, and a number of reversals being required. I did not supplement the interview statements with statements obtained from theoretical literature to enable 'communication concourse' integrity. In 2002, it generally took participants between one and two hours to undertake the sorting, with most participants splitting the period of time required between sort A and sort B.

The selection of participants for the Q-sorting process adhered to the protocols identified in the Interviewed Participants. Consequently, the participants were included in terms of their ability to provide the study with a range of representative perspectives. In addition, demographic information (see appendix 7) was recorded to ensure that the voices were representative of the context. However, it was unnecessary to ensure equal numbers of women and men for example but clearly it would have restricted the study had all the participants been male.

Forty participants (n = 40) were identified in total across the three sites and their details are contained within Appendix seven, similarly the information sheets and consent forms can be found within appendices three and four. Of the 40 Q-

sort participants six of them had been involved in the original interviews which formed the 'concourse', of which four had positive loadings. Out of the 40 Q-participants, 27 had positive loadings, of which 10 had two positive loadings each over the two Q-sorts.

The participants were requested as per information/instruction sheet (Appendix 3) to separate the Q-sort statement cards into those that they 'most agreed with' and those that they 'most disagreed with,' and place them within the respective hierarchical grids. The numbered statements were then recorded in terms of their position on the scoring grid (Appendix 3).

5.5 Q-factor Analysis.

In 2004, the forty completed Q-sorts were a factor analysed using the adapted PQ Method 2.11 (Atkinson and Brown, 2002) programme. This involved completing the following steps:

1.	STATES:	creating the statement text.
2.	QENTER:	entering the data from the individual Q-sorts
3.	QPCA :	performing a principal components factor analysis
4.	QVARIMAX	performing a varimax rotation of the factors
5.	QANALYZE	performing the final Q-analysis of the rotated factors, which involves exporting factors and printing.

5.6 Interpretation

The criterion factor for the level of significance or 'Eigen Value' was 1.00 (Brown, 1980, p40). Adhering to the eigenvalue principles it resulted in the first Q-set analysis producing ('A': understanding personality disorder), eight significant factors which are discussed in chapter six. The second Q-set

analysed ('B': understanding relationships) identifies seven significant factors and are discussed within chapter seven.

In Q-factor interpretation Brown (1980, p.247), comments that when compared with R-methodology:

> 'the relationship between person and test is reversed to some extent: subjects' are variables and statements are sample elements drawn, however, by design rather than random selection. But in Q, the greatest interest is in the sample elements, the statements, since the factor scores they receive reflect an attitude in operation. What is of interest are the *attitudes as attitudes* quite independently of whoever may have provided them. This is not to say that the persons as such are of no interest, but the principle of limited independent variety. (Keynes, 1921) holds that a small number of factors are likely to be involved in any domain of discussion'.

Ultimately, I was interested in obtaining the table of factor scores (Figures 6.1-8, 7.1-7) and then the table of factor loadings (Tables 6.2, 7.2), and it is on the basis of these that factor description and interpretation proceeds. However, as Brown (1980, p247) pointed out, 'there is no set strategy for interpreting factor structure; it depends foremost on what the investigator is trying to accomplish.' Consequently, the reader is referred to the general aims identified in (1.6.) as an introduction to the following interpretation chapters.

Nevertheless, with all interpretative processes, the researcher's interpretation of the factors is open to challenge but based on his reflective note taking, the interview data, and by maintaining close proximity to the issues being considered, the expectation is that the integrity of the accounts will remain true and within the communication concourse. Curt (1994) perhaps helpfully argues, that if factor description were the end result of analysis, then criticism of relativism could be levelled.' Hence, this methodology only represents one stage of this study in which further analysis will be undertaken. Further

transparency is hopefully achieved by the step by step details described through the process of collection of data.

In the following chapter (6) I present the first Q-set, pertaining to the concourse and the subsequent thematic analysis regarding what Mental Health Nurses understand about personality disorder, which will be contextualised and discussed.

CHAPTER SIX.

RESULTS: UNDERSTANDING OF PERSONALITY DISORDER (Q-SET 'A').

Chapter Six:

Results: Understanding Personality Disorder ('A' Q-Set).

6.1 Introduction.

This chapter presents the results of Q-set 'A' in the form of eight factor accounts which is related to the studies first research aim identified in section 1.6. The aim or 'communication concourse' of this section of the study was to in part address the first aim identified below:

1) Elicit what Mental Health Nurses understand about male patients who have been diagnosed with personality disorder.

To assist the contextualising of this research aim chapter 2 consists of a literature review and discussion pertaining to what Mental Health Nurses understand about personality disorder. The literature review was not used as part of the concourse due to the richness of the participant interviews, but can be understood alongside the factor accounts in this chapter. A brief summary of the procedure will be provided, followed by the factor loadings. Each of the eight distinct factor's/accounts is presented separately and includes its factor array (clustered statements), participant information, interpretation of the clustered statements (each statement is referenced in the text alongside its loading).

As a means of signposting the eight accounts Table 6.1 also lists the eight accounts with titles followed by their explanatory section number in brackets. The titles (e.g. Labels are unhelpful look deeper) only serve to provide an approximate description of the accounts and should be understood to have a broader interpretation. Subsequently each account is presented, discussed, and supported with its relevant statements, including statement number and value/loading it was accorded e.g. +6/-6 (described in section 5.4).

Procedure.

To create the specific statements for Q-set 'A' the transcripts from ten, one hour semi-structured interviews (interview schedule - appendix 2, details of interviewees - appendix 5) across high medium and low secure environments were utilised to provide statements for the 'understanding of personality disorder' Q-sort. A total of 160 separate statements were created, reduced to 152, of which following the pilot study 70 statements were generated for the Q-set ('A') pertaining to this research aim. The final version of Q-set 'A' statements can be found in appendix 6, along with the instructions for completing the Q-sort (including the values, and scoring grid) are in appendix 1. The Q-sorting was undertaken by n=40 and their data (the numerical value of their choice of statements) was individually entered onto the dedicated computerised Q-methodology package 'p.c.q.' Version 2.0 factor analysis program (described in sections 4.3.6., 5.5). The factor analysis program determines the level of agreement or disagreement between participant Q-sorts resulting in a correlation matrix. The statistical program determines the significant clustering of similar viewpoints, culminating in the production of a 'factor array' (positioning of statements for that factor) based on the weighted average of all the Q-sorts which correlate/load (5.6). In addition, the analysis can involve varimax rotation which was utilised but did not change the factors due to their strength of loading e.g. above the minimum default threshold of 0.45 (4.3.7). Each of the eight factors achieved an eigenvalue above 1.00 which indicates a strong loading and significance (5.4) and have been individually highlighted prior to each factor in this chapter. No non-significant (does not load onto any factor) or confounding (load significant onto more than one factor) Q-sorts were highlighted. The final part of this process involves the interpretation of the statistical data by the

researcher which involves a qualitative description of the emerging viewpoints discussed in 5.6 and presented in this chapter.

Following the factor analysis eight accounts were extracted pertaining to the Q-set – 'understanding of male personality disorder', which all loaded positively with no negative loadings (factor loadings, e.g. position of statements for each account and z-scores are contained within appendix 8a and in figures 6.1-8). Table 6.2 indicates the participants and their factor loading, whilst in Table 6.1 the participants are identified below by their participant number, gender and site (further details in appendix 7). It was decided not to include the Mental Health Nurses' job title due to a potential for breaching their anonymity, however all the participants in this section are registered mental nurses. Nevertheless, where job titles are referred to anonymity is preserved due to their large numbers e.g. Staff Nurse, and broad interpretation e.g. manager.

As noted in Chapter Five, only a brief account of the procedure is provided here and only factor summaries (as accounts) will be presented in this chapter.

Table 6.1: Understanding of Male Personality Disorder – significantly loading Q-sorts.

Factor/Account No. Title and (section number). (All factors loaded positively).	**Participant No.**	**Gender.**	**Site.**
One: Labels Are Unhelpful - Look Deeper (5.2).	15 19	F F	Low Secure Low Secure
Two: Social Groups and Difference: Gender and Ethnicity (5.3).	23 36	M M	Low Secure High Secure
Three: Personality Disorder? (Pejorative Label for Men and Women (5.4).	25 33	F M	Low Secure High Secure
Four: The Personality Disorder Label - Beyond the Mist (5.5)	5 14	M M	Medium Secure Low Secure
Five: Personality Disorder and Relationships (5.6).	11 37	M F	Medium Secure High Secure
Six: Personality Disorder, Relationships and Society (5.7).	6	F	Medium Secure
Seven: Race, Gender, Treatment, and the Non-prejudicial Society (5.8).	26	M	Low Secure
Eight: 'Personality Disorder'? (5.9).	8	M	Medium Secure

Table 6.2: Factor Matrix with an X Indicating a Defining Sort Loadings.

QSORT	1	2	3	4	5	6	7	8
1 1SM	0.4762	0.1611	0.2073	0.3005	0.1430	-0.0334	0.1919	0.4159
2 2SM	0.0883	0.2328	0.0743	0.5376	0.0419	0.0370	0.4830	0.2391
3 3SF	0.4167	0.3292	-0.1439	0.2715	0.1878	0.5501	0.0842	0.2299
4 4SF	-0.0307	-0.0021	0.3344	0.3568	0.0954	0.5323	0.3663	0.1880
5 5SM	0.3201	0.1977	0.1320	0.6412X	0.2787	0.2818	-0.0484	-0.0251
6 6SF	0.1408	0.0958	0.2169	0.4516	0.1914	0.6747X	0.1331	0.2068
7 7SM	0.5319	0.0142	0.0677	0.4319	0.2286	0.0573	0.4130	0.0736
8 8SM	0.0237	0.0714	0.1215	0.1031	0.1566	0.2548	0.1069	0.8031X
9 9SM	0.2381	-0.1544	-0.1280	0.5184	0.2689	0.2940	0.3089	0.2550
10 10SF	0.0890	-0.0099	0.4061	0.5913	0.2014	0.3743	0.1503	0.0897
11 11SF	0.2261	-0.0443	-0.0811	0.2960	0.7039X	0.0694	0.0963	0.1260
12 12SM	0.2338	0.1987	0.1273	0.4075	0.0027	0.5481	0.2334	0.2941
13 13SM	0.2743	0.1982	0.2183	0.4731	0.1485	0.4822	0.2156	0.0123
14 140M	0.2861	0.0249	0.1456	0.7833X	-0.0310	0.1528	0.0126	-0.0324
15 150F	0.6314X	-0.1029	0.3676	0.2924	0.1716	0.2132	:0.1989	-0.1625
16 160M	0.2628	0.2215	0.5911	0.3056	-0.0610	0.2128	-0.0364	0.3221
17 170F	0.4191	0.2590	0.4165	0.3605	0.3400	0.0109	-0.0281	0.2596
18 180M	0.5401	0.2654	0.2457	0.2537	0.2278	0.1541	0.2989	0.1715
19 190F	0.7526X	0.1756	0.0536	0.3066	0.0989	0.2330	0.0229	0.0183
20 200F	0.4765	0.0910	0.0812	0.0777	0.1747	0.4895	0.0962	0.3001
21 210F	0.2716	0.4457	0.1584	0.3933	0.2892	0.0083	0.3943	0.0449
22 220M	0.1495	0.0295	0.2112	0.2598	0.3957	0.2901	0.0413	0.2150
23 230M	0.1264	0.7491X	0.0050	0.0986	-0.0751	0.1289	0.1432	0.1118
24 240F	0.2174	0.1757	0.2391	0.6785X	0.2515	0.2135	-0.0027	0.2514
25 250F	0.0397	-0.0457	0.5200X	0.1687	0.0395	0.2967	0.2545	0.2254
26 260M	0.1506	0.1809	0.0212	-0.0289	0.1085	0.1694	0.7334X	-0.0462
27 27AM	0.2868	0.1185	0.4859	0.1265	0.2805	0.3277	0.0386	0.0373
28 28AM	0.2741	0.5155	0.2825	0.2107	0.2244	0.4715	0.2484	-0.1354
29 29am	0.3360	0.2214	0.5058	0.0033	0.1030	0.3714	0.1782	-0.0910
30 30AF	-0.2662	0.2341	0.5428	0.0292	0.4604	0.0926	0.0257	0.1503
31 31AM	0.2672	0.2519	0.3424	0.1204	0.0899	0.1274	0.4934	0.1913
32 32AF	0.2057	0.4277	0.2902	-0.0892	0.4722	0.1423	0.2491	-0.0130
33 33AM	0.1172	0.0612	0.7992X	0.1492	-0.0696	-0.0945	0.1157	-0.0197
34 34AM	-0.0200	0.3444	0.4372	0.4017	0.3086	0.0649	0.3758	0.0113
35 35AM	0.0272	0.5795	0.0922	0.1964	0.1712	0.5497	0.2529	0.0318
36 36AM	0.0352	0.6133X	0.2199	0.0700	0.4586	-0.0906	0.2732	0.0206
37 37AF	0.2344	0.2380	0.0071	0.1089	0.6067X	0.4133	0.0628	0.0457
38 38AM	0.1964	-0.0345	0.4176	0.1214	0.4213	0.4002	0.3271	0.0750
39 39AM	0.0164	0.4674	0.2422	-0.0542	0.0229	0.3033	0.5477	0.1697
40 40AM	0.0303	0.3396	0.2299	0.4351	0.0452	0.1853	0.5916	0.1339
expl.Var.	9	8	10	12	7	10	8	5

6.2 Account One: Labels Are Unhelpful - Look Deeper.

Figure 6.1: Factor Array: Factor 1.

-6	-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5	+6
44	63	9	8	65	15	60	31	53	19	46	39	16
17	35	27	66	29	34	40	43	5	37	1	38	12
59	23	7	67	69	15	20	55	32	10	3	28	22
		70	33	58	62	26	45	4	64	11		
			25	47	61	42	24	52	14			
			6	51	13	48	36	2	21			
				34	57	56	41	18				
					30	54	49					

This account had an eigenvalue of 18.8 and was presented by two experienced female nurses (participants 15 (loading 0.63), and 19 (loading 0.75) who work within a low secure environment.

They presented the understanding of males with personality disorder mainly through the perspective of society and its perceived unhelpful legal and medical classifications. The media is seen as a benign force by comparison. Consequently, in this account they want to look beyond the 'label' for the reasons for their behaviour.

Classification, Labels & Prejudice.

This account suggests that the media has little influence on society's prejudices towards men diagnosed with personality disorder (44. –6). Additionally, the media make few gender distinctions:

59. -6 Female sex offenders are given more support and sympathy by the majority of the media.

They perceive that society views personality disorder with negative connotations but seemingly not fuelled by the media, despite various media representations, it is believed that other ‘institutions’ feed the perception:

12. +6 Society predominantly uses the term Personality disorder in a derogatory manner.

The ‘institutions’ that act more as society’s arbiters in influencing this negative perception are understood to be represented by legal and medical domains who have created classification systems which reduces understanding. Hence, the Mental Health Act is not seen as helpful in defining personality disorder (19. +3), and Personality Disorder is considered a convenient label which limits peoples’ understanding of the individual (11. +4). This creates and compounds prejudice regarding the expected pattern of behaviours that someone diagnosed with personality disorder might exhibit (39. +5), and purely exists to control/manage:

22. +6 Personality Disorder is a label which is put on people who cannot be managed.

Consequently, it is believed that the diagnostic definitions within the Mental Health Act and psychiatry exist as convenient labels which limit understanding about individuals, rather than illuminating understanding, used to control and manage rather than usefully inform their treatment pathway. Resulting in a vicious cycle of prejudice and alienation, in a vacuum of misunderstanding, compounded by the labels that can remain with the individual indefinitely:

16. +6 Once diagnosed with personality disorder it stays with the individual for the rest of their life.

They believe that these prejudices can lead to the mistaken perception by ‘others,’ that men diagnosed with personality disorder will exhibit egocentric difficulties in terms of: only thinking about themselves (23. -5) and saying what others want to hear whilst in their experience this is not entirely the case (9. -4). These connotations seem erroneously to imply badness (17. -4) revisiting the debate discussed in chapter three.

In this account the argument about whether this diagnosis is caused by nature or nurture seems firmly to exclude nature, evidenced by the agreement that people are not born with personality disorder but develop it through their experiences (37. +3).

The stigmatisation that they perceive as existing enhances the perception by others that men diagnosed with personality disorder present very differently from other people in terms of their needs and traits. This appears to place their understanding away from categorical systems towards the notion of a personality continuum discussed in cognitive and social interpersonal theory (27. -4). Due to this categorisation, supported by, psychiatry’s use of potentially ill-defined, untested, broad diagnostic labels and legal classifications which have barely changed since the dawn of the ‘asylum’ (discussed in chapter two) it is believed that the clinicians would gain more understanding by examining the behaviour which originally brought them to the attention of the health services (28. +5). However, although it is recognised that people who have ‘personality disorder’ will have difficulties in society it is certainly not always the case that it becomes manifest when they break the law (28. -5).

Within the various therapeutic models there is recognition that individuals that come to their attention may find themselves in repetitious cycles of behaviour dating back to childhood, which are not entirely understood by the individual concerned. Nevertheless, this account refutes the notion that people diagnosed with personality disorder cannot learn from past experiences/mistakes and prevent its repetition (7. -4). It could be argued from other theoretical perspectives (e.g. attachment theory) that learning has taken place, and that in childhood they have found the best available adaptive response available to them, in the face of traumatic, abusive, or other dangerous experiences. Hence, the belief that when treating men diagnosed with personality disorder clinicians need to look beyond the mist of challenging behaviour (46. +4) or legal/medical diagnosis and more importantly attempt to understand the reasons ('how and why') these individuals interact in certain ways (38. +5).

Nevertheless, this account does suggests that they can slip into responding to certain situations/relationships in similar ways that existed in the past, having coped with rejection (1. +4) or other forms of danger (3. +4) by being sensitive to its potential re-emergence in the present, along with the unresolved issues associated with it. This may result in often waiting for people to abandon and reject them (1 +4). Furthermore, they will even have a difficulty or simply avoid forming close relationships because of their past negative experiences evidenced by:

3. +4 MdwPD don't form close relationships because they fear negative outcomes.

Many nurses interviewed in this study expressed concerns regarding the consequences of the potentially challenging impact, of men diagnosed with

personality disorder, at every level, upon themselves, ranging from emotional, psychosocial, and at a career level. This is the focus of the second sort discussed further in Chapter Seven, in terms of potential relationship difficulties and how they are processed. However, interestingly the two female nurses, from a low secure environment denied feeling either weak, inadequate (70. -4), threatened or having to worry about their careers (35. -5). The potential reasons for this perspective could include: the differing challenges presented/encountered in their environment, an informed and insightful perspective of themselves and/or the 'individual' concerned, or a persona to avoid personal weakness, a matriarchal or a specific personal adaptive attachment strategy.

6.3 Account Two: Social Groups and Difference: Gender and Ethnicity.

Figure 6.2: Factor Array: Factor 2.

-6	-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5	+6
56	**6**	**66**	70	27	47	15	63	28	40	**30**	**45**	**62**
44	**21**	**36**	69	14	11	37	9	48	39	**5**	**55**	**64**
13	**4**	**22**	52	32	24	61	49	3	34	**19**	**23**	**38**
		65	58	2	7	51	10	68	12	**46**		
			57	60	20	17	8	25	16			
			18	67	29	59	41	26	1			
				35	42	31	50	53				
					43	54	33					

This account had an eigenvalue of 2.09 and was presented by two experienced male staff nurses (participants 23 (loading 0.74) and 36 (loading 0.61) who work within a low and a high secure environment.

Within this account there was a greater focus upon gender and race distinctions. Firstly, they believed that there is little difference between genders when they express aggression towards property, others, or towards themselves in the form of suicide threats or self-harm (56. -6).

Despite this similarity of expression, there is then a focus on the differences, emphasised firstly, by their perception that it is easier to detect avoidant strategies to hide emotions when used by women diagnosed with personality disorder, than it is with men (55. +5). However, when they compare the genders for the likelihood of convictions for sexual offences they believe that men are more likely to have committed sexual offences (62. +6). This maybe their perception of an imbedded moral norm in society which constrains women not to act outside matriarchal stereotypes, evidenced by the following statement:

64. +6 Society predominantly equates women to idealised images of motherhood, so when they behave outside this stereotype they cause more concern.

The importance of gender was further highlighted in their denial that male Mental Health Nurses created difficulties for female staff, in their development of therapeutic relationships, with men diagnosed with personality disorder (66. -4).

The significance of difference pertaining to race and the utility of classification were highlighted by their agreement that black Afro-Caribbean males are more likely to be classified with mental illness rather than personality disorder (45. +5). They disagreed that the diagnosis of personality disorder ('label') is simply for those people who either cannot be managed (22. -4) or is used as a form of social control when they cause concern to society and cannot be classified mentally ill (22. -4), as evidenced by:

21. -5 Men are 'DwPD' as a form of social control because they fall outside a major mental illness category and cause concern to society.

They hold strong beliefs that the dominant view of society is that it does not consider men diagnosed with personality disorder within their own hospitals as psychopaths (13. -6), and that the media does not create negative stereotypes about personality disorder that would feed prejudicial fears about them (44. -6).

The Mental Health Act was not felt to be helpful in defining personality disorder (19. +4) but rather it was felt to be more important to understand how the individual acts in certain ways rather than use a legal/medical diagnosis (38.

+6), and that it is necessary to look beyond the challenging behaviour (46. +4). In reference to the above point there is some concurrence here with account one.

However, having identified the difficulties associated with diagnosis and the importance of looking beyond challenging behaviour their picture becomes less clear, in their belief that personality disorder does not affect perceptions:

6.	-5	Personality Disorder is a condition which affects their perception of others and their relationships.

In addition, they believe that men diagnosed with personality disorder do not have faulty learning styles, resulting in a distorted understanding of the morality of right and wrong (36. -4), or that they recreate past relationships which evoke similar responses in the present (4. -5), whilst they can often seek disturbing ways to extract a sense of safety from others (5. +4). Exacerbating this picture is the belief that men diagnosed with personality disorder will provide accounts of themselves and others which are factually incorrect (30. +4).

6.4 Account Three: Personality Disorder? (Pejorative Label for Men and Women).

Figure 6.3: Factor Array: Factor 3.

-6	-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5	+6
56	69	63	27	49	50	13	9	38	46	37	24	12
68	66	8	10	6	23	15	30	11	16	14	39	62
7	28	67	26	60	57	3	52	42	53	21	47	17
		65	58	5	4	45	54	32	70	19		
			36	48	25	64	2	44	22			
			51	59	1	31	29	35	33			
				43	41	61	18	34				
					55	40	20					

This account has an eigenvalue of 1.61 and was presented by an experienced female staff nurse who works within a low secure environment and an experienced male staff nurse who works within a high secure environment (participants 25 (loading 0.52) and 33 (loading 0.79).

This account strongly identifies that personality disorder implies badness (17. +6) and that society predominantly use the term in a derogatory manner (12. +6). Compounding this negative connotation is their strong belief that men diagnosed with personality disorder are more likely to have committed a sexual offence than women (62. +6).

Nobody, including the patient, really understands why men diagnosed with personality disorder behave the way they do (24. +5). In addition, should they have more than one type of personality disorder, it renders the diagnosis as meaningless (19 +4). However, the term does create prejudices regarding the expected patterns of behaviour (39. +5). Consequently, it is perhaps unsurprising that given the perceived, lack of understanding of their behaviour,

concerns about comorbidity, and preconceived patterns of behaviour, that there is a strong belief that men diagnosed with personality disorder cannot be treated (47 +5).

Following the rather pessimistic understanding above, regarding the lack of understanding about personality disorder, an attempt is made to understand this diagnosis.

They believe that the different personality types used to classify this condition are unhelpful labels that do not adequately describe the condition (14. +4), and that these categories are used because they fall outside the mental illness categorisation and cause concern to society (21. +4). Hence, they are used as a form of social control. Additionally, they do not present significantly with different areas of need and traits (27. -3). However, despite the perceived diagnostic problems clinicians should not focus simply on the behaviour which brought them to the attention of the health services (28 -5).

It is believed that people are not born with personality disorder but develop it through their experiences (37. +4), consequently it is strongly thought that they can learn from their experiences and minimise the repetition of past mistakes (7.-6). This would help to develop stable and lasting relationships (8. -4), but despite being given the right attention and boundaries they may not respond favourably (10. -3). Interestingly, the participants of this account did not see men diagnosed with personality disorder as powerful and controlling (69. -5) but felt that when treating them you need to look beyond the challenging behaviour

(46. +3). The latter point is also shared in the two previous accounts discussed above.

Within this account it was felt important to clarify some distinctions that are made about gender associated with personality disorder. Firstly, a distinction is made regarding the perceived likelihood that men diagnosed with personality disorder are more likely to have committed a sexual offence than women (62. +6). This is the only distinction made, however there is a strong emphasis on discounting differences between male and female patients and the gender influences between Mental Health Nurses.

They do not believe that women are more likely to be diagnosed with mental illness rather than personality disorder (63. -4) or that it is more difficult to see a male offender as the victim than it would be for a woman (68. -6). Additionally, they do not believe that, men diagnosed with personality disorder express aggressive behaviour towards others or property, whereas women will display self-harm behaviour and suicidal threats (56. -6), or that famous male sex offenders are considered evil (67. -4).

Regarding the gender influences between Mental Health Nurses, they disagree that within their own hospital that male rather than female Mental Health Nurses objectify men diagnosed with personality disorder as simply ‘offenders’ (65. -4), or that male Mental Health Nurses create difficulties for female staff to develop therapeutic relationships with men diagnosed personality disorder (66. -5).

6.5 Account Four: The Personality Disorder Label (Beyond the Mist).

Figure 6.4: Factor Array: Factor 4.

-6	-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5	+6
13	44	67	56	24	61	53	31	21	14	22	39	12
47	25	40	66	9	20	30	69	19	43	11	52	17
6	15	26	23	60	18	64	55	54	28	38	46	37
		51	27	48	49	7	5	2	10	32		
			62	50	59	8	45	3	1			
			65	70	36	33	68	4	41			
				35	57	42	58	16				
					63	29	34					

This account had an eigenvalue of 1.62 and was presented by three nurses, two newly qualified staff nurses (one female from a low secure environment, and a male from a medium secure environment), and one experienced senior nurse (male) from a low secure environment (participants 24 (loading 0.67), 5 (loading 0.64) and 14 (loading 0.78)).

The participants in this account believe that the label of 'personality disorder' is a convenient descriptor which limits peoples' understanding of the individual (11.+4) and that the diagnostic types within the term personality disorder do not adequately describe the nature of the condition (14. +3). Furthermore, its utility serves to label people who cannot be managed (22. +4), whereas it is more important to understand how and why the individual interacts in certain ways rather than use a legal/medical diagnosis (38. +4), which does little in providing professionals with a common language to work together (40. -4).

On the other hand, personality disorder is used in a derogatory manner by society (12. +6), being strongly understood to imply badness (17. +6), and creating prejudice regarding the expected patterns of behaviour (39. +5).

They do not believe that the media feeds this prejudicial stereotype of fear about personality disorder (44. -5), which seems to imply that the perceived prejudice is generated from elsewhere. E.g. medical/legal. On a less cautious note they do not believe that male sex offenders are considered evil (67. -4), or that men diagnosed with personality disorder are a danger to the public (15. -5). Perhaps reflecting the less secure nature of these participants' environments, they strongly believe that society does not regard men diagnosed with personality disorder within their hospitals as psychopaths (13. -6).

It is strongly believed that people are not born with personality disorder but develop it through their experiences (37. -6). They strongly disagree that personality disorder affects their perception of others and their relationships (6. -6) and that men diagnosed with personality disorder consistently demonstrate negative emotions (26. -4), or cannot control their anger (25. -5). Additionally, the distinction made regarding men externalising their anger whilst women internalise it towards themselves, is dismissed (56. -3), which may be recognition of the increasing trend for young men to self-harm and young women who act aggressively towards others, evidenced in the following statement:

56. -3	MdwPD are more likely to express aggressive behaviour towards others or property, but females will display self-harm behaviour and suicide threats.

It was strongly disagreed with that men diagnosed with personality disorder are untreatable (47. -6) or that the only aspects that can be treated are the personality factors which cause a danger to society (51. -4). Regarding the offences that they 'may' commit, they disagreed that this should result in their indefinite detention (43. +3), which may reflect recent suggestions pertaining to potential changes in legislation. It was felt that current treatment interventions for men diagnosed with personality disorder will be considered quite primitive in the future (52. +5) and that if they themselves were treated in this fashion they might respond in similar ways (32. +4). Ultimately, when treating men with this diagnosis one needs to look beyond the challenging behaviour (46. +5).

6.6 Account Five: Personality Disorder and Relationships.

Figure 6.5: Factor Array: Factor 5.

-6	-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5	+6
13	56	25	69	70	9	55	51	63	11	62	1	61
44	27	54	43	6	19	40	65	38	36	28	31	4
35	66	8	17	21	48	42	50	68	41	58	37	2
		7	26	29	23	24	22	16	45	5		
			67	12	34	20	14	3	10			
			47	15	60	49	30	39	53			
				59	18	46	57	32				
					33	64	52					

This account had an eigenvalue of 1.52 and was presented by two experienced female staff nurses, one from a medium secure environment, and the other from a high secure environment (participant 11 (loading 0.70), 37 (loading 0.60)).

Within this account they believe that people are not born with personality disorder but that they developed it through their experiences (37 +5). Past relationships are strongly perceived as being recreated to the extent that they evoke similar responses (4 +6). Similarly, their current narrative style can often be linked to important past coping functions with childhood attachment figures (31. +5). This can often lead to intense dependent relationships with key individuals (2. +6), exacerbated by the sense that they appear to be waiting for people to abandon and reject them (1. +5). Overall, they find disturbing ways to try and extract a sense of safety from others (5. +4). However, they believe that although there is a repetition of behaviour they refute the notion that they can't learn from their mistakes (7. -4) or that it impedes them entirely from developing stable lasting relationships (8. -4). They also refute the notion that:

54. -4 MdwPD can function reasonably well with a personality disorder in society and it only becomes a problem if they break the law.

They believe that both men and women diagnosed with personality disorder have learnt in childhood not to express certain emotions (58 +4), but do not believe that they cannot control their anger (25.-4).

Their behaviour (described above) within relationships is not perceived as powerful and controlling (69. -3) and consequently, they strongly deny feeling threatened or worried about their careers when working with men diagnosed with personality disorder (35. -6).

Within this account, they did not feel that men and women have significant distinctions, between internalised and externalise forms of aggression or that men had different areas of need and traits (27. -5). The former point is evidenced in the following statement:

56. -5 MdwPD are more likely to express aggressive behaviour towards others or property, but females will display self-harm behaviour and suicide threats.

They denied the notion that male Mental Health Nurses create difficulties for female staff to develop a therapeutic relationship with men diagnosed with personality disorder (66. -5).

It is strongly denied, that the mass media creates stereotypes about personality disorder which feeds society's prejudicial fears (44. -6), or that the dominant view in society is that they consider men hospitalised with the diagnoses of

personality disorder, as psychopaths (13. -6). It is perhaps, unsurprising given the emphasis upon early childhood disruptions in relationships, described above, that they also do not believe that they can cope in society, even prior to their problem becoming apparent/manifest when they may break the law (54. -4). Unfortunately, it is perceived that personality disorder is a convenient label which limits people's understanding of the individual (11. +3), and that due to the diagnostic problems, clinicians should focus on the behaviour that brought them to the attention of the health services (28. +4).

6.7 Account Six: Personality Disorder, Relationships and Society.

Figure 6.6: Factor Array: Factor 6.

-6	-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5	+6
47	**44**	**67**	68	69	24	14	11	40	31	**10**	**4**	**1**
36	**64**	**51**	66	9	63	18	33	41	32	**12**	**37**	**2**
6	**27**	**65**	7	22	23	19	48	42	5	**45**	**58**	**3**
		13	15	56	8	20	49	43	38	**46**		
			59	25	29	50	21	52	39			
			55	28	35	16	54	57	53			
				26	34	30	60	62				
					17	61	70					

This account had an eigenvalue of 1.32 and was presented by one experienced female staff nurse from a medium secure environment (participant 6 (loading 0.67)).

Within this account, it was felt that people are not born with personality disorder but develop it through their experiences (37. +5) and that men diagnosed with personality disorder often recreate past relationships which evokes similar responses (4. +5). It was felt strongly that these relationships are often intense and dependent with key individuals (2. +6). However, they do not form close relationships because they fear negative outcomes (3. +6), often waiting for people to abandon and reject them (1. +6). Consequently, both men and women diagnosed personality disorder are understood to have learnt in childhood not to express certain emotions. Nevertheless, they do not believe that they have 'faulty learning' resulting in a distorted understanding of what is right or wrong (36. -6) or that it is a condition which affects their perceptions of others and their relationships (6. -6).

This account differs in similarity slightly from account five with its stronger emphasis on the belief that men within this diagnostic group do not have 'faulty learning' which results in distorted morality (36. -6) or that they have difficulty in their perception of others and their relationships (6. -6). Nevertheless, it is believed that they do not form close relationships because of a fear of negative outcomes (3. +6).

Society predominately uses the term personality disorder in a derogatory manner (12 +4). However, it is refuted that the mass media feeds society's prejudicial fears (44 -5), including the notions associated with gender that: society is concerned when women act outside idealised images of motherhood (64 -5), or that famous male sex offenders are considered evil (67. -4). In agreement with account five, she does not believe that society views men diagnosed with personality disorder within her hospital as psychopaths (13. -4). From a cultural perspective it was felt that, black Afro-Caribbean males are more likely to be diagnosed mentally ill than with a personality disorder (45. +4), which opens up interesting questions about the cultural stereotyping associated with diagnosis. Finally, she does not believe that male rather than female Mental Health Nurses have difficulty seeing men diagnosed personality disorder as anything other than offenders (65. -4).

The treatment needs and personality traits are understood not to differ significantly from others (27. -5). It was felt strongly, that men diagnosed with personality disorder are treatable (47. +4) and not only the parts of their personality which caused danger to society (51. -4). Treatment needs to look beyond the challenging behaviour (46. +4), with provision given to the right

attention to boundaries it can provide men diagnosed with personality disorder with favourable responses (10. +4).

6.8 Account Seven: Race, Gender, Treatment, and the Non-prejudicial Society.

Figure 6.7: Factor Array: Factor 7.

-6	-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5	+6
67	35	69	70	8	7	36	12	27	16	10	43	45
61	44	56	68	3	11	24	37	29	26	34	50	46
17	13	55	65	6	9	47	38	30	33	39	62	64
		52	19	23	32	51	41	48	42	66		
			14	1	5	54	2	53	59			
			25	4	20	57	49	15	63			
				18	28	58	21	60				
					40	31	22					

This account had an eigenvalue of 1.14 and was presented by one experienced male staff nurse from a low secure environment (participant 26 (loading 0.73)).

It was strongly felt within this account that black Afro-Caribbean males are more likely to be diagnosed mentally ill than with personality disorder (45. +6). This appears to indicate that the diagnosis of personality disorder is often the preserve of white males, and that other races presentations are often 'mis/understood' as mental illness.

In terms of gender, it is strongly thought that society predominantly equates women to idealised images of motherhood, resulting in concern when they act outside this stereotype (64. +6). It is understood that men diagnosed with personality disorder are more likely to have committed a sexual offence than women (62. +5), but the notion is strongly disputed regarding the likelihood that women are more likely to commit acts of arson (61. -6). Further gender distinctions are refuted concerning:

55. -4 When women DwPD use avoidant strategies to keep their emotions hidden it is easier to see than with men.

56. -4 MdwPD are more likely to express aggressive behaviour towards others or property, but females will display self-harm behaviour and suicide threats.

The final, gender distinction is reserved for the belief that male Mental Health Nurses can create difficulties for female staff to develop a therapeutic relationship with men diagnosed with personality disorder (66 +4), which may be understood as an attempt to provide a protective strategy.

Personality disorder creates a prejudice regarding their expected pattern of behaviours (39. +4), consequently when treating men diagnosed with personality disorder you need to look beyond the challenging behaviour (46. +6). Treating people within this diagnostic group can be difficult unless they have been detained after breaking the law (50. +5), but equally they should not be detained indefinitely for offences they 'may' commit (43. +5). Given the right attention and boundaries they can eventually be led to favourable treatment responses (10. +4). Nevertheless, the current treatments available for men diagnosed with personality disorder will, in the future, be regarded as quite primitive (52. -4).

On self-reflection, when working with men diagnosed with personality disorder there is an expectation, for the need to be guarded, and explore ways to protect oneself (34. +4). However, this does not amount to perceiving them as powerful and controlling (69. -4) or having to feel threatened or worried about one's career (35. -5).

The media does not create stereotypes regarding personality disorder which can feed societies prejudicial fears (44. -5). It is strongly felt that society does not consider: famous male sex offenders to be evil (67 -6), the term personality disorder is used to imply badness (17. -6), or that men diagnosed and hospitalised with personality disorder are thought of as psychopaths (13. -5).

6.9 Account Eight: 'Personality Disorder'?

Figure 6.8: Factor Array: Factor 8.

-6	-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5	+6
6	7	60	67	69	63	24	25	4	1	29	21	28
22	66	26	65	39	19	20	32	11	31	43	58	37
44	48	8	52	64	55	13	2	30	35	46	70	49
		12	61	47	53	40	42	33	9	5		
			36	59	51	41	15	14	50			
			56	38	3	45	57	54	68			
				27	17	18	23	10				
					34	16	62					

This account had an eigenvalue of 1.09 and was presented by one experienced male staff nurse from a medium secure environment (participant 8 (loading 0.80)). Account eight focuses primarily on attempting to understand the nature of personality disorder from both a personal and sociological perspective.

Firstly, it is strongly believed that people are not born with personality disorder but develop it through their experiences (37. +6), suggesting there is a focus upon learnt behaviour. Consequently, people diagnosed with personality disorder have learnt, in childhood not to express certain emotions (58. +5), which doesn't mean that they consistently demonstrate negative emotions (26. -4) or that they do not learn from their experiences and repeat past mistakes (7. -5). Secondly, diagnostic problems should be resolved by focusing on the behaviour which brought them to the attention of the health services (28. +6).

However, within their relationships they do find disturbing ways to try and extract a sense of safety from others (5. +4), seeming always to want their own way (29. +4), but not entirely effecting their perception of others and their relationships (6. -6). This does not mean that they are unable to develop stable

trusting relationships (8. -4) or that they cope with any lack of relationships by creating a rich fantasy life (48. -5).

They have awareness that they have a problem but are unwilling/unable to embrace an alternative perspective (49. +6), consequently one needs to look beyond their challenging behaviour (46. +4).

It was acknowledged that at times men diagnosed with personality disorder can evoke feelings of weakness and inadequacy (70. +5). These feelings and others do not result in 'protective strategies' being utilised, involving male Mental Health Nurses creating difficulties for female staff in their endeavours towards developing therapeutic relationships with men diagnosed with personality disorder, evidenced by the following statement:

66. -5 Within your hospital male Mental Health Nurses create difficulties for female staff to develop a therapeutic relationship with MDwPD.

Society does not predominantly use the term personality disorder in a derogatory manner (12. -4) and it was strongly felt that the media does not create stereotypes about personality disorder which may feed society's potential prejudicial fears (44. -6).

Generally, it is understood that personality disorder is not a label which is put on people who cannot be managed (22. -6), but maybe used as a form of social control because they fall outside of a major mental illness category and cause concern to society (21. +5). It is not believed that women diagnosed with personality disorder will be more often sent to prison than men (60. -4) and that

indefinite detention should not occur for offences that they ‘may’ commit (43. +4).

6.10 A Brief Summary of All the Accounts

All eight accounts were distinctly different with additional themes which appeared to overlap.

In account one, it was suggested that although participants do not feel threatened by the worrying stigma associated with men diagnosed with personality disorder, they wish to understand them. In this account and others there was an absence of what personality disorder is, alongside strong opinions about what personality disorder is not. Furthermore, there were consistently strong views expressed about the lack of utility associated with the legal and psychiatric definitions/diagnosis of the term 'personality disorder.' Various perspectives were offered regarding how the 'label' is used to negatively stigmatise or used inappropriately to control and manage, rather than help inform a productive treatment pathway.

In account two, again there was a focus on what personality disorder does not represent, appearing to dismiss theoretical understanding, raised concern about the utility of classification systems, and appeared to challenge the authenticity of information provided by men diagnosed with personality disorder. Centrally, it reflected upon the distinctions and similarities regarding race and gender for those people diagnosed with the term personality disorder. In common with another account it raised an important racial distinction based on the observation that the diagnosis of personality disorder is predominantly the preserve of white British men, whilst black Afro-Caribbean men will more often be diagnosed as mentally ill.

In account three, it focused upon what the enigma of personality disorder was not, compounded by notions of ‘badness', and believing that it is used to manage and control those people that cannot be constrained within a mental illness classification. It also highlighted a developmental cause which would be amenable to new learning. Gender equity was identified in terms of perceived behaviour.

Account four, identified classification difficulties and raised concerns about others perceptions: that the only treatable aspects of men diagnosed with personality disorder are those that brought them to the attention of the law or health services, and that their civil liberties should not be transgressed through potential legislation which would lead to pre-emptive detention. Again, developmental causes were identified but not affecting their perceptions of relationships or resulting in unstable negative emotions.

In account five, there was a strong emphasis upon relationships understood within contemporary theory associated with the term personality disorder and how this can be demonstrated through the replication in the present of difficult past relationship dynamics. The gender distinctions were again highlighted from a differing perspective, but in harmony with other accounts it was felt that poor diagnostic classification inadequately informs the treatment pathway.

Account six, had a stronger emphasis on what personality disorder is, with a particular focus upon the impact it has on relationship dynamics. It also dismisses notions that society or the mass media creates stereotypes

surrounding personality disorder. The question of ethnicity contributing towards diagnosis was also raised.

Within **account seven**, there was a stronger emphasis upon race and gender distinctions; reinforcing the potential ethnic influence upon diagnosis and introducing perceptions in society of matriarchal influences affecting different gender presentations in people diagnosed with personality disorder.

Account eight, was congruent with contemporary theoretical relationship perspectives. Nevertheless, it was felt that the reason for the referral and the type of treatment context would be essential factors in terms of the treatment outcome. The reflective capacity of the Mental Health Nurse was also felt to be an important consideration. Diagnostic classification was also considered to be an unhelpful tool.

6.11 Conclusion.

This chapter has briefly extended the description of the data analysis process commenced in the previous methodology chapter. The Mental Health Nurse participants' data was then reported and described. Within this chapter the participants have been focusing upon what they understand about personality disorder, which has quite naturally started to focus upon a central component of personality disorder concerning their relationships. Consequently, the next chapter will focus upon how 'Mental Health Nurses make sense/process the relationship difficulties'.

CHAPTER SEVEN:

RESULTS: UNDERSTANDING OF PERSONALITY DISORDER RELATIONSHIPS ('B'-SET).

Chapter Seven.

Results: Understanding Of Personality Disorder Relationships (‘B’-Set).

7.1 Introduction.

This chapter presents the results of Q-set ‘B’ in the form of seven factor accounts which is related to the studies second and third research aims identified in section 1.6. The aim or 'communication concourse' of this section of the study was in part to address the second aim, identified below:

2. What are Mental Health Nurses’ understandings of the relationship difficulties that men diagnosed with personality disorder have and how does this influence the nurse-patient relationship?

To assist the contextualising of these research aims chapter 3 consists of a literature review and discussion pertaining to what Mental Health Nurses’ understand about personality disorder relationships and how does this influence the nurse-patient relationship?

The literature review was not used as part of the concourse due to the richness of the participant interviews, but can be understood alongside the factor accounts in this chapter. In the previous chapter Q-set ‘A’ was presented pertaining to Mental Health Nurses’ understanding of personality disorder, some of which was contextualised within their understanding of the relationship. A brief summary of the procedure will be provided, followed by the factor loadings. Each of the seven distinct factor’s/accounts is presented separately and includes its factor array (clustered statements), participant information, interpretation of the clustered statements (each statement is referenced in the text alongside its loading).

As a means of signposting the seven accounts, Table 7.1 also lists the accounts with titles followed by their explanatory section number in brackets. The titles (eg. 'Coping with the 'Relationship' & the Utility of Labels'.) only serve to provide an approximate description of the accounts and should be understood to have a broader interpretation. Subsequently each account is presented, discussed, and supported with its relevant statements, including statement number and value/loading it was accorded e.g. +6/-6 (described in section 5.4).

Procedure.

As in Chapter Six which focussed on the results from Q-set 'A' the procedure description to create the specific statements for Q-set 'B', the transcripts from ten, one hour semi-structured interviews (interview schedule - appendix 2, details of interviewees - appendix 5) across high, medium and low secure environments were utilised to provide statements for the 'understanding of personality disorder relationships' Q-sort. A total of 160 separate statements were created, reduced to 152, of which following the pilot study generated 80 statements for the Q-set ('B') pertaining to the research aims. The final version of Q-set 'B' statements can be found in appendix 6, along with the instructions for completing the Q-sort (including the values, and scoring grid) are in appendix 1. The Q-sorting was undertaken by N=40 and their data (the numerical value of their choice of statements) was individually entered onto the dedicated computerised Q-methodology package 'p.c.q.' Version 2.0 factor analysis program (described in sections 4.3.6 and 5.5). The factor analysis program determines the level of agreement or disagreement between participant Q-sorts resulting in a correlation matrix. The statistical program determines the significant clustering of similar viewpoints, culminating in the

production of a ‘factor array’ (positioning of statements for that factor) based on the weighted average of all the Q-sorts which correlate/load (5.6). In addition, the analysis can involve varimax rotation which was utilised but did not change the factors due to their strength of loading e.g. above the minimum default threshold of 0.45 (4.3.7). Each of the seven factors achieved an eigenvalue above 1.00 which indicates a strong loading and significance (5.4) and have been individually highlighted prior to each factor in this chapter. No non-significant (does not load onto any factor) or confounding (load significant onto more than one factor) Q-sorts were highlighted. The final part of this process involves the interpretation of the statistical data by the researcher which involves a qualitative description of the emerging viewpoints discussed in 5.6 and presented in this chapter.

Following the factor analysis seven accounts were extracted pertaining to the Q-set – ‘understanding of male personality disorder relationships, which all loaded positively with no negative loadings (factor loadings, e.g. position of statements for each account and z-scores are contained within appendix 8b and in figures 7.1-7). Table 7.2 indicates the participants and their factor loading, whilst in Table 7.1 the participants are identified below by their participant number, gender and site (further details in appendix 7). It was decided not to include the Mental Health Nurses’ job title due to a potential for breaching their anonymity, however all the participants in this section are registered mental nurses. Nevertheless, where job titles are referred to anonymity is preserved due to their large numbers e.g. Staff Nurse, and broad interpretation e.g. manager.

As noted in chapter 4 and 5, only a brief account of the procedure is provided here and only factor summaries (as accounts) will be presented in this chapter

Table 7.1: Relationships Difficulties with Men Diagnosed with Personality Disorder Factors – significantly loading Q-sorts.

Factor/Account No. Title and (section number). (All factors loaded positively).	**Participant No.**	**Gender.**	**Site.**
One: Processing Present Relationships**.** (7.2).	1 3 5 6 7 9 10 14 16 24 37	M F M F M M F M M F F	Medium Secure Medium Secure Medium Secure Medium Secure Medium Secure Medium Secure Medium Secure Low Secure Low Secure Low Secure High Secure
Two: The Impact on Therapeutic Relationships ('Emotional Rape') (7.3).	26 27	M M	Medium Secure High Secure
Three: Relationships Are Consciously Driven but Don't Talk About the Past (7.4).	13 29 32 35	F M F M	Medium Secure High Secure High Secure High Secure
Four: Coping with Emotional & Other Responses. (7.5)	23	M	Low Secure
Five: Coping with the 'Relationship' & the Utility of Labels. (7.6).	36	M	High Secure
Six: The Relevance of Past and Present Behaviour, and Female Staff Issues (7.7).	11 25	F F	Medium Secure Low Secure
Seven: Relationship Strategies, The Impact & Processing (7.8).	8 22	M M	Medium Secure Low Secure

Table 7.2: Factor Matrix with an X Indicating a Defining Sort Loadings.

QSORT	1	2	3	4	5	6	7
1 1SM	0.6135X	0.2649	0.3569	0.0314	0.0295	0.1859	0.0831
2 2SM	0.5869	0.1408	0.2204	0.4006	0.1330	0.1404	-0.0060
3 3SF	0.7985X	0.1144	0.0682	0.0675	0.0607	0.0804	0.0535
4 4SF	0.4215	0.2232	0.3275	0.3361	0.1709	0.4435	0.1426
5 5SM	0.5781X	0.1552	0.2181	0.1613	0.3509	0.1962	0.2236
6 6SF	0.7275X	0.0492	0.2231	0.2123	0.0780	0.3166	0.1715
7 7SM	0.7149X	0.2923	0.2585	-0.0209	-0.1498	0.1505	0.0382
8 8SM	-0.0067	0.1113	0.1712	0.0248	0.0922	0.1035	0.7912X
9 9SM	0.6233X	0.2589	0.1437	0.2911	0.1520	0.0300	0.1126
10 10SF	0.7168X	0.0946	0.2516	0.0486	0.0735	0.2012	-0.0708
11 11SF	0.2904	-0.0256	0.1388	-0.0092	0.1626	0.7962X	0.1986
12 12SM	0.6044	0.0808	0.3326	-0.0751	0.3543	0.2291	0.1043
13 13SF	0.3186	-0.0849	0.7145X	0.2657	0.0136	0.1794	-0.0613
14 14OM	0.5887X	0.2862	0.3502	0.2516	-0.1820	-0.0047	0.0748
15 15OF	0.2476	0.3444	0.4503	0.0810	0.2443	0.3669	0.0978
16 16OM	0.7072X	0.1283	0.1409	0.0070	-0.0559	0.2977	0.3231
17 17OF	0.5138	0.3702	0.4149	0.2509	0.1097	0.1656	0.1672
18 18OM	0.3498	0.1952	0.2792	0.4979	0.2523	0.2268	0.1455
19 19OF	0.4485	0.5261	0.2624	-0.1452	0.1370	-0.0773	0.1546
20 20OF	0.5353	0.2945	0.1508	0.3532	0.1936	0.3041	-0.0492
21 21OF	0.5535	-0.0046	0.4447	0.3019	0.0777	0.2736	0.1739
22 22OM	0.2600	0.0496	0.2048	0.3192	-0.0131	0.2625	0.6815X
23 23OM	0.1232	0.1111	0.1958	0.8170X	0.0107	-0.0479	0.1596
24 24OF	0.7474X	0.0936	0.2049	0.1822	0.0526	0.0959	0.1115
25 25OF	0.1823	0.3103	0.2656	0.0774	0.1099	0.6678X	0.1049
26 26OM	0.3895	0.5701X	0.2244	0.1988	-0.0102	0.1355	0.1413
27 27AM	0.1437	0.7203X	-0.0528	0.1810	0.0547	0.1992	0.0084
28 28AM	0.4227	0.1713	0.3345	0.3533	-0.3650	0.3929	0.1157
29 29AM	0.2997	0.0960	0.7125X	0.1234	0.0403	0.0979	0.3245
30 30AF	0.2302	0.3027	0.4572	-0.0373	0.1440	0.3544	0.1715
31 31AM	0.5200	0.4139	0.1461	0.1880	0.0711	0.2225	0.0249
32 32AF	0.2962	0.1947	0.6082X	0.1742	0.2060	0.0755	0.3225
33 33AM	0.2285	0.1887	0.0951	0.1470	0.1406	-0.0334	0.2377
34 34AM	0.1854	0.3871	0.3628	0.1761	0.0833	0.3085	0.1889
35 35AM	0.1720	0.2041	0.6369X	0.1150	0.1210	0.2410	0.1507
36 36AM	0.0446	0.0967	0.1613	0.0842	0.8382X	0.1971	0.0607
37 37AF	0.5159X	0.0957	0.3061	0.2426	-0.0887	0.2073	-0.0335
38 38AM	0.4483	0.2243	0.2701	-0.0289	0.0178	0.4691	-0.0081
39 39AM	0.4585	0.0954	0.5175	0.1387	0.1800	0.0886	0.0356
40 40AM	0.3784	0.0684	0.5145	0.0697	-0.0322	0.2476	0.0485
% expl.Var.	22	7	12	6	4	8	5

7.2. Account One: Processing Present Relationships.

Figure 7.1: Factor Array: Factor 1.

-6	-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5	+6
61	74	60	27	54	19	3	70	72	58	69	44	24
78	53	35	79	29	17	38	48	7	71	76	41	66
62	4	55	2	50	26	22	56	77	51	52	63	46
	67	1	37	11	82	39	47	6	68	23	75	
		81	57	43	20	14	65	64	12	21		
			15	18	33	8	59	45	42			
			31	13	32	30	16	73	40			
				34	9	5	49	80				
					28	10	36					
						25						

This account had an eigenvalue of 18.81 and was presented by seven nurses who work within a medium secure environment (participants 1M* (loading 0.61), 3F (loading 0.79), 5M (loading 0.57), 6F (loading 0.72), 7M (loading 0.71), 9M (loading 0.62), 10F (loading 0.71), three from a low secure environment (participants 14M (loading 0.58), 16M (loading 0.70), 24F (loading 0.74)), one from a high secure environment (participant 37F (loading 0.51)).

> * The 'M' or 'F' letter following the participant number indicates the participants gender.

It was strongly felt within this account that an increased understanding of men diagnosed with personality disorder is obtained by ignoring pejorative labels and relating to them as individuals (66. +6), and that even diagnostic labels do not make it easier to work with this group of individuals (2. -3). Despite the above confusion about personality disorder, it is felt that understanding about men diagnosed with personality disorder is evolving rapidly and hence the importance of maintaining a contemporary knowledge base (71. +3). Unfortunately this is insufficiently catered for in basic nurse training, resulting in problems when attempting to identify relationship difficulties (58. +3).

Men diagnosed with personality disorder often repeat past dynamics which are acted out within their current environment (69. +4), and will try to elicit responses from people which are similar to significant people from their past (21. +4). Nevertheless, it does not necessarily mean that they have learned to use avoidant strategies due to past rejection that would impinge upon their ability to form trusting relationships (1. -4). Neither, does it mean that one would need to be constantly aware of potentially: extreme care eliciting strategies (35 -4) or charming, manipulative, seductive strategies (4. -5). The latter point is evidenced by the following statement:

> 4. -5. When working with MdwPD you need to be constantly aware that they can be charming, manipulative and seductive.

However, it was felt that understanding was not necessarily to be found through the consistent responses they elicit in their relationships with others (60. -4), or through transference relationships (53. -5). Interestingly, they also believed that the information that men diagnosed with personality disorder withhold may have equal significance to the information they impart (76. +4).

Despite, the above focus on the importance of past relationships, there was a strong rejection regarding: the importance of collecting information about: childhood relationships (62. -6), how they coped with childhood adversity (61. -6) or exploring why certain types of relationships are sought (74. -5). It was felt that they do not often provide unreliable accounts that would require the necessity of obtaining a comprehensive history from a variety of sources (67. -5).

On a positive level they do not believe that men diagnosed with personality disorder are affected to the degree of either being unable to: think of the consequences of their actions (37. -3), or maintain trusting/honest relationships which would limit their therapeutic alliance (27. -3).

It was strongly felt that it is important to understand yourself before working with men diagnosed with personality disorder otherwise relationship difficulties may increase (24. +6), and that one needs to be aware of their relationship style because it could evoke unresolved feelings belonging to oneself (23. +4, 52. +4). However, this does not amount to a transference relationship, which was perceived as not enhancing understanding (53. -5).

Supervision for Mental Health Nurses is seen as important due to the above impact upon oneself, which can be exacerbated by the horrific histories that men diagnosed with personality disorder can present (44. +5). Hence, one should not ignore the negative feelings in your relationship until it becomes too much (78. -6), or become involved in self-defeating strategies in which one views men diagnosed with personality disorder in terms of a challenge that one will not be defeated by (51. +3). Confiding in someone else about ones relationship difficulties with men diagnosed with personality disorder was not understood as a weakness (55. -4).

Seemingly, insignificant information about men diagnosed with personality disorder is considered to be potentially relevant within a reflective practice group (75. +5), particularly because different perspectives may be held by various professionals which should be integrated through discussion (68. +3)

and the reflective processes within it (63. +5). Recognition of the relationship difficulties becomes easier through the collective expertise of the group (41. +5), which can enhance one's ability to both challenge and support men diagnosed with personality disorder (46 +6). Nevertheless, the group process should not hinder individual professionals' flexibility to act on new information (79. -3, 81 -4) as evidenced by the following statements:

79. -3	Before acting on a new understanding in your relationship with MDwPD you should consult with your peer group.
81. -4	Decisions should be acted on consistently when working with MDwPD

7. 3. Account Two: The Impact on Therapeutic Relationships ('Emotional Rape').

Figure 7.2: Factor Array: Factor 2.

-6	-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5	+6
53	62	13	72	11	51	32	3	27	47	82	75	56
54	78	61	71	31	17	7		49	77	9	38	12
81	79	35	67	15	34	22	59	25	14	33	44	58
	74	4	29	19	26	36	41	76	16	68	69	
		45	39	64	50	20	21	65	66	80		
			2	1	23	40	46	6	63			
			24	42	18	73	5	55	60			
				37	48	52	43	57				
					30	28	10					
						8						

This account had an eigenvalue of 2.09 and was presented by two experienced nurses (male), who work within a low secure environment, and the other was a Ward Manager from a high secure environment (participants 26 (loading 0.57) and 27 (loading 0.72).

Within this account there was a strong recognition of the emotional impact of the nurse/patient relationship, underlined for example by powerful imaged statements: 'men diagnosed with personality disorder can make you feel emotionally raped' (33. +4), they elicit feelings of guilt when they set you up to reject them (38. +5), a caring nursing role will be dramatically eroded by the challenging nature of their relationships (82. +4). To underline and assist contextualisation of the impact that men diagnosed with personality disorder can have on Mental Health Nurses the following extract is provided from the participant who contributed the statement (33. +4):

> I think the first thing that a Mental Health Nurse (M.H.N) needs to know is what the 'opposition' have, the effect they can have on you, what they are going to present you with. I think you can under-estimate them. The

> effect they can have on you? They can have a massive effect on you. They can leave you going home in a sense of failure, in a sense ang, angry, annoyance, almost as I, you feel, you have been infiltrated. You can be, be emotionally raped by these guys. It is a dramatically strong word but I hope I have used it in the right context. These guys can take every ounce of energy out of you and not so much as a thank you, and once done, that go against everything you have done with them the day before. I think a MHN's needs to realise their potential. And one of the most important things that I have learnt, that MHNs need to learn, is not only are you here to treat them, or to treat their presentation, or their traits that I spoke about earlier, but you are also here to protect them from their own worst instincts, that is something is very often forgotten. Erm, and I think the last thing is there is very little rewards, successes are small, you are not going to cure them over night, you are not going to cure them as such, these are my beliefs. Erm, so be prepared for this. From a moralistic point of view, from a moral point of view, you know, they don't send you home singing their praises. You need to be realistic because potentially you have, and don't invest everything into the relationship, don't give of yourself too much because they will just take, take, and take, and give nothing back. (Participant 27).

This extract helps to highlight the emotional impact that men diagnosed with personality disorder can generate. This participant is a respected clinical leader who is normally very fluent but becomes dysfluent when expressing the emotional affect.

However, they are not perceived as either egocentric (13 -4), or requiring a constant awareness of their ability to be charming, manipulative and seductive (4 -4). There was a strong recognition of their potential to seduce others into feeling special (56 +6) and their ability to undermine ones authority (9 +4), which may not seem to be a problem at the time.

Nevertheless, the potential difficulty of distinguishing which feelings belong to oneself and which to the person diagnosed with personality disorder was not thought to be excessively problematic (45 -4). Although they were clear about this distinction, they did not seem complacent, perhaps evidenced by the

importance attached to: the need to constantly reappraise the direction of the relationship (80 +4), their denials of not reporting relationship difficulties for fear of potential consequences (54 -6) and not reporting negative feelings until they become too much (78 -5).

The negative feelings engendered, which cause current relationship difficulties are recognised, as partly originating from their relationship difficulties in the past, which often parallel past dynamics (69 +5). The variety of extreme strategies utilised by men diagnosed with personality disorder were not thought to be motivated to elicit caring responses from others (35 -4).

The recognition identified above, of the importance of past relationships upon current relationship difficulties, appears to be deemed less significant when attempting to process the current dynamic. It was not felt to be important to gather information about: significant childhood relationships (62 -5), how they coped with adverse childhood experiences (61 -4), or to understand why they seek out certain types of relationships (74 -5). However, there was recognition of the importance of processing seemingly insignificant information about men diagnosed with personality disorder because within the context of a reflective practice group it may be very relevant (75 +5), particularly due to the differing understandings which can benefit from an integrative narrative (68 +4).

The histories that men diagnosed with personality disorder present are often considered so horrific, that it was thought to be imperative that supervision is utilised to explore the impact upon oneself (44 +5). Despite the importance of utilising the group, the flexibility of acting on new understanding outside one's

peer group was understood as valuable, as evidenced in the following statements:

79 -5 Before acting on a new understanding in your relationship with MDwPD you should consult with your peer group.

81 -6 Decisions should be acted on consistently when working with MDwPD

The paucity of specific training in relation to personality disorder, within basic nurse training, is seen as one of the strongest reasons for problems in identifying relationship difficulties (58 +6) and also for being unable to set appropriate boundaries and limits with men diagnosed with personality disorder (evidenced below in 12 +6). However, it was understood that the absence of adequate training does not necessarily lead to a damaging experience (53 -6).

12 +6 Setting boundaries and limits with MDwPD has been difficult because my basic nurse training did not prepare me sufficiently.

7.4. Account Three: Relationships Are Consciously Driven but Don't Talk About the Past.

Figure 7.3: Factor Array: Factor 3.

-6	-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5	+6
37	31	62	78	50	19	65	21	52	13	76	44	30
54	79	57	61	45	20	25	77	23	39	41	71	32
53	67	26	35	60	38	8	69	36	46	10	9	34
	55	4	1	15	22	64	6	63	80	75	3	
		56	28	14	2	70	16	66	42	24		
			81	27	82	11	48	68	47			
			74	7	18	29	5	72	49			
				43	17	12	51	73				
					33	58	40					
						59						

This account had an eigenvalue of 1.61 and was presented by four nurses (two male and two female) one of whom works in a medium secure environment (participant 13F (loading 0.71)), whilst three work within a high secure environment (all very experienced including two ward managers - participants 29M (loading 0.71), 32F (loading 0.60), 35M (loading 0.63)).

It is believed that men diagnosed with personality disorder are egocentric (32. +6) and lacking empathy for the feelings of others (30. +6). Their ability to think of the consequences of their actions is not thought to be impeded (37. -6), suggesting that their actions are consciously driven. At one level it is understood that some transparency exists in that their general behaviour is not designed to minimise or to draw others into their minimisation (31. -5). This transparency is underlined further by the belief that they do not often give unreliable accounts; hence it negates the need to obtain comprehensive historical accounts from a variety of sources, as evidenced by:

67. -5 MdwPD will often give unreliable accounts so it is important to obtain a comprehensive history from a variety of sources

Alternatively, when working with men diagnosed with personality disorder one cannot judge anything purely on face value (3. +5), particularly when they attempt to undermine one's authority (9. +5) or use very indirect ways to express their difficulties (47. +3). Consequently, the information they impart and do not impart may have equal significance in understanding them (76. +4).

From a motivational perspective it is believed to be difficult to work with men diagnosed with personality disorder because they do not appear to want to change (13. +3), often understanding that they do not have a problem (34. +6), compounded by the difficulty in negotiating (10. +4).

There is less significance associated with past events which may inform present difficulties, evidenced by the belief that men diagnosed with personality disorder do not use a variety of extreme strategies to elicit caring responses from others (35. -3) or that their foundation in establishing trusting relationships is impeded because they have learnt to use avoidant strategies due to past rejection. Additionally, it is not considered important to gather information about significant childhood relationships (62. -4) or how they cope with adverse childhood experiences (61. -4).

Interestingly, there is recognition of the excessive use of drugs and alcohol as a coping mechanism (39. +3) and the importance of observing their lifelong script/narrative, which presumably would have early origins as evidenced in:

42. +3 Failure to recognise relationship difficulties with MDwPD Can occur when failing to observe their life long script/narrative.

When working with men diagnosed with personality disorder it was not felt necessary to be constantly aware that they can be charming, manipulative, and seductive (4. -4). Equally, there was a denial of either being: seduced into feeling special (56. -4), having colluded with them to feel safe (26. -4) or that they themselves had conformed to offensive staff group behaviour (28. -3). Nevertheless, there was a strong denial that they would resist reporting relationship difficulties for fear of potential consequences (54. -6), believing that one should never ignore negative feelings in relationships until it is too late (78. -3). Importantly, it was understood that relationship difficulties may increase if one does not understand oneself (24. +4) or if there was a lack of vigilance in constantly reappraising the direction of the relationship (80. +3).

Supervision/reflective practice were considered important to explore the impact upon oneself particularly after being exposed to sometimes 'horrific histories' (44. +5). They appeared confident that using this process they would not be negatively interpreted (57. -4) or that by confiding it would be evaluated as a weakness (55. -5). It was recognised that seemingly insignificant information about men diagnosed with personality disorder could be very relevant within a reflective practice group (75 +4), and that their collective expertise enables easier recognition of relationship difficulties (41. +4). However, without sufficient feedback from others it can be difficult to both challenge and support men diagnosed with personality disorder (46. +3). Nevertheless, all decisions outside the group do not necessarily require to be acted upon consistently (81. -3), and

acting upon new understandings in one's relationship does not always require consultation with one's peer group (79. -5).

Finally, due to the rapidly evolving understanding about men diagnosed with personality disorder it was felt to be important to maintain a contemporary knowledge base (71. +5) but without adequate training this working relationship would not be very damaging (53. -6).

7.5 Account Four: Coping with Emotional & Other Responses.

Figure 7.4: Factor Array: Factor 4.

-6	-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5	+6
50	51	55	37	15	1	38	20	14	22	28	32	30
36	13	54	78	19	81	8	16	25	24	29	33	40
39	43	4	77	74	72	47	12	9	27	31	3	41
	35	5	56	53	18	49	21	10	44	42	71	
		45	57	70	11	63	59	2	65	46		
			48	62	26	66	64	58	69			
			67	61	6	68	73	17	75			
				23	60	7	76	80				
					52	34	79					
						82						

This account had an eigenvalue of 1.43 and was presented by one newly qualified nurse (male) who works in a low secure environment (participant 23 (loading 0.81)).

Within this account it is believed that men diagnosed with personality disorder are egocentric (32. +5), lacking in empathy for the feelings of others (30. +6), and not only minimise their own behaviour but draw others into their minimisation (31. +5). Consequently, one cannot judge anything purely on face value (3. +5), but not to the extent of having to be constantly aware that they can be charming, manipulative and seductive (4. -4). Nevertheless, it is believed that female Mental Health Nurses are more likely to have their boundaries eroded (29. +4). But, generally, it is not believed that jealousy or acting out behaviour is caused if female staff spend too much time with one man diagnosed with personality disorder rather than another (5. -4).

It is not believed that men diagnosed with personality disorder use a variety of extreme strategies to elicit caring responses from others (35. -5) or that they use drugs and alcohol excessively as a coping mechanism (39. -6).

Regardless of their presentation it is understood that they do wish to change (13. -5). Despite some of the negative evaluations noted above it was strongly felt that they should not be seen entirely from this perspective, and do not become desensitised, or view the relationship as a self-defeating challenge. Equally, it is not believed that if one is not shocked at some stage by them that one could be missing something (43. -5). Furthermore, the following statements lend support to the above position:

50 -6	It is easier to see the negatives rather than the positive aspects of MDwPD.
36 -6	When I have worked for a long period of time with MDwPD I can become desensitised to their behaviour.
51 -5	It is self-defeating to see MDwPD in terms of a challenge that you will not be defeated by.

A measure of the potential impact that men diagnosed with personality disorder can have is contained in the belief that they can make you feel emotionally raped (33. +5). Clearly, if such strong feelings can be raised it is important to have a clarity about what may belong to oneself and what may belong to the person within this diagnostic category. However, there is a denial of a difficulty in determining what feelings belong to men diagnosed with personality disorder and what belongs to oneself (45. +6). There was a strong recognition that relationship difficulties do exist when one experiences feelings which are uncharacteristic of oneself (45. -4). This uncharacteristic experience/behaviour can also extend to conforming to collective responses in staff groups, which can prove offensive to men diagnosed with personality disorder, which is evidenced further in a statement below (28. +4). A failure to recognise this relationship

difficulty can be compounded when not observing for their life long script/narrative (42. +4).

28. +4 At times, I find myself conforming to staff group behaviour which is outside my character and can prove offensive to MDwPD.

In the midst of seeming pressures from both staff groups and clients it could be imagined that defensive structures could be created to inhibit further understanding. This seems to be refuted in the belief that confiding in others about relationship difficulties does not feel like a weakness (55. -4) and that there is not a fear of the potential consequences when reporting these relationship difficulties (54. -4). Furthermore, it was strongly felt that it is easier to recognise relationship difficulties with men diagnosed with personality disorder when consulting with the collective expertise of the staff group (41. +6) and without sufficient feedback from others it can be difficult to challenge and support them (46. +4). Clearly, a distinction/understanding is required about these two group processes and the differing outcomes highlighted above. Finally, there was a strong acknowledgement that an understanding of men diagnosed with personality disorder is evolving rapidly and that there is an importance in maintaining a contemporary knowledge base (71. +5).

7.6 Account Five: Coping with the 'Relationship' & the Utility of Labels.

Figure 7.5: Factor Array: Factor 5.

-6	-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5	+6
30	66	37	27	28	81	42	29	24	38	7	17	13
23	61	49	1	54	79	6	36	33	9	2	18	39
14	78	31	40	74	26	52	11	44	10	41	20	47
	71	48	4	67	16	25	51	3	69	46	32	
		35	45	22	68	8	56	50	75	82		
			34	62	63	59	58	53	77			
			43	60	21	64	70	76	80			
				57	15	65	73	12				
					55	72	19					
						5						

This account had an eigenvalue of 1.17 and was presented by one experienced qualified nurse (male) who works in a high secure environment (participant 36 (loading 0.83)).

In this account there was a strong belief that men diagnosed with personality disorder use drugs and alcohol as a coping mechanism (39. +6) and that it can be difficult to work with them because they appear increasingly unlikely to want to make changes (13. +6). They are perceived as being egocentric (32. +5), often expressing their difficulties in very indirect ways (47. +5). Their egocentricity does not extend to their ability to both empathise with the feelings of others (30. -6) and their ability to appreciate the consequences of their actions (37. -6), both of which are perceived as unproblematic.

To be aware of their relationship style and how it might evoke unresolved feelings belonging to oneself (23. -6), was strongly perceived, as not being entirely important. One of the impacts of their presentation upon the therapeutic

alliance is that they can make one feel that one does not care enough for them (20. +5), hence a caring nursing role can also be dramatically eroded by the challenging nature of their relationships (82. +4). Furthermore, the situation can be compounded by their sophisticated ways of getting other patients to make one's life a misery (17. +5).

However, this does not extend to the point of recognising relationship problems through somatic sensations e.g. stomach churning, headaches etc. (48. -4) or for it to be exacerbated due to the duel responsibilities of maintaining therapy and security (14. -6).

The impact of this challenging presentation on the relationship will often result in having to find coping strategies to protect oneself (18. +5), without ignoring the negative feelings that are generated (78. -5). Additionally, it was not considered important to gather information about how men diagnosed with personality disorder coped with adverse childhood experiences (61. -5). Nevertheless, being aware of their gender preferences was considered of potential importance within the context of their historical dynamic (7. +4).

Recognition and understanding of relationship difficulties is not thought to be provided through the interpretation of boundary violations (49. -4), but it is easier to recognise when consulting with the collective expertise of the staff group (41. -4). Without sufficient feedback from others it can be difficult not only to challenge men diagnosed with personality disorder but also to provide them with support (46. +4). Interestingly, this account subscribed to the notion that pejorative labels and the diagnostic labels increased understanding, thus

improving one's ability to work more productively with men diagnosed with personality disorder, which is supported by the following statements:

2. +4	Diagnostic labels make it easier to work with MdwPD.
66 -5.	Increased understanding of MDwPD is obtained by ignoring pejorative labels and relating to them as individuals.

Finally, maintaining a contemporary knowledge base in the realm of a rapidly evolving understanding of men diagnosed with personality disorder was not considered of great importance, which may demonstrate a cynical perspective regarding either the utility or the pace of new knowledge in this domain, supported by the following:

71. -5	Understanding MdwPD is evolving rapidly hence the importance of maintaining a contemporary knowledge base.

7.7 Account Six: The Relevance of Past and Present Behaviour, and Female Staff Issues.

Figure 7.6 Factor Array: Factor 6.

-6	-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5	+6
35	**29**	**53**	**62**	20	43	63	51	39	**36**	**7**	**76**	**44**
27	**34**	**14**	**2**	57	31	64	73	48	**80**	**37**	**77**	**5**
4	**79**	**81**	**12**	4	15	16	32	65	**10**	**9**	**11**	**21**
	67	**56**	74	6	49	18	41	66	40	**75**	**24**	
		61	72	26	46	8	59	68	52	**13**		
			71	50	28	45	38	69	3			
			1	70	47	17	22	82	30			
				54	25	60	23	33				
					78	19	58					
						55						

This account had an eigenvalue of 1.07 and was presented by two experienced qualified nurses (female) who work in a medium and low secure environment respectively (participants 11 (loading 0.79), 25 (loading 0.67)).

Within this account it is believed that men who are diagnosed with personality disorder recognise that they do have a problem (34. -5) and do not provide unreliable accounts which would require the collation of a comprehensive history from a variety of sources (67 -5). However, it is difficult working with men from this diagnostic group because they do not appear to want to change (13. +4), compounded by their difficulty in negotiating (10. +3) and being able to think of the consequences of their actions (37. +4). However, an alternative perception that their presentation can extend to being charming, manipulative, seductive, or that they have difficulty maintaining trusting/honest relationships, which would either require constant awareness (4. -6) or limit the therapeutic alliance respectively (27. -6), was refuted. Unfortunately, clarity regarding their

presentation was understood to be not enhanced through the use of diagnostic labels as evidenced further below:

2 -3 Diagnostic labels make it easier to work with MdwPD.

Identifying and Processing the Relationship.

It was strongly felt that one of the main origins of the relationship style of men diagnosed with personality disorder related to the perception that they try to elicit responses which are similar to significant people from their past (21. +6), but equally their extreme strategies are not designed to elicit caring responses from others (35. -6). Their attempt to replicate past relationship dynamics is understood to be a coping mechanism in which they strive to control others in the present, due to their lack of control in the past (77. +5). Despite the significance of the past, it was not considered to be important to gather information about significant childhood relationships (62. -3) or how they coped with adverse childhood experiences (61. -4). This would seem to suggest that their current relationships carry most significance and that the information that they may or may not impart can be equally relevant (76. +5) in terms of processing and understanding.

An interesting emphasis was given regarding the female gender and their relationship with men diagnosed with personality disorder, particularly because this account was generated by two female Mental Health Nurses, concerning the relevance of a historical dynamic. It was considered to be important to be aware of their gender preferences due to significant past relationships (7. +4). In the present, it was understood that jealousy and acting out behaviour could

be caused by female staff spending too much time with one man at a time (5. +6).

In addition, it was believed that female Mental Health Nurses can be lulled into a false sense of security (11. +5). Nevertheless, when they compare themselves to the majority of female Mental Health Nurses they did not consider that they were more likely to have their boundaries eroded (29. -5) and that they would recognise that a problem may exist when they are being seduced into feeling special by men diagnosed with personality disorder, as evidenced below in 56. -4. Moreover, they did not believe that insufficient basic nurse training had made it difficult to set boundaries and limits with this diagnostic group, (as underlined in the statement contained in 12. -3 below), which appears to suggest that an inherent alternative reason may exist.

56. -4	Being seduced into feeling special by MDwPD may not seem like a problem at the time
12. -3	Setting boundaries and limits with MDwPD has been difficult because my basic nurse training did not prepare me sufficiently.

It has often been suggested that relationship difficulties can occur due to the dual responsibilities of therapy and security (authoritarian perception) undertaken by Mental Health Nurses, however this is not perceived to be the case within this account (14. -4). Despite their understanding that men diagnosed with personality disorder will attempt to undermine one's authority (9. +4). This may relate to the above understanding, of striving to cope with past 'control' dynamics. A further measure of the impact on the relationship and particularly upon the Mental Health Nurses is provided by the strong emphasis

on the importance of supervision to explore the consequences of the sometimes horrific histories presented (44. +6). In addition, it was acknowledged that they can become desensitised to their behaviour, which is elaborated in 36. +3 below:

36. +3 When I have worked for a long period of time with MDwPD I can become desensitised to their behaviour.

Hence, the importance of understanding oneself before working with men diagnosed with personality disorder, otherwise relationship difficulties may increase (24. +5). Obtaining adequate training did not appear to be the most relevant factor in preventing potentially damaging outcomes (53. -4), but it did appear important to constantly reappraise oneself of the direction of the relationship (80. +3). Consequently, seemingly insignificant information about men diagnosed with personality disorder is considered to be very relevant to understand, within the context of a reflective practice group (75. +4). Although understanding can be achieved within a group context, maintaining autonomy in terms of decisions and actions outside the group was valued, which are evidenced further in the following statements:

79. -5 Before acting on a new understanding in your relationship with MDwPD you should consult with your peer group.

81. -4 Decisions should be acted on consistently when working with MDwPD.

7.8 Account Seven: Relationship Strategies, The Impact & Processing.

Figure 7.7 Factor Array: Factor 7.

-6	-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5	+6
53	4	37	47	26	66	48	65	22	73	30	17	44
35	74	61	28	52	71	20	13	31	58	63	41	45
54	27	12	19	50	40	32	72	77	69	38	79	16
	56	67	25	60	21	2	46	49	76	5	34	
		23	7	42	36	62	6	82	11	9		
			78	43	57	64	39	70	75			
			81	55	14	3	80	18	8			
				24	29	15	33	10				
					59	1	68					
						51						

This account had an eigenvalue of 1.06 and was presented by two newly qualified nurses (male) who work in a medium and low secure environment, respectively (participants 8 (loading 0.79), 22 (loading 0.68)).

Within this account, it is believed that men diagnosed with personality disorder will present a variety of difficulties which will impact upon their relationships. Firstly, they perceived that men diagnosed with personality disorder do not understand that they have a problem (34. +5). This is perhaps exemplified by the perceived: repetition of past dynamics (69. +3), grandiose claims about themselves to protect them from feelings of vulnerability (16. +6) and their lack of empathy for the feelings of others (37. -4).

Nevertheless, despite their 'past repetitions', it is not believed to be important to: understand why they seek out certain types of relationships (74. -5) gather information about childhood experiences (61. -4), or seek to obtain

comprehensive histories from various sources, due to perceptions of their unreliable accounts, evidenced by:

67. -4 MdwPD will often give unreliable accounts so it is important to obtain a comprehensive history from a variety of sources.

Furthermore, the notion that strategies exist, are exemplified by the perception that their grandiose claims to protect them from feelings of vulnerability (16. +6) are expanded upon through the belief that they can elicit feelings of guilt when they set up situations in which they will be rejected (38. +4) e.g. respond with jealousy and 'acting out' behaviour when female staff spend too much time with someone else (5. +4). However, it is strongly felt that despite their use of a variety of extreme strategies, that they are not designed to elicit caring responses from others (35. -6). These strategies can be muddied by their lack of empathy towards others (30. +4) and their difficulty thinking of the consequences of their actions (37. -4), perhaps indicating a dissonance between the consequences of feelings and thoughts/behaviours.

An indication of their consequential behaviour is noted in the understanding that they are very sophisticated in getting other patients to attempt to make one's life a misery (17. +5), often undermining one's authority (9. +4). Nevertheless, responding to the above challenges does not equate necessarily, to having to be constantly aware of their ability to be charming, manipulative, and seductive (4. -5) or a belief that they have difficulty maintaining a trusting/honest relationship which would limit the therapeutic alliance (27. -5). The notion of being seduced into feeling special by men diagnosed with personality disorder

would be recognised by these nurse participants at the time, which is supported further in the following statement:

56. -5 Being seduced into feeling special by MDwPD may not seem like a problem at the time

In response to the various strategies highlighted above there was a strong awareness of the difficulty in determining what feelings belong to men diagnosed with personality disorder and what belongs to oneself (45. +6). Although it was not perceived as being imperative, to understand their relationship style, that could evoke unresolved feelings belonging to oneself, as evidenced below:

23. -4 It is important to be aware of the relationship style of MDwPD because it could evoke unresolved feelings belonging to myself.

Blame was proportioned towards insufficient basic nurse training for the problem in being unable to adequately identify relationship difficulties with men diagnosed with personality disorder (58. +3). However, training was not considered to be the root cause for potentially damaging relationships (53. -6) and difficulties in setting boundaries and limits (evidenced further below in 12. -4), which seems to imply an inherent/characterological reason within the individual.

12. -4 Setting boundaries and limits with MDwPD has been difficult because my basic nurse training did not prepare me sufficiently.

The remainder of the account focuses on the importance of processing and understanding the relationship dynamic within a reflective context. There was a strong recognition that the sometimes horrific histories presented by men

diagnosed with personality disorder, importantly requires supervision to explore the impact upon oneself, where it is also easier to recognise relationship difficulties, utilising the collective expertise of the staff group (41. +5,). They felt confident to report relationship difficulties despite others fears of the potential consequences (strongly evidenced in 54. -6 below). The importance of understanding, identifying, responding, and acting within the consistent contexts of one's peer group and in accordance with the individual's schemas was also regarded highly (79. +5, 73. +3). The importance of utilising a group reflective process was underlined further by the strong representations accorded in the following prioritised statement:

44. +6	Supervision is important to explore the impact upon yourself of the sometimes horrific histories that MDwPD present.
63. +4	Understanding of MDwPD is gained by using reflective processes within group supervision.
54. -6	I sometimes do not report relationship difficulties when working with MDwPD for fear of the potential consequences.

7.9 Summary of the Accounts.

All seven accounts were distinctly different with occasional themes which appeared to overlap.

Account One raised concerns about preconceived notions related to the term 'personality disorder' and how this impacts upon their relationships, which extends the debate from the previous chapter. In common with several other accounts they identify repetitious patterns of relating, originating from childhood as a core difficulty, but rather than understand this from past behaviour they prefer to focus on its present manifestation. Interestingly, information imparted by men diagnosed with personality disorder was suggested to have hidden meaning, which may have potential links to interpretive approaches such as discourse analysis. The importance of maintaining an appropriate level of self-awareness was stressed through the utilisation of reflective group processes. The importance of self-awareness will be examined further within the Discussion chapter pertaining to adult attachment, in which the attachment styles of both nurse and patient will be explored.

Account Two has a strong emphasis upon the emotional consequences of 'the relationship,' providing an initial insight into discourse analysis related to emotions, which will be expanded upon in chapter eight pertaining to the adult attachment interview. In parallel, with the above account, past relationship difficulties in this diagnostic groups' history were acknowledged, but the current presentation was the prime focus of attention. Processing the relationship dynamic and enhanced self-awareness should preferably be undertaken in a

reflective practice group but nevertheless autonomous decision making, should not be constrained by the group.

Account Three identified various difficulties and attributes associated with the relationships that men diagnosed with personality disorder present, in which they create coping strategies linked to past events, but again the present dynamics are deemed most important. The use of drugs and alcohol were considered to be a type of coping. This type of coping alongside poor negotiation skills and poor motivation to change, compound their relationship difficulties. This account also recognised the importance of reflective practice groups and processing understanding about the relationship, although there was less emphasis on the need for self-awareness. Maintaining a contemporary knowledge base was considered important but not essential in avoiding damaging relationships.

Account Four identified several negative perceptions associated with male personality disorder and initially focused on their strategies that can erode boundaries, particularly female Mental Health Nurses. The potential erosion requires considerable self-awareness, particularly when one partakes in: self-defeating strategies and become desensitised to their behaviour, experience uncharacteristic feelings, or when one unquestioningly adheres to the staff peer group dynamics. Once again, the most appropriate context in which to understand the relationship dynamics is within a reflective practice group.

Accounts Five described the relationship difficulties in more detail and the egocentric strategies which may be used in deceptive ways against others or in

self-destructive ways through excessive use of drugs and alcohol, which is generally perceived as causing a poor prognosis in terms of being motivated for change. The Mental Health Nurse needs to be aware that men diagnosed with personality disorder may elicit various responses which may feel uncharacteristic.

However, the impact upon the Mental Health Nurse is not so profound that it could be confused with one's own unresolved issues or trigger somatic responses. Additionally, this situation is not compounded by the dual responsibilities of maintaining therapy and security. Uniquely, an awareness of their current gender preferences, and the positive utility of classification/pejorative labels were considered to be important.

Account Six was presented solely by female participants and understands that female Mental Health Nurses can be manipulated by men diagnosed with personality disorder, and unbeknownst to them they can cause 'acting out' behaviour related to past relationship dynamics.

It was recognised that although men diagnosed with personality disorder have the insight to recognise the existence of a problem, due to other deficits and confusing diagnostic classifications, progress can be difficult. Very much in common with other accounts, there was recognition of the importance of past adversity affecting their current relationships, in repetitious negative cycles. Nevertheless, their primary focus remained firmly fixed on their present relationships. It could be speculated that this understanding derives from a particular therapeutic modality e.g. cognitive behavioural therapy, but equally it

could demonstrate a lack of confidence or skill in exploring issues which if mishandled could have profound consequences. Again, the most suitable medium to process their understanding of the relationship is thought to be within a reflective practice group, which in addition, encourages autonomous decision making outside the group.

Accounts Seven also identified the repetitious patterns of relating, emanating from the past, but often they do not realise this problem exists. Despite identifying various motives for this pattern of relating, and in common with other accounts, it was felt unnecessary to obtain further information about past events. Men diagnosed with personality disorder can have a profound effect upon the Mental Health Nurse, which can trigger one's own unresolved issues, but an analysis of this dynamic would not enhance understanding. Poor training, partially explains this relationship difficulty but not completely. Again, the reflective practice group was seen as the panacea to understanding the relationship dynamic.

Overall, this summary should not detract or minimise the importance of the separate accounts and that although some themes do appear to overlap, it should be borne in mind that they have developed from differing perspectives.

7.10 Conclusion.

In conclusion, this chapter has reinforced the previous methodological chapters by outlining the Q-methodology data analysis. It has built upon the previous chapter 6 which focused on Mental Health Nurses' understanding of personality disorder by presenting the results of the Mental Health Nurses' understanding of

the relationship difficulties when working with patients diagnosed personality disorder in the form of seven factor accounts. The following chapter will draw from the results in both Q-sets (described in chapter 6 and 7) to focus on exploring and discussing the implications of what the Mental Health Nurses have reported. The results will also be explored as a means to increasing understanding about the relationship dynamic and offer increased insight into methods that would enhance the processing of this relationship.

CHAPTER EIGHT.

DISCUSSION OF RESULTS.

Discussion of Results.

8.1 Introduction.

In the previous two chapters I separately reported the two Q-sort results (1) Q-sort ‘A’ entitled ‘Understanding Personality Disorder’ (Comprising of eight factors/accounts), and (2) Q-sort ‘B’ entitled ‘Understanding Of Personality Disorder Relationships’ (Comprising of seven factor’s/accounts).The factors/accounts that emerged through factor analysis were presented in thematic groups (eight and seven respectively).

This chapter will firstly, present the discussion and interpretation of results of Q-set ‘A’ in the form of eight factor accounts preceded by the related research aim, followed by the emerging themes across all the Q-sort ‘A’ factors which is supported by literature search from chapter 2, and provides recommendations following each emerging theme. Secondly, the above process is repeated for Q-sort ‘B’ but in this case there are seven factor accounts and the literature search will be related to chapter 3. The presentation of the emerging themes across all factors have been referenced to the original factor source by referencing the original factor, its title and subtitles prior to each theme and within the narrative. It should be noted that ‘accounts’ and ‘factors’ are the same and have been used interchangeably throughout.

8.2 Discussion of Q-set ‘A’ Results - Understanding Personality Disorder.

8.2.1 A Brief Summary of All the Q-set ‘A’ Accounts.

The aim or 'communication concourse' of this section of the study was to in part address the first aim identified below:

2) Elicit what Mental Health Nurses understand about male patients who have been diagnosed with personality disorder.

- One: Labels Are Unhelpful - Look Deeper (6.2).
- Two: Social Groups and Difference: Gender and Ethnicity (6.3).
- Three: Personality Disorder? (Pejorative Label for Men and Women (6.4).
- Four: The Personality Disorder Label - Beyond the Mist (6.5)
- Five: Personality Disorder and Relationships (6.6).
- Six: Personality Disorder, Relationships and Society (6.7).
- Seven: Race, Gender, Treatment, and the Non-prejudicial Society (6.8).
- Eight: 'Personality Disorder'? (6.9).

8.2.2 Account One. Labels Are Unhelpful - Look Deeper (6.2).

Unhelpful Diagnostic Labels.

Within this account the participants presented the understanding of males diagnosed with personality disorder mainly through the perspective of society and its perceived unhelpful legal and medical classifications which exist to manage, control, and exacerbate stigma which in turn distorts responses to them. The media is seen as a benign force by comparison. The stigma and prejudices can lead to the mistaken perception by others that they are egocentric (manipulative) by saying what others may want to hear and erroneously implies badness. Nevertheless, there is little distinction between genders in media representations of offenders. However, it is strongly felt that society predominantly uses the term personality disorder in a derogatory manner. The situation is compounded by the belief that the diagnosis remains with the individual indefinitely. Overall, this account does not say what male personality disorder is but is clear about what it should not be perceived as.

Consequently, in this account they want to look beyond the ‘label’ for the reasons for their behaviour, whilst expressing through their understanding, that they do not feel threatened, but wish to understand them at a deeper level.

Need For Deeper Understanding

The cause of personality disorder excludes nature but the participants’ understand that it is developed through their experiences, resulting in finding themselves in repetitious and at times insight-less cycles dating back to childhood but can learn from their mistakes. It can be understood from various theoretical perspectives (e.g. attachment theory) that perceived maladaptive learning could actually be an unhelpful adaptive learning and that when the clinician is faced with the ‘mist of challenging behaviours’, often rooted in past traumatic, abusive or dangerous experiences it is more important to attempt to understand the reasons for this type of interaction. There is an important recognition for the nurse to be aware of men diagnosed with personality disorder can be acutely sensitive to the re-emergence of past traumatic unresolved issues becoming manifest in the present, possibly triggered by perceptions of rejection, loss, and abandonment. This can potentially result in avoidance of close relationships for fear of negative outcomes.

The Impact upon the Nurse.

Concern was expressed by nurses regarding the consequences upon themselves in response to the potentially challenging effect of working with men diagnosed with personality disorder. This impact ranges from emotional and psychosocial to concerns about their careers, which will be focussed on further in the relationship Q-set ‘B’ discussion. Conversely, two female nurses within a

low secure environment denied feeling either weak, inadequate, threatened or having to worry about their careers.

8.2.3 Account Two: Social Groups and Difference: Gender and Ethnicity.

This account has a strong focus on the similarities and differences between the two genders and also highlights race distinctions.

Patient Gender Similarities and Differences.

Firstly, they believed that there is little difference between genders when they express aggression towards property, others, or towards themselves in the form of suicide threats or self-harm. This similarity of expression is a position which is perhaps reflected in the 'Health of the Nation' statistics which shows an increased rate of young male suicides and Home Office statistics showing increases in young female assaultive behaviour. Nevertheless, gender differences were highlighted by the perception that it can be easier to detect avoidant strategies to hide emotions in women than in men diagnosed with personality disorder. In addition, there is a strong belief that men are more likely to be convicted of sexual offences. This may be their perception of an imbedded moral norm in society which constrains women not to act outside matriarchal stereotypes e.g. idealised images of motherhood.

Nurse Gender and the Therapeutic Relationship.

This account denies that male Mental Health Nurses create difficulties for female staff in their development of therapeutic relationships with men diagnosed with personality disorder. Outside this account other participants argued that this potential impediment to the relationship by male Mental Health

Nurses was born out of either being protective against perceived threat or that female Mental Health Nurses might overcompensate to prevent showing any weakness, within a predominantly male hierarchy. Nevertheless, it represents an interesting perspective of equality within both a low and high security context.

Racial Distinctions.

There was agreement that black Afro-Caribbean males are more likely to be classified with mental illness rather than personality disorder. This may suggest perhaps, that alternative cultural (Afro-Caribbean) expression may be explained simply as overt symptoms of mental illness. Whilst, if they are expressed by white British males they are perceived as covert and more worthy of a subtle/sinister pattern of personality disorder, which in other participants' accounts explained the great disparity of diagnosis concerning race. For example, black men are predominately diagnosed with mental illness and excluded from personality disorder. However, this suggests a potential flaw in the utility of the diagnostic system. Nevertheless, they disagreed that a personality disorder diagnosis is simply for those people that either could not be managed or used as a form of social control when an alternative mental illness classification cannot be used. Hence, they appear to be suggesting that personality disorder classification is not an arbitrary tool used for social control, but they do question why Afro-Caribbean men are more likely to be diagnosed with mental illness as opposed to personality disorder. Furthermore, it represents another interesting shared perspective within both a low and high security contexts.

Diagnostic Classification and Understanding.

They do not believe that society considers men diagnosed with personality disorder as psychopaths or that the media feeds prejudicial stereotypes about them. Again, this represents an interesting perspective from the participants in low and high security contexts particularly in light of the differing levels of offence/personality disorder that they would be reflecting upon.

They do not believe that personality disorder affects the patients' perception of others and their relationships or that they have faulty learning styles which can result in distorted understanding of the morality of right and wrong.

The Legal/Medical Diagnosis was not considered helpful in defining personality disorder, whereas it was felt to be more important to look beyond the challenging behaviours to its causation and why it is maintained/reinforced. They disagreed that men diagnosed with personality disorder recreate past relationships that evoke similar responses in the present but did acknowledge that they can often seek disturbing ways to extract a sense of safety from others which can be compounded by a propensity to provide accounts which are factually incorrect. Arguably the misinformation could relate to an additional method of achieving a sense of safety because the participants have previously dismissed problems with misperceptions and faulty learning.

In summary, various constructs that are used to understand personality disorder are also questioned in terms of their utility. This account is clear about what men diagnosed with personality disorder do not represent, dismissing aspects of established theoretical understanding and confounding this further by

focussing on the unreliability of the information presented by men diagnosed with personality disorder. This account identifies interesting distinctions and similarities between race and gender, and the difficulties concerning legal and psychiatric classification, particularly regarding how this can lead to distorted value laden assumptions by diagnosticians.

8.2.4 Account Three: Personality Disorder? (Pejorative Label for Men and Women).

In this account it raises concerns about preconceived expectations, treatability, and the utility of diagnosis and despite the confusion surrounding this diagnostic term there is an attempt to understand how people do and do not present.

Society's Negative Perception.

It is understood in this account that society equates personality disorder to notions of badness and use the term derogatively with all its preconceived outcomes. In addition, they strongly believe that men diagnosed with personality disorder are more likely to have committed a sexual offence than a woman with a similar diagnosis. Despite the participants' understanding of society's negative perceptions of patients diagnosed with personality disorder, they do not appear to have been influenced by this factor, evidenced for example by their understanding that they do not consider famous male sex offenders with personality disorder to be evil.

Poor Diagnostic Utility.

It acknowledges the enigma of the diagnostic term personality disorder, of which the behaviours confounds everyone including the patient. It is believed that the diagnostic term is also used to control/manage people who cannot be

constrained within a mental illness classification to satisfy the concerns of society. In fact they are understood as unhelpful labels that do not adequately describe the condition. Nevertheless, it is understood that their areas of need and traits do not vary significantly and their perceived behaviour is the same whether the patient is male or female. Should they have more than one personality disorder diagnosis (comorbidity) it is perceived to render the diagnosis meaningless.

Issues concerning comorbidity across Axis II (DSM-IV) personality disorder have previously been highlighted by Dolan and Coid (1994), when they identified considerable comorbidity at a High Secure Hospital, raising concerns about the precision of the diagnosis within psychiatry and raised questions about the utility of the diagnostic tool itself.

Treatment Pessimism.

Perhaps due to the perceived lack of understanding about this diagnostic term and the negative preconceived societal influences, they strongly believe that men diagnosed with personality disorder cannot be treated.

Treatment Optimism.

Despite the negative understanding of the term personality disorder an attempt is made within this account to comprehend it. They understand personality disorder as having a developmental cause which in some cases, is amenable to profiting from new learning experiences to reduce the repetition of past mistakes. Consequently this could contribute to the development of stable lasting relationships, but even with the right attention

and boundaries they may not respond favourably. Nevertheless, men diagnosed with personality disorder were not considered powerful and controlling because they should be understood beyond their challenging behaviours.

Gender Distinctions.

Despite this study's focus on men diagnosed with personality disorder this account highlighted some gender distinctions by firstly, focusing on the perceived likelihood that men diagnosed with personality disorder are more likely to commit sexual offences than women. Secondly, it discounted differences by emphasising that the gender made no difference to mental illness or personality disorder diagnosis and this extended to the perception that both were equally likely as offenders to have previously been victims. Gender similarities also extend to the understanding that they are equally likely to undertake aggressive behaviours towards themselves, others or property. This is despite Eaton, et al (2012) suggesting that men are more likely to externalise their aggression (e.g. towards others and property) whilst women will often internalise their aggression (e.g. self harm). As in 'account two' there is a noticeable equality regarding the lack of differences between men and women diagnosed with personality disorder, which are again represented from male and female participants from low and high secure settings respectively.

They also emphasised gender issues between Mental Health Nurses by disagreeing that male and female nurses within their own hospital objectified men diagnosed with personality disorder as offenders and discounted the notion

that male Mental Health Nurses can create difficulties for female staff when they are developing therapeutic relationships with their patients.

8.2.5 Account Four: The Personality Disorder Label (Beyond the Mist).

Within this account there is a strong emphasis on the perception of the diagnostic term personality disorder both in terms of its clinical utility and what it represents in terms of the prejudices within the media/society. Finally, there is an exploration of what personality is not and its treatability.

Concerns Regarding the Psychiatric and Legal Diagnosis.

This account believes that the term personality disorder is an enigma which is clinically inadequate, serving only to limit understanding and is worryingly perceived as a label to manage/control. The negative stigma associated with the term personality disorder raises expectations of fear that carers may guard against. The protagonist of this prejudice amongst society is not the mass media but is focussed on the psychiatric and legal arbiters of the diagnostic term - personality disorder. Perhaps reflecting the less secure nature of the participants' environments, they strongly believe that society does not regard men diagnosed with personality disorder within their hospitals as either psychopaths, or that if they have committed a sex offence they are considered evil. They also dismissed the distinction that men externalising anger whilst women internalise it towards themselves, which may in my professional experience be recognition of the increasing trend for young men to self-harm and young women who act aggressively towards others.

They believe that that the diagnostic types within the term personality disorder does not adequately describe the nature of the condition. Consequently they feel that it is more important to understand how and why the individual interacts in certain ways and provide a common language to enable clinicians and patient's to work together to enhance treatment efficacy.

What Aspects of Patients Diagnosed with Personality Disorder Are Treatable?

Personality disorder is considered to have a developmental origin. However, the diagnostic traits and general understanding of personality disorder that are often considered to be born out of faulty perceptions of relationships, culminating unstable negative emotions and disinhibited anger control are thought of as poor generalised descriptors to mobilise suitable treatment.

Nevertheless, men diagnosed with personality disorder are understood to be treatable, beyond the personality aspects that cause a danger to society. This may reflect the prominence of the many evidence based treatment programmes which seek to reduce offence behaviour rather than address the deeper developmental issues. In a further attempt to normalise or expose stigmatised responses towards this diagnostic group, the participants believe that if they were exposed to the same behaviour from staff whilst in a 'treatment setting' they may respond with similar behaviour. The potential civil liberty issues are raised regarding the concern that legislation may seek to detain people diagnosed with personality disorder pre-emptively or indefinitely which presumably is of concern to the participants because of the negative stigma surrounding the diagnostic term will cause unjustified premature responses

through the use of the proposed new powers. In addition, they believe that current treatment interventions will be considered quite primitive in the future. Nevertheless, when the mist of confusion created by the term personality disorder is lifted, there is recognition that they can still present with many challenging behaviours which need to be examined at a deeper level, perhaps relating to the earlier developmental issues in their lives.

8.2.6 Account Five: Personality Disorder and Relationships.

Within this account there is a stronger focus upon the significance of relationships and attempts to explain what personality disorder is, rather than in previous accounts which have focused upon what personality disorder is not. Furthermore, it also links their presentation to perceived causes, which appear to be informed from contemporary theoretical understanding. Finally, there is an examination of the perceived gender distinctions and some oppositional perspectives regarding the utility of the term 'personality disorder', when compared with other accounts.

Personality Disorder Relationships.

This account differs slightly from the previous ones, through its emphasis on the significance of relationships. Centrally, they understand that people are not born with personality disorder but develop it through their experiences, particularly with past negative relationships being recreated in the present and evoking similar responses. The narrative style within these relationships can be similar to the coping strategies that they used with childhood attachment figures, often resulting in intense dependent relationships with key individuals. It is believed that these relationships can be exacerbated by the expectation that the patients

within these relationships are waiting for others to abandon and reject them. Consequently, they utilise disturbing ways to extract a sense of safety from others.

It is understood that the consequence of disruptive early attachment relationships is that it will have an important impact upon their expression of emotions. Consequently, they have learnt in childhood not to express certain emotions; however these nurses do not believe that they cannot control their anger.

These nurse participants' believe that patients do not necessarily function well in society and dismiss the notion that their issues are only considered problematic when they break the law. In addition, they do not believe that the media creates negative stereotypes that feed society's prejudicial fears, particularly concerning hospitalised patients diagnosed with personality disorder being indistinguishable from psychopaths. Despite the cycle of negative relationships they are optimistic that the patient can learn from their mistakes and that they can develop stable lasting relationships. In addition, these nurses, despite describing the potentially powerful relationship dynamics, do not perceive these patients as powerful and controlling to the extent that they feel threatened or worried about their careers.

However, they do perceive that the diagnosis of personality disorder is often used as a convenient label that can limit understanding of an individual. Consequently, assessment and treatment interventions should initially focus on

the antecedents and behaviour that brought them to the attention of the health services.

Gender Distinctions.

Within this account they felt that there were no gender distinctions regarding the internalisation (e.g. self harm) or externalisation (e.g. towards property or others) of aggression, or in terms of needs and traits. However, they did feel there were gender distinctions concerning their offence behaviour and the likelihood that women would commit more arson and men would commit more sexual offences, respectively.

It is interesting that the two female participants who provided this account from secure environments, which are often perceived as predominantly masculine, denied that their male colleagues interfered with the therapeutic relationships. For example, perhaps using excessively protective strategies in an attempt to support of their female colleagues.

In summary, there is a stronger emphasis on the perception that personality disorder is a term that mainly concerns relationships. These relationships appear to be understood from the perspective of contemporary, evidence based theory e.g. attachment theory, psychodynamic theory, etc. Hence, it is understood that people in this diagnostic group can often exhibit patterns of behaviour which replicate difficult experiences from earlier in their lives, which may lead to dependency, a heightened tendency to perceive rejection, or to utilise disturbing means of attempting to extract a sense of safety from others.

Their ability to express and understand their own and others' emotions in relation to these difficulties are considered equally important to address.

The need to address the neurologically encoded emotions in relation to their distress is gathering increasing merit, particularly in relation to contemporary neurological understanding of attachment theory and emotional learning. They also believe that they are amenable to learning and forming lasting, stable relationships, which appears to represent a long term treatment aim. The significance of relationships is the subject of chapter 7 and the latter part of this chapter. The notion of gender distinctions associated with the discharge of emotions through acts of aggression or offences, suggests less similarities than within previous accounts.

In harmony with other accounts, there is recognition of the limitations associated with the diagnostic term of ‘personality disorder’ and its ability to adequately inform a treatment pathway. Additionally, they do not believe that the mass media creates prejudicial fears about 'personality disorder'.

8.2.7 Account Six: Personality Disorder, Relationships and Society.

In this account it provides some similarities in understanding of 'personality disorder' relationships to that of account five, but offers some subtle distinctions. The societal perspective of personality disorder is again examined. Finally, treatability issues are discussed in the latter part.

Personality Disorder Causation and Maintenance.

This one experienced female participant from a medium secure environment believes firmly that the cause of personality disorder is developmental and rooted in childhood experiences. These experiences often results in the creation of past relationships which evoke similar responses which may be intense and dependent. Nevertheless, the relationships are not necessarily close due to their fear of negative outcomes in relation to expected abandonment and rejection, resulting in some emotional expression being curtailed. This can be understood from a childhood attachment theory perspective whereby for example a child wishing to maintain a safe attachment with their caregiver may have learnt not to express their emotional needs because to do so could provoke a negative response from an inconsistent caregiver. Hence the child's needs become secondary to the caregivers to maintain attachment, thus avoiding abandonment and rejection. In addition, false cognitions can also be created to validate/excuse the caregivers' non-containing behaviour.

There are some strong links within this account and account five regarding the understanding of relationships associated with personality disorder. However, this participant does not believe that patients have developed 'faulty learning' in terms of knowing the difference between right and wrong, or that it impedes their perception of others and their relationships.

The Societal Perspective of Personality Disorder.

Although society is perceived to view personality disorder in derogatory terms, prejudicial issues surrounding the term 'personality disorder' are acknowledged

but understood not to be promoted by the mass media. It also dismisses matriarchal stereotypes in society associated with women offending, along with psychopathy and badness which is referred to in chapter two Interestingly, this account also raises the perception that Afro-Caribbean men will predominantly be diagnosed with mental illness as opposed to personality disorder, as highlighted in account two and discussed in greater detail in account seven.

Finally, it is understood that personality disorder traits have more in common with normal personality traits, perhaps suggesting that the term should not be pathologised to the extent it sometimes achieves. Nevertheless, it is believed that in harmony with other accounts that if one looks beyond the challenging behaviour, men diagnosed with personality disorder are treatable and amenable to lasting positive change, particularly when the their boundaries are maintained. In addition, treatability can impact beyond the personality factors which caused a danger to society.

In summary, this account supports account five, to some extent, by focusing on the relationship difficulties associated with men diagnosed with personality disorder, particularly the understanding concerning the replication of past relationships in the present. Within this process of replicating relationships/similar dynamics, Mental Health Nurses are perceived to be exposed to intense, dependent and rejecting dynamics. Nevertheless, they are understood not to have difficulty with new learning to enable appropriate moral decisions in the future, which suggests that either this problem does not exist or that alternative reasons for it do exist e.g. their past relationship difficulties may influence the way they reach their decisions. This example may have some

credence when one examines the statement (3. +6) which strongly agrees that they do not form close relationships because they fear negative outcomes. Relationships and the processing of relationships will form the basis of discussion in the latter part of this chapter.

8.2.8 Account Seven: Race, Gender, Treatment, and the Non-. prejudicial Society.

This account was presented by one experienced male staff nurse from a low secure environment who strongly focuses on race and gender issues in relation to personality disorder. Race is commented on, in terms of differential diagnosis, whilst gender is reflected upon in terms of society's perspective and distinctions between types of offences they are likely to commit. Treatability issues are discussed, alongside the most favourable circumstances in which this should take place. Finally, society's perspective of personality disorder is commented upon.

Racial Distinctions.

This account highlights concerns about the belief that black Afro-Caribbean men are more often diagnosed as mentally ill, rather than with personality disorder. It appears to indicate that the diagnosis of personality disorder is often the preserve of white males, and that other races presentations are often 'mis/understood' as mental illness. Consequently this raises questions about (1) the culturally situated basis of the diagnostic tools, (2) the cultural awareness and diagnostic training of those diagnosing, (3) the notion that a personality disorder and mental illness co-exist along a continuum, in which cultural expression is either manifest differently or misinterpreted.

Gender Distinctions.

Gender distinctions are raised in terms of the perceptions that men and women predominantly commit certain offences e.g. men are more likely to commit sexual offences. This may be influenced by the participant's strong belief that society equates women to idealised images of motherhood which can cause concern if they act outside this stereotype. Other distinctions which have been raised in other participants' accounts were denied e.g. it is believed that the notion that women resort to covert/internalised forms of aggression whilst men utilise more overt forms of aggressive offences were denied. Similarly it was also felt that women would no more use avoidant strategies to hide their emotions than it would be the case for men.

Interestingly, it was felt that Male Mental Health Nurses do influence/impede therapeutic relationships between female Mental Health Nurses and men diagnosed with personality disorder. This influence is often interpreted as a protective strategy by male nurses, which may carry within it a perception that female nurses may get sexualised or that they represent a matriarchal image. Within this account it appears that women need protecting if they are nurses, and treated with equality in terms of their offences if they are patients diagnosed with personality disorder.

Treatment.

Treatment of men diagnosed with personality disorder preferably needs to be undertaken when looking beyond their challenging behaviour, perhaps interpreting what the challenging behaviour represents in terms of an internal dynamic. For example, aggressive verbal responses, to keep others at a

distance because they may fear that others may be able to control them and make them feel vulnerable. Additionally, the treatment context preferably needs to be a restricted one, where they are detained following an offence, which seems to suggest, that either, the person from this diagnostic group will take their situation more seriously (away from some of the potential stressors), or conversely it may be perceived as a place where health agencies are available, relevant, and appropriately resourced.

It is acknowledged that when working with men diagnosed with personality disorder nurses need to find means to protect themselves, remaining alert to potential boundary violations but not so concerned that they will become overwhelmed. Whilst remaining vigilant regarding the potential difficulties this participant does not consider them to be powerful and controlling the extent that he feels threatened or worried about his own career. In most training programmes concerning work with personality disorder there is recognition of the importance of being consistent and boundaried.

The Societal Perspective of Personality Disorder.

Finally, the influence of the mass media and the perspective of society were considered to be benign in relation to the diagnosis of personality disorder. In particular, it was felt that the media does not feed prejudicial fears culminating in offenders being considered evil, and personality disorder implying badness or psychopathy.

8.2.9 Account Eight: 'Personality Disorder'?

This account was presented by one experienced male staff nurse from a medium secure environment.

Causation and Presentation.

This account strongly represents the notion that personality disorder is caused by learnt behaviour, impinging upon how patients express their emotions (e.g. learning from childhood to hide emotions to maintain a safe attachment with their caregiver), but nevertheless it is a condition which is amenable to change. This strongly suggests that attempts in childhood were made to adapt to difficult and challenging circumstances, a position which is compatible with attachment and psychodynamic theoretical understanding.

There is acknowledgement of the uncertain utility associated with the diagnosis of personality disorder, which can partly be addressed by focusing on the events which brought them to the attention of the health services, often related to behaviours which represent a danger to themselves, other people, or property. Presumably, as a means of coping, they can demonstrate egocentricity and disturbing strategies to elicit a sense of safety from others. Although men diagnosed with personality disorder have the potential to establish long lasting stable relationships, however it was strongly felt they have some awareness of their difficulties but sometimes struggle to comprehend alternative perspectives for themselves.

Reflection.

In terms of the therapeutic working relationship it was importantly recognised that others can be made to feel weak and inadequate. This account appears to highlight the importance of understanding not only the relationship strategies people diagnosed with personality disorder utilise but also for people working with this diagnostic group to have a strong reflective capacity to understand what responses are being elicited from them. In keeping with other accounts it was felt to be important that nurses look beyond the challenging behaviours for the origins and triggers which can meaningfully be addressed.

Society and Personality Disorder.

Society and the mass media represent a benign perspective related to the term personality disorder, which does not feed prejudicial fears. Nevertheless, their presentation appears to represent an enigmatic group that fall outside mental illness classification, causing concern to society, hence the diagnosis is believed to be used as a form of social control.

Overall, this account highlights the importance of understanding the relationships men diagnosed with personality disorder have and how Mental Health Nurses' reflect upon this process for the patient and themselves, which will be discussed in greater detail in the latter part of this chapter.

In summary, a common theme that exists across accounts, particularly within Q-set 'A' was the classification of personality disorder, which was considered to represent an unhelpful pejorative label, used for social control by the medical/legal systems. Whilst one factor considered the diagnosis of personality

disorder to be the preserve of white males, suggesting that non-white males could be conceptualised culturally easier within a mental illness diagnosis. Some considered the assessment of personality disorder better represented either within the current relationship, the reasons PD patients were detained, whilst others conceptualised it within the re-enactment of childhood developmental issues. In fact most ‘A’ accounts had a tendency to focus more on what personality disorder isn’t rather than what it is.

8.3 Emerging Themes Across Q-set 'A'.

The eight factors identified pertaining to what Mental Health Nurses' understand about personality disorder have been individually interpreted above, whilst below the emerging themes that traverse some of the factors will be identified and discussed below. Preceding each emerging theme, the original source will be indicated both within the narrative and the related factor sub-title will be bullet pointed**.**

8.3.1 Diagnosis and Nursing Assessment of Personality Disorder.

- Factor 1: Unhelpful Diagnostic Labels.
- Factor 2: Diagnostic Classification and Understanding.
- Factor 3: Poor Diagnostic Utility.
- Factor 1: Need For Deeper Understanding
- Factor 6: Personality Disorder Causation and Maintenance.
- Factor 8: Causation and Presentation.

Factor One and Factor Three share the belief that the current categorical psychiatric diagnostic system and legal classifications of personality disorder have limited functional use other than serving to detain, and control/manage. Factor Five believes that the diagnostic system is a convenient label that can limit understanding of an individual. The classification is considered to be lifelong (F1).

The main diagnostic assessments stated above all have difficulties: DSM-IV R and ICD-10 represents a categorical system which does not explain behaviour but represents higher reliability because it uses multiple sources of corroborating evidence; the MMPI relies on potentially unreliable self-reporting and is often recommended alongside other personality disorder assessment tools; whilst

psychodynamic assessment requires specialist training but uses a categorical and dimensional approach in formulating and hypothesising the origins of traits and functions of behaviours in the form of formulations. The minimum requirement suggested by Dolan and Coid (1994) recommend the use of the PCL-R in conjunction with either DSM-IV-R or ICD-10. Many other assessments of personality disorder are emerging related to various therapeutic modalities but require further scientific rigour to determine their effectiveness. For example: schema therapy, cognitive analytical therapy, dialectical behavioural therapy, interpersonal cognitive therapy. However, their effectiveness as personality disorder treatment modalities will be discussed in section 2.2.

The limited functional use of the categorical diagnostic models for the diagnosis of personality disorder has been the source of criticism from multiple authors (see section 2.1). This widespread criticism was exemplified by Bernstein et al. (2007) who undertook a survey of experts which reported that 80% were dissatisfied with the most popular diagnostic tool - DSM-IV. The following problems were identified, (1) Austin and Deary (2000) demonstrated that empirical analysis failed to identify structures resembling DSM-IV diagnosis, (2) Verheul and Widiger (2004), highlighted limited association between diagnostic constructs and clinical presentation and (3) Livesley (2012a) commented on extensive diagnostic co-occurrence, poor inter-rater reliability, lack of structural validity and the fact that evidence demonstrates that personality disorder is continuous with normal personality variations and not discontinuous with its reliance on a categorical system using ten types of personality disorder. It is further argued by Livesley et al. (2013) that to improve validity there needs to be consideration of (1) how personality disorders are classified and (2) how

classifications are compiled. In terms of classification historically DSM-III personality disorders appear to have been based on the simplified medical model (Klerman, 1978), which may have utility treating infectious diseases but struggles when dealing with,

> 'personality disorders that have a complex multidimensional psychopathology arising from the interplay of multiple genetic and environmental factors' (Livesley et al., 2014, p.213).

The diagnosis is considered meaningless should they have more than one personality type (F3) which is consistent with Dolan and Coid (1994) research outcomes. Furthermore, Factor One suggests that the classification system fosters stigma and prejudice resulting in mistaken perceptions of their egocentricity leading to manipulative behaviours, and implying badness.

In the perceived absence of a suitable diagnostic modality (F8) it was considered more important to look beyond challenging behaviours to its causation and why it is maintained/reinforced (F2). Factor's One, Eight and Five add that due to the uncertain diagnostic utility this can partly be addressed by focusing on the events that brought them to the attention of the health services, often related to behaviours which represent a danger to themselves, other people, or property. A close definition of targeted problems would complement discussion about the function and context of any service for individuals with a diagnosis of personality disorder who are considered a risk to others. For example, if the aim of the service is primarily criminological, it would be important to look at research into the reduction of reoffending rates, rather than mistakenly applying more general research into healthcare interventions with the patient group (Kurtz 2002b).

Alternatively, Factor Six understands that personality disorder traits have more in common with normal personality traits, perhaps suggesting that the term should not be pathologised to the extent it sometimes achieves. Nevertheless, it is believed that in harmony with other accounts that if one looks beyond the challenging behaviour, men diagnosed with personality disorder are treatable and amenable to lasting positive change, particularly when the their boundaries are maintained (F6). In addition, treatability can impact beyond the personality factors that may have caused them to be a danger to society (F6). Livesley et al. (2013, p.213) hypothesised that a more practical method of dealing with this complex diagnostic issue could be to ask the questions, 'what diagnostic information do clinicians need to treat personality disorder'? This in turn results in two more questions, (1) 'what diagnostic information best predicts prognosis and outcome', and (2) 'what information do clinicians need to identify treatment targets and select treatment methods'?

In attempting to answer point (1) Crawford et al. (2011) and Verheul et al. (2008) have provided increasing evidence that the severity of personality pathology is more predictive of outcome than a categorical diagnosis. Subsequently, DSM-V recognised this by using severity of impairment. However it appears that the ICD-11 proposal has gone one step further by making the severity the only mandatory criterion.

With regard to point (2) Livesley et al. (2013, p.214) suggest that this could be approached by, ‘considering the level at which clinicians typically intervene when treating personality disorder’.

Theory is a construct of reality and reflects the understanding that exists at the time of social history in which the theory is developed. Any discussion about underlying personality and motivation must take in the wider social context. The concept of personality development is a constructivist view which remains essential. Personality can be seen as a combination of three elements:

- the individual’s behaviour,
- the meaning of that behaviour as constructed by other people,
- the meaning of that behaviour as constructed by himself/herself.

The underlying rationale of this constructionist view is that studying personality outside its social context is bound to give an incomplete account. It is only when behaviour is imbued with social meaning that it becomes 'personality' (diagnostic concerns are discussed further in section 2.1.6).

Gathering historical information to inform diagnosis or assessment from PD patients can be difficult due their propensity to provide factually incorrect accounts (F2). This position is supported by Clark and Harrison (2001) who recommended that wherever possible the data should be corroborated from credible multiple sources due to the potential for misleading under and over reporting by the respondent.

Dimentional Functional Assessment.

Within chapter 2 the international contemporary understanding was equally contentious as the nurse participant accounts above, with a growing recognition that categorical personality disorder diagnosis has a poor theoretical foundation. Whilst dimensional models provide a continuum between maladaptive and adaptive personality structures that can be described functionally within differing individualised contexts. The dimensional model has now achieved some recognition as an emerging model within the appendix of DSM-V. However, this dimensional approach still requires research in to its utility and it remains unclear when this approach will be utilised by Mental Health Nurses.

Nursing Assessments.

When considering a specific Nursing Assessment several accounts in this study suggests that the 'therapeutic relationship' is a favourite method for assessing patients with personality disorder, which Bowen and Mason (2012) describe in chapter 3, as a 'bedrock' for forensic and non-forensic psychiatric nurses. However, the Tidal Model (2003) and Peplau Model (1952) have both widely been recognised for their utility for nurses, to contextualise and work with relationships as described in chapter 3, yet arguably they do not appear to be broadly utilised (Delaney and Ferguson, 2014).

The Tidal model (often used as a relational model for psychiatric nurses) provides evidence regarding its utility as a supervision model (Triantefillou, 1997). The model appears to demonstrate a degree of versatility as a relational tool by asking practitioners,

> How do we tailor care to fit the specific needs of the person and the person's story and unique lived experience, so that the person might begin, or advance further on, the voyage of recovery? (Barker and Buchanan-Barker, 2010, p. 173).

In recent years the Tidal Model has been utilised as part of the recovery process across the hospital-community spectrum (Barker and Buchanan-Barker, 2005, 2008; Buchanan-Barker and Barker, 2008; Fletcher and Stevenson, 2001; Stevenson and Fletcher, 2002) have demonstrated considerable utility in a controlled study undertaken by Gordon et al. (2005). In this study they compared the use of the Tidal Model on an acute ward, alongside three similar acute wards in the same hospital. In the 12 months following-up their numbers of untoward incidents were shown to be reduced by 55% whilst the other wards demonstrated 8%. Other reductions were demonstrated as follows:

- Intended or actual self-harm: -55%
- AWOL: -51%
- Use of physical restraint: -46%
- Threats of physical violence: -52%
- Actual physical assault: -40%
- Verbal abuse: -71%
- Intimidation: -67%

In England, 1998 saw the creation of the Tidal Model of mental health nursing (Barker, 1998a,1998b), developed over a three-year period and evolved from a series of studies that initially examined the 'need for mental health nursing' (Barker et al., 1999). Henceforth, the Tidal Model has introduced a radical model of mental health nursing that puts the lived experience of the person and his/her significant other as the focal point of treatment.

Providing a more systematic and skilled approach to listening and talking, and developing a relational style that is theoretically informed could provide a useful

framework for the psychiatric nurse to get to know their patients, which is a fundamental and universal prerequisite of good clinical judgement (Horvath et al., 1990; Radwin, 1996) is essential in providing good quality care (Luker et al., 2000).

Delaney and Ferguson (2014) argue that mental health nursing leaders have not sufficiently described what Mental Health Nurses do within the relationship to ensure a more meaningful life for their patients. Despite the psychotherapeutic relationship being the defining element of mental health nursing since introduced by Peplau in the 1950s, they believe that Mental Health Nurses appear to be faltering in certain aspects of their relationship process. However, Bowen and Mason (2012) identified that Mental Health Nurses consider their therapeutic relationships with PD patients as the bedrock of their practice. Nevertheless, Delaney and Ferguson (2014) expressed concern that despite the wealth of literature involving Mental Health Nurses' relationship building, the relationship remains 'ambiguous and unformulated'. As a means of addressing this deficit they had drawn upon the language of interpersonal neurobiology (Siegel, 1999) in the form of:

1) relate meaningfully to the reactions of patients;
2) help the patient become aware of reactions; and
3) get to know the patient's view of self and predicament.

and merged it with relationship principles from Peplau (1997):

1) resonance,
2) attunement, and
3) mentalising).

In short, they believe that by using these *relational techniques combined with evidence from neurobiology* (Siegel, 1999) can demonstrate that new experiences can create new neural pathways, based on positive experiences of

relationships. This could potentially have significant benefits for PD patients who can experience considerable emotional dysregulation (borderline personality disorder) due to past traumas. It is further understood from an interpersonal neurobiological perspective that this can change the patients' autobiographical memory and lead to a more coherent sense of self. A similar process of reprocessing experiences is known as 'limited re-parenting' which is an important therapeutic tool within the contemporary evidence-based personality disorder orientated schema therapy intervention (Young, 2003).

Alternatively, the *solution focused model* discussed by Gralton et al. (2006), claims to share features with Dialectical Behavioural Model of therapy (effective in the treatment of borderline personality disorder), Gralton et al. (2006), highlight an aspect of a solution focused model which stresses the importance of the 'problem-free talk', this indicates an interest in the person rather than the problem and involves the initial discourse with the patient on subjects other than the problem area. This in turn can help break out of the cycle in which the patient presents with a 'problem' as the key to interacting with staff. However, this can have the potential of assisting the patient to avoid the issues altogether.

Integrated Assessment and Treatment Approach.

In light of the potentially effective therapeutic nursing interventions identified above and the deficits of skills identified by Bowen and Mason (2012) and highlighted throughout the study, further consideration is required to define the forensic nurse's role, alongside providing suitable evidence-based interventions for this patient group. Arguably it is not unreasonable to consider that when undertaking an assessment we should consider how this will relate to our

evidence-based intervention and vice versa. It is with this in mind that In Chapter One and Two, Livesley (2013) was identified not only for considering a more functional evidence-based assessment tool for personality disorder but also promoting and utilising an integrative model for treatment, utilising best practice from each modality of therapeutic intervention. Within this integrative therapeutic model he also promotes the integration of therapeutic disciplines in pursuance of providing a consistency of approach, which potentially could provide a wealth of transferable efficacious skills. This in turn could be utilised in training to more effectively meet the needs of PD patients. For example, dialectical behavioural therapy comprises of three modes of therapy, one of which is a modulised approach for teaching skills in emotional regulation, interpersonal effectiveness, distress tolerance, and mindfulness. These are basic skills found to be essential in the treatment of people with borderline personality disorder who often have characteristic problems associated with impulsivity, emotional dysregulation, and self-harm.

CARE Framework: As previously mentioned, a large percentage of people who self-harm also have a diagnosis of personality disorder. Consequently, within this context there are useful frameworks for working with people who self-harm, such as the CARE framework (McAllister and Walsh, 2003). Utilising this model, Rayner et al. (2005) have developed a cycle to illustrate some of the interpersonal effects of self-injury on nurses. The CARE framework has four broad principles of intervention: Containment (encourages healthcare seeking), Awareness (being available to discuss perceptions, process, and to encourage self-knowledge), Resilience (reframing of distressing events), and Engagement (building a trusting partnership and learning new problem-solving skills). They

indicate that this tool could be used in reflection or supervision, to assist nurses in using the CARE framework with clients.

Recovery Model: The use of the Recovery Model has been gradually achieving recognition as highlighted in chapter 3, due to its solution focused, none medicalised approach to care. However, despite early pilot studies in the forensic settings and expectations of its use within NMC Competency Guidelines, evidence to date suggests that employing its principles within a restrictive medium and high secure forensic context would be fraught with difficulties (Mann et al., 2014; Mezey, et al., 2010).

Shared Formulation in Assessment: Assessment should enable nurses and other clinicians to move beyond labelling people simply as personality disordered, towards recognising the distress and difficulties within the context of their own individual world. Millon and Davis (2000) argue that an assessor should capture a holistic understanding of the patient which embraces his risk, interpersonal and social functioning, symptoms and their inner experience. However, Evans and Watson (2010), suggest that the diagnosis of personality disorder does not suggest how that person may present or respond within a specific situation. It also neglects to specify: the nature or course best suited, potential intervention/therapy interfering behaviour, and argues for the development of case formulation for personality disordered patients. PD patients often feel overwhelmed by the complexity of the difficulties and the impact these have upon many aspects of their life. The formulation enables the patient and clinician to link and chain events into patterns, which can be considered containing for the patient. Another central principle of formulation is

that it is shared which assists the nursing team and others to understand the patient and not perceiving them simply through their presenting problem. This in turn results in the therapeutic team being able to develop and engage in relationships that will decrease the reinforcement of their childhood re-enacted relationships and subsequent challenging behaviour.

There are many perceived benefits to utilising a shared formulation with a PD patient. There is recognition that it strengthens the 'therapeutic alliance' (Needleman, 1989), and sharing the formulation with the wider team can have further benefits. For example, a patient with extremely challenging behaviour towards himself and others may have a diagnosis of borderline personality disorder, which provides very little understanding. However, a formulation will illuminate the patient's history of neglect and abuse in which he developed the pattern of dependency whilst expecting others to reject, abuse or abandon him. The formulation would identify the resulting need to achieve dependency in relationships, which in turn can trigger subsequent feelings of rejection and self-harming. Thus, the formulation provides an understanding of why this seemingly benign behaviour in the current tense can have its roots entrenched in past traumatic relationships. This insight can enable Mental Health Nurses to adjust their response accordingly. Other benefits include: enabled the prediction of behaviour e.g. therapy interfering behaviour (Linehan, 1993), assessed the understanding and treatment of relationship difficulties (Persons, 1989) and if treatment is unsuccessful it can allow for re-formulation because information is available to conceptualise why, in the available alternatives previously conceptualised. The notion of a shared formulation enters into the spirit of providing a space for diversity and interchange of understanding.

Recommendations.

It is clear from the participant data, the literature search (2.1) and discussion above that diagnosis and assessment of personality disorder remains contentious. However, opportunities now exist to utilise integrative, functional, shared, evidence based diagnostic and assessment models that would benefit from further practice based research to broaden and establish its evidence base. As a consequence of this study the following considerations could be helpful to consider when contemplating diagnosis and assessment of patients' diagnosed with personality disorder:

Functional Dimensional Model:

The provision of training for nurses to utilise the new DSM functional dimensional model (contained in the subsection of the DSM manual entitled emerging models). In addition, encourage research control trials to further explore the efficacy of this model, to assist its future evaluation within DSM and ICD.

This provides an opportunity for clinicians/nurses to utilise a model that is widely recognised by academic practitioners to not only assist a more accurate contextualisation of personality disorders within assessment and formulations, but also to select a specific an evidence-based intervention, whilst demonstrating change on a continuum which measures severity and describes function.

Diagnostic Considerations:

When considering the construction of a personality disorder assessment a more practical method of dealing with this complex diagnostic issue could be to ask the questions, 'what diagnostic information do clinicians need to treat personality disorder'? This in turn results in two more questions, (1) 'what diagnostic information best predicts prognosis and outcome', and (2) 'what information do clinicians' need to identify treatment targets and select treatment methods'? (Livesley et al, 2013).

A Common Language:

Work towards the provision of a common language to enable clinicians and patient's to work together to enhance treatment efficacy. Although many personality disorder treatment interventions have their own parlance some do encourage the patient to use their own descriptors particularly to name their experiences and any recognition of symptoms e.g Cognitive Analytical Therapy. Similarly, the Recovery Star model also appears to promote the strategy. In light of the growing evidence of the efficacy of specific aspects of differing therapeutic interventions (e.g. mindfulness in DBT, re-parenting in schema therapy) and the interest in integrating these effective components, perhaps a new shared language could be created to embrace these therapeutic modalities. However, it could be argued that a specific treatment modality's integrity could be compromised (not using all but only using part), reducing its research evidence base.

Nursing Assessments:

This study demonstrates the importance of the therapeutic relationship as part of the nursing role when working with patients diagnosed with personality disorder. Consequently, it would appear appropriate to encourage nurses to explore/utilise a nursing relational model (as discussed above) e.g. The Tidal Model, Peplau combined with interpersonal neurobiology. Alternatively a Solution Focused Model can potentially assist in helping the patient break out of the problem focused cycle. The CARE framework could be used in reflection or supervision, to assist nurses in using the CARE framework with clients.

Alternative Shared Assessments:

Utilising models that encourage the nurse, other disciplines and patient to share their collective expertise should be encouraged.

The Recovery Model with its solution focused collaborative approach has been achieving some recent recognition but insufficient pilot studies have been undertaken in the forensic setting with patients diagnosed with personality disorder. In addition, some of its guiding principles (e.g. autonomy in a restrictive forensic context) may impede its full use without modification.

A Shared Formulation as the name implies provides multiple expert perspectives towards an evolving collaborative narrative to make sense of the patients past, present, future behaviours. A shared formulation can provide a consistency of understanding and responses which can be crucial in supporting and managing patients diagnosed with personality disorder.

8.3.2 Relationships.

- Factor 5: Personality Disorder Relationships.
- Factor 1: Impact upon the Nurse.
- Factor 6: Personality Disorder Causation and Maintenance.
- Factor 8: Causation and Presentation**.**

Factor Two does not believe that men diagnosed with personality disorder recreate past relationships that evoke similar responses in the present but acknowledged that they can often seek disturbing ways to extract a sense of safety from others. Conversely Factor's One, Five and Six believe that due to their adverse childhood experiences PD patients' find themselves in repetitious, insightless negative relationship cycles but can learn from their mistakes. In addition, Factor Six understands that the re-creation of these relationships in the present can be intense and dependent. Nevertheless this relationship is not necessarily close due to the fear of a negative outcome in which they anticipate being abandoned and rejected, resulting in presenting defensively with limited emotions. Encouragingly, Factor Eight believes that they have the potential to establish long lasting stable relationships (F5) and strongly felt that they have some awareness of their difficulties although they struggle to comprehend alternative perspectives for themselves.

Despite the potentially powerful relationship dynamics Factor Five participants do not believe that this would extend to feeling threatened or worried about their careers. Whilst Factor One acknowledges the challenging effect on themselves of working with men diagnosed with personality disorder which can involve emotional, psychosocial and concerns about their careers. This is consistent with Bowers (2002) who also reported nurses' concerns about being

manipulated to obtain information/advantage (e.g. information about nurses, their opinions, families, likes and dislikes, interests, foibles, past decisions and actions) to be used within a patient hierarchy to create power. This resulted in nurses' feeling vulnerable and cautious. Consequently, in 2003, the National Institute for Mental Health in England (NIMHE) published a document (NIMHE, 2003a) entitled Personality Disorder No Longer a Diagnosis of Exclusion (which highlighted the importance of debriefing and clinical supervision to manage and contain feelings often triggered by patients' pathology within this diagnostic category, who may have committed incomprehensible offences. The impact of the relationship will be discussed further in Q-Set (B) which specifically focuses on relationships.

Recommendations.

Training and Support:

Due to the challenging nature of the relationship dynamics for Mental Health Nurses working with patients diagnosed with personality disorder, which is indicated throughout this study training (e.g. recognising and processing relationship issues) and support (e.g. supervision/reflective practice), as indicated by NIMHE and the NMC guidelines, should be supported and resourced towards a mandatory requirement.

8.3.3 Features of Personality Disorder.

- Factor 2. Social Groups and Difference: Gender and Ethnicity.
- Factor 6. Personality Disorder, Relationships and Society
- Factor 8. 'Personality Disorder'?

It is understood that Personality Disorder does not affect the patients' perception of others and their relationships (F2). In addition, it is refuted that they have faulty learning styles that can result in distorted understanding of the

morality of right and wrong, often understood as a characteristic of psychopathy or antisocial personality disorder (F2, F6, F8). The understanding of perceptions of relationships, learning, and morality can be clarified utilising the Unified Model (Huesmann, 1998) in which the role of schema (e.g. organised knowledge about self, events and beliefs), emotions and the interpretation of environmental responses (i.e. how individuals interpret the responses of others/society influences and how this serves to maintain a negative script). Information processing is discussed further in section 1.4.1.

Recommendations.

Approaches to Address, Morality, Learning and Perceptions of Relationships in PD Patient:

The Home Office, 'Dangerous and Severe Personality Disorder Project' was undertaken to determine how best to treat high-scoring PCL-R (psychopathy scale) who previously were considered to be immensely difficult to treat using conventional interventions. They are often considered to have difficulties with regard to morality due to the positive ratings on the 20 factor scale e.g. empathy. Consequently, if the PD patient meets the high-scoring PCL-R criteria reference should be made to the extensive literature pertaining to the DSPD project to maximise their treatment. Alternatively for those patients considered high-scoring psychopaths, distorted perceptions of relationships and ingrained beliefs that may impede perceptions of learning adaptive strategies have been shown to benefit from both offender focused training utilising attribution theory or therapy focusing on schemas.

8.3.4 Perceived Understanding of Society.

- Factor 3: Society's Negative Perception.
- Factor 6: The Societal Perspective of Personality Disorder.
- Factor 7: The Societal Perspective of Personality Disorder.
- Factor 8: Society and Personality Disorder.

Factor's Two, Five, Seven and eight do not believe that society considers men diagnosed with personality disorder as psychopaths or that the media feeds prejudicial stereotypes about them. Nevertheless, Factor Eight believes that their presentation appears to represent an enigmatic group that fall outside mental illness classification, causing concern to society, hence the diagnosis is believed to be used as a form of social control. The understanding of personality disorder dangerousness and social control appeared to gain prominence in the UK following the murders by Michael Stone (discussed in section 1.2) in which public fears were raised about predatory paedophiles and serial killers. Consequently, policy-makers appeared pressed to respond to these concerns (Freestone, 2005; Manning, 2002; Prins, 2007; White, 2002). In response Straw (1999) introduced the phrase: Dangerous and Severe Personality Disorder (DSPD) which was not a medical diagnosis but a new administrative category for risky individuals, and sought to combine antisocial personality disordered who were believed to represent a clear and enduring danger to the public, to enable powers for indeterminate detention within specific DSPD Units, to reduce the risk they presented with. In addition, Jasanoff (2005) claims that the UK is not alone amongst other nations to have debated clinical and moral issues in relation to psychopathy, adding that mental health law is frequently used as a method of managing 'dangerous' and 'risky' individuals. As a consequence and reinforcing the notion of social control,

Bartlett (2003) noted that concerns were raised that further polarisation from a therapeutic regime towards one of public protection would be augmented, and would create a situation where health practitioners would be agents of social control.

Factor Three and Six believe that society equates personality disorder to notions of badness and uses the term derogatively with its associated preconceived outcomes. This influence on nurses was also identified by Bowers (2002) who reported that the largest proportion of nurses (20%) in his study of three high secure hospitals in England, blamed the media for their negative beliefs and acknowledged that some of this was formative prior to undertaking nursing. As a means of recognising and addressing this issue NIHME (2003b) published a paper entitled 'Breaking the Cycle of Rejection' which challenged the discriminatory link between personality disorder and dangerousness by providing services to reduce vulnerability and promote effective coping. The report also highlighted the fact that the disproportionate emphasis on dangerousness and risk pertaining to the minority obscured the fact that many of the people diagnosed with personality disorder were extremely vulnerable to abuse and violence towards themselves, through self-harm and suicide. However, Factor Six does not attribute the promotion of this negative stereotype to be caused by the mass media.

Recommendations:

Further Evaluation of the Perceived Link between Personality Disorder and Dangerousness:

Participant data from this study provides differing perspectives with regard to society's perception of/on PD patients, yet significant evidence from (1) Bowers

(2002) indicating society's negative influence on nurses' attitudes in formative years and (2) society's influential concerns that has culminated in legislative changes to definition and risk (e.g. DSPD), detention based on notions of treatability/risk (e.g. the very wide margin of error when we detain someone against their will on the basis of risk that they might pose to themselves or to others). It remains unclear if the NIHME (2003b) paper has had a sufficient impact on challenging the discriminatory link between personality disorder and dangerousness. Consequently, the recommendations made in the DSPD study need to be thoroughly evaluated and partially reflected upon by Duggan (2011, p.433) who concluded that,

> The DSPD initiative therefore focuses particularly the minds of those who work at the interface of the criminal justice and mental health services on how they manage the conflicting demands of satisfying these two 'cultures' (i.e. being an agent of the state to safeguard public safety and/or a provider of services to those with mental distress) Currently, the accepted wisdom is that one is able to achieve both. If, however, one of the consequences of the DSPD Programme is that severe personality disorder is shown to contribute only a small proportion of the variance to violent behaviour, will this result in resources again being diverted away from the health needs of a very marginalised and poorly provided for group. And will anyone care?

8.3.5 Gender Issues.

- Factor 2: Patient Gender Similarities and Differences.
- Factor 3: Gender Distinctions.
- Factor 5: Gender Distinctions.
- Factor 7: Gender Distinctions.

Although this study is focused on men diagnosed with personality disorder this Q-set highlighted some gender distinctions were the focus in Factor's Two, Three and Five. They shared a belief that there is little gender difference in relation to the expression of aggression in patients' diagnosed with personality disorder, in particular aggression towards others, property or themselves (e.g.

suicide threats and self-harm). Other accounts suggest that men are more likely to externalise their aggression (e.g. towards others and property) and women will often internalise their aggression (e.g. self harm). This lack of gender distinction also included patients' diagnosis of mental illness or personality disorder (F3). However, they did believe that men would be more likely to be convicted of sex offences (F2, F3, F5, F7), whilst Factor Five and Seven considered female patients to be more likely to commit more arson offences. This maybe their perception of an imbedded moral norm in society which constrains women not to act outside matriarchal stereotypes e.g. idealised images of motherhood. Factor Three felt that male and female patients were equally likely as offenders to have previously been victims. Rosenfield (2000) reported that women have a greater lifetime of major depression, posttraumatic stress disorder, eating disorder, and borderline personality disorder; men were more likely than women to meet criteria for antisocial personality disorder. Additionally, female offenders were found to have a higher degree of internalizing disorders than male offenders, but there were no gender differences in degree of externalizing disorders. They also discounted the notion that nurses' objectify patients' diagnosed with personality disorder as offenders (F3). With regard to the use of avoidant strategies to hide emotions they felt that it was easier to detect in women, presumably suggesting that men are less open about expressing their feelings (F2).

When exploring nurse gender distinctions the participants in Factor Three and Five did not feel that male Mental Health Nurses can create difficulties for female staff when they are developing therapeutic relationships with their

patients. For example, perhaps using excessively protective strategies in an attempt to support of their female colleagues.

Recommendations.

Reflection:

From a personal historical anecdotal perspective it has often been believed that PD men often externalise their aggression (towards others or property) whilst women internalise their aggression (towards self and evidenced by high levels of self harm in the high secure context). However, the high secure environment over the last decade has received a considerable increase in transfers from prison with particularly young male patients exhibiting high levels of self harm behaviour which represented considerable challenges to the organisation. However, the participants in this study reported only marginal or no distinctions between male and female patients. Nevertheless, this study's aim was to focus on male personality disorder, chosen because of the disproportionate amount of research being undertaken in male patients compared to women within the institution. My study also coincided with all the female patients within the high secure environment being transferred to conditions of lower security due to the perceived inappropriateness of the environment for a variety of reasons. With regard to female Mental Health Nurses having distinctly different issues associated with their relationships, this was denied across three factors/accounts. Nevertheless, this potential is discussed and reported by participants in Q-set 'B'.

8.3.6 Racial Issues.

- Factor 1: Racial Distinctions.
- Factor 7: Racial Distinctions.

In Factors Two, Six and Seven it is suggested that black Afro-Caribbean males are more likely to be classified with mental illness rather than personality disorder, perhaps suggesting that an alternative cultural expression is being interpreted as overt symptoms of mental illness. Whereas, white British males are perceived as having perhaps more covert expression which is understood as a pattern of personality disorder. This appears consistent with the understanding that the category of PD has been criticised as culturally biased (Bhugra and Bhui, 2001) and that the diagnosis is a reflection of North American and Western European concepts of personality functioning (Loranger et al, 1997). Behavioural norms in one culture may be considered deviant in another, however, there are insufficient studies addressing the role of ethnicity in diagnostic practice (Loranger et al, 1997). This potentially points towards a flaw in the diagnostic system but not to the extent that it is used as a means of social control as indicated in other accounts. Worryingly these two accounts point towards racial distinctions affecting the psychiatric diagnosis which may require further investigation, pertaining to the following areas: (1) the culturally situated basis of the diagnostic tools, (2) the cultural awareness and diagnostic training of those diagnosing, (3) the notion that a personality disorder and mental illness co-exist along a continuum, in which cultural expression is either manifest differently or misinterpreted.

However, due to a lack of research pertaining to racial distinction in PD diagnosis the evidence base remains inconclusive. This position is supported by McGilloway et al (2010) who undertook a meta-analyses from the limited

amount of available literature and repported that some studies demonstrated significant differences in prevalence between black and white (diagnosed more with PD) groups but no differences between Asian or Hispanic groups compared with white groups. However, McGilloway et al (2010) concluded that,

> The existing data are sparse. There is a risk that PD is overlooked and not treated in black people with PD. More specific research in different service settings is necessary to investigate pathways to care. There is almost no aetiological and treatment research on more refined cultural and ethnic categories, leaving unexplained the reasons for differences across broad racial groups (McGilloway et al, 2010, p.13).
>
> These methodological differences may account for the findings, however, if case note diagnoses are associated with a lower prevalence, this means that the routine care of black patients is likely to overlook PD diagnoses, particularly if they have associated co-morbidity (McGilloway et al, 2010, p.11).

Recommendations.

Further Research:

Although some participants' reported worrying distinctions between white men being diagnosed more with personality disorder and black men being diagnosed with mental illness, the research tentatively supported this position but concluded that the research was currently sparse. Consequently, racial distinctions affecting the psychiatric diagnosis which may require further investigation, pertaining to the areas identified below.

(1) the culturally situated basis of the diagnostic tools,

(2) the cultural awareness and diagnostic training of those diagnosing,

(3) the notion that a personality disorder and mental illness co-exist along a continuum, in which cultural expression is either manifest differently or misinterpreted.

4) Do more white men get diagnosed with personality disorder whilst black men will often be diagnosed with mental illness instead?

8.3.7 Treatment.

- Factor 3: Treatment Pessimism.
- Factor 3: Treatment Optimism.
- Factor 7: Treatment.
- Factor 8: Reflection.

Possibly due to the perceived lack of understanding about the diagnostic term and the negative preconceived societal influences. Factor Three strongly believes that men diagnosed with personality disorder cannot be treated. This pessimistic treatability perspective is not unfamiliar as evidenced by Pickersgill (2012) who claims that historically, antisocial personality disorder and psychopathy have been considered to be resistant to treatment; which has been the dominant understanding of these conditions even into the late 1990s. In the past and in harmony with Factor Three personality disorder was considered untreatable, while this should be considered untrue, however the perception is understandable because treatment is still hampered by inconsistent research methodology. The RCT is considered the ‘gold standard’ of evidence in medicine, usually because it strives to identify what intervention is better than another for a specific disorder, and in its absence treatment efficacy cannot be definitive. Nevertheless, Murphy and McVey (2010) suggest that mental health service providers have denied personality disordered people access to services on the grounds of ‘lack of treatability’ without sufficient evidence (discussed further in section 1.2).

In the review of PD assessment and treatment interventions in chapter two it can be recognised that there is still much to understand about personality disorder in terms of origin, assessment, treatment efficacy, which can be confounded by inconsistent research methodology and the pejorative and categorical nature of

the disorder. Placing this 'understanding' within the context of a forensic culture creates yet another level of difficulty in relation to the severity of risk and how this should be managed and treated. Psychiatric nursing and forensic psychiatric nursing roles appear to be ill-defined in relation to the management and treatment of personality disorder.

Despite an emerging improvement in assessment (e.g. dimensional models) and some indications of improvement in treatment efficacy in relation to presenting problems from this diagnostic group, psychiatric nursing does not stand alone in relation to other clinical disciplines in terms of understanding how best to approach their needs. Nevertheless, Factor Three does believe that personality disordered patients can benefit from new learning experiences to reduce the repetition of past mistakes that may contribute to the development of stable lasting relationships. This can be optimised when it is long-term, intensive, well structured, theoretically coherent, and when follow-up is provided in post residential care (Bateman and Fonagy, 2000). Furthermore, it is argued by Luborsky & Auerbach (1985), that the strongest predictor of outcome in psychotherapy is the therapeutic alliance, which will be explored in the Q-set 'B' part of this chapter.

It is perhaps with the therapeutic alliance in mind that Factor Seven prefers to look beyond the patient's challenging behaviour and interpret what this behaviour represents in terms of an internal dynamic/need. Strengthening this positive treatability understanding NIHME published the first of several reports (NIHME, 2003a) arguing that personality disordered individuals were treatable and that the treatability test in the 1983 Mental Health Act should be removed

(discussed in chapter one). This was further supported by Livesley, (2007, p. 28) who stated that, “the literature was now clear that personality disorder can be treated”.

However, despite an emerging improvement in assessment (e.g. dimensional models) and some indications of improvement in treatment efficacy in relation to presenting problems from this diagnostic group, psychiatric nursing does not stand alone in relation to other clinical disciplines in terms of understanding how best to approach their needs. Despite the recognition of an absence of a dominant efficacious therapeutic intervention, Livesley (2012) suggests that a more integrated therapy is utilised drawing upon the best components of what works from each intervention (discussed in more detail in chapter two). He argues that an, ‘integrated treatment cannot be based simply on eclecticism’ and in the absence of an evidence-based personality disorder theory that the clinician should demonstrate a conceptualisation of the personality disordered individual’s psychopathology alongside therapeutic principles of change (Livesley, 2012, p.20).

To improve the treatment outcome the patient is perceived to benefit from a treatment context which is restricted in the form of a detention (F7). Presumably offering a restricted context provides a structure, boundaries, consistency of care for a diagnostic group who have often had counter-productive unstructured and chaotic experiences. However, even with the right attention and boundaries they may not respond favourably (F3). The efficacy of inpatient treatment for personality disordered patients is supported by a committee consensus representing the American Psychiatric Association (2001) whose guideline for the treatment of borderline personality disorder recommends that, "When the patient's safety is judged to be a serious risk, hospitalization may be indicated."

(American Psychiatric Association, 2001, p.8). However, there is no evidence that hospitalisation reduces mortality or increases the safety (Paris, 2006). Furthermore, chronic suicidality tends to result in hospitalisation becoming recurrent (Hull et al, 1996). In fact, Paris (2002) understands that when recurrent admissions disrupt the patients' life hospitalisation can be harmful. In addition, Livesley (2003) advocates keeping hospitalisation to a rarity, whilst Linehan (1993) is only willing to tolerate an overnight hospital stay believing that hospitalisation can interfere with effective treatment. In support of outpatient treatment provided by The Day Hospitals, clinical trials have supported its use for borderline personality disorder when in crisis, by providing intensive treatments from experienced teams without the disadvantages of a full inpatient admission (Bateman and Fonagy, 1999).

Factor Seven acknowledges the importance of protecting oneself psychologically, particularly by being vigilant/alert to potential difficulties, including boundary violations. Extending this concern Factor Eight recognises the potential within the nurse-patient relationship to have feelings of weakness and inadequacy elicited, necessitating the importance of utilising a strong reflective capacity, to interpret the challenging behaviours to enable the origins and triggers to be meaningfully addressed. Concerns about the profound impact upon nurses of men diagnosed with personality disorder and the importance of utilising effective supportive strategies to manage this impact forms the basis of a wealth of literature contained within chapter 3 and will be discussed in detail in the second part of this chapter pertaining to Q-sort 'B' 'Understanding Personality Disorder Relationships'.

Recommendations.

Integrative Evidence Based Interventions:

Mental Health Nurses should be encouraged to develop a skill set based on integrative evidence based interventions (discussed in the therapeutic interventions section of chapter 2). These transferable skills should conform to the effective generic principles for therapeutic change identified from the analysis of empirical literature by Castonguay and Beutler (2006) and Critchfield and Benjamin (2006). They include a strong working alliance, an empathetically flexible approach to repairing ruptures in the alliance, a caring attitude, warmth, empathy, positive regard, congruence and authenticity, patient-therapist agreement on treatment goals, strong collaboration between patient and therapist in working towards goals, and a high level of therapist activity. They further suggest that treatment should be organised in relation to change mechanisms universal to all therapies.

Reflective Practice:

Strategies and structures are considered an essential requirement to support nurses to interpret and effectively intervene with challenging behaviours, whilst providing mechanisms to maintain their own safety e.g. emotional.

The Treatment Context:

The context in which they are detained particularly following an offence may be worthy of further investigation to explore whether the treatment context needs to be a place where consistent and meaningful boundaries are in place to ensure

a safe and containing space to enable the patient to explore and learn from their challenging issues. For example, whether this should be a physical environment or a structured/boundaries relational context.

Understanding and Utility of Contemporary Relationship Theories:

Relationships appear to be understood from the perspective of contemporary, evidence based theory (e.g. attachment theory, psychodynamic theory, etc). This appears to be expressed by nurse participants through their consistent understanding that PD patients can often exhibit patterns of behaviour which replicate difficult experiences from earlier in their lives, which may lead to dependency, a heightened tendency to perceive rejection, or to utilise disturbing means of attempting to extract a sense of safety from others. Mental Health Nurses' theoretical understanding could be further enhanced by exploring the neurologically encoded emotions in relation to their distress which is gathering increasing merit, particularly in relation to contemporary neurological understanding of attachment theory and emotional learning. This understanding could also support nurses' belief that PD patients are amenable to learning and forming lasting, stable relationships, which appear to represent a long term treatment aim.

8.4 Discussion of Q-set 'B' Results – Understanding the Relationship Difficulties with Men Diagnosed with Personality Disorder.

8.4.1 A Brief Summary of All the Q-set ('B') Accounts.

The aim or 'communication concourse' of this section of the study was to in part address the second and third aims identified below:

2. What are Mental Health Nurses' understandings of the relationship difficulties that men diagnosed with personality disorder have and how does this influence the nurse-patient relationship?
3. How does the understanding gleaned from aims one and two inform clinical practice?

- One: Processing the Present Relationships. (7.2).
- Two: The Impact on Therapeutic Relationships ('Emotional Rape') (7.3).
- Three: Relationships Are Consciously Driven but Don't Talk About the Past (7.4).
- Four: Coping with Emotional & Other Responses. (7.5)
- Five: Coping with the 'Relationship' & the Utility of Labels. (7.6).
- Six: The Relevance of Past and Present Behaviour, and Female Staff Issues (7.7).
- Seven: Relationship Strategies, the Impact & Processing (7.8).

8.4.2 Account One. Processing Present Relationships.

This account was represented by seven participants from across all three study sites. Within this account, as with others, it reflects again on the utility of the term personality disorder and identifies gaps in knowledge. It also acknowledges and refutes various perceptions associated with relationships, and points towards appropriate methods to identify and process relationship dynamics.

The Importance of Prior Knowledge in the Therapeutic Relationship.

It was strongly felt within this account that an increased understanding of men diagnosed with personality disorder is obtained by ignoring pejorative labels and relating to them as individuals. However, even with diagnostic labels it does not make it easier to work with this group of individuals The difficulty associated with 'labels' was a consistent feature of the accounts in the previous sort 'A' (discussed in Chapter two), and has arisen here to prevent preconceived notions confusing the therapeutic relationship. They feel that the lack of training impedes the identification of relationship difficulties, hence the importance of seeking contemporary knowledge.

Beliefs about Relationship.

An understanding of the repeated relationship difficulties which emanate from the past and are acted out in the present is an important component of understanding how PD patients may relate to others, which consistently causes PD patients' problems. Having arrived at this understanding Mental Health Nurses in this account then dismiss a considerable variety of conventional approaches and perceptions that would inform their understanding of negative repetitious cycles of relating. These Mental Health Nurses would not gather information about this diagnostic group's past traumatic events (e.g. rejection) and expressed a willingness to accept that the accounts related to them would be accurate. This trusting approach would not be impeded by a patient's insincerity or a lack of consequential thinking (eg. Partly evidenced by a denial of the statement: 'When working with men diagnosed with PD you need to be constantly aware that they can be charming, manipulative and seductive'). Further exclusion of information gathering involved little reliance on

countertransference of the analysis or assessment of consistent responses. It was unclear whether this latter point suggested either: a lack of skill or awareness, subscription to a differing theoretical modality in this area, a dismissive response based on experience, or if it should be used alongside other approaches.

Nevertheless, it was felt that when attempting to obtain information to inform their relationship hypothesis, they believe that the information they do not disclose can be important. At one level it may seem obvious, that people who have been subject to difficult past histories may wish to impart sensitive aspects of themselves last of all. However, in the participants' interviews this also related to spontaneous denials which meant the opposite e.g. 'My mother never hit us.' Then later they may provide physically abusive histories, which were perpetrated by their mother. This type of information could form part of a 'discourse marker' when analysing adult attachment interviews, to be discussed later in this chapter. Generally, there appeared to be some acknowledgement of the significance of past events but in the main, the importance of gathering past information about childhood adversity and coping was strongly dismissed, perhaps to avoid potential pitfalls associated with creating distorted perceptions in the present. Distorted perceptions could be caused by difficulty corroborating patient information (patient's accounts considered reliable), limited skills to interpret historical data, or limited opportunities for reflection/supervision to limit potential personal bias. Alternatively it could simply be a pragmatic approach to dealing with difficulties which are tangible and in the present.

Processing Relationship Difficulties.

Prior to processing their understanding of the relationship, an awareness of the above information associated with prior knowledge and beliefs about relationships with men diagnosed with personality disorder seemed important. There appeared to be some acknowledgement of past events but generally past information was dismissed, perhaps to avoid potential pitfalls associated with creating distorted perceptions in the present. Consequently, the majority of the remaining account appears to focus on the importance of understanding the relationship and oneself, in the present from a variety of perspectives, ideally within a reflective practice group.

Understanding of Self.

An understanding of oneself and the relationship style demonstrated by men diagnosed with personality disorder is seen as crucial for the safety of both parties, in which a third-party feedback in this process is desirable and should not be considered a weakness. It is believed that one should not underestimate one's own unresolved feelings which can be exacerbated by horrific accounts from patients and can be overwhelming and even culminate in colluding with self-defeating relationship patterns.

Supervision.

Once some clarity is achieved through understanding oneself and addressing potential distortions of information, supervision is deemed important in understanding the relationship. Reflective group processes which examine even seemingly insignificant information are considered to be potentially important, particularly when various informed perspectives can be shared and integrated

to enable the patient ultimately to be challenged and supported in a flexible manner by the individual professional. Nevertheless, they consider that the group process should not hinder individual professionals' flexibility to act on new information.

This account recognises the relationship difficulties that exist based on past difficulties but it would appear to consider that the present relationship difficulties should be the measure that would inform the treatment pathway. It could be argued that this approach has some commonality with standard cognitive behavioural approaches which perhaps lack the sophistication of its contemporary 'cousin' known as schema therapy. Reflective practice groups also appear important in gathering, interpreting, analysing, and actioning interventions in a safe manner for all concerned.

8.4.3 Account Two: The Impact on Therapeutic Relationships ('Emotional Rape').

This account was represented by two experienced male nurses from a high and low secure environment. It examines the origins of personality difficulties, the strategies that are used to cope, and examines its impact upon Mental Health Nurses. Training issues and appropriate forums to process understanding of the therapeutic relationship are also discussed.

Relationships.

This account provides one of the strongest perspectives on the relationship impact that men diagnosed with personality disorder have on Mental Health Nurses, describing the potentially profound emotions (eg. 'feeling emotionally raped') aroused in response to patient strategies that have emanated from their past experiences. In addition, feelings of guilt were also aroused when it is perceived that the patient has established a pattern to reject them. Consequently, there can be a dramatic erosion of the caring nursing role caused by the challenging nature of the patients' relationships. The extract taken from the transcript of the participant who reported 'feeling emotionally raped' which produces the statement is available in the results chapter. It clearly highlights the emotional impact that men diagnosed with personality disorder can generate. This participant is a respected clinical leader who is normally very fluent but becomes dysfluent when expressing the emotional affect. The dysfluency and its relationship with emotional dysregulation will be discussed further in relation to attachment theory, later in this chapter.

Whilst recognising potentially deceptive patterns, the Mental Health Nurse does not require to be excessively vigilant to the strategies that they may present with

(e.g. charming, manipulative, and seductive). Nevertheless, they acknowledge a requirement to have a measure of alertness to it, particularly their ability to seduce others into feeling special or subtly undermine one's authority. However, they do recognise the existence of various strategies but they are unclear about their motivation other than it is not used to elicit caring responses.

Processing Relationship Difficulties.

The participants did not feel that potential therapeutic relationship difficulties could emanate from a lack of awareness between self and others. However, they did recognise the importance of constantly reappraising the therapeutic relationship. In addition, there was recognition of the importance of how past relationships impact upon present relationship difficulties and that gathering information about adverse experiences to illuminate the past was considered less important.

The utility of processing all relevant information (e.g. early negative feelings) within the context of a safe reflective practice group was felt to be imperative to cope with the disturbing histories and the emotional and psychological effect.

It was recognised that seemingly insignificant information about men diagnosed with personality disorder could be very relevant within a reflective practice group and that their collective expertise enables easier recognition of relationship difficulties. The reflective practice group was also considered beneficial in enabling the formation of an integrative narrative to negate the differing understandings which can exist within the therapeutic context, providing consultation prior to consistent action. Despite the importance of the reflective

practice group it was felt to be equally important to act flexibly outside the consistency of the group, in response to their presentation.

Training.

Training deficits are highlighted as a significant reason for nurses' poor identification of relationship difficulties and being able to set boundaries. This reinforces Halford and Rugan's (1993) understanding and personal accounts suggesting that training pertaining to personality disorder, often amounted to one day in three years training. However, they believe that this is not necessarily a damaging experience, despite the profound impact that men diagnosed with personality disorder can generate to the degree that they can describe it as being tantamount to 'emotional rape'.

8.4.4 Account Three: Relationships Are Consciously Driven but Don't Talk About the Past.

This account was represented by four nurses from high and medium secure environments. Within this account consideration is given to the perceived relationship components often attributed to men diagnosed with personality disorder and methods required to process relationship difficulties are discussed in terms of self-awareness, training and group reflection.

What is Personality Disorder?

The participants strongly believe that men diagnosed with personality disorder are egocentric and lack empathy for others, adding that their actions are consciously driven because their ability to consider the consequences is not impeded. It is also believed that they do not tend to minimise their behaviour or provide unreliable historical accounts. Nevertheless, the participants would judge them on face value particularly when they are attempting to undermine one's authority. They perceive that this diagnostic group appear not to be motivated to change due to a lack of insight into their problems and poor ability to negotiate. Compounding the perceived problems above is the understanding that patients will use excessive use of drugs and alcohol to cope, and utilise lifelong scripts/narratives to reinforce their negative behaviours.

Processing Relationship Difficulties

Self-Awareness

When working with men diagnosed with personality disorder it was not felt necessary to be constantly aware that they can be charming, manipulative, and seductive. The participants also denied being involved in feeling seduced or

colluding with patients, or conversely conforming to offensive staff group behaviour. There was a powerful recognition that even if they felt fearful of the consequences it is important to report relationship difficulties and never leave this too late. Consequently, the earlier relationship difficulties can be recognised (through a good understanding of oneself and a constant reappraisal of one's relationships the better for an effective therapeutic relationship.

Supervision and Training.

When processing the relationship difficulties it was felt that self-awareness, supervision and training are important issues to address. It was denied that Mental Health Nurses can become embroiled into seductive types of relationships with men from this diagnostic group, no matter what the motive. In addition, they acknowledged that they would not conform to potentially offensive staff group behaviour.

Despite the above potential to be drawn into negative interpersonal behaviour it was suggested that one needs to be vigilant to their maladaptive strategies and maintain a constant self-awareness to guard against potential difficulties. The most effective method to achieve this awareness was considered to be gained from supervision/reflective practice. Confiding in this fashion was not considered a weakness and not only provides safety but a collective informed clarity of purpose, which can independently be acted upon. Maintaining a contemporary knowledge base was also considered important but not essential in avoiding damaging relationships.

8.4.5 Account Four: Coping with Emotional and Other Responses.

This account was presented by a newly qualified nurse who works in the low secure context. Within this account it focuses upon the various relationship strategies men diagnosed with personality disorder use and their affect upon Mental Health Nurses, including gender distinctions within this professional group. Destructive dynamics are discussed in terms of self-awareness. In addition, recognition and processing of these difficulties are discussed.

What is Personality Disorder?

This account describes men diagnosed with personality disorder with some similar negative perceptions associated with the previous account three, but added a concern about the potential of patients to minimise and attempts to draw others into colluding in this process. Although the participants are aware that men diagnosed with personality disorder can be charming, manipulative, seductive, it was felt that female Mental Health Nurses would be more susceptible to this boundary erosion. Nevertheless, attention by female nurses does not necessarily elicit jealousy or 'acting out' from others.

Encouragingly, it is believed that men within this diagnostic group do wish to make appropriate changes. However, due to the repeated exposure to negative patterns of behaviour it is essential for Mental Health Nurses to have an awareness of the potentially self-defeating strategies. Whilst recognising their patients' positive aspects and not becoming desensitised or alternatively seeing their behaviour as something that they will not be defeated by at any cost.

Recognition and Processing of Relationships Difficulties.

There was recognition of the profound affect that men diagnosed with personality disorder can elicit, nevertheless in these circumstances they generally have an ability to determine what belongs to them and what belongs to the Mental Health Nurse. Relationship difficulties can be identified when one experiences feelings that are uncharacteristic to oneself or shaped by one's peer group. Recognition and processing of relationship difficulties can be further understood through reflective group processes, and particularly through examining their life long scripts or narratives.

The recognition and the need to process the emotional impact upon the therapeutic relationship has been gaining increasing support in wider academic domains, following advances in understanding in the areas of emotional learning, attachment theory, and neuroscience. The focus of understanding is linked to how emotional experiences are processed in the brain and represented through life experiences.

8.4.6 Account Five: Coping with the 'Relationship' & the Utility of Labels.

This account was presented by an experienced nurse in a high secure context and highlighted that the coping strategies used by men diagnosed with personality disorder and identifies defining descriptors. Responses to these strategies are discussed from individual and group perspectives. The utility of classification and pejorative labels are noted from a unique position.

Personality Disorder Coping Strategies.

This account represented a strong description of the relationships it believed men diagnosed with personality disorder often demonstrate. It identified their propensity to use drugs and alcohol as a coping strategy which would exacerbate their poor motivation to change. In common with other accounts egocentricity was considered to be synonymous with the diagnosis but encouragingly it did not impinge upon 'empathy and consequential thinking', unless of course, one takes the position that PD patients may use these attributes to feed into their egocentricity. For example, in the form of charm/seduction to have their egocentric needs met.

PD Patients and the Impact upon the Nurse.

The degree of psychological impact upon the Mental Health Nurse suggests an importance of being aware of uncaring responses being elicited which are alien to the nursing role and may be augmented surreptitiously via a third-party. Despite the importance of self-awareness in response to potentially destructive relationship dynamics it was not felt that this would impinge upon one's own unresolved issues or that it would manifest in somatic problems. This latter point may indicate that the participant either perceives Mental Health Nurses as

having a strongly integrated ‘sense of self,’ or is less prepared to examine these issues more fully, for a potential variety of reasons. Nevertheless, this account was not impervious to the notion that one is required to create protective strategies to cope with the potential challenges that can occur within the relationship, without ignoring the feelings which can generate understanding. The interpretation of boundary violations is not thought to aid the identification and understanding of relationship difficulties, although this process is far more enabling within the context of a reflective practice forum. Without sufficient feedback from others it can be difficult not only to challenge men diagnosed with personality disorder but also to provide them with support.

Challenges to the Nursing Role.

The participant from this account highlighted a strong conviction that the dual responsibilities of maintaining both therapy and security did not affect their relationship, whereas other participants’ outside this account, particularly within the high secure site, have often struggled to integrate them without eliciting difficulties within their therapeutic relationship e.g. being perceived as an uncompromising authoritarian figure from the past. Another feature which may be pertinent to the high secure site concerns the importance of the gender preferences of men diagnosed with personality disorder, which may relate to the fact that a large percentage of the men diagnosed with personality disorder within this environmental context have sexual components within their offence history or it might have some significance associated with their attachment history.

In opposition to many other accounts, it is believed that diagnostic classification and pejorative labels can enhance understanding, whilst embracing contemporary knowledge is not seen as entirely useful.

8.4.7 Account Six: The Relevance of Past and Present Behaviour, and Female Staff Issues.

This account was presented by two experienced female nurses from a medium and low secure context. The account examined various relationship strategies utilised by men diagnosed with personality disorder, particularly those emanating from past relationships and how they affect the present. The female participants, who contributed towards this account, also provide insight about how they and other female colleagues are specifically affected by men diagnosed with personality disorder, and how best to make sense of these issues.

Perceived Presentation Personality Disorder.

Unlike previous accounts, these participants understand that men diagnosed with personality disorder do have the insight to recognise that they have a problem and consequently are generally prepared to give a candid account of themselves. Nevertheless, moving forward from this initially encouraging position is negated by: the appearance of not wanting to change, poor negotiation skills and consequential thinking. Other negative descriptors concerning various manipulative factors (e.g. charming, manipulative, and seductive) were refuted and not made any clearer with the use of diagnostic classifications.

The recognition that men diagnosed with personality disorder replicate past relationships, which are not motivated out of a desire to be cared for, but to achieve control over past adversity, appears to focus the importance upon the past. However, the importance of the past context is seemingly diminished by not seeking further information to clarify the adverse experiences, with the

exception of attempting to link current gender preferences to past figures of importance.

Gender Issues in Relation to Boundaries.

The two female participants strongly identified that their female colleagues could be lulled into a false sense of security and even cause jealous ‘acting out’ behaviour, if they spent disproportionate times with men diagnosed with personality disorder. However, when specifically referring to themselves they did not feel subtly manipulated or consider their boundaries eroded. In addition, potentially poor boundaries do not emanate from poor basic training.

Processing Relationship Difficulties.

Making sense of the relationship difficulties that men diagnosed with personality disorder create is best undertaken through a meaningful understanding of oneself and through the collective expertise of a reflective practice group, to enable a consistent reappraisal of the relationship and which ultimately encourages flexible and autonomous decision making.

8.4.8 Account Seven: Relationship Strategies, The Impact & Processing.

This account was represented by two newly qualified nurses from a medium and low secure context. Within this account there is recognition of the repetitious patterns of relating, their origins, and the profound effect upon current relationships. It also speculates on the causes of the difficulties within the nurse-patient relationship. In addition, it examines a strategy for coping and understanding this dynamic.

Relationship Patterns.

This account, akin with some other accounts identifies the importance of the maladaptive repetitious patterns of relating that men diagnosed with personality disorder often display. This account suggests that men in this diagnostic group often have difficulty consciously understanding that they have a problem but this account uniquely suggests that their grandiose claims about themselves are often motivated to protect them from feelings of vulnerability in which their ability to empathise is unavailable. It is also believed that their relationship strategies can also repeat and recreate rejecting responses and thus present jealous 'acting out' behaviour. Despite identifying this central relationship difficulty and surprisingly in common with several other accounts, it was felt to be unnecessary to seek or clarify information from the past regarding significant people or adverse experiences.

There is recognition that men diagnosed with personality disorder can use consequential thinking, which is at odds with other accounts. This was demonstrated by virtue of manipulating other patients to undermine Mental Health Nurses, for which the only motives stated here, concerns either:

protecting their own vulnerability, undermining authority, recreating rejecting responses, or responding to some form of jealousy.

Processing Relationship Difficulties.

This account strongly recognised that working with men diagnosed with personality disorder can evoke feelings that do not belong to oneself; nevertheless they did not feel that this would enhance the understanding of the relationship difficulty. Poor training was claimed partly to explain the relationship difficulty but was not considered to be the root cause. There was recognition of patients' sophisticated techniques to manipulate other patients to act on their behalf to make a nurse's life a misery or alternatively to seduce the nurse into feeling special (idealised). Nevertheless, despite these difficulties the participants were of the opinion that a trusting/honest relationship can be achieved as a foundation to the therapeutic alliance.

Finally, they felt confident using the expertise of reflective practice groups to understand and process the impact of some of the horrific histories and at times their potential fearful consequences.

8.5 Emerging Themes Across Q-Set ('B').

Across the seven factors identified pertaining to what Mental Health Nurses understand about personality disorder relationships have been individually interpreted above, whilst below the emerging themes that traverse some of the factors will be identified and discussed below. Preceding each emerging theme the original source will be indicated both within the narrative and the related factor sub-title will be bullet pointed**.**

8.5.1 Relationship Patterns.

- Factor 7: Relationship Patterns.
- Factor 4: What is Personality Disorder?
- Factor 6: Perceived Presentation Personality Disorder.
- Factor 2: Relationships.
- Factor 5: Personality Disorder Coping Strategies.

A significantly common theme across the accounts is emphasised in Factor Seven in which it is recognised that PD patients often engage in maladaptive repetitious patterns of relating in the present which has its roots within past relationships. One of their relationship patterns pertains to the repetition and re-creation of rejecting responses from others which in turn can lead to them utilising jealous 'acting out' behaviour (F7). As part of these patterns Factor Four understands that patients diagnosed with personality disorder can minimise their behaviour and draw others into colluding with this process. In addition, they recognise that they can also present as charming, manipulative and seductive (refuted by Factor Six), believing that female nurses are often more susceptible to this boundary erosion. Nevertheless, female nurses are not believed to elicit jealousy or 'acting out, from others throughout this process (F4). Despite identifying the importance of past adverse experiences impacting

upon current relationships, and surprisingly in common with several other accounts from Q-set (A), it was felt to be unnecessary to seek clarification of past adverse experiences.

The replication of past relationships by PD patients is not, according to Factor Six and Two motivated for a desire to be cared for but rather to achieve control over past adversity (F6) or often remains unclear (F2). Alternatively, Factor Seven understands that when they make grandiose claims about themselves (often in the face of a considerable weight of oppositional evidence) it is motivated to protect them from feelings of vulnerability, compounded by an unavailability of empathy (a lack of empathy is refuted in F5). However, clarification of these past adverse experiences were not considered important other than establishing links with their past and current gender preferences (F6).

Factor Four believes that men diagnosed with personality disorder are motivated to make appropriate changes. However, Factor Six believes that they have insight into their problems or recognise they have a problem (F7) and will provide candid accounts of themselves but are not motivated to change. In addition, their ability to change can be hindered by: their appearance of not wishing to change, poor negotiation skills and consequential thinking (F6). Motivation to change can be compromised by their propensity to misuse drugs and alcohol as a potential coping mechanism (F5). Conversely, Factor Seven and Five believe that they do demonstrate consequential thinking evidenced by their ability to manipulate other patients to undermine Mental Health Nurses, albeit motivated to protect their own sense of vulnerability, recreate past

problems, or a response to jealousy. The differing views concerning whether PD patients can utilise consequential thinking effectively are often addressed in programme orientated therapies in which they would be taught to consider the short, medium, long term cost/benefit analysis for themselves and others. It could be suggested that some of the accounts consider patients can utilise consequential thinking but it is only evident in the absence of consideration for the longer consequences for themselves and the consequences for others.

The personality disorder relationship patterns described above are confirmed and discussed in the literature search in chapters two and three. In chapter 2, I focused on understanding personality disorder relationship patterns, and specifically how relationship patterns are: conceptualised through personality theory, the diagnostic/assessment tools, and the origins of personality disorder and importantly from the viewpoint of contemporary treatment modalities. Whilst chapter 3 (Understanding of Personality Disorder Relationships) focuses on the understanding of the origins of personality disorder relationship difficulties (3.1.2), potential problems (3.3.1) and the theoretical understanding of relationship dynamics (3.3.3).

Recommendation.

Evaluation of the Forensic/Mental Health Nurse Competency Base:

It is clear from the nurse participants that they recognise a variety of personality factors which impact upon the PD patients' relationships, motivated for differing reasons and in the main are understood to be caused by historical adversity, re-enacted at some level in the present relationships. However, it does not seem clear that their understanding is theoretically grounded. James and Cowmann

(2007) have reflected whether a skills deficit exists due to reports of negative attitudes of staff (Markham, (2003) and reports of poor service experience by PD patients (NIHME, 2003b). This was responded to in the UK by the provision of skills and competencies in the form of the Personality Disorder Capability Framework (NIHME, 2004) and by the National Institute of Clinical Excellence (NICE) guidelines for working with antisocial (2009a) and borderline (2009b) personality disorders which also provided advice for the development of staff.

When exploring these terms skills and competencies, Ramritu and Barnard (2001, p.49) identify one competency definition as, 'possession of knowledge, skills, attitudes and the ability to perform to a prescribed standard. Yet there is no reference to competencies and skills required for working with patients diagnosed with personality disorder in the Standards for Pre-registration Nurse Education (NMC, 2010). However, in table 3.1 the NMC Standards do require, in my opinion 'seemingly compatible' specific competence for Mental Health Nurses for non-specific diagnostic groups.

Despite the above competencies for preregistration nursing James and Cowmann (2007) argue that training is inadequate to prepare nurses for work in this area in relation to personality disordered patients. This position is supported further in the forensic context by Bowen and Mason's (2012) study that demonstrates that different training is required for forensic and non-forensic nurses (section 3.2.6).

Consequently, further evaluation should be considered regarding the suitability of the competency base for working with personality disorder relationships in

which the useful generic NMC (2010) guidelines (table 3.1) could be employed alongside an integrative evidence based model suggested by Livesley (2012a).

8.5.2 The Impact of PD Relationships on the MHN.

- Factor 5: PD Patients and the Impact Upon the Nurse.
- Factor 7: Processing Relationship Difficulties.

Whilst recognising the significant psychological impact upon the Mental Health Nurse which can be augmented by the patient or surreptitiously via a third-party collaborator (F5, F7), causing potentially unfamiliar negative responses by the nurse (F5). Bowers (2002) supports this perception by reporting that apart from the crimes PD patients have committed, what can cause most difficulty are perceptions of: manipulation, self-harm, violence, complaints, and informal exploitative hierarchy within the ward context. Consequently, violence and aggression can be understood in various ways. These can include death, rape, taking a hostage and making serious (but fabricated) complaints. Patients occasionally threaten nurse's families and children and say what they will do on release from hospital, with such threats being particularly intimidating. In addition, Factor Seven felt that these relationship dynamics can make the nurse's life a misery or alternatively to seduce the nurse into feeling special (idealised).

However, these potentially evoked dynamics are considered insufficient to impinge upon one's own unresolved issues to the extent that they could manifest as somatic symptoms (F5). In addition, Factor Four were also able to recognise the profound effect upon nurses of PD patients but did not feel that this impacted upon their ability to recognise what issues belong to themselves

or their patients. It was also felt to be sufficient to maintain self-awareness for these dynamics (F5).

Further literature supporting the participant's accounts above can be found throughout chapters one and three but specifically in section 3.3.2.

Recommendation.

Reflection:

It is noted by the HMSO (1992) that Nurses have the longest contact time with patients but they also had little respite from the 'contamination' of negative feelings in forensic settings. There is no doubt from every review but has been undertaken of professionals working with patients diagnosed with personality disorder that the impact can be profound culminating in consistent recommendations for appropriate training, relational structures, practice guidelines and more often the provision of a containing supervision/reflective practice, which will be discussed later under reflective practice.

8.5.3 Nurses Coping Strategies.

- Factor 4: What is Personality Disorder?
- Factor 2: Relationships.
- Factor 5: PD Patients and the Impact Upon the Nurse.
- Factor 1: The Importance of Prior Knowledge in the Therapeutic Relationship.
- Factor 4: Recognition and Processing of Relationships Difficulties.

Whilst recognising the effects on nurses of repeated exposure to patients' potentially self-defeating strategies, it was felt important not to become desensitised or respond to their behaviour as something that they will not be defeated by at any costs (F4). Mental Health Nurses need to strike a balance, by not being excessively vigilant, but having a measure of alertness to their patient's ability to seduce others into feeling special or subtly undermining one's

authority (F2). A social defence system model has been considered useful when thinking about work with individuals with a diagnosis of personality disorder who are considered a risk to others. It describes the way in which organisational structure and practices function to limit or avoid painful affect among group members (Jacques, 1953, 1955; Menzies Lyth, 1960). Kurtz (2002b), suggest that difficulty can arise when the social defences undermine the main task of the organisation which can result in moralistic attitude towards those with a diagnosis of personality disorder which can act as a way of distancing staff and patients. It is believed that this can impede this patient group from getting the hospital care they need and once they are admitted to hospital it can place a custodial, rather than therapeutic emphasis on their management.

Alternatively, far from being desensitised Factor Two focused on the profound emotional impact equating to 'feelings of being emotionally raped' in response to patients' strategies emanating from past experiences. The nurse can also feel a sense of guilt when embroiled in a patient's patterns of eliciting rejecting responses, all of which can dramatically erode the caring nursing role (F2). The participant in Factor 2 who reported the severe emotional impact was part of the transcribed semi-structured interviews (part of the communication concourse) in which it was noted that his level of unfamiliar dysfluency associated with recalling this emotional arousal can often be seen as an important discourse markers in narrative analysis when undertaking adult attachment interviews (AAI). The utility of the AAI in assisting nurses' reflective capacity will be discussed as part of the Conclusions Chapter: Further Research.

However, there is recognition that nurses do need to develop protective strategies without ignoring the feelings that can generate understanding (F5). Furthermore, the interpretation of boundary violations does not assist the identification of relationship difficulties unless it is done within the context of a reflective practice context (F5). Factor Four supports this position indicating that relationship difficulties can be identified when nurses' responses to the patient are uncharacteristic, which can be clarified through reflective group processes and particularly through examining their lifelong scripts or narratives. Without sufficient feedback from others it can be difficult not only to challenge men diagnosed with personality disorder but also to provide them with support (F5). Other sources of unhelpful information gathering pertain to the diagnostic and pejorative labels (refuted by F5) which are believed to cause preconceived notions that can confuse the therapeutic relationship, preferring instead, to relate to them as individuals (F1). Many of the coping dynamics identified above are recognised and correspond to the literature search contained in section 3.2.5 entitled 'Nurses Defences'.

Recommendation.

Reflection:

Many of the coping dynamics identified above are recognised and correspond to the literature search contained in section 3.2.5 entitled 'Nurses Defences'. In this section and in support of the participants' feedback above I summarised that,

> It is widely acknowledged that individuals with a diagnosis of personality disorder who are considered a risk to others are particularly difficult to work with, often find it extremely difficult to make constructive use of help, and can arouse intense negative feelings in staff (Hinshelwood, 2002). Patients with personality disorder are, arguably, among the most problematic of in-patient cases, invariably arousing strong feelings among staff. Expertise in the combination of responsiveness and limit-setting that is more appropriate for this patient group rarely comes

without training and support. Whittington and McLaughlin (2000) argue that unless there is change in 'organisational' attitude supported by a management structure committed to psychotherapeutic education, training and supervision aligned to appropriate clinical placements then the potential of the nurse as a powerful and dynamic therapeutic resource will remain largely untapped.

8.5.4 Nurses Role.

- Factor 5: Challenges to the Nursing Role.

It was strongly felt by Factor Five that the nurses' dual role of maintaining both therapy and security did not impact upon their therapeutic relationship (F5). Whilst in other accounts there was recognition that the dual role (e.g. maintaining security versus providing care and therapy) or even the specific gender of nurses (particularly in the high secure context) could trigger negative responses in a patient because it may remind them of someone who abused that type of role and responsibilities in the past. This position is supported by Markham (2003) who believes that it has the potential of impacting upon the therapeutic relationship due to issues of mistrust, and eliciting responses from patients that they may have reserved for past authoritarian abusive figures (discussed further in section 1.4).

Mental health practitioners, especially those who work in in-patient settings, will often trigger associations with primary attachment figures or become emotionally significant to patients in their own right (Adshead, 1998). This is a theme that was identified across both Q-sets. In forensic services this is enhanced by the power and control vested in staff, evoking memories of authoritarian and withholding relationships in childhood. Adshead has argued that the ubiquity of threat and fear in forensic institutions make it important for them to function as a 'secure base' for both staff and patients (Adshead, 2002).

Factors which contribute to this sense of an emotional safety in Adshead's study include: the creation and maintenance of boundaries between staff and patients to protect therapeutic space, particularly for nursing staff who are on the wards for hours at a time; the careful management of separation, loss, and the avoidance of abrupt endings; and the monitoring, naming, and regulating of affect in staff and patients to promote the capacity of patients to think about and understand themselves in relation to other people.

Within the context of a secure forensic environment issues of 'care and control' can be seen as a significant omnipresent influence on the therapeutic relationship. The Blom-Cooper et al report (HMSO, 1992) clearly highlighted a negative prejudiced and bullying nursing culture in a U.K. High Secure Hospital at that time, and yet the later (HMSO, 1999) report into the same institution suggested that the regime had become too liberal. Perhaps this demonstrates the difficulty in establishing a fine balance between security and therapy. Rogers and Topping-Morris (1997) and UKCC (1993) highlighted that there was little doubt that skills in supervision are central to ensuring the effectiveness of clinical governance in forensic settings, yet Mason (1993) in his research of the nursing culture in a high secure setting identified a small group of negative staff, a small group of positive staff, and a much larger 'toggle' group of nursing staff who would switch allegiances to whoever was in charge at the time. Morrison (1990) also studied and identified psychiatric nursing cultural groups. For example, those that like to 'put on a show' in which they appear positive, therapeutic and considerate of patients' needs and rights, but behind the scenes they are domineering, rough and inconsiderate. He also identified the

‘superman’, which refers to the strongest and toughest nurse on the ward, who is known for his/her ability to ‘handle’ any patient that steps out of line.

In secure and forensics services ethical issues can arise for staff who look after the patients diagnosed with personality disorder particularly associated with the balance between care and control (Kaye and Franey, 1998). This can mean that staff groups can be artificially split into two main camps: those who are predominantly delivering therapy and those whose main role is to maintain security (Clark, 1996; Durrant, 1993; McCann et al., 2000). Divisions of this nature accentuate the tensions between professional groups, and rank as the highest source of stress for staff working in secure settings (Whyte and Brooker, 2001). Arguably, divisions of this nature could be exacerbated and conflicted in terms of perception of role through nurses’ union affiliations with a large majority of high secure nurses being members of the Prison Officers Association. However this might not be a salient factor in light of Dale and Storey’s (2004) study which identified forty-five forensic nurse competencies within a high secure environment discovered a high degree of concordance with nurses from medium and low secure environment who are not affiliated to the POA.

Maintaining the balance between security and therapy was one of the most reported difficulties in secure environments within the context of Dale and Storey’s (2004) study. Hopkins and Ousley (2000), have suggested that the main distinction between a nurse working in a secure context and one working in the general psychiatry is the ethical dilemma of ‘control versus care'. Swinton, (2000, p. 119-120) attempts to explain this as follows:

> A focus on pathology and control inevitably means that the personal needs become subsumed to control and security needs, leading to the

> disempowerment of the client, the development of models of care which can be oppressive and abusive … Within such a situation, therapeutic risk-taking and patient empowerment, two of the central tenets of contemporary forensic mental health nursing practice, cease to be realistic options.

The nurses' role within British secure mental health hospitals has ambiguously included security; consequently patients in these environments often view nurses as jailers as well as nurses, rather than recognising this task as everybody's responsibility (Dale and Storey, 2004).

When comparing high, medium and low secure environments Dale and Storey (2004), identified that the higher the level of security the more respondents recognised that staff support in relation to boundaries as being an important part of their role. However, Rayner et al. (2005) concluded that they had been able to illustrate a cycle for understanding nurses' countertransference reactions when working with people who self-injure and are often diagnosed with personality disorder. Although they recognised that some nurses' emotional and cognitive reactions to these clients may be perceived as a very negative and difficult, these reactions may be reflected upon and used to develop deeper empathetic relationships with clients. It is believed that by changing how nurses' think about clients, their emotions and behaviours can become more positive (or less negative) and avoid exacerbation of the clients' cognitions and emotions that trigger self-injury. This, in turn, can promote a more positive therapeutic environment, rather than a punitive rejecting one.

Compounding this situation, Holmes (2002) identifies that the maintenance of the ward culture and management of the ward as a whole is left, by default, to

the nurses, rather than being a collaborative therapeutic enterprise managed by a ‘combined parent’ of medical and nursing staff.

Recommendations.

The Role of the Forensic Nurse:

Tom Mason was my early research mentor, colleague and friend who sadly died in 2011. Anecdotally he has probably researched and produced more academic literature about forensic nursing than most and once informed me that, “if we could bottle what forensic nurses do intuitively we would be onto a winner!” Consequently, further work is required to build upon to his considerable wealth of pioneering endeavour to enhance the understanding and evidence base of the role of the forensic nurse.

Integrative Shared Formulation and Reflective Practice:

One of many significant aspects that Bowen and Mason (2012) identified was that Mental Health Nurses consider their therapeutic relationships with PD patients as the ‘bedrock’ of their practice. Furthermore, it has been consistently reported in psychotherapy research literature that the quality of the therapeutic alliance is the best predictor of a good outcome in therapy (Roth and Fonagy, 1996). Hence, a more integrated view of the custodial and therapeutic needs of patients in which each patient’s needs are plotted at different stages of their care is required. This I would suggest could be assisted by utilising multidisciplinary, integrated systems such as shared formulation and/or reflective practice to make sense of a complex and potentially contradictory task of maintaining a balance between combining therapeutic tasks with their duty to protect and maintain safety.

8.5.5 Understanding of Self.

- Factor 1: Understanding of Self.
- Factor 3: Self-Awareness
- Factor 6: Gender Issues in Relation to Boundaries.
- Factor 7: Processing Relationship Difficulties.

It is crucial to understand oneself (F1, F6) and the PD patients' relationship style which desirably should be facilitated via a third-party context (e.g. reflective practice), and should not be considered a weakness to partake in (F1). Nurses' own unresolved feelings which can be exacerbated by the horrific patient accounts should not be underestimated because they can have the potential to feel overwhelming and even result in colluding with self-defeating relationship patterns (F1). Factor Three stressed the importance of early recognition and reporting of relationship difficulties (through a good understanding of oneself and a constant reappraisal of one's relationships), even if the nurse is fearful of the consequences. However, Factor Three denied that Mental Health Nurses can become embroiled into seductive types of relationships with men from this diagnostic group. Nevertheless, the early recognition or involvement was not extended to having to be constantly aware of charming, manipulative and seductive behaviours from patients or conforming to offensive staff group behaviour (F3). When specifically focusing on potential female nurses' boundary erosion with PD patients two female nurses reported that they had not been subject to this but strongly recognised that their female colleagues could be lulled into a false sense of security and even cause jealous acting out behaviour if they spent a disproportionate amount of time with a particular PD patient (F6). However, Factor Seven strongly recognised that working with PD patients can evoke feelings that do not belong to oneself, but did not feel that this recognition

would enhance understanding of the relationship difficulty. Despite these difficulties the participants were of the opinion that a trusting/honest relationship can be achieved as a foundation to the therapeutic alliance (F7).

Gallop et al. (2003), argued that nurses can benefit in their interpersonal therapeutic relationships with patients through the use of increased understanding of psychodynamic principles, and suggest that as a minimum, nurses need to understand how they become who they are, including how their own and the patient's history are re-enacted and modified in current interactions. This understanding would then help them make a more balanced distinction of their own inner world and that of the patient. Without this understanding Gallop et al. (2003, p. 214), believes that, 'nurses are at a tremendous disadvantage and at risk of acting in an inappropriate and at times sadistic manner.' Welldon, (1993, p. 487) conceptualises this further by stating that,

> 'an early and severe emotional deprivation is usually found in forensic patients/offenders of both sexes'. It is argued that traumatic, continuous and inconsistent attitudes towards them have effectively interfered with the processes of individuation and separation. There is a basic lack of trust towards the significant carer, which accompanies PD patients throughout their lives. As such some psychopathological features are evident and can be understood in the light of PD patient's early background' (Sharp, 1995). West et al. (1993) have provided empirical results to support the hypothesised relationship between dysfunctions of the attachment system and personality disorder. Similarly, Sack et al. (1996) utilised a battery of assessment tools to compare two control groups and reported that maladaptive interpersonal relations associated with personality disorder can usefully be understood from an attachment perspective.

The literature review related to self-awareness is explored in detail in section 3.4.2 and provides considerable support for the understanding of the participants related to this emerging theme of the factors. Within this section

Duff (2003) explores three important areas (1) self-awareness (being familiar with one's own responses, blind spots, prejudices and vulnerabilities), awareness of people with a personality disorder (positive and negative aspects based on a wide range of detailed sources of information in order to facilitate links between their past behaviour), and systems awareness (providing a list of difficulties e.g. reduced ability of the staff group to empathise with this client group). Dozier et al (1994), in a seminal study compared the role of attachment organisation between the case manager and their clients who had serious psychopathological disorders, indicating a significant correlation in terms of attachment type and interventions provided.

Recommendation.

Further Research and Provision of a Reflective Space:

Dozier, et al (1994) stress that it is important for people who work with patients diagnosed with PD to have an awareness of their own attachment style, to assist in determining what issues belong to oneself and what belongs to the patient. Consequently, further research has been suggested in the last recommendation of this chapter. The importance of reflection has been recommended by study participants and the literature in relation to supporting and managing self-awareness and will be the focus of the Reflective Practice theme below.

8.5.6 Processing Relationship Difficulties.

- Factor 2: Processing Relationship Difficulties.
- Factor 1: Processing Relationship Difficulties.
- Factor 1: Beliefs about Relationship.

Despite some acknowledgement of the importance of knowing about ones 'self' (above) Factor Two did not feel that lack of awareness between self and others could cause potential therapeutic relationship difficulties. Nevertheless, they did stress the importance of constantly reappraising the therapeutic relationship and maintaining an awareness of how past relationships impact upon the present relationship difficulties (F2). However, collating information about adverse experiences to illuminate the past was considered less important (F2).

Factor One believes that the repeated relationship difficulties experienced by PD patients emanate from their past and are acted out in present relationships. Unconventionally, they understand that nurses would not attempt to corroborate past difficulties and coping strategies and would take patients' accounts at face value and would not utilise countertransference to assist in triangulating information in the assessment process (F1). However, countertransference may not be entirely understood without specific training and support (Maier, Van Rybroek., 1995) and discussed further in section 1.4.

The literature search related to processing relationship difficulties is contained in chapter 3 (Understanding Relationship Difficulties) and specifically in the section concerning the therapeutic relationship (3.2.2). In light of the participants' contradictory positions regarding processing issues, it is useful to reflect that a psychodynamically informed Mental Health Nurse who maintains a thoughtful and reflective therapeutic stance will be less likely to either collapse

or retaliate (Glass, et al., 1989; Jackson, 1992, 2001; Jackson and Williams, 1994; Moore, 1998a; Van Humbeek et al., 2001). Apart from benefiting the patient, there is also good evidence to suggest that psychiatric nurses who are psychotherapeutically informed are less likely to suffer from stress, low morale and have better treatment outcomes (Miller, 1993). A growing body of clinical evidence tentatively suggests that a psychodynamic-analytic approach can provide a valuable framework to help the sufferer and their primary care giver make sense and live with severe chronic mental illness (Jackson, 1992, 2001., Sohn, 1997., Lucas, 1998, 2003., Kriegman, 2000., De Waelhens and Ver Eecke, 2001., Karon, 2003., Ver Eeke, 2003). This is also supported by the National Institute for Clinical Excellence (NICE 2003a,b). As highlighted in chapter 2, in more recent years there has been a growing trend in recognising that no one contemporary therapeutic modality has proven to be more efficacious than the other, yet every modality has its strengths. Consequently, Livesley (2012) has advocated an integrative model utilising the strengths from each. With this in mind Alvin et al. (2006) has not stressed the importance of using specifically a psychodynamic approach to inform understanding (as highlighted above) but focuses on the important utility of a shared understanding through the creation of a formulation, when working with patients diagnosed with PD.

Recommendation.

Reflection:

Mental Health Nurses need to develop methods to safely understand and challenge these relationship dynamics. The earlier the recognition that a relationship difficulty exists is obviously important to enable prompt interventions to prevent any exacerbation of the difficulty and thus support the

therapeutic alliance. Consequently, training is essential to understand the potential relationship dynamics, whilst understanding of 'self' mediated through a shared formulation and reflective practice (recommended elsewhere) are essential.

8.5.7 Reflective Practice.

- Factor 6: Processing Relationship Difficulties.
- Factor 6: Processing Relationship Difficulties.
- Factor 1: Supervision.
- Factor 2: Processing Relationship Difficulties.
- Factor 7: Processing Relationship Difficulties.

Factor Two and Six felt that it was imperative to process all relevant information (e.g. early negative feelings, coping with the disturbing histories, emotional and psychological effects) and seemingly insignificant information within the safe context of a reflective practice group. The collective expertise of a reflective practice group can enable: easier recognition of relationship difficulties, the formation of an integrative narrative, a shared understanding, consultation, and a consistent plan of action (F1, F2, F7). Despite the consistency of a shared action plan/formulation following reflective practice they still felt that it was important to respond to their patients flexibly, dependent upon the PD patient's presentation (F1, F2).

The literature for supporting and discussing the importance of reflective processes can be found in the following sections:

3.5.1 The Importance of Reflective Processes.
3.5.3 Provision of Reflective Space.
3.5.4 Working with Relationship Difficulties.
3.5.7 Reflective Models for MHN to Work with Personality Disordered Patients.
3.5.8 Clinical Supervision.

The importance of reflective practice is often due to a variety of challenging dynamics: listening to these traumatic experiences in some depth (National Institute for Mental Health in England, 2003, emotional stress that overflows into their personal lives (Bowers et al, 2000), in environments where there is a propensity for frequent periods of crisis which involves self-harm or aggression (Mitchell and Everly,1995), difficulties monitoring, naming, and regulating of affect in the staff and patients (Kurtz , 2005). As a consequence caring for patients with personality disorders can result in tension, exhaustion, burnout and high staff turnover (Piccinino, 1990; Bland and Rossen, 2005).

It has been reported that nurses experience higher levels of occupational stress and burnout than any other profession (Aiken et al., 2002; Medland et al., 2004). Whilst the highest rates of burnout are experienced by nurses and care workers in secure settings such as prisons and forensic mental health units (Dickinson and Wright 2008). The stress is compounded within these settings often due to the perception of the threat of violence or actual violence (Coldwell and Naismith, 1989). Due to this experience of burnout staff can present as cold and cynical culminating in reduced empathy and avoidance of patient interaction (Ewers et al*.,* 2002). This in turn can lead to a loss of therapeutic optimism Bowers (2002) of which the latter study was explored in chapter 3 due to other members of staff being able to thrive more positively within this environmental climate.

The importance of a reflective practice model when working with men diagnosed with personality disorder is evivenced in research literature which has long recognised the importance of formal and informal supervision and

support structures for staff working with this client group (Ford et al, 1997; Paine, 1981; Wilkin, 1999). Many examples of the benefits of the reflective practice processes are exemplified in the following summary. Reflection helps develop and maintain personal coping strategies and support systems that help to prevent staff burnout (Ford et al., 1997). This enhances the awareness of the people with whom staff work which must be based on a wide range of detailed sources of information in order to facilitate links between their past behaviour (Davidson, 2000). This awareness should help Mental Health Nurses to manage and treat people with personality disorders safely and effectively. Reducing the personal impact of contact with these highly distressed and sometimes threatening people, thus supporting the exploration of dynamics that develop in the context of the therapeutic relationship Cox (1996). As a consequence Mann et al (2014) observed that reflective practice in secure settings has enhanced the staff's ability to reflect on problematic countertransference and to distance themselves from re-enacting the patients' insecure attachments. In addition, Kho et al. (1998) provide evidence that the existence of such a group serves to reduce the number of violent episodes on a ward, possibly by reducing expressed emotion and enhancing cohesion within the group.

Formalising the above importance of reflective practice the NMC (2006) and the HMP Service (Freshwater et al., 2001; 2002) have developed guidance on the benefits and suggested models for implementing clinical supervision in secure environments. Nurses within these samples felt that clinical supervision would provide a consistent time to reflect on the contents and process of their work, even though they suggested that secure mental health care is a breeding

ground for resistance and suspicion. Nevertheless, Dale and Storey's (2004), study identified that the consequences of not having supervision can result in making staff vulnerable to stress-related illnesses, burnout, boundary violations and dangerous practice.

Provision of reflective practice/clinical supervision for nurses is unclear but has been reported as sparse and even absent altogether in many secure services, often the excuse is due to a lack of resources both in terms of time and expertise (Dale and Storey, 2004). In an attempt to clarify the implementation of the Nursing and Midwifery Council (NMC) (2006) standards for clinical supervision, Cookson et al. (2014) instigated a questionnaire survey of 191 participants from predominantly nursing, and allied professionals, which identified that staff were receiving regular, formalised clinical supervision that met their needs but with important inconsistencies. They suggested that against best evidence clinical and managerial supervision was not entirely separate with limited opportunities to choose their own supervisor, and problems with duration and frequency, and supervision agreements.

Various considerations in relation to reflective practice have been suggested which will be briefly explored.

The delivery of staff support groups should be undertaken at a bare minimum of weekly or fortnightly, by a multidisciplinary team, facilitated by a psychotherapist with training in group dynamics (Holmes, 2002). Regular debriefing is recommended by Mitchell and Everly (1995). Whilst the composition should

comprise of robust systems to support and supervise staff, which ideally should be provided by external services (Bowers et al, 2000).

Structures could include 'shared formulation' alongside reflective practice, providing a contextualisation to understand relationship issues and the emotional impact for Mental Health Nurses, to enhance their ability to understand the origin of the patients' presentation. Additionally, Gallop (1992), suggested that behaviours need to be understood in terms of their meaning for the patient. This understanding could be assisted by Cameron, et al (2005), who suggested that a human (object[8]) – relations model of the therapeutic relationship and psychopathology would provide the psychiatric nurse with a useful dialectical framework to get to know and understand the illness predicament or state of mind of the patients with severe psychiatric illness.

Another important component of reflection is knowledge of self. Although there has been a recognition of the difficulties that PD patients can bring to the therapeutic relationship, concerns were also raised about what difficulties Mental Health Nurses can bring to the therapeutic relationship themselves, particularly in terms of knowledge of self, and other issues that may influence their ability to process the situation with therapeutic clarity e.g. countertransference. It is within this context, that themes were generated regarding the importance of reflective practice to provide personal support and therapeutic clarity. This was emphasised by account F8 (Q-Set 'A') which

[8] **Object**: The development of a healthy cohesive self arises from the interaction with those significant figures in our earliest childhood environment" Donna, M., Czuchta, R. (2004). Kohut (1971) terms these figures as self-objects when they are internalised and viewed them as extensions of the self.

suggested that the reflective capacity of the Mental Health Nurse is an important determinants of the therapeutic relationship and treatment outcome.

The role of resilience has achieved some prominence in the literature, towards the reduction of the negative impact of work-related stress/burnout (Howard, 2008). A definition of resilience is 'the general capacity for flexible and resourceful adaptation to external and internal stressors' (Klohnen, 1996, p.1070). In addition, Kinman and Grant (2011) have described 'interventions designed to enhance inter-personal and intra-personal emotional competencies that are likely to foster resilience, which in turn, has the potential to protect the future well-being of carers'. Some of the components within this study again are transferable skills from within the dialectical behavioural therapy, which may provide utility not only for patients but Mental Health Nurses. The principles of resilience and flexible adaptation could arguably be provided within the context of reflective practice.

Attachment Theory and Reflective Practice. The most prevalent theme expressed by Mental Health Nurse participants throughout both Q-sets is the understanding that relationship difficulties in the present with PD patients are considered to be re-enactments of past childhood difficulties. However, if these patterns of relating are not understood, perhaps due to the absence of a shared formulation or through the process of reflection, then an awareness of attachment theory should help provide insight. Attachment theory is considered to be important to the extent that significant elements can be found as a central component of practically every contemporary efficacious treatment model (described in chapter 2). Not only does it provide understanding about the PD

patients' attachment style but conversely they can provide insight into the people who care for them, and ultimately the interplay of attachment styles can be significant factors in terms of the therapeutic relationship as demonstrated by Dozier, et al. (1994). They indicate that it is important for people who work with patients diagnosed with PD to have an awareness of their own attachment style, to assist in determining what issues belong to oneself and what belongs to the patient. This can not only be important when attempting to understand countertransference issues, but also to ensure that nurses have not activated their own childhood attachment patterns. It is within this context that themes emerged within the study regarding account F4 (Q-set 'B') highlighting the importance of an awareness of experiencing feelings that are uncharacteristic of oneself. This could have represented countertransference feelings, however within this factor account it actually represented a response to staff group behaviour. However, account F7 (Q-set 'B') highlighted the need to determine what feelings belong to oneself and which to the PD patient. A theme that arose from account F1 (Q-set 'B') identified the importance of contradictory accounts by PD patients. For example, a patient provides the verbal information that his mother never hit him, yet case notes report significant physical abuse from the mother. With further exploration conceptualised within the attachment theory, this could be understood as a child maintaining an avoidant insecure attachment style by learning to dismiss/deny his own feelings (e.g. rage). Thus the patient subscribes to his mother's script/narrative of events, which enables him to have at least an inconsistent attachment with his mother, all of which becomes ingrained throughout life. Without historical information, this process would most likely not be revealed unless it is re-enacted and understood. However, this process can often be revealed by undertaking a semi-structured

adult attachment interview which is transcribed and subject to a discourse analysis to reveal unconscious patterns within the script. This again represents a transferable skill that Mental Health Nurses could utilise to understand the re-enactments of past relationships within the therapeutic alliance. This is described in more detail below.

As noted previously the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) published by the American psychiatric Association defines personality disorder relationships as, ‘patterns of unstable and intense relationships noted by alternating between extremes of idealisation and devaluation’. Welldon (1993, p.487) conceptualises by this stating that, ‘an early and severe emotional deprivation is usually found in forensic patients/offenders of both sexes’. It is argued that traumatic, continuous and inconsistent attitudes towards them have effectively interfered with the processes of individuation and separation. There is a basic lack of trust towards the significant carer, which accompanies PD patients throughout their lives. As such some psychopathological features are evident and can be understood in the light of PD patient’s early background’ (Sharp, 1995). West et al. (1993) have provided empirical results to support the hypothesised relationship between dysfunctions of the attachment system and personality disorder. Similarly, Sack et al. (1996) utilised a battery of assessment tools to compare two control groups and reported that maladaptive interpersonal relations associated with personality disorder can usefully be understood from an attachment perspective.

Attachment theory is defined by Rycroft, (1995, p.10) as,

> A new and illuminating way of conceptualising the propensity of human beings to make strong affection at bonds to particular others and of

> explaining the many forms of emotional distress and personality disturbance, including anxiety, anger, depression and emotional detachment, to which unwilling separation and loss give rise.

Attachment theory is perceived like a map which can provide a framework for understanding relationships. Attachment experiences are increasingly being understood as internalised self-narrative which emanate from three to five years and remain latent throughout life.

Attachment theory has been heavily influenced by ‘Object Relation’ theorists such as Klein, Balint and Winnicott (Greenberg and Mitchell, 1983) who represented the psychoanalysts who moved away from 'Drive Theory' towards any relational perspective. Object Relations Theorists examine how early relationships are internalised into a sense of self and how in turn this impacts upon the individuals’ relationships.

Bowlby on the other hand, who most people would associate with attachment theory, based his psychology on the opposing themes of attachment and separation/loss, which was based on a study of children who were evacuated and the Second World War. Bowlby moved beyond behavioural manifestations of grief to the meaning and significance of loss and the narrative structures that surround them. This period represented the beginning of the empirical research into development of psychology.

Attachment theory, as developed by Bowlby (1969/82, 1973, 1980), is an organizational, systemic theory regarding the function and development of human protective behaviour. The theory was generated as an integration of ethological, evolutionary, psychoanalytic, and cognitive theories. Attachment

theory postulates that humans are innately predisposed to: form attachment relationships to their primary caregivers, that attachment relationships function to protect the attached person, and that such relationships exist in an organized form by the end of the first year of life. The attachment relationship itself is defined as a tie, that endures across time and space, to a specific person to whom one turns when one feels vulnerable and in need of protection (Ainsworth, 1973).

Bowlby presented considerable evidence indicating that separation from, or loss of, an attachment figure is associated with a variety of psychological and physical disorders, including anxiety and depressive disorders (Bowlby, 1944, 1958, 1973, 1980). He believed that such disorders were relatively stable, but amenable to change through treatment (Bowlby, 1979). In his later work, Bowlby proposed the construct of internal representational models to explain how prior experience was retained over time and used to guide expectations and future behaviour. He further suggested that there were multiple internal representational models tied to (a) different relationships and (b) different memory systems, e.g., semantic and episodic memory (Bowlby,1980). Bowlby discussed mental integration of information held in different memory systems from the perspective of cognitive theory about information processing.

Bowlby also introduced the notion of developmental pathways. Such pathways were not *trajectories*, such that, once the direction was established, it was maintained throughout the lifespan. To the contrary, the metaphor of *pathways* was used explicitly because it contained the notion of change points and intersections where one's direction could be modified in ways that were not

necessarily predictable from the original path. This aspect of mental and behavioural organization is especially important because Bowlby was dedicated to the development of theory that would be clinically relevant to initiating change. The notion of pathways is relevant to the *AAI* classifications that are "earned" or "reorganizing."

Bowlby understood that attachment had several significant aspects which included:

1) A biological function of protection against predation.
2) A reciprocal relationship between secure attachment and creative/playful exploration.
3) The pattern of attachment continues from childhood and remains latent throughout life.
4) An important link exists between attachment relationships and the disruption of emotions.

Consequently, attachment theory provides a relational context in which disturbing feelings can be located and understood: fear, anger and protest about separation; sadness about loss; terror rage and guilt in reaction to traumatic abuse of bonds; jealousy of those whose attachment potential one imagines to be greater than one's own; envy of withholding attachment figures (Bowlby, 1979) and key for the understanding and relating to PD patients.

Recommendation.

Further Evaluation:

The essential process of sharing, identifying, and processing whether this is 'in or on action' provides not only an important method of containment but a rich source of individual and shared understanding, particularly with patients complex personality disorder issues. Consequently, reflective practice not only is a requirement of pre and post registered Mental Health Nurses but has been

a key recommendation of the majority of UK practice guidelines for the treatment of personality disorder (E.g. NICE Guidelines for Borderline and Antisocial Personality Disorder 2009a, b). Hence, further exploration is required to evaluate the consistency of its availability, its effectiveness, and whether a more specific/bespoke reflective practice methodology is required for working with personality disorder, as proposed in further research, contained in Chapter Nine: Conclusions.

8.5.8 Training.

- Factor 1: Supervision.
- Factor 5: Challenges to the Nursing Role.
- Factor 6: Gender Issues in Relation to Boundaries.
- Factor 7: Processing Relationship Difficulties.
- Factor 3: Supervision and Training.

Compounding and impeding the identification of relationship difficulties is the perceived lack of training, hence the importance of seeking contemporary knowledge (F1). However, embracing contemporary knowledge is not seen as entirely useful (F5) which may be seen as preferring to individualise patient care.

Potentially poor boundaries do not emanate from poor basic training (F6). Poor training was claimed partly to explain the relationship difficulty but was not considered the root cause (F7). Finally, when processing relationship difficulties it was felt that self-awareness, supervision and training are important issues to address (F3). Research literature provides a consistent theme of nursing staff feeling inadequately prepared to treat and manage patients diagnosed with personality disorder (Krawitz, 2004; Miller and Davenport, 1996). Bowers (2002)

reported that high secure psychiatric nurses' felt unprepared for their treatment role. Beyond the high secure context other studies echoed this concern evidence by: James and Cowmen (2007) reported that only 3% of Irish nurses in their study claimed to have received training about borderline personality disorder; Deans and Meocevic (2006) identified that 56% of psychiatric nurses felt lacking in training, whilst Cleary et al. (2002) identified 29% of Australian nurses' considered themselves lacking sufficient training. The issue of nurse training to work with patients diagnosed with personality disorder is discussed in more detail in the following sections: 1.3 (Mental Health Nurses Training/Readiness to Work with Patients Diagnosed with Personality Disorder), 3.2 (Mental Health Nursing) and the discussion and recommendation of the 'Nurses Role' in this chapter.

This chapter has presented, discussed and interpreted the results of Q-set 'A' (related to the first aim of the research study) and Q-sort 'B' (related to the second aim of the research study) in the form of the respective factors and the emerging themes across each Q-sort. Recommendations for clinical practice (related to the third aim of the research study) have been made following each emerging theme presented. The next chapter will draw conclusions from the study and suggest further research.

CHAPTER NINE:

Conclusions and Recommendations for Future Research

Chapter Nine:

Conclusions and Recommendations for Future Research.

9.0 The perspectives expressed by Mental Health Nurses in this research study have been broad and occasionally contradictory. To summarise the variety of perspectives in this section would not be appropriate or ethical, particularly in light of Q-methodology's strength in highlighting subjective voices. However, the participants' views do appear to be supported and situated within the available literature. Consequently, this chapter will revisit the aims and purpose of the study, briefly summarising the clinical implications, prior to considering suggestions for areas of future research.

9.1 Aim One: What are Mental Health Nurses' understandings of men diagnosed with personality disorder?

Diagnosis and Nursing Assessment of Personality Disorder.

Based on the available literature and participant data, conceptualising what personality disorder is remains problematic, ranging from nurses perceiving diagnosis as a form of social control to manage risk, to diagnosticians advocating static categorical systems without considering the dynamic psychosocial function within a given context. Whilst nurses' recognise the importance of how personality disorder patients relate to others as a means of processing and assessing their needs, nursing models which focus on relationships are not widely used. Encouraging nurses to utilise and evaluate contemporary emerging models (e.g. DSM-V, Emerging Model Appendix) which are integrative, functional, dimensional and linked to evidence-based personality theory and efficacious treatment interventions, should be considered

a best practice objective (8.3.1 recommendation). Other advantages of using this type of assessment tool are that it provides the possibility of a shared language across differing theoretical treatment models and clinicians. It could also have the advantage of assisting patients to work more collaboratively by improving their understanding and overcoming some of the barriers that lead to treatment failure, increased risk and multiple service contacts. In the absence of a clear nursing assessment tool, the recovery model or even a solution-focused model could assist in gathering information towards the provision of (1) a shared formulation, and (2) the corroboration of information to support a functional diagnosis and care planning.

Relationships.

A key component identified by nurses in understanding personality disorder is that of the relationship. They particularly focussed on the developmental causes, manifestation and maintenance of difficult relationships and the impact upon the patients and nurse. The significant concerns raised highlight the need for improved consistency of understanding utilising training based on contemporary evidence-based theory and practice. In addition, there was recognition of the importance of obtaining supervision/reflective practice in accordance with professional guidelines (recommendation 8.3.2) to assist clear processing whilst maintaining psychological and professional support.

Features of Personality Disorder.

Some contradictions were identified in relation to nurses' understanding of psychopathy, which in turn raised questions about treatability and risk. By utilising attribution theory/models and evaluating the outcomes of the DSPD

project (recommendation 8.3.3) risk issues could be contextualised for nurses and assessed and treated for patients. Participants reported risk concerns perpetuated by society and the media culminating in legislative changes. There was also acknowledgement of the formation of negative beliefs about personality disordered individuals, emanating from influences in the nurses' formative years prior to entering nursing. Consequently, it is suggested that further evaluation is required of the perceived link between risk and personality disorder (recommendation 8.3.4).

Gender and Racial Issues.

Although this study focused on male personality disorder, some gender distinctions were highlighted focusing on the types of aggression expressed by patients. When focussing on nursing gender distinctions, there was a denial that male nurses may be excessively protective towards female staff when they are relating with male PD patients. Participants' identified racial differences pertaining to diagnosis, which is supported by the sparse literature, requiring further investigation (recommendation 8 .3.6).

Treatment.

The participant data highlighted different perspectives regarding the treatability of personality disorder, which is synonymous with the available literature, although there is currently an improving positive evidence base. Despite differing perspectives and no one therapy proving more efficacious than another, there is a growing recognition of the utility of an integrative approach, utilising what works most effectively from different modalities. However, critics have argued that this may reduce the treatment integrity of the specific modality. Nurses could also benefit from understanding the guiding principles

that underpin an effective treatment context. In addition, nurses could also benefit from developing further understanding regarding contemporary relationship theories, helping to contextualise their promising intuitive relationship hypothesis (recommendation 8.3.7). An important part of any treatment delivery for the care of patients diagnosed with personality disorder is the provision of reflective practice to assist the development of shared insights and mutual support.

In summary, revisions of diagnostic tools have not resulted in an agreed consensus, however new and hopefully illuminating diagnostic and treatment options are gaining a degree of acceptance, which will need to be evidenced by ongoing further research. Assessing and managing risk can potentially lead forensic nurses to focus on control rather than therapeutic engagement in which the former may seem easier to quantify. In the face of these difficulties, nurses need to maintain positive attitudes about their role and contribution, to maintain a therapeutic boundaried atmosphere to maximise therapeutic success. Maintaining a contemporary understanding will also enable forensic nurses to develop a credible dialogue with other healthcare professionals, thus promoting positive views and attitudes about their own role (Kirkman, 2002).

9.2 Aim Two: What are Mental Health Nurses' understandings of the relationship difficulties that men diagnosed with personality disorder have, and how does this influence the nurse-patient relationship?

Relationship Patterns.

Most nurse participants' recognise that patients' diagnosed with personality disorder had significant relationship difficulties born out of historical adversity

and re-enacted in the present, motivated, triggered and enacted in differing ways. All of which has a significant impact upon others engaging with these individual's. Despite the provision of guidelines for skills and competencies in the form of the Personality Disorder Capability Framework (NIHME, 2004), it is argued that the standards are ill-defined and training is not sufficient in terms of duration, specificity, evidence base for assessment, engagement and treatment. This is compounded further by poorly defined forensic nursing roles and training. As a means of assessing these issues, further evaluation regarding the suitability of the competency base for working with personality disorder relationships needs to be considered. To enhance the competency base consideration should be given to embracing the generic NMC (2010) guidelines (table 3.1), alongside the utility of an integrative evidence based model suggested by Livesley (2012a) (recommendation 8.5.1).

The Impact of PD Relationships on the MHN, Coping and Reflection.

The profoundly challenging nature of working with men diagnosed with personality disorder has been consistently recognised by nurse participants and the available literature. Nurse participants had varying degrees of understanding regarding the coping strategies that they and their colleagues may use in response to these relationship challenges (8.5.3). There was some recognition of the importance of understanding what issues belong to oneself that may complicate the nurse-patient relationship, believing that this can best be processed in reflective practice (recommendation 8.5.5). In response to the relationship challenges, it has been equally consistent from participants and the available literature that they require appropriate training, relational structures, practice guidelines and the provision of a containing supervision/reflective practice (8.5.2., 8.5.4). Furthermore, the utility of a bespoke reflective practice

model for working with personality disorder should be evaluated and is discussed in further research (recommendation 8.5.7).

Nurses' Role.

It has been consistently reported that the therapeutic relationship can be challenged by the dual nursing role of maintaining a balance between therapy and security, in which both roles can trigger responses in the patients. For example: (1) patients becoming dependent on a caring therapeutic response which is perceived as not being perfect enough can be attacked, and (2) a nurse undertaking routine rub down search of a patient's clothing or room search or reinforcing a relational boundary may remind the patient of an abusive figure and provoke an aggressive response. This situation can be exacerbated by limited basic Mental Health Nurse training in the personality disorder domain, which extends to a poorly defined forensic nursing role. Consequently, further work is required to build on the identified evidence base pioneered by Bowen and Mason (2012) (recommendation 8.5.4).

In summary.

Mental Health Nurses' consider the therapeutic relationship to be the bed-rock for nursing patients diagnosed with personality disorder, whilst also representing a strong indicator of outcome. The participant data and literature provided considerable evidence of a broad array of influences that can impact and confuse the interface of this dynamic relationship, yet there are indications that the provision of training, supportive models, and supervision/reflection are less than adequate or appropriate, despite professional competency requirements. Nevertheless, new and evolving models and treatment are beginning to provide some treatment efficacy with various aspects of personality

disorder, culminating in recent suggestions towards the creation of an integrated approach. Many of the factors that have proven to have utility with patients diagnosed with personality disorder, have transferable skills that could support Mental Health Nurses to enhance their role, alongside consistent recommendations for all disciplines to use shared formulations and reflection.

9.3 Aim Three: How does the understanding gleaned from aims one and two inform clinical practice?

The implications for practice have been briefly highlighted within the narrative of the above aims, and can be found summarised in the recommendations in Chapter 8. In addition, further clinical implications for practice are explained within the future research below.

9.4 Final Reflections.

It should be borne in mind that the data collection was undertaken in 2002, alongside the initial literature searches which have been updated with contemporary evidence. The benefits and limitations of Q-sort have been discussed within the methodology chapters. However, a key feature of Q-Sort is that it explores subjectivity by providing a voice to individual experiences. Consequently, it could be argued that a reductionist gathering of themes (8.3., 8.5) across factors potentially minimises their experiences. To ensure that individual and collective voices are captured equally the discussion chapter presents the factor accounts and the common emerging themes separately to prevent further dilution.

Finally, Mental Health Nurses' continue to have a significant role to play in meeting the challenging needs of patients diagnosed with personality disorder.

Nurses are subject to a broad array of influences that can shape their understanding of the therapeutic relationship with inconsistent internal and external resources. Nevertheless, innovative opportunities exist to support a shared understanding and change (e.g. functional diagnostic assessments, shared formulation, integrative efficacious treatment modalities). However, I am drawn back to the impetus for this research involving the vignette (1.1) involving the marginalised/disempowered intuitive voices that were interpreted and empowered through group reflective practice. Reminding me of the importance of searching for understanding often in the most 'unlikely places' whilst maintaining hope for something better, as coined by Roald Dahl,

> "And above all, watch with glittering eyes the whole world around you because the greatest secrets are always hidden in the most unlikely places. Those who don't believe in magic will never find it."
> (Dahl, 1991, p. 48)

It is with this in mind that I hope that this study can serve as a foundation for future research as described below.

9.5 Future Research.

Finally, I hope that this study can serve as a foundation of understanding, to support future research possibly using the adult attachment interview/dynamic maturation interview (Crittenden, 2002) to replicate Dozier et al.'s (1994) study (as introduced in 8.5.7). This would involve assessing, interpreting and comparing attachment interviews undertaken by patients and carer participants, to provide an appreciation of the importance of understanding 'self' within the context of the therapeutic alliance with patients diagnosed with personality

disorder. On completion and building upon this understanding, further research could then be undertaken through action research, utilising vignettes from the information gleaned in this study and the attachment interviews. The vignettes would comprise of scenarios of difficult personality disordered patients' relationships with others, which the action research group participants would attempt to process utilising reflective practice principles. The aim of the proposed study would be to provide an understanding based on many of the issues raised in this study towards the potential creation of a specific reflective practice tool for clinicians who work with patients diagnosed with personality disorder.

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APPENDICES.

Appendix One.

INSTRUCTIONS FOR COMPLETING Q-SORT.

INTRODUCTION.

The purpose of this study is to explore and understand the relationships that Mental Health Nurses have with men who have been diagnosed with the term - personality disorder. I then hope to apply this understanding to develop a model of working to enhance future therapeutic relationships.

Due to the limited amount of space within the statements men diagnosed with personality disorder will be abbreviated to M.D.w.P.D.

Enclosed in this set of materials you will find **two** Q-sorts, based around the above theme. These statements have been collected from a variety of sources. Your task will be to sort these statements in relation to how much you either agree or disagree with them. These include:

A. What are Mental Health Nurses' understandings of men diagnosed with personality disorder?

B. What are Mental Health Nurses' understandings of the relationship difficulties that men diagnosed with personality disorder have and how does this influence the nurse-patient relationship?

PREPARATION.

1) Once you have read the information sheets and signed the consent form, please complete the section headed 'Participant Details'. Anything which you write here will be treated in total confidence. This will assist in interpreting the results.

2) Take the pieces of paper out of the envelope labelled 'Marker Cards'. Lay these out in an area where you have plenty of room in the order outlined in the diagram under the title 'completing Q-Sort statements':

3) Take the first package of 'A' statements. You should have 70 statements.

In this Q-sort you are asked to consider what is important in understanding men diagnosed with personality disorder. The statements you have been given have been taken from what other people consider to be important, and have been adapted to offer a balance of positive and negative aspects.

To begin, sort the numbered statements fairly roughly into three piles as follows:

Pile 1	**Pile 2**	**Pile 3**
Strongly	Unsure	Strongly
Disagree	Don't Understand	Agree

At this stage it is probably worth going through the piles a second time, to make sure you are happy with where you have placed the statements. Include in Pile (1) all those with which you do not agree. In Pile (3) ensure that there are all the statements which you feel you do agree. Pile (2) should include statements about which you either, can't as yet, make up your mind or about which you have no strong feelings. You can go on changing the statements from pile to pile right up until the end of the Q-sort, however the rest of the process is likely to be easier if you are happy at this stage.

COMPLETING THE Q-SORT.

Take out the sheet marked 'Scoring Grid', which corresponds to the above statements (A). Write your name at the top of the grid. This grid forms the layout for the number of statements needed under each marker card:

-6	-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5	+6
(3)	(3)	(4)	(6)	(7)	(8)	(8)	(8)	(7)	(6)	(4)	(3)	(3)

Now take the pile (3) statements with which you agree and look through once more in order to select the three statements with which you **most** strongly agree. Place these statements below the marker, which he is labelled +6. Now look through the agree pile once more and select three of the remaining statements that you feel to be most relevant, and place these under the +5 marker card. Continue in this way until you have placed all the statements in this pile in columns beneath the marker cards. You must stick to the pattern showing on the scoring grid.

Once you have positioned all of the statements with which you agree, take the statement's with which you disagree (1). Arrange the statements in columns in exactly the same way, at the other end of the row, i.e., three statements with which you strongly disagree and place them under the marker card -6 = 3, -5 = 3, etc.

Finally, take the middle pile of statements and arrange these so that they occupy an appropriate position within one of the central columns of the sorting grid. When you have completed this, the pattern should represent the scoring grid, and all the statements should have been used.

FILLING IN THE SCORING GRID.

Now is a good time to look at the total layout of your statements to see whether you would like to change their position. You can change position as often as you like.

When you are reasonably happy with your choices, fill in the grid with the numbers on the statements. It is important that numbers are placed **only** in the spaces provided, no matter how much you would like to put more in one column.

THE REMAINING SET OF Q-SORTS (B).

Follow exactly the same process, please arrange the statements headed 'B' (How do you understand relationships with men diagnosed with personality disorder?). Please note that these contain 82 statements, and should be arranged in the following format:

-6	-5	-4	-3	-2	-1	-0	+1	+2	+3	+4	+5	+6
(3)	(4)	(5)	(7)	(8)	(9)	(10)	(9)	(8)	(7)	(5)	(4)	(3)

PLEASE STICK TO THE RIGHT NUMBER OF STATEMENTS UNDER EACH COLUMN OR I WILL NOT BE ABLE TO USE YOUR RESULTS.

THINGS TO REMEMBER WHEN DOING THE Q-SORT.

1. The Q-sort contains a number of statements - because I have decided to include them does not mean that I necessarily support them.

2. This is NOT a test and I am NOT trying to diagnose or measure anything. I am purely studying the different accounts and understandings that are held.

3. Whilst I will interpret information by computer, no information linked to you as an individual will be kept in a data file. If I quote from what you say, this will be done anonymously.

When you have completed and recorded the results of the Q-sorts, please put them in the enclosed addressed envelope and return them. If you have any questions regarding the study I will be happy to answer them, and can be contacted on 0151-472-4509.

Thank you very much for helping with this research project. I realise how much time and efforts is required and therefore appreciate your support.

Frank Sharp

Psychological Services Department.

SCORING GRID. Stage (1B).

Name and Reference No: .....

'A' Q-Sort Statements Scoring Grid

-6	-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5	+6

'B' Q-Sort Statements Scoring Grid

-6	-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5	+6

Appendix Two

Interview Schedule

Aims for Reference.

1. What are Mental Health Nurses' understandings of men diagnosed with personality disorder?

2. What are Mental Health Nurses' understandings of the relationship difficulties that men diagnosed with personality disorder have and how does this influence the nurse-patient relationship?

3. How does the understanding gleaned from aims one and two inform clinical practice?

<u>Interview Schedule for 'A' Q-Sort: Understanding Personality Disorder.</u>

1.0 Definition/understanding of personality disorder and gender. (What is personality and what characterises a male patient as having a disordered personality?)

1.1 What is personality disorder and why do men get diagnosed with this term?

General Responses:

- Socially defined.
- Categorically defined.
- Oppressive, stigmatised label.
- Legal definition.
- An interpersonal strategy that people use to relate to others.
- Politically defined.

1.2 What is personality?

General Responses:

- Relationships.
- Mal/adaptive.
- Perception.
- Cognitions: flexibility, impulsivity, patterns.
- Affect.
- Behaviour.
- Interpersonal functioning.
- Sense of Self.
- Different contexts.
- Influence of race, gender, class, appearance, sexuality, age.
- Areas of need.

1.3 What is a disorder of personality?

1.4 How would you describe a man you know who has been diagnosed with the term personality disorder...?

1.5 What differences exist between men and women who have been diagnosed as personality disordered?

Interview Schedule for 'B' Q-Sort: Understanding Relationship Difficulties.

2.0 (Understanding of relationship difficulties and how they process this information).

2.1.0 What relationship difficulties do Mental Health Nurses experience with male patients diagnosed with personality disorder?

2.1.1 How do they know the difficulty exists? (E.g. feelings, behaviour etc.)

2.1.2 Why do they think the difficulty exist? (Eg. cause, function, context, etc)

2.13 What do they choose to understand about the difficulty? (Eg. Inclusion and exclusion of information).

2.2.1 Can you describe a male patient diagnosed with personality disorder with whom you had relational difficulties?

2.2.2 Would others describe it differently and if yes in which way?

2.2.3 How did you know the difficulty existed? (Eg. Did it evoke a particular response?)

2.2.4 Would others perceive this differently and if yes in which way?
(* Others = MH Nurses, the patient, other patients, his family, society).

2.2.5 Why do you think these difficulties exist?

2.2.6 How would others answer this question?

2.2.7 How do you attempt to understand the difficulty?

2.2.8 How do others attempt to understand the difficulty?

2.2.9 What did you choose to understand about the difficulty? (E.g. Inclusion and exclusion of information)

2.2.10 What would others choose to understand about the difficulty?

2.2.11 What other factors that you feel may influence the above process

Appendix Three.

Information Sheets:

For Each of the Three Stages & Approved by Each of the Three Local Ethics Committees. Each Are Given The Appropriate Local Headers.

Stage One.
Information Sheet For Participants With A Mental Health Nursing Background. (S1/HH/MHN/28-10-99)

*** Please note that stage 1b will only apply to you.**

Title of Project
The Mental Health Nurses' Understanding of the relationship Difficulties Experienced By Male Patients Diagnosed - Personality Disorder as defined within DSM-IV.

Invitation.
I would like to invite you to partake in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and with friends, relatives, colleagues if you wish. Ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

What is the purpose of the study?
I am presently undertaking the above research project as part of a course Manchester Metropolitan University and due to the consistent therapeutic dilemmas that nurse's experience when working with patients from this diagnostic category. The aim is to explore and understand the relationships that are created in response to men who have been diagnosed with the term - personality disorder. I then hope to apply this understanding to develop a model of working to enhance future therapeutic relationships. The study should take me three years. However, your participation would be limited to the interview described below.

Why have I been chosen?
I have requested to collaborate with you and your organisation to provide a contrast between yourselves and two very differing therapeutic environments who deliver care for people diagnosed with personality disorder. E.g. Medium Secure Hospital, York; High Secure Hospital, Liverpool, and Low Secure Hospital, W. Lancashire.

If you have been approached, it is because you are a Mental Health Nurse who works with patients who have been diagnosed with personality disorder and you have been recommended by a colleague.
In stage one I am hoping to obtain the assistance of three participants from each of the three sites to be followed by a further ten participants from each of the three sites.

Do I have to take part?
It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form, you would also be free to withdraw at any time without giving a reason.

What will happen to me if I take part?
Stage (1a).
The three nurse participants from each site would be requested initially to partake in an audio taped semi-structured interview which would take approximately one hour. The questions would broadly focus on:

1) the notion of personality disorder
2) relationships associated with men diagnosed - personality disordered.
3) how do people understand the above relationships?

The information obtained from the interview would be collated along with information from the two other sites and a literature search to inform a Q-sort in stage (1b).

Stage (1b)
A Q-sort is based on the information gained from stage (1a). I would create a series of statements written on cards which I would like you to spend thirty to sixty minutes arranging into those statements that you agree with most and those that you don't agree with and place them on a template which I would provide. I would arrange to undertake stage (1b) with you three months after stage (1a) has been completed across the three sites.
On completion of the study the participant would be offered a summary of the research findings**.**

What do I have to do?
There are no special preparations to enable you to partake in the study.

What are the possible disadvantages of taking part?
I am not aware of any disadvantages of taking part. The questions are mainly in a third person context and there are no right or wrong answers expected.

What are the possible benefits of taking part?
There are no direct benefits of taking part in this study although I would hope that the generation of information may provide some benefit indirectly. i.e. opportunity to discuss ideas, and contribute to knowledge regarding this difficult area of work and the generation of a new method in which to understand the therapeutic relationship.

What if something goes wrong?
If you are harmed by taking part in this research project, there are no special compensation arrangements. If you are harmed due to someone's negligence, then you may have grounds for legal action but you may have to pay for it. Regardless of this, if you wish to complain about any aspect of the way you have been approached or treated during the course of this study, the normal National Health Service

complaints mechanisms may be available to you. Debriefing will be provided should you require further support or information.

Will my taking part in this study be kept confidential?
All the information imparted by you during the course of the research will be kept strictly confidential. Names would be coded to provide anonymity. The researcher is bound by the Data Protection Act and the United Kingdom Code of Conduct for Nurses. The information would be stored in a locked draw in the researcher's place of work. All audio tapes would be destroyed once they have been transcribed normally six months after the interview and the participant would be offered a copy of the transcript. In the event of the study being published, all due care would be taken to protect the identity of individuals who kindly support this project. The option to withdraw at any time in this process would be honoured without prejudice.

What will happen to the results of the research study?
The results of the research should be in draft form as part of my thesis in four years to be presented to appropriate research committee at Manchester Metropolitan University. There is a strong likelihood that the research will eventually be published in a peer journal following the final draft. I would provide a summary of the results of the research to all participants on completion with particular emphasis on the section they were involved in.

Who has reviewed the study?
This research has been reviewed by independent Research Ethics Committees on behalf of Medium Secure Hospital, Low Secure Hospital, High Secure Hospital, and Manchester Metropolitan University accordingly.

It has also been reviewed by the High Security Psychiatric Services Commissioning Board who have also part sponsored the research through the Sir Kenneth Calman Bursary Award. It has also been reviewed by Prof. E. Burman and Dr S. Warner at Manchester Metropolitan University**,** Senior Clinicians at Medium Secure Hospital.

Contact for Further Information.
Should you require any further information at any stage I would be pleased to speak to you if you contact me at the address below:
Psychological Services Department
N. Administration Building
High Secure Hospital,
Parkbourn
Maghull
Liverpool
L31 1HW
Tel. No. 0151-472-4509

Many thanks in anticipation of your support

Frank Sharp

Appendix Four.

Consent Form

Stage One, Two, Three. Consent form for staff to partake in the stage one interview, Q-sort; (S123/HH/MHN/28-10-99).

Title of Project: The Mental Health Nurses' Understanding of the relationship Difficulties Experienced By Male Patients Diagnosed - Personality Disorder as defined within DSM- IV.

Have you read the Invitation Letter/Information Sheet? Yes/No
Information Sheet Reference_____

Were you given an opportunity to ask questions and discuss this study? Yes/No

Are you satisfied with the answers to your questions? Yes/No

Do you consider that you have received enough information about the study to make your decision? Yes/No

Who have you spoken to? Dr/Mr/Ms _____

Do you understand that the study is confidential and you are free to decline entry into the study and to leave the study at any time without having to give a reason for leaving and without prejudice. Yes/No

I agree to take part in the above study Yes/No

Participant signature:_____ Name (in block letters) _____ Date: _____

Signature of Person taking consent (if different from researcher). ---------- Name (in block letters)_____Date: _____

Signature of Researcher: ---------- Name (in block letters) _____Date: _____

Consent Withdrawn. Signed:_____ Printed:_____ Date:_____

Appendix Five.

Details of Interviewees.

Participant No. & Site initial	Age	Religion	Gender	Race	Years Qualified as a MH Nurse	Nursing Title
28 H	53	CE	M	WB	15	Charge Nurse
27 H	35	RC	M	WB	13	Charge Nurse
29 H	37	RC	M	WB	9	Charge Nurse
43 M	31	Meth	F	WB	6	Charge Nurse
41 M	37	RC	M	WB	18	Clinical Nurse Manager
42 M	27	CE	F	WB	3	Staff Nurse
14 L	54	None	M	WB	29	Senior Clinical Nurse
15 L	54	CE	F	WB	4	Community Mental Health Nurse
44 L	36	CE	F	WB	18	Senior Clinical Nurse (CPN)
30 H	36	CE	F	WB	15	Staff Nurse

Appendix Six.

Final Version of Q-Sort Statements.

Key:

- MDWPD – Men diagnosed with personality disorder.
- MHN – Mental Health Nurses.

'A' Q-Sort: Understanding of Personality Disorder.

- MdwPD are often waiting for people to abandon and reject them within their relationships. A1
- MdwPD often form intense dependent relationships with key individuals. A2
- MdwPD don't form close relationships because they fear negative outcomes. A3
- MdwPD often recreate past relationships which evoke similar responses. A4
- MdwPD find disturbing ways to try and extract a sense of safety from others. A5
- Personality Disorder is a condition which affects their perception of others and their relationships. A6
- MdwPD do not learn from experience and repeat past mistakes. A7
- MdwPD are unable to develop stable lasting relationships. A8
- MdwPD only say what they think other people want to hear. A9
- Given the right attention, boundaries MDwPD can eventually respond favourably. A10
- Personality Disorder is a convenient label which limits peoples understanding of the individual. A11
- Society predominantly uses the term Personality disorder in a derogatory manner. A12
- The dominant view of Society is that they view MDwPD within my hospital as psychopaths. A13
- Personality types are unhelpful labels that don't adequately describe the nature of the condition. A14
- MdwPD are a danger to the public. A15
- Once diagnosed with personality disorder it stays with the individual for the rest of their life. A16
- Personality Disorder implies badness. A17
- MdwPD have more than one type which renders the diagnosis meaningless. A18
- The Mental Health Act is not helpful in defining personality disorder. A19
- The medical definition of personality disorder identified within ICD-10 and DSM-IV has no clinical purpose. A20
- Men are DwPD as a form of social control because they fall outside a major mental illness category and cause concern to society. A21
- Personality Disorder it is a label which is put on people who cannot be managed. A22
- MdwPD are only interested in themselves. A23
- Nobody, including the patient, really understands why MDwPD behave the way they do. A24
- MdwPD cannot control their anger. A25
- MdwPD consistently demonstrate negative emotions. A26
- MdwPD present with different areas of need and traits. A27
- Due to the diagnostic problems clinicians should focus on the behaviour which brought them to the attention of health services. A28

- MdwPD always want their own way. A29
- MdwPD provide accounts of themselves and their relationships which are factually incorrect. A30
- MdwPD have a narrative style which served a function with significant childhood attachment figures. A31
- If I was treated like MDwPD I might behave in similar ways to them. A32
- When working with MDwPD I expect their behaviour to make me feel uncomfortable. A33
- When working with MDwPD I expect to be guarded and explore ways to protect myself. A34
- When working with MdwPD I often feel threatened and worry about my career. A35
- MdwPD have faulty learning, resulting in a distorted understanding of what is right or wrong. A36
- People are not born with personality disorder but develop it through their experiences. A37
- It is more important to understand how and why the individual interacts in certain ways than use a legal/medical diagnosis. A38
- The term personality disorder creates a prejudice regarding the expected pattern of behaviours. A39
- The term personality disorder provides most people in the hospital with a common language to work together. A40
- Illicit drug use can lead to a misdiagnosis of personality disorder. A41
- Most men only receive a diagnosis of personality disorder when they have committed an offence. A42
- I do not believe that MDwPD should be detained indefinitely for offences they 'may' commit. A43
- The media creates stereotypes about personality disorder which feeds societies prejudicial fears. A44
- Black Afro Caribbean males are more likely be diagnosed mentally ill than with personality disorder. A45
- When treating MDwPD you need to look beyond the challenging behaviour. A46
- I don't believe you can treat MDwPD. A47
- MdwPD cope with their lack of relationships by creating a rich fantasy life. A48
- MdwPD know they have a problem but are unwilling/unable to embrace an alternative perspective. A49
- It is difficult to treat MDwPD unless they have been detained after breaking the law. A50
- When treating MDwPD we can realistically only affect the parts of his personality which have caused a danger to society. A51
- Within the context of time our current treatment of MDwPD will be considered quite primitive. A52
- MdwPD can function reasonably well with a personality disorder in society it only becomes a problem if they break the law. A53
- If MDwPD were treated earlier then they would be less likely to commit a crime. A54
- Men are often diagnosed with antisocial personality disorder and women are more likely diagnosed with borderline personality disorder. A57
- MdwPD are more likely to express aggressive behaviour towards others or property, but females will display self-harm behaviour and suicide threats. A56
- When women DwPD use avoidant strategies to keep their emotions hidden it is easier to see than with men. A57

- Men and women diagnosed personality disorder have learnt in childhood not to express certain emotions. A58
- Female sex offenders are given more support and sympathy by the majority of the media. A59
- Women who are DwPD will be sent to prison more often than men. A60
- Women DwPD are more likely than men to have committed arson. A61
- MdwPD are more likely to have committed a sexual offence than women. A62
- Women are more likely than men to be diagnosed with mental illness rather than personality disorder. A63
- Society predominantly equates women to idealised images of motherhood, so when they behave outside this stereotype they cause more concern. A64
- Within your hospital male MHN find it more difficult than female MHNS to see MDwPD as anything other than offenders. A65
- Within your hospital male mental health nurses create difficulties for female staff to develop a therapeutic relationship with MDwPD. A66
- Famous male sex offenders are considered evil. A67
- It is more difficult to see a male offender as a victim than it would be for a woman. A68
- At times, MDwPD present as powerful and controlling. A69
- At times, MDwPD can make me feel weak and inadequate. A70

'B' Q-Sort: Understanding & Processing Relationship Difficulties.

- MdwPD have difficulty in establishing trusting relationships because they have learnt to use avoidant strategies due to past rejection. B1
- Diagnostic labels make it easier to work with MdwPD. B2
- When working with MDwPD you can never judge anything purely on face value. B3
- When working with MdwPD you need to be constantly aware that they can be charming, manipulative and seductive. B4
- If female staff spend too much time with one man DwPD it can cause jealousy and acting out behaviour in others. B5
- The response to boundaries in MDwPD, often provides an opportunity to understand their feelings about deeper issues. B6
- It is important to be aware of the gender preference of MDwPD as it may have significance in their historical dynamic. B7
- MdwPD fantasise jealously about the successful relationships you have. B8
- MdwPD attempt to undermine your authority. B9
- MdwPD have difficulty negotiating. B10
- Female Mental Health Nurses can be lulled into a false sense of security by MDwPD. B11
- Setting boundaries and limits with MDwPD has been difficult because my basic nurse training did not prepare me sufficiently. B12
- It is difficult working with MDwPD because they don't appear to want to change. B13
- The dual responsibilities of therapy and security cause difficulties in my relationship with MDwPD. B14
- MdwPD do not consider all their options when problem solving. B15
- MdwPD often make grandiose claims about themselves to protect them from feelings of vulnerability. B16
- MdwPD are very sophisticated in getting other patients to attempt to make my life a misery. B17
- I often need to find coping strategies to protect myself from attacks by MDwPD. B18
- MdwPD concern me because of their ability to humiliate me. B19
- MdwPD often make me feel that I do not care enough for them. B20
- MdwPD will try to elicit responses from me which are similar to significant people from their past. B21
- Sometimes I find that have colluded with MDwPD because of a lack of information/support. B22
- It is important to be aware of the relationship style of MDwPD because it could evoke unresolved feelings belonging to myself. B23
- It is important to understand yourself before working with MDwPD, otherwise relationship difficulties may increase. B24
- MdwPD create staff stereotypes to make it easier to do things to them B25
- Sometimes I find that I have colluded with MDwPD because it felt safe. B26
- MdwPD have difficulty maintaining a trusting/honest relationship which limits a therapeutic alliance. B27
- At times, I find myself conforming to staff group behaviour which is outside my character and can prove offensive to MDwPD. B28
- Compared to myself the majority of female Mental Health Nurses are more likely to have their boundaries eroded by MdwPD. B29
- MdwPD have a lack of empathy for the feelings of others. B30

- MdwPD minimise their behaviour and attempt to draw others into their minimisation. B31
- MdwPD are egocentric. B32
- MdwPD can make you feel emotionally raped. B33
- MdwPD do not understand that they have a problem. B34
- MdwPD will attempt to use a variety of extreme strategies to elicit a caring response from others. B35
- When I have worked for a long period of time with MDwPD I can become desensitised to their behaviour. B36
- MdwPD have difficulty thinking of the consequences of their actions. B37
- MdwPD elicit feelings of guilt when they set you up to reject them. B38
- MdwPD use drugs and alcohol excessively as a coping mechanism. B39
- I recognise relationship difficulties with MDwPD when I experience feelings which are uncharacteristic of me. B40
- It is easier to recognise relationship difficulties with MDwPD when consulting with the collective expertise of the staff group. B41
- Failure to recognise relationship difficulties with MDwPD can occur when failing to observe their life long script/narrative. B42
- You may be missing something if you are not shocked by MDwPD. B43
- Supervision is important to explore the impact upon yourself of the sometimes horrific histories that MDwPD present. B44
- It can be difficult to determine what feelings belong to MDwPD and what belongs to oneself. B45
- Without sufficient feedback from others it can be difficult to challenge and support MDwPD. B46
- MdwPD will express their difficulties in very indirect ways. B47
- Experiencing somatic difficulties (e.g. Stomach churning, headaches etc) when working with MdwPD may indicate a problem in the relationship. B48
- MdwPD present an opportunity to understand them when they violate a boundary. B49
- It easier to see the negatives rather than the positive aspects of MDwPD. B50
- It is self-defeating to see MDwPD in terms of a challenge that you will not be defeated by. B51
- It is important to be aware that relationships with MDwPD may result in addressing aspects of ourselves. B52
- Without adequate training, working with MDwPD can be very damaging. B53
- I sometimes do not report relationship difficulties when working with MDwPD for fear of the potential consequences. B54
- To confide in someone else about your relationship difficulties with MDwPD feels like a weakness. B55
- Being seduced into feeling special by MDwPD may not seem like a problem at the time. B56
- When working with MDwPD I am reluctant to use a reflective/ supervision process with others for fear of being interpreted negatively. B57
- Due to insufficient basic nurse training problems occur when attempting to identify relationship difficulties with MDwPD. B58
- MdwPD are negatively affected by media stereotypes which only highlight extreme behaviours. B59
- Understanding is gained through the consistent responses MDwPD elicit in their relationships with others. B60
- It is important to gather information about how MdwPD coped with adverse childhood experiences. B61

- It is important to gather information about significant childhood relationships in MDwPD. B62
- Understand of MDwPD is gained by using reflective processes within group supervision. B63
- Understanding of MDwPD is gained by addressing transference relationships.B64
- Understand of MDwPD is gained by exploring and examining their distinction between fantasy and reality. B65
- Increased understanding of MDwPD is obtained by ignoring pejorative labels and relating to them as individuals. B66
- MdwPD will often give unreliable accounts so it is important to obtain a comprehensive history from a variety of sources. B67
- My understanding of a MDwPD may be different from other professionals and should be integrated through discussion. B68
- MdwPD often repeat past dynamics which are acted out within their current environment. B69
- The ward environmental context may replicate traumatic past experiences for MDwPD. B70
- Understanding MdwPD is evolving rapidly hence the importance of maintaining a contemporary knowledge base. B71
- Understand of MDwPD is gained through self-reflection. B72
- Understanding of MDwPD is gained through identifying and responding accordingly to the individual's schema. B73
- Understanding why MDwPD seek out certain types of relationships is important. B74
- Seemingly insignificant information about MDwPD may be very relevant within a reflective practice group. B75
- The information imparted and not imparted may have equal significance in understanding MDwPD. B76
- MdwPD may cope with a lack of control in the past by attempting to control others in the present. B77
- You should ignore the negative feelings in your relationship with MDwPD until it becomes too much. B78
- Before acting on a new understanding in your relationship with MDwPD you should consult with your peer group. B79
- When working with MDwPD you should constantly reappraise the direction of the relationship. B80
- Decisions should be acted on consistently when working with MDwPD. B81
- A caring nursing role with MDwPD will be dramatically eroded by the challenging nature of their relationships. B82

Appendix Seven: Details of Q-Sort Participants.

Participant No. & Site initial	Age	Religion	Gender	Race	Registered nursing years and (years working with PD)	Nursing Title
1 M	42	CE	M	WB	20 (various)	Clinical Nurse Manager
2 M	29	RC	M	BA	1 (1)	Staff Nurse
3 M	29	RC	F	WB	3 (2)	Staff Nurse
4 M	34	None	F	WB	6 (1)	Staff Nurse
5 M	33	CE	M	WB	2 (2)	Staff Nurse
6 M	35	None	F	WB	14 (2)	Staff Nurse
7 M	47	None	M	WB	20 (various)	Senior Nurse Practice Development.
8 M	25	Anglican	M	BA	1 (1)	Staff Nurse
9 M	39	None	M	WB	15 (7)	Nurse Therapist
10 M	30	Atheist	F	WB	8 (4)	Charge Nurse
11 M	34	CE	F	WB	2 (2)	Staff Nurse
12 M	33	None	M	WB	7 (7)	Practice Development Nurse
13 M	49	CE	F	WB	8 (8)	Practice Development Nurse
14 L	54	None	M	WB	29 (various)	Senior Clinical Nurse
15 L	52	CE	F	WB	2 (9)	Community Mental Health Nurse
16 L	30	None	M	WB	6 (5)	Clinical Team Manager.
17 L	26	RC	F	WB	3 (1)	Staff Nurse
18 L	44	CE	M	WB	11 (10)	Senior Clinical Nurse
19 L	35	RC	F	WB	8 (5)	Staff Nurse
20 L	38	RC	F	WB	15 (15)	Senior Clinical Nurse.
21 L	35	CE	F	WB	1 (1)	Staff Nurse.
22 L	38	None	M	WB	1 (1)	Staff Nurse
23 L	27	RC	M	WB	6 (6)	Staff Nurse
24 L	24	CE	F	WB	2 (1)	Staff Nurse
25 L	37	None	F	WB	15 (12)	Staff Nurse
26 L	41	CE	M	WB	1 (16)	Staff Nurse
27 H	35	RC	M	WB	13 (9)	Clinical Manager
28 H	56	CE	M	WB	15 (15)	Team Leader
29 H	37	RC	M	WB	9 (6)	Charge Nurse
30 H	39	CE	F	WB	19 (10)	Staff Nurse
31 H	32	None	M	WB	1 (1)	Staff Nurse
32 H	38	CE	F	WB	15 (4)	Staff Nurse
33 H	37	None	M	WB	13 (5)	Staff Nurse
34 H	38	CE	M	WB	14 (10)	Clinical Manager
35 H	37	CE	M	WB	11 (7)	Ward Manager
36 H	37	None	M	WB	13 (10)	Staff Nurse
37 H	29	Jewish	F	WB	1 (1)	Staff Nurse
38 H	31	None	M	WB	5 (4)	Staff Nurse
39 H	39	RC	M	WB	18 (4)	Team Leader
40 H	41	CE	M	WB	17 (17)	Nurse Therapist
41 M	37	None	M	WB	18 (10)	Clinical Nurse Manager
42 M	31	Methodist	F	WB	6 (6)	Charge Nurse
43 M	27	CE	F	WB	2 (1)	Staff Nurse
44 L	36	CE	F	WB	18 (5)	Senior Clinical Nurse (community)

Appendix Eight (a)

‘A’ Q-Sort Factors: Understanding Personality Disorder.

Factor One Q-Sort Grid

-6	-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5	+6
44	**63**	**9**	8	65	15	60	31	53	**19**	**46**	**39**	**16**
17	**35**	**27**	66	29	34	40	43	5	**37**	**1**	**38**	**12**
59	**23**	**7**	67	69	15	20	55	32	10	**3**	**28**	**22**
		70	33	58	62	26	45	4	64	**11**		
			25	47	61	42	24	52	14			
			6	51	13	48	36	2	21			
				34	57	56	41	18				
					30	54	49					

Factor One Q-Sort Grid

-6	-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5	+6
44 The media creates stereotypes about personality disorder which feeds societies prejudicial fears.	**63 MdwPD can function reasonably well with a personality disorder in society it only becomes a problem if they break the law.**	**9 MdwPD only say what they think other people want to hear.**	8 MdwPD are unable to develop stable lasting relationships.	65 Within your hospital male MHN find it more difficult than female MHNS to see MDwPD as anything other than offenders.	15 MdwPD are a danger to the public.	60 Women who are DwPD will be sent to prison more often than men.	31 MdwPD have a narrative style which served a function with significant childhood attachment figures.	53 MdwPD can function reasonably well with a personality disorder in society it only becomes a problem if they break the law.	**19 The Mental Health Act is not helpful in defining personality disorder.**	**46 When treating MDwPD you need to look beyond the challenging behaviour.**	**39 The term personality disorder creates a prejudice regarding the expected pattern of behaviours.**	**16 Once diagnosed with personality disorder it stays with the individual for the rest of their life.**
17 Personality Disorder implies badness.	**35 When working with MdwPD I often feel threatened and worry about my career.**	**27 MdwPD present with different areas of need and traits.**	66 Within your hospital male mental health nurses create difficulties for female staff to develop a therapeutic relationship with MDwPD.	29 MdwPD always want their own way.	34 When working with MDwPD I expect to be guarded and explore ways to protect myself.	40 The term personality disorder provides most people in the hospital with a common language to work together.	43 I do not believe that MDwPD should be detained indefinitely for offences they 'may' commit.	5 MdwPD find disturbing ways to try and extract a sense of safety from others.	**37 People are not born with personality disorder but develop it through their experiences.**	**1 MdwPD are often waiting for people to abandon and reject them within their relationships.**	**38 It is more important to understand how and why the individual interacts in certain ways than use a legal/medical diagnosis.**	**12 Society predominantly uses the term Personality disorder in a derogatory manner.**
59 Female sex offenders are given more support and sympathy by the majority of the media.	**23 MdwPD are only interested in themselves.**	**7 MdwPD do not learn from experience and repeat past mistakes.**	67 Famous male sex offenders are considered evil.	69 At times, MDwPD present as powerful and controlling.	15 MdwPD are a danger to the public.	20 The medical definition of personality disorder identified within ICD-10 and DSM-IV has no clinical purpose.	55 When women DwPD use avoidant strategies to keep their emotions hidden it is easier to see than with men.	32 If I was treated like MDwPD I might behave in similar ways to them.	10 Given the right attention, boundaries MDwPD can eventually respond favourably.	**3 MdwPD don't form close relationships because they fear negative outcomes.**	**28 Due to the diagnostic problems clinicians should focus on the behaviour which brought them to the attention of health services.**	**22 Personality Disorder it is a label which is put on people who cannot be managed**
		70 At times, MDwPD can make me feel weak and inadequate.	33 When working with MDwPD I expect their behaviour to make me feel uncomfortable.	58 Men and women diagnosed personality disorder have learnt in childhood not to express certain emotions.	62 MdwPD are more likely to have committed a sexual offence than women.	26 MdwPD consistently demonstrate negative emotions.	45 Black Afro Caribbean males are more likely be diagnosed mentally ill than with personality disorder.	4 MdwPD often recreate past relationships which evoke similar responses.	64 Society predominantly equates women to idealised images of motherhood, so when they behave outside this stereotype they cause more concern.	**11 Personality Disorder is a convenient label which limits peoples understanding of the individual.**		
			25 MdwPD cannot control their anger.	47 I don't believe you can treat MDwPD.	61 Women DwPD are more likely than men to have committed arson.	42 Most men only receive a diagnosis of personality disorder when they have committed an offence.	24 Nobody, including the patient, really understands why MDwPD behave the way they do.	52 Within the context of time our current treatment of MDwPD will be considered quite primitive.	14 Personality types are unhelpful labels that don't adequately describe the nature of the condition.			
			6 Personality Disorder is a condition which affects their perception of others and their relationships.	51 When treating MDwPD we can realistically only affect the parts of his personality which have caused a danger to society.	13 The dominant view of Society is that they view MDwPD within my hospital as psychopaths.	48 MdwPD cope with their lack of relationships by creating a rich fantasy life.	36 MdwPD have faulty learning, resulting in a distorted understanding of what is right or wrong.	2 MdwPD often form intense dependent relationships with key individuals.	21 Men are DwPD as a form of social control because they fall outside a major mental illness category and cause concern to society.			
				34 When working with MDwPD I expect to be guarded and explore ways to protect myself.	57 When women DwPD use avoidant strategies to keep their emotions hidden it is easier to see than with men.	56 MdwPD are more likely to express aggressive behaviour towards others or property, but females will display self-harm behaviour and suicide threats.	41 Illicit drug use can lead to a misdiagnosis of personality disorder.	18 MdwPD have more than one type which renders the diagnosis meaningless.				
					30 MdwPD provide accounts of themselves and their relationships which are factually incorrect.	54 If MDwPD were treated earlier then they would be less likely to commit a crime.	49 MdwPD know they have a problem but are unwilling/unable to embrace an alternative perspective.					

Normalized Factor Scores - For Factor 1

No.	Statement	No.	Z-SCORES
16	Once diagnosed with personality disorder it stays with the i	16	2.144
12	Society prominently uses the term personality disorder in a	12	2.009
22	Personality Disorder is a label which is put on people who c	22	1.874
39	The term personality disorder creates prejudice regarding th	39	1.698
38	It is moreimportant to understand how and why the individual	38	1.652
28	Due to the diagnostic problems clinicians should focus on th	28	1.382
46	When treating mdwpd you need to look beyond the challenging b	46	1.382
1	Mdwpd are often waiting for people to abandon and reject the	1	1.294
3	Mdwpd don't form close relationships because they fear negat	3	1.294
11	Personality Disorder is a convenient label which limits peop	11	1.206
19	The Mental Health Act is not helpful in defining personality	19	1.119
37	People are not born with personality disorder but develop it	37	1.072
10	Given the right attention, boundaries mdwpd can eventually r	10	0.937
64	Society prodominently equates women to idealised images of m	64	0.937
14	Personality types are unhelpful labels that don't adaquately	14	0.896
21	Men are dwpd as a form of social control because they fall o	21	0.890
53	Mdwpd can function reasonably well with a personality disord	53	0.808
5	Mdwpd find disturbing ways to try and extract a sense of saf	5	0.802
32	If I was treated like mdwpd I might bahavein similar ways to	32	0.761
4	Mdwpd often recreate past relationshipswhich evoke similar r	4	0.668
52	Within the context of time our current treatment of mdwpd wi	52	0.580
2	Mdwpd often form intense dependent relationships with key in	2	0.404
18	Mdwpd have more than one type which renders the diagnosis me	18	0.404
31	Mdwpd have a narrative style which served a function with si	31	0.357
43	I do not believe that mdwpd shouldbe detained indeffinetly f	43	0.357
55	Men are often diagnosed with antisocial personality disorder	55	0.311
45	Black Afro Carribbean males are more likely to be diagnosed	45	0.269
24	Nobody, including the patient really understands why mdwpd b	24	0.223
36	Mdwpd have faulty learnin, resulting in a distorted understa	36	0.223
41	Illicit drug use can lead to a misdiagnosis of personality d	41	0.176
49	Mdwpd know they have a problem but are unwilling/unable to e	49	0.176
60	Women who are dwpd will be sent to prison more often than me	60	0.047
40	The term personality disorder provides some people in the ho	40	0.041
20	The medical definition of personality disorder identified wi	20	0.000
26	Mdwpd consistently demonstrate negative emotions.	26	0.000
42	Most men only receive a diagnosis of personality disorder wh	42	-0.041
48	Mdwpd cope with their lack of relationships by creating a ri	48	-0.093
56	Mdwpd are more likely to express aggressive behaviour toward	56	-0.181
54	If mdwpd were treated earlier then they would be less likely	54	-0.269
68	It is more difficult to see a male sex offender as a victim	68	-0.269
50	It is difficult to treat mdwpd unless they have been detain	50	-0.311
30	Mdwpd provide accounts of themselves and their relationships	30	-0.316
57	When women dwpd use avoidant strategies to keep their emotio	57	-0.357

Normalized Factor Scores - For Factor 1 Continued.

No.	Statement	No.	Z-SCORES
13	The dominent view of society is that they view mdwpd within	13	-0.357
61	Women dwpd are more likely than men to have committed arson.	61	-0.357
62	Mdwpd are more likely to have committed a sex offence than w	62	-0.357
15	Mdwpd are a danger to the the public.	15	0.357
34	When working with mdwpd I expect to be guarded and explore w	34	-0.398
51	When treating mdwpd we can realistically only affect the par	51	-0.627
47	I don't believe you can treat mdwpd.	47	0.627
58	Men and women dwpd have learnt in childhood not to express c	58	-0.668
69	At times, mdwpd present as powerful and controlling.	69	-0.668
29	Mdwpd always want their own way.	29	-0.756
65	Within your hospital male MHN find it more difficult than fe	65	-0.756
6	Personality disorder is a condition which affects their perc	6	-0.802
25	Mdwpd cannot contro their anger.	25	0.849
33	When working with mdwpd I expect their behaviour to make me	33	-0.849
67	Famous male sex offenders are considered evil.	67	-0.937
66	Within your hospital male MHN's create difficulties for fema	66	-0.978
8	Mdwpd are unable to develop stable lasting relationships.	8	-0.984
70	At times, mdwpd can make me feel weak and inadaquate.	70	-1.025
7	Mdwpd do not learn from their experiences and repeat past mi	7	-1.119
27	Mdwpd present with different areas of need and traits.	27	-1.253
9	Mdwpd only say what they think other people want to hear.	9	-1.341
23	Mdwpd are only interested in themselves.	23	-1.382
35	When working with mdwpd I often feel threatened and worry ab	35	-1.605
63	Women are more likely than men to be diagnosed with mental i	63	-1.652
59	Female sex offenders are given more support and sympathy by	59	-1.698
17	Personality disorder implies badness.	17	-2.009
44	The media creates stereotypes about personality disorderwhic	44	-2.144

Factor Two Q-Sort Grid)

-6	-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5	+6
56	**6**	**66**	70	27	47	15	63	28	40	**30**	**45**	**62**
44	**21**	**36**	69	14	11	37	9	48	39	**5**	**55**	**64**
13	**4**	**22**	52	32	24	61	49	3	34	**19**	**23**	**38**
		65	58	2	7	51	10	68	12	**46**		
			57	60	20	17	8	25	16			
			18	67	29	59	41	26	1			
				35	42	31	50	53				
					43	54	33					

Factor Two Q-Sort Grid

-6	-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5	+6
56 MdwPD are more likely to express aggressive behaviour towards others or property, but females will display self-harm behaviour and suicide threats.	**6 Personality Disorder is a condition which affects their perception of others and their relationships.**	**66 Within your hospital male mental health nurses create difficulties for female staff to develop a therapeutic relationship with MDwPD.**	70 At times, MDwPD can make me feel weak and inadequate.	27 MdwPD present with different areas of need and traits.	47 I don't believe you can treat MDwPD.	15 MdwPD are a danger to the public.	63 Women are more likely than men to be diagnosed with mental illness rather than personality disorder.	28 Due to the diagnostic problems clinicians should focus on the behaviour which brought them to the attention of health services.	40 The term personality disorder provides most people in the hospital with a common language to work together.	**30 MdwPD provide accounts of themselves and their relationships which are factually incorrect**	**45 Black Afro Caribbean males are more likely be diagnosed mentally ill than with personality disorder.**	**62 MdwPD are more likely to have committed a sexual offence than women**
44 The media creates stereotypes about personality disorder which feeds societies prejudicial fears.	**21 Men are DwPD as a form of social control because they fall outside a major mental illness category and cause concern to society.**	**36 MdwPD have faulty learning, resulting in a distorted understanding of what is right or wrong.**	69 At times, MDwPD present as powerful and controlling.	14 Personality types are unhelpful labels that don't adequately describe the nature of the condition.	11 Personality Disorder is a convenient label which limits peoples understanding of the individual.	37 People are not born with personality disorder but develop it through their experiences	9 MdwPD only say what they think other people want to hear.	48 MdwPD cope with their lack of relationships by creating a rich fantasy life.	39 The term personality disorder creates a prejudice regarding the expected pattern of behaviours.	**5 MdwPD find disturbing ways to try and extract a sense of safety from others.**	**55 When women DwPD use avoidant strategies to keep their emotions hidden it is easier to see than with men.**	**64 Society predominantly equates women to idealised images of motherhood, so when they behave outside this stereotype they cause more concern.**
13 The dominant view of Society is that they view MDwPD within my hospital as psychopaths.	**4 MdwPD often recreate past relationships which evoke similar responses.**	**22 Personality Disorder it is a label which is put on people who cannot be managed.**	52 Within the context of time our current treatment of MDwPD will be considered quite primitive.	32 If I was treated like MDwPD I might behave in similar ways to them.	24 Nobody, including the patient, really understands why MDwPD behave the way they do.	61 Women DwPD are more likely than men to have committed arson	49 MdwPD know they have a problem but are unwilling/unable to embrace an alternative perspective.	3 MdwPD don't form close relationships because they fear negative outcomes.	34 When working with MDwPD I expect to be guarded and explore ways to protect myself.	**19 The Mental Health Act is not helpful in defining personality disorder.**	**23 MdwPD are only interested in themselves**	**38 It is more important to understand how and why the individual interacts in certain ways than use a legal/medical diagnosis.**
		65 Within your hospital male MHN find it more difficult than female MHNS to see MDwPD as anything other than offenders.	58 Men and women diagnosed personality disorder have learnt in childhood not to express certain emotions	2 MdwPD often form intense dependent relationships with key individuals.	7 MdwPD do not learn from experience and repeat past mistakes.	51 When treating MDwPD we can realistically only affect the parts of his personality which have caused a danger to society.	10 Given the right attention, boundaries MDwPD can eventually respond favourably.	68 At times, MDwPD present as powerful and controlling.	12 Society predominantly uses the term Personality disorder in a derogatory manner.	**46 When treating MDwPD you need to look beyond the challenging behaviour.**		
			57 Men are often diagnosed with antisocial personality disorder and women are more likely diagnosed with borderline personality disorder.	60 Women who are DwPD will be sent to prison more often than men.	20 The medical definition of personality disorder identified within ICD-10 and DSM-IV has no clinical purpose.	17 Personality Disorder implies badness.	8 MdwPD are unable to develop stable lasting relationships.	25 MdwPD cannot control their anger.	16 Once diagnosed with personality disorder it stays with the individual for the rest of their life.			
			18 MdwPD have more than one type which renders the diagnosis meaningless.	67 Famous male sex offenders are considered evil.	29 MdwPD always want their own way.	59 Female sex offenders are given more support and sympathy by the majority of the media.	41 Illicit drug use can lead to a misdiagnosis of personality disorder.	26 MdwPD consistently demonstrate negative emotions.	1 MdwPD are often waiting for people to abandon and reject them within their relationships.			
				35 When working with MdwPD I often feel threatened and worry about my career.	42 Most men only receive a diagnosis of personality disorder when they have committed an offence.	31 MdwPD have a narrative style which served a function with significant childhood attachment figures.	50 It is difficult to treat MDwPD unless they have been detained after breaking the law.	53 MdwPD can function reasonably well with a personality disorder in society it only becomes a problem if they break the law.				
					43 I do not believe that MDwPD should be detained indefinitely for offences they 'may' commit.	54 If MDwPD were treated earlier then they would be less likely to commit a crime.	33 When working with MDwPD I expect their behaviour to make me feel uncomfortable.					

Normalized Factor Scores - For Factor 2.

No.	Statement	No.	Z SCORES
62	Mdwpd are more likely to have committed a sex offence than w	62	2.250
64	Society prodominently equates women to idealised images of m	64	2.250
38	It is moreimportant to understand how and why the individual	38	1.738
45	Black Afro Carribbean males are more likely to be diagnosed	45	1.399
55	Men are often diagnosed with antisocial personality disorder	55	1.262
23	Mdwpd are only interested in themselves.	23	1.226
30	Mdwpd provide accounts of themselves and their relationships	30	1.161
5	Mdwpd find disturbing ways to try and extract a sense of saf	5	1.154
19	The Mental Health Act is not helpful in defining personality	19	1.125
46	When treating mdwpd you need to look beyond the challengig b	46	1.089
40	The term personality disorder provides some people in the ho	40	0.988
39	The term personality disorder creates prejudice regarding th	39	0.952
34	When working with mdwpd I expect to be guarded and explore w	34	0.923
12	Society prominently uses the term personality disorder in a	12	0.916
16	Once diagnosed with personality disorder it stays with the i	16	0.887
1	Mdwpd are often waiting for people to abandon and reject the	1	0.887
28	Due to the diagnostic problems clinicians should focus on th	28	0.851
48	Mdwpd cope with their lack of relationships by creating a ri	48	0.815
3	Mdwpd don't form close relationships because they fear negat	3	0.786
68	It is more difficult to see a male sex offender as a victim	68	0.786
25	Mdwpd cannot contro their anger.	25	0.613
26	Mdwpd consistently demonstrate negative emotions.	26	0.613
53	Mdwpd can function reasonably well with a personality disord	53	0.613
63	Women are more likely than men to be diagnosed with mental i	63	0.577
9	Mdwpd only say what they think other people want to hear.	9	0.411
49	Mdwpd know they have a problem but are unwilling/unable to e	49	0.411
10	Given the right attention, boundaries mdwpd can eventually r	10	0.375
8	Mdwpd are unable to develop stable lasting relationships.	8	0.368
41	Illicit drug use can lead to a misdiagnosis of personality d	41	0.274
50	It is difficult to treat mdwpd unless they have been detaine	50	0.274
33	When working with mdwpd I expect their behaviour to make me	33	0.238
15	Mdwpd are a danger to the the public.	15	0.202
37	People are not born with personality disorder but develop it	37	0.137
61	Women dwpd are more likely than men to have committed arson.	61	0.108
51	When treating mdwpd we can realistically only affect the par	51	0.036
17	Personality disorder implies badness.	17	0.036
59	Female sex offenders are given more support and sympathy by	59	0.036
31	Mdwpd have a narrative style which served a function with si	31	0.000
54	If mdwpd were treated earlier then they would be less likely	54	-0.036
43	I do not believe that mdwpd shouldbe detained indeffinetly f	43	-0.137
42	Most men only receive a diagnosis of personality disorder wh	42	0.303
29	Mdwpd always want their own way.	29	-0.375
20	The medical definition of personality disorder identified wi	20	-0.411

Normalized Factor Scores - For Factor 2 Continued.

No.	Statement	No.	Z-SCORES
7	Mdwpd do not learn from their experiences and repeat past mi	7	-0.447
24	Nobody, including the patient really understands why mdwpd b	24	-0.476
11	Personality Disorder is a convenient label which limits peop	11	0.476
47	I don't believe you can treat mdwpd.	47	-0.512
35	When working with mdwpd I often feel threatened and worry ab	35	-0.512
67	Famous male sex offenders are considered evil.	67	-0.584
60	Women who are dwpd will be sent to prison more often than me	60	-0.613
2	Mdwpd often form intense dependent relationships with key in	2	0.613
32	If I was treated like mdwpd I might bahavein similar ways to	32	0.649
14	Personality types are unhelpful labels that don't adaquately	14	-0.714
27	Mdwpd present with different areas of need and traits.	27	-0.714
18	Mdwpd have more than one type which renders the diagnosis me	18	-0.750
57	When women dwpd use avoidant strategies to keep their emotio	57	-0.851
58	Men and women dwpd have learnt in childhood not to express c	58	-0.851
52	Within the context of time our current treatment of mdwpd wi	52	-0.887
69	At times, mdwpd present as powerful and controlling.	69	0.887
70	At times, mdwpd can make me feel weak and inadaquate.	70	0.923
65	Within your hospital male MHN find it more difficult than fe	65	0.952
22	Personality Disorder is a label which is put on people who c	22	-1.053
36	Mdwpd have faulty learnin, resulting in a distorted understa	36	-1.500
66	Within your hospital male MHN's create difficulties for fema	66	1.500
4	Mdwpd often recreate past relationshipswhich evoke similar r	4	-1.601
21	Men are dwpd as a form of social control because they fall o	21	-1.738
6	Personality disorder is a condition which affects their perc	6	-1.774
13	The dominent view of society is that they view mdwpd within	13	-1.839
44	The media creates stereotypes about personality disorderwhic	44	1.976
56	Mdwpd are more likely to express aggressive behaviour toward	56	-2.113

Factor Three Q-Sort Grid

-6	-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5	+6
56	**69**	**63**	**27**	49	50	13	9	38	**46**	**37**	**24**	**12**
68	**66**	**8**	**10**	6	23	15	30	11	16	**14**	**39**	**62**
7	**28**	**67**	26	60	57	3	52	42	53	**21**	**47**	**17**
		65	58	5	4	45	54	32	70	**19**		
			36	48	25	64	2	44	22			
			51	59	1	31	29	35	33			
				43	41	61	18	34				
					55	40	20					

Factor Three Q-Sort Grid

-6	-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5	+6
56 MdwPD are more likely to express aggressive behaviour towards others or property, but females will display self-harm behaviour and suicide threats.	**69 At times, MDwPD present as powerful and controlling.**	**63 Women are more likely than men to be diagnosed with mental illness rather than personality disorder.**	**27 MdwPD present with different areas of need and traits.**	49 MdwPD know they have a problem but are unwilling/unable to embrace an alternative perspective.	50 It is difficult to treat MDwPD unless they have been detained after breaking the law.	13 The dominant view of Society is that they view MDwPD within my hospital as psychopaths.	9 MdwPD only say what they think other people want to hear.	38 It is more important to understand how and why the individual interacts in certain ways than use a legal/medical diagnosis.	**46 When treating MDwPD you need to look beyond the challenging behaviour.**	**37 People are not born with personality disorder but develop it through their experiences.**	**24 Nobody, including the patient, really understands why MDwPD behave the way they do.**	**12 Society predominantly uses the term Personality disorder in a derogatory manner.**
68 It is more difficult to see a male offender as a victim than it would be for a woman.	**66 Within your hospital male mental health nurses create difficulties for female staff to develop a therapeutic relationship with MDwPD.**	**8 MdwPD are unable to develop stable lasting relationships.**	**10 Given the right attention, boundaries MDwPD can eventually respond favourably.**	6 Personality Disorder is a condition which affects their perception of others and their relationships.	23 MdwPD are only interested in themselves.	15 MdwPD are a danger to the public.	30 MdwPD provide accounts of themselves and their relationships which are factually incorrect.	11 Personality Disorder is a convenient label which limits peoples understanding of the individual.	16 Once diagnosed with personality disorder it stays with the individual for the rest of their life.	**14 Personality types are unhelpful labels that don't adequately describe the nature of the condition.**	**39 The term personality disorder creates a prejudice regarding the expected pattern of behaviours.**	**62 MdwPD are more likely to have committed a sexual offence than women.**
7 MdwPD do not learn from experience and repeat past mistakes.	**28 Due to the diagnostic problems clinicians should focus on the behaviour which brought them to the attention of health services.**	**67 Famous male sex offenders are considered evil.**	26 MdwPD consistently demonstrate negative emotions.	60 Women who are DwPD will be sent to prison more often than men.	57 Men are often diagnosed with antisocial personality disorder and women are more likely diagnosed with borderline personality disorder.	3 MdwPD don't form close relationships because they fear negative outcomes.	52 Within the context of time our current treatment of MDwPD will be considered quite primitive.	42 Most men only receive a diagnosis of personality disorder when they have committed an offence.	53 MdwPD can function reasonably well with a personality disorder in society it only becomes a problem if they break the law.	**21 Men are DwPD as a form of social control because they fall outside a major mental illness category and cause concern to society.**	**47 I don't believe you can treat MDwPD.**	**17 Personality Disorder implies badness**
		65 Within your hospital male MHN find it more difficult than female MHNS to see MDwPD as anything other than offenders.	58 Men and women diagnosed personality disorder have learnt in childhood not to express certain emotions.	5 MdwPD find disturbing ways to try and extract a sense of safety from others.	4 MdwPD often recreate past relationships which evoke similar responses.	45 Black Afro Caribbean males are more likely be diagnosed mentally ill than with personality disorder.	54 If MDwPD were treated earlier then they would be less likely to commit a crime.	32 If I was treated like MDwPD I might behave in similar ways to them.	70 At times, MDwPD can make me feel weak and inadequate.	**19 MdwPD have more than one type which renders the diagnosis meaningless. A18** **The Mental Health Act is not helpful in defining personality disorder.**		
			36 MdwPD have faulty learning, resulting in a distorted understanding of what is right or wrong.	48 MdwPD cope with their lack of relationships by creating a rich fantasy life.	25 MdwPD cannot control their anger.	64 Society predominantly equates women to idealised images of motherhood, so when they behave outside this stereotype they cause more concern.	2 MdwPD often form intense dependent relationships with key individuals.	44 The media creates stereotypes about personality disorder which feeds societies prejudicial fears.	22 Personality Disorder it is a label which is put on people who cannot be managed.			
			51 When treating MDwPD we can realistically only affect the parts of his personality which have caused a danger to society.	59 Female sex offenders are given more support and sympathy by the majority of the media.	1 MdwPD are often waiting for people to abandon and reject them within their relationships.	31 MdwPD have a narrative style which served a function with significant childhood attachment figures	29 MdwPD always want their own way.	35 When working with MdwPD I often feel threatened and worry about my career.	33 When working with MDwPD I expect their behaviour to make me feel uncomfortable.			
				43 I do not believe that MDwPD should be detained indefinitely for offences they 'may' commit	41 Illicit drug use can lead to a misdiagnosis of personality disorder.	61 Women DwPD are more likely than men to have committed arson.	18 MdwPD have more than one type which renders the diagnosis meaningless.	34 When working with MDwPD I expect to be guarded and explore ways to protect myself.				
					55 When women DwPD use avoidant strategies to keep their emotions hidden it is easier to see than with men.	40 The term personality disorder provides most people in the hospital with a common language to work together.	20 The medical definition of personality disorder identified within ICD-10 and DSM-IV has no clinical purpose.					

Normalized Factor Scores - For Factor 3.

No.	Statement	No.	Z-SCORES
12	Society prominently uses the term personality disorder in a	12	2.079
62	Mdwpd are more likely to have committed a sex offence than w	62	1.991
17	Personality disorder implies badness.	17	1.903
24	Nobody, including the patient really understands why mdwpd b	24	1.366
39	The term personality disorder creates prejudice regarding th	39	1.347
47	I don't believe you can treat mdwpd.	47	1.277
37	People are not born with personality disorder but develop it	37	1.180
14	Personality types are unhelpful labels that don't adaquately	14	1.171
21	Men are dwpd as a form of social control because they fall o	21	1.101
19	The Mental Health Act is not helpful in defining personality	19	1.092
46	When treating mdwpd you need to look beyond the challengig b	46	1.074
16	Once diagnosed with personality disorder it stays with the i	16	0.995
53	Mdwpd can function reasonably well with a personality disord	53	0.907
70	At times, mdwpd can make me feel weak and inadaquate.	70	0.898
22	Personality Disorder is a label which is put on people who c	22	0.828
33	When working with mdwpd I expect their behaviour to make me	33	0.810
38	It is moreimportant to understand how and why the individual	38	0.810
11	Personality Disorder is a convenient label which limits peop	11	0.801
42	Most men only *receive* a diagnosis of personality disorder wh	42	0.731
32	If I was treated like mdwpd I might bahavein similar ways to	32	0.652
44	The media creates stereotypes about personality disorderwhic	44	0.643
35	When working with mdwpd I often feel threatened and worry ab	35	0.634
34	When working with mdwpd I expect to be guarded and explore w	34	0.537
9	Mdwpd only say what they think other people want to hear.	9	0.537
30	Mdwpd provide accounts of themselves and their relationships	30	0.449
52	Within the context of time our current treatment of mdwpd wi	52	0.449
54	If mdwpd were treated earlier then they would be less likely	54	0.449
2	Mdwpd often form intense dependent relationships with key in	2	0.440
29	Mdwpd always want their own way.	29	0.370
18	Mdwpd have more than one type which renders the diagnosis me	18	0.352
20	The medical definition of personality disorder identified wi	20	0.282
13	The dominent view of society is that they view mdwpd within	13	0.167
15	Mdwpd are a danger to the the public.	15	0.097
3	Mdwpd don't form close relationships because they fear negat	3	0.088
45	Black Afro Carribbean males are more likely to be diagnosed	45	0.088
64	Society prodominently equates women to idealised images of m	64	0.009
31	Mdwpd have a narrative style which served a function with si	31	0.000
61	Women dwpd are more likely than men to have committed arson.	61	0.000
40	The term personality disorder provides some people in the ho	40	-0.009
55	Men are often diagnosed with antisocial personality disorder	55	-0.176
41	Illicit drug use can lead to a misdiagnosis of personality d	41	-0.185
1	Mdwpd are often waiting for people to abandon and reject the	1	-0.273
25	Mdwpd cannot contro their anger.	25	-0.352

Normalized Factor Scores - For Factor 3 Continued.

No.	Statement	No.	Z-SCORES
4	Mdwpd often recreate past relationships which evoke similar	4	-0.361
57	When women dwpd use avoidant strategies to keep their emotio	57	-0.361
23	Mdwpd are only interested in themselves.	23	-0.361
50	It is difficult to treat mdwpd unless they have been detaine	50	-0.370
43	I do not believe that mdwpd shouldbe detained indeffinetly f	43	-0.370
59	Female sex offenders are given more support and sympathy by	59	-0.449
48	Mdwpd cope with their lack of relationships by creating a ri	48	-0.458
5	Mdwpd find disturbing ways to try and extract a sense of saf	5	-0.546
60	Women who are dwpd will be sent to prison more often than me	60	-0.546
6	Personality disorder is a condition which affects their per	6	-0.722
49	Mdwpd know they have a problem but are unwilling/unable to e	49	-0.819
51	When treating mdwpd we can realistically only affect the par	Si	-0.907
36	Mdwpd have faulty learnin, resulting in a distorted understa	36	-0.907
58	Men and women dwpd have learnt in childhood not to express c	58	-0.916
26	Mdwpd consistently demonstrate negative emotions.	26	-0.986
10	Given the right attention, boundaries mdwpd can eventually r	10	-1.004
27	Mdwpd present with different areas of need and traits.	27	-1.083
65	Within your hospital male MHN find it more difficult than fe	65	-1.083
67	Famous male sex offenders are considered evil.	67	-1.347
8	Mdwpd are unable to develop stable lasting relationships.	8	-1.532
63	Women are more likely than men to be diagnosed with mental i	63	-1.542
28	Due to the diagnostic problems clinicians should focus on th	28	-1.620
66	Within your hospital male MHN's create difficulties for fema	66	-1.718
69	At times, mdwpd present as powerful and controlling.	69	-1.718
7	Mdwpd do not learn from their experiences and repeat past mi	7	-1.727
68	It is more difficult to see a male sex offender as a victim	68	-1.991
56	Mdwpd are more likely to express aggressive behaviour toward	56	-2.167

Factor Four Q-Sort Grid

-6	-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5	+6
13	**44**	**67**	**56**	24	61	53	31	21	**14**	**22**	**39**	**12**
47	**25**	**40**	66	9	20	30	69	19	**43**	**11**	**52**	**17**
6	**15**	**26**	23	60	18	64	55	54	28	**38**	**46**	**37**
		51	27	48	49	7	5	2	10	**32**		
			62	50	59	8	45	3	1			
			65	70	36	33	68	4	41			
				35	57	42	58	16				
					63	29	34					

Factor Four Q-Sort Grid

-6	-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5	+6
13 The dominant view of Society is that they view MDwPD within my hospital as psychopaths	**44 The media creates stereotypes about personality disorder which feeds societies prejudicial fears.**	**67 Famous male sex offenders are considered evil.**	**56 MdwPD are more likely to express aggressive behaviour towards others or property, but females will display self-harm behaviour and suicide threats.**	24 Nobody, including the patient, really understands why MDwPD behave the way they do.	61 Women DwPD are more likely than men to have committed arson.	53 MdwPD can function reasonably well with a personality disorder in society it only becomes a problem if they break the law.	31 MdwPD have a narrative style which served a function with significant childhood attachment figures.	21 Men are DwPD as a form of social control because they fall outside a major mental illness category and cause concern to society.	**14 Personality types are unhelpful labels that don't adequately describe the nature of the condition.**	**22 Personality Disorder it is a label which is put on people who cannot be managed.**	**39 The term personality disorder creates a prejudice regarding the expected pattern of behaviours.**	**12 Society predominantly uses the term Personality disorder in a derogatory manner.**
47 I don't believe you can treat MDwPD.	**25 MdwPD cannot control their anger.**	**40 The term personality disorder provides most people in the hospital with a common language to work together**	66 Within your hospital male mental health nurses create difficulties for female staff to develop a therapeutic relationship with MDwPD.	9 MdwPD only say what they think other people want to hear.	20 The medical definition of personality disorder identified within ICD-10 and DSM-IV has no clinical purpose.	30 MdwPD provide accounts of themselves and their relationships which are factually incorrect.	69 At times, MDwPD present as powerful and controlling	19 The Mental Health Act is not helpful in defining personality disorder.	**43 I do not believe that MDwPD should be detained indefinitely for offences they 'may' commit.**	**11 Personality Disorder is a convenient label which limits peoples understanding of the individual.**	**52 Within the context of time our current treatment of MDwPD will be considered quite primitive.**	**17 Personality Disorder implies badness.**
6 Personality Disorder is a condition which affects their perception of others and their relationships.	**15 MdwPD are a danger to the public.**	**26 MdwPD consistently demonstrate negative emotions.**	23 MdwPD are only interested in themselves.	60 Women who are DwPD will be sent to prison more often than men	18 MdwPD have more than one type which renders the diagnosis meaningless.	64 Society predominantly equates women to idealised images of motherhood, so when they behave outside this stereotype they cause more concern.	55 When women DwPD use avoidant strategies to keep their emotions hidden it is easier to see than with men.	54 If MDwPD were treated earlier then they would be less likely to commit a crime.	28 Due to the diagnostic problems clinicians should focus on the behaviour which brought them to the attention of health services.	**38 It is more important to understand how and why the individual interacts in certain ways than use a legal/medical diagnosis.**	**46 When treating MDwPD you need to look beyond the challenging behaviour.**	**37 People are not born with personality disorder but develop it through their experiences.**
		51 When treating MDwPD we can realistically only affect the parts of his personality which have caused a danger to society.	27 MdwPD present with different areas of need and traits.	48 MdwPD cope with their lack of relationships by creating a rich fantasy life.	49 MdwPD know they have a problem but are unwilling/unable to embrace an alternative perspective.	7 MdwPD do not learn from experience and repeat past mistakes.	5 MdwPD find disturbing ways to try and extract a sense of safety from others.	2 MdwPD often form intense dependent relationships with key individuals.	10 Given the right attention, boundaries MDwPD can eventually respond favourably.	**32 If I was treated like MDwPD I might behave in similar ways to them.**		
			62 MdwPD are more likely to have committed a sexual offence than women.	50 It is difficult to treat MDwPD unless they have been detained after breaking the law.	59 Female sex offenders are given more support and sympathy by the majority of the media.	8 MdwPD are unable to develop stable lasting relationships.	45 Black Afro Caribbean males are more likely be diagnosed mentally ill than with personality disorder.	3 dwPD don't form close relationships because they fear negative outcomes.	1 MdwPD are often waiting for people to abandon and reject them within their relationships.			
			65 Within your hospital male MHN find it more difficult than female MHNS to see MDwPD as anything other than offenders.	70 At times, MDwPD can make me feel weak and inadequate.	36 MdwPD have faulty learning, resulting in a distorted understanding of what is right or wrong.	33 When working with MDwPD I expect their behaviour to make me feel uncomfortable	68 It is more difficult to see a male offender as a victim than it would be for a woman.	4 MdwPD often recreate past relationships which evoke similar responses.	41 Illicit drug use can lead to a misdiagnosis of personality disorder.			
				35 When working with MdwPD I often feel threatened and worry about my career.	57 Men are often diagnosed with antisocial personality disorder and women are more likely diagnosed with borderline personality disorder.	42 Most men only receive a diagnosis of personality disorder when they have committed an offence.	58 Men and women diagnosed personality disorder have learnt in childhood not to express certain emotions.	16 Once diagnosed with personality disorder it stays with the individual for the rest of their life.				
					63 Women are more likely than men to be diagnosed with mental illness rather than personality disorder.	29 MdwPD always want their own way.	34 When working with MDwPD I expect to be guarded and explore ways to protect myself.					

Normalized Factor Scores - For Factor 4

No.	Statement	No.	Z-SCORES
12	Society prominently uses the term personality disorder in a	12	2.206
17	Personality disorder implies badness.	17	1.931
37	People are not born with personality disorder but develop it	37	1.838
39	The term personality disorder creates prejudice regarding th	39	1.773
52	Within the context of time our current treatment of mdwpd wi	52	1.354
46	When treating mdwpd you need to look beyond the challengig b	46	1.286
22	Personality Disorder is a label which is put on people who c	22	1.273
11	Personality Disorder is a convenient label which limits peop	11	1.261
38	It is moreimportant to understand how and why the individual	38	1.209
32	If I was treated like mdwpd I might bahavein similar ways to	32	1.155
34	Personality types are unhelpful labels that don't adaquately	14	1.130
43	I do not believe that mdwpd shouldbe detained indeffinetly f	43	1.040
28	Due to the diagnostic problems clinicians should focus on th	28	0.934
10	Given the right attention, boundaries mdwpd can eventually r	10	0.933
1	Mdwpd are often waiting for people to abandon and reject the	1	0.931
41	Illicit drug use can lead to a misdiagnosis of personality d	41	0.906
21	Men are dwpd as a form of social control because they fall o	21	0.749
19	The Mental Health Act is not helpful in defining personality	19	0.682
54	If mdwpd were treated earlier then they would be less likely	54	0.667
2	Mdwpd often form intense dependent relationships with key in	2	0.642
3	Mdwpd don't form close relationships because they fear negat	3	0.642
4	Mdwpd often recreate past relationshipswhich evoke similar r	4	0.590
16	Once diagnosed with personality disorder it stays with the i	16	0.510
31	Mdwpd have a narrative style which served a function with si	31	0.437
69	At times, mdwpd present as powerful and controlling.	69	0.418
55	Men are often diagnosed with antisocial personality disorder	55	0.394
5	Mdwpd find disturbing ways to try and extract a sense of saf	5	0.301
45	Black Afro Carribbean males are more likely to be diagnosed	4S	0.238
68	It is more difficult to see a male sex offender as a victim	68	0.210
58	Men and women dwpd have learnt in childhood not to express c	58	0.197
34	When working with mdwpd I expect to be guarded and explore w	34	0.185
53	Mdwpd can function reasonably well with a personality disord	53	0.129
30	Mdwpd provide accounts of themselves and their relationships	30	0.041
64	Society prodominently equates women to idealised images of m	64	0.013
7	Mdwpd do not learn from their experiences and repeat past mi	7	0.011
8	Mdwpd are unable to develop stable lasting relationships.	8	-0.106
33	When working with mdwpd I expect their behaviour to make me	33	-0.118
42	Most men only receive a diagnosis of personality disorder wh	42	0.120
29	Mdwpd always want their own way.	29	-0.183
63	Women are more likely than men to be diagnosed with mental i	63	-0.221
57	When women dwpd use avoidant strategies to keep their emotio	57	0.222
36	Mdwpd have faulty learnin, resulting in a distorted understa	36	-0.251
59	Female sex offenders are given more support and sympathy by	59	-0.281

Normalized Factor Scores - For Factor 4 Continued.

No.	Statement	No.	Z SCORES
49	Mdwpd know they have a problem but are unwilling/unable to	49	-0.287
18	Mdwpd have more than one type which renders the diagnosis	18	-0.304
20	The medical definition of personality disorder identified	20	-0.344
61	Women dwpd are more likely than men to have committed	61	-0.447
35	When working with mdwpd I often feel threatened and worry	35	-0.486
70	At times, mdwpd can make me feel weak and inadaquate.	70	-0.589
50	It is difficult to treat mdwpd unless they have been	50	0.592
48	Mdwpd cope with their lack of relationships by creating a	48	-0.615
60	Women who are dwpd will be sent to prison more often than	60	-0.630
9	Mdwpd only say what they think other people want to hear.	9	0.682
24	Nobody, including the patient really understands why mdwpd b	24	-0.708
65	Within your hospital male MHN find it more difficult than	65	-0.735
62	Mdwpd are more likely to have committed a sex offence than	62	0.786
27	Mdwpd present with different areas of need and traits.	27	-0.868
23	Mdwpd are only interested in themselves.	23	-0.877
66	Within your hospital male MHN's create difficulties for	66	-0.918
56	Mdwpd are more likely to express aggressive behaviour	56	-1.010
51	When treating mdwpd we can realistically only affect the	51	-1.011
26	Mdwpd consistently demonstrate negative emotions.	26	-1.013
40	The term personality disorder provides some people in the	40	-1.196
67	Famous male sex offenders are considered evil.	67	-1.302
15	Mdwpd are a danger to the the public.	15	1.430
25	Mdwpd cannot contro their anger.	25	-1.706
44	The media creates stereotypes about personality	44	-1.944
6	Personality disorder is a condition which affects their	6	-2.035
47	I don't believe you can treat mdwpd.	47	-2.100
13	The dominent view of society is that they view mdwpd within	13	-2.100

Factor Five Q-Sort Grid

-6	-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5	+6
13	**56**	**25**	**69**	70	9	55	51	63	**11**	**62**	**1**	**61**
44	**27**	**54**	43	6	19	40	65	38	36	**28**	**31**	**4**
35	**66**	**8**	17	21	48	42	50	68	41	**58**	**37**	**2**
		7	26	29	23	24	22	16	45	**5**		
			67	12	34	20	14	3	10			
			47	15	60	49	30	39	53			
				59	18	46	57	32				
					33	64	52					

Factor Five Q-Sort Grid

-6	-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5	+6
13 The dominant view of Society is that they view MDwPD within my hospital as psychopaths.	**56 MdwPD are more likely to express aggressive behaviour towards others or property, but females will display self-harm behaviour and suicide threats.**	**25 MdwPD cannot control their anger.**	**69 At times, MDwPD present as powerful and controlling**	70 At times, MDwPD can make me feel weak and inadequate	9 MdwPD only say what they think other people want to hear.	55 When women DwPD use avoidant strategies to keep their emotions hidden it is easier to see than with men.	51 When treating MDwPD we can realistically only affect the parts of his personality which have caused a danger to society.	63 Women are more likely than men to be diagnosed with mental illness rather than personality disorder.	**11 Personality Disorder is a convenient label which limits peoples understanding of the individual.**	**62 MdwPD are more likely to have committed a sexual offence than women**	**1 MdwPD are often waiting for people to abandon and reject them within their relationships.**	**61 Women DwPD are more likely than men to have committed arson.**
44 The media creates stereotypes about personality disorder which feeds societies prejudicial fears.	**27 MdwPD present with different areas of need and traits.**	**54 MdwPD can function reasonably well with a personality disorder in society it only becomes a problem if they break the law.**	43 I do not believe that MDwPD should be detained indefinitely for offences they 'may' commit	6 Personality Disorder is a condition which affects their perception of others and their relationships.	19 The Mental Health Act is not helpful in defining personality disorder.	40 The term personality disorder provides most people in the hospital with a common language to work together.	65 Within your hospital male MHN find it more difficult than female MHNS to see MDwPD as anything other than offenders.	38 It is more important to understand how and why the individual interacts in certain ways than use a legal/medical diagnosis.	36 MdwPD have faulty learning, resulting in a distorted understanding of what is right or wrong.	**28 Due to the diagnostic problems clinicians should focus on the behaviour which brought them to the attention of health services**	**31 MdwPD have a narrative style which served a function with significant childhood attachment figures.**	**4 MdwPD often recreate past relationships which evoke similar responses.**
35 When working with MdwPD I often feel threatened and worry about my career.	**66 Within your hospital male mental health nurses create difficulties for female staff to develop a therapeutic relationship with MDwPD**	**8 MdwPD are unable to develop stable lasting relationships.**	17 Personality Disorder implies badness.	21 Men are DwPD as a form of social control because they fall outside a major mental illness category and cause concern to society.	48 MdwPD cope with their lack of relationships by creating a rich fantasy life.	42 Most men only receive a diagnosis of personality disorder when they have committed an offence.	50 It is difficult to treat MDwPD unless they have been detained after breaking the law	68 It is more difficult to see a male offender as a victim than it would be for a woman	41 Illicit drug use can lead to a misdiagnosis of personality disorder	**58 Men and women diagnosed personality disorder have learnt in childhood not to express certain emotions.**	**37 People are not born with personality disorder but develop it through their experiences**	**2 MdwPD often form intense dependent relationships with key individuals**
		7 MdwPD do not learn from experience and repeat past mistakes.	26 MdwPD consistently demonstrate negative emotions.	29 MdwPD always want their own way	23 MdwPD are only interested in themselves.	24 Nobody, including the patient, really understands why MDwPD behave the way they do.	22 Personality Disorder it is a label which is put on people who cannot be managed.	16 Once diagnosed with personality disorder it stays with the individual for the rest of their life.	45 Black Afro Caribbean males are more likely be diagnosed mentally ill than with personality disorder.	**5 MdwPD find disturbing ways to try and extract a sense of safety from others.**		
			67 Famous male sex offenders are considered evil.	12 Society predominantly uses the term Personality disorder in a derogatory manner.	34 When working with MDwPD I expect to be guarded and explore ways to protect myself.	20 The medical definition of personality disorder identified within ICD-10 and DSM-IV has no clinical purpose.	14 Personality types are unhelpful labels that don't adequately describe the nature of the condition	3 MdwPD don't form close relationships because they fear negative outcomes.	10 Given the right attention, boundaries MDwPD can eventually respond favourably			
			47 I don't believe you can treat MDwPD.	15 MdwPD are a danger to the public	60 Women who are DwPD will be sent to prison more often than men.	49 MdwPD know they have a problem but are unwilling/unable to embrace an alternative perspective.	30 MdwPD provide accounts of themselves and their relationships which are factually incorrect.	39 The term personality disorder creates a prejudice regarding the expected pattern of behaviours.	53 MdwPD can function reasonably well with a personality disorder in society it only becomes a problem if they break the law.			
				59 Female sex offenders are given more support and sympathy by the majority of the media	18 MdwPD have more than one type which renders the diagnosis meaningless	46 When treating MDwPD you need to look beyond the challenging behaviour	57 Men are often diagnosed with antisocial personality disorder and women are more likely diagnosed with borderline personality disorder	32 If I was treated like MDwPD I might behave in similar ways to them				
					33en working with MDwPD I expect their behaviour to make me feel uncomfortable	64 Society predominantly equates women to idealised images of motherhood, so when they behave outside this stereotype they cause more concern.	52 Within the context of time our current treatment of MDwPD will be considered quite primitive					

Normalized Factor Scores - For Factor 5.

No.	Statement	No.	Z-SCORES
61	Women dwpd are more likely than men to have committed arson.	61	2.223
4	Mdwpd often recreate past relationshipswhich evoke similar r	4	2.072
2	Mdwpd often form intense dependent relationships with key in	2	1.921
1	Mdwpd are often waiting for people to abandon and reject the	1	1.853
31	Mdwpd have a narrative style which served a function with si	31	1.702
37	People are not born with personality disorder but develop it	37	1.482
62	Mdwpd are more likely to have committed a sex offence than w	62	1.414
28	Due to the diagnostic problems clinicians should focus on th	28	1.345
58	Men and women dwpd have learnt in childhood not to express c	58	1.097
5	Mdwpd find disturbing ways to try and extract a sense of saf	5	1.043
11	Personality Disorder is a convenient label which limits peop	11	1.029
36	Mdwpd have faulty learnin, resulting in a distorted understa	36	0.892
41	Illicit drug use can lead to a misdiagnosis of personality d	41	0.892
45	Black Afro Carribbean males are more likely to be diagnosed	45	0.741
10	Given the right attention, boundaries mdwpd can eventually r	1p	0.673
53	Mdwpd can function reasonably well with a personality disord	53	0.673
63	Women are more likely than men to be diagnosed with mental i	63	0.658
38	It is moreimportant to understand how and why the individual	38	0.590
68	It is more difficult to see a male sex offender as a victim	68	0.576
16	Once diagnosed with personality disorder it stays with the i	16	0.522
3	Mdwpd don't form close relationships because they fear negat	3	0.522
39	The term personality disorder creates prejudice regarding th	39	0.507
32	If I was treated like mdwpd I might bahavein similar ways to	32	0.453
51	When treating mdwpd we can realistically only affect the par	51	0.453
65	Within your hospital male MHN find it more difficult than fe	65	0.425
50	It is difficult to treat mdwpd unless they have been detaine	50	0.371
22	Personality Disorder is a label which is put on people who c	22	0.356
14	Personality types are unhelpful labels that don't adaquately	14	0.356
30	Mdwpd provide accounts of themselves and their relationships	30	0.302
57	When women dwpd use avoidant strategies to keep their emotio	57	0.248
52	Within the context of time our current treatment of mdwpd wi	52	0.219
55	Men are often diagnosed with antisocial personality disorder	55	0.205
40	The term personality disorder provides some people in the ho	40	0.151
42	Most men only receive a diagnosis of personality disorder wh	42	0.137
24	Nobody, including the patient really understands why mdwpd b	24	0.068
20	The medical definition of personality disorder identified wi	20	0.000
49	Mdwpd know they have a problem but are unwilling/unable to e	49	-0.068
46	When treating mdwpd you need to look beyond the challengig b	46	-0.137
64	Society prodominently equates women to idealised images of m	64	-0.137
33	When working with mdwpd I expect their behaviour to make me	33	-0.219
18	Mdwpd have more than one type which renders the diagnosis me	18	-0.219
60	Women who are dwpd will be sent to prison more often than me	60	-0.219
34	When working with mdwpd I expect to be guarded and explore w	34	-0.288

Normalized Factor Scores - For Factor 5 Continued.

No.	Statement	No.	Z-SCORES
23	Mdwpd are only interested in themselves.	23	-0.371
48	Mdwpd cope with their lack of relationships by creating a ri	48	-0.507
19	The Mental Health Act is not helpful in defining personality	19	-0.507
9	Mdwpd only say what they think other people want to hear.	9	-0.522
59	Female sex offenders are given more support and sympathy by	59	-0.536
15	Mdwpd are a danger to the the public.	15	-0.590
12	Society prominently uses the term personality disorder in a	12	-0.590
29	Mdwpd always want their own way.	29	0.590
21	Men are dwpd as a form of social control because they fall o	21	0.590
6	Personality disorder is a condition which affects their pert	6	-0.673
70	At times, mdwpd can make me feel weak and inadaquate.	70	-0.673
47	I don't believe you can treat mdwpd.	47	-0.755
67	Famous male sex offenders are considered evil.	67	-0.755
26	Mdwpd consistently demonstrate negative emotions.	26	-0.795
17	Personality disorder implies badness.	17	-0.810
43	I do not believe that mdwpd shouldbe detained indeffinetly f	43	-0.906
69	At times, mdwpd present as powerful and controlling.	69	1.097
7	Mdwpd do not learn from their experiences and repeat past mi	7	-1.112
8	Mdwpd are unable to develop stable lasting relationships.	8	-1.180
54	If mdwpd were treated earlier then they would be less likely	54	-1.180
25	Mdwpd cannot contro their anger.	25	-1.263
66	Within your hospital male MHN's create difficulties for fema	66	-1.331
27	Mdwpd present with different areas of need and traits.	27	-1.482
56	Mdwpd are more likely to express aggressive behaviour toward	56	-1.921
35	When working with mdwpd I often feel threatened and worry ab	35	-1.921
44	The media creates stereotypes about personality disorderwhic	44	-2.004
13	The dominent view of society is that they view mdwpd within	13	-2.223

Factor Six Q-Sort Grid

-6	-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5	+6
47	**44**	**67**	68	69	24	14	11	40	31	**10**	**4**	**1**
36	**64**	**51**	66	9	63	18	33	41	32	**12**	**37**	**2**
6	**27**	**65**	7	22	23	19	48	42	5	**45**	**58**	**3**
		13	15	56	8	20	49	43	38	**46**		
			59	25	29	50	21	52	39			
			55	28	35	16	54	57	53			
				26	34	30	60	62				
					17	61	70					

Factor Six Q-Sort Grid

-6	-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5	+6
47 I don't believe you can treat MDwPD.	**44 The media creates stereotypes about personality disorder which feeds societies prejudicial fears.**	**67 Famous male sex offenders are considered evil.**	68 It is more difficult to see a male offender as a victim than it would be for a woman.	69 At times, MDwPD present as powerful and controlling.	24 Nobody, including the patient, really understands why MDwPD behave the way they do	14 Personality types are unhelpful labels that don't adequately describe the nature of the condition.	11 Personality Disorder is a convenient label which limits peoples understanding of the individual.	40 The term personality disorder provides most people in the hospital with a common language to work together.	31 MdwPD have a narrative style which served a function with significant childhood attachment figures	**10 Given the right attention, boundaries MDwPD can eventually respond favourably.**	**4 MdwPD often recreate past relationships which evoke similar responses.**	**1 MdwPD are often waiting for people to abandon and reject them within their relationships.**
36 MdwPD have faulty learning, resulting in a distorted understanding of what is right or wrong.	**64 Society predominantly equates women to idealised images of motherhood, so when they behave outside this stereotype they cause more concern.**	**51 When treating MDwPD we can realistically only affect the parts of his personality which have caused a danger to society.**	66 Within your hospital male mental health nurses create difficulties for female staff to develop a therapeutic relationship with MDwPD.	9 MdwPD only say what they think other people want to hear.	63 Women are more likely than men to be diagnosed with mental illness rather than personality disorder	18 MdwPD have more than one type which renders the diagnosis meaningless.	33 When working with MDwPD I expect their behaviour to make me feel uncomfortable.	41 licit drug use can lead to a misdiagnosis of personality disorder.	32 If I was treated like MDwPD I might behave in similar ways to them.	**12 Society predominantly uses the term Personality disorder in a derogatory manner.**	**37 People are not born with personality disorder but develop it through their experiences.**	**2 MdwPD often form intense dependent relationships with key individuals.**
6 Personality Disorder is a condition which affects their perception of others and their relationships.	**27 MdwPD present with different areas of need and traits.**	**65 Within your hospital male MHN find it more difficult than female MHNS to see MDwPD as anything other than offenders.**	7 MdwPD do not learn from experience and repeat past mistakes.	22 Personality Disorder it is a label which is put on people who cannot be managed.	23 MdwPD are only interested in themselves	19 The Mental Health Act is not helpful in defining personality disorder.	48 MdwPD cope with their lack of relationships by creating a rich fantasy life.	42 Most men only receive a diagnosis of personality disorder when they have committed an offence.	5 MdwPD find disturbing ways to try and extract a sense of safety from others.	**45 Black Afro Caribbean males are more likely be diagnosed mentally ill than with personality disorder.**	**58 Men and women diagnosed personality disorder have learnt in childhood not to express certain emotions.**	**3 MdwPD don't form close relationships because they fear negative outcomes.**
		13 The dominant view of Society is that they view MDwPD within my hospital as psychopaths.	15 MdwPD are a danger to the public.	56 MdwPD are more likely to express aggressive behaviour towards others or property, but females will display self-harm behaviour and suicide threats.	8 MdwPD are unable to develop stable lasting relationships.	20 The medical definition of personality disorder identified within ICD-10 and DSM-IV has no clinical purpose	49 MdwPD know they have a problem but are unwilling/unable to embrace an alternative perspective.	43 I do not believe that MDwPD should be detained indefinitely for offences they 'may' commit.	38 It is more important to understand how and why the individual interacts in certain ways than use a legal/medical diagnosis.	**46 When treating MDwPD you need to look beyond the challenging behaviour.**		
			59 Female sex offenders are given more support and sympathy by the majority of the media.	25 MdwPD cannot control their anger.	29 MdwPD always want their own way.	50 difficult to treat MDwPD unless they have been detained after breaking the law.	21 Men are DwPD as a form of social control because they fall outside a major mental illness category and cause concern to society.	52 Within the context of time our current treatment of MDwPD will be considered quite primitive.	39 The term personality disorder creates a prejudice regarding the expected pattern of behaviours.			
			55 When women DwPD use avoidant strategies to keep their emotions hidden it is easier to see than with men.	28 Due to the diagnostic problems clinicians should focus on the behaviour which brought them to the attention of health services.	35 When working with MdwPD I often feel threatened and worry about my career.	16 Once diagnosed with personality disorder it stays with the individual for the rest of their life.	54 If MDwPD were treated earlier then they would be less likely to commit a crime.	57 Men are often diagnosed with antisocial personality disorder and women are more likely diagnosed with borderline personality disorder.	53 term personality disorder creates a prejudice regarding the expected pattern of behaviours.			
				26 MdwPD consistently demonstrate negative emotions.	34 When working with MDwPD I expect to be guarded and explore ways to protect myself.	30 MdwPD provide accounts of themselves and their relationships which are factually incorrect.	60 Women who are DwPD will be sent to prison more often than men.	62 MdwPD are more likely to have committed a sexual offence than women.				
					17 Personality Disorder implies badness.	61 Women DwPD are more likely than men to have committed arson.	70 At times, MDwPD can make me feel weak and inadequate.					

Normalized Factor Scores - For Factor 6.

No.	Statement	No.	Z-SCORES
1	Mdwpd are often waiting for people to abandon and reject the	1	1.920
2	Mdwpd often form intense dependent relationships with key in	2	1.920
3	Mdwpd don't form close relationships because they fear negat	3	1.920
4	Mdwpd often recreate past relationshipswhich evoke similar r	4	1.600
37	People are not born with personality disorder but develop it	37	1.600
58	Men and women dwpd have learnt in childhood not to express c	58	1.600
10	Given the right attention, boundaries mdwpd can eventually r	10	1.280
12	Society prominently uses the term personality disorder in a	12	1.280
45	Black Afro Carribbean males are more likely to be diagnosed	45	1.280
46	When treating mdwpd you need to look beyond the challengig b	46	1.280
31	Mdwpd have a narrative style which served a function with si	31	0.960
32	If I was treated like mdwpd I might bahavein similar ways to	32	0.960
5	Mdwpd find disturbing ways to try and extract a sense of saf	5	0.960
38	It is moreimportant to understand how and why the individual	38	0.960
39	The term personality disorder creates prejudice regarding th	39	0.960
53	Mdwpd can function reasonably well with a personality disord	53	0.960
40	The term personality disorder provides some people in the ho	40	0.640
41	Illicit drug use can lead to a misdiagnosis of personality d	41	0.640
42	Most men only receive a diagnosis of personality disorder wh	42	0.640
43	I do not believe that mdwpd shouldbe detained indeffinetly f	43	0.640
52	Within the context of time our current treatment of mdwpd wi	52	0.640
57	When women dwpd use avoidant strategies to keep their emotio	57	0.640
62	Mdwpd are more likely to have committed a sex offence than w	62	0.640
11	Personality Disorder is a convenient label which limits peop	11	0.320
33	When working with mdwpd I expect their behaviour to make me	33	0.320
48	Mdwpd cope with their lack of relationships by creating a ri	48	0.320
49	Mdwpd know they have a problem but are unwilling/unable to e	49	0.320
21	Men are dwpd as a form of social control because they fall o	21	0.320
54	If mdwpd were treated earlier then they would be less likely	54	0.320
60	Women who are dwpd will be sent to prison more often than me	60	0.320
70	At times, mdwpd can make me feel weak and inadaquate.	70	0.320
14	Personality types are unhelpful labels that don't adaquately	14	0.000
18	Mdwpd have more than one type which renders the diagnosis me	18	0.000
19	The Mental Health Act is not helpful in defining personality	19	0.000
20	The medical definition of personality disorder identified wi	20	0.000
50	It is difficult to treat mdwpd unless they have been detaine	50	0.000
16	Once diagnosed with personality disorder it stays with the i	16	0.000
30	Mdwpd provide accounts of themselves and their relationships	30	0.000
61	Women dwpd are more likely than men to have committed arson.	61	0.000
17	Personality disorder implies badness.	17	-0.320
34	When working with mdwpd I expect to be guarded and explore w	34	-0.320
35	When working with mdwpd I often feel threatened and worry ab	35	-0.320
29	Mdwpd always want their own way.	29	-0.320

Normalized Factor Scores - For Factor 6 Continued.

No.	Statement	No.	Z-SCORES
8	Mdwpd are unable to develop stable lasting relationships.	8	-0.320
23	Mdwpd are only interested in themselves.	23	-0.320
63	Women are more likely than men to be diagnosed with mental i	63	-0.320
24	Nobody, including the patient really understands why mdwpd b	24	-0.320
26	Mdwpd consistently demonstrate negative emotions.	26	-0.640
28	Due to the diagnostic problems clinicians should focus on th	28	-0.640
25	Mdwpd cannot contro their anger.	25	-0.640
56	Mdwpd are more likely to express aggressive behaviour toward	56	-0.640
22	Personality Disorder is a label which is put on people who c	22	-0.640
9	Mdwpd only say what they think other people want to hear.	9	-0.640
69	At times, mdwpd present as powerful and controlling.	69	-0.640
55	Men are often diagnosed with antisocial personality disorder	55	-0.960
59	Female sex offenders are given more support and sympathy by	59	-0.960
15	Mdwpd are a danger to the the public.	15	-0.960
7	Mdwpd do not learn from their experiences and repeat past mi	7	-0.960
66	Within your hospital male MHN's create difficulties for fema	66	-0.960
68	It is more difficult to see a male sex offender as a victim	68	-0.960
13	The dominent view of society is that they view mdwpd within	13	-1.280
65	Within your hospital male MHN find it more difficult than fe	65	-1.280
51	When treating mdwpd we can realistically only affect the par	51	-1.280
67	Famous male sex offenders are considered evil.	67	-1.280
27	Mdwpd present with different areas of need and traits.	27	1.600
64	Society prodominently equates women to idealised images of m	64	-1.600
44	The media creates stereotypes about personality disorderwhic	44	-1.600
6	Personality disorder is a condition which affects their perc	6	-1.920
36	Mdwpd have faulty learnin, resulting in a distorted understa	36	-1.920
47	I don't believe you can treat mdwpd.	47	-1.920

Factor Seven Q-Sort Grid

-6	-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5	+6
67	**35**	**69**	70	8	7	36	12	27	16	**10**	**43**	**45**
61	**44**	**56**	68	3	11	24	37	29	26	**34**	**50**	**46**
17	**13**	**55**	65	6	9	47	38	30	33	**39**	**62**	**64**
		52	19	23	32	51	41	48	42	**66**		
			14	1	5	54	2	53	59			
			25	4	20	57	49	15	63			
				18	28	58	21	60				
					40	31	22					

Factor Seven Q-Sort Grid

-6	-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5	+6
67 Famous male sex offenders are considered evil.	**35 When working with MdwPD I often feel threatened and worry about my career.**	**69 At times, MDwPD present as powerful and controlling.**	70 At times, MDwPD can make me feel weak and inadequate.	8 MdwPD are unable to develop stable lasting relationships	7 MdwPD do not learn from experience and repeat past mistakes.	36 MdwPD have faulty learning, resulting in a distorted understanding of what is right or wrong.	12 Society predominantly uses the term Personality disorder in a derogatory manner.	27 MdwPD present with different areas of need and traits.	16 Once diagnosed with personality disorder it stays with the individual for the rest of their life.	**10 Given the right attention, boundaries MDwPD can eventually respond favourably.**	**43 I do not believe that MDwPD should be detained indefinitely for offences they 'may' commit.**	**45 Black Afro Caribbean males are more likely be diagnosed mentally ill than with personality disorder.**
61 Women DwPD are more likely than men to have committed arson.	**44 The media creates stereotypes about personality disorder which feeds societies prejudicial fears.**	**56 MdwPD are more likely to express aggressive behaviour towards others or property, but females will display self-harm behaviour and suicide threats.**	68 is more difficult to see a male offender as a victim than it would be for a woman.	3 MdwPD don't form close relationships because they fear negative outcomes.	11 Personality Disorder is a convenient label which limits peoples understanding of the individual.	24 Nobody, including the patient, really understands why MDwPD behave the way they do.	37 People are not born with personality disorder but develop it through their experiences.	29 MdwPD always want their own way.	26 MdwPD consistently demonstrate negative emotions.	**34 When working with MDwPD I expect to be guarded and explore ways to protect myself.**	**50 It is difficult to treat MDwPD unless they have been detained after breaking the law.**	**46 When treating MDwPD you need to look beyond the challenging behaviour.**
17 Personality Disorder implies badness.	**13 The dominant view of Society is that they view MDwPD within my hospital as psychopaths.**	**55 When women DwPD use avoidant strategies to keep their emotions hidden it is easier to see than with men.**	65 Within your hospital male MHN find it more difficult than female MHNS to see MDwPD as anything other than offenders.	6 Personality Disorder is a condition which affects their perception of others and their relationships.	9 MdwPD only say what they think other people want to hear.	47 I don't believe you can treat MDwPD.	38 It is more important to understand how and why the individual interacts in certain ways than use a legal/medical diagnosis.	30 MdwPD provide accounts of themselves and their relationships which are factually incorrect.	33 When working with MDwPD I expect their behaviour to make me feel uncomfortable.	**39 The term personality disorder creates a prejudice regarding the expected pattern of behaviours.**	**62 MdwPD are more likely to have committed a sexual offence than women.**	**64 Society predominantly equates women to idealised images of motherhood, so when they behave outside this stereotype they cause more concern.**
		52 Within the context of time our current treatment of MDwPD will be considered quite primitive.	19 The Mental Health Act is not helpful in defining personality disorder.	23 MdwPD are only interested in themselves.	32 If I was treated like MDwPD I might behave in similar ways to them.	51 When treating MDwPD we can realistically only affect the parts of his personality which have caused a danger to society.	41 Illicit drug use can lead to a misdiagnosis of personality disorder.	48 MdwPD cope with their lack of relationships by creating a rich fantasy life.	42 Most men only receive a diagnosis of personality disorder when they have committed an offence.	**66 Within your hospital male mental health nurses create difficulties for female staff to develop a therapeutic relationship with MDwPD.**		
			14 Personality types are unhelpful labels that don't adequately describe the nature of the condition.	1 MdwPD are often waiting for people to abandon and reject them within their relationships.	5 MdwPD find disturbing ways to try and extract a sense of safety from others.	54 If MDwPD were treated earlier then they would be less likely to commit a crime.	2 MdwPD often form intense dependent relationships with key individuals.	53 MdwPD can function reasonably well with a personality disorder in society it only becomes a problem if they break the law.	59 Female sex offenders are given more support and sympathy by the majority of the media.			
			25 MdwPD cannot control their anger.	4 MdwPD often recreate past relationships which evoke similar responses.	20 The medical definition of personality disorder identified within ICD-10 and DSM-IV has no clinical purpose.	57 Men are often diagnosed with antisocial personality disorder and women are more likely diagnosed with borderline personality disorder.	49 MdwPD know they have a problem but are unwilling/unable to embrace an alternative perspective.	15 MdwPD are a danger to the public.	63 Women are more likely than men to be diagnosed with mental illness rather than personality disorder.			
				18 MdwPD have more than one type which renders the diagnosis meaningless.	28 Due to the diagnostic problems clinicians should focus on the behaviour which brought them to the attention of health services.	58 Men and women diagnosed personality disorder have learnt in childhood not to express certain emotions.	21 Men are DwPD as a form of social control because they fall outside a major mental illness category and cause concern to society.	60 Women who are DwPD will be sent to prison more often than men.				
					40 The term personality disorder provides most people in the hospital with a common language to work together	31 MdwPD have a narrative style which served a function with significant childhood attachment figures.	22 Personality Disorder it is a label which is put on people who cannot be managed.					

Normalized Factor Scores - For Factor 7.

No.	Statement	No	Z-SCORES
45	Black Afro Carribbean males are more likely to be diagnosed	45	1.920
46	When treating mdwpd you need to look beyond the challengig b	46	1.920
64	Society prodominently equates women to idealised images of m	64	1.920
43	I do not believe that mdwpd shouldbe detained indeffinetly f	43	1.600
50	It is difficult to treat mdwpd unless they have been detaine	50	1.600
62	Mdwpd are more likely to have committed a sex offence than w	62	1.600
10	Given the right attention, boundaries mdwpd can eventually r	10	1.280
34	When working with mdwpd I expect to be guarded and explore w	34	1.280
39	The term personality disorder creates prejudice regarding th	39	1.280
66	Within your hospital male MHN's create difficulties for fema	66	1.280
16	Once diagnosed with personality disorder it stays with the i	16	0.960
26	Mdwpd consistently demonstrate negative emotions.	26	0.960
33	When working with mdwpd I expect their behaviour to make me	33	0.960
42	Most men only receive a diagnosis of personality disorder wh	42	0.960
59	Female sex offenders are given more support and sympathy by	59	0.960
63	Women are more likely than men to be diagnosed with mental i	63	0.960
27	Mdwpd present with different areas of need and traits.	27	0.640
29	Mdwpd always want their own way.	29	0.640
30	Mdwpd provide accounts of themselves and their relationships	30	0.640
48	Mdwpd cope with their lack of relationships by creating a ri	48	0.640
53	Mdwpd can function reasonably well with a personality disord	53	0.640
15	Mdwpd are a danger to the the public.	15	0.640
60	Women who are dwpd will be sent to prison more often than me	60	0.640
12	Society prominently uses the term personality disorder in a	12	0.320
37	People are not born with personality disorder but develop it	37	0.320
38	It is moreimportant to understand how and why the individual	38	0.320
41	Illicit drug use can lead to a misdiagnosis of personality d	41	0.320
2	Mdwpd often form intense dependent relationships with kcy in	2	0.320
49	Mdwpd know they have a problem but are unwilling/unable to e	49	0.320
21	Men are dwpd as a form of social control because they fall o	21	0.320
22	Personality Disorder is a label which is put on people who c	22	0.320
36	Mdwpd have faulty learnin, resulting in a distorted understa	36	0.000
24	Nobody, including the patient really understands why mdwpd b	24	0.000
47	I don't believe you can treat mdwpd.	47	0.000
51	When treating mdwpd we can realistically only affect the par	51	0.000
54	If mdwpd were treated earlier then they would be less likely	54	0.000
57	When women dwpd use avoidant strategies to keep their emotio	57	0.000
58	Men and women dwpd have learnt in childhood not to express c	58	0.000
31	Mdwpd have a narrative style which served a function with si	31	0.000
40	The term personality disorder provides some people in the ho	40	-0.320
28	Due to the diagnostic problems clinicians should focus on th	28	-0.320
20	The medical definition of personality disorder identified wi	20	-0.320
5	Mdwpd find disturbing ways to try and extract a sense of saf	5	-0.320

Normalized Factor Scores - For Factor 7 Continued

No.	Statement	No.	Z-SCORES
32	If I was treated like mdwpd I might bahavein similar ways to	32	0.320
9	Mdwpd only say what they think other people want to hear.	9	-0.320
11	Personality Disorder is a convenient label which limits peop	11	-0.320
7	Mdwpd do not learn from their experiences and repeat past mi	7	-0.320
18	Mdwpd have more than one type which renders the diagnosis me	18	0.640
4	Mdwpd often recreate past relationshipswhich evoke similar r	4	-0.640
1	Mdwpd are often waiting for people to abandon and reject the	1	-0.640
23	Mdwpd are only interested in themselves.	23	0.640
6	Personality disorder is a condition which affects their perc	6	0.640
3	Mdwpd don't form close relationships because they fear negat	3	-0.640
8	Mdwpd are unable to develop stable lasting relationships.	8	0.640
25	Mdwpd cannot contro their anger.	25	-0.960
14	Personality types are unhelpful labels that don't adaquately	14	-0.960
19	The Mental Health Act is not helpful in defining personality	19	-0.960
65	Within your hospital male MHN find it more difficult than fe	65	-0.960
68	It is more difficult to see a male sex offender as a victim	68	0.960
70	At times, mdwpd can make me feel weak and inadaquate.	70	-0.960
52	Within the context of time our current treatment of mdwpd wi	52	-1.280
55	Men are often diagnosed with antisocial personality disorder	55	-1.280
56	Mdwpd are more likely to express aggressive behaviour toward	56	-1.280
69	At times, mdwpd present as powerful and controlling.	69	-1.280
13	The dominent view of society is that they view mdwpd within	13	-1.600
44	The media creates stereotypes about personality disorderwhic	44	1.600
35	When working with mdwpd I often feel threatened and worry ab	35	-1.600
17	Personality disorder implies badness.	17	-1.920
61	Women dwpd are more likely than men to have committed arson.	61	1.920
67	Famous male sex offenders are considered evil.	67	-1.920

Factor Eight Q-Sort Grid

-6	-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5	+6
6	**7**	**60**	67	69	63	24	25	4	1	**29**	**21**	**28**
22	**66**	**26**	65	39	19	20	32	11	31	**43**	**58**	**37**
44	**48**	**8**	52	64	55	13	2	30	35	**46**	**70**	**49**
		12	61	47	53	40	42	33	9	**5**		
			36	59	51	41	15	14	50			
			56	38	3	45	57	54	68			
				27	17	18	23	10				
					34	16	62					

Factor Eight Q-Sort Grid

-6	-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5	+6
6 Personality Disorder is a condition which affects their perception of others and their relationships.	**7 MdwPD do not learn from experience and repeat past mistakes.**	**60 Women who are DwPD will be sent to prison more often than men.**	67 Famous male sex offenders are considered evil.	69 At times, MDwPD present as powerful and controlling.	63 Women are more likely than men to be diagnosed with mental illness rather than personality disorder.	24 Nobody, including the patient, really understands why MDwPD behave the way they do.	25 MdwPD cannot control their anger.	4 MdwPD often recreate past relationships which evoke similar responses	1 MdwPD are often waiting for people to abandon and reject them within their relationships.	**29 MdwPD always want their own way.**	**21 Men are DwPD as a form of social control because they fall outside a major mental illness category and cause concern to society.**	**28 Due to the diagnostic problems clinicians should focus on the behaviour which brought them to the attention of health services.**
22 Personality Disorder it is a label which is put on people who cannot be managed.	**66 Within your hospital male mental health nurses create difficulties for female staff to develop a therapeutic relationship with MDwPD.**	**26 MdwPD consistently demonstrate negative emotions.**	65 Within your hospital male MHN find it more difficult than female MHNS to see MDwPD as anything other than offenders.	39 The term personality disorder creates a prejudice regarding the expected pattern of behaviours.	19 The Mental Health Act is not helpful in defining personality disorder.	20 The medical definition of personality disorder identified within ICD-10 and DSM-IV has no clinical purpose.	32 If I was treated like MDwPD I might behave in similar ways to them.	11 Personality Disorder is a convenient label which limits peoples understanding of the individual.	31 MdwPD have a narrative style which served a function with significant childhood attachment figures	**43 I do not believe that MDwPD should be detained indefinitely for offences they 'may' commit.**	**58 Men and women diagnosed personality disorder have learnt in childhood not to express certain emotions.**	**37 People are not born with personality disorder but develop it through their experiences.**
44 The media creates stereotypes about personality disorder which feeds societies prejudicial fears.	**48 MdwPD cope with their lack of relationships by creating a rich fantasy life.**	**8 MdwPD are unable to develop stable lasting relationships.**	52 Within the context of time our current treatment of MDwPD will be considered quite primitive.	64 Society predominantly equates women to idealised images of motherhood, so when they behave outside this stereotype they cause more concern.	55 When women DwPD use avoidant strategies to keep their emotions hidden it is easier to see than with men.	13 The dominant view of Society is that they view MDwPD within my hospital as psychopaths.	2 MdwPD often form intense dependent relationships with key individuals.	30 MdwPD provide accounts of themselves and their relationships which are factually incorrect.	35 When working with MdwPD I often feel threatened and worry about my career.	**46 When treating MDwPD you need to look beyond the challenging behaviour.**	**70 At times, MDwPD can make me feel weak and inadequate.**	**49 MdwPD know they have a problem but are unwilling/unable to embrace an alternative perspective.**
		12 Society predominantly uses the term Personality disorder in a derogatory manner.	61 men DwPD are more likely than men to have committed arson.	47 I don't believe you can treat MDwPD.	53 MdwPD can function reasonably well with a personality disorder in society it only becomes a problem if they break the law.	40 The term personality disorder provides most people in the hospital with a common language to work together.	42 Most men only receive a diagnosis of personality disorder when they have committed an offence.	33 When working with MDwPD I expect their behaviour to make me feel uncomfortable.	9 MdwPD only say what they think other people want to hear.	**5 MdwPD find disturbing ways to try and extract a sense of safety from others**		
			36 MdwPD have faulty learning, resulting in a distorted understanding of what is right or wrong.	59 Female sex offenders are given more support and sympathy by the majority of the media.	51 When treating MDwPD we can realistically only affect the parts of his personality which have caused a danger to society.	41 Illicit drug use can lead to a misdiagnosis of personality disorder	15 MdwPD are a danger to the public	14 Personality types are unhelpful labels that don't adequately describe the nature of the condition.	50 It is difficult to treat MDwPD unless they have been detained after breaking the law.			
			56 MdwPD are more likely to express aggressive behaviour towards others or property, but females will display self-harm behaviour and suicide threats.	38 It is more important to understand how and why the individual interacts in certain ways than use a legal/medical diagnosis.	3 MdwPD don't form close relationships because they fear negative outcomes	45 Black Afro Caribbean males are more likely be diagnosed mentally ill than with personality disorder.	57 Men are often diagnosed with antisocial personality disorder and women are more likely diagnosed with borderline personality disorder.	54 If MDwPD were treated earlier then they would be less likely to commit a crime	68 It is more difficult to see a male offender as a victim than it would be for a woman			
				27 MdwPD present with different areas of need and traits	17 Personality Disorder implies badness.	18 MdwPD have more than one type which renders the diagnosis meaningless	23 MdwPD are only interested in themselves	10 Given the right attention, boundaries MDwPD can eventually respond favourably.				
					34 When working with MDwPD I expect to be guarded and explore ways to protect myself.	16 Once diagnosed with personality disorder it stays with the individual for the rest of their life.	62 MdwPD are more likely to have committed a sexual offence than women					

Normalized Factor Scores - For Factor 8.

No.	Statement	No.	Z-SCORES
53	Mdwpd can function reasonably well with a personality disord	53	-0.320
55	Men are often diagnosed with antisocial personality disorder	55	-0.320
19	The Mental Health Act is not helpful in defining personality	19	-0.320
63	Women are more likely than men to be diagnosed with mental i	63	-0.320
27	Mdwpd present with different areas of need and traits.	27	-0.640
38	It is moreimportant to understand how and why the individual	38	-0.640
59	Female sex offenders are given more support and sympathy by	59	-0.640
47	I don't believe you can treat mdwpd.	47	-0.640
64	Society prodominently equates women to idealised images of m	64	-0.640
39	The term personality disorder creates prejudice regarding th	39	-0.640
69	At times, mdwpd present as powerful and controlling.	69	-0.640
56	Mdwpd are more likely to express aggressive behaviour toward	56	-0.960
36	Mdwpd have faulty learnin, resulting in a distorted understa	36	-0.960
61	Women dwpd are more likely than men to have committed arson.	61	, -0.960
52	Within the context of time our current treatment of mdwpd wi	52	-0.960
65	Within your hospital male MHN find it more difficult than fe	65	-0.960
67	Famous male sex offenders are considered evil.	67	-0.960
12	Society prominently uses the term personality disorder in a	12	-1.280
8	Mdwpd are unable to develop stable lasting relationships.	8	-1.280
26	Mdwpd consistently demonstrate negative emotions.	26	-1.280
60	Women who are dwpd will be sent to prison more often than me	60	-1.280
48	Mdwpd cope with their lack of relationships by creating a ri	48	-1.600
66	Within your hospital male MHN's create difficulties for fema	66	-1.600
7	Mdwpd do not learn from their experiences and repeat past mi	7	-1.600
44	The media creates stereotypes about personality disorderwhic	44	-1.920
22	Personality Disorder is a label which is put on people who c	22	-1.920
6	Personality disorder is a condition which affects their perc	6	-1.920

Normalized Factor Scores - For Factor 8

No.	Statement	No.	Z-SCORES
28	Due to the diagnostic problems clinicians should focus on th	28	1.920
37	People are not born with personality disorder but develop it	37	1.920
49	Mdwpd know they have a problem but are unwilling/unable to e	49	1.920
21	Men are dwpd as a form of social control because they fall o	21	1.600
58	Men and women dwpd have learnt in childhood not to express c	58	1.600
70	At times, mdwpd can make me feel weak and inadaquate.	70	1.600
29	Mdwpd always want their own way.	29	1.280
43	I do not believe that mdwpd shouldbe detained indeffinetly f	43	1.280
46	When treating mdwpd you need to look beyond the challengig b	46	1.280
5	Mdwpd find disturbing ways to try and extract a sense of saf	5	1.280
1	Mdwpd are often waiting for people to abandon and reject the	1	0.960
31	Mdwpd have a narrative style which served a function with si	31	0.960
35	When working with mdwpd I often feel threatened and worry ab	35	0.960
9	Mdwpd only say what they think other people want to hear.	9	0.960
50	It is difficult to treat mdwpd unless they have been detaine	50	0.960
68	It is more difficult to see a male sex offender as a victim	68	0.960
4	Mdwpd often recreate past relationshipswhich evoke similar r	4	0.640
11	Personality Disorder is a convenient label which limits peop	11	0.640
30	Mdwpd provide accounts of themselves and their relationships	30	0.640
33	When working with mdwpd I expect their behaviour to make me	33	0.640
14	Personality types are unhelpful labels that don't adaquately	14	0.640
54	If mdwpd were treated earlier then they would be less likely	54	0.640
10	Given the right attention, boundaries mdwpd can eventually r	10	0.640
25	Mdwpd cannot contro their anger.	25	0.320
32	If I was treated like mdwpd I might bahavein similar ways to	32	0.320
2	Mdwpd often form intense dependent relationships with key in	2	0.320
42	Most men only receive a diagnosis of personality disorder wh	42	0.320
15	Mdwpd are a danger to the the public.	15	0.320
57	When women dwpd use avoidant strategies to keep their emotio	57	0.320
23	Mdwpd are only interested in themselves.	23	0.320
62	Mdwpd are more likely to have committed a sex offence than w	62	0.320
24	Nobody, including the patient really understands why mdwpd b	24	0.000
20	The medical definition of personality disorder identified wi	20	0.000
13	The dominent view of society is that they view mdwpd within	13	0.000
40	The term personality disorder provides some people in the ho	40	0.000
41	Illicit drug use can lead to a misdiagnosis of personality d	41	0.000
45	Black Afro Carribbean males are more likely to be diagnosed	45	0.000
18	Mdwpd have more than one type which renders the diagnosis me	18	0.000
16	Once diagnosed with personality disorder it stays with the i	16	0.000
34	When working with mdwpd I expect to be guarded and explore w	34	-0.320
17	Personality disorder implies badness.	17	-0.320
3	Mdwpd don't form close relationships because they fear negat	3	-0.320
51	When treating mdwpd we can realistically only affect the par	51	-0.320

Appendix Eight (b).

‘B’ Q-Sorts: Understanding Relationship Difficulties.

B Sort/Factor One Grid

-6	-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5	+6
61	**74**	**60**	**27**	54	19	3	70	72	**58**	**69**	**44**	**24**
78	**53**	**35**	**79**	29	17	38	48	7	**71**	**76**	**41**	**66**
62	**4**	**55**	**2**	50	26	22	56	77	**51**	**52**	**63**	**46**
	67	**1**	**37**	11	82	39	47	6	**68**	**23**	**75**	
		81	57	43	20	14	65	64	12	**21**		
			15	18	33	8	59	45	42			
			31	13	32	30	16	73	40			
				34	9	5	49	80				
					28	10	36					
						25						

B Sort/Factor One Grid

-6	-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5	+6
61 It is important to gather information about how MdwPD coped with adverse childhood experiences.	**74 Understanding why MDwPD seek out certain types of relationships is important**	**60 Understanding is gained through the consistent responses MDwPD elicit in their relationships with others.**	**27 MdwPD have difficulty maintaining a trusting/honest relationship which limits a therapeutic alliance**	54 I sometimes do not report relationship difficulties when working with MDwPD for fear of the potential consequences.	19 MdwPD concern me because of their ability to humiliate me.	3 When working with MDwPD you can never judge anything purely on face value.	70 The ward environmental context may replicate traumatic past experiences for MDwPD.	72 Understanding of MDwPD is gained through self-reflection.	**58 Due to insufficient basic nurse training problems occur when attempting to identify relationship difficulties with MDwPD**	**69 MdwPD often repeat past dynamics which are acted out within their current environment.**	**44 Supervision is important to explore the impact upon yourself of the sometimes horrific histories that MDwPD present.**	**24 It is important to understand yourself before working with MDwPD, otherwise relationship difficulties may increase.**
78 You should ignore the negative feelings in your relationship with MDwPD until it becomes too much.	**53 Understanding of MDwPD is gained by addressing transference relationships**	**35 MdwPD will attempt to use a variety of extreme strategies to elicit a caring response from others.**	**79 Before acting on a new understanding in your relationship with MDwPD you should consult with your peer group.**	29 Compared to myself the majority of female mental health nurses are more likely to have their boundaries eroded by MdwPD.	17 MdwPD are very sophisticated in getting other patients to attempt to make my life a misery.	38 MdwPD elicit feelings of guilt when they set you up to reject them.	48 Experiencing somatic difficulties (e.g. Stomach churning, headaches etc) when working with MdwPD may indicate a problem in the relationship.	7 It is important to be aware of the gender preference of MDwPD as it may have a significance in their historical dynamic	**71 Understanding MdwPD is evolving rapidly hence the importance of maintaining a contemporary knowledge base**	**76 The information imparted and not imparted may have equal significance in understanding MDwPD.**	**41 It is easier to recognise relationship difficulties with MDwPD when consulting with the collective expertise of the staff group.**	**66 Increased understanding of MDwPD is obtained by ignoring pejorative labels and relating to them as individuals.**
62 It is important to gather information about significant childhood relationships in MDwPD.	**4 When working with MdwPD you need to be constantly aware that they can be charming, manipulative and seductive.**	**55 To confide in someone else about your relationship difficulties with MDwPD feels like a weakness.**	**2 Diagnostic labels make it easier to work with MdwPD**	50 It easier to see the negatives rather than the positive aspects of MDwPD.	26 Sometimes I find that I have colluded with MDwPD because it felt safe.	22 Sometimes I find that have colluded with MDwPD because of a lack of information/support	56 Being seduced into feeling special by MDwPD may not seem like a problem at the time	77 MdwPD may cope with a lack of control in the past by attempting to control others in the present.	**51 It is self-defeating to see MDwPD in terms of a challenge that you will not be defeated by.**	**52 It is important to be aware that relationships with MDwPD may result in addressing aspects of ourselves.**	**63 Understand of MDwPD is gained by using reflective processes within group supervision**	**46 Without sufficient feedback from others it can be difficult to challenge and support MDwPD**
	67 MdwPD will often give unreliable accounts so it is important to obtain a comprehensive history from a variety of sources.	**1 MdwPD have difficulty in establishing trusting relationships because they have learnt to use avoidant strategies due to past rejection**	**37 MdwPD have difficulty thinking of the consequences of their actions**	11 Female Mental Health Nurses can be lulled into a false sense of security by MDwPD.	82 A caring nursing role with MDwPD will be dramatically eroded by the challenging nature of their relationships.	39 MdwPD use drugs and alcohol excessively as a coping mechanism.	47 MdwPD will express their difficulties in very indirect ways	6 The response to boundaries in MDwPD, often provides an opportunity to understand their feelings about deeper issues.	**68 My understanding of a MDwPD may be different from other professionals and should be integrated through discussion.**	**23 It is important to be aware of the relationship style of MDwPD because it could evoke unresolved feelings belonging to myself.**	**75 Seemingly insignificant information about MDwPD may be very relevant within a reflective practice group.**	
		81 Decisions should be acted on consistently when working with MDwPD	57 When working with MDwPD I am reluctant to use a reflective/ supervision process with others for fear of being interpreted negatively.	43 You may be missing something if you are not shocked by MDwPD.	20 MdwPD often make me feel that I do not care enough for them	14 The dual responsibilities of therapy and security cause difficulties in my relationship with MDwPD	65 Understand of MDwPD is gained by exploring and examining their distinction between fantasy and reality.	64 Understanding of MDwPD is gained by addressing transference relationships	12 Setting boundaries and limits with MDwPD has been difficult because my basic nurse training did not prepare me sufficiently.	**21 MdwPD will try to elicit responses from me which are similar to significant people from their past.**		
			15 MdwPD do not consider all their options when problem solving.	18 I often need to find coping strategies to protect myself from attacks by MDwPD.	33 MdwPD can make you feel emotionally raped.	8 MdwPD fantasise jealously about the successful relationships you have.	59 MdwPD are negatively affected by media stereotypes which only highlight extreme behaviours.	45 It can be difficult to determine what feelings belong to MDwPD and what belongs to oneself	42 Failure to recognise relationship difficulties with MDwPD can occur when failing to observe their life long script/narrative.			
			31 MdwPD minimise their behaviour and attempt to draw others into their minimisation	13 MdwPD are egocentric.	32 MdwPD are egocentric.	30 MdwPD have a lack of empathy for the feelings of others	16 MdwPD often make grandiose claims about themselves to protect them from feelings of vulnerability.	73 Understanding of MDwPD is gained through identifying and responding accordingly to the individual's schema.	40 I recognise relationship difficulties with MDwPD when I experience feelings which are uncharacteristic of me.			
				34 MdwPD do not understand that they have a problem	9 MdwPD attempt to undermine your authority.	5 If female staff spend too much time with one man DwPD it can cause jealousy and acting out behaviour in others.	49 MdwPD present an opportunity to understand them when they violate a boundary	80 hen working with MDwPD you should constantly reappraise the direction of the relationship.				
					28 At times, I find myself conforming to staff group behaviour which is outside my character and can prove offensive to MDwPD.	10 MdwPD have difficulty negotiating.	36 When I have worked for a long period of time with MDwPD I can become desensitised to their behaviour.					
						25 MdwPD create staff stereotypes to make it easier to do things to them						

Normalized Factor Scores - For Factor One.

Normalized Factor Scores -- For Factor 1

No.	Statement	No.	Z-SCORES
24	It is important to understand yourself before working with m	24	1.684
66	Increased understanding of mdwpd is obtained by ignoring per	66	1.662
46	Without sufficient feedback from others it can be difficult	46	1.554
44	Supervision is important to explore the impact upon yourself	44	1.550
41	It is easier to recognise relationship difficulties with mdw	41	1.522
63	Understanding of mdwpdis gained by usin reflective processes	63	1.446
75	Seemingly insignificant information about mdwpd maybe be ver	75	1.411
69	Mdwpd often repeat past dynamics which are acted out in thei	69	1.243
76	The information imparted and not imparted may have equal sig	76	1.230
52	It is important to aware that relationships with mdwpd may r	52	1.218
23	It is important to be aware of the relationship style of mdw	23	1.168
21	Mdwpd will try to elicit responses from me which are similar	21	1.120
58	Due to insufficient basic nurse training problems occur when	58	1.107
71	Understanding mdwpd is evolving rapidly hence the importance	71	1.056
51	It is self defeatingto see mdwpd in terms of a challenge tha	51	1.040
68	My understanding of mdwpd may be different from other profes	68	1.035
12	Setting boundaries and limits with mdwpd has been difficult	12	0.973
42	Failure to recognise relationship difficulties with mdwpd ca	42	0.957
40	I recognise relationship difficulties with mdwpd when a I ex	40	0.949
72	Understanding mdwpd is gained through self reflection	72	0.924
7	It is important to aware of the gender preference of mdwpd a	7	0.866
77	Mdwpd may cope with with a lack of control in the past by at	77	0.839
6	The response to boundaries in mdwpd, often provides an oppor	6	0.837
64	Understanding of mdwpd is gained by addressing transference.	64	0.829
45	It can be difficult to determine what feelings belong to mdw	45	0.800
73	Understanding mdwpd is gained through by identifying and res	73	0.769
80	When working with mdwpd you should constantly reappraise the	80	0.724
70	The ward environmental context may replicate traumatic past.	70	0.659
48	Experiencing somatic difficulties () when working working wi	48	0.589
56	Being seduced into feeling something special by mdwpd may no	56	0.534
47	Mdwpd will express their difficulties in very indirect ways.	47	0.471
65	Understanding of mdwpd is gained by exploring and examining	65	0.450
59	Mdwpd are negatively affected by media stereotypes which onl	59	0.447
16	Mdwpd often make grandiose claims about themselves to protec	16	0.403
49	Mdwpd present an opportunity to undertsand them when they vi	49	0.323
36	When I have worked for a long period of time with mdwpd I ca	36	0.233
3	When working with mdwpd you can never judge anything on face	3	0.229
38	Mdwpd elicit feelings of guilt when they set you up to rejec	38	0.163
22	Sometimes I find that I have colluded with mdwpd because of	22	0.150
39	Mdwpd use drugs and alcohol excessively as a coping mechanis	39	0.035
14	The dual responsibilities of therapy and security cause diff	14	0.025
8	Mdwpd fantasise jealously about the successful relationships	8	-0.035
30	Mdwpd have a lack of empathy for the feelings of others.	30	-0.053

Normalized Factor Scores - For Factor One.

Normalized Factor Scores -- For Factor 1

No.	Statement	No.	Z-SCORES
5	If female staff spend too much time with one man dwpd it can	5	-0.119
10	Mdwpd have difficulty negotiating.	10	-0.172
25	Mdwpd create staff stereotypes to make it easier to do thing	25	-0.188
28	At times, I find myself conforming to staff group behaviour	28	-0.233
9	Mdwpd attempt to undermine your authority.	9	-0.245
32	Mdwpd are egocentric.	32	-0.318
33	Mdwpd can make you feel emotionally raped.	33	-0.322
20	Mdwpd often make me feel that I don't care enough for them.	20	-0.326
82	A caring nursing role with mdwpd will be dramatically eroded	82	-0.332
26	Sometimes I find that I have colluded with mdwpd because it	26	-0.422
17	Mdwpd are very sophisticated in getting other patients to at	17	-0.469
19	Mdwpd concern me because of their ability to humiliate me.	19	-0.528
34	Mdwpd do not understand that they have a problem.	34	-0.581
13	It is difficult working with mdwpd because they don't appear	13	-0.595
18	I often have to find coping strategies to protect myself fro	18	-0.624
43	You maybe missing something if you are not shocked by mdwpd.	43	-0.749
11	Female MHN's can be lulled into a false sense of security by	11	-0.752
50	It is easier to see the negatives rather than the positive a	50	-0.762
29	Compared to myself the majority of female MHN's are more lik	29	-0.841
54	I sometimes do not report relationship difficulties when wor	54	-0.860
31	Mdwpd minimise their behaviour and attempt to draw others in	31	-0.862
15	Mdwpd do not consider all their options when problem solving	15	-0.938
57	When working with mdwpd I am reluctant use a reflective/supe	57	-0.951
37	Mdwpd have difficulty thinking of the consequences of their	37	-1.052
2	Diagnostic labels make it easier to work with mdwpd.	2	-1.085
79	Before acting on a new understanding in your relationship wi	79	-1.133
27	Mdwpd have difficulty maintaining a trusting/honest relation	27	-1.221
81	Decisions should be acted on consistently when with mdwpd.	81	-1.269
1	Mdwpd have difficulty establishing trusting relationships be	1	-1.279
55	To confide in someone else about your relationship difficult	55	-1.284
35	Mdwpd will attempt to use a variety of extreme strategies to	35	-1.353
60	Understanding is gained through consistent resonses to mdwpd	60	-1.357
67	Mdwpd will often give unreliable accounts so it is important	67	-1.411
4	When working with mdwpd you need to be constantly aware that	4	-1.501
53	Without adaquate training, working with mdwpd can be very da	53	-1.653
74	Understanding why mdwpd sekk out certain types of relationsh	74	-1.719
62	It is important to gather information about significant chil	62	-1.767
78	You should ignore the negative feelings in your relationship	78	-1.901
61	It isimportant to gather information about how mdwpd coped w	61	-1.963

B Sorts/Factor Two Grid

-6	-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5	+6
53	**62**	**13**	72	11	51	32	3	27	47	**82**	**75**	**56**
54	**78**	**61**	71	31	17	7	70	49	77	**9**	**38**	**12**
81	**79**	**35**	67	15	34	22	59	25	14	**33**	**44**	**58**
	74	**4**	29	19	26	36	41	76	16	**68**	**69**	
		45	39	64	50	20	21	65	66	**80**		
			2	1	23	40	46	6	63			
			24	42	18	73	5	55	60			
				37	48	52	43	57				
					30	28	10					
						8						

B Sorts/Factor Two Grid.

-6	-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5	+6
53 Without adequate training, working with MDwPD can be very damaging.	**62 It is important to gather information about significant childhood relationships in MDwPD.**	**13 MdwPD are egocentric.**	72 Understanding of MDwPD is gained through self-reflection.	11 Female Mental Health Nurses can be lulled into a false sense of security by MDwPD.	51 It is self-defeating to see MDwPD in terms of a challenge that you will not be defeated by	32 MdwPD are egocentric.	3 When working with MDwPD you can never judge anything purely on face value.	27 MdwPD have difficulty maintaining a trusting/honest relationship which limits a therapeutic alliance.	47 MdwPD will express their difficulties in very indirect ways.	**82 A caring nursing role with MDwPD will be dramatically eroded by the challenging nature of their relationships.**	**75 Seemingly insignificant information about MDwPD may be very relevant within a reflective practice group.**	**56 Being seduced into feeling special by MDwPD may not seem like a problem at the time.**
54 I sometimes do not report relationship difficulties when working with MDwPD for fear of the potential consequences.	**78 You should ignore the negative feelings in your relationship with MDwPD until it becomes too much.**	**61 It is important to gather information about how MdwPD coped with adverse childhood experiences.**	71 Understanding MdwPD is evolving rapidly hence the importance of maintaining a contemporary knowledge base.	31 MdwPD minimise their behaviour and attempt to draw others into their minimisation.	17 MdwPD are very sophisticated in getting other patients to attempt to make my life a misery.	7 It is important to be aware of the gender preference of MDwPD as it may have a significance in their historical dynamic.	70 The ward environmental context may replicate traumatic past experiences for MDwPD.	49 MdwPD present an opportunity to understand them when they violate a boundary.	77 MdwPD may cope with a lack of control in the past by attempting to control others in the present.	**9 MdwPD attempt to undermine your authority.**	**38 MdwPD elicit feelings of guilt when they set you up to reject them**	**12 Setting boundaries and limits with MDwPD has been difficult because my basic nurse training did not prepare me sufficiently.**
81 Decisions should be acted on consistently when working with MDwPD	**79 Before acting on a new understanding in your relationship with MDwPD you should consult with your peer group.**	**35 MdwPD will attempt to use a variety of extreme strategies to elicit a caring response from others.**	67 MdwPD will often give unreliable accounts so it is important to obtain a comprehensive history from a variety of sources.	15 MdwPD do not consider all their options when problem solving	34 MdwPD do not understand that they have a problem.	22 Sometimes I find that have colluded with MDwPD because of a lack of information/support	59 MdwPD are negatively affected by media stereotypes which only highlight extreme behaviours.	25 MdwPD create staff stereotypes to make it easier to do things to	14 The dual responsibilities of therapy and security cause difficulties in my relationship with MDwPD.	**33 MdwPD can make you feel emotionally raped.**	**44 Supervision is important to explore the impact upon yourself of the sometimes horrific histories that MDwPD present.**	**58 Due to insufficient basic nurse training problems occur when attempting to identify relationship difficulties with MDwPD.**
	74 Understanding why MDwPD seek out certain types of relationships is important	**4 When working with MdwPD you need to be constantly aware that they can be charming, manipulative and seductive.**	29 Compared to myself the majority of female mental health nurses are more likely to have their boundaries eroded by MdwPD.	19 MdwPD concern me because of their ability to humiliate me.	26 Sometimes I find that I have colluded with MDwPD because it felt safe.	36 When I have worked for a long period of time with MDwPD I can become desensitised to their behaviour.	41 It is easier to recognise relationship difficulties with MDwPD when consulting with the collective expertise of the staff group.	76 MdwPD often make grandiose claims about themselves to protect them from feelings of vulnerability.	16 MdwPD often make grandiose claims about themselves to protect them from feelings of vulnerability.	**68 My understanding of a MDwPD may be different from other professionals and should be integrated through discussion.**	**69 MdwPD often repeat past dynamics which are acted out within their current environment**	
		45 It can be difficult to determine what feelings belong to MDwPD and what belongs to oneself.	39 MdwPD use drugs and alcohol excessively as a coping mechanism.	64 Understanding of MDwPD is gained by addressing transference relationships.	50 It easier to see the negatives rather than the positive aspects of MDwPD	20 MdwPD often make me feel that I do not care enough for them.	21 MdwPD will try to elicit responses from me which are similar to significant people from their past.	65 Understand of MDwPD is gained by exploring and examining their distinction between fantasy and reality	66 Increased understanding of MDwPD is obtained by ignoring pejorative labels and relating to them as individuals.	**80 When working with MDwPD you should constantly reappraise the direction of the relationship.**		
			2 Diagnostic labels make it easier to work with MdwPD.	1 MdwPD have difficulty in establishing trusting relationships because they have learnt to use avoidant strategies due to past rejection.	23 It is important to be aware of the relationship style of MDwPD because it could evoke unresolved feelings belonging to myself.	40 I recognise relationship difficulties with MDwPD when I experience feelings which are uncharacteristic of me.	46 Without sufficient feedback from others it can be difficult to challenge and support MDwPD	6 The response to boundaries in MDwPD, often provides an opportunity to understand their feelings about deeper issues.	63 Understand of MDwPD is gained by using reflective processes within group supervision			
			24 It is important to understand yourself before working with MDwPD, otherwise relationship difficulties may increase.	42 Failure to recognise relationship difficulties with MDwPD can occur when failing to observe their life long script/narrative.	18 I often need to find coping strategies to protect myself from attacks by MDwPD.	73 Understanding of MDwPD is gained through identifying and responding accordingly to the individuals schema	5 If female staff spend too much time with one man DwPD it can cause jealousy and acting out behaviour in others	55 To confide in someone else about your relationship difficulties with MDwPD feels like a weakness.	60 Understanding is gained through the consistent responses MDwPD elicit in their relationships with others.			
				37 MdwPD have difficulty thinking of the consequences of their actions.	48 Experiencing somatic difficulties (e.g. Stomach churning, headaches etc) when working with MdwPD may indicate a problem in the relationship.	52 You may be missing something if you are not shocked by MDwPD.	43 You may be missing something if you are not shocked by MDwPD	57 When working with MDwPD I am reluctant to use a reflective/ supervision process with others for fear of being interpreted negatively.				
					30 MdwPD have a lack of empathy for the feelings of others.	28 At times, I find myself conforming to staff group behaviour which is outside my character and can prove offensive to MDwPD.	10 MdwPD have difficulty negotiating					
						8 MdwPD fantasise jealously about the successful relationships you have						

Normalized Factor Scores - For Factor Two.

Normalized Factor Scores -- For Factor 2

No.	Statement	No.	Z-SCORES
56	Being seduced into feeling something special by mdwpd may no	56	2.244
12	Setting boundaries and limits with mdwpd has been difficult	12	1.839
58	Due to insufficient basic nurse training problems occur when	58	1.704
75	Seemingly insignificant information about mdwpd maybe be ver	75	1.631
38	Mdwpd elicit feelings of guilt when they set you up to rejec	38	1.600
44	Supervision is important to explore the impact upon yourself	44	1.496
69	Mdwpd often repeat past dynamics which are acted out in thei	69	1.465
82	A caring nursing role with mdwpd will be dramatically eroded	82	1.465
9	Mdwpd attempt to undermine your authority.	9	1.392
33	Mdwpd can make you feel emotionally raped.	33	1.361
68	My understanding of mdwpd may be different from other profes	68	1.287
80	When working with mdwpd you should constantly reappraise the	80	1.257
47	Mdwpd will express their difficulties in very indirect ways.	47	0.987
77	Mdwpd may cope with with a lack of control in the past by at	77	0.987
14	The dual responsibilities of therapy and security cause diff	14	0.926
16	Mdwpd often make grandiose claims about themselves to protec	16	0.913
66	Increased understanding of mdwpd is obtained by ignoring per	66	0.913
63	Understanding of mdwpdis gained by usin reflective processes	63	0.852
60	Understanding is gained through consistent resonses to mdwpd	60	0.821
27	Mdwpd have difficulty maintaining a trusting/honest relation	27	0.687
49	Mdwpd present an opportunity to undertsand them when they vi	49	0.644
25	Mdwpd create staff stereotypes to make it easier to do thing	25	0.613
76	The information imparted and not imparted may have equal sig	76	0.613
65	Understanding of mdwpd is gained by exploring and examining	65	0.582
6	The response to boundaries in mdwpd, often provides an oppor	6	0.509
55	To confide in someone else about your relationship difficult	55	0.478
57	When working with mdwpd I am reluctant use a reflective/supe	57	0.478
3	When working with mdwpd you can never judge anything on face	3	0.447
70	The ward environmental context may replicate traumatic past.	70	0.405
59	Mdwpd are negatively affected by media stereotypes which onl	59	0.374
41	It is easier to recognise relationship difficulties with mdw	41	0.343
21	Mdwpd will try to elicit responses from me which are similar	21	0.343
46	Without sufficient feedback from others it can be difficult	46	0.300
5	If female staff spend too much time with one man dwpd it can	5	0.239
43	You maybe missing something if you are not shocked by mdwpd.	43	0.239
10	Mdwpd have difficulty negotiating.	10	0.208
32	Mdwpd are egocentric.	32	0.135
7	It is important to aware of the gender preference of mdwpd a	7	0.135
22	Sometimes I find that I have colluded with mdwpd because of	22	0.092
36	When I have worked for a long period of time with mdwpd I ca	36	0.061
20	Mdwpd often make me feel that I don't care enough for them.	20	0.000
40	I recognise relationship difficulties with mdwpd when a I ex	40	-0.074
73	Understanding mdwpd is gained through by identifying and res	73	-0.074

Normalized Factor Scores - For Factor Two.

Normalized Factor Scores -- For Factor 2

No.	Statement	No.	Z-SCORES
52	It is important to aware that relationships with mdwpd may r	52	-0.135
28	At times, I find myself conforming to staff group behaviour	28	-0.135
8	Mdwpd fantasise jealously about the successful relationships	8	-0.135
30	Mdwpd have a lack of empathy for the feelings of others.	30	-0.208
48	Experiencing somatic difficulties () when working working wi	48	-0.239
18	I often have to find coping strategies to protect myself fro	18	-0.239
23	It is important to be aware of the relationship style of mdw	23	-0.239
50	It is easier to see the negatives rather than the positive a	50	-0.270
26	Sometimes I find that I have colluded with mdwpd because it	26	-0.300
34	Mdwpd do not understand that they have a problem.	34	-0.300
17	Mdwpd are very sophisticated in getting other patients to at	17	-0.343
51	It is self defeatingto see mdwpd in terms of a challenge tha	51	-0.405
37	Mdwpd have difficulty thinking of the consequences of their	37	-0.509
42	Failure to recognise relationship difficulties with mdwpd ca	42	-0.509
1	Mdwpd have difficulty establishing trusting relationships be	1	-0.582
64	Understanding of mdwpd is gained by addressing transference.	64	-0.582
19	Mdwpd concern me because of their ability to humiliate me.	19	-0.613
15	Mdwpd do not consider all their options when problem solving	15	-0.644
31	Mdwpd minimise their behaviour and attempt to draw others in	31	-0.644
11	Female MHN's can be lulled into a false sense of security by	11	-0.674
24	It is important to understand yourself before working with m	24	-0.717
2	Diagnostic labels make it easier to work with mdwpd.	2	-0.717
39	Mdwpd use drugs and alcohol excessively as a coping mechanis	39	-0.779
29	Compared to myself the majority of female MHN's are more lik	29	-0.852
67	Mdwpd will often give unreliable accounts so it is important	67	-0.883
71	Understanding mdwpd is evolving rapidly hence the importance	71	-0.895
72	Understanding mdwpd is gained through self reflection	72	-0.926
45	It can be difficult to determine what feelings belong to mdw	45	-1.122
4	When working with mdwpd you need to be constantly aware that	4	-1.153
35	Mdwpd will attempt to use a variety of extreme strategies to	35	-1.361
61	It isimportant to gather information about how mdwpd coped w	61	-1.361
13	It is difficult working with mdwpd because they don't appear	13	-1.465
74	Understanding why mdwpd sekk out certain types of relationsh	74	-1.631
79	Before acting on a new understanding in your relationship wi	79	-1.631
78	You should ignore the negative feelings in your relationship	78	-1.735
62	It is important to gather information about significant chil	62	-1.766
81	Decisions should be acted on consistently when with mdwpd.	81	-1.974
54	I sometimes do not report relationship difficulties when wor	54	-2.005
53	Without adaquate training, working with mdwpd can be very da	53	-2.244

B Sorts/Factor Three Grid

-6	-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5	+6
37	**31**	**62**	**78**	50	19	65	21	52	**13**	**76**	**44**	**30**
54	**79**	**57**	**61**	45	20	25	77	23	**39**	**41**	**71**	**32**
53	**67**	**26**	**35**	60	38	8	69	36	**46**	**10**	**9**	**34**
	55	**4**	**1**	15	22	64	6	63	**80**	**75**	**3**	
		56	**28**	14	2	70	16	66	**42**	**24**		
			81	27	82	11	48	68	**47**			
			74	7	18	29	5	72	49			
				43	17	12	51	73				
					33	58	40					
						59						

B Sorts/Factor Three Grid

-6	-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5	+6
37 MdwPD have difficulty thinking of the consequences of their actions.	**31 MdwPD minimise their behaviour and attempt to draw others into their minimisation**	**62 It is important to gather information about significant childhood relationships in MDwPD.**	**78 You should ignore the negative feelings in your relationship with MDwPD until it becomes too much.**	50 It easier to see the negatives rather than the positive aspects of MDwPD.	19 MdwPD concern me because of their ability to humiliate me.	65 Understand of MDwPD is gained by exploring and examining their distinction between fantasy and reality.	21 MdwPD will try to elicit responses from me which are similar to significant people from their past.	52 It is important to be aware that relationships with MDwPD may result in addressing aspects of ourselves.	**13 It is difficult working with MDwPD because they don't appear to want to change.**	**76 The information imparted and not imparted may have equal significance in understanding MDwPD.**	**44 Supervision is important to explore the impact upon yourself of the sometimes horrific histories that MDwPD present.**	**30 MdwPD have a lack of empathy for the feelings of others.**
54 I sometimes do not report relationship difficulties when working with MDwPD for fear of the potential consequences.	**79 Before acting on a new understanding in your relationship with MDwPD you should consult with your peer group.**	**57 When working with MDwPD I am reluctant to use a reflective/ supervision process with others for fear of being interpreted negatively.**	**61 It is important to gather information about how MdwPD coped with adverse childhood experiences.**	45 It can be difficult to determine what feelings belong to MDwPD and what belongs to oneself.	20 MdwPD often make me feel that I do not care enough for them.	25 MdwPD create staff stereotypes to make it easier to do things to them	77 MdwPD may cope with a lack of control in the past by attempting to control others in the present.	23 It is important to be aware of the relationship style of MDwPD because it could evoke unresolved feelings belonging to myself.	**39 MdwPD use drugs and alcohol excessively as a coping mechanism.**	**41 It is easier to recognise relationship difficulties with MDwPD when consulting with the collective expertise of the staff group.**	**71 Understanding MdwPD is evolving rapidly hence the importance of maintaining a contemporary knowledge base**	**32 MdwPD are egocentric.**
53 Without adequate training, working with MDwPD can be very damaging.	**67 MdwPD will often give unreliable accounts so it is important to obtain a comprehensive history from a variety of sources**	**26 Sometimes I find that I have colluded with MDwPD because it felt safe.**	**35 MdwPD will attempt to use a variety of extreme strategies to elicit a caring response from others.**	60 Understanding is gained through the consistent responses MDwPD elicit in their relationships with others.	38 MdwPD elicit feelings of guilt when they set you up to reject them.	8 MdwPD fantasise jealously about the successful relationships you have.	69 MdwPD often repeat past dynamics which are acted out within their current environment.	36 When I have worked for a long period of time with MDwPD I can become desensitised to their behaviour.	**46 Without sufficient feedback from others it can be difficult to challenge and support MDwPD.**	**10 MdwPD have difficulty negotiating.**	**9 MdwPD attempt to undermine your authority.**	**34 MdwPD do not understand that they have a problem.**
	55 To confide in someone else about your relationship difficulties with MDwPD feels like a weakness.	**4 When working with MdwPD you need to be constantly aware that they can be charming, manipulative and seductive.**	**1 MdwPD have difficulty in establishing trusting relationships because they have learnt to use avoidant strategies due to past rejection.**	15 MdwPD do not consider all their options when problem solving.	22 Sometimes I find that have colluded with MDwPD because of a lack of information/support.	64 Understanding of MDwPD is gained by addressing transference relationships.	6 The response to boundaries in MDwPD, often provides an opportunity to understand their feelings about deeper issues.	63 Understand of MDwPD is gained by using reflective processes within group supervision.	**80 When working with MDwPD you should constantly reappraise the direction of the relationship.**	**75 Seemingly insignificant information about MDwPD may be very relevant within a reflective practice group.**	**3 When working with MDwPD you can never judge anything purely on face value.**	
		56 Being seduced into feeling special by MDwPD may not seem like a problem at the time	**28 At times, I find myself conforming to staff group behaviour which is outside my character and can prove offensive to MDwPD.**	14 The dual responsibilities of therapy and security cause difficulties in my relationship with MDwPD.	2 Diagnostic labels make it easier to work with MdwPD.	70 The ward environmental context may replicate traumatic past experiences for MDwPD.	16 The ward environmental context may replicate traumatic past experiences for MDwPD.	66 Increased understanding of MDwPD is obtained by ignoring pejorative labels and relating to them as individuals.	**42 Failure to recognise relationship difficulties with MDwPD can occur when failing to observe their life long script/narrative.**	**24 It is important to understand yourself before working with MDwPD, otherwise relationship difficulties may increase.**		
			81 Decisions should be acted on consistently when working with MDwPD	27 MdwPD have difficulty maintaining a trusting/honest relationship which limits a therapeutic alliance.	82 A caring nursing role with MDwPD will be dramatically eroded by the challenging nature of their relationships.	11 Female Mental Health Nurses can be lulled into a false sense of security by MDwPD	48 Experiencing somatic difficulties (e.g. Stomach churning, headaches etc) when working with MdwPD may indicate a problem in the relationship.	68 My understanding of a MDwPD may be different from other professionals and should be integrated through discussion.	**47 MdwPD will express their difficulties in very indirect ways.**			
			74 Understanding why MDwPD seek out certain types of relationships is important	7 It is important to be aware of the gender preference of MDwPD as it may have a significance in their historical dynamic.	18 I often need to find coping strategies to protect myself from attacks by MDwPD.	29 Compared to myself the majority of female mental health nurses are more likely to have their boundaries eroded by MdwPD.	5 If female staff spend too much time with one man DwPD it can cause jealousy and acting out behaviour in others.	72 Understanding of MDwPD is gained through self-reflection.	49 MdwPD present an opportunity to understand them when they violate a boundary			
				43 You may be missing something if you are not shocked by MDwPD.	17 MdwPD are very sophisticated in getting other patients to attempt to make my life a misery	12 Setting boundaries and limits with MDwPD has been difficult because my basic nurse training did not prepare me sufficiently.	51 It is self-defeating to see MDwPD in terms of a challenge that you will not be defeated by.	73 Understanding of MDwPD is gained through identifying and responding accordingly to the individual's schema.				
					33 MdwPD can make you feel emotionally raped	58 Due to insufficient basic nurse training problems occur when attempting to identify relationship difficulties with MDwPD.	40 I recognise relationship difficulties with MDwPD when I experience feelings which are uncharacteristic of me.					
						59 MdwPD are negatively affected by media stereotypes which only highlight extreme behaviours.						

Normalized Factor Scores - For Factor Three.

Normalized Factor Scores -- For Factor 3

No.	Statement	No.	Z-SCORES
30	Mdwpd have a lack of empathy for the feelings of others.	30	2.051
32	Mdwpd are egocentric.	32	1.943
34	Mdwpd do not understand that they have a problem.	34	1.935
44	Supervision is important to explore the impact upon yourself	44	1.868
71	Understanding mdwpd is evolving rapidly hence the importance	71	1.419
9	Mdwpd attempt to undermine your authority.	9	1.413
3	When working with mdwpd you can never judge anything on face	3	1.371
76	The information imparted and not imparted may have equal sig	76	1.231
41	It is easier to recognise relationship difficulties with mdw	41	1.206
10	Mdwpd have difficulty negotiating.	10	1.133
75	Seemingly insignificant information about mdwpd maybe be ver	75	1.118
24	It is important to understand yourself before working with m	24	1.107
13	It is difficult working with mdwpd because they don't appear	13	1.079
39	Mdwpd use drugs and alcohol excessively as a coping mechanis	39	1.043
46	Without sufficient feedback from others it can be difficult	46	1.028
80	When working with mdwpd you should constantly reappraise the	80	1.023
42	Failure to recognise relationship difficulties with mdwpd ca	42	1.008
47	Mdwpd will express their difficulties in very indirect ways.	47	1.006
49	Mdwpd present an opportunity to undertsand them when they vi	49	0.953
52	It is important to aware that relationships with mdwpd may r	52	0.909
23	It is important to be aware of the relationship style of mdw	23	0.884
36	When I have worked for a long period of time with mdwpd I ca	36	0.820
63	Understanding of mdwpdis gained by usin reflective processes	63	0.712
66	Increased understanding of mdwpd is obtained by ignoring per	66	0.688
68	My understanding of mdwpd may be different from other profes	68	0.652
72	Understanding mdwpd is gained through self reflection	72	0.611
73	Understanding mdwpd is gained through by identifying and res	73	0.511
21	Mdwpd will try to elicit responses from me which are similar	21	0.503
77	Mdwpd may cope with with a lack of control in the past by at	77	0.432
69	Mdwpd often repeat past dynamics which are acted out in thei	69	0.424
6	The response to boundaries in mdwpd, often provides an oppor	6	0.386
16	Mdwpd often make grandiose claims about themselves to protec	16	0.344
48	Experiencing somatic difficulties () when working working wi	48	0.288
5	If female staff spend too much time with one man dwpd it can	5	0.287
51	It is self defeatingto see mdwpd in terms of a challenge tha	51	0.226
40	I recognise relationship difficulties with mdwpd when a I ex	40	0.154
65	Understanding of mdwpd is gained by exploring and examining	65	0.109
25	Mdwpd create staff stereotypes to make it easier to do thing	25	0.089
8	Mdwpd fantasise jealously about the successful relationships	8	0.039
64	Understanding of mdwpd is gained by addressing transference.	64	0.031
70	The ward environmental context may replicate traumatic past.	70	0.031
11	Female MHN's can be lulled into a false sense of security by	11	-0.053
29	Compared to myself the majority of female MHN's are more lik	29	-0.060

Normalized Factor Scores - For Factor Three.

Normalized Factor Scores -- For Factor 3

No.	Statement	No.	Z-SCORES
12	Setting boundaries and limits with mdwpd has been difficult	12	-0.116
58	Due to insufficient basic nurse training problems occur when	58	-0.118
59	Mdwpd are negatively affected by media stereotypes which onl	59	-0.123
33	Mdwpd can make you feel emotionally raped.	33	-0.141
17	Mdwpd are very sophisticated in getting other patients to at	17	-0.149
18	I often have to find coping strategies to protect myself fro	18	-0.168
82	A caring nursing role with mdwpd will be dramatically eroded	82	-0.178
2	Diagnostic labels make it easier to work with mdwpd.	2	-0.213
22	Sometimes I find that I have colluded with mdwpd because of	22	-0.231
38	Mdwpd elicit feelings of guilt when they set you up to rejec	38	-0.339
20	Mdwpd often make me feel that I don't care enough for them.	20	-0.400
19	Mdwpd concern me because of their ability to humiliate me.	19	-0.447
43	You maybe missing something if you are not shocked by mdwpd.	43	-0.459
7	It is important to aware of the gender preference of mdwpd a	7	-0.570
27	Mdwpd have difficulty maintaining a trusting/honest relation	27	-0.751
14	The dual responsibilities of therapy and security cause diff	14	-0.860
15	Mdwpd do not consider all their options when problem solving	15	-0.903
60	Understanding is gained through consistent resonses to mdwpd	60	-0.927
45	It can be difficult to determine what feelings belong to mdw	45	-0.948
50	It is easier to see the negatives rather than the positive a	50	-0.969
74	Understanding why mdwpd sekk out certain types of relationsh	74	-0.992
81	Decisions should be acted on consistently when with mdwpd.	81	-1.000
28	At times, I find myself conforming to staff group behaviour	28	-1.037
1	Mdwpd have difficulty establishing trusting relationships be	1	-1.078
35	Mdwpd will attempt to use a variety of extreme strategies to	35	-1.090
61	It isimportant to gather information about how mdwpd coped w	61	-1.099
78	You should ignore the negative feelings in your relationship	78	-1.107
56	Being seduced into feeling something special by mdwpd may no	56	-1.190
4	When working with mdwpd you need to be constantly aware that	4	-1.214
26	Sometimes I find that I have colluded with mdwpd because it	26	-1.218
57	When working with mdwpd I am reluctant use a reflective/supe	57	-1.312
62	It is important to gather information about significant chil	62	-1.332
55	To confide in someone else about your relationship difficult	55	-1.392
67	Mdwpd will often give unreliable accounts so it is important	67	-1.426
79	Before acting on a new understanding in your relationship wi	79	-1.434
31	Mdwpd minimise their behaviour and attempt to draw others in	31	-1.453
53	Without adaquate training, working with mdwpd can be very da	53	-1.673
54	I sometimes do not report relationship difficulties when wor	54	-1.718
37	Mdwpd have difficulty thinking of the consequences of their	37	-2.176

B Sorts/Factor Four Grid

-6	-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5	+6
50	**51**	**55**	37	15	1	38	20	14	22	**28**	**32**	**30**
36	**13**	**54**	78	19	81	8	16	25	24	**29**	**33**	**40**
39	**43**	**4**	77	74	72	47	12	9	27	**31**	**3**	**41**
	35	**5**	56	53	18	49	21	10	44	**42**	**71**	
		45	57	70	11	63	59	2	65	**46**		
			48	62	26	66	64	58	69			
			67	61	6	68	73	17	75			
				23	60	7	76	80				
					52	34	79					
						82						

B Sorts/Factor Four Grid

-6	-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5	+6
50 It easier to see the negatives rather than the positive aspects of MDwPD.	**51 It is self-defeating to see MDwPD in terms of a challenge that you will not be defeated by.**	**55 To confide in someone else about your relationship difficulties with MDwPD feels like a weakness.**	37 MdwPD have difficulty thinking of the consequences of their actions	15 MdwPD have difficulty thinking of the consequences of their actions	1 MdwPD have difficulty in establishing trusting relationships because they have learnt to use avoidant strategies due to past rejection.	38 MdwPD elicit feelings of guilt when they set you up to reject them.	20 MdwPD often make me feel that I do not care enough for them.	14 The dual responsibilities of therapy and security cause difficulties in my relationship with MDwPD.	22 Sometimes I find that have colluded with MDwPD because of a lack of information/support.	**28 At times, I find myself conforming to staff group behaviour which is outside my character and can prove offensive to MDwPD.**	**32 MdwPD are egocentric**	**30 MdwPD have a lack of empathy for the feelings of others**
36 When I have worked for a long period of time with MDwPD I can become desensitised to their behaviour.	**13 It is difficult working with MDwPD because they don't appear to want to change.**	**54 I sometimes do not report relationship difficulties when working with MDwPD for fear of the potential consequences.**	78 You should ignore the negative feelings in your relationship with MDwPD until it becomes too much.	19 MdwPD concern me because of their ability to humiliate me	81 Decisions should be acted on consistently when working with MDwPD.	8 MdwPD fantasise jealously about the successful relationships you have.	16 MdwPD often make grandiose claims about themselves to protect them from feelings of vulnerability.	25 MdwPD create staff stereotypes to make it easier to do things to them	24 It is important to understand yourself before working with MDwPD, otherwise relationship difficulties may increase.	**29 Compared to myself the majority of female mental health nurses are more likely to have their boundaries eroded by MdwPD.**	**33 MdwPD can make you feel emotionally raped.**	**40 I recognise relationship difficulties with MDwPD when I experience feelings which are uncharacteristic of me.**
39 MdwPD use drugs and alcohol excessively as a coping mechanism.	**43 You may be missing something if you are not shocked by MDwPD.**	**4 When working with MdwPD you need to be constantly aware that they can be charming, manipulative and seductive.**	77 MdwPD may cope with a lack of control in the past by attempting to control others in the present.	74 Understanding why MDwPD seek out certain types of relationships is important	72 Understanding of MDwPD is gained through self-reflection.	47 MdwPD will express their difficulties in very indirect ways.	12 Setting boundaries and limits with MDwPD has been difficult because my basic nurse training did not prepare me sufficiently.	9 MdwPD attempt to undermine your authority.	27 MdwPD have difficulty maintaining a trusting/honest relationship which limits a therapeutic alliance	**31 MdwPD minimise their behaviour and attempt to draw others into their minimisation.**	**3 When working with MDwPD you can never judge anything purely on face value**	**41 It is easier to recognise relationship difficulties with MDwPD when consulting with the collective expertise of the staff group.**
	35 MdwPD will attempt to use a variety of extreme strategies to elicit a caring response from others.	**5 If female staff spend too much time with one man DwPD it can cause jealousy and acting out behaviour in others.**	56 Being seduced into feeling special by MDwPD may not seem like a problem at the time	53 Without adequate training, working with MDwPD can be very damaging	18 I often need to find coping strategies to protect myself from attacks by MDwPD.	49 MdwPD present an opportunity to understand them when they violate a boundary.	21 MdwPD will try to elicit responses from me which are similar to significant people from their past.	10 MdwPD have difficulty negotiating.	44 Supervision is important to explore the impact upon yourself of the sometimes horrific histories that MDwPD present.	**42 Failure to recognise relationship difficulties with MDwPD can occur when failing to observe their life long script/narrative.**	**71 Understanding MdwPD is evolving rapidly hence the importance of maintaining a contemporary knowledge base.**	
		45 It can be difficult to determine what feelings belong to MDwPD and what belongs to oneself.	57 When working with MDwPD I am reluctant to use a reflective/ supervision process with others for fear of being interpreted negatively.	70 The ward environmental context may replicate traumatic past experiences for MDwPD	11 Female Mental Health Nurses can be lulled into a false sense of security by MDwPD.	63 Understand of MDwPD is gained by using reflective processes within group supervision.	59 MdwPD are negatively affected by media stereotypes which only highlight extreme behaviours.	2 Diagnostic labels make it easier to work with MdwPD	65 Understand of MDwPD is gained by exploring and examining their distinction between fantasy and reality.	**46 Without sufficient feedback from others it can be difficult to challenge and support MDwPD.**		
			48 Experiencing somatic difficulties (e.g. Stomach churning, headaches etc) when working with MdwPD may indicate a problem in the relationship.	62 My understanding of a MDwPD may be different from other professionals and should be integrated through discussion.	26 Sometimes I find that I have colluded with MDwPD because it felt safe	66 Increased understanding of MDwPD is obtained by ignoring pejorative labels and relating to them as individuals.	64 Understanding of MDwPD is gained by addressing transference relationships	58 Due to insufficient basic nurse training problems occur when attempting to identify relationship difficulties with MDwPD.	69 Due to insufficient basic nurse training problems occur when attempting to identify relationship difficulties with MDwPD.			
			67 MdwPD will often give unreliable accounts so it is important to obtain a comprehensive history from a variety of sources.	61 It is important to gather information about how MdwPD coped with adverse childhood experiences.	6 The response to boundaries in MDwPD, often provides an opportunity to understand their feelings about deeper issues.	68 My understanding of a MDwPD may be different from other professionals and should be integrated through discussion.	73 Understanding of MDwPD is gained through identifying and responding accordingly to the individual's schema.	17 MdwPD are very sophisticated in getting other patients to attempt to make my life a misery.	75 Seemingly insignificant information about MDwPD may be very relevant within a reflective practice group.			
				23 It is important to be aware of the relationship style of MDwPD because it could evoke unresolved feelings belonging to myself.	60 Understanding is gained through the consistent responses MDwPD elicit in their relationships with others.	7 It is important to be aware of the gender preference of MDwPD as it may have a significance in their historical dynamic.	76 The information imparted and not imparted may have equal significance in understanding MDwPD.	80 When working with MDwPD you should constantly reappraise the direction of the relationship.				
					52 It is important to be aware that relationships with MDwPD may result in addressing aspects of ourselves.	34 MdwPD do not understand that they have a problem.	79 Before acting on a new understanding in your relationship with MDwPD you should consult with your peer group.					
						82 A caring nursing role with MDwPD will be dramatically eroded by the challenging nature of their relationships						

Normalized Factor Scores - For Factor Four.

Normalized Factor Scores -- For Factor 4

No.	Statement	No.	Z-SCORES
30	Mdwpd have a lack of empathy for the feelings of others.	30	1.929
40	I recognise relationship difficulties with mdwpd when a I ex	40	1.929
41	It is easier to recognise relationship difficulties with mdw	41	1.929
32	Mdwpd are egocentric.	32	1.607
33	Mdwpd can make you feel emotionally raped.	33	1.607
3	When working with mdwpd you can never judge anything on face	3	1.607
71	Understanding mdwpd is evolving rapidly hence the importance	71	1.607
28	At times, I find myself conforming to staff group behaviour	28	1.286
29	Compared to myself the majority of female MHN's are more lik	29	1.286
31	Mdwpd minimise their behaviour and attempt to draw others in	31	1.286
42	Failure to recognise relationship difficulties with mdwpd ca	42	1.286
46	Without sufficient feedback from others it can be difficult	46	1.286
22	Sometimes I find that I have colluded with mdwpd because of	22	0.964
24	It is important to understand yourself before working with m	24	0.964
27	Mdwpd have difficulty maintaining a trusting/honest relation	27	0.964
44	Supervision is important to explore the impact upon yourself	44	0.964
65	Understanding of mdwpd is gained by exploring and examining	65	0.964
69	Mdwpd often repeat past dynamics which are acted out in thei	69	0.964
75	Seemingly insignificant information about mdwpd maybe be ver	75	0.964
14	The dual responsibilities of therapy and security cause diff	14	0.643
25	Mdwpd create staff stereotypes to make it easier to do thing	25	0.643
9	Mdwpd attempt to undermine your authority.	9	0.643
10	Mdwpd have difficulty negotiating.	10	0.643
2	Diagnostic labels make it easier to work with mdwpd.	2	0.643
58	Due to insufficient basic nurse training problems occur when	58	0.643
17	Mdwpd are very sophisticated in getting other patients to at	17	0.643
80	When working with mdwpd you should constantly reappraise the	80	0.643
20	Mdwpd often make me feel that I don't care enough for them.	20	0.321
16	Mdwpd often make grandiose claims about themselves to protec	16	0.321
12	Setting boundaries and limits with mdwpd has been difficult	12	0.321
21	Mdwpd will try to elicit responses from me which are similar	21	0.321
59	Mdwpd are negatively affected by media stereotypes which onl	59	0.321
64	Understanding of mdwpd is gained by addressing transference.	64	0.321
73	Understanding mdwpd is gained through by identifying and res	73	0.321
76	The information imparted and not imparted may have equal sig	76	0.321
79	Before acting on a new understanding in your relationship wi	79	0.321
38	Mdwpd elicit feelings of guilt when they set you up to rejec	38	0.000
8	Mdwpd fantasise jealously about the successful relationships	8	0.000
47	Mdwpd will express their difficulties in very indirect ways.	47	0.000
49	Mdwpd present an opportunity to undertsand them when they vi	49	0.000
63	Understanding of mdwpdis gained by usin reflective processes	63	0.000
66	Increased understanding of mdwpd is obtained by ignoring per	66	0.000
68	My understanding of mdwpd may be different from other profes	68	0.000

Normalized Factor Scores - For Factor Four.

Normalized Factor Scores -- For Factor 4

No.	Statement	No.	Z-SCORES
7	It is important to aware of the gender preference of mdwpd a	7	0.000
34	Mdwpd do not understand that they have a problem.	34	0.000
82	A caring nursing role with mdwpd will be dramatically eroded	82	0.000
52	It is important to aware that relationships with mdwpd may r	52	-0.321
60	Understanding is gained through consistent resonses to mdwpd	60	-0.321
6	The response to boundaries in mdwpd, often provides an oppor	6	-0.321
26	Sometimes I find that I have colluded with mdwpd because it	26	-0.321
11	Female MHN's can be lulled into a false sense of security by	11	-0.321
18	I often have to find coping strategies to protect myself fro	18	-0.321
72	Understanding mdwpd is gained through self reflection	72	-0.321
81	Decisions should be acted on consistently when with mdwpd.	81	-0.321
1	Mdwpd have difficulty establishing trusting relationships be	1	-0.321
23	It is important to be aware of the relationship style of mdw	23	-0.643
61	It isimportant to gather information about how mdwpd coped w	61	-0.643
62	It is important to gather information about significant chil	62	-0.643
70	The ward environmental context may replicate traumatic past.	70	-0.643
53	Without adaquate training, working with mdwpd can be very da	53	-0.643
74	Understanding why mdwpd sekk out certain types of relationsh	74	-0.643
19	Mdwpd concern me because of their ability to humiliate me.	19	-0.643
15	Mdwpd do not consider all their options when problem solving	15	-0.643
67	Mdwpd will often give unreliable accounts so it is important	67	-0.964
48	Experiencing somatic difficulties () when working working wi	48	-0.964
57	When working with mdwpd I am reluctant use a reflective/supe	57	-0.964
56	Being seduced into feeling something special by mdwpd may no	56	-0.964
77	Mdwpd may cope with with a lack of control in the past by at	77	-0.964
78	You should ignore the negative feelings in your relationship	78	-0.964
37	Mdwpd have difficulty thinking of the consequences of their	37	-0.964
45	It can be difficult to determine what feelings belong to mdw	45	-1.286
5	If female staff spend too much time with one man dwpd it can	5	-1.286
4	When working with mdwpd you need to be constantly aware that	4	-1.286
54	I sometimes do not report relationship difficulties when wor	54	-1.286
55	To confide in someone else about your relationship difficult	55	-1.286
35	Mdwpd will attempt to use a variety of extreme strategies to	35	-1.607
43	You maybe missing something if you are not shocked by mdwpd.	43	-1.607
13	It is difficult working with mdwpd because they don't appear	13	-1.607
51	It is self defeatingto see mdwpd in terms of a challenge tha	51	-1.607
39	Mdwpd use drugs and alcohol excessively as a coping mechanis	39	-1.929
36	When I have worked for a long period of time with mdwpd I ca	36	-1.929
50	It is easier to see the negatives rather than the positive a	50	-1.929

B Sorts/Factor Five Grid

-6	-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5	+6
30	**66**	**37**	27	28	81	42	29	24	38	**7**	**17**	**13**
23	**61**	**49**	1	54	79	6	36	33	9	**2**	**18**	**39**
14	**78**	**31**	40	74	26	52	11	44	10	**41**	**20**	**47**
	71	**48**	4	67	16	25	51	3	69	**46**	**32**	
		35	45	22	68	8	56	50	75	**82**		
			34	62	63	59	58	53	77			
			43	60	21	64	70	76	80			
				57	15	65	73	12				
					55	72	19					
						5						

B Sorts/Factor Five Grid

-6	-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5	+6
30 MdwPD have a lack of empathy for the feelings of others.	**66 Increased understanding of MDwPD is obtained by ignoring pejorative labels and relating to them as individuals.**	**37 MdwPD have difficulty thinking of the consequences of their actions.**	27 MdwPD have difficulty maintaining a trusting/honest relationship which limits a therapeutic alliance.	28 At times, I find myself conforming to staff group behaviour which is outside my character and can prove offensive to MDwPD.	81 Decisions should be acted on consistently when working with MDwPD.	42 Failure to recognise relationship difficulties with MDwPD can occur when failing to observe their life long script/narrative.	29 Compared to myself the majority of female mental health nurses are more likely to have their boundaries eroded by MdwPD.	24 It is important to understand yourself before working with MDwPD, otherwise relationship difficulties may increase.	38 MdwPD elicit feelings of guilt when they set you up to reject them.	**7 It is important to be aware of the gender preference of MDwPD as it may have a significance in their historical dynamic.**	**17 MdwPD are very sophisticated in getting other patients to attempt to make my life a misery.**	**13 It is difficult working with MDwPD because they don't appear to want to change.**
23 It is important to be aware of the relationship style of MDwPD because it could evoke unresolved feelings belonging to myself.	**61 It is important to gather information about how MdwPD coped with adverse childhood experiences.**	**49 MdwPD present an opportunity to understand them when they violate a boundary.**	1 MdwPD have difficulty in establishing trusting relationships because they have learnt to use avoidant strategies due to past rejection.	54 I sometimes do not report relationship difficulties when working with MDwPD for fear of the potential consequences.	79 Before acting on a new understanding in your relationship with MDwPD you should consult with your peer group.	6 The response to boundaries in MDwPD, often provides an opportunity to understand their feelings about deeper issues.	36 When I have worked for a long period of time with MDwPD I can become desensitised to their behaviour.	33 MdwPD can make you feel emotionally raped.	9 MdwPD attempt to undermine your authority.	**2 Diagnostic labels make it easier to work with MdwPD.**	**18 I often need to find coping strategies to protect myself from attacks by MDwPD.**	**39 MdwPD use drugs and alcohol excessively as a coping mechanism.**
14 The dual responsibilities of therapy and security cause difficulties in my relationship with MDwPD.	**78 You should ignore the negative feelings in your relationship with MDwPD until it becomes too much.**	**31 MdwPD minimise their behaviour and attempt to draw others into their minimisation.**	40 I recognise relationship difficulties with MDwPD when I experience feelings which are uncharacteristic of me	74 Understanding why MDwPD seek out certain types of relationships is important.	26 Sometimes I find that I have colluded with MDwPD because it felt safe.	52 It is important to be aware that relationships with MDwPD may result in addressing aspects of ourselves.	11 Female Mental Health Nurses can be lulled into a false sense of security by MDwPD.	44 Supervision is important to explore the impact upon yourself of the sometimes horrific histories that MDwPD present.	10 MdwPD have difficulty negotiating.	**41 It is easier to recognise relationship difficulties with MDwPD when consulting with the collective expertise of the staff group.**	**20 MdwPD often make me feel that I do not care enough for them.**	**47 MdwPD will express their difficulties in very indirect ways.**
	71 Understanding MdwPD is evolving rapidly hence the importance of maintaining a contemporary knowledge base.	**48 Experiencing somatic difficulties (e.g. Stomach churning, headaches etc) when working with MdwPD may indicate a problem in the relationship.**	4 When working with MdwPD you need to be constantly aware that they can be charming, manipulative and seductive.	67 MdwPD will often give unreliable accounts so it is important to obtain a comprehensive history from a variety of sources.	16 MdwPD often make grandiose claims about themselves to protect them from feelings of vulnerability.	25 MdwPD create staff stereotypes to make it easier to do things to them	51 It is self-defeating to see MDwPD in terms of a challenge that you will not be defeated by.	3 When working with MDwPD you can never judge anything purely on face value.	69 MdwPD often repeat past dynamics which are acted out within their current environment.	**46 Without sufficient feedback from others it can be difficult to challenge and support MDwPD.**	**32 MdwPD are egocentric.**	
		35 MdwPD will attempt to use a variety of extreme strategies to elicit a caring response from others.	45 It can be difficult to determine what feelings belong to MDwPD and what belongs to oneself.	22 Sometimes I find that have colluded with MDwPD because of a lack of information/support.	68 My understanding of a MDwPD may be different from other professionals and should be integrated through discussion.	8 MdwPD fantasise jealously about the successful relationships you have.	56 Being seduced into feeling special by MDwPD may not seem like a problem at the time.	50 It easier to see the negatives rather than the positive aspects of MDwPD.	75 Seemingly insignificant information about MDwPD may be very relevant within a reflective practice group.	**82 A caring nursing role with MDwPD will be dramatically eroded by the challenging nature of their relationships.**		
			34 MdwPD do not understand that they have a problem.	62 It is important to gather information about significant childhood relationships in MDwPD.	63 Understand of MDwPD is gained by using reflective processes within group supervision.	59 MdwPD are negatively affected by media stereotypes which only highlight extreme behaviours.	58 Due to insufficient basic nurse training problems occur when attempting to identify relationship difficulties with MDwPD.	53 Without adequate training, working with MDwPD can be very damaging.	77 MdwPD may cope with a lack of control in the past by attempting to control others in the present.			
			43 You may be missing something if you are not shocked by MDwPD.	60 Understanding is gained through the consistent responses MDwPD elicit in their relationships with others.	21 MdwPD will try to elicit responses from me which are similar to significant people from their past.	64 Understanding of MDwPD is gained by addressing transference relationships.	70 The ward environmental context may replicate traumatic past experiences for MDwPD.	76 The information imparted and not imparted may have equal significance in understanding MDwPD.	80 When working with MDwPD you should constantly reappraise the direction of the relationship.			
				57 When working with MDwPD I am reluctant to use a reflective/ supervision process with others for fear of being interpreted negatively.	15 MdwPD do not consider all their options when problem solving.	65 Understand of MDwPD is gained by exploring and examining their distinction between fantasy and reality.	73 Understanding of MDwPD is gained through identifying and responding accordingly to the individual's schema.	12 Setting boundaries and limits with MDwPD has been difficult because my basic nurse training did not prepare me sufficiently.				
					55 To confide in someone else about your relationship difficulties with MDwPD feels like a weakness.	72 Understand of MDwPD is gained through self-reflection.	19 MdwPD concern me because of their ability to humiliate me.					
						5 If female staff spend too much time with one man DwPD it can cause jealousy and acting out behaviour in others.						

Normalized Factor Scores - For Factor Five.

Normalized Factor Scores -- For Factor 5

No.	Statement	No.	Z-SCORES
13	It is difficult working with mdwpd because they don't appear	13	1.929
39	Mdwpd use drugs and alcohol excessively as a coping mechanis	39	1.929
47	Mdwpd will express their difficulties in very indirect ways.	47	1.929
17	Mdwpd are very sophisticated in getting other patients to at	17	1.607
18	I often have to find coping strategies to protect myself fro	18	1.607
20	Mdwpd often make me feel that I don't care enough for them.	20	1.607
32	Mdwpd are egocentric.	32	1.607
7	It is important to aware of the gender preference of mdwpd a	7	1.286
2	Diagnostic labels make it easier to work with mdwpd.	2	1.286
41	It is easier to recognise relationship difficulties with mdw	41	1.286
46	Without sufficient feedback from others it can be difficult	46	1.286
82	A caring nursing role with mdwpd will be dramatically eroded	82	1.286
38	Mdwpd elicit feelings of guilt when they set you up to rejec	38	0.964
9	Mdwpd attempt to undermine your authority.	9	0.964
10	Mdwpd have difficulty negotiating.	10	0.964
69	Mdwpd often repeat past dynamics which are acted out in thei	69	0.964
75	Seemingly insignificant information about mdwpd maybe be ver	75	0.964
77	Mdwpd may cope with with a lack of control in the past by at	77	0.964
80	When working with mdwpd you should constantly reappraise the	80	0.964
24	It is important to understand yourself before working with m	24	0.643
33	Mdwpd can make you feel emotionally raped.	33	0.643
44	Supervision is important to explore the impact upon yourself	44	0.643
3	When working with mdwpd you can never judge anything on face	3	0.643
50	It is easier to see the negatives rather than the positive a	50	0.643
53	Without adaquate training, working with mdwpd can be very da	53	0.643
76	The information imparted and not imparted may have equal sig	76	0.643
12	Setting boundaries and limits with mdwpd has been difficult	12	0.643
29	Compared to myself the majority of female MHN's are more lik	29	0.321
36	When I have worked for a long period of time with mdwpd I ca	36	0.321
11	Female MHN's can be lulled into a false sense of security by	11	0.321
51	It is self defeatingto see mdwpd in terms of a challenge tha	51	0.321
56	Being seduced into feeling something special by mdwpd may no	56	0.321
58	Due to insufficient basic nurse training problems occur when	58	0.321
70	The ward environmental context may replicate traumatic past.	70	0.321
73	Understanding mdwpd is gained through by identifying and res	73	0.321
19	Mdwpd concern me because of their ability to humiliate me.	19	0.321
42	Failure to recognise relationship difficulties with mdwpd ca	42	0.000
6	The response to boundaries in mdwpd, often provides an oppor	6	0.000
52	It is important to aware that relationships with mdwpd may r	52	0.000
25	Mdwpd create staff stereotypes to make it easier to do thing	25	0.000
8	Mdwpd fantasise jealously about the successful relationships	8	0.000
59	Mdwpd are negatively affected by media stereotypes which onl	59	0.000
64	Understanding of mdwpd is gained by addressing transference.	64	0.000

Normalized Factor Scores - For Factor Five.

Normalized Factor Scores -- For Factor 5

No.	Statement	No.	Z-SCORES
65	Understanding of mdwpd is gained by exploring and examining	65	0.000
72	Understanding mdwpd is gained through self reflection	72	0.000
5	If female staff spend too much time with one man dwpd it can	5	0.000
55	To confide in someone else about your relationship difficult	55	-0.321
15	Mdwpd do not consider all their options when problem solving	15	-0.321
21	Mdwpd will try to elicit responses from me which are similar	21	-0.321
63	Understanding of mdwpdis gained by usin reflective processes	63	-0.321
68	My understanding of mdwpd may be different from other profes	68	-0.321
16	Mdwpd often make grandiose claims about themselves to protec	16	-0.321
26	Sometimes I find that I have colluded with mdwpd because it	26	-0.321
79	Before acting on a new understanding in your relationship wi	79	-0.321
81	Decisions should be acted on consistently when with mdwpd.	81	-0.321
57	When working with mdwpd I am reluctant use a reflective/supe	57	-0.643
60	Understanding is gained through consistent resonses to mdwpd	60	-0.643
62	It is important to gather information about significant chil	62	-0.643
22	Sometimes I find that I have colluded with mdwpd because of	22	-0.643
67	Mdwpd will often give unreliable accounts so it is important	67	-0.643
74	Understanding why mdwpd sekk out certain types of relationsh	74	-0.643
54	I sometimes do not report relationship difficulties when wor	54	-0.643
28	At times, I find myself conforming to staff group behaviour	28	-0.643
43	You maybe missing something if you are not shocked by mdwpd.	43	-0.964
34	Mdwpd do not understand that they have a problem.	34	-0.964
45	It can be difficult to determine what feelings belong to mdw	45	-0.964
4	When working with mdwpd you need to be constantly aware that	4	-0.964
40	I recognise relationship difficulties with mdwpd when a I ex	40	-0.964
1	Mdwpd have difficulty establishing trusting relationships be	1	-0.964
27	Mdwpd have difficulty maintaining a trusting/honest relation	27	-0.964
35	Mdwpd will attempt to use a variety of extreme strategies to	35	-1.286
48	Experiencing somatic difficulties () when working working wi	48	-1.286
31	Mdwpd minimise their behaviour and attempt to draw others in	31	-1.286
49	Mdwpd present an opportunity to undertsand them when they vi	49	-1.286
37	Mdwpd have difficulty thinking of the consequences of their	37	-1.286
71	Understanding mdwpd is evolving rapidly hence the importance	71	-1.607
78	You should ignore the negative feelings in your relationship	78	-1.607
61	It isimportant to gather information about how mdwpd coped w	61	-1.607
66	Increased understanding of mdwpd is obtained by ignoring per	66	-1.607
14	The dual responsibilities of therapy and security cause diff	14	-1.929
23	It is important to be aware of the relationship style of mdw	23	-1.929
30	Mdwpd have a lack of empathy for the feelings of others.	30	-1.929

B Sorts/Factor Six Grid

-6	-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5	+6
35	**29**	**53**	**62**	20	43	63	51	39	**36**	**7**	**76**	**44**
27	**34**	**14**	**2**	57	31	64	73	48	**80**	**37**	**77**	**5**
4	**79**	**81**	**12**	4	15	16	32	65	**10**	**9**	**11**	**21**
	67	**56**	74	6	49	18	41	66	40	**75**	**24**	
		61	72	26	46	8	59	68	52	**13**		
			71	50	28	45	38	69	3			
			1	70	47	17	22	82	30			
				54	25	60	23	33				
					78	19	58					
						55						

B Sorts/Factor Six Grid

-6	-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5	+6
35 MdwPD will attempt to use a variety of extreme strategies to elicit a caring response from others.	**29 Compared to myself the majority of female mental health nurses are more likely to have their boundaries eroded by MdwPD.**	**53 Without adequate training, working with MDwPD can be very damaging.**	**62 It is important to gather information about significant childhood relationships in MDwPD.**	20 MdwPD often make me feel that I do not care enough for them	43 You may be missing something if you are not shocked by MDwPD.	63 Understand of MDwPD is gained by using reflective processes within group supervision.	51 It is self-defeating to see MDwPD in terms of a challenge that you will not be defeated by.	39 MdwPD use drugs and alcohol excessively as a coping mechanism.	**36 When I have worked for a long period of time with MDwPD I can become desensitised to their behaviour.**	**7 It is important to be aware of the gender preference of MDwPD as it may have a significance in their historical dynamic**	**76 The information imparted and not imparted may have equal significance in understanding MDwPD. B76**	**44 Supervision is important to explore the impact upon yourself of the sometimes horrific histories that MDwPD present.**
27 MdwPD have difficulty maintaining a trusting/honest relationship which limits a therapeutic alliance.	**34 MdwPD do not understand that they have a problem**	**14 The dual responsibilities of therapy and security cause difficulties in my relationship with MDwPD.**	**2 Diagnostic labels make it easier to work with MdwPD.**	57 When working with MDwPD I am reluctant to use a reflective/ supervision process with others for fear of being interpreted negatively.	31 MdwPD minimise their behaviour and attempt to draw others into their minimisation	64 Understanding of MDwPD is gained by addressing transference relationships.	73 Understanding of MDwPD is gained through identifying and responding accordingly to the individual's schema.	48 Experiencing somatic difficulties (e.g. Stomach churning, headaches etc) when working with MdwPD may indicate a problem in the relationship.	**80 When working with MDwPD you should constantly reappraise the direction of the relationship.**	**37 MdwPD have difficulty thinking of the consequences of their actions.**	**77 MdwPD may cope with a lack of control in the past by attempting to control others in the present.**	**5 If female staff spend too much time with one man DwPD it can cause jealousy and acting out behaviour in others.**
4 When working with MdwPD you need to be constantly aware that they can be charming, manipulative and seductive.	**79 Before acting on a new understanding in your relationship with MDwPD you should consult with your peer group.**	**81 Decisions should be acted on consistently when working with MDwPD.**	**12 Setting boundaries and limits with MDwPD has been difficult because my basic nurse training did not prepare me sufficiently.**	4 When working with MdwPD you need to be constantly aware that they can be charming, manipulative and seductive.	15 MdwPD do not consider all their options when problem solving.	16 MdwPD often make grandiose claims about themselves to protect them from feelings of vulnerability.	32 MdwPD are egocentric.	65 Understand of MDwPD is gained by exploring and examining their distinction between fantasy and reality.	**10 MdwPD have difficulty negotiating.**	**9 MdwPD attempt to undermine your authority.**	**11 Female Mental Health Nurses can be lulled into a false sense of security by MDwPD.**	**21 MdwPD will try to elicit responses from me which are similar to significant people from their past**
	67 MdwPD will often give unreliable accounts so it is important to obtain a comprehensive history from a variety of sources.	**56 Being seduced into feeling special by MDwPD may not seem like a problem at the time**	74 The response to boundaries in MDwPD, often provides an opportunity to understand their feelings about deeper issues.	6 The response to boundaries in MDwPD, often provides an opportunity to understand their feelings about deeper issues.	49 MdwPD present an opportunity to understand them when they violate a boundary.	18 I often need to find coping strategies to protect myself from attacks by MDwPD.	41 It is easier to recognise relationship difficulties with MDwPD when consulting with the collective expertise of the staff group.	66 Increased understanding of MDwPD is obtained by ignoring pejorative labels and relating to them as individuals.	40 I recognise relationship difficulties with MDwPD when I experience feelings which are uncharacteristic of me.	**75 Seemingly insignificant information about MDwPD may be very relevant within a reflective practice group.**	**24 It is important to understand yourself before working with MDwPD, otherwise relationship difficulties may increase.**	
		61 It is important to gather information about how MdwPD coped with adverse childhood experiences.	72 Understanding of MDwPD is gained through self-reflection.	26 Sometimes I find that I have colluded with MDwPD because it felt safe.	46 Without sufficient feedback from others it can be difficult to challenge and support MDwPD.	8 MdwPD fantasise jealously about the successful relationships you have	59 MdwPD are negatively affected by media stereotypes which only highlight extreme behaviours.	68 My understanding of a MDwPD may be different from other professionals and should be integrated through discussion.	52 It is important to be aware that relationships with MDwPD may result in addressing aspects of ourselves.	**13 It is difficult working with MDwPD because they don't appear to want to change.**		
			71 Understanding MdwPD is evolving rapidly hence the importance of maintaining a contemporary knowledge base.	50 It easier to see the negatives rather than the positive aspects of MDwPD	28 At times, I find myself conforming to staff group behaviour which is outside my character and can prove offensive to MDwPD.	45 It can be difficult to determine what feelings belong to MDwPD and what belongs to oneself.	38 MdwPD elicit feelings of guilt when they set you up to reject them.	69 MdwPD often repeat past dynamics which are acted out within their current environment.	3 When working with MDwPD you can never judge anything purely on face value.			
			1 MdwPD have difficulty in establishing trusting relationships because they have learnt to use avoidant strategies due to past rejection.	70 The ward environmental context may replicate traumatic past experiences for MDwPD.	47 MdwPD will express their difficulties in very indirect ways.	17 MdwPD are very sophisticated in getting other patients to attempt to make my life a misery	22 Sometimes I find that have colluded with MDwPD because of a lack of information/support	82 A caring nursing role with MDwPD will be dramatically eroded by the challenging nature of their relationships.	30 MdwPD have a lack of empathy for the feelings of others.			
				54 I sometimes do not report relationship difficulties when working with MDwPD for fear of the potential consequences.	25 MdwPD create staff stereotypes to make it easier to do things to them	60 Understanding is gained through the consistent responses MDwPD elicit in their relationships with others.	23 It is important to be aware of the relationship style of MDwPD because it could evoke unresolved feelings belonging to myself.	33 MdwPD can make you feel emotionally raped				
					78 You should ignore the negative feelings in your relationship with MDwPD until it becomes too much.	19 MdwPD concern me because of their ability to humiliate me.	58 Due to insufficient basic nurse training problems occur when attempting to identify relationship difficulties with MDwPD.					
						55 To confide in someone else about your relationship difficulties with MDwPD feels like a weakness.						

Normalized Factor Scores - For Factor Six.

Normalized Factor Scores -- For Factor 6

No.	Statement	No.	Z-SCORES
44	Supervision is important to explore the impact upon yourself	44	2.012
5	If female staff spend too much time with one man dwpd it can	5	1.783
21	Mdwpd will try to elicit responses from me which are similar	21	1.758
76	The information imparted and not imparted may have equal sig	76	1.680
77	Mdwpd may cope with with a lack of control in the past by at	77	1.680
11	Female MHN's can be lulled into a false sense of security by	11	1.656
24	It is important to understand yourself before working with m	24	1.529
7	It is important to aware of the gender preference of mdwpd a	7	1.426
37	Mdwpd have difficulty thinking of the consequences of their	37	1.377
9	Mdwpd attempt to undermine your authority.	9	1.299
75	Seemingly insignificant information about mdwpd maybe be ver	75	1.197
13	It is difficult working with mdwpd because they don't appear	13	1.147
36	When I have worked for a long period of time with mdwpd I ca	36	1.094
80	When working with mdwpd you should constantly reappraise the	80	1.070
10	Mdwpd have difficulty negotiating.	10	1.045
40	I recognise relationship difficulties with mdwpd when a I ex	40	0.992
52	It is important to aware that relationships with mdwpd may r	52	0.967
3	When working with mdwpd you can never judge anything on face	3	0.943
30	Mdwpd have a lack of empathy for the feelings of others.	30	0.943
39	Mdwpd use drugs and alcohol excessively as a coping mechanis	39	0.943
48	Experiencing somatic difficulties () when working working wi	48	0.840
65	Understanding of mdwpd is gained by exploring and examining	65	0.713
66	Increased understanding of mdwpd is obtained by ignoring per	66	0.713
68	My understanding of mdwpd may be different from other profes	68	0.586
69	Mdwpd often repeat past dynamics which are acted out in thei	69	0.561
82	A caring nursing role with mdwpd will be dramatically eroded	82	0.561
33	Mdwpd can make you feel emotionally raped.	33	0.484
51	It is self defeatingto see mdwpd in terms of a challenge tha	51	0.459
73	Understanding mdwpd is gained through by identifying and res	73	0.459
32	Mdwpd are egocentric.	32	0.357
41	It is easier to recognise relationship difficulties with mdw	41	0.357
59	Mdwpd are negatively affected by media stereotypes which onl	59	0.357
38	Mdwpd elicit feelings of guilt when they set you up to rejec	38	0.177
22	Sometimes I find that I have colluded with mdwpd because of	22	0.152
23	It is important to be aware of the relationship style of mdw	23	0.152
58	Due to insufficient basic nurse training problems occur when	58	0.127
63	Understanding of mdwpdis gained by usin reflective processes	63	0.102
64	Understanding of mdwpd is gained by addressing transference.	64	0.102
16	Mdwpd often make grandiose claims about themselves to protec	16	0.000
18	I often have to find coping strategies to protect myself fro	18	0.000
8	Mdwpd fantasise jealously about the successful relationships	8	0.000
45	It can be difficult to determine what feelings belong to mdw	45	-0.025
17	Mdwpd are very sophisticated in getting other patients to at	17	-0.102

Normalized Factor Scores - For Factor Six.

Normalized Factor Scores -- For Factor 6

No.	Statement	No.	Z-SCORES
60	Understanding is gained through consistent resonses to mdwpd	60	-0.102
19	Mdwpd concern me because of their ability to humiliate me.	19	-0.152
55	To confide in someone else about your relationship difficult	55	-0.180
78	You should ignore the negative feelings in your relationship	78	-0.205
25	Mdwpd create staff stereotypes to make it easier to do thing	25	-0.229
47	Mdwpd will express their difficulties in very indirect ways.	47	-0.229
28	At times, I find myself conforming to staff group behaviour	28	-0.254
46	Without sufficient feedback from others it can be difficult	46	-0.254
49	Mdwpd present an opportunity to undertsand them when they vi	49	-0.357
15	Mdwpd do not consider all their options when problem solving	15	-0.381
31	Mdwpd minimise their behaviour and attempt to draw others in	31	-0.381
43	You maybe missing something if you are not shocked by mdwpd.	43	-0.381
54	I sometimes do not report relationship difficulties when wor	54	-0.586
70	The ward environmental context may replicate traumatic past.	70	-0.586
50	It is easier to see the negatives rather than the positive a	50	-0.611
26	Sometimes I find that I have colluded with mdwpd because it	26	-0.611
6	The response to boundaries in mdwpd, often provides an oppor	6	-0.635
42	Failure to recognise relationship difficulties with mdwpd ca	42	-0.713
57	When working with mdwpd I am reluctant use a reflective/supe	57	-0.815
20	Mdwpd often make me feel that I don't care enough for them.	20	-0.893
1	Mdwpd have difficulty establishing trusting relationships be	1	-0.918
71	Understanding mdwpd is evolving rapidly hence the importance	71	-0.943
72	Understanding mdwpd is gained through self reflection	72	-0.943
74	Understanding why mdwpd sekk out certain types of relationsh	74	-0.967
12	Setting boundaries and limits with mdwpd has been difficult	12	-1.020
2	Diagnostic labels make it easier to work with mdwpd.	2	-1.172
62	It is important to gather information about significant chil	62	-1.197
61	It isimportant to gather information about how mdwpd coped w	61	-1.197
56	Being seduced into feeling something special by mdwpd may no	56	-1.221
81	Decisions should be acted on consistently when with mdwpd.	81	-1.221
14	The dual responsibilities of therapy and security cause diff	14	-1.274
53	Without adaquate training, working with mdwpd can be very da	53	-1.324
67	Mdwpd will often give unreliable accounts so it is important	67	-1.426
79	Before acting on a new understanding in your relationship wi	79	-1.553
34	Mdwpd do not understand that they have a problem.	34	-1.631
29	Compared to myself the majority of female MHN's are more lik	29	-1.656
4	When working with mdwpd you need to be constantly aware that	4	-1.680
27	Mdwpd have difficulty maintaining a trusting/honest relation	27	-1.758
35	Mdwpd will attempt to use a variety of extreme strategies to	35	-2.012

B Sorts/Factor Seven Grid

-6	-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5	+6
53	**4**	**37**	47	26	66	48	65	22	**73**	**30**	**17**	**44**
35	**74**	**61**	28	52	71	20	13	31	**58**	**63**	**41**	**45**
54	**27**	**12**	19	50	40	32	72	77	**69**	**38**	**79**	**16**
	56	**67**	25	60	21	2	46	49	76	**5**	**34**	
		23	7	42	36	62	6	82	11	**9**		
			78	43	57	64	39	70	75			
			81	55	14	3	80	18	8			
				24	29	15	33	10				
					59	1	68					
						51						

B Sorts/Factor Seven Grid

-6	-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5	+6
53 Without adequate training, working with MDwPD can be very damaging	**4 When working with MdwPD you need to be constantly aware that they can be charming, manipulative and seductive.**	**37 MdwPD have difficulty thinking of the consequences of their actions.**	47 MdwPD will express their difficulties in very indirect ways.	26 Sometimes I find that I have colluded with MDwPD because it felt safe.	66 Increased understanding of MDwPD is obtained by ignoring pejorative labels and relating to them as individuals.	48 Experiencing somatic difficulties (e.g. Stomach churning, headaches etc) when working with MdwPD may indicate a problem in the relationship.	65 Understand of MDwPD is gained by exploring and examining their distinction between fantasy and reality.	22 Sometimes I find that have colluded with MDwPD because of a lack of information/support.	**73 Understanding of MDwPD is gained through identifying and responding accordingly to the individual's schema.**	**30 MdwPD have a lack of empathy for the feelings of others.**	**17 MdwPD are very sophisticated in getting other patients to attempt to make my life a misery.**	**44 Supervision is important to explore the impact upon yourself of the sometimes horrific histories that MDwPD present.**
35 MdwPD will attempt to use a variety of extreme strategies to elicit a caring response from others.	**74 Understanding why MDwPD seek out certain types of relationships is important**	**61 It is important to gather information about how MdwPD coped with adverse childhood experiences.**	28 At times, I find myself conforming to staff group behaviour which is outside my character and can prove offensive to MDwPD.	52 It is important to be aware that relationships with MDwPD may result in addressing aspects of ourselves.	71 Understanding MdwPD is evolving rapidly hence the importance of maintaining a contemporary knowledge base.	20 MdwPD often make me feel that I do not care enough for them.	13 It is difficult working with MDwPD because they don't appear to want to change.	31 MdwPD minimise their behaviour and attempt to draw others into their minimisation.	**58 Due to insufficient basic nurse training problems occur when attempting to identify relationship difficulties with MDwPD.**	**63 Understand of MDwPD is gained by using reflective processes within group supervision.**	**41 It is easier to recognise relationship difficulties with MDwPD when consulting with the collective expertise of the staff group.**	**45 It can be difficult to determine what feelings belong to MDwPD and what belongs to oneself.**
54 I sometimes do not report relationship difficulties when working with MDwPD for fear of the potential consequences.	**27 MdwPD have difficulty maintaining a trusting/honest relationship which limits a therapeutic alliance.**	**12 Setting boundaries and limits with MDwPD has been difficult because my basic nurse training did not prepare me sufficiently.**	19 MdwPD concern me because of their ability to humiliate me.	50 It easier to see the negatives rather than the positive aspects of MDwPD.	40 I recognise relationship difficulties with MDwPD when I experience feelings which are uncharacteristic of me.	32 MdwPD are egocentric.	72 Understanding of MDwPD is gained through self-reflection.	77 MdwPD may cope with a lack of control in the past by attempting to control others in the present	**69 MdwPD often repeat past dynamics which are acted out within their current environment.**	**38 MdwPD elicit feelings of guilt when they set you up to reject them.**	**79 Before acting on a new understanding in your relationship with MDwPD you should consult with your peer group.**	**16 MdwPD often make grandiose claims about themselves to protect them from feelings of vulnerability.**
	56 Being seduced into feeling special by MDwPD may not seem like a problem at the time	**67 MdwPD will often give unreliable accounts so it is important to obtain a comprehensive history from a variety of sources.**	25 MdwPD create staff stereotypes to make it easier to do things to them	60 Understanding is gained through the consistent responses MDwPD elicit in their relationships with others.	21 MdwPD will try to elicit responses from me which are similar to significant people from their past.	2 Diagnostic labels make it easier to work with MdwPD.	46 Without sufficient feedback from others it can be difficult to challenge and support MDwPD.	49 MdwPD present an opportunity to understand them when they violate a boundary	76 The information imparted and not imparted may have equal significance in understanding MDwPD.	**5 If female staff spend too much time with one man DwPD it can cause jealousy and acting out behaviour in others.**	**34 MdwPD do not understand that they have a problem**	
		23 It is important to be aware of the relationship style of MDwPD because it could evoke unresolved feelings belonging to myself.	7 It is important to be aware of the gender preference of MDwPD as it may have a significance in their historical dynamic.	42 Failure to recognise relationship difficulties with MDwPD can occur when failing to observe their life long script/narrative.	36 When I have worked for a long period of time with MDwPD I can become desensitised to their behaviour.	62 It is important to gather information about significant childhood relationships in MDwPD	6 The response to boundaries in MDwPD, often provides an opportunity to understand their feelings about deeper issues.	82 A caring nursing role with MDwPD will be dramatically eroded by the challenging nature of their relationships	11 Female Mental Health Nurses can be lulled into a false sense of security by MDwPD.	**9 MdwPD attempt to undermine your authority.**		
			78 You should ignore the negative feelings in your relationship with MDwPD until it becomes too much.	43 You may be missing something if you are not shocked by MDwPD.	57 When working with MDwPD I am reluctant to use a reflective/ supervision process with others for fear of being interpreted negatively.	64 Understanding of MDwPD is gained by addressing transference relationships	39 MdwPD use drugs and alcohol excessively as a coping mechanism.	70 The ward environmental context may replicate traumatic past experiences for MDwPD	75 Seemingly insignificant information about MDwPD may be very relevant within a reflective practice group.			
			81 Decisions should be acted on consistently when working with MDwPD	55 To confide in someone else about your relationship difficulties with MDwPD feels like a weakness.	14 The dual responsibilities of therapy and security cause difficulties in my relationship with MDwPD.	3 When working with MDwPD you can never judge anything purely on face value.	80 When working with MDwPD you should constantly reappraise the direction of the relationship.	18 I often need to find coping strategies to protect myself from attacks by MDwPD.	8 MdwPD fantasise jealously about the successful relationships you have.			
				24 It is important to understand yourself before working with MDwPD, otherwise relationship difficulties may increase.	29 Compared to myself the majority of female mental health nurses are more likely to have their boundaries eroded by MdwPD.	15 MdwPD do not consider all their options when problem solving.	33 MdwPD can make you feel emotionally raped.	10 MdwPD have difficulty negotiating.				
					59 MdwPD are negatively affected by media stereotypes which only highlight extreme behaviours.	1 MdwPD have difficulty in establishing trusting relationships because they have learnt to use avoidant strategies due to past rejection.	68 My understanding of a MDwPD may be different from other professionals and should be integrated through discussion.					
						51 It is self-defeating to see MDwPD in terms of a challenge that you will not be defeated by.						

Normalized Factor Scores - For Factor Seven.

Normalized Factor Scores -- For Factor 7

No.	Statement	No.	Z-SCORES
44	Supervision is important to explore the impact upon yourself	44	2.216
45	It can be difficult to determine what feelings belong to mdw	45	1.800
16	Mdwpd often make grandiose claims about themselves to protec	16	1.708
17	Mdwpd are very sophisticated in getting other patients to at	17	1.708
41	It is easier to recognise relationship difficulties with mdw	41	1.662
79	Before acting on a new understanding in your relationship wi	79	1.524
34	Mdwpd do not understand that they have a problem.	34	1.478
30	Mdwpd have a lack of empathy for the feelings of others.	30	1.431
63	Understanding of mdwpdis gained by usin reflective processes	63	1.386
38	Mdwpd elicit feelings of guilt when they set you up to rejec	38	1.292
5	If female staff spend too much time with one man dwpd it can	5	1.108
9	Mdwpd attempt to undermine your authority.	9	1.108
73	Understanding mdwpd is gained through by identifying and res	73	1.108
58	Due to insufficient basic nurse training problems occur when	58	1.016
69	Mdwpd often repeat past dynamics which are acted out in thei	69	1.016
76	The information imparted and not imparted may have equal sig	76	0.924
11	Female MHN's can be lulled into a false sense of security by	11	0.923
75	Seemingly insignificant information about mdwpd maybe be ver	75	0.832
8	Mdwpd fantasise jealously about the successful relationships	8	0.831
22	Sometimes I find that I have colluded with mdwpd because of	22	0.784
31	Mdwpd minimise their behaviour and attempt to draw others in	31	0.739
77	Mdwpd may cope with with a lack of control in the past by at	77	0.739
49	Mdwpd present an opportunity to undertsand them when they vi	49	0.647
82	A caring nursing role with mdwpd will be dramatically eroded	82	0.647
70	The ward environmental context may replicate traumatic past.	70	0.645
18	I often have to find coping strategies to protect myself fro	18	0.600
10	Mdwpd have difficulty negotiating.	10	0.553
65	Understanding of mdwpd is gained by exploring and examining	65	0.508
13	It is difficult working with mdwpd because they don't appear	13	0.508
72	Understanding mdwpd is gained through self reflection	72	0.463
46	Without sufficient feedback from others it can be difficult	46	0.416
6	The response to boundaries in mdwpd, often provides an oppor	6	0.369
39	Mdwpd use drugs and alcohol excessively as a coping mechanis	39	0.323
80	When working with mdwpd you should constantly reappraise the	80	0.323
33	Mdwpd can make you feel emotionally raped.	33	0.277
68	My understanding of mdwpd may be different from other profes	68	0.232
48	Experiencing somatic difficulties () when working working wi	48	0.231
20	Mdwpd often make me feel that I don't care enough for them.	20	0.229
32	Mdwpd are egocentric.	32	0.139
2	Diagnostic labels make it easier to work with mdwpd.	2	0.000
62	It is important to gather information about significant chil	62	-0.047
64	Understanding of mdwpd is gained by addressing transference.	64	-0.092
3	When working with mdwpd you can never judge anything on face	3	-0.184

Normalized Factor Scores - For Factor Seven.

Normalized Factor Scores -- For Factor 7

No.	Statement	No.	Z-SCORES
15	Mdwpd do not consider all their options when problem solving	15	-0.185
1	Mdwpd have difficulty establishing trusting relationships be	1	-0.231
51	It is self defeatingto see mdwpd in terms of a challenge tha	51	-0.369
59	Mdwpd are negatively affected by media stereotypes which onl	59	-0.369
29	Compared to myself the majority of female MHN's are more lik	29	-0.369
14	The dual responsibilities of therapy and security cause diff	14	-0.371
57	When working with mdwpd I am reluctant use a reflective/supe	57	-0.416
36	When I have worked for a long period of time with mdwpd I ca	36	-0.416
21	Mdwpd will try to elicit responses from me which are similar	21	-0.461
40	I recognise relationship difficulties with mdwpd when a I ex	40	-0.461
71	Understanding mdwpd is evolving rapidly hence the importance	71	-0.461
66	Increased understanding of mdwpd is obtained by ignoring per	66	-0.553
24	It is important to understand yourself before working with m	24	-0.553
55	To confide in someone else about your relationship difficult	55	-0.555
43	You maybe missing something if you are not shocked by mdwpd.	43	-0.555
42	Failure to recognise relationship difficulties with mdwpd ca	42	-0.600
60	Understanding is gained through consistent resonses to mdwpd	60	-0.647
50	It is easier to see the negatives rather than the positive a	50	-0.647
52	It is important to aware that relationships with mdwpd may r	52	-0.692
26	Sometimes I find that I have colluded with mdwpd because it	26	-0.694
81	Decisions should be acted on consistently when with mdwpd.	81	-0.739
78	You should ignore the negative feelings in your relationship	78	-0.784
7	It is important to aware of the gender preference of mdwpd a	7	-0.831
25	Mdwpd create staff stereotypes to make it easier to do thing	25	-0.923
19	Mdwpd concern me because of their ability to humiliate me.	19	-0.924
28	At times, I find myself conforming to staff group behaviour	28	-0.969
47	Mdwpd will express their difficulties in very indirect ways.	47	-0.969
23	It is important to be aware of the relationship style of mdw	23	-1.016
67	Mdwpd will often give unreliable accounts so it is important	67	-1.108
12	Setting boundaries and limits with mdwpd has been difficult	12	-1.200
61	It isimportant to gather information about how mdwpd coped w	61	-1.200
37	Mdwpd have difficulty thinking of the consequences of their	37	-1.384
56	Being seduced into feeling something special by mdwpd may no	56	-1.478
27	Mdwpd have difficulty maintaining a trusting/honest relation	27	-1.570
74	Understanding why mdwpd sekk out certain types of relationsh	74	-1.662
4	When working with mdwpd you need to be constantly aware that	4	-1.708
54	I sometimes do not report relationship difficulties when wor	54	-1.847
35	Mdwpd will attempt to use a variety of extreme strategies to	35	-1.986
53	Without adaquate training, working with mdwpd can be very da	53	-2.216

Appendix Nine: Glossary of Q Methodology Terms.

Q- Methodology Term.	Definition
Concourse.	All the things that can be said and thoughts about the topic in question among the population the study is about.
Condition of instruction.	Where participants adopt different positions from which to sort - such as 'as I saw things as a teenager', 'how my therapist would see it', 'as I see it when I am happy'.
Correlation (inter-correlation).	The statistical comparison of one person's Q sort with another person's Q sort to determine the level of similarity or difference.
Distribution grid	The grid produces a shape of quasi-normal distribution (bell shaped curve) into which the participants sort the statements.
Eigenvalue.	A factors' significance (importance) is estimated by the sum of its squared factor loadings (eigenvalue divided by the number of variates (Q-sorts in Q, traits in R) equals the percentage of the total variance accounted for by a factor). As previously stated, an Eigenvalue greater than 1.00 is considered strong, whilst those with a lesser value are considered weak.
Exemplificatory (expl var) Q-sort.	Those Q-sorts that only correlates significantly with just one factor, used (generally with others) as the basis for constructing a 'best estimate' of the sorting pattern for that Factor.

Factor	A viewpoint that can be considered to be part of the same „family resemblance", represented by participants whose Q sorts are similar.
Factor array.	• The viewpoint of the participants loading onto a factor in relation to the position of all items placed on the grid. • A composite Q-sort, (significant cluster), creating one for each factor. This is achieved by the calculation of factor weights to establish the factor scores, the factor scores in turn are then computed as 'z-scores' but for convenience are converted to whole numbers (+5 to -5) to facilitate comparisons between factor arrays.
Q-factor analysis.	The form of regular factor analysis devised by Stephenson, where it is whole patterns Q-sorting are correlated with each other.
Factor account.	A short summary outlining the key elements that distinguish the viewpoint of discourse being expressed by the Factor.
Factor loading score	Indicates the degree of association with another participant. The significance of the loading of a factor is determined by the eigenvalue criteria, whereby a factors' significance (importance) is estimated by the sum of its squared factor loadings (eigenvalue divided by the number of variates (Q-sorts in Q, traits in R) equals the percentage of the total variance accounted for by a factor).

Factor Rotation.	'Varimax' which is a method of orthogonal (when each factor is independent and at right angles to another) rotation, with the purpose of maximising the purity of saturation of as many variates (Q-sorts) as possible. Thus, rotation provides a change in the vantage point in which the data is viewed.
Fixed grid/fixed distribution.	Where the participants have a forced choice in terms of the position of the statements within the grid.
Negative loadings.	Indicate a rejection of a factor perspective. For example, in the case of my study, non-conformity of nurses' to a particular attitude to personality disorder.
Positive loading.	Indicates their shared subjectivity with others on that factor
Q-items.	Usually statements, selected as a sample of the concourse for the study. These are what are sorted.
Q-sample	In Q-methodology the 'sample' is composed of the items in the Q-sort and the people who complete the Q-sort are equivalent to, in R-ethodology, the experimental condition.
Q-set.	The set of Q-items that will be presented to participants. In order to arrive at the Q set 'sampling' has to take place. Sampling (generating items) may be the 'research question' driven or part of the formulation of the research question. The sources of sampling will vary study by study, but the following are commonly used: individual and/or group interviews, literature review (professional and/or popular), transmitted media output or the cultural experience of the researchers.

Q-sorting	The process of placing the items of the Q-set into the positions on the Q-Grid.
Q-sort	• The pattern produced when the completed set of items are placed onto the Q-Grid and recorded. • The rank-ordering of a set of statements from agree to disagree.
Variance.	A statistical term indicating how much of the variability in the whole data-set can be 'explained' by the factor.
Varimax	Is a method of orthogonal (when each factor is independent and at right angles to another) rotation, with the purpose of maximising the purity of saturation of as many variates (Q-sorts) as possible. Thus, rotation provides a change in the vantage point in which the data is viewed.
Z-scores	In most research, factor interpretation is undertaken on the basis of factor loading, however Q is based primarily on factor scores. The aim is to generate a **'factor array'** (significant cluster), creating one for each factor. This is achieved by the calculation of factor weights to establish the factor scores, the factor scores in turn are then computed as **'z-scores'** but for convenience are converted to whole numbers (+5 to -5) to facilitate comparisons between factor arrays.