Exploring the past, present, and future of training for staff working with individuals diagnosed with borderline personality disorder

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Exploring the past, present, and future of training for staff working with individuals diagnosed with borderline personality disorder

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Declaration

I hereby state that the work presented in this thesis is my own and reference to other work has been cited with full details. No part of this thesis has been submitted for any other qualification at another university.

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Signature: A H Shah Date: 03/01/2023

General Abstract

Background

Mental health professionals have reported that they often lack the knowledge and skills to work with individuals diagnosed with borderline personality disorder. Hence, it is crucial to provide BPD-specific training, so service users receive optimal care from competent professionals. However, a range of training programmes is available with no evidence about their components. It is necessary, at first, to determine staff training needs, which can form the basis for training development and ensure it is appropriately targeted.

Aim

The thesis had two aims. The first was to understand the training needs of mental health professionals working with individuals diagnosed with borderline personality disorder and to identify effective training components. The second was to reflect and discuss the role of non-verbal cues in qualitative interviews through videoconferencing to inform other researchers working in this area.

Method

Three studies were conducted: 1) the scoping review mapped and analysed the components of available training programmes for staff working with individuals diagnosed with BPD from 18 peer-reviewed journal articles using Framework Synthesis, 2) the qualitative study interviewed 17 mental health professionals about their training needs and their perspectives on effective training components and analysed the data using Reflexive Thematic Analysis, 3) the methodological study discussed how non-verbal data could influence online qualitative interviews through examples and researcher reflections from the qualitative study.

Findings

Scoping review

Eleven training components were charted and mapped through the scoping review: type of training, duration, setting, aim, trainer, trainees, materials and teaching methods, content (knowledge, skills, service user perspectives), supervision, challenges for implementation, and evaluation/feedback.

Qualitative study

The socio-ecological model was used as a framework to categorise staff training needs at a multi-faceted level, which generated the following overarching themes and themes: intrapersonal needs (knowledge-related needs are subjective, understanding is fundamental, skills for working with service users and colleagues), needs at the organisational level (practical arrangements for training, systemic issues that influence training application and sustainability), and needs at the national level (consistency in training nationwide, discipline-specific areas for training development). During the interviews, participants were asked if they were a training developer how would they design their ideal training; participant responses produced 13 training components.

Methodological study

It illustrated through examples and researcher reflections how different non-verbal cues (chronemics, kinesics, proxemics, paralinguistics, environmental factors, and physical appearance) could influence online qualitative interviews. Since these play a role in online data collection, researchers must incorporate thinking about the kind of data they wish to collect and analyse during the design phase of the research. If they choose to incorporate non-verbal cues, there are several ways to achieve this by using practical resources such as matrices and software, involving linguists, and practising reflexivity.

Conclusion

Many training programmes are available for staff working with individuals diagnosed with BPD. However, they need to be reported in more detail as there is insufficient information about their components. Furthermore, service users and staff need to be involved in training development to make it more efficient in practice and to ensure that their needs are reflected in training. Staff training needs are related to knowledge, understanding, and skills embedded within the larger organisational and national context, which needs consideration. It is hoped that the training components reviewed and those produced by participants will provide a reference point for training developers. Lastly, the methodological paper concluded that researchers need a more nuanced understanding of data in online qualitative research, as non-verbal data could influence the interviews.

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Note for examiners

This thesis has been reported in accordance with the guidelines of the Thesis Handbook as part of the Doctorate program. The handbook requires the papers to be written in the format of a peer-reviewed academic journal; hence, the Personality and Mental Health journal has been chosen, and author guidelines are presented in Appendix A.

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List of Abbreviations

BPD- Borderline Personality Disorder

DSM- 5- Diagnostic and Statistical Manual Fifth Edition

DSM-5-TR- Diagnostic and Statistical Manual Fifth Edition Text Revision

DBT- Dialectical Behaviour Therapy

MBT- Mentalisation-based Therapy

MDD- Major Depressive Disorder

GPM- Good Psychiatric Management

UK- United Kingdom

KUS- Knowledge, Understanding, and Skills Framework

QuADS- The Quality assessment with diverse studies

GPs- General Practitioners

PRISMA- Preferred Reporting Items for Systematic reviews and Meta-Analyses

PRISMA-ScR- Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews

AMED- The Allied and Complementary Medicine Database

EUPD- Emotionally Unstable Personality Disorder

ICD- International Classification of Diseases

MBT-S- Mentalisation-Based Therapy Skills Training

STEPPS- Systems Training for Emotional Predictability and Problem Solving

CC- Clinicians Connections

NIMHE- The National Institute for Mental Health in England

NICE- National Institute for Health and Care Excellence

TA- Thematic Analysis

NHS- National Health Service

COREQ- the Consolidated criteria for reporting qualitative research checklist

CPD- Continuing Professional Development

KUF- Knowledge and Understanding Framework

IPE- Interprofessional Education

RCPsych- Royal college of Psychiatrists

APA- American Psychological Association

FACS- Facial Action Coding System

GDPR- General Data Protection Regulation

ERA- Experience, Reflection, Action

Chapter 1- General Introduction

The thesis topic is training for mental health professionals working with individuals diagnosed with borderline personality disorder (BPD). The introduction chapter will establish the key concepts and discuss the current research and debates in the field. It will also summarise the three papers within the thesis while presenting their main arguments and findings.

The term 'borderline' was first coined in 1938 by psychoanalyst Adolf Stern to describe a group of people that did not fit in the existing 'neurotic' or 'psychotic' diagnostic categorisations and did not respond well to psychotherapy. (1) It has since been referred to as a borderline state, borderline personality organisation, borderline syndrome, and then disorder. (2) According to the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition Text Revision (DSM-5-TR), (3) BPD is now defined as a mental health condition characterised by a pervasive pattern of unstable interpersonal relationships, self-image, and affect, and marked impulsivity arising in early adulthood and present in a variety of contexts.[1] The prevalence of BPD in the general population is between 0.7-2% (4, 5) and 15-20% in inpatient settings. (6, 7) The symptoms usually appear in late adolescence or early adulthood. (8) The causes are variable, with a possible role of biological factors such as genetics, brain development, and brain functioning and environmental factors such as childhood abuse and neglect. (9, 10) A meta-analysis of 97 studies showed that individuals diagnosed with BPD are 13 times more likely to report childhood adversity than the non-clinical population, particularly emotional abuse and neglect. (11)

The difficulties experienced by individuals diagnosed with BPD include rapidly

[1] An individual needs to present with at least 5 of the following symptoms: frantic efforts to avoid real or imagined abandonment, pattern of unstable and intense interpersonal relationships, identity disturbance, impulsivity or self-damaging behaviours, recurrent suicidal behaviours, affective instability, chronic feelings of emptiness, inappropriate and intense anger, and transient, stress-related paranoid ideation or severe dissociative symptoms.

changing intense emotions, which tend to be related to fear of abandonment and rejection, chronic feelings of emptiness, and an unstable sense of self. [1] They might also engage in recurrent self-harm or experience thoughts of suicide. [1] The adjusted risk for having a recent suicide attempt with a diagnosis of BPD was reported to be 13.55 in a large-scale survey, the highest across all mental health disorders. [12] The treatment for these difficulties usually involves psychological therapy such as Dialectical Behaviour Therapy (DBT) and Mentalisation-based Therapy (MBT). [4, 13, 14] Most individuals diagnosed with BPD experience a remission of the disorder, and many fully recover, according to long-term follow-up studies. [15]

Historically, a categorical system has been used to conceptualise BPD and other personality disorders based on the medical disease model. According to this conceptualisation, BPD is diagnosed based on a list of symptoms or criteria, meaning that the clinician examines the majority of an individual's symptoms, which leads to the diagnosis. [16] There are only two possible outcomes: an individual either has the diagnosis or does not. [17] This approach has been found to have clinical utility [18] as it facilitates communication among professionals, and between clinicians and clients/families; it is also clear and easy to use. [16] Various affective, cognitive, and impulsive symptoms might co-occur in the same person, which can be explained by the diagnosis. [19] Furthermore, BPD has been found as highly responsive to psychotherapy, so an accurate diagnosis can lead to better access to therapeutic approaches. [19] Some service users feel validated about their experiences after receiving the diagnosis, as it helps them understand their difficulties. [20] Lastly, this approach helps standardise research and organise public awareness. [21]

However, there are several concerns about a categorical approach. First, the reliability and validity of the diagnostic criteria have been criticised. [1] Second, BPD has high co-morbidity rates with other diagnoses and personality disorders, making it hard for

professionals to assign the correct diagnosis. [22] Third, there is much heterogeneity in symptoms; hence two service users correctly diagnosed may have little resemblance to each other, making diagnostic agreement challenging. [1] Fourth, there are views that the label is unhelpful because it leads to considerable stigma and reduced access to services. [8] Fifth, service users have expressed that it does not explain their symptoms accurately. [20] These drawbacks have been summarised well by Derksen [23] [p35], who stated that BPD is "clinically factual, empirically fictional and theoretically chaotic". Furthermore, Peter Tyrer [24] [p254] has claimed that the diagnosis "has no right to exist" and should be abolished.

In response to these criticisms, there has been a movement in the mental health field towards more dimensional models of conceptualising BPD and other personality disorders. The dimensional model views personality features on a continuum with varying degrees of impairment and functioning. There have been several dimensional models for diagnosing personality disorders, such as the Five-factor model (FFM), [25] and Cloninger's seven-factor model. [26] A meta-analytic review by Bornstein and Natoli [27] compared clinical utility ratings by clinicians of categorical and dimensional frameworks and found that dimensional models received more positive clinical utility ratings than categorical models.

A significant contribution to this movement towards dimensional models has been the Alternative Model of Personality Disorder (AMPD) by the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-5). [28] It is a hybrid dimensional-categorical approach to diagnosis characterised by dimensions of impairments in personality functioning and pathological traits, representing individual differences in addition to categories. [29] According to this system, a personality disorder diagnosis is warranted when the impairment of personality functioning (self and interpersonal functioning evaluated on a continuum) is at a moderate level or higher, while the pathological personality traits are used to describe the individual expression or specific features of the individual's difficulties. [28] In addition, the

system allows practitioners to derive any of the six traditional personality disorder categories based on combinations of functioning and traits. [28] Typical features of BPD, according to this model, are instability of self-image, personal goals, interpersonal relationships, and affects, accompanied by impulsivity, risk-taking, and/or hostility. [28]

The hybrid approach helps resolve the issue of co-morbidity across and heterogeneity within personality disorder categories [30] as it focuses on what is shared by all personality disorders while portraying individual features. [31] It provides more coverage [30] and comprehensive information about the individual's presenting difficulties. [32] As a result, it is seen as easily incorporated into clinical practice and aligned with clinical decision-making. [32] This is supported by an emerging yet promising evidence base for the AMPD. [33] A comprehensive review of 237 publications on functioning and maladaptive traits of the AMPD found acceptable interrater reliability and substantial convergent validity with a range of clinically relevant measures. [34]

While the AMPD is a step forward and addresses the shortcomings of the categorical approach, it is still incorporated in section 3, with the categorical model remaining the official model in DSM5-TR. This is because the APA Board of Trustees wish to preserve the continuity of current clinical practice, [31] and a complete change was seen as too radical. [33] There are some concerns that still need to be addressed before a complete shift to a dimensional or hybrid model occurs. [29] Firstly, while the hybrid model has shown high clinical utility, the process of matching the dimensional criteria to personality disorder constructs can be seen as complex. [35] Furthermore, it is unknown what the effects of these models will be on the stigmatisation and labelling issues of the categorical model. [16] There also needs to be more communication and training in dimensional approaches for mental health professionals. [21] Furthermore, the available training for health professionals working with individuals diagnosed with BPD utilises the categorical model to educate staff about the

BPD diagnosis and its criteria; categorical models are still prominently taught and applied in teaching and clinical areas. [21] Hence, while the current thesis acknowledges the benefits and potential of moving towards a dimensional conceptualisation of BPD and other personality disorders, it utilises the traditional categorical framework to conceptualise BPD.

Knowledge about the history of the diagnosis itself, and the confusion that underlies its meanings, can provide some explanation towards professionals' negative attitudes towards it and resistance to work with it. Structural stigma related to BPD is pervasive in health systems and is embedded in institutional policies, cultural norms, and practices. [36] There is consistent literature demonstrating negative staff attitudes towards service users diagnosed with BPD. [37-39] A study by Bodner et al. [40] revealed that compared to service users diagnosed with major depressive disorder (MDD), those with BPD were viewed as more selfish, manipulative, and dramatic by psychiatric hospital staff. Kling [41] stressed that service users and professionals come to the relationship expecting a negative experience. [42] Research has also shown that clinicians tend to withdraw from service users with BPD [43] and even deny providing treatment due to the 'difficult patient' status. [44] Furthermore, staff have reported feeling under-skilled, [38] lacking knowledge about BPD, [45, 46] and experiencing reduced confidence in working with this population. [47, 48] They have voiced their need for further training. [49]

The theory of planned behaviour by Ajzen [50] posits that behaviour is determined by an individual's intention to perform the behaviour (the motivation necessary to engage in the behaviour). This intention is impacted by determinants which are attitudes (the degree to which an individual has a favourable or unfavourable evaluation of the behaviour), subjective norms (the perceived social pressure to perform or not to perform the behaviour), and perceived behavioural control (the perceived ease or difficulty of performing the behaviour). [50] It leads to the idea that behaviour might be modified if the determinants, such as attitudes,

norms, and behaviour control, can be addressed. [51] One way to address these determinants would be through training for working with individuals diagnosed with BPD. Training could help change negative attitudes, reduce stigma, and equip staff with the knowledge and skills (increasing their self-efficacy) to improve service user experiences and outcomes.

According to patient rights and ethics, [52] service users have a right to be treated with high standards by professionals with the competencies to deliver optimal care. Hence, training is essential for professionals to provide good quality care to service users. Many training programmes have been developed for staff working with individuals diagnosed with BPD, such as DBT, [53] MBT, [54] Good Psychiatric Management (GPM), [55] along with other specialised workshops. [56, 57] Most of these training programmes have been evaluated using quantitative methods, such as pre and post-training questionnaires. [58] While they have been beneficial, there are some drawbacks. Staff have reported that the available training is inadequate [49] and not appropriately targeted. [48] Furthermore, the evidence to support the programmes is of poor-moderate methodological quality. [58] Moreover, the long-term effects of these programmes have not been evaluated, so it is unknown whether they lead to improved service user outcomes. [58]

A major issue has been the heterogeneity in the training programmes delivered. The components of the training programmes, such as the duration, setting, and trainer, all differ, and the effective components remain unknown and content uncertain. [38, 59] Another problem has been that the training programmes have been designed from established treatment models rather than the training needs of staff; hence, their applicability in practice remains questionable. Staff have also not been involved in training development, so their perspectives on training components remain unexplored.

In summary, it seems that the training programmes have been developed by trainers or professionals with an unclear rationale about their components. There is a need to step back

and identify staff training needs, which can form the basis for training development. It would ensure it is fit for purpose and meets their requirements regarding how they would apply it in practice. Al Ismail et al. [60] stated that conducting a needs assessment is more likely to lead to a change in practice as the learning is directly linked to personal and practice needs. Ludwikowska [61] illustrated a positive correlation between training needs analysis and employee efficiency; they suggested that if training needs analysis is properly conducted, then employee efficiency will increase because of training participation. Additionally, Sahoo and Mishra [62] found that conducting a training needs analysis significantly predicted the trainee's motivation to transfer training to practice with a moderate effect size. The Personality Disorder: no longer a diagnosis of exclusion policy by NIMHE also suggests that staff training should be appropriately targeted to their needs. [63]

Hence, two of the components of the current thesis aimed to understand the training needs of staff to ensure training is appropriately targeted and efficient in practice. It also aimed to identify effective training components from the perspective of staff and by reviewing the available training.

Specifically, the thesis comprises three papers: review, empirical, and methodological. The scoping review aimed to map and review the training programmes available for health professionals working with individuals diagnosed with BPD. Since the available training programmes are diverse, their content remains uncertain and components unidentified. [38,59] Hence, reviewing them gave an opportunity to synthesise and examine the training components, such as the duration, setting, and content, find gaps, make recommendations, and inform future training and research. Eighteen peer-reviewed journal articles that met inclusion/exclusion criteria were analysed using framework synthesis, and eleven training components were identified, synthesised, and examined in the review. It was found that a range of training programmes are available for health professionals working with individuals

diagnosed with BPD, and their training components are varied. However, the training programmes need to be reported in more detail, and there needs to be more service user involvement in design and implementation.

The empirical paper is a qualitative study that aimed to explore the specific training needs of mental health staff working with individuals diagnosed with BPD in inpatient settings in the United Kingdom (UK) and to identify the effective components of training from their perspective. Considering the training needs of staff would potentially lead to a change in practice [60] and ensure the training is appropriately targeted. [63] Furthermore, involving staff in training development ensures their priorities and needs are reflected, and increases the likelihood that the resources will be adopted in practice. [64] Seventeen qualified mental health professionals were recruited, and online semi-structured interviews were conducted. Reflexive Thematic Analysis was employed from a critical realist-contextualist position, and the analytic process was guided by the six phases by Braun and Clarke. [65] The training needs generated had the following overarching themes and themes: intrapersonal needs (knowledge-related needs are subjective, understanding is fundamental, skills for working with service users and colleagues), needs at the organisational level (practical arrangements for training, systemic issues that influence training application and sustainability), and needs at the national level (consistency in training nationwide, discipline-specific areas for training development). Additionally, participants designed their own training and generated 13 training components. A KUS (knowledge, understanding, and skills) framework is proposed from the study's findings, which could be used as a basis for BPD-related training and national policy. Furthermore, the components identified by participants can be used as a reference point for training developers. It was prominent that several organisation-level factors hinder training implementation, application, and maintenance, which need to be addressed urgently.

As a whole, the first two components of the thesis looked at the past, present, and future of BPD-related training by 1) reviewing the training programmes that have been delivered, 2) identifying current staff training needs and designing training collaboratively with staff, 3) and producing recommendations for organisations, researchers, training developers, and policymakers to inform future training. It is hoped that the ideas produced will support training development and implementation in this area and improve staff knowledge, understanding, skills, and, eventually, service user outcomes.

The thesis handbook required a paper which reflected on and discussed a methodological choice which informed other researchers working in the research area. Accordingly, the methodological paper explored further a limitation in the qualitative study related to the exposure to non-verbal cues in videoconferencing. This is because it became apparent at the end of data collection through the researcher's notes in a reflexive diary that non-verbal cues could have influenced the interview dynamics since the cameras were switched on during the interviews. It illustrated through examples and researcher reflections how different non-verbal cues (chronemics, kinesics, proxemics, paralinguistics, environmental factors, and physical appearance) could influence online data collection. It then argues for researchers to develop a more nuanced understanding of data and incorporate thinking about it during the design phase of online qualitative research. It concludes with different ways in which non-verbal data can be included in the research process using practical resources like matrices and software, involving linguists, and practising reflexivity. The thesis concludes with a reflexive statement where the researcher's influence on the research process is acknowledged and discussed.

The overall aims of the thesis were to review available staff training programmes for BPD, identify current staff training needs and explore their perspectives on training components. The objectives were 1) to synthesise and examine training components of

available training programmes, 2) to determine specific staff training needs and their ideas about training components, 3) to identify gaps and produce recommendations for training developers, researchers, services, policymakers, and educators 4) reflect on a methodological decision in the thesis.

Chapter 2, Review Paper- Training for health professionals working with individuals diagnosed with borderline personality disorder: a scoping review

Abstract

Background

The symptoms of borderline personality disorder present significant challenges for health professionals, who often feel they are not equipped with the knowledge and skills to work with this population. Hence, it is necessary to deliver adequate BPD-specific training that meets staff needs and improves service user care. However, the available training programmes are diverse, and their components remain unidentified. This scoping review mapped the training programmes available for health professionals working with individuals diagnosed with BPD and examined their components.

Data Sources

A systematic search (powered by EbscoHost Research Database) was performed in AMED, CINAHL, MEDLINE, APA PsycArticles, and APA PsycINFO.

Review Methods

The review included eighteen peer-reviewed journal articles that described or evaluated a training programme for health professionals working with individuals diagnosed with BPD following screening against inclusion/exclusion criteria. The Quality assessment with diverse studies (QuADS) appraisal tool was used to assess the quality of selected papers. Framework synthesis was employed as the method of analysis.

Results

Eleven training components were charted and mapped through the analysis: type of training, duration, setting, aim, trainer, trainees, materials and teaching methods, content (knowledge, skills, service user perspectives), supervision, challenges for implementation, and evaluation/feedback.

Conclusion

A range of training programmes are available for health professionals working with individuals diagnosed with BPD, and their training components are varied. The training needs to focus more on meeting service user needs and improving staff competence rather than changing negative attitudes. The training programmes need to be reported in more detail, and there needs to be more service user involvement in design and implementation.

Keywords

Training, health professionals, borderline personality disorder, BPD, scoping review.

Background

Borderline personality disorder is a mental health condition characterised by a pervasive pattern of unstable interpersonal relationships, self-image, and affect, and marked impulsivity. [3] Individuals diagnosed with BPD are usually treatment-seeking, with a prevalence of 12% in outpatient clinics [66] and 15-20% in inpatient settings. [6, 7] It is a debilitating condition affecting relationships, work, and quality of life [28] and is also highly stigmatised in society. [67] The present paper aimed to map and review the training

programmes [2] available for health professionals working with individuals diagnosed with BPD.

The emotional instability, self-destructive behaviours, and interpersonal difficulties central to BPD present significant challenges for health professionals. [48] The term 'health professionals' in this context refers to physical and mental health professionals providing care/health services to individuals diagnosed with BPD, such as general practitioners (GPs), nurses, psychologists, counsellors, psychiatrists, psychotherapists, and social care workers. Some challenges health professionals experience in managing specific behaviours by service users include acting out behaviours, repeated self-injurious behaviour and suicide attempts, [68] and team splitting and pushing boundaries. [41]

These challenges often lead to negative staff [3] attitudes towards service users, which is consistently and extensively reflected in the literature. [37-39] Health professionals have expressed negative views such as individuals with BPD are attention-seeking, [41] manipulative, [37] dangerous, [59] time-consuming, [45] deliberately not improving, [69] and like a "destructive whirlwind". [48] [p705] They have also reported feeling incompetent, threatened, challenged, angry, and anxious when working with this population. [70] These negative thoughts and feelings are evident in their behaviours towards service users, such as maintaining social distance, [43] rejection, [43] providing less empathic care, [40] and even denying treatment. [44] Research has found these negative experiences in different professional subgroups [71] and, in comparison, with affective disorders [69] and schizophrenia. [72, 73] In response to these attitudes, service users feel rejected, judged, stigmatised, discriminated against, and undeserving of care. [46, 74]

Staff-service user interactions can be understood as follows: Service users present with

[2] The term training programme is used for a specific training delivered in a study, whereas the term training is used to mean all training in general.
[3] The terms staff and health professionals are used interchangeably in this review.

‘difficult’ behaviours implicit to their diagnostic criteria, such as frequent self-harm, leading to health professionals’ negative cognitions, emotions, and behaviours such as being socially distant and rejecting. When service users experience these behaviours, they often feel undeserving of care and stigmatised, causing them to engage in further difficult behaviours confirming staff perceptions. Staff and service users often get into this cycle of interpersonal processes causing harm and affecting the quality of care received by service users. [40, 59]

Service users have a right to be treated with high standards by professionals who have the competencies to deliver optimal care. As per patient rights and ethics, [52] there inherently exists a patient-provider fiduciary relationship whereby the service user places trust in the acts of the professional and is based on the foundation that the professional is learned, skilled, and experienced in the subject of most importance to the service user. However, in the matter of BPD, health professionals often lack the knowledge and skills to respond efficiently to service user behaviours due to inadequate BPD-specific training, thus, conflicting with the patient-provider fiduciary relationship.

A qualitative study by Woollaston and Hixenbaugh [48] found that being ‘unable to help’ is one of the main reasons for staff’s negative attitudes towards service users diagnosed with BPD. The nurses who participated in O'Connell and Dowling's [49] qualitative study stated that the education and training linked to BPD were insufficient, and they desired further training on BPD and self-management. A survey by James and Cowman [75] found that only 3% of nurses out of a sample of 65 nurses reported having any BPD-specific training outside of their undergraduate degree, mostly consisting of a single lecture or workshop. It is not surprising, then, that health professionals experience strong internal reactions when working with this population; they are not equipped with the knowledge and skills. This lack of training has been identified and is consistent across different countries. [39]

Hence, it is imperative to deliver adequate BPD-specific staff training that provides

them with the knowledge and skills to improve service user care. [41] Additionally, the nature and characteristics of BPD are different from other personality disorders, such as difficulties in interpersonal relationships, rapidly changing presentation, and increased self-harm behaviours, which can affect interactions with staff; therefore, training needs to be specifically tailored for working with this client group. [76] Notably, health professionals are interested in attending BPD-specific training. A survey by Cleary et al. [38] found that 95% of health professionals were willing to spend one hour or more per month for training, and James and Cowman [75] found that 90% of nurses needed more training to increase their skill base. Based on a review of five studies that used Cleary et al.'s [38] survey questionnaire, Dickens et al. [39] found that 90-100% of respondents wanted more education and training; specifically, 51-76% wanted skills training workshops.

Several training programmes have been developed for health professionals working with individuals diagnosed with BPD over the years. Some of them are based on established treatments such as DBT, [53] MBT, [54] and GPM, [55] whereas others have been created specifically for working with this population. [56, 57] Whilst some of these training programmes have increased staff knowledge and competence, they have some drawbacks. A systematic review of interventions to improve nurses' attitudes found either no effect or small effect size for 74% of all measured outcomes, such as cognitive, affective, and behavioural. [58] The authors concluded by stating there is insufficient evidence of high quality to support the training programmes strongly. [58] Furthermore, studies have not evaluated whether these programmes eventually lead to clinical or organisational outcomes and improved service user care, so their long-term effectiveness remains unknown. [58]

A further issue has been the heterogeneity in training delivered. For example, Carmel et al.'s [77] training programme involved a DBT training delivered for ten days across 13 months providing DBT knowledge and skills. In contrast, a training programme by Clark et

al. [78] was a 90-minute training session based on Porr's neurobiological framework [79] delivered through a PowerPoint presentation, and the training programme by Krawitz and Rreal [80] was a 2-day foundation training designed explicitly for BPD utilising student-centred participatory learning. These examples highlight the diversity of the training programmes and their different components, such as duration, content, and teaching methods. A wide range of training programmes has caused their effective content to remain uncertain and its components unidentified. [38, 59]

Only one previous study has aimed to review the existing training programmes for BPD. [58] However, the review incorporated articles with training programmes delivered only to nurses and focused exclusively on attitude change. Furthermore, it did not include qualitative studies, excluding training programmes that had been qualitatively evaluated, even though the training description was available. [54, 81] Lastly, the objective of the review was to identify and appraise interventions methodologically rather than to review their specific components. [58] Hence, to date, large-scale mapping of the training components has not yet been conducted.

Since training is crucial for health professionals, and the available training programmes are diverse, it is necessary to identify and review the training programmes delivered. [38, 59] Reviewing the training programmes will give an opportunity to synthesise and examine the training components, such as the duration, setting, and content, which are currently in disarray, and provide future directions for training developers. Furthermore, it will allow us to identify knowledge gaps and research priorities for researchers. Hence, mapping what is already being delivered will enable us to determine the composition of BPD-related staff training, find gaps, make recommendations, and inform future training and research.

Present study

The present study aimed to map and review the training programmes available for health

professionals working with individuals diagnosed with BPD. Specifically, the objectives were 1) to systematically synthesise and examine the training components, for example, the duration, materials, teaching methods, and content, 2) to identify gaps in training components, and 3) to produce recommendations for training developers and researchers. The review question was: What training is available for health professionals working with individuals diagnosed with BPD, and what are its components?

A scoping review was conducted to answer the above research question. Scoping review, often known as 'mapping', is a process of summarising, synthesising, and disseminating a range of research evidence to illustrate the breadth and depth of a particular field, the way research is conducted, and to identify research gaps. [82, 83] Therefore, they are especially helpful when a body of literature has not yet been comprehensively reviewed or exhibits a complex or heterogeneous nature not amenable to a more precise systematic review. [84] Hence, epistemologically, compared to other types of review, a scoping review is the most suitable method that allows one to address the research question.

Method

The review involved the analysis of peer-reviewed journal articles; hence, it did not require institutional ethics review. An initial scoping search was conducted to become familiar with the literature. A review protocol was created, which can be made available upon request. The review is reported in accordance with the Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) Checklist. [85] PRISMA-ScR is a 22-item checklist that ensures transparent and detailed reporting.

Eligibility criteria

Table 1 below illustrates the eligibility criteria for the studies chosen in the review.

Inclusion criteria	Exclusion criteria
Described or evaluated a training programme delivered to health professionals who are working with individuals diagnosed with BPD	Focused on training in personality disorders in general
Details of the training components were provided	Described or evaluated interventions and treatment models aimed at service users
Peer-reviewed journal articles: quantitative, qualitative, and mixed methods	Described a curriculum for a professional degree
	Systematic reviews, grey literature, books, and opinion papers.

Table 1: Eligibility Criteria

The population was kept general to health professionals, as training has been delivered to various professionals; if mental health professionals were chosen specifically, articles focusing on other professionals would have been overlooked. Articles were aimed at BPD because the characteristics of the condition are different from other personality disorders, as mentioned earlier, and require training to be tailored to working with this population. [76] Details of the training programmes were necessary to extract its specific components. Grey literature, books, and opinion papers were excluded as only peer-reviewed journal articles were included to ensure studies had gone through a rigorous peer-reviewed process. Systematic reviews were excluded to avoid duplicating the findings, as from the initial search it was identified that systematic reviews included studies which were already identified separately in the search. No restrictions on time were applied because there has been no significant milestone in this area of work. No limitation on language was applied to ensure the inclusion of all relevant articles.

Information Sources

The following bibliographic databases were searched on the EbscoHost Research Databases platform: AMED (The Allied and Complementary Medicine Database), CINAHL, MEDLINE, APA PsycArticles, and APA PsycINFO. These databases were chosen as they were considered relevant to the subject area of the review, and the articles identified in the initial search were detected on these databases. Additionally, research suggests that at least 2 to 4 databases should be searched to ensure adequate coverage and minimise selection bias. [86, 87]

Search Strategy

Multiple combinations of search terms and keywords were used to ensure the inclusion of all permutations. The Boolean operators 'AND' and 'OR' were used to incorporate the various synonyms for keywords and expand the search. Asterisks (*) were used as part of the wild card approach to truncate keywords. Initial searches were performed between March 2021 and May 2021, wherein the keywords were revised until a suitable search string was identified. The final search string was as follows:

training* or education* or program* or workshop* AND
"health professional*" or clinician* or staff or psychiatrist* or psychologist* or psychotherapist* or counsellor* or nurs* AND
"borderline personality disorder" or bpd or "emotionally unstable personality disorder" or eupd.

The term 'emotionally unstable personality disorder' and its acronym were incorporated in the search string because it is the International Classification of Diseases 10th edition (ICD-10) [88] equivalent of BPD and is also used for research purposes. [89, 90] However, it is important to note that the recently launched ICD-11 [91] no longer uses this term as it

introduced a dimensional approach to diagnosis focusing on severity and personality traits. [92] The search string above was entered in the EbscoHost Research Databases platform with the above-mentioned databases selected and the search field as 'All fields'. The following limiters were then applied: Academic journals, and journals. The final search was performed on 10 May 2021.

Selection process

The search results were exported to the Covidence systematic review software [93] for screening. Covidence is a web-based software platform that streamlines the production of reviews and helps manage the organisation and screening of records. The principal researcher was the reviewer throughout the selection process. First, the reviewer screened the records by abstract and title against the eligibility criteria. The records that could potentially be included in the review were moved to the full-text review stage. All studies were retrieved either online or through the University library. The studies were examined thoroughly, and those that met all the inclusion criteria were moved to the quality appraisal stage.

Quality Appraisal

The Quality assessment with diverse studies (QuADS) appraisal tool [94] was used to assess the quality of selected papers. The QuADS tool was chosen as it allows for assessing the quality of mixed-methods research. It has demonstrated substantial inter-rater reliability (k=0.66) and face and content validity. [94] The scores are applied on a four-point scale (0-3) to enable researchers to distinguish the degree to which a criterion is met. There is also no cut-off score for a study to be considered high or low quality. Thirteen domains are scored; examples include a statement of research aim/s, rationale for data collection tool/s, and strengths and limitations critically discussed.

The appraisal was conducted by the reviewer and a peer (MSc Advanced Physiotherapy student at the university). A peer reviewer was included to sense-check the reviewer's interpretation of the included papers, and to enhance the rigour and reliability of the scoring. The team (reviewer and peer reviewer) first met to discuss how the tool would be applied to the studies. The QuADS tool requires researchers to apply their own methodological knowledge and judgment in making decisions about the appropriate scoring for each study. Since the peer reviewer did not belong to the field of psychology or have knowledge about the research area, the team thoroughly discussed the QuADS criteria and how these might be applied in the context of the work of focus. This enabled a shared understanding of the items in the context of the review. An iterative process was followed, whereby the team members independently applied the QuADS tool to a small number of same studies, each blind to the scoring of the other. The team then met to discuss their scorings and experiences. A shared understanding of applying the criteria, and discussing inconsistencies was developed. Each team member then applied the tool to the remaining studies independently. In the context of substantial disagreement in any given study, each team member stated the justification and rationale for giving a particular score, and a consolidated understanding was developed. Once all papers had been reviewed by both reviewers, the team met again to discuss their scoring, any discrepancies, and those discrepancies that may be resolved.

Inter-rater reliability analysis of the final scores was then undertaken. The agreement between raters was assessed using Cohen's kappa statistic on the SPSS Statistics software, Version 27. Cohen's kappa is a statistical measure of inter-rater reliability analysis that allows one to assess the agreement between raters while considering and accounting the effect of chance. Agreement between raters was substantial (k=0.734). [95]

Data Extraction and Analysis

The studies chosen were subject to framework synthesis. Framework synthesis originates from framework analysis, a qualitative method developed in the context of social and applied policy research. [96] It sits within the family of 'thematic' approaches and is flexible but systematic and structured, with clear steps laid out. It is best suited to research with specific questions, a limited timeframe, a priori issues identified, and a large amount of data. [97] The current study has a specific objective, i.e., to review training components, and has identified a priori certain issues with training as discussed in the previous sections. Hence, framework synthesis was deemed appropriate to answer the review question. The synthesis was performed by the reviewer following five stages, [98] namely: 1) Familiarisation, 2) Thematic framework, 3) Indexing, 4) Charting, and 5) Mapping and Interpretation.

During the familiarisation stage, the reviewer read and re-read the chosen studies. The purpose was to become familiarised with the range and diversity of training programmes and gain an overview of their components. The reviewer also made notes of any key ideas or recurrent themes. Following this, the reviewer set up a thematic framework within which the training components could be extracted and organised. The construction of the thematic framework involved considering the research objectives, training information provided in the chosen studies, and themes (i.e., commonalities between components arising across studies). The thematic framework was then applied to a few studies and refined and revised where relevant. For example, the index category of 'Accreditation of training' was removed, as none of the training programmes had reported on it.

The final thematic framework can be found in figure 1 below. The next stage comprised 'indexing', meaning applying the thematic framework systematically to the data in its textual form. [96] The reviewer read the included studies and annotated them according to the framework. References were recorded on the margins based on the framework headings.

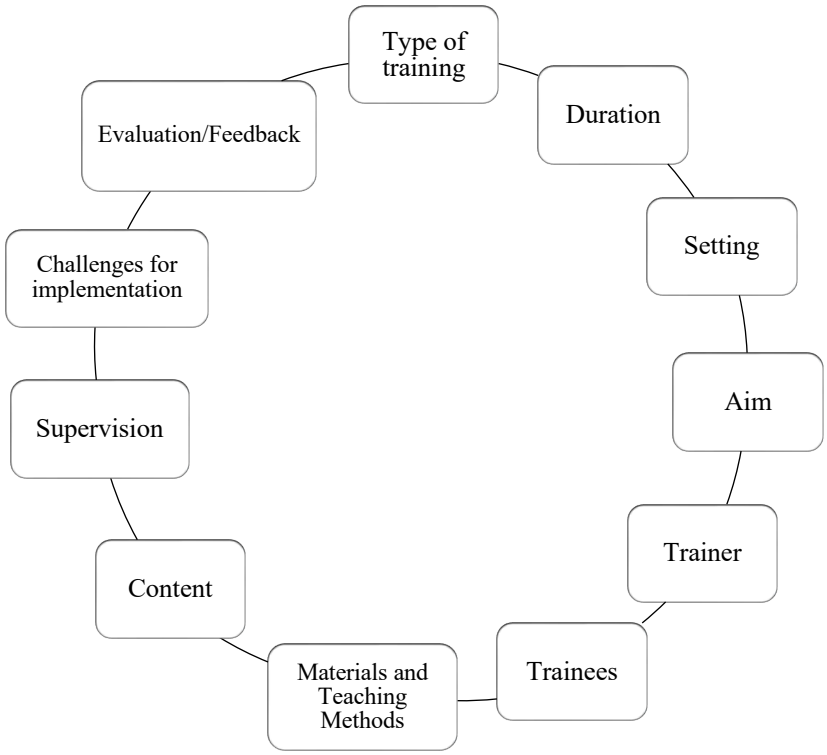

Figure 1: Thematic Framework

The following stage involved charting the data to build a picture of training components as a whole. A chart was devised with the headings from the thematic framework and was laid out thematically for each theme across studies (i.e., for each training component across studies). Charting involved abstraction and synthesis, so the annotated text was read, and a summary was entered on the chart. The final chart can be found in Appendix C. The last stage was mapping and interpretation. This stage involved understanding the data rather than managing it and articulating one's own sense-making of the data in the light of the research question. [97] The reviewer analysed the chart by identifying patterns, similarities, and differences within and across training components.

Results

The final search yielded 1034 records. Covidence removed 240 exact duplicates. The remaining 794 records were initially screened by abstract and title by the reviewer against the eligibility criteria. Articles in a language other than English were 35; where the title and abstract were not provided in English, Google Translate was used. Consequently, 750 articles were irrelevant and excluded. The remaining 44 articles were retrieved, and their full-text was reviewed, as additional information was needed to determine eligibility. One article was in Norwegian, and its full text was translated using Google Translate. Studies (n=26) were excluded at this stage for numerous reasons. Nine studies were excluded because they described an intervention/treatment model for service users, the focus was not on staff training but the delivery of interventions for BPD. Seven studies outlined general training programmes for personality disorders; these were excluded because the characteristics of BPD are different from other personality disorders, as mentioned earlier, and require training to be tailored to working with this population. Five studies were excluded because they were opinion papers and hence had not been peer-reviewed. Three studies involved a curriculum for a professional degree and these were excluded because they were considered as part of formal clinical training so their content was more detailed over a longer duration compared to a professional development training or workshop which was the focus of the current review. One study was excluded because the training details were not provided and 1 additional study was excluded because it was a systematic review and the relevant papers identified within it were already included in this review. The final number of studies meeting the criteria was 18. Figure 2 below is a PRISMA flowchart [99] demonstrating the study selection process.

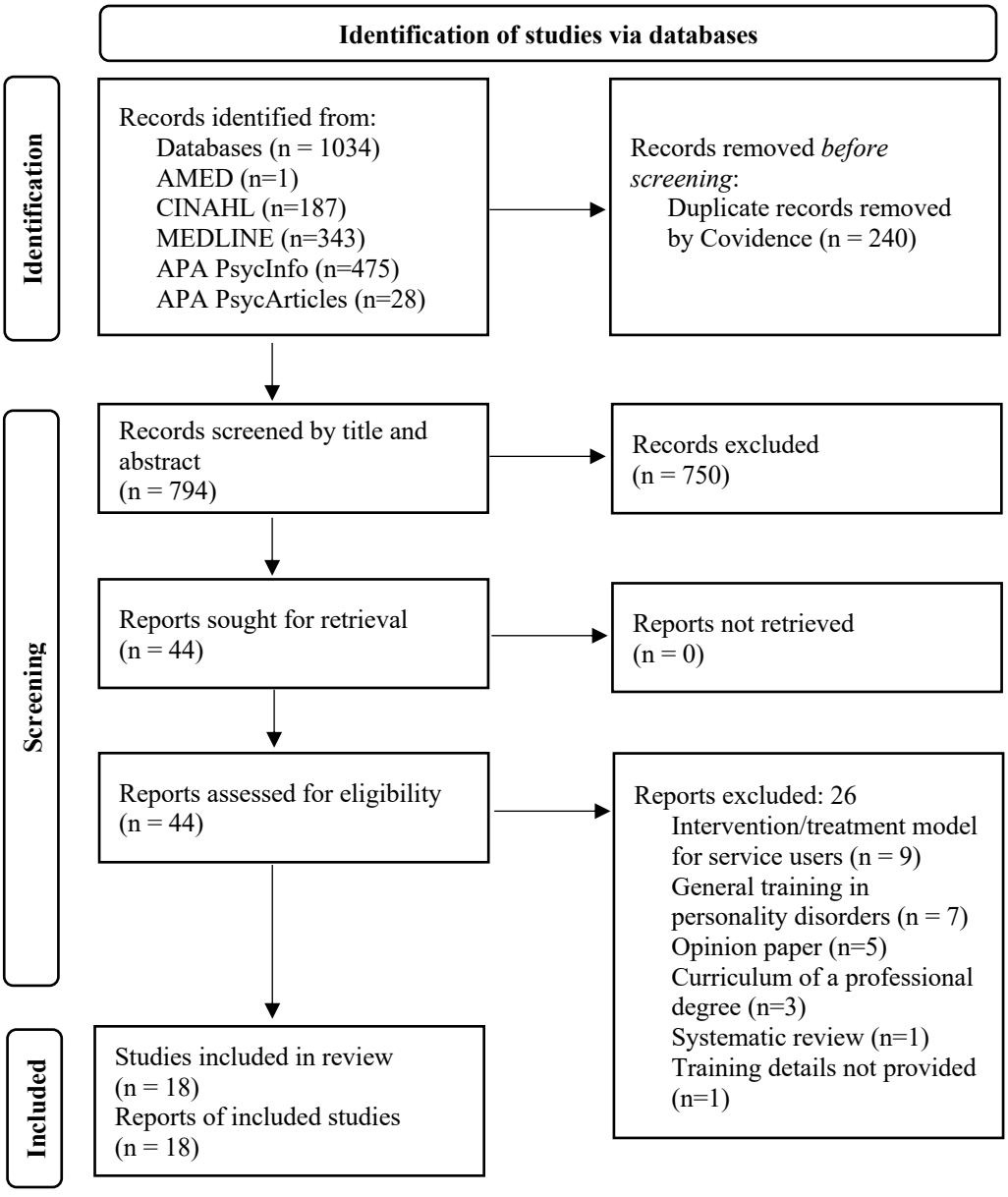

Figure 2: PRISMA flowchart

Study characteristics

The characteristics of the 18 studies chosen [53, 54, 56, 57, 76-78, 80, 81, 100-108] (Title, Author, Publication Year, Country, and Design) can be found in table 2 below. The studies were from 1996-2020. The highest number of studies were from the United States (five studies). There were four studies from the UK, and four studies were undertaken in Australia and New Zealand together. Sweden, the Republic of Ireland, Australia, New Zealand, and Canada each had one study. Twelve studies were quantitative, four were mixed-methods, and two were qualitative. Interestingly, all the qualitative data collection methods used in the studies were focus groups.

Study	Title	Country	Design
Miller and Davenport (1996)	Increasing staff knowledge of and improving attitudes toward patients with borderline personality disorder	United States	Cross-sectional. Two-group, pre-and post-test design. Staff knowledge, attitudes, and behavioural intention were measured before and after the educational intervention, approximately four weeks apart.
Krawitz and Rreal (2001)	Borderline personality disorder: Foundation training for public mental health clinicians	Australia/New Zealand	Cross-sectional. Subjective ratings pre-and post-workshop.
Krawitz (2004)	Borderline personality disorder: attitudinal change following training	Australia/New Zealand	Experimental before-after survey study. A questionnaire was administered pre-and post-workshop and at the 6-month follow-up.
Hazelton et al. (2006)	Managing the 'unmanageable': training staff in the use of dialectical behaviour therapy for borderline personality disorder	Australia	Mixed methods: Longitudinal survey, descriptive analysis; Qualitative focus groups, discourse analysis. Pre-training, and at 1-and 6-months post-training.
Krawitz and Jackson (2007)	Consumer-clinician co-taught borderline personality disorder training: A pilot evaluation	New Zealand	Survey, descriptive statistics. Ratings pre-and post-workshop.
Perseius et al. (2007)	Stress and burnout in psychiatric professionals when starting to use dialectical behavioural therapy in the work with young self-harming women showing borderline personality symptoms	Sweden	Mixed methods: Longitudinal survey (repeated measure). Qualitative, group interviews, content analysis. The questionnaire was administered for self-assessment at the start of the education before the treatment phase (baseline) and after 6, 12 and 18 months in the treatment phase. The group interviews took place 2 months later.
Treloar and Lewis (2008)	Targeted clinical education for staff attitudes towards deliberate self-harm in borderline personality disorder: randomised controlled trial	Australia/New Zealand	Cross-sectional. Pre-and post-training questionnaire. One way between-group analysis.
Treloar (2009)	Effectiveness of education programs in changing clinicians' attitudes toward treating borderline personality disorder	Australia/New Zealand	Experimental. Three groups: cognitive-behavioural education program, psychoanalytic education program, and control group. Pre-workshop rating, post-workshop rating (for experimental group) and at 6 months follow-up.
Shanks et al. (2011)	Can negative attitudes toward patients with borderline personality disorder be changed? The effect of Attending a STEPPS workshop	United States	Experimental, within-subjects pre-and post-questionnaires. Regression analysis.
Carmel et al. (2014)	Dialectical behavior therapy training to reduce clinical burnout in a public behavioral health system	United States	Longitudinal. Pre-and post-training scores (after 13 months). Between-group analysis.

Study	Title	Country	Design
Knaak et al. (2015)	Stigma towards borderline personality disorder: effectiveness and generalizability of an anti-stigma program for healthcare providers using a pre-post randomized design	Canada	Cross-sectional. Pre-and post-questionnaires. 2x2 mixed model factorial analysis of variance.
Warrender (2015)	Staff nurse perceptions of the impact of mentalization-based therapy skills training when working with borderline personality disorder in acute mental health: a qualitative study	United Kingdom	A qualitative phenomenological approach using two focus groups. Exploratory thematic analysis.
Clark et al. (2015)	Can teaching staff about the neurobiological underpinnings of borderline personality disorder instigate attitudinal change?	United Kingdom	Within-subjects, a quantitative questionnaire design was employed. Data was collected at three-time intervals: pre-and post-training and at an eight-week follow-up.
Haynos et al. (2016)	Effects of dialectical behavior therapy skills training on outcomes for mental health staff in a child and adolescent residential setting	United States	Cross-sectional, repeated measure. Questionnaires before and after training.
Dickens et al. (2019)	Mixed-methods evaluation of an educational intervention to change mental health nurses' attitudes to people diagnosed with borderline personality disorder	United Kingdom	Mixed-Methods. Prospective uncontrolled cohort intervention design study. Attitudinal and knowledge-related outcomes were determined at three time points (pre-and post-intervention and 4-month follow-up). Focus groups were conducted with participants 4 months after the intervention, and thematic analysis was performed.
Masland et al. (2018)	Enduring Effects of One-Day Training in Good Psychiatric Management on Clinician Attitudes About Borderline Personality Disorder	United States	Longitudinal. Questionnaire before and after training, and at 6 months follow-up. One-way repeated measures.
Burke et al. (2019)	Exploring staff perceptions of the utility of clinician connections when working with emotionally dysregulated clients	Republic of Ireland	Qualitative research design using focus groups and thematic analysis.
Darongkamas et al. (2020)	Training NHS staff to work with people with trauma induced emotional regulation & interpersonal relational difficulties (TIERI)/borderline personality disorder	United Kingdom	Mixed methods. Cross-sectional design. Within-group analysis. At the start and end of the training, staff completed questionnaires and wrote down their thoughts on working with PWDPD on sticky notes. Sticky notes were subject to thematic analysis.

Table 2: Study Characteristics

Study Quality

No study was excluded based on quality and there are three reasons for the same. Firstly, the quality appraisal tool used, QuADS, has no cut-off score for high or low quality and the researchers using the tool are encouraged to report narratively on criteria considered important to the research field. [94] Secondly, the key focus of the review was on the components of the training programmes rather than the quality of the research articles included. This ensured inclusion of studies which provided a detailed description of the training programmes regardless of their methodological quality. Thirdly, the study is a scoping review and not a meta-analysis wherein poor quality of the included studies would influence results. The current review aimed to identify and map training components, and the methodological quality of the included studies would not influence these components.

However, using the appraisal tool allowed for an opportunity to identify methodological shortcomings. All studies provided basic information about the research aim/s, setting, target population, and data collection tool/s. The studies had chosen an appropriate design to answer the research question/s. However, few studies did not provide information on the sampling approach [80, 81, 102] and recruitment data. [108] Furthermore, several studies did not provide justification or rationale for the choice of data collection tool/s [54, 56, 57, 80, 102-104] and method of data analysis. [54, 77, 78, 80, 104, 105] Only four studies provided some indication of stakeholder involvement. [80, 103, 106, 108]

Training Components

The analysis resulted in the following training components reported in the studies.

1. Type of training

The training programmes were either based on an established treatment model for BPD or were designed specifically for staff working with individuals diagnosed with BPD. Five training programmes were based on DBT. [53, 76, 77, 101, 105] Other established models involved Mentalisation-Based Therapy Skills Training (MBT-S), [54] GPM, [107] the Systems Training for Emotional Predictability and Problem Solving (STEPPS), [57] and Clinicians Connections (CC). [81]

The remaining were either training, [80, 108] workshops [56] or educational programs [102, 103] designed specifically for staff working with individuals diagnosed with BPD. The training programme by Treloar [104] involved cognitive-behavioural and psychoanalytic educational components. Clark et al. [78] based their training programme on Porr's neurobiological framework. [79] Additionally, Dickens et al. [106] used the same framework along with 'Wot R U Like', an expert by experience designed programme in their 'Positive about BPD' workshop. The only self-instruction educational intervention was delivered in Miller and Davenport's [100] training programme.

2. Duration

There was a wide variation in the duration of the training programmes, with the shortest being 90 minutes and the longest across 24 months. The majority of training programmes were between 90 minutes to 6 hours. [57, 76, 78, 100, 103, 104, 106, 107] Some training programmes were 2-3 days long. [54, 56, 80, 101, 102, 108] Training programmes were also delivered across a period. [53, 77, 81, 105] Specifically, the training programme delivered by Perseius et al. [53] provided clinicians with education and skills for six months, and the next phase was 18 months of delivering supervised treatment to clients alongside continued education. The training programme described by Carmel et al. [77] involved ten days of intensive DBT

training over 13 months. Haynos et al. [105] and Burke et al. [81] delivered short sessions (2 hours and 3.5 hours long) across 12 weeks and one month, respectively.

3. Setting

The training programmes took place in health services, [76, 77, 103, 104, 106, 107] mental health services, [56, 80, 81, 101, 108] and inpatient settings. [53, 54, 78, 100, 105] Krawitz and Jackson [102] and Shanks et al. [57] did not mention the specific training setting; however, they took place in New Zealand and the United States (Arizona), respectively.

4. Aim

The training programmes aimed to improve attitudes, perceptions, or both, [56, 57, 76, 78, 80, 100, 103-108] improve behavioural intentions and reduce stigma, [76] provide knowledge and skills, [54, 56, 78, 80, 100, 101, 105] reduce stress and burnout, [53, 77, 105] and evaluate the training effectiveness. [81, 102, 104, 106] Few training programmes had some combination of these aims. [56, 76, 78, 80, 100, 105]

5. Trainer

The majority of the training programmes were delivered by qualified professionals such as psychiatrists, [80, 108] psychologists, [80, 103] counsellors, [104] social workers, [57] and clinical psychologists. [78, 108] Some training programmes were delivered by trainers who were experts in the model, such as DBT trainers [77, 78] and Family Connections trainers. [81] Many training programmes were delivered by the authors themselves. [56, 57, 80, 103, 104, 106, 107] The training described in Knaak et al. [76] was delivered by a professional who is a DBT specialist, psychiatrist, and also author. The study, however, did not report on the specialisation of the three co-trainers. [76] Similarly, other studies did not report on the trainer's expertise. [53, 54, 100,

[101] Those who did report it had provided very little information on the trainer's experience and background, and simply qualifications were mentioned. Only two studies had trainers who had previously received a diagnosis of BPD. [102, 106]

6. Trainees

The total number of trainees the training programmes were delivered to ranged from 9 to 910; the trainees for a single training programme ranged from 8 to 94. The studies by Krawitz and Rreal [80] and Krawitz [56] each had 910 participants; however, the number of participants per workshop was from 8 to 35 or 40. Krawitz and Jackson [102] , Shanks et al. [57], Knaak et al. [76], and Darongkamas et al. [108] did not mention the exact number of participants for each training programme. The trainees were professionals from a variety of disciplines, such as nurses, social workers, psychologists, occupational therapists, doctors, allied health professionals, pharmacists, physicians, mental care assistants, medical practitioners, psychiatrists, substance abuse counsellors, mental health counsellors, community-supported living workers, mental health practitioners, educators, students, administrative, mental health nurses and technicians, mental health workers, director/manager, and professionals. Some studies included multidisciplinary teams, whereas others focused on a specific occupational subgroup. Nurses were the most popular trainees among studies, with some studies focusing exclusively on these professionals. [54, 100, 102, 105, 106]

The professionals worked in various settings such as community mental health centres, acute inpatient settings, crisis services, rehabilitation services, public mental health and substance and alcohol abuse services, outpatient, local emergency department and regional hospitals, local pharmacy departments, front-line community and outreach services, the local psychiatric rehabilitation service, and child and family health nursing services.

7. Materials and Teaching Methods

Materials used in the training programmes involved an instruction booklet, [100] a 150-page workbook, [56, 80, 102] online resources, [77] and a training package. [108] Seven studies incorporated case studies in the form of clinical vignettes, [56, 80] case examples, [57] instructive case videos and written vignettes, [107] case studies to illustrate theoretical concepts, [103, 104] and a case study to demonstrate recovery. [76] Furthermore, two training programmes [56, 80] used multiple educational media such as overheads, posters, audiotapes, videotapes, and other interactional methods.

Teaching methods comprised of a self-paced program, [100] experiential learning techniques, [101] lectures, [103, 104] formal didactics, [54, 57] video presentations, [54, 57] role plays, [54] and PowerPoint presentations. [78, 103, 107] The facilitator in Knaak et al. [76] modelled person-first (rather than disorder-first) language and behaviour to set the tone of the training. Some training programmes did not report any teaching methods or materials used. [53, 81, 105, 106]

The studies by Krawitz and Rreal [80] and Krawitz [56] provided a detailed description of the teaching methods. Both the training programmes used student-centred participatory learning, and didactic teaching was kept to a minimum. The trainers in Krawitz and Rreal [80] affirmed and validated clinicians' current skills, assisted participants to synthesise divergent views and constructively process conflict, and used group brainstorming, clinical vignettes for discussion, role plays, group discussions and guided self-imagery. Contextually relevant video cartoons, patient-generated black humour, and spontaneous humour were used. [80] Additionally, the trainers in Krawitz [56] used interactional learning through structured discussions and planned and spontaneous role play. Interactional activities accounted for 85% of the workshop, whereas didactic teaching was 10% and video viewing was 5%. [56] They

also found that providing participants with a workbook assisted participants' attention as they did not focus on notetaking.

8. Content

The content of the training programmes could be summarised into the following: knowledge, skills, and service user perspectives.

I. Knowledge

The training programmes covered information about the condition itself, such as diagnosis, prognosis, aetiology, [56, 80] epidemiology, [106] the efficacy of treatments, prevalence rates, [104] risk, trauma, [108] and the neurobiological underpinnings. [78] It also contained information about societal views, [108] staff attitudes, [103] and correcting common misconceptions. [76] Furthermore, knowledge about working with individuals diagnosed with BPD was also delivered, including therapeutic alliance and boundaries, [108] therapeutic responses, [104] treatment structure, [56] self-care, [56] and the importance of staff communication and consistency. [100] Lastly, training by Treloar and Lewis [103] provided information on clinical guidelines, and Krawitz [56] incorporated ethical-medicolegal issues.

II. Skills

The skills imparted through the training programmes included interviewing, assessment, formulation, emotional management, good enough endings, [108] creating individualised treatment plans, [56] behavioural chain analysis, [102] and ability to interact with and help service users effectively. [76] Some training programmes focused on skills building in specific treatment models, such as DBT [77, 101, 105] and MBT-S. [54]

III. Service User Perspectives

While two training programmes had trainers with lived experience of BPD, [102, 106] four other programmes [76, 80, 106, 108] incorporated service user perspectives through other methods. Krawitz and Rreal [80] aired patient and relatives'/friends' perspectives using video and literature, and Knaak et al. [76] incorporated a live, personal testimony from an individual with lived experience of BPD. The training programme mentioned in Darongkamas et al. [108] incorporated service user perspectives, and the training itself was introduced by someone with lived experience who shared their viewpoint in person or via an audio recording. Lastly, while Dickens et al. [106] had a trainer with lived experience, they also included a booklet in the training programme, which stated a personal story of somebody with lived experience, the challenges they have faced, and coping strategies they have used.

9. Supervision

Only four studies provided trainees with supervision or some form of support, and all of them were training within an established treatment model, specifically DBT or MBT-S. [53, 54, 77, 101] The therapist consultation meetings and peer group supervision and support held weekly in the Hazelton et al. [101] DBT training enabled staff to continue to enhance their DBT skills. Whereas the 3 hours a week of group supervision received by trainees in the Perseius et al. [53] DBT training was especially helpful in coping with stress. Furthermore, the case consultation, phone consultation, and feedback on recorded sessions provided in the Carmel et al. [77] DBT training most likely influenced therapist adherence to treatment strategies and maintained clinician motivation and hope.

A detailed description of the impact of supervision on trainees is provided in Warrender's [54] qualitative study. In their training programme, only three out of the nine participants could attend group clinical supervision highlighting the activities in clinical areas

and the lack of protected time for staff. Those who could not attend voiced willingness and enthusiasm to attend, and those who did attend found it extremely useful. The key themes surrounding supervision were consolidating the MBT model, providing reassurance and peer support, increasing self-confidence in nurses, ensuring consistency and adherence to MBT-S, and strategies for moving forward with severely distressed patients.

10. Challenges for implementation

Three studies reported on the challenges trainers faced in delivering the training programmes. The difficulties mentioned by Hazelton et al. [101] involved constant staff turnover and administrative changes and operating in a semi-rural region. Additional challenges were staff finding their location distant from the main city, which caused an issue in accessing support and ongoing professional development. [101] The training developers in the Burke et al. [81] study had to determine the training programme contact hours and sessions primarily by practical service constraints. Lastly, the authors of the Darongkamas et al. [108] study experienced an urgency in setting up and implementing the training programme because of the constraint of spending funds at the financial year-end.

11. Evaluation/Feedback

All the articles provided information on training evaluation. However, the components they evaluated were varied, such as knowledge, attitudes, stigma, behavioural intention, clinical skills, optimism, confidence, the experience of working with service users, burnout, perceptions, beliefs, and experience of training. The evaluation methods were also varied, ranging from questionnaires, surveys, and subjective ratings to focus groups. The evaluation by Darongkamas et al. [108] asked participants to write their thoughts on sticky notes pre-and post-training, alongside some questionnaires.

The training programmes led to increased knowledge and skills for working with individuals diagnosed with BPD and improved attitudes, and the professionals participating found them significantly useful. The training programmes also led to optimistic therapeutic outlooks, [101] self-reflections, increased confidence, instillation of hope, willingness to work, common language, shared understanding, [80] structure, improved capacity and competence, decreased burnout and stigma, improved perceptions of the therapeutic relationship, [108] and feeling empowered. [54] Trainees found the expert-by-experience workshops highly influential in their practice. [102, 106] There were also some areas for improvement identified, such as DBT was seen as stressful and complex to learn, [53] more practical tools and consolidation of learning were needed, [106] and training sessions needed to be shorter and frequent. [81]

Discussion

Training for health professionals working with individuals diagnosed with BPD is essential as the symptoms of BPD can be challenging for them to manage, which often leads to them feeling inadequate to provide care to these individuals. Furthermore, ethically, service users have a right to receive high-quality treatment from competent professionals. However, the wide range of training programmes available for health professionals are often varied, and their components are unknown. This scoping review aimed to map and review the training for health professionals working with individuals diagnosed with BPD; specifically, it synthesised and examined training components to identify gaps and produce recommendations (see Appendix D for a Recommendations Table). Eighteen studies met the eligibility criteria for the review, and the components of the training programmes from these studies were analysed using Framework synthesis. [97, 98] The analysis determined the following training components: type of training, duration, setting, aim, trainer, trainees,

materials and teaching methods, content, supervision, challenges for implementation, and evaluation/feedback.

The training programmes were either based on established treatment models or specifically designed for staff working with individuals diagnosed with BPD. Both types of training programmes were equally popular; among these, only one was a self-instruction educational program. [100] Furthermore, the training programmes that mentioned their setting were almost equally delivered within health services, [76, 77, 103, 104, 106, 107] mental health services, [56, 80, 81, 101, 108] and inpatient settings, [53, 54, 78, 100, 105] highlighting that no specific health setting is increasingly popular in delivering staff training for BPD.

There was a wide variation in the duration of the training programmes; some were 90 minutes-6 hours long, with others 2-3days, and a few others delivered across months. The brief training programmes were impactful, with statistically significant results. [56, 107] For example, the training outlined by Clark [78] was only 90 minutes long, but the authors found an enduring change in knowledge and attitudes regarding BPD at an eight-week follow-up. Whereas the skills training in Haynos et al. [105] was delivered over 12 weeks, and the authors found significant benefits, such as increased staff knowledge and decreased burnout and stigma towards individuals diagnosed with BPD. Overall, training programmes from 90 minutes and those delivered across 24 months have been delivered and have led to positive outcomes.

While the training programmes reviewed had multiple aims, such as improving knowledge and skills and evaluating effectiveness, 12 of the 18 included studies aimed to improve negative staff attitudes and perceptions. This is relevant as abundant literature highlights negative staff attitudes towards service users diagnosed with BPD. [38, 39] However, these negative attitudes have been described as a human response to a lack of training and challenging service user behaviours. [70] The research literature has emphasised the negative

staff attitudes over the years, [37, 39] attributing a sense of responsibility to health professionals. It can be argued that if health professionals are provided with adequate training and support, they would not possibly develop negative attitudes. There needs to be a shift in perspective within researchers and training developers from focusing on changing negative attitudes to equipping health professionals with the knowledge and skills to meet service user needs.

The trainers were qualified professionals, experts in therapeutic models, authors of the articles, or experts-by-experience. While the studies mentioned the trainers' qualifications, no additional information was provided, such as the trainer's expertise or familiarity with BPD. Research has found that the trainer's attributes, such as interpersonal skills and knowledge, can impact training and trainee satisfaction. [109] Hence, it is recommended that researchers provide a detailed description of the trainer and their approach to training.

The minimum number of participants for a single training programme was 8, and the maximum was 94, with the majority being less than 50. It can be considered common practice to deliver training to a cohort of around 50 health professionals. The training programmes were delivered to different occupational subgroups working in various health and mental health settings. This is consistent with the literature identifying a range of health professionals that find working with BPD challenging. [40] Among these, nurses were the most common occupational group, with some studies focusing specifically on these professionals. It is argued that there is a greater need among mental health nurses to receive adequate training because they are more frequently in contact with service users during crises and have little chance to reflect on their cognitions and emotions. [58]

Notably, 11 of the 18 training programmes reported the use of any materials; however, only two provided detailed information. Seven studies incorporated case studies which is promising as it prepares professionals for clinical practice by allowing for an application of

knowledge using inquiry-based learning methods. [110] The teaching methods employed in the training programmes were a mixture of trainee-led activities, such as group discussions and role-plays and trainer-led activities, such as lectures and didactics. It is necessary to report the teaching methods employed as they would determine the type of learning that took place, like active learning, which involves engagement from learners [111] or passive learning, wherein the learners receive information from the instructor and internalise it. [112]

The content of the training programmes was comprehensive, including knowledge about the condition, skills training, and service user perspectives. The training programmes differed in their focus within these domains, such as the study by Treloar [104] focused only on building knowledge about the cognitive-behavioural or psychoanalytic approach, and the study by Haynos [105] focused specifically on DBT skills training. Even though only four training programmes included service user perspectives through a booklet, video, literature, or lived experience speaker, [76, 80, 106, 108] these were seen as extremely valuable by trainees. Additionally, two training programmes were delivered by an expert-by-experience trainer; these were also well-received by trainees. [102, 106] Specifically, listening to service users as trainers sharing their recovery journey gave clinicians a sense of hopefulness. This finding is consistent with the literature demonstrating the effectiveness of service users as trainers of mental health clinicians. [113, 114] It is recommended that service users should be involved in at least some capacity in training, such as by participating in advisory committees, producing learning materials, or becoming trainers. [115] The Personality Disorder Capabilities Framework by the National Institute for Mental Health in England (NIMHE) [116] also states that training programmes should consider how best to reflect the views and experiences of service users. When service users are involved in designing the training, they can ensure that their priorities and needs are reflected in the content, [117] which is absent from the current

training programmes. This would enable health professionals to be aware of their needs and to meet them in practice.

It can be argued that incorporating service user voices can elicit emotive responses from staff, leading to changes in their affective responses to service users in practice. A review by Repper and Breeze [117] found that trainees from courses with consumer involvement developed better interpersonal skills and greater empathy towards service users. Clark et al. [78] found that participants' affective responses did not change after training; they hypothesised that it was because the content involved only factual information rather than the emotional voices of service users. Since only six training programmes added this component, it is not surprising then that a review by Dickens et al. [58] on the interventions to change nurses' attitudes towards BPD found smaller effect sizes in changes in affective outcomes compared to cognitive attitudes. As the training content currently incorporates cognitive and skills domains, it is necessary to emphasise the affective domain in future training for more holistic learning.

The positive impact of the training programmes was evident in trainees' evaluation; the training programmes led to increased knowledge and skills, improved attitudes and reduced stigma, shared understanding among clinicians, increased confidence and willingness to work, and reduced burnout. However, the majority of the training programmes were evaluated using quantitative methods such as surveys with very few mixed methods, and only two studies employed a qualitative method. Quantitative studies have various benefits, such as they allow for a large sample size and findings are more generalisable. [118] However, a qualitative exploration of trainee experiences would provide in-depth information about the subjective views of participants. [119] The use of solely quantitative methods can provide limited information about the impact of the training programme; hence, it is recommended that more qualitative methods are employed in training evaluation. Furthermore, all the

qualitative data collection methods from the studies involved focus groups. Focus groups allow for common experiences to be explored, but they often present several drawbacks. The group dynamics can influence the quality of the data generated, the voices of quiet individuals may not be heard, and some participants may feel inhibited in expressing themselves in a group setting. [118] It is recommended that alternative data collection methods should be used, such as individual semi-structured interviews, which can help understand trainees' subjective experiences, and consequently help improve the training programmes delivered. [120]

None of the studies evaluated whether training programmes eventually led to improved service user outcomes. Dickens et al. [58] highlighted the need to establish whether improvements from training led to significant clinical outcomes such as improved therapeutic relationships, service user satisfaction, or reduced self-harm. Hence, future research could identify the impact of training on service users and perhaps involve them in training evaluation.

Supervision was only provided in training programmes based on DBT or MBT-S. [53, 54, 77, 101] This could be attributed to the important role of supervision in building skills and knowledge in these treatment models. Trainees valued supervision and found it useful in consolidating learning, coping with stress, enhancing skills, increasing self-confidence, motivation, and hope, and improving treatment adherence. Supervision is also frequently recommended in the literature to maintain the knowledge from training and address professionals' internal processes. [48, 121] According to a review by Rothwell et al., [122] good clinical supervision improved working conditions, staff retention, job satisfaction, and quality of care. It also lowered stress and anxiety. [122] However, Warrender et al. [54] found that staff did not have protected time for supervision. This was also reflected in the wider literature; there was a reported lack of opportunity for health professionals to access supervision,

leaving them frustrated. [41, 45, 121] Since supervision improves staff and service user outcomes, [123] it is recommended that services make routine supervision available and provide protected time for it. The National Institute for Clinical Excellence (NICE) guideline [4] also states that mental health professionals working with individuals diagnosed with BPD should have routine access to supervision and support.

The review identified some challenges faced in delivering the training programmes. These were mainly related to the service context, such as staff turnover, administrative challenges, [101] time available for training, [81] and funding. [108] Hence, it is recommended that during the planning and implementation stage, service context is considered. Furthermore, participants in Hazelton et al. [101] found the training location difficult to access. Perhaps future training could be delivered online to increase accessibility to staff. This would also overcome other hindrances such as time and resources and support skill strengthening. It would also be helpful when face-to-face training may not be feasible, such as during a global pandemic. [124]

There were several reporting gaps throughout the research studies. First, while the studies provided some fundamental information about the training programmes, such as duration, setting, and trainees, there was minimal information on components, such as teaching methods and materials. It is crucial to report on the training components in detail to advance knowledge, share best practices, and review components timely to meet staff needs. Furthermore, there was minimal information about the process of training development and delivery. Reporting on how the training programme was developed and the challenges that facilitators experienced during its implementation would provide valuable information for training developers who can subsequently improve its efficiency.

Limitations

The current review had some limitations. Forward and backwards searching was not completed, included articles were not hand searched, and citation chaining was not performed. This was a methodological decision as after the data was mapped from a comprehensive search, it was believed that further searches would not have added any significant training components to what was already identified.

The current review included only peer-reviewed journal articles, which was a strength as it ensured a peer-reviewed process. However, it is acknowledged that the search criteria could have been unnecessarily restrictive for a scoping review by excluding opinion papers, grey literature, and books. This could have led to some studies with training details being missed in the review.

An additional drawback was that only one reviewer performed the analysis and synthesis, which did not allow for an inter-rater reliability analysis of the synthesis product to be performed. However, the applicability of such an analysis in qualitative synthesis is contentious. [125, 126] Additionally, to increase the credibility and robustness of the findings, the quality of the studies was peer-appraised.

The reviewer was simultaneously conducting data collection for an empirical study (See chapter 3) on the training needs of mental health staff in inpatient settings, so the interviews could have influenced what was looked for within the training programmes. However, a reflexive diary was used to record experiences, thoughts, and feelings, which were further discussed in regular supervision with the wider team to ensure objectivity between the two projects.

The results of the review do not provide information regarding the optimal and most effective components, such as the suitable duration or the ideal number of trainees. However, the review's objective was to map and synthesise the existing training components rather than

evaluate their effectiveness. Furthermore, the studies that evaluate training programmes have not provided data on the effects of specific components, so at this stage, a scoping review was the best way forward. It is recommended that future research should focus on the effectiveness of individual components to ensure evidence-based training is provided to staff.

Conclusion

Training is crucial for health professionals working with individuals diagnosed with BPD. A range of training programmes and their components were identified, synthesised, and examined in the review. There were prominent gaps determined in reporting the training, which should be addressed in future research. The inclusion of service user perspectives in training design, delivery, and evaluation should be considered as it ensures that their needs are reflected within training. A shift in perspective is required within the training field from focusing on changing negative attitudes to equipping health professionals with the knowledge and skills to meet service user needs.

The review paper (Chapter 2) synthesised and examined the training components of the available training for staff working with individuals diagnosed with BPD. The review paper was completed simultaneously to the qualitative study, so the findings from the review did not inform the research questions of the qualitative study. Nevertheless, the two sources of information together enabled the identification of gaps and recommendations for future training, policy, research, and practice.

Chapter 3, Empirical Paper- Borderline Personality Disorder: A qualitative exploration of the training needs of mental health staff in inpatient settings

Abstract

Background

Mental health professionals working in inpatient settings often view service users diagnosed with BPD as challenging and have reported a need for further training. Furthermore, service users have a right to be treated by competent professionals who can provide optimal care. Hence, it is necessary to deliver adequate BPD-specific training. However, the available training for staff has some drawbacks. The training programmes are designed from therapeutic models only rather than the training needs of staff, creating a training-practice gap. Furthermore, due to heterogeneity, the preferred content and most effective components of the training programmes remain unknown.

Aim

To explore the specific training needs of mental health staff working with individuals diagnosed with BPD in inpatient settings and to identify the effective components of training from their perspective.

Method

A qualitative research design was chosen, and semi-structured interviews were performed with 17 mental health professionals working in an inpatient setting in the UK with at least one year of experience in working with individuals diagnosed with BPD. The interviews took

place online and were audio recorded. The recording was transcribed verbatim, and Reflexive Thematic Analysis from a critical realist-contextualist position was employed.

Findings

The socio-ecological model was used as a framework to categorise staff training needs at a multi-faceted level, which generated the following overarching themes and themes: intrapersonal needs (knowledge-related needs are subjective, understanding is fundamental, skills for working with service users and colleagues), needs at the organisational level (practical arrangements for training, systemic issues that influence training application and sustainability), and needs at the national level (consistency in training nationwide, discipline-specific areas for training development). When participants were encouraged to describe the ideal training programme for staff working with individuals diagnosed with BPD, they identified 13 different components.

Conclusion

A knowledge, understanding, and skills (KUS) framework based on staff training needs is proposed to form the basis of future training and policy. The training components identified by participants in the study can be used as a reference point for training developers. Several organisation-level factors influence the training implementation, application, and maintenance which need to be addressed urgently.

Keywords

Training, training needs, mental health professionals, borderline personality disorder, BPD, qualitative, reflexive thematic analysis.

Background

Mental health professionals [4] working with individuals diagnosed with BPD in inpatient settings face significant challenges due to the nature of the disorder and a lack of appropriately targeted training. (45) Available training programmes for staff have some drawbacks. There is insufficient high-quality evidence to support their implementation, the most effective training components remain uncertain, (58) and staff training needs have not been considered. Hence, the current study aims to explore staff training needs and identify the most effective components of training from their perspective so that future training is appropriately targeted to those needs.

According to the DSM-5-TR, borderline personality disorder is defined as a mental health condition characterised by a pervasive pattern of rapidly changing intense emotions, chronic feelings of emptiness, unstable sense of self, and marked impulsivity. (3) Individuals diagnosed with BPD might engage in recurrent self-harm or experience thoughts of suicide. (1) These symptoms of BPD often have a debilitating impact on service users' interpersonal relationships, work, and quality of life. (28) Additionally, the diagnosis is highly stigmatising because it has historically been used to describe a group of people that did not respond well to psychotherapy or fit the existing diagnostic categorisations. (22)

Individuals diagnosed with BPD are usually treatment-seeking, with a prevalence of around 15-20% in inpatient settings. (6) However, staff find it difficult to manage behaviours and difficulties inherent in the condition, such as acting out behaviours, repeated self-injurious behaviour, suicide attempts, (68) team splitting, and repeatedly challenging boundaries. (41) These challenges have been represented in extensive literature highlighting negative staff responses towards service users diagnosed with BPD. (43, 69, 127)

Staff often view individuals diagnosed with BPD as challenging and difficult, (41)

[4] Staff, mental health staff, professionals, and mental health professionals are used interchangeably in this study.

attention-seeking, [47] manipulative and time-consuming, [45] dangerous, [128] deliberately not improving, [69] in control of their behaviours, [73] and like a "destructive whirlwind". [48] (p705) A literature review by Sansone and Sansone [70] identified negative emotions in staff, such as feeling anxious, challenged, frustrated, and apathetic. Unsurprisingly, these thoughts and feelings have been associated with negative behaviours towards service users, such as maintaining social distance, [43] rejection, [6] and providing less empathic care. [40] Research has found these negative experiences in different professional subgroups [71] and, in comparison, with affective disorders [69, 129] and schizophrenia. [72, 73]

These negative staff responses are also exacerbated by staff feeling 'unable to help' and a lack of appropriately targeted staff training. [45, 48] James and Cowman [75] surveyed a sample of 65 nurses and found that nearly 90% wanted further training to work with this client group, and only 3% of nurses reported having any BPD-specific training outside of their undergraduate degree, which mostly consisted of a single lecture or workshop. Additionally, the nurses participating in the qualitative study by O'Connell and Dowling [49] expressed that the education and training related to BPD were inadequate, and they wanted more training not only on BPD but also on how to manage themselves. Studies conducted in Australia, Canada, the United States, Ireland, Taiwan, and Greece, have stated that therapists in these countries wish to improve their skills in dealing with individuals diagnosed with BPD. [68]

Researchers have repeatedly urged that more training for working with this population should be made available. [6, 40, 41, 71, 121, 130, 131] For example, Westwood and Baker [6] suggested that training needs to be provided to staff working in acute settings, so they have a clearer understanding of the disorder, and Stroud and Parsons [121] concluded that it is critical to ensure staff receive the appropriate training in a theoretical framework to understand the rapidly changing presentation of service users. Moreover, service users also perceive staff as

lacking knowledge and understanding of BPD [46] and find staff without training unhelpful. [8]

Service users have a right to be treated with high standards by professionals who have the competencies to deliver optimal care. In accordance with patient rights and ethics, [52] there is a patient-provider fiduciary relationship based on the premise that the professional is learned, skilled, and experienced in the subject of most importance to the service user. However, in the matter of BPD, health professionals often lack the knowledge and skills to respond efficiently to service user behaviours due to inadequate BPD-specific education and training, thus, conflicting with the patient-provider fiduciary relationship. Hence, it is imperative to deliver effective BPD-specific staff training that provides them with the knowledge and skills to improve service user care. [41]

Several training programmes have been developed for professionals working with individuals diagnosed with BPD. Some of them are based on established treatments such as DBT, [53, 105] MBT, [54] and GPM, [55] whereas others have been developed specifically for working with this population. [56, 57] Whilst these have increased staff knowledge and improved skills, they have some drawbacks. A review of interventions for nurses working with individuals diagnosed with BPD found insufficient evidence of high quality to support the programmes strongly, as most were of poor-moderate methodological quality. [58] Furthermore, studies have not evaluated whether these programmes eventually lead to improved service user outcomes, so their long-term effectiveness remains unknown. [58]

A further issue has been that the training programmes are currently developed from therapeutic models only rather than the training needs of staff. [59] It is vital to conduct a needs assessment before implementing any educational program. [132] Firstly, considering staff needs in training development would ensure that staff have the right skills [133] and feel competent, consequently improving service delivery and overall quality of care. [134] Al-Ismail et al. [60] stated that conducting a needs assessment is more likely to lead to a change in

practice as the learning is directly linked to personal and practice needs. The Personality Disorder: no longer a diagnosis of exclusion policy by NIMHE also suggests that staff training should be appropriately targeted to their needs. [63] Secondly, it helps make efficient use of training investment by the organisations as resources can be appropriately allocated to meet staff needs. [133, 135] Lastly, it enables the identification of training gaps and provides a foundation to guide training design. [134]

A survey of mental health staff by Cleary et al. [38] identified the training needs of staff working with individuals diagnosed with BPD as skills training workshops and regular in-service education; however, it recommended further exploration of these needs. Furthermore, a review has previously summarised mental health nurses' training needs, such as more education and clinical supervision, skills training in treatments, a therapeutic framework to inform their practice, and an understanding of predisposing factors, trauma, and treatment components. [39] However, the review focused on mental health nurses and had a wider focus on their attitudes, behaviour, and experience rather than needs. Hence, it is necessary to explore mental health staff training needs in depth so training can be designed appropriately to meet those needs, consequently improving its practice efficiency.

An additional shortcoming has been the heterogeneity in the training programmes delivered. For example, Carmel et al.'s [77] training programme involved DBT training delivered for ten days across 13 months providing DBT knowledge and skills, whereas a training programme by Clark et al. [78] was a 90-minute training session based on Porr's neurobiological framework [79] delivered through a PowerPoint presentation. There is a huge variety in the training components, such as duration, content, and teaching methods. Hence, the most effective components of the training programmes remain unknown; [38, 39] there is uncertainty regarding how the training should be delivered, by whom, to which audience [59] and, importantly, what would be more effective as the training content. [58]

One way to resolve this issue would be to involve mental health staff in training development by co-designing the training with them. Currently, the training programmes are developed by professionals, trainers, or researchers, with little wider consultation or input from trainees, i.e., staff to whom the training will be delivered (See Chapter 2). However, involving staff in training development would ensure that the priorities and needs of staff are reflected in training. According to Janamian et al., [64] working with stakeholders to customise resource content and delivery to address their needs increases the likelihood that resources will be adopted, sustainable, used over the long term, and contribute to co-creating outcomes of value. Dickens et al. [39] also suggested that involving staff in the development and implementation of structured approaches for BPD can be of greater value to ensure they can apply the approach in practice with ease.

Present Study

The present study aimed to explore the specific training needs of mental health staff working with individuals diagnosed with BPD in inpatient settings and to identify the effective components of training from their perspective. It focused on inpatient settings as staff report the most frequent contact with service users with BPD in these services and are more likely to have unpleasant interactions with them due to more severe presentations. [40, 75] The prevalence of BPD is also higher in these settings compared to outpatient settings. [6, 7, 66]

The research questions were: 1) What are the training needs of staff working with individuals diagnosed with BPD in inpatient settings? 2) What are the components of an effective training programme from the perspective of staff? The objectives of the study were: 1) to identify detailed and specific training needs of staff working with individuals diagnosed with BPD in inpatient settings, 2) to identify the components of training from their perspective by asking them to design their own training, 3) to disseminate the findings of the

study through journal publication and conference presentations, 4) to create an infographic of the findings, which is a summary that informs inpatient services and training developers of staff training needs.

The study received ethics approval from the Research Ethics and Governance Committee of Manchester Metropolitan University (Ref: 25131) (Appendix B).

Research Design

A qualitative research design was chosen to determine the subjective training needs of participants. [119] As mentioned previously, the identified training needs of staff required further exploration, and thus, a qualitative design enabled an in-depth understanding of these needs as expressed by the participants. [136] An experiential approach was adopted, focusing on the needs and opinions of participants, underpinned by a critical realist ontology and contextualist epistemology. A Critical realist ontology assumes that reality is 'out there', but our understanding of it is mediated by language and culture, and contextualism views knowledge as contextually situated, partial, and perspectival. [65] These positions enabled the researcher to explore the participants' perceptions of their training needs (their representation of reality), which was considered mediated by cultural and social factors such as their work setting, role, culture within the organisation and other individual experiences. They also provided the opportunity to consider the wider systemic and contextual issues that influenced training.

The method of analysis was Reflexive Thematic Analysis (TA), as it allowed for systematically developing, analysing, and interpreting patterns of meaning, i.e. training needs and components, across the qualitative dataset, while valuing a subjective, situated, aware, and questioning researcher. [65] This approach fits well with the study's philosophical positions as reflexive TA also treats knowledge as situated, contextual, and inevitably shaped

by the practices of the researcher. [65] Furthermore, reflexive TA was deemed suitable as the study aims to capture and describe detailed participant training needs rather than interpreting their sense-making of their lived experiences (such as in Interpretative Phenomenological Analysis). [137] An inductive approach to theme development was undertaken, and coding took place at a semantic level, further explained in later sections.

Method

Recruitment and Sampling

The study was designed to recruit qualified mental health professionals working in an inpatient setting in the UK with experience of at least one year in working with individuals diagnosed with BPD. A minimum one-year of experience was deemed sufficient for staff to have had enough contact and experience with those with BPD to identify their own training needs. Purposive sampling was chosen, which entails selecting participants on the basis that they will be able to provide 'information-rich' data. [138] It ensures that the participant group is homogenous and can provide insight into the topic of interest. Hence, purposive sampling ensured that the participants were best placed to provide data about their training needs and ideas. [139]

Recruitment of participants took place online through a research poster (Appendix E) that was shared in the following ways: 1) advertised on Facebook, Twitter, and LinkedIn, 2) shared as a direct message to the researcher's professional network on Twitter and LinkedIn, 3) contacting inpatient services and organisations in the UK that support individuals diagnosed with BPD via email and Twitter, 4) snowballing. Seventeen mental health professionals met the inclusion/exclusion criteria and agreed to participate in the research. Most participants were recruited through LinkedIn (n=11), some through word of mouth (n=4), one through Twitter and one through an email to an organisation. This number of

interviews was considered appropriate as they generated adequate and relevant data to tell a meaningful story about patterning but not too much that it precluded deep and complex engagement. Additionally, Braun and Clarke [140] recommend a participant group of 10-20 for a doctorate project, and 15-30 interviews are common for research that aims to identify patterns. [141]

Participants

The socio-demographic data about participants can be found in table 3 below.

Pseudonym	Age	Gender	Profession	Work Setting	Years of experience in mental health	Years of experience working with BPD	Frequency	Highest Education	Previous training in BPD	Support available at work
Mark	54	Male	Psychologist	Part-time low-secure psychiatric hospital, Part-time in a priory	34	34	Everyday	Doctorate	Yes	Yes
Gemma	36	Female	Mental Health Nurse	Acute inpatient	13	13	Everyday	Post-graduate diploma	Yes	Yes
Olivia	22	Female	Mental Health Nurse	Inpatient	4	4	Everyday	Bachelors	No	Yes
Evie	29	Female	Assistant Psychologist	Inpatient forensic	5	2.5	Everyday	Masters	Yes	Yes
Tom	33	Male	Psychologist	Forensic mental health	10	6	Everyday	Masters	Yes	Yes
Sallyann	27	Female	Senior Healthcare Assistant	Inpatient personality disorder rehab within a hospital	3.5	2.4	3-4 days a week	Masters	Yes	Yes
Rose	24	Female	Assistant Psychologist	Forensic inpatient	1.5	1.5	Weekly	Masters	No	Yes
Jane	59	Female	Professional Head, Consultant of Clinical Psychology Inpatient CYPS, Approved Clinician	Inpatient CYPS	34	34	Everyday	Doctorate	Yes	Yes
Lauren	36	Female	Social Worker and Senior Practitioner	Partly in the psychotherapy department but works across all settings	15	9	Everyday	Masters	Yes	Yes
Freya	51	Female	Mental Health Nurse	Acute inpatient male psychiatric ward	20	20	Daily	Post-graduate diploma	Yes	Yes

Pseudonym	Age	Gender	Profession	Work Setting	Years of experience in mental health	Years of experience working with BPD	Frequency	Highest Education	Previous training in BPD	Support available at work
Margaret	27	Female	Senior Staff Qualified Registered Learning Disability Nurse	Inpatient mental health, specifically for service users with personality disorders and traumatic background	4	1.3	3-4 times a week	Diploma	No	Yes
Hazel	29	Female	Psychology	Mental health	6	6	Frequently	Masters	Yes	Yes
Lucy	44	Cis female	Counselling Psychologist	Acute ward at a mental health hospital	15	4	Daily	Professional Doctorate	Yes	Yes
Nicola	29	Female	Registered Mental Health Nurse	Acute inpatient female mental health ward	6.5	4	Every day at work	Undergraduate degree	No	Yes
Nathan	42	Male	Registered Mental Health Nurse	Acute inpatients adult working age	23	6-7	Once a week or more	Diploma, Non-medical prescriber degree level	Yes	Yes
Natalie	22	Female	Mental Health Nurse	Acute ward	4	4	Regularly	Degree	No	Yes
Lily	25	Female	Recovery Worker	Inpatient psychiatric unit for personality disorder	1	1	3-4 times a week minimum	Masters	No	Yes

Table 3: Socio-demographic data

Of the 17, 14 participants identified as female and 3 as male. This is reflective of the gender ratio in healthcare. The total National Health Service (NHS) staff comprises 77% females, and there are more female doctors specialising in psychiatry than males. [142] Furthermore, most participants were either mental health nurses (n=6) or psychologists/assistant psychologists (n=5). This is also a trend observed in research; more nurses and psychologists are willing to participate in research related to working with BPD. [143] Nurses have also been the most popular in research related to BPD training. [54, 100, 102, 105, 106] It may be because nurses receive less training related to BPD than other professional groups [75] and have expressed an interest in learning more about this population [143] as they have an everyday encounter with service users. [40] Hence, the high number of nurses in the present study may be explained as nurses have more training needs than the other groups. Six participants had received no training in working with BPD, similar to previous research, and a prominent lack of available training in this area. [75]

Data collection

Semi-structured interviews were the chosen method for data collection as they allowed for the expression of detailed thoughts and feelings from the participants. [144] They enabled rapport formation, which was suitable as it was a personal and sensitive discussion about participant experiences and needs. Furthermore, they enabled flexibility for the participant to discuss issues important to them and for the researcher to respond to the participant's developing account to produce detailed and rich data. [145] The individual interviews took place online on Microsoft Teams due to the COVID-19 restrictions and guidelines. This allowed for the opportunity to interview geographically distant participants. It also provided ease for mental health professionals to participate despite their busy schedules.

An interview schedule was prepared beforehand with three parts (Appendix F). The

first part asked about their experiences of working with individuals diagnosed with BPD, their training needs, and views on available training with questions such as What is needed for existing training to be more effective? and What areas do you need further training in? The second part asked them if they were a training developer, how would they design their ideal training. This enabled them to share ideas about effective components. The third part showed participants a schematic diagram of research recommendations to change negative staff attitudes (Appendix G) and asked them about the barriers to applying these recommendations. This enabled them to explore systemic and contextual issues. The interview guide was changed slightly as the interviews progressed (Appendix F) to make the questions more relevant; however, the structure mentioned above remained the same.

The principal researcher, who is a qualified counsellor but has not worked with individuals diagnosed with BPD or worked in inpatient settings, conducted the interviews. There was no existing relationship between the researcher and the participants. The interviews lasted between 30 to 60 minutes. The total recording time was 11 hours and 27 minutes. All interviews were video conversations, with only one interview that was audio-only. Following informed consent, the interviews were audio-recorded using a separate recording device. Participants were given the opportunity to ask questions before and after the interview and were completely informed. The participants were asked socio-demographic questions at the beginning of the interviews (see table 3). The researcher followed all the necessary protocols, safeguarding policies, and data protection guidelines.

The audio recording was then transcribed verbatim by the researcher, focused on transcribing spoken words and other sounds, such as laughs and sighs, in the recorded data. [140] Participant identifying details were changed or omitted to ensure confidentiality and anonymity. Participants either chose their own pseudonym or the researcher assigned one to the participant. The quotes presented in this chapter and the next have been edited for

sections with irrelevant text, and this is represented with dotted lines in square brackets '[...]'. Line numbers of the quote from the transcript are presented at the end of the quote with the participant's pseudonym. The word 'sic' is used in square brackets to indicate text which may be grammatically erroneous but was spoken exactly that way by the participant. Square brackets are also used to indicate sounds and inaudible data and to provide enhanced information where pronouns are used.

Data Analysis

After the data was transcribed, the transcripts were then added to the software NVivo (Version 12), [146] which was used as a platform for analysis. Reflexive TA was approached from a critical realist-contextualist position. The analytic process was guided by the six phases of reflexive TA, [65] and the principal researcher conducted the analysis. The process was recursive rather than linear, as it involved moving back and forth between the whole dataset, each data item, and the research question.

The analysis began with phase 1 familiarisation and phase 2 coding. Each transcript was first read multiple times, which enabled immersion in the data. Annotations were made about initial ideas to facilitate critical engagement with the data. Next, the transcript was coded for segments of data that might be pertinent to the research question, and code labels (analytically meaningful descriptions) were assigned. The codes were semantic, capturing explicitly expressed meaning in the data. While coding, memos were created for each participant on NVivo to make notes about reflections and ideas, but there was also a memo for the whole dataset. The researcher completed these stages for each transcript. Phase 3 involved the generation of initial themes by identifying shared patterned meaning across the dataset. It involved clustering the codes into meaningful chunks of data that share a core idea or central organising concept relevant to the research question. These clusters led to the

development of potential or candidate themes that captured broader, shared meaning. While the analysis took place on NVivo, the researcher used physical paper strips to visually map the codes into candidate themes (Appendix H).

The candidate themes were around being unprepared, knowledge and skills needed, barriers to training implementation, need for understanding, and the training design. However, whilst reflecting upon, reviewing, and refining those candidate themes in the supervisory team during Phase 4, a highly more complicated structure of the interrelationship of the themes was identified. It became evident that a model was needed to help organise the codes into themes. The domains of learning (cognitive, affective, and psychomotor) [147] were initially considered for this purpose, however these addressed the training needs only at the individual level. A model was needed that would allow the consideration of themes at an individual and a wider system's level simultaneously. The socio-ecological model was identified as the most suitable one for this purpose. It is a framework that can be used to understand the interrelationships between the individual and the environment within a social system. [148, 149] While the model has predominantly been used in health behaviour change and implementation research, [150, 151] the rationale for choosing this model was that it enabled us to compartmentalise staff training needs as arising from different contextual and systemic levels: intrapersonal, organisational, and national. The theory captures the complexity of systems, and hence it allowed us to encapsulate the complexity of training in real practice and that training needs are not only influenced by individual but also other social and economic factors. A structured codebook was not applied to the data or developed from the data, and the codes were data-driven. Hence, the approach to analysis was inductive, and a model was used in the mere organising of the codes into themes to represent the complexity.

The themes were then refined in Phase 5 to ensure there was a clear demarcation and that they were related to the wider research question. The themes were also named at this

stage, and a summary for each theme was created. The final Phase 6 involved writing-up the analytic narrative to tell a coherent story about the data.

Study Quality

Study quality in reflexive TA depends on creativity and insight rather than consensus or reliability. [65] Certain strategies were employed to ensure the current study was rigorous, systematic, and reflexive. First, a reflexive journal was used as a tool throughout the research process for facilitating reflection and critical engagement. Second, the principal researcher met with the supervisory team regularly, who are experienced researchers, to share insights, clarify assumptions and thinking, and explore alternative ways of thinking about data. Particularly, the supervisory team helped to prevent the premature closure of the analysis by encouraging the researcher to delve deeper. Third, an electronic audit trail of the developing analysis was maintained to ensure the process was rigorous such as lists of codes, data items, and thematic maps. Fourth, the 15-point checklist by Braun and Clarke [65] was used as a quality measure to ensure the resulting report was a good enough practice of reflexive TA. Lastly, the research is reported in compliance with the Consolidated criteria for reporting qualitative research (COREQ) checklist for interviews and focus groups, which enhances the overall rigour of the study. [152]

Findings and Discussion

The analysis is reported in two separate sections as per the research questions: training needs and training design.

Section 1: Training Needs

The socio-ecological model was used as a framework to categorise staff training needs at a multi-faceted level, which generated the following overarching themes: intrapersonal needs, needs at the organisational level, and needs at the national level. Each of the overarching themes has themes residing within it. Table 4 below illustrates this with a brief overview, and the schematic map (Figure 3) demonstrates the interconnections between the themes.

Overarching theme	**Theme**	**Summary/Definition**
Intrapersonal needs	Knowledge-related needs are subjective	Needs in relation to gaining theoretical and factual information about BPD differed depending on the stage of their professional career.
	Understanding is fundamental	A core need to make sense of service user behaviours with regard to their life experiences.
	Skills for working with service users and colleagues	Needs concerning practical skills in various aspects of client work and working in a wider team.
Needs at the organisational level	Practical arrangements for training	A need for organisations to ensure barriers to training implementation are addressed, and training opportunities are provided.
	Systemic issues that influence training application and sustainability	A need for organisations to address factors that impact whether training will be applied in practice and whether its effects will last in the long term.
Needs at the national level	Consistency in training nationwide	A need for a national guideline for BPD training and the implementation of a national training programme.
	Discipline-specific areas for training development	A need for training developers to address the gaps in available training within varying disciplines.

Table 4: Overview of themes

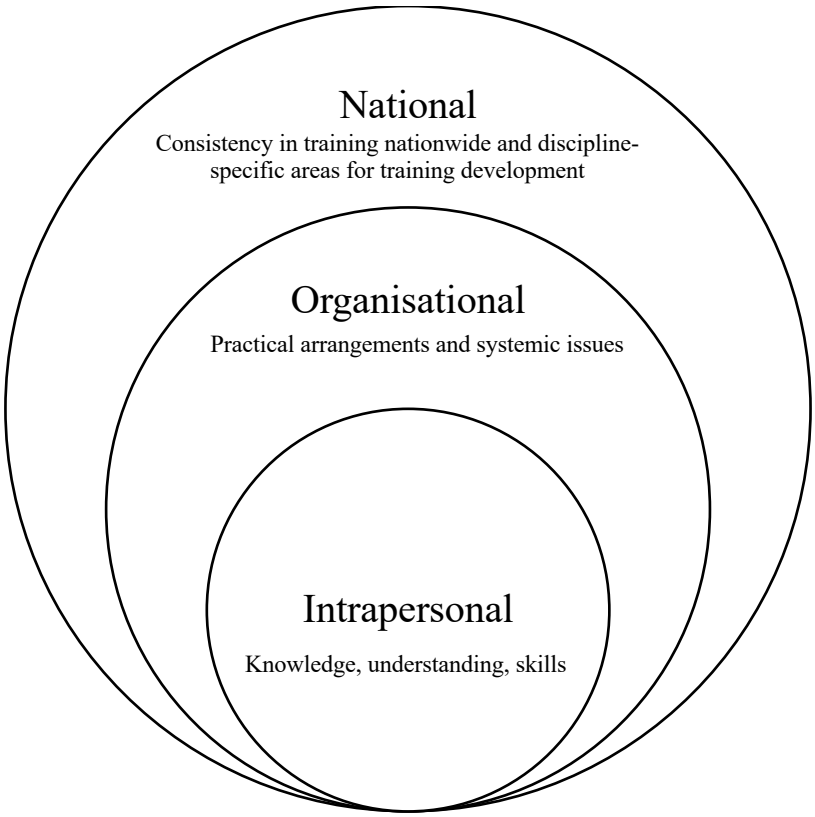

Figure 3: Schematic Map based on the socio-ecological model (150, 153)

Figure 3 demonstrates that training takes place in a system, and multiple levels of factors influence it, all inextricably linked. Participants' training needs were embedded within these different levels, each encompassing the next.

Intrapersonal needs

Intrapersonal means occurring within the person. When participants shared their training needs in relation to themselves, they referred to the areas of knowledge, understanding, and skills. These were personal training needs that were respective to their client work and context.

I. Knowledge-related needs are subjective:

Knowledge-related needs were a need for acquiring more theoretical or cognitive information about BPD. These needs differed for each individual; they were subjective, contextual, personal, and related to their years of work experience or stage of professional career.

Participants who were at the beginning of their careers, and those who reflected on their training needs from when they started, needed basic information about the diagnosis. They wanted factual information such as the diagnostic criteria, reasons for diagnosis, and client presentation. For example, Hazel, a psychologist with six years of experience in working with individuals diagnosed with BPD, shared her training needs from early in her career:

> "so getting just basic education on what it is and why people might have it and also how we how we work with that." Hazel [267-268]

Furthermore, Margaret, a learning disability nurse with 15 months of work experience with this population, mentioned that she still struggles to understand the client presentation:

> "I think it would be useful if they was [sic] to have that knowledge of how the personality disorder is reflected within [...] I constantly wonder, am I being manipulated by this person, or is this just generally them as a person um I feel like I'd like more of an insight into that and kind of maybe tell tale signs of stuff." Margaret [99-100 and 121-123]

While relatively new starters wanted more information about BPD, participants with more years of work experience had their training needs about continuing professional development (CPD). These included topics such as approved clinician training, group

psychotherapy, intense training in an approach, schemas, therapeutic community, trauma-informed training, and the long-term impact of the work. These participants had a strong knowledge base and wanted to expand this by exploring different approaches to client work. For instance, Lauren, a social worker and senior psychotherapist with nine years of work experience in this area and a master's degree, wished to further her competencies by getting trained as an approved clinician:

> "I'd like to also become a an approved clinician so be able to have some degree of [...] influence when thinking about um admitting people, so um so I think some kind of support to be kind of validated in that area would be really good." Lauren [532-534 and 543-544]

Since knowledge-related needs are subjective, training content needs to be appropriately targeted by considering the audience to which the training will be delivered and their pre-existing knowledge. For example, induction training for new starters, which covers the basics of the disorder, would be useful, whereas experienced professionals should be given opportunities to seek training in areas that appeal to them based on their training pathway. The Personality Disorder: no longer a diagnosis of exclusion policy [63] recognises the subjective nature of training needs and demands that training is appropriately targeted to meet staff needs.

II. Understanding is fundamental:

In addition to knowledge, it was important for many participants to develop an understanding of the service user, their history, and the function of their behaviour. Understanding is more than theoretical knowledge; it is about constructing meaning through interpreting or

explaining. [147] In this context, it was developing meaning about service user behaviours through their life experiences.

Participants saw it as crucial to working with individuals diagnosed with BPD, regardless of years of work experience or level of training. Gemma, a mental health nurse who has worked with individuals with this diagnosis for 13 years and continues to work with them every day, emphasised the importance of understanding by saying:

> "all I see is you need you need to be able to do your job but to truly understand what's happening for people, understand how um things that have happened to them many, many years ago are still impacting on them now." Gemma [259-261]

Additionally, Sallyann, a senior healthcare assistant with over two years of work experience in this area, described how useful understanding has been in her work with clients:

> "you know understanding what what they're after and why they're behaving like that has been really helpful in not becoming frustrated with them, not getting us burned out because from when you know why somebody is behaving like something [...] it's easier to to rationalise the the behaviour." Sallyann [160-164]

It seemed like the participants were constantly looking for the answer to the question, 'Why?' in practice, as many service users' behaviours did not make sense or were unfamiliar to them. When the why was answered in relation to service user history or needs, it provided an explanation, and consequently, they responded better. McGrath and Dowling [41] highlighted that staff need to understand the origins and functions of service user problems. They implied that the more staff understood the complexity of BPD, the easier it would get for them to respond therapeutically without anger, frustration, or fear. Stroud and Parsons [121]

noticed that when staff participating in their qualitative interviews did not have a framework to understand client behaviours, they were more likely to use pejorative terms like 'attention-seeking'.

It is recommended that training could incorporate a framework to understand the function of service user behaviour better, as it could allow staff to apply the knowledge 'in the moment' with the service user. Furthermore, reflective practice, team discussions, case reviews, and formulation meetings can be used to facilitate an understanding of service user behaviours by linking their past and present and developing a consistent understanding of the service user as a team.

III. Skills for working with service users and colleagues:

Skills refer to practical abilities needed, the 'how to' of client work. Some participants shared that they lacked skills in working with individuals diagnosed with BPD. Rose, who has a master's degree and 18 months of experience in working with this population, said:

> "I'm lacking some of the skills sometimes [...] I don't feel like I've been trained on any specific skills for working with BPD [...] I guess skills training could be really helpful." Rose [149-154]

Research has previously reported mental health professionals feeling that they need more skills in working with BPD; [48, 68] it appears that skill deficits still exist and remains an unmet need. During the qualitative interviews in the present study, participants were asked to describe the specific skills they wanted more training in, as these had not been explored in previous research. [38, 39] Participant responses were related to working with specific

demographics, managing boundaries and self-harm behaviours, supporting their colleagues, and training other staff.

There was a sense of anxiety in some participants about the best way to communicate with service users, predominantly among mental health nurses. Natalie, a mental health nurse with four years of work experience in this area and no previous BPD-specific training, articulated her needs by saying:

> "how to actually talk to these individuals, especially like at times where they are highly distressed [...] you're always kind of treaded on eggshells um wondering if what you're gonna say is gonna kind of upset them or things like that." Natalie [88-89 and 148-150]

Research has found that the way mental health professionals communicate with service users has an impact on their subsequent behaviours; [40, 59] hence, communication is an important part of the work. However, given the relational difficulties inherent in the condition and the lack of communication skills in staff, staff and service users often get into a cycle of miscommunication which is unhelpful for treatment. [20, 40] It is crucial that training provides staff with a toolkit of communication skills they can use in practice, especially skills that focus on communication during times of distress, as mentioned by Natalie above.

The toolkit could involve de-escalation techniques, a range of strategies designed to reduce distress within service users when conflict escalates, [154] such as establishing verbal contact, identifying wants and feelings, active listening, concise and clear communication, and offering choices and alternatives. [155, 156] Evidence indicates that de-escalation training leads to a reduction in aggressive behaviours and the use of physical restraint in acute psychiatric units. [156] Furthermore, training could also incorporate skills practice through role play of practice-based scenarios to build staff confidence and expertise. Since the lack of communication skills is particularly evident in mental health nurses, maybe university

degrees could focus on addressing this need in higher education.

There was also a sense that one cannot work in isolation with these service users and that team working is essential. Lucy summarised the importance of this by saying:

> "individually you can do what you hoped to be best, I mean that moment to be helpful, but if it's not part of a team, where its where the team comes together, its it it it can really really unravel and really flounder." Lucy [346-349]

Olivia, a mental health nurse who works with these service users every day, shared an example from practice:

> "they might have like swallowed a pen or used a pen to self-harm with previously, so like I would say no you know you're not having a pen [...] but if someone else might try and um take a bit of a positive risk-taking and allow them to use the pen um so then when I when I would say no they'd be like oh well this person said yes [...] um so then that comes into the team splitting." Olivia [80-91]

This quote illustrates the importance of team communication in setting consistent boundaries. Service users have also identified improved team communication as positive to their care. [157] Training could incorporate some team building and team working skills; however, open communication as a team [158] and a clear plan for working with service users would be necessary to facilitate this further.

Needs at the organisational level

Participant training needs were related to not only themselves but also the context of the organisation they worked within. They identified several barriers to the implementation, application, and sustainability of training that needed to be addressed by the organisations.

I. Practical arrangements for training:

Many participants specified the lack of training availability. Specifically, Natalie argued that there is a need for more training as the demand for services is rising:

> "I think practically definitely more training or awareness [clears throat] or things like that because like I said there's there's none and we're having to support these individuals quite regularly at the moment." Natalie [79-81]

The paucity of training was identified in the NIMHE policy, [63] and the Department of Health committed to pump prime the development of new training initiatives in personality disorder and support this at a local level. However, there continues to be a lack of training opportunities. Participants thought about the root cause of this and identified some barriers to training implementation as budget and funding, opportunity to release staff, and the number of staff to deliver training. They urged organisations to address these issues and make practical arrangements for training.

A common theme in interviews was that training implementation has several financial implications for organisations, such as funding to provide training, headroom in the budget to release staff, pay for staff to attend training, and pay bank staff to cover for staff. As a result, it acts as a significant barrier, as affirmed by Lily, who works in a private setting:

> "budget seem to be a very big thing um so I think that would definitely constitute for barrier cause obviously you'd have to pay for the overtime for people attending training, but you'd also be having to be the person doing the training to spend time creating um the training materials, so you've got the cost in terms of financial." Lily [396-399]

It was reiterated by Hazel, who works in the NHS:

> "I think funding definitely does get in the way, I think that's probably one of the biggest reason you don't see organisations implementing it cause it takes so much money." Hazel [836-839]

Another barrier identified was releasing staff to attend the training. Participants felt that organisations needed to see training as important and release staff to attend training, so they do not burnout and leave. Rose, who works in the NHS, saw this as the biggest challenge and said:

> "if we're putting training in place, which I think is so important, um again, staffing always limits people's ability to actually come." Rose [278-280]

The NIMHE policy [63] requires organisations to free up staff to attend training. However, there is a contradiction between policy recommendation and practice implementation, organisations may put training in place, but realistically staff are not able to leave their work to attend it.

In addition, participants in this study also recognised that there are not enough staff to implement and deliver the training due to busy work schedules and workloads. Freya further explained this issue:

> "they're [trainers] actually the ones that are doing the one-to-one therapy with the patient, so doing the training [chuckles] and education with the staff has to fit in." Freya [665-667]

This theme demonstrates that numerous organisational factors determine whether training will be provided to staff. Research on available training for staff working with individuals diagnosed with BPD does not report on challenges in training implementation or provide more information on service context (see Chapter 2); hence, these issues are not widely reported, and recommendations are not provided. An evaluation of the national 'Knowledge and Understanding Framework' (KUF) training programme for personality disorders reported several important factors for effective training delivery, such as funding, organisational support, culture, leadership, administration support, and protocols. [159] However, the study failed to provide ideas to help organisations apply these in practice. It is proposed that a policy or guideline specifically aimed at organisations should address these barriers and provide further direction.

II. Systemic issues that influence training application and sustainability:

According to participants, alongside training delivery, it was important to ensure its applicability and sustainability in practice. Participants mentioned how the impact of training lasts 2-3 weeks and then people usually resorted to habitual behaviour due to some systemic and structural issues such as culture, long hours of work, or no emotional support. For participants, it was crucial to address these issues so they could apply their learning to practice and ensure lasting effects from the training.

For example, Lucy, who has previously worked in an NHS acute ward and a private hospital, spoke about how the work setting influences her experience more than the training:

> "The settings influence things probably more than my training has done [...] the structures of the therapeutic setting, um that's what makes a difference as to whether it feels safe and contained and effective work or whether it feels like oh [sighs] right lets lets see what the heck happens today that doesn't happen [chuckles] in other in other places like that." Lucy [264-265 and 271-275]

Additionally, Tom, who works in the NHS, shared how long hours of work make it difficult for staff to apply the training due to how physically tiring the job is:

> "after our that day of training [...] the staff are really really motivated [...] but after two or three weeks they go back to the same old patterns of behaviours, and I think that's I think that's because they spend so much time on the floor doing long days for instance so long days like 14-hour shifts." Tom [338-343]

Nathan, a mental health nurse with over 23 years of experience in mental health, explained that after training if staff go back to a culture that is negative, behaviour change will be difficult. For him, it all comes down to the organisational culture:

> "I think because um training only lasts as long as your culture." Nathan [181]

Participants also needed support networks in place alongside the training, such as supervision and reflective practice, to maintain learning from the training. Tom narrated this succinctly when he said:

> "if you just do training and if you don't combine training with supervision, reflective practice, team discussions, I don't see the training being really effective [...] that's go going to be beyond the training, uh the training alone it doesn't do much." Tom [420-423 and 438]

The importance of supervision for staff working with individuals diagnosed with BPD has been reflected in policy [4, 63] and research. [48, 121] Research on the KUF programme found that improvements in subjective ratings of the capability of staff were not maintained at a three-month follow-up. [159] The researchers suggested a need for ongoing supervision and support for staff to consolidate and maintain learning. [159]

If the organisational context determines whether training is applied in practice and if its effects last in the long term, then training must be developed within supportive management structures. [38] Furthermore, the current evaluations of training programmes need to explore the long-term impact of the training [58] and the factors influencing that, which has been a major shortcoming and needs urgent consideration.

Needs at the national level

The barriers to meeting the staff needs went beyond the individual and service context to the wider national system in which training is created and implemented in the UK. Participants provided suggestions for policymakers and training developers to improve the available training for BPD.

I. Consistency in training nationwide:

Freya, a mental health nurse working in an acute inpatient setting within the NHS, shared her training idea to work with individuals diagnosed with BPD nationwide consistently. She has

20 years of experience working with this client group, so, understandably, her training needs are not concerning herself but wider national policy.

Freya expressed that different areas throughout the nation have different therapeutic approaches that they practice and train staff in, such as DBT and MBT. She advocates for a core set of general skills nationwide for all staff working with individuals diagnosed with BPD. She explained:

> "encompassing the biggest the largest number of staff to be able to work consistently with a client group, um for me preferably an agreement nationwide on a core um core skills for working with people that are emotionally dysregulated and then build on the speciality after that." Freya [233-235]

The benefit of this, according to Freya, would be consistent care received by service users regardless of the service they access geographically and for all staff to have a basic toolkit that they can refer to that can help them support service users.

The Personality Disorder Capabilities Framework [116] identified the specific capabilities required for staff working with individuals diagnosed with personality disorders and provided a framework for appropriate education and training at local and regional levels. However, it is argued that the nature and characteristics of BPD are different from other personality disorders and require training competencies to be tailored to working with this population. [76] Furthermore, there are policies regarding personality disorder generally; however, only the NICE have a specific clinical guideline for BPD. [4] Whilst the guideline provides recommendations for the diagnosis, treatment, and management of the diagnosis, it provides very little guidance on BPD-related training. It briefly mentions that mental health professionals should be trained in the assessment, diagnosis, and management of BPD. [4] It further states the specific professional subgroups and settings where the training is needed

and that the programmes should address problems around stigma and discrimination. [4] However, it provides no further guidance on the core competencies staff should be trained in or the specific components of the training that should be delivered.

Given the lack of a training framework or guideline, it is recommended that a policy that specifies the requirements for training nationwide or core competencies for staff should be developed. A national training programme for working with BPD could also be implemented to ensure staff throughout the country receive consistent training, and the cost of developing regional training material would also be reduced. It could be similar to the KUF training [160] since the structure is already there for the national training, but it would need to be tailored for BPD.

II. Discipline-specific areas for training development:

While participants stated that the available training is useful, they identified some gaps in the training content. They would like to see more national training developed for certain topics. Interestingly, these areas were related to their practice discipline.

Lauren is a social worker and senior practitioner who identified that training needs to incorporate more information about marginalised communities, relational and systemic practice, and therapeutic communities. For Mark, a psychologist, the available therapeutic approaches for working with individuals diagnosed with BPD usually shame service users, and he advocates for a model that recognises and validates the challenging life experiences that service users have had. He emphasised this by saying:

> "I think you need a model that just doesn't shame people and disorder people." Mark [244-245]

Whereas Olivia, who is a mental health nurse, shared a training gap in her discipline:

> "I just I think the training needs just I don't know we need some sort of like evidence-based practice to base what we're doing our nursing on and I don't feel like there is enough, enough of that." Olivia [127-129]

Hence, depending on their discipline, participants wanted further training to be developed in specific areas.

Contrary to discipline-specific training, Interprofessional education (IPE) has been advocated as a way to enhance effective team collaboration and improve health outcomes. [161] While there is value in IPE as it trains professionals to become a part of a collaborative practice-ready health workforce, [162] certain discipline-specific training needs must be met, as highlighted by some participants in this study. Hence, along with the common training framework or national programme mentioned above, it would also be useful to consider discipline-specific training requirements.

Section 2: Training Design

During the interviews, participants were asked if they were a training developer how would they design their ideal training, this section reports on the ideas generated by the participants in discussion with the researcher. Participant responses were synthesised and grouped under 13 training components, summarised in table 5 below.

Training Component	Participants' response
Timing	Near the beginning of starting the job
Setting	Away from the environment or in-house
Delivery	Face-to-face, only e-learning is not enough
Frequency	At least once a year, refresher training needed
Duration	At least one full day or more, space between training sessions
Trainer	Psychologists, health professionals from different disciplines, and lived experience staff and service users
Trainees	All professionals, specifically non-psychology staff, new starters and experienced professionals, students, agency staff, and nurses
Content	Knowledge (based on available training, factual information about BPD, theoretical models), Understanding (service user behaviour and self), Skills (working with service users, working as a team, care planning, and building formulations)
Teaching Methods	Group tasks and role plays
Materials	PowerPoint presentation and case studies
Nature	Fluid and flexible, like a forum for discussion, and space to learn and reflect
Ongoing support	Regular debriefs, supervision, and reflective practice
Development	Coproduced with lived experience service users and multidisciplinary professionals

Table 5: Summary of Training Components and Participant Responses

Rose and Lily designed their training to be delivered near the beginning of when people join the job, such as during induction or after a couple of weeks of working there. Rose stated:

> "training people as soon as they like come into the service um cause that affects their attitude throughout um whatever they do in mental health, I think it's really important." Rose [366-370]

The Royal College of Psychiatrists (RCPsych) Standards [163] on inpatient mental health training require organisations to ensure new staff members receive an induction based on a

set of key competencies. Furthermore, the Chartered Institute of Personnel and Development [164] stated that an effective induction may affect turnover and absenteeism. Hence, induction can be an appropriate time to introduce basic knowledge, understanding, and skills to new staff members.

Regarding the setting of the training, only Gemma described it in her training outline. She mentioned that both away from the environment and in-house would be useful. It appeared that other participants did not have a specific preference regarding the training setting, and other components were deemed more important. This is perhaps something for future training developers to keep in mind.

Margaret and Olivia mentioned how the training should be delivered. Margaret suggested a face-to-face training; she expressed:

> "I don't think e-learning is sufficient enough." Margaret [385]

Whereas Olivia suggested that the training should consist of two parts: e-learning beforehand and trainees then take that to the in-person training. This is in line with the available training related to BPD, as most training programmes are still delivered face-to-face (see Chapter 2).

There was a general consensus among participants that the training would take place annually, at least once a year. Many participants emphasised the importance and need for refresher training when working with this population. Continuing education or refresher training provides an opportunity for staff to expand their knowledge and update their skills, [165] and acts as a reminder to think about the service user's history and trauma. As Olivia mentioned:

> "you kind of have to be reminded that they're this way because because what what has happened to them, and like sometimes you kind of forget that." Olivia [197-200]

Participants agreed that the training should be at least one full day or more. Previously, research has found that training programmes which were only 90 minutes long led to an enduring change in knowledge and attitudes in staff working with individuals diagnosed with BPD. [78] However, participants in the present study felt the need to have at least one full day of training; this is an important finding for training developers when determining the duration of the training. Some participants added space between their training sessions to incorporate the learning into practice. This is known as the spacing effect. It is a phenomenon that long-term memory is enhanced, and learning is better when learning sessions are spaced in time across multiple days rather than massed together in a single day. [166-168] Hence, spaced learning could be incorporated into future training.

Participants suggested psychologists, health professionals from different disciplines, and lived experience staff and service users as trainers of training. Many participants proposed that the trainer should be somebody with lived experience of working with individuals diagnosed with BPD. Gemma shared the benefits of this:

> "particularly if you've got staff who um can be a bit resistive to thinking about things in in a different way. If there's somebody there who has not had their experience [...] they'll say, 'well you don't know what its like on the inpatient wards or you don't know what its like to do this,' but if somebody stood there and says 'well actually I do'[...] I think that's really useful." Gemma [410-419]

Additionally, participants shared that having a trainer who has lived experience of a diagnosis of BPD is even more impactful. They said it would provide insight, motivation,

validation, and a different understanding, aid reflection, instil confidence and can be inspirational and powerful. Hazel summarised this well:

> "you know its so much more inspirational to hear that from someone whose been through it than have someone tell you somebody else's experiences, people engage more, they ask more questions um and you can see them being so much more compassionate towards this person rather than just a trainer stood in front of you telling you all these things [chuckles]." Hazel [478-483]

This is consistent with research demonstrating the benefits of service users as trainers of clinicians. [113, 114, 169]

A few participants said that training should be received by all professionals who work with individuals diagnosed with BPD. However, they also specified certain professional sub-groups that would particularly benefit from the training: non-psychology staff, new starters and experienced professionals, students, agency staff, and nurses. It has been reported that different professional subgroups face challenges while working with this population, [71] and hence, training could be beneficial for any clinician providing care for service users.

The themes around the training content were related to knowledge, understanding, and skills. In terms of knowledge, participants thought that the training content should be based on available training (KUF, DBT, Schema Therapy), factual information related to BPD (client presentation, diagnosis and characteristics, human nature and biology, reasons behind diagnosis, trauma and its impact, challenges faced by staff, comorbidities, critical approach to the label, difficulties faced by service users, personality disorders, and stigma), and theoretical models (attributions of control, Karpman's Drama Triangle, intersectionality and the social model, and the biopsychosocial model).

The content also included an understanding of service user behaviour and understanding of self. Mark emphasised the importance of reflecting on one's own reactions:

> "if you're going to work with [inaudible] you need to recognise that there will be an effect on you. There will be times when you feel angry, upset, anxious or whatever so you need to start to learn about yourself and how these different feelings um are manifested in yourself." Mark [305-308]

It was important for staff that the training should include practical skills for supporting service users. Evie mentioned:

> "how can we how can staff support them kind of more like a practical tip as well not only just a academical knowledge but also practical." Evie [165-166]

Some of the skills they mentioned they would include were: managing challenging behaviours and boundaries, DBT skills, communication, building management plans with service users, and empathy and compassion. Staff also mentioned skills such as building formulations, working as a team, and care planning. The training content designed by participants has themes similar to their training needs (knowledge, understanding, and skills) which reinforces the importance of these areas in staff training.

The teaching methods included in the design were group tasks and role plays, whereas the materials included were a PowerPoint presentation and case studies. Case studies were generally seen as something that could be useful to understand the function of behaviour, review incidents, and think about helpful responses. Margaret shared:

> "I feel like you're only ever really going to learn if you're on the job, so if you was [sic] to bring in examples from practice I feel like that would be a good starting point." Margaret [362-364]

Research has found that the advantages of this approach include enhanced clinical knowledge and skills, improved practice behaviour and patient outcomes, and learning on a deeper level. (170)

Participants also identified some additional components. They designed the training as something in-depth, fluid and flexible, like a forum for discussion, and space to learn and reflect. They also felt that only training is not enough, and ongoing support needs to be provided for staff through regular debriefs, supervision, and reflective practice. For Mark, it should be monthly:

> "so that would be I think at least monthly supervision and probably at least monthly staff support reflective practice." Mark [352-353]

The benefit of formal support, especially supervision, has been emphasised in research (48, 121) and policy. (4) However, it is important for organisations to provide opportunities for support and embed it in the organisational structure. (54)

Lauren mentioned coproduction as essential to the training she would design. For her:

> "the key to training moving forward has to be coproduction." Lauren [196-197]

She urges organisations to support coproduction as she believes it works well in practice. She would want to coproduce the training with lived experience service users and seek advice from colleagues within other professional subgroups to incorporate a range of perspectives.

Previous research has stated that service users could provide useful input to clinicians' training and, with support, can be involved in training professionals. [8] This has also been demonstrated as good practice in the development of the KUF programme. [159]

Implications for Practice

The findings of the current study have implications for training development, organisations, policy, research, and higher education. The areas that mental health staff needed further training in were related to knowledge, understanding, and skills. A framework for BPD-related staff training is proposed that incorporates all three elements, called the Knowledge, Understanding, and Skills (KUS) framework. As per this framework, training needs to address the 'what, why, and how to' of the work, i.e., what is BPD, why service users behave the way they do, and how to work with them. A three-tier model for mental health training has previously been suggested by Heru [171] specifically for psychiatric training, and the elements mentioned in the KUS framework have been incorporated into various national frameworks and training programmes. [160, 172, 173]

Since there is a lack of a coherent framework in BPD-related staff training due to high levels of heterogeneity, the KUS framework could be used as a guiding principle by training developers to ensure staff needs related to the three core areas are included in the training content. It could also be used in building a policy for competencies needed to work with individuals diagnosed with BPD. The KUS framework could also form the basis for a national training programme for working with BPD, similar to the national KUF programme for personality disorders [160] but tailored specifically to BPD. The commissioning of such a programme would ensure that mental health staff across the UK are trained in a standardised way and have a core understanding of BPD, which would make it easier to work in teams and across organisations.

The training designed by participants in the current study provides training developers with a concrete idea of components that are important for mental health staff. These components, along with the KUS framework, provide accessible guidance and a starting point for the development of future training based on staff perspectives. They could also be applied to formal clinical training embedded in curricula at University degrees, so trainees have the necessary competencies for clinical practice. However, it is hoped that future research empirically evaluates the framework and components to determine their use in practice.

The representation of staff training needs at different levels embedded within a system using the socioecological model can be a conceptualisation useful for thinking about health professionals' training needs in other disciplines and contexts. Furthermore, it is evident from the current study that many organisation-level factors act as barriers to training implementation and maintenance. It is hoped that the findings of the current study will encourage organisations to make changes to address these issues. Additionally, research to date has focused on changing negative staff attitudes (see Chapter 2); however, a shift into thinking about staff training needs and organisational structures impacting training is warranted.

The current study provides an example of involving mental health professionals in training development through research. It was found that mental health staff had useful ideas related to the training they would like to receive. It is argued that, where possible, training should be developed in collaboration with staff to ensure their needs are incorporated within it.

Limitations

The findings of the study are based on 17 interviews with mental health staff working with individuals diagnosed with BPD in inpatient settings in the UK. While the results can be transferable to similar contexts, the research reflects primarily the training needs of staff working within British organisational structures and policies. However, it is anticipated that the findings will be useful for organisations and training developers globally as international evidence suggests mental health staff face challenges while working with this population, require further training, (68) and the available training is insufficient. [39]

The mental health staff participating in the current study had at least one year of experience in working with individuals diagnosed with BPD. While it was assumed that one year of experience would be needed for individuals to recognise their training needs, the participant responses suggested that they had training needs even before or soon after starting work with this population, as university education did not prepare them adequately for this area of work. Hence, future research could explore the training needs of new starters and perhaps develop induction training that could be useful for them.

The current study focused on mental health staff only, whereas research has found that service users could provide useful input to clinicians' training. [8] However, this was beyond the scope of the current research, and it is recommended that future research involve service users in training development. Furthermore, future research could triangulate the results by conducting a Delphi study (a well-established approach to answering a research question through the identification of a consensus view across subject experts) [174] that involves staff, service users, relatives of individuals diagnosed with BPD, health providers, and higher education providers, with the view to develop a consensus guideline of training competencies for staff and implementing a national training programme.

While the audio from the interviews was recorded and transcribed verbatim, the

researcher's and participants' cameras were switched on during the conversations (except for one audio-only interview), exposing the researcher to a range of non-verbal cues. While these were not necessary to be incorporated as per the chosen method of data analysis, it became apparent through reflection that access to these non-verbal cues may have influenced the interview dynamics or helped develop a deeper understanding of participant responses. This is explored further by the researcher in Chapter 4, the methodological paper. However, the audio was transcribed and analysed rigorously following Braun and Clarke's steps to reflexive TA, [65] and the themes generated captured participants' views accurately, so the limitation did not affect the data analysis.

The research incorporated the training needs of a range of professionals in inpatient settings; however, majority were mental health nurses or psychologists. Some professional subgroups, such as occupational therapists, did not participate in the research, and staff working in other health services were not included. Future research could explore the training needs of a wider professional subgroup from different settings such as community services, day care services, emergency services, etc., as these professionals are involved in service user care and could have different training needs.

While the inclusion criteria enabled some homogeneity in the sample i.e., mental health professionals working with individuals diagnosed with BPD in inpatient settings with more than one year of work experience, it was perhaps wide-ranging as there were some variations in the sample. Participants had a broad range of work experience (1 year-34 years), and differing levels of roles and responsibilities with some senior practitioners working at managerial positions. This was considered as a strength and limitation. For example, individuals in managerial positions were more likely to talk about the positive aspects of their work or successes rather than identifying challenges and needs, nevertheless, due to their immense work experience they were more likely to identify training barriers and needs at the

organisational and policy level. So, while a more homogeneous sample, which focused on newly qualified staff only, staff with 1-5 years of experience, or those in a specific position, would have been more fruitful, the different characteristics of participants led to a discussion of a wide range of training needs arising at different levels.

Conclusion

The training needs of mental health staff working with individuals diagnosed with BPD in inpatient settings can be understood at a multi-faceted level comprising the individual, organisational, and national. Individual training needs were in the areas of knowledge, understanding, and skills. Consequently, a KUS framework is proposed, which could be used as a basis for future BPD-related training, national policy or a national training programme. Furthermore, certain components of training are important for staff and have been demonstrated by the training that participants designed in the study. These components can be used as a reference point for training developers. Lastly, several organisation-level factors hinder the implementation of training, its application in practice, and the maintenance of its effects. Addressing these issues needs to be prioritised for training to be effective in practice.

Chapter 4, Methodological Paper- The role of non-verbal cues in qualitative interviews through videoconferencing: a reflective discussion

Introduction

When one thinks of qualitative research interviews, the first thing that comes to mind is 'verbal conversation'; however, there is a whole range of non-verbal cues at the disposal of the researcher, which could influence online interviews along with generating deeper meaning about participant responses. This paper explores further a limitation in Chapter 3 related to the exposure to non-verbal cues in videoconferencing. It begins with a brief description of videoconferencing and non-verbal communication. Next, Gorden's [175] and Knapp's [176] typology is used to discuss different modes of non-verbal communication that could influence online qualitative interviews through videoconferencing using examples and reflections from Chapter 3. It then argues for researchers to develop a more nuanced understanding of data and incorporate thinking about it during the design phase of online qualitative research. It concludes with different ways in which non-verbal data could be included in the research process.

Background

An interview is the most common method of data collection in qualitative research. [140] It is a 'professional conversation' where the interviewer asks questions to participants to gather information about their experiences concerning a pre-determined topic. [177, 178] Traditionally, a face-to-face interview was considered the 'gold standard', as it resembles a natural encounter between people and allows for an opportunity to build a rapport with participants. [179] However, online interview methods have been developed over the years due to the several drawbacks of face-to-face interviews, such as time and financial restrictions,

geographical limitations, and the physical mobility boundaries of participants. [180] Furthermore, the increase in digitisation and technological advances have created an increasingly sophisticated experience of online qualitative interviewing, a process even more accelerated due to the COVID-19 pandemic. [181] These developments have led to various asynchronous (non-real-time) remote communicative exchange methods, such as emails, bulletin boards, discussion groups, and online forums, and synchronous (real-time) methods, such as instant messaging, telephone, and videoconferencing. The focus of this paper is videoconferencing, as it allows for the discussion of a larger group of non-verbal cues that are often limited in other online interview methods.

Videoconferencing is an internet-based communication technology that allows for a synchronous conversation to happen with an exchange of audio-visual information. [182] It is the closest experience to face-to-face interviews as it allows researchers to meet their participants whilst geographically distant. The functionality offered by this mode of interviewing allows for communication to take place at a verbal and non-verbal level. Verbal communication refers to the explicit words spoken by participants, and non-verbal communication is expressed through non-linguistic modes (behaviour or attributes of individuals such as their body language, facial expressions, and use of time and space). Although a participant's words are considered central to qualitative interviews, non-verbal cues can provide data that can help identify deeper underlying meanings, even more important than that from speech. [183] Non-verbal communication, such as through facial expressions, convey core semantic information, [184] which leads to an increased understanding of participants. Thus, the participant's tone of voice, body language, clothes, and background all send messages to the interviewer and provide additional descriptions and meaning formations or assumptions to the verbal data.

Non-verbal communication also aids in building rapport with participants in qualitative interviews. Tickle-Degnen and Rosenthal [185, 186] proposed a theory of the nature of rapport that describes not only the affective nature of rapport but also its behavioural expression. The three essential components of rapport, according to them, are mutual attentiveness (intense mutual interest in what the other person is saying or doing), positivity (mutual friendliness and caring), and coordination (observable non-verbal behavioural coordination, synchrony, responsiveness). [186] They further describe the nonverbal correlates of these components of rapport, for example, attentive correlates would be bodily postures that signal communication accessibility, positivity correlates would be behaviours like smiling and head nodding that indicate liking and approval, coordination correlates are behaviours such as postural mirroring and interactional synchrony. [185] Furthermore, Tickle-Degnen's [187] research concluded that non-verbal expressivity is important for the formation and maintenance of rapport. Researchers have empirically tested the non-verbal correlates of rapport in different contexts and have confirmed its interrelationship. [188-190] Thus, in addition, to providing a deeper understanding of participant meanings, non-verbal cues can also help develop rapport with participants.

Non-verbal elements of conversation can be analysed in isolation from the spoken word. For example, Pell et al.'s [191] study looked at the expression of emotion through vocal cues, when the words spoken have no contextual relationship to the emotion being expressed. Ekman and Friesen [192] found that participants in their study could identify emotions from facial expressions alone. Sutherland et al. [193] found that faces look most trustworthy with a happy expression when they are facing the perceiver, compared to when they are facing elsewhere, whereas the opposite is true for anger and disgust. While it is possible to study non-verbal cues in isolation from the spoken word, communication is multimodal and verbal and nonverbal messages are co-occurring and interrelated phenomena. [194] Nonverbal cues

are often used in conjunction with verbal and other nonverbal cues, and their meaning can be influenced by the context in which they are used. To ignore either of the elements would lead to limited understanding of the phenomena under investigation. [194] For example, there can be discrepancies or inconsistencies between the non-verbal and verbal communication i.e., differences between what an individual says and how they say it. [195] Hence, to achieve a holistic understanding of social interaction it would be useful to analyse both elements in conjunction and the interaction between them.

The study

The study in Chapter 3 aimed to explore the specific training needs of staff working with individuals diagnosed with BPD in inpatient settings and to identify the components of effective training from their perspective. A qualitative research design was chosen. Data collection involved semi-structured interviews with 17 qualified mental health professionals working in an inpatient setting in the UK with experience of at least one year in working with individuals diagnosed with BPD. The interviews took place online through Microsoft Teams due to the COVID-19 pandemic restrictions and institutional guidelines. The interviews were video conversations, except for one audio-only interview, but all interviews were audio-recorded only using a separate recording device. The audio recordings were transcribed verbatim and anonymised, and participants were assigned pseudonyms. Hence, even though the researcher's and participants' cameras were switched on during the interviews, only audio data was recorded, transcribed, and analysed. The analysis was conducted following Braun and Clarke's steps to reflexive TA. [65]

The researcher maintained a reflexive diary throughout the research process. It became apparent at the end of data collection through reflection that non-verbal cues could have influenced the interview dynamics since the cameras were switched on during the interviews.

Gorden's [175] and Knapp's [176] typology will now be used to illustrate the different modes of non-verbal communication that could have influenced the online interviews: chronemics, kinesics, proxemics, paralinguistics, environmental factors, and physical appearance. Haptics, another mode included in Knapp's typology, [176] was not explored as it focuses on communication through physical contact in the form of touch, which is not relevant for online interviews. Each mode will first be introduced, followed by an example from the research interviews and reflections.

Chronemics

Chronemics refers to how we use and manipulate time, specifically in this context, how time affects communication. [196] Time-related cues in online interviews can be conversational rhythm, temporal speech markers (such as pauses, silences, gaps, and hesitations), or the time of day. [197, 198] These cues send messages to the interviewer and can convey several meanings. For example, if the participant took a long pause to answer a question, does this mean they are thinking of the response, are uncomfortable answering, do not understand the question, or simply the internet connection is lost? As illustrated, a simple pause can mean different things, and each would affect the interview dynamics in some way. Consider the following example from my interview with Lauren:

> Interviewer: would you say you have support available at work?
>
> Lauren: [short pause] yes, mostly [laughs] [24-25]

I asked Lauren the above question as part of the socio-demographic information I collected at the beginning of the interview. Even though her overall response was yes, the pause and laugh added more meaning to the verbal statement. It seemed to me that she used the pause to

think about the appropriate thing to say in the interview and was hesitant to say no (apparent in her eye gaze as she looked away) but wanted to convey that there was more to her response. If I did not pay attention to the non-verbal cues and focused on the 'yes, mostly', I would have interpreted her response differently by not putting more emphasis on the words. However, the non-verbal cues conveyed to me that there was more to unpack on the topic of support, which I explored later in the interview with her. This example demonstrates how a pause and other non-verbal cues can change the interpretation of participant responses and provide opportunities to ask follow-up questions that can delve deeper into a topic.

Kinesics

Kinesics refers to communication cues through body movements such as facial expressions, eye contact, postures, and gestures. [199] Specifically, facial expressions provide additional information to the spoken word and influence how we understand an interlocutor and our perception of the pragmatics of the interview. This is demonstrated by the strong evidence-base of the Facial Action Coding System (FACS), [200] a comprehensive anatomically based system used to measure all observable facial muscle movements. It has repeatedly been used by researchers to study the emotional experience of participants through their facial expressions. [201, 202]

I had an online video interview with a participant who joined the meeting from their workplace during the middle of a working day. I tried establishing rapport by introducing myself, informing them what would happen in the interview, and asking how they were doing. As the interview progressed, I noticed that the participant had a straight face during the interview; there were no facial expressions. It made me wonder if the participant was bored, tired, formal, uninterested, or did I ask something inappropriate. Many assumptions were going on in my mind, and as a result, I was conscious about asking questions or any

follow-ups. Additionally, I could observe only half of their body language due to the limitations of video interviews, so I could not rely on other non-verbal cues. The participant engaged in the discussion and answered the questions, but the lack of non-verbal cues meant that I was constantly trying to navigate through what appeared as unclear messages. I was trying to understand their emotional state, and I caught myself not being fully present in my quest to interpret the non-verbal cues. This resulted in me not asking many follow-up questions.

Facial expressions are considered critical to communication and offer insight into the speaker's attitudes, emotions, or intentions. [203] They are the primary source of identifying an individual's internal feelings. [203] It is not surprising then that the lack of facial expressions, in this case, meant that I struggled to delve into their communicative world. The example above illustrated how the lack of facial expression impacted the researcher and, in turn, the conversation. It also demonstrates how much facial expressions and body language can provide context and add meaning to the spoken word.

Proxemics

Proxemics refer to how space and distance influence communication. [196] Edward Hall [204] described four zones of interpersonal communication that characterised western culture, namely: public space (12 feet or more), social space (4-12 feet), personal space (1.5-4 feet), and intimate space (0-1.5 feet). Our personal zone extends from 1.5 to 4 feet away from our body, with the outer personal zone from 2.5 to 4 feet away. [205] The outer personal zone is used for conversations in professional settings that are private but not intimate or interpersonally close. In everyday life, this zone would be for friends or close acquaintances. Hence, in a face-to-face interview, it is unlikely that the researcher and participant would sit this close and instead be in the proxemic zone of social space. Participants would feel

uncomfortable if the researcher were in their personal space.

However, when we are conducting an interview online, the proxemics shift. Proxemics online would be how close or far away one is from the camera. Moreover, it is not uncommon for a person to be close to their computer screen, probably 2-3 feet away. Hence, unknowingly we allow others into our personal space. What this means for interviewers is an opportunity to develop a rapport with participants and understand their experiences. During the qualitative interviews in my study, the proximity between the participants and their screens varied; those using a laptop were closer to the screen, and those using a computer were a bit far away. Nevertheless, it enabled some intense and honest conversations about their experiences, reflected in the rich data produced. Participants were able to establish rapport quickly with the researcher and share challenging experiences from work, such as describing details of service-user self-harm, their experiences of not receiving support after major incidents and the negative attitudes of other staff members towards service users. For example, my participant Olivia shared a challenging incident from work:

> "I had um a patient I was only a month qualified and uh this patient tied a significant ligature, and she ends up having to have CPR, and I was the only nurse on shift and um it it was horrible, the patient survived and everything but I it was it was just you know quite traumatic, so I was newly qualified um and even after that um one of the matrons like promised me supervision to talk about everything that had happened and all that kind of stuff and I never actually got it um." Olivia [143-149]

Olivia shared this only a few minutes after the interview started, demonstrating that being in the personal zone of interpersonal communication possibly allowed participants to feel comfortable while communicating their experiences.

Paralinguistics

Paralanguage or paralinguistics refers to the vocalised but nonverbal aspects of communication. It involves the vocal qualities of words such as volume, pitch, quality of voice, frequency, and verbal fillers like 'um'. [196] These nonverbal cues enhanced the meaning of the words in the online interviews. For example, consider the following extract from my interview with Rose:

> "cause they're [nurses] just so fed up [inaudible] they get assaulted and they're not sort of there's no like recognition or rewards, um you know the NHS as a whole are so stretched at the moment um yeah so I think that's a big big problem [pause] [sighs] hmm [lowered voice] [long pause] yeah." Rose [303-306]

The words spoken by Rose helped me understand on a semantic level that she was trying to highlight the challenges faced by nurses in the NHS and that they are not appreciated for their work, and Rose sees the issue as a big problem. However, the paralinguistic cues, such as the sigh and hmm, showed Rose's personal reaction to this issue. There was a sense of helplessness, and exhaustion conveyed through the sigh, and there was possible sadness in the 'hmm' as she had a lowered tone of voice. When I considered her words in the context of these non-verbal cues, I realised that the topic of conversation was difficult for Rose. Hence, during her long pause, I did not interrupt her and gave her a few seconds to process before responding further. Therefore, the vocalised aspects of language can play a role in communication during interviews; it can help us understand the same participant words in a different light, and we can consequently respond in an appropriate manner.

Environmental factors

The environment is the physical space in which conversations take place. The place, setting,

or location of the interaction plays a significant role and can influence verbal and non-verbal communication. [196] Participants joined their online interview from various settings such as their living room, kitchen, bedroom, backyard, garden, and private or shared workspace. The researcher noticed that when participants were in their homes, the conversations were deeper as participants could share difficult experiences. This could be attributed to the fact that they were more comfortable in their homes, and confidentiality would be maintained as some questions were related to the organisation and organisational support. Whereas when they were at their work, the researcher identified a sense of restriction in what was being shared as any colleague could walk in and overhear their conversation. This was identifiable through various nonverbal cues such as pressured speech, closed body language, and limited facial expressions. Hence, the space determined how much participants disclosed about their experiences, influencing the interview conversation.

Another aspect of online interviews is that participants had more control over their setting and environment, and I had no control over it, which led to some surprises in the interviews. For example, a participant had her husband watching television in the background, and I had no idea about it until the participant mentioned it. It was interesting to reflect on how some factors in the participants' setting, which the researcher was unaware of, may have influenced what they shared in the interview, like, would the participant have given different responses if they were alone or at their workplace or the researcher's physical research setting?

Physical appearance

Physical appearance refers to physical characteristics such as body shape, height, weight, skin colour, hair, and attractiveness, and artefacts refer to objects we adorn ourselves and our surroundings with, such as clothes and jewellery. Our physical characteristics and the

artefacts surrounding us are an essential part of nonverbal communication because they not only reveal information about who we are and things that are important to us but also impact how others perceive us and communicate with us. [196, 206] For example, from a man wearing a white lab coat, you can quickly make a judgement that he is a doctor.

Even though online interviews can limit the information we gather about participants' physical appearance, they can still influence the interview dynamics or our perceptions of participants. For example, one of my participants joined the interview from her backyard after a long day at work, so she was wearing comfortable home clothes. She also appeared younger and close to my age. It gave me a sense of familiarity and comfort, and I could easily establish a rapport with her as I could relate to her. Whereas another participant joined the interview from her office, wore formal clothes, had her hair and nails done, and looked older in age, which collectively gave me the perception that she is influential and probably at a higher position, with a lot of experience. This made me feel conscious, and I ended up rethinking my questions to her to not sound foolish. As a result, I could sense the power differential, which made me reflect on how this could have influenced our conversation. Both examples illustrate how our perceptions of our participants' appearance can influence how we approach the interview.

Making a decision about data

The previous sections have demonstrated how non-verbal cues could impact online qualitative interviews, whether the interviewer is aware of it or not. Since they play a vital role, the question arises about whether to record and analyse this data. It is argued that researchers need to make a decision about this during the early phases of the project, perhaps during the design stage. They need to develop a more nuanced understanding of what constitutes data from video encounters and be mindful of the kind of data they wish to collect

and the procedures followed.

If they do not want to record and analyse non-verbal data, researchers must keep their cameras switched off during data collection, record the audio, transcribe the audio and analyse it. This is a benefit of online interviews, it allows us to keep our cameras off, while we cannot shut our eyes in face-to-face interviews. If they keep their cameras on and record only the audio, as I did in my qualitative research, the non-verbal visual cues in the video conversation still influence the interview, as illustrated by examples in this paper. We cannot ignore the physical appearance, body language, and environment of the participants once we have seen it, even though we do not formally record and transcribe it. Hence, researchers must keep their cameras off if they are not interested in recording the visual cues.

If they record both the audio and video but analyse only the audio recording, this raises governance issues, as ethically, researchers are not allowed to collect data that they do not analyse and report. The data minimisation principle of the General Data Protection Regulation (GDPR) [(207)] requires us to only collect personal data that we actually need for our specified purposes. Therefore, researchers need to make a decision a priori of the kind of data they need and the reasons for the same, and consequently only record and analyse what they need.

Alternatively, if they wish to record and analyse non-verbal data, researchers must keep their cameras switched on during data collection, record the audio and video, and analyse the audio and video. In summary, this relatively new way of conducting research requires a more nuanced understanding of what counts as data and requires researchers to think about the kind of data they are interested in during the design stage, as it subsequently impacts the type of transcription and method of analysis chosen. Figure 4 below provides a simple visual tool for the decision-making process.

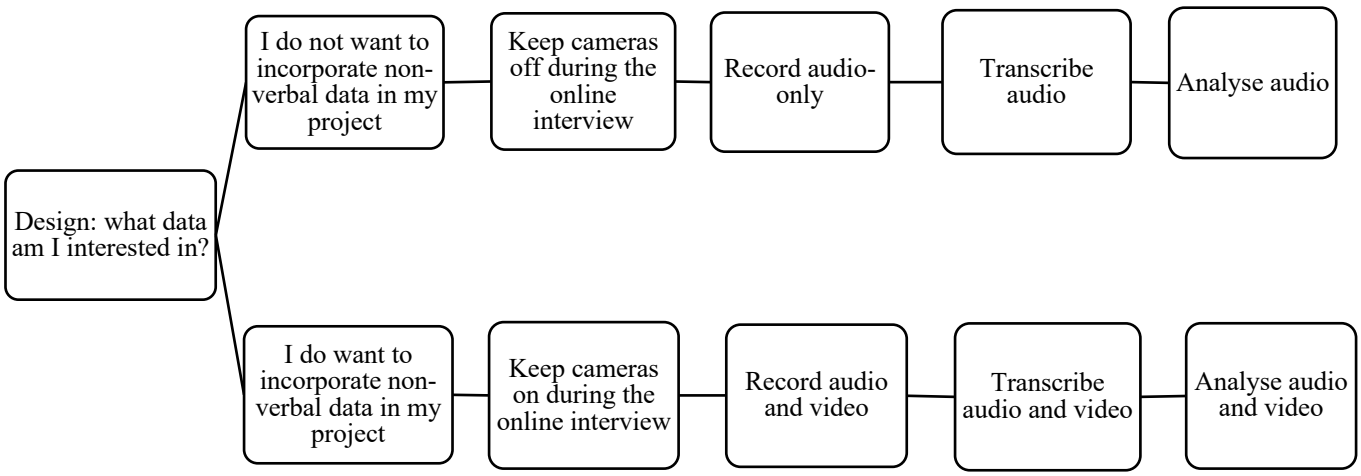

Figure 4: Decision-making tool for data in online qualitative research

Ways to incorporate non-verbal data in qualitative research

If the researchers decide to incorporate non-verbal data, there are some practical ways in which this can be achieved. Researchers can make notes during the interview of non-verbal cues that seem essential to the participant's meaning. For example, if the participant was looking away while sharing something difficult or if a particular question led to a long pause, noting these would provide some context to the verbal information shared and enable a deeper understanding. There are matrices developed by Onwuegbuzie et al., [208] which can be used as a framework for recording non-verbal cues in qualitative interviews.

Moreover, non-verbal cues could be mentioned in the transcript. This could be achieved by involving linguists who could tag the non-verbal data and help develop an understanding of the same data from a different angle. For example, if the transcript said, "The work with individuals with BPD is one of those things. For me, hmm, it's not challenging", a linguist with their expertise might transcribe it with linguistic tagging as "The work with individuals with BPD is one of those things [apprehension] For me, hmm

[contemplating] it's not challenging [uncertainty] [sigh]". Hence, such a methodological triangulation approach enables the exploration of the same data using different epistemologies and could enhance the rigour of a study. Researchers can also use software, such as ELAN (Version 6.4), [209] to annotate, document, and analyse verbal and non-verbal communication for video recordings. It also has plugins that automatically detect and annotate non-verbal cues such as pauses and utterances. Reflexivity can also be used to incorporate thinking about non-verbal communication, such as making notes during and after interviews and reflecting on how aspects of self influenced the interview and the participant's responses.

Conclusion

The current paper has illustrated, through examples and researcher reflections, how different non-verbal cues such as body language, physical appearance, and the environment could influence online qualitative interviews. Since these play a role in online data collection, it is imperative that researchers incorporate thinking about the kind of data they wish to collect and analyse during the design phase of the research. If they choose to incorporate non-verbal cues, there are several ways in which this can be achieved by using practical resources such as matrices and software, involving linguists, and practising reflexivity.

Chapter 5- Reflexive Statement

Subjectivity- who we are and what we bring- influences the research process within the qualitative paradigm. [65] I engaged in reflexive practice to acknowledge and interrogate my role in the research. In this section, first, I reflect on how my professional experience influenced my research, and then I describe two specific entries from my reflexive diary that were pertinent throughout my research.

Professional Experience

I am a qualified counsellor who works with children and adults in local charities in the city. However, I have never worked with individuals diagnosed with BPD or worked in inpatient settings. What this meant for my thesis was that I had an insider and outsider perspective. When I listened to participants share their experiences, I had a sense of empathy as I have worked with service users whose behaviours I have also found challenging. It has led to negative emotional reactions such as frustration and anger, and a need for further training or supervision. My experiences as a practitioner deepened my understanding of the participants' narratives and their needs. If the research had been conducted by an academic, who did not have experience working with service users, perhaps the findings would have been different.

Reflexive Diary

I maintained a reflexive diary throughout the research process and used the Experience, Reflection, and Action (ERA) model [210] to structure my reflections. It includes experience (the incident or situation), reflection (thinking through and learning from the experience), and action (applying what was learned) cyclically, where one component leads to the next. [211, 212] I will discuss two particular entries from my diary as they were central to my research experience.

My position on the label

When I began my Doctorate research, I had no specific opinion on the diagnostic system or psychiatry. Then, when I shared my recruitment poster on Twitter, I received comments from academics who negatively criticised my use of the term 'individuals with BPD.' I was reluctant to respond to those comments, and now thinking back, I did not know what to say, and hence I deleted the post (Experience). This instigated some thinking around, 'where do I stand on this debate?' It was important for me to answer this question because I was aware that my positionality would influence how I view my research and present it.

Consequently, I read literature about the argument, pros and cons from professionals' and service users' perspectives. [19, 20] Looking at it holistically, I felt that it is okay to use the diagnosis as long as it increases access to services and improves care rather than leading to stigma and rejection. I saw the diagnosis as not the problem but the stigmatising beliefs and behaviours as the problem. We would not drop the diagnosis of cancer as it leads to the right treatment; similarly, a diagnosis of BPD can be useful, but the stigma associated with it needs to be eliminated. Furthermore, I also believe it is important to see the service user as an individual first, as the diagnosis is a part of their life; they are not the diagnosis (Reflection). I approached my interviews and analysis with this position. Hence, throughout the project, I used the term individuals diagnosed with BPD rather than BPD individuals or service users with BPD (Action).

Imposter Syndrome

I am 24 years old, and soon after completing my masters, I started my professional doctorate. When I met other PhD students at the university, I perceived them as having more research experience, and I was concerned that they were more knowledgeable. I felt that I did not

belong and that my opinion did not matter as I was not smart enough. This denial of one's achievements and abilities is commonly known in academia as the imposter syndrome. [213] Consequently, this sense of underconfidence and self-doubt was reflected in my writing. The examiners of my RD2 (research milestone) viva identified this when they said I did not speak enough about the importance of my work (Experience). After reflection, I realised that because I did not believe in my abilities, I felt the work I was doing would not have an impact (Reflection). Following this, I spoke to my supervisors, who provided useful guidance and encouragement along the way. I also made active efforts to remind myself through journaling to have confidence in my research arguments; this improved my writing and how I communicated about my work (Action).

Appendices

Appendix A: Author Guidelines, Personality and Mental Health journal

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2. Thornicroft GJ. *Shunned: Discrimination Against People with Mental Illness*. Oxford University Press, 2006.
3. Clark L-A, Shapiro JL, Daly E, Vanderbleek EN, Oiler MR, Harrison J. Empirically validated diagnostic and assessment methods. In: Livesley WJ, ed. *Handbook of personality disorders, 2nd Edition*, pp. 35-51. New York: Guilford Press, 2015 (in press).
4. Lancet. Burnished or burnt out: the delights and dangers of working in health (editorial). *Lancet*1994; **344**: 1583-4.
5. Pharmaceutical Research and Manufacturers of America (PhRMA). *PhRMA Guiding Principles on Direct to Consumer Advertisements About Prescription Medications*. PhRMA, 2005. **http://www.phrma.org/codes-and-guidelines/phrma-guiding-principles-for-direct-to-consumer-ads-on-medicines**
6. Viding E, Frick P, Plomin R. Aetiology of the relationship between callous-unemotional traits and conduct problems in childhood. *Br J Psychiatry 2007*; **190** (suppl 49): s33-8.

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Appendix B: Ethical Approval Documentation

Manchester Metropolitan University

06/10/2020
Project Title: Borderline Personality Disorder: A qualitative exploration of the training needs of mental health staff in inpatient settings

EthOS Reference Number: 25131

Ethical Opinion

Dear Aashni Himanshu Shah,

The above application was reviewed by the Health, Psychology and Social Care Research Ethics and Governance Committee and, on the 06/10/2020, was given a favourable ethical opinion. The approval is in place until 14/01/2022 .

Conditions of favourable ethical opinion

Application Documents

Document Type	File Name	Date	Version
Project Protocol	Protocol Aashni V1.1	02/10/2020	1.1
Recruitment Media	Poster V1.1	02/10/2020	1.1
Recruitment Media	Email for potential gatekeepers V1.1	02/10/2020	1.1
Consent Form	Consent Form V1.1	02/10/2020	1.1
Information Sheet	Participant Information Sheet Staff V1.1	02/10/2020	1.1
Information Sheet	Debrief Sheet Staff V1.1	02/10/2020	1.1
Information Sheet	Withdrawal Form V1.1	02/10/2020	1.1
Additional Documentation	Interview Schedule V1.1	02/10/2020	1.1

The Health, Psychology and Social Care Research Ethics and Governance Committee favourable ethical opinion is granted with the following conditions

Adherence to Manchester Metropolitan University's Policies and procedures

This ethical approval is conditional on adherence to Manchester Metropolitan University's Policies, Procedures, guidance and Standard Operating procedures. These can be found on the Manchester Metropolitan University Research Ethics and Governance webpages.

Amendments

If you wish to make a change to this approved application, you will be required to submit an amendment. Please visit the Manchester Metropolitan University Research Ethics and Governance webpages or contact your Faculty research officer for advice around how to do this.

We wish you every success with your project.

HPSC Research Ethics and Governance Committee

HPSC Research Ethics and Governance Committee

For help with this application, please first contact your Faculty Research Officer. Their details can be found here

Page 1 of 1

26/03/2021
Project Title: Borderline Personality Disorder: A qualitative exploration of the training needs of mental health staff in inpatient settings

EthOS Reference Number: 25131

Ethical Opinion

Dear Aashni Himanshu Shah,

The above amendment was reviewed by the Health, Psychology and Social Care Research Ethics and Governance Committee and, on the 26/03/2021, was given a favourable ethical opinion. The approval is in place until 14/01/2022 .

Conditions of favourable ethical opinion

Application Documents

Document Type	File Name	Date	Version
Additional Documentation	Protocol Aashni V1.2	18/03/2021	v1.2

The Health, Psychology and Social Care Research Ethics and Governance Committee favourable ethical opinion is granted with the following conditions

Adherence to Manchester Metropolitan University's Policies and procedures

This ethical approval is conditional on adherence to Manchester Metropolitan University's Policies, Procedures, guidance and Standard Operating procedures. These can be found on the Manchester Metropolitan University Research Ethics and Governance webpages.

Amendments

If you wish to make further changes to this approved application, you will be required to submit an amendment. Please visit the Manchester Metropolitan University Research Ethics and Governance webpages or contact your Faculty research officer for advice around how to do this.

We wish you every success with your project.

HPSC Research Ethics and Governance Committee

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For help with this application, please first contact your Faculty Research Officer. Their details can be found here

Appendix C: Final Chart from the Scoping Review

Study	Training	Duration	Setting	Aim	Trainer	Trainees	Materials and/or teaching methods	Supervision	Challenges for implementation
Miller and Davenport, 1996	Educational intervention in the form of a programmed instruction module	90 minutes	Acute adult inpatient psychiatric units in general hospitals	Effect of the program on knowledge, attitudes, and behavioural intention	N/A	N=19. Registered Nurses.	A self-paced programmed instruction module in the form of a booklet titled Success with Patients Who Have Borderline Personality Disorder.	N/A	N/A
Krawitz and Rreal, 2001	Foundation training	2 days	Public mental health organisation	Achieve positive attitude change, provide a framework for treatment provision, and development of practical skills	The author, a psychiatrist, trained in psychodynamic, cognitive-behavioural, and dialectical behaviour therapy, delivered the workshops. A later development was the recruitment of another trainer, a psychologist managing a public sector consultation and treatment service for people with BPD.	N=910. Nurses, social workers, psychologists, occupational therapists, and doctors. They worked in community mental health centres, acute inpatient settings, crisis services and rehabilitation services. The number of training participants ranged from 8 to 40, with a mean of 19.9.	Student-centred participatory learning. Current skills were affirmed and validated. Multiple educational media used included overheads, posters, audiotapes, videotapes, and interactional methods. Similarly, didactic teaching was kept to a minimum, with considerable use of group 'brain-storming' ideas, clinical vignettes for discussion and role play, role play of participant-generated situations, small and large group discussion, and guided self-imagery. Preparatory information (4,000 words) and 150-page workbook.	N/A	N/A
Krawitz, 2004	Workshop	2 days	Public mental health and substance abuse services	Achieve positive attitude change, provide a framework and common foundation for treatment provision, and development of practical skills	Author	N=910. Workshop numbers ranged from 8 to 35, with a mean of 20.7. Clinicians worked in public mental health and substance and alcohol abuse services and worked in inpatient, outpatient, crisis, and rehabilitation settings.	Student-centred participatory learning. Multiple educational media used included overheads, posters, audiotapes, videotapes, and interactional methods. Similarly, didactic teaching was kept to a minimum with considerable use of interactional learning in small and large groups using both open and structured discussion (including clinical vignettes and questions generated by the presenter or participants) and planned and spontaneous role play. Interactional learning activities-85%, didactic teaching-10% and video viewing-5% of workshop time. Each workshop participant was given a 150-page book co-authored by the paper's author.	N/A	N/A
Hazelton et al., 2006	DBT Staff Training Program	2 day (basic) 2 day (advanced)	Mental health service	Provide an understanding of BPD and DBT	N/A	N=94. Basic training: all staff from both inpatient and community teams within the mental health service, doctors, nurses and allied health professionals	The program also incorporated the principles of adult learning, including a strong emphasis on experiential learning techniques.	Therapist consultation meetings, peer group supervision and support, using the same strategies used to support consumers. Involvement in consultation/supervision meetings held weekly, in conjunction with personal study and supervised experience, enabled staff to continue	Constant staff turnover and administrative changes amplified difficulties associated with operating in a

						from local drug and alcohol services, nursing staff from the local emergency department and regional hospitals, a pharmacist from the local pharmacy department, allied health and nursing staff from the local psychiatric rehabilitation service and representatives from child and family health nursing services. Advanced training (n=20).		to enhance their skills as DBT therapists.	large semi-rural region. Staff identified their location distant to the main regional city as an issue in accessing both support and ongoing professional development.
Krawitz and Jackson, 2007	Consumer-clinician Co-taught workshop	2 days	N/A	To examine the effect of a consumer-trainer involvement in training	Consumer and clinician presenter.	N=269. Nurses worked in public mental health and substance use services in hospital, community, crisis, and rehabilitation settings. 12 training workshops.	Each workshop participant was given a 150-page book co-authored by one of the authors of the paper.	N/A	N/A
Perseius et al., 2007	DBT training programme	24 months	Psychiatric clinics	Effect of training on occupational stress and professional burnout	N/A	N=22. Two physicians, three psychologists, eight registered nurses, eight mental care assistants and one occupational therapist.	N/A	The therapists received group supervision for 3 hours a week. The mindfulness training, the support from the team and the supervision were seen as especially helpful in coping with stress.	N/A
Treloar and Lewis, 2008	Clinician Education Program	120 minutes	Health services	Effect of targeted education on attitudes towards working with deliberate self-harm behaviours in BPD	Psychologist, PhD Candidate, also author.	N=9. Registered practitioners. Mental health and emergency department staff of the health service.	The educational material was presented in a lecture format using a PowerPoint Presentation. Clinical guidelines were provided at the end of the program.	N/A	N/A
Treloar, 2009	Educational programs: cognitive-	2 hours	Health services	Effect of two types of theoretical	Author, M.A.P.S., M. Psychotherapy.Couns.	N=140. 41 in the control group, 50 in the cognitive-	Lecture format	N/A	N/A

	behavioural and psychoanalytic			frameworks in changing attitudes toward deliberate self-harm behaviours in BPD		behavioural group, and 49 in the psychoanalytic. Nurses, allied health professionals, and medical practitioners.			
Shanks et al., 2011	the Systems Training for Emotional Predictability and Problem Solving (STEPPS)	6 hours	N/A	Effect of training workshop on attitudes toward patients with BPD	MSW and author.	N=271. Psychiatrists, psychologists, social workers, nurses, substance abuse counsellors, mental health counsellors, and community supported living workers.	Teaching involved formal didactics, video presentations, and case examples.	N/A	N/A
Carmel et al., 2014	DBT Training	10 days across 13 months	Large urban public behavioural health system	Effect of DBT training on burnout	An expert DBT trainer.	N=34. Mental health practitio ners and substance abuse counsellors.	A variety of resources on maintaining successful adherence to DBT were made available to clinicians, including an international DBT listserv, an online forum of video demonstrations of DBT interventions, phone consultation, and feedback on recorded sessions.	Case consultation, phone consultation, and feedback on recorded sessions. The structure and support provided by the weekly consultation group, which explicitly focused on adherence to the treatment strategies, were most likely to be effective in maintaining clinician motivation and hope.	N/A
Knaak et al., 2015	Anti-stigma program, BPD and DBT	3 hours	Hospital	Effect of the program at improving attitudes and behavioural intentions and reducing stigma towards patients with BPD and mental illness more generally.	Professional- MD, FRCPC, a specialist in DBT and a general adult inpatient psychiatrist in Calgary, Canada and three co-presenters.	N=230. Healthcare providers targeting front-line community and outreach service providers as well as hospital-based providers. Social worker, nurse, counsellor, occupational therapist, psychologist/psychiatri st, student, director/manager, and others.	An enthusiastic facilitator who set the tone and modelled person-first (as opposed to disorder-first) language and behaviour.	N/A	N/A
Warrender, 2015	Mentalisation-Based Therapy Skills Training (MBT-S)	2 days	Acute mental health wards	Provide MBT skills	N/A	N=9 staff nurses	The format was a combination of didactic teaching, role play and DVD clips.	All participants were offered the opportunity to attend group clinical supervision after training. Only 3 of the 9 participants could attend. Activity in clinical areas and lack of protected time. Those who could not	N/A

								attend voiced willingness and enthusiasm to attend. Of the three participants that had attended, all found it extremely useful. Key themes emerged as consolidating the MBT model, providing reassurance and peer support, increased self-confidence in nurses, ensuring consistency and adherence to MBT-S, and strategies for moving forward with severely distressed patients.	
Clark et al., 2015	Brief MDT training session based on Porr's (2011) neurobiological framework	90 minutes	23-bed low secure unit	Increase knowledge, increase empathic concern, increase perspective taking, and change locus of origin of BPD	Consultant clinical psychologist.	N=34. Nursing staff, occupational therapy staff, psychology staff, education, social work staff member, and administration staff.	Power-Point presentation entitled 'The Science of Borderline Personality Disorder.'	N/A	N/A
Haynos et al., 2016	DBT skills coaching training	6, 2-hour sessions across 12 weeks	116-bed residential facility	Increase DBT skills and knowledge, decrease burnout, decrease stigma	PhD level clinical psychologist who is an internationally recognised expert trainer in DBT with more than 20 years' experience in the delivery, training, and supervision of DBT. Assisted by two intensively trained master's level (in marriage and family therapy and clinical psychology, respectively) DBT clinicians, with at least two years' experience delivering DBT.	N=22. Three cohorts of mental health nursing staff, consisting primarily of mental health technicians and nurses.	N/A	N/A	N/A
Dickens et al., 2019	'Positive About Borderline' training programme	6 hours	NHS site	Evaluate intervention to improve attitudes	3 Authors and an NHS employee.	N=28 Clinical nursing staff.	N/A	N/A	N/A

Masland et al., 2018	Good Psychiatric Management (GPM)	1 day	Academic medical center	Effect of training on changing clinician attitudes about BPD	Three of the authors were instructors for the workshop.	N=52. Mental health workers within the MMC system of care.	Presentation, instructive case videos, and written case vignettes.	N/A	N/A
Burke et al., 2019	Clinician Connections (CC)	2, 3.5-hour sessions, one month apart	Public mental health setting	Investigate the perceived utility and acceptability of the training and explore areas for further development	Family Connections leaders and trainers.	N=26 qualified mental health professionals	N/A	N/A	Both the contact hours and the number of sessions for CC were informed primarily by practical service constraints.
Darongkamas et al., 2020	Training course	3 days	Large mental health trust	To record and alter staff perceptions through training	Experienced Clinical Psychologists from in-house and the region, as well as one in-house experienced Consultant Psychiatrist.	N=442. Psychiatrists, psychologists, nurses, occupational therapists, and support workers, mainly from community and inpatient mental health teams.	A local training package	N/A	There was some urgency to setting up and implementing the training, not least because of patient and service needs but also because of the constraint of spending funds by the financial year end.

Study	Content	Evaluation/Feedback
Miller and Davenport, 1996	• Topics covered were the aetiology of BPD, behaviour of patients with the disorder and staffs' reactions, and treatment. • Staffs' reactions toward the patients were emphasised, as was the importance of recognising and modifying these reactions. • The program further explained the importance of staff communication and consistency.	Significant differences were found post-test in change in knowledge of and attitudes toward patients with BPD. The self-directed aspect of this intervention may be one reason for its success in changing staff knowledge and attitudes.
Krawitz and Rreal, 2001	• History of the disorder, epidemiology, diagnosis, aetiology, prognosis, suicide statistics, treatment outcome studies and an introduction to psychodynamic, self-psychology, relationship management, dialectical behaviour therapy and integrated treatment models, identifying a treating system structure, and a treating system culture that promotes cohesion and integration of services, individualised agreements, and clinical and crisis plans developed in the context of a committed patient-clinician relationship, conceptual frameworks guiding treatment such as patient self-responsibility and limits of clinician responsibility, power and power struggles, optimal amount of therapist input, acute versus chronic suicidality and balancing short versus long-term risks and gains. • Specific treatment topics explored were how to keep acute hospitalisations brief, containment, skills training, behavioural chain analysis, pharmacology, and self-harm. • Ethical and medico-legal issues covered included optimal relationship closeness, therapeutically indicated risk-taking, risk/benefit analysis and the minimal use of mental health legislation. Patient and relatives'/friends' perspectives were aired using video and literature. • Staff differences, boundaries and countertransference topics were woven into the workshop.	• Participants' subjective ratings of their theoretical knowledge and clinical skills improved post-workshop at a statistically significant level. • Optimism, confidence, and a willingness to work with people with borderline personality disorder also statistically improved on post-workshop ratings. • An overarching theme of participants valuing the workshop for its instillation of hope, affirmation of the importance of the work and the provision of a theoretical and treatment perspective, which was enabling for the clinician. • Staff members felt they developed a common language and shared an understanding of aetiology and a similar treatment perspective.
Krawitz, 2004	• Workshop content included diagnosis, aetiology, prognosis, identifying an effective treatment system structure, and a treating system culture that promotes cohesion and integration of services. • Individualised treatment plans developed in the context of a committed patient-clinician relationship, conceptual frameworks guiding treatment such as the finely tuned balancing of client and clinician responsibility, power and power struggles, acute versus chronic suicidality, and balancing short versus long-term risks and gains. • Specific treatment topics explored were how to keep acute hospitalisations brief, containment, skills training, behavioural chain analysis, pharmacology, and self-harm. • Ethical and medico-legal issues included boundaries, professionally indicated risk-taking, risk/benefit analysis and the minimal use of mental health legislation. • The workshop concluded with clinician self-care issues, including supervision. The topics of staff differences, boundaries and the importance of monitoring and processing clinician emotions were woven into the workshop.	• The results from post-workshop evaluation showed that the workshop overall was positively received and was relevant to participants' work. • The vast majority of the participants (99%) stated they would recommend the workshop to colleagues. • At 6-month follow-up, participants reported that the workshop had considerably impacted their clinical practice.
Hazelton et al., 2006	DBT principles and practice.	• The post-training transcripts indicated a shift towards much more optimistic therapeutic outlooks. In particular, this post-training discourse suggested that staff were much more critically self-reflective, frequently indicating the influence of exposure to the principles and practice of DBT. • In some cases, participants spoke of DBT as having provided a more lucid framework to structure forms of engagement and intervention that had been tried previously but in ways that were unclear and poorly focused. DBT was seen to have provided a structure and logic that could now be followed; moreover, as the second excerpt following indicates, the language of DBT was seen to provide the 'positive catchwords' or slogans driving a more therapeutically optimistic clinical practice.

		• An unexpected finding of the study was the extent to which the lessons of the DBT training had an impact on participants' personal lives. In particular, a number of those involved spoke of how mindfulness training had become important, not only in their clinical work but also in their daily lives. • Finally, a number of participants expressed surprise and satisfaction regarding the extent to which service leaders had supported the DBT program; this was seen as 'high level' support for a project that was important to those at the clinical 'coalface'.
Krawitz and Jackson, 2007	Workshop content included diagnosis, aetiology, prognosis, treatment system structure (community-based treatment with crisis service and brief hospitalisation support), treatment plans, behavioural chain analysis, skills training, pharmacology, balancing client and clinician responsibility, acute versus chronic suicidality, short-versus long-term risks and gains and clinician emotions, supervision and self-care.	• Using means, the results of the co-taught training reported in this paper are superior to those of the clinician-only-presented training reported by Krawitz (2004). In the written survey, 'What did you like most about the workshop?' the consumer-presenter was specifically named three times more frequently than the clinician-presenter. • Participants rated the consumer-presenter's contribution highly, with 100% stating that the consumer-presenter should continue to be a co-presenter in future training. • Participants' views on co-taught training also changed because of attending the training. Providing training from both a clinician and consumer perspective can be successfully traversed, and the rewards and benefits far exceed that of training provided from one perspective only.
Perseius et al., 2007	Theory and Practice of DBT along with supervised treatment of patients.	DBT emerges as a treatment that may be stressful to learn but seems to improve the psychiatric professionals' capacity to deal with a difficult patient group because of its structured nature. What components in DBT increase/decrease stress? 1. mindfulness training makes you cope with stress better, 2. the team and supervision bring support, 3. a complex method that takes time to learn.
Treloar and Lewis, 2008	• Research findings on attitudes to BPD, prevalence rates, DSM-IV diagnostic criteria, aetiological factors, definitions and rates of self-harm and suicide, and therapeutic responses to BPD. • Each education session then illustrated the applicable concepts of the theoretical discussions on BPD using the presentation of case studies of three female patients diagnosed with BPD. • Clinical guidelines for working with BPD, including Crisis Intervention in Emergency Department Guidelines and National Clinical Practice Guideline Number16:Self-harm, were also provided at the end of the education program.	Statistically significant improvements in attitude ratings were found for both emergency medicine clinicians and mental health clinicians in working with deliberate self-harm behaviours in borderline personality disorder, following attendance at the education program with a medium effect size.
Treloar, 2009	• Research findings on attitudes toward borderline personality disorder, prevalence rates, DSM-IV diagnostic criteria, etiological factors, definitions and rates of self-harm and suicide, and therapeutic responses to BPD. Discussing and illustrating the applicable concepts of the theoretical discussions of BPD using three case studies of female patients diagnosed as having this disorder. • The cognitive-behavioural education program (which covered a dialectic behavioural therapy approach) used these three case studies to illustrate the use of deliberate self-harm behaviours as a means by which to modulate overwhelming affective experiences among patients who had developed affective instability through a process of invalidation in childhood. • The psychoanalytic education program (which covered the theoretical framework of moral masochism) used these three case studies to illustrate the use of deliberate self-harm behaviours as a process by which to discharge an unconscious sense of guilt. • Clinical guidelines, including guidelines on crisis intervention in emergency departments and the national clinical practice guideline on self-harm, were discussed in the last 30 minutes of the lecture.	Compared with participants in the control group, participants in the cognitive-behavioural program showed significant improvement in attitudes immediately after attending the program ($p=.02$), as did participants in the psychoanalytic education program ($N=25$) ($p<.01$). However, the six-month follow-up revealed that only the psychoanalytic education group maintained significant changes in attitude ($p<.05$).

Shanks et al., 2011	STEPPS is a fully manualised 20-week group treatment program for outpatients with BPD that combines cognitive-behavioural elements with skills training and psychoeducation. Additional information about the program is available at www.steppsforbpd.com.	• The results support the hypothesis that clinician education can modify negative attitudes toward BPD patients, including self-perceptions of their ability to treat these patients and to experience a positive treatment outcome. • Importantly, compared with pre-workshop results, responses following the training indicated that attendees were more likely to endorse feeling competent to care for these patients, and they were less likely to endorse the statement that they would prefer to avoid these patients. • Clinicians were more confident of their ability to make a positive contribution to the patient's favourable treatment outcome as well. • The results offer preliminary evidence that education about the nature and treatment of BPD can lead to more positive attitudes toward these patients and eventually serve to decrease the stigma they face.
Carmel et al., 2014	The first training offered an introduction to DBT and included a background of the biosocial theory and an overview of the research supporting the efficacy of DBT. A three-day training followed a month later focused on program development and intensive team building. At 4 months post-baseline, a two-day training was presented on DBT skills, problem assessment, skills coaching and DBT consultation team building. An advanced training in DBT followed 13 months after the initial training focusing on a review of previous materials and case consultation.	• The study showed a significant decrease in mean ranked scores of burnout after attending a series of DBT training over a period of 13 months. The findings suggest that DBT training holds promise as a way to reduce exhaustion and fatigue associated with burnout. • Possible reasons for this include the specific targeting and strategies DBT provides in crisis and other highly stressful interactions, an emphasis on DBT clinicians practising the core DBT skills of distress tolerance, mindfulness, emotion regulation, and interpersonal effectiveness, as well as the structure and support provided by the weekly consultation group which explicitly focuses on adherence to the treatment strategies most likely to be effective and maintaining clinician motivation and hope.
Knaak et al., 2015	BPD and DBT. The program's objective was to improve healthcare providers' attitudes and behavioural intentions towards persons with BPD through a combination of education and skills training, as well as social contact. The workshop contained a number of ingredients shown to be effective for improving attitudes among healthcare providers towards persons with mental illnesses, including an educational/skills training component designed to improve healthcare providers' abilities to effectively interact with and help patients, education to correct common misperceptions, social contact in the form of a live, personal testimony from a person with lived experience of BPD, an emphasis on and demonstration of recovery (including a case study which exemplified recovery and achievement), and an enthusiastic facilitator who set the tone and modelled person-first (as opposed to disorder-first) language and behaviour.	• Results showed that stigma towards persons with BPD was significantly higher than that against persons with a mental illness more generally. Scores on the BPD-specific scale remained high, higher even than the baseline scores for mental illness more generally, even after the intervention. • Results suggest that the targeted intervention was successful at improving healthcare provider attitudes towards persons with BPD and a mental illness more generally, although the improvement in attitudes towards persons with a mental illness was considerably smaller than that towards persons with BPD. • Such results further suggest that attitudes towards a highly stigmatised disorder like BPD can be improved through relatively short interventions if those interventions are designed and delivered properly. • The results further suggest that anti-stigma interventions effective at combating stigma against a specific disorder may also have positive generalisable effects towards a broader set of mental illnesses, albeit to a lessened degree.
Warrender, 2015	MBT-S theory, skills, and principles.	• Participants found the approach easy to grasp, improving of consistency between staff, and flexible in its use in planned or 'off the cuff' discussions. MBT-S promoted empathy and humane responses to self-harm, impacted on participants' ability to tolerate risk, and went someway to turning the negative perception of BPD through changing the notion of patients as 'deliberately difficult'. • Staff felt empowered and more confident in working with people with a diagnosis of BPD. • The positive implication for practice was the ease with which the approach was adopted and participants' perception of MBT-S as an empowering skill set which also contributed to attitudinal change.

Clark et al., 2015	The course content was based on the work of Porr (2011), and topics covered included: an overview of BPD, DSM-IV diagnostic criteria, the role of the invalidating environment and neurobiological vulnerabilities, the role of neurotransmitters, the architecture of the brain, brain functioning and the related behavioural aspects in BPD.	Attendance at the training session was associated with significant increases in theoretical knowledge, Perspective Taking and Locus of Origin scores. However, there were no changes observed in Empathic Concern scores.
Haynos et al., 2016	Focused on the acquisition of DBT skills, knowledge, and strategies for implementing effective skill coaching.	• The results suggest that the brief DBT skills coaching training increased knowledge of DBT skills and reduced personal and work-related burnout, as well as patient stigma. These results support the utility of providing brief DBT skill coaching training for nursing staff in inpatient or residential psychiatric settings, at least in facilities providing treatment for children and adolescents. • The skill training was also conducted in relatively small groups, was interactive, and was delivered over many weeks. This training format intentionally provided opportunities for staff to practice skills coaching both in the training in order to receive coaching and feedback themselves and between training sessions.
Dickens et al., 2019	• Part 1: epidemiology and aetiology of BPD grounded in a biosocial understanding of the disorder together with discussion and activities. • Part 2: The programme comprises (a) an introductory booklet, 'Borderline Personality Disorder: A Personal Story', which outlines some of the challenges Jo has faced over the years as a person living with BPD, and the coping strategies she has employed in an attempt to overcome them and (b) introduction of a package of activities and resources (e.g., flashcards, suggested talking points) designed to aid clinicians in working with people with a BPD diagnosis and covering four key concepts, each related to DSM-5 diagnostic criteria for BPD: feelings, thoughts and behaviours; relating to others; identity; and planning for the future.	• The qualitative data suggested that attendees welcomed the expert by experience (Wot R U Like?) input and found it informative and enlightening, certainly the experiential aspect. • Participants largely felt very differently about The Science of BPD. While some found at least some interesting information, the session was considered by participants to be a refresher of existing knowledge, commonly to be a waste of time and even potentially detrimental to what were viewed as core skills already practised. • One of the key criticisms of The Science of BPD approach was that it was not rooted in the realities of service provision as participants experienced it. Indeed, this perspective is reinforced by the contrast between enthusiasm for the experiential aspect of Wot R U Like? and the more circumspect response to and lack of uptake of the interventional resource. • For future learning, participants suggested that needs included consolidation of education and training to ensure application; more whole team networking; consistency across care; individual practical tools rather than introductions to therapeutic methods; and more service user input-particularly on what they wanted and needed from the services.
Masland et al., 2018	A series of didactics on BPD's aetiology, course, and treatment, as well as instructive case videos and written case vignettes.	Findings indicate that brief training can foster enduring improvements in clinician attitudes and beliefs about BPD.
Burke et al., 2019	There is an initial focus on providing up-to-date psychoeducation about BPD, the biosocial theory and the transactional model. Clinician Connections: Day 1: Understanding Emotion Dysregulation, Mindfulness Skills, Emotional Awareness of Self and Other. Day 2: Validation and Acceptance Skills, Problem Management Skills.	• Several practical suggestions were made about the structure of the workshop. These minor suggestions included increasing font size on handouts and providing electronic copies of the presentation slides to improve the resources offered. • One key point centred on the volume of information that was communicated over the course of the workshop. Specifically, practitioners felt that too much information was presented but recognised that it was necessary to convey all the content. • Practitioners noted that they experienced difficulty concentrating during the latter part of the session. It is therefore recommended that the intervention is delivered in shorter but more frequent sessions to cover the existing CC programme, as well as the additional DBT skills.
Darongkamas et al., 2020	• Diagnosis (both potentially helpful and harmful aspects, classification systems and subtypes of PD), societal views, presenting difficulties commonly reported, service user perspectives, the role of trauma, associated risks to the person, influence on a person's development (including a brief explanation of brain development), national perspectives, and published features of helpful services. Clinicians also examined relational/interactional reciprocal roles and CAT concepts.	• Positive changes resulted from a mixed-methods evaluation of the training. • In the teaching materials, there was some minimal information given about how trauma can affect the physical development of the part of the brain that controls emotion. Observation suggests that this did seem to be noteworthy to some, to help understand and possibly break the stereotype of 'oh, but they can help it'.

- The influence of traumatic experiences on development (childhood interpersonal interactional roles & self-limiting beliefs), explored the therapeutic alliance, the importance of boundaries, ways we all have of trying to cope plus unintended consequences, PTSD and Dissociation, and the efficacy of psychological and other interventions.
- Training was then provided on: interviewing, assessment, and formulation, agreeing target difficulties and intervention, some emotional management skills to teach patients, staff self-care and the importance of good-enough endings.
- Courses were introduced by someone with lived experience, speaking of their viewpoint; when this was not possible, an audio recording was often used.

- It is noteworthy that increased self-reported self-confidence was found in staff, as was improved perception of the therapeutic relationship. The latter was likely helped by an improved understanding of potentially difficult dynamics and potential avoidance of additional iatrogenic relating difficulties.

Appendix D: Recommendations from the Scoping Review

Training developers	Researchers	Services
Service users should be involved in at least some capacity in training, such as participating in advisory committees, producing learning materials, or becoming trainers.	Report training components in detail.	Make routine supervision available and provide protected time for it.
During the planning and implementation stage, service context should be considered.	Report on how the training was developed and the challenges and facilitators experienced during its implementation.	
Training could be delivered online to increase accessibility for staff.	There needs to be a shift in perspective from focusing on changing negative attitudes to equipping health professionals with the knowledge and skills to meet service user needs.	
The affective domain should be emphasised for more holistic learning.	More qualitative methods should be employed in training evaluation.	
There needs to be a shift in perspective from focusing on changing negative attitudes to equipping health professionals with the knowledge and skills to meet service user needs.	Alternative data collection methods should be used, such as semi-structured interviews.	
	Identify the impact of staff training on service user outcomes and perhaps involve service users in training evaluation.	

Appendix E: Research Recruitment Poster

Manchester Metropolitan University

Borderline Personality Disorder: Training needs of mental health staff

OBJECTIVES

- Explore training needs of staff
- Identify components of training from their perspective

FOR WHOM?

- Qualified **mental health professionals**,
- Currently working in an **inpatient setting** in the United Kingdom,
- At least **one year experience** in working with individuals diagnosed with BPD.

WHAT IT INVOLVES?

An online interview for approx 45 mins.

IF INTERESTED, PLEASE CONTACT

Aashni.h.shah@stu.mmu.ac.uk

Ethics Approval Reference Number: 25131
Version Number 1.1, 2nd October 2020

Appendix F: Interview Schedules

Original Schedule

Manchester Metropolitan University

Interview Schedule
Borderline Personality Disorder: A qualitative exploration of the training needs of mental health staff in inpatient settings

1. Could you please tell me what interested you in this study?
2. Can you please tell me about your experience of working with individuals with BPD?
- What has been rewarding/positive while working with them? What challenges have you faced while working with them?
- Could you please provide details about any previous BPD-specific training you have received?
3. What do you need when providing services to those with BPD?
- What support do you need?
- What organisational systems do you need in place?
4. What are your training needs?
- What areas do you need further training in?
- Could you please elaborate on that? (explore specific needs)
5. What are your thoughts on the existing training for staff?
- What would you like to see more/less of?
- What is needed for existing training to be more effective?
6. What would an ideal training look like for you?
- Could you outline an effective training from your perspective?
- What would the content look like? Who would deliver it? What should it focus on? How long should it be?
7. If you were a training developer, what would you incorporate in the training?
- How would you approach training development and delivery?
8. Do you have any further comments or questions?

Revised Schedule

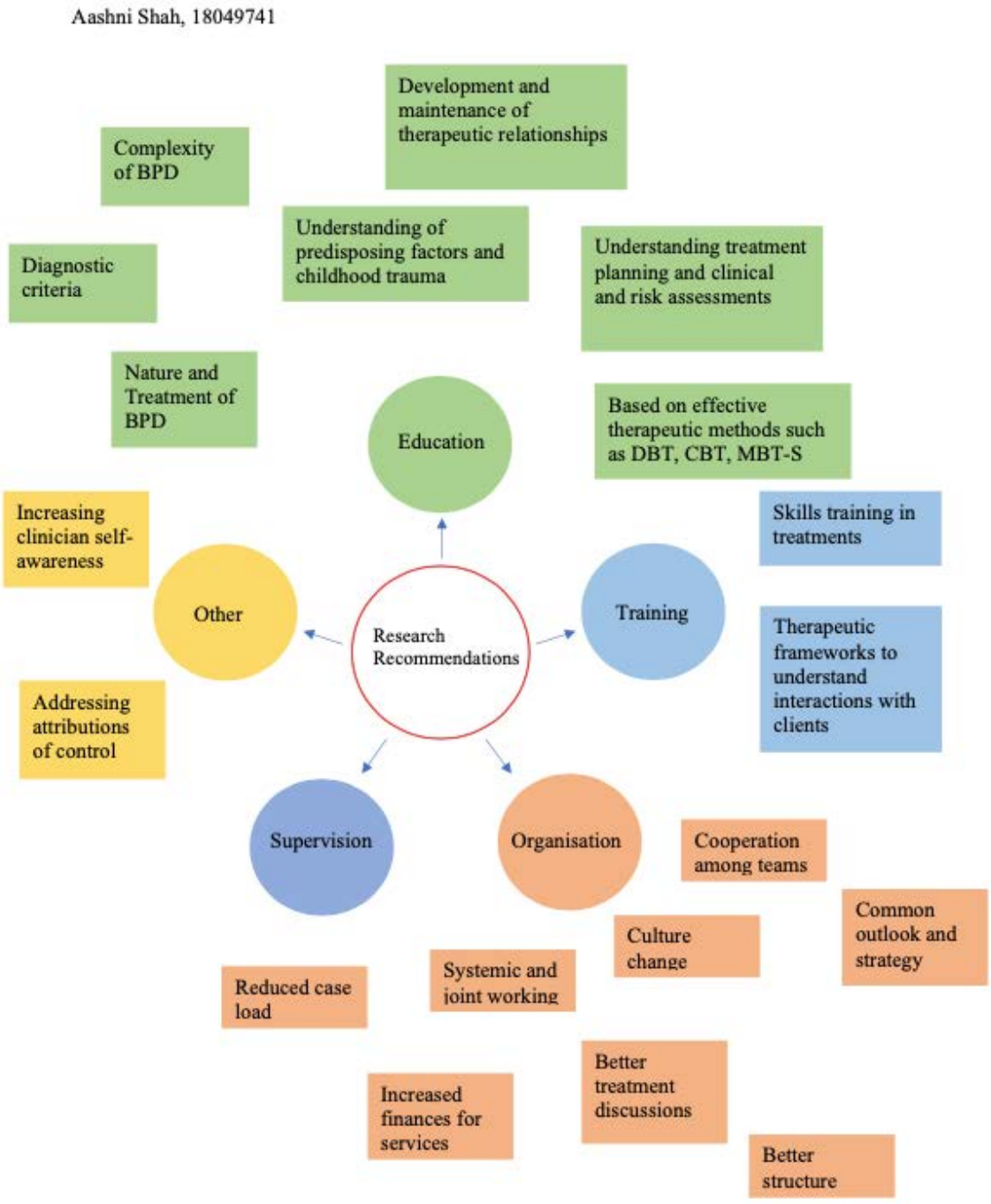
Manchester Metropolitan University

Interview Schedule

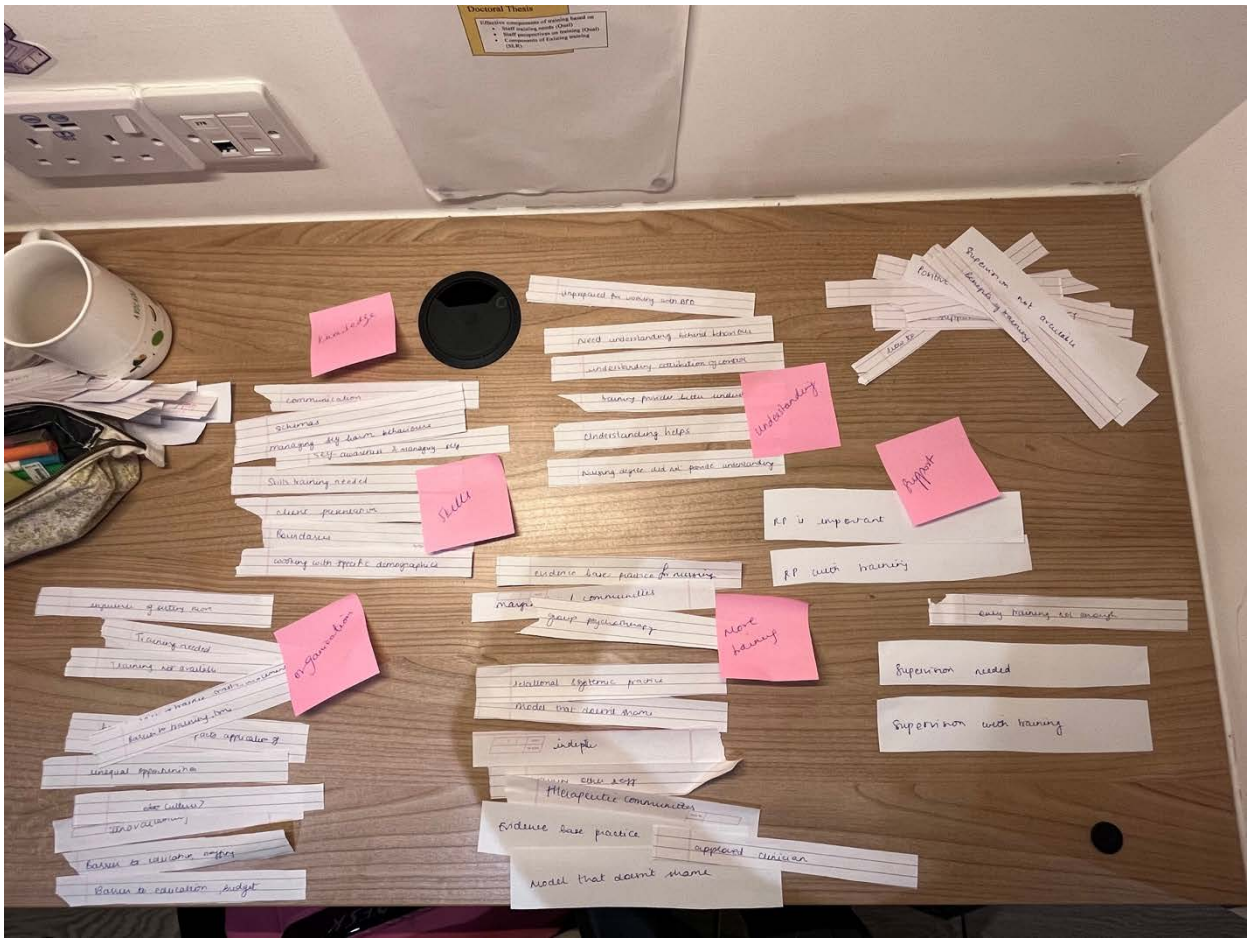
Borderline Personality Disorder: A qualitative exploration of the training needs of mental health staff in inpatient settings

1. Could you please tell me what interested you in this study?
2. Can you please tell me about your experience of working with individuals diagnosed with BPD?
- What has been rewarding/positive while working with them?
- What challenges have you faced while working with them?
3. Could you please provide details about any previous training you have received?
- Could you please provide details about any training you received prior to starting your role?
- Did any parts of the training focus on clients diagnosed with BPD? Any BPD-specific training you have received? Was it trauma-informed?
4. What are your thoughts on the existing training for staff?
- What would you like to see more/less of?
- What is needed for existing training to be more effective?
5. What do you need when providing services to those diagnosed with BPD? (Probe more, clarify the term need)
- What support do you need? Anybody in the organisation you can talk to? What kind of support would be helpful, emotional, practical support? Do you feel supported with supervision?
- What organisational systems do you need in place? What supports you? Anything else the organisation can do/put in place to support staff (with tasks and otherwise)?
- When you first joined, what skills you should have received training for?
6. What are your training needs?
- What areas do you need further training in or further support with? What kind of knowledge and skills do you need to further develop?
- Could you please elaborate on that? (explore specific needs)
7. What would an ideal training look like for you?
- Could you outline an effective training from your perspective?
- What would the content look like? Who would deliver it? What should it focus on? How long should it be? How often should you receive it (renew training, one-off, training at multiple stages, once a year, top-up training)?
- Would you need supervision in the context of training or following on from it? When would it be valuable?
8. If you were a training developer, what would you incorporate in the training?
- How would you approach training development and delivery?
9. Do you have any further comments or questions?

Appendix G: Schematic Diagram



Appendix H: Mapping of codes



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