Title: Exploring therapeutic engagement with individuals with a diagnosis of personality disorder in acute psychiatric inpatient settings: a nursing team perspective

Running head: Nursing therapeutic engagement in inpatient wards

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Abstract

Individuals with personality disorders (PD) face negative attitudes and are often deemed harder to care for than individuals with other diagnoses. To improve care and engagement with services it is essential to understand the ways general psychiatric nursing staff approach this client group. This research aims to examine the ways inpatient psychiatric nursing staff therapeutically engage with individuals with PD. Focus groups were conducted with Registered Mental Health Nurses (N=7) and Health Care Assistants (formally known as nursing assistants; N=12) who care for individuals with a diagnosis of PD in a general psychiatric inpatient setting. A thematic analysis indicated six themes; the right frame of mind, knowing the service user, knowing when to engage, service user input, a unified approach, and structured admissions. The findings highlight what non-PD specialist inpatient nursing staff do in order to engage therapeutically with this group of service users and areas that require improvement. Supporting good practice could improve staff confidence when caring for this client group, lower stigma around the diagnosis, and promote a more positive experience of care for individuals with a diagnosis of PD who are using general inpatient mental health services.

Personality disorder can be defined as a long term pattern of experience and behaviour that deviates from the norm in at least two of the following; cognition, affect, interpersonal functioning and impulse control. These patterns generate feelings of distress and impairment in the individual's everyday life (American Psychiatric Association, 2013). However, the label is viewed as stigmatising ('Shining lights', 2018) and has been associated with exclusion from mental health services (NIMHE, 2003). Guidelines such as those developed for the National Health Service in the UK (National Institute for Health and Clinical Excellence; NICE, 2009) suggest that treatment for individuals with a diagnosis of PD should be, as far as possible, based within the community. There is some evidence to suggest that individuals with PD who are admitted to general psychiatric inpatient services experience deterioration in their mental health instead of an improvement (Links, Ross & Gunderson, 2015). Indeed, NICE (2009) suggests that inpatient admissions should be limited to the "management of crises involving significant risk to self or others that cannot be managed within other services or detention under the Mental Health Act (for any reason)" (p23). However, a lack of specialist services for these individuals can mean that individuals are admitted to general psychiatric inpatient wards even when they are not in crisis (Willmot & Gordon, 2010).

Service user engagement promotes better health outcomes and is cost effective for health services (McAndrew, Chambers, Nolan, Thomas & Watts, 2014). However, given the difficulties in interpersonal functioning associated with a PD diagnosis, it is not surprising to see that the engagement between staff and service user can be difficult, particularly in mental health services where staff may experience stress and exhaustion (Morse, Salyers, Rollins, Monroe-DeVita & Pfahler, 2012) or where staff do not feel skilled to work with these individuals. To foster engagement, staff need to spend time with the individual, be

empathetic, interested and sensitive toward their needs (McAndrew, et al., 2014). However, in some cases, staff members do not want to engage (McAndrew et al., 2014) or do not feel confident working with the service user's subjective understanding of their diagnoses (Ruddick, 2010). Compounding this, those with the diagnosis of PD are often viewed as less unwell and more in control of their behaviour than other diagnoses (Black et al., 2011) with some nurses believing that their admission to inpatient settings is unjustified compared to individuals with other diagnoses (Bodner et al., 2015). Further, 80% of nurses report finding these individuals difficult to care for (James & Cowman, 2007) and that staff felt anger toward them (Deans & Meocevic, 2006). These attitudes and emotional reactions are likely to have a detrimental effect on the therapeutic engagement and care these individuals receive and do not go unnoticed by service users with PD, who report feeling discriminated against and treated with a lack of respect (Lawn & McMahon, 2015).

Having a positive therapeutic relationship has been linked to general therapy outcomes, motivation to engage and hope for recovery (Benjamin, 2006; Castonguay & Beutler, 2006; Livesley, 2003) and may be particularly important for individuals with a diagnosis of PD as the relationship can promote boundaries, decrease psychological arousal and increase collaboration (McMain, Boritz & Leybman, 2015). To encourage a strong therapeutic relationship, research suggests the importance of empathy, positive regard, shared goals, likability and trustworthiness (Bender, 2005; Castonguay & Beutler, 2006). However, maintaining a positive therapeutic relationship with individuals with a diagnosis of PD can be difficult due to the interpersonal functioning difficulties they can experience (Bender, 2005). A good relationship with the service user may also promote a more person-centred approach to care; with attention to individual needs, preferences and values (Epstein, Fiscella, Lesser & Stange, 2010). These authors note several benefits to person-centred care, including

improved rapport, shared understanding and the opportunity for the service user to be involved in their care. Despite the reported benefits of person-centred care, this approach is not always implemented with individuals who have a diagnosis of PD. Without this person-centred care approach, it is likely that service users will not feel listened to and may adopt a more helpless or antagonistic stance in relation to their recovery. Further, if individuals do not have the opportunity to be involved in treatment or care decisions it is more likely that they will not engage with their treatment or the service.

A structured treatment approach in an integrated service in which staff of different specialties work together can facilitate an individual's engagement within inpatient settings (Bateman & Tyrer, 2004; Livesley, 2003; Paris, 2008). Thus, adopting a planned and coordinated team model may help overcome barriers of communication often experienced and promotes a more refined level of care (Bateman & Tyrer, 2004). Indeed, Livesley (2003) argues that structured treatment plans help staff members with consistency and help to minimise confusion for the service user. Paris (2008) adds to this, stating that structured discharge planning can help decrease feelings of anxiety or rejection that individuals with a diagnosis of PD often experience prior to being discharged.

Considering the research relating to therapeutic engagement between staff and individuals with a diagnosis of PD in an inpatient setting, there appears to be a significant limitation. Research in this area highlights the need for a positive relationship but tends to focus on problems staff face and the stigma those with the diagnosis face. There appears to be a lack of 'positive' or 'what works' research considering the ways in which non-PD specialist staff foster engagement with these individuals. This is particularly the case when seeking to

understand what staff members in general psychiatric inpatient settings do to engage with this group of service users.

The aim of this study is to explore the ways in which front line nursing staff therapeutically engage with individuals with a diagnosis of PD in general psychiatric (non-PD specialist) inpatient settings. In inpatient settings the core nursing team consists of Health Care Assistants (formally called nursing assistants or nursing auxillaries) and Registered Mental Health Nurses who together provide nursing care. The health care assistants work under the direction and supervision of the registered nursing staff. In this paper, the collective term 'nursing staff' will be used when referring to participants as a group. Using focus groups, the research seeks to highlight what nursing staff find effective in their current practice and, in turn, what methods could be implemented to improve therapeutic engagement of individuals with a diagnosis of PD.

Methods

Ethical considerations

This project was approved by the Research and Development department for the NHS Trust involved and the Health Research Authority for NHS England (IRAS: 238261). In order to protect participant's anonymity, very limited demographical information was collected. Participants were made aware of confidentiality, their right to withdraw and the complaints procedure. Consent was achieved with a signed consent form prior to participation and verbal confirmation recorded at the start of each focus group.

Participants

       Participants were recruited via an internal email sent directly to all nursing staff within the adult acute mental health and Psychiatric Intensive Care Units (PICU) of a single psychiatric hospital.

       The following inclusion criteria were used:

a) Registered Mental Health Nurse (RMN) or Health Care Assistant (HCA)

b) work within an acute inpatient unit or PICU

c) have worked with individuals with a diagnosis of PD on a daily basis for a minimum of six months

Those working in inpatient rehabilitation units were excluded as service users here are largely independent and spend less time on the ward. Staff members from the wider multi-professional team (psychiatrists, occupational therapists, psychologists) were also excluded.

It was anticipated that these inclusion / exclusions criteria would enable the experiences of the nursing team to be gathered while allowing any themes specific to a subgroup (e.g. registered nurses vs HCAs) to be understood.

       Out of 28 responses received, 19 met the inclusion criteria and were able to attend the scheduled focus groups. Of the 9 who did not take part in the research, 3 did not meet the inclusion criteria and 6 were unable to make the scheduled focus groups. Participants were 12 HCA and 7 RMN. Table 1 provides information on the participants in each focus group including their job role and work setting. Only one staff member reported having received any specialist PD training. Groups included any participant meeting the criteria in order to

allow natural exploration of the extent to which ideas raised were shared or unique to one area of practice (e.g. by ward; registered /unregistered staff).

INSERT TABLE 1

ABOUT HERE

Measures

Two measures were included to contextualise the study participants in relation to published research of those working with individuals with a diagnosis of PD.

Personality Disorders Knowledge, Attitudes and Skills Questionnaire (PD-KASQ; Bolton, Feigenbaum, Jones & Woodward, 2010) contains three subscales; understanding, capability, and emotional reactions toward individuals with a diagnosis of PD. Good reliability, with Cronbach's alpha (r=0.82) for the overall scale and the subscales (r=0.70 to r=0.93; Shaw, Minoudis, Craissati & Bannerman, 2012) has been reported. Higher scores indicate greater perceived understanding, capability and negative emotions toward PD.

Scale to Assess Therapeutic Relationships, clinician version (STAR-C; McGuire-Snieckus, McCabe, Catty, Hansson & Priebe, 2007) has three subscales; positive collaboration (rapport, shared goals, openness), positive clinician input (extent of encouragement, support, regard) and emotional difficulties (feeling accepted by the service user). Test-retest reliability for the overall scale (r=0.68), the positive collaboration (r=0.72) and positive clinician input

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(r=0.73) subscales are acceptable, while the emotional difficulties (r=0.58) is weaker (McGuire-Snieckus et al., 2007). Higher scores indicate a more positive view of their relationship with individuals with a diagnosis of PD. For the emotional difficulties subscale, higher scores, indicate fewer emotional difficulties.

Procedure

Participants completed the STAR-C and PD-KASQ and provided basic demographic information before their focus group. Focus group interviews were used because of the fit of this method with the aims of the research (see Kitzinger, 1995). A total of 5 focus groups took place. The focus groups were moderated by the first author, and conversations were structured using a topic guide developed by both authors. This included questions on general experiences with engaging with individuals with a diagnosis of PD, techniques used in engagement, actions that led to negative engagement and the nature of rapport with individuals with a diagnosis of PD. The guide used open ended questions to promote conversation and reflection on experience, and remained consistent across groups. Each group consisted of 4-6 participants and lasted up to one hour. Groups were audio recorded and transcribed in full.

Data analysis

Transcripts were initially analysed by the first author using a thematic approach as described by Braun and Clarke (2006). This included familiarization with the data, generating initial codes and searching for, reviewing and naming themes. Emergent themes were reviewed by both authors (along with the process of initial coding) to examine their uniqueness, relationships and the evidence to support them within the data. To evidence the final themes, direct quotes are presented in the results.   A reflexive journal was kept

throughout the research which recorded thoughts, changes, feedback and reasoning. This was consulted during the analysis to examine the origins of themes and ideas and to ensure that themes were not simply the result of decisions made or ideas raised during the research process.

Results

The participants in this study (table 2, PD-KASQ) reported lower levels of understanding, perceived capability and positive emotional response to PD than the pre-training scores for mental health service staff (mental health nurses and occupational therapists working in inpatient and community settings) reported by Ebrahim et al (2016). In addition they reported lower levels of positive therapeutic engagement, and more emotional difficulties (table 2, STAR-C), than the community mental health staff group reported by Catty et al. (2012).

INSERT TABLE 2

ABOUT HERE

Thematic analysis

As shown in table 3, thematic analysis revealed six themes which represented three facets of care provision - interpersonal components, intrapersonal components and service operation components. Each of these are discussed below with the most representative direct quotes from participants included. Not all participants are quoted directly, however data from all participants contributed to the analysis and theme development.

INSERT TABLE 3

ABOUT HERE

Intrapersonal components

The two themes within this facet concerned the functioning of the member of staff.

Theme 1: The right frame of mind.

This theme captured how participants' own emotional wellbeing and reactions to situations

could impact on their engagement with individuals with a diagnosis of PD. Participants noted

that negative emotions may be unintentionally projected onto the service user which could

have a negative effect on their engagement.

> *"if I'm having a bad day, I really need to cheer myself up, before I start*
>
> *engaging with somebody that might read that as being their fault"* P10
>
> *"I ave* [sic] *to be in a position where I feel totally in control of my own*
>
> *emotions. If I'm feeling like slightly out of control …. I think that then tends to*
>
> *feed where they are emotionally… I think a lot of these people are really*
>
> *sensitive to where other people are emotionally and they pick up very quickly*
>
> *on what emotions being given out"* P11

When discussing incidents involving violence and aggression, three out of four groups

mentioned not taking these personally in a bid to prevent it effecting engagement with these

individuals.

"People have bad days and they'll say horrible things to you [laugh] and you might even get a slap every now and then but it doesn't mean that you have to be like 'well that's our therapeutic relationship over' , if that happens to everyone they work with then what's gonna happen?" P18

Participants also noted that being emotionally resilient was beneficial in terms of managing their emotions during periods of violence and aggression.

"I think you need good resilience as well ... they may well like at some stage sort of lash out at you in a sense ... how's that gonna be handled? Are you still gonna be that same person that they met the first time that's still quite caring and about their emotions?" P9

Theme 2: Knowing the service user.
Participants found that knowing the service user, and especially having a formulation was a cornerstone when engaging with individuals with a diagnosis of PD.

"Just reading the history helps you sort of empathise doesn't it" P19

"you can get so lost ... but formulation is such a good idea to bring you back to why you're doing this, why this person was in crisis or what not… formulation brings it back to reality like… It's good to have formulation [laugh] cause you get to know what works and what didn't with previous stuff." P17

Interpersonal components

Themes 3 and 4 concerned the interpersonal aspects of engagement which related to timing, responsiveness and the service user having meaningful involvement in their care planning.

Theme 3: Knowing when to engage.

Participants agreed that engagement was more therapeutic when the individual was calm, and noted that 'selective disengagement' was helpful when used appropriately.

> *"I think um therapeutic disengagement they call it works as well ... if you self-harm or ligature we will come and make you safe and then we won't spend time but this is the time we will spend with you doing something positive like an activity every day, that's the way we're gonna engage and staff sticking to that, I think that works well." P9*

> *"I've seen that spending time after an incident is a negative [interrupted] ... Reinforcement of it, the reinforcement of the 'your safe' every time it happens, people will help you. It's negative for them in the future cause when they're out of the ward, in the community there's not gonna be anyone to help them is there?" P17*

Participants also discussed how to approach engagement following the rupture of relationship. Groups 2 and 3 mentioned it was helpful to acknowledge the problem in an honest manner.

> *"we quite honestly sat down with the patient and we were like "we are bound to be upset by what you've done. You've done something really serious... I actually thought you were going, to, die and, I am a health care professional*

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but I care about people and I do care about you" ... we were people that actually wanted to help her.. and I think that probably helped us build a rapport with her following that" P10

Participants felt that time was also needed to mend a ruptured relationship.

"when things have escalated or their emotions are high, people with personality disorders sort of need a lot longer to come back down to base level." P9

Something mentioned by all groups was the use of boundaries, for example; allocating a set amount of time each shift with an allocated member of staff.

"When some people feel that maybe they're not getting enough time with staff which I think is quite a big thing with personality disorders having, a care plan where they have an allocated amount of time ... so they know that they're getting time to speak to someone or to express something ... because without those sorts of consistent boundaries... they can just go onto someone else and it can just end up being that cycle" P6

Participants indicated that knowing when to engage or disengage is therapeutic for individuals with a diagnosis of PD as it can encourage them to identify ways to cope and manage interactions more realistically.

Theme 4: Service user input.
During discussion, participants mentioned the benefits of individuals with a diagnosis of PD having options and input to their care.

> *"clarify it and say "well look, this is where you stand in life, and you can do this or you can do that, this is the support you've got here… and this is an opp this is not a crisis, it's an opportunity"* P11

More specifically, group 3 (predominantly made up of RMNs) mentioned the use of tools such as 'Early warning signs' and 'Recovery action plans' which were completed with the service user to help them identify patterns and changes in their mental state.

> *"it makes them feel a little bit validated to be using a tool ... to recognise their own triggers, and recognise how they can work with these triggers in the community. ... I feel like that always has a positive outcome as they feel like it's something they can take with them"* P10

> *"we do a early warning signs ... green for when they're well, amber for when they're starting to become unwell and what they should do, and red when their in crisis and in desperate need for help. ... go through what really helps when they do start becoming well, and identifying what they are like when that is, whether they become a little less talkative or whether they become a little bit withdrawn ... it's also important to kind of trial it as well, think about how it sort of would work, whether it's calling a friend, speaking to your mum or dad about it.. cause otherwise it can lead back up to red and end up back in hospital.."* P12

When discussing providing the service user with options, deliberate self-harm was mentioned. Participants spoke about offering safe self-harm options, such as squeezing ice or pinging elastic bands, however those who had experienced these had mixed views on its effectiveness.

"I have seen people with an elastic bands or sqeezin ice cubes, splashin water. Those things can be effective" P3

"I spose as a ward we've tried a couple of times sort of allowing positive or like safe self harming and that's seems to have never particularly worked" P7

Service operation components

The final two themes concerned the ways in which the team needed to operate to be most effective, including care pathways and relationships with other services.

Theme 5: A unified approach.

Participants in all focus groups identified the need for a supportive inpatient team and a planned, unified approach to caring for individuals with a diagnosis of PD with input from the community teams, specialists and crisis teams.

> *"I think only recently when we've had the specialists come on there have been proper planning behind it, whereas before, I think generally people didn't really know what what to do"* P18

Participants in all groups noted anxiety around risk taking with individuals with a diagnosis of PD which was improved by a more supportive unified approach.

> *"People tend to stand back and don't want to take the responsibility"* P1

> *"having that outside support for the team... they're working with the ward to take positive risks ... to stay on the right track and keep moving, keep moving forward... last year there wasn't that same team so it was like you wouldn't*

ever know when to take that risk because there wasn't back up, there wasn't

support" P16

According to staff, developing strong connections between inpatient and community services was important and may empower staff in decision making around what is best for the service user.

Theme 6: Structured admissions.

Participants in all four focus groups felt that engaging with and caring for individuals with a diagnosis of PD was more therapeutic when admissions had a clear structure that included aims of admission, management plans and discharge plans.

> *They're also doing planned admissions now, which we did one. So, if they*
>
> *breach that contract you discharge them… It's a planned admission, a*
>
> *management plan. I fink [sic] one persons had about 4 of them and it works*
>
> *quite well… but you need a very very structured approach"* P2

> "*I feel like.. like if they come in with an exit plan they should also come in with*
>
> *like a, or we should automatically have a plan ready in place for like how*
>
> *we're gonna manage a situation and if we don't have that I feel like it makes it*
>
> *more difficult"* P4

Participants also noted the benefits of a structured admission.

> *"I think more recently there's been some more plans for the few people I can*
>
> *think of, that have been able to be discharged quicker, made informal quicker*
>
> *and things like that so .. it's a good change"* P16

Participants felt that without this structured approach that staff "did not know what to do", with one participant describing inpatient settings as a "holding pen" for people with PD. Therefore, structured admissions may provide staff with a framework of how to engage with the service user, as well as making the admission clearer and in turn more therapeutic for the service user.

Discussion

This research aimed to examine the approaches used by non-PD specialist inpatient psychiatric nursing staff to therapeutically engage with individuals with a diagnosis of PD. Only one participant had received any specialist PD training, and as a group, the participants reported lower levels of therapeutic engagement, knowledge and understanding of PD than the mental health staff comparison groups (Ebrahim et al, 2016; Catty et al., 2012). Thus, the group here could be considered non-specialist in relation to working with PD.

Six sub-themes were identified and grouped into three interconnected themes concerning the interpersonal, intrapersonal and service operation aspects of care. The findings indicate that nursing staff adopt a number of principles when working with individuals with a diagnosis of PD which might be considered core to mental health nursing practice. For example, an integrative review by McAllister, Roberts, Tsianakas and McCrae (2019) suggest that collaboration between staff and service users, staff self awareness and deciphering patterns of behavior may be important for 'nurse-patient' therapeutic engagement in acute mental health inpatient settings. Staff self regulation - the 'right frame of mind' as reported by participants in this study - may be critical because individuals with a diagnosis of PD may be more sensitive to the mental state of others (Fertuck et al., 2009). Supporting service user choice and input into care planning may enable individual's with PD

to feel empowered and listened to while in hospital. Although focus group 3 (predominantly made up of RMN) noted specific tools used for this, the absence of any discussion of these in the other groups may indicate that such approaches are not embedded widely within the team, or are only employed by registered staff. Promoting such tools could provide practical ways to support co-produced / person-centred care (Epstein, Fiscella, Lesser & Stange, 2010; Freeman et al., 2016) to aid therapeutic engagement. Although not a specific question on the topic guide, the discussion of 'team level formulations' (Johnstone, 2013) in groups 1 and 2 suggested these to be important for developing staff knowledge and understanding of individual service users (deciphering patterns in behavior; McAllister et al, 2019). As a result of this, staff reported feeling more sympathetic, compassionate and understanding toward the individual as has been reported by others (Wainwright & Bergin, 2010). However, formulation was not mentioned by groups 3 and 4 which may reflect different views of their importance, a lack of team consistency, or differences in training (groups 1 & 2 contained more HCA).

Staff described using a number of evidence-based practices although they did not explicitly conceptualize them using recognized frameworks. For example, staff discussed limiting engagement and selectively disengaging to minimise reinforcing harmful behaviours. Reducing interpersonal and environmental reinforcement of destructive behaviours has been found to be associated with clinical improvements (Neacsiu, Ward-Ciesielski & Linehan, 2012). Similarly, recognising and addressing relationship ruptures in an explicit manner was highlighted. Methods for addressing the cause of a ruptured relationship promptly and clarifying intentions or meanings in a bid to repair the relationship have been noted (Livesley, 2003; Safran, Muran & Eubanks-Carter, 2011) and may be critical for individuals with a diagnosis of PD who struggle to repair relationships (King-Casas et al., 2008).

Staff also considered structured admissions involving clear admission aims, management plans and discharge plans were seen as important to engagement, providing a rationale and purpose for the inpatient stay. Both Livesley (2003) and Paris (2008) discuss the usefulness of structured treatment and discharge plans, with Bateman and Tyrer (2004) adding the importance of admission goals. Despite these findings, it appears treatment and discharge planning is inconsistent in inpatient services (Rogers & Dunne, 2011). Adopting such structure may also assist in meeting the National Institute of Health and Care Excellence (2009) guidance which states that admission of individuals with a diagnosis of PD should be brief and structured. The importance of the context of the team was emphasized, specifically the benefits of a unified approach among different service components (e.g. community teams, crisis services and specialist PD services). Achieving 'joined up working' led to staff feeling more supported and empowered to make difficult decisions, and has been noted by others to impact positively on communication and service user care (Bateman & Tyrer, 2004). In contrast to this, a lack of team support can lead to staff burn out, high staff turnover and a weaker relationship with the service user (Aarons & Sawitzky, 2006; Morse, Salyers, Rollins, Monroe-DeVita & Pfahler, 2012). Together these suggest that the participants used specific techniques even though the underlying principles or the process by which this learning had taken place was not explicit.

There were a number of factors which have been identified in the literature which were absent from the discussions captured in this study. For example, staff did not speak explicitly about establishing and maintaining rapport, validation or motivation which have been highlighted as essential general therapeutic and engagement strategies (Benjamin, 2006; Castonguay & Beutler, 2006; Livesley, 2003). While some of the aspects of these were implied it may be that training and supervision focusing on working with individuals

diagnosed with PD would provide an explicit framework for including and recognising these factors; however, this remains to be tested. Second, despite their discussions about staff resilience and wellbeing, staff did not discuss formal and informal clinical supervision which might be valuable in fostering this (Bond & Holland, 2010; Davies, 2015). This may highlight a practice that was not being utilised by the participants in their place of work and could be developed to provide a forum for reflection, development and fostering wellbeing when working with individuals with a diagnosis of PD.

All groups discussed a lack of PD specialist training. Based on the findings here, such training should emphasis the transferable 'core nursing skills' (e.g. service user inclusion; respectful care), provide a rationale and theoretical basis for some areas of practice (e.g. selective disengagement; structured care planning) and perhaps most importantly cover areas for which evidence exists but which were not evident in the data collected here (e.g. carer involvement; staff supervision). Such training may also have a broader impact on staff attitudes toward PD and staff perceptions of their ability to care for these individuals (Ebrahim, Robinson, Crooks, Harenwall and Forsyth; 2016).

Limitations and future research

One limitation is that the interview schedule did not probe for participants to discuss how they learnt specific techniques and how they selected when to (or not to) apply them. Further research could explicitly consider core mental health nursing principles and strategies along with the ways in which new skills are acquired and the decision processes used to determine how and when to deploy each of these. Second, this study did not include external validation of whether the reported factors had an independently observable or measureable positive

impact on engagement or outcome. Future research should consider including the views and experiences of individuals with a diagnosis of PD who have been in the services.

Further research is needed to examine the extent to which the themes identified here are a) generalizable to other settings (e.g. community) and b) relevant to work with other clients groups within acute mental health settings.

Conclusion

This research identified the interpersonal, intrapersonal and service operation factors that inpatient nursing staff consider important to promoting therapeutic engagement with individuals with a diagnosis of Personality Disorder. For nursing staff with no specialist training in PD, attention to their own wellbeing, knowing and involving individuals in their care, and collaboration between services, were seen as key to therapeutic engagement with individuals with a diagnosis of PD. While some of the themes identified appear to reflect core nursing competencies, training and practice supervision may enable staff to enhance their practice based on theory and research. Consideration is also needed for those areas of practice which might be important (e.g. staff support and supervision) which did not feature in the findings here.

Relevance to clinical practice

The findings reported here indicate some of the factors which influence engagement with individuals with a diagnosis of PD in a general acute psychiatric inpatient setting. Staff report drawing on a range of skills to care for individuals with a diagnosis of PD which might be considered core to mental health nursing. A number of these reflect practice guidelines developed for working with PD although the staff within this study had little or no formal

training in working with these individuals. They also provide a unique insight into those

factors seen as most important by those working within general inpatient settings. However

there are also factors which have been identified in the literature which were not highlighted

by participants. Combining research on working with individuals with a diagnosis of PD

with the factors identified here could enhance engagement and the quality of care, and reduce

stigma.

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Table 1: Summary of the participants in each focus group

Group	Participant	Gender	Job role	Area of work	Training
1	P1	Female	HCA	Acute	No
	P2	Female	RMN	Acute	Yes
	P3	Male	HCA	Acute & PICU	No
	P4	Female	HCA	Acute	No
	P5	Male	HCA	Acute & PICU	No
2	P6	Male	HCA	Acute	No
	P7	Female	RMN	Acute	No
	P8	Male	HCA	Acute	No
	P9	Female	HCA	Acute	No
3	P10	Female	RMN	PICU	No
	P11	Male	RMN	Acute	No
	P12	Male	RMN	Acute	No
	P13	Female	HCA	Acute	No
4	P14	Female	HCA	Acute	No
	P15	Female	HCA	Acute	No
	P16	Female	HCA	PICU	No
	P17	Female	HCA	Acute & PICU	No
	P18	Female	RMN	Acute	No
	P19	Female	RMN	Acute	No

Table 2. Questionnaire results compared to other mental health care staff members

Scale	Subscale (max score)	Mean (s.d.)	Comparison data (s.d.)
PD KASQ*			
	Total (90)	55.5 (7.1)	64.8
	Understanding (25)	15.7 (3.5)	22.6
	Capability (20)	14.8 (3.1)	18.7
	Emotional reaction (20)	11.4 (2.3)	14.7
STAR C			
	Total (48)	34.5 (3.9)	41.5 (5.7)
	Positive collaboration (24)	16.4 (2.1)	19.9 (3.5)
	Emotional difficulties (12)	8.3 (1.3)	10.8 (1.7)
	Positive clinician input (12)	9.9 (1.5)	10.9 (1.3)

*s.d. not shown in published data