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Staff attitudes toward patients with borderline personality disorder

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Abstract

Objective: Our aims were (1) to develop 2 inventories for the measurement of cognitive and emotional attitudes toward borderline personality disorder (BPD) patients and their treatment and (2) to use these tools to understand and compare attitudes of psychiatrists, psychologists, and nurses toward BPD patients.
Method: Two lists of items referring to cognitive (47 items) and emotional attitudes (20 items) toward BPD patients were formulated. Fifty-seven clinicians (25 nurses, 13 psychologists, and 19 psychiatrists), who had been working in public psychiatric institutions for more than 1 year, rated their level of agreement with each item. The list of cognitive attitudes yielded 3 factors (required treatment, suicidal tendencies, and antagonistic judgment). The list of emotional attitudes yielded 3 other factors (negative emotions, experienced difficulties in treatment, and empathy).
Results: Psychologists scored lower than psychiatrists and nurses on antagonistic judgments, whereas nurses scored lower than psychiatrists and psychologists on empathy. Regression stepwise analyses conducted on the 3 emotional attitudes separately showed that suicidal tendencies of BPD patients mainly explained the negative emotions and the difficulties in treating these patients. All groups were interested in learning more about the treatment of these patients.
Conclusions: Suicidal tendencies of BPD patients provoke antagonistic judgments among the 3 professions. Nevertheless, psychiatrists, psychologists, and nurses hold distinctive cognitive and emotional attitudes toward these patients. Mapping these differences can improve the education and training in the management of BPD patients.

1. Introduction

Frequency rates of borderline personality disorder (BPD) in hospitals and community settings are estimated at 20% and 11%, respectively [1]. A large survey in Australia [2] found that 85% of staff reported having contact with clients with BPD at least once a month, with 32% of respondents reporting daily contact. Borderline personality disorder patients have a very bad "reputation"; and the diagnosis of BPD is considered difficult and destructive by researchers in various countries, such as in Australia, Canada, and the United States [2-6]. The situation of BPD patients in Israel seems to be not different and, in fact, may even be more complicated. In Israel, BPD patients are not recognized as suffering from mental illness; and the hospitals' management does not always see them as mandatory candidates for hospitalization, especially not long ones. Furthermore, as the Israeli reform in mental health has not been implemented for 15 years [7], the Sick Funds that are the service providers for ambulatory patients do not take responsibility for these patients. We thought therefore that it would be interesting to evaluate in Israel staff attitudes toward patients with BPD.

Borderline personality disorder is associated with significant risks for suicide, other self-harm behaviors, and emotional dysregulation; and it is difficult to treat clinically. Even the label *borderline* triggers negative cognitions and emotions regarding these patients [8,9]. Sometimes, it is the acting-out behaviors that leave staff helpless in assisting them; and sometimes, it is the repeated self-injurious behaviors and suicide attempts (almost 4 times that of schizophrenia and bipolar affective disorder patients [10]) that create apprehension and worry [11,12]. At other times, it is their high dropout rate from therapy [11,12] that can infuriate therapists or the split they sometimes create between multidisciplinary staff members [2].

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Despite the high rate of BPD and the negative reactions induced by these patients in staff members, data about cognitive and emotional attitudes of staff members toward these patients are scant [3,4,8-14]. An Australian survey on psychiatric staff members (ie, nurses, psychiatrists, psychologists, social workers, and occupational therapists) examined attitudes toward BPD patients and found that the majority of respondents (80%) indicated difficulties posed by these patients [2]. Moreover, the vast majority (84%) considered the interaction with these patients as more difficult than communicating with other groups of patients. A study in Ireland with nurses from various psychiatric services revealed similar findings [13]. Again, 80% viewed BPD patients as more difficult to treat than other patients; and 81% believed that the care BPD patients are receiving is inadequate. A comparison of the attitudes of psychiatric nurses toward patients with diagnoses of BPD, schizophrenia, and depression found more negativity and less sympathy and optimism toward patients with BPD than the 2 other diagnoses [14]. Nurses also perceived BPD patients as more dangerous than other patients and were more socially rejecting of these patients.

Although the above-mentioned studies portray a coherent picture about the attitudes mental health staff have toward BPD patients, most of these studies examined psychiatric nurses. These studies were descriptive and did not use inferential statistics to compare the attitudes of different mental health professions toward BPD patients. Moreover, they did not explore the factorial structure of the attitudes; nor did they try to understand the relationship between affective (emotional) and cognitive (belief) attitudes, 2 important aspects of attitudes in general [15,16].

To explore these issues, the current study was planned (*a*) to develop tools for the measurement of cognitive and emotional attitudes that psychiatrists, psychologists, and psychiatric nurses have toward BPD patients; (*b*) to compare attitudes among these 3 professions; and (*c*) to study the relationship between emotional and cognitive components that mental health staff have toward BPD patients.

2. Methods

2.1. Participants

The participants were 57 clinicians (35.1% men and 64.9% women; mean age, 41.40 ± 8.54 years; range, 25-65). The clinicians were sampled from several psychiatric institutions that provide services to a large population at the center of Israel. Twenty-five psychiatric nurses (43.9%), 13 psychologists (22.8%), and 19 (33.3%) psychiatrists agreed to participate. The distribution of sex and age among the 3 groups of clinicians was similar, with no significant differences: χ^2 (2) = 0.19, P = .91; χ^2 (2) = 2.78, P = .25, respectively. The distribution of seniority (hierarchical status) was significant: χ^2 (2) = 12.86, P = .002. Hence, the seniority variable was entered as a covariate variable in further statistical analyses. Participants were included in the study if they fulfilled the following criteria: (1) agreed to sign written informed consent to participate in the study after the procedure had been fully explained; (2) were older than 25 years; (3) had a minimal level of personal and professional experience (>1 year); (4) worked in public psychiatric institutions; and (5) were certified psychiatrists, psychologists, or nurses. The study was approved by the main institution's review board.

2.2. Procedure

Research assistants approached all the professionals meeting the above criteria, while serving a shift on the ward. Using the study informed consent document, the research assistant explained the purpose of the study and gave the questionnaires to the subjects. The participants filled out the questionnaires in the presence of the research assistant. Completed questionnaires were then placed together with other completed questionnaires to ensure anonymity. Data collection continued for about 10 months.

2.3. Instruments

2.3.1. Personal details forms

The subjects provided details about their personal and professional data (eg, sex, age, seniority) and experience with BPD patients (eg, years of experience with these patients, familiarity with therapies for BPD patients, and interest in studying therapies for BPD patients).

2.3.2. Borderline patients–Cognitive Attitudes and Treatment inventory

The inventory was constructed by the authors based on previous brainstorming and review of the literature on BPD patients. It consisted of 47 items concerning cognitive perceptions of borderline patients, suitable treatment for them, the perception of suicidal attempts committed by them, and some prejudiced perceptions that clinicians hold about BPD patients. The participants rated their level of agreement on a 5-point Likert scale from 1 (strongly disagree) to 5 (strongly agree). To examine the construct validity of the inventory, a principle components factor analysis with varimax rotation was conducted (Table 1).

The analysis revealed 3 factors (33% of explained variance). Factor 1 (13.5% of variance, α = 0.87) included 21 items that seem to represent the required treatment characteristics of BPD patients (loading of each item >0.30). Factor 2 (11.5% of variance, α = 0.71) contained 13 items that related to attitudes toward BPD suicidal tendencies (loading >0.33). Factor 3 (8.0% of variance, α = 0.70) consisted of 7 items that seemed to express antagonistic judgments of BPD patients and their behavior (loading >0.30). Six items were omitted because of low loadings in all factors. Therefore, 3 scores were computed for each participant based on the means of responses on the items that were included in each factor separately (higher scores indicate a better agreement with the factor).

Table 1
Explanatory factor analysis of the BPD-CAT items*

Item	Treatment characteristics	Perception of suicidal tendencies	Antagonistic judgments
1. The purpose for hospitalizing a BPD patient is improving his/her insight.	**0.75**	−0.20	−0.18
2. The purpose for hospitalizing a BPD patient is rehabilitation.	**0.72**	−0.11	−0.17
3. Suicide attempts which are committed by BPD patients can be interpreted as a way to communicate with the therapist.	**0.65**	0.04	−0.05
4. BPD patients' treatment in the hospital should be based on supportive therapy sessions.	**0.65**	0.14	0.20
5. The purpose for hospitalizing a BPD patient is emotional support.	**0.63**	−0.14	−0.02
6. The purpose for hospitalizing a BPD patient is improving his/her impulse control.	**0.60**	−0.20	0.02
7. BPD patients' treatment in hospital should be based on medications.	**0.60**	0.17	0.14
8. A legitimate reason for hospitalizing a BPD patient is rehabilitation.	**0.55**	0.04	−0.11
9. While being in the hospital, BPD patients demonstrate rapid mood changes and suicidal threats because they react to events in their surrounding	**0.55**	0.14	0.02
10. When a new patient is being introduced as a BPD patient, it is probable that the staff will be extremely supportive to this patient.	**0.52**	0.18	−0.12
11. The purpose for hospitalizing a BPD patient is symptomatic improvement.	**0.51**	−0.14	−0.04
12. BPD patients' treatment in the hospital should be based on dynamic-oriented therapy sessions.	**0.50**	−0.06	0.44
13. The purpose for hospitalizing a BPD patient is to protect him/her and prevent suicide.	**0.50**	−0.44	−0.01
14. When a new patient is presented to the staff as a BPD patient, the staff's reactions will be similar to psychotic patients.	**0.49**	0.16	−0.29
15. BPD patients' treatment in the hospital should be based on a combination of medication, supportive behavioral and dynamic sessions.	**0.48**	−0.12	0.34
16. BPD patients will benefit from rehabilitation in hostels.	**0.46**	0.38	−0.28
17. A suitable setting for BPD patients is an open psychiatric ward.	**0.44**	−0.02	−0.12
18. A legitimate reason for hospitalizing a BPD patient is suicidal threats.	**0.43**	−0.34	0.02
19. The health services that BPD patients receive suffer from lack of resources.	**0.40**	−0.10	0.21
20. A legitimate reason for hospitalizing a BPD patient is a conflict with partners, mate, etc.	**0.39**	0.06	−0.05
21. When a BPD patient commits several suicidal attempts, it is better to transfer the patient to a closed ward and to special care.	**0.36**	−0.21	0.24
22. Death by suicide in BPD patient is very rare.	−0.05	**0.72**	0.11
23. BPD patients express repeated suicidal threats, but the risk of suicide is only by accident.	0.02	**0.67**	−0.03
24. BPD patients express repeated suicidal threats, but the risk of suicide is similar to that of the general population.	0.16	**0.63**	0.08
25. BPD patients express repeated suicidal threats, but the risk of suicide is minimal.	−0.13	**0.62**	−0.05
26. When being in hospital, BPD patients demonstrate rapid mood changes and suicidal threats while they actually do not want to commit suicide.	0.22	**0.62**	0.21
27. When a BPD patient commits several suicidal attempts, the patient should not be released from the hospital.	−0.30	**0.58**	−0.04
28. Treatment of BPD patients should be conducted by a psychologist.	−0.01	**0.56**	0.15
29. Hospitalizing BPD patients may harm patients and cause regression.	−0.07	**0.52**	0.05
30. When a BPD patient demonstrates fears, auditory hallucinations, and suicidal threats, the secondary gain should be diagnosed and treated accordingly.	0.13	**0.50**	0.14
31. Death by suicide in BPD patient is inevitable.	0.20	**0.48**	−0.16
32. The suitable setting for BPD patients is a psychiatric day care.	0.25	**0.47**	−0.01
33. When BPD patients demonstrate rapid mood changes and suicidal threats, it is an attempt to extend their hospitalization.	−0.03	**0.42**	0.34
34. When BPD patient commit several suicidal attempts, psychiatric observation should start and home leaves should be stopped.	0.26	**0.41**	0.22
35. A suitable setting for BPD patients is a closed psychiatric ward.	0.01	0.28	**0.57**
36. The mental health services for BPD patients are sufficient enough.	0.04	0.27	**0.51**
37. The treatment of BPD patients in hospital should be based on behavioral psychotherapy and setting of limits.	0.17	0.19	**0.50**
38. Psychotherapists should not be held responsible for a BPD patient dying by suicide.	−0.15	0.40	**0.50**
39. Psychotic manifestations among BPD patients are very common.	0.33	−0.12	**0.49**
40. While being in hospital, BPD patients demonstrate rapid mood changes and suicidal threats as a way to manipulate others.	0.15	0.11	**0.49**
41. Treatment of BPD patients should be conducted by a psychiatrist.	0.09	0.01	**0.48**
42. Treatment of BPD patients should be conducted by a social worker.	0.02	−0.02	**0.48**
43. BPD patients receive insufficient mental health services due to difficulties they create.	0.10	0.06	**0.44**
44. Clinical depression among BPD patients may be followed by suicide.	0.23	0.31	**0.43**
45. BPD should be defined as a psychiatric disorder because it is an Axis I disturbance.	0.07	0.16	**−0.40**
46. The mental health services that BPD patients receive are limited because of staff's lack of knowledge.	0.22	−0.02	**0.38**
47. Psychotic manifestations among BPD patients are in fact malingering.	−0.01	0.02	**0.35**

*Table entries in boldface are of loadings above 0.35.

Table 2
Explanatory factor analysis of the BPD-EA items*

Item	Negative emotions	Experienced treatment difficulties	Empathy
1. I feel angry when a BPD patient threatens to commit suicide.	**0.74**	0.20	0.06
2. When I treat a BPD patient, I easily get furious.	**0.72**	0.36	−0.02
3. I find it difficult to understand the problematic behaviors of BPD patients.	**0.70**	−0.08	−0.17
4. I easily lose my temper when a BPD patients tells me about his/her problems.	**0.65**	0.37	−0.29
5. I become impatient when a BPD patient applies to me.	**0.63**	0.44	0.62
6. I'm embarrassed when I notice that a BPD patient becomes attached to me.	**0.62**	0.14	0.19
7. I do not like to treat BPD patients because they always tell me how miserable they are.	**0.60**	0.45	−0.30
8. When a BPD patient tries to harm himself/herself, I feel that the patient violates the therapeutic contract.	**0.52**	0.07	−0.11
9. I feel helpless while treating BPD patients.	**0.41**	0.29	0.39
10. It is easier for me to treat schizophrenic patients than BPD patients.	−0.09	**0.77**	−0.06
11. Treating BPD patients can wear me out.	0.38	**0.69**	0.14
12. It's difficult for me to treat BPD patients.	0.27	**0.64**	0.15
13. Treatment sessions with BPD patients make me easily angry.	0.45	**0.54**	−0.09
14. I do not enjoy treating BPD patients because it is difficult to help them.	0.26	**0.46**	−0.11
15. I rarely pity BPD patients.	0.01	**0.40**	−0.30
16. I feel empathy toward BPD patients.	−0.01	−0.23	**0.66**
17. Taking care of BPD patients can evoke unfamiliar feelings.	0.19	0.21	**0.65**
18. Patients with BPD evoke parental emotions in me.	0.25	0.40	**0.61**
19. I would like to relieve the suffering of BPD patients.	−0.21	−0.04	**0.58**
20. Treating a BPD patient is one of the most difficult treatments.	−0.31	0.24	**0.42**

*Table entries in boldface are of loadings above 0.41.

2.3.3. Borderline patients–Emotional Attitudes inventory

This inventory was formulated for the present study by the authors in a similar manner. It consisted of 20 items concerning emotional attitudes toward BPD patients on a 5-point Likert scale (Table 2).

A factor analysis with varimax rotation performed on the BPD–Emotional Attitudes (EA) scale yielded 3 factors (50.7% of explained variance). Factor 1 (21.6% of variance, $\alpha = 0.84$) included 9 items (loading >0.40) concerning negative emotions toward BPD patients. Factor 2 (17.0% of variance, $\alpha = 0.75$) consisted of 6 items (loading >0.40) that related to difficulties experienced while treating BPD patients. Factor 3 (12.1% of variance, $a = 0.60$) included 5 items (loading >0.40) that described empathy feelings toward BPD patients. Hence, 3 scores were formed for each participant based on the means of responses for each factor separately (higher scores indicate agreement with the factor).

2.4. Statistical analysis

Statistical analysis was performed with SPSS (Chicago, IL) version 15.0. Multivariate analyses of variance (MANOVAs) were conducted to compare the 3 groups of clinicians (ie, nurses, psychologists, and psychiatrics) on the factors of the BPD–Cognitive Attitudes and Treatment (CAT) (ie, required treatment characteristics, perception of suicidal tendencies, and antagonistic judgments) and on the factors of the BPD-EA (ie, negative emotions, experienced difficulties, and empathy). Three stepwise regression analyses were conducted to assess the contribution of personal data (eg, age, sex, seniority, wish to improve treatment skills, and familiarity with therapy methods) and of the BPD-CAT factors to the BPD-EA factors. Independent variables were introduced into the model in a stepwise forward regression procedure as long as the partial correlation of the next variable to be introduced was statistically significant ($P < .05$). The comparative distributions of familiarity with BPD training and other therapy methods, and training needs of the 3 groups of clinicians were examined. Differences between groups were evaluated by using the c^2 test with continuity correction.

3. Results

3.1. Differences between clinicians on BPD-CAT

The MANOVA revealed differences between clinicians on the antagonistic judgments factor: F(2,54) =

Table 3
Summary of stepwise regressions predicating BPD-EA factors

Predicting negative emotions				
Variable	*B*	SE	*b*	*P*
Constant	1.23	.70		
Suicidal tendencies	.93	.24	.52	.001
Wishing to improve treatment skills	.45	.19	.34	.02
Seniority (y)	−.21	.10	−.30	.04
Predicting difficulties in treatment				
Variable	*B*	SE	*b*	*P*
Constant	−.52	.86		
Suicidal tendencies	.99	.28	.54	.001
Familiarity with other therapy methods	.46	.22	.32	.04
Predicting empathy				
Variable	*B*	SE	*b*	*P*
Constant	4.64	.44		
Negative judgments	−.46	.13	−.52	.02
Sex	.35	.13	.40	.001

This table is a summary of 3 sets of separate regressions.

16.37, $P = .001$, $\eta^2 = 0.38$. A post hoc analysis (Scheffe) showed that psychologists scored significantly lower (M = 2.71, SD = 0.48) than psychiatrists (M = 3.30, SD = 0.33) and nurses (M = 3.47, SD = 0.39). No significant differences were found (Fs <1) regarding the other 2 factors. That is, all 3 groups of clinicians reported similar cognitive attitudes regarding the treatment characteristics required for BPD patients and concerning attitudes toward suicidal tendencies. As mentioned in the subjects' section, there were differences in the distribution of the seniority variable (hierarchical status) between the 3 groups of clinicians. Because of these differences, this variable served as a covariate in the MANOVA, but was nonsignificant: F(3,50) = 1.62, $P = 0.20$, $\eta^2 = 0.08$.

3.2. Differences between clinicians on BPD-EA

The MANOVA revealed differences between clinicians on the empathy factor: F(2,53) = 6.56, $P = .003$, $\eta^2 = 0.20$. A post hoc analysis (Scheffe) showed that nurses scored significantly lower (M = 3.34, SD = 0.65) compared with psychiatrists (M = 3.71, SD = 0.38) and psychologists (M = 3.98, SD = 0.46). No significant differences were found (Fs <1) regarding the 2 other factors. That is, all 3 groups of clinicians reported similar emotional attitudes regarding experienced difficulties and negative emotions toward the treatment of BPD patients. As calculated in the previous MANOVA, seniority (hierarchical status) served as a covariate variable and was found to be insignificant: F(3,51) = 0.98, $P = .41$, $\eta^2 = 0.05$.

3.3. Regression analyses for BPD-CAT

The results of the 3 regression stepwise analyses that were conducted to examine the relative contribution of the predicting variables for each the 3 BPD-EA factors separately are shown in Table 3.

Regarding the negative emotions factor, the perception of suicidal tendencies variable entered in the first step explained 24.5% of the variance. The wish to improve diagnostic skills entered in the second step contributed 18.4% more to the variance explained. Finally, the clinicians' seniority entered in the third step added 8.2% to the variance explained. All 3 variables together explained 51.1% of the variance.

For the perceived difficulties in treatment with BPD patients, only 2 predictors came out significantly. In the first step, perception of suicidal tendencies explained 27.3% of the variance; and familiarity with other therapy methods added 10.1% in the second step. Both predictors explained together 34.4% of the variance.

As for empathy, 2 variables came out significantly in 2 steps. The first variable was antagonistic judgments, explaining 23.4% of the variance; and sex (female) contributed an additional 15.6%. Both variables together explained 39.0% of the variance. All steps described above were significant ($P < .001$), whereas other predictors did not enter the regression analyses because their contribution was low and insignificant.

Table 4
Familiarity and training needs of the sample of clinicians

	Nurses (n = 25)		Psychologists (n = 25)		Psychiatrists (n = 19)		χ^2	*df*	*P*
	No.	%	No.	%	No.	%			
Formal studies of DBT							0.27	2	NS
No	18	75.0	9	69.2	13	68.4			
Yes	6	25.0	4	30.8	6	31.6			
Familiarity with other BPD training (the last 2 y)							7.32	2	.03
No	23	100.0	9	69.2	16	84.2			
Yes	0	0.0	4	30.8	3	15.8			
Interested in other therapies with BPD									
Short term							0.32	2	NS
No	4	16.7	3	23.1	3	15.8			
Yes	20	83.3	10	76.9	16	84.2			
Long term							3.82	2	NS
No	9	37.5	1	7.7	5	26.3			
Yes	15	62.5	12	92.3	14	73.7			
Family therapy							0.26	2	NS
No	4	16.7	3	23.1	4	21.1			
Yes	20	83.3	10	76.9	15	78.9			
Wish to improve diagnostic skills							3.75	2	NS
No	2	8.7	2	15.4	6	31.6			
Yes	21	91.3	11	84.6	13	68.4			
Wish to improve therapy skills							0.46	2	NS
No	3	12.5	1	7.7	3	15.8			
Yes	21	87.5	12	92.3	16	84.2			

To deepen our understanding of clinicians' needs regarding their practice with BPD patients, comparative distributions of familiarity with treatment methods for BPD patients and the treatment needs of the 3 groups of clinicians (ie, nurses, psychologists, and psychiatrists) were examined. Differences between groups were evaluated by using the χ^2 test with continuity correction. The findings are presented in Table 4.

As shown in Table 4, high percentages of participants in all 3 groups reported lack of formal studies of dialectical behavior therapy (DBT). Most of the psychologists reported being familiar with other therapy methods for BPD patients as compared with the 2 other groups (psychiatrists and nurses), and this difference was significant. All nurses reported that they were unfamiliar with other therapy methods for BPD patients.

As for interest in acquiring new therapy methods for working with BPD patients, all 3 groups were interested in short-term therapy methods and in family therapy. However, most of the psychologists and many of the psychiatrists expressed interest in long-term therapy methods, as compared with the low interest in long-term therapy methods expressed by the nurses. The 3 groups reported high interest in improving their therapy skills. However, fewer psychiatrists showed interest in improving diagnostic skills, whereas most of the nurses and psychologists expressed their wish to improve their diagnostic skills.

4. Discussion

Our study attempted to evaluate cognitive and emotional attitudes of 3 groups of practitioners toward patients with BPD. Our findings show that, in comparison with psychiatrists and nurses, psychologists had less antagonistic judgments toward BPD patients. For example, the psychologists perceive the BPD patients to be less manipulative and think it is more justified to hospitalize them. Although we did not find a similar report in the literature, we speculate that this finding derives from the psychologists' attempt to accept, empathize and understand patients as opposed to the authoritarian and limit-setting styles of the other professions [17].

Yet, all the 3 groups of practitioners answered similarly on the other 2 factors, treatment characteristics and suicidal tendencies. Interestingly, in regard to treatment needs, all the 3 groups perceived the treatment of BPD patients as rehabilitative and as improving the patients' clinical condition. Moreover, all practitioners supported the idea that the treatment of hospitalized BPD patients should combine emotional support, containment, and psychotherapeutic and pharmacologic treatment. This may show that, although many clinicians have negative opinions about BPD patients, practitioners from multiple fields still acknowledge their complexity and understand the need for different disciplines to combine efforts in treating these patients [18]. In regard to the practitioners' attitudes toward suicidal tendencies, all 3 groups of practitioners perceived the tendency for suicide among these patients seriously and considered them in high risk for suicide [18].

Another finding was that nurses expressed less empathy toward BPD patients in comparison with psychiatrists and psychologists. This finding is in line with a previous study [8] in which the responses of nurses toward psychiatric patients were monitored along 20 group sessions. It was found that nurses were less empathetic and less confirming in their responses toward patients with BPD, as compared with patients with other diagnoses. These findings may reflect the fact that nurses are on the frontline with these patients, especially in the psychiatric ward, and may be frustrated and burnt out because of the conflicts provoked by these patients. Psychiatric nurses have been reported to have negative attitudes and even to show discriminatory treatment of patients with BPD [19]. Borderline personality disorder patients are seen as difficult, annoying, manipulative, and as "bad" and not "ill" [19,20]. Nurses had been found to regard BPD patients as being more in control of negative behavior than patients with schizophrenia or depression [12], and attributions of control were inversely related to staff sympathy. However, although one might see the "impervious" or "lacking in emotion" behaviors of nurses as nonempathic, these behaviors could be examples of strategic use of distraction, limit-setting, and containment methods done by nurses. Yet, in our study, the nurses openheartedly reported less empathy, thus denying the possibility that those "cold behaviors" are only a professional attitude.

The findings regarding the other 2 factors of emotional attitudes (negative emotions and experienced treatment difficulties) indicated insignificant differences between the 3 groups of practitioners. That is, nurses, psychologists, and psychiatrists expressed high frustration feelings, such as anger, impatience, and agitation, regarding the treatment of BPD patients. This finding is in accordance with the high ratings of difficulties in the treatment of such patients, which were expressed by all 3 groups [6,17,18].

Regression analyses conducted to explain the contribution of the practitioners' personal data and their cognitive attitudes to the emotional attitudes demonstrated the role of suicidal tendencies in explaining both the variance of negative feelings practitioners have toward these patients and the difficulties they expect in their treatment. These findings are in line with our previous results that showed that practitioners perceive the suicidal tendencies of these patients as risky and dangerous. It is possible that the awareness of clinicians to the suicidal tendencies of these patients infuriates them and results in negative feelings toward these patients. The regression analysis showed that practitioners' motivation to improve their diagnostic skills and to study other therapeutic methods predicted a reduction in their negative emotions and in the difficulties they foresee with the treatment of BPD patients. This finding is in accordance with the medical model, which

stresses the need for an accurate diagnosis as a necessary condition for proper treatment.

Seniority was also associated with negative emotions toward BPD patients, that is, the higher the practitioners' seniority, the lesser negative emotions to these patients. It seems that more experience in the psychiatric arena assists in seeing these patients less negatively. This is in accordance with countertransference reactions toward BPD patients that had been reported to decrease as clinicians' years of experience increased [21]. This might reflect more training and supervision, increased confidence, or heightened objectivity [21].

The regression analysis also demonstrated that the less negative the practitioners' evaluations, the higher the empathy they expressed toward BPD patients. This is logical because *empathy* is defined as a mental state that is not associated with judgmental cognitive processes [22] or with criticism and rejection thoughts, which lead to a contradictory state of mind, that is, to an aggressive behavior [23,24]. The regression analysis also showed that women expressed more empathy toward BPD patients as compared with men. This finding is in line with previous findings showing that women are more empathic than men [25].

How familiar are practitioners who work with BPD patients with diagnostic and therapy methods for these patients, and what needs do they express regarding their treatment? In contrast to psychologists and psychiatrists, none of the nurses reported having any training during the last 2 years regarding therapy methods for BPD. In addition, many participants in all study groups reported that they had not participated in a formal training of DBT. However, all the 3 study groups noted that they were interested in receiving more education on how to work with BPD patients (ie, short-term, long-term, and family therapy methods). Moreover, many practitioners expressed interest in improving their diagnostic skills. These findings are in line with previous studies [2,12,13] that reported of the need of psychiatric practitioners to gain further education and training in the management of these clients.

Our findings show a problematic attitude toward BPD patients in Israel. Despite Israel's specific mental health care system (dominant hospitals, inadequate ambulatory services, and lack of implementation of the mental health reform), the problematic status of BPD patients is not specific to Israel and has been reported worldwide. Studies in Australia [2], Canada [8], the United States [10,11], Ireland [13], Taiwan [26], and Greece [27] have reported unsatisfactory experiences and ambiguity toward these patients. All these studies are unanimous in stating that therapists in all countries wish to improve their skills in dealing with BPD patients.

The current study has several limitations. Although the size of our sample is similar to the size of samples used in previous studies [13,14], it is a rather small nonrandom sample and is based only on hospitals from the center of the country. Although this is certainly a limitation, nevertheless, Israel is a very small country; and more than 50% of the psychiatric hospitals and much more than half of the psychiatric beds are located in the center of Israel ([28]; Kotler, personal communication, 2010). This fact was already acknowledged by previous investigators, who also based their sample only on central region hospitals in Israel [29]. In addition, one may wonder if the data reflect reactions of staff to a particular group of patients being seen at the time of this survey. This seems not to be the case of our study because the data were collected over a period of 10 months, whereas the average length of stay for patients with personality disorders in Israel is 50.34 days [30]. Therefore, it is most probable that the staff had been exposed to a variety of BPD patients during the time of the study.

Future studies should test our 2 questionnaires on larger samples, using stricter sampling methods (eg, stratified sampling) and confirmatory factor analysis to examine if the factors are reconstructed. Nevertheless, the present study is the first to suggest 2 psychometric inventories for measuring the structure of cognitive and affective attitudes toward BPD patients and the relationship between them. It is also the first examination that uses inferential statistics to compare the attitudes of different mental health professions toward BPD patients.

Finally, patients with BPD are a challenge to the mental health system. It is mandatory to improve the knowledge and skills of all mental health professionals about BPD and also to improve empathy (especially among the sector of nurses) toward these patients [31]. Addressing attributions of control may provide a means to modify staff sympathy toward patients with BPD and counteract their negative experiences [12]. Our findings are consistent with those of others [20] who found that therapists want to improve their interactions with BPD patients. We hope that our study will serve as the first step in the recognition of staff attitudes toward these patients and produce more training and education for their treatment, especially for nurses, who work in the frontline around the clock with these patients in the mental health ward.

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