An Evaluation of a BPD-Specific Training That Was Developed and Delivered in Collaboration with Experts by Lived Experience on the Attitudes, Empathy and Optimism of Mental Health Professionals

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Declaration

This dissertation contains no material which has been accepted for the award of any other degree or diploma in any University, and, to the best of my knowledge, contains no materials previously published except where due reference is made.

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Statement of Contribution

M.P supervised the project and was involved in the planning of the project, the analysis and interpretation of the results and contributed to the manuscript. D.B. devised the research project, managed the data collection and storage, helped supervise the project and contributed to the final manuscript. C.M-E provided information on the Foundation Skills training to support the development of the manuscript. M.W was involved in the planning of the research project, the data analysis and interpretation and the writing and preparation of the final manuscript.

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Article Classification: Research Paper

This article is intended for submission to The Journal of Mental Health Training, Education and Practice. Please note, the journal did not specify formatting or title page requires, or which Harvard referencing style to be used. Therefore, this article adheres to the UoA Harvard referencing style. At present, the article has been written according to the Master of Psychology (Clinical) thesis requirement of 6,000-8,000 words but will be edited prior to submission to meet the 3500 – 6500 word limit specified by the journal. Furthermore, for the purpose and ease of submission some manuscript requirements have not been adhered to (e.g., separate documents for graphs, tables and acknowledgements), however this will be rectified prior to submission to the journal.

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Abstract

Purpose: Individuals with BPD are frequent users of mental health services. Research has shown that individuals with BPD are perceived negatively by mental health clinicians. Educational training has shown to be effective in improving attitudes towards individuals with BPD among mental health clinicians. To date, very few evaluated interventions have been developed and delivered in collaboration with experts by lived experience. This study aimed to evaluate a BPD-specific educational intervention for mental health professionals that was developed and delivered in collaboration with lived experience experts. The impact of the training on clinician attitudes, empathy and treatment optimism towards BPD was examined.

Methodology: Clinicians working with individuals with BPD within South Australian Health Networks and community-based services attended a 1-day training on Foundation Skills for Working with Individuals with BPD. A questionnaire to assess attitudes, empathy and treatment optimism towards BPD was completed by 694 clinicians before and after the training.

Findings: Attitudes, empathy and optimism were significantly greater post-training. Clinician characteristics related to experience and familiarity with BPD were key factors in determining training outcomes. The findings provide support for clinician training that is developed and delivered in collaboration with lived experience experts. Further research is needed to determine the extent to which the lived experience perspective contributed to training outcomes.

Originality: This study adds to the limited literature examining BPD-specific education for clinicians that has been developed and delivered in collaboration with experts by lived experience.

Key Words*:* Borderline Personality Disorder, Lived Experience, Education, Training, Health Services, Stigma

An Evaluation of a BPD-Specific Training that Has Been Developed and Delivered in Collaboration with Experts by Lived Experience on the Attitudes, Empathy and Optimism of Mental Health Professionals

Borderline Personality Disorder (BPD) is a complex mental health condition characterised by pervasive emotional dysregulation, impulsivity, unstable interpersonal relationships and poor self-image (American Psychological Association, 2015). Self-harm and suicidal behaviour are core features of BPD and statistics show that people diagnosed with BPD are significantly more likely to die from suicide than the general population (Broadbear *et al*., 2020). Individuals with BPD are among the highest users of mental health services, and up to 43% of adult mental health inpatients and 23% of outpatients meet criteria for BPD, with a large proportion of adults going on to access mental health support for upwards of 10 years (Ahmed *et al.,* 2021; Carrotte *et al*., 2019; Broadbear *et a*l., 2022; Grenyer, 2014; Lawn *et al*., 2019; Lewis *et al.,* 2019; National Health and Medical Research Council, 2012). BPD regularly occurs alongside other, comorbid mental health challenges, such as depression, anxiety, disordered eating and substance use difficulties (Ferguson, 2016; Shah and Zanarini, 2018). As a result, individuals with this diagnosis commonly present with complex needs, that can be clinically challenging for mental health services to manage (Ferguson, 2016; Grenyer *et al*., 2017).

In recent times, there has been significant interest in the attitudes of mental health clinicians towards individuals with BPD. This research has consistently demonstrated that despite their professional training, mental health clinicians commonly hold negative attitudes towards individuals with BPD (e.g., Deans and Meocevic, 2006; Lam *et al*., 2016; Markham 2003; Markham and Trower 2003; McKenzie *et al*., 2022; Sansone and Sansone, 2013). Patients with BPD are frequently viewed by mental health clinicians as manipulative, unrelenting, time-consuming, more in control of the causes of their behaviour and as more dangerous than individuals with other mental health diagnoses (Markham, 2003; Markham and Trower, 2003; Sansone and Sansone, 2013). In line with this, mental health clinicians report experiencing high levels of negative emotion towards

patients with BPD, including feelings of discomfort, anxiety, frustration and anger (Sansone and Sansone, 2013). In addition, despite evidence that psychological treatment can lead to positive outcomes for people with BPD, mental health clinicians also report more pessimistic views regarding treatment outcomes for patients with BPD (McKenzie *et al*., 2022). For example, one study found that individuals with a comorbid diagnosis of BPD were judged to be less 'curable', less likely to comply with treatment requirements and to have less motivation to change, than individuals without a diagnosis of BPD (Lam *et al*., 2016).

These negative attitudes may be reflected in mental health clinicians' behavioural responses to patients with BPD, as well as their overall willingness to work with this group of individuals. Common behavioural responses of mental health clinicians toward individuals with BPD include self-distancing, defensiveness, and reduced helpfulness (McKenzie *et al*., 2022; Sansone and Sansone, 2013). Black *et al*., (2011) examined the attitudes of 706 mental health clinicians including psychiatrists, psychiatry residents, social workers, nurses and psychologists across nine academic centres in the US. They found that nearly half of all participants (47%) would avoid caring for a patient with BPD if given the choice. Given that sensitivity to rejection and perceived abandonment are key characteristics of BPD, it has been suggested that the self-distancing that occurs between mental health clinicians and patients with BPD can be particularly problematic as it may unintentionally trigger behaviours such as self-harm, that reinforce stigmatising beliefs about BPD (Aviram *et al*., 2006). Lamont and Dicken (2019) conducted a review of service users' perspectives on mental health services, care provision and professional support. They found that in their interactions with mental health professionals, individuals with BPD often received minimal information about professionals' roles, the purpose of their contact and about their BPD diagnosis (Lamont and Dickens, 2019). Consequently, individuals with BPD reported feeling unsupported, confused about what to expect and pessimistic about their prognosis (Lamont and Dickens, 2019).

A growing body of research that documents the experiences of individuals with BPD in receiving mental health care highlights corresponding experiences of stigmatisation, discrimination,

and invalidation. Within the Australian context, individuals with BPD report feeling dismissed, misunderstood, not taken seriously, and in some cases demonised by health care professionals (Proctor *et al*., 2021). In one study that explored the perspective of individuals with a diagnosis of BPD on the management of BPD in Australia, individuals reported feeling that they did not receive the help they required, or said that were actively ignored and, or mistreated by health staff when seeking help (Proctor *et al*., 2021). Another study examining the treatment experiences of individuals with BPD in Australia, Carrotte *et al*., (2018) found that individuals with BPD were critical of the perceived lack of empathy, understanding and training in the area of BPD by some clinicians, particularly in generalist services.

While overall BPD appears to attract more negative reactions from clinicians compared to other diagnoses, there is evidence to suggest that this may be impacted by clinician-level factors such as experience and familiarity. Baker and Beazley (2022) conducted a systematic review of clinician's attitudes and responses to BPD. Their results highlighted a consistent trend toward more favourable attitudes in clinicians who had more regular contact with individuals with BPD and who had received previous training in this area. However, of note, one study found that while increased contact was associated with more positive attitudes to BPD for psychologists, social workers and psychiatrists, the opposite relationship was found among psychiatric nurses, for whom higher caseload numbers were associated with more negative attitudes (Bodner *et al*., 2015). In contrast, Baker and Beazley (2022) found that the results regarding clinical experience and attitudes were more mixed. Some studies found that less experienced clinicians had more positive attitudes towards individuals with BPD and perceived them as less dangerous than more experienced clinicians did, despite experiencing more difficulties when working with individuals with diagnosis and being more likely to perceive them as presenting with conduct problems (Baker and Beazley, 2022). Other studies found that there was no clear pattern of differences in attitudes between novice and experienced clinicians (Baker and Beazley, 2022). Overall, the results suggests that greater contact with individuals with BPD leads to more positive attitudes to individuals with this

diagnosis, except perhaps for psychiatric nurses. In contrast, the relationship between experience and attitudes to BPD is less clear, with no apparent consensus within the literature (Baker and Beazley, 2022).

In line with this, the attitudes of mental health professionals towards BPD may also be linked to a lack of training and skills to work confidently with this group of individuals. It has been suggested that key features of BPD, such as self-harm, suicidality, and interpersonal difficulties, generate uncomfortable personal responses and feelings of incompetence from clinicians (McKenzie *et al*., 2022; Treloar, 2009). In support of this, within the literature clinicians have reported a lack of confidence in their skills and knowledge regarding BPD and have acknowledged a need and desire for further training (McKenzie *et al*., 2022). A systematic review that explored stigma perpetuation at the interface of mental health care identified six key processes that contribute to the stigmatisation of individuals with BPD. Included in these processes were perceived untreatability, stigma due to preconceptions of patients as manipulative and low BPD health literacy (Ring and Lawn, 2019). Recommendations from this review for addressing the stigmatisation of BPD in mental health settings included improved education of mental health professionals to enhance their skills and attitudes and education that provides clinicians with the necessary empathy, tools, skills and attitudes to work effectively with individuals with BPD (Ring and Lawn, 2019). Understanding the factors that may influence clinicians' attitudes and emotional reactions towards BPD, is important when considering how best to implement interventions designed to elicit attitudinal change.

It is well established that mental-health related stigma can have a negative impact on seeking and participating in mental health care (Andrade *et al*., 2014; Clement *et al*., 2015; Corrigan *et al*., 2014). Unsurprisingly, negative attitudes from care-providers have also been identified as a key barrier to treatment by individuals with BPD (Lawn and McMahon, 2015; Lohman *et al*., 2017). A study that explored the treatment seeking and receiving experiences of 153 Australians with a diagnosis of BPD, as well as their perceptions of barriers to care, found that 65.4% of respondents reported experiencing significant discrimination in their attempts to seek help from mental health

services and most felt anxious (or very anxious) about discrimination associated with having a BPD diagnosis (Lawn and McMahon, 2015). Not being respected or having their help-seeking attempts taken seriously by health professionals, were identified as key distressing factors by individuals with BPD (Lawn and McMahon, 2015). In addition to acting as a barrier to help-seeking behaviour, negative reactions from health care providers may result in individuals terminating treatment prematurely and thus impede them from engaging with services in a manner that is most effective (Bender *et al*., 2001; Thornicroft *et al*., 2016). Strike *et al*. (2006) explored health service use among suicidal men with BPD. They found that engagement with services often followed a cyclical pattern, wherein negative experiences with health care providers were followed by avoidance of health care settings, crisis, and then by involuntary service utilisation (Strike *et al*., 2006).

Given the high frequency in which individuals with BPD come into contact with mental health services, mental health clinicians are undoubtedly a key source of support for this group of individuals. However, it is evident from the literature that mental health clinicians often experience strong, negative emotional reactions towards patients with BPD, which is reflected in their behavioural responses towards individuals with BPD and in turn in the experiences of individuals with BPD in their interactions with services (McKenzie *et al.,* 2022). Unsurprisingly, these negative experiences impact help-seeking by individuals with BPD and there is evidence to suggest they may also have implications for continuity of engagement with services (Strike *et al*., 2006). More broadly, they may play a role in reinforcing stigma, by eliciting behaviour that reinforces pre-existing negative preconceptions about BPD (Aviram *et al*., 2006). Given this, interventions that aim to improve attitudes, empathy and treatment optimism among mental health clinicians working in this area, may improve access to treatment and lead to overall better quality of care for individuals with BPD.

Clinician training is one tool that has shown to be effective in improving mental health professionals' attitudes towards individuals with BPD (Clark *et al*., 2015; Dickens *et al*., 2019; Fraser, 2001; Hazelton *et al*., 2006; Klein *et al*., 2022; Knaak *et al*., 2015; Krawitz and Rreal, 2001; Shanks *et al*., 2011; Treloar, 2009). Klein *et al*., (2022) conducted an integrative review on the impact of

educational interventions on modifying health practitioners' attitudes and practice in treating people with BPD. Overall, findings from the review suggested that educational interventions for BPD may positively impact health practitioners' attitudes and practice in treating people with BPD. The results suggest that brief, evidenced-based education interventions that are targeted to the specific clinical setting in which they are delivered (i.e., considering the realities and constraints of clinical practice in that setting) are likely to have the greatest uptake by clinicians and affect more positive change in attitudes towards BPD (Klein *et al*., 2022). However, high-quality evidence is lacking in this area and further research is needed.

While many studies have demonstrated the efficacy of clinician training on improving mental health professionals' attitudes towards individuals with BPD, including cognitive (e.g., beliefs about etiology, knowledge of BPD), affective (e.g., attitudes, desire for social distance) and behavioural factors (e.g., intent to practice, improved clinical skills) (Klein *et al*., 2022), few studies have included delivery with individuals who have lived experience of BPD. This is despite research that suggests that for adults, in-person contact or first-person narratives from individuals with mental illness, are significantly more effective at improving attitudes and behavioural intentions toward individuals with mental illness, than education alone (Corrigan *et al*., 2012; Martínez-Martínez, 2019; Thornicroft *et al*., 2016). The few studies that have incorporated individuals with lived-experience in clinician training in the context of BPD, have found that the integration of a lived-experience perspective is highly valued by clinicians. Krawitz and Jackson (2007) examined a novel consumer-clinician co-taught BPD training program for clinicians working in mental health and substance-use fields. The two-day workshop conducted in New Zealand involved 73 mental health clinicians working in hospital, community, crisis and rehabilitation settings. The training included content such as the aetiology and diagnosis of BPD, prognosis, treatment planning, behavioural chain analysis, skills training, pharmacology, balancing client and clinician responsibility and acute versus chronic suicidality. Following the workshop, participants completed an evaluation of the training and rated its relevance to their work. Results showed that the input of an individual with lived-experience was

highly valued by participants, with 22% of participants identifying the combination of consumer-clinician presenters as their most valued aspect of the training. All participants stated that the consumer-presenter should continue to be involved in future workshops.

Similarly, Dickens *et al*., (2019) implemented an educational intervention aimed at improving attitudes and knowledge regarding BPD in mental health nursing staff that was co-produced with an individual with lived experience of BPD. Attitudinal and knowledge-related outcomes were measured at pre- and post-intervention and 4-month follow-up. Focus groups were also conducted to explore participants' experiences of the intervention. Staff involved in the intervention demonstrated significant improvement in attitudes towards the perceived treatment characteristics of individuals with BPD*,* the perception of their suicidal tendencies and their overall attitudes towards patients with BPD, which comprised of three factors: negative attitudes, experienced treatment difficulties and empathy. At 4-month follow-up, the improvement in in staff's attitudes towards patients with BPD and their perceptions of treatment characteristics was sustained, however that for perceived suicidal tendencies was not. There was no change in perceptions of difficulty to treat post-intervention. Focus group data showed that staff identified the most influential aspect of the intervention was the presence of an individual with lived experience of BPD, specifically an individual they perceived to be in recovery.

Davies *et al*., (2014) examined the effectiveness of a co-production model in the delivery of a three-day training programme in personality disorder awareness in the UK. The training was co-delivered with service users who have lived experience of a personality disorder diagnosis to 162 participants. Results showed an improvement in levels of understanding and capability efficacy and a reduction in negative emotional reactions. At 3-month follow-up, understanding and emotional reactions remain improved, however capability efficacy regressed to pre-training levels. The authors concluded that this indicated the need for ongoing supervision and support to consolidate clinicians' skills following the training (Davies *et al*., 2014).

While there is reasonable evidence to suggest that the use of lived experience experts within BPD-specific training for clinicians may enhance training effectiveness, to date there are very limited empirically evaluated interventions that have incorporated individuals with lived-experience. The present study aimed to evaluate the 'Foundations Skills for Working with People with Borderline Personality Disorder' training (here on referred to as the 'Foundations Skills Training') being rolled out across South Australia. The Borderline Personality Disorder Collaborative (BPD Co) is a state-wide service that was developed in response to the demonstrated need for enhanced, evidence-based BPD service development in South Australia. The 'Foundation Skills Training' is a free training workshop that BPD Co offers to SA Health Local Health Networks and non-government agency employees. The training was developed and is delivered in collaboration with individuals with lived experience of BPD. The objective of this study was to determine if the Foundation Skills training is effective in modifying negative attitudes towards individuals with BPD and increasing clinicians' feelings of empathy and optimism regarding treatment outcomes for individuals with this diagnosis. Based on the current literature, it is anticipated that clinicians will report more positive attitudes towards BPD and higher levels of empathy and optimism following completion of the Foundation Skills training. It is also anticipated that participant characteristics such as expertise and familiarity with BPD may impact the training outcomes. Given that higher levels of contact with BPD have shown to be associated with more favourable attitudes, it is hypothesised that the training will have the greatest impact on the attitudes of clinicians who are less familiar with BPD (i.e., those in the early stages of their career and, or who work less frequently with individuals with BPD). It is unclear what impact the clinician characteristics may have on empathy and optimism and hence this will be explored in an exploratory nature. This study adds to the existing literature concerning BPD-specific training through the incorporation of lived experience experts in the development and delivery of the training and through the increased scope of training delivery (i.e., state-wide implementation, across multiple service settings).

Method

Setting and Participants

The Foundation Skills training was delivered to participants who work with individuals with a diagnosis of BPD, across South Australian mental health services and partner agencies between May 2020 and November 2021. The training was offered to mental health professionals (18 years and above) working with individuals with BPD. A total of 694 participants completed the pre-training and post-training survey. Participants were predominantly women (81.9%) and aged between 35-54 years (46.3%). Specific professions represented included Psychiatrists (1.4%), Occupational Therapists (5.4%), Psychologists (9.7%), Social Workers (34.4%), Nurses (21.8%), mental health peer workers (2.7%), Aboriginal Mental Health Consultants (1.5%), Administration Staff (0.5%), paraprofessionals (15.1%) and other professions (5.8%). The majority of participants reported working in their profession between 0-4 years (35.9%) or 5-10 years (22.5%). Participants practiced in both government (47.2%) and non-government mental health settings (49.95). Clinicians employed in government mental health settings worked across a range of contexts, including inpatient units (8.3%), mental health triage services (13.9%), community mental health teams (72.1%) and community rehabilitation centres (2.4%). Overall, participants predominately worked with adult populations (52.9%), youth (11%) and individuals within the criminal justice system (13.8%). Most participants had worked with between 1-4 (35.6%) individuals with BPD in the past 12 months.

Procedure

The Foundation Skills training is a free, 1-day (6hrs) CPD training workshop delivered by BPD Co. The training was originally developed by the Project Air Strategy of the University of Wollongong in collaboration with staff, NSW health clinicians and individuals with lived experience of BPD and aligns with the Project Air Strategies for Personality Disorders Treatment Guidelines for Personality Disorders (2015). The training provides an overview of a relationship-based approach to working alongside clients with BPD. Topics covered in the training include BPD prevalence and aetiology,

health service use, the stigmatisation of BPD, diagnostic criteria and diagnosis, comorbidity, evidence-based treatments for BPD (and common challenges), the stepped-care model of treatment, principles for working with individuals with personality disorders, risk management, countertransference and self-care for clinicians and strategies for working with carers, partners and families of individuals with BPD. The training format includes formal teaching from facilitators that is supported by a slideshow and video components, group activities and discussion, and personal narratives from individuals with lived experience of BPD. In South Australia, the training is delivered jointly by BPD Co staff and individuals with lived experience of BPD, who have all undergone a two-day training workshop delivered by Project Air.

The Foundation Skills training was advertised to employees within South Australian mental health services and partner agencies who work with individuals with BPD. All participants self-nominated to be involved in the training. Upon attendance at the training, participants were invited to complete the pre-training survey, which included a description of how their information will be stored. Participants were asked to consent for their responses to be utilised in future service evaluations. No identifiable information was collected, and participants created their own unique code to allow pre- and post-training survey data to be matched. The Foundations Skills training was then delivered by a trained facilitator from BPD Co, alongside an individual with lived experience of the diagnosis. At the end of the training, participants completed the post-training survey. The study was approved by the University of Adelaide Human Research Ethics Sub-Committee for the School of Psychology (approval number 21/66).

Due to COVID-19 pandemic, in addition to the original face-to-face format, the Foundation Skills training was also offered in an online format. The online mode of the training included the same content as the face-to-face training and an interactive and conversational focus. When partaking in the training online, participants received an email prior to the training outlining the participatory nature of the workshop and providing instructions for ensuring they had the correct

software installed to support the training. Participants received an electronic copy of the workshop materials, including the pre and post workshop questionnaires.

Measures

A 19-item survey was used to assess clinician empathy, treatment optimism and attitudes toward working with individuals with BPD. The survey was compiled by BPD Co for the purpose of evaluating the training. Social and demographic information was also collected from participants including gender, age, occupational subgroup, number of years worked in profession, service setting, level of expertise in working with individuals with a diagnosis of BPD and number of people with BPD cared for in the past year.

Empathy

Empathy was assessed using three items from the empathy subscale from the Borderline Patients Emotional Attitudes Inventory (Bodner *et al*., 2011). While this is originally a 5-item scale, the questionnaire used in this study included the three items that were most relevant to the clinical context of the training (e.g., "I feel empathy towards people experiencing BPD symptoms/a diagnosis of BPD*"* and "I would like to relieve the suffering of people with BPD symptoms/a diagnosis of BPD"). The wording of item 3 was changed from that in the original subscale ("evoking parental emotions in me" to "evoking caring emotions to me") to ensure relevance to the participant group. All items were scored on a 5-point scale ranging from strongly disagree to strongly agree. Higher scores indicated greater empathy for people with a diagnosis of BPD. Internal consistency for the three items was acceptable at pre-test (α = .62) and post-test (α = .68).

Optimism

Optimism was assessed using three items from the Treatment Optimism Scale (Black *et al*., 2011); (e.g., "I feel professionally competent in caring for a person experiencing BPD symptoms/a diagnosis of BPD*"*). All items were scored on a 5-point scale ranging from strongly disagree to strongly agree. Higher scores indicated greater treatment optimism for people with a diagnosis of BPD. Initially, the item exploring attitudes toward the effectiveness of psychotherapies for

individuals with BPD from the original scale was split into two items to examine short-term and long-term therapies respectively in order to reflect the stepped-care model within SA mental health services. However, examination of internal consistency led us to omit the item that examined perceptions of the effectiveness of brief interventions for BPD. With this item omitted, internal consistency was acceptable at pre-test (α = .64) and post-test (α = .56).

Attitudes

Attitudes towards working with individuals with BPD was assessed using 5 items from the Attitude and Skills Questionnaire (ASQ; Krawitz, 2004) (e.g., "I am willing to work with people BPD symptoms/a diagnosis of BPD"). All items were measured on a 5-point scale. In the current study we reported a total ASQ score which ranged between 5 and 25, with higher scores indicating more positive attitudes. The internal consistency for the ASQ has previously been reported at .82 (Day et al., 2018). We also calculated the internal consistency using Cronbach's alpha, which was acceptable at pre-test (α =.77) and post-test (α =.78).

Data Analysis

One-way Analyses of Variance (ANOVAs) were used to determine which groups differed in attitudes, empathy and treatment optimism at pre-test across all relevant participant characteristics (i.e., self-rated level of expertise, number of years in profession, number of individuals with BPD worked with in the past 12-months and whether clinicians worked in public or non-government sector settings). To evaluate the overall influence of the Foundations Skills training on clinician attitudes, empathy and treatment optimism, repeated measures *t*-tests were completed to compare pre- and post- training scores across the whole sample. These were repeated excluding those who completed the training online, to examine the impact of modality. To explore the influence of clinician characteristics on the training outcomes, a series of two-way mixed Analysis of Variance models (ANOVAs) were completed for groups that differed at pre-test. Tukey and Scheffe post-hoc tests were used to make pairwise comparisons between groups. Effect size was calculated for the overall ANOVAs using partial eta squared.

Results

Baseline Differences in Attitudes, Optimism and Empathy

The descriptive statistics of all one-way ANOVAs are presented in Table 1. The results showed that prior to the training attitudes towards BPD differed significantly between all levels of expertise. Clinicians who identified their expertise as minimal (*M*=12.98, *SD*=2.08) reported less favourable attitudes towards BPD than those with developing (*M*=15.54, *SD*=2.34), sound (*M*=17.89, *SD*=2.31), or advanced (*M*=20.34, *SD*=2.99) expertise. Similarly, clinicians who had worked in their profession for 0-4 years (*M*=15.35, *SD*=2.77) reported significantly less favourable attitudes towards BPD, compared to those who had worked in their profession for 11-19 years (*M*=16.49, *SD*=2.83) or 20 or more years (*M*=16.20, *SD*=3.21). There was no difference in attitudes at pre-test between those working in their profession 0-4 and 5-10 years (*M*=16.09, *SD*=3.18) or 5-10, 11-19 and 20 or more years. Clinicians who worked with 1-4 clients with BPD in the past 12-months reported more negative attitudes towards BPD (*M*=14.78, *SD*=2.65), compared to those who had worked with 5-10 (*M*= 16.69, *SD*=2.75), 11-19 (*M*=17.08, *SD*=2.70) or 20 or more individuals (*M*=17.44, *SD*=2.86). Additionally, there was no difference in attitudes between clinicians who worked with 5-10, 11-19 or 20+ individuals. The results showed that those who had worked with no individuals with BPD in the past year (*M*=13.69, *SD*=2.55) also did not differ in attitudes from those who had worked with 1-4 individuals prior to the training. Furthermore, individuals working in a government setting reported more positive attitudes towards individuals with BPD (*M*=16.24, *SD*=3.01), than clinicians working in non-government settings (*M*=15.64, *SD*=2.94).

Prior to the training, clinicians who identified as having minimal expertise in working with individuals with BPD (*M*=13.12, *SD*=1.81) reported significantly less optimism regarding treatment outcomes for individuals with BPD, compared to those with developing (*M*=14.85, *SD*=1.96), sound (*M*=16.30, *SD*=1.73) and advanced levels of expertise (*M*=17.68, *SD*=1.69). Similarly, clinicians who had worked in their profession for 0-4 years reported significantly lower optimism regarding treatment outcomes for BPD (*M*=14.62, *SD*=2.19) than those who working for 5-10 (*M*=15.25,

SD=2.22), 11-19 (*M*=15.43, *SD*=2.03) and 20 or more years (*M*=15.30, *SD*=2.29). There was no difference in optimism at pre-test between those working in their profession for 5-10, 11-19 or 20 or more years. In addition, those who had not worked with any individuals with BPD in the past year reported significantly lower optimism for treatment outcomes (*M*=13.51, *SD*=2.06), compared to those who worked with 1-4 (*M*=14.41, *SD*=2.12), 5-10 (*M*=15.53, *SD*=1.91), 11-19 (*M*=15.87, *SD*=2.23) and 20 or more individuals (*M*=15.85, *SD*=2.03). Those who had worked with 5-10, 11-19 and 20 or more individuals with BPD in the past year, did not differ in optimism at pre-test. Furthermore, clinicians working in a government setting reported significantly greater optimism for treatment outcomes for those with BPD (*M*=15.30, *SD*=2.17), than clinicians working in non-government settings (*M*=14.82, *SD*=2.22).

Comparatively, empathy scores only differed significantly across levels of expertise and number of years in profession prior to the training. The results showed that clinicians with minimal expertise in working with BPD reported less empathy towards BPD (*M*=11.49, *SD*=1.68), than those with sound (*M*=12.21, *SD*=1.71) and advanced expertise (*M*=13.21, *SD*=1.32). Those who identified as having minimal and developing (*M*=11.79, *SD*=1.71) expertise, did not differ significantly at pre-test. In addition to this, clinicians who had worked in their profession for 0-4 years (*M*=12.15, *SD*=1.66) reported higher levels of empathy towards individuals with BPD prior to the training, than those who had worked in their profession for 20 or more years (*M*=11.60, *SD*=1.81). Those who worked in their profession for 0-4, 5-10 years (*M*=11.93, *SD*=1.79) or 11-19 years (*M*=11.79, *SD*=1.67) did not differ significantly. Likewise, there was no difference in empathy at pre-test for those who had worked 5-10, 11-19 or 20 or more years.

Table 1

One-way ANOVA Differences For Clinician Characteristic Across Outcome Variables At Pre-test

Predictor	Sum of Squares	*df*	Mean Square	*F*	partial eta^2
Attitudes					
Setting	67.28	1	67.278	7.612	.010**
Expertise	2765.437	3	921.812	170.418	.396*
Years in Profession	164.953	3	54.984	6.257	.024*
Number of Clients with BPD in Past Year	1270.61	4	317.652	43.29	.182*
Optimism					
Setting	45.359	1	45.359	*9.412*	.012**
Expertise	1105.936	3	368.645	106.252	.290*
Years in profession	92.562	3	30.854	6.472	.024*
Number of Clients with BPD in Past Year	478.330	4	119.583	27.94	.126*
Empathy					
Expertise	112.416	3	37.472	13.130	.048*
Years in profession	33.795	3	11.265	3.806	.015**

Note. *p<.001, **<.05

Training Outcomes

Overall, most participants reported that they were satisfied (32%) or very satisfied (53.4%) with the training and most reported feeling that the training was helpful (30.5%) or very helpful (55.3%) in improving outcomes for individuals with BPD.

The results from a series of repeated measures *t*-tests, showed that overall, clinician attitudes, empathy, and treatment optimism towards individuals with BPD were significantly greater following the Foundations Skills training, with large effect sizes. Table 2 summarises the results for these analyses. This result was not significantly impacted by the mode of training (i.e., face-to-face or online), with the effects remaining significant (with large effect sizes) when only face-to-face training was considered (N=639, Attitudes: t(638)=-27.85,p<.001, d=2.41; Empathy: t(638)=-13.90, p<.001, d=1.55; Optimism: t(638)=-22.90, p<.001, d=2.10). To examine the impact of participant

characteristics on training outcomes, a series of two-way mixed ANOVAS were completed for the variables that showed differences at pre-test.

Table 2

Overall Attitudes, Empathy and Treatment Optimism Before and After the Foundation Skills Training

	Pre-training	Post-training	t	*df*	*d*
	Mean (SD)	Mean (SD)			
Attitudes	15.91 (3.01)	18.53 (2.47)*	-28.24	693	2.45
Empathy	11.96 (1.75)	12.82 (1.59)*	-14.42	693	1.57
Treatment Optimism	15.07 (2.24)	16.93 (1.69)*	-22.99	693	2.13

Note. N=694, higher scores indicate more positive attitudes and greater empathy and optimism, *p<.001.

Attitudes

The mixed-model ANOVAs showed a significant main effect of training, with all participants showing an improvement in attitudes following the Foundation Skills training. However, the effect of training was moderated by significant interactions between Foundation Skills Training and level of expertise (F(3,690)=36.29, p<.001, partial eta^2=.136), number of years in profession (F(3,685)=3.63, p=.013, partial eta^2=.016), number of individuals with BPD worked with in the past 12-months (F(4,686)=7.41, p<.001, partial eta^2=.041) and whether clinicians worked in the public sector or in a non-government setting (F(1,672)=7.51, p=.006, partial eta^2=.011). To examine these interactions further, contrasts were performed across all levels of the independent variables.

The contrasts revealed that the Foundation Skills training had the greatest impact on attitudes for those who identified has having minimal expertise in working with individuals with BPD. As shown in Figure 1, the impact of the Foundations Skills training on clinician attitudes reduced as level of expertise increased, with those identifying their level of expertise as advanced demonstrating the smallest increase in attitudes.

In addition to this, as shown in Figure 2, the Foundation Skills Training was found to be associated with greater improvement in attitudes for clinicians who reported working in their profession for 0-4 years, compared to those who had worked in their profession for 11-19 years. There was no significant difference between those who had been working for 0-4 years and those who had worked 5-10 or 20+ years or those working for 5-10 and those who had been working for 11-19 or 20+ years.

Similarly, those who identified as having worked with no individuals with BPD in the past 12-months demonstrated the greatest improvement in attitudes following the Foundation Skills training (see Figure 3). Clinicians who identified working with 1-4 individuals with BPD in the past 12-months also demonstrated significantly greater improvement attitudes post-training compared to those who identified having worked with 5-10, 11-19 or 20 or more individuals with BPD. Clinicians who had worked with 5 or more individuals with BPD all demonstrated comparable improvement in attitudes as a result of the training.

Figure 4 shows that while the Foundation Skills training was associated with significant improvement in attitudes for clinicians employed in both government and non-government settings, those who identified as working in a non-government setting demonstrated a greater improvement in attitudes following the training.

Figure 1

Changes in Attitudes as a Function of Expertise

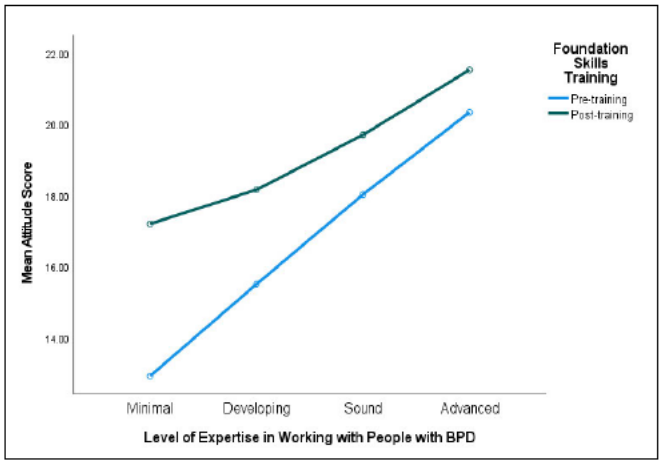


Figure 2

Changes in Attitudes as a Function of Number of Years Worked in Profession

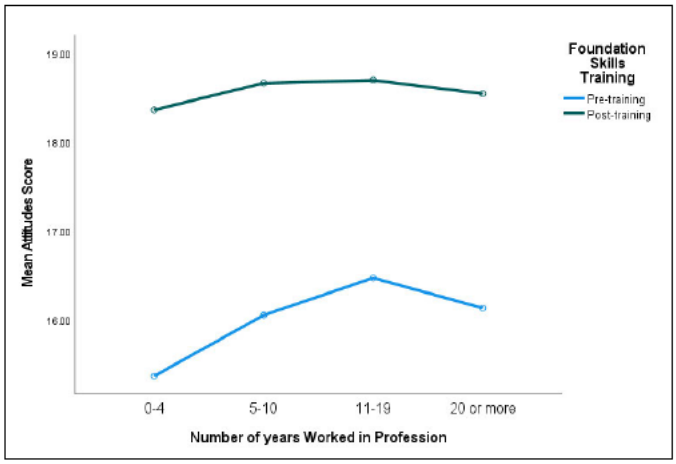


Figure 3

Changes in Attitudes as a Function of Number of Individuals With BPD Worked With In the Preceding Year

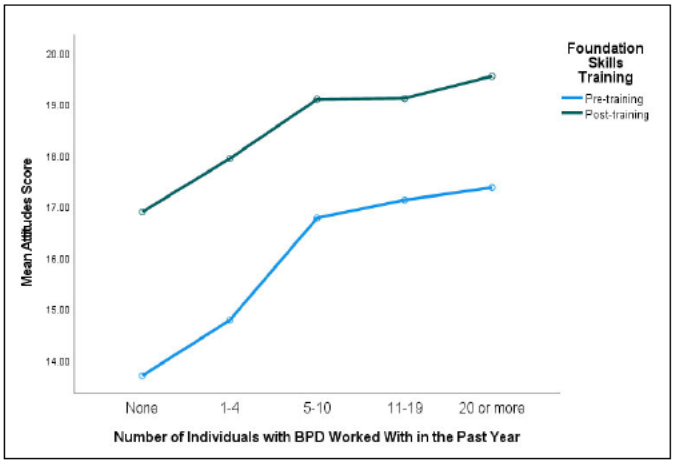
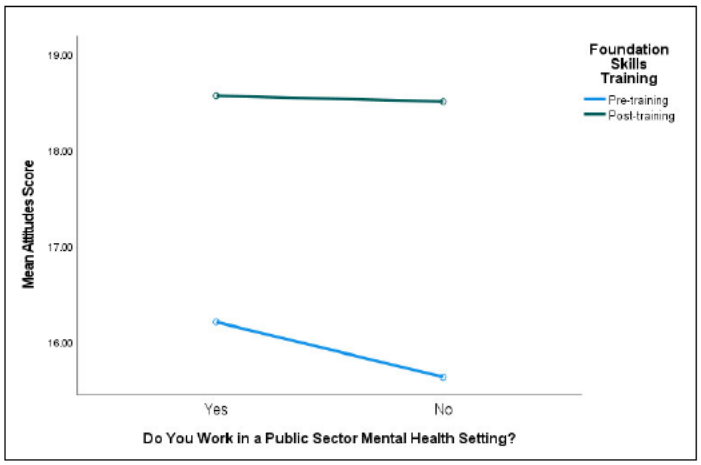


Figure 4

Changes in Attitudes as a Function of Employment Setting



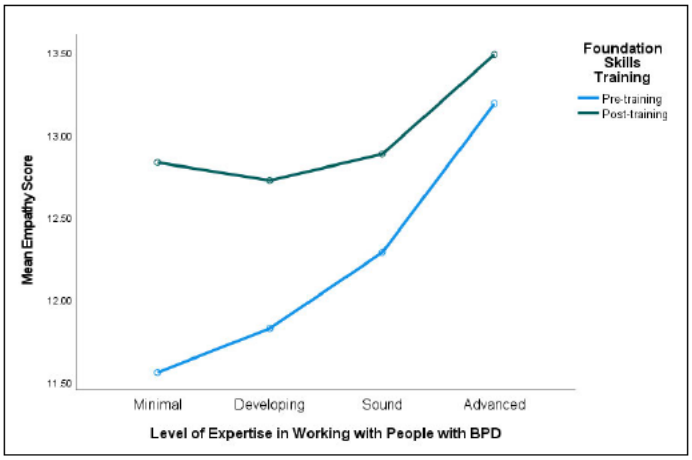
Empathy

Results revealed a significant interaction between Foundation Skills training and level of expertise ($F(3,690)=6.233$, $p<.001$, partial $eta^2=.026$). As seen in Figure 5, those who rated their level of expertise as advanced demonstrated significantly less improvement in empathy post-training, compared to all other groups (minimal, developing and sound). There was no significant difference in level of improvement between any of the other levels of expertise.

While there was a significant main effect of Foundations Skills training ($F(1,685)=183.145$, $p<.001$, partial $eta^2=.211$) and a significant between-subjects main effect for number of years in profession ($F(1, 685)=7.883$, $p<.001$, partial $eta^2=.033$), there was no significant interaction between these two factors. This suggests that the impact of the training on empathy was similar, regardless of how many years clinicians had worked in their profession.

Figure 5

Changes in Empathy as a Function of Expertise



Optimism

While all participants showed an improvement in treatment optimism following the Foundation Skills training, there were significant interactions between the Foundations Skills training and level of expertise ($F(3,690)=37.946$, $p<.001$, partial $eta^2=.142$), number of years in profession ($F(3,685)=2.755$, $p=.042$, partial $eta^2=.012$), number of individuals with BPD worked with in the past 12-months ($F(1,4)=9.438$, $p<.001$, partial $eta^2=.052$) and whether clinicians worked in a government or non-government setting ($F(1,672)=5.430$, $p=.02$, partial $eta^2=.008$).

Post-hoc tests revealed that, the Foundation Skills training had the greatest impact on treatment optimism for those who reported lower levels of expertise in working with individuals with BPD. As illustrated in Figure 6, the impact of the Foundation Skills training on clinician optimism lessened as level of expertise increased, with those who rated their level of expertise as advanced demonstrating the smallest increase in optimism following the training. There was a significant difference between all levels of expertise.

Figure 6

Changes in Optimism as a Function of Expertise

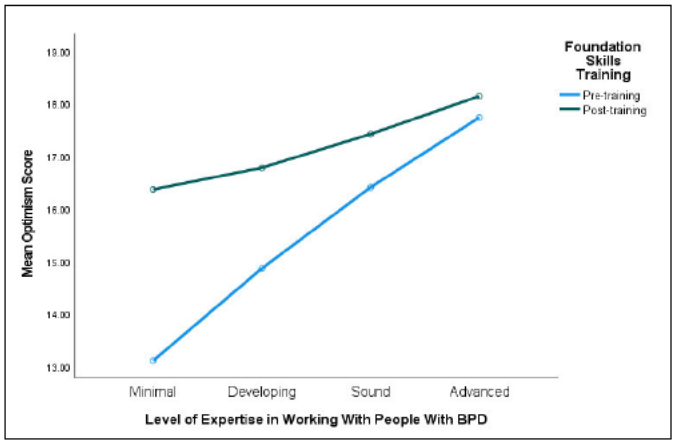
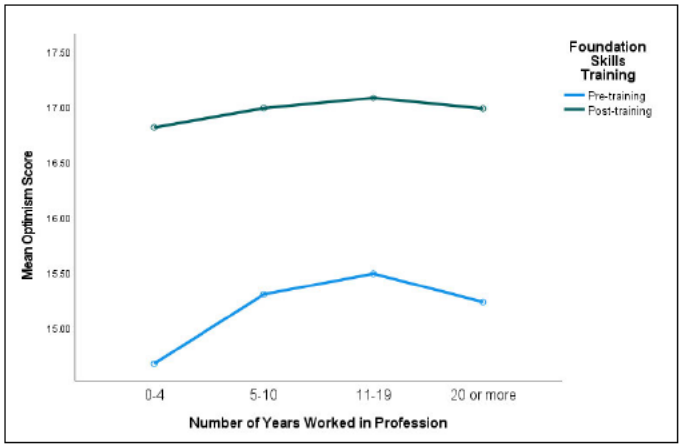


Figure 7

Changes in Optimism as a Function of Number of Years Worked in Profession



Similarly, Figure 7 shows that the Foundation Skills Training was found to be associated with greater improvement in treatment optimism for clinicians who reported working in their profession for 0-4 years, compared to those who had worked in their profession for 11-19 years. Again, there was no significant difference between those who had been working for 0-4 years and those who had worked 5-10 or 20+ years or those working for 5-10 and those who had been working for 11-19 or 20+ years.

As illustrated by Figure 8, clinicians who identified having worked with no individuals with BPD in the past 12-months demonstrated the greatest improvement in treatment optimism following the training, compared to all other groups (i.e., those who reported working with 1-4, 5-10, 11-19 and 20 or more individuals with BPD). Those who reported working with 5 or more individuals with BPD in the past year all demonstrated similar improvement in treatment optimism following the training.

While clinicians across both government and non-government settings demonstrated an improvement in treatment optimism following the training, Figure 9 shows that the Foundation Skills training had a greater impact on treatment optimism for those working in non-government settings.

Figure 8

Changes in Optimism as a Function of Number of Individuals With BPD Worked With In the Preceding Year

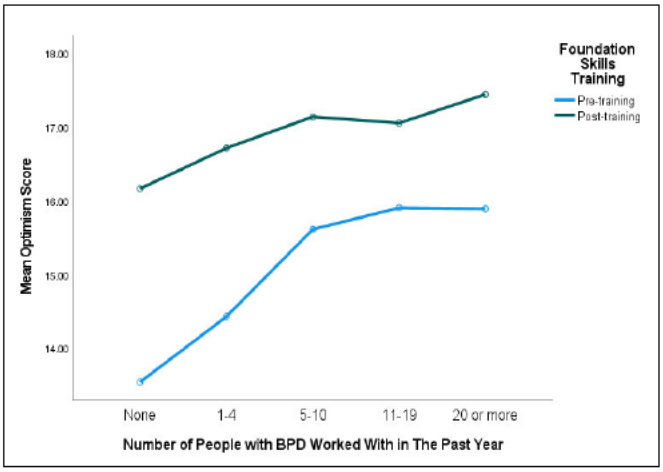
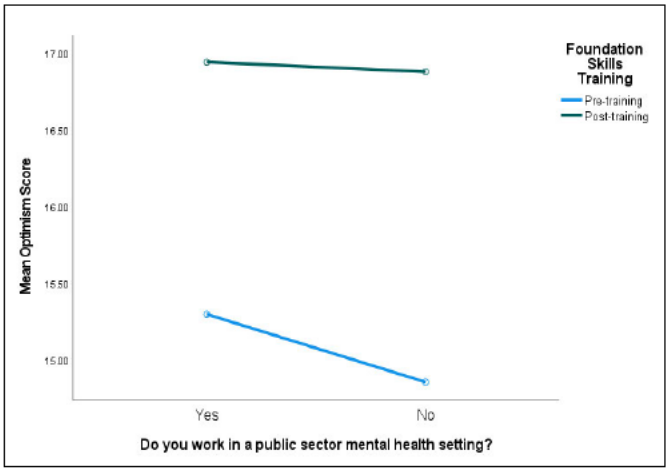


Figure 9

Changes in Optimism as a Function of Employment Setting



Discussion

This study aimed to evaluate a BPD-specific educational intervention for mental health professionals, that was developed and delivered in collaboration with experts by lived experience. Overall, the results showed that the Foundation Skills training is an effective tool for improving clinician's attitudes towards BPD and increasing feelings of empathy and optimism regarding treatment outcomes for individuals with this diagnosis. These findings are in line with existing studies that have shown BPD-specific training to be an effective intervention for improving mental health professionals' attitudes towards people with BPD. While there is currently limited research examining the efficacy of clinician training that has been co-delivered with experts by lived experience, the results from this study are encouraging and provide support for this emerging body of literature (i.e., Davies et al., 2014; Dickens et al., 2019; Klein et al., 2022).

While the Foundations Training resulted in improved clinician attitudes and emotional reactions to BPD, participant characteristics related to experience and familiarity with BPD were found to be key factors in determining training outcomes. The results showed the training had the greatest impact on attitudes and treatment optimism for clinicians who were in the early stages of their career and who identified as being less skilled and less familiar in working with people with

BPD. Clinicians who were in the first four years of their career demonstrated greater improvement in attitudes and optimism post-training, compared to clinicians who had been working in their profession for 11-19 years. The training had a similar impact on attitudes and treatment optimism for those who had worked in their career for 0-4 and 5-10 years and 11-19 and 20 or more years. In line with this, the greatest improvement in attitudes and optimism was demonstrated by clinicians who had not worked with any individuals with BPD in the past year, followed by those who had only worked with 1-4 individuals with BPD in the past 12-months. Once clinicians had worked with 5 or more individuals with BPD in the past year, the impact of the training on attitudes and treatment optimism was similar, regardless of the total number of individuals worked with during that 12-month period.

Overall, this pattern of results may reflect important differences in clinicians' attitudes and optimism prior to the training. Analysis of baseline differences showed that clinicians in the first four years of their career, who had less experience and who worked less frequently with individuals with BPD, reported significantly poorer attitudes and optimism towards BPD prior to the training. These findings are consistent with existing literature that has shown higher levels of clinical experience and more frequent contact with individuals with BPD to be associated with more positive attitudes and more favourable perceptions regarding the chronicity of this diagnosis (Baker & Beazley, 2022; Black et al., 2011; Bodner, Cohen-Fridel & Iancu; 2011; Liebman & Burnette, 2013).

Comparatively, the impact of the Foundation Skills training on empathy was less influenced by clinician characteristics and differed only according to level of expertise. The results showed that the training was least effective in improving empathy for clinicians who already had a high level of expertise in working with individuals with BPD. Clinicians who self-identified as having 'advanced' expertise in working with BPD demonstrated a significantly smaller increase in empathy following the training, compared to clinicians with minimal to sound expertise, who all demonstrated a similar improvement. While clinicians with advanced expertise demonstrated a significantly smaller increase in empathy, they also reported significantly higher levels of empathy towards individuals

with BPD prior to the training. While it cannot be ascertained from this study design, it may be that when clinicians feel more confident in their ability to work effectively with clients with BPD, their interactions with this client population become less self-focused and more client-centred, generating more empathetic responses. In support of this, Liebman & Burnette (2013) found that greater expertise and prior training in BPD was associated with greater empathy towards individuals with this diagnosis. Furthermore, research on empathy in health care has demonstrated links between empathy and clinician knowledge, attitudes and skills (Nembhard *et al*., 2022). This proposition is in line with speculation that uncomfortable personal reactions and feelings of incompetence may underly mental health clinicians' negative reactions towards individuals with BPD in the first place (McKenzie et al., 2022; Treloar, 2009a). However, it is important to note that the categorisation of level of expertise within the present study was based on self-report and therefore conclusions drawn regarding the impact of expertise on training outcomes should be made with caution.

In addition to clinician characteristics, the results also revealed differences in training outcomes according to clinicians' treatment setting. Whilst clinicians across both government and non-government sectors demonstrated improvement in attitudes, empathy and optimism following the training, attitudes and optimism were most improved for clinicians working in non-government settings. This finding may also be best explained by baseline differences in attitudes and optimism, given that in this sample, clinicians working in non-government settings reported significantly poorer attitudes and optimism prior to the training. While there is limited publicly available information regarding the frequency in which individuals with BPD come into contact with government and non-government health services in Australia, there is some evidence to suggests that individuals with BPD may more commonly seek support from public hospitals, compared to private hospitals (Lawn & McMahon, 2015). Given that familiarity and frequency of contact have been shown to be associated with more positive reactions to BPD (as discussed above), this finding may also reflect the frequency in which clinicians working in non-government settings come into contact with and provide care to individuals with BPD. Equally, this pattern of results may reflect differences in training or educational

opportunities across sectors. It may be that non-government organisations receive less BPD specific educational opportunities compared to tertiary mental health settings, where clinically challenging presentations such as BPD are considered core business.

Within the literature, research on the impact of clinician characteristics on training outcomes in the context of co-delivered BPD-specific training is lacking. The relationship between clinician characteristics and training outcomes was not documented by Davies et al., (2014), Dickens et al., (2019) or Krawitz and Jackson (2007) in their evaluations of co-produced educational interventions for clinicians working in the area of BPD. In evaluation of BPD-specific training for clinicians more broadly (and where lived experience involvement in development and delivery is not documented), findings regarding the impact of clinician characteristics on training outcomes, where available, is mixed. In contrast to the present study, Clark and Long (2015) found that changes in knowledge following a BPD educational intervention for mental health professionals did not differ according to experience or previous training in BPD. Furthermore, Commons-Treloar and Lewis (2008b) found an opposite pattern of results to us, such that clinicians who had less frequent contact with individuals with BPD demonstrated significantly lower attitudinal improvement post-training, compared to clinicians who had more regular contact. While these findings differ from that of the present study, it is important to note that they differ significantly in methodology. For example, the intervention examined by Clark and Long (2015) was significantly shorter (90 minutes) than the Foundation Skills training and clinicians in the study were employed in an inpatient setting and worked primarily with patients who were detained under the Mental Health Act (2007). Similarly, the training evaluated by Commons-Treloar and Lewis (2008b) focused specifically on attitudes towards deliberate self-harm and BPD, as opposed to attitudes to BPD more broadly as in the present study. While commons-Treloar and Lewis (2008b) had contrasting results regarding the impact of frequency of contact on training outcomes, their findings in terms of level of expertise were similar. They found that clinicians with fewer years of clinical experience (0-15 years) demonstrated an improvement in attitudes post-training, whereas clinicians who had with more

years of clinical experience (16+) did not. However, while these results are more in line with our findings, comparison is limited by differences in the categorical organisation of years of experience. Given that BPD-specific clinician education is well documented as an effective intervention for improving clinician attitudes and hence reducing BPD-related stigma in health care settings, further research to determine the impact of clinician characteristics on training outcomes may be useful to inform the most effective implementation of such training (Klein et al., 2022).

Consequently, while the Foundation Skills training showed to be effective in modifying clinician attitudes and increasing feelings of empathy and optimism overall, the results suggest that the training may be best targeted towards clinicians who are in the early stages of their career and, or who have had less contact with individuals with BPD. Given this, future research may wish to consider the utility of the training outside of the health care system, in settings where contact with individuals with BPD is likely, but BPD-specific expertise is less common. For example, the education system, child protection settings or the broader criminal justice system. Given that those who were most familiar with and who already had significant experience in working with individuals with BPD demonstrated the smallest benefit on outcome measures, future research may want to explore what factors are needed to enhance the training's effectiveness for more experienced clinicians and those who frequently provide care for individuals with BPD.

This study has several limitations that must be considered when interpreting the results. Firstly, while clinician attitudes, empathy and treatment optimism were greater following the training, this study did not include measures of behavioural outcomes and therefore the extent to which these improvements translate to changes in clinical practice, remains unknown. While this is not addressed in the present study, Klein et al., (2022) identified two studies that measured changes in clinical practice as a result of BPD-specific training. While the results from these studies suggest that clinician training may translate to changes in clinical practice, the quality of this evidence is limited by the use of self-report measures.

In addition to this, while clinicians demonstrated improvement directly following the training, this study did not include follow-up assessment and therefore the longevity of training outcomes is also unknown. Future research may benefit from the inclusion of both measures of clinical skills and behaviour, as well as follow-up assessment of attitudes, empathy and optimism at a later time point. This will help to determine the extent to which the Foundations Skills training results in sustained and tangible improvements in the care received by individuals with BPD. While our study did not include follow-up measures, results from similar studies (i.e., Davies et al., 2014; Dickens et al., 2019) provide preliminary evidence that improvements in emotional reactions toward BPD following clinician training, may be sustained up to 4-months (with moderate to large effect sizes).

Additionally, while this study adds to the limited literature by evaluating an BPD-specific educational training that was both developed and delivered in collaboration with individuals with lived experience, the study design did not allow for examination of the true impact of a lived-experience perspective on the training outcomes. To allow for such conclusions to be drawn, it would be useful for future research to consider the use of a control and experimental groups in which lived experience involvement is varied. This would also act to provide further, more robust evidence for the effectiveness of the Foundation Skills training.

Lastly, because all individuals who participated in the training self-nominated to undertake further education on BPD, they may have been more open-minded and willing to change their attitudes towards this patient population than others. Consequently, the results of this study may not generalise to clinicians who have less interest in learning about BPD.

In conclusion, this study provides support for the Foundations Skills training as an effective intervention for modifying mental health clinicians' attitudes towards BPD. The findings suggest that training that is developed and delivered in collaboration with experts by lived experience can lead to increases in clinicians' attitudes, empathy and feelings of optimism regarding treatment outcomes for individuals with BPD. However, further research is needed to determine to what extent the lived

experience perspective contributed to the training outcomes. The results provide further support for existing literature that highlights clinician training an important tool for targeting BPD-related stigma within health care settings and adds to the limited body of research evaluating BPD-specific training that has been developed and delivered in collaboration with individuals with BPD. For the Foundation Skills training specifically, the results showed that clinician characteristics related to experience and familiarity with BPD played an important role in determining the level of benefit received from the intervention. This finding has clinical implications for the delivery and implementation of the Foundation Skills training moving forward and may be useful in informing the application of other, similar intervention programs targeted at improving clinician attitudes and emotional reactions to BPD.

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Appendix

Manuscript Requirements For the Journal of Mental Health Training, Education and Practice

Format	Article files should be provided in Microsoft Word format While you are welcome to submit a PDF of the document alongside the Word file, PDFs alone are not acceptable. LaTeX files can also be used but only if an accompanying PDF document is provided. Acceptable figure file types are listed further below.
Article length / word count	Articles should be between 3500 and 6500 words in length. This includes all text, for example, the structured abstract, references, all text in tables, and figures and appendices. Please allow 350 words for each figure or table.
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Biographies and acknowledgements	If you want to include these items, save them in a separate Microsoft Word document and upload the file with your submission. Where they are included, a brief professional biography of not more than 100 words should be supplied for each named author.
Research funding	Your article must reference all sources of external research funding in the acknowledgements section. You should describe the role of the funder or financial sponsor in the entire research process, from study design to submission.
Structured abstract	All submissions must include a structured abstract, following the format outlined below. These four sub-headings and their accompanying explanations must always be included: • Purpose • Design/methodology/approach • Findings • Originality The following three sub-headings are optional and can be included, if applicable: • Research limitations/implications • Practical implications • Social implications You can find some useful tips in our write an article abstract how-to guide. The maximum length of your abstract should be 250 words in total, including keywords and article classification (see the sections below).

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Notes/endnotes	Notes or endnotes should only be used if absolutely necessary. They should be identified in the text by consecutive numbers enclosed in square brackets. These numbers should then be listed, and explained, at the end of the article.
Figures	All figures (charts, diagrams, line drawings, webpages/screenshots, and photographic images) should be submitted electronically. Both colour and black and white files are accepted. There are a few other important points to note: • All figures should be supplied at the highest resolution/quality possible with numbers and text clearly legible. • Acceptable formats are .ai, .eps, .jpeg, .bmp, and .tif. • Electronic figures created in other applications should be supplied in their original formats and should also be either copied and pasted into a

	blank MS Word document, or submitted as a PDF file. • All figures should be numbered consecutively with Arabic numerals and have clear captions. • All photographs should be numbered as Plate 1, 2, 3, etc. and have clear captions.
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