2020

Nurses' Social Distancing Behaviors Toward Patients with Borderline Personality Disorder

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Walden University
2022

Abstract

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MS, Walden University, 2015

MA, Chapman University, 2004

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Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Clinical Psychology

Walden University

February 2022

Abstract

Nurses often fear interacting with patients diagnosed with borderline personality disorder (BPD) and use self-preservation distancing strategies that can exacerbate the BPD patient's fear of abandonment, paranoia, self-harm, and relational conflict. Prior research identified individual predictors of nurses' social distancing. This study used multivariable and multivariate correlational profiles of fear of violence and BPD bias that influence distance, reassessing, and constructive coping. Guided by social cognitive and appraisal transaction theories, data were collected from 113 nurses in a northwestern U.S. state on measures of interpersonal stress coping, attitudinal dispositions, perceived prevention of violence, perceived likelihood of future violence, and perceived coping ability. In regression analyses, fear of violence positively predicted all three coping types, threat to self negatively predicted reassessing and constructive coping, belief that those with BPD had impaired emotional capacities positively predicted distance and constructive coping, psychological treatment as useful negatively predicted reassessing and positively predicted constructive coping, and coping well if assaulted negatively predicted distance coping and positively predicted reassessing. Root 1 of a canonical correlation found nurses with high scores on distance and low scores on reassessing believed that (a) the BPD patient a threat to others, (b) BPD was caused by a stressful family environment (not by brain abnormalities), (c) thought psychological treatments effective, and (d) they (the nurse) would cope well if assaulted. Results may have positive social change implications in training and supervision of nurses and workplace safety protocols to improve safe interaction with and treatment outcomes for the BPD patient.

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Dedication

I would like to start with gratitude for all the nurses who took time to assist in this research during the pandemic as their skills were needed in other areas. I am also grateful for the unwavering support of family, friends, coworkers, mentors and professors. I am appreciative for the different roles each one of you have held for me in this journey.

Acknowledgments

I would like to acknowledge several individuals' whos' guidance and assistance helped me to remain focused in completing my educational goals. My grandmother and my parents provided the foundation in completing this educational goal by instilling the importance of education. My sister and husband no matter how difficult an obstacle has been in front of me, they have provided the necessary encouragement whenever needed. Dr. Mitchell Hicks served as a mentor as well as helping to form this research from an idea into a cohesive research topic. Dr. Diebold served in different roles in my dissertation committee, supported my research and assisted in making the statistics make sense. I had numerous friends, coworkers and colleagues who provided validation and encouragement when necessary. Lastly, I want to thank all the nurses who are working in a difficult time as COVID -19 this is impacting their stress and burnout levels in an already difficult job.

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Chapter 1: Introduction to the Study

Many professionals have openly discussed their frustrations working with the borderline personality disorder (BPD) patient (McGrath & Dowling, 2012). The professional's views of the BPD patient are based on their own experiences and others opinions about the disorder (McGrath & Dowling, 2012). These frustrations manifest as the professionals treating the patient as fragile and the professional separating themselves by creating distance from the patient (Markham & Trower, 2003). Nurses are one group of professionals that have a distinctive history with extreme treatment of individuals with BPD (Sansone & Sansone, 2013). Social distancing is one of the tactics or interventions that nurses identify as specific to their interactions with the BPD patient (Woollaston & Hixenbaugh, 2008). The social distancing has been identified as an intervention to protect from violence or to manage the nurse's fears of the potential actions of the patient with BPD (Cleary et al., 2002).

Background

The diagnosis of BPD influences perceptions and assumptions made by professionals in their interactions with the BPD population (Markham & Trower, 2003). Research has shown that, historically, professionals have taken a negative view towards these individuals (McGrath & Dowling, 2012). Nurses are considered as one of the primary healthcare workers that have difficulties interacting with the BPD population (Markham & Trower, 2003). Social distancing, avoidance, hostile interactions, and cold demeanor are some examples of the treatment individuals with BPD have identified experiencing from nurses (Sansone & Sansone, 2013). While some nurses create distance

between themselves and the BPD patient, others enmesh themselves in the treatment and provide excessive help by treating the individual as fragile in the hopes of curing the individual (Woollaston & Hixenbaugh, 2008). Beliefs and assumptions have guided the interactions and influenced the treatment between nurses and the BPD patient.

Research has found that most nurses feel a lack of training influences the treatment and interaction occurring with this population (Woollaston & Hixenbaugh, 2008). The identified training specifically relates to interventions and techniques to manage the care of the patient with BPD (Woollaston & Hixenbaugh, 2008). While research supports a need for more training to assist the nurses, a theme found is the fear of violence is often the motive for the social distancing by nurses from the BPD patient (Sansone & Sansone, 2013; Woollaston & Hixenbaugh, 2008). Limited training compounded by fear of violence appear to be factors influencing social distancing for nurses.

In addition to training and fear of violence, other potential predictors of nurses' distancing, behavior, and demeanor towards patients with BPD include multiple factors: (a) actual and perceived knowledge of BPD and perceived confidence in dealing with BPD (Cleary et al., 2002), (b) immediate and future consequences mindset (Strathman et al., 1994), (c) professional consequences (e.g., fear of disciplinary action, licensure) (Woollaston & Hixenbaugh, 2008), (d) patient consequences (e.g., likelihood of self-harm) (Bowers & Allan, 2006), and (e) one or more demographics (e.g., years' experience as a nurse) (James & Cowman, 2007). Some of these potential predictors of social distancing are expected to be avoidance, hostile interactions, and cold demeanor

(Markham & Trower, 2003). These were expected to be protective factors that mitigate the negative behaviors of the patient with BPD.

Problem Statement

Nurses in a variety of different psychiatric settings have identified difficulties with treating and interacting with the BPD clientele (Markham & Trower, 2003). Distancing from the BPD patient has been documented as a tactic used by nurses for self-preservation (Sansone & Sansone, 2013). Nurses distance themselves as a way to protect themselves from the perceived threat of violence from the BPD patient (Markham, 2003). The assumption or belief that the BPD patient will become violent influenced the nurse distancing themselves from the patient with BPD. Limited skill sets, assumptions, lack of hope and views of others contribute to the nurses' social distancing (King, 2014). Fear of abandonment, stress induced paranoia, self-damaging impulsive behavior and relational conflict (American Psychiatric Association, 2013) are a few of the BPD symptoms that are exacerbated when social distancing occurs (Linehan, 1993). The nurses varying use of distancing are used as tactics that does not appear to have one specific meaning.

Social distancing is identified by both nurses and the patient with BPD as occurring (Markham & Trower, 2003) Nurses identified the belief of perceived violence as contributing to their separation from the patient with BPD. What is not known is whether the social distancing is due to perceived violence or if nurses have a bias against BPD patients which contributes to their distancing.

Understanding the contributing factors to the nurses' social distancing from the BPD patient will assist in future training to support the nurses. This research will help

with providing more information on working with individuals with BPD as well as a rationale to assist supervisors when training nurses in psychiatric programs. The finding may provide nurses with more accurate knowledge of BPD, allowing them to base their actions on the actual situation rather than responding to personal bias, generalizations or assumptions of BPD patients.

Purpose of the Study

The purpose of this study was to examine the combined and relative effects of risk and protective factors of nurses' distancing behavior and demeanor towards patients with BPD. While prior research has examined individual predictors, the original contribution of this study was to develop a multivariable profile of risk and protective factors that influence the social distancing.

Theoretical Framework

The theoretical frameworks for this study were Bandura's (1989) social cognitive theory (SCT) and appraisal transaction theory (ATT). SCT operates under the premise that an individual's behavior is based on past experiences, influences of others, and observations (Bandura, 1989). One fundamental concept within SCT is the ability to predict and the ability to control outcomes (Bandura, 1989). The use of SCT is a foundation in the nursing field to further the acquisition of clinical skills (Kuiper & Pesut, 2004). SCT's focus on problem solving and reasoning influences the perceptions nurses have that results in social distancing. ATT principles are grounded in the evaluation of an individual's intensity during a stressful encounter and what coping mechanisms are used to mitigate the stressful situation (Fortinash & Holoday-Worret, 2012). The individual's

vulnerabilities such as stress and burnout are accentuated and the response to the stressful situation can have an over or under reaction that is disproportionate to the situation (Spector et al., 2007).

Both SCT and ATT have their foundations in cognitive theories and support problem solving abilities which are foundational concepts in the nursing field. SCT focuses on the individual's reaction in the moment (Kuiper & Pesut, 2004) whereas ATT addresses the intensity of the reaction from the situation (Lazarus & Folkman, 1987). Taking the information, the nurses are processing in the moment and then how their stress level influences the interaction and those around them is how ATT and SCT serve as a framework for this study.

Research Questions and Hypotheses

Nurses social distancing from BPD patients has been well documented as a treatment issue by treatment teams and the BPD patient (Cleary et al., 2002, Markham, 2003; Markham & Trower, 2003, McGrath & Dowling, 2012; Markham & Trower, 2003, Sansone & Sansone, 2013; Woollaston & Hixenbaugh, 2008). There has been some research to support the fear of violence as a contributing factor to the social distancing (Martinez et al., 2011; Nachreiner et al., 2007; Spector et al., 2007). Currently, there are no quantitative studies that explores the relationship between nurse's social distancing from the BPD patient and how burnout, experience, and bias from other team members contribute to the social distancing and the perception of violence (verbal or physical) occurring.

To fully research the current beliefs for this study, I posed four research questions that focus on the significance in the relationship between social distancing and fear of violence in the interactions between nurses and the BPD patient.

RQ1: In a multiple linear regression, what is the combined effect of the 10 Attitudinal Dispositions Measures (ADM) subscales, the three violence-related scales, and the three demographic items in accounting for variance in each of the three Interpersonal Stress Coping Scale (ISCS) subscale scores (distancing coping, reassessing coping, and constructive coping)?

RQ2: In a multiple linear regression, what is the relative effect (sr^2) of each predictor in each of the three ISCS subscale regression models?

RQ3: What are the number of statistically significant multivariate roots relating the set of dependent variables with the set of independent variables?

RQ4: For each statistically significant multivariate root, what is the weighted combination of variables in the dependent and independent set that define the root?

Nature of the Study

The nature of this study was a quantitative research design using a survey method. A quantitative design was fitting for this research with the numerical data gathering process (see Creswell, 2009) to identify risk and protective factors associated with nurses distancing from and behavior towards patients with BPD. A survey design was used to identify current beliefs, trends, and knowledge base (see Creswell, 2009) of nurses and their interactions with the patient with BPD. The survey was available via an online survey system for accessibility, availability, convenience to more participants and cost.

Those individuals that participated in this study were over the age of 18 and had a professional title and licensure as a nurse in varying capacities.

The key variable for this study consisted of the independent variable of nurses' general beliefs of BPD, causes of BPD, treatments for BPD, Perceived Prevention of Violence Measure (PPVM), Perceived Likelihood of Future Violence Scale (PLFVS), Perceived Coping Ability Measure (PCAM) and demographic items. The dependent variable is the ISCS: distance coping, reassessing coping and constructive coping. The covariates are identified by using a multiple regression using a correlational design.

Definitions

Appraisal Transaction Theory (ATT): A ttheory focused on assessing emotional intensity after a stressful event and how that impacts the interaction (Fortinash & Holoday-Worret, 2012).

Borderline Personality Disorder (BPD): A diagnosis given to individuals who display extremes in behaviors, emotions, thoughts, and interpersonal interactions that creates negative consequences in their daily living (American Psychiatric Association, 2013).

Nurse: A professional on a treatment team that assists in diagnoses and treats concerns a patient has with actual and potential varying health concerns (Fortinash & Holoday-Worret, 2012).

Social Cognitive Theory (SCT): SCT is a theory that assess the impact that observations of thoughts and behaviors have on situations (Bahn, 2001).

Social Distancing: Purposeful separation from people to avoid a violent or uncomfortable situation (Martinez et al., 2011).

Violence: An interaction where verbal or physical threats or actions are made towards others (Soliman & Reza, 2001).

Assumptions

With using a self-completing survey, I was assumed that all individuals who completed the survey answered honestly. Another assumption was that each individual completing the survey would have credentials, licensure, and practice in Washington state. I also assumed that nurses would identify with currently or historically working in a psychiatric setting. I presumed that all participants identified as a practicing nurse and had experience treating individuals with BPD diagnosis. It was also assumed the nurses had varying experience and education working with patients with BPD. Knowing the current availability of internet access, it was assumed that the nurses had availability, possessed necessary reading comprehension, and understood the instructions to complete the survey.

Scope and Delimitations

This study was a quantitative survey study to define the perceived violence that nurses identify as factors that contribute to their social distancing of the patient with BPD. Research has identified the general summary of fear of violence contributes to nurses distancing themselves from individuals with BPD (e.g., Harris & Leather, 2012; Nachreiner et al., 2007). To date, there was no research that has identified the specific threats of violence that nurses attribute to their social distancing from the BPD patient.

There was no significant amount of research finding a high association with acts of violence and the BPD patient (Soliman & Reza, 2001). Soliman and Reza (2001) addressed the concern that there is no clear definition of violence and it was over generalized without identifying the varying differences such as physical and verbal violence. The aim of this study was identifying specific perceived violence of verbal or physical violence, acts or perceived potential risk of violence, and who is the potential victim of the perceived violence. Then assess if experience and burnout influence the perception of harm by the nurse.

The findings of this study will benefit psychiatric nurses working with patients with BPD in identifying factors that contribute to the perceived fear and how burnout influences the fear. This study might not have substantial findings for nurses working in other capacities or who predominately work with other diagnosis specific patients. These finding also might have limited relevance to other professions or job titles that work in depth with individuals with BPD such as psychiatrists, therapists, social workers, security officers, probation officers, law enforcement, and other mental health professionals.

Limitations

The primary limitation to this research is that individuals who completed the survey were only from a specific pacific northwest state's nursing association with a psychiatric emphasis. Nurses completing the survey may have contributed to some additional limitations such as self-reporting with accurate reporting or wanting to provide an over favorable response for themselves. Another limitation was the modifying of the initial instrument used for the survey as well as participants choosing not to answer

certain questions. The participants also needed internet access, time to complete the survey, and English proficiency. The study topic could limit participants based on their interest and bias towards the population.

Significance of the Study

The outcomes from this study may provide insight into the relatively more important risk and protective factors that influence nurse's social distancing and hostile interpersonal interactions. Identifying these factors can benefit the treatment a BPD patient receives and can further assist in tailoring continuing education trainings that can build confidence to the nurses while treating BPD patients. This should ultimately assist in genuine interactions between the nurse and the BPD patient, which in turn will hopefully increase better treatment outcomes and decrease interpersonal conflicts between nurse and BPD patient.

Social Change

Positive social change can occur from the implementation of this research study. The outcomes from this research can assist in training and supervision and decrease negative beliefs and perceptions of the BPD patient. With having information identifying the specific concerns with violence and impact burnout has on the interaction between nurse and patient can further training interventions to openly concentrate on fears and worries of violence.

Summary

The relationship with BPD and varying health professionals is well documented with biases and assumptions on the motives of the BPD patient (Smith & Cashwell, 2010;

Schultze, 2007). The health professionals have viewed the BPD patient as manipulative and retaliatory, which interferes in treatment and the interactions the health professionals have with the patient (Liebman & Burnette, 2013; Markham & Trower, 2003). Nurses are one of the populations that have an extensive history working with the BPD patient and distancing themselves from the patient when there is perceived fear of violence (Woollaston & Hixenbaugh, 2008). Studies have found that nurses have a high rate of socially distancing themselves from the BPD patient as a way to separate themselves and limit the potential of violence, verbal aggression, and manipulative behaviors (McGrath & Dowling, 2012; Sansone & Sansone, 2013). Anxiety, burnout, and stress can influence the perception of an individual being threatening or attacking (Harris & Leather, 2012). There was little research to support a high rate of physical violence nurses have experienced at the hands of a BPD patient (Soliman & Reza, 2001).

As the number of individuals diagnosed with BPD increases it will be important to identify the contributing factors that influence professionals distancing themselves from the patient and impacts treatment outcomes. Identifying how stress, burnout, and diagnostic bias influence the perception of violence, subsequently increasing fear and decreasing interpersonal connection necessary for treatment may create opportunities for nurse training that will result in better care for the BPD patient. This information has the ability to improve interventions, training, and supervision of nursing staff on the BPD diagnosis and patients. Increasing education will allow personalized plans to assist new nurse hires to interact with BPD patient based on knowledge and personal experiences versus prejudice based on diagnosis, and opinions of others.

The intention of this study was to provide additional research focusing on defining specific forms of violence influencing social distancing and the outside influences of the nurse (burnout, stress, experience level, and opinions of others) impacting the interaction between the nurse and BPD patient. Chapter 2 presents a literature review that expands upon the terms used in the study: BPD, assumptions of BPD by mental health providers, SCT, ATT, social distancing, transference and countertransference, validation and invalidation, violence, suicidality, and self-harming. Chapter 3 addresses the research procedure, design, and method in more detail. Chapter 4 will have the results and chapter 5 will focus on the discussion, conclusion and recommendations for future research.

Chapter 2: Literature Review

Chapter 2 focuses on the research surrounding professionals and their interactions with individuals with BPD. The literature will reflect the previous research that has led to beliefs professionals have that result in the social distancing with the BPD patient, specific studies, data collection, data analysis methodology used, and theoretical frameworks used in previous research.

Literature Search Strategy

The research reviewed consisted of searches using Google scholar and Walden library in psychology, counseling, and nursing research databases. Following the suggestions of Harvard (2007), having a clear and cohesive concept is imperative in finding topical literature related to the current research. Using a variety of databases enhances the ability to find research, texts, online resources, and documents to support the current research (Harvard, 2007). The Psychology and Counseling data bases used consisted of PsycArticles and PsycINFO. Nursing databases used consisted of Books by OVID, ProQuest Health & Medical Complete, Medline, and CINAH. Plus, all these data bases were filtered by peer-reviewed literature and texts. Terms used to assist with exhausting available research were *nurses, borderline personality disorder, treatment, therapeutic interventions, nursing, interactions, personality disorder, violence, social distancing, countertransference, invalidation, healthcare workers, beliefs, values, workplace violence,* and *patient violence*.

The initial search focused on literature that was published with in the last 5 years (2016-2011). This provided a minimal amount of literature. In order to have exhausted

the literature available for this topic I focused on literature from 2000- present with some articles that provide significance in the research that was published prior to 2000. The empirical literature found consisted of studies with varying sample sizes, theoretical framework, and models of analysis that will provide the foundation for the present research.

Theoretical Framework

The literature identified a variety of different theoretical frameworks used in the studies. Theoretical frameworks consisted of the medical model (Engel, 1977; Fortinash & Holoday-Worrett, 2012; Hall, 1996; Yakeley et al., 2014; Zigmond, 2012), mental health literacy framework (Bland & Rosen, 2005; Furnham & Dadabhoy, 2012b; Jorm et. al, 1997; Jorm, 2000; Linehan, 1993**)**, and cognitive behavioral therapy (Baumann, 2007; Cukrowicz et al., 2011; Fortinash & Holoday-Worret, 2012; Liebman & Burnettte, 2013; Woodward et al., 2009). Appraisal-transaction theory (ATT) and SCT were two additional theoretical frameworks identified in the literature and best fit the intention of this research.

Appraisal-Transaction Theory (ATT)

The basic concept of ATT is based on the theory that a stressful situation occurs and then the intensity is evaluated (Fortinash & Holoday-Worret, 2012). The initial phase of the stressful situation is assessing the threat of the situation and using an appropriate reaction to the current situation (Lazarus & Folkman, 1987). The second phase is where the specific coping mechanism is employed to assist in the current situation (Fortinash & Holoday-Worret, 2012). In both phases, stress and burnout creates vulnerabilities for the

individual to respond to the situation which can lead to an over or under response to the situation (Spector et al., 2007). Nachreiner et al. (2007) furthered the influence stress has on nurses in the workplace creates a cycle that heightens in intensity quickly and challenging to disentangle. Nurses can face difficulty in managing situations when they are exhibiting emotion-escalating coping skills that manifest from fear and anxiety which presents as denial, repression, or anger (Fortinash & Holoday-Worret, 2012). Typically, the high stress level is contagious among coworkers, which can then lead to difficulty in the assessing of harm (Nachreiner et al., 2007). Harris and Leather (2011) connected the impact of stress and job satisfaction influenced the perceptions and assessment. These perceptions and assessment of the individual as well as their behaviors influenced the type of interaction between the hospital staff and interfacing with their patients (Harris & Leather, 2011).

Social Learning Theory (SLT) and Social Cognitive Theory (SCT)

SLT and SCT both have their roots in cognitive theories that are influential and necessary in problem solving (Bandura, 1997, ; Lazarus & Folkman, 1987). SLT and SCT assist in the application of the problem solving across a variety of different conditions and circumstances (Bahn, 2001). The combining of thoughts, behaviors and observations that are both internal and external all can influence outcomes (Bahn, 2001). Risks occur when individuals only consider their own actions and behaviors without observing the actions and behaviors of others (Bandura, 1977). The observing of others' behaviors allows for others to learn from those behaviors' verses learning from their own behaviors by trial and error (Bahn, 2001).

The SCT and SLT models are primarily used in nursing school and teaching situations. Kuiper and Pesut (2004) stressed the importance of nursing students knowing how to problem solve in context to their own experiences as well as modelling of behaviors their senior nurses exhibit. The use of SCT to assist nurses in using experiences as a foundation to gain knowledge; address safety concerns and enhance problem solving abilities (Kupier & Pesut, 2004). Kupier and Pesut (2004) defined this as a metacognition.

SLT was the initial creation of Rotter and Bandura (Bahn, 2001). Rotter's contribution to SLT was the idea that an individual's behavior is the result of their interfacing in the environment and the individual's internal and external control of their behaviors (Bahn, 2001). Bandura's view was the belief that shared views of helplessness or hopelessness create debilitating obstacles (Bahn. 2001). The premise of SLT is the focus on an individual's observations from others in their environment impacts their behavior (Bandura, 1977).

Bandura (1989) took his work from SLT and added self-efficacy and maintenance as additional needed components that became SCT. Self-efficacy is the effect an individual's observations and insights on their ability, emotional responses, and themes of thoughts impact behaviors (Keller et-al, 1991). Self-assessment thought patterns and the impact of those thoughts can help or hamper goals (Bandura, 1989) depending on the setting, circumstance, and situation (Bandura, 1997).

Research Variables

Borderline Personality Disorder (BPD)

BPD is a diagnosis that is identified as a Cluster B personality disorder (American Psychiatric Association, 2013). Cluster B personality disorders are identified as a grouping of disorders that exhibit extremes in behaviors, thoughts, and emotions that impact daily living and personal development (American Psychiatric Association, 2013). BPD specifically is identified with characteristics of extremes with managing impulse control, emotional expressions, interpersonal and intrapersonal conflicts, and thought dysregulation that results in high intensity expression and a slow return to baseline (Linehan, 1993). Initially, BPD was defined as a diagnosis that focuses on symptoms that were at the borderline of psychosis and neurosis (Gunderson, 2009). In the 1980s it was seen that BPD patients did not exhibit a similar symptomology as persons with schizophrenia who did not support a psychotic diagnosis (Gunderson, 2009). BPD patients, unlike those with schizophrenia, had a high rate of reality testing, which does not equal psychosis diagnostic presentation (Gunderson, 2009). McWilliams (2011) referenced that the BPD patient uses defensive behavioral patterns that have specific characteristics such as denial, environmental or external influences, and viewing experiences in “black and white” concepts. Additional issues have related to the BPD patient not responding to pharmacotherapy like other biological and organic diagnoses (Gunderson, 2009).

Research is finding that the BPD diagnosis occurs from an invalidating environment and inability self-soothe when emotionally aroused (Linehan, 1993). Many

have surmised that a history of childhood trauma can contribute to the diagnosis and is not a must in the diagnosis presentation (Gunderson, 2009). There was some research supporting that child sexual abuse has more correlation with BPD than the overarching term child trauma (Gunderson, 2009).

It is believed that 2% of the population has the BPD diagnosis (James & Cowman, 2007) and 10% of the inpatient (Bland & Rossen, 2005) and 20% of the psychiatric population is given the diagnosis of BPD (Bland & Rossen, 2005; Hersen & Beidel, 2012). These same individuals are high and frequent users of in-patient and out-patient services with little variances in their identified presenting need for crisis interventions (Liebman & Burnette, 2013). The complex presentations of the individuals and the primary diagnostic symptomology, irritability, poor interpersonal skills, and impulsive behaviors, creates difficulty in accurately treating, assisting, and managing BPD (Liebman & Burnette, 2013). There was not a high rate of practitioners who want to work with or treat BPD patients (Gunderson, 2009).

Mental Health Professionals Assumptions

Assumptions were made that the general public are the predominate factor in stigma and discrimination toward mental health patients because of their lack of knowledge, education, or understanding of mental health diagnostics (Smith & Cashwell, 2010; Schultze, 2007). Instead, mental health professionals contribute to the assumptions, alienation, and stigma that is expressed towards mental health patients (Gormley & Quinn, 2009; McWilliams, 2011; Smith & Cashwell, 2010; Wahl & Aroesty-Cohen, 2010). When a mental illness is present, the perception was that the individual is a “less

than" (Martinez et al., 2011). Martinez et al. (2011) further explained that when an individual with a psychiatric diagnosis that has a cure or able to manage mental health symptoms the professionals can view the treating patient through a positive lens.

Assumptions and perceptions of individuals are documented on the influence it has on the treatment of individuals with BPD (Deans & Meocivic, 2006; Liebman & Burnette, 2013; Filer, 2005; Markham, 2003; Markham & Trower, 2003; Westwood & Baker, 2010; Woollaston & Hixenbaugh, 2008). Gallop (1988) stated "In self-fulfilling prophecies, the expected outcomes are already confirmed, regardless of the reality" (p. 18) are the views of professionals working with the BPD population. In hospital settings, the staff working with the BPD patient are viewed as seeing them as fragile and helpless (Linehan, 1993; McWilliams, 2011) or as retaliatory and vindictive (Linehan, 1993; McWilliams, 2011). Markham and Trower (2003) conducted research to assess the influence the BPD diagnosis has on mental health practitioners implementing treatment. The preconceived view of the BPD patient making choices to not manage negative interactions (Markham & Trower, 2003), the negative attitudes directed towards the BPD patient (Westwood & Baker, 2010), mental health professionals' countertransference (Liebman & Burnette, 2013) and fear of violence (Woollaston & Hixenbaugh, 2008) influences the effect the treatment has for the individuals. Liebman and Burnette (2013) were unable to identify one specific factor that contributes to the countertransference. Instead, they found education level, history, and exchanges with the BPD patient influenced the countertransference (Liebman & Burnette, 2013). Woollaston and Hixenbaugh (2008) found the concern professionals have with working with the BPD

patient is the preconceived worries of violence and unrelenting manipulative behavior that creates the negative views that influence the interactions. Woollaston and Hixenbaugh further found that the professionals demonizing the BPD patient further creates difficulties in managing the BPD patient care. While patient care was a factor the high lethality rate with individuals with BPD, it also contributes to the fear and interactions (Soloff & Fabio, 2008).

The BPD diagnosis also identified by many as an incapacitating long-standing disorder which leads to feelings of hopelessness from professionals interacting with this population (Woodward et al., 2009). Shanks et al. (2011) and Markham (2003) found that professionals interfacing with individuals with the BPD diagnosis had a high level of frustration, annoyance, and an inability to find empathy or other emotions that help build rapport in compared to other diagnosis. Carr-Walker et al. (2004) conducted a study of different mental health professionals and prison guards in a prison setting. The study found that the guards were more positive working with the personality disordered prisoners, whereas nurses felt more vulnerable with the need to care and manage the patients (Carr-Walker et al., 2004).

There were also differences in treatment based on setting (inpatient or outpatient) and clinical position on the treatment team. The inpatient treatment staff report finding themselves separated from other treatment team members based on their assumptions of the BPD patient (McWilliams, 2011). Outpatient practitioners find they have more internal split with treatment depending on the conflict or even the client is presenting with (McWilliams, 2011). Psychiatrists are viewed as the leader on most treatment teams

and viewed as encouraging the stigma associated with many diagnoses (Gormley & Quinn, 2009). The perceptions are that this negative view held by some psychiatrists influences the treatment team and has a more destructive effect on patients than the diagnosis or medications (Gormley & Quinn, 2009).

Nurses

The job expectations of a nurse include organizing patients' personalized basic needs in a variety of diverse settings with respect, dignity, and compassion (American Nurses Association, 2015). Nurses have been the most researched population with their treatment and interactions with the BPD patient in comparison to other mental health professionals (Sansone & Sansone, 2013). The setting, as well as managing behavioral and symptom management of individuals with personality disorders, is identified as additional stressors in the nurse's duties (Deans & Meocivic, 2006; Markham & Trower, 2003; McGrath & Dowling, 2012; Sansone & Sansone, 2013). Managing the behaviors and symptoms of an individual with BPD has increased concerns with inconsistent treatment by nurses (Markham & Trower, 2003).

Inconsistencies in treatment have been reflected in interactions with the BPD and nurses in all settings (McGrath & Dowling, 2012). Extremes in interactions have occurred from over enmeshment such as coddling, over involvement, indulging, and active passivity to hostility, distancing, detachment, avoidance, antipathy, and aggressive behavior towards the BPD patient (Filer, 2005; Markham & Trower, 2003; McGrath & Dowling, 2012; Sansone & Sansone, 2013). Some of the behaviors that nurses' exhibit towards the BPD patient have been viewed as a struggle with having a low level of hope

of the BPD patient having positive outcomes in treatment that lead to decreasing the negative symptomology (Filer, 2005).

Nurses have been identified to have perception differences when knowingly interacting with an individual with BPD (Markham, 2003). Sansone and Sansone's (2013) review of the literature found most research identified nurses' negative views of the BPD patient influenced the treatment. Markham's (2003) study found a slight significance in social distancing by registered mental health nurses (RMHN) when interacting with the BPD patient in comparison to other psychiatric disorders. James and Cowan's (2007) found that 80% of nurses identified BPD patients as the most difficult population with which to work . Limited optimism on effective treatment outcomes for the BPD patient to have an improved and better quality of life had a minimal impact based on the study (Markham, 2003). This was furthered explored as supporting the RMHNs views that a BPD patient can manage negative exchanges more efficiently than those with other diagnoses (Markham & Trower, 2003).

A further implication on the RMHNs interactions with the BPD patient is the limited education on the BPD patient and diagnosis (Westwood & Baker, 2010). Filer (2005) noted that when the behaviors of the BPD patients were viewed as attention seeking instead of as being symptomatic of the BPD diagnosis, nurses drastically decreased their interactions. Deans and Meocivic (2006) reported that 88% of the nurses found the BPD patient to be manipulating and 51% identified the BPD patient as participating in emotional blackmailing behaviors. This same research also found that 21% of the nurses found the BPD population fascinating and 13% found them charming

(Deans & Meocivic, 2006). Bowers and Allan (2006) documented that nurses often felt useless when they identified a patient as uncooperative or as having a chronic mental illness and that this feeling of being useless caused increased judgement and negative responses from the nurses. The BPD individual can often interpret the negative views which then adversely impacts the treatment received (Filer, 2005).

Social Distancing

Social rejection or social distancing as a common action for individuals to avoid violent or uncomfortable situations (Martinez et al., 2011). Social distancing has been documented as one of the factors that impact the relationship between nurses and the BPD patient. With clinician's views of a BPD patient at a higher rate of dangerousness this creates the social distancing (Liebman & Burnette, 2013). Markham (2003) identified that staff's preconceived perception, assumption of violence and pessimistic views of effective treatment outcomes influence the interaction between the nurse and BPD patient. The views, perception and assumptions contribute to nurses and health care professionals social distancing from the BPD patient (Markham, 2003). Conlon and O'Tuathail (2012) identified antipathy as one of the issues that is viewed as a disconnect between mental health professionals and treating specific individuals. Antipathy increases the separation between the patient and treating provider where empathy creates joining (Conlon & O'Tuathail, 2012). King (2014) explained that nurses can separate themselves from the BPD individual based on not believing they have the skill set to work with this patient and are the nurse is distressed with the thoughts and feelings they are having in regard to the patient.

Transference and Countertransference

Transference and countertransference are two terms used to describe the interactions that occurs between a professional and the individual seeking treatment (King, 2014). Both transference and countertransference definitions can differ depending on the modality and theory (Liebman & Burnette, 2013). Transference and countertransference can create a hurdle in the initial and throughout the therapeutic relationship phases (King, 2014).

For the purpose of this study transference will be defined as the process where an individual displaces their feelings, emotions, incidents and experiences upon another person as an unconscious visceral reaction (King, 2014). When transference is occurring the BPD patient presents as being decisive, resilient, defiant, and challenging therapeutic interventions (McWilliams, 2011). Aviram et al. (2006) identified a clinician's initial transference as an initial need for self-protection based on diagnosis or pathology instead of what was occurring in the moment. A clinician's past experiences with a BPD patient can create the transference in the relationship (Gallop, 1988). Gallop (1988) identified initial stereotyping and stigma associated to individual's certain populations primarily the BPD population are examples of transference that impacts the interaction.

Countertransference for the purpose of this study is defined as the reaction of the other person to the individual experiencing transference (King, 2014). It presents as the effect, impact or influence one individual has over the other in an interaction (King, 2014). Linehan (1993, p. 140) defined countertransference as behaviors that interfere in treatment that can occur by both the professional and the BPD patient. Themes with the

definitions are that it focuses on the providers conscious and unconscious actions towards the patient and the impact it has on the therapeutic relationship and exchanges (Liebman & Burnette, 2013). The type of reaction an individual receives from the professional can reinforce both positive and negative views of themselves (Liebman & Burnette, 2013). The interaction and stress from the interaction can further exacerbate symptoms (Schultze, 2007). Prior experiences, overidentification or under identification personality and burnout all can contribute to the countertransference (Liebman & Burnette, 2013).

Countertransference is a common issue when working with the BPD population. An individual with the BPD diagnosis increases countertransference by virtue of the name (Gallop, 1988; Liebman & Burnette, 2013). Professionals focusing on diagnosis, minimizing reported symptoms, viewing individual as manipulative, tiring, upsetting, believing an individual is not trying hard enough, or viewing behaviors as attention seeking increases likelihood of countertransference occurring (Liebman & Burnette, 2013; McWilliams, 2011).

King (2014) further identified the difficulty in managing treating professional's countertransference with the development of the BPD pathology, history of abuse and the presentation of traumatic experiences, which then influences the professional's sense of optimism. The interactions with a BPD individual can have countertransference in both positive and negative situations (McWilliams, 2011). McWilliams (2011) explained how interacting with a BPD patient on a positive situation can be as taxing as encountering negative situations.

Older clinicians and psychiatrists have been documented as the two populations that have a higher rate of countertransference based on diagnosis (Liebman & Burnette, 2013). The countertransference can create issues with early ending of both personal and professional relationships for the BPD patient (King, 2014). Aviram et al. (2006) further explains that a professional's countertransference towards a BDP patient results in the stigma associated with the interactions with the patient. The countertransference in most cases by the professional leads to an extreme of behavior of the BPD patient (Aviram et al., 2006). This then creates the cycle of actions and reactions by both patient and professional. The BPD patient becomes emotionally dysregulated which leads to negative behaviors that the professional views as unsafe which then creates the social distancing themselves from the BPD patient for self-protection (Aviram et al., 2006).

Invalidation

Linehan (1993, p. 49) termed the use of invalidation as a form of countertransference. Invalidation is identified as one of two components in the biosocial model for the BPD diagnosis (Linehan, 1993). Linehan (1993) identifies the BPD patient has a higher level of emotional intensity with being raised and remaining in an invalidating environment. Invalidation occurs when an individual communicates a thought, experience, or feeling and then is met with disdain or an extreme reaction (Linehan, 1993). McWilliams (2011) identifies as one of the primary defenses of a BPD patient is the primitive devaluation. Devaluation is the negative aspect of idealization (McWilliams, 2011). Idealization is the placing value and authority on individuals that a person depends on mentally and emotionally (McWilliams, 2011). Both the behaviorist

and psychoanalytic frameworks identify that invalidating or devaluing impacts a BPD patient in the way they interface with the world around them.

Vangronsveld et al. (2010) found that validating an individual's illness, feelings, and thoughts by professionals working as their care team built a connection to communication. Invalidation broke the communication connection which then results in negative interactions and behaviors between the professional and the patient (Vangronsveld et al., 2010). When a BPD individual has viewed a response as invalidation, they will view themselves as "being wrong" in how they experienced the situation and they were unacceptable in their reactions (Linehan, 1993, p. 50). When practitioners have identified a patient with BPD there is a high level of invalidation in the communication style (Linehan, 1993) and a lower level of empathy towards the patient (Liebman & Burnette, 2013).

Swenson (2016) explained that invalidation can be presented by both the professional and the BPD patient. An individual can experience invalidation by negative self-talk or by the environment reinforcing maladaptive behaviors (Linehan, 2003). An individual who experiences an invalidating environment has experienced frustrations, criticisms, embarrassment, and shame from others when they are not acting as their environment believes they should (Swenson, 2016). When the environment is invalidating it creates the black and white extreme thinking for the BPD patient which results in despair of having no supportive support system and no hope in achieving goals (Swenson, 2016). A BPD patient's self-invalidation expression such as self-hatred can escalate and present itself as a behavior such as cutting (Swenson, 2016).

Violence

Mental health workers in both inpatient and outpatient settings are at a higher rate of non-fatal violence than other professions (Nachreiner et al., 2007). Nurses are at a higher risk than other mental health professionals (Nachreiner et al., 2007). Nachreiner et al. (2007) found that 22 per 1000 nurses in the United States from 1993 to 1999 experienced violence at their workplace. Exposure to physical and verbal violence at the workplace increases when an individual has the responsibility to exert control over another individual, interaction with individuals on medication, responsibility for individual's care (Spector et al., 2007) and witnessed a co-worker's assault by a patient (Nachreiner et al., 2007). Stress, fear, and anxiety in the workplace also are viewed as contributors to perception of violence (Harris & Leather, 2012). The threat of violence or fear of violence is viewed as prevalent, inescapable, and disempowering for the professionals (Harris & Leather, 2012).

There is not a clear or concise definition of violence throughout the numerous research that had been conducted as of 2001 (Soliman & Reza, 2001). Soliman and Reza (2001) defined violence "as any incident in which a patient attempted to physically harm others… or attempted to damage property" (p. 76).

Physical and verbal violence have a higher rate of occurring in a hospital setting committed by patients and family members (Spector et al., 2007). An individual diagnosed with a mental illness has an increase in perceptions of violence with being placed in devalued social class (Martinez et al., 2011). The fear of violence can be the individual's intuition of danger, physical assault, and verbal aggression (Spector et al.,

2007). The nurses' expectation of a violent act to occur increased the reactions and actions of the nurses prior to interaction with patients (Nachreiner et al., 2007). Spector et al. (2007) found that nurses reported 88% of verbal violence or verbal aggression from patients towards them.

Fear of violence is documented as an influence in the interactions between BPD patient and nursing staff (Woollaston & Hixenbaugh, 2008). The fear is exacerbated by the depiction of BPD individuals on television and through conversations with fellow co-workers (Fortinash & Holoday-Worret, 2012). Harris and Leather (2011) found the fear of violence related to professionals' feelings of vulnerability. The perceived threat of violence or actual violence impacts the interactions professionals have with the different mental health patients (Harris & Leather, 2011; Koritsas et al., 2010; MacDonald & Sirotich, 2005).

Soliman and Reza (2001) found that there is a high rate of difficulty in predicting violence. Harris and Leather's (2011) study on violence was broken into categories of sexual abuse/harassment, verbal abuse, threats/intimidation, and physical assaults (Harris & Leather, 2011). Harris and Leather (2011) found a correlation between perceived violence, actual violence, and the stress level of the professional. When an individual's stress was minimized, there was a reduction in their perception of violence and actual violence occurring (Harris & Leather, 2011).

Soliman and Reza (2001) were unable to find a high rate of correlation between violence and the BPD patient. Factors that increased the likelihood of violence is the prolonged time and individual spends hospitalized, history of violence, comorbid

diagnosis formulations, high number of medications, as needed medications, and high rate of medication changes (Soliman & Reza, 2001).

Suicidality

Suicidal ideation is one criterion in the disorder for BPD that creates concern, worry, and fear for the professionals working with this population (Soloff & Fabio, 2008). The difficulty individuals with BPD have with managing impulsive behavior contributes to the worry by professionals about the lethality when working with this population (Soloff & Fabio, 2008). Extreme fears of abandonment, interpersonal chaos, mood lability, and aggression further the concern with an impulsive behavior resulting in a suicidal act (Soloff & Fabio, 2008). As of 2005, BPD individuals had a mortality rate of 6.7% to 8.5% (Langley & Klopper, 2005).

Fortinash and Holoday-Worret (2012) identified five levels of suicidal behavior. The first level is suicidal ideation. Suicidal ideation is the verbal or written discussions that are vague thoughts or fantasies of self-harming behavior (Fortinash & Holoday-Worret, 2012). The second level is threats of suicide. These are direct thoughts of a plan that shows intent for suicide (Fortinash & Holoday-Worret, 2012). The third level is suicidal gestures that result in minimal injury if any, without the intention of ending their life (Fortinash & Holoday-Worret, 2012). The fourth level is a suicide attempt. Suicide attempt is the intentional act of causing harm to themselves with the intention of death (Fortinash & Holoday-Worret, 2012). The last level is a completed suicide. A completed suicide is when an individual intentionally takes one's life by their own means (Fortinash & Holoday-Worret, 2012).

Self-Harm

Self-harm is viewed as an intentional attempt to cause harm to oneself via numerous means to manage stress or intense emotional experiences without the intention of killing oneself (Conlon & O' Tuathail, 2012). Linehan (1993) and Swenson et al. (2001) emphasized the highly dysregulated individual views the goal of self-harming is to diminish whatever the individual is viewing as painful in that moment to alleviate the suffering and misery currently experiencing. The rate of individuals reporting to self-harm has increased steadily (Saunders & Hawton, 2011). Conlon and O'Tuathail (2012) found that 45% of individuals that presented to emergency rooms in Ireland in 2005 with self-harming acts were seen more than once in the emergency rooms for self-harming behaviors. Self-harming is identified as a predictor of future suicidal behavior (Conlon & O'Tuathail, 2012). Linehan (1993) also expressed concern that an individual intention is to block the pain by a means of self-harming with no intention of killing self yet the self-harming results in suicidal act.

The views and beliefs professional holds about self-harming can influence the interactions when treating the patient (Saunders & Hawton, 2011). General hospital staff has been identified as one population that tends to have a higher rate of negative views towards individuals that self-harm (Saunders & Hawton, 2011). Knowledge and attitude by professionals influence the interactions with the self-harming patient (Saunders & Hawton, 2011).

Summary and Conclusion

Research is limited on specific interactions with nurses only. Studies have researched the different interactions that encompass professionals interfacing with the BPD patient in the capacity of physicians, nurses, mental health professionals, and corrections officers. Literature reflects high level of research on personality disorders as a general grouping instead of identifying the individual personality disorders.

Studies about nurses and their interfacing with BPD patients have covered a variety of topics. The interactions that have been highly documented is the fear that nurses have when working with the BPD patient. Their fear is grounded in the perception of violence. The violence is not identified as what the violence is specifically. Most research shows the fear nurses have with physical violence. There is also numerous anecdotal statements with verbal violence and patients causing harm to themselves.

Chapter 3: Research Method

The purpose of this study was to explore the extent to which a set of three attitudinal dispositions toward patients with BPD, a set of three workplace violence related variables, and a set of three demographic variables account for variance in each of three interpersonal stress coping strategies. This chapter focuses on the formulation and implementation of the research study. The formulation of the research study consisted of research design, questions, sampling, and recruitment procedures. The implementation of the procedure focused on the instruments, variables, and the ethical considerations that influenced the outcomes of the study.

Research Design and Rationale

For this research, I used a correlational design and multiple regression to analyze the data. A correlational design is a study that does not randomly assign participants to groups or experimentally manipulate the independent variables (see Creswell, 2009). Rather, it observes the naturally occurring relationships between variables (Shadish et al., 2002). Table 1 lists and briefly describes the three criterion variables and the 19 predictor variables. More detailed information on the instruments, subscales, and items is presented in a subsequent section of this chapter.

Table 1

List and Brief Description of Criterion and Predictor Variables

Instrument/subscale	DV	IV	Description
Interpersonal Stress Coping Scale (ISCS)			
Distance coping (5)	.86		An avoidance strategy
Reassessing coping (5)	.79		A laissez-faire strategy
Constructive coping (5)	.73		A reflective and empathetic strategy
Attitudinal Dispositions Measure (ADM)			
General beliefs			
Threat to others (4)		.74	People with BPD are a threat to others
Impulsivity and instability (4)		.58	People with BPD are impulsive and instable
Emotional capacities (3)		.71	People with BPD have emotional deficits
Causes			
Brain abnormalities/imbalances (4)		.78	BPD is caused by brain abnormalities or chemical imbalances
Fate and karma (3)		.78	BPD is caused by fate and karma
Early trauma and neglect (3)		.75	BPD is caused by early trauma and neglect
Genetic or birth complications (3)		.71	BPD is caused by genetics or birth complications
Treatments			
Sociological (5)		.83	Sociological treatments help people with BPD
Psychological (4)		.75	Psychological treatments help people with BPD
Neuropsychological (2)		.83	Extreme neuropsychological treatments help people with BPD
Perceived Prevention of Violence Measure (PPVM; 4)		.82	Assesses preventive measures in the workplace
Perceived Likelihood of Future Violence Scale (PLFVS; 3)		.74	Assesses probability of future violence in the workplace
Perceived Coping Ability Measure (PCAM; 2)		.60	Assesses coping ability to return to baseline if threatened or assaulted in the workplace
Demographic items			
Sex		X	Male or female
Setting		X	Working in an inpatient or outpatient setting
Years of experience		X	Years of experience as a nurse

Note. Numbers in parenthesis following name of a scale indicate the number of items. Values in the DV and IV columns are Cronbach alpha values. ISCS values are from Kato (2013a); ADM values are from Furnham and Dadabhoy (2012b); PPVM, PLFVS, and PCAM values are from Mueller and Tschan (2011a).

Methodology

In this section, I describe the target population and criteria to be eligible to participate in the study, the target sample size based on a power analysis, the sampling strategy, the sampling procedures, and the data collection method.

Target Population and Eligibility Criteria

The purpose of the study was to identify factors that contribute to nurses social distancing from the patient identified with a BPD diagnosis. The target population included nurses in a state in the northwestern part of the United States who have had experience working with BPD diagnosed patients. Specifically, participants must meet both of the following criteria to be eligible to participate in the study:

- Have the title, degree, registration, or license as a nurse
- Have experience working with BPD patients

Initially, the organization for the specific state's nurses association agreed to assist with recruiting participants by providing their 17,000 members an invitation to participate and the survey link in their magazine (Appendix A). Of 17,000 members, the number of nurses with experience working with BPD diagnosed patients is not known. With the Corona-19 outbreak, the nurse's organization was unable to meet this study's participant needs. I recruited participants through specific pages on Facebook that identified as associated with nurses in their members' location within the specific northwestern state of the United States.

Sample Size and Power Analysis

When using a multiple regression there is no predetermined sample size (see Creswell, 2009). I calculated a sample size for a multiple regression by identifying the number of independent variables, minimal effect size of interest, and probability of Type I and Type II errors. There were 19 independent variables for this study, as previously listed in Table 1. G*Power (Faul et al., 2009) returned a total sample size of 139 for power of .80 and alpha of .05 to detect a medium-size sr^2 population effect of .05 in an overall medium-size population model with $R^2 = .13$ in each of the three regression models. As noted previously, this allowed detection at alpha = .10 of sample-specific values of sr^2 as low as .02 that are considered as substantively contributing to a model.

Sampling Strategy

My sampling strategy consisted of a purposive sample of the participants from a variety of nursing pages on Facebook. A introduction to the study was posted on the Facebook wall and provided the Survey Monkey link to the study's survey. Nurses meeting the eligibility criteria voluntarily self-selected as a participant.

The moderator for each of the groups received information on the intention of the study, the use of Survey Monkey to participate in the study, information on me as the researcher, proposed data collection, contact information for the person supervising this research study at Walden University, and the rationale for using the organization to obtain participants. Each moderator agreed to provide their members access to the link to complete the survey for this research.

The use of internet surveys for data collection in research studies has increased with the ability to maintain consistency with all participants receiving the same information (Babbie, 2013). Individuals accessing a survey via the internet allowed all members to receive the information from the same source, which allowed for consistency with how each member received the survey. The increased access to online surveys in a brief timeframe in comparison to the counterpart of paper and pencil distributed surveys also allows for simplicity in the collection process (Babbie, 2013; Porter & Whitcomb, 2007).Completing surveys online is an accepted form of data collection that limits the amount of financial burden placed upon a graduate student (Porter & Whitcomb, 2007).

Participants received no compensation for their contribution in this research study. Each of the moderators of the groups were given the option of receiving a summary of findings they can make available to their members.

Sampling Procedure

The initial plan was to send an invitation to participate in the study to the 17,000 association membership pool via the magazine two to three times or until the number of 139 participants needed for the study was met. The invitation (Appendix A) described the purpose of the study, eligibility criteria, voluntary and anonymous nature of participation, my contact information, and a SurveyMonkey link. The plan changed from using the association membership to extending an invitation to participate in the study to a variety of Facebook nurse group that their geographic location encompasses a specific state within the pacific northwestern United States.

The first page of the survey contained the informed consent that participants acknowledged by clicking “I Agree.” Those who clicked “I Do Not Agree” were automatically routed to an exit page. Those who clicked “I Agree” proceeded to the eligibility page where they affirmed that they meet each eligibility criteria. Those who did not meet all criteria were automatically routed to an exit page. Those who did meet all eligibility criteria proceeded to the survey items. The survey remained open until the sample size was met or a discussion had occurred between my committee members and myself about number of additional survey responses received with additional information thought to be gained by waiting for more.

Data Collection Method

Initially, the association was to provide their membership the SurveyMonkey link using the Mail Chimp system. With the change to using nursing Facebook groups, the invitation was posted on the different group’s main page and each participant was directed to SurveyMonkey through a link in the invitation. SurveyMonkey is a secure online data collection site and only I had the login and password. Those agreeing to the informed consent and who affirmed eligibility to participate gained access to the survey. The survey did not contain any individual identifying information to ensure anonymity of participants. All data was exported from SurveyMonkey to IBM SPSS for analysis.

Instrumentation and Operationalization of Constructs

The survey contained the 15-item ISCS (see Kato, 2013a), the 35-item (ADM, the 4-item PPV measure, the 3-item PLFVS measure, the 2-item PCA measure, and demographic items. The five instruments and demographic items are detailed in this

section. Descriptions include item response options, example items, and available psychometrics such as reliability. Appendix G contains the survey's eligibility and demographic items and list of measures but without the items due to permissions for data collection only, not publication.

Interpersonal Stress Coping Scale (ISCS)

The ISCS (Kato, 2013a) was designed to measure three types of coping strategies for dealing with interpersonal stressors. The ISCS is a 15-item self-report measure that uses a 4-point scale of 0 (*did not use*), 1 (*used somewhat*), 2 (*used quite a bit*), and 3 (*used a great deal*) to index the extent to which specific strategies are used. The ISCS contains the three subscales of distance coping, reassessing coping, and constructive coping, each based on five items. These three subscales constituted the dependent variables in this study. Mean composite scores for each subscale were computed to remain interpretable on the original 4-point item response scale. The ISCS can be used for noncommercial research without seeking written permission, but distribution of the instrument is limited (Kato, 2013b; Appendix B).

Distance coping is an avoidance strategy (Kato, 2013a). An example item is "Tried to avoid talking with the person" (Kato, 2013a). Kato (2013a) reported the five distance coping items formed a unique factor separate from the other 10 items, which established its construct validity and had a Cronbach's alpha coefficient of reliability of .81. Distance coping scores were statistically significantly correlated with a related measure of antisocial coping, $r(182) = .45$, $p < .001$, which established convergent validity (Kato, 2013a).

Reassessing coping is a laissez-faire strategy (Kato, 2013). An example item is "Thought that a solution would be found somehow or other." Kato (2013a) reported the five reassessing items formed a unique factor separate from the other 10 items, which established its construct validity and had a Cronbach's alpha coefficient of reliability of .79. Reassessing coping scores were statistically significantly correlated with two related measures of restraint coping, $r(182) = .39$, $p < .001$, and detached coping, $r(182) = .37$, $p < .001$, which established convergent validity (Kato, 2013a).

Constructive coping is a reflective and empathetic strategy (Kato, 2013a). An example item is "Tried to understand the other person's feelings." Kato (2013a) reported the five constructive coping items formed a unique factor separate from the other 10 items, which established its construct validity and had a Cronbach's alpha coefficient of reliability of .73. Constructive coping scores were statistically significantly correlated with two related measures of prosocial coping, $r(182) = .48$, $p < .001$, and relationship-focused coping, $r(182) = .62$, $p < .001$, which established convergent validity (Kato, 2013a).

Attitudinal Dispositions Measure (ADM)

The ADM (Furnham & Dadabhoy, 2012a, 2012b) was designed to measure attitudes about characteristics, causes, and treatment of individuals with BPD. The ADM is a self-report that uses a 10-point Likert scale of 1 (*strongly agree*) to 10 (*strongly disagree*) to index extent of agreement with BPD statements across three broad domains: general beliefs, causes, and treatments. The ADM is a suitable measure to assess beliefs individuals have towards individuals diagnosed with BPD.

The ADM published in PsycTESTS (Furnham & Dadabhoy, 2012a) contains 50 items, but Furnham and Dadabhoy (2012b) found only 35 items that loaded across 10 factors. There are also some minor discrepancies in item wording between Furnham and Dadabhoy (2012a) and Furnham and Dadabhoy (2012b). For purposes of this study the 35 loading items and wording will be used. Mean composite scores for each of the 10 ADM subscales will be computed to retain interpretable on the original 10-point item response scale. The ADM can be used for noncommercial research without seeking written permission, but distribution of the instrument is limited (Furnham & Dadabhoy, 2012a; Appendix C).

The general beliefs about BPD domain of 11 items factored into Threat to Others (4 items), Impulsivity and Instability (4 items), and Emotional Capacities (3 items; Furnham & Dadabhoy, 2012b). Example items include: “People with BPD are usually dangerous to society,” “People with BPD can change their mood suddenly,” and “People with BPD cannot adequately control their emotions and actions” (Furnham & Dadabhoy, 2012b). Furnham and Dadabhoy (2012b) reported Cronbach alpha values of .74 for threat to others, .58 for impulsivity and instability, and .71 for emotional capacities.

The causes of BPD domain of 13 items factored into Brain Abnormalities/Imbalances (4 items), Fate and Karma (3 items), Early Trauma and Neglect (3 items), and Genetic or Birth Complications (3 items; Furnham & Dadabhoy, 2012b). Example items include: “BPD is due to a brain neurotransmitter dysfunction,” “BPD is due to evil done in a previous life,” “Chronic maltreatment and attachment difficulties in childhood cause BPD,” and “BPD can be caused by having blood relatives

who also suffer from personality disorders" (Furnham & Dadabhoy, 2012b). Furnham and Dadabhoy (2012b) reported Cronbach alpha values of .78 for brain abnormalities/imbalances, .78 for fate and karma, .75 for early trauma and neglect, and .71 for genetic or birth complications.

The BPD treatments domain of 11 items factored into Sociological Treatments (5 items), Psychological Treatments (4 items), and Extreme Neuropsychological Treatments (2 items; Furnham & Dadabhoy, 2012b). Example items include: "Going to self-help groups will help the person suffering from BPD get better," "Sufferers of BPD can really benefit from counselling," and "It is possible to treat BPD by brain surgery (lobotomy)" Furnham & Dadabhoy, 2012b). Furnham and Dadabhoy (2012b) reported Cronbach alpha values of .83 for sociological treatments, .75 for psychological treatments, and .83 for extreme neuropsychological treatments.

Perception of Violence Measures

Mueller and Tschan (2011a) reported on a series of separate instruments used to assess employees' perceptions of client-initiated violence (Mueller & Tschan, 2011b, 2011c, 2011d). The Perceived Prevention of Violence Measure (PPVM; Mueller & Tschan, 2011d) contains four items using a 7-point scale from 1 (*strongly disagree*) to 7 (*strongly agree*). An example item is "My employer takes the necessary measures to prevent violence in the workplace." The PPVM had good reliability as indexed by a Cronbach's alpha value of .82 and was negatively correlated with fear of future violence in the workplace, $r(327) = -.30$, $p < .01$ (Mueller & Tschan, 2011a). The PPVM can be

used for non-commercial research purposes without written permission (Mueller and Tschan, 2011d; Appendix D).

The Perceived Likelihood of Future Violence Scale (PLFVS; Mueller & Tschan, 2011c) contains three items using an 11-point scale from 0 (*zero*) to 10 (*almost 100%*) in 10% increments. An example item is "Likelihood of being hit, kicked, grabbed, shoved, pushed, spat on, bitten, or something being thrown at me while at work in the next year." Reliability as indexed by Cronbach's alpha was .74 and Mueller and Tschan (2011a) found it correlated with fear of future violence, $r(327) = .38$, $p < .01$. Permission to use the PLFVS is in Appendix E.

The Perceived Coping Ability Measure (PCAM; Mueller & Tschan, 2012b) is a 2-item assessment of being shaken profoundly or able to cope well that uses a 7-point scale from 1 (*strongly disagree*) to 7 (*strongly agree*). Mueller and Tschan (2011a) reported a Cronbach's alpha of .60 and found the PCAM to be negatively correlated with fear of future violence, $r(327) = -.28$, $p < .01$, and negatively correlated with impaired psychological well-being, $r(327) = -.26$, $p < .01$. Permission to use the PCAM for noncommercial use with limited distribution is in Appendix F.

Demographic Variables

Three potentially key demographic items will be included as predictors in each of the three ISCS regression models. These include participant's sex (male or female), the setting they work in (inpatient or outpatient), and years of experience as a nurse.

Research Questions and Analysis Plan

Research Question 1

RQ1: In a multiple linear regression, what is the combined effect (R^2) of the 10 ADM subscales, the three violence-related scales, and the three demographic items in accounting for variance in each of the three (ISCS) subscale scores (distancing coping, reassessing coping, and constructive coping)?

Research Question 2

In a multiple linear regression, what is the relative effect (sr^2) of each predictor in each of the three ISCS subscale regression models?

Research Question 3

What are the number of statistically significant multivariate roots relating the set of dependent variables with the set of independent variables?

Research Question 4

For each statistically significant multivariate root, what is the weighted combination of variables in the dependent and independent set that define the root?

To answer the first two research questions, three separate multiple linear regressions were conducted, one for each criterion variable. Linear regression is the most appropriate procedure to determine the variance accounted for in a criterion by a set of predictors and to determine the relative contribution of each predictor (Tabachnick & Fidell, 2007). Analyses will follow a model building approach (Jaccard & Jacoby, 2010) to select the best set of predictors that accounts for substantive variance in each criterion variable. A squared semi-partial correlation (sr^2) indicates the proportion of variance in a

criterion uniquely accounted for by a predictor (Tabachnick & Fidell, 2007) and are the statistic of interest in selecting the best model. Predictors with $sr^2 \geq .02$ will be considered as substantively contributing to the model.

For research questions 3 and 4, a multivariate canonical correlation analysis will be conducted. Canonical correlation examines the relationship between two sets of variables and provides multiple solutions equal to the number of variables in the smallest set. In this analysis, with three variables in the dependent set, three roots of differently weighted combinations of variables will be generated.

Threats to Validity

This study will focus on nurses' interactions with individuals diagnosed with BPD in psychiatric settings. Per Shadish et al. (2002), threats to validity occur in the following four areas: statistical conclusion, internal, construct, and external validity. One threat to validity is the use of a survey to gather information and no experiment is conducted. With using a correlational research design, the identifying similarity in characteristics can impact disparity in other variables. Another factor that can contribute to validity is the nurses historical and potential biased views of interactions with the BPD population, such as the predisposed view as a BPD patient as presenting a specific way. Another threat to validity is the age of some of the testing measurements. The PLFVS, PCAM, and PPVM were all written in 2011. The ADM was written in 2012 and the ISCS was in 2013. Another concern for validity with the PPVM, PLFVS, and PCAM is that these measures have been seen as having valid results with Japanese populations and has not been identified as a testing measurement used with other populations.

Delimitations

Data gathered in this study pertains to nurses and may not generalize to other medical professions and their interactions with the BPD patient. This information may not generalize to nurses' interactions with other diagnosed individuals in a psychiatric setting. Lastly, this data will reflect nurses' interactions specifically with the BPD patient in psychiatric setting and will not assume similar data and conclusions would occur with nurses in other settings.

Ethical Procedures

Initially it was thought participants will be enlisted using the association's membership list requesting members to participate in this study. Those agreeing to participate will receive the link per agreed upon method with the association to complete the survey. With the changes made using Facebook nursing groups participants were enlisted by posting an invitation on a variety of group main pages inviting members to participate. Those that agreed to participate would read the initial introduction to the study and then would click to the link that would take them to the SurveyMonkey link. The request specified anonymous data collection from the surveyed participants, as well as no compensation for completing of the survey. The Walden Institutional Review Board approval number was 03-18-20-0307184.

Potential Negative Effects

When participants begin the process of agreeing to participate in the research study they are initially provided information on potential negative effects that can impact their completing the survey and after. Participants can have some potential negative

effects with completing this survey such as, an intense emotional response with answering and rating their actions, thoughts, and behaviors. In the initial agreement to contribute to this research, options will be given for an individual to discontinue the survey if they believe it is causing adverse effects for the participant and who to contact for help.

Confidentiality and Informed Consent

The initial information each participant will read and agree to the requirements for participation in this study as it pertains to anonymity, agreed to informed consent to participate in study as they are participating in the study online and they can discontinue the survey at any time through the process. Each participant will be informed that their participation is voluntary and anonymous. There will be no data collected that can identify any specific participant in this study. The expectation will be that when a participant completes the survey that they have agreed to all confidentiality, informed consent and over the age of 18. Each of these items will be asked when the participant initial enters into the survey with brief questions such as agreeing to participate in the study and asks if the individual is over the age of 18 before the survey begins.

Treatment of Data

All participants who consent to participate to this study will click the prompt that they agree to participate in this study. By their agreeing to participate in this study it is giving consent to continue with the survey. Participants will complete the survey using SurveyMonkey and then transfer the data to SPSS. This data will be saved for five years and stored in a password protected file and laptop. After five years from the completion

date of the publication of this dissertation the data will be destroyed. Results will be made available to all originators of testing instruments used in this research study and any participants want a copy of the findings.

Summary

Interactions between nurses and the patient with BPD diagnosis have been widely researched. Social distancing is one of the more common coping mechanisms identified by nurses used to separate themselves from the patient with BPD and to protect themselves from safety concerns working with this population. Examining the perceived beliefs of the nurses and their coping skills will provide information to further training and education to the nursing community as well as decrease the stigma associated with the BPD diagnosis.

This proposed study is an invitation survey study that will use multiple regression with three separate regressions for distancing coping, reassessing coping, and constructive coping using the ISCS measure that assesses interpersonal coping strategies. There will also be a canonical correlation that will examine the multivariate relationships of the three interpersonal coping strategies with a set of predictors that include demographic information (sex, setting, and), beliefs about people with a BPD diagnosis, perceived prevention of workplace, likelihood of future workplace violence, and perceived coping abilities if a violent event occurred.

Facebook group moderators will assist in recruiting their members to participate in this research study. They will assist by providing space in their group page by allowing for researcher to post an invitation to direct participants to the SurveyMonkey link to

complete the survey or they will post the invitation directly. Findings of the research will be provided to the moderators of the group, participants of the study and the originators of the measurements.

Chapter 4: Results

The purpose of this study was to examine the combined and relative effects of risk and protective factors of nurses' social distancing behavior and demeanor towards patients with BPD. The dependent variables for this study consisted of the three different coping measures (distance, reassessing, and constructive) that make up the ISCS (Kato, 2013a). The independent variables were from the ADM, PCAM, PLFVS, and PPVM. The ADM created by Furnham and Dadabhoy (2012a, 2012b) to measure attitudes about characteristics, causes, and treatment of individuals with BPD. Three different perception of violence measures were used by Mueller and Tschan (2011b, 2011c, 2011d). The PCAM assesses the ability to cope after a significant event (Mueller & Tschan, 2011b). The PLFVS assesses likelihood of future violence in the workplace (Mueller & Tschan, 2011c). The PPVM assess prevention of future violence in the workplace (Mueller & Tschan, 2011d). Three multiple regressions and a canonical correlation analysis were used to evaluate the four research questions for this study related to (a) predicting overall model effects for each of the three ISCS subscale scores from the ADM variables and four violence-related variables, (b) determining the relative effect of each predictor in each model, (c) determining the number of statistically significant multivariate roots, and (d) determining the variables that define each root. This chapter begins with revisiting the research questions, data collection, descriptive statistics of the sample, reported results from multiple regressions, and canonical correlational analysis and closes with a transition to Chapter 5.

Data Collection

For this study I used an invitation sample of nurses that were currently or had practiced in a specific Northwestern state in the United States. The nurses were invited to participate through geographic nursing groups and general nursing groups through the Facebook platform. The invitation then directed them to the SurveyMonkey link to participate in the study.

Data collection occurred over a 15-week time span. It began May 12, 2020 and the last survey was collected on August 25, 2020. Over this time a total of 161 participants accessed the Survey Monkey site to attempt to complete the survey, of which 125 met the eligibility criteria by identifying as practicing in a specific state in the northwestern part of the United States as a nurse and having worked with BPD diagnosed individuals. As detailed later, 12 participants were excluded as univariate or multivariate outliers, leaving a final valid sample of 113 participants.

Initially the goal was to collect a total of 139 surveys that met G*Power criteria and effect size of interest ($sr^2 \geq .02$) in the best model multiple regressions. More than 139 initial responses were obtained but, with only 113 valid cases, power criteria was affected. Instead of statistically significantly detecting a population effect size for an individual predictor of sr^2 of .05 within a population effect size of $R^2 = .13$ for the overall model, a population sr^2 of .062 (still of medium size) is required (C. T. Diebold, personal communication, February 11, 2021). However, in the actual sample a $sr^2 = .035$ would be statistically significant at alpha = .05, and a $sr^2 = .025$ would be statistically significant at

alpha = .10 (C. T. Diebold, personal communication, February 11, 2021), which for interpretation purposes is considered as substantively contributing to a regression model.

Data Cleaning

Data Screening for Scale Reliability

Instruments themselves are not reliable or unreliable; reliability has to do with responses to items by a sample, which is why it is essential to examine the sample-specific reliability of each scale used in this research (Wilkinson and The Task Force on Statistical Inference, 1999). Of the 16 scales used, 10 had adequate reliability in initial screening (Table 2). One other, ISCS distance coping, had adequate reliability but a clerical error inadvertently left one of the five items off the online survey.

The five scales with reliability issues were ADM fate and karma, ADM early trauma and neglect, ADM genetic or birth complications, ADM psychological, and PCAM. For comparison, Cronbach's α for each scale is listed as was found in prior research, in my sample-specific initial computation, after any revision, and a final value after univariate and multivariate outlier participants were excluded from analysis.

Table 2

Reliability Analysis of Measurement Scales

Instrument/subscale/item	Cronbach's α				Actions
	Prior[1]	Initial[2]	Revised[2]	Final[3]	
Interpersonal Stress Coping Scale (ISCS)					
Distance coping (5)	.81				
Distance coping (4)		.82	na	.77	Inadvertently left off of survey "Tried to avoid talking with the person."
Reassessing coping (5)	.79	.69	na	.68	
Constructive coping (5)	.73	.83	na	.84	
Attitudinal Dispositions Measure (ADM)					
General beliefs					
Threat to others (4)	.74	.77	na	.71	
Impulsivity and instability (4)	.58	.78	na	.70	
Emotional capacities (3)	.71	.70	na	.65	
Causes					
Brain abnormalities/ imbalances (4)	.78	.75	na	.65	
Fate and karma (3)	.78	.53			Two items eliminated due to insufficient response variance: "Borderline Personality Disorder is due to evil done in a previous life." "The cause of Borderline Personality Disorder is the "sick" society we live."
Prearranged fate (1)			na	na	"Borderline Personality Disorder is pre-arranged fate for an individual."

Instrument/subscale/item	Cronbach's α				Actions
	Prior[1]	Initial[2]	Revised[2]	Final[3]	
Early trauma and neglect (3)	.75	.67			One item did not statistically or conceptually fit with the other two items.
Early trauma and neglect (2)			.78	.78	Includes: "Borderline Personality Disorder is caused by sexual abuse, neglect and/or separation early in life." "Chronic maltreatment and attachment difficulties in childhood causes Borderline personality disorder."
Stressful family environment (1)			na	na	"It is likely that Borderline Personality Disorder is caused by a stressful family environment."
Genetic or birth complications (3)	.71	.44			No combination of the three items formed a reliable scale. Each item treated as a separate variable.
BPD genetic (1)			na	na	"Borderline Personality Disorder is caused by genetic factors."
BPD birth complications (1)			na	na	"Borderline Personality Disorder is caused by complications before or during birth."
BPD inherited (1)			na	na	"Borderline Personality Disorder can be caused by having blood relatives who also suffer from personality disorders."

Instrument/subscale/item	Cronbach's α				Actions
	Prior[1]	Initial[2]	Revised[2]	Final[3]	
Treatments					
Sociological (5)	.83	.80	na	.81	
Psychological (4)	.75	.57			One item was not statistically reliable with the other three and was separate out as an individual variable.
Psychological (3)			.73	.70	
Freudian treatment (1)				na	"Borderline Personality Disorder can be successfully treated by Freudian psychoanalysis."
Neuropsychological (2)	.83		.67	.62	
Perceived Prevention of Violence Measure (PPVM; 4)	.82	.77	na	.77	
Perceived Likelihood of Future Violence Scale (PLFVS; 3)	.74	.84	na	.77	
Perceived Coping Ability Measure (PCAM; 2)	.60	.51			
Profoundly shaken (1)			na	na	"I suppose that threats or violence from a patient/client would shake me profoundly."
Cope well (1)			na	na	"I consider myself to be able to cope well after an assault by a client/patient."

Note. Bold labels designate final variables for analysis. Numbers in parenthesis following name of a scale or item indicate the number of items.

[1] Cronbach α values for ISCS from Kato (2013a; N = 523)); for ADM values from Furnham and Dadabhoy (2012b; N = 102); for PPVM, PLFVS, and PCAM from Mueller and Tschan (2011a; N = 329).

[2] N = 125.

[3] N = 113 after eliminating univariate and multivariate outliers.

ADM fate and karma was a 3-item scale that had Cronbach's $\alpha = .53$ in initial screening. Two of the items—one about evil done, the other about sick society—had insufficient response variance with 84.8% and 65.6%, respectively, of participants responding at the extreme strongly disagree end of the 10-point response scale. Only four of 125 (3.2%) participants had a response on the agree side of the scale for BPD due to evil done in a previous life and only 16 of 125 (12.8%) had a agree-side response for BPD being caused by the sick society one lives in. These two items were removed from further analysis and the remaining item about BPD being a prearranged fate was used as its own variable.

ADM trauma and neglect was a 3-item scale that had an initial reliability of .67, but was improvable to .78 if the item about BPD being caused by a stressful family environment was removed. The two items capturing BPD being caused by sexual abuse, neglect, or separation in early life and attachment difficulties were retained to form the trauma and neglect scale; the single item stressful family environment was used as its own separate variable.

ADM genetic or birth complications was a 3-item scale that had initial reliability of .44. No 2-item combination had a larger reliability, and because the intercorrelations among the items were small (.14 to .25), each item was used as a separate variable.

ADM psychological treatment was a 4-item scale with initial reliability of .57. The item about Freudian treatment being effective had very small correlations with the other three items (.05 to .12) and was used as its own variable. The other three items had a Cronbach's $\alpha = .73$.

The PCAM 2-item scale had an initial reliability of .51, which was insufficient for analysis, so the two items were used as separate variables. As a result of sample-specific reliability analysis, 21 variables emerged as reliable scales or items that could be used in further analyses.

Screening for Univariate and Multivariate Outliers

Potential univariate outliers are cases with standardized *z*-score exceeding ±3.29 and/or that is severely discontinuous with the distribution of other cases (Tabachnick & Fidell, 2007). Standardized *z*-scores and histograms were examined for all 20 variables, whether composite scales or individual items. Ten participants were identified with one or more outlier values across the study variables and were eliminated from further analysis. Two additional participants were removed as multivariate outliers having excessive Mahalanobis values and distribution discontinuity.

Results

Descriptive Characteristics of Participants

Characteristics of the 113 participants are displayed in Table 3. Of the nurses that participated in this sample, 92% were female and 8% were male. An attempt was made in the survey for individuals to identify other than male or female and no one identified outside of male or female. Age was broken into six different age categories More than half (54.0%) of the participants were between 35 and 54 years old. Only one was less than 25, and six were 65 or older.

Additional demographic information was collected on education and setting in which the nurses worked. The nurses were asked to identify the highest level of nursing

degree or credentials they had received. This was broken into five different categories. Two-thirds (67.3%) had either an Associate or Bachelor's degree, which is typical for nurses.

Table 3

Descriptive Characteristics of Participants

Variable	*n*	%
Sex		
Female	104	92.0
Male	9	8.0
Age		
18-24	1	0.9
25-34	20	17.7
35-44	32	28.3
45-54	29	25.7
55-64	25	22.1
65+	6	5.3
Education		
Some college	5	4.4
Associate degree	38	33.6
Bachelor's degree	38	33.6
Master's degree	26	23.0
Doctoral degree	6	5.3
Setting		
Inpatient	63	55.8
Outpatient	34	30.1
Emergency room	7	6.2
Private practice	9	8.0

Descriptive Statistics of Study Variables

Of the 113 participants that completed the survey, four of the 13 scale scores had reliability less than .70 and should be interpreted with caution. Cronbach's α for the three dependent variables ranged from .68 to .84 and the 10 independent variables ranged from .63 to .81. The dependent variables had high internal consistency for both distance coping (.77) and constructive coping (.84). The independent variables had higher internal consistency with threats to others (.71), impulsivity and instability (.70), early trauma and neglect (.80), sociological treatment (.81), psychological treatment (.70), PPVM (.77) and PLVM (.77). Scale and item variables generally had skewness and kurtosis values within ±1.0 and can be considered normally distributed. The observed minimum and maximum values for each variable generally paralleled the possible minimum and maximum values and variance was adequate for statistical analysis.

Table 4

Descriptive Statistics of Study Variables

Scale	*α*	Min.	Max.	Mdn	*M*	*SD*	Skewness	Kurtosis
ISCS								
Distance coping	.771	1.00	3.50	2.00	2.01	0.68	0.28	-0.74
Reassessing coping	.682	1.00	3.60	2.20	2.25	0.59	0.09	-0.40
Constructive coping	.838	1.00	4.00	3.00	2.84	0.71	-0.48	-0.23
ADM								
General beliefs								
Threats to others	.707	1.75	10.00	5.25	5.28	1.60	0.26	0.05
Impulsivity and instability	.703	4.75	10.00	7.75	7.61	1.28	-0.10	-0.85
Emotional capacities	.649	1.67	10.00	6.00	5.91	1.83	-0.19	-0.64
Causes								
Brain abnormalities/ imbalances	.649	2.25	9.50	6.75	6.61	1.53	-0.73	0.64
Prearranged fate	N/A	1.00	10.00	3.00	3.32	2.32	0.64	-0.70
Early trauma and neglect	.779	1.00	10.00	7.00	6.95	1.86	-0.42	0.32
Stressful family environment	N/A	1.00	10.00	7.00	6.84	1.98	-0.69	1.16
Genetic	N/A	1.00	10.00	7.00	6.72	2.13	-0.94	0.81
Birth complications	N/A	1.00	8.00	5.00	4.18	2.25	-0.16	-1.42
Inherited	N/A	1.00	10.00	7.00	6.41	2.09	-0.50	-0.07
Treatment								
Sociological	.806	1.00	10.00	6.80	6.61	1.66	-0.56	0.71
Psychological	.696	3.00	10.00	8.67	8.17	1.56	-1.10	0.99
Freudian	N/A	1.00	10.00	6.00	4.82	2.46	-0.12	-0.90
Neuropsychological	.624	1.00	7.50	3.00	3.08	1.88	0.52	-0.91
PPVM	.771	1.00	6.25	3.50	3.46	1.34	-0.09	-0.65
PLFVS	.771	1.00	7.00	4.33	4.47	1.68	-0.32	-0.76
PCAM								
Profoundly shaken	N/A			6.00		2.00	-0.14	-1.14
Cope Well	N/A			4.00		1.66	-0.24	-0.55

Note. $N = 113$. α = Cronbach's alpha. Possible minimum and maximum values for ISCS scales is 1 to 4, for ADM scales or items is 1 to 10, and for PPVM, PLFVS, and PCAM is 1 to 7.

Screening for Potential Covariates

Data were collected, as previously reported, on sex, age, education level, and practice setting. These were examined as potential covariates in their extent of influence on each of the dependent variables. There were insufficient number of males for analysis, so sex was ruled out. For age, there were insufficient number of cases in the 18-24 and in the 65+ categories, so ANOVAs were conducted for just four age categories. While distance coping slightly decreased as age increased, the differences between categories was not statistically significant, $F(3, 102) = 1.50$, $p = .219$, $\eta^2 = .042$. There was no discernable pattern of age category scores with respect to reassessing coping or constructive coping, and neither were statistically significant, $F(3, 102) = 1.03$, $p = .384$, $\eta^2 = .029$ and $F(3, 102) = 0.44$, $p = .723$, $\eta^2 = .013$, respectively.

For education level there were sufficient cases to compare only Associates, Bachelors, and Master's degree participants. There were no statistically significant group mean differences on distance coping or constructive coping, $F(2, 99) = .019$, $p = .669$, $\eta^2 = .008$ and $F(2, 99) = 2.10$, $p = .128$, $\eta^2 = .041$, respectively. For reassessing coping there was a statistically significant difference, $F(2, 99) = 6.14$, $p = .003$, $\eta^2 = .110$, in which Associate degree participants ($M = 2.53$, $SD = 0.58$) had higher scores than both the Bachelors ($M = 2.16$, $SD = 0.55$) and Masters ($M = 2.08$, $SD = 0.55$) degree groups.

For the setting within which a participant worked there were adequate number of cases to compare inpatient and outpatient. Those in outpatient settings had slightly higher scores on all three dependent variables, but none were statistically significant: distance

coping, $F(1, 95) = 1.49$, $p = .225$, $\eta^2 = .015$; reassessing coping, $F(1, 95) = 0.25$, $p = .618$, $\eta^2 = .003$; constructive coping, $F(1, 95) = 1.45$, $p = .232$, $\eta^2 = .015$.

Multiple Regression

To answer the first two research questions, three separate multiple linear regressions were conducted, one for each criterion variable (distance coping, reassessing coping, and constructive coping). Analyses followed a model building approach (Jaccard & Jacoby, 2010) to select the best set of predictors that accounts for substantive variance in each criterion variable. A squared semi-partial correlation (sr^2) indicates the proportion of variance in a criterion uniquely accounted for by a predictor (Tabachnick & Fidell, 2007) and were the statistic of interest in selecting the best model. Predictors with $sr^2 \geq .02$ were considered as substantively contributing to the model.

Because of the results from reliability analysis and screening for potential covariates, the research questions proposed in Chapter 3 needed to be slightly modified. Instead of 10 ADM scale scores, ADM was represented by 14 variables, 8 scale scores and 6 separate items; and, PCAM was represented by two items rather than one scale score. These, along with the PPVM score and the PLFVS score, constituted the 18 predictors. For the model with reassessing coping as the criterion the level of education variable was added as a covariate which is reported in Table 5.

For each criterion model the assumptions of multicollinearity, outliers, normality, linearity, and homoscedasticity were assessed with no major violations noted. The best model results of the multiple regression were statistically significant for each of the three ISCS scales, and summary results are reported in Table 5.

RQ1: In a multiple linear regression, what is the best model combined effect (R^2) of the ADM variables and the four violence-related variables accounting for variance in each of the three ISCS subscale scores (distancing coping, reassessing coping, and constructive coping)? As identified in Table 5, the best model predictors accounted for 27.5% of the variance in distance coping, 31.7% in reassessing coping, and 35.9% in constructive coping.

Of the 18 potential predictors (see previously presented Table 4), six did not statistically significantly or substantially contribute to any of the three ISCS coping models. These were (a) the ADM general beliefs subscale scores for impulsivity and instability of the BPD patient; (b) the prearranged fate, birth complications, and inherited subscale scores of ADM beliefs about causes of BPD; and (c) the Freudian and neuropsychological scores of the ADM beliefs about effective treatment approaches. Because these six predictors did not contribute to any of the ISCS models, they are not listed in the Table 5 best model results.

PLFVS contributed to predicting all three coping strategies. Four predictors (threat to others, impaired emotional capacities, psychological treatment, and coping well) contributed to predicting two of the three coping strategies. Seven predictors, and the Associates degree covariate, contributed to predicting only one of the coping strategies. Overall, the best model for predicting distance coping included five predictors, the best model for reassessing coping included six predictors, and the best model for constructive coping included eight predictors. These results are further described with respect to the second research question's focus on the relative importance of predictors.

RQ2: In a multiple linear regression, what is the best model relative effect (sr^2) of each predictor in each of the three ISCS subscale regression models?

The best model for distance coping included five predictors identified in Table 5. Impaired emotional capacities, stressful family environment, and likelihood of future workplace violence were positively related to distance coping, while brain abnormalities or imbalances as cause of BPD and coping well if assaulted were negatively related with distance coping.

Reassessing coping best model identified five predictors. Sociological treatment, perceived likelihood of future violence, and coping well were positively related to reassessing coping, while threats to others and psychological treatment were negatively related to reassessing coping.

Constructive coping model identified eight predictors. Emotional capacities, genetic of birth complications, psychological treatment, perceived prevention of violence measure, perceived likelihood of future violence, and profoundly shaken were positively related, while threats to others and early trauma were negatively related to constructive coping. A positive predictor was identified for reassessing was with individuals with Associates degrees.

There were some themes between the three coping skill models. Perceived likelihood of future violence was the only predictor in all three subscale models and was positive in each model. Threat to self was identified in both reassessing and constructive as a negative predictor. Emotional capacities was a positive predictor for both distance and constructive coping. Psychological treatment identified as a negative predictor with

reassessing coping and a positive predictor with constructive. Coping well was a negative predictor of distance coping and a positive predictor of reassessing coping.

An anomaly, of sorts, was observed in the constructive coping model. The ADM belief that those with BPD have impaired emotional capacities had a simple negative correlation of -.11 with constructive coping, but in the best model controlling for other important predictors, the impaired emotional capacities predictor had a positive partial correlation of .19 with constructive coping. The change in sign between impaired emotional capacities and constructive coping from a negative simple correlation to a positive partial correlation in the regression can be explained by the threat to others variable. Threat to others was highly positively correlated (r = .55) with impaired emotional capacities and was more highly negatively correlated (r = -.291) with constructive coping. Impaired emotional capacities had a small negative simple correlation with constructive coping that was not statistically significant (r = -.112, p = .236). Regression controls for the effects of other predictors, so the common relationship between threat to others and impaired emotional capacities with constructive coping was accounted for in the regression by threat to others; the relationship between impaired emotional capacities and constructive coping was, thus, suppressed. The part of impaired emotional capacities not related to threat to others was what remained to explain variance in constructive coping. In essence, when there is no perceived threat to others, then perception of impaired emotional capacities increases constructive coping.

Table 5

Best Model Regressions of Distance, Reassessing, and Constructive Coping

	Distance coping R^2 = .275			Reassessing coping R^2 = .317			Constructive coping R^2 = .359		
Variable	β	*p*	sr^2	β	*p*	sr^2	β	*p*	sr^2
Constant	1.65	.000		1.88	.000		1.51	.006	
ADM									
General beliefs									
Threat to others				-0.06	.042	.027	-0.19	.000	.105
Emotional capacities	0.09	.008	.050				0.08	.055	.023
Causes									
Brain abnormalities	-0.11	.004	.060						
Early trauma and neglect							-0.09	.009	.044
Stressful family environment	0.06	.048	.027						
Genetics							0.05	.065	.021
Treatments									
Sociological				0.05	.107	.017			
Psychological				-0.07	.047	.026	0.09	.016	.037
PPVM							0.12	.015	.038
PLFVS	0.14	.000	.113	0.08	.005	.053	0.16	.000	.102
PCAM									
Profoundly shaken							0.06	.057	.023
Cope well	-0.10	.006	.053	0.10	.001	.073			
Associates degree				0.30	.005	.052			

Canonical Correlation Analysis

The use of a canonical correlation analysis was completed to assess significant findings to support RQ3 and RQ4. For RQ3 and RQ4 a canonical correlation examined the relationship between two sets of variables and provided multiple solutions equal to the number of variables in the smallest set. In this analysis, with three variables in the dependent set, three roots of differently weighted combinations of variables was generated. Research question 3: What are the number of statistically significant

multivariate roots relating the set of dependent variables with the set of independent variables? Research question 4: For each statistically significant multivariate root, what is the weighted combination of variables in the dependent and independent set that define the root?

The canonical analysis was conducted using the three ISCS coping variables (distance coping, reassessing coping and constructive coping) as dependent variable set and the 18 variables representing ADM, PCAM, PLFVS, and PPVM as the independent variable set. In an initial run all variables were included but 6 of the 18 predictors did not substantially contribute to any of the three canonical solutions. Substantial contribution was assessed by having either a standardized coefficient or structure coefficient on any root greater than about ±.32 (Tabachnick & Fidell, 2007). The final overall model with the three ISCS coping variables and 12 variables representing ADM, PCAM, PLFVS, and PPVM was statistically significant, Wilks's $\lambda = .29$, $F(36, 290.3) = 4.19$, $p < .001$, accounting for 71% of the generalized variance between the ISCS set and the predictor set. The CCA model statistics are presented in Table 6 and the variable coefficients are presented in Table 7. All three roots were statistically significant. Within the first root, there was 40% shared variance between the ISCS set and the predictor set. Shared variance between the two sets in Root 2 was 38% and in Root 3 was 22%.

Table 6

Canonical Correlation Analysis Overall Model Results

Root	Eigenvalue	%	R_c	R_c^2
1	.67	42.8	.63	.40
2	.61	38.9	.61	.38
3	.28	18.3	.47	.22

Roots	Wilks's λ	*F*	*df*	*p*
1 to 3	.29	4.2	36, 290.3	< .001
2 to 3	.48	3.9	22, 198	< .001
3	.78	2.8	10, 100	.004

Table 7

Canonical Correlation Analysis Summary Coefficient Results of Three-Root Solution

	Root 1 R_c^2 = .40			Root 2 R_c^2 = .38			Root 3 R_c^2 = .22			
Variable	β	*r*	r^2	β	*r*	r^2	β	*r*	r^2	h^2
ADM										
General beliefs										
Threat to others	.46	.51	.26	.59	.29	.09	-.06	-.18	.03	.38
Impaired emotional capacities	.03	.22	.05	-.45	.08	.01	-.37	-.42	.17	.23
Causes										
Brain abnormalities/imbalances	-.43	-.24	.06	.42	.06	.00	.04	.17	.03	.09
Early trauma and neglect	.01	.19	.04	.45	.18	.03	.06	-.32	.10	.17
Stressful family environment	.26	.44	.19	-.09	-.09	.01	-.22	-.18	.03	.23
Genetics	.07	.11	.01	-.39	-.18	.03	.45	.38	.15	.19
Treatments										
Sociological	-.14	-.07	.01	-.19	-.40	.16	-.14	.03	.00	.17
Psychological	.35	.16	.03	-.40	-.60	.36	.35	.30	.09	.48
PPVM	-.20	-.18	.03	-.25	.10	.01	.17	.40	.16	.20
PLFVS	-.08	-.05	.00	-.67	-.51	.26	-.65	-.62	.38	.64
PCAM										
Profoundly shaken	-.01	-.23	.05	-.24	-.32	.10	.36	.03	.00	.15
Cope well	-.61	-.70	.49	.27	-.09	.01	-.25	-.20	.04	.53
Adequacy			.10			.09			.10	
ISCS										
Distance coping	.80	.62	.39	-.36	-.29	.08	-.55	-.73	.53	1.0
Reassessing coping	-.80	-.63	.39	.25	-.28	.08	-.78	-.73	.53	1.0
Constructive coping	.00	-.36	.13	-1.04	-.93	.86	.41	.08	.01	1.0
Adequacy			.31			.34			.35	

On Root 1, individuals who identified with high scores in distance coping and low scores on the reassessing coping variable tended to find the identified borderline personality patient a threat to others and it was caused by a stressful family environment. They were aware that BPD was not caused by brain abnormalities and thought psychological treatments could be effective. These individuals also identified they would not cope well after an assault by a BPD identified patient.

From the second root it was found that individuals with very low scores on constructive coping and somewhat low scores on distance coping were inclined to consider individuals identified as BPD a threat to others and were not considered to have impaired emotional capacities. They also viewed BPD diagnosis causes were from brain abnormalities or imbalances and early trauma and neglect. Genetic factors were not seen as significant cause of BPD nor was it thought that sociological or psychological treatment would be effective treatments. Future violence in the workplace was not perceived as likely a patient threat would not shake them profoundly.

The third root identified with a pattern of low scores on both distance coping and reassessing coping and high score on constructive coping. This pattern of ISCS scores was associated with perceiving individuals identified with BPD not having impaired emotional capacities. In addition, they perceived the cause of BPD to be genetic and not due to early trauma or neglect and that psychological treatments could be effective. They also viewed adequate violence prevention in the workplace and future violence in the workplace unlikely, but if a BPD patient threatened them, they would be profoundly shaken.

Summary

This study examined the combined and relative effects of risk and protective factors of nurse' social distancing behavior and demeanor towards patients with BPD. Three multiple regressions and canonical correlation analyses were used to evaluate the three-dependent variables (distance, reassessing, and constructive) coping measures. Beliefs about emotional capacities, brain abnormality and stressful family environment causes, likelihood of future workplace violence, and coping well were the best predictors of distance coping. Perceived threat to others, sociological and psychological treatments, likelihood of future violence, coping well, and having only an Associate's degree were the best predictors of reassessing coping. Perceived threats to others, beliefs about emotional capacities early trauma and neglect and genetic cause, psychological treatment, perceived prevention of workplace violence, likelihood of future workplace violence, and profoundly shaken if assaulted were the best predictors of constructive coping. These results for the first two research questions were univariate in nature while research questions 3 and 4 examined the multivariate canonical roots of the variables. All three of the canonical correlation roots were statistically significant with various patterns of predictors differentiating distance and reassessing coping on the first root, reassessing and constructive coping on Root 2, and constructive coping from both distance and reassessing coping on the third root. In-depth interpretation of the results is in Chapter 5 as well as discussion of the limitations, recommendations and implications for positive social change and further research.

Chapter 5: Discussion, Conclusions, and Recommendations

Nurses have a history of expressing their frustrations with working with the BPD patient throughout a variety of different settings. McGrath and Dowling (2012) stated a professional's reactions are based upon their experiences from others and their own opinions about the disorder. Markham and Trower (2003) believed that professionals treat the BPD patient as fragile and then create distance from them. The social distancing was viewed as a specific intervention treatment used by some (Woollaston & Hixenbaugh, 2008) and for others it was used as a safety measure for themselves(Cleary et al., 2002).

Purpose of Study

The purpose of this research study was to examine the combined and relative effects of risk and protective factors of nurses' social distancing behavior and demeanor toward patients with BPD. Three dependent variables were measured using three variables of the ISCS: distance coping, reassessing coping, and constructive coping. Five independent variables were measured from demographic items, ADM (Furnham & Dadaboy, 2012), PPVM (Mueller & Tischan, 2011a), PLFVS (Mueller & Tischan, 2011d), and PCAM (Mueller & Tischan, 2011b

This research was organized to add insight as to how the nurses' coping style can influence the interaction with the individual with BPD. Each of the three coping strategies (distance, reassessing, and constructive) nurses employ influence the interactions with the BPD patient. In my research, I sought to identify the association of specific predictors such as beliefs about BPD diagnosis, treatment for the BPD patient,

perceived prevention of violence, and perceived likelihood of future violence with the three coping strategies.

Key Findings

Three separate multiple linear regressions, one for each criterion variable (distance coping, reassessing coping, and constructive coping), were used to answer the first two research question for this study. Analyses followed a model building approach (see Jaccard & Jacoby, 2010) to select the best set of predictors that accounted for substantive variance in each criterion variable. The subset of influential predictors varied across the three coping strategies and accounted for 35.9% of the variance in constructive coping, 31.7% of the variance in reassessing coping, and 27.5% of the variance in distance coping.

From these three regressions the relative importance of predictors could be determined to answer RQ2. For distance coping, the best predictor was likelihood of future workplace violence that uniquely accounted for 11.3% of the variance. Brain abnormalities or imbalances as cause of BPD (6.0% unique) and coping well if assaulted (5.3% unique) were negatively related to distance coping, while belief that those with BPD had impaired emotional capacities (5.0% unique) and a stressful family environment as cause of BPD (2.7% unique) were significantly positively related to distance coping.

For reassessing coping, the best predictor was coping well if assaulted that uniquely accounted for 7.3% of the variance. Likelihood of future workplace violence (5.3% unique) and having only an Associate's degree (5.2% unique) were positively related to reassessing coping. Considering the BPD patient as a threat to others (2.7%

unique) and thinking psychological treatment effective (2.6%) were negatively related to reassessing coping, while thinking sociological treatment effective (1.7% unique) was positively related.

For constructive coping, the best predictor was considering the BPD patient not a threat to others that uniquely accounted for 10.5% of the variance. Believing that early trauma and neglect was not a cause of BPD uniquely accounted for 4.4% of the variance in constructive coping. Believing that those with BPD had impaired emotional capacities (2.3% unique) and that BPD was caused by genetics (2.1% unique) were positively related to constructive coping.

I completed the canonical correlation analysis to assess the significance of multivariate roots relating to the set of dependent variables with the set of independent variables (RQ3) and for each statistically significant multivariant root what is the weighted combination of variables in the dependent and independent set that define the root (RQ4). The overall model was statistically significant accounting for 71% of the generalized variance between the ISCS set and the predictor set and all three roots were statistically significant. The first root was characterized by those who scored high on distance coping and low on reassessing coping and who tended to think they would not cope well if assaulted, that the BPD patient was a threat to others, did not have brain abnormalities or imbalances, that psychological treatment could be effective, and thought that BPD was caused by a stressful family environment.

Interpretation of Findings

All three of the coping skills models had similar themes. One theme found in all three of the coping skill models was the perceived likelihood of future violence. In the reassessing and constructive coping models, threat to self was identified as a negative predictor. This would lead to the assumption that nurses, no matter the coping strategy, presumed that the individual diagnosed with BPD has a likelihood of violence but they are not viewed as a threat to the individual nurse. There was not enough information to assess if the distance coping viewed threat to themselves as a concern. This would support the research of Harris and Leather (2012) that found stress, anxiety, and burnout can influence the perception of someone being threatening and of Soliman and Reza (2001), who found that nurses experienced few incidents of physical violence from a BPD patient.

These findings supported some of the general findings identified in Chapter 2. Liebman and Burnette (2013) and Woollaston and Hixenbaugh (2008) identified mental health professionals having a high fear of violence by individuals with a diagnosis of BPD. Soloff and Fabio (2008) specifically explored the mental health professionals fear of the interactions. These three studies did not distinguish the different mental health professionals by their individual titles (psychiatrist, psychologist, nurse, therapist, etc.). Instead, the prior research identified a whole group as mental health professionals instead of their identified professional occupation. My study differs in that I specifically looked at how nurses interact with individuals with BPD.

Additional themes included emotional capacities as a positive predictor for both distance and constructive coping. Reassessing coping had a negative predictor and constructive coping had a positive predictor to psychological treatments. Coping well was viewed as a negative predictor for distance coping and positive for reassessing.

There was an additional theme found in Root 1 of the canonical correlation in which nurses with a high score in distance coping and a low score in reassessing coping identified a BPD patient a threat to others and that BPD was caused by a stressful family environment. While viewing the BPD identified patient a threat to others, nurses also viewed themselves as not coping well after an assault. Root 2 showed that nurses who had very low scores on constructive coping and somewhat low scores on distance coping were inclined to consider individuals with BPD a threat to others yet did not view them to have impaired emotional capacities. Participants also felt the BPD originated from a brain abnormality, imbalances, early trauma, and/or neglect. Genetic factors were not viewed as a significant cause of BPD and sociological or psychological treatments were deemed ineffective. Future violence in the workplace was not perceived as likely that a patient threat would not shake them profoundly.

The last root (Root 3) had low scores on both distance coping and reassessing coping while having a high score on constructive coping. This pattern was associated with the BPD-identified patient not having impaired emotional capacities. The nurses' perception was that BPD was caused by genetics and not due to early trauma or neglect and that psychological treatments could be effective. Violence prevention in the

workplace and future violence was seen as unlikely yet, if a BPD identified patient threatened them, they would be profoundly affected.

Theoretical Framework Context

This study integrated two theoretical frameworks of appraisal transaction theory (ATT: Fortinash & Holoday-Worret, 2012) and social learning theory (SLT) or social cognitive theory (SCT; Bandura, 1991). The foundation of ATT theory is evaluating the intensity of a stressful event after the event has occurred (Fortinash & Holoday-Worret, 2012). SLT and SCT explores how problem-solving is influenced by different conditions and circumstances and uses a cognitive (Bahn, 2001).

Appraisal-Transaction Theory (ATT)

ATT is a two phased coping mechanism employed by individuals to manage stressful situations (Lazarus & Folkman, 1987). The first phase of ATT is where an individual assesses threat and how to react using an appropriate reaction to the situation (Lazarus & Folkman, 1987), and in the second phase the action is put into place coping mechanisms an individual has at their disposal (Lazarus & Folkman, 1987). The basis of ATT's theory for my research was to look at how the constructive, distance, and reassessing coping strategies employed by the nurses related to the BPD patient. Results of this study showed that there were some connections with each of the coping strategies with nurses' views of an individual diagnosed with BPD being violent. There was also the likelihood that the individual would be violent yet, only with distance coping was it unclear if there was a concern for harm towards the nurse themselves. The others were stating violence was a concern yet not that the violence towards themselves.

Social Learning Theory (SLT) and Social Cognitive Theory (SCT)

SLT and SCT focus on how problem solving is used internally and externally when combining the intake of information through observations, thoughts and behaviors (Bahn, 2001). SLT and SCT theories were highlighted in the finding of Root 2. In these findings there were minimal findings in constructive coping and somewhat low scores in distance coping where the nurses had views of the BPD patient as a threat to others yet also viewed their diagnosis as individuals who did not have impaired emotional capacities, brain abnormalities or experienced trauma and neglect.

Limitations of the Study

This study was conducted using a purposive sample of nurses invited to participate from a specific geographic location. Majority of the nurses were female, and ethnicities were not identified in this study. These limit the generalizability of this study.

The study also had limitations with being conducted during the Covid-19 with nurses as the study's population. The pandemic occurring created limitations with gathering participants and difficulties getting the participant numbers initially sought per G*Power calculations. Additionally, some participants were dealing with the effects of stress and burnout at an even higher level than in times when a pandemic is not occurring which resulted in them not having the time or energy to participate in the survey.

Another limitation was the lack of a controlled setting that the participants had for taking the survey. Each participant had the opportunity to access an on-line link after they were given an invitation. They were able to complete the survey at a convenient time and

place using their own device. These factors could be viewed as influencing the validity and reliability of this study.

Recommendations

Further research could examine how setting, gender, and age of nurses influence the coping strategies. Also, ANOVA might be useful in a comparison of setting, gender, and age with respect to coping strategy and attitudes and beliefs about the BPD patient. Also, a qualitative study would provide an understanding of how the nurses view their own coping strategies in a more narrative type of style. Further research on coping strategies could focus on how other professionals, not just nurses, interface with the patient diagnosed with BPD. Lastly, there are additional variables that may predict nurses social distancing to the BPD patient that was beyond the scope of this research study. Using additional variables in combination with the ones used in this study could enhance the findings and would benefit both nurses and the BPD disorder patient.

Implications for Social Change

Positive social change can occur in multifaceted levels by way of the individual nurses, the setting, and the organization in the treatment of the BPD patient.

The individual nurses with their own beliefs and understanding about BPD and how they cope, is a factor that needs to be addressed individually. From the results of this study, it appears there is a high level of concern or fear of violence when working with the BPD identified patients. There also appeared to be some concerns with clarity on genetic factors and brain abnormalities and how these contribute to the development of the diagnosed of the BPD disordered patient. This information from this study can help to

garner assistance as to what is inciting fear and hopefully can increase communication and hope to build a safe environment between nurses and the BPD disordered patient.

At the place of employment or setting where the nurse works can also benefit with assisting with implementing the social change. Nurses were concerned about violence by the BPD disordered patient at their workplace. The individual setting can assist with addressing the specific safety concerns specific to the setting. In addition, the setting can provide supervision to increase needs specialized to the nurse to enhance knowledge on the BPD disordered patient.

On an organizational level it is clear through the results that there are concerns about safety. Nurses were concerned about violence by the BPD disordered patient. By increasing professional standards for trainings and supervision this will increase open conversations about worries and fears that are inhibiting the treatment provided to the BPD disordered patient on a national level. By increasing the conversation on an organizational level more advocacy can occur to address educational needs and other issues that are impacting work environment and treatment being provided to the BPD disorder patient.

Results have positive social change implications in nursing practice with patients diagnosed with BPD. Having information identifying the specific concerns with violence and the impact burnout and distancing have on the interaction between nurse and patient can inform specific training interventions and supervision of nurses to openly concentrate on fears and worries of violence, decreasing negative beliefs and perceptions of the BPD

patient. Results can also inform workplace safety protocols to improve safe interaction with and treatment outcomes for the BPD patient.

Conclusion

This study was a correlational study to examine the three coping scales (constructive, distance and reassessing) and how they relate to the 20 independent variables that relate demographics and measurements associated to the BPD diagnosis (ADM), coping ability (PCAM), and the two perceived violence measures (PPVM and PLFV). Results suggest that specific factors contribute to nurses' social distancing to the BPD disordered patient and the type of coping strategies they employ. That type of coping strategy is influenced by the perceived threat a BPD patient is to others.

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Appendix A: Text of Invitation to Participate

Hello, my name is Nicole York. I am a doctoral candidate at Walden University in the clinical Psychology Department. I am conducting research on nurses' interactions with individuals that are diagnosed with borderline personality disorder, and I am inviting you to participate because you have identified as working with this population.

Participation in this research includes taking a survey about your general demographic information, understanding of the Borderline Personality Disorder diagnosis, attitudes towards your perception of safety, which will take approximately 20 to 30 minutes.

If you have any questions or would like to participate in the research, I can be reached at [*deidentified information*].

Appendix B: Interpersonal Stress Coping Scale Permission

PsycTESTS®

Interpersonal Stress Coping Scale

PsycTESTS Citation:
Kato, T. (2013). Interpersonal Stress Coping Scale [Database record]. Retrieved from PsycTESTS. doi: https://dx.doi.org/10.1037/t21432-000

Instrument Type:
Rating Scale

Test Format:
Instructions are as follows: "Please recall the specifics of your own experiences of stress due to interpersonal relationships. These may include quarreling with others, being talked about behind your back, feeling awkward while speaking, and worrying if you have hurt someone's feelings. Please read each item and indicate to what extent you used that strategy in the situations you encountered. Please mark the appropriate response by using the following rating scale." Responses to each of the 15 items are provided on a 4-point scale (0 = "did not use," 1 = "used somewhat," 2 = "used quite a bit," and 3 = "used a great deal").

Source:
Kato, Tsukasa. (2013). Assessing coping with interpersonal stress: Development and validation of the Interpersonal Stress Coping Scale in Japan. International Perspectives in Psychology: Research, Practice, Consultation, Vol 2(2), 100-115. doi: https://dx.doi.org/10.1037/ipp0000002

Appendix C: Attitudinal Dispositions Measure Permission

PsycTESTS®

Attitudinal Dispositions Measure

Note: Test name created by PsycTESTS

PsycTESTS Citation:
Furnham, A., & Dadabhoy, H. (2012). Attitudinal Dispositions Measure [Database record]. Retrieved from PsycTESTS. doi: https://dx.doi.org/10.1037/t16973-000

Instrument Type:
Test

Test Format:
Participants rate the extent to which they agree with the statement on a Likert-type scale (1 = Strongly Agree, 10 = Strongly Disagree).

Source:
Furnham, Adrian, & Dadabhoy, Hina. (2012). Beliefs about causes, behavioural manifestations and treatment of borderline personality disorder in a community sample. Psychiatry Research, Vol 197(3), 307-313. doi: https://dx.doi.org/10.1016/j.psychres.2011.12.024, © 2012 by Elsevier. Reproduced by Permission of Elsevier.

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Appendix D: Perceived Prevention of Violence Measure Permission

PsycTESTS®

Perceived Prevention of Violence Measure

PsycTESTS Citation:
Mueller, S., & Tschan, F. (2011). Perceived Prevention of Violence Measure [Database record]. Retrieved from PsycTESTS. doi: https://dx.doi.org/10.1037/t04519-000

Instrument Type:
Test

Test Format:
The 4 items were rated on a 7-point scale ranging from 1 (strongly disagree) to 7 (strongly agree).

Source:
Mueller, Sonja, & Tschan, Franziska (2011). Consequences of client-initiated workplace violence: The role of fear and perceived prevention. Journal of Occupational Health Psychology, Vol 16(2), 217-229. doi: https://dx.doi.org/10.1037/a0021723.

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Appendix E: Perceived Likelihood of Future Violence Scale Permission

From Nicole York:

Mon 10/7/2019 8:56 AM

Dear Dr. Mueller,

I am a doctoral candidate with Walden University and am working on my Dissertation. I am sending this email to request permission to use your scale in this research project.

I would like permission to use your scale on Perceived Likelihood of Future Violence Scale. This scale will be used in the study I am conducting on distancing factors that result in nurses behaviors towards patients with Borderline Personality Disorder diagnosis.

Thank you for taking the time to consider this request.

Nicole York

Walden University Doctoral Candidate

From Sonja Müller:

Mon 10/7/2019 11:12 AM

Dear Ms York

It is my pleasure to give you permission to use the scale. Do you have the wordings of the items or do you need anything from me?

Good luck with your Dissertation!

Best regards,

Sonja Mueller

Appendix F: Perceived Coping Ability Measure Permission

PsycTESTS®

Perceived Coping Ability Measure

Note: Test name created by PsycTESTS

PsycTESTS Citation:
Mueller, S., & Tschan, F. (2011). Perceived Coping Ability Measure [Database record]. Retrieved from PsycTESTS. doi: https://dx.doi.org/10.1037/t04518-000

Instrument Type:
Test

Test Format:
The Perceived Coping Ability Measure is rated on a 7-point Likert-type scale ranging from 1 (strongly disagree) to 7 (strongly agree).

Source:
Mueller, Sonja, & Tschan, Franziska (2011). Consequences of client-initiated workplace violence: The role of fear and perceived prevention. Journal of Occupational Health Psychology, Vol 16(2), 217-229. doi: https://dx.doi.org/10.1037/a0021723.

Appendix G: Survey

Eligibility and demographic items are listed. Instrument items permissions were restricted to data collection use only, not for item-specific publication.

I. Eligibility Items

1. Do you or have you practiced in the state of Washington? 1 (*Yes*) 2 (*No*)
2. Are you currently or have you worked as a Nurse? 1 (*Yes*) 2 (*No*)
3. Have you worked with an individual diagnosed with Borderline Personality Disorder? 1 (*Yes*) 2 (*No*)

II. General Demographic Information

1. What is your Sex? 1 (*Male*) 2 (*Female*) 3 (*X, non-binary, non-gender conforming, non-gender identifying*)
2. Age categories (1= 18- 24, 2= 25- 34, 3= 35- 44 4= 45-55 5= 55-64 6= 65+)
3. What is the highest level of nursing degree or credentials you have received? 1 (*Some college No Degree*) 2 (*AA Degree*) 3 (*BA/ BS*) 4 (*Master's Degree*) 5 (*Doctorate Degree*)
4. What setting do you work in? 1 (*Inpatient*) 2 (*Outpatient*) 3 (*Emergency Room*) 4 (*Private Practice*)

III. Attitudinal Disposition Measures (Furnham & Dadabhoy, 2012)

Likert- type scale 1 (*Strongly Agree*) to 10 (*Strongly Disagree*)

General Beliefs subscales: threat to others (TO), impulsivity and instability (II), emotional capacities (EC).

Causes subscales: brain abnormalities/imbalances (BAI), fate and karma (FK), early trauma and neglect (ETN), genetic or birth complications (GBC).

Treatment subscales: sociological (S), psychological (P), neuropsychological (N).

IV. Perceived Likelihood of Future Violence (Mueller & Tschan, 2011c)

11 -point scale ranging from 0 (*zero*) to 10 (*almost 100%*), in 10% increments.

V. Perceived Prevention of Violence Measure (Mueller & Tschan, 2011d)

7 point Likert type rating scale 1 (*strongly disagree*) to 7 (*strongly agree*)

VI. Perceived Coping Ability Measure (Mueller & Tschan, 2011b)

7 point Likert type rating scale 1 (*strongly disagree*) to 7 (*strongly agree*)

VII. Interpersonal Stress Coping Scale (Kato, 2013)

Instructions: Recalling specifics of your own experience of stress due to interpersonal relationships. This can include quarrelling with others, being talked about behind your back, feeling awkward while speaking and worrying if you have hurt someone's feelings. Please read the following items and indicate to what extent you used the strategy. This is a 4 point scale 0 (*did not use*), 1 (*used somewhat*), 2 (*used quite a bit*), 3 (*used a great deal*).