

# Inpatient staff experiences of providing treatment for males with a diagnosis of borderline personality disorder: A thematic analysis

Meghan Davies<sup>1</sup> | Alastair Pipkin<sup>1</sup>  | Claudia Lega<sup>2</sup>

<sup>1</sup>Adult Inpatient Psychology, Berrywood Hospital, Duston, UK

<sup>2</sup>Birmingham Newman University, Birmingham, UK

## Correspondence

Alastair Pipkin, Adult Inpatient Psychology, Berrywood Hospital, Duston, Northamptonshire, NN5 6UD, UK.  
Email: [alastair.pipkin@nhft.nhs.uk](mailto:alastair.pipkin@nhft.nhs.uk)

## Accessible Summary

### What is known on the subject?

- We know that there are similar rates of borderline personality disorder (BPD) diagnosed in both men and women; however, some research suggests that BPD is diagnosed later and less frequently in men. Some research suggests that males diagnosed with BPD present differently to women, but not much is known about how this influences the care men receive in inpatient mental health hospitals.

### What the paper adds to existing knowledge?

- This paper is the first to specifically ask inpatient staff about men diagnosed with BPD, and to hear about their perceptions and experiences.
- It identified that some staff do not feel as knowledgeable in identifying and treating BPD in men compared to women. Some staff talked about how emotional difficulties like BPD are often not the first thought when men present with distress compared to women. Staff also talked about needing a safe, open and transparent working culture to be able to ask questions and to be questioned on their own assumptions, biases or lack of training.

### What are the implications for practice?

- This paper suggests that inpatient staff may hold some assumptions about men and their emotions, such as assuming that they are less likely to struggle with emotional difficulties like BPD. Staff anxieties about risk management may influence how they perceive and care for men in inpatient wards. The findings suggest that male-specific training in identifying and treating BPD should be provided for staff on inpatient wards, to improve knowledge and confidence.

## Abstract

**Introduction:** Research highlights discrepancies in recognition of borderline personality disorder (BPD) in men, despite similar rates of prevalence across genders.

**Aim:** To investigate inpatient mental health professionals' experiences of delivering treatment for males with a diagnosis of BPD.

**Method:** Six mental health professionals working within adult acute inpatient wards completed a semi-structured interview. All participants were members of the nursing team. Thematic analysis was used to analyse the data.

**Results:** Five themes were identified: *Gender Differences, Stereotyping, Facilitators to Care Delivery, Barriers to Care Delivery and Ways to Improve Care*. Participants talked of

a lack of awareness and understanding of BPD in males impacting both diagnosis and treatment in an acute inpatient setting.

**Discussion:** There may be factors ranging from gender stereotypes, limited knowledge and understanding of gender differences in presentations, and personal/organisational cultures influencing the formulation and treatment of males with a diagnosis of BPD in inpatient settings.

**Implications for Practice:** The findings suggest that gender stereotypes such as masculine norms may influence how male patients' emotional difficulties are understood and managed, and that additional training in male-specific issues to improve knowledge and care provision. This research will support inpatient staff, service leads and clinical educators to identify ways to adapt care provision for men.

#### KEYWORDS

barriers and facilitators to care, borderline personality disorder, gender, Men's mental health, mental health professionals, stigma

## 1 | INTRODUCTION

People with a diagnosis of borderline personality disorder (BPD) sometimes require admission to acute inpatient psychiatric units to maintain safety, though prior research highlights discrepancies in approaches to such admissions and mixed outcomes (Carlyle et al., 2020; Maconick et al., 2023). Prior studies demonstrate that attitudes towards both BPD and gender norms may influence how mental health professionals perceive and enact care in a range of healthcare settings (Klein et al., 2022; Ociskova et al., 2017). While inpatient staff views and experiences of admissions for people diagnosed with BPD have been explored (e.g., Lindgren et al., 2023), to the authors' knowledge no prior studies have specifically explored staff perceptions of treating men diagnosed with BPD in inpatient settings. This leaves gaps in knowledge for how evidence-based care may be influenced by gender stereotypes regarding mental health and BPD, and what care for this population looks like in inpatient settings. The present study aimed to explore inpatient nursing staff's experiences of providing inpatient care to men with a diagnosis of BPD to better understand current perceptions about care provision.

Borderline personality disorder (BPD) is a common personality disorder denoting pervasive difficulties with regulating emotions, tolerating distress, impulsivity and interpersonal relationships (Lieb et al., 2004). With an estimated prevalence between 0.7% and 2% in the general population (NICE, 2009), individuals with a diagnosis of BPD are more likely to utilise mental health care than individuals with any other psychiatric condition (Bender et al., 2001; Broadbear et al., 2022). Research suggests that people with a diagnosis of BPD account for 10%–30% of those accessing inpatient psychiatric wards and outpatient settings and 37%–53% accessing drug and alcohol services (Bowden-Jones et al., 2004; Doering, 2019; NICE, 2009).

The primary recommended treatment for BPD is psychological therapy with an ethos of promoting autonomy, empowerment and collaboration (NICE, 2009). A systematic review highlighted that

specialist psychotherapies (e.g., dialectical behaviour therapy and schema therapy) are effective in reducing overall severity of BPD (Oud et al., 2018). Of the 20 studies reviewed, only one was conducted in an inpatient setting, reflecting that such therapies are predominantly delivered as outpatient treatments. However, in crisis, those with a diagnosis of BPD present with increased self-injurious behaviours and suicidality requiring intensive risk management, crisis-focused psychosocial interventions and/or an inpatient hospital admission to ensure safety (Carlyle et al., 2020). Inpatient admissions and crisis-focused psychological interventions have shown some improvement in BPD symptom severity, regardless of the type of admission (Maconick et al., 2023). This is counter to clinical guideline recommendations and other research, which suggests that inpatient admissions should be avoided or be brief in nature where possible for this population, to not promote a loss of autonomy or perceived ability to cope (Borschmann et al., 2013; NICE, 2009; Westling et al., 2019). Lindgren et al. (2023) recently explored inpatient staff experiences of delivering patient-initiated brief admissions for people with diagnosis of BPD. Their findings reported staff perceptions that brief admissions afford a sense of autonomy and empowerment as it enabled patients to plan elements of their care, create a sense of security through knowing care was readily accessible and improved nurse–patient collaboration and trust. In light of limited evidence and conflicting perspectives about care options, individuals with a diagnosis of BPD may find attempts to avoid admissions, lack of treatment options within hospital and swift discharges traumatising and/or invalidating of their distress during crises (Oud et al., 2018). With access to specialist community therapies remaining the current best known treatment option overall, what effective treatment involves during inpatient admissions remains unclear. Some argue that well-equipped inpatient teams providing crisis-focused psychosocial interventions and applying therapeutic principles can be effective, though this is not well researched or defined (Fagin, 2004; Maconick et al., 2023). Little is known about how

inpatient staff experience and perceive providing support for people with a diagnosis of BPD in hospital.

The way in which people with a diagnosis of BPD typically communicate their distress through self-injurious behaviours and difficulty with interpersonal relationships sometimes raises considerable challenges in clinical practice between a need to be risk-averse and taking positive risks to promote autonomy and self-regulation (Bland & Rossen, 2005). Research into healthcare professionals' attitudes towards individuals with a diagnosis of BPD suggests that they often hold stigmatising and negative views (Fallon, 2003), which leads to attributions of them being 'less ill' and more 'in control' of their behaviour compared to people with other diagnoses (Markham & Trower, 2003). Ociskova et al. (2017) further highlighted that derogatory phrases such as 'demanding', 'manipulative' and 'attention-seeking' are commonly used by healthcare professionals when describing patients with a diagnosis of BPD. A qualitative study characterised stigmatisation amongst professionals working in health care to be partially related to the tendency to 'see the illness ahead of the person', consequently impacting patient care in areas such as failure to use person-centred language and engagement in behaviours that could be viewed as disparaging or dismissive (Knaak & Patten, 2016).

Research has long found that such views can negatively impact care decision-making, including a tendency to minimise or distance oneself, language use, and reduced displays of empathy (Aviram et al., 2006). Klein et al. (2022) conducted a scoping review of the impact of stigma on healthcare provision for people with a diagnosis of BPD. They found evidence of some providers refusing to provide care to people with a diagnosis of BPD; providers actively avoiding providing care due to perceived untreatability; and providers not knowing how to treat individuals with a diagnosis of BPD. Conversely, research highlighted the people with a diagnosis of BPD frequently reported feeling judged, labelled and misunderstood by healthcare professionals. This suggests a direct link between negative clinician attitudes and impacted care provision, which may be crucial for a group already experiencing stigma and interpersonal sensitivities to perceived rejection and invalidation.

There is evidence that clinician attitudes are slowly positively changing, with increasing awareness of the available treatments likely influencing treatment optimism (Choi-Kain et al., 2017). Black et al. (2011) identified that negative perceptions differed amongst occupations within mental health professionals, with social workers, psychiatrists and psychologists being more optimistic about elements of treatment (e.g., therapy and medication). Staff nurses were shown to have the lowest self-ratings of empathy and treatment optimism towards these individuals. Lower ratings of antagonistic judgements and higher ratings of empathy have been shown by psychologists (Bodner et al., 2011). However, all professionals showed willingness in learning more about the treatment of these individuals.

Gender is another variable known to influence attitudes and care decision-making. Healthcare professionals presented with identical cases are more likely to give an eating disorder diagnosis if the individual was female (Currin et al., 2007). A study of mixed

healthcare professionals found that gender biases influenced healthcare decision-making, with men with mental health difficulties perceived more likely to engage in aggressive behaviours and substance misuse than females (Amato Gauci et al., 2022). A recent study found that when presented with a vignette depicting an individual with a diagnosis of BPD, males were perceived with more fear and greater danger, consistent with gender stereotypes, whereas females were perceived with greater pity (Masland & Null, 2022). Despite population-based studies indicating it is equally common in both genders (Grant et al., 2008), there remains a significant gender gap at a diagnostic level, with females eight times more likely to be diagnosed with BPD (Kuja-Halkola et al., 2021). This may be in part due to men being less likely to access mental health services (Sagar-Ouriaghli et al., 2019) or entering other systems where diagnoses may not be given (e.g., criminal justice systems) (Wetterborg et al., 2015). However, a recent study by Dehlbom et al. (2022) found that overall fewer men are diagnosed with BPD and those that are diagnosed receive it at a later age and are less likely to receive the same treatment as their female counterparts. It is not clear in existing research how treatment for men with a diagnosis of BPD is conceptualised and delivered, particularly within an inpatient setting. Given this, and the influence of gender on decision-making, there may be unique and under-researched difficulties facing men with a diagnosis of BPD and those that support them.

The present study aimed to examine mental health professionals (MHP) attitudes and experiences of delivering care to men diagnosed with BPD in an acute inpatient setting to identify and facilitators and barriers to positive care experiences from MHPs perspectives. It aimed to fill a gap in knowledge concerning how men with a diagnosis of BPD in inpatient settings are perceived and how care is enacted. The following research question was addressed:

What is the experience of MHPs delivering NICE concordant care for males with a diagnosis of BPD within acute inpatient environments?

## 2 | METHODS

### 2.1 | Design

To investigate subjective experience, the study used a qualitative design involving semi-structured interviews conducted directly with participants. A purposive sampling design was used.

### 2.2 | Study setting and recruitment

The study recruited from MHPs working across four inpatient units within a National Health Service (NHS) mental health trust. The wards treated adults admitted for a mental health crisis and risks to self and/or others that were otherwise not manageable in the community. Staff from across the wards who treated males were recruited via adverts in ward offices and an email advertisement via Ward Management.

## 2.3 | Inclusion and exclusion criteria

Recruitment adhered to the following inclusion criteria: over 18 years of age; experience working with males with a diagnosis of BPD in acute inpatient settings; worked within a permanent role providing direct patient intervention. Participants were excluded if they had less than 3 months experience, though no participants who expressed interest were excluded.

## 2.4 | Data collection

A semi-structured interview schedule was used (see Table 1) which covered topics of interest with prompts (such as any difference in presentation between genders, experience of implementing NICE guideline recommendations, and barriers and facilitators to implementing NICE care at different levels, for example, personal, team, organisational) but largely followed participants' leads.

Once a potential participant expressed interest in response to the study advert, the first author returned contact with full information and the opportunity to provide informed consent to take part. Following consent being obtained, participants completed a demographic questionnaire. Interviews were conducted at a mutually convenient confidential place at the hospital ( $N=2$ ) or via teams ( $N=4$ ). No participants raised any concerns, needs or distress during or following the interview, and they were all provided a participant debrief sheet. Interviews were transcribed verbatim and anonymised

and checked by the first author. Interviews lasted between 25 and 45 minutes. Recruitment was stopped following six interviews to accommodate detailed analysis and coverage of the participants' narratives, as noted to be important in qualitative research and specifically meeting recommended numbers for thematic analysis (Fugard & Potts, 2015). The authors further noted that similar themes were being discussed across interviews, suggesting thematic saturation. There was a short time frame for recruitment due to time constraints on the project and despite recruitment being extended to all MHPs, participants were all nursing team members (psychiatric nurses, nursing associates and healthcare assistants).

## 2.5 | Data analysis

Braun and Clarke's (2006) framework for thematic analysis was used to analyse the data. This approach involved seven stages: transcription; reading and familiarisation with the data; initial coding; searching for themes by grouping codes referring to similar issues or concepts; reviewing themes across the transcript and how they fit together, ensuring codes are all broadly covered; defining and naming the themes; and finalising and expressing the analysis in written and/or visual format. Close attention was paid to the use of language and any omissions or repetitions. Two transcripts (33.3%) were checked by the second author to ensure reliability, with good overall agreement. The identified themes were discussed and agreed by all three authors, through a reiterative process of continually revisiting the data.

TABLE 1 A table showing the topic guides, questions and indicative prompts used in the semi-structured interview.

Topic guides	Example prompts
What is your experience of working with men with BPD?	<i>How does this compare with women with BPD? Are there any noticeable differences between presentations in men and women with BPD?</i>
Is there a set treatment pathway for males with BPD within acute wards?	<i>If so, what does this usually look like? Are you able to adhere to this for the majority of the patients? If not, what do you think it should look like?</i>
What do you understand about NICE concordant care for males with BPD?	<i>Are you aware of the recommendations made by NICE? Is this something that is covered within training?</i>
The National Institute of Care and Excellence (NICE) guidelines recommend that the treatment of BPD should involve: <ul style="list-style-type: none"> <li>• Develop autonomy</li> <li>• Promote choice</li> <li>• Utilise a person-centred care approach</li> <li>• Support individuals to develop problem solving skills</li> <li>• Empower individuals to make decisions regarding their care</li> </ul>	<i>What is your experience of the pathway fulfilling these recommendations within practice? Prompt each bullet point</i>
What are your views on the barriers to delivery of treatment pathway within line of these recommendations?	<i>Prompt for factors at different levels, e.g., organisational, management, team, patient, personal etc. What do you feel may need to be improved to allow for successful delivery of treatment pathway?</i>
What do you feel makes it easier to provide the recommended treatment pathway to this population?	<i>How do the factors mentioned above (organisational, management, team, patient, personal, etc). ease delivery—include any participant may have mentioned previously too</i>
How do the patients respond to this treatment pathway?	<i>Are they aware of the barriers and do they accept these? How do you as staff explain challenges to patients? What do you feel improves patient experience for this particular pathway?</i>

## 2.6 | Ethical considerations

Ethical approval was gained via Newman University Ethics Board (Reference: 1282) and Northamptonshire Healthcare NHS Foundation Trust's Research Ethics Committee (Reference: 200123/R1). All involvement in the project was strictly confidential, and care was taken given the small sample size to protect participant anonymity throughout the presentation of the results.

## 2.7 | Rigour and reflexivity

The first author was completing a Masters degree in Clinical Psychology at the time of the project. She acknowledges passion and interest in critically considering stigma, burnout and whole person approaches to mental health care which stemmed from working within this environment. The second author was a male Clinical Psychologist working in inpatient services who acknowledges theoretical and clinical interests in stigma, emotional difficulties and psychosis. Considering this, supervision was used to consider the researchers' own responses to and interpretations of the data, in acknowledging and bracketing any assumptions prior to, during and after both interviews and analysis.

In aiming to provide a more holistic understanding of this research topic which goes beyond both positivism and constructivism (Bergin et al., 2008), the researcher acknowledges a critical realist epistemological position (Willig, 2016). Under critical realism, language use and relational positioning can be interpreted to explore the reality of individual's experiences and conclusions are considered a reading of participants' experiences and influenced by the researcher's subjectivity. Rigour was promoted by using co-coding of one-third of the transcripts, and through in-depth discussions of the entire set of final codes throughout the theming process using a team supervisory approach. Reflective diaries were kept which were regularly discussed by the research team to monitor and limit bias. Bracketing interviews were utilised throughout the design and conduct of the study to identify any assumptions, biases and personal/professional resonances, which were monitored throughout the analytic process using team discussions. Data were continually revisited to ensure closeness to the participants' language and original meaning.

## 3 | RESULTS

Six participants took part in the study. Table 2 below summarises participant characteristics.

The thematic analysis identified five super-ordinate themes (see Table 3 for summary): (1) *Gender Differences*; (2) *Stereotyping*; (3) *Facilitators to care delivery*; (4) *Barriers to care delivery*; and (5) *Ways to improve care*. Two subthemes were identified within Facilitators to care delivery, these being: (3: 1) *'Essentials of care'*; and (3: 2) *'Finding resolution in understanding'*. Barriers to care delivery consisted of three subthemes: (4: 1) *'Attitudes towards positive risk taking'*; (4: 2)

TABLE 2 A table displaying participant demographics.

Participant number	Gender	Age (years)	Role	Number of years' experience in mental health
1	Male	32	Student Nurse	6–10
2	Female	40	Mental Health Nurse	11–15
3	Female	23	Healthcare Assistant	1–5
4	Male	26	Nurse Associate	6–10
5	Female	36	Personality Disorder Link Worker (Mental Health Nurse)	6–10
6	Female	36	Staff Nurse	15+

*'Working in a strained system'*; (4: 3) *'Recovery is a choice'*. Illustrating quotes have been selected that summarise each theme noted above in turn. Quotes are verbatim however where required, the use of [] will provide additional context for clarity.

### 3.1 | Theme 1: Gender differences

Participants referred to apparent gender differences between males and females with a diagnosis of BPD and what that means for their care within the acute inpatient setting. The differences in the way males and females with a diagnosis of BPD present (i.e., in terms of communicating and coping with distress) were discussed by all participants. It was noted how men do not present in the *'typical'* way, compared to women. Males were characterised as using *'outward ways'* of expressing their distress such as verbal or physical aggression, whereas females were typified to direct theirs internally through methods of self-harm, for example:

[Men] they do not know how to communicate it [distress] and so we see a lot more physical aggression, more threats happening whereas females I've noticed in my role, they self-harm ... to communicate' Participant 6.

Similarly, all participants referred to a potential bias in diagnosis of those with BPD. Four participants specifically mentioned how males with a diagnosis of BPD are not seen as often within acute inpatient units, with some reflecting that this may be due to them presenting to other services (e.g., criminal justice system). Moreover, it appeared that men's distress and difficulties were often made sense of in the context of substance misuse or antisocial behaviour, with BPD rarely being considered as an initial diagnosis by the MDT. Three participants referenced males being diagnosed with BPD much later—both in inpatient and community settings—than women.

[BPD], it's not half as common as we see with females or if it is, we're just not able to kind of identify it earlier on ... they get like diagnosed more so with antisocial

TABLE 3 A table displaying theme summaries.

Theme	Subthemes	Summary
1. Gender differences		Men were perceived to not present with 'typical' borderline personality disorder due to 'outward ways' of expressing emotional distress. Some participants thought there was a bias against considering BPD as a diagnosis in men
2. Negative stereotyping and stigma		All six participants thought that negative stereotypes existed against BPD within the team, which reduced compassion and consideration of traumatic backgrounds. They perceived their male patients to live up to 'toxic masculinity' norms, such as 'men don't talk' for fear of 'appearing weak'
3. Facilitators to care delivery	3.1 Essentials of care 3.2 Finding resolution in understanding	Participants felt that core nursing skills, such as active listening and working hard to understand their patient's presentation and experiences, helped facilitate positive care
4. Barriers to care delivery	4.1 Attitudes to positive risk taking 4.2 Working in a strained system 4.3 Recovery is a choice	Participants viewed a lack of willingness within the team to take positive risks or overusing restrictive practices to manage risk, lack of resources both inside and outside of hospital, and patients' readiness to change all negatively impacted care delivery
5. Ways to improve care		Participants thought that increased knowledge and awareness as a team about BPD in men, an open and curious organisational culture, and being aware of personal biases would all improve care for this population

half the time as well when it's actually their emotional dysregulation ... females are kind of identified from the offset, whereas males tend to take a bit longer, to kind of unpick that a little bit'. Participant 5.

Participants highlighted this lack of understanding of males' needs and delay in diagnosis resulted in disparity in accessing treatment between genders, with men being less likely to be on the appropriate treatment pathway from the offset. One participant noted '*their behaviour tends to exclude them from care a little bit*', and this was echoed throughout the transcripts in various ways including the '*aggressive*' and '*threatening*' ways males are perceived leading to them being discharged from care or limiting their access to groups because of the risk they may pose. Additionally, three participants acknowledged that current therapeutic intervention is typically a group setting which tends to be female dominated, which can impact men's willingness to engage or ability to access based on risk.

### 3.2 | Theme 2: Negative stereotyping and stigma

All six participants described pervasive negative stereotypes and stigma associated with the BPD diagnosis that can be held by staff. Participants discussed how the distress of those with a diagnosis of BPD can be invalidated or dismissed due to the way in which this patient group seeks to get their needs met, with negative labels such as '*manipulative*', '*antisocial*' or '*disrespectful*' often being used to classify these behaviours rather than staff seeking to understand the function. Participant 6 captures this in their statement: '*[staff] will put a label on it instead of trying to understand where their trauma has come from*'.

'They tend to focus on the negative attributes, or add negative attributes they might not be adding to other

people ... maybe even denying they have a mental illness, you know people sort of say they're not mentally ill they're just rude or aggressive'. Participant 1.

Similarly, all participants referred to concepts fitting with internalised stereotypical masculine norms, with three participants referring directly to '*toxic masculinity*'. Traits such as emotional indifference, dominance and self-reliance were noted as 'typical' of males and often commented on in the context of barriers to care. Phrases such as '*men don't talk*' were common within the transcripts. It was discussed whether this reluctance stems from the fear of '*appearing weak*' or vulnerable or whether it is a gender norm that is instilled in them from childhood which impacts on their ability to feel able to seek care or support from services. These norms appear to be implicated in the wider healthcare system, particularly during initial assessment whereby their difficulties get made sense of in the context of substance misuse or aggression, as one participant stated, '*they are perceived to be sort of an angry male that needs anger management rather than that being some complex emotional needs*'.

'For men there's still that cultural view that you need to be strong, you cannot have emotions like this, you cannot feel this way because it is not a manly thing. And I think that that is inadvertently portrayed through how health care sees them as well'. Participant 4.

It was found that these stereotypes were not just limited to staff, with two participants sharing the confusion experienced by some of their male patients who had assumed BPD to be '*a thing that women have*'. Repercussions of these negative stereotypes and long-standing stigma were also identified. Participants spoke about how the '*tolerance*' staff have towards these individuals and their behaviour can vary and this

is often reflected in the strength of the therapeutic rapport build between staff and patient:

'They [males with a diagnosis of BPD] can be very dismissive; they already assume that they are being judged... Once they feel or sense that someone does not understand them or makes them feel unwanted, they kind of revert back to themselves and then isolate and that is when we see risk getting higher' Participant 6.

### 3.3 | Theme 3: Facilitators of care delivery

#### 3.3.1 | Subtheme 1: Essentials of care

All participants spoke about how core skills such as honesty, empathy, active listening, collaboration, compassion and clear communication are fundamental elements in effective care delivery. Participants recognised that these '*basic skills*' are essential for providing high-quality and patient-centred care. It was acknowledged how these basic skills foster patient engagement, develop therapeutic rapport and ultimately ensure the patient feels comfortable to seek support and guidance from staff.

'[It is] important to appreciate that they are struggling, regardless of how you personally feel about their illness ... they are having a challenging time and we have all been through challenging times ... just trying to empathise ... they tend to come and speak to you more frequently than anyone else because they know that you're listening to them and that you want to help them'. Participant 4.

Participants also noted the importance of collaborative working with the individual during their admission to ensure the '*needs are identified*' and a co-produced plan of how to meet these needs is discussed. Participants spoke about how '*clarifying expectations*', '*setting goals*' and '*holding each other accountable*' were vital in fostering a collaborative therapeutic relationship. It was highlighted that collaborative working helped to '*place responsibility*' on the individual by promoting independence and confidence, which benefits to the individual post-discharge. Some participants saw collaborative care planning as a way of ensuring the patient's voice and a sense of control is maintained throughout the admission.

#### 3.3.2 | Subtheme 2: Finding resolution in understanding

Facilitating understanding for this population was discussed generally across participants and identified as an important contributor to effective care for males. Participants noted experiences whereby males with a diagnosis of BPD are often left feeling misunderstood

or struggling with difficulties that they feel unable to manage because they do not understand it themselves and services have never considered them in the context of BPD. Staff identified that providing understanding '*builds rapport*' and gives the individual confidence that someone is in their corner to '*advocate for them*'. For some, this making sense of their difficulties also provides them a sense of hope and drives motivation for recovery.

'Their eyes kind of light up and they are like oh my God, that's me, that's me on a bit of paper ... their perception is that you are the only one that ever understood them. [They will say] I knew it was something other than anger. I knew it was something other than depression, that makes sense to me'. Participant 5.

### 3.4 | Theme 4: Barriers to care delivery

#### 3.4.1 | Subtheme 1: Attitudes towards positive risk taking

All participants emphasised how '*extended stays in hospital aren't helpful*' but acknowledged how '*risk is always going to be higher in males*' and how this can present a challenge to recommended care delivery due to '*worries around discharging*'. Differing opinions amongst the MDT in relation to taking positive risk was a challenge noted by some participant with two commenting on how they felt nursing staff were more willing to take positive risks, whereas at times they felt doctors '*reluctancy to stick with the framework*' and were more likely to '*wrap people up and restrict them and to try and maintain safety*'. Participants showed agreement around positive risk taking being a way of scaffolding skills development in this population and an important part of the individual '*taking responsibility for their actions*', both of which are vital to ensure they can thrive in the community as '*dependency on services ... strips people of their own skills*'.

#### 3.4.2 | Subtheme 2: Working in a strained system

Participants frequently referenced limits to care provision being a consequence of working amongst a strained healthcare system, where staffing and availability of appropriate services and therapeutic intervention were common areas of discontent. All participants spoke about how when supporting individuals with a diagnosis of BPD there is often an increased demand for individual staff support to help manage emotional dysregulation. However, it was a common narrative that the price of juggling high workload in the face of reduced staffing numbers was the quality of care, as staff do not have the time to support how they would like to:

'We haven't got the sufficient amount of staff and management aren't supporting us to be able to give

that person centre approach and plan that we want to do and collaborate with the patients more effectively ... and it is them [patients] that are suffering the consequences ... that breaks my heart as a qualified nurse to see people in distress but knowing that you cannot help them'. Participant 6.

Consequences of this reality were recognised as staff burnout, patient dissatisfaction and unhelpful lengthy admissions, all of which were considered by some participants to increase risk and trap patients in a cycle of readmissions:

'It's a lack of resources, so you know, it's a struggle for the patients ... a struggle to services and the burnout is also another struggle' Participant 2.

### 3.4.3 | Subtheme 3: Recovery is a choice

Choice being vital to recovery was highlighted throughout the transcripts. Words such as '*readiness*' or '*willingness to engage*' were regularly used by participants to emphasise that irrespective of barriers within the system, ultimately the decision to take advantage of the care or intervention offered and commit to their recovery journey is one that can only be made by the patient:

'It has to be their choice because they are not going to stick to something that someone has told them they have to do. They have to feel that it's what they want to do, and they may not be ready ... we don't have the power of the people to tell them this is what you need to do, we can only advise. I think that is the really difficult part'. Participant 4.

## 3.5 | Theme 5: Ways to improve care

All participants made suggestions on ways to improve the treatment pathway for males with a diagnosis of BPD within inpatient settings. Participant frequently referenced a '*lack of awareness*' or understanding around the presentation and needs of males with a diagnosis of BPD. This was reasoned to be a lack of exposure to males with a diagnosis of BPD due to the diagnosis being '*less common*' in males on the wards. Four participants specified that training to bridge this '*gap in knowledge base*' would be helpful and benefit clinical practice and patient care. Additionally, space to '*reflect on practice*' and '*debrief*' were identified as important to '*encourage staff to be able to communicate*'.

Organisational culture was identified by four participants as a barrier to effective care. Participants talked about how unhelpful narratives about men with a diagnosis of BPD may be perpetuated: '*breaking that idea that they [individuals with a diagnosis of BPD] are just a problem and that it is not actually that difficult to make a difference*'.

To address this, participants stated that having a more open culture, in which questions could be asked and different perspectives could be considered, and strengths and weaknesses could be more openly discussed or challenged would help: '*I think we need to hone in on those in order to provide the care that we are looking at trying to provide for all of the patients*'. One participant reflected how this was important for staff to '*upskill each other*' and improve overall care delivery.

One participant acknowledged how their personal culture previously informed their understanding—or lack of—of BPD and how they consider this when questioning other colleagues practice, especially those who may experience the same challenges in supporting these individuals whose behaviour may be seen as unacceptable to them because of their cultural upbringing:

'I'm from an island, we don't have this [diagnosis] in my country at all. [But] it's so common over here in Britain ... you'll see things [colleagues do] and you'll have to say "ok, you cannot do that", even though I can kind of relate ... where we're from it's [the patient's behaviour] like no'. Participant 2.

## 4 | DISCUSSION

The present study aimed to evaluate the experiences of mental health inpatient staff delivering care for men diagnosed with BPD. Six members of the nursing team took part. Across the five themes identified, all participants referred to how gender differences lead to a disparity in diagnosis and care for males, and how negative stereotypes influence staff perceptions of this population. Core skills such as compassion, collaboration and providing understanding seemed to bolster care delivery, whereas factors such as working within a strained system and willingness to take positive risks negated this.

Internalised typical masculinity norms, sometimes called '*toxic masculinity*', may exert a significant impact on males' mental health care, highlighting the complex interplay between gender norms and psychological well-being (Harris, 2021). Traditional societal expectations often emphasise traits such as emotional stoicism, dominance and self-reliance, which can deter men from seeking help for mental health concerns to conform to masculine ideals and maintain this status of a '*strong*' man (Exner-Cortens et al., 2021). The current study highlights that these negative stereotypes persist within an acute inpatient setting and impact staff perception of males' distress, with some questioning its validity; and the males' ability to communicate their experience, echoing previous findings whereby MHPs could be dismissive and '*see the illness ahead of the person*' (Knaak & Patten, 2016). Consequently, as in previous studies' findings, '*toxic masculinity*' may perpetuate a culture of silence and stigmatisation surrounding men's mental health and underlying emotional difficulties, leading to delayed or inadequate treatment (Yousaf et al., 2015). Addressing the impact of toxic masculinity on males' mental healthcare necessitates challenging these harmful norms, promoting emotional expression and help-seeking behaviours, and

fostering inclusive and supportive environments that validate the diverse experiences of men.

Participants described experiencing that men with a diagnosis of BPD tended to 'externalise' their distress, such as through aggression and substance misuse, which fits with previous research on some differences in how men have been shown to cope with emotional difficulties related to BPD (Sher et al., 2019). Additionally, they mentioned perceiving that BPD was highlighted later on and less in men on their wards, with labels such as antisocial and addictions being considered first. Previous studies have highlighted how BPD as a label attracts stigma, which can negatively influence how healthcare professionals interact with them, such as increasing communication that can be construed as dismissive, or outright refusing health care (Klein et al., 2022). The present findings add that gender adds an additional layer; the behaviour of men struggling with a diagnosis of BPD may be construed as antisocial and/or raise anxieties in the first instance. This may contribute to particular ways of understanding and interacting with patients such as less curiosity about their experiences, emotions or trauma, which may denote delays in diagnosis, treatment access and constitute negative healthcare experiences (Bozzatello et al., 2021). Ongoing attention to the roles of stigma and gender biases in inpatient settings is therefore important to ensure holistic and timely assessments, beyond assumptions. Inpatient staff being aware to consider emotional and/or personal difficulties in men attentive to these differences throughout the assessment and diagnostic process and promoting a more holistic understanding of the distress experienced by males may reduce this.

The externalisation of distress in males was often discussed by participants in the context of risk to others. There is growing evidence questioning whether risk assessments are more about managing clinician anxiety as opposed to supporting the distressed individual, subsequently being countertherapeutic due to the impact this has on how they approach risk (Espeland et al., 2021; Undrill, 2007). Hence, if males with a diagnosis of BPD are seen to pose more of a risk due to how professionals perceive or interpret their distress, this may impact decisions made about their care and prompt either premature discharges or prolonged admissions and restrictive practices as ways of managing risk. Both can have a detrimental impact on treatment outcomes and experiences of care for the individual (Stapleton & Wright, 2019). It is important for clinicians to be aware of how their emotional responses to risk may impact decisions made. Close team working, ongoing training and supervision around working with people with personality disorders, and the application of evidence-based strategies (for example consistency, transparency and clear boundaries) may all be efficacious options to improve the therapeutic impact of inpatient admissions (Fagin, 2004; Maconick et al., 2023).

Nursing staff have been shown to have lower levels of empathy and optimism towards treatment outcomes for BPD compared to other occupations (Black et al., 2011; Bodner et al., 2011). This study highlighted negative perceptions that are still maintained; however, the experiences provided by participants were able to put some of these into context. Therefore, consideration should be given to the amount of exposure nursing staff have to this patient base,

particularly within the inpatient setting, and how this may contribute to negative attitudes due to factors such as burnout or compassion fatigue (Papathanasiou & Stylianidis, 2022). Indirect psychological interventions are often offered within acute mental health inpatient settings. These have been shown to support positive changes in staff perceptions of patients, incidents and staff-patient relationships, as well as increasing staff team satisfaction (Man et al., 2023). Utilisation of such input should be considered for nursing teams who may be more at risk of burnout and compassion fatigue.

Some participants considered their own cultural background impacted their awareness and ability to understand and support those with a diagnosis of BPD. A positive organisational culture that prioritises patient safety, teamwork and continuous improvement can enhance patient care by promoting collaboration and fostering a supportive environment to learn, reflect and be curious (Dellegar, 2010). A lack of psychological safety for MHPs can impede patient care, leading to poor communication, burnout amongst healthcare professionals and suboptimal outcomes (Hunt et al., 2021). Participants reiterated the importance of feeling safe and supported to question practice and promote a cohesive team dynamic. A recent qualitative study by Lindgren et al. (2023) found that inpatient nursing staff experienced brief, patient-initiated admissions as empowering, suggesting that perceptions of nursing teams may continue to vary towards care for these populations. Evaluation of specific skills training in MHPs supporting those with a diagnosis of BPD found it promoted empathy, increased tolerance of risk and positively influenced the negative perception towards those with a diagnosis of BPD (Warrender, 2015). Ward teams may consider further training and support to identify and question gender- and stigma-related biases or assumptions in practice.

## 5 | STRENGTHS AND LIMITATIONS OF THE WORK

The study gives voice to inpatient staff's perceptions and experiences of working with men with a diagnosis of borderline personality disorder. It is the first specific study to the authors' knowledge to explore this specifically for men with a diagnosis of BPD, highlighting that gender stereotypes, staff attitudes and perceived competence warrant further attention to improve care. Attempts were made to acknowledge and monitor researcher positionality throughout the process in an attempt to promote rigour in qualitative research.

The study faced certain limitations, primarily associated with the sample size and selection process. The sample size was small, consisting of only six self-selected participants from a single healthcare trust. This limited scope may have hindered the inclusion of diverse experiences and perspectives, for example no participants from medical or therapy roles were recruited. The use of semi-structured interviews may also be considered a limitation due to the potential influence on participants' responses through follow-up, leading or suggestive questioning. Although the analysis revealed similar themes across all

interviews, there is still a need for larger-scale studies which include different services and settings. Moreover, the involvement of additional researchers or participants in the coding and analysis process could have further enhanced the validity of the findings.

## 6 | IMPLICATIONS

Future research would benefit from full recruitment of a wider range of MHPs within the inpatient setting to capture differences that may exist here. Evaluating both organisational and personal culture on stigma and masculine norms on beliefs about men with a diagnosis of BPD is also suggested to provide a more in-depth understanding of how these factors impact quality of mental health care. Moreover, evaluating outcomes of training would serve to improve care for men with a diagnosis of BPD. These are all necessary to cultivate a meaningful framework which can assist MHPs awareness and understanding of challenges facing males with a diagnosis of BPD.

Results indicate a need for more training for inpatient nursing staff teams to enhance awareness of BPD in males. Findings also highlight a need for more routine consideration of BPD in males and gender inclusive assessment, not just within an acute inpatient setting, but perhaps throughout mental health services to avoid dismissing BPD-related emotional difficulties as secondary to other, more obvious, presenting issues.

## 7 | CONCLUSION

In summary, the study highlighted that negative stereotypes and internalised typical masculine norms may play a role in the disparity of care males with a diagnosis of BPD receive. Focus should be given to the provision of training tailored to this population and promotion of a positive organisational culture to enhance quality of care.

### ACKNOWLEDGEMENTS

This research received no specific grant from any funding agency in the public, commercial or not-for-profit sectors.

### CONFLICT OF INTEREST STATEMENT

The authors declare no conflicts of interest.

### DATA AVAILABILITY STATEMENT

Research data are not shared.

### ETHICS STATEMENT

All data utilised in the submitted manuscript have been lawfully acquired in accordance with The Nagoya Protocol on Access to Genetic Resources and the Fair and Equitable Sharing of Benefits Arising from Their Utilization to the Convention on Biological Diversity The project received ethical approval from Newman University Ethics Board and from Northamptonshire Healthcare NHS Foundation Trust Psychology Research Ethics Board.

### DESCRIPTION

This paper is a qualitative study with inpatient nursing staff using semi-structured, individual interviews and thematic analysis.

### RELEVANCE STATEMENT

This paper reports the experiences and perspectives of inpatient psychiatric on the treatment of males with a diagnosis of BPD, therefore having direct relevance to inpatient nursing practice. To the authors' knowledge, there is no research exploring the perspectives and experiences of inpatient staff in treating males with a diagnosis of BPD, so this paper aims to reflect the current state of play from nursing staff perspectives to highlight possible themes for further research, training and support, with the aim of improving care for men with this diagnosis.

### REPORTING CHECKLIST

The EQUATOR Guidelines for Qualitative Research—Standards for Reporting Qualitative Research (SRQR—see [Supplementary Material S1](#)) were followed in the write-up of this study.

### ORCID

Alastair Pipkin  <https://orcid.org/0000-0001-8202-6383>

### REFERENCES

- Aviram, R. B., Brodsky, B. S., & Stanley, B. (2006). Borderline personality disorder, stigma, and treatment implications. *Harvard Review of Psychiatry*, 14(5), 249–256. <https://doi.org/10.1080/1067322060975121>
- Bender, D. S., Dolan, R. T., Skodol, A. E., Sanislow, C. A., Dyck, I. R., McGlashan, T. H., Shea, M. T., Zanarini, M. C., Oldham, J. M., & Gunderson, J. G. (2001). Treatment utilization by patients with personality disorders. *The American Journal of Psychiatry*, 158(2), 295–302.
- Bergin, M., Wells, J. S., & Owen, S. (2008). Critical realism: A philosophical framework for the study of gender and mental health. *Nursing Philosophy*, 9(3), 169–179.
- Black, D. W., Pfohl, B., Blum, N., McCormick, B., Allen, J., North, C. S., Phillips, K. A., Robins, C., Siever, L., Silk, K. R., Williams, J. B. W., & Zimmerman, M. (2011). Attitudes toward borderline personality disorder: A survey of 706 mental health clinicians. *CNS Spectrums*, 16(3), 67–74.
- Bland, A. R., & Rossen, E. K. (2005). Clinical supervision of nurses working with patients with borderline personality disorder. *Issues in Mental Health Nursing*, 26(5), 507–517.
- Bodner, E., Cohen-Fridel, S., & Iancu, I. (2011). Staff attitudes toward patients with borderline personality disorder. *Comprehensive Psychiatry*, 52(5), 548–555.
- Borschmann, R., Barrett, B., Hellier, J. M., Byford, S., Henderson, C., Rose, D., Slade, M., Sutherby, K., Szmukler, G., Thornicroft, G., Hogg, J., & Moran, P. (2013). Joint crisis plans for people with borderline personality disorder: Feasibility and outcomes in a randomised controlled trial. *The British Journal of Psychiatry: the Journal of Mental Science*, 202(5), 357–364. <https://doi.org/10.1192/bjp.bp.112.117762>
- Bowden-Jones, O., Iqbal, M. Z., Tyrer, P., Seivewright, N., Cooper, S., Judd, A., Weaver, T., & the COSMIC Study Team. (2004). Prevalence of personality disorder in alcohol and drug services and associated comorbidity. *Addiction*, 99(10), 1306–1314.
- Bozzatello, P., Garbarini, C., Rocca, P., & Bellino, S. (2021). Borderline personality disorder: Risk factors and early detection. *Diagnostics*, 11(11), 2142.

- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77–101.
- Broadbear, J. H., Rotella, J. A., Lorenze, D., & Rao, S. (2022). Emergency department utilisation by patients with a diagnosis of borderline personality disorder: An acute response to a chronic disorder. *Emergency Medicine Australasia*, 34(5), 731–737.
- Carlyle, D., Green, R., Inder, M., Porter, R., Crowe, M., Mulder, R., & Frampton, C. (2020). A randomized-controlled trial of mentalization-based treatment compared with structured case management for borderline personality disorder in a mainstream public health service. *Frontiers in Psychiatry*, 11, 561916.
- Choi-Kain, L. W., Finch, E. F., Masland, S. R., Jenkins, J. A., & Unruh, B. T. (2017). What works in the treatment of borderline personality disorder. *Current Behavioral Neuroscience Reports*, 4(1), 21–30. <https://doi.org/10.1007/s40473-017-0103-z>
- Curran, L., Schmidt, U., & Waller, G. (2007). Variables that influence diagnosis and treatment of the eating disorders within primary care settings: A vignette study. *International Journal of Eating Disorders*, 40(3), 257–262.
- Dehlbom, P., Wetterborg, D., Lundqvist, D., Maurex, L., Dal, H., Dalman, C., & Kosidou, K. (2022). Gender differences in the treatment of patients with borderline personality disorder. *Personality Disorders, Theory, Research, and Treatment*, 13(3), 277–287.
- Dellegar, S. (2010). Team building: A continuous challenge for today's nurse leaders. *The Oklahoma Nurse*, 55(2), 16.
- Doering, S. (2019). Borderline personality disorder in patients with medical illness: A review of assessment, prevalence, and treatment options. *Psychosomatic Medicine*, 81(7), 584–594.
- Espeland, K., Hjelmeland, H., & Loa Knizek, B. (2021). A call for change from impersonal risk assessment to a relational approach: Professionals' reflections on the national guidelines for suicide prevention in mental health care in Norway. *International Journal of Qualitative Studies on Health and Well-Being*, 16(1), 1868737.
- Exner-Cortens, D., Wright, A., Claussen, C., & Truscott, E. (2021). A systematic review of adolescent masculinities and associations with internalizing behavior problems and social support. *American Journal of Community Psychology*, 68(1–2), 215–231.
- Fagin, L. (2004). Management of personality disorders in acute in-patient settings. Part 1: Borderline personality disorders. *Advances in Psychiatric Treatment*, 10(2), 93–99. <https://doi.org/10.1192/apt.10.2.93>
- Fallon, P. (2003). Travelling through the system: The lived experience of people with borderline personality disorder in contact with psychiatric services. *Journal of Psychiatric and Mental Health Nursing*, 10(4), 393–401.
- Fugard, A. J. B., & Potts, H. W. W. (2015). Supporting thinking on sample sizes for thematic analyses: A quantitative tool. *International Journal of Social Research Methodology: Theory & Practice*, 18(6), 669–684. <https://doi.org/10.1080/13645579.2015.1005453>
- Gauci, A., Attoe, C., Woodhead, C., Hatch, S., & Kainth, R. (2022). The influence of patient gender in healthcare professional decision-making: An interaction analysis of simulation debriefings. *International Journal of Healthcare Simulation*, 1(3), 66–74. <https://doi.org/10.54531/IIVD1435>
- Grant, B. F., Chou, S. P., Goldstein, R. B., Huang, B., Stinson, F. S., Saha, T. D., Smith, S. M., Dawson, D. A., Pulay, A. J., Pickering, R. P., & Ruan, W. J. (2008). Prevalence, correlates, disability, and comorbidity of DSM-IV borderline personality disorder: Results from the wave 2 National Epidemiologic Survey on alcohol and related conditions. *Journal of Clinical Psychiatry*, 69(4), 533–545.
- Harris, B. (2021). Toxic masculinity: An exploration of traditional masculine norms in relation to mental health outcomes and help-seeking behaviours in college-aged males.
- Hunt, D. F., Bailey, J., Lennox, B. R., Crofts, M., & Vincent, C. (2021). Enhancing psychological safety in mental health services. *International Journal of Mental Health Systems*, 15(1), 1–18.
- Klein, P., Fairweather, A. K., & Lawn, S. (2022). Structural stigma and its impact on healthcare for borderline personality disorder: A scoping review. *International Journal of Mental Health Systems*, 16(1), 48. <https://doi.org/10.1186/s13033-022-00558-3>
- Knaak, S., & Patten, S. (2016). A grounded theory model for reducing stigma in health professionals in Canada. *Acta Psychiatrica Scandinavica*, 134, 53–62.
- Kuja-Halkola, R., Lind Juto, K., Skoglund, C., Rück, C., Mataix-Cols, D., Pérez-Vigil, A., Larsson, J., Hellner, C., Långström, N., Petrovic, P., Lichtenstein, P., & Larsson, H. (2021). Do borderline personality disorder and attention-deficit/hyperactivity disorder co-aggregate in families? A population-based study of 2 million swedes. *Molecular Psychiatry*, 26(1), 341–349.
- Lieb, K., Zanarini, M. C., Schmahl, C., Linehan, M. M., & Bohus, M. (2004). Borderline personality disorder. *The Lancet*, 364(9432), 453–461.
- Lindgren, T., Westdahl, J., Stjernswärd, S., Saliba-Gustafsson, E. A., Flyckt, L., Jayaram-Lindström, N., & Eckerström, J. (2023). Psychiatry nurses' experiences of patient-initiated brief admission from inpatient and outpatient perspectives: A qualitative exploratory study. *Issues in Mental Health Nursing*, 1–10, 66–75. <https://doi.org/10.1080/01612840.2023.2270059>
- Maconick, L., Ikhtabi, S., Broeckelmann, E., Pitman, A., Barnicot, K., Billings, J., Osborn, D., & Johnson, S. (2023). Crisis and acute mental health care for people who have been given a diagnosis of a 'personality disorder': A systematic review. *BMC Psychiatry*, 23(1), 720. <https://doi.org/10.1186/s12888-023-05119-7>
- Man, H., Wood, L., & Glover, N. (2023). A systematic review and narrative synthesis of indirect psychological intervention in acute mental health inpatient settings. *Clinical Psychology & Psychotherapy*, 30(1), 24–37.
- Markham, D., & Trower, P. (2003). The effects of the psychiatric label 'borderline personality disorder' on nursing staff's perceptions and causal attributions for challenging behaviours. *The British Journal of Clinical Psychology*, 42(Pt 3), 243–256. <https://doi.org/10.1348/01446650360703366>
- Masland, S. R., & Null, K. E. (2022). Effects of diagnostic label construction and gender on stigma about borderline personality disorder. *Stigma and Health*, 7(1), 89–99.
- NICE. (2009). *Borderline personality disorder: Recognition and management. Clinical guideline [CG78]*. NICE.
- Ociskova, M., Prasko, J., Latalova, K., Sedlackova, Z., Kamaradova, D., Sandoval, A., & Grambal, A. (2017). F\*ck your care if you label me! Borderline personality disorder, stigma, and self-stigma. *Activitas Nervosa Superior Rediviva*, 59(1), 16–22.
- Oud, M., Arntz, A., Hermens, M. L., Verhoef, R., & Kendall, T. (2018). Specialized psychotherapies for adults with borderline personality disorder: A systematic review and meta-analysis. *The Australian and New Zealand Journal of Psychiatry*, 52(10), 949–961. <https://doi.org/10.1177/0004867418791257>
- Papathanasiou, C., & Stylianidis, S. (2022). Experiences of futility among nurses providing care to patients with borderline personality disorder in the Greek mental health system. *Journal of Psychosocial Nursing and Mental Health Services*, 60(6), 33–42.
- Sagar-Ouriaghli, I., Godfrey, E., Bridge, L., Meade, L., & Brown, J. S. (2019). Improving mental health service utilization among men: A systematic review and synthesis of behavior change techniques within interventions targeting help-seeking. *American Journal of Men's Health*, 13(3), 1557988319857009.
- Sher, L., Rutter, S. B., New, A. S., Siever, L. J., & Hazlett, E. A. (2019). Gender differences and similarities in aggression, suicidal behaviour, and psychiatric comorbidity in borderline personality disorder. *Acta Psychiatrica Scandinavica*, 139(2), 145–153.
- Stapleton, A., & Wright, N. (2019). The experiences of people with borderline personality disorder admitted to acute psychiatric inpatient wards: A meta-synthesis. *Journal of Mental Health*, 28(4), 443–457.

- Undrill, G. (2007). The risks of risk assessment. *Advances in Psychiatric Treatment*, 13(4), 291–297.
- Warrender, D. (2015). Staff nurse perceptions of the impact of mentalization-based therapy skills training when working with borderline personality disorder in acute mental health: A qualitative study. *Journal of Psychiatric and Mental Health Nursing*, 22(8), 623–633.
- Westling, S., Daukantaite, D., Liljedahl, S. I., Oh, Y., Westrin, Å., Flyckt, L., & Helleman, M. (2019). Effect of brief admission to hospital by self-referral for individuals who self-harm and are at risk of suicide: A randomized clinical trial. *JAMA Network Open*, 2(6), e195463. <https://doi.org/10.1001/jamanetworkopen.2019.5463>
- Wetterborg, D., Långström, N., Andersson, G., & Enebrink, P. (2015). Borderline personality disorder: Prevalence and psychiatric comorbidity among male offenders on probation in Sweden. *Comprehensive Psychiatry*, 62, 63–70.
- Willig, C. (2016). Constructivism and 'the real world': Can they co-exist? *QMIP Bulletin*, 21. <https://core.ac.uk/download/pdf/42629916.pdf>
- Yousaf, O., Popat, A., & Hunter, M. S. (2015). An investigation of masculinity attitudes, gender, and attitudes toward psychological help-seeking. *Psychology of Men & Masculinity*, 16(2), 234–237.

## SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

**How to cite this article:** Davies, M., Pipkin, A., & Lega, C. (2024). Inpatient staff experiences of providing treatment for males with a diagnosis of borderline personality disorder: A thematic analysis. *Journal of Psychiatric and Mental Health Nursing*, 00, 1–12. <https://doi.org/10.1111/jpm.13032>