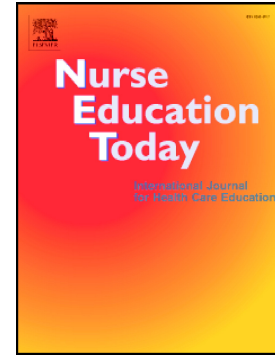# Accepted Manuscript

Student health professionals' attitudes and experience after watching "Ida's diary", a first-person account of living with borderline personality disorder: Mixed methods study

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STUDENT HEALTH PROFESSIONALS' ATTITUDES AND EXPERIENCE AFTER WATCHING 'IDA'S DIARY', A FIRST-PERSON ACCOUNT OF LIVING WITH BORDERLINE PERSONALITY DISORDER: MIXED METHODS STUDY

Running Head: Borderline Personality Disorder education

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ABSTRACT

BACKGROUND: There is increasing interest in the use of commercial movies in nursing education, or 'cinenurducation'. There is a need for educational interventions which target mental health nurses' attitudes towards people with borderline personality disorder.

OBJECTIVES: To investigate and evaluate the experience and effects of attendance at a screening of the movie *Ida's Diary*, a first-person account of living with borderline personality disorder.

DESIGN: Mixed methods design comprising a within-subjects AB longitudinal survey, and a qualitative analysis of participant-generated data and researcher field notes from a World Café discussion group.

SETTINGS: One university in Scotland.

PARTICIPANTS: *N*=66 undergraduate and postgraduate mental health nursing and counselling students.

METHODS: Participants completed measures of cognitive and emotional attitudes towards, and knowledge about, people with borderline personality disorder before and after one of two film screenings. We conducted a World Café discussion group after the second screening. Resulting data were subject to a qualitative thematic analysis.

RESULTS: Quantitative analysis revealed a five-factor cognitive and a single-factor emotional attitude structure. Cognitive-attitudinal items related to *treatment deservingness* and *value of mixed treatment approaches* improved across iterations. Total knowledge score did not change, but one item about borderline personality disorder as a precursor to schizophrenia received considerably more incorrect endorsement post-screening. Qualitative analysis revealed five themes: *Facilitation and inhibition of learning*; *promotion but not*

satiation of appetite for knowledge; challenging existing understanding; prompting creativity and anxiety; and *initiating thinking about the bigger picture.*

CONCLUSIONS: Participants found the film thought provoking; it increased their appetite for knowledge. Findings suggest that screening should be delivered in conjunction with more didactic information about borderline personality disorder.

KEYWORDS: Borderline personality disorder, emotionally unstable personality disorder, nursing, attitudes, education, film, mixed methods, cinenurducation

BACKGROUND

There is a growing interest in and use of techniques and materials from the creative arts in nursing education. Diverse methods have been used for pre-registration nurses and other health students including reading and discussion of written celebrity autobiography (Mathibe 2006), creative design (Emmanuel et al. 2010), song composition, poetry writing, and drawing (Chan 2014). One of the more widely used educational methods is film-screening, sometimes clips but more commonly whole commercial movies; this has even attracted the portmanteau label 'cinenurducation' (Oh et al. 2012). However, there is a lack of studies demonstrating the usefulness and utility of movie screening; identified issues include too many 'loosely designed' studies, the vast range of movies that could be shown, and the vast range of potential educational targets and outcomes (Diaz et al. 2015). Nevertheless, movie screening in nursing education has been promoted because it is student-centred, experiential, and facilitates reflection and problem-solving learning (Oh et al. 2012). In this context, we aimed to identify a commercial movie that could be used in the education of mental health students in relation to the experiences, care, and management of, people with a diagnosis of borderline personality disorder.

Borderline personality disorder

Diagnostic criteria for borderline personality disorder include pervasive and persistent instability of affective regulation, self-image, impulse control, behaviour and interpersonal relationships (Lieb et al. 2004). The condition is associated with substantial psychiatric and physical morbidity (Grant et al. 2008); lifetime incidence in adults is 6%. Management is resource-intensive; there is a very high rate of self-harm associated with disproportionate service (Elisei et al. 2012; Hayashi et al. 2010, Comtois & Carmel 2014), while impulsive aggression is common (Látalová & Praško 2010).

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People with borderline personality disorder are unpopular among mental health practitioners (Cleary et al. 2002), and some respond to them in disconfirming (Fraser & Gallop 1993), stigmatising (Aviram et al. 2006), and other negative ways (Markham & Trower 2003). Nurses hold the poorest attitudes relative to other disciplines and to patients with other diagnoses (Dickens et al., 2016) bringing them into potential conflict with their professional requirements (Nursing and Midwifery Council 2015). It is important that mental health professionals receive effective related education during their pre-registration preparation and beyond. While various approaches been trialled, there is limited evidence about which interventions are effective and none thus far has offered a service user/ expert-by-experience perspective on living with the diagnosis (Dickens et al. 2016).

Aim of the present study

We aimed to investigate the experiences and responses of student mental health nurses and counsellors to an educational intervention comprising a screening of the Norwegian language feature film Ida's Diary (Hanssen & Aanonsen 2014) which presents a first-person account of one young woman's experience of living with borderline personality disorder.

METHODS

Design

We used mixed methods comprising an AB repeated measures design, and thematic analysis of qualitative data from a World Café-style discussion group (Steier et al. 2014).

Setting and Participants

We conducted the study between April and August 2016 at a single university in Scotland. Eligible participants were students on pre- and post-registration nursing and

counselling courses. Two film screenings were conducted; those attending the second (*n=*22) were invited to participate in a World Cafe-style event following.

Materials and Measures

Ida's Diary

Ida's Diary (Hanssen & Aanonsen 2014; English language subtitles, 63 minutes) is a 2015 Norwegian language film, written and directed by August B. Hanssen and starring Ida Storm. The Internet Movie Database (n.d.) synopsis states: "Ida is a young Norwegian woman, struggling with a very turbulent emotional life caused by emotionally unstable personality disorder (borderline). For the last eight years, Ida has kept a video diary in order to ease her mind and structure her thoughts... we get a unique insight into a world of fear and anxiety, but also precious moments of everyday victories and self-discovery. Most importantly, we get to witness her powerful struggle towards self-acceptance and a genuine appreciation of life". Evidence suggests that nursing students prefer to watch a whole movie rather than selected clips (Oh & Steefel, 2015).

Borderline Personality Disorder Questionnaire (Cleary et al., 2002)

This questionnaire was designed to evaluate knowledge related to clinical features and treatment of borderline personality disorder. Respondents are invited to agree or disagree with seven fact-based knowledge statements (see Table 1). Further items address current practice, perceived self-confidence, staff resources, and development needs related to working with individuals with the diagnosis.

>>Insert Table 1 about here<<

Borderline Personality Disorder-Cognitive and Emotional Attitudes Inventories (Bodner et al., 2011, 2015)

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Primary outcome measure selection reflected that our intervention targeted cognitive and emotional attitudinal attitudes. They were previously used in Israel (Bodner et al. 2011, 2015) and, on examination, we agreed that some items did not make sense in a UK-service context and amended the language accordingly. In order to test construct validity of the amended tool we combined completed questionnaires from this sample ($n=66$) with those of mental health clinicians and students who completed the tool in a related study ($n=55$) (see Table 2).

>>Insert Table 2 about here<<.

World Café

The World Café method provides a flexible format for hosting discussions in large groups. Guidelines (Brown & Isaacs 2005) suggest that tables be set up and sub-groups rotate between them every twenty minutes. Each table is hosted by an educator and focuses on one or more relevant, pre-determined questions. Two questions per table (see Box 1) were written on an A1 flipchart and participants were provided with pens and post-it notes to record their group discussions and any non-verbalised thoughts they wished to share in a process called graphic recording (Sibbet, 2010). Data collection is iterative in that each group sees and builds upon the responses of previous groups as they rotate around the tables. As a result, the data corpus comprises a collection of ideas from multiple voices. We also made field notes during the event.

>>Insert Box 1 about here<<

Procedure

Ethical approval was granted by Abertay University Research Ethics Committee. Participants were given with full, written information about the study and provided written consent. The film-screening occurred in the purpose-built cinema in the University's Arts

building. There is good evidence that nursing students prefer watching films as a group rather than individually (Oh & Steefel 2015). Outcome measures were administered pre- and post-screening.

Data Analysis

Quantitative. Data were inspected for normality of distribution; as a result, non-parametric Wilcoxon signed ranks tests were used to detect changes in the primary outcome measures. Data from cognitive and emotional attitude questionnaires were subject to principal components analyses. Scree plots from initial solutions were examined to determine the appropriate number of components to extract subsequently. Analysis of component items including item-item correlation, and identification of non-loading and cross-loading items informed item-reduction. Orthogonal rotation (varimax) was applied where factor correlation was significant. Internal consistency (Cronbach's alpha) of resulting factors were calculated and judged against criteria suggested by Nunnally and Bernstein (1994), i.e., >0.9 Excellent; >0.8 Excellent; >0.7 Acceptable; >0.6 Questionable. Factor and total scores were compared between Time 1 (T1) and Time 2 (T2) iterations; knowledge questionnaire items across iterations were subject to chi-square analyses and the total score to the Wilcoxon signed ranks test. Data analysis was conducted in SPSS v 23.0 (IBM, Chicago: IL).

Qualitative. Field notes were added to graphic recordings. We followed the steps of thematic analysis (Braun and Clarke, 2006). First, we familiarised ourselves with the data by meeting as a team and laying out all the graphical and field note data. We generated initial codes manually within and across questions; analysis was more data- than theory-driven. In this phase we worked together, physically moving around the data under each question to produce a visual representation from which to derive initial codes. Author 3 led further analysis, identifying patterns from the codes produced under each question and defining themes across the data corpus as a whole. Themes were further refined by the team until a

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cohesive interpretation was available, and naming and definition took place to capture the story told within the data (Braun & Clarke, 2006). The final phase involved producing the analysis for the final report over a number of iterations.

RESULTS

N=66 students attended a movie screening. All completed the questionnaire battery before and after. The sample comprised *n*=7 registered mental health nurses, *n*=40 pre-registration mental health nursing students, and *n*=19 undergraduate counselling students; *n*=55 females, *n*=11 males; age categories were <31 years *n*=39, 31-40 *n*=14, 41-50 *n*=8, 51+ *n*=5; self-rated experience of working with people with borderline personality disorder: 'none' *n*=11, 'some' *n*=41, 'moderate' *n*=12, 'extensive' *n*=2); Students were primarily in their second year of education (*n*=53, 80.3%). Sixty four (97.0%) reported working with people with borderline personality disorder to be 'somewhat', 'moderately' 'very', or 'extremely' difficult; 33 (50.0%) found this group 'more difficult to work with than others'.

Knowledge

Baseline *M*(*SD*) knowledge questionnaire score was 5.4 (1.2); *n*=12 (18.2%) correctly answered all seven questions; *n*=60 (90.9%) answered half or more ($\geq$4) correctly. Total knowledge score ranged from 2 to 7 on both iterations (T1 *Mdn*= 5; T2 *Mdn* = 6) (see Table 1). There was no statistically significant difference in knowledge total score across iterations (*Z*=-.20, *P*=.85). Item 7 ('Borderline personality disorder can progress to schizophrenia') was answered incorrectly ('Agree') by significantly more respondents at T2 (see Table 1).

Cognitive and emotional attitudes

Principal components analysis of cognitive-attitudinal items revealed a 5-factor, 33-item structure (see Table 2). Cronbach's alpha ranged from .64 (questionable) to .99 (Excellent) via .76 (good) and .81 (Very good) and the model explained 58.3% of variance

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(see Table 2). Item groupings suggested latent variables related to i) the legitimacy of treatment in an inpatient mental health setting; ii) the value of using a range of mixed approaches; iii) the extent to which patients are perceived to deserve treatment (expressed as a negative); iv) perception of suicidal behaviour; and v) the extent to which people are perceived as being manipulative. Analysis of the emotional inventory items resulted in a 12-item single factor solution (Cronbach's alpha = .94) which explained 72.2% of variance (see Table 3).

>>Insert Table 3 about here<<.

Cognitive and emotional attitude change

Statistically significant positive changes occurred T1-T2 (see Table 4) for the cognitive latent variables 'value of mixed approaches' (i.e., use of mixed approaches seen as more valuable), and 'deserving of treatment' (i.e., people with a diagnosis of borderline viewed as more worthy of treatment).

>>Insert Table 4 about here<<

Qualitative analysis

Thematic analysis generated five themes, each encompassing intellectual *and* emotional responses. The former indicated development of knowledge, while the latter spoke to individual attitudes and personal reactions. There was between-theme overlap, but each was agreed to depict a discrete area within post-screening discussion.

Learning: the technical aspects of the film can facilitate or inhibit learning.
Participants experienced the film's structure as facilitating understanding of the content. Some participants demonstrated considerable insight in connecting the presentation of the film to their own emotional responses. This theme encompassed discussion of editing, use of symbolism, the impact of subtitles, and the narrative style. The most developed point of

discussion was the editing which was described as *'erratic', 'chaotic', 'disjointed',* and *'confusing'*. However, this was perceived as promoting identification with Ida.

> '*it felt really raw, like it didn't make sense. But I think that was to make the audience feel what she was feeling*'

Participants said the film's editing evoked an empathic response, allowing them to '*be caught in the moment, experiencing her symptoms with her*'. However, some participants experienced distress: scenes such as Ida alone in dark woods were described as having been edited to '*create a sense of danger'*, and expressed anxiety as they did not want Ida to self-harm.

> *'It was a relief to see her move away from this and become more hopeful'*

The use of symbolism throughout the film was appreciated for its power to communicate messages of positive change for Ida.

> *'I liked how the tunnel showed light at the end indicating hope for recovery'*

> *'The mountain at the end, and all the water, it was a journey going somewhere better'*

Participants found the English language subtitles to be influential or distracting. For some, subtitles provided a safe distance between themselves and the film, providing an experience of the extent to which Ida's experiences were alienating. Others however found that subtitles simply blocked engagement with Ida's story: their preference was for an English language version of the film.

The narrative style of *Ida's Diary* – how the story is presented and told - is solely from a first-person perspective. Ida's is the only voice in the film, and the narrative is sculpted to exclude others. This was an issue for the participants, who expressed a desire to see other people in the film; three reasons for this emerged. First, participants wanted to see

what relationships looked like for Ida, how the condition manifested socially. Second, they wanted - particularly when Ida was in psychiatric care - to experience the stories of others' with a diagnosis of borderline personality disorder. Third, Ida's trustworthiness as a narrator became a focus of debate and there was a desire from participants to hear from Ida's family and her psychiatrist almost to corroborate her story.

Overall, this theme indicated that participants experienced the film as insightful, absorbing, and, to varying extents, intense; for some overwhelmingly so. The way the story was told appeared to challenge participants' preconceptions.

Promoting: the film promotes interest in the causes and diagnosis of borderline personality disorder, but does not wholly satisfy that interest. Participants expressed that the film had raised their interest in the aetiology of, and the meaning and function, of the diagnosis, though also felt that it left them with unanswered questions. Participants wanted information about what might trigger borderline personality disorder, and what early signs and symptoms might be. While the film hints at the role of Ida's own early experiences as a cause of her diagnosis, it does not do so in extensive detail.

Within groups, the diagnosis was debated at length, commonly when prompted by discussion of a particular scene when Ida received a diagnosis of schizophrenia some time before that of borderline personality disorder. *'If [it's] so difficult to diagnose, is it real?'* was a question asked, which led to a proposal that borderline is a '*fashionable diagnosis*' given to those who do not fit neatly in another diagnostic category, or bestowed when the doctor does not know what to do. One participant suggested that borderline did "*not exist prior to the diagnostic term being coined*".

Some participants felt that labelling was irrelevant, and that *Ida's Diary* was simply a film about distress, trauma, and learning to cope. It was noted, however, that Ida's recovery

occurred post- diagnosis, and that potentially it had helped her to make sense of her experiences. Overall, discussions in this theme converged on a view that borderline personality disorder is an individual experience and no easy generalisations can be made.

Challenging: the film promoted and challenged participants' understanding of Ida's behavioural, cognitive, and emotional life. Despite participants' identification that their information needs about diagnostic criteria were not fully met by the film, there was evidence that they had picked up on features including rapid mood changes, risk taking behaviours, and substance misuse. The film's intimations that hallucinations or other psychotic features were part of Ida's experience were less recognised as part of participants' existing knowledge, and some expressed surprise at this (e.g., *'There is so much more going on in someone's head than we see'*). Similarly, Ida's demonstration of clear insight into her own distress surprised some. Interest was expressed in learning more about the longitudinal course of the disorder. There was an understanding that Ida's maladaptive coping strategies made sense in terms of her quest for survival.

Participants observed that the film suggested those with borderline personality disorder could be '*living in fear, looking for a safe space*'; be '*haunted by something*' and '*feel weird - different from everyone else*'. Ida's experiences were likened to '*taking drugs*' or '*being on LSD*'. Shock was expressed at the extent of Ida's self-harm; this prompted group explorations of potential behavioural and motivational differences between self-harm and suicide. Most of all, the film was experienced as making aspects of Ida's internal life real for the participants.

> *'Someone called her sweetie pie and it was like a record got stuck in her head – I didn't realise how stuck they*[sic] *got'*

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> *'...it felt more like someone experiencing mental health problems than BPD is considered'*

While the film was experienced by many as a real and genuine portrayal, some struggled to accept Ida's reality. Her experiences of highs and lows were viewed as cycling '*too quickly'*. It appeared challenging for people to picture how they could be an effective carer '*with someone at that pace because everything can shift so quickly*'. Additionally, Ida's behaviour was sometimes dismissed as over-pathologised.

> *'Some of the behaviour seems normal in a young person. The film was about growing up'*

Creativity and anxiety: the film prompted discussions about 'thinking outside the box' in terms of how best to support individuals with their recovery journey. Participants discussed issues around the best potential treatments and approaches for supporting patients with BPD, and about what recovery looks like for this group. Psychological approaches were favoured including cognitive-behavioural and solution focused therapy. Reasons influencing their selection included the new coping mechanisms such approaches might offer, and their potential to promote individual empowerment and self-esteem. Participants felt the inpatient care shown in the film had not helped Ida, but that *'she might have been worse off without it'* as there was no '*safe space for a crisis'*. The role of medication was discussed. It was noted that when Ida was heavily medicated she appeared unhealthy, and it did not necessarily improve her symptoms or mood.

> *'...there is no set method of treatment for BPD – people are to an extent guinea pigs in their own treatment'*

There was support for a proposal to '*think outside the box'* and for care planning to be service user-led. Flexibility in the development and delivery of care was seen as essential.

Such individualised care was supported by participants realisations of Ida's own insight and motivation to improve. Reflecting the previous theme, some participants had their expectations confounded:

> *'She [Ida] really took on the support offered – I expected her not to want help'*

> *'I thought it was quite resourceful of her; She had a lot of moments like that when she reacted and had insight; I thought it was really good she was able to do that; Like she was going to the water because she loved water'*

Participants' discussions around recovery addressed what recovery might look like, and whether it was possible for people with this condition. Participants acknowledged that, when it came to recovery in BPD, perhaps it '*doesn't look like the wellness we expect'*. The film raised concerns among some participants for their future relationships with service users: one participant '*felt anxiety at the prospect of a BPD client being co-dependent [on them]... I actually felt less able to empathise – in the sense of a shared feeling – I can't imagine experiencing all those feelings at once'*

The bigger picture: stigma, prejudice, and service access. This theme captured discussion of wider socio-political issues for those with a diagnosis. Stigma was recognised as a major barrier, and it was felt by some that, in inpatient services, patients were pre-judged from their notes before admission and were met with immediate exasperation. This led to a struggle for patients to be understood, and an inability to express themselves in the way Ida had been able to. The attitude on inpatient wards was reported to be that such patients were '*unreasonable and could not learn from experience'* or were '*essentially untreatable'*. These problems resulted from '*not enough understanding of what BPD is'* both in staff, and in the general public. Resource shortage post-diagnosis was identified as an issue and it was

concluded that the issue was '*not treated like a real mental health condition*' by many services.

Finally, there was a reported inability from participants to confront or address these poor attitudes in others. As students, this would mean challenging more senior or experienced staff, which was experienced as an intimidating prospect. One participant was left confused for example by the disparity between what her colleagues on placement had taught her, and what *Ida's Diary* had communicated.

> *'...Got nothing from the film. I wanted to learn more about BPD, but the film made no difference or maybe made it worse. It was not like I heard nurses talk about on placement'*

While Ida had shared her experience, the participant was unable to assimilate this information in line with the ideas from experienced staff, and therefore chose to dismiss it.

DISCUSSION

We evaluated and explored the experiences of a group of healthcare students and practitioners of a screening of the feature film Ida's Diary. Quantitative data analysis revealed relatively minor change in outcomes related to knowledge and attitudes in the pre- to post-screening period. Overall knowledge did not alter, and only one knowledge questionnaire item did so significantly. Interestingly, the item suggested an increase post-screening of the incorrect assertion that 'borderline personality disorder can progress to schizophrenia'. The World Café style discussion groups did not allow us to actively pursue this specifically as a discussion point since questionnaire data was unavailable at that point. However, information gleaned from our records suggested that participants were strongly influenced by the portrayal of Ida's psychotic episodes in the film; we therefore speculate that this may have led people to conclude that there might be a developmental link between borderline and

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schizophrenia. Knowledge total scores were comparable to, or improved upon, those reported in previous studies (Dickens et al. 2016); however, the post-screening proportion of correct responses for the 'borderline as precursor to schizophrenia' item fell from exceeding that in any other study to undercutting all of them. This suggests that to maximise benefit it may be useful to deliver the film screening with additional education about the development and diagnosis of borderline personality disorder. This is consistent with themes emerging from our qualitative analysis where respondents identified the film had whetted their appetites for knowledge.

In terms of measurable attitudes, we found significant changes indicating improvement related to statements that suggested the value of mixed approaches to management and those related to the 'treatment deservingness' of this group. This was encouraging; however, no other significant differences were revealed including on the scale items related to emotional response. Factor scores are not directly comparable to those reported in previous research since our principal components analysis revealed a different structure to that reported by Bodner et al. (2015).

World Café

Collection and analysis of qualitative data from a post-screening World Café event shed light on participants' experience of the film, allowing us to speculate from an informed position about which aspects of the film supported – or did not support - participants' learning. We suggest that the editing and production of the film invited emotional engagement on the part of participants, and made Ida's experience accessible to them. This emotional engagement continued after the film for many participants, easing their ability to explore borderline personality disorder in an empathic way. The diagnosis appeared to be perceived as more genuine in the context of the film; for example, concepts such as rapid mood shifts were illustrated in an identifiable way. Debate around the role of diagnosis was

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encouraging as it indicated a philosophical interest from students in considering the fundamental discourse of mental health and psychiatric care.

Participants' dissatisfaction with Ida as the sole narrator highlighted the desire for additional voices, possibly reflecting the value that trainee practitioners place on individual, expert-by-experience narratives and on professional expertise-by-preparation perspectives. Further understanding of the ideal balance of these viewpoints in education could be important in ensuring that trainee mental health professionals are left feeling confident to advance their personal and professional development through consideration of new approaches. In the case of the participant who found the film confusing in how it contradicted her placement learning, it would be useful to consider why lived experience might be easily dismissed, and how the patient experience can be communicated more successfully.

While the film promoted emotional engagement, factual learning was more limited. There is a lack of concrete, reliable information communicated, and there are potentially confusing moments such as Ida's misdiagnosis of schizophrenia. Points identified by participants for further clarification related to borderline aetiology, the role of diagnosis, and what to expect in recovery. The film also proved too intense for some in terms of the feelings shared, and appeared related to at least one participant experiencing what could be described as an empathy block: an anticipated inability to empathise effectively or 'knowing how to be' in the therapeutic relationship (Fulton, 2005). While understanding of symptomatology appeared improved by the film, some aspects remained inaccessible to participants as their own experience of reality was so different. This could indicate areas for focused training, skilfully titrated to avoid overwhelming learners. Participants felt encouraged by the film to appreciate the possibility for change in people with borderline personality disorder, particularly in their ability to be motivated and insightful. While this displayed encouraging openness to identifying individual paths for recovery, there was a concurrent confidence gap

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related to the perceived inability to maintain appropriate boundaries and empathise with extreme and rapidly changing emotions. Overall, there appeared to be a clear impact from screening *Ida's Diary*, and an appetite for further learning through lived experiences of others. This is in line with current evidence from the use of 'cinenurducation' more generally (Diaz et al., 2015; Oh & Steefel, 2015; Oh et al., 2012).

Limitations

No further longitudinal data collection was conducted which means we cannot tell whether the film viewing had any longer lasting effects. While we selected attitiudinal outcomes measures with previous evidence of validity, their factor structure was not replicated in our sample and thus we report on different combinations of items than those previously reported (Bodner et al., 2015). We included counselling students and registered mental health nurses (in the university for postgraduate study) in the study, meaning it is not a truly homogeneous group of mental health nursing students. On balance we thought it worthwhile to do this as it potentially added to the diversity and richness of perspectives that were aired in World Café discussions.

Conclusions

Ida's Diary provides an authentic voice of expertise-by-experience and can be incorporated into education about individuals who are diagnosed with borderline personality disorder, their experience, care, and management. Given the Norwegian service setting of the film, educationalists located in other nations should consider presenting additional information about the contextual differences in their own country. Further, our data suggested that participants wanted - and in context of erroneous reports of schizophrenia as a consequence of borderline personality disorder, required - additional fact-based information to complement Ida's narrative.

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Table 1: Baseline and post-fil viewing BPD-related knowledge of participants

Knowledge-related item ('Correct'/ 'Incorrect' response)	T1 Correct response *n* (%)	T2 Correct response *n* (%)	Statistical test
Diagnosis of Borderline Personality Disorder is characterized by unstable mood with rapid shifts (Correct)	46 (69.7)	56 (84.8)	χ^2=3.49, *P*=.06
Diagnosis of BPD is characterized by a grandiose sense of self-importance (Incorrect)	41 (62.1)	45 (68.2)	χ^2=0.30, *P*=.58
Diagnosis of BPD is characterized by impulsive, particularly self-destructive, behaviour (Correct)	56 (84.8)	61 (92.4)	χ^2=1.20, *P*=.27
Patients with a BPD diagnosis should not be hospitalized (Incorrect)	42 (63.6)	51 (77.2)	χ^2=2.33, *P*=.13
Short term psychotherapy can be useful in managing crisis in patients with BPD (Correct)	59 (89.4)	55 (83.3)	χ^2=0.58, *P*=.45
Antidepressant medication is of no benefit in treating depression in people with BPD (Incorrect)	54 (81.8)	52 (78.8)	χ^2=0.05, *P*=.83
BPD can progress to schizophrenia (Incorrect)	51 (77.3)	30 (45.5)	χ^2=12.78, *P*<.001

Table 2: Cognitive attitudes principal components analysis

	Inpatient treatment legitimacy	Value of mixed approaches	Deserving of treatment	Suicidal behaviour	Perceived manipulation
For a person with BPD, the purpose of hospitalization is to improve their insight	.99				
People with BPD express repeated suicidal threats, but their suicide is only ever by accident (-)	.99				
For a person with BPD, the purpose of hospitalization is to alleviate their symptoms	.99				
It is a legitimate reason to hospitalize a person with BPD for the purpose of rehabilitation	.99				
Admitting a person with BPD to a mental health ward may cause them harm and cause their condition to worsen (-)	.98				
Inpatient treatment for people with BPD should be based on a mix of medication, supportive behavioural, and dynamic sessions		.80			
People with BPD will benefit from rehabilitation in a supported living environment like a hostel		.70			
It is a legitimate reason to hospitalize a person with BPD because they are making suicidal threats		.65			
Psychotic manifestations among BPD patients are very common		.61			
Psychiatric day care is a suitable setting for treatment of BPD-diagnosed individuals		.60			
It is a legitimate reason to hospitalize a person with BPD in order to provide emotional support		.58			
Hospital treatment for people with BPD should be based on solution-focused therapy sessions		.56			
When a person with BPD has made several suicidal attempts it is better to transfer them to a closed/locked ward. (-)		.54			
When ward staff identify a new patient as an individual with BPD, their reaction will be similar to those for psychotic patients (-)			.73		
The purpose of hospitalizing a person with BPD patient is for rehabilitation (-)			.67		
While in hospital, patients with BPD demonstrate rapid mood changes and suicidal threats as a way to manipulate others			.67		
Hospital treatment of people with a BPD diagnosis should be based on supportive therapy sessions (-)			.62		
Current mental health services for people with BPD patients are already adequate			.57		
Death by suicide in BPD patients is inevitable			.56		
A suitable setting for BPD patients is an open psychiatric ward (-)			.56		
When a person with BPD makes several suicidal attempts, psychiatric observation should start and home leave stopped			.56		
When a BPD patient makes several suicidal attempts they should not be discharged from the hospital			.54		
It is a legitimate reason to hospitalize a person with BPD to improve their impulse control.				.72	
When a hospital patient with BPD has made several recent suicide attempts they should not be discharged				.71	
Suicide attempts by BPD patients are a way in which they communicate with their therapist				.67	
The objective of a hospital admission for a person with BPD is to prevent suicide				.65	
The mental health services that people with BPD receive are limited due to staff's lack of knowledge				.59	
In hospital, people with BPD have rapid mood changes and make suicidal threats because they react to events in their surroundings				.57	
When a person with BPD expresses fear, has auditory hallucinations, and suicidal threats, it is because it helps them get their own way					.80
Hospital treatment of people with BPD should primarily be based on medication.					.68
On being told that a new patient being admitted to the ward is diagnosed with BPD, the staff will be extremely supportive to them (-)					.62
People diagnosed with BPD express repeated suicidal threats, but the risk of suicide is minimal.					.62
Psychotic symptoms in BPD patients are in fact malingering in an attempt to lengthen admission.					.62

(-) Reverse scored

Table 3: Emotional attitudes principal components analysis (N=121 including n=28 in this study plus n=93 nursing and counselling students)

Item	Loading
Treating a BPD patient is one of the most difficult treatments	.94
I easily lose my temper when a BPD patients tells me about his/her problems	.89
I do not like to treat BPD patients because they always tell me how miserable they are	.89
I would like to relieve the suffering of BPD patients (-)	.87
When I treat a BPD patient, I easily get furious	.86
I become impatient when a BPD patient is referred to me	.86
Treatment sessions with BPD patients make me easily angry	.85
When a BPD patient tries to harm himself/herself, I feel that the patient violates the therapeutic contract	.80
I feel angry when a BPD patient threatens to commit suicide	.78
I feel empathy toward BPD patients (-)	.78
I'm embarrassed when I notice that a BPD patient becomes attached to me	.71
I rarely pity BPD patients	.69

Table 4: Mean factor scores on cognitive and emotional attitiudes pre- and post- film screening

	Mean (SD) T1	Mean (SD) T2	Wilcoxon Test*
Inpatient treatment legitimacy	14.9 (3.1)	15.6 (3.1)	P=.16
Value of mixed approaches	22.3 (5.3)	28.2 (4.4)	Z=-4.6, P<.001
Deserving of treatment	23.2 (4.6)	28.5 (4.9)	Z=5.8, P<.001
Suicidal behaviour	18.5 (4.6)	18.5 (4.1)	P=.85
Perceived manipulation	17.4 (3.2)	17.9 (4.2)	P=.54
Emotional Factor	29.9 (7.2)	30.2 (7.1)	P=.79

Box 1: World Café event questions

- What did you think about the film?

- What did you learn from the film that you didn't know about borderline personality disorder?

- Did the film help you think about ways to approach care for people with borderline personality disorder?

- Did you have any preconceptions about borderline personality disorder and did this film challenge them?

- Does hearing about a person's individual experience help you understand and empathise, if so please give examples?

- In your experience, are people with borderline personality disorder treated equally to others with different mental health conditions?

- What else would you like to learn about borderline personality disorder?

- What do you find interesting about borderline personality disorder?