

Qualifications, Self-esteem, and Attitude of Health Practitioners toward Personality Disorders in Saudi Arabia



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Abstract:

Background: The attitudes of society and mental health practitioners towards mental illness are subject to multiple dimensions. This may affect the quality of health services and the client's ability to seek treatment. It was hypothesized that there is a relationship between qualification, self-esteem, and attitudes toward personality disorders among mental health practitioners in Saudi Arabia.

Objective: This study aimed to assess how attitudes toward clients' personality disorders relate to work qualifications and self-esteem among health practitioners in Saudi Arabia.

Methods: A correlational, within-subject, cross-sectional study was conducted, including psychologists and psychiatrists (N=171) across the five regions of Saudi Arabia, using a survey research design. The online survey contained a demographic information sheet and two standardized scales of attitudes toward personality disorders and self-esteem.

Results: Descriptive analysis, Pearson's correlation coefficient, and ANOVA were conducted using SPSS. Significant positive correlations were found between the total Attitude to Personality Disorder Questionnaire and self-esteem, APDQ, and qualification scores ($r = .319$ and $.283$, both $p < .001$). There was also a significant positive correlation between self-esteem and qualification scores ($r = .378$, $p < .001$).

Conclusion: The findings of the study may help mental health practitioners understand attitudes toward personality disorders and the role of qualification and self-esteem in prompting a positive attitude. Mental health practitioner training interventions can enhance and support service quality. On-job professional training, additional training on how to treat personality disorders, and proper supervision for clinicians are highly recommended.

Keywords: Mental health, Personality disorder, Attitude, Qualifications, Borderline personality disorder, Supervision, Psychotherapy, Mental health practitioners, Self-esteem.

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1. INTRODUCTION

Personality Disorders (PD) are among the most common disorders. It preoccupies the mental health sector with great controversy between overdiagnosis and underdiagnosis. In addition, the changing classification of

PD in each version of the International Classification of Mental Disorders guidelines makes the diagnosis more complex. According to one often-used classification system for mental disorders (ICD-10), personality disorders are defined as 'extremely ingrained and continuing patterns of

behavior, shown as inflexible responses to a wide range of psychosocial situations; they represent marked deviations from the expectations of the individual in a specific culture. Usually, the onset of PD in childhood or adolescence continues until adulthood [1].

Therefore, it is necessary to understand PD and treatment-related factors. It may sometimes be vague and unclear to non-specialized; however, PD is the subject of interest in the clinical psychology field. According to a meta-analysis conducted in twenty-one countries, including Arab countries, patients with PD constitute 7.9% of society [2]. Studies show a high percentage of health-service consumers, among which, more than 52% are those suffering from PDs as outdoor patients [3]. Unfortunately, studies have shown that people diagnosed with PD are generally dissatisfied with the services provided, particularly during crises [3]. On the other hand, Mental Health Practitioners (MHP) conveyed a lack of support due to failure to meet their professional needs while dealing with clients with PD [4]. Consequently, some essential factors affect therapeutic relationships. Studies have shown that strong therapeutic alliances can predict better outcomes. Conversely, poor therapeutic alliances or ruptures can result in poor therapeutic outcomes [5]. Therefore, an understanding of PD and the challenges faced by clients and specialists is essential for fulfilling MHP goals [3].

According to a study on mental health practitioners, there is a relationship between qualifications such as training, knowledge, specialized educational sessions, and high levels of self-esteem [6]. Potentially, high self-esteem may be followed by higher work outcomes among mental health professionals when they deal with mental health problems [7]. Previous studies have indicated that multiple factors may affect the quality of delivered services for patients with PD. MHP qualifications and self-esteem level are considered essential factors influencing therapy. In addition, the MHP's attitude plays a vital role as a confounding factor that affects therapeutic outcomes.

The first factor in this study is qualification, which affects any job in general, particularly those workers in mental health, the field of, and dealing with PD. It refers to the capability, characteristics, or experience that qualifies a person for a specific activity or job [8]. According to the only published study conducted in Saudi Arabia on the attitude of health workers towards borderline personality disorder, the result indicates that positive attitudes among MHP were associated with receiving specific training, more years of experience, and more significant interaction with clients with personality disorder [9]. In addition, this result is consistent with a study conducted in Australia that mentioned the importance of specialized training. It showed that the more MHPs are exposed to PD cases or clients, the more positive their attitudes toward PD [10]. In contrast, based on a study conducted in Saudi Arabia, General Physicians (GP) and specialists showed a more negative attitude toward clients with anxiety and depression as compared to family medicine practitioners [11]. In this context, it

becomes more alarming when these physicians and specialists are dealing with PDs. A systematic review proved that receiving training and cooperation from highly experienced people is associated with a more positive attitude toward PD [12].

The second factor of this study, self-esteem, is a general self-evaluation that describes the extent of self-satisfaction in various aspects. Self-esteem is associated with success, social affiliation, happiness, and health [13]. One of the two most essential elements of the self-determination theory is that people have an intrinsic tendency towards perfect and complete performance, and optimum or ideal actions are innate motives, but they do not occur automatically [14]. Therefore, self-esteem may be affected by external factors, such as appreciation and encouragement, and thus, behaviours and productivity may improve [15]. High self-esteem may help health practitioners provide better services and feel more satisfied with their accomplishments [7]. Self-esteem, and self-efficacy are related concepts. The current study aimed to explore the relationship between existing factors among MHPs, which is why self-esteem has been targeted compared to self-efficacy. High self-esteem can contribute to a practitioner having happier outcomes regardless of stress [13]. MHPs working with PDs are more exposed to burnout [16]; therefore, high self-esteem can help them overcome such feelings effectively.

MHP who work in motivational, organizational workplaces have higher self-esteem [17]. A study conducted in Greece on more than 180 hospitals found that higher self-esteem was linked to a lower likelihood of burnout and, thus, a greater quality of life among health practitioners [18]. These findings are consistent with a study conducted in India with more than 300 health practitioners found that low self-esteem was associated with burnout and responses to high stress [19].

The third variable of this study is the attitude of the MHP towards clients with PD. "Attitudes" are the evaluation of individuals, groups, thoughts, or beliefs that reflect whether people like or dislike them. MHP attitudes can be affected by other factors such as qualifications, training, and self-esteem levels [12]. Some clients with borderline personality are reported to be neglected and negatively directed by health service providers during their request for help, especially after engaging in risky or self-harming behaviours [20]. Many studies have indicated a relationship between empathy and good therapeutic services [21]. A systematic review showed that MHP's negative attitudes were related to less effective therapy outcomes and decreased feelings of acceptance in clients with mental illness [22].

Attitude refers to evaluating individuals, groups, thoughts, or beliefs, which reflect whether people like or dislike them [23]. Attitudes play a central role in social psychology, as well. Decades of research have demonstrated that attitudes are essential for understanding how individuals behave and perceive the world [19].

The Theory of Reasoned Action (TRA) is a psychological theory that explains the relationship between an individual's beliefs, attitudes, and behavioural intentions. TRA could be used to study the relationship between attitudes and behaviour and explain the MHP attitudes toward PD and their subjective norms about treating PD will influence their intentions to treat PD. MHPs who believe that they should treat PD and have positive attitudes toward PD are more likely to have an intention to treat people with PD [24].

Health practitioners' attitudes may be affected by several factors, such as the qualifications of the health practitioner, years of experience, received training, and number of exposures to the cases, in addition to the MHP's self-esteem. Thus, the outputs of mental health services are affected. Training can also help mental health workers develop the resilience and coping skills necessary to deal with this field's challenges [25].

This research aimed to study and explore the relationship between qualifications and self-esteem and the attitude of mental health practitioners towards personality disorders in Saudi Arabia. This research will help to develop services related to mental health in the Kingdom of Saudi Arabia, especially since only one study has been reported in Saudi Arabia studying the attitudes of health workers toward borderline personality disorder [9]. This is almost compatible with international research, where borderline personality disorder has been studied extensively, but there has not been much focus on PD in general. International studies have indicated that health practitioners have a negative attitude toward PD and that clients are described as dangerous and challenging to deal with [26]. In addition, studies have emphasized the importance of specialized training roles in raising positive attitudes toward PD [26, 27]. This study assessed the relationship between qualification and self-esteem among mental health practitioners in Saudi Arabia. It aimed to measure the attitudes of mental health practitioners towards PD and the relationship between qualifications, self-esteem, and attitudes of mental health practitioners in Saudi Arabia. There is a lack of research on PD in the Arab region, particularly in Saudi Arabia. After reviewing the literature, it was hypothesized that there is a significant relationship between qualification, self-esteem, and attitudes toward personality disorders among mental health practitioners in Saudi Arabia.

2. MATERIALS AND METHODS

2.1. Research Design

A cross-sectional, correlational design was conducted to measure the relationship between qualifications, self-esteem, and attitude among mental health practitioners in Saudi Arabia.

2.2. Participants

The research sample comprises Mental health practitioners, including psychologists and psychiatrists (N=329). The inclusion criteria of this study were psychologists and psychiatrists working with PD.

Participants who did not work with PD patients were excluded. A total of 340 questionnaires were sent to mental health practitioners who, according to the WHO Atlas of Psychologists and Psychiatrists, were expected to work with PD patients in Saudi Arabia. Of this target sample, 171 (52.9%) responded. The first question in the questionnaire was a screening question. "Have you ever worked with patients with personality disorders?" A total of 39 of the participants answered no, so they were excluded from the research because they did not meet the research criteria. Among 171 respondents, 132 (77.2%) met the study criteria and had prior work experience with personality disorder patients, and 39 (22.8%) did not meet the inclusion requirements. The majority of participants were female (70.5%). Some limitations were taken into consideration, such as the lack of available data on MHP who work with personality disorders and language barriers [28].

2.3. Measures

This research used two standardized scales and one demographic information sheet.

2.3.1. Qualifications and Demographic Information

The demographic information sheet consists of 17 items, including general information, work experience with PD, and supervision availability. In the general information section, the survey contained information regarding the age, gender, nationality, job title, specialty category, region of the workplace, work experience in MHP, and the category of the workplace of the participants. In the survey section on work experience with PD, participants were asked about the frequency of exposure to the PD client in a week, any special training for PD, the duration, and when they received this training. In addition, participants were asked to rate the difficulty of dealing with PD and their knowledge and skills while dealing with PD. In the survey section on supervision, the questions about availability and need for supervision were asked. General information such as gender and age were found in previous studies to be important factors for the attitudes of MHPs. In addition, studies have shown that training and supervision play a significant role in attitude [10, 29, 30].

2.3.2. Attitude to Personality Disorder Questionnaire (APDQ)

The APDQ is a scale containing 37 items that evaluate mental health practitioners' attitudes toward dealing clients with personality disorders. The items include positive and negative attitude statements; an example of a positive item is 'I feel warm and caring toward PD patients, and an example of a negative item is 'I feel vulnerable in a PD patient company.' All items with negative statements were scored in reverse. The items were rated on a 6-point Likert scale. The score range was converted from 1-6 to 0-5-to decrease the heterogeneity between the scores. The total APDQ score was calculated by summing up all the item scores. The scale has five factors: enjoyment, security, acceptance, purpose, and

enthusiasm [31]. The general score represents the attitude level toward clients with PD; a high score indicates a more positive attitude toward PD clients. The test-retest reliability ranges were reported from good to excellent (0.72 to 0.85) for subscale scores. The APDQ has shown high validity in general health, job performance, burnout, and executive perception and has made predictions for performance testing, unit comparisons, and periodic audits of employee attitudes [31].

2.3.3. Rosenberg Self-esteem Scale

The scale contains ten items that measure overall self-worth (positive and negative self-statements). The survey questions were answered using a 4-point Likert scale, with options ranging from strongly agree to strongly disagree. The scores were then converted from 1-4 to 0-3 in order to reduce heterogeneity between the scores of the different items. The higher score was considered to be high self-esteem on the measure. The scale has shown good validity, internal consistency, and test-retest reliability. A study showed high results in Cronbach coefficient ($M = 0.81$) consistent with the internal coherence of the scale [32].

2.4. Procedure

A survey form was disseminated after obtaining approval from the institutional review committee. The informed consent was used to explain all participants' volunteer participation, privacy, and confidentiality. Permission was sought for the APDQ scale. Rosenberg scale was publicly available for research use. An online survey was used to collect data, and only researchers had access to the participants' data. The online survey included a consent form, qualifications, demographic information form, the Rosenberg Self-Esteem Scale, and the APDQ. The completion time for the survey was approximately 8 minutes on average. In the analysis phase, all participant information was converted into codes.

2.5. Ethical Considerations

The study proposal was submitted to an institutional review committee at Princess Nourah Bint Abdulrahman University to obtain exemption status (IRB Log Number: 23- 0262). All ethical considerations were implemented. Informed consent was obtained from all participants, and confidentiality and privacy were respected and clearly

explained to the participants. The goals and objectives of the study were thoroughly explained to the participants to ensure their voluntary agreement. For privacy and confidentiality, all participants' data were converted to codes to prevent identity identification.

2.6. Data Analysis

Descriptive statistics were conducted to provide an overview of the given data and help identify the characteristics of the sample on qualifications, self-esteem, and attitude toward PD and to describe the data and draw inferences about the population based on a sample using the central tendency (mean, and standard deviation). After checking the normality of the data, Pearson's correlation and regression analyses were applied to explore and predict the relationship between the variables. Analysis of Variance (ANOVA) was used to compare the differences in demographic and professional characteristics of participants on APDQ and self-esteem scales. Before calculating the ANOVA, the data was checked for normal distribution of scores, independence, homoscedasticity and multicollinearity. Statistical significance was set at $p < 0.05$, using SPSS version 29.0.

3. RESULTS

3.1. Participants Demographic Variables

Descriptive statistics on demographic characteristics were used to provide an overview of the sample.

Internal reliability for APDQ used in the Saudi population was calculated using Cronbach's alpha coefficient. It indicated high reliability for the APDQ ($\alpha = 0.88$) in the Saudi population [33].

The majority of the participants were female (70.5%), Saudi Arabia (97.7%), and specialists (60.8%). The most common age group was 25-30 years (49.2%), followed by 31-40 years (31.8%). Most of the participants were psychologists (64.4%), worked in the middle region of the KSA (68.9%), and in a hospital setting (63.6%). The distribution of years of experience in the mental health field was somewhat balanced, with 15.9% having less than one year, 26.5% having 1 to 3 years, 34.8% having 3.5 to 10 years, and 22.7% having more than 10 years. Three-quarters of the participants (75.0%) received training in dealing with personality disorders, but the length of training varied from <1 month (17.2%) to >1 year (25.3%) (Table 1).

Table 1. Descriptive characteristics of the study participants.

Variables	Categories	N	Percentage
Gender	Female	93	70.5%
	Male	39	29.5%
Age	25-30	65	49.2%
	31-40	42	31.8%
	41-50	18	13.6%
	> 50	7	5.3%
Nationality	Non-Saudi	3	2.3%
	Saudi	129	97.7%

(Table 1) contd....

Variables	Categories	N	Percentage
Job title	Intern	4	3.3%
	Resident	15	12.5%
	Specialist	73	60.8%
	Consultant	28	23.3%
Job specialty	Psychiatrist	35	26.5%
	Psychologist	85	64.4%
	Non-specified	12	9.1%
In which region of KSA are you working?	Western	18	13.6%
	Southern	5	3.8%
	Northern	5	3.8%
	Middle	91	68.9%
	Eastern	13	9.8%
How many years have you worked in the mental health field?	Less than 1 year	21	15.9%
	1-3 years	35	26.5%
	3.5-10 years	46	34.8%
	More than 10 years	30	22.7%
Most frequent workplace	Hospital	84	63.6%
	Private clinic	52	39.4%
	Mental health center	37	28.0%
When was the last training you had in dealing with personality disorders?	None	33	25.0%
	Less than 1 year	36	27.3%
	1-2 years	23	17.4%
	3-5 years	20	15.2%
	More than 5 years	20	15.2%
How long was the training?	Less than 1 month	17	17.2%
	1-3 months	21	21.2%
	4-6 months	16	16.2%
	7-12 months	20	20.2%
	More than 12 months	25	25.3%
How often do you work with a client diagnosed with personality disorders?	Daily	21	15.9%
	A few times a week	49	37.1%
	A few times a month	27	20.5%
	A few times a year	24	18.2%
	Once a year or less	11	8.3%
In general, how difficult it is to deal with clients who have personality disorders?	Very difficult	15	11.4%
	Difficult	81	61.4%
	Average	34	25.8%
	Easy	2	1.5%
Overall, how would you rate your skill in dealing with clients diagnosed with personality disorders?	Insufficient	9	6.8%
	Below average	19	14.4%
	Average	63	47.7%
	Above average	35	26.5%
	Excellent	6	4.5%
How would you rate your knowledge about personality disorders?	Insufficient	4	3.0%
	Below average	8	6.1%
	Average	60	45.5%
	Above average	45	34.1%
	Excellent	15	11.4%
Are professional supervision services offered to you while you work with a personality disorder?	Yes	43	32.6%
	Sometimes	42	31.8%
	No	47	35.6%
Do you feel you need professional supervision while dealing with personality disorders more than others?	Yes	96	72.7%
	No	36	27.3%

More than one-third (37.1%) of the participants had a frequency of working with personality disorder patients a few times a week, with 84.2% expressing difficulty dealing

with them. Participants rated their skill and knowledge in dealing with personality disorders as average (47.7% and 45.5%), above average (26.5% and 34.1%), or excellent

(4.5% and 11.4%), and about two-thirds (72.7%) felt they needed professional supervision when dealing with personality disorders more than when dealing with other disorders (Table 1).

3.2. Correlation and Regression

The data were analyzed using Pearson's correlation to assess the linear relationships between variables. The Shapiro-Wilk test was used to determine whether the data were normally distributed. The data were normally distributed, the variables were linearly related, and the variables were independent. Correlation analysis was used to calculate correlation coefficients among the key variables in the study.

Participants had a mean qualification score of 20.1 (SD = 4.6) out of 33 and a mean self-esteem score of 22.0 (SD = 4.5) out of 30. The mean total APDQ score was 21.3 (SD = 2.9) of 30. The APDQ subscales showed that the participants had the highest mean scores on acceptance (M = 4.9, SD = .7) and security (M = 4.7, SD = .7),

followed by purpose (M = 4.4, SD = .9), and enjoyment (M = 3.4, SD = .9). The lowest mean score was for enthusiasm (M = 3.9, SD = 1.0) (Table 2). There were significant positive correlations between the total APDQ and self-esteem scores ($r = .319, p < .001$), and between the total APDQ and qualification scores ($r = .283, p < .001$). There was also a significant positive correlation between self-esteem and qualification scores ($r = .378, p < .001$) (Table 3).

A stepwise multiple linear regression model with two predictors (self-esteem scale and qualification score) explained 13.2% of the variance in attitudes toward personality disorders ($F(2,132) = 9.8, p < .001$). The two predictors were significant, with the self-esteem scale having the strongest effect ($\beta = .247, p = .006$), followed by the qualification score ($\beta = .189, p = .0034$). The model suggests that higher self-esteem and higher qualification scores are associated with more positive attitudes toward personality disorders (Table 4).

Table 2. Summary of participants scores regarding qualifications, self-esteem, and attitude towards personality disorders.

Variables	Mean	SD	Minimum	Maximum
Qualification score	20.1	4.6	5.0	31.0
Self-esteem scale	22.0	4.5	8.0	30.0
Total APDQ scale	21.3	2.9	13.5	30.0
Enjoyment subscale	3.4	.9	1.0	6.0
Security subscale	4.7	.7	2.4	6.0
Acceptance subscale	4.9	.7	3.2	6.0
Purpose subscale	4.4	.9	1.3	6.0
Enthusiasm subscale	3.9	1.0	1.5	6.0

Table 3. Relationship between participants qualification, self-esteem, and attitude towards personality disorders.

Scales		APDQ Scale	Self-esteem Scale
Self-esteem scale	Pearson Correlation	.319**	-
	<i>p</i> -value	.000	-
Qualification score	Pearson Correlation	.283**	.378**
	<i>p</i> -value	.001	.000

Note: **. Correlation is significant at the 0.01 level (2-tailed).

Table 4. Self-esteem and qualification as predictors of attitude toward personality disorders.

Model	Unstandardized Coefficients		Standardized Coefficients	t	Sig.	
	B	Std. Error	Beta			
1	(Constant)	16.773	1.198	14.000	.000	
	Self-esteem scale	.204	.053	.319	3.832	.000
2	(Constant)	15.396	1.346	11.438	.000	
	Self-esteem scale	.158	.057	.247	2.786	.006
	Qualification score	.119	.056	.189	2.138	.034

Note: a. Dependent Variable: Total APDQ scale.

3.3. Analysis of Variance

Using the Shapiro-Wilk test, the data were found to be normally distributed. One-way ANOVA showed no significant differences in the total APDQ scale and self-esteem scale scores according to nationality, job title, job specialty, and duration of training in dealing with personality disorders. However, there were significant

differences in the total APDQ scale scores according to age group ($p = 0.025$, $F = 3.2$), with the younger age group having the lowest mean score (20.5) (Table 5). There were also significant differences in self-esteem according to age ($p < 0.01$, $F = 8.1$), gender ($p = 0.044$, $t = 2.0$), duration of working in the mental health field ($p = 0.01$, $F = 6.2$), and time of training in dealing with personality disorders ($p < 0.01$, $F = 6.3$) (Table 6).

Table 5. Differences in participants' attitudes toward personality disorders according to demographic and professional characteristics.

Variables		Total APDQ Scale					
		M	SD	SS	MS	F	p
Gender	Female	21.0	2.7	-	-	1.8	0.069
	Male	22.0	3.3				
Age	25-30	20.5	2.8	77.5	25.8	3.2	0.025*
	31-40	21.8	3.2				
	41-50	22.5	2.4				
	> 50	21.7	2.4				
Nationality	Non-Saudi	20.8	4.3	-	-	0.3	0.76
	Saudi	21.3	2.9				
Job title	Intern	19.3	4.5	43.9	14.6	1.66	0.18
	Resident	20.5	2.7				
	Specialist	21.7	3.0				
	Consultant	20.7	2.7				
Job specialty	Psychiatrist	20.5	2.8	29.7	14.9	1.8	0.173
	Psychologist	21.5	3.1				
	Non-specified	21.8	1.8				
How many years have you worked in the mental health field?	Less than 1 year	21.5	3.5	1.4	0.46	0.05	0.984
	1-3 years	21.2	2.7				
	3.5-10 years	21.2	2.5				
	More than 10 years	21.3	3.4				
When was the last training you had in dealing with personality disorders?	None	20.6	3.2	43.0	10.7	1.3	0.281
	Less than 1 year	21.2	3.0				
	1-2 years	21.6	2.6				
	3-5 years	21.0	2.7				
	More than 5 years	22.4	2.7				
How long was the training?	Less than 1 month	21.6	2.7	14.8	3.7	0.46	0.76
	1-3 months	20.8	2.9				
	4-6 months	21.6	3.5				
	7-12 months	22.0	2.5				
	More than 12 months	21.4	2.6				

Note: * $p < 0.05$, M=mean, MS=Mean Square, SD=Standard Deviation, SS=Sum of Squares, p=Significance level.

Table 6. Differences in participants' self-esteem according to demographic and professional characteristics.

Variables		Total Self-esteem Scale					
		M	SD	SS	MS	F	p
Gender	Female	21.5	4.6	-	-	2.0	0.044*
	Male	23.2	4.3				
Age	25-30	20.3	4.5	427.8	142.6	8.1	< 0.01*
	31-40	23.0	3.7				
	41-50	24.7	4.2				
	> 50	25.3	4.2				

(Table 6) contd.....

Variables		Total Self-esteem Scale					
		M	SD	SS	MS	F	p
Nationality	Non-Saudi	24.0	7.9	-	-	-0.77	0.443
	Saudi	22.0	4.5				
Job title	Intern	20.3	5.9	134	44.7	2.2	0.096
	Resident	19.5	4.6				
	Specialist	22.3	4.4				
	Consultant	22.9	4.6				
Job specialty	Psychiatrist	22.0	5.0	2.4	1.2	0.057	0.944
	Psychologist	22.1	4.5				
	Non-specified	21.6	3.8				
How many years have you worked in the mental health field?	Less than 1 year	19.7	4.7	341	113.7	6.2	0.01*
	1-3 years	21.0	5.0				
	3.5-10 years	22.2	3.8				
	More than 10 years	24.5	3.8				
When was the last training you had in dealing with personality disorders?	None	21.1	4.8	446	111.5	6.3	< 0.01*
	Less than 1 year	20.3	4.9				
	1-2 years	23.2	3.6				
	3-5 years	21.5	3.6				
	More than 5 years	25.7	2.9				
How long was the training?	Less than 1 month	21.9	5.2	71.9	18.0	0.9	0.462
	1-3 months	22.0	5.0				
	4-6 months	21.3	4.3				
	7-12 months	22.0	4.2				
	More than 12 months	23.7	3.6				

Note: *p < 0.05, M=mean, MS=Mean Square, SD=Standard Deviation, SS=Sum of Squares, p=Significance level.

4. DISCUSSION

The findings of the study confirm that there is a relationship between qualifications, self-esteem, and attitudes toward personality disorders among mental health professionals, which is consistent with previous studies and literature [6, 10]. In addition, the findings confirm local studies, Aljohani and Alatram, that there is a moderate difficulty level in dealing with PD [9, 10, 34]. The results of this study support the hypothesis that the need for supervision, self-perception of knowledge, and skills influence the attitude of MHP towards PD.

The results showed a significant correlation between self-esteem, qualifications, and Attitudes toward Personality Disorders (APDs) among mental health practitioners. Several significant correlations are observed. A positive correlation between APDQ scores and self-esteem suggests that individuals with higher self-esteem tend to hold more positive attitudes toward APDs [6, 12]. This could be due to their greater self-confidence and belief in managing challenging situations effectively. Moreover, the positive correlation between the APDQ and qualification scores indicates that practitioners with higher qualifications tend to have more favourable views toward APDs [12, 15]. This may be attributed to the increased knowledge and understanding of these disorders gained through additional training and education. Additionally, the positive correlation between self-esteem and qualification scores suggests that individuals with higher qualifications also tend to have higher self-esteem. This could be due to increased confidence in their skills and knowledge and a sense of

accomplishment from achieving educational goals. No significant differences were found based on nationality, job title, job specialty, or duration of training in dealing with personality disorders. The study revealed interesting variations based on job title and age, with interns exhibiting the lowest average APDQ score and specialists the highest. This suggests that specialists might develop more positive attitudes towards APDs through their extended experience and expertise in managing complex disorders. Younger practitioners (25-30 years old) displayed the lowest average self-esteem score, while the oldest group (> 50 years old) reported the highest score. This finding could be attributed to diverse factors such as increased life experience and self-assurance among older individuals.

These findings highlight the importance of considering individual characteristics and professional development in shaping attitudes toward APDs. Addressing self-esteem concerns and providing continuous training, particularly for younger practitioners, could foster positive and supportive environments for individuals with APDs [18]. In general, the results of this study are consistent with previous international studies conducted in several countries with different cultural characteristics, such as Egypt, Turkey, the UK, Australia, and the US. These findings demonstrate the significance of specialist training, knowledge level, self-assurance, and professional supervision in shaping their attitudes toward psychiatric patients, especially those with personality disorders. The results of this study are consistent with the results of a study conducted in Australia that showed that health

practitioners who received specialized training and [30]. Future research is needed to understand how these factors affect attitudes toward PD professional development.

4.1. Theoretical Implications

The TRA can help MHPs understand their attitudes and subjective norms about treating PD and identify areas where they may need to change their attitudes or beliefs. Additionally, interventions should be developed to improve MHPs' attitudes and subjective norms regarding PD treatment. For example, MHPs can be educated about the prevalence and impact of PD. They can also be taught the importance of empathy and understanding when working with PD. Role modeling: MHPs can be exposed to other MHPs with positive attitudes and subjective norms about PD. This can help them see that it is possible to have positive attitudes and to believe that they can make a difference in the lives of PD. MHPs can be provided with support from colleagues and supervisors. This can help them feel more confident about their ability to treat PD. Using the TRA, MHPs can improve their attitudes and subjective norms about treating PD. This can improve treatment outcomes in patients with PD [24].

4.2. Practical Implications

The results of this study have focused on the implications of the training, skills, and knowledge of MHPs in clinical practice, and specific training in PD should be established and implemented for patients with MHP who work with PD. Additionally, training in self-confidence and self-assertiveness is essential for MHP to enhance self-esteem and prevent burnout. This can be achieved through workshops, support groups, and other self-care activities.

Moreover, supervision services and sessions can be essential in improving attitudes toward PD and the quality of service provision. In conclusion, the findings of this study suggest that it is vital to investigate PD through educational workshops, conferences, and awareness campaigns for communities and health workers in general.

A systematic review and meta-analysis indicate that interventions targeting cognitive processes hold promise for long-term self-esteem improvement. Specifically, Cognitive Behavioral Therapy (CBT) and reminiscence-based interventions appear more effective than approaches focusing solely on emotional regulation, social perception, or positivity [35]. Among these, CBT emerges as a potentially powerful approach for promoting lasting positive changes in self-esteem. Therefore, as a practical implication, CBT-based training programs for MHPs will be valuable initiatives to improve their attitudes toward personality disorders.

The absence of data on MHPs working with PDs and the lesser number of MHPs working with PDs were among the most important limitations of this study. It highlighted the need for further research in this area to gain a deeper understanding of their specific experiences, challenges, and needs. The sample included more female participants (70.5%) than males. This gender imbalance could

potentially influence the results, as women may have different experiences or perspectives on mental health compared to men, and this could limit the generalization of the study findings. Additionally, the participants were primarily from Saudi Arabia. This geographical concentration may limit the generalizability of the findings to other regions with potentially different cultural attitudes or access to resources. The most important recommendations for future research are to expand the sample, make it more comprehensive, and include more male MHPs in the sample size, include a more balanced gender distribution of participants to explore further the factors that influence the attitudes of MHPs towards PD. It could be beneficial to consider geographical regions by evaluating the attitude of MHP from different regions and cultural backgrounds.

This study used a self-report survey to assess skills and knowledge ratings regarding PD; therefore, future studies can address it using qualitative measures. It is recommended that other data collection methods be used, such as face-to-face interviews, observations, and focus groups. Quantitative research can help obtain a more comprehensive understanding of the factors influencing attitudes toward PD. Arabic translation and validation studies for the APDQ Scale may help to reach a larger sample of health practitioners in Saudi Arabia and other Arab countries. Moreover, there is a dire need to build data on the official level for MHP working with PD to have better access to this population. For the practical implications, hospital administration can provide regular training programs, especially for treating PDs, that can improve the practitioners' skills. Future research could explore the interplay between self-efficacy and training programs for MHPs in this context, providing a more comprehensive picture of how a practitioner's overall sense of worth and confidence interacts with their specific skills and abilities when dealing with personality disorders [35].

CONCLUSION

The findings of this study have important implications for the mental health field by understanding the factors that influence the attitudes of MHPs towards PD and improving the quality of care for clients with PD. These outcomes suggest that MHPs with high SE, knowledge, and good skills in PD are more likely to have positive attitudes toward PD. It is essential for MHPs to have access to training and continuing education on PD, which will help them develop a better understanding of PD and be more effective in working with clients.

AUTHORS' CONTRIBUTION

It is hereby acknowledged that all authors have accepted responsibility for the manuscript's content and consented to its submission. They have meticulously reviewed all results and unanimously approved the final version of the manuscript.

LIST OF ABBREVIATIONS

PD	=	Personality Disorder
SE	=	Self-Esteem
MHP	=	Mental Health Practitioners
APDQ	=	Attitude to Personality Disorder Questionnaire
SDT	=	Self-determination theory TRA= Theory of Reasoned Action
TRA	=	Theory of Reasoned Action

ETHICS APPROVAL AND CONSENT TO PARTICIPATE

The study involving survey-based data of human participants was reviewed and approved by (Institutional Review Board of Princess Nourah bint Abdulrahman University (IRB registration number with KACST, KSA: HAP-O1-R-059). The study was granted with the letter of exemption status (IRB Log Number: 23-0262).

HUMAN AND ANIMAL RIGHTS

No Animals were used in this research. All human research procedures followed were in accordance with the ethical standards of the committee responsible for human experimentation (institutional and national), and with the Helsinki Declaration of 1975, as revised in 2013.

CONSENT FOR PUBLICATION

The participants were provided with written informed consent to participate in this study.

STANDARDS OF REPORTING

STROBE guidelines were followed.

AVAILABILITY OF DATA AND MATERIALS

The data supporting the findings of the article is available in the (OSF) at (<https://osf.io/a5zg8/>) and can be shared on request to the author.

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CONFLICT OF INTEREST

The authors declare no conflict of interest, financial or otherwise.

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