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Jessica Fritz
“She’s Such a Borderline:”
Exploring the Stigma of
Borderline Personality
Disorder Through the Eyes of
the Clinician

ABSTRACT

This study was undertaken to explore the attitudes and feelings that mental health clinicians have towards Borderline Personality Disorder (BPD), which, as the literature shows, is a highly stigmatized diagnosis within the field. Special attention was paid to the participants’ treatment experiences with this client population, including initial reactions, issues of countertransference, treatment approaches, prognosis, and clinician disclosure. The study was designed to explore the reasons or meanings behind the negative stereotypes that often accompany discussions around BPD.

Previous research has not utilized a qualitative approach with therapists. Instead, the existing literature has focused on evidence-based treatments for BPD and measuring the existence of the stigma. Furthermore, the majority of current studies around “BPD stigma” have been quantitative and executed primarily with the nursing population, leaving out in-depth narratives from clinicians.

Eleven therapists were interviewed on their perspectives of working with clients with BPD. Questions were open-ended to give respondents room to speak freely. Findings revealed all participants expressing the unique complexities associated with clients who have BPD and the challenges in treating them. Data analysis showed that negative feelings and attitudes often come from the clinician’s reactions to the client and/or what develops from the therapeutic process with these individuals. Additional findings showed that while respondents determine BPD to be especially difficult to treat, they are able to locate a place of empathy and compassion for those with the diagnosis.

“SHE’S SUCH A BORDERLINE:” EXPLORING THE STIGMA OF BORDERLINE
PERSONALITY DISORDER THROUGH THE EYES OF THE CLINICIAN

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements for the
degree of Master of Social Work.

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CHAPTER I

Introduction

Chances are you have heard a statement in one form or another referring to a client or patient being *a borderline*, or perhaps you have been warned to stay away from the diagnosis altogether. There seems to exist an unspoken implication when one calls another person *borderline, a borderline, or borderline-y*. It is a stereotype that has developed into an all-encompassing diagnostic category describing someone who is typically hard to deal with in treatment. Attributes stereotypically attached to Borderline Personality Disorder include manipulative, needy, or dangerous. Literature on the subject explores the many realms in which these individuals experience impairments and the mental health field often forgets the theory behind this complex disorder. With some variance according to agency or treatment setting, these derogatory, pejorative, and stigmatizing statements are woven throughout the language used in the mental health field. In some cases, like an inpatient psychiatric unit, the language and frequency of comments are particularly severe. The following are quotes from an attending psychiatrist on one such unit: “She is a chronic borderline who we can’t help,” “We got a baby borderline today...she is so crazy,” and “She’s like other borderlines on the upswing...we need to get her out soon so she doesn’t say she wants to kill herself again.” Where do these statements originate? What causes a clinician to get to a point of feeling such hostility towards an entire client population? In this exploratory study, I will be discussing and challenging these notions of

what it means to be diagnosed with Borderline Personality Disorder (BPD) and seek to uncover the reasons for the stigma attached to this often misunderstood diagnosis.

Borderline Personality Disorder first appeared as a legitimate diagnosis in the Diagnostic and Statistical Manual of Mental Disorders (DSM) 3rd edition in 1980 (Friedel, 2012). However, by that time, it had already received attention from various clinicians and researchers, the most significant being Otto Kernberg, MD (Friedel). In the 1960s, he proposed the existence of a *borderline personality*, which was thought to be on a border between psychosis and neurosis (Friedel). As the diagnosis has continued to evolve, specific symptoms and characteristics have been linked to BPD and it is now defined as encompassing nine criteria in areas ranging from behavioral to cognitive to interpersonal in nature, as enumerated in the DSM-IV-TR. Alongside the characteristics, certain labels have become attached to not just the diagnosis, but the person who “wears” the diagnosis as well. Anecdotally, the mental health community tends to dislike clients who meet the criteria. Furthermore, it has seemingly become a diagnosis given to clients who are difficult and unlikable. Sometimes the label is used in a way to implicitly designate someone as a nuisance or dangerous.

A review of the existing literature highlights several studies that examine the causes, etiology, and treatment for BPD. Some research has also focused on the stigma surrounding the diagnosis with a common outcome that professionals who work directly with patients diagnosed with BPD typically have adverse perceptions associated with the diagnosis. Current studies illustrate the pervasiveness of negative stereotypes associated with the label *borderline* in the mental health field. However, there has been a substantial gap in the literature in terms of focusing on qualitative studies that offer in-depth exploration of why those who work with these clients feel and react with such negativity. Previous researchers have mostly used quantitative

approaches in their studies, and the few qualitative studies conducted have only focused on the voices of mental health nurses, as opposed to other professionals in health care. This research study aims to provide a voice to the field of mental health clinicians in order to demonstrate clinicians' attitudes and feelings toward a client with a diagnosis of BPD. In examining interviews with 11 therapists who have worked with one or more individuals who carry the BPD diagnosis, I have focused this study on examining clinicians' perspectives and viewpoints, and ultimately their treatment stance in working with a client with BPD. The study also explored issues of countertransference and disclosure in the treatment relationship.

The results of this study provide empirical data regarding treatment issues for professionals working with clients diagnosed with BPD. This study sought to provide insight into what drives the negative stereotypes attached to BPD. Findings have the potential to further our understanding of how we clinicians as a field formulate a borderline personality disorder diagnosis and how we emit subsequent perceptions about our attitudes on both the clinician and client community. This study encouraged participants to be critically self-reflective about past and current clinical work and provided a space for clinicians to think "candidly and freely" about their ideas and feelings that inevitably informs them and imbues their clinical work.

The next section will present a review of the current literature on the BPD clinical picture, treatment considerations, and studies with a focus on the stigmatizing effects of this diagnosis.

CHAPTER II

Literature Review

Borderline personality disorder (BPD) affects an estimated 1-2% of the general population—about 10% of individuals seen on an outpatient basis, and about 20% of individuals on an inpatient psychiatric basis (American Psychiatric Association, 2000). It is not entirely clear what causes BPD to develop but it is thought to have genetic and environmental factors, similar to other personality disorders. Something that stands apart from other mental disorders is the array of negative connotations and responses associated with BPD that occurs among some treatment providers.

This chapter provides a review of the literature that explores past research pertaining to the stigmatizing effects of labeling an individual with BPD. First I will discuss the diagnosis of Borderline Personality Disorder from a psychiatric diagnostic standpoint, and then outline the disorder from a treatment perspective. I will then review previous research regarding the negative stereotypes that exist in the mental health field, as well as studies from the user's perspective in which there is a tendency for non-disclosure of the diagnosis.

Borderline Personality Disorder

According to the DSM-IV-TR, Borderline Personality Disorder is characterized by a pervasive pattern of instability in interpersonal relationships, self-image, affect regulation, and impulse control (American Psychiatric Association, 2000). A diagnosis results when an individual meets five or more of the following criteria:

(1) frantic efforts to avoid real or imagined abandonment; (2) a pattern of unstable and intense interpersonal relationships; (3) identity disturbance; (4) impulsivity in at least two areas that are potentially self-damaging; (5) recurrent suicidal behavior, gestures, threats, or self-mutilating behavior; (6) affective instability due to a marked reactivity of mood; (7) chronic feelings of emptiness; (8) inappropriate, intense anger, transient; (9) stress-related paranoid ideation or severe dissociative symptoms (p. 689).

Eda Goldstein (1990) utilizes various conceptual models to offer a vivid illustration of the clinical picture one might see in an individual with borderline personality disorder. She starts with discussing the features of an identity disturbance. This can involve possessing a confused or vague perception of oneself—lacking continuity in self-presentation, taking on identities of others, and viewing oneself in a highly inflated or depreciated manner. Goldstein then goes on to describe some of the defenses seen in individuals with BPD, which the DSM-IV-TR does not include in their clinical picture. The most commonly used defense among borderline individuals is splitting, or keeping apart two contradictory feelings or ideas or objects to avoid having to tolerate ambivalence. Because simultaneously experiencing contradictory feeling states is difficult, their feelings can shift suddenly and the past will not hold much bearing in retaining stability. Objects or people are viewed as either all “good” or all “bad” because internal representations are harder to retain. In relation to this defense are the acts of idealizing and devaluing the self or others. All three defenses are utilized to help ward off anxiety or potentially destructive impulses.

Problems in anxiety tolerance are another feature of the borderline personality structure. Goldstein (1990) explains that borderline individuals have difficulty managing anxiety when there is an increase in stress, sometimes leading to feeling disorganized and overwhelmed. As a

means to dealing with these hard-to-tolerate states, they may engage in compulsive, impulsive, or destructive behavior. In some individuals with BPD, episodes of extreme stress or anxiety can lead to problems in reality testing or psychotic-like features. This can take on a variety of presentations: ideas that seem delusional, reality distortion, and feelings of depersonalization, derealization, and dissociation.

People with BPD often have difficulty controlling impulses. Impulsivity can manifest as alcohol and drug use, risky sexual behavior, eating disorders, overspending or gambling, or suicidal behavior. Many individuals with BPD have unpredictable, turbulent, and crisis-ridden lives due to poor impulse control in the face of experiences that shatter their self-concept or ego functioning. These experiences also make affect regulation especially difficult for those with BPD. Goldstein (1990) explains the different ways this problem can manifest itself: rapid escalation of feeling states, being overwhelmed by too intense positive or negative feelings, labile moods without apparent reason, and inappropriate anger. Other challenges related to affect include persistent feelings of anger, resentment, and dissatisfaction. Additionally, individuals with BPD have a feeling of inner emptiness and aloneness that makes them feel disconnected and hopeless (Goldstein). Like dealing with anxiety, individuals may engage in addictive or compulsive and self-destructive behaviors in an attempt to relieve the painful experience.

One explanation for the problems individuals with BPD have in controlling impulses, anxiety, and affects is their difficulty in self-soothing (Goldstein, 1990). Goldstein explains that this could be the result of lacking the internalization of sufficient positive experiences and not being able to evoke the image of a sustaining and soothing caretaker. They can become dependent on others to reassure and soothe them and therefore people with BPD commonly

exhibit fears of abandonment. This can lead to a person needing to constantly be with others but also keeping others at a safe distance to avoid losing them. In his or her mind, separation and individuation is equated with object loss rather than autonomy. Separation or rejection may precipitate crises or suicidal threats and acts.

Also commonly seen in people with BPD are problems in self-cohesion, difficulty regulating self-esteem, and superego defects (Goldstein, 1990). In some individuals, self-cohesion is fragile and decompensation or fragmentation can occur under stress or abandonment. People with BPD also rely heavily on others for approval and recognition for the maintenance of positive self-esteem. They may lack self-regard that is realistically based. In other words, their conceptions of themselves are either grandiose or devalued and they may often feel entitled or unworthy. Furthermore, many individuals with BPD are sensitive to perceived criticism, disapproval, and lack of appreciation. The result can be self-loathing or self-hate (Goldstein, 1990). Lastly, the superego development in these individuals is incomplete. This results in an unreliable and inconsistent regulator of behavior. On one hand one may not experience any guilt or remorse about something; conversely, the guilt felt affects all aspects of one's life.

The picture described above results in a pattern of intense and unstable relationships among individuals with BPD. Intimacy can be a struggle, closeness rarely lasts, and fights can occur all too often. Impulsiveness can lead to frequent breakups and reconciliation but at the same time, separations are extremely difficult, as discussed earlier. Separation may also result in desperate and seemingly manipulative behavior (Goldstein, 1990).

There are strengths and weaknesses to the two models discussed thus far. However, in my opinion, Goldstein's description and explanation of the diagnosis should be the preferred literature for any person interested in learning about the clinical picture. More importantly, if a

clinician is considering a diagnosis of BPD for a client, I feel that they owe it to the individual to read about BPD from a source that empathically describes the disorder. In other words, it is far more helpful to gain an understanding about *why* a person is presenting with certain characteristics or behaving in a particular manner. The DSM-IV-TR merely lists the symptoms, which, without context, can appear overwhelming to a clinician at any level. Furthermore, I believe that the diagnostic criterion is pejorative at its core. I feel that diagnosing someone with Borderline Personality Disorder is more of a judgment than a tool for treatment purposes. But when a clinician speaks in terms of “characteristics” or “features” pertaining to BPD, to me it suggests that she or he may have a broader and more in depth understanding of what the label means.

Marsha Linehan and Dialectical Behavioral Therapy

Marsha Linehan is considered to be the leading expert in treating borderline personality disorder due to the great success of the evidence-based method she herself developed and still practices. Dialectical behavioral therapy (DBT) is a cognitive behavioral therapy approach that concentrates on ways to change the high-risk behavior seen among individuals with BPD. Created in the 1980's and combining Eastern and Western practices, research shows that DBT is the most effective treatment for BPD (Koons et al., 2001; Linehan, Armstrong, Suarez, Allmon, & Heard, 1991; Linehan, Heard, & Armstrong, 1993; Linehan, Tutek, Heard, & Armstrong, 1994; Verheul et al., 2003). In all of these studies, DBT has been clinically tested against treatment-as-usual interventions for the treatment of BPD. Results indicate that subjects who receive DBT have less parasuicidal behavior (self-harming behavior that may seem suicidal but that does not typically result in death; such as cutting, burning, or taking a handful of pills), less anger, and improved social adjustment. The participants who had DBT also spent fewer days as

psychiatric inpatients than those receiving treatment-as-usual interventions. Additionally, in their study with female veterans with BPD, Koons et al. (2001) found that those in DBT reported a decrease in depression and hopelessness. The research suggests that dialectical behavioral therapy is an effective intervention for improving functioning among individuals with BPD.

To gain an understanding about why DBT is effective in treating BPD, it is worth examining how Linehan conceptualizes the diagnosis, as well as what the treatment involves. Linehan organizes the DSM-IV-TR criteria into five sectors: affective, cognitive, behavioral, self, and interpersonal (Lieb, Zanarini, Schmahl, Linehan & Bohus, 2004). DBT is based on a model of borderline personality disorder that takes into account the likelihood that individuals with the disorder do not have the skills required to regulate and tolerate emotions, distress, and conflicts associated with these sectors. Also known as biosocial theory, Linehan expounds that BPD results from a series of transactions over time between an individual's vulnerability to negative emotional experiences and the environment's invalidating response (Robins, Ivanoff, & Linehan, 2001). Robins, Ivanoff, and Linehan explain that this experience can lead to emotional dysregulation—the core problem of BPD. Linehan and Dexter-Mazza (2001) explain, “Such an individual has never learned how to label and regulate emotional arousal, how to tolerate emotional distress, or when to trust his or her own emotional responses as reflections of valid interpretations of events resulting in self-invalidation” (p. 374). More specifically, when others respond to a person's experience with insensitivity, he or she learns to mistrust his or her internal states and instead uses the environment for cues about how to act, think, or feel, which in turn disrupts the individual's development of a cohesive self (Linehan & Dexter-Mazza). Linehan's perspective views the dysfunctional behaviors associated with BPD as “maladaptive solutions to overwhelming, intensely painful negative affect” (p. 374).

DBT addresses these “dysfunctional behaviors” by first teaching individuals methods for controlling behaviors, especially life-threatening ones, then focusing on managing emotions. After these skills are achieved, DBT seeks to help individuals achieve an ordinary level of happiness and unhappiness, in other words, a life worth living. Finally, the last stage of treatment involves managing the individual’s sense of incompleteness. To teach these skills, DBT draws on behavior therapy, Zen, and dialectics (Linehan & Dexter-Mazza, 2001). The behavioral component asks for change and the Zen aspect requires acceptance. Because the two are poles, dialectics are used to find the proper balance. In origin, dialectics encourage a dialogue or discussion when there are two contradictory or conflicting points. A dialectical stance considers things as related to each other and having no absolute truth. Put briefly, the “dialectical” part of DBT asks therapists and clients to hold two opposing things at once so that they may be open to alternative explanations. Linehan came up with the model after failed attempts to help chronically suicidal patients. While other cognitive behavioral approaches require patients to stop self-destructive behaviors, DBT seeks to both accept and change the behavior. Mindfulness practice is central in DBT, and exists separately from standard behavior and cognitive therapies. Through mindfulness practice, individuals learn to manage or tolerate pain and distress (Linehan & Dexter-Mazza).

Negative Stereotypes Among Treatment Providers

A review of the current literature illustrates the pervasiveness of negative stereotypes associated with the label *borderline* in the mental health field. The literature suggests that professionals who work directly with patients diagnosed with BPD typically have adverse perceptions associated with the diagnosis (Deans & Meocevic, 2006; Markham, 2003; Markham & Trower, 2003; Treloar, 2009; Woollaston & Hixenbaugh, 2008). This is a concern because it

implies that a diagnosis of BPD will influence the quality of care a patient will receive from staff. Through a thorough examination of previous studies, I have come to learn that this is an area that needs further research and a closer examination of the factors that have paved the way for some in this field to label and marginalize this particular population. This section will discuss previous research studies that reflect some of the negative reactions experienced by those who come into contact with individuals with BPD.

In their study, Woollaston and Hixenbaugh (2008) interviewed six nurses about their experiences of working with this client group. Through open-ended questions, they found that nurses generally saw these patients as manipulative, threatening, and destructive. The participants described BPD patients as having a “demanding and draining presence” and they disclosed that they felt “sucked into the world of BPD patients” (p. 705). Woollaston and Hixenbaugh discuss how their data suggest the nurses developed negative stereotypical perceptions and reactions after working with BPD patients overtime. The researchers propose that the participants’ negative feelings are the result of feeling unable to help the patients. When reflecting on patients who did exhibit improvement, it was noted that he or she received specialized services, such as a DBT course. This suggests that being properly trained to treat BPD improves a treatment provider’s attitude toward the symptoms.

A longitudinal, quantitative study by Krawitz (2004) set out to achieve change in clinician attitudes toward people with BPD after a two-day training workshop. His hypothesis was that attitudes would change from negative to positive if clinicians were better equipped with knowledge, skills and language designed to help clients with a BPD diagnosis. By measuring their attitudes pre- and post-workshop and again at six months, he was able to determine that the

training produced statistically significant changes. This implies that a lot of the negative feelings are the result of not properly understanding the diagnosis.

This lack of understanding or feeling ill equipped to handle individuals with BPD has presented itself as a theme in several of the studies out there. Deans and Meocevic (2006) found that a large proportion of the 65 nurses they surveyed admitted to feeling like they did not know how to care for people with BPD. The authors perceptively point out that one of the problems facing individuals with BPD is the negative attitudes of those staff that care for them. The data derived from their study indicated that the majority of the participants perceived people with BPD as manipulative, as nuisances, and as engaging in emotional blackmail. Additionally, a high proportion of the respondents felt that people with BPD are responsible for their own actions. This is another theme among the research. However, there is also scientific evidence that has discovered that people with BPD “are physically unable to regulate emotion” (Nauert, 2009). Dr. Nauert discusses the findings of an imaging study that compared the brains of individuals with BPD against those without the disorder. By using magnetic resonance imaging while disturbing emotional scenes were presented to the research participants, researchers concluded that the area of the brain used to regulate emotion remained inactive in those with BPD. Dr. Koenigsberg, the professor in charge of the study, says that the results may help explain why emotional reactions among people with BPD are so extreme. This suggests that there is an underlying biological explanation for why individuals with BPD experience difficulty controlling their emotions or affective responses. More studies like this one could be useful in disputing the idea or belief that people with BPD are in control of their behavior.

This is not to say that exposing the mental health community to the scientific evidence out there will change how clinicians react. Similar to the studies cited above, Treloar (2009)

conducted a study in which 103 mental health practitioners provided comments about their experiences in working with individuals with a diagnosis of BPD. A review of their responses revealed that these patients “generate an uncomfortable personal response in the clinicians” (p. 31). Again, the participants reported that they often feel inadequate, frustrated, or powerless when working with BPD patients. Some of them felt that due to the patients’ manipulation, poor coping abilities, and time consumption, the clinicians were unable to see any impact of their treatment efforts. Given this theme, one might suspect that the data from these studies has more to do with what certain patients evoke within clinicians, rather than what the clinicians think or feel about individuals who display characteristics of BPD.

In a compelling paper, Shannon Hodges (2003) argues for the need to integrate the diagnoses of BPD and PTSD due to the pejorative connotation attached to BPD. Through her own review of the literature, she comes to the conclusion that although the symptoms of both diagnoses overlap significantly, BPD is more often attached to patients when a clinician is having a difficult time in treatment. To illustrate this, Beck and Freeman (as cited in Hodges, 2003) developed the following hypothetical dialogue:

“Supervisor: Why are you having trouble with Mr. Schultz?

Therapist: Because he’s borderline.

Supervisor: Why do you consider him borderline?

Therapist: Because I’m having so much trouble with him” (p. 410)

Although this transaction between supervisor and supervisee was generated to be an example of the countertransference that can occur when dealing with a difficult client, it speaks to the issue that sometimes a diagnosis of BPD is referred to as if it were equivalent to a symptom (Hodges, 2003). Hodges offers an interesting, and admittedly cynical, option to consider when it comes to

diagnosing BPD: “Clinicians find what they intend to find” (p. 412). She calls attention to the fact that symptoms of BPD overlap with those of many other disorders. Yet, instead of seeing this as evidence that boundaries between diagnoses may be blurred or arbitrary, some researchers have argued that comorbid disorders actually mask an underlying “borderline pathology” (p. 412). I suspect that when a clinician is attempting to distinguish between two diagnoses for a client, if there has been any countertransference that one would commonly feel with a person with BPD, she or he will be inclined to give the diagnosis. Furthermore, Hodges explains, “BPD has the distinction of being one of the few diagnoses for which failure to thrive in treatment and the countertransference reactions of the counselor serve as evidence of validity” (p. 410). Such thinking aligns with a major concern for patients given the stigmatized diagnosis: BPD essentially characterizes a person as “disordered” due to a character flaw. In contrast, PTSD is of a diagnostic category that depicts an individual’s symptoms as a consequence of circumstances (Hodges).

Both BPD and PTSD have been linked to traumatic experiences but the diagnoses have differing conceptualizations of trauma. Hodges argues that a traumatic experience resulting in the development of PTSD is preferable to the traumatic stress derived from intrapsychic phenomenon, such as an invalidating environment. In this case, a particular label matters greatly. Maracek (as cited in Hodges, 2003) interviewed forty therapists and observed that many of them found PTSD to be more acceptable (nonstigmatizing and nonblaming) than any other diagnosis given to women. This is, in part, due to some of the existing literature on treatment with clients with BPD, which sometimes “includes lengthy discussions of relational horrors that counselors might anticipate” (p. 414). In a workshop she attended, Hodges noticed that the speakers kept referring to “containing the borderlines”—a description that sounds negative and marginalizing.

A study by Markham and Trower (2003) investigated the idea that a label affects staff perceptions. They examined how the psychiatric label of BPD affects staff perceptions about patient behavior. Questionnaires with descriptions of patient behavior and a linked diagnosis were given to 48 nurses. Patients with a label of BPD received more negative responses than those with other labels. They were also thought to be more capable of controlling their negative behavior and staff reported less sympathy and optimism toward patients with a label of BPD. Further, in Markham's study (2003), 71 mental health nurses completed questionnaires relating to BPD, schizophrenia, and depression. Results indicated that staff had unfavorable attitudes toward the BPD diagnosis and considered these patients more dangerous than the other diagnoses. Markham concluded that a diagnosis of BPD can have damaging implications for patients because of these stereotypical beliefs.

A particular gap in the current research is the voice of clinicians. In other words, the majority of the data pointed to in this review of the literature is from studies done with psychiatric nurses. Furthermore, the studies that were conducted with therapists, counselors, psychiatrists, or psychologists were pursued through quantitative measures and did not capture a deeper understanding of their experience. I do not claim to know why there is a lack of research on the attitudes of mental health clinicians regarding this area of study, but I believe it may be related to the culture that surrounds Borderline Personality Disorder. In my experience, nurses (those who generally practice within a medical model) are excused when it comes to making insensitive or non-empathic remarks about patients who they experience as difficult. But, if a person with a graduate level education in behavioral health makes the same remark, heads will turn because "they should know better." If there is someone present to confront the derogatory statement, perhaps the individual will learn something or maybe she or he will simply not voice

the opinion next time. I can sense an awareness out there that it is not “proper” to label every patient that cuts or manipulates staff as *borderline*. However, it is not enough to just know better and keep operating from a place that carries assumptions and judgments. There is no escaping having negative reactions to clients or patients, but I propose that there is a way to talk about them in a sensitive, constructive, and productive manner that advances the de-stigmatization of diagnoses such as Borderline Personality Disorder. The studies referenced above show, without a doubt, that there is a stigma attached to BPD. But at what point do these studies stop illuminating the issue and start perpetuating the stigma? I am aware that progress is being made in regards to the DSM’s approach to diagnoses like BPD and Post-Traumatic Stress Disorder, and therefore, this research study comes about at a particularly opportunistic time.

Patient Experience with the Stigma

The data discussed in the previous section could offer a possible explanation for why clients with a BPD diagnosis sometimes sense these negative and stigmatizing feelings from providers. There have been a few studies conducted from the client’s point of view in navigating the mental health system with this label (Fallon, 2003; Horn, Johnstone & Brooke, 2007; Nehls, 1999). Nehls (1999) interviewed 30 clients with the diagnosis and found that once given the label of BPD, clients felt blamed and perceived as manipulative. The interviewer asked the participants what the diagnosis meant to them and inquired about the experience of living with it. Themes that emerged include living with a label, living with self-destructive behavior perceived as manipulation, and living with limited access to care. Many of the interviews gave rise to an interesting paradox: the diagnostic criteria fit but a diagnosis was not beneficial in guiding treatment. The problem, they stated, is the prejudice of providers.

Horn, Johnstone & Brooke (2007) interviewed five clients with a diagnosis of BPD. In their analysis, they found that participants often felt rejected due to the diagnosis. They talked about feeling like the diagnosis was a negative judgment and that it was more a label than anything. Receiving the diagnosis did not give them any understanding or knowledge about what they were experiencing. Fallon (2003) sought to explore what psychiatric service was like for people with BPD. After interviews, she found that her seven participants all had negative experiences and encountered negative staff attitudes. This did not, however, stop them from pursuing psychiatric help because they often needed it to avert further decompensation, which means these individuals ask for assistance even when they do not feel welcome.

While it is good that patients who carry a BPD diagnosis continue to seek services in the face of crisis, the treatment framework for BPD is not in their favor. For example, it is a common belief that someone diagnosed with BPD was sexually or physically abused. So, where does that leave those individuals who meet the criteria but never experienced direct abuse? Hodges (2003) highlights the benefit of moving toward a more developmental perspective that considers stressors, experiences, and expressions along a continuum. Doing so would consider the multiple possibilities of stress and response that the current diagnostic system does not.

Non-Disclosure of Borderline Personality Disorder

The studies reviewed above involve clients who were informed of their diagnosis. There is evidence that a BPD diagnosis is often not disclosed to a patient because of the stigma associated with it (Lequense & Hersh, 2004). Lequense & Hersh reviewed medical literature about disclosure to explore why clinicians may or may not disclose the diagnosis of BPD. Their experience led them to believe that a BPD diagnosis is disclosed less often than other psychiatric disorders. They examined the barriers to informing clients of the diagnosis and discussed why

disclosure is in the patient's best interest. The study found a few explanations for why clinicians do not inform clients of a BPD diagnosis: uncertainty regarding the validity of BPD, the feeling that the diagnosis is too negative, and concern about transference/countertransference. In regards to the stigma attached to the disorder, Lequense & Hersh accurately describe why it may exist. They discuss how the symptoms in the DSM-IV-TR criteria can be "frightening and frustrating" for clinicians (p. 172). They state, "Impulsivity, self-mutilating behaviors, recurrent suicidal gestures and threats, affective instability, and inappropriate and intense anger can be intimidating and unnerving for clinicians to treat" (p. 172). This type of symptomology, they report, can lead to countertransferential feelings of rage or frustration. Some clinicians may use the diagnosis loosely (and liberally) by ascribing it to any person who evokes these feelings. This has caused the pejorative connotations associated with the word *borderline*. Further contributing to the stigma is the perception that BPD is untreatable (Lequense & Hersh).

As Hodges (2003) puts it, "Recovery is held out as a possibility for clients with PTSD, whereas for those labeled with BPD, the outlook is bleak" (p. 414). Not to say that trauma-based counseling is the answer, but it does use language that makes healing and recovery the goal of treatment. Terms like "injury, wound, and pain" immediately change the connotation of what is being addressed. Saying something along the lines of "containing a borderline" suggests the goal of treatment is to control the individual. Synonyms for contain include "restrain, inhibit, and suppress." Such a stance implies treatment should stop someone from behaving in a particular manner, but the root of any treatment should be progress.

In summary, I believe there is a great opportunity to explore these negative perceptions and what lies behind these attitudes for clinicians. More specifically, there exists a need to hear directly from clinicians, since most existing studies are conducted solely with mental health

nurses. In my own field experience with clinicians and peers, I too, often hear derogatory statements in regards to *a borderline patient*. I want to understand why so many mental health professionals have such negative feelings surrounding this particular diagnosis. In the following chapter, I will describe the methodology of my research study.

CHAPTER III

Methodology

The research question for this study is the following: How do mental health clinicians think and feel about working with clients who carry a diagnosis of Borderline Personality Disorder (BPD)? A qualitative, exploratory study was conducted using open-ended, semi-structured interviews with the aim of getting clinicians to examine their own perspective and treatment stance when working with a client diagnosed with BPD. Particular attention was paid to issues of countertransference and factors that inform their diagnosis. Interview questions elicited narrative responses that opened up many possible reasons for why there exists such a stigma around BPD. Participants also shed some light on what type of clinician will typically lean towards a non-stigmatizing and non-labeling stance when it comes to this client population.

Sample

Eleven mental health clinicians were interviewed between March and April 2012. The study was limited to clinicians who have worked with at least one client who meets the diagnostic criteria for Borderline Personality Disorder, according to the DSM-IV-TR (American Psychiatric Association, 2000). They were also required to hold a professional level degree (Master's or Doctorate) in a mental health field (social work, marriage and family therapy, psychology, and/or counseling). The participants were screened via email correspondence or telephone calls prior to the interview to confirm they met these criteria (see Appendix A).

The following information was collected from the demographic portion of my questions. Eight participants were females and three were males. The age range of the acquired sample was between 33 and 68 years old. Eight of the participants identified as White and three identified as biracial (one who was Black/White and one who was Latino/White). Nine individuals obtained a Master's of Social Work and two received a Master's of Arts in Counseling Psychology. The number of years participants have been practicing in the mental health field ranged from 2 to 39, with the average being about 19 years of experience. There were no specific requirements for setting of work or treatment modality, so it was assumed that the participants worked with clients with BPD in various environments and capacities.

For this study, a non-probability, convenience sample was utilized (Rubin & Babbie, 2010). Availability and snowball sampling were used to maximize the potential sample size. I did not specifically recruit for diversity because I was concerned about not getting a large enough sample. The sampling method was purposive so that finding participants who met the required criteria would be more easily available. Once my research study was approved by the Smith College Human Subjects Review Board (see Appendix B), I began my recruitment by asking clinicians I had known to pass along my recruitment letter (see Appendix C), which invited them to contact me if they were interested in participating. The letter was initially sent to several listservs, which enabled me to have wide access to several groups of clinicians. Over the course of two months I was contacted by a variety of therapists who met the criteria and were interested in participating. During this time, a snowball sampling strategy was also employed to increase the number of people I could reach. I asked participants to forward my information along to anyone they knew who might be interested and who fit the criteria.

At one point, I was able to use the Smith College School for Social Work (SCSSW) alumnae/i listserv to reach a large number of potential participants. This is a particular area of bias because these individuals once went through the process of designing and executing a study in completion of their SCSSW degree. Therefore, their willingness to participate may have been influenced by that experience. I received a huge response of interested clinicians through email and telephone. At first I responded on a first come, first serve basis, but I was also selective when it came to males because there were far more females than males contacting me. I stopped taking participants when I reached 15 but 4 of them never followed through with the interview, creating a non-response bias. The dropout may or may not have been related to disinterest in participating. Another possibility is lack of time availability, because participating meant having the time and space to complete an interview. I wrote back to those people who I could not use to thank them for their interest.

Data Collection

The interviews were held over the telephone, as this was most convenient for the participants. They ranged from approximately 30 to 60 minutes in duration, depending on how responsive the participant was in sharing their experience with clients diagnosed with BPD. Participants were asked a series of questions designed to solicit experiences and case examples of their experiences in working with this population. The interview questions were open-ended and flexible by design to allow clinicians to deeply reflect and develop their responses (see Appendix D).

When potential participants contacted me by email or phone, I corresponded with them via email to confirm their interest in participating. I simultaneously sent along the letter of informed consent during this period (see Appendix E). These were signed and returned to me

either by email or fax. Interviews were scheduled at this time. Approximately one hour was designated to complete the entire process of introductions, answering any questions, and conducting the interview. All of the interviews were audio tape-recorded. I simultaneously took notes on relevant observations or themes that arose. I strived to remain neutral and ask the questions in the same manner each time to ensure reliability of data. When necessary or beneficial, I asked follow up questions for clarification on a response. At the end of each interview I asked if there was anything the participant wanted to add. In some of the interviews offering open-ended questions produced some of the richest and most genuine responses from participants.

Upon completion of each interview, I transcribed the data and compared each transcription with the tapes for accuracy. All identifying information obtained was kept separate from the transcriptions. After the interview took place, the recording and transcriptions were labeled with numbers to prevent specific names from being attached to the data.

Risks for participation. Participants were informed that they might face risks associated with discussing their clinical experiences with BPD. After all, the purpose of the research was to talk about a subject that, as evidence shows, could be quite charged. For example, they were warned that opening up about their work with this population could evoke unexpected emotional responses. The questions called upon each clinician to remember certain clients from the past or present and tell me about what it was like to work with them. Sometimes these recollections were not positive or happy.

Benefits of participation. Participants were told that the opportunity to share their experience and voice their story might benefit them and the mental health field. The interviews had the potential to offer participants a deeper understanding of cases, interventions, and their

own strengths and challenges with treating BPD. They were told that their contribution would illuminate this area of research that remains quite untouched.

Data Analysis

For the purpose of this exploratory study, the narrative reports were analyzed using a thematic analysis procedure (Rubin & Babbie, 2010). First, the transcribed data was read and re-read to identify initial thoughts and ideas. Then, an open coding process was utilized to assign codes to themes that emerged through close examination of the data. To increase validity and reliability, I coded the manifest and latent content. Both methods have the potential to produce researcher bias: themes were based on my own understanding and judgments and there is no guarantee that I remained constant throughout the process. Furthermore, I created the interview guide, which ended up serving as a foundation for themes that emerged. The questions developed from my interpretation of other studies, as well as my experience in the field with BPD. I paid special attention to themes within the narratives that I was not expecting to find as a way to reduce researcher bias.

Once coding was completed, I grouped the data into categorical themes. Because the study was geared to illicit information on how clinicians think and feel about Borderline Personality Disorder, I looked for similarities and differences between narratives and responses. In some cases, answers to some questions overlapped or responded to other questions, so these responses were organized according to themes instead of corresponding questions. For example, the first question that asked clinicians to open up with any initial thoughts and reactions led some to tell a story about a client that provided information about treatment approach or emotional responses to clients. This was the case throughout each interview, most likely because participants were reflecting back on their experience in an active and engaging manner. They

did not have the questions beforehand so a question later in the interview could have reminded them of something I had asked earlier. In addition, notes were taken throughout the data collection and analysis process in order to reflect and theorize ideas in more depth, which later contributed to my Discussion chapter later in this study.

These along with a select number of vivid extracts were later used to illustrate the main themes generated by the analysis procedures. In the following section, I will present the results of this research to illustrate how clinicians feel about BPD.

CHAPTER IV

Findings

The purpose of this study was to explore the clinician's attitudes, feelings, or beliefs surrounding the diagnosis of Borderline Personality Disorder (BPD). This chapter presents data collected from interviews with 11 mental health clinicians. Demographic information was collected from each participant regarding their gender, age, race, professional degree, and number of years in the field. The interview questions were organized around the following major themes: initial thoughts and reactions to the diagnosis of BPD, issues of countertransference, factors that inform a diagnosis, disclosure of BPD to the client, treatment approach and implications, and about the general parlance of BPD in clinician circles.

Demographic Characteristics of the Sample

The study was comprised of 11 mental health clinicians. Eight participants were female and three were male. Participants were between the ages of 33 and 64 years of age. Nine of them hold Master's in Social Work and two have a Master's in Counseling. Eight of them identified as White and three described their ethnicity as mixed. Number of years in the field ranged from 2 to 39 years.

Initial Thoughts and Reactions to the Diagnosis of BPD

The participants were asked to describe any thoughts, feelings, or beliefs surrounding the BPD diagnosis (see Appendix D). The questions were posed in an open and broad manner in order to provide the clinicians with a space to make meaning of their knowledge and experiences.

The challenge of the work. All but two participants initially used the word “challenging” to describe clients with BPD. One participant who did not use that terminology could not readily separate her feelings about the diagnosis itself from her feelings about certain clients with whom she has worked but as she continued her narrative, it later came out that she very much finds clients with BPD to be challenging. She has had particularly negative experiences with this population, so when she thinks about the disorder, there is a negative reaction inside herself, which she has discussed extensively in supervision. The other clinician who did not see them as a challenging population explained that he knows why others might find them challenging, “They tend to be impulsive and volatile. They will often test you in the early stages and some of those tests can be scary.” The same clinician continued, “The challenge that comes with these clients is an indication of their struggle.”

As each participant elaborated on why they find the population challenging, certain dynamics started to appear. One therapist commented, “It’s really hard to work with people who push all your buttons and don’t make much progress. It’s really satisfying to work with someone who does well but you don’t have that trajectory with BPD.” While slow recovery is challenging for some, others find the effort to be taxing. Another participant finds them hard to work with because, “People with BPD take up a lot of energy. There is a constant pattern of needing people, then using people, and rejecting them.” For another clinician, it is the common inflexibility that comes with the diagnosis that is the most challenging in the therapeutic environment, referring to clients who react when a new way of thinking about something is suggested by the therapist.

Features that cause struggle in the treatment relationship. Other terms common among the participants to describe their feelings about BPD included words such as *needy*, [having] *poor boundaries*, and *dysregulated*. *Needy* was used to describe the hot and cold way

of functioning for the client or the desperate desire for attention and time. Similarly, one participant talked about the demanding engagement involved with clients with BPD. For two participants, the struggle with this population comes from the shifting progress these clients typically make. They feel like so much work is put into these clients and very little comes out. One participant asserted that “a borderline is someone who makes you feel rung out,” speaking to the level of need these clients bring with them.

The participants who mentioned *poor boundaries* as being a very common impairment among clients with BPD discussed the difficulty of setting limits with someone who has borderline traits. They explained that how these individuals learn requires establishing secure boundaries from the beginning of treatment. One clinician mentioned, “When you’re a therapist and you are kind and you are empathizing and you’re there for them, it can be taken as the most amazing thing and they will want the relationship to be special.” Another participant spoke about balancing that struggle, “I found it difficult to have that Christian empathy and still have decent boundaries.” She remembered a client that had a very hard time refraining from blurring the boundary between therapeutic alliance and acquaintance. Her client did things like join the therapist’s church choir or call at all times of the day.

Lastly, the interviewees spoke about the *dysregulation* that is common among individuals with BPD. The cycling of intense affects and their difficulty in regulating them can be a real challenge for some therapists and especially to and with the clients. Eight participants talked in some way about the client’s inclination to act impulsively or act out during these intense emotion states. One of them described how she wished she could be with her client out in the world so she could assist her when she was overcome with emotions and unable to regulate herself.

Issues of Countertransference

All clinicians easily responded to questions about countertransference that comes up with clients carrying the diagnosis of BPD. Countertransference is the therapist's unconscious emotional reaction to the client (Kernberg, 1965). While most participants had less than positive feelings for these clients, three of them spoke about the affirmative change that occurred for them over time in treatment. The clinicians who experienced this started off not liking their client but they grew to like or even love her or him as time progressed. One participant stated, "I developed a tremendous affection for her. I ended up loving her once she could get out of her own way." This implies it is the particular challenges associated with BPD that lends to feelings of dislike towards the client.

Warning signs. A theme that came up in this area of discussion was the fear and caution evoked for some of the participants in their work with clients with BPD. For some, this means working with this population can be frightening, with issues like suicidality or self-harm being common characterological behaviors for this population. Many individuals stated that these are intimidating features to work with at times. For others, the trepidation comes from a stance of not knowing how to manage the client. One participant explained, "Depending upon how emotionally reactive they may be, there may be a reluctance to enter into a therapeutic alliance when you don't know where it could go." The previously mentioned rigidity appears to be a contributing factor. For some individuals with BPD, change or alternate views to something can shake them at their core because the structure of their mind prefers things to remain constant and familiar. This is related to the phrase, 'Walking on eggshells,' which is often used to describe the experience of interacting or living with a person who carries this diagnosis. Half of the clinicians discussed how quickly they could move from the *good object* to the *bad object* or how

a simple suggestion could be misinterpreted and lead to a lack of attunement or impasse. The ease at which this can happen in the therapeutic process leaves many therapists afraid to work with these clients.

Evolution of attitudes and feelings. There does seem to be a learning curve in working with the diagnosis, however. Four participants talked about how their views and feelings have changed over the years, as they have gotten more experienced. One said, “When I was new they were frightening and hard to be with but through the years I have learned how to work well with them.” These clinicians described their evolution in understanding this diagnosis but few of them jump at the opportunity to work with it. For six of them, preference is toward *not* taking on any clients with BPD and that, they explained, is about the feeling they get when sitting with a client who has the diagnosis or strong features. In other words, their countertransference informs them that they would exclude these individuals from their caseloads altogether.

Projective identification. Four participants spoke of their feelings of inadequacy and impatience for the clients’ slow progress that can accompany working with this population. This is also known as projective identification, or when the client projects their unconscious, unmetabolized feelings onto the therapist, leaving the therapist with the task of sitting with whatever is being projected. One clinician explained, “There are a lot of feelings of inadequacy or not being successful, both from things she has said and from how I feel in sitting with her.” She further spoke about how the experience of past therapists not being effective can easily be projected onto her and make her feel very helpless. Along similar lines, another participant stated, “I was very naïve in thinking I could affect major change.” Besides not helping enough some feel that they cannot help quickly enough. One therapist revealed, “Sometimes I get impatient and want them to move along faster. It can be very slow and frustrating. I also get

over confident or not attentive.” The overall idea in both of these themes is that making progress with a client who meets the BPD criteria can be an extreme challenge, if there is progress at all.

Utilizing countertransference to inform the work. Four participants talked about using their countertransference to better understand their client or for help with diagnosing. For instance, one participant spoke about the overwhelming anxiety in the room with these clients and how when it does not seem to go away, it is most likely because they are struggling with BPD. Another participant explained that when she finds herself thinking, “She’s such a borderline,” it gives her the opportunity to reflect on that feeling by stepping back and figuring out why it is there. When a therapist is mindful of these feelings and does not allow them to get in the way of the work, countertransference can be used as a tool for things like case formulation, diagnosing, or appropriate interventions.

Demonstrating compassion. Despite the majority of clinicians not being eager to work this population, five mentioned just how hard it must be to live with a diagnosis like BPD, indicating some level of compassion. Stigma aside, clinicians can usually find a place in their heart for empathizing with the borderline struggle as indicated by their reflections in the interview process. In referring to what she learned during a study conducted with patients with BPD, one participant stated, “I really, really came away impressed with the daily struggle that most of these individuals had to live with.” Another clinician commented that in sitting with these clients she often thinks to herself, “God, it’s got to be really hard to be her.” A powerful statement another participant said speaks to just how challenging it can be to live in the shoes of a borderline, “I wouldn’t wish that situation on my worst enemy because it takes a lot of work and a lot of commitment.” All of the clinicians seem to believe that the clients themselves do not

bring on the diagnosis and that it is not their fault for having the characteristics. Therefore, they can really imagine just how hard it would be to struggle with the diagnosis.

Factors that Inform a Diagnosis

The interviewees were asked about what factors inform this diagnosis for them. Participants were squarely divided between those who think the DSM-IV-TR is useful and those who do not. The former category is much smaller, with only three participants mentioning the DSM-IV-TR as a reference source. For those individuals who do rely on the DSM-IV-TR as a tool for diagnosing, they do not necessarily feel that diagnoses are relevant to the work but they do look to it for guidance. One clinician said, “I can’t give a diagnosis if the person doesn’t meet the criteria.” Another spoke about which criteria in the DSM she looks for first, “I would weight the behavioral characteristics more strongly than the experiential ones. So things like drug and alcohol abuse, acting out, suicidal ideation and attempts, and dyscontrol episodes.” The same participant feels strongly that BPD is a physiological brain disorder, as well as a chronic mental health disorder.

Besides the DSM-IV-TR, many or the majority of clinicians seem to rely on intuition and feelings as they arise in the room. One clinician appears to use countertransferential feelings to pinpoint the diagnosis. She said, “I usually get this feeling when it’s Axis II of, ‘This person is creepy’ or ‘I don’t wanna deal with this person’ that I don’t get when it’s solely Axis I.” Another participant explained, “I discover it throughout the course of the therapeutic relationship and from their interpersonal style and the way they interpret events.” This idea that it is useful to assess how the client is reacting to certain interventions or statements came up in three interviews. The same participant went on to describe, “An early warning sign for me is when I

get feedback about the impact of my interventions. I would call it an over-exuberant response to me when what I did is not something that should cause such a reaction.”

One clinician has a few characteristics he always looks for when figuring out this diagnosis. When he experiences anxiety that persists, it informs his assessment a great deal. He also notices their difficulty with relationships and regulating their moods. He went on to talk about the anxiety being mainly annihilation anxiety. He said, “So much of the drama and acting out is to reassure themselves that they won’t disappear and to see how the environment will respond to their behavior.” He also stated, “I’ll look for reflective capacity and mentalization. If those are lacking, I’m dealing with a borderline.” This portion really speaks to some of the deficits in a person with BPD but it also points out the main things on which the therapy can focus. A clinician such as the one quoted above is working from a psychodynamic perspective, which relies on examining the conscious and unconscious processes a person utilizes to navigate their internal and external worlds. Every individual has an ego that functions to keep her or him from becoming unstable in the face of triggering stimuli. These functions can sometimes become impaired, usually as a defensive operation for protection, and this is what the clinician above is assessing.

The pitfalls of the Diagnostic Statistical Manual. A prevalent theme within the discussion of diagnosis was the therapists’ negative views of utilizing the DSM-IV-TR as a reference guide. Six clinicians talked about their negative biases in having to rely on the DSM-IV-TR. One participant argued the following:

It’s a book of descriptions of patterns we see. It’s not a person. It’s an attempt to have some kind of language to talk about repeated experiences but it is never the person.

People are far more complex and we put them in boxes and the boxes just don't take everything into account. They're clumsy tools at their best, all diagnoses.

Another participant, who does not use diagnoses at all, discussed how he feels about the DSM, "I only know the DSM because I have to but it's not the way I think about my patients. It's too threatening for the psychiatric system to look into something dynamically." Finally, a couple of clinicians talked about the DSM as not accounting for any strengths in the client. One said, "With the multi-axial diagnosis there is no room for any mention of the client's strengths and positive qualities."

The all-encompassing label. Lastly, an emerging theme arose in the data in regard to the topic of the BPD diagnosis as being a diagnosis based on personal reaction—whether consciously recognized or not by the therapist. An interviewee stated, "These clients have always experienced, 'I freak other people out.' Unfortunately, in American psychiatry [sic], that's what borderline means. It's the patient that freaks you out and makes you feel uncomfortable." Four participants talked about the idea that BPD is a catch-all or last resort diagnosis to describe how some clinicians might diagnose it when they do not know what else it could be. These clinicians believe BPD is often applied to the most difficult clients, whether they meet the criteria or not.

Disclosure of BPD to the Client

One of the research queries was to elicit if the participants disclose the diagnosis of BPD to the client directly. This is another area that turned out to be fairly mixed in responses. Some clinicians see the benefits of disclosure, no matter what the diagnosis. Others believe that telling the client this diagnosis could instead be harmful to the client. Starting with those who are pro-disclosure, the benefits they see coming from disclosure are the value of psycho-education and

the potential for “de-shaming” or de-stigmatizing the diagnosis if it is talked about. One interviewee responded, “I have found disclosure to go the distance because it helps them understand themselves more. If they have an adverse reaction to it then you work with it and later on they have something more concrete.” Regarding her use of disclosure with a client, one clinician said:

It was helpful for her. I told her that knowledge is power. If you understand something you can manage it better than when it doesn't make sense to you... You have to be very careful when you introduce a borderline diagnosis and enough of an alliance needs to be built. I can easily see how that information would not be received well and maybe they don't come back but you never know how they ended up making use of it.

Another participant spoke to the shift she had with the issue of disclosure, by learning from how a colleague handles this sensitive topic. The following quote illustrates this:

You know, I don't know I would have [disclosed] until I started working with [colleague] and really understood her point of view of how she finds it to be really important to be clear and name it because that deshames it. So I would eventually disclose. We are pushed to diagnose in the first session and I don't feel comfortable telling someone that quickly. Because they could go look it up and have a reaction because of all this information out there. And the fact that in some ways it seems kind of hopeless when you read the stuff out there.

One more participant noticed her feelings about disclosing BPD changing over the years she has been a therapist. Towards the start of her career she felt the diagnosis was not something clinicians talked about but today she says she would have no problem telling someone that they carry this diagnosis. She explained, “I am such a strong believer in psycho-education and I think

that people need to understand their disorder.” This clinician sees BPD “as sort of a handicap,” so she thinks it helps their situation to know that.

In contrast, the reasons mentioned for being against or reluctant to talking about this diagnosis included the following reasons: the notion that the actual diagnosis is not relevant to the treatment; the potential for the diagnostic language to add complicated, unnecessary layers; and the fact that it is a stigmatizing diagnostic label that can have harmful consequences. Three clinicians were adamantly against disclosing the diagnosis and three talked about their hesitation in disclosing BPD with the client. One remarked, “I think Axis II is something I don’t even want to touch because there are so many other ways to talk about something that don’t lend to coming across as stigmatizing.” Another clinician mentioned he would be reluctant to disclose unless he was able to really discuss it: “If I can explain the disorder in terms of what the dynamics are then I don’t see a problem but I don’t like to call people names.” Another participant said it is not something she likes to share, “I don’t think it’s really relevant. I think you can treat someone without it because it’s such a labeling diagnosis.” Along those same lines, one participant described how she feels disclosure can take away from the session. Her only reason for ever using a diagnosis is for insurance purposes, which was the case for a few others. She stated, “I do not feel that spending time talking about diagnoses is useful at all. We don’t need to throw extra, unnecessary language on it because it’s not helpful.” Another participant spoke about his reluctance to disclose the diagnosis to his client but he sees the usefulness in talking about it with family and significant others so they can get a better understanding of how to live with their loved one.

One clinician used this question as an opportunity to really explain his frustration with diagnoses in the first place, let alone disclosing them to clients. His response illuminated this position:

I don't use diagnoses. I don't tell anybody what their diagnosis is. They tell me what their experience is and I ask how they would like it to be different. I don't ever tell anybody what they have because I don't think it's relevant. I think that the whole diagnostic thing is for the comfort of the clinician. It doesn't have anything to do with the therapy. I think we like say, 'Oh I know what it is, therefore, I'll go down my little decision tree and I'm all comfy.' That's why I don't think about the DSM or use the medical model because for me, it's about how the person is relating to themselves and the world around them, and that's the source of the problem.

Treatment Approaches and Implications

The participants were asked whether they thought BPD is treatable and why or why they may not think it possible. This question led to discussions around the potential hope that clients could in fact get better. Participants also elaborated on effective treatment approaches and the experience of treating a client with BPD in general. Every participant answered that they thought BPD is treatable, but not without a lot of work, motivation, and time. The majority talked about there being hope for making progress but not necessarily a cure. Factors that need to be there for a reduction of symptomatic features included motivation, the right setting or treatment environment, and a lot of time and hard work. One clinician explained, "Progress can occur for people who are committed and interested in learning better self emotional regulation and how to break out of thinking in black and white terms."

This question also elicited a common response about the natural change in this diagnosis as a client ages. The DSM-IV-TR also discusses this concept. Three participants mentioned that the research shows people with BPD become less afflicted by the disorder as they get older. One clinician said, “If you reach your 40s it kind of works itself out.” In talking about a follow-up study on patients with BPD another clinician said patients who clearly met the criteria before did not have the diagnosis anymore. Another participant said, “The older a borderline is the better they get.”

In continuing with the discussion around treatment, many participants shared what approach they take with BPD. While cognitive behavioral therapies were mentioned briefly, most clinicians use their own skills that have been refined over the years, also sometimes called “eclectic” or “integrative” because they combine several theoretical models and treatment approaches into one. A more psychodynamically-oriented clinician stated the following:

My role is to do some of that reflecting and slow the process down enough so we have a little bit of space because that's the one thing that the borderline tries to do, is try to collapse space so nothing new can happen. And that's the great challenge and why they can be so frustrating. They are incredibly unhappy but they are terrified of change. I think annihilation anxiety is the driving force for them. Giving up all of these defenses that are so problematic threatens them with disappearance.

He described his overriding goal in his long-term work to be leaving the patient feeling that they are understood so they can begin to understand themselves. He continued, “They get to know who they are by how I reflect them. Therefore, I have to be able to keep my stuff together while we’re doing some of this intense work.” This technique is known as “mirroring.”

Another participant talked about her use of object relations and self-psychology to understand the underlying mechanisms behind the disorder. She also talked about teaching the client when to notice thoughts and feelings so that crisis might be avoided by intervening early before a crisis escalates. This clinician feels that normalizing the client's experience is hugely important and letting the client know that his or her brain works differently.

Three interviewees discussed the importance of only offering services to a client with BPD if the clinician is equipped for it. All of them feel that it is more effective to offer what they are capable of until they no longer can and when that happens, they think the client should see someone who has other things to offer the client. Another important caveat in working with this population is having empathy for the client's struggle. One participant feels that clinicians should not work with clients when they cannot find a place in their heart that sees the immense struggle in the client's life. This ties in with the earlier discussion of feeling compassion for the client and using empathy to join in a therapeutic alliance.

Lastly, a few participants discussed the idea of not taking on more than one or two clients with BPD at one time because of the intensive work that can be involved. This refers to those clinicians that have private practices and the power to take or reject a client at will. One clinician talked about balancing the caseload with only one Axis II client. She added, "And that's clinically sound to you because if you can't offer them what they need, you can't help." The reason behind it appears to be about the sheer amount of energy a client with BPD can involve. Another participant answered, "It certainly makes a difference to your workload so you need to know how many you're taking in and how you can balance it because, again, it's energy and it's exhausting." Two clinicians mentioned they would want to reserve their space and time for a client with a higher amount of insight and motivation.

How BPD is Talked About Among Other Clinicians

Finally, the participants were asked how others in the field generally talk about BPD. All respondents mentioned in some way the pejorative connotation this diagnosis holds. Reasons for this differed slightly but, overall, there seems to be shared experiences of hearing other clinicians talk about it in a negative manner. One participant said, “When I hear the terminology being used in a more coffee table way, it’s generally about referring to a patient that is very difficult to manage. There’s almost a sense of dread.” He also explained, “When clinicians are talking freely, the single word *borderline* carries a pejorative connotation. When the word *borderline* is said there’s a shared implicit knowing of what one means by that.” In elaborating he said it can be like a roller coaster to work with these clients and that is usually why a lot of clinicians do not like to work with these individuals. Another participant shared how she feels when she hears it talked about in an insensitive fashion: “I tend to cringe when I hear people talking about being *a borderline* and I also observe negative attitudes surrounding the diagnosis and those that carry it.” She explained that she can handle someone using the label in a way to describe something using a common language and if their heart is in the right place with the term, but not when it is used flippantly to put someone in that category. In other words, time and place seem to be important when deciding when and how to use language that is less compassionate.

One participant who works in a hospital setting talked about how she notices the language used does not necessarily come with malicious intent. She said, “It is more derogatory than I am used to but a lot of it is shorthand and medically-oriented so I don’t know that anyone means to be harsh or judgmental but there is less awareness around being sensitive.” She continued, “I think when it does come up in a derogatory way it’s more about self-preservation. People are overloaded and they don’t want to deal with people who are difficult. So it comes up

because those clients suck energy and resources.” She has also noticed that those clinicians who specialize in working with BPD are really good about not being shaming but she thinks it is because they have chosen to work with the population. Perhaps the desire and willingness to treat BPD counteracts the various challenges and complexities of the work.

Another clinician reflected on the contrast between her orientation and how it is viewed around her. She stated, “Despite my orientation in my slice of the world, it is still a very stigmatizing diagnosis. It is used pejoratively and I think a lot of therapists keep their distance or refuse to treat it.” She feels that someone’s understanding of the diagnosis largely influences how he or she will talk about it. In other words, if one has a good grasp on what causes BPD, he or she will most likely be more sensitive. She also discussed the benefit of thinking about BPD on a spectrum, “Then it’s not so mean-spirited and you don’t feel like you’re branding them.”

Three other participants spoke about what they have noticed in the language and feelings surrounding BPD. One said, “It is the most vilified diagnosis there is. Sex offenders are not talked about with as much disgust as borderlines. And I can’t tell you how many colleagues have said over the years that they will not treat borderlines.” Another clinician commented, “There is anger, frustration, and disgust surrounding this diagnosis.” One more reflected on a warning she received in the beginning of her career, “In my first year internship I was told I’d be working a lot of borderlines and it would feel like there are weights around my ankles.”

Overall, this study produced interesting and rich data that sheds some light on the stigma attached to BPD. The participants’ narratives weaved together to form possible reasons for the pejorative language attributed to individuals with BPD and the resistance to treat the diagnosis. In the following chapter I will present a synthesis of the reviewed literature and this study’s findings. The discussion will also include implications for the field and areas for further research.

CHAPTER V

Discussion

As previously discussed in Chapter Two, existing literature demonstrates there is strong evidence of a pervasive stigma attached to Borderline Personality Disorder. Studies have shown that providers who work with these individuals (whether it is an accurate diagnosis or not) tend to hold negative attitudes and feelings towards the client (Deans & Meocevic, 2006; Treloar, 2009; Woolaston & Hixenbaugh, 2008). With the assumption that the examined studies carry some validity, I sought to find out the origin and reason for the stigma, and discovered that there was a significant gap in the literature on this topic. Existing studies did not focus on clinician narratives about their experiences throughout their work with this population. Upon inspection of the collected data, I analyzed the transcribed interviews for themes. Comparing and contrasting quotes from each theme pointed towards many interesting and important implications. Analysis also bridged previous research with the current study.

Links to Reviewed Literature

Due to most of the literature asserting that clinicians have adverse reactions to clients who fit the BPD clinical picture, I purposely began each interview with a loose association exercise in order to draw out initial thoughts, beliefs, and feelings about BPD. Not surprisingly, participants seemed to rely on experiences with specific clients that immediately popped into their minds. This observation supports Treloar's (2009) study, which implied the negative perceptions derive from what is evoked within the clinician while working with a client on the borderline spectrum. I will discuss this in further depth below.

Hodges (2003) says she is being cynical when she says clinicians will find whatever it is that they want to find. This suggestion is actually quite accurate, considering several participants mentioned this treatment dilemma. Similar to Treloar's (2009) idea, Hodges goes further to say BPD is often diagnosed in *any* client that is especially difficult or not making enough progress. Also like Treloar, Hodges argues that countertransference hugely informs this particular diagnosis. My research wholly confirms these concepts, which I will also discuss further in this chapter.

One prominent theme that emerged was why it remains unclear why clinicians favor clients with PTSD (post-traumatic stress disorder) over those with BPD. My findings indicate that clinicians are aware of the trauma component that often exists in the histories of these individuals, yet there does not seem to be the same compassion towards healing those wounds. Even if direct trauma did not occur in an individual's life, perhaps it was still an invalidating environment or that there were insecure attachments that led to BPD traits for an individual. Still, there does not seem to be as much of an acknowledgment of the pain or tragedy these clients bring into therapy. Maracek (as cited in Hodges, 2003) discussed the stark differences in what could be called the "blame game." Clinicians typically do not blame an individual who has developed PTSD and there appears to be more empathy readily available to survivors of trauma. In contrast, BPD has long been discussed in professional circles as something to run away from rather than embrace with open arms. Comparing clinician attitudes on the two diagnoses could be worthwhile to examine in future studies.

My research supports a study by Markham and Trower (2003) that found a pre-existing label of BPD affects staff perceptions. A theme that came up throughout my interviews had to do with not working with clients who have BPD altogether, or at least keeping the number to a

maximum of only two clients (as if it suggest that more would be too overwhelming on a clinician). As discussed in the Findings section, participants felt they would rather not treat someone who meets the criteria for BPD due to the intensity and energy consumption of the work. Fortunately for these clients, several participants also insisted that clinicians should not treat clients who present beyond the scope of their knowledge.

My findings also support Markham's (2003) study that found individuals with BPD as *dangerous* to clinicians. I listened to many anecdotes from participants describing messy, complicated, or dreadful interactions with clients they felt met the criteria for BPD. I did not explore what exactly they fear but this could be a very interesting piece of work in the future. I would have loved to probe further into this particular phenomenon, the notion of this population being "threatening" to clinicians. On the contrary, these individuals are the hurt and scared ones.

Considering the various correlations referenced thus far, it is no wonder studies from the patient's perspective (Johnstone & Brooke, 2007; Nehls, 1999) have found that clients feel blamed and perceived as manipulative. Participants in Nehl's study stated that receiving a diagnosis of BPD is not so much the problem; instead, the problem is the prejudices or assumptions of the providers.

Disclosure was discussed both in the literature and within the context of my interviews. This is tricky territory and it depends entirely on both the provider and the client. While diagnosis disclosure can be liberating or relieving or informative, it can also provide a breeding ground for the stigma. Lequense and Hersh (2004) discuss the reasons to disclose or not disclose the diagnosis of BPD to the client. The participants in my study had mixed feelings about disclosing but it became clear that their reservations are attached to the stigma and negative information available to the public on BPD. Like some of my participants, I feel that

psychoeducation is a vital part of our work but perhaps this particular diagnosis requires special attention and consideration in determining how and when to deliver the information. I would imagine if the clinician has existing negative attitudes about BPD, it probably would not come across to the client as anything but destructive and defeating. The countertransference would come out prominently, even non-verbally.

Lastly, my research supports Hodges' (2003) discussion around the concept of recovery for this population. She called it "bleak," which is an accurate description of how clinicians feel about overcoming BPD. I asked participants if they thought BPD could be treated. Similar to Hodges' findings, there is an overwhelming sense that BPD is extremely hard to conquer, or even manage. All participants talked about how long and how much effort would be involved in overcoming the many challenges that these clients endure. There seemed to be a hopeless tone to their answers, as if they felt bad about stating it would be incredibly hard to get better. It makes me wonder, if the experts do not have hope, how will the clients have hope? Our jobs as clinicians and our social work values assert that we help individuals in need and to address social problems. Several participants mentioned "growing out" of this disorder, so there is hope.

Conclusions Regarding Clinician Attitudes

I propose there are certain types of clinicians who will always feel negatively towards individuals with BPD. In some circles of thought it seems to be somewhat of a truth or a fact that *borderlines* are horrible clients. Clinicians may also be aware of their stigmatizing viewpoints but need an outlet such as supervision, peer consultation, or psychoeducation to process their biases. Clinicians need to remain mindful of what is being evoked and not letting it get in the way of treatment. And then there seems to be a third group of clinicians who simply do not judge in the ways I have discussed. Of course they form assumptions and cannot avoid all

judgment, but this group will gladly receive and accept anyone who walks through their door, exclusive of the diagnosis or presenting characteristics. I believe only one participant fell into the last category but I know more are out there doing what is no doubt extremely challenging but crucial work with this population.

So, what leads to these differences in thinking about BPD? I say it is a mixture of life experiences, cultural aspects, and training. I believe the negative attitudes and beliefs regarding this diagnosis are definitely out there among clinicians who use the DSM-IV-TR as an important tool for treatment. In other words, people who do not use the DSM as a “tell-all” for a client, and do not focus as much on diagnoses, are going to be those who are more accepting and compassionate about treatment altogether. The participant mentioned above was adamant about not using diagnoses at all and several others made it clear diagnostic categories or labels are not relevant to making progress in treatment. Of course there needs to be a focus and sessions should be leading in a linear progression, but those clinicians who do not rely on the DSM as a roadmap seem to be much less stigmatizing in general.

I also believe that those who do rely heavily on the DSM tend to be treating the diagnosis and not the person. Individuals with BPD are especially at risk working with this type of clinician because an individual who has BPD or features of BPD typically and naturally causes conflict within the treatment dyad. When treating or working with a client that is especially difficult, I believe some clinicians would prefer to slap on a label and call it out than to stay with the client through the messy and difficult transactions. Labeling can sometimes be a way for a clinician to close a door on a client when they just do not want to work through it. BPD remains a label that is broadly accepted as a warning or caution sign. Clinicians who can and want to sit with a person despite negative countertransference feelings are those who would be more willing

to accept and embrace a client who presents with this clinically complex picture.

The second group (those who can go either way) provided the richest data among the interviews. Although the “majority” of clinicians associate words like “challenging” and “manipulative” with BPD, when a deeper conversation is had, you will find that they have an understanding of this disorder from a humanistic perspective. So perhaps this is a diagnosis that is largely talked about in short, brief encounters and not as much in more depth. The open-ended questions allowed the clinicians some reflective space that they don't normally have, and several of them said this. Some of this may come from the fact that our current mental health system just does not warrant time for meaningful case conceptualizations, or perhaps it is simply because of the stigma attached to the label. In my experience, clinicians either talk too much or too little about BPD. And by that I mean they love to slap it on to any frustrating client or they believe it is taboo to talk about. Both explanations are not conducive to helping those who struggle with BPD.

Implications for the Social Work Field

I think this study shows there is an absolute stigma and I think we, the providers, contribute to the stigma. It seems to be attached to this diagnosis due to the particular treatment challenges that often occur with clients with BPD. It is no secret that individuals on the borderline spectrum can be a struggle to work with no matter the capacity, whether the person is a client, family member, friend, or colleague. Ironically, I feel that if this client population did not genuinely need mental health treatment so desperately, there would be no context or platform for a discussion in the first place. I believe the negative feelings surrounding BPD is a cycle. It is a very real diagnosis in the sense that the client’s experience is a real personal and interpersonal challenge, but I think it is vilified because providers also have the very real experience of

emotional outcomes such as frustration, disappointment, fear, and dislike during their work with a client who meets the diagnostic criteria. As described in Chapter Two, Linehan's biosocial theory supports the notion that people with BPD might be more vulnerable than other clients because the environment has been so invalidating to their negative emotional experiences. Therefore, the treatment relationship has the potential to recreate the transactions that contributed to the impairments in the realms of affective, cognitive, behavioral, self, and interpersonal. Therapy is not unidirectional; instead, it is relational and involves vulnerability of both clinician and client.

This study clearly showed that the therapeutic alliance and the interactions with clients who carry the diagnosis could be more challenging overall. It came up in at least half of the interviews that treating BPD could be "dangerous." I imagine this is due to the possibility that the therapeutic relationship could be messy, uncomfortable, and unstable. As previously discussed in Chapter Two, the literature paints a fairly vivid picture of symptomology, prognosis, and treatment anecdotes. To some, perhaps this information is overwhelming or scary, or just something a clinician would prefer not to touch. Referring back to the concept of "dangerous," it was one of my participants who said it is risky for the field of American psychiatry to look at anything psychodynamically. To call a client one thing, whether it carries a negative connotation or not, is safer and easier.

As a few participants said, self-preservation is important and perhaps that is what we are dealing with here. Chances are, it is going to be complex, complicated, and challenging to treat the clinical picture of BPD. All this being said, if a positive shift is going to occur regarding the blatant stigma attached to BPD, maybe the clinician's task is to simply be more honest and open about who she or he is equipped to treat. In other words, those who do experience adverse

reactions towards clients with BPD, and especially those who seem reluctant to engage with them, should probably avoid or limit taking the cases as an ultimate service to the clients.

Implications for Theoretical Stances or Treatment Approaches

An important consideration that participants alluded to in their narratives is the way in which this diagnosis is used with a client. It is one thing to speak about it in pejorative terms among colleagues but it is another to do so with a client. The tricky part is how easily a client can come across the stigmatizing and hopeless views on their own. Furthermore, I personally feel that personality disorders can be hurtful or scary for an individual to process versus something like a mood or anxiety disorder, which society accepts as chemical imbalances. But, with BPD and other Axis II diagnoses, it can come across or feel like the clinician is insulting the client's character or the way the client works internally and externally. Personality disorders are a cluster of impairments in someone's personality structure that has become entrenched over several years starting from early adulthood. When the concept of personality is up for discussion, the chances of hearing or interpreting something as offensive and hurtful are greater since interpreting and internalizing the idea that there is something wrong with the core of your personhood is tremendously defeating. Therefore, any discussion of this diagnosis should be well thought out and executed with sensitivity and compassion.

I do not think clinicians intend to be pejorative when speaking in terms that sound stigmatizing. Rather, I think it is about using a common language to describe clients who present with a certain picture. The diagnosis of BPD makes it harder to separate the disorder from the person because some traits of BPD evoke strong feelings within ourselves. I truly wonder if naming certain behaviors as *borderline* or deciding someone has a personality disorder in the first place is more about the therapist than the client. How often do we hear a therapist saying,

“This client is just so difficult because she is help rejecting and makes me feel inadequate to treat her or him”? We rarely hear this in the field. Instead, one hears “She’s such a borderline.” Saying this alone to a colleague says a lot without the need to elaborate because there is so much implied in the word. But if you did have time to have a chat about that particular client, I think most clinicians would be able to describe exactly what they mean when they call a client *a borderline*. Most of the narratives had some mention of how much tragedy and trauma and disappointment have occurred in most individuals’ lives who are diagnosed with BPD, which gives me hope that our field can readily accept and explore the diagnosis of Borderline Personality Disorder.

Strengths and Limitations

There were both strengths and limitations to this study. I aimed to fill a gap in the research. The literature lacks qualitative, interview-based studies with clinicians. The focus has been on determining if a stigma exists through an empirical study vs. simply to take at face value that this does indeed exist. A casual conversation with a random sample of clinicians about BPD easily points to this notion. This study attempted to move past that in order to explore the reasons that underlie the stigma. This study also focused on a mental health population that has not previously been studied: clinicians. Also, the research design of in-depth interviews contributed greatly to the rich data collected and subsequent findings and conclusions.

Limitations to this study include a small sample size with the majority of participants having social work degrees. A larger population would increase the validity of my findings. Clinical social workers are important to target but they do not comprise the entire mental health field and therefore, other perspectives and voices were not heard. Along those same lines, the majority of participants were female. I do think it would be important to look into differences

between genders in future studies.

Lastly, the questions used in this study were my own and informed by past research, as well as theory. Therefore, I brought into the interviews a certain bias that may or may not have influenced the outcome. Questions were devised in a manner to convey neutrality so the participant would feel they could speak freely, but this could not be guaranteed. Some of the questions, or the way I phrased them, could have held underlying meaning or insinuated that I do not come from a non-neutral stance. The questions, or even the letter of informed consent, could have been interpreted by the interested participant as favorable or unfavorable towards BPD. Not knowing what I could ask next may have produced caution in some clinicians. My probing questions in response to their answers may have altered the rest of the interview to the point of affecting the results. In addition, I designed this study around an issue in which I am interested; it would be false to assume that my own intentions did not influence or skew the results. For example, I am personally invested in contributing towards reducing, and hopefully erasing, the stigma associated with BPD. It is my hope that the language and the reactions attached to it will shift towards a more empathic perspective within the mental health field.

In Retrospect

Perhaps if I had devised this study in a different way, such as surveys or a focus group, it could that have lent itself to more honesty and openness. There is the potential for discomfort around being judged by the researcher. Technically, they are being judged in the interview and they may be very aware of that and feel bad for being judgmental towards clients. Interestingly, to show this point, one participant made a very pejorative statement during the screening and it seemed like she would open up a lot about her negative feelings when the interview came along. However, after reading and returning the informed consent, something changed and the interview

felt very rigid and carefully worded. There is no doubt this subject is both complex and sensitive, so I wonder if anonymity would increase the level of honesty that participants are willing to undergo with a researcher.

Areas for Future Research

I propose that the clinicians who will be most compassionate and non-stigmatizing towards this population are those who have some type of connection to spirituality or religion. This became a theme in the narratives of the interviews and it leads me to believe there is a connection between spirituality and treatment stance towards certain populations. This makes sense because DBT is clinically proven to be the most effective treatment for BPD and there is a huge component of spirituality (Zen Buddhism) directly incorporated into this treatment. Perhaps it is the reason why those therapists who have a positive understanding of BPD are those who utilize or incorporate some form of spirituality (big or small; directly or indirectly) practices into their own treatment approaches. Testing this connection could be informative in regards to therapist-client matches and treatment approaches. In addition, exploring the specific characteristics associated with non-stigmatizing attitudes in clinicians towards BPD could result in a deeper understanding of who works best with this population.

Something I am especially curious about is what clinicians do when they realize they are working with someone who has BPD and then quickly choose to resign from the treatment. Considering how many participants mentioned they prefer not wanting to work with this population, I would imagine they have to anyways because it is not always feasible (agency vs. private practice) to know what a new client's presenting issues will be. So this leads me to wonder what happens to these clients and how does the therapist go about terminating or discontinuing treatment. How many people are being left behind by those who have made it

their life's work to help others? This is something that could be explored in a study similar to this one, but with questions of a different focus. For the client's sake, I would hope she or he terminates the work themselves if they sense stigma or dislike in the room. It would not benefit either party to continue if a genuine alliance could not be established.

Conclusion

On a much broader level, mental illness as a whole is still somewhat of a forbidden topic and people who struggle with their mental health are stigmatized and alienated enough by larger society. It is my hope that those who treat and heal mental illness do not add to that process by being afraid, ill-informed or unwilling to work with an entire population of clients. This experience reminded me of the dynamic aspect to doing clinical social work or psychotherapy. Most participants reflected on their changing views, as they gained more experience or acquired new knowledge in their professional journeys. The field will also be affected by a new edition of the Diagnostic Statistical Manual, which has indeed modified the way the community conceptualizes BPD. I am interested to see if the changes inform a shift in thinking about it altogether for mental health professionals. What is most important is that our minds remain forever open and flexible because there is never just one way of doing things when it comes to the complexities and wonders of the human condition.

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Appendix A

Screening Questions

1. Do you have a master's or doctorate level degree in a mental health field?
2. Do you have or have you had at least one client within the past 5 years that meets the DSM-IV diagnostic criteria for Borderline Personality Disorder?

Appendix B

Approval Letter from Human Subjects Review Board



School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 F (413) 585-7994

January 29, 2012

Jessica Fritz

Dear Jessica,

I did not understand your revision letter as your numbers did not seem to match the numbers I put in the first letter. But that does not matter as all of the concerns were well and carefully addressed in the revision itself. You did a nice clear job in making changes! Your project is hereby approved by the Human Subjects Review Committee and you may proceed.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Congratulations!

Sincerely,

A handwritten signature in black ink, reading "David L. Burton". The signature is written in a cursive style with a long horizontal flourish extending to the right.

David L. Burton, M.S.W., Ph.D.
Chair, Human Subjects Review Committee

CC: Mariko Ono, Research Advisor

Appendix C

Recruitment Letter

Dear Potential Participants,

I am looking for clinicians who might be interested in participating in a study exploring the attitudes and feelings surrounding the diagnosis of Borderline Personality Disorder, as well as in sharing their experiences in working with these clients.

I am a graduate student at the Smith College School for Social Work, and am conducting this study for my masters' thesis. For this study I will be interviewing mental health clinicians who have had the experience of working with at least one client within the past 5 years who meets the DSM-IV criteria for Borderline Personality Disorder. For the purpose of this study, you must be a social worker, psychologist, or marriage and family therapist with a master's or doctorate degree. If you meet these criteria, I would appreciate your consideration to participate in this study.

If you agree to participate, you will be interviewed over the phone at a time that is convenient for you. The interview will take no more than 40 minutes. It will be audiotaped for my use only. Any information that would identify you will be kept confidential. Your name will not be attached to your interview and pseudonyms will be used instead.

I believe you may benefit from participating in this study by sharing your experiences of working with this population and reflecting on your own attitudes about this complex diagnosis. Your contribution will be incredibly useful to the field, especially in creating awareness among mental health professionals.

Please contact me if you agree to participate and to set up a time and date for the interview. If you require further information, feel free to call or email me at **(personal information deleted by Laura H. Wyman, 11/30/12)**. I appreciate you taking the time to read this and I look forward to hearing from you.

Sincerely,

Jessica Fritz

Appendix D

Interview Guide

- Do you have any questions about the informed consent or the study itself before we begin?
- I want to start by reminding you not to use any identifying information when talking about any clients you have worked with.

Demographics

1. What is your age?
2. What race or ethnicity do you identify as?
3. What professional degree(s) do you hold?
4. How long have you been practicing as a mental health clinician?
5. What is the setting of your work and how many hours do you typically work in a week?

Interview Questions

1. What words come to mind when you think about Borderline Personality Disorder?
2. What about the word “borderline”?
3. How would you describe your feelings surrounding this diagnosis?
4. Can you tell me a little about your experience of working with a client that meets criteria for Borderline Personality Disorder and, if you can, try to pinpoint your initial reaction when recalling that treatment relationship?
5. Can you describe any countertransference issues that may come up when working with a client with BPD?
6. What factors inform a diagnosis of BPD for you? For example, it may be symptoms that meet DSM criteria, intuition, past clinical experiences, prior diagnoses, etc.
7. Do you disclose the diagnosis to the patient or client? Why or why not?

(a) If you have discussed it with your client, how was it received or what was the transaction like?

8. How do your colleagues talk about this diagnosis in places like the break room or treatment planning room?

9. Hypothetically, if a potential client calls you to start treatment and he or she tells you that they have a diagnosis of BPD, is there anything different about how you proceed from there in comparison to if it was someone struggling with depression or anxiety?

10. Do you feel that BPD is treatable? If so, what do you feel is an effective treatment approach to helping a client function better?

11. Is there anything else you want to add?

Appendix E

Letter of Informed Consent

Dear Participant,

My name is Jessica Fritz and I am a graduate student at Smith College School for Social Work. I am conducting a research study to explore clinician attitudes and feelings toward a client with a diagnosis of Borderline Personality Disorder (BPD). The data collected will contribute to the completion of my master's thesis and possible future presentation and publication.

If you decide to participate, you will complete a telephone interview that will take no more than 40 minutes. I would like to explore your attitudes and feelings regarding the diagnosis of Borderline Personality Disorder, as well as your experience of working with this population. Also included will be a few demographic questions. I will audiotape the interview and later transcribe it myself.

There is the chance that talking about this topic might bring up uncomfortable feelings for you. However, you may benefit from talking about your professional experiences. In addition, the information will contribute to the social work field's understanding of what attitudes and perceptions play a role in our diagnostic impressions and treatment decisions pertaining to Borderline Personality Disorder.

Your privacy is very important to me and I will take steps to keep confidentiality throughout the research study. Your real name will not be used during the interview, nor will it be attached to any of the data. My research advisor will have access to the data, but only after the identifying information is disguised. If anyone else is used for transcription or data analysis, they will sign a confidentiality pledge. When the data is published as my thesis and presented, the data and all identifying information will be carefully disguised. All data collected throughout the research study will be kept in a secure location for a period of three years as required by Federal guidelines and any electronic data will be password protected. If I need to keep the material beyond three years, it will continue to be kept secure and will be destroyed when no longer needed.

Participation in this study is voluntary. You may withdraw from the study at any time during the data collection process and you may refuse to answer any or all questions. If you decide to withdraw, you may do so by emailing me at **(personal information deleted by Laura H. Wyman, 11/30/12)** before April 15, 2012. If you do withdraw by the deadline, all material pertaining to you will be immediately destroyed. Should you have any concerns about your rights or about any aspect of the study, please do not hesitate to contact me or call the Chair of the Smith College School for Social Work Human Subjects Review Committee at (413) 585-7974.

Your signature below indicates that you have read and understand the above information and that you have had the opportunity to ask questions about the study, your participation, and your rights and that you agree to participate in the study.

Participant's Signature

Date

Researcher's Signature

Date

Please keep a copy of this form for your records. Thank you for your participation. If you need to reach me, you can email me at **(personal information deleted by Laura H. Wyman, 11/30/12)**