# Research Bulletin

## Borderline Personality Disorder, Stigma and Young People

**Borderline personality disorder (BPD) has been identified as the most stigmatised psychiatric diagnosis (Nehls, 1998). Stigma is of understandable concern to young people and families. Stigma not only affects clients and families, but also clinicians, making them reluctant to diagnose BPD, particularly in young people, for fear of rejection and discrimination affecting their clients (Chanen & McCutcheon, 2013).**

**This research bulletin aims to review and integrate research relating to stigma, BPD and young people, and the influence this then has on diagnosis. Some of the studies relate specifically to BPD, and others to personality disorder more broadly; the latter are included in this review when the research focuses on the psychiatric inpatient setting, where BPD is the most prevalent personality disorder (PD).**

## What is stigma?

Stigma has been said to have three components: stereotyped, incorrect beliefs about those in the stigmatised group; negative evaluation (including beliefs and emotions); and discriminatory behavior (Corrigan & Watson 2002; Thornicroft et al. 2007). Stigma has been identified as a key reason as to why young people do not seek mental health care (Gulliver, Griffiths & Christensen 2010; Rickwood, Deane & Wilson 2007), with only a minority of those with clinically significant difficulties accessing mental health treatment (e.g. Sawyer et al., 2001).

## Stigma, BPD and young people

Evidence demonstrates that BPD is a highly stigmatised condition. A number of studies (e.g. Markham & Trower, 2003, outlined below; Markham, 2003) suggest that the diagnostic label of 'BPD' elicits particular negative beliefs and emotions in psychiatric nurses relating to sympathy, rejection, and optimism. This seems to stem from inaccurate beliefs about how stable and controllable the cause of behaviour and behaviour itself are in people with BPD, and how dangerous people with BPD are.

While labels may have different meanings for members of different groups (Link et al. 1987), it is important to point out that other mental health clinicians also endorse negative beliefs and feelings about people with BPD. Other studies (e.g. Black et al. 2011; Bodner et al. 2015; Liebman & Burnette 2013) suggest that these beliefs extend to other staff, such as psychologists, psychiatrists and social workers, although nurses seem least empathic and optimistic about care, perhaps

because they see the most people with BPD of all these groups, spend the most time with them, or see clients when they are struggling most and require inpatient care. Nursing staff may also be provided with the least support and supervision in working with this client group.

Clinicians' negative beliefs may then guide behavior, becoming the 'guiding imagery for action' (Scheff 1966, p82) and result in discrimination against those with BPD. In the only study we could find relating to discriminatory behaviour, Fraser and Gallop (1993) reported that nurses observed on an inpatient unit interacted with people with BPD with greater negative intensity and less empathy than those with schizophrenia, being 'more indifferent and impervious' towards those with BPD. This study, however, left a number of variables uncontrolled, including previous knowledge of the client, such that further evidence is required to fully support these conclusions.

Young people with BPD are also stigmatised. Inpatient nursing staff in Reiss and Gannon (2015, reviewed below) working with young people reported a range of difficulties, including negative emotions, in this work. Liebman and Burnette (2013, reviewed below) report that clinicians had particularly negative beliefs about younger people with BPD. Young people with BPD also report a high subjective sense of being stigmatised (Catthoor et al. 2015, reviewed below).

The label of BPD does not evoke the same stigma in the general community as it does in mental health clinicians. A recent study (Furnham et al. 2015, reviewed below) indicates that, in the general public, the capacity to accurately label BPD was unrelated to negative beliefs about people with BPD; it was the behaviours associated with BPD that prompted negative judgments, regardless of the diagnostic label applied to them.

We do not know of any empirical research that explains why these negative beliefs develop in mental health workers. However, a number of authors have suggested what might underlie these beliefs. Reasons suggested included the feelings that can be evoked in work with people with BPD, including frustration, helplessness, fear, and incompetence, in the face of features such as intense anger and chronic self-harm, suicidal ideation and suicide attempts (e.g. Markham & Trower 2003; Aviram, Brodsky & Stanley 2006).

We would suggest that it is the relational problems at the heart of BPD that make it difficult for people with BPD to effectively engage in treatment and can make it difficult for clinicians to feel like effective helpers; this, combined with the anxiety created by the risk that often accompanies BPD, contribute to the particular stigma associated with BPD among mental health clinicians.

> " I do think people that work away from that patient and who don't spend a day on the ward with them struggle to see how difficult it is spending seven-and-a-half hours on your shift, or fourteen if it's a long day, with that person is, and how emotionally draining that actually is."
>
> **– Maggie**, psychiatric nurse, in Reiss & Gannon, 2015

## Stigma, young people, BPD and diagnosis

This stigma of the BPD label is so pronounced that some (e.g. Griffiths 2011, reviewed below) suggest avoiding the diagnosis in young people, in particular, because of beliefs that the diagnosis communicates both intractability and chronicity to other staff and to young people and their families (see also Koehne et al. 2012, reviewed below). However, the Furnham et al. (2015) paper outlined earlier suggests that the BPD label itself does not prompt particular beliefs about treatability or chronicity in the general population. By avoiding the label, we avoid the judgment of mental health clinicians in particular.

Our concern with the tendency not to diagnose BPD in young people when it is properly assessed to be present is that it further reinforces the stereotype of BPD as an enduring illness from which people have little hope of recovery. The label is likely to be left for those for whom it cannot be avoided. This stereotype is at odds with an emerging literature that demonstrates both the natural history of attenuation of BPD features over time (Gunderson et al. 2011) and the effectiveness of indicated prevention and early intervention for BPD or features of BPD (Chanen et al. 2008, Mehlum et al. 2014, Rossouw & Fonagy 2012, Schuppert et al. 2012). We believe that avoiding the diagnosis of BPD in young people can, paradoxically, serve to perpetuate the stigma of the label of BPD (Chanen, in press). It excises from the diagnostic category the many for whom treatment leads to meaningful change, in part guided by treatment informed by our understanding of the problem (i.e. the diagnosis). However, we do suggest using considerable caution in making the diagnosis in those regrettable contexts in which people are likely to experience discrimination because of the diagnosis.

# Avoiding the diagnosis of BPD in young people can, paradoxically, serve to perpetuate the stigma of the label of BPD.

The BPD label appears most stigmatised by clinicians. We think a preferable alternative to restricting the use of the diagnosis to avoid this stigma is to broaden clinicians' understanding of BPD. Efforts have been made to reduce clinician stigmatising of BPD, some using specific therapies as the basis for this training (e.g. Clarke et al. 2014, reviewed below; Knaak et al. 2015; Shanks et al. 2011). Knaak et al. (2014) identify, based on systematic review, the six primary requirements for an effective stigma-reduction initiative (see Box 1). A limitation to all of these studies is that they require that staff volunteer to participate in these training programs, and as such, select out those who are least interested in further training, potentially as a consequence of having little interest and the most negative views of working with people with BPD.

> " A preferable alternative to restricting the use of the diagnosis to avoid this stigma is to broaden clinicians' understanding of BPD.

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**Box 1. Stigma-reduction initiatives: program requirements**

Educational/skills training component to increase abilities to interact with and help patients

Education to correct common misperceptions

Social contact in the form of lived personal testimony delivered by a trained speaker

Multiple forms or points of social contact including, for example, live and via video, of people with lived experience of disorder

Emphasis on and demonstration of recovery

Enthusiastic facilitator who sets tone and models person-first language and behavior

*(Knaak et al. 2014)*

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## How does a BPD diagnosis affect clinicians' perceptions?

**The effects of the psychiatric label 'borderline personality disorder' on nursing staff's perception and causal attributions for challenging behaviours**
Markham, D., & Trower, P. (2003)

This study aimed, among other things, to explore psychiatric nurses' report of their sympathy towards and optimism for clients with BPD and their beliefs (or 'attributions') of clients' 'challenging behaviours' (e.g. being violent, not complying with a request from staff). Participants were 48 registered mental health nurses working in adult or older adult inpatient units in the UK National Health Service (NHS). Participants each answered three vignettes. The only difference between the three vignettes was the diagnostic label given to the client ('BPD', 'schizophrenia', or 'depression'). Participants were asked to (a) generate a cause for the behaviour and (b) rate their attributions with reference to, among other things, how stable and controllable the cause of the behaviour, and how controllable the behaviour itself was. Results suggested that participants scored stability and controllability attributions (both for cause and behaviour) higher for BPD than for schizophrenia or depression. Sympathy and optimism levels were lower, and ratings of personal experience more negative, for those with BPD than with depression or schizophrenia, and sympathy appeared lower when control attributions were higher.

**Take home messages** This study shows that the diagnostic label of BPD elicits particular negative beliefs and emotions in psychiatric nurses relating to sympathy and optimism. This seems to be linked to inaccurate stereotyped information about how stable and controllable the cause of the behaviour and the behaviour itself are in people with BPD. This was the case even though **the only difference in vignettes was diagnosis, that is, the label attached to the behaviour**. The nurses in this study also felt less sympathetic (and actively unsympathetic) towards people with BPD, and had least optimism about the prospect of change in these behaviours. Markham and Trower (2003) note that staff beliefs that people with BPD are more in control over negative events than those with other diagnoses is at odds with reports that people with BPD feel they have limited control over their own lives, including negative events.

# How does a BPD diagnosis affect the general public's perceptions?

### Mental health literacy and borderline personality disorder: What do the public 'make' of those with BPD?
Furnham, A., Lee, V., Kolzeev, V. (2015)

This study assessed the extent to which 193 participants could identify BPD from a vignette, and compared this recognition of BPD to post-traumatic stress disorder, depression, and schizophrenia. Respondents were also asked how distressing it would be to have these problems, how difficult treatment would be, what their levels of sympathy towards the person were, what the happiness of the person described was, what their work success was, how satisfying their personal relationships were, and whether the person described should seek help for the problem.

Few people accurately recognised BPD. Problems associated with the BPD vignettes (regardless of whether accurately recognised) were regarded as less distressing than both schizophrenia and depression and harder to treat than depression, but easier to treat than schizophrenia. They evoked the lowest amount of sympathy and people with BPD were regarded as having the highest level of happiness, the highest success at work and the best interpersonal relationship quality of all

psychiatric labels. Participants were less likely to suggest seeking help for BPD than for either depression or schizophrenia.

**Take home messages** This study's vignettes relating to BPD may have influenced the findings in this study, as they focus particularly on features such as angry outbursts and deliberate self-harm and less on more 'internalising' features such as emptiness. The focus on these features may prompt more negative judgments. Indeed, it may be that the more negative judgments of psychiatric nurses may stem from the degree to which they manage more 'externalising' features of BPD in the inpatient environment and thereby lose a sense of the distress associated with BPD, although this needs further research. Despite this, this study suggests that negative beliefs about BPD exist even in the absence of correct diagnostic labelling. The diagnostic label of BPD appears to activate particular attitudes and possibly behaviours for mental health workers to a greater extent than for the community at large.

# Clinicians' experience of working with BPD

### How do nurses experience working with adolescents with a diagnosis of 'personality disorder' or 'emerging personality disorder'?
Reiss, R., & Gannon, K. (2015).

This study, conducted in a child and adolescent mental health service (CAMHS) inpatient unit in the UK for 13–18-year-olds, was a qualitative study of the experience of six nurses of working with young people with PD or 'emerging' PD. Themes included the significant emotional impact of this work (extreme responses of dislike/anger or warmth/positivity towards the client; feeling demanded upon, leading to frustration and negativity, and not knowing how to respond) and conflict and need for support in managing young people with personality (including common conflict within the wider team; desire for support and supervision while feeling this was insufficient in the context of feeling inadequately prepared for work with this client group; and lack of certainty about diagnosis of personality disorder in adolescence and associated dilemmas about what treatment to provide).

**"** Because I wanted to be a nurse with her and I also found it difficult because she didn't really need nursing, she needed therapy, so that was when I found it quite difficult to work with her because I didn't really know what my role was in that".

– **Catherine**, nurse, Reiss & Gannon 2015

**It's not you, it's me: An examination of clinician- and client-level influences on countertransference toward borderline personality disorder.**
Liebman, R.E., & Burnette, M. (2013).

This study recruited 560 clinicians, who completed an online survey after reading a vignette describing a client meeting criteria for BPD, with four different versions reflecting differences in gender (male/female) and age (15 years/25 years). Clinicians were asked to diagnose the client and to answer questions relating to whether the client difficulties reflected a behavioural problem or a mental illness, how empathic the clinician felt towards the client, and how chronic the illness was likely to be. Among other results, this study found that clinicians were more likely to see younger people as having conduct problems than a psychiatric illness, and rated the adolescent as less trustworthy and more dangerous.

**Adolescents with personality disorders suffer from severe psychiatric stigma: Evidence from a sample of 131 patients.**
Catthoor, K., Feenstra, D.J., Hutsebaut, J., Schrijvers, D., & Sabbe, B. (2015).

This study aimed to establish the extent to which young people with personality disorder, seen in an inpatient setting, report experiencing stigma. 131 adolescent clients (mean age 16.1, range 14–19) who had been referred to a specialist inpatient youth unit for complex problems that had not responded adequately to outpatient treatment participated. Clients with personality disorder experienced more stigma than clients without personality disorder and clients with other severe mental state disorders on both measures. Of all personality disorders, BPD was the strongest predictor of experiences of stigma. Those with comorbid problems (both mental state and personality disorder problems) experienced higher levels of stigma than those without comorbid problems on both stigma measures. Those with more severe personality disorder features (as indicated by number of features) tended to experience the highest levels of stigma.

**Take home messages**  Nursing staff in Reiss and Gannon (2015) working with young people with personality disorder report a range of difficulties in this work, including negative emotions, which likely form the foundations of negative beliefs about young people with personality disorder. Liebman and Burnette (2013) found that clinicians report having particularly negative beliefs about young people with BPD, including erroneous beliefs about trustworthiness and dangerousness, and that they are 'bad, not ill'. Young people with BPD also experience themselves to be stigmatised in Catthoor et al. (2015), with those with both BPD and mental state disorders (representing the vast majority of young people with BPD) reporting feeling stigmatised more than any other client group. Although research with young people is in its infancy, early data suggest that BPD-related stigma for young people may be as significant as it is for older adults.

# Diagnosis of BPD in young people

### Working around a contested diagnosis: Borderline personality disorder in adolescents
Koehne, K., Hamilton, B., Sands, N., & Humphreys, C. (2012)

This study used a qualitative framework to understand the experience of 23 clinicians (nurses, doctors, allied health clinicians) working in a Melbourne CAMHS. The core question was, 'How do CAMHS clinicians talk about BPD?' In particular, the study explored how the diagnosis of BPD is used and disclosed in these services in two different contexts – an outpatient care team and an inpatient unit.

The study identified a number of themes. Of particular note is that in the inpatient unit context, the diagnosis of BPD was felt by staff to be discouraged by the lead consultant psychiatrist, and diagnosis was regarded as a task for psychiatrists rather than nursing or allied health professionals. This left staff engaging in 'backstage borderline talk' in which staff spoke about patients' BPD features amongst themselves, but did not disclose the diagnosis to clients. Those who felt permitted to make the diagnosis universally 'hedged', or modified the degree of membership of the BPD group by talking about 'emerging BPD'

or 'BPD traits', or about behaviours rather than diagnosis. This appeared to occur due to concerns about what the label of BPD implies about stability of illness, seen as particularly problematic by these clinicians when communicated to young people; Koehne et al. (2012) talk of clinicians focusing on 'anything but diagnosis' (p. 52).

### Validity, utility, and acceptability of borderline personality disorder diagnosis in childhood and adolescence: Survey of psychiatrists
Griffiths, M. (2011)

This study explored the beliefs of child and adolescent psychiatrists about the diagnosis of BPD, using a 17-item questionnaire developed for this research. Of the sample of 52 consultant psychiatrists, 82% thought that BPD was a valid diagnosis for adults, 37% for adolescents, and 2% for children under 12 years. The majority of respondents viewed the BPD label as stigmatising, with the diagnostic category including pejorative language and value judgments, and the diagnosis leading to stigmatisation, marginalisation, and therapeutic pessimism. However, almost half of respondents also thought a diagnosis of BPD was necessary to provide appropriate interventions, and some psychiatrists felt it helped young people and families understand their difficulties and access appropriate treatment. Others used 'hedges' by speaking of 'emerging' personality difficulties. Some respondents regarded the diagnosis as overly reductive, that it excludes the possibility of 'complex descriptive developmental formulations'.

**Take home messages**  Both of these studies outline the basis of the reluctance of clinicians to diagnose BPD in young people: the BPD label is said to be inherently stigmatising. However, not using the label also led to other problems, such as 'backstage borderline talk', which may have relied less on thorough assessment of the problem and more on staff reaction to clients. It is also concerning that some psychiatrists felt that the diagnosis of BPD meant that a thorough biopsychosocial formulation of the client was not possible.

# How can we reduce stigma?

### Ameliorating patient stigma amongst staff working with personality disorder: Randomized controlled trial of self-management versus skills training
Clarke, S., Taylor, G., Bolderston, H., Lancaster, J., & Remington, B. (2014).

This study randomised 95 participants to receive a two-day staff workshop over two one-day sessions with the aim of reducing negative beliefs and discrimination in staff working with BPD in UK services. In groups of approximately 16, staff participated in workshops focusing on the use of either acceptance and commitment therapy (ACT; Hayes et al. 1999) or dialectical behaviour therapy (DBT; Linehan 1993). Both interventions aimed to reduce prejudice and discrimination: DBT by providing staff with knowledge and skills to improve effectiveness of clinical practice, and ACT by providing them with self-management skills to strengthen behaviour driven by core values and reduce the impact of negative evaluations by decatastrophising them.

The study aimed to establish, among other things, whether the interventions led to differences in attitudes to personality disorder, perceived quality of the therapeutic relationship with people with personality disorder, and the extent to which staff distanced themselves from people with personality disorder. The results suggested very few differences between the two groups. Attitudes towards clients with personality disorder and perceptions of the therapeutic relationship improved and social distancing decreased after the intervention. These results were maintained at 6-month followup.

**Take home messages** This research demonstrates that staff interventions can assist in reducing negative beliefs about working with people with personality disorder, although it suffers from the lack of a control condition. The extent to which Clarke et al.'s (2014) interventions included all six components outlined in Knaak et al.'s (2014) review of successful stigma reduction initiatives in clinicians is unclear, but the fact that both were effective, including over the followup period, suggests that an intervention combining them may be particularly useful.

# Conclusions

In research comparing the stigma that various diagnoses attract, BPD appears the most stigmatised. In mental health clinicians, the label evokes erroneous beliefs that are associated with negative judgments and emotions. Particular beliefs held by mental health clinicians about people with BPD include that their difficulties are more controllable, and as such, people with BPD are 'weak, not sick', and that their difficulties are chronic and, relatedly, less treatable. The label appears much less powerful for the general community, although some behaviours associated with BPD do attract negative beliefs. These inaccurate beliefs and negative emotions emerge even in clinicians working with young people with BPD, and young people with BPD feel stigmatised.

Given that these beliefs and emotions lead some clinicians to avoid making the diagnosis of BPD, it is possible that those young people who do receive a diagnosis of BPD represent a particularly severe subgroup of young people with BPD – those for whom a diagnosis could not be denied – which thus perpetuates the stigma associated with this label. Interventions designed to reduce stigma in clinicians can be helpful, but they generally require a reasonably significant investment in time (up to 1–2 days of training) and, when voluntarily completed, may select out those with the highest level of negative beliefs.

The research reviewed here suggests that mental health clinicians often believe that people with BPD are in control of their difficulties, which are intractable. What we now know, though, is that people with BPD often feel out of control, rather than in control. Furthermore, their problems need not be chronic: BPD is a treatable condition. With effective, targeted treatment that appropriately acknowledges the particular difficulties that young people with BPD will bring to treatment, these young people, their families, and their clinicians can justifiably feel hopeful about the creation of a meaningful life.

# Where to from here?

## Questions for future research

From the research reviewed here, we believe the following questions may help guide future research into the causes of stigma about BPD in young people and how to reduce it.

- By whom do young people with BPD feel stigmatised?

- Do negative beliefs and emotions towards young people with BPD differ according to BPD severity, as objectively assessed?

- What predicts negative beliefs and emotions towards young people with BPD, and are these predictors different in different services (e.g. acute psychiatry, specialist BPD services, emergency departments)?

- What kind of stigma intervention will get the most significant 'take-up' by those who are less likely to attend a face-to-face workshop?

- Do changes in attitudes of clinicians change behaviour?

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Research Bulletins are designed to provide clinicians and researchers with an overview of the recent research on a specific topic, without having to source the primary research studies. Opportunities for future research to advance knowledge in the particular topic area are also canvassed.

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