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F*ck your care if you label me! Borderline personality disorder, stigma, and self-stigma

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Abstract

INTRODUCTION: According to recent results, a significant number of psychiatrists, psychologists, psychotherapists, and general public show negative and stigmatizing attitudes towards patients with toward borderline personality disorder (BPD). Such attitudes may manifest in negative thoughts and harmful or discriminating behavior towards people with this disorder.

METHOD: Studies were identified through the Web of Science, Medline, and Scopus databases, including resources within the period 1990–2014. Additional references were found using reviews of relevant articles. The search terms included "borderline", "stigma", "self-stigma", "therapy", "treatment", "psychotherapy", and "psychosocial treatment".

RESULTS: The stigmatizing beliefs of the professionals and the general public are common in the case of the patients with BPD. Health care professionals tend to be more prone to stigmatize the individuals with BPD than lay population. People with BPD come across serious difficulties, such as unstable emotionality, impulsivity, low threshold of frustration, and following issues in social and occupational functioning. These problems are inevitably present the patients' contact with the health care professionals. Insufficient supervision of the therapeutic process and lack of sufficient competence in the work with the patients with BPD can lead to the clinicians' stigmatizing attitudes and behavior. In these cases, the health care professionals often use derogatory expressions to describe persons with BPD, such as "treatment resistant", "complicated", "demanding", "dangerous", "manipulative", and "attention seeking". Negative attitudes among psychiatrists, other physicians, nurses, psychotherapists, and health care administrators support the marginalization of BPD within the systems of mental health care.

CONCLUSION: Substantial development in the empirical and practical knowledge of the patients suffering from BPD challenges the stereotypical labels of the individuals with this disorder. Continual supervision may offer a solution in the case to case scenario of the stigmatizing professionals. The fundamental questioning of the marginalized status of patients with BPD is also required.

Introduction

Psychiatrists, psychologists, nurses, other physicians, and general population often perceive borderline personality disorder (BPD) negatively. The stigma of those, who suffer from BPD, is more extent and severe than the stigma of other psychiatric diagnoses (Aviram *et al* 2006). We have an adequate understanding of the stigma processes among patients with serious mental disorders, such as schizophrenia, bipolar affective disorder, and major depression (Barney *et al* 2006; Yanos *et al* 2008; Margetić *et al* 2010; Latalova *et al* 2013). However, the understanding of the role of the stigma in the lives and treatment of the patients with other mental disorders is lacking.

The stereotyped imagery of the psychiatric patients comes from deep-rooted prejudices and conservative interpretations of the psychiatric disorders. A response to the social environment and culture, which results in a conclusion "this person suffers from a mental illness", is called a labeling reaction. The label of the mental disorder may then lead to stigmatizing attitudes and behavior towards the labeled individuals. The stigma of those with mental illnesses manifests in various negative ways that others treat the patients, mainly on the level of the close interpersonal relationships. Besides these individual and micro social levels, the stigma also influences the macro social level as it affects the position of the psychiatric patients and psychiatry itself in the society (Prasko *et al* 2011). It is society, with its evaluation of what is normality that represents a cornerstone of the stigmatization process.

The understanding of the causes of psychiatric disorder plays the crucial role in the labeling process and subsequent stigmatization. It can be divided into several categories: the presence of a disorder might be presumed to be due to a *character flaw* (such as psychopathy, mental inferiority, weakness, perversion, or amorality), *organicity* (hereditary burden, brain disease) or *situational influences* (a consequence of highly stressful events, grief or suffering). The patients with BPD, who often act noticeably in public, are labeled by the lay community with pejorative terms like "freak", "having tantrums", "hysterical" or simply "weird". The general public holds certain expectations when meeting a person with BPD. They may expect that the individuals with BPD keep their distance, are rather cold and show dysfunctional behavior. However, they usually do not consider them being "dangerously mad" (Aviram *et al* 2006). Also, society itself keeps a distance from these patients (Markham 2003). General population often prefers to believe that the origin of this disorder is based on *personality flaws and traits*, and this is why they tend to expect that the afflicted "should make some effort and change," eventually "should be reeducated" (James & Cowman 2007; Ociskova *et al* 2014).

BPD is characterized by instabilities and dysfunctions in affective, behavioral, and interpersonal domains. Extreme affective instability often leads to an impulsive and self-destructive behaviors (Prasko *et al* 2010a). It is true that the patients with BPD exhibit impulsive aggression, self-mutilation, self-damaging behavior (e.g., promiscuous sex, substance abuse, reckless spending, overeating), and dissociation (Pastucha *et al* 2009; Latalova & Prasko 2010). Aggression against themselves or others is one of the core components of BPD. Such behavior can present a trigger of stigmatization in the therapy. Indeed, high level of stigmatization of the patients with BPD is connected to the counter-transference (Prasko *et al* 2010b). As the un-reflected counter-transference is one of the most frequent causes of the damage resulting from the psychotherapy (Prasko *et al* 2012), this kind of stigma present one of the issues that require more theoretical and empiric attention.

Method

Studies were identified through the Web of Science, Medline, and Scopus databases by including resources within the period 1990–2015. Additional references were found using reviews of the relevant papers. The search terms included "borderline", "stigma", "self-stigma", "therapy", "treatment", "psychotherapy", and "psychosocial treatment". The search was completed by repeated use of the words in different combinations without language and time constraints. The articles were collected, organized by their importance, and key articles itemized in reference lists were investigated. Reference lists of publications recognized by these procedures were enriched by manually tracing the relevant citations. The report also includes information from books referred to by other reviews. This article is a review.

Stigma and self-stigma in borderline personality disorder

The labeling process is common in the cases of the patients that are traditionally said to be difficult to treat. This is the case of the individuals with personality disorders, mainly with the borderline type. The persons with borderline personality disorder do not deal only with the symptoms of their disorder but also with social stigma and self-stigma. Negative social attitudes toward people with personality disorders might lead to missed opportunities for education, employment, and housing. Pejorative expressions to describe individuals with BPD such as "treatment resistant," "complicated," "demanding," "dangerous," "manipulative," and "attention seeking" are frequently used (Aviram *et al* 2006).

Studies of psychiatric stigma have mainly concentrated on public attitudes to the patients. Because stigma presents an ultimately private experience and these attitudes and beliefs vary in their influence on the individuals, current studies can only provide an approximate guide to how stigma affects the patients

with mental health issues. Bigger focus on personal experiences of the psychiatric patients would be beneficent for better understanding what the patients struggle with, what obstacles they come across, and how stigma affects their interpersonal relationships and self-view.

Stigma is an umbrella term that consists of three main components: ignorance (a problem of the absence of knowledge), prejudice (an issue with attitude) and discrimination (an issue with behavior). Stigma can be divided into three subgroups – social, structural (institutional), and internalized (i.e. self-stigma) (Livingston & Boyd 2010). Self-stigma happens when individuals assimilate social stereotypes about the condition they suffer from. Personality traits, which once formed a core of a personality, recede into the distance and traits, which are stereotypically attributed to the group of stigmatized individuals, become dominant in self-concept. Changes in behavior, which also adjust to the stereotypes, are a part of the picture, too.

The self-stigma develops in a three-part process. The process starts with an individual who notices unwelcoming or opposite reactions from others and becomes aware of the stereotypes that led to the inadequate approach. The stigma internalization continues in the second phase during which the person agrees with the stereotypes and believes that they are legitimate. The internalization is completed when the person applies the stereotypes on oneself (Corrigan *et al* 2011). The consequences of the self-stigma manifest on various levels – there can be present an increase of dysphoric emotions, reduction of self-esteem and overall quality of life, and anxious anticipation of the adverse actions of others. The afflicted person might prefer to withdraw socially, develop phobias and depression, maladaptive behavior, or a change in identity (Livingston & Boyd 2010; Camp *et al* 2002). A progressive model of self-stigma contains these four steps which lead to decreased self-esteem and hope: appreciation of related stereotypes, agreement with them, applying the stereotypes to oneself, and following suffering from lower self-esteem (Corrigan *et al* 2011).

Stigma forms unique barriers if stigmatized individuals internalize perceived prejudices and are persuaded that such beliefs are entirely correct (Corrigan *et al* 2002). For example, internalized stigma predicts deterioration of morale among psychiatric outpatients. In a research of Ritsher and Phelan (2004), internalized stigma led to increased levels of depressive symptoms and reduced self-esteem at 4-month follow-up, when controlling for baseline levels. In our study (Ociskova *et al* 2014) of a mixed group of patients with anxiety disorders, depression and borderline personality disorder, the degree of internalized stigma positively correlated with substance use and tendencies to give up when confronted with the stress. Self-stigma was also significantly negatively connected to self-directedness (one of the traits in Cloninger's theory of personality), pathway thinking (a part of Snyder's cognitive theory of hope), an ability to plan solutions to stressful events, and ability to find positive elements in them to support inner growth. Internalized stigma was significantly positively associated with a degree of dissociative symptoms, too (Ociskova *et al* 2014).

Relatives of the patients with BPD also deal with stigma (Trosbach *et al* 2003). Family members often worry about stigma and discourage patients from seeking early psychiatric intervention. Thus, when diagnosed with a psychiatric disorder, it is not only a patient, who has to get accustomed to the fact, but also his or her family. It is no surprise then that close relatives tend to keep the borderline diagnosis as a secret. Relatives might come across specific experiences and prefer to apply certain coping strategies in expectation that they could avoid stigmatization and shame. They may have a tendency to isolate themselves or hide the patient's symptoms from the "outer world". The psychiatric disorder is perceived as a secret that cannot be shared.

Specific personality traits that increase the risk of the development of the self-stigma across the spectrum of the mental disorders are a higher level of harm avoidance and lower level of self-directedness and persistence (Margetić *et al* 2010; Ociskova *et al* 2014). Self-directedness and persistence both resemble Snyder's cognitive theory of hope that is based on an assumption that hope flourishes from the ability to establish goals and realistic pathways to achieve them and to dispose of an appropriate amount of willpower to endure possible complications (Snyder 2000). It has been shown that people with the internalized stigma, including the individuals with BPD, have lower levels of hope compared to the non-affected persons (Snyder 2000; Ociskova *et al* 2014). They expect in advance that the goal cannot be achieved and that it is beyond their abilities to live a satisfying life (Corrigan *et al* 2009). The patients, who develop internalized stigma, also prefer emotion-focused coping strategies and tend to avoid interpersonal contacts (Yanos *et al* 2008; Rüsch *et al* 2009). Such attitudes may contribute to a non-adherence in treatment and lead to a worse overall prognosis.

Stigmatization and therapeutic care for borderline patients

Stigma may affect how physicians, psychiatrists, psychologists, nurses, and social workers perceive and tolerate the behavior, thoughts, and emotional reactions of the patients with BPD. It might lead to tendencies to minimize perceived symptoms, increased suffering, and aggressive behavior from the patients' side and overlooking strengths from both sides – patients' and professionals' (Aviram *et al* 2006). A considerable number of the individuals with borderline personality disorder prefer to adjust on their own or to rely on their families rather than seek a mental health professional. Fear of stigmatization is one of the reasons why individuals suffering from borderline personality disorder

fear the psychiatric diagnosis in such magnitude that they might actively avoid seeking adequate support.

In society, people tend to distance themselves from stigmatized persons, and there is the evidence that many physicians, including psychiatrists, may emotionally detach themselves from the patients with BPD. This distancing may be particularly problematic in the case of the people with BPD, who are extremely sensitive to expressions of rejection and abandonment. They may react negatively (e.g., by dirty critique, harming themselves or withdrawing from treatment) if they perceive such behavior (Aviram *et al* 2006).

We might be inclined to believe that the general population shows the larger amount of readiness to stigmatize than the health care professionals. Surprisingly the opposite is true, especially in the borderline patients. The individuals with BPD face considerable problems, both regarding their symptomatology and functional status, as well as in attempting to achieve professional help (Kealy & Ogrodniczuk 2010). Attitudes of many psychiatrists are paradoxically more tolerant towards psychotic patients than borderline ones. These attitudes are largely shaped both by university education, where a greater emphasis is being put on the most severe mental illnesses and by first work experience when young graduates typically work in intake departments and meet mainly psychotic patients.

A psychiatrist can put a label of "a difficult patient" on a person that he does not find likable, is not able to create a therapeutic relationship with or is criticized by. Such therapist often speaks about the patient in pejorative terms (*"a borderliner," "a psychopath"*). Many clinicians understand the diagnosis of the personality disorders as a synonym for inevitable therapeutic failure and resign in advance to the possibility of therapeutic change. It is a stereotype that stigmatizes these patients, as it denies them a sufficient level of therapeutic care. The patients with BPD typically receive multiple medications (often in high doses), although it is not indicated for this group of patients and it is not sure that "reasonable and predictable results" might be achieved (Gunderson & Philips 1995). When doing research with the decision to include patients with comorbid BPD, this decision can confound the results of pharmacotherapy studies aimed at the treatment of the depressive and anxiety disorders. They drop out of the studies frequently because of non-compliance, or they respond poorly to the treatment (Turner 1987; Persons *et al* 1988). Therefore, more and more designs of the studies put this diagnosis in the exclusion criteria. This leads to a current situation when there is still little information about a treatment that could be successful when treating a borderline comorbidity. Also, this vicious circle helps to keep stickers of non-treatability of the individuals with BPD.

Pervasive negative attitudes among psychiatrists and other clinicians, nurses, health care administrators, and policy-makers also maintain the marginalization of the individuals with BPD within psychiatric care. The patients with BPD may be viewed as not suffering from a valid disorder, being only a minority of the medical population, and being a constant drain on care resources (Kealy *et al* 2010). These beliefs may rationalize the lack of proper psychiatry services. The labeling can also be found among general practitioners. Pejorative labels serve as a defense of a physician who explains by them a failure in treatment or reluctance to treat the person more intensively. It seems that the more a psychiatrist labels patients, the less is a treatment successful, and the lesser scope of patients a therapist can help (Prasko *et al* 2011). Attitudes of psychiatric nurses are the most frequently studied group in this field, followed by samples of different mental health clinicians, and psychologists and psychotherapists (Sansone & Sansone 2013). Interestingly, there is no study of psychiatrists as the particular group.

Psychiatric nurses' view on the patients with BPD

Mental health nurses are often in a contact with the patients with BPD in both hospital and community settings which is why so many studies focused on them (Fraser & Gallop 1993; Cleary *et al* 2002; Markham 2003; Markham &Trower 2003; Deans &Meocevic 2006; James & Cowman 2007; Woollaston & Hixenbaugh 2008; Ma *et al* 2009; McGrath & Dowling 2012). These studies account nurses' perceptions of the patients with BPD being strong, manipulative, and destructive in their behaviors and disposing of the ability to split staff (Aviram *et al* 2006; Woollaston and Hixenbaugh 2008; Ma *et al* 2009).

Psychiatric nurses' view the individuals with BPD as tough cases with unpredictable and interpersonal relationships, poor impulse control, affective instability, and self-injuring behavior. The suicidal or self-harming reaction is one of the core diagnostic criteria in DSM for BPD, and management, and recovery from this personality disorder can be difficult, complex, and challenging. The symptoms associated with BPD are often dramatic and emotionally upsetting (e.g., splitting, stalking behavior, rage reactions, self-mutilation, and suicide attempts). Many professionals find these patients difficult to treat and exhibit low empathy towards them, as such behavior may adversely affect the patients' relationships with the nursing staff (Stuart & Laraia 2004). Also, it is reported that the patients with BPD tend to induce high levels of aggressive feelings among staff members (Holmqvist 2000). In contrast, nurses are more likely to react with sadness, guilt, and self-critical feelings towards patients with psychoses and with empathetic feelings towards patients suffering from neuroses. Nurses also consider the individuals with BPD to have a higher degree of control over their negative behaviors when compared to patients with other mental disorders (Markham & Trower 2003).

In an Australian study, Deans and Meocevic (2006) found that 65 psychiatric nurses working in both inpa-

tient and outpatient settings reported negative emotional reactions and attitudes toward the patients with BPD. The majority of the participants perceived the persons with BPD as manipulative, with nearly one-third of the participants reporting that such patients anger them (Deans & Meocevic 2006). McGrath and Dowling's (2012) study explored registered psychiatric nurses' interactions and their level of empathy towards the patients with a diagnosis of BPD. Four types of beliefs about the patients emerged following information from this quantitative research: "challenging and difficult", "manipulative, destructive, and threatening behavior", "preying on the vulnerable resulting in splitting staff and other service users", and "boundaries and structure." Lack of empathy towards these patients was evident in the majority of the participants' responses (McGrath & Dowling 2012).

Response to the patients with BPD of different mental health professionals

Some studies have examined clinicians' responses to the patients with BPD using study samples that consisted of several different professional disciplines. Cleary *et al* (2002) in their study of management of the patients with BPD focused on the attitudes regarding the treatment of these patients, experience, and knowledge about the disorder in the health staff. They showed that 80 % of 229 employees found dealing with the BPD patients to be moderate to extraordinarily difficult; 84 % of the staff felt that dealing with them was harder than dealing with other patients groups (Cleary *et al* 2002). Similarly, Newton-Howes *et al* (2008) examined the attitudes of a mixed group of the mental health clinicians toward the patients with personality disorders. Using a survey and the interview approach, the researchers found that the participants believed that the patients with the personality disorders were harder to manage than other groups of the patients.

Krawitz and Batcheler (2006) surveyed 29 mental health clinicians from inpatient, crisis, and outpatient services regarding their attitudes toward the patients with BPD. Using a self-report survey approach, researchers found that defensive approaches were common among the applicants. Indeed, 85 % admitted that they were practicing the care in a style that was not in the best interest of the patient (Krawitz & Batcheler 2006).

Commons Treloar (2009) examined a mixed sample of 140 mental health clinicians using an open query method: "Please provide some comments about your experience or interest in working with patients diagnosed with BPD". The respondents showed that the patients with BPD generated uncomfortable feelings within them. Also, the respondents acknowledged specific negative emotions, including feelings of frustration, failure, and feelings of being challenged. The respondents also perceived the patients with BPD as manipulative and time-consuming and believed that such patients have poor coping skills, engage in frequent crisis behaviors, and have difficulty interacting with others appropriately (Commons Treloar 2009).

Bodner *et al* (2011) also focused on a mixed group of mental health clinicians practicing in public institutions (n=57) regarding their attitudes toward BPD. Using a self-report survey of cognitive and emotional attitudes, the researchers found that psychologists scored lower than psychiatrists and nurses on adverse judgments, whereas nurses scored lesser than psychologists and psychiatrists on empathy. This is in accordance with the studies focused solely on nurses that found low empathy of nurses towards this group of patients (Deans & Meocevic 2006; McGrath & Dowling 2012).

Finally, Black and colleagues (2011) examined 706 mental health clinicians regarding their attitudes toward BPD. Using a self-report survey method, nearly half of the sample showed their inclination to avoid the patients with this disorder. Psychiatric nurses had the lowest scores on overall understanding attitudes toward patients with BPD, whereas social workers had the highest ratings. Psychiatric nurses also had the lowest ratings of empathy toward the patients with BPD (Black *et al* 2011).

Responses of psychotherapists to the patients with BPD

There are only three studies focused on the answers of psychotherapists to the patients with BPD. In the first research, Servais and Saunders (2007) surveyed 306 clinical psychologists, who were asked to rate their responses to the patients with depression, borderline personality features, and schizophrenia. The psychologists reported distancing themselves from the patients with the borderline personality features. These patients were perceived as dangerous, and nearly half of the respondents believed such patients to be undesirable (Servais & Saunders 2007). Bourke and Grenyer (2010) performed a study with 80 Australian psychotherapists. The authors interviewed and elicited narratives from the participants regarding their views of the patients with BPD and the patients with major depression. The researchers found significantly more negative attitudes toward the patients with BPD. Also, the psychologists felt less satisfied in their therapeutic role with such patients. Finally, in a German study, Jobst and colleagues (2010) examined 174 psychotherapists working in Munich. The participants were presented with a brief case report followed by several queries. Findings indicated that these psychotherapists often experienced anxiety and demonstrated prejudices when working with the patients with BPD.

The professionals' reactivity may be self-protective in response to actual behavior associated with the psychopathology. However, as a consequence of this reactivity, partly deriving from stigmatizing attitudes, it is harder to work with the patients with BPD (Aviram *et al* 2006). When considering that human communication is always two-way, it is not surprising that the self-protective behavior and overall reactivity

of professionals exacerbate maladaptive behavior of the patients. The results are a self-fulfilling prophecy and a vicious cycle of stigmatization to which both the patient and the therapist contribute. There is a possibility that the stigma associated with BPD can have an independent impact on poor treatment outcome with these patients.

Lived experiences of the patients diagnosed with BPD

Over last 20 years have the lived experience of BPD patients been occasionally in the center of attention (Kaysen 1993; Miller *et al* 1994; Nehls 1999; Byrne 2000; Castillo *et al* 2001; Fallon 2003; Holm & Severinsson 2011; Rogers & Dunne 2011). The patients with BPD have reported feelings that they were living with a derogatory label, with self-injuring behavior perceived as manipulative, and having restricted access to the adequate care because of this (Byrne 2000). According to the patients, health care providers held predetermined and unfavorable opinions of the patients with BPD, and they spoke about the experience as if being labeled and not diagnosed (Byrne 2000). Some patients talked about being frightened of disapproval or rejection, particularly from their therapists (Miller *et al* 1994). Nehls's study (1999) also confirms that the patients often feel judged (Nehls 1999). Regarding living with the diagnosis, the patients described hopelessness and self-injuring behavior as a short-term strategy to relieve painful emotions and tensions. The patients with BPD also described the health care staff being unwilling to tell them the diagnosis (Fallon 2003). The perception of the patients that there is the unwillingness to tell them the BPD diagnosis is also reported elsewhere (Castillo *et al* 2001).

Discussion

The goal of this review was to explore the current knowledge regarding the stigma and self-stigma in the individuals with borderline personality disorder. The overwhelming majority of the papers has pointed to gloomy attitudes and emotional reactions of the professionals toward the patients with BPD (Sansone & Sansone 2013). Some authors clarified that such results suggested that mental health professionals are too judgmental and prejudicial to these patients, in contrast to psychiatric patients with other mental disorders. The individuals with BPD tend to show maladaptive interpersonal behaviors that tend to elicit negative reactions from others. Perhaps these findings largely reflect a natural human response to the complex behaviors of these patients. The systematic guidance of mental health workers by supervisors is needed in order not to harm the patients, especially when staff disposes of such high levels of counter-transference (Prasko *et al* 2012).

Conclusions

Borderline personality disorder is characterized by significant negative emotional, interpersonal, and behavioral symptoms. The patients with BPD tend to experience difficulties in their relationships with others, in the family, at work or school, and mental health professionals. Comparing the various groups of the mental health professionals, the nurses tend to perceive the individuals in the most negative and judgmental way. Proper education and continuous supervision are needed to manage the negative counter-transference and subsequent stigmatizing beliefs and behavior of the mental health workers.

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