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Lindsay Heightman
Origins of Clinician Bias
Against People Diagnosed
with Borderline Personality
Disorder

ABSTRACT

A growing body of literature confirms that bias exists and thrives in mental health settings among clinicians charged with the care of individuals who meet criteria for BPD as outlined in DSM V – TR and DSM V. This study explores the origins of such bias against individuals diagnosed with Borderline Personality Disorder (BPD). Second, this study examines the various sources of learning that shape student clinicians' attitudes about people with a BPD diagnosis.

Study participants, all students in Master's-level clinical social work programs, responded to an anonymous online survey wherein they were asked to reflect on their learning experiences and rate their sources of learning on scales measuring strength of influence and attitude toward people with BPD. They were also asked open-ended questions about their experiences learning about and working with individuals diagnosed with BPD.

The study found that student clinicians credit their clinical work with individuals diagnosed with BPD as the most influential source of learning. They also credit colleagues as the most negative influence in their learning process about individuals diagnosed with BPD. The paper concludes with a discussion of the implications for social work education, further questions, and suggestions for future research.

**ORIGINS OF CLINICIAN BIAS AGAINST PEOPLE DIAGNOSED
WITH BORDERLINE PERSONALITY DISORDER**

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

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CHAPTER I

Introduction

I sit uncomfortably in the conference room of the outpatient clinic where I have just begun my internship. My group co-facilitator gathers her things after the patients have left. As we debrief, the tone of the discussion turns negative and, in reference to one person who seemed intent on dominating group time today, my co-facilitator states in a tone that implies mutual understanding, “She’s such a borderline.” Such scenes are not rare in team meetings and hospital rounds and anywhere mental health practitioners gather. And it can be confusing. Psychiatrists, psychologists, psychiatric nurses, counselors, and social workers tend to go into the helping professions with good intentions, and then come to embrace concepts and promote attitudes that are harmful to those whose care they are charged with. In no case is this contradiction more glaring than with patients or clients who are diagnosed with Borderline Personality Disorder or who have characteristics that align with some of the criteria for BPD. The label *borderline* is often tossed out in such a way that it loses its diagnostic utility and pollutes perceptions of would-be professional helpers. As a label used across health and mental health settings, the word *borderline* is often used to implicitly designate clients or patients who may be considered unlikeable, difficult, dangerous, or a nuisance.

When used diagnostically, BPD as outlined in the DSM-IV-TR (2000) refers to nine criteria in areas from behavior and cognition to relationships and interpersonal challenges. These criteria evolved from what Otto Kernberg, MD, proposed in the 1960s was a personality structure situated on the border between psychosis and neurosis on a spectrum of personality

organization. BPD appeared as a formal diagnosis in 1980 when it entered the DSM III (Friedel, 2012).

The existing literature examines some of the etiology of symptoms of BPD and efficacy of treatment modalities (Weston & Gabbard, 1999; Klein, 1952; Bowlby, 1988; Mitchell & Black, 1995), particularly focusing on Dialectical Behavior Therapy (Linehan, 1993; Leib, Zanarini, Linehan & Bohus, 2004) Some studies have explored stigma against people diagnosed with BPD (Nels, 1998; Nels, 2000; Aviriam, Brodsky, & Stanley, 2006, Lester, 2013; Liebman & Burnette, 2013; Ussher, 2013), confirming the existence of pervasive negative stereotypes associated with a BPD diagnosis as well as the label *borderline*, used often used regardless of whether the person being labeled meets diagnostic criteria (Lester, 2013; Gabbard, 1997, Aviriam, Brodsky, & Stanley, 2006).

However, there is a considerable gap in the literature. Though the current literature confirms the existence of stigma, I could find no studies focused on how mental health workers come to adopt this negative bias (Wright & Jones, 2012; James & Cowman, 2007). The majority of the research uses quantitative methodology and focuses solely on attitudes and experiences of mental health nurses. In this mixed methods study I examine the ways in which new social workers are exposed to ideas and attitudes around BPD. This study encouraged student clinicians to reflect on the things they have learned about BPD, the sources of their learning, and the manner in which that information was conveyed. This study utilized an online, mixed-methods survey to examine the information and attitudes about BPD that student-clinicians had been exposed to. Survey questions were qualitative and quantitative. Data were analyzed using descriptive statistics and thematic coding.

The next section is a review of the theoretical basis of BPD and current literature on the stigmatizing effects of the diagnosis. It is followed by a section detailing the methodology of the current study. I share the findings of the study, followed by a discussion of the strengths and limitations of the study and the implications of the study's findings.

CHAPTER II

Literature Review

The following literature review explores the theoretical writings and empirical research relevant to the question: *What factors influence clinician bias against individuals who carry a diagnosis of Borderline Personality Disorder?*

The first section of this chapter covers the basic theoretical understanding of Borderline Personality Disorder (BPD) and the importance of the therapeutic alliance in psychotherapy. In the second section I explore the concept of stigma in the mental health field as it relates to BPD. The last section outlines existing research and examines the limitations of the current body of research on how helping professionals acquire biased attitudes toward individuals with a BPD diagnosis.

Theoretical understanding of BPD

The term “borderline” is used in the DSM V to describe individuals with a pattern of emotional experiences and relational habits characterized by turbulent relationships and emotional instability (American Psychiatric Association, 2013). The DSM does not address the etiology of the cluster of symptoms that make up its definition of Borderline Personality Disorder, though several theories attempt to explain the cluster of traits that make up the criteria for BPD (Winnicott, 1960; Klein, 1952; Cassidy & Mohr, 2001; Lieb, Zanarini, Linehan, & Bohus, 2004).

In her writings on object relations, Klein (1952) posits that failure to integrate both good and bad objects is characteristic of the schizo-paranoid position. Interpreted through the lens of

object relations theory, the intense affective reactions of individuals with borderline personality features represent a developmental state wherein it is difficult or impossible for the individual to experience complex others as both good and bad simultaneously, a milestone which Klein refers to as “the depressive position”. As articulated by Westen & Gabbard (1999), “Individuals with a borderline level of personality organization can clearly distinguish inner and outer (that is, they do not hallucinate), but they have difficulty maintaining consistent views of themselves and others over time, and they are prone to severe distortions in the way they perceive reality . . .” In short, theorists conceive of individuals with personality structure situated between neurotic and psychotic personality organization as functioning on the border between the two poles.

Object relations theorists Bowlby and Ainsworth formed a subset of ideas related to the individual’s tendency to attach to external objects and evaluated the characteristics of three basic attachment styles (Bowlby, 1988; Mitchel & Black, 1995). Research in this area suggests that borderline disorders correlate with assessments of disorganized attachment often precipitated by neglect or abuse in early childhood (Cassidy & Mohr, 2001; Lieb, Zanarini, Linehan, & Bohus, 2004). This has important implications for the student practitioner who is charged with creating an atmosphere wherein a corrective experience of secure attachment may be fostered and a client’s true self can emerge (Berzoff, 2011; Aron, 2003; Winnicott, 1960; Linehan, 1993).

Treatment Prevalence

O’Brien (1998) estimated prevalence of BPD at 1.8% in the general population, and 8-15% of the clinical population seeking treatment through mental health services. One study of personnel in an integrated public mental health service found that almost all staff have regular

contact with people diagnosed with BPD, with 85% reporting contact at least once a month and 32% reporting daily contact (Cleary, Seigfried & Walter, 2002).

Patients with a BPD diagnosis frequently present themselves for care in both hospital and community settings; prevalence rates of clients with BPD in these settings have been estimated at 20-23 % in hospitals and 11 in community settings (Swartz *et al.*, 1990; Widiger & Weissman, 1991). Social workers working in nearly any setting are likely to encounter individuals diagnosed with Borderline Personality Disorder or with personality traits consistent with at least some of the BPD criteria outlined in the DSM.

The Therapeutic Alliance

The quality of the relationship between therapist and client is one of the greatest correlates of therapeutic outcomes, indicating that development of a therapeutic alliance is central to treatment (Shedler, 2010). McWilliams (1994) suggests that clients who most evoke difficult feelings in therapists are depressed and borderline clients. McIntire and Schwartz (1998) posit therapists may experience these negative emotions in their work with clients with BPD because of clients' poor interactional skills and threats of suicide. Within the therapeutic relationship, negative countertransference reactions can easily reinforce the clients' self-critical feelings and foster hopelessness and shame (Dinos, Stevens, Serfaty, Weich, & King, 2004; Link & Phelan, 2006; Link, Struening, Rahav, Phelan, & Nuttbrock, 1997; Reusch, Lieb, Bohus, & Corrigan, 2006; Sterlin, 2006). Studies on service delivery illustrate how "offering services devoid of caring deprives clinicians and clients of the perspective that only genuine concern evokes. When problem behaviors are seen as volitional and intractable, a sense of hopelessness about treatment effectiveness prevails" (Nels, 1998, p. 103).

Stigma against individuals with a BPD diagnosis

Like “hysteria” and other diagnosis that tend to stigmatize the emotionality thought typically feminine, diagnoses of borderline personality disorder are disproportionately assigned to women (Nehls, 1998; Ussher, 2013). Additionally, given that the preponderance of social workers are women, the conceptualization and stigma of borderline personality disorder in a female-dominated profession could be indicative of internalized sexism that plays out in the therapeutic relationship through countertransference (Liebman & Burnette, 2013).

Colloquially, the term “borderline” is often used pejoratively as a label. Lester (2013) proffers, “Officially, ‘borderline’ is a diagnostic label. Unofficially, in clinical parlance, it is synonymous with ‘anathema.’” And Gabbard (1997) explains that many professionals regard individuals who exhibit borderline symptoms with contempt. In this second context, referring to a person as a borderline often refers to a person the speaker finds difficult to work with rather than being used as a potentially useful diagnostic label (Aviriam, Brodsky, & Stanley, 2006). Nehls (1998) explicated the paradox in which diagnosed individuals find themselves: “as persons with this label interact with clinicians, they find that their behavior is regarded as attention seeking. This attitude has resulted in widespread stigma toward persons who have been diagnosed, correctly or incorrectly, with borderline personality disorder” (p. 104). The term has retained so much negative connotation that Herman (1992) suggested abandoning the term altogether, just as the term “hysteria” has been eliminated from professional usage.

Social work students and other mental health workers encounter biases and stigma against people with mental illness as they enter their field work, and many take on the pervasive attitude that individuals with borderline personality features are difficult clients they would rather not deal with. Inherent in some agency cultures is the message that it is acceptable to

conceptualize and speak about clients in pejorative ways behind closed doors (Nehls, 1998; Nehls, 2000; Aviriam, Brodsky, & Stanley, 2006; Servais & Saunders, 2007).

Existing Research on Clinicians and Clients Diagnosed with BPD

Much of the existing literature confirms that many mental health clinicians find working with clients with a BPD diagnosis challenging. Cleary, Siegfried and Walter (2002) found that 84% of staff in their study felt working with clients with BPD was more difficult than working with other populations, and 80% found working with these clients moderately to very difficult. Similarly, James and Cowman (2007) studied attitudes of nurses in Ireland and found that 80% of their study sample felt people with BPD were more difficult to care for than clients with other mental health diagnoses (as cited in Wright & Jones, 2012).

The perceived difficulty of working with people with a BPD diagnosis led Fraser and Gallop (1993) to study variance in empathetic responses from staff. They discovered that staff tended to be less empathetic toward people diagnosed with BPD than they were toward people with other diagnoses. According to Nehls (1992; 1994), negative attitudes of staff toward patients presenting with self-destructive gestures and acting out behaviors characteristic of BPD are connected to feelings of helplessness and incompetence. James and Cowman (2007) concluded that staff training is generally inadequate and care is provided inconsistently for individuals diagnosed with BPD seeking treatment (as cited in Wright & Jones, 2012).

Additionally, it is somewhat common for people with BPD to reject therapeutic care, which may engender feelings of frustration or anger in staff (McIntire & Schwartz, 1998). McIntire & Schwartz (1998) assessed countertransference reactions of 155 licensed psychotherapists of varied experience and theoretical orientations; clients with a BPD diagnosis elicited more extreme reactions of hostility and dominance than clients presenting with depression who

provoked more feelings of submissiveness, friendliness and salience. Fifty registered mental health nurses in the United Kingdom participated in a study that measured causal attributions; the researchers found that nurses interacting with patients with a diagnostic label of BPD perceived those patients to be more in control of their negative behaviors than patients with other diagnostic labels such as schizophrenia or depression. The attribution of control was inversely related to staff sympathy and optimism regarding BPD patients (Markham & Trower, 2003; Markham, 2003).

Deans and Meocevic (2006) found a large portion of 65 registered psychiatric nurses reported negative attitudes and emotional reactions toward people with BPD. The majority of nurses saw people with BPD as manipulative, one third reported that patients with BPD made them angry, and more than a third “disagreed” or “strongly disagreed” that they know how to provide adequate care for people diagnosed with BPD. Cleary, Siegfried, and Walter (2002) also looked at clinician knowledge about appropriate symptoms and treatment BPD and found some significant deficits. Another study showed that mental health professionals in Australia are generally amenable to further training aimed at changing attitudes about working with patients with BPD, and that such training is effective in producing attitudinal changes as measured by optimism, enthusiasm, confidence and willingness to work with people with BPD (Krawitz, 2004). Given the proposed correlation of provider feelings of incompetence and lack of empathy, the shift in attitude following training outlined in Krawitz (2004) is promising.

Limitations in the Literature

Current literature documents the existence of widespread bias against individuals diagnosed with BPD and individuals with tendencies toward emotional dysregulation whether or not they meet official diagnostic criteria for BPD. The literature partially explores how bias is

propagated and accepted in psychiatric nursing settings; some researchers suggest reasons mental health workers dislike working with clients diagnosed with BPD (Nels, 1998). However, there is no existing literature that explores the origins of biased attitudes among mental health workers in general or social workers in particular. These suppositions are limited to clinical work and there is no literature that explores the impact of factors on clinicians' attitudes toward individuals diagnosed with BPD.

Conclusion

Individuals who experience great emotional pain and dysregulation in the context of interpersonal relationships are most likely to receive a BPD diagnosis in treatment settings. Given the prevalence of the diagnosis among individuals who seek treatment in mental health settings, it is important that social workers and other helping professionals develop competence and compassion in the care of clients and patients with BPD. The therapeutic alliance is an important aspect in treatment and recovery, and such an alliance is made more complicated by the widespread prejudice in helping professions against people with a BPD diagnosis. The existing gaps in the literature call for inquiry into the genesis of bias against individuals with a BPD diagnosis.

CHAPTER III

Methodology

This study explores the sources of attitudes and bias against individuals who carry a diagnosis of borderline personality disorder. The study was designed to answer the following question: What are the factors that influence clinician bias against individuals who carry a diagnosis of borderline personality disorder? Individuals diagnosed with borderline personality disorder have long been a subject of interest to clinicians and researchers alike; this interest and corresponding research has led to well-documented clinician bias, though no study has been published exploring the genesis of such bias. A mixed methods study was appropriate for studying a new aspect of an established phenomenon because this study explores an unstudied aspect of an established phenomenon. I chose to survey a sample of student clinicians because they are more likely to remember the tone of their first exposures to the learning environments wherein they learned about BPD and their first relationships with individuals who carry a BPD diagnosis.

Embedded in the larger research questions are several hypotheses. My hypotheses are informed by social cognitive learning theory which posits that individuals learn vicariously from their social surroundings (Bandura, 1986). One assumption underlying my research is that bias toward individuals who carry a BPD diagnosis is not an inherent. I designed the survey to isolate which sources of learning are most potent and learn which of them, if any, transmits the most bias. My hypotheses are as follows:

1. Exposure to biased attitudes among colleagues and supervisors is the most significant source of influence on student clinicians' attitudes toward individuals diagnosed with BPD.
2. Working in a clinical setting with clients or patients who have a BPD diagnosis is an influential source of learning.
3. Personal experiences with a person with a BPD diagnosis impact student clinicians' attitudes toward patients or clients with a BPD diagnosis.

I created a mixed method, exploratory survey in order to 1) understand the genesis/etymology of the well-documented stigma against individuals who carry a diagnosis of BPD, 2) determine which sources of information and knowledge are most influential (See Appendix C). I used an online survey instrument rather than personal interviews in order to maximize the number of individual participants, to allow for participant anonymity in order to reduce any potential social desirability bias in participant answers (Crowne & Marlowe, 1964).

Sample & Recruitment

People eligible to participate had to meet only two requirements. Each participant had to be 1) over 18 and 2) a currently enrolled student in a master of social work degree program. The survey was administered solely in English, so it is assumed, though not explicitly stated that participants will have a relatively high degree of fluency in reading and writing English. Additionally, because the survey was administered on the internet, a second implicit requirement for participation is access to a computer and the internet.

I used convenience, non-probability sampling for this study (Rubin & Babbie, 2010). Recruitment included both purposive and snowball recruitment techniques. Recruitment flyers

were distributed among my acquaintances and colleagues from various schools and agencies in the Boston Area. Recruitment took place from February 2014 through March 2014. It consisted of 1) emailing my personal contacts 2) requesting that my contacts send on the recruitment flyer to others who met study eligibility requirements 3) posting a flyer on social media websites (Facebook groups) frequented by MSW students in my program, and 4) contacting deans of two social work schools to request distribution of the flyer to their schools' students.

I used primarily my own personal contacts in the social work field to access student clinicians. I sent a recruitment flyer to these contacts and requested that they send it to their contacts who might be both eligible and interested. In order to screen out non-eligible persons, all respondents first encountered a welcome page where they had to confirm they met the criteria before being allowed to give consent and begin the official survey.

All data I collected is self-reported, thus there are intrinsic limitations in the design, such as limited validity. The sample characteristics may also limit the generalizability. The sample is not random, and therefore a result of self-selection bias. Additionally, each of the questions was optional, so even those who completed the survey did not have to answer every question, in some cases potentially compounding the self-selection bias.

Ethics and Safeguards

The study proposal was reviewed and approved by the Human Subjects Review (HSR) board at Smith College School for Social Work, a body whose job it is to ensure that research under its purview meets federal ethics standards. As part of the review, the proposal was examined to ensure all efforts were made to minimize risks to participants in the study.

The informed consent that each participant was presented with before beginning the survey outlined potential risks and benefits of participation. It also informed potential participants of measures to protect confidentiality and listed the researcher's contact information (see Appendix B). All participants had to acknowledge the information and give their consent before their answers were recorded for analysis. Additionally, study participants had to "submit" their responses at the conclusion of the survey in order for them to be included in data analysis.

Reasonable risks of participation in the study included the possibility of participants experiencing feelings of discomfort. Before they affirmed their consent, participants were reminded that, should they feel such discomfort, they could withdraw from the study any time before they submitted their responses. Additionally, the end of the consent form I listed contact information for contacting the Smith College HSR committee to be used in the event of participants becoming distressed or developing problems as a result of participation (see Appendix D).

There were some benefits individuals may have experienced through their participation. By participating in this survey, subjects may have experienced insight into their work with clients diagnosed with borderline personality disorder. Additionally, by reflecting on the process of social work education, subjects may be able to identify both strengths and deficits so that they may attend to any educational or experiential gaps that may help them in their work with clients.

It is my hope that social work instructors and social work students may also benefit from the data if they suggest which aspects of social work education helps student clinicians be prepared for working with individuals diagnosed with borderline personality disorder. Additionally, clients of future student clinicians could potentially benefit from pertinent findings.

Data Collection

The survey was available to potential participants from February 2014 through March 2014. I collected the data for this research study through an original mixed method survey I authored. The survey was administered online through Survey Monkey, a website that hosts customized surveys. The first section of the survey consisted of eight demographic questions, asking participants to disclose their gender and age, the type of program they were enrolled in (full-time, part-time), their progress toward program completion (first, second, or third year student, or advanced standing), the name of their college or university, years of clinical experience, and how many individuals diagnosed with BPD they had worked with at the time they took the survey.

Following the demographic questions, participants were asked to answer three multiple choice questions concerning their sources of learning about BPD, which source they encountered first, and which source was most influential. The seven following questions asked respondents to assess the attitudes conveyed by each of their sources of learning about BPD. The measurement of attitude is a Likert scale ranging from 1 – more negative to 6 – more positive. Each question had an N/A option. The last five questions are open-ended questions; two of the last five questions are specific to participants who have worked clinically with individuals diagnosed with BPD. Roughly 30-40 participants responded to each of the open-ended questions. Convenience and snowball sampling created a sample that is not geographically diverse. The vast majority of respondents attend social work school in Massachusetts. Though my hope was that the sample would become more diverse through snowball sampling, most of the people who participated in the sample likely received the link directly from me through email and social media.

Researcher biases

I am a cis-gender hetero white woman from a lower-middle class background. The intersection of my various identities and my personal experiences inevitably shape the research questions I ask and the way in which I ask them. This topic is of interest to me because BPD is disproportionately diagnosed in women and the label and its predecessors have been socially constructed as a means of invalidating ways of being that are often labeled feminine (e.g. “moody” and “emotional”). As a female-identified person who is also a clinician, I find it important to understand common perceptions of and biases against women’s behaviors and ways of being in the world and how those perceptions and biases develop through the learning process. Further, diagnoses are constructs that attempt to organize phenomena, and BPD is no different. However, BPD and other stigmatized diagnoses also tend to carry other meanings that are neither diagnostic nor helpful to those who engage in mental health services or the social workers who work with them. My intent while developing the survey instrument was to use neutral language. However, it is plausible that some participants could read my orientation toward the topic within the content and syntax of the questions. For example, I chose to use “person with a diagnosis of BPD” rather than “person with BPD”.

Data Analysis

I used descriptive statistics to analyze the survey data generated from the quantitative questions. Results are explicated in charts in the findings chapter. I studied the qualitative data for emerging themes, then isolated responses illustrative of these themes for further analysis.

CHAPTER IV

Findings

Sixty-nine student clinicians completed and submitted their responses to the survey. Figure 1 provides a summary of the descriptive demographics of the study sample.

Figure 1. Study sample demographic information.

| School Demographics | Frequencies | Percent of Sample |
|------------------------------|--------------------|--------------------------|
| First Year | 11 | 16% |
| Second Year | 41 | 60% |
| Third Year | 15 | 22% |
| Advanced Standing | 1 | 1% |
| BSW | 3 | 4% |
| Part-time | 6 | 9% |
| Full-time | 63 | 91% |
| SSW X | 51 | 74% |
| SSW Y | 12 | 17% |
| SSW Misc. combined | 3 | 3% |
| Gender Identification | | |
| female identified* | 60 | 87.0% |
| male identified** | 10 | 9.0% |
| did not identify | 3 | 4.0% |
| Age in years | | |
| 25 and under | 19 | 27.9% |
| 26-30 years | 32 | 47.1% |
| 31-35 | 7 | 10.3% |
| 36-40 | 6 | 8.8% |
| 40-55 | 4 | 6% |
| Clinical Experience | | |
| 0 months | 22 | 32% |
| 3-9 months | 3 | 4% |
| 1-2 years | 12 | 17% |
| 24-36 months | 21 | 30% |
| 3 or more years | 19 | 28% |
| 5 or more years | 6 | 9% |

*including those who identified themselves as female gender non-conforming and genderqueer

**including those who identified themselves as transmale and genderqueer

Figure 2 displays participants' initial source of learning about BPD listed next to all indicated sources of learning about BPD. Figure 3 illustrates the amount of influence attributed to each source of learning, lower numbers indicating more influence, higher numbers indicating less influence. Figures 4 and 5 report participant perceptions of attitude of the sources from which they learned about BPD. Figures 3, 4, and 5 can be found in Appendix A.

Figure 2. Sources from which student clinicians learned about BPD.

| Sources of Learning | Initial Source | | All Sources | |
|--|-----------------------|---------|--------------------|---------|
| | Frequency | Percent | Frequency | Percent |
| One or more people in personal life | 15 | 22.1% | 26 | 37.7% |
| Conversations with colleagues prior to master's program | 11 | 16.2% | 37 | 53.6% |
| DSM | 3 | 4.4% | 55 | 79.7% |
| Working clinically with individuals with a BPD diagnosis | 14 | 20.6% | 44 | 63.8% |
| Articles or texts outside assigned | 5 | 7.4% | 44 | 63.8% |
| Colleagues at placement | 3 | 4.4% | 50 | 72.5% |
| Assigned texts or articles | 2 | 2.9% | 57 | 82.6% |
| Other | 11 | 16.2% | 61 | 88.4% |
| Don't remember when learned about it | 4 | 5.9% | | |

Themes present in qualitative data

There were several prominent themes that emerged from the qualitative data. Student clinicians in the study tended to have some knowledge of BPD. Some report having had their

initial exposure through the general media and pop culture. Study participants tended to be aware of some presenting symptoms, some common etiology of symptoms, and the gender differential of the diagnosis. Most who were familiar with the disorder knew that DBT is one treatment modality recommended for people with a diagnosis of BPD. Last, student clinicians in the study expect work with people who meet BPD criteria to be difficult, they tend to be aware that BPD is a stigmatized diagnosis, and many are reluctant to use the diagnosis.

Initial exposure through pop culture. One theme that emerged in the qualitative data was learning about BPD through pop culture and pop psychology. In one response representative of this phenomenon, a participant stated, “Besides hearing it in everyday conversation, I had heard about it in my work setting and read about it as portrayed in Susanna Kaysen's book *Girl, Interrupted*.” Another participant related, “I read a book called *I Hate You, Dont Leave Me*. I was trying to understand myself. Later it helped me to understand one of my girlfriends. I knew it was a chaotic and painful condition. I also knew of it from *Girl, Interrupted*.” Additionally, a movie referenced throughout was *Fatal Attraction*.

Many participants were aware of some of the presenting symptoms of BPD. One person said he or she knew that individuals diagnosed with BPD tend toward “affect dysregulation, problems with relationships, [and] distress intolerance.” Another noted that “mood swings” are characteristic. One respondent detailed, “I knew that it involved emotional instability, self-harming, sexual promiscuity,” and another stated, “I knew that individuals struggling with BPD were very dependent on others and had a lot of emotional dysregulation problems.” One person described the clinical presentation in more detail:

People with BPD tend to think in absolutes, Black v. White. More likely to suffer health issues from poor diet and substance use. These individuals are prone to boredom with people and activities. Many experience an absence of feeling and gravitate towards heightened emotional experiences (drama and love etc.) to feel something. Relationships are characterized by the 'push/pull'.

Understanding of common etiology. Understanding the etiology of the symptoms of BPD emerged as an important theme in the qualitative data. One person said of the diagnosis, “[I knew] that it seemed to reflect an experience of childhood abuse, neglect or abandonment, resulting in a volatile personality that could misjudge relationships and behave in (self) destructive ways, unless the individual felt very safe.” Another knew “that it was generally situated in past trauma history.” A large portion of student clinicians who participated in this study tend to have some knowledge about the context in which BPD symptoms develop. One person stated, “The biggest takeaway I got in school was that people who develop traits of borderline personality disorder are more likely than not people who experiences trauma and have developed a set of very maladaptive coping skills to manage their feelings.” Another response summarizes concisely, “[I learned that] a history of trauma and neglect influence the development of BPD.”

Some participants reported that education had emphasized the importance of a nuanced understanding and approach, often including understanding of etiology and mentalization of the experiences of clients presenting with BPD symptoms. One respondent stated, “More recently a brilliant professor described it as an inability to stay grounded in the self for very long which I thought was a great description of it. I have also learned that so many of these so called disorders are often understood by many in the trauma field to simply be manifestations of the impact of

traumatic stress rather than a unique disorder unto themselves.” Another related he or she had been taught, “splitting is a normal symptom and not indicative of individuals as bad people.” A third example indicates:

The current social work training on BPD underlines that many people who have been given a diagnosis of BPD have trauma histories. There's a big emphasis on how trauma may play a role in the features of BPD like impulsivity, self-injurious behaviors, substance abuse, etc. as a way to manage posttraumatic responses.

BPD as gendered phenomenon. Many study participants noted BPD is more commonly associated with women, and some respondents identified women in their lives who they believe meet the criteria for diagnosis. One fairly typical response illustrates this theme: “[I knew] that people, largely women, would create relationships that were very difficult to be in, they would have a "go away/don't leave me" way of relating that was very hard to be around.” Another participant observed, “They’re very manipulative, often female, sometimes dangerous.”

Several other respondents noted women they knew personally who they thought of as having traits associated with borderline personality disorder. One such response illustrates this trend: “Though I don't know if she has been officially diagnoses, my mother appears to meet all the criteria. I grew up with her and my personal experience informs my understanding of BPD.” No participants identified male-identified people as individuals who carried a diagnosis or exhibited traits of BPD.

DBT treatment for BPD. Many participants report learning that DBT is the preferred treatment for people with a BPD diagnosis. One such response is that individuals with BPD are “difficult to treat, in need of DBT trained therapist, [and] receive minimal empathy from therapists.” Another person said she, “learned more about etiology and trauma. I also learned

some ideas about treatment and skills, especially DBT therapy for borderline personality disorders.” The following was the most typical response indicating DBT as a good method for treating a person with a diagnosis of BPD: “I learned a little bit more about the criteria needed to be met in order to fit a BPD diagnosis and also learned about DBT as a great treatment for individuals with BPD.”

Clinicians expect work to be difficult. Many study participants discussed that they had learned individuals with a BPD diagnosis can be “hard to treat” and because of the behaviors associated with the clinical presentation. The following response typifies this learning: “[I learned] that their insecure attachment styles will feature prominently in the clinical relationship, and working with them will be an intense rollercoaster.” Another person said he had learned that individuals with a BPD diagnosis are “taxing to work with, [and] require long-term therapy.” Others listed characteristics they had learned to associate with individuals with BPD including” self-harm behaviors, chronic suicidality, trauma history” with “difficulty with boundaries and were exhausting to work with. One respondent stated at the beginning of her education she knew “nothing really. Mainly that it was difficult to work with people with this diagnosis,” and another related that “some people in the mental health field “refuse” to work with clients diagnosed with BPD because of the perceived difficulty in working with those clients.”

Stigma against people diagnosed with BPD. Many participants stated that their education about BPD included acknowledgement of the stigma that accompanies the diagnosis. One study participant described her learning experience this way: “It was presented with acknowledgement of the stigma against it and then assessed as to what it really might be, how people are treated when given that label and how to work compassionately with these

individuals.” Another said it was first presented “As one of the ‘personality disorders’ and that it was one of the most stigmatized disorders in the DSM,” and a third stated,

The first thing I heard was about the stigma, before I ever heard about the content of the diagnosis. And after I read about the diagnosis, the classroom conversations about it still revolved largely around the stigmatizing effects of giving someone this diagnosis.

Other student clinicians observed their colleagues’ stigma in the language in which BPD was presented. For example, one person stated that BPD had been initially presented “almost as a joke. Someone said something and my professor said ‘oh yup that’s majorly Borderline’.”

Another was taught “If you had BPD you would be “screwed” for lack of a better word. You would be deeply unlikable, and most likely un-treatable.” A third person indicated his or her first exposure was during an MSW course wherein the instructor illustrated BPD with “the scary scene from Fatal Attraction”. In a similar vein, many report learning during their first exposure that BPD symptoms are “unremitting, life-long, with very poor prognosis for recovery or significant positive change”. Another relates her experience learning “that they are very challenging to work with, and that as a clinician, you will generally need “manage” them as opposed to expecting “real” progress.”

Reluctance to use diagnosis of BPD. Among the student clinicians who responded to the survey, one third expressed reluctance to utilize BPD as a diagnosis at all. One stated, “a [client] of mine was diagnosed recently and it makes me angry because to me she has complex trauma issues and this diagnosis seems like a condemnation of her.” Another indicated, “I struggle diagnosing anyone who has experience[d] trauma with any disorder.” And a third related, “I used a diagnosis of Complex PTSD, never one of BPD, as I learned in my first year placement that it made an enormous difference for the client to use the PTSD diagnosis (so behaviors are in a

context that they can understand . . .).” Only two participants indicated that they involved the client in the discussion about diagnosis, and one of those conversations led to a differential diagnosis of PTSD.

Themes from qualitative data show that student clinicians have a working knowledge of the basic presenting symptoms and etiology of BPD, and some of them had their initial exposure through popular media. Participants generally know that women tend to be more commonly diagnosed with BPD. They report they expect working with this client population to be challenging and they have some knowledge of the stigma associated with the diagnosis, which leads some student clinicians to avoid giving a BPD diagnosis when possible.

CHAPTER V

Discussion

Introduction

The purpose of this study is to explore the means by which stigma associated with BPD is perpetuated. The data gathered as part of this study was done so through an online survey instrument designed to collect self-reported data about the learning experiences of student clinicians. The findings of this study provide insight into how this stigmatized diagnosis is treated in various settings and the ways that new clinicians perceive that information. This section connects this study's findings with theory and existing literature outlined in Chapter II and explores the findings. Last, I discuss the study's strengths and limitations and outline potential implications for practice, policy, and future research.

Connection to existing literature

The current study indicates student clinicians report perceiving their colleagues as very negative or negative more often than any other source of learning about BPD (See Figures 4 and 5). Knowledge of stigma among professionals was consistent with existing literature. Perceived negativity of colleagues is consistent with Fraser and Gallop (1993) that indicated staff have less empathetic response toward people diagnosed with BPD. Consistent with Wright and Jones (2012) who indicated that many clients are never told of their BPD diagnosis, only two study participants who had diagnosed a client with BPD indicated they had discussed the diagnosis with the client.

Many study participants report having learned prior to developing relationships with people carrying a BPD diagnosis that working with this client population would be difficult. Cleary, Seigfried and Walter (2002) reported 80 % of clinicians found working with these clients moderately to very difficult and James and Cowman who similarly report 80 % of participants felt people with BPD were more difficult to treat than clients with other mental health diagnoses(as cited in Wright & Jones, 2012) . The qualitative data suggest that some found that perspective confirmed, some found the work more difficult than expected, and a third group found the clinical work was easier than expected.

Discussion of findings

Though the majority of study participants had worked with at least one person with a BPD diagnosis, 20.3 % of respondents reported that they had not. Given the high percentage of student clinicians in their second placement combined with the relatively high number of people diagnosed with BPD in the clinical treatment-seeking population, it seems unlikely that one-fifth of MSW students have not yet worked in some capacity with individuals diagnosed with BPD. It is probable that some of the student clinicians are not familiar with the symptoms or presentation as outlined in the DSM IV or the DSM V. Although, if this many students really do not get clinical experience with individuals with features of BPD, it may be setting the stage for stigma. As indicated in the literature, some researchers propose that feelings of inadequacy and lack of training contribute to mental health workers' negative attitudes about working with BPD diagnosed clients.

Approximately one-fifth of participants, 22 %, indicated their first exposure to the concept of Borderline Personality Disorder was through an individual in their personal life who carries the diagnosis. This number is remarkable given the low incidence in the general

population. Individuals affected by their relationships with people diagnosed by BPD may be motivated to enter the social work field in order to make sense of their emotional experiences in these relationships or to contextualize the lives of their friends or parents who experience persistent emotional dysregulation.

Findings indicate a significant amount of participants' initial learning about BPD came from colleagues prior to their master's level social work clinical placements, the group rated most negative in their attitudes toward people diagnosed with BPD. If this original exposure in a professional human services environment is so negative, it becomes even more important that subsequent instructors and supervisors take a critical, deconstructive stance in order to undermine negative assumptions and help new masters-level clinicians approach BPD diagnosed clients with compassion and empathy.

Given the amount of student clinicians who indicated their initial learning about BPD came through pop culture media exposure, it may be useful to incorporate this exposure into classroom conversations and field work training. Without those important discussions about how characters are portrayed, people watching *Girl Interrupted* or *Fatal Attraction*, films cited by participants, clinicians may develop a reductive perspective of individuals who carry the diagnosis or display traits consistent with some of the criteria. Social cognitive theory suggests that latent learning such as one experiences from watching other in person or through media can have a profound effect on our perceptions and subsequent behaviors (Bandura, 1986). Hyler & Schanzer (1997) advocate utilizing this capacity for vicarious learning by showing Hollywood produced films in the classroom as illustrations of the criteria for BPD. He and his colleagues argue in an earlier publication that Hollywood films stigmatize people diagnosed with or suspected to meet criteria for various mental illnesses (Hyler, Gabbard, & Schneider). It seems

important for social work programs and professors to assess the amount and tone of exposure to BPD students have prior to entering their social work training. If instructors choose to use films as illustrative of disorder, it is essential that the limitations of such methods be discussed openly and explicitly. Even if using films is done with sensitivity and intention, there is still a chance that students will remember primarily, “that scary scene from *Fatal Attraction*” she saw in class as an illustration of a person diagnosed with BPD.

Participants tended to credit their clinical work with individuals carrying a diagnosis of BPD as their most influential learning experience. Sixty-nine percent of respondents reported having worked with one or more people diagnosed with BPD during their master’s level clinical social work placement. This kind of clinical training in agency settings is a hallmark of clinical social work field education, and the findings in this study support continued emphasis on field work as integral to social work education.

The data reveal that students tend to credit themselves with less negativity than their colleagues. Though it is possible that student clinicians are in fact less biased toward individuals with BPD, it may be that it is easier for students to see the ways in which their colleagues express bias than it is for them to see or admit to it in themselves. It is clear that many student clinicians are aware of pervasive stigma and some take measures to account for it by not utilizing a BPD diagnosis if another is possible.

Student clinicians report their colleagues at their master’s-level field placements tended to be slightly less negative toward individuals with BPD diagnoses than previous colleagues. This is an interesting finding in part because it may correlate to education or licensing. Settings where student clinicians worked prior to their master’s programs likely afforded less access to their more experienced or educated colleagues. It is possible there is a negative correlation

between education or years of experience and expressed bias toward people with a BPD diagnosis.

Participants tend to perceive the DSM as moderately negative, which is interesting given that the DSM's expressed descriptive purpose. Participants' assessments of the tone of the DSM may reflect clinician attitudes regarding the utility of diagnosis in general or toward the DSM in particular. This perceived bias in the criteria of the DSM may lead individuals to dismiss the utility of the DSM or, as indicated in the data, search out and use diagnoses that may be equally applicable but less negatively biased. This relates to the finding that student clinicians perceive that individuals who carry a BPD diagnosis tend to view themselves more negatively as a result of their diagnosis. The DSM is based on a deficit-based medical model that some social workers find offensive or irrelevant to their work. This may be particularly true of the personality disorder diagnoses outlined in the DSM, as symptoms thought to be indicative of disordered personality are not generally thought to be biologically rooted.

A focus on etiology was common throughout. Though it is not listed in the DSM criteria for BPD, many student clinicians had some understanding of the etiology of the symptoms of BPD. Understanding of etiology may be helpful in reducing stigma by helping understand causal attributions. Prior research suggests that nurses who could attribute behaviors to an illness rather than intent of a patient were more likely to be sympathetic toward that individual. Perhaps there is a similar connection to understanding etiology, creating an "it's not her fault she behaves this way" attitude. It may be that trauma narratives engender more compassion toward individuals with a BPD diagnosis. The potential problem is that there is no simple etiology, no single narrative about BPD develops, and it's possible that if trauma is assumed it may guide the course of treatment in ways that are not universally helpful.

Implications for practice, policy, and research

Participants' first exposure to the concept of Borderline Personality Disorder was often through personal interactions both clinical and personal life, though overall, most participants credited clinical work as the most influential source of learning about BPD. This has important implications for training and supervision of student clinicians. In the literature, some explanations of bias point to feelings of professional inadequacy as a contributor to the pervasive aversion to people who meet criteria for BPD. Given its influence on perception, it seems clinical work with clients diagnosed with BPD is an important part of social work education. Additionally, since supervisors and colleagues tend to be the most negative influence, it may be beneficial to research confidence of instructors, professors, and clinical supervisors, to treat individuals diagnosed with BPD.

The references of BPD in popular culture has important implications for incorporating critical theory into social work training, providing a critical analysis of the messages that have already been incorporated into students' understanding of BPD by the popular media.

Longitudinal study that measures attitude over time and accounts for learning experiences as they happen could control for attribution of learning/recency, perhaps a design that measures attitude prior to MSW training, after first academic exposure, after first relationship in clinical setting, after graduation, and after licensing. Additionally, further research might include an observational component that combines self-report with a more objective measure that may balance social-desirability bias.

Strengths of the study

Though there were few male-identified individuals in the sample, the gender representation is relatively reflective of the field in general. As opposed to most studies that survey licensed professionals, students may have better access to recent and primary knowledge than their more seasoned colleagues. Additionally, the majority of studies on bias focus on psychiatric nursing or psychiatrists. This study is among the first to examine the attitudes and experiences of social workers as they relate to working with people with a BPD diagnosis.

Limitations of the study

A major limitation of the current study is the use of a new instrument that was not tested for reliability or validity within this study. I also recognize a relatively small sample size as a limitation, particularly as study participants were not required to answer all survey questions and thus there were fewer responses to open-ended qualitative questions. Lastly, the title of the study combined with the study's sampling strategy likely provided a sample who were potentially already interested in and aware of bias against individuals diagnosed with BPD.

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Appendix A

| People in my personal life who have a diagnosis of borderline personality disorder view themselves ____ as a result of their diagnosis. | | | Colleagues in my work prior to my master's degree program generally view individuals diagnosed with borderline personality disorder: | | | The Diagnostic and Statistical Manual of Mental Disorders presents the criteria for borderline personality disorder in a way that is: | | |
|---|-----------|---------|--|-----------|---------|---|-----------|---------|
| | Frequency | Percent | | Frequency | Percent | | Frequency | Percent |
| very negatively | 4 | 15.4% | very negatively | 14 | 31.1% | very negative | 6 | 11.5% |
| negatively | 6 | 23.1% | negatively | 10 | 22.2% | negative | 21 | 40.4% |
| somewhat negatively | 13 | 50.0% | somewhat negatively | 16 | 35.6% | somewhat negative | 23 | 44.2% |
| somewhat positively | 3 | 11.5% | somewhat positively | 3 | 6.7% | somewhat positive | 2 | 3.8% |
| positively | 0 | 0.0% | positively | 2 | 4.4% | positive | 0 | 0.0% |
| very positively | 0 | 0.0% | very positive | 0 | 0.0% | very positive | 0 | 0.0% |
| Total | 26 | 100.0% | Total | 45 | 100.0% | Total | 52 | 100.0% |
| NA | 34 | | NA | 15 | | NA | 7 | |
| Mean | | 2.58 | Mean | | 2.31 | Mean | | 2.40 |
| Median | | 3.00 | Median | | 2.00 | Median | | 2.00 |
| Std. Deviation | | .902 | Std. Deviation | | 1.125 | Std. Deviation | | .748 |

Figure 3. Student clinicians' perceptions of attitudes toward individuals with a BPD diagnosis.

| Articles or texts assigned as part of my social work education generally express opinions about individuals diagnosed with borderline personality disorder that reveal attitudes that are | | | After working clinically with individuals diagnosed with borderline personality disorder, my perception of those individuals is: | | | Colleagues at my social work internship/clinical placement tend to express views of individuals diagnosed with borderline personality disorder that are | | |
|---|-----------|---------|--|-----------|---------|---|-----------|---------|
| | Frequency | Percent | | Frequency | Percent | | Frequency | Percent |
| very negative | 2 | 3.5% | very negative | 0 | 0% | very negative | 10 | 17.5% |
| negative | 10 | 17.5% | negative | 3 | 6.1% | negative | 16 | 28.1% |
| somewhat negative | 33 | 57.9% | somewhat negative | 17 | 34.7% | somewhat negative | 19 | 33.3% |
| somewhat positive | 9 | 15.8% | somewhat positive | 18 | 36.7% | somewhat positive | 8 | 14.0% |
| positive | 3 | 5.3% | positive | 10 | 20.4% | positive | 4 | 7.0% |
| very negative | 0 | 0.0% | very positive | 1 | 2.0% | very positive | 0 | 0.0% |
| Total | 57 | 100.0% | Total | 49 | 100.0% | Total | 57 | 100.0% |
| NA | 3 | | NA | 11 | | NA | 3 | |
| Mean | | 3.02 | Mean | | 3.78 | Mean | | 2.65 |
| Median | | 3.00 | Median | | 4.00 | Median | | 3.00 |
| Std. Deviation | | .834 | Std. Deviation | | .919 | Std. Deviation | | 1.142 |

Figure 4. Student clinicians' perceptions of attitudes toward individuals with a BPD diagnosis.

| Conversations with colleagues in my work prior to my master's degree program | | | The Diagnostic and Statistical Manual of Mental Disorders | | | Reading articles or texts assigned as part of my social work education | | |
|---|-----------|---------------|---|-----------|---------------|---|-----------|---------------|
| Influence Rating | Frequency | Valid Percent | Influence Rating | Frequency | Valid Percent | Influence Rating | Frequency | Valid Percent |
| 1 | 7 | 17.5% | 1 | 3 | 5.7% | 1 | 13 | 22.0% |
| 2 | 7 | 17.5% | 2 | 9 | 17.0% | 2 | 19 | 32.2% |
| 3 | 5 | 12.5% | 3 | 13 | 24.5% | 3 | 8 | 13.6% |
| 4 | 4 | 10.0% | 4 | 11 | 20.8% | 4 | 9 | 15.3% |
| 5 | 5 | 12.5% | 5 | 8 | 15.1% | 5 | 5 | 8.5% |
| 6 | 2 | 5.0% | 6 | 6 | 11.3% | 6 | 5 | 8.5% |
| 7 | 10 | 25.0% | 7 | 3 | 5.7% | 7 | 0 | 0.0% |
| Total | 40 | 100.0% | Total | 53 | 100.0% | Total | 59 | 100.0% |
| NA | 16 | | NA | 3 | | NA | 2 | |
| Mean | | 3.98 | Mean | | 3.79 | Mean | | 2.81 |
| Median | | 4.00 | Median | | 4.00 | Median | | 2.00 |
| Std. Deviation | | 2.259 | Std. Deviation | | 1.598 | Std. Deviation | | 1.570 |
| Reading articles or texts outside the readings assigned in my classes | | | Working clinically with individuals diagnosed with borderline personality disorder | | | Colleagues at my social work internship/clinical placement | | |
| Influence Rating | Frequency | Valid Percent | Influence Rating | Frequency | Valid Percent | Influence Rating | Frequency | Valid Percent |
| 1 | 7 | 14.6% | 1 | 25 | 49.0% | 1 | 11 | 19.6% |
| 2 | 15 | 31.3% | 2 | 10 | 19.6% | 2 | 12 | 21.4% |
| 3 | 10 | 20.8% | 3 | 5 | 9.8% | 3 | 12 | 21.4% |
| 4 | 4 | 8.3% | 4 | 1 | 2.0% | 4 | 8 | 14.3% |
| 5 | 4 | 8.3% | 5 | 1 | 2.0% | 5 | 7 | 12.5% |
| 6 | 4 | 8.3% | 6 | 3 | 5.9% | 6 | 3 | 5.4% |
| 7 | 4 | 8.3% | 7 | 6 | 11.8% | 7 | 3 | 5.4% |
| Total | 48 | 100.0% | Total | 51 | 100.0% | Total | 56 | 100.0% |
| NA | 10 | | NA | 8 | | NA | 4 | |
| Mean | | 3.23 | Mean | | 2.53 | Mean | | 3.16 |
| Median | | 3.00 | Median | | 2.00 | Median | | 3.00 |
| Std. Deviation | | 1.848 | Std. Deviation | | 2.129 | Std. Deviation | | 1.735 |

Figure 5. Amount of influence attributed to sources of learning about BPD. Lower ratings indicate higher influence.

Appendix B

Informed Consent Agreement

Consent to Participate in a Research Study

Smith College School for Social Work • Northampton, MA

Title of Study: The origins of clinician bias in diagnosing and treating individuals with borderline personality disorder

Investigator(s): Lindsay Heightman

Email address: lheightman@smith.edu

Introduction:

You are being asked to be in a research study which intends to examine what shapes social workers' opinions about people diagnosed with borderline personality disorder. You were selected as a possible participant because you are currently in a social work degree program. We ask that you read this form and ask any questions that you may have before agreeing to be in the study.

Purpose of Study:

The purpose of the study is to gain a better understanding of the forces that influence student clinicians' opinions and attitudes about individuals diagnosed with borderline personality disorder. This study is being conducted in partial fulfillment of a master's in social work degree. Ultimately, this research may be published or presented at professional conferences.

Description of the Study Procedures:

The survey will ask you a series of demographic questions (age, sex, school you are attending, years of experience, number of clients diagnosed with borderline personality you have treated). Then you will be asked a series of questions related to how you learned about borderline personality disorder and asked to rank which sources of learning have influenced you the most. The survey ends with four open-ended questions.

Risks/Discomforts of Being in this Study:

There are no reasonable foreseeable (or expected) risks. The survey deals with your attitudes about and experiences with individuals who are diagnosed with borderline personality disorder. If you find the survey questions make you uncomfortable, please remember you can withdraw from the survey at any time prior to submitting your answers.

Benefits of Being in the Study:

You will be able to share your opinions on a clinically relevant subject with important implications in your practice, in addition to potentially gaining insight into your personal feelings regarding your past, current, or future work with individuals diagnosed with borderline personality disorder. The research has implications for social work practice as it relates to clients, clinicians, and the systems in which their work together takes place. Additionally, findings may have implications for social work education that could affect the way in which new clinicians conceptualize their work with people diagnosed with borderline personality disorder.

Confidentiality:

This study is anonymous. We will not be collecting or retaining any information about your identity. The survey website will not forward any identifying information (such as your IP address) to me in order to keep your identity anonymous. I will have no way to tell who has participated.

Payments:

You will not receive any financial payment for your participation.

Right to Refuse or Withdraw:

The decision to participate in this study is entirely voluntary. You may refuse to take part in the study at any time without affecting your relationship with the researchers of this study or Smith College. You have the right not to answer any single question, as well as to exit from the survey at any point during it. However, since I will not know participants' identities, once you click on the "submit" button on the last page of the survey you will be unable to withdraw.

Right to Ask Questions and Report Concerns:

You have the right to ask questions about this research study and to have those questions answered by me before, during, or after the research. If you have any further questions about the study feel free to contact me at any time **using the email address at the top of this page**. If you like, a summary of the results of the study will be sent to you. If you have any other concerns about your rights as a research participant, or if you have any problems as a result of your participation, you may contact the Chair of the Smith College School for Social Work Human Subjects Committee at (413) 585-7974.

Consent:

By clicking on the "I agree" button below you will indicate you have decided to volunteer as a research participant for this study, and that you have read and understood the information provided above.

*We encourage participants to print a copy of this consent for their records.

Appendix C

Demographic and Survey Questions

Demographic questions:

In my MSW program I am a:

First year student

Second year student

Third year student

Advanced standing student

I am in a

Part-time program

Full-time program

I attend (please write name of college or university you currently attend)

How do you identify your gender?

Do you have a bachelor's degree in social work? Y/N

Approximately how many years and months of clinical experience did you have prior entering your MSW program? ___ year(s) ___ month(s)

What is your age in years _____

Approximately how many individuals diagnosed with borderline personality disorder have you worked with in your role as clinician?

Survey questions:

- 1) I **first** learned about borderline personality disorder from: (**choose one**)
 - One or more people in my personal life have a diagnosis of borderline personality disorder
 - Conversations with colleagues in my work prior to my master's degree program
 - *The Diagnostic and Statistical Manual of Mental Disorders*
 - Reading articles or texts assigned as part of my social work education
 - Reading articles or texts outside the readings assigned in my classes
 - Working clinically with individuals diagnosed with borderline personality disorder
 - Colleagues at my social work internship/clinical placement
 - Other _____
 - **I don't remember when I first learned about borderline personality disorder.**
 - **I have never heard of borderline personality disorder.**

(if participant selects the last answer option, participant will be directed to the "submit" page).

- 2) I have learned about borderline personality disorder from the following sources (**check all that apply**):
 - One or more people in my personal life have a diagnosis of borderline personality disorder
 - Conversations with colleagues in my work prior to my master's degree program
 - *The Diagnostic and Statistical Manual of Mental Disorders*
 - Reading articles or texts assigned as part of my social work education
 - Reading articles or texts outside the readings assigned in my classes
 - Working clinically with individuals diagnosed with borderline personality disorder
 - Colleagues at my social work internship/clinical placement
 - Other _____

- 3) Please rank which sources of learning have influenced your perception the most (1 = most influential, 0 = does not apply):
 - One or more people in my personal life have a diagnosis of borderline personality disorder
 - Conversations with colleagues in my work prior to my master's degree program
 - *The Diagnostic and Statistical Manual of Mental Disorders*
 - Reading articles or texts assigned as part of my social work education
 - Reading articles or texts outside the readings assigned in my classes
 - Working clinically with individuals diagnosed with borderline personality disorder

- Colleagues at my social work internship/clinical placement
- Other _____

Drawing on the sources of learning you identified above, indicate on the scale your understanding of how each group perceives individuals diagnosed with borderline personality disorder: (questions 4-9)

- 4) People in my personal life who have a diagnosis of borderline personality disorder view themselves

More negatively ← 1-----2-----3-----4-----5-----6→ More positively
as a result of their diagnosis.

- 5) Colleagues in my work prior to my master's degree program generally view individuals diagnosed with borderline personality disorder

More negatively ← 1-----2-----3-----4-----5-----6→ More positively

- 6) *The Diagnostic and Statistical Manual of Mental Disorders* presents the criteria for borderline personality disorder in a way that is:

More negative ← 1-----2-----3-----4-----5-----6→ More positive

- 7) Articles or texts assigned as part of my social work education generally express opinions about individuals diagnosed with borderline personality disorder that reveal attitudes that are

More negative ← 1-----2-----3-----4-----5-----6→ More positive

- 8) Articles or texts I have read outside the readings assigned in my classes express opinions about individuals diagnosed with borderline personality disorder that reveal attitudes that are generally

More negative ← 1-----2-----3-----4-----5-----6→ More positive

9) After working clinically with individuals diagnosed with borderline personality disorder, my perception of those individuals is:

More negative ← 1-----2-----3-----4-----5-----6→ More positive

10) Colleagues at my social work internship/clinical placement tend to express views of individuals diagnosed with borderline personality disorder

More negatively ← 1-----2-----3-----4-----5-----6→ More positively

11) Prior to your program, what did you know about Borderline Personality Disorder?

12) What did you learn in school about individuals with Borderline Personality Disorder?

13) During your social work courses, how was borderline personality disorder first presented to you?

14) Have you worked with one or more people who are diagnosed with Borderline Personality Disorder during your master's level clinical social work field placement: Y/N (If you answer No, please skip the following two questions.)

15) How has your experience working with individuals diagnosed with borderline personality disorder been different than you expected based on the information you received in your coursework?

16) If you have diagnosed an adult with borderline personality diagnosis, how did you arrive at that diagnosis?

Appendix D
HSR Approval Letter



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

January 17, 2014

Lindsay Heightman

Dear Lindsay,

You did a very nice job on your revisions. Your project is now approved by the Human Subjects Review Committee.

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 and our best wishes on your interesting study.

Sincerely,

A handwritten signature in black ink, appearing to read 'Elaine Kersten'.

Elaine Kersten, Ed.D.
Co-Chair, Human Subjects Review Committee

CC: Hannah Karpman, Research Advisor