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Marja Walthall  
Clinicians' Attitudes Towards  
Borderline Personality Disorder and  
Posttraumatic Stress Disorder:  
Implications of Gender and a  
Diagnostic Label

### **ABSTRACT**

The purpose of the current study was to investigate mental health clinicians' diagnostic assessments of individuals who have features associated with both Borderline Personality Disorder (BPD) and Posttraumatic Stress Disorder (PTSD), the effect of gender on their assessments, and associated attitudes. Recruitment resulted in a participant sample of 38 mental health clinicians who completed the survey in its entirety. Most of the participants identified as white (71.2%), were female (61.5%), worked in a community mental health center setting (76.9%) and had their LCSW (25%) or MA/MS in counseling (28.8%). Three surveys were evenly distributed between potential participants and each included a vignette describing an individual with features consistent with BPD and PTSD which differed only in gender; male, female, or no gender pronouns. The vignette was followed by an adapted form of the Attitude Towards Personality Disorder Questionnaire created by Bowers and Allen (2006) to assess participant attitudes to the individual they had diagnosed.

Because of the small sample size, significance of the findings for diagnosis provision across vignettes could not be determined, though participants diagnosed the vignettes primarily with BPD or PTSD in similar frequencies. Findings from the APDQ indicated more negative attitudes towards individuals diagnosed with BPD than other diagnoses. Implications for further research include replicating the current study with a larger sample size. Indications for clinical practice are also discussed relating to pervasive negative attitudes towards BPD and the interaction of these attitudes with stigma, gender bias, and within clinical relationships.

**CLINICIANS' ATTITUDES TOWARDS BORDERLINE PERSONALITY DISORDER  
AND POSTTRAUMATIC STRESS DISORDER: IMPLICATIONS OF GENDER AND A  
DIAGNOSTIC LABEL**

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

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2013

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## **CHAPTER I**

### **Introduction**

The purpose of the current study was to investigate mental health clinicians' diagnostic assessments of individuals who have diagnostic features associated with both Borderline Personality Disorder (BPD) and Posttraumatic Stress Disorder (PTSD) and the effect of gender on their assessments. The similarities between symptoms of individuals diagnosed with BPD and PTSD when an individual has a history of interpersonal stress or trauma may influence clinician attitudes and treatment. Within the Diagnostic and Statistical Manual of Mental Disorders (4<sup>th</sup> ed.; text rev.; *DSM-IV-TR*; American Psychiatric Association 2000), interpersonal stress refers to experiences such as childhood abuse (sexual, emotional, physical, verbal) and domestic violence. Through continued research, the overlap in the *DSM-IV-TR*'s diagnostic criteria for BPD and PTSD has implications for treatment, attitudes towards individuals with these diagnostic features, and the power of a diagnostic label (Aviram, Brodsky & Stanley, 2006; Becker, 2000; Bowers & Allan, 2006; Commons Treloar, 2009; Deans & Meocevic, 2006; Hodges, 2003; Lewis & Grenyer, 2009).

It is this particular constellation of symptoms that I will primarily focus on in this study as the effects of interpersonal trauma can be unique to those from other forms of life-threatening or catastrophic trauma. Further, the focus on this particular set of symptoms is most pertinent to a comparison of BPD and PTSD as researchers have found that as many as 81% to 91% of individuals diagnosed with BPD experienced childhood trauma, primarily childhood sexual trauma (Lewis et al., 2009). Within these two diagnoses, I will focus specifically on the

implications each diagnostic title, PTSD or BPD, has on clinicians attitudes toward working with these individuals.

My own experience as an intern in a community mental health outpatient treatment center during my first year of graduate school exposed me to widespread sentiment, opinions, and attitudes toward working with individuals who have been diagnosed “axis 2” and primarily BPD. Individuals with BPD were often seen as undesirable clients, and clinicians expressed discomfort and frustration when working with them. There is ample literature on the topic that speaks to this same sentiment as will be discussed later (Aviram, Brodsky & Stanley, 2006; Becker, 2000; Bowers & Allan, 2006; Commons Treloar, 2009; Deans & Meocevic, 2006; Hodges, 2003; Lewis & Grenyer, 2009). The impetus for the proposed study about the similarities between BPD and PTSD diagnoses emerged from my work with a young woman in individual therapy during this first internship year. The client (identity obscured) was a 15 year old girl who had experienced physical and verbal abuse from her father and had witnessed domestic violence between her parents. The client demonstrated great emotional lability, explosive anger, threats of suicide, self-harming behaviors, and intense interpersonal relationships. In discussing this client’s diagnosis with a Smith College field advisor, the advisor questioned why I had noted the possibility of BPD through a “rule out” diagnosis rather than diagnosing her with PTSD. When reflecting on the decision I had made and through further research and discussions, I found the particular features I saw in my client consistent with BPD were also consistent with PTSD, particularly when the trauma an individual has experienced constitutes chronic interpersonal stress (*DSM-IV-TR*).

Through personal experience as an intern in a clinical setting and continued research, it has become apparent that the implications of a BPD or PTSD diagnosis continue to inform



treatment and practice throughout an individual's involvement with mental health systems and access to services (Aviram et al., 2006; Hodges, 2003; Nehls, 1998; Shaw & Procter, 2005; Skodol & Bender, 2003). In addition, the diagnostic label given to an individual with features consistent with both BPD and PTSD affects perspectives and attitudes towards this individual's treatment within an agency and in larger social settings. The specific question that I will address is: What are clinicians' views of and attitudes towards a client who has a history of childhood interpersonal trauma and presents with diagnostic features consistent with both BPD and PTSD resulting from interpersonal trauma? The current study will also examine how these views and attitudes are influenced by the client's gender.

## **CHAPTER II**

### **Literature Review**

This chapter describes the history of post-traumatic stress disorder (PTSD) and borderline personality disorder (BPD) as diagnostic formulations, and the present constructions of these diagnoses in the *DSM-IV-TR*. A comparison of the two sets of diagnostic features is presented, followed by a description of the ways in which theories related to stigma have been offered as explanations for the stigmatization of mental illness and more specifically, BPD. Lastly, a summary of previous studies on mental health professionals' attitudes towards certain diagnostic presentations is provided to place this study in the context of existing knowledge on the topic.

#### **The History of BPD and PTSD Diagnoses**

As a formal diagnosis, BPD was introduced in the *DSM* in 1980, though the concept has been used since 1884 when American psychiatrist Charles Hamilton Hughes noted erratic and unstable moods as “affective insanity” or “moral insanity” (p.297). Borderline features consistent with the current diagnosis were seen next in 1921 when Kraepelin, as cited in Millon (1996), identified “excitable personality.” Borderline was also used in 1938 by Adolf Stern to describe individuals who were mentally instable but were “on the border line between neurosis and psychosis” (Lewis et al., 2009, p.322). The next adjustment to the term was made by Kernberg in 1967 whose concept “borderline personality organization” (BPO) generated interest as a psychodynamic concept of a personality dysfunction. BPO focused on the presence of identity diffusion derived from early integration difficulties in object relations experiences and acknowledged trauma as the genesis of much of this lack of integration (Lewis et al., 2009).

Since its incorporation into the *DSM-III*, BPD has had little modification other than one change to the eight diagnostic criteria in the addition of a ninth criterion (transient stress related paranoid ideation or severe dissociative symptoms) in the *DSM-IV-TR* (Lewis et al., 2009).

Unlike BPD, the diagnosis of PTSD has had substantial alteration since its inclusion in the *DSM-III* in 1980. The development and alteration in the categorization, naming, and treatment of trauma responses is embedded within the social climate of the time (Lewis et al., 2009; Parrish, 2008). The concept of a psychological reaction to trauma began as early as the 1800s when military doctors began diagnosing soldiers with “exhaustion” post battle. This exhaustion was characterized as a mental shutdown due to extreme and repeated stress which “fatigued” their body’s natural reaction to shock (Parrish, 2008, p.1). Also in England during this time, the syndrome “railway spine” or “railway hysteria” resembled current conceptions of PTSD and was used to describe the effects of disastrous railway accidents of the period on affected populations. By 1876, the term “soldier’s heart” was used to diagnose United States Civil War veterans with symptoms including hyper vigilance, heart arrhythmias and an increased startle response (Parrish, 2008, p. 2).

The first edition of the *DSM* published in 1952 called what is now termed PTSD, “stress response syndrome” which was caused by “gross stress reaction” (Parrish, 2008, p.2). In the second edition of the *DSM* published in 1968, trauma related disorders were categorized under “situational disorders.” During this time, it was common sentiment that veterans whose symptoms were not short term had a pre-existing condition and their symptoms were not related to their combat experience (Parrish, 2008, p.2). By the time the symptoms became known as PTSD in 1980 in the *DSM-III*, the associated symptoms changed from a “syndrome” to a “disorder” and became categorized as an anxiety disorder rather than a situational disorder.

Until the *DSM-IV*, most treatment models for PTSD were not long term and were influenced by what has been called a “get over it” attitude, an example of which is seen in the 1970 World War II biographical film “Patton” in which the General accused soldiers of malingering. Once the symptoms were defined as PTSD, the biggest alteration in the diagnostic features has been the definition of the stressor necessary to cause the symptoms of the disorder (Lewis et al., 2009). In the *DSM-III* the stressor needed to be an event outside the range of normal human experience, where the *DSM-IV* broadened the criteria to include events within usual experience where an individual’s or community’s reaction to the event is what characterizes the event as a stressor (*DSM, IV-TR*; Lewis et al., 2009).

Borderline Personality Disorder is defined and discussed in the *DSM-IV-TR* as an Axis II, Cluster B disorder:

A pervasive pattern of instability of interpersonal relationships, self-image and affects, as well as marked impulsivity, beginning by early adulthood and present in a variety of contexts.

According to *DSM-IV-TR*, a diagnosis of BPD is warranted if five (or more) of the following behaviors are present:

1. Frantic efforts to avoid real or imagined abandonment. **Note:** Do not include suicidal or self-injuring behavior covered in Criterion 5
2. A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.
3. Identity disturbance: markedly and persistently unstable self-image or sense of self.

4. Impulsivity in at least two areas that are potentially self-damaging (e.g., promiscuous sex, excessive spending, eating disorders, binge eating, substance abuse, reckless driving). **Note:** Do not include suicidal or self-injuring behavior covered in Criterion 5
5. Recurrent suicidal behavior, gestures, threats or self-injuring behavior such as cutting, interfering with the healing of scars or picking at oneself (excoriation).
6. Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability or anxiety usually lasting a few hours and only rarely more than a few days).
7. Chronic feelings of emptiness
8. Inappropriate anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).
9. Transient, stress-related paranoid ideation, delusions or severe dissociative symptoms (p.710)

PTSD is defined in the *DSM-IV-TR* as an anxiety disorder whose diagnostic criteria are:

A. The person has been exposed to a traumatic event in which both of the following were present:

(1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others

(2) the person's response involved intense fear, helplessness, or horror. **Note:** In children, this may be expressed instead by disorganized or agitated behavior

B. The traumatic event is persistently re-experienced in the form of: (1) re-current and intrusive distressing recollections of the event, including images, thoughts, or perceptions. [**Note:** In young children, repetitive play may occur in which themes or aspects of the trauma are expressed]; (2) recurrent distressing dreams of the event [**Note:** In children, there may be frightening dreams without recognizable content]; (3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated) [ **Note:** In young children, trauma-specific reenactment may occur]; (4) intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event; or (5) physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

- (1) efforts to avoid thoughts, feelings, or conversations associated with the trauma;
- (2) efforts to avoid activities, places, or people that arouse recollections of the trauma;
- (3) inability to recall an important aspect of the trauma;
- (4) markedly diminished interest or participation in significant activities;
- (5) feelings of detachment or estrangement from others;
- (6) restricted range of affect (e.g., unable to have loving feelings); or

(7) sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following: (1) difficulty falling or staying asleep; (2) irritability or outbursts of anger; (3) difficulty concentrating; (4) hypervigilance; or (5) exaggerated startle response

E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functions (p.467).

It is also very important to note that the *DSM-IV-TR* outlines a specific combination of symptoms within a PTSD formulation caused by exposure to interpersonal trauma “e.g., childhood sexual or physical abuse, domestic battering” (p. 465). These symptoms include: ...impaired affect modulation; self-destructive and impulsive behavior; dissociative symptoms; somatic complaints; feelings of ineffectiveness, shame, despair or hopelessness; feeling permanently damaged; a loss of previously sustained beliefs; hostility; social withdrawal; feeling constantly threatened; impaired relationships with others; or a change from the individual’s previous personality characteristics.

Table 1 provides a summary and comparison of the features associated with the diagnostic criteria for BDP and PTSD.

Table 1. Summary of Criteria and Features of BPD and PTSD

	PTSD	PTSD (Interpersonal trauma)	BPD
Criteria/Features	<ul style="list-style-type: none"> <li>- Exposure to a traumatic event</li> <li>- Reexperiencing the event including:               <ul style="list-style-type: none"> <li>- intrusive memories</li> <li>- distressing dreams</li> <li>- reliving; illusions; hallucinations; dissociation</li> </ul> </li> <li>- distress upon exposure to internal or external cues symbolizing the trauma</li> <li>-physical reactivity upon response to internal or external stimuli</li> <li>- Avoidance of stimuli associated with the trauma; numbing               <ul style="list-style-type: none"> <li>-avoidance of thoughts, feelings or conversation associated with the trauma</li> <li>- avoiding people or places associated with the trauma</li> <li>-restricted affect</li> <li>- estrangement from people</li> <li>- diminished interest in activities</li> <li>- sense of foreshortened future</li> </ul> </li> <li>- Increased arousal including:               <ul style="list-style-type: none"> <li>- difficulty sleeping</li> <li>- emotional outbursts</li> <li>- difficulty concentrating</li> <li>- hypervigilance</li> <li>- exaggerated startle Response</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>-impaired affect modulation</li> <li>- self destructive or impulsive behavior</li> <li>- dissociative symptoms</li> <li>- somatic complaints</li> <li>- feelings of ineffectiveness</li> <li>-shame, despair, or hopelessness</li> <li>- feeling permanently damaged</li> <li>- loss of previously held beliefs</li> <li>- hostility</li> <li>- social withdrawal</li> <li>- feeling constantly threatened</li> <li>-impaired relationships with others</li> <li>- change from previous personality characteristics</li> </ul>	<ul style="list-style-type: none"> <li>- Frantic efforts to avoid real or imagined abandonment</li> <li>- pattern of unstable and intense interpersonal relationships; extremes of idealization and devaluation</li> <li>- identity disturbance</li> <li>- impulsivity/self-damaging behaviors</li> <li>- recurrent suicidal behavior, gestures, threats, or self- injuring behavior</li> <li>- affective instability due to reactive mood</li> <li>- chronic feelings of emptiness</li> <li>- inappropriate anger or difficulty controlling anger</li> <li>- paranoid ideation, delusions, dissociation</li> </ul>



To summarize the presentation of the above table, and in line with Herman & van der Kolk's (1987) research, the similarities between the clinical presentations of PTSD caused by interpersonal trauma and BPD can be organized into 5 main domains (Lewis et al., 2009). These domains are an inability to regulate emotions, impulsivity, difficulty differentiating the objective world from one's relationship to it, trouble forming and maintaining interpersonal relationships, and difficulty integrating the various parts of one's identity or self. (Herman & van der Kolk, 1987 as cited in Lewis et al., 2009, p. 423). For purposes of this study, these five shared domains will be the focus of the discussion of clinical similarities between BPD and PTSD caused from interpersonal trauma.

### **Comparison of the Diagnostic Criteria**

BPD and PTSD have often been seen to have potential for applicability to a similar clinical presentation (Hodges, 2003; Lewis & Grenyer, 2009; Marshal-Berenz et al., 2011; Trippany et al., 2006). As discussed previously, PTSD was originally named to describe the symptoms of war veterans however the *DSM-IV-TR* now includes a discussion of the effects of interpersonal trauma including childhood neglect, physical abuse, child sexual abuse, rape and domestic violence (*DSM-IV-TR*, p. 465). As seen previously in the table outlining the similarities of BPD and PTSD resulting from interpersonal trauma, the specific observed similarities between clients diagnosed with BPD and PTSD can be seen in five domains: "Affect regulation, impulse control, reality testing, interpersonal relationships, and self-integration" (Herman & van der Kolk, 1987 as cited in Lewis et al., 2009, p. 423). Disturbances in affect regulation in both BPD and PTSD include depression, intense anger, irritability and feelings of chronic emptiness (*DSM-IV-TR*; Lewis et al., 2009; Trippany et al., 2006). Similarly, BPD and PTSD diagnoses implicate problems in impulse control including substance abuse and self-

harming behaviors (*DSM-IV-TR*, Lewis et al., 2009; Trippany et al., 2006). Common disturbances within the reality testing domain include paranoid ideation and dissociation, and shared disturbances in interpersonal relationships include intense attachment and withdrawal (*DSM-IV-TR*; Lewis et al., 2009; Trippany et al., 2006). Finally, shared problems between BPD and PTSD within the domain of self- integration include identity diffusion and a sense of inner badness (*DSM-IV-TR*; Lewis et al., 2009; Trippany et al., 2006). In addition, PTSD inherently requires the experience of a traumatic event, however it has been reported that as many as 81% to 91% of individuals diagnosed with BPD also experienced childhood abuse or neglect, most predominately childhood sexual abuse (Lewis et al., 2009).

Although individuals diagnosed with BPD and PTSD can share many diagnostic criteria, there is a significant difference in the diagnostic labels themselves, particularly the classification and presumed etiology of each disorder. BPD's diagnostic criteria indicate great heterogeneity within the diagnosis itself as two BPD individuals are only required to share one diagnostic feature (Lewis et al., 2009). Also, a BPD diagnosis within the *DSM-IV-TR* does not indicate an etiology whereas PTSD is one of the few diagnoses in the *DSM-IV-TR* which attributes symptoms solely to situational causes (*DSM-IV-TR*; Hodges, 2003).

### **Stigma within the Diagnoses**

Another primary difference between a BPD and PTSD diagnosis is the stigma ascribed to a BPD diagnosis (Hodges, 2003; Lewis et al., 2009; Marshall-Berenz et al., 2011; Skodol & Bender, 2003; Trippany et al., 2006). One such stigma is the gender bias within the diagnosis. BPD is diagnosed primarily in women as there is a 7:1 female to male ratio in individuals with this diagnosis (Becker, 2000) and the *DSM-IV-TR* (2000) posits that 75% of individuals diagnosed with BPD are women. This discrepancy has informed theories on why more women

are diagnosed with BPD including gender bias, the tendency of diagnostic criteria to be more socially characteristic of women, gender related risk factors (Skodol & Bender, 2003), and a higher likelihood that women would experience childhood sexual abuse (Lewis et al., 2009). Some of the possible risk factors influenced by gender presented by Skodol and Bender (2003) are: Genes, childhood temperament, autonomic nervous system arousal, neurotransmitter responsivity, brain structure and functioning, perinatal factors, hormones, environmental toxins, cognitive and other neuropsychological factors, antecedent childhood or adolescent psychopathology, personality structure or traits, parenting, child abuse or neglect, peer influences, socioeconomic status, family and community disintegration (p. 357). Skodol and Bender (2005) present many other ideas of the etiology and biological factors that differ between males and females in the development of BPD diagnostic features; further demonstrating the lack of clarity of an etiology of this disorder.

There are various theories that have been developed about stigma to provide insight into the gender bias and marginalizing affect of a BPD diagnosis. Labeling theory is one such source (Henry & Cohen, 1983). Developed in the 1960s, labeling theory holds that a deviant behavior is not inherent to a specific act, but rather the act is defined as deviant as a result of social constructions (Henry & Cohen, 1983). Further, labeling theory encourages that focus be put not only on the individual being labeled as “deviant” but also those who make such a judgment, how the judgment is made, and the situation within which the judgment is made (Henry & Cohen, 1983). Henry and Cohen (1983) sought to examine the ways in which labeling theory interacts with the increased rate of BPD in women. They used an analog study, similar to the present research, which presented a *DSM-III* case study of a BPD individual. There were 65 participants who were all psychiatrists working at metropolitan hospitals. Half received the case study with

female pronouns, and half received it with male pronouns and were asked to diagnose the case presentation. Henry and Cohen (1983) hypothesized that participants would be more likely to diagnose the female case study with BPD. Their findings of this hypothesis did not show much difference in diagnosis; only 3%, however another hypothesis in their study demonstrated the effects of labeling processes. Their other hypothesis was tested with 277 undergraduate and graduate students of various academic majors. These participants did not themselves have mental health diagnoses. Participants were given a BPD diagnostic criteria questionnaire and asked to describe themselves based on the presented criteria. Henry and Cohen (1983) hypothesized that more women would evidence borderline characteristics. Their research demonstrated however that significantly more “normal” men (those without a mental health diagnosis or any previous mental health treatment) self-ascribed BPD characteristics than did female students (Henry & Cohen, 1983). Henry and Cohen (1983) thus concluded that the labeling of these behaviors was more commonly seen as pathological when occurring in women even though undiagnosed and socially accepted men were more likely to demonstrate features of BPD.

Other investigations of the nature, reasoning behind, and implications of stigma were examined in Erving Goffman’s (1968) book *Stigma: Notes on the management of spoiled identity*, which led to a great increase in subsequent research on stigma (Link & Phelan, 2001). Goffman’s (1968) book primarily discussed the presence of stigma as located only within a social context. Similar to labeling theory (Henry & Cohen, 1983), Goffman (1968) observed the development of what constitutes “normal” social functioning and the pressure on individuals to conform to these conventions (as cited in Flowerdew, 2008, p. 79). Goffman characterized stigmatization in the following passage:

While the stranger is present before us, evidence can arise of his possessing an attribute that makes him different from others in the category of persons available for him to be, and of a less desirable kind – in the extreme, a person who is quite thoroughly bad, or dangerous, or weak. He is thus reduced in our minds from a whole and usual person to a tainted, discounted one. Such an attribute is a stigma, especially when its discrediting effect is very extensive; sometimes it is also called a failing, a shortcoming, a handicap (Goffman, 1968, p. 12 as cited in Flowerdew, 2008, p. 79).

Further, Goffman (1968) describes three main types of stigmatization: physical deformity, deviation in personal characteristics perceived as resulting from mental disorder (addiction, unemployment etc.), and “tribal stigma” including race, nationality, or religion (p. 14 as cited in Flowerdew, 2008, p. 80). It is the notion of deviation of personal characteristics that describes a personality disorder both linguistically and by *DSM-IV-TR* definition. Similar to labeling theory which asserts that what is not normal behavior is only present within a social environment, Goffman’s (1968) theory of stigma posits that stigmatization is not the result solely of attributes, but of relationships (p.14, as cited in Flowerdew, 2008).

Feminist theorists in particular offer critiques of the BPD diagnosis and possible explanations for the gender bias closely related to the foundation of stigma and labeling theories (Becker, 2000; Goffman, 1968 as cited in Flowerdew, 2008; Henry and Cohen, 1983; Nehls, 1998; Shaw & Proctor, 2005; Skodol & Bender, 2003; Wastell, 1996). BPD is characterized in the *DSM-IV-TR* (2000) by what Wastell (1996) asserts are commonly viewed gender-specific behaviors and traits including unpredictable emotions and relationships and a deep fear of being abandoned. The gender specific behaviors and traits associated with the characterization of BPD may derive from the construction of the diagnostic criteria that favor male-specific interpersonal

functioning as the norm which values independence and devalues connectedness (Shaw & Procter, 2005; Wastell, 1998). These standards describe the notion of socially constructed and located ideas of “normal” or valued functioning (Goffman, 1968 as cited in Flowerdew, 2008).

Further, the gender bias within diagnostic criteria can be explained as “social causation” in that women develop ways to cope with life in a society in which they are less likely to earn as much as men or have access to power, and more likely to experience sex abuse and other forms of violence (Shaw & Procter, 2005). Feminist theorists have argued that women are also disempowered by the constructions of members of the not objective field of psychiatry. Women’s behaviors are evaluated as unreasonable and inappropriate rather than as an understandable adaptation within a context of a history of being violated or abandoned (Shaw & Procter, 2005).

Scheff (1974), in the paper *Labeling theory of mental illness*, assesses and critiques a series of studies about social characteristics and mandated “commitment” to psychiatric treatment. This research supports Shaw and Procter’s (2005) views about the ways in which people develop, act, relate and are viewed in disempowering social situations. For example, Scheff (1974) describes a study that found a correlation between petitioners’ decisions to “commit” (mandate psychiatric hospitalization) an individual and the social characteristics of these patients (p.448). Non- whites were more likely to be “committed” than whites. Scheff (1974) raises questions about this correlation and whether non whites are committed more often because mental illness is more highly correlated with this social category, or as a result of negative social reactions to and constructions of this demographic (p. 449). Scheff’s (1974) criticism of the constructions of pathology from a labeling theory perspective relates closely to Shaw and Procter’s (2005) ideas about whether the characteristics of BPD that are gendered and

stigmatized are truly a personal deviance (Goffman, 1968 as cited in Flowerdew, 2008), or instead an “understandable adaptation” to their social location and the associated experiences (Shaw & Procter, 2005). Related to the actual diagnostic criteria, Kroll (1988) similarly posits that the presentation of personality disorder features in the *DSM* “seem to represent medical diseases least of all and to be dependent on social conventions most of all” (as cited in Becker & Lamb, 1994, p. 9).

Another perspective on gender bias can be seen in the findings of some researchers that suggest the etiology of BPD is childhood trauma (Lewis et al., 2009). Thus, as girls are more likely to experience childhood abuse, primarily sexual abuse, the gender difference in BPD is to be expected (Herman & van der Kolk, 1987 as cited in Lewis et al., 2009).

Further developments resulting from Goffman’s (1968) theory of stigma include Link & Phelan’s (2001) and Read and Harre’s (2001) theories of which personal and social characteristics make an individual more likely to be stigmatized and how people categorize and attribute stereotyped beliefs. Read and Harre (2001) specifically have asserted that the general public, through their research with 469 New Zealand residents, is less likely to stigmatize “mental patients” when the etiology of the diagnosis or disorder is attributed to social or external factors (p. 223). PTSD, as discussed previously, is one of the only diagnoses in the *DSM* which is attributed solely to situational or external events, whereas BPD has been described as a “character flaw”(Hodges, 2003) or a “personality dysfunction” (Lewis et al., 2009) and does not necessarily have, nor does it by definition have, an external cause. Similarly, BPD does not have a specific etiology within the *DSM-IV-TR* (2000) which can encourage ascribing the cause of the disorder to individual weakness or characterological impairment, rather than another known cause (Hodges, 2003).

Woodward, Gordon, Taft and Meis (2009) similarly state that PTSD symptoms are commonly linked to situational events and responses to external circumstances. Woodward et al. (2009) assert that this link to external cause of symptoms is beneficial to patients with this diagnostic label as it can enhance empathy from clinicians and encourage less self blame or guilt. With the presence of a history of trauma, PTSD has been described diagnostically as a “normal” reaction to such experiences, where BPD has been described as the maladaptive response (Hodges, 2003).

There is not a breadth of research available which has countered or disproved the presence of stigma for a BPD diagnosis. Nor was there research available that found that clinicians don't demonstrate negative feelings or opinions of individuals diagnosed with BPD. There is the argument, however, that PTSD has become more “attractive to feminist therapists” as a less blaming diagnosis and that both diagnoses have become “women's diagnoses” (Becker, 2000).

### **Implications of BPD and PTSD Diagnostic Labels in Treatment**

Apart from the stigma associated with a BPD diagnosis, there are implications associated with this diagnostic label for treatment and involvement within systems. For example, Hodges (2003) cited a study by Stefan (1998) which found that women who are diagnosed with BPD are often considered within public systems as psychologically unstable and more likely than those not diagnosed with BPD to be institutionalized, have forced medication, lose parental rights and not be considered credible witnesses in cases involving sexual assault. However, women who are diagnosed with PTSD can be considered for disability, though they are not considered to have a mental disability (Hodges, 2003). There are also implications of a BPD diagnosis versus a PTSD diagnosis for the type of treatment each diagnosis will result in within a clinical setting



as well as the attitudes clinicians have towards clients depending on each diagnosis , as will be described next (Lewis et al., 2009).

### **Mental Health Professionals' Feelings towards Clients**

Researchers have sought to examine the attitudes professionals hold towards clients with BPD. In surveys given to nurse practitioners it was found that 89% of those surveyed perceived individuals with BPD to be manipulative, 38% viewed them as nuisances and 32% reported that BPD individuals made them angry (Deans & Meocevic, 2006). Consistent with views of BPD individuals being more responsible for their disorder (Hodges, 2003), one study demonstrated that 64% of the respondent nurse practitioners viewed people, male and female, with BPD as responsible for their own suicidal actions (Deans & Meocevic, 2006). Other surveys of mental health professionals working with individuals with BPD isolated markers for BPD as “demandingness/entitlement, treatment regressions, and the ability to evoke inappropriate responses in one’s therapist” (Zanarini, Gunderson, Frankenburg & Chauncey, 1990 as cited in Becker, 2000, p.423). Similar themes identified in a qualitative study with clinicians working with individuals with BPD were “BPD patients generate an uncomfortable personal response in the clinicians, characteristics of BPD contribute to negative clinician and health service response, the presence of inadequacies in the health system in addressing BPD patient needs, and techniques/strategies needed to improve service provision with BPD” (Commons Treloar, 2009, p.32). Specifically, examples from each theme respectively include “I find them too difficult to deal with,” “They are a waste of my time,” “Once labeled BPD, they will not get an objective assessment,” and “We need more training and education on this disorder” (Commons Treloar, 2009, p.32).

As seen in the previous section on stigma and construction of ideas of “normal,” there is considerable stigmatization associated with mental illness and social location (Becker, 2000; Goffman, 1968 as cited in Flowerdew, 2008; Henry and Cohen, 1983; Nehls, 1998; Shaw & Proctor, 2005; Skodol & Bender, 2003; Wastell, 1996). Research has also demonstrated that BPD holds significantly more stigma than other mental illness diagnoses (Markham, 2003). This stigma is present within mental health treatment capacities and has been shown to greatly influence the treatment individuals with mental health diagnoses receive (Markham, 2003). Markham (2003) sought to assess whether staff of a psychiatric inpatient unit were more socially rejecting of patients with BPD diagnoses than patients with diagnoses of schizophrenia or depression. Markham (2003) used a modified version of a social distance scale with 11 measures assessing how much participants would be willing to interact socially or interpersonally with individuals with various *DSM* diagnoses. A total of 71 staff participants were also asked to rate their own experiences of working with individuals with diagnoses of BPD, schizophrenia or depression (Markham, 2003). It was found that staff were least optimistic about the recovery of patients with a BPD diagnosis as well as more negative about their experience working with them (Markham, 2003). Staff nurses were also more likely to rate individuals with BPD as more dangerous and requiring more social distance (Markham, 2003). This study has implications for both the clinical experience of individuals with BPD and the extent to which they are socially stigmatized (Markham, 2003).

In addition to the social distance scale used by Markham (2003) to assess stigma and attitudes of staff towards individuals with BPD, Bowers and Allen (2006) developed a scale specifically intended to assess mental health professionals’ attitudes towards individuals with personality disorders. The Attitude to Personality Disorder Questionnaire or APDQ (Bowers &

Allen, 2006) was developed through a series of round table discussions on “affective statements” about individuals with personality disorders. It will be discussed further in the methods section of this study as it is central to the methodology of the current study (Bowers & Allen, 2006, p.285). Bowers and Allen (2006) developed the questionnaire to measure professionals’ attitudes and feelings about working with individuals with personality disorders in 5 different factors: “enjoyment versus loathing...security versus vulnerability...acceptance versus rejection... purpose versus futility...[and] exhaustion versus enthusiasm” (Bowers & Allen, 2006, p.286).

Bowers and Allen (2006) found that contextual factors with the greatest influence on mental health professionals’ attitudes towards clients with personality disorders include organizational factors such as training, supervision and staff support, where less clinical and diagnostic training was associated with more negative attitudes and appropriate training was associated with more positive attitudes (Bowers & Allan, 2006).

Purves and Sands (2009) also utilized Bowers and Allen’s (2006) Attitude to Personality Disorder Questionnaire (APDQ) to assess 61 clinicians’ attitudes who were working in a crisis and triage capacity. Overall, Purves and Sands (2009) found that clinicians working in this setting held more negative than positive attitudes towards individuals with personality disorders. More specifically, Purves and Sands (2009) also examined the way that education decreases the presence of negative attitudes towards this population. Similar to the original findings of Bowers and Allen (2006), lack of skills, confidence, and training negatively impacts clinicians’ perceptions of individuals with personality disorders (Purves & Sands, 2009). Thus, not only has there been found to be an overwhelming presence of negative attitudes towards personality disorders, specifically BPD, these attitudes are related to the amount of training and confidence

professionals have and thus impacts the care that individuals receive (Becker, 2000; Bowers & Allen, 2006; Commons Treloar, 2009; Deans & Meocevic, 2006; Hodges, 2003; Markham, 2003; Purves & Sands, 2009; Zonarini, Gunderson, Frankenburg & Chauncey, 1990 as cited in Becker, 2000).

There were fewer studies that looked at clinicians' views of working with clients diagnosed with PTSD which itself could be indicative of a lower focus on the effect of PTSD on the therapeutic relationship. Researchers have reported that clinicians working with clients with PTSD and substance abuse feel less gratified than when working with clients with only a PTSD diagnosis (Najavits, 2002).

### **Gender Bias in the Diagnosis of BPD and PTSD**

Becker and Lamb (1994) completed a study with a similar purpose to the current study of examining sex bias in the diagnosis of BPD and PTSD. In their study, Becker and Lamb (1994) using survey methods, presented 311 mental health professionals with a randomly selected clinical vignette that would vary only in gender and would describe an individual who had features from both BPD and PTSD diagnoses. The authors of this study based their overlapping criteria on the *DSM-III*, so the features were slightly different as discussed previously in the history of both diagnoses. Becker and Lamb (1994) found that the female vignette was diagnosed significantly more often with BPD whereas the male vignette was more likely to be diagnosed with PTSD.

Becker and Lamb (1994) presented a longer vignette than the present study and did not ask about clinicians' attitudes and feelings towards the individual after diagnosing them. Another similarity between the present study and Becker and Lamb's (1994) study was the presence of sexual abuse history in the case vignette presentation. The reasoning behind the

inclusion of this case history for both the present study and Becker and Lamb's (1994) is the location of other research that has suggested a strong correlation between childhood sexual abuse and the development of BPD features (Herman & van der Kolk, 1987 as cited in Lewis et al., 2009; Shaw & Procter, 2005). Also, Becker and Lamb (1994) include the discussion of individuals with a history of sexual abuse victimization being "better served" by a less stigmatizing diagnosis like PTSD (p. 56).

Woodward et al (2009) completed a study designed after Becker and Lamb's (1994) research with a sample of 119 randomly selected psychologists in New York State. Both Woodward et al (2009) and Becker and Lamb (1994) utilized an analog design with case vignettes varied by gender. Both research designs also utilized a Likert scale to measure applicability of diagnoses to each clinical vignette (Woodward et al., 2009; Becker & Lamb, 1994). Woodward et al's (2009) findings differed from those found by Becker & Lamb (1994) in that there were no differences in diagnosis of BPD or PTSD by gender of the individual in the clinical vignette. Also, Woodward et al (2009) found that clinician gender and age did not affect diagnostic label given.

## **Summary**

There is ample literature addressing the similarities of BPD and PTSD diagnoses with the presence of a history of childhood abuse. There has also been significant research addressing the stigma, gender bias, and implications for treatment between these diagnoses as well as studies assessing mental health professionals' views of clients with BPD (Aviram, Brodsky & Stanley, 2006; Becker, 2000; Becker & Lamb, 1994; Bowers & Allan, 2006; Commons Treloar, 2009; Deans & Meocevic, 2006; Hodges, 2003; Lewis & Grenyer, 2009; Woodward et al, 2009). There is minimal literature or studies about clinicians' views of working with clients with PTSD and no

found studies focusing on clinicians' views related to the overlap of diagnostic features. Becker and Lamb's (1994) study offers an analog study examining the interaction of gender, of both the participant and clinical vignette, and overlap of diagnostic features, though there isn't a further investigation of the ways in which these factors influence clinicians' attitudes and feelings of working with the presented individual. The intention of this study is to discuss some insight into clinicians' views of clients whose diagnostic features are consistent with both BPD and PTSD and the way these views are affected by gender. The next chapter describes the methods used to conduct the study.

## **CHAPTER III**

### **Methodology**

This chapter outlines the way the current study was completed, including the specific research question and hypotheses that were tested, the design of the study, and the characteristics of the participant sample as well as the process of recruiting the sample. This chapter also presents the ways confidentiality and anonymity of the recruited sample were protected, how data were collected, and finally, the methods used to analyze the data.

#### **Research Questions and Hypotheses**

The research question investigated in this study was: What are clinicians' views of and attitudes towards a client who has a history of childhood interpersonal trauma and presents with diagnostic features consistent with both BPD and PTSD resulting from interpersonal trauma? The current study also examined how these views and attitudes were influenced by the client's gender. Three hypotheses were posed:

1. Participants are expected to diagnose the individual presented in the female vignette with BPD significantly more than other diagnoses and more than the nonspecific or male vignettes.
2. Participants are expected to diagnose the individual presented in the male vignette with PTSD significantly more than the nonspecific or female vignettes.
3. Participants are expected to express more negative attitudes towards individuals that they diagnose with BPD than those given other diagnoses.

## **Project Purpose and Design**

This research project stems from an interest in the similarities between the clinical presentations of Borderline Personality Disorder (BPD) and Posttraumatic Stress Disorder (PTSD) when an individual has a history of interpersonal trauma, with the focus on the implications each diagnostic label has on clinicians' views of working with these individuals. The implications of a BPD or PTSD diagnosis continue to inform treatment throughout an individual's involvement with mental health systems and have implications for his/her access to services (Aviram et al., 2006; Hodges, 2003; Nehls, 1998; Shaw & Procter, 2005; Skodol & Bender, 2003). The importance of investigating clinicians' perspectives of individuals with each diagnosis when an individual's presenting features inform either diagnosis, are centered within the effects these perspectives have on an individual's treatment as a client within an agency and in larger social settings.

In order to answer the research question, a mixed method, though primarily quantitative, design was used as a way of gathering data about clinicians' views of clients with BPD and PTSD. Clinicians who opted to participate were asked to complete a survey which contained both questions with a Likert scale which was analyzed quantitatively and one free response question which was analyzed both quantitatively and qualitatively. There were three surveys that were distributed evenly between potential participants, who each received and completed only one. All three surveys included a short vignette describing a client whose diagnostic presentation included features that BPD and PTSD with a history of interpersonal trauma diagnoses share. The only discrimination between the three surveys was gender so as to explore the gender bias discussed in the literature. Vignette #1 described a client with no gendered pronouns, vignette #2 had the same description using female pronouns, and vignette #3 used



male pronouns (See appendices F,G and H). The subsequent questions were adapted from Bower and Allen's (2006) Attitude to Personality Disorders Questionnaire (See appendices F, G and H). None of the surveys included a diagnosis and all participants were asked to write in a diagnosis of the client presented in their vignette: the one qualitative question.

### **Sampling and Recruitment**

**Sample.** Participants in this study were required to have a master's degree in counseling, psychology, marriage and family therapy, or social work, or a doctoral degree in counseling, psychology or social work, a PsyD degree, a degree in psychiatric nursing, or a medical degree in psychiatry. Participants were required to currently be practicing full or part time therapy, assessment, crisis work, social work, psychiatry, or any other clinical work intended to address mental health treatment or have practiced within the last two years. Participants could practice in inpatient and outpatient capacities in a variety of settings such as a social agency, hospital, school, court, private practice, community mental health center, or family health clinic. Participants had to have a minimum of two years of experience, full or part time, working in a clinical setting where they have diagnosed or worked with adult clients with *DSM* diagnoses. Information was collected during the survey about participants' gender, years of experience, degree, work capacity, ethnicity and age (See screening and demographic questions in Appendix E).

Participants were not be included if they did not meet any of the above described criteria. It was assumed that as practicing professionals, potential participants would make an informed decision about the topic and nature of the research process to not participate if they didn't feel comfortable. The goal was to have 100 participants.

**The recruitment process.** The sample was recruited through non-probability sampling methods. Specifically, the sample was a convenience sample and recruitment included snowball sampling as well. Incentives were not provided. The recruited sample was from local mental health agencies including Mental Health Partners (MHP) and Clinica Family health services (Clinica). MHP and Clinica do not have IRBs and did not require an additional review apart from the approval from Smith's IRB (See Appendices C and D). Participant lists were developed with the assistance of human resource and quality improvement employees at MHP. Access was available, because of this researcher's position as an intern, to all staff emails at both MHP and Clinica, that were divided by team which allowed for distribution to clinical staff rather than all staff. This was approved by MHP and Clinica as a method to distribute recruitment emails. Recruitment was also attempted through snowball sampling with the assistance of professional colleagues through an email sent to other unaffiliated professional acquaintances. In this email, it was requested that recipients receiving the recruitment email forward it with a link to the questionnaire to their acquaintances or colleagues who may have also met inclusion criteria (See Appendix B). The recruitment email sent to all potential participants also requested that they forward it to other professional acquaintances who may meet the sampling criteria.

### **Data Collection Instrument and Procedure**

As included in the discussion of sampling, potential participants were sent an email requesting their enrollment in the study. Requests for agency affiliated professionals were distributed via the internet in the form of an email request outlining the nature of participation and the topic of research (See Appendix A). The email request included the criteria for participation including experience and degree requirements. If potential participants believed they met criteria of eligibility for the study, they clicked on the hyperlink included in the email

which took them directly to the SurveyMonkey website (See Appendix J for SurveyMonkey's security statement). They initially had to answer "yes" to three screening questions regarding degree attained, if they have more than 2 years of clinical experience in one of the identified disciplines, and if they have worked with individuals with axis 1 and 2 diagnoses. If participants met inclusion criteria determined by the screening questions, they were directed to the Informed Consent form and the vignette and questionnaire. If they did not meet inclusion criteria per the screening tool, they were thanked for their interest, informed they did not meet inclusion criteria and were directed to not complete the survey.

As the participant sample was intended to be representative of the clinician population in the United States, diversity was encouraged, by including a statement in the email request encouraging ethnically diverse clinicians to participate.

The email request was sent to approximately 330 clinical staff at MHP, and 10 behavioral health staff at Clinica. Originally, there was intent to set up the survey as such that the three vignettes would be randomly distributed evenly to participants when they clicked on a singular link. Because of the price and restrictions of the SurveyMonkey plan that allowed for this, it was an option. Instead, three identical surveys, save for the vignette, were created and the number of people receiving each email was calculated so that distribution was divided between each survey as evenly as possible. After a week and a half, the reminder email was sent with the link each potential participant had received during the original request. A week following the reminder email, the surveys were deactivated and data from each was exported into excel spreadsheets, and a printable version of each survey was created.

The exported data and printable surveys were sent to Marjorie Postal, Research Analyst, at Smith College School for Social Work. Along with the exported data was the codebook (See Appendix L), information on data analysis, hypotheses, factors and scoring (see Appendix M).

There were 52 participants who started the survey and completed the demographic and screening questions. Only 38 individuals completed the majority of the survey. The majority of participants were between the ages of 28 and 32 (19.23%), followed by the age groups 33-37, 38-42, and 53-57, each at 15.38%. 71.2% of participants self identified as white or Caucasian, followed by 7.7% identifying as Hispanic, Latino, Chicano, or of Spanish origin. 5.8% identified as mixed race or biracial, and there was 1 participant each who identified as Middle Eastern or Other. 61.5% of participants identified as a woman, 23.1% as a man, and 1.9% checked both man and woman. Most participants had 15 years or less of experience, though 2 individuals had more than 26 years of experience working in the mental health field. Most participants had their master's degree in counseling or social work and 25% were licensed clinical social workers while 19.2% were licensed professional counselors. 28.8% of participants had a master's degree in counseling or psychology and were unlicensed. Of the other participants, one was a doctor of medicine, one had a master's degree in marriage and family therapy, one was a physician's assistant, one had a master's degree in nursing, one had a doctorate of philosophy, and 2 had doctorates in psychology. The majority of participants worked in a community mental health center during the past two years (76.9%) while 13.5% worked in a family health clinic. Others worked in a social agency, hospital inpatient center, private practice, or another setting. Below is a table of the demographic characteristics of the participants. Professional characteristics will be presented further in the Findings chapter.

Table 2. Demographic Characteristics of Sample Members: Age

Demographic characteristic	f	%
<b>Age</b>		
28-32	10	19.23
33-37	8	15.38
38-42	8	15.38
43-47	3	5.77
48-52	4	7.69
53-57	8	15.38
58-62	4	7.69
63-67	2	3.85

Average Age: 44

Table 3. Demographic Characteristics of Sample Members: Race/ethnicity

Demographic characteristic	f	%
<b>Race/ethnicity</b>		
Hispanic, Latino, Chicano or of Spanish Origin	4	7.7
Middle Eastern	1	1.9
Mixed Race or Biracial	3	5.8
Asian	0	0
Native American or Alaska Native	0	0
Pacific Islander	0	0
White or Caucasian	37	71.2
Other	1	1.9

Table 4. Demographic Characteristics of Sample Members: Gender

Demographic characteristic	f	%
<b>Gender</b>		
Woman	32	61.5
Man	12	23.1
Checked Woman and Man	1	1.9

The average sample member determined by the above demographic variables was a 44 year old woman who identified as white/Caucasian.

### **Informed Consent Procedures**

Participants saw an informed consent page at the beginning of the survey after they had affirmatively answered the screening questions which outlined the purpose and goals of the study and the possible minimal risks of participation (See Appendix I). This consent information also included a disclaimer about the participant partaking in the research on their own volition without coercion or threat from the researcher. To continue to the next survey question, participants were required to click “I agree” on the informed consent document. Those who did check “I agree” were directed to the beginning of the survey. All participants were over the age of 18 and did not require further permission or assent.

### **Precautions Taken to Safeguard Confidentiality and Identifiable Information**

Participant information was safeguarded and entirely anonymous. Surveys did not require email addresses, names, or institution affiliation information. Informed consent forms did not require the participant to write their name and only included checking a box agreeing to the information in the consent form. As information was collected anonymously, there was no risk to exposing individual participants through presentations, write up, or to advisors. All

electronically stored data were secure through a survey database and will be secure for three years after the time of data collection as required by Federal regulations, after which time it will be discarded if no longer needed. SurveyMonkey.com, the location of any stored data, is a website that is firewalled, password-protected, and encrypted (See Appendix J). The survey included a fill in the blank answer in which participants wrote in an Axis 1 or 2 *DSM* diagnosis. This write in answer provided a space where people could potentially disclose their identity if they were to write anything other than one diagnostic label. Instructions asked participants to only write in one diagnosis label and were informed of the potential for identifying information to be included in this fill in the blank section (See Appendix F, G and H).

### **Data Analysis Plan**

As discussed before, the research question investigated in this study was: What are clinicians' views of and attitudes towards a client who has a history of childhood interpersonal trauma and presents with diagnostic features consistent with both BPD and PTSD resulting from interpersonal trauma? The current study also examined how these views and attitudes are influenced by the client's gender. The specific hypotheses were:

1. Participants are expected to diagnose the individual presented in the vignette with female pronouns with BPD significantly more than the nonspecific or male vignettes.
2. Participants are expected to diagnose the individual presented in the vignette with male pronouns with PTSD significantly more than the nonspecific or female vignettes.
3. Participants are expected to express more negative attitudes towards individuals that they diagnose with BPD than those given other diagnoses.

All quantitative questions, the bulk of the survey, were divided and coded into various categories. These categories were in line with Bower & Allen's (2006) study, described

previously regarding mental health professionals' views of individuals with personality disorders. The questions asked of participants were assigned one of 5 categories for coding purposes and were noted by the number in parentheses at the end of each question. Factor 1 represents liking and interest in and is called "enjoyment versus loathing" (Bower & Allen, 2006, p. 286). Factor 2 represents anxiety, fear and helplessness and is termed "security versus vulnerability" (Bowers & Allen, 2006, p. 286). Factor 3 includes questions focusing on both anger toward and questions which indicate difference from. It is called "acceptance versus rejection" (Bower & Allen, 2006, p.286). Factor 4 items referred to as "purpose versus futility" focus on ideas towards the effectiveness of treatment (Bowers & Allen, 2006, p. 286). Factor 5 is termed "exhaustion versus enthusiasm" (Bowers & Allen, 2006, p.286). Questions were coded within these categories and relationships were tested between diagnosis given, demographic information of participant and factors.

Within the factors, the responses on the Likert scale were assigned a numerical value. For questions about positive attitudes, the number 5 was assigned to Always, with a lower direction for the other points on the scale i.e.: Very Frequently (4), Occasionally (3), Rarely (2), Very Rarely (1), and Never (0). For the questions which ask for the frequency of negative attitudes or experiences the points began at zero for Always, and moved in a positive direction for the other points on the scale i.e., Very Frequently (1), Occasionally (2), Rarely (3), Very Rarely (4), and Never (5). Thus, higher scores were representative of a more positive attitude and fewer negative attitudes towards the presented client. The coding of each question within the five factors: enjoyment vs. loathing, security vs. vulnerability, acceptance vs. rejection, purpose vs. utility, and exhaustion vs. enthusiasm, allowed for negative attitudes to be measured within each factor.



Multivariate analyses were used to look at relationships between variables. Multivariate tables were helpful in the analysis of the relationship between variables such as gender of vignette, diagnosis given, and level of negative attitudes.

Below is a table outlining the specific tests used in the analysis of each hypothesis.

Table 5. Statistical Analysis of Hypotheses

Hypothesis	Outcome variable	Statistic
Participants are expected to diagnose the individual presented in the vignette with female pronouns with BPD significantly more than the nonspecific or male vignettes.	Percentage of BPD diagnoses given to female vignette	Chi square
Participants are expected to diagnose the individual presented in the vignette with male pronouns with PTSD significantly more than the nonspecific or female vignettes.	Percentage of PTSD diagnoses given to male vignette	Chi square
Participants are expected to express more negative attitudes towards individuals that they diagnose with BPD than those given other diagnoses.	Negative attitudes score	T test

Inferential statistics were useful to rule out the possibility of chance within the relationships that were addressed through descriptive statistics.

The only free response question, as previously discussed, was the fill-in answer about the diagnosis the participant would give the client presented in the vignette. This answer was compared to many other variables within the survey as diagnostic labeling is central to the research question and the factors being analyzed including gender bias and attitudes.

Specifically, when conducting analyses, the questions within the five factors were reversed as appropriate and Cronbach's alpha was performed to test internal reliability. Frequencies and descriptive statistics were performed for each of the factors for the entire participant pool, as well as means and standard deviations for all five factors by vignette group. T tests were run to determine if there were differences in each factor between diagnoses of BPD and all other diagnoses. Chi square was also computed to determine if there was a difference in BPD diagnosis versus other diagnoses in each vignette.

## CHAPTER IV

### Findings

This chapter will include a report of some of the demographic and professional characteristics of the participant sample not already discussed in the previous chapter. This will be followed by a report of the findings of each of the three hypotheses including the statistical tests used, and the significance of each finding.

The following tables present the professional characteristics of the participants.

Table 6. Professional Characteristics of Sample Members: Years of Practice

Professional Characteristic	f	%
<b>Years of Practice</b>		
0-5	16	30.8
6-10	13	25
11-15	9	23.1
16-20	4	7.7
21-25	2	3.8
26-30	1	1.9
31+	1	1.9

Average years of practice: 9.84

Table 7. Professional Characteristics of Sample Members: Degree

Professional Characteristic	f	%
<b>Degree</b>		
LCSW	13	25
MD	1	1.9
MS/MA in counseling	15	28.8
MSW	2	3.8
LPC	9	19.2
MFT	1	1.9
PA	1	1.9
MSN	1	1.9
PhD	1	1.9
PsyD	2	3.8

Table 8. Professional Characteristics of Sample Members: Practice Capacity

Professional Characteristic	f	%
<b>Practice Capacity</b>		
Social agency	1	1.9
Community mental health center	40	76.9
Hospital inpatient center	2	3.8
Hospital outpatient center	0	0
Veteran Assistance	0	0
Court	0	0
School	2	3.8
Private practice	4	7.7
Family health clinic	7	13.5
Other	5	9.5

Professionally, the average participant worked for 9.84 years in the field of mental health. Most participants had their LCSW or their MA/MS in counseling and worked in a community mental health center.

### **Diagnosis Frequencies**

The purpose of the study was to explore the ways the overlap of diagnostic features of BPD and PTSD discussed in previous literature affected clinicians' diagnosis of an individual presenting with such features. Further, an intention of this study was also to measure participants' attitudes towards working with an individual based on the diagnostic label they were given. The first hypothesis to be tested posited that participants were expected to diagnose

the individual presented in the female vignette with BPD significantly more than other diagnoses and more than the nonspecific or male vignettes. A chi-square test was used to compare the frequencies of the diagnoses of three vignettes by two or more groups of diagnoses, both of which are nominal measures. Because the expected cell frequencies were less than five, these findings do not provide evidence that the diagnosis of BPD or PTSD by vignette were related. The crosstabulation however shows that 46.7% of the clinicians diagnosed the female vignette with BPD while 46.7% diagnosed PTSD.

The second hypothesis posited that the male vignette was expected to be given a diagnosis of PTSD more than the female or the gender neutral vignette. A chi square test was also used to compare the frequencies of the vignettes. Because the expected cell frequencies were less than five these findings do not provide evidence that the diagnosis of BPD of PTSD by vignette were related. Examination of the crosstabulation shows that within the male vignette 57.1% of the clinicians diagnosed the vignette with BPD, while 28.6% diagnosed it with PTSD. Fifty percent of the clinicians diagnosed the individual in the gender neutral vignette with BPD while 30% diagnosed PTSD.

To further examine these results, an analysis of the three vignettes by only a diagnosis of BPD and PTSD was conducted. The analysis of the crosstabulation provided no evidence that the diagnosis of BPD and PTSD by vignette were related because the expected cell frequencies were less than five. The crosstabulation does show that for the female vignette, sample members equally provided a diagnosis of BPD (50%) compared to a diagnosis of PTSD (50%). For the male vignette the diagnosis of BPD was provided by 66.7% of the sample compared to PTSD (33.3%), and for the gender neutral vignette 62.5% of sample members reported a diagnosis of BPD compared to the 37.5% who provided a PTSD diagnosis.

Also, an analysis of the three vignettes was completed looking at the frequencies of a BPD diagnosis versus all other diagnoses. Crosstabulation was used in this analysis and demonstrated no statistically significant differences (chi square = .327 df=2 p=.849). For the female vignettes 46.7% of sample members provided a diagnosis of BPD, compared to 53.3% of all other diagnoses. For the male vignette 57.1% of the sample members diagnosed BPD compared to the 42.9% who provided other diagnoses while in the gender neutral vignette, an equal percentage provided a diagnosis of BPD compared to other diagnoses (BPD=50% and other diagnoses=50%).

### **APDQ Analysis**

This next section will address the analysis of participants' responses to the Attitude to Personality Disorder Questionnaire (APDQ). A factor analysis of the original data upon which the APDQ was based found five separate factors. These were enjoyment vs. loathing, security vs. vulnerability, acceptance vs. rejection, purpose vs. futility and exhaustion vs. enthusiasm. Reliability statistics were computed for each of these factors, based on the data collected for this study. Below are the reliability statistics for the APDQ. The reliability statistics on these factors ranged from .896 to .581. All but one of the factors had a reliability statistic at or above .60.

Table 9. Reliability Statistics for the Factors of the APDQ

Factor	N	Number of items	Alpha
Enjoyment vs Loathing	36	12	.896
Security vs Vulnerability	36	8	.883
Acceptance vs Rejection	35	2	.748
Purpose vs Futility	36	4	.780
Exhaustion vs Enthusiasm	36	2	.581

Before using the APDQ scores for further analysis, a preliminary comparison of the mean APDQ scores for each of the factors by vignette was conducted. The following table compares each case vignette by each of the APDQ mean scores.



Table 10. A Comparison of Case Vignette by APDQ Mean Scores

	N	Mean Score	Standard Deviation
Enjoyment vs Loathing			
Female	15	55.9333	6.35235
Male	14	51.6429	10.34488
Neutral	9	56.2222	6.90612
Security vs Vulnerability			
Female	15	31.533	6.88546
Male	14	29.3571	6.58211
Neutral	9	30.4444	8.33833
Acceptance vs Rejection			
Female	15	8.2667	1.94447
Male	13	7.0000	2.91548
Neutral	9	8.1111	1.53659
Purpose vs Utility			
Female	15	17.7333	3.08143
Male	14	15.5000	4.51919
Neutral	9	16.8889	4.31406
Exhaustion vs Enthusiasm			
Female	15	6.6667	1.54303
Male	14	5.6429	2.16997
Neutral	9	6.4444	2.00693

The above table shows the mean attitude scores for each factor and in each gender vignette. As each factor had a different number of questions within it, the reference for each score was different. The highest possible (most positive) score for the first factor was 60, the highest score for factor two was 40, for factor three the highest score was 10, in factor four the highest score was 20 and for factor five the highest score was 10. These average scores demonstrate the mean of the responses to the APDQ for all diagnoses combined. The standard deviation shows the size of the range, or how much the scores vary among participants.

The third hypothesis investigated in the study stated that more negative attitudes are expected to be associated with vignettes diagnosed with BPD than other diagnoses. A t-test was used to compare APDQ mean scores by case vignette diagnoses of BPD versus other diagnoses. A statistically significant difference was found in mean scores on factors 1-4 of the APDQ, though there was no significant difference in attitude scores in factor 5. The t-test results were as follows: A statistically significant difference was found between Factor 1 APDQ mean scores [enjoyment vs. loathing] by case vignette ( $t(36)=2.506$ ,  $p=.017$ , two-tailed). The other diagnosis group had a higher mean on this factor ( $M=57.72$ ) than the BPD group ( $M=51.45$ ). Factor 2 APDQ mean scores [security vs. vulnerability] were significantly different by case vignette ( $t(36)=1.999$ ,  $p=.053$ , two tailed). The other diagnosis group had a higher mean score ( $M=32.7778$ ) than the BPD group ( $M=28.4000$ ). In factor 3 the APDQ mean score [acceptance vs. rejection] was statistically different by case vignette ( $t(35)=2.102$ ,  $p=.043$ , two tailed). The mean score for the other diagnosis group was 8.5556 and that for BPD was 7.0526. APDQ mean scores in factor 4[purpose vs. utility] were significantly different by case vignette ( $t(36)=2.260$ ,  $p=.030$ , two tailed). The mean score for the other diagnosis group was 18.1667 while the mean score for the BPD group was 15.4000. There were no statistically significant differences in

attitude score within factor 5[exhaustion vs. enthusiasm] by case vignette ( $t(36)= 1.151, p=.257$ , two tailed). The mean score for the other diagnosis group was 6.6111 and BPD was 5.9000.

As discussed in the methodology chapter, the scoring of the survey responses indicated the higher scores are representative of more positive attitudes. Consistently across the five factors, participants demonstrated more positive attitudes towards diagnoses other than BPD and more negative attitudes towards BPD. Factors one through four had findings that were significant, while factor five's findings were not significant.

Table 11. Comparison of APDQ Factor Mean Scores by Case Vignette

	N	Mean	t	p
Enjoyment vs Loathing			2.506	.017
BPD	20	51.4500		
Other Diagnoses	18	57.7222		
Security vs Vulnerability			1.999	.053
BPD	20	28.4000		
Other Diagnoses	18	32.7778		
Acceptance vs Rejection			2.102	.043
BPD	19	7.0526		
Other Diagnoses	18	8.5556		
Purpose vs Futility			2.260	.030
BPD	20	15.4000		
Other Diagnoses	18	18.1667		
Exhaustion vs Enthusiasm			1.151	.257
BPD	20	5.9000		
Other Diagnoses	18	6.6111		

In summary, there were no significant findings in hypotheses one and two, meaning that because of the small sample size, significance of diagnosis across vignettes could not be determined.

The third hypothesis did have statistically significant findings. Questions were divided into five factors and were reverse scored so that more positive attitudes received a higher score and more negative attitudes received a lower score. The first four factors demonstrated statistically significant findings that participants had more negative views of the clinical presentations diagnosed with BPD. The fifth factor did not have significant findings though mean scores were higher (more positive) for diagnoses other than BPD.

The next chapter will address the findings in the context of previous literature, present the limitations of the current study and explore some of the implications for further research and practice.

## **CHAPTER V**

### **Discussion**

This chapter will summarize the major findings of the study and place them in the context of the previously discussed literature. It will also describe the limitations of the current study and draw implications of these findings for future research and clinical practice.

#### **Summary of Major Findings**

As discussed previously, the hypotheses of this study posited that:

1. Participants were expected to diagnose the individual presented in the female vignette with BPD significantly more than other diagnoses and more than the nonspecific or male vignettes.
2. Participants were expected to diagnose the male vignette with PTSD more than the female or nonspecific vignettes.
3. Participants were expected to express more negative attitudes towards individuals that they diagnose with BPD than those given other diagnoses.

There were no statistically significant findings in hypotheses one and two, meaning that no vignette was given a BPD, PTSD, or other diagnosis significantly more than another. For the female vignette, participants gave a diagnosis of BPD 50% of the time compared to all other diagnoses. For the male vignette, PTSD was diagnosed by 28.6% of the sample members compared to the 57.1 % who diagnosed BPD. As will be discussed further, it is important to note the fairly even distribution of diagnostic labels given to the same clinical presentation, even between and within each vignette. The comparisons were statistically non-significant in large part because the diagnoses provided by sample members were not evenly distributed across cells.

Without an expected frequency of at least five, a comparison of expected and observed frequencies would result in erroneous findings even though no statistically significant differences were found.

The third hypothesis did have statistically significant findings. The five factors of the APDQ measured in this study were as follows: Factor 1: Enjoyment vs. Loathing, Factor 2: Security vs. Vulnerability, Factor 3: Acceptance vs. Rejection, Factor 4: Purpose vs. Futility, and Factor 5: Exhaustion vs. Enthusiasm. Questions were reverse scored so that more positive attitudes received a higher score and more negative attitudes received a lower score. When comparing the mean scores of attitudes within each of the five factors between ascribed diagnoses of BPD or all other diagnoses, the mean scores were higher for the participants who had given a diagnosis besides BPD across the first four factors. Conversely, the mean attitude score for participants who had given their vignette a diagnosis of BPD was lower in the first four factors. Thus, participants demonstrated more negative attitudes towards BPD, and more positive attitudes towards other diagnoses. For the fifth factor, the mean scores were not significantly different for BPD compared to all other diagnoses.

### **Findings in the Context of Previous Literature**

This section will highlight some of the main areas of discussion within the reviewed literature for this study and the ways in which the current findings either fit or differ from previous findings. Possible explanations for any differences will also be discussed.

**Comparison of the diagnostic criteria.** The distribution of diagnoses to the presented vignette is similar to that of the study of a similar design by Henry and Cohen (1983). As discussed previously, Henry and Cohen (1983) utilized an analog design with a vignette from the *DSM-III* that was then given female or male pronouns and distributed evenly to participants who

were asked to provide a diagnosis. Henry and Cohen (1983) report no significant difference between a diagnosis of BPD for each vignette. The current study also compared the frequency of a BPD diagnosis for each vignette versus any other diagnosis. Although there was not adequate distribution across cells in the current study to report significance based on a chi square value, the percentages of a diagnosis of BPD versus other diagnoses suggest similar distribution to Henry and Cohen's (1983) study. Much of the previous literature discussed the overlap in diagnostic criteria and the similarity in presentation between an individual with BPD and one with PTSD with a history of interpersonal trauma (Hodges, 2003; Lewis & Grenyer, 2009; Marshal-Berenz et al., 2011; Trippany et al., 2006). This overlap is supported by the close to even split in assigned diagnoses of BPD or PTSD, especially for the female vignette. This even distribution of diagnostic labels supports the previous literature that suggests similarity in the presenting features of BPD and PTSD. Also as previously discussed, the vignette used in this study was created in line with Herman & van der Kolk's (1987) discussion of five domains shared between BPD and PTSD resulting from interpersonal trauma (as cited in Lewis et al., 2009). The close to even distribution of assigned diagnoses supports the validity of these domains.

**Gender bias.** The findings of this study were not consistent with the discussion of gender bias of BPD in previous literature. As seen in the Findings chapter, the female vignette was no more likely to be diagnosed with BPD than the male vignette (46.7% vs. 57.1%). A possible reason for this inconsistency could be the small sample size and that perhaps the responses of a larger, more heterogeneous sample would be more consistent with other findings. Another possibility for this inconsistency could be related to what was included in the informed consent document participants signed (Appendix I). Following distribution of the survey, a

colleague expressed interest in discussing the study after she had submitted her survey. She stated that she suspected the focus of the study was BPD and PTSD and that she considered diagnosing her female vignette with BPD though didn't because of the mention of gender bias of diagnoses in the informed consent document. This safeguard against participant deception included in the informed consent may have swayed other diagnostic formulations as well.

**Attitudes and stigma.** The current study demonstrated similar findings to previous literature as relates to attitudes towards individuals with personality disorders, particularly BPD. Both current and previous literature show that clinicians have consistently negative attitudes towards individuals diagnosed with BPD (Bowers & Allen, 2006; Commons Treloar, 2009; Deans & Meocevic, 2006; Hodges, 2003; Markham, 2003; Purves & Sands, 2009; Zanarini et al., 1990 as cited in Becker, 2000). The APDQ, developed by Bowers and Allen (2006) which was also utilized by Purves and Sands (2009), yielded similar findings in the current study as it did in its previous uses; clinicians hold more negative attitudes towards individuals diagnosed with BPD than other diagnoses.

The specific way the survey was adapted for this study (Appendices F, G, and H) provides insight into the level of stigma participants hold towards individuals with BPD. Each question asked participants to rate their feelings based on how they *anticipate* their work will be with the individual presented in the vignette or individuals with a similar diagnostic presentation. Participants' significantly more negative attitudes towards a BPD diagnosis indicate that they already have preconceived ideas about how this clinical work will be, thus supporting much of the previous literature about the stigmatization of these individuals (Hodges, 2003; Lewis et al., 2009; Marshall-Berenz et al., 2001; Skodol & Bender, 2003; Trippany et al., 2006).



The five factors within the APDQ (see Appendices F, G, and H for specific questions) each have implications for participant attitudes and beliefs. Factors two and four, security vs. vulnerability and purpose vs. futility respectively, both include questions related to the therapeutic relationship and participants' beliefs that they are able to help an individual with BPD (Bowers & Allen, 2006). The significant findings within both of these factors coincide with previous research that found similar sentiments. Specifically, shared sentiment about individuals with BPD included statements in research by Commons Treloar (2009) such as "they are a waste of my time" and "I find them too difficult to deal with" that match similar questions in factors two and four of the current study that measure feeling "unable to gain control of the situation," "outmaneuvered," "uncomfortable," "pessimistic," or "like I'm wasting my time with" this population.

Significant findings within factors one and three also coincided with more specific aspects of stigma discussed in previous research. Factor three, acceptance vs. rejection, focused on anger and "distance from" individuals with BPD (Bowers and Allen, 2006). This notion of social distance fits with previously discussed research by Markham (2003) which found that clinicians rate individuals with BPD as requiring more social distance than other psychiatric diagnoses. Factor one, enjoyment vs. loathing, focused on participants feelings of liking or "interest in," and whose significant findings of participants' more negative attitudes further supports previously discussed research that also found such sentiments (Bowers & Allen, 2006; Commons Treloar, 2009; Markham, 2003; Purves & Sands, 2009).

Factor five, exhaustion vs. enthusiasm, was the only factor to not have significant findings. This factor had only two questions throughout the survey which may account for the statistically non-significant finding in this study. The mean score for this factor was higher

(meaning more positive) for non-BPD diagnoses and lower (more negative) for BPD diagnoses (M= 6.6111 and M=5.9000 respectively), though not statistically significant. This may be the result of so few questions being used to measure the factor. If there were more questions within this factor the results may have been statistically significant.

### **Limitations**

A primary limitation of the current study is the small sample size. It was anticipated that there would be a higher response rate, which ended up only being about 10%. The low response rate and consequentially small sample size may have influenced the results of the statistical analysis. When using crosstabulation, there wasn't an equal distribution of sample members across the cells due to lack of variation within demographic variables. This accounts for the non-significant chi square tests comparing the diagnosis given and other demographic characteristics of participants. A higher response rate may have provided a more equal distribution across demographic and professional characteristics of participants which would have allowed for further statistical tests to be performed. Similarly, lack of heterogeneity in the sample could have influenced the responses and a more diverse sample may have allowed for further statistical tests and relationships between responses.

Another limitation of this study resides within the constrictions of the online survey database Survey Monkey. Originally, the research plan was to create a link to the survey which would randomly assign one of the three vignettes discussed in the methods chapter to each participant as they enrolled in the study. Because of pricing and membership plans to the online survey database, this option was not feasible. Instead, three separate surveys were created for each of the three vignettes. The participant distribution list was then divided into three equal groups and each group received one of the three vignettes to reference for their survey. This

adaptation to the original plan did not ensure equal distribution of responses to each survey and did result in an unequal distribution.

Another possible limitation of the study is the use of an analog design. The vignette used for this study was not standardized and did not have any previous testing to determine validity. Though the vignette was created with the guidance and approval of various supervisory figures including a Smith College research professor, an LCSW supervisor, and two other professional colleagues, there were no previous studies completed to standardize the clinical vignette. The use of an analog design as well has its own limitations as discussed by Henry and Cohen (1983) as participants “base their judgments on fictitious cases, rather than a naturalistic approach in which actual therapist-patient relationships are examined” (p.1528). Diagnosing and subsequent attitudes may have been different had participants been presented with a real case.

### **Implications of the Findings for Practice and Future Research**

As discussed previously, the small sample size has implications for the limitations of this study, but it also has implications for further research. As there were significant findings even with a relatively small sample size, it would be of value to replicate the study with more participants to determine if significant findings are still present and also to be able to perform additional tests that were not possible due to lack of diversity. The current study includes a focus on the influence of stigma and its location within society and relationships (Becker & Lamb, 1994; Goffman, 1968, as cited in Flowerdew, 2008; Henry & Cohen, 1983; Link & Phelan, 2001; Read and Harre, 2001; Scheff, 1974; Shaw & Procter, 2005). Additional questions that would be valuable to explore with a larger sample size focus on the demographic characteristics of the participants and the relationships between these variables, diagnosis given, and subsequent attitudes. These questions might include:

1. Is the gender of the participant related to the diagnosis they give and attitudes toward their assigned vignette?
2. Is the participant's educational degree related to the diagnosis they give and attitudes toward their assigned vignette?
3. Is the participant's years of experience related to the diagnosis they give and attitudes toward their assigned vignette?

It would be valuable to have participants who work in more varied treatment settings. The vast majority of the participants in the current study worked in a community mental health center however further research could focus on the differences between individuals working within this setting and other settings to explore the relationship between treatment capacity, diagnosis given, and attitudes.

In addition to ideas for further research, there are also implications for clinical practice. While the current study found significant findings indicating that the clinicians who participated primarily held more negative attitudes towards individuals with a label of BPD, it should be noted that this does not necessarily mean that these attitudes are translated into clinical practice. Clinicians will unavoidably have certain attitudes or feelings about clients they encounter clinically. Supervision can hopefully provide a space for exploration and awareness of these feelings so they don't negatively impact the therapeutic space. It seems it should be noted that the purpose of this study was in no way to criticize clinicians for some of the attitudes they may hold, as clinical work with many populations and clinical presentations can be difficult. The purpose was to explore the constructions of these attitudes and belief sets so as to continue awareness and acknowledgement of the social climate, assumptions and systems within which individuals are diagnosed and treated.

Despite the opportunity for transference and countertransference discussions within supervisory relationships, the pervasiveness of negative attitudes requires further acknowledgment. This study in particular demonstrates the impact of a diagnostic label on such attitudes, as even though each participant was presented with the same clinical material, the diagnostic label participants assigned was significantly related to subsequent attitudes.

This finding has further implications for practice and the widespread use of *DSM-IV-TR*(2000) as the standard for diagnostic labeling; especially if there can be such discrepancy in diagnosing as demonstrated by this study. PTSD as a diagnostic formulation has been altered significantly in the *DSM* over the past 30 years (Parrish, 2008). While these changes have helped to incorporate many different types of traumatic experiences, especially interpersonal trauma, the symptoms or diagnostic criteria have not been sufficiently adjusted to aptly address this unique constellation of symptoms and lasting effects. When exploring the ways to lessen the stigma associated with a BPD diagnosis, one idea, as researchers support, is to focus more on the intersection of symptoms shared by BPD and PTSD resulting from interpersonal trauma, through the creation of a separate diagnosis (Shaw & Proctor, 2005).

Another assertion about a way to decrease negative attitudes towards BPD is in line with previous literature about stigma and labeling theory and findings that the lack of etiology for a diagnosis of BPD increases the level of associated stigma (Hodges, 2003; Lewis et al., 2009; Read & Harre, 2001; Woodward et al., 2009). Therefore, more discussion within clinical settings about the presence of childhood trauma in individuals with characteristics of BPD (as much as 81-91%) may be helpful in decreasing blaming attitudes and pessimistic beliefs about recovery (Lewis et al., 2009). In the discussion of how to decrease stigma, the timing of the current study coincides with the publication of the *DSM-V-TR* (forthcoming) which will not include any

changes or expansion in the areas discussed in this study. This raises an opportunity for further exploration of the social construction and decision making behind these diagnostic categories and the purpose of maintaining this traumatized population within such a stigmatized label.

### **Summary**

The findings of this study, both statistically significant and non-significant are relevant in the context of previous literature and research about the overlap in diagnostic criteria, stigma and gender bias. Similarly, the findings have implications for further research including replication with a larger, more heterogeneous study. Implications for clinical practice include increased awareness and discussion of the prevalence of negative attitudes towards individuals who present characteristics of BPD. Also, findings implicate continued acknowledgement of the ways negative attitudes can affect clinical practice and treatment of individuals within systems. Further, the findings indicate the potential damaging effects of the subjective construction of diagnostic labeling and the effects these constructions have on furthering negative attitudes, gender bias, and stigma.

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## Appendix A

### Agency email request (Mental Health Partners and Clinica Family Health Services)

Dear Mental Health Professional,

My name is Marja Walthall and I am a Graduate Social Work student at Smith College School for Social Work. I am currently an intern on the Integrated Services Team at Mental Health Partners and I am stationed at Clinica Family Health Services in Boulder, CO. I am conducting a study exploring mental health professionals' perspectives and beliefs about clinical presentations and subsequent diagnoses.

I would like to ask you participate in my study by completing a brief online questionnaire. You have received this email because you are a mental health clinician at Mental Health Partners, or Clinica, working full or part time with individuals diagnosed with axis 1 or 2 diagnoses.

This exploratory study coincides with literature whose authors address the impact a diagnostic label has on the way a client is treated professionally and interpersonally. Researchers also have explored differential diagnoses and the overlap of diagnostic criteria in the Diagnostic and Statistical Manual-TR-IV. My interest in this study also stems from gender differences within DSM diagnoses and in treatment. By participating in this research you could help provide important information regarding the implications of overlap in diagnostic criteria and the ways in which gender affects diagnosis and treatment. Your responses could benefit mental health clinicians and professionals, supervisors, and educators.

You are eligible to participate in this study if you have a master's or doctoral degree in the field of mental health, and you are currently practicing full or part time diagnosing or working with adult clients with DSM diagnoses. If you are not eligible, please consider passing this email on to colleagues who are.

Participation in this study is very easy. You are asked only to read a short vignette, assign a preliminary DSM diagnosis to the individual described in the vignette, and answer a few multiple choice questions following. Participation will take approximately 15 minutes. If you become a participant, you will be presented with an informed consent form which will not require a signature but only to check a box if you agree to participate.

If you meet criteria, I encourage you to participate in my study. Participation is completely anonymous so I will never know if you participated or not and there will be no way of identifying who filled out each survey. If you do not meet criteria, I ask you to please forward this email to any colleagues you know of who may be eligible to participate. Any participation is greatly appreciated! Below is the link to the website where my thesis vignette and survey are located.

[www.XXXXXXX.com](http://www.XXXXXXX.com) (Actual link was distributed to participants)

If you have any questions about my research or the nature of participation please feel free to reply to this email or contact me at your convenience. If you reply to this email, make sure to not hit "reply all."

Thank you for your time and interest in my thesis research.

Sincerely,

Marja Walthall

MSW Candidate, Smith College School for Social Work

## Appendix B

### Recruitment Email to Unaffiliated Professional Acquaintances for Snowball sampling

Dear Friends, Colleagues, and Classmates,

As you may already know, I am currently working on my Master's thesis which involves conducting an exploratory research study. My study coincides with literature whose authors address the impact a diagnostic label has on the way a client is treated professionally and interpersonally. Researchers also have explored differential diagnoses and the overlap of diagnostic criteria in the Diagnostic and Statistical Manual-TR-IV. My interest in this study also stems from gender differences within DSM diagnoses and in treatment. By participating in this research you could help provide important information regarding the implications of overlap in diagnostic criteria and the ways in which gender affects diagnosis and treatment. Your responses could benefit mental health clinicians and professionals, supervisors, and educators.

You are eligible to participate in this study if you have a master's or doctoral degree in the field of mental health, and you are currently practicing full or part time diagnosing or working with adult clients with DSM diagnoses. If you are not eligible, please consider passing this email on to colleagues who are. Participation in this study is very easy. You are asked only to read a short vignette, assign a preliminary DSM diagnosis to the individual described in the vignette, and answer a few multiple choice questions following. Participation will take approximately 15 minutes. Below is a link to the website containing my survey.

If you meet eligibility criteria, I encourage you to participate in my study. Participation is completely anonymous, I will have no way of knowing if you participated or not. If you do not meet participation criteria, I ask you to please **forward this email** to any colleagues or peers you know who may be eligible. Forwarding this email would be very helpful and greatly appreciated!

\*Please follow this link to the survey [www.XXXXXX.com](http://www.XXXXXX.com) (Actual link was sent to participants)

If you have any questions about my research or the nature of participation please feel free to reply to this email or contact me at your convenience. If you reply to this email, make sure to not hit "reply all."

Thank you for your time and interest in my thesis research.

Sincerely,

Marja Walthall

MSW Candidate, Smith College School for Social Work

## Appendix C

### Permission for Recruitment of Staff from Mental Health Partners

**\*A SIGNED COPY OF THIS DOCUMENT ON AGENCY LETTERHEAD WILL BE FAXED TO THE HSR COMMITTEE**

Smith College School for Social Work  
Human Subjects Review Board  
Northampton, MA 01063

To Whom It May Concern:

This letter is to grant permission for Marja Walthall, a second year MSW student, to recruit staff of Mental Health Partners for her MSW thesis research study. Marja is an Intern on the Integrated Services Project team at Mental Health Partners and is stationed at Clinica Family Health Services in Boulder, CO.

Marja's research coincides with literature whose authors address the impact a diagnostic label has on the way a client is treated professionally and interpersonally. Her research is also based in researchers' exploration of differential diagnoses and the overlap of diagnostic criteria in the Diagnostic and Statistical Manual-TR-IV. This study will be conducted through the use of a quantitative questionnaire that will be administered to practicing clinicians via the internet. The survey is completely anonymous and all data will be kept confidential.

To reach the target participation population, Marja has been given permission to distribute her survey to clinicians in the email distribution list she has access to as an intern. I understand that the recruitment email will include information about the purpose of the research, inclusion and exclusion criteria, nature of participation, and any possible risks associated with participation. The email will also include a hyperlink to the website that contains her thesis questionnaire. The email will also invite recipients to forward the email and hyperlink to the research study on to colleagues or peers who may be eligible to participate in the study.

I am aware that although risks of participation are minimal, for any Mental Health Partners employee who participates in the study, there is a small chance for unpleasant emotions to arise while they are responding to survey questions that ask them to reflect on their practice and feelings about certain diagnostic presentations.

Sincerely,

Kate Parker  
Director of Quality Improvement  
Mental Health Partners

## Appendix D

**Permission for Recruitment of Staff from Clinica Family Health Services**  
**\*A SIGNED COPY OF THIS DOCUMENT ON AGENCY LETTERHEAD WILL BE**  
**FAXED TO THE HSR COMMITTEE**

Smith College School for Social Work  
Human Subjects Review Board  
Northampton, MA 01063

To Whom It May Concern:

This letter is to grant permission for Marja Walthall, a second year MSW student, to recruit behavioral health staff of Clinica Family Health Services for her MSW thesis research study. Marja is an Intern on the Integrated Services Project team at Mental Health Partners and is stationed at Clinica Family Health Services, People's Clinica site, in Boulder, CO.

Marja's research coincides with literature whose authors address the impact a diagnostic label has on the way a client is treated professionally and interpersonally. Her research is also based in researchers' exploration of differential diagnoses and the overlap of diagnostic criteria in the Diagnostic and Statistical Manual-TR-IV. This study will be conducted through the use of a quantitative questionnaire that will be administered to practicing clinicians via the internet. The survey is completely anonymous and all data will be kept confidential.

To reach the target participation population, Marja has been given permission to distribute her survey to clinicians in the email distribution list she has access to as an intern. I understand that the recruitment email will include information about the purpose of the research, inclusion and exclusion criteria, nature of participation, and any possible risks associated with participation. The email will also include a hyperlink to the website that contains her thesis questionnaire. The email will also invite recipients to forward the email and hyperlink to the research study on to colleagues or peers who may be eligible to participate in the study.

I am aware that although risks of participation are minimal, for any Clinica Family Health Services employee who participates in the study, there is a small chance for unpleasant emotions to arise while they are responding to survey questions that ask them to reflect on their practice and feelings about certain diagnostic presentations.

Sincerely,

Janet Rasmussen  
Director of Accountable Care and Behavioral Health  
Clinica Family Health Services

## Appendix E

### Screening and Demographic Questions

**Screening Questions:** Participants must answer “yes” to all screening questions to meet inclusion criteria. If they answer “no” to any questions, participants will be directed to away from the survey.

**1. Do you hold a Master’s degree, Doctorate degree, PsyD, or MD in one of the following disciplines: Social Work, Psychiatry, Psychology, Mental Health Counseling, Psychiatric Nursing, or Marriage and Family Therapy?**

Yes

No

**2. Are you currently practicing or have you practiced in the last 2 years full or part time therapy, assessment, crisis work, social work, psychiatry, or any other clinical work intended to address mental health treatment?**

Yes

No

**3. Do you have at least 2 years of experience, full or part time, working in a setting where you have either diagnosed or worked with adult clients with *DSM-IV-TR* Axis 1 or 2 diagnoses?**

### Demographic Questions

**1. What is your discipline?**

Clinical Social Worker

Mental Health Counselor

Psychologist

Marriage and Family Therapist

Psychiatrist

Psychiatric Nurse Specialist

**2. Please list your degree(s) and license(s). If you are not licensed, please write “Not licensed.”**

---

**3. How many years have you been practicing in your discipline that makes you eligible for this study? Please round to the nearest year.**

\_\_\_\_\_

**4. What is your age?**

\_\_\_\_\_

**5. How do you identify racially/ethnically?**

Black or African American

Hispanic, Latino, Chicano, or of Spanish Origin

Asian

Middle Eastern

Native American or Alaskan Native

Pacific Islander

Mixed Race or Biracial

White or Caucasian

Other (please specify) \_\_\_\_\_

**6. Please select the gender you most identify with.**

Woman



Man

Transgender

Other (please specify) \_\_\_\_\_

**7. In which of the following capacities do you currently, or did you in within the last two years, primarily practice?**

Social agency

Community mental health center

Hospital inpatient center

Hospital outpatient center

Veteran Assistance

Court

School

Private practice

Family health clinic

## Appendix F

### Vignette (No gender pronouns) and Online Questionnaire

*C.R. is a 34 year old client who lives in a one bedroom apartment and works in a call center for a national internet provider. C.R. is currently inpatient at a psychiatric hospital due to a suicide attempt of swallowing 20 ibuprofen pills During the evaluation, C.R. had pressured and expansive speech though at times would switch to a blank, somewhat absent expression. C.R. reports a history of many years of sexual abuse as a young child. C.R. discusses having great difficulty in romantic relationships and reports having had many relationships, all of which were unfulfilling and conflictual C.R. reports experiencing intense angry outbursts and cutting which was evidenced by a few superficial cuts on both arms and one thigh. C.R. reports at times having difficulty managing emotions and will sometimes feel “empty” and sometimes feel “flooded” with emotion and feelings. C.R. also describes having “dreamlike out of body” experiences accompanied by feelings of being disconnected or detached from reality. C.R. is currently estranged from family members who will not be involved in any subsequent treatment.*

**Please provide ONE DSM-IV-TR diagnostic label to the clinical presentation of this individual on EITHER Axis 1 or Axis 2. The diagnosis can be a preliminary working diagnosis and should be the diagnosis consistent with features or criteria that you believe will be the most pertinent in subsequent treatment. It is not necessary to complete a diagnosis on all five axes.**

---

**In your work with C.R. or clients with similar diagnostic presentations you are likely to feel: (Please keep your assigned diagnosis in mind when answering the following questions)**

**1. Able to help C.R or clients with similar diagnostic presentations**

Always   Very Frequently   Occasionally   Rarely   Very Rarely   Never

**2. Uncomfortable or uneasy with C.R or clients with similar diagnostic presentations**

Always Very Frequently Occasionally Rarely Very Rarely Never

**3. Warm and caring towards C.R or clients with similar diagnostic presentations**

Always Very Frequently Occasionally Rarely Very Rarely Never

**4. Helpless in relation to C.R. or clients with similar diagnostic presentations**

Always Very Frequently Occasionally Rarely Very Rarely Never

**5. Patient towards C.R. or clients with similar diagnostic presentations**

Always Very Frequently Occasionally Rarely Very Rarely Never

**6. Frustrated with C.R. or clients with similar diagnostic presentations**

Always Very Frequently Occasionally Rarely Very Rarely Never

**7. Fondness and affection toward C.R. or clients with similar diagnostic presentations**

Always Very Frequently Occasionally Rarely Very Rarely Never

**8. Oppressed or dominated by C.R. or clients with similar diagnostic presentations**

Always Very Frequently Occasionally Rarely Very Rarely Never

**9. Excited to work with C.R. or clients with similar diagnostic presentations**

Always Very Frequently Occasionally Rarely Very Rarely Never

**10. Pessimistic about C.R. or clients with similar diagnostic presentations**

Always Very Frequently Occasionally Rarely Very Rarely Never

**11. Understanding toward C.R. or clients with similar diagnostic presentations**

Always Very Frequently Occasionally Rarely Very Rarely Never

**12. Powerless in the presence of C.R. or clients with similar diagnostic presentations**

Always Very Frequently Occasionally Rarely Very Rarely Never

**13. Fulfilled by my work with C.R. or clients with similar diagnostic presentations**

Always Very Frequently Occasionally Rarely Very Rarely Never

**14. Unable to gain control of the situation/session with C.R. or clients with similar diagnostic presentations**

Always Very Frequently Occasionally Rarely Very Rarely Never

**15. Close to C.R. or clients with similar diagnostic presentations**

Always Very Frequently Occasionally Rarely Very Rarely Never

**16. Manipulated by C.R. or clients with similar diagnostic presentations**

Always Very Frequently Occasionally Rarely Very Rarely Never

**17. Like I've had enough training to effectively work with C.R. or clients with similar diagnostic presentations**

Always Very Frequently Occasionally Rarely Very Rarely Never

**18. Irritated by C.R. or clients with similar diagnostic presentations**

Always Very Frequently Occasionally Rarely Very Rarely Never

**19. Protective toward C.R. or clients with similar diagnostic presentations**

Always Very Frequently Occasionally Rarely Very Rarely Never

**20. Drained by C.R. or clients with similar diagnostic presentations**

Always Very Frequently Occasionally Rarely Very Rarely Never

**21. Enjoyment in spending time with C.R. or clients with similar diagnostic presentations**

Always Very Frequently Occasionally Rarely Very Rarely Never

**22. Vulnerable in the company of C.R. or clients with similar diagnostic presentations**

Always Very Frequently Occasionally Rarely Very Rarely Never

**23. Interested by C.R. or clients with similar diagnostic presentations**

Always Very Frequently Occasionally Rarely Very Rarely Never

**24. Outmaneuvered by C.R. or clients with similar diagnostic presentations**

Always Very Frequently Occasionally Rarely Very Rarely Never

**25. Optimistic about the recovery of C.R. or clients with similar diagnostic presentations**

Always Very Frequently Occasionally Rarely Very Rarely Never

**26. Angry toward C.R. or clients with similar diagnostic presentations**

Always Very Frequently Occasionally Rarely Very Rarely Never

**27. Respect toward C.R. or clients with similar diagnostic presentations**

Always Very Frequently Occasionally Rarely Very Rarely Never

**28. Like I'm wasting my time with C.R. or clients with similar diagnostic presentations**

Always Very Frequently Occasionally Rarely Very Rarely Never

## Appendix G

### Vignette (Female pronouns) and Online Questionnaire

*C.R. is a 34 year old female client who lives in a one bedroom apartment and works in a call center for a national internet provider. She is currently an inpatient at a psychiatric hospital due to a suicide attempt of swallowing 20 ibuprofen pills. During the evaluation, she had pressured and expansive speech though at times would switch to a blank, somewhat absent expression. She reports a history of many years of sexual abuse as a young child. She discusses having great difficulty in romantic relationships and reports having had many relationships, all of which were unfulfilling and conflictual. She reports experiencing intense angry outbursts and cutting which was evidenced by a few superficial cuts on both arms and one thigh. C.R. reports at times having difficulty managing emotions and will sometimes feel “empty” and sometimes feel “flooded” with emotion and feelings. She also describes having “dreamlike out of body” experiences accompanied by feelings of being disconnected or detached from reality. C.R. is currently estranged from family members who will not be involved in any subsequent treatment.*

**Please provide ONE DSM-IV-TR diagnostic label to the clinical presentation of this individual on EITHER Axis 1 or Axis 2. The diagnosis can be a preliminary working diagnosis and should be the diagnosis consistent with features or criteria that you believe will be the most pertinent in subsequent treatment. It is not necessary to complete a diagnosis on all five axes.**

---

**In your work with C.R. or clients with similar diagnostic presentations you are likely to feel: (Please keep your assigned diagnosis in mind when answering the following questions)**

**1. Able to help C.R or clients with similar diagnostic presentations**

Always Very Frequently Occasionally Rarely Very Rarely Never

**2. Uncomfortable or uneasy with C.R or clients with similar diagnostic presentations**

Always Very Frequently Occasionally Rarely Very Rarely Never

**3. Warm and caring towards C.R or clients with similar diagnostic presentations**

Always Very Frequently Occasionally Rarely Very Rarely Never

**4. Helpless in relation to C.R. or clients with similar diagnostic presentations**

Always Very Frequently Occasionally Rarely Very Rarely Never

**5. Patient towards C.R. or clients with similar diagnostic presentations**

Always Very Frequently Occasionally Rarely Very Rarely Never

**6. Frustrated with C.R. or clients with similar diagnostic presentations**

Always Very Frequently Occasionally Rarely Very Rarely Never

**7. Fondness and affection toward C.R. or clients with similar diagnostic presentations**

Always Very Frequently Occasionally Rarely Very Rarely Never

**8. Oppressed or dominated by C.R. or clients with similar diagnostic presentations**

Always Very Frequently Occasionally Rarely Very Rarely Never

**9. Excited to work with C.R. or clients with similar diagnostic presentations**

Always Very Frequently Occasionally Rarely Very Rarely Never

**10. Pessimistic about C.R. or clients with similar diagnostic presentations**

Always Very Frequently Occasionally Rarely Very Rarely Never

**11. Understanding toward C.R. or clients with similar diagnostic presentations**

Always Very Frequently Occasionally Rarely Very Rarely Never

**12. Powerless in the presence of C.R. or clients with similar diagnostic presentations**

Always Very Frequently Occasionally Rarely Very Rarely Never

**13. Fulfilled by my work with C.R. or clients with similar diagnostic presentations**

Always Very Frequently Occasionally Rarely Very Rarely Never

**14. Unable to gain control of the situation/session with C.R. or clients with similar diagnostic presentations**

Always Very Frequently Occasionally Rarely Very Rarely Never

**15. Close to C.R. or clients with similar diagnostic presentations**

Always Very Frequently Occasionally Rarely Very Rarely Never

**16. Manipulated by C.R. or clients with similar diagnostic presentations**

Always Very Frequently Occasionally Rarely Very Rarely Never

**17. Like I've had enough training to effectively work with C.R. or clients with similar diagnostic presentations**

Always Very Frequently Occasionally Rarely Very Rarely Never

**18. Irritated by C.R. or clients with similar diagnostic presentations**

Always Very Frequently Occasionally Rarely Very Rarely Never

**19. Protective toward C.R. or clients with similar diagnostic presentations**

Always Very Frequently Occasionally Rarely Very Rarely Never

**20. Drained by C.R. or clients with similar diagnostic presentations**

Always Very Frequently Occasionally Rarely Very Rarely Never

**21. Enjoyment in spending time with C.R. or clients with similar diagnostic presentations**

Always Very Frequently Occasionally Rarely Very Rarely Never

**22. Vulnerable in the company of C.R. or clients with similar diagnostic presentations**

Always Very Frequently Occasionally Rarely Very Rarely Never

**23. Interested by C.R. or clients with similar diagnostic presentations**

Always Very Frequently Occasionally Rarely Very Rarely Never

**24. Outmaneuvered by C.R. or clients with similar diagnostic presentations**

Always Very Frequently Occasionally Rarely Very Rarely Never

**25. Optimistic about the recovery of C.R. or clients with similar diagnostic presentations**

Always Very Frequently Occasionally Rarely Very Rarely Never

**26. Angry toward C.R. or clients with similar diagnostic presentations**

Always Very Frequently Occasionally Rarely Very Rarely Never

**27. Respect toward C.R. or clients with similar diagnostic presentations**

Always Very Frequently Occasionally Rarely Very Rarely Never

**28. Like I'm wasting my time with C.R. or clients with similar diagnostic presentations**

Always Very Frequently Occasionally Rarely Very Rarely Never

## Appendix H

### Vignette (Male pronouns) and Online Questionnaire

*C.R. is a 34 year old male client who lives in a one bedroom apartment and works in a call center for a national internet provider. He is currently an inpatient at a psychiatric hospital due to a suicide attempt of swallowing 20 ibuprofen pills. During the evaluation, he had pressured and expansive speech though at times would switch to a blank, somewhat absent expression. He reports a history of many years of sexual abuse as a young child. He discusses having great difficulty in romantic relationships and reports having had many relationships, all of which were unfulfilling and conflictual. He reports experiencing intense angry outbursts and cutting which was evidenced by a few superficial cuts on both arms and one thigh. C.R. reports at times having difficulty managing emotions and will sometimes feel “empty” and sometimes feel “flooded” with emotion and feelings. He also describes having “dreamlike out of body” experiences accompanied by feelings of being disconnected or detached from reality. C.R. is currently estranged from family members who will not be involved in any subsequent treatment.*

**Please provide ONE DSM-IV-TR diagnostic label to the clinical presentation of this individual on EITHER Axis 1 or Axis 2. The diagnosis can be a preliminary working diagnosis and should be the diagnosis consistent with features or criteria that you believe will be the most pertinent in subsequent treatment. It is not necessary to complete a diagnosis on all five axes.**

---

**In your work with C.R. or clients with similar diagnostic presentations you are likely to feel: (Please keep your assigned diagnosis in mind when answering the following questions)**

**1. Able to help C.R or clients with similar diagnostic presentations**

Always   Very Frequently   Occasionally   Rarely   Very Rarely   Never



**2. Uncomfortable or uneasy with C.R or clients with similar diagnostic presentations**

Always Very Frequently Occasionally Rarely Very Rarely Never

**3. Warm and caring towards C.R or clients with similar diagnostic presentations**

Always Very Frequently Occasionally Rarely Very Rarely Never

**4. Helpless in relation to C.R. or clients with similar diagnostic presentations**

Always Very Frequently Occasionally Rarely Very Rarely Never

**5. Patient towards C.R. or clients with similar diagnostic presentations**

Always Very Frequently Occasionally Rarely Very Rarely Never

**6. Frustrated with C.R. or clients with similar diagnostic presentations**

Always Very Frequently Occasionally Rarely Very Rarely Never

**7. Fondness and affection toward C.R. or clients with similar diagnostic presentations**

Always Very Frequently Occasionally Rarely Very Rarely Never

**8. Oppressed or dominated by C.R. or clients with similar diagnostic presentations**

Always Very Frequently Occasionally Rarely Very Rarely Never

**9. Excited to work with C.R. or clients with similar diagnostic presentations**

Always Very Frequently Occasionally Rarely Very Rarely Never

**10. Pessimistic about C.R. or clients with similar diagnostic presentations**

Always Very Frequently Occasionally Rarely Very Rarely Never

**11. Understanding toward C.R. or clients with similar diagnostic presentations**

Always Very Frequently Occasionally Rarely Very Rarely Never

**12. Powerless in the presence of C.R. or clients with similar diagnostic presentations**

Always Very Frequently Occasionally Rarely Very Rarely Never

**13. Fulfilled by my work with C.R. or clients with similar diagnostic presentations**

Always Very Frequently Occasionally Rarely Very Rarely Never

**14. Unable to gain control of the situation/session with C.R. or clients with similar diagnostic presentations**

Always Very Frequently Occasionally Rarely Very Rarely Never

**15. Close to C.R. or clients with similar diagnostic presentations**

Always Very Frequently Occasionally Rarely Very Rarely Never

**16. Manipulated by C.R. or clients with similar diagnostic presentations**

Always Very Frequently Occasionally Rarely Very Rarely Never

**17. Like I've had enough training to effectively work with C.R. or clients with similar diagnostic presentations**

Always Very Frequently Occasionally Rarely Very Rarely Never

**18. Irritated by C.R. or clients with similar diagnostic presentations**

Always Very Frequently Occasionally Rarely Very Rarely Never

**19. Protective toward C.R. or clients with similar diagnostic presentations**

Always Very Frequently Occasionally Rarely Very Rarely Never

**20. Drained by C.R. or clients with similar diagnostic presentations**

Always Very Frequently Occasionally Rarely Very Rarely Never

**21. Enjoyment in spending time with C.R. or clients with similar diagnostic presentations**

Always Very Frequently Occasionally Rarely Very Rarely Never

**22. Vulnerable in the company of C.R. or clients with similar diagnostic presentations**

Always Very Frequently Occasionally Rarely Very Rarely Never

**23. Interested by C.R. or clients with similar diagnostic presentations**

Always Very Frequently Occasionally Rarely Very Rarely Never

**24. Outmaneuvered by C.R. or clients with similar diagnostic presentations**

Always Very Frequently Occasionally Rarely Very Rarely Never

**25. Optimistic about the recovery of C.R. or clients with similar diagnostic presentations**

Always Very Frequently Occasionally Rarely Very Rarely Never

**26. Angry toward C.R. or clients with similar diagnostic presentations**

Always Very Frequently Occasionally Rarely Very Rarely Never

**27. Respect toward C.R. or clients with similar diagnostic presentations**

Always Very Frequently Occasionally Rarely Very Rarely Never

**28. Like I'm wasting my time with C.R. or clients with similar diagnostic presentations**

Always Very Frequently Occasionally Rarely Very Rarely Never

**Appendix I**  
**Informed Consent**

Dear Participant,

My name is Marja Walthall and I am a graduate Social Work student at Smith College School for Social Work. I am conducting an anonymous study exploring mental health professionals' perspectives and beliefs about clinical presentations and subsequent diagnoses. There has been literature whose authors address the impact a diagnosis has on the way a client is treated professionally and interpersonally. Researchers also have explored differential diagnoses and the overlap of diagnostic criteria in the Diagnostic and Statistical Manual-TR-IV. My interest in this study also stems from gender differences within DSM diagnoses and in treatment. The data collected in this study will be used in my MSW thesis, possible publication, and presentations.

To be eligible for participation, you must have answered "yes" to meeting inclusion criteria in all three screening questions. After answering a few demographic questions you will read a very short clinical vignette which you will provide with a working diagnosis, and then answer questions about your feelings about working with this individual or individuals with the same diagnosis.

Risks to participants are minimal. It is possible that the content of the vignette may create emotional distress, in which case participants are suggested to seek support from appropriate resources. Benefits of participation include a contribution to the development of knowledge relating to clinicians' perceptions of certain diagnostic presentations. This contribution has the potential to inform training and supervision procedures.

Your information will be safeguarded and will be entirely anonymous. All electronically stored data will be secured through a survey database that is password protected, where it will be

maintained for three years per Federal regulations. After that time, it will be discarded. Should the data be needed beyond the three years, it will be kept in a secure location until such time as it is no longer needed.

Participation is voluntary and you may refuse to answer any question. You may withdraw from the study at any time by simply discontinuing completion of the survey or exiting out of the online survey page. Incomplete surveys will not be used. Once completed surveys are submitted, however, you cannot withdraw or change your responses as it will be impossible to identify your survey. As information will be anonymous, it will not be necessary to destroy your information in the event of withdrawal. My codebook, data sheets and the final paper will be available to anyone who requests it for supervisory or educational purposes. As stated before though, no one will be able to know if you participated or not. If you have any questions about the study please contact me at XXXXXXXX, or the HSR chair at Smith College School for Social Work, David L. Burton PhD, XXXXXXXXX.

**BY CHECKING “I AGREE” BELOW YOU ARE INDICATING THAT YOU HAVE READ AND UNDERSTAND THE INFORMATION ABOVE AND THAT YOU HAVE HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.**

## Appendix J

### SurveyMonkey.com's Security Statement ([http://www.surveymonkey.com/Monkey\\_Security.aspx](http://www.surveymonkey.com/Monkey_Security.aspx))

#### User Security

- SurveyMonkey requires users to create a unique user name and password that must be entered each time a user logs on. SurveyMonkey issues a session "cookie" only to record encrypted authentication information for the duration of a specific session. The session cookie does not include either the username or password of the user.
- When a user accesses secured areas of our site, Secure Sockets Layer (SSL) technology protects user information using both server authentication and data encryption, ensuring that user data is safe, secure, and available only to authorized persons
- Passwords and credit card information are always sent over secure, encrypted SSL connections.
- Accounts which are **SSL enabled** ensure that the responses of survey respondents are transmitted over a secure, encrypted connection
- We are **PCI-DSS compliant**

#### Physical Security

- Our data center is located in a SAS70 Type II certified facility
- Data center staffed and surveilled 24/7
- Data center secured by security guards, visitor logs, and entry requirements (passcards/biometric recognition)
- Servers are kept in a locked cage
- Digital surveillance equipment monitors the data center
- Environmental controls for temperature, humidity and smoke/fire detection
- All customer data is stored on servers located in the United States

#### Availability

- Fully redundant IP connections
- Multiple independent connections to Tier 1 Internet access providers
- Uptime monitored constantly, with escalation to SurveyMonkey staff for any downtime
- Database is log-shipped to standby servers and can failover in less than an hour
- Servers have redundant internal and external power supplies

#### Network Security

- Firewall restricts access to all ports except 80 (http) and 443 (https)
- Intrusion detection systems and other systems detect and prevent interference or access from outside intruders

- QualysGuard network security audits are performed weekly
- McAfee SECURE scans performed daily

### **Storage Security**

- All data is stored on servers located in the United States
- Backups occur hourly internally, and daily to a centralized backup system for offsite storage
- Backups are encrypted
- Data stored on a RAID 10 array
- O/S stored on a RAID 1 array

### **Organizational Security**

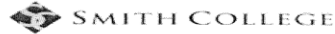
- Access controls to sensitive data in our databases and systems are set on a need-to-know basis
- We maintain and monitor audit logs on our services and systems (we generate gigabytes of log files each day)
- We maintain internal information security policies, including incident response plans, and regularly review and update them

### **Software**

- Code in ASP.NET 2.0, running on SQL Server 2008, Ubuntu Linux, and Windows 2008 Server
- Our engineers use best practices and industry-standard secure coding guidelines to ensure secure coding
- Latest patches applied to all operating system and application files
  - Billing data is encrypted

## Appendix K

### Approval Letter from the Smith College Human Subjects Review Committee



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

February 12, 2013

Marja Walthall

Dear Marja,

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.

Good luck with your very interesting study.

Sincerely,

A handwritten signature in cursive script that reads "Marsha Kline Pruett".

Marsha Kline Pruett, M.S., Ph.D., M.S.L.  
Vice Chair, Human Subjects Review Committee

CC: Joyce Everett, Research Advisor

## Appendix L

### Codebook

? N U M	VAR NAME	VAR LABEL	L O M	VALUE LABELS	MISSING VALUES
1	CASE	Participant/survey number			
2	DISCIPLI	Participant discipline	N	1-Clinical Social Worker 2-Mental Health Counselor 3-Psychologist 4- Marriage and Family Therapist 5- Psychiatrist 6-Psychiatric Nurse Specialist 9-Missing	9= Missing
3	DEGREE	Participant degree	N	1- LCSW 2-MD 3-MS/MA in counseling 4-MSW 5-LPC 6-MFT 7-PA 8-MSN 9-Missing 10-PhD 11-PsyD	9= Missing
4	YRSPRACT	Participant years of practice	R	1-0-5 2-6-10	99= Missing



				3-11-15 4-16-20 5-21-25 6-26-30 99-missing	
5	AGE	Participant age		1-28-32 2-33-37 3-38-42 4-43-47 5-48-52 6-53-57 7-58-62 8-63-67 999- Missing	999=Missing
6	RACE	Participant race/ethnicity	N	1-Black or African American 2-Hispanic, Latino, Chicano, or of Spanish Origin 3- Middle Eastern 4- Native American or Alaskan Native 5- Pacific Islander 6- Mixed Race or Biracial 7-White or Caucasian 8-other 9-Missing	9= Missing
7	GENDER	Participant gender	N	1-Woman 2-Man 3-Transgender	9= Missing

				4- Other 9-Missing	
8	CAPACITY	Capacity/location in which participant practices	N	1-Social agency 2- Community mental health center 2- Hospital inpatient center 3- Hospital outpatient center 4- Veteran assistance 5- Court 6-School 7- Private Practice 8- Family health clinic 9-Missing	9=Missing
9	VIGNETTE	Randomly assigned vignette	N	1- No Gender 2- Female 3- Male 9- Missing	9= Missing
10	DIAGNOSE	Diagnosis given to vignette	N	1-Bipolar Disorder 2- BPD 3- PTSD 4- Mood d/o NOS 5- Dissociative d/o NOS 9- Missing	9= Missing
11	HELP	Able to help	O	1-Always 2-Very Frequently 3- Occasionally 4-Rarely 5-Very Rarely 6-Never	9=Missing

				9-Missing	
12	UNCOMFT	Uncomfortable or Uneasy	O	1-Always 2-Very Frequently 3-Occasionally 4-Rarely 5-Very Rarely 6-Never 9-Missing	9=Missing
13	CARING	Warm and caring	O	1-Always 2-Very Frequently 3-Occasionally 4-Rarely 5-Very Rarely 6-Never 9-Missing	9=Missing
14	HELPLESS	Helpless in relation	O	1-Always 2-Very Frequently 3-Occasionally 4-Rarely 5-Very Rarely 6-Never 9-Missing	9=Missing
15	PATIENT	Patient towards	O	1-Always 2-Very Frequently 3-Occasionally 4-Rarely 5-Very Rarely 6-Never 9-Missing	9=Missing
16	FRUSTRAT	Frustrated with	O	1-Always 2-Very Frequently	9=Missing

				3-Occasionally 4-Rarely 5-Very Rarely 6-Never 9-Missing	
17	FONDNESS	Fondness and affection toward	O	1-Always 2-Very Frequently 3-Occasionally 4-Rarely 5-Very Rarely 6-Never 9-Missing	9=Missing
18	OPPRESS	Oppressed or dominated by	O	1-Always 2-Very Frequently 3-Occasionally 4-Rarely 5-Very Rarely 6-Never 9-Missing	9=Missing
19	EXCITED	Excited to work with	O	1-Always 2-Very Frequently 3-Occasionally 4-Rarely 5-Very Rarely 6-Never 9-Missing	9=Missing
20	PESSIMIS	Pessimistic about	O	1-Always 2-Very Frequently 3-Occasionally 4-Rarely 5-Very Rarely	9=Missing

				6-Never 9-Missing	
21	UNDERSTA	Understanding toward	O	1-Always 2-Very Frequently 3-Occasionally 4-Rarely 5-Very Rarely 6-Never 9-Missing	9=Missing
22	POWERLES	Powerless in the presence of	O	1-Always 2-Very Frequently 3-Occasionally 4-Rarely 5-Very Rarely 6-Never 9-Missing	9=Missing
23	FULFILL	Fulfilled by my work with	O	1-Always 2-Very Frequently 3-Occasionally 4-Rarely 5-Very Rarely 6-Never 9-Missing	9=Missing
24	CONTROL	Unable to gain control of the situation/session	O	1-Always 2-Very Frequently 3-Occasionally 4-Rarely 5-Very Rarely 6-Never 9-Missing	9=Missing
25	CLOSE	Close to	O	1-Always	9=Missing

				2-Very Frequently 3-Occasionally 4-Rarely 5-Very Rarely 6-Never 9-Missing	
26	TRAINING	Had enough training to effectively work with	O	1-Always 2-Very Frequently 3-Occasionally 4-Rarely 5-Very Rarely 6-Never 9-Missing	9=Missing
27	IRRITATE	Irritated by	O	1-Always 2-Very Frequently 3-Occasionally 4-Rarely 5-Very Rarely 6-Never 9-Missing	9=Missing
28	PROTECTI	Protective toward	O	1-Always 2-Very Frequently 3-Occasionally 4-Rarely 5-Very Rarely 6-Never 9-Missing	9=Missing
29	DRAINED	Drained by	O	1-Always 2-Very Frequently 3-Occasionally 4-Rarely	9=Missing

				5-Very Rarely 6-Never 9-Missing	
30	ENJOY	Enjoyment in spending time with	O	1-Always 2-Very Frequently 3-Occasionally 4-Rarely 5-Very Rarely 6-Never 9-Missing	9=Missing
31	VULNERAB	Vulnerable in the company of	O	1-Always 2-Very Frequently 3-Occasionally 4-Rarely 5-Very Rarely 6-Never 9-Missing	9=Missing
32	INTEREST	Interested by	O	1-Always 2-Very Frequently 3-Occasionally 4-Rarely 5-Very Rarely 6-Never 9-Missing	9=Missing
33	OUTMANEU	Outmaneuvered by	O	1-Always 2-Very Frequently 3-Occasionally 4-Rarely 5-Very Rarely 6-Never 9-Missing	9=Missing

34	OPTIMIST	Optimistic about the recovery of	O	1-Always 2-Very Frequently 3-Occasionally 4-Rarely 5-Very Rarely 6-Never 9-Missing	9=Missing
35	ANGRY	Angry toward	O	1-Always 2-Very Frequently 3-Occasionally 4-Rarely 5-Very Rarely 6-Never 9-Missing	9=Missing
36	RESPECT	Respect toward	O	1-Always 2-Very Frequently 3-Occasionally 4-Rarely 5-Very Rarely 6-Never 9-Missing	9=Missing
37	WASTING	Wasting time with	O	1-Always 2-Very Frequently 3-Occasionally 4-Rarely 5-Very Rarely 6-Never 9-Missing	9=Missing



## Appendix M

### Scoring structure within factors

**#question number in survey/Number in Codebook (VAR NAME) Scoring direction for Likert Scale**

**Factor 1: Enjoyment versus loathing:**

#1/11 (HELP) Scored 5-1

#3/13(CARING) Scored 5-1

#5/15 (PATIENT) Scored 5-1

#7/17(FONDNESS) Scored 5-1

#9/19(EXCITED) Scored 5-1

#11/21 (UNDERSTA) Scored 5-1

#13/23 (FULFILL) Scored 5-1

#15/25 (CLOSE) Scored 5-1

#19/29 (PROTECTI) Scored 5-1

#21/31 (ENJOY) Scored 5-1

#23/33(INTEREST) Scored 5-1

#27/37 (RESPECT) Scored 5-1

**Factor 2: Security versus vulnerability:**

#2/12(UNCOMFT) Scored 1-5

#4/14 (HELPLESS) Scored 1-5

#8/18 (OPPRESS) Scored 1-5

#12/22(POWERLES) Scored 1-5

#14/24(CONTROL) Scored 1-5

#16/26 (MANIPULA) Scored 1-5

#22/32 (VULNERAB) Scored 1-5

#24/34 (OUTMANEU) Scored 1-5

**Factor 3: Acceptance versus rejection:**

#18/28 (IRRITATE) Scored 1-5

#26/36 (ANGRY) Scored 1-5

**Factor 4: Purpose versus futility:**

#10/20 (PESSIMIS) Scored 1-5

#17/27 (TRAINING) Scored 5-1

#25/35 (OPTIMIST) Scored 5-1

#28/38 (WASTING) Scored 1-5

**Factor 5: Exhaustion versus enthusiasm:**

#6/16 (FRUSTRAT) Scored 1-5

#20(DRAINED) Scored 1-5