# Studying Borderline Personality Disorder and Childhood Trauma: Exploring Clinicians' Lived Experiences and Attitudes Toward Treating BPD Individuals

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A Dissertation Presented in Partial Fulfillment

Of the Requirements for the Degree

Doctor of Education

School of Behavioral Sciences

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**Abstract**

A recurring theme in research on borderline personality disorder (BPD) and childhood trauma was the stigma associated with a BPD diagnosis often resulting in barriers to recovery processes and challenges to treatment for this population. The purpose of this transcendental phenomenological study focused on the lived experience of licensed clinicians who work with BPD clients, with the aim to find common themes experienced by clinicians regarding clinicians' BPD clients, what successes and challenges experienced by clinicians led to their attitudes and perspectives toward treating BPD clients, and what perspectives clinicians have regarding what resources (education, training, etc.) are available in helping clinicians work with BPD clients. Understanding clinicians' perspectives may lead to removal of the stigma associated with a BPD diagnosis and thereby remove challenges to treatment. This study, grounded by developmental and learning theoretical framework, was guided by both social cognitive theory and transformative learning theory. Research questions focused on how clinicians described their experience in working with BPD clients, how they described challenges and successes, and how they described resources available to them to treat BPD clients. One-on-one interviews and observations were conducted. Phenomenological data analysis was conducted using the simplified version of Moustaka's Modified Stevick-Colaizzi-Keen Method, and data were analyzed for significant phrases before developing meanings, and clustering them into themes, and presenting an exhaustive description of the phenomenon were the general guidelines.

*Keywords*: borderline personality disorder, childhood trauma, clinicians, stigma, recovery processes, treatment, social cognitive theory, and transformative learning theory

## Copyright Page

## Dedication

I dedicate my dissertation with much love and gratitude to my father and his memory. Growing up he was my encouragement, my rock, and my strength as a father should be to his children. Through his wisdom and encouragement growing up, has allowed me to achieve this lifelong dream that he encouraged me to pursue. I am deeply thankful and blessed to have had him as my father and consider him a huge part in earning my doctoral degree. I thank my God and Savior every day for him, and the love he had for my family and me.

**Acknowledgements**

I would like to most of all thank my God and Savior for blessing me and making it possible for me to achieve my lifelong dream of receiving my doctorate degree. I sincerely thank Guy for his support and encouragement of me during the many hours, long weekends, and late nights throughout my journey to achieve my dream. I am thankful for my family, my mother, children, and siblings for the support they have given me in pursuit of my dream. There have been so many challenges over the past few years, and completion of my journey is due no less to their love, support, and sacrifices in support of me and my journey. I thank God for all of you and love you all. My completion of this degree is a testimony of your love and support and my love for you.

I would like to thank the clinician participants of this study. Thank you for giving your valuable time and perspectives working with BPD clients. Your lived experiences and input in this study will be beneficial in the removal of barriers and challenges to recovery processes and treatment for BPD individuals.

Thank you to my committee members, who have guided and assisted me on my journey. It has been an honor to have your guidance and help. I have the utmost respect for all of you and consider it an honor to have completed my degree under your watch. A special thank you to Dr. Lilley, for always being available when I needed advice, help, and guidance, and to Dr. Todd for her guidance and support.

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## List of Abbreviations

Acceptance and commitment therapy (ACT)

Adverse childhood experiences (ACEs)

Borderline personality disorder (BPD)

Career and technical education (CTE)

Cognitive behavioral theory (CBT)

Dialectical behavioral therapy (DBT)

*Diagnostic and Statistical Manual of Mental Disorders,* 5th Edition (*DSM-5*)

Individual education plan (IEP)

Internal family systems (IFS)

Institutional review board (IRB)

Mentalization-based treatment (MBT)

Mindfulness-based cognitive therapy (MBCT)

Mindfulness-based stress reduction (MBSR)

Posttraumatic stress disorder (PTSD)

Substance Abuse and Mental Health Services Administration (SAMHSA)

Social cognitive theory (SCT)

Transformative learning theory (TLT)

Trauma focused cognitive behavioral therapy (TF-CBT)

# CHAPTER ONE: INTRODUCTION

## Overview

Research on borderline personality disorder (BPD) has shown a connection between exposure to childhood and adolescent trauma and the onset of BPD (Chan, 2004). Though it is important to study the relationship between childhood trauma and BPD to allow for continued development of disorder-specific approaches for treatment (Kverme et al., 2019), it is equally important to study the stigma associated with a BPD diagnosis, which research has shown may lead to barriers to recovery processes and challenges to finding treatment among this population (Lohman et al., 2017; Resick et al., 2017). Research has found among mental health care professionals that BPD individuals are expected to be the clients most difficult to treat due to the characteristic behaviors, thoughts, and emotions of individuals diagnosed with a personality disorder (Resick et al., 2017). Interest in this study was based on this finding and personal experience as an educator working with students with a BPD diagnosis.

Since research has shown biased attitudes among some clinicians toward treating these individuals due to the stigma associated with a BPD diagnosis (Bodner et al., 2015), the purpose of this study was to gain a better understanding of clinicians' attitudes toward clients with BPD. Findings from this study address the gap in research and can provide a better understanding of BPD clients among clinicians, which can help in removing barriers to recovery processes for individuals diagnosed with BPD, including those who experienced childhood trauma (Lohman et al., 2017). Focusing on the lived experience of licensed clinicians with a minimum of 5 years' experience treating individuals with BPD, I aimed to find common themes regarding clinicians' BPD clients, what challenges and successes may have led to clinicians' perspectives toward treating BPD clients, and what perspectives clinicians have regarding what resources are

available to clinicians (e.g., education and training) in helping work with BPD clients. Understanding the challenges and successes in treating BPD clients from the perspective of the clinician rather than the client could be beneficial in overcoming the stigma associated with treating BPD clients and barriers to treatment they may encounter (Lohman et al., 2017). Findings from this study could be beneficial in the training of future clinicians and other professionals (i.e., health care providers, law enforcement, criminal justice workers, educators, and family members) who work with BPD individuals (Sheehan et al., 2016). This chapter introduces this transcendental phenomenological study, which was guided by both social cognitive theory (SCT; Bandura, 1989) and transformative learning theory (TLT; Mezirow, 1997).

## Background

### Borderline Personality Disorder Characteristics

BPD is characterized as a chronic disturbance in which there is a pervasive pattern of instability of interpersonal relationships, self-image and affects, and marked impulsivity, which starts by early adulthood and present in a variety of contexts as described in the *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition (*DSM-5*; American Psychiatric Association, 2013). Borderline personality traits may be largely posttraumatic in nature, and the genesis of this disorder is traced to dysfunctional parental (primarily maternal) behavior in the first several years of the child's life by most traditional theories (Briere & Scott, 2015). BPD is the most dramatic example of chronic relational trauma activations (Briere & Scott, 2015). In childhood histories of individuals with BPD, physical and sexual abuse, neglect, hostile conflict, and early parental loss are common (American Psychiatric Association, 2013). Depressive and bipolar disorders, substance use disorders, eating disorders (notably bulimia nervosa), posttraumatic

stress disorder (PTSD), and attention-deficit/hyperactivity disorder are common co-occurring disorders in individuals with BPD (American Psychiatric Association, 2013).

Diagnosis of BPD can be difficult especially among adolescents and young adults, and treatment and resources are frequently a challenge to acquire because of the stigma associated with individuals diagnosed with BPD. As a result, many individuals are well into adulthood before diagnosis and treatment. Stigma is often associated with treating individuals with a personality disorder diagnosis, since these individuals are seen as more likely to require more work due to the characteristic behaviors, thoughts, and emotions of individuals with a personality disorder diagnosis (Resick et al., 2017).

**Borderline Personality Disorder Development**

To understand why there is stigma associated with a BPD diagnosis, it is important to understand the development of BPD; the relationship between childhood trauma and BPD; its characteristic behaviors, thoughts, and dysregulated emotions; and the difficulty in treating and managing individuals with BPD. Trauma is defined as an exposure to an event that is either actual or threatened (i.e., sexual violence, significant injury, or death) in one or more ways (American Psychiatric Association, 2013, as cited in Briere & Scott, 2015). The trauma exposure may include a person experiencing the traumatic event, witnessing the traumatic event occurring to others, learning of a traumatic event's occurrence of a close friend or family member, and experiencing extreme or repeated exposure to aversive details of traumatic events (American Psychiatric Association, 2013, as cited in Briere & Scott, 2015). Even though this definition is useful, it has been criticized by some because of the requirement that the definition be limited to "exposure to actual or threatened death, severe injury, or sexual violence" (American Psychiatric Association, 2013, as cited in Briere & Scott, 2015, p. 9); even if the threat of injury or life is not

a factor, many events may be traumatic to certain individuals (Anders et al., 2011, as cited in Briere & Scott, 2015; Briere, 2004). Thus, a crisis (traumatic event) can be defined as where a person perceives a situation or event to be more intolerable or greater than their own ability to cope with or assimilate to the circumstances (Levers, 2012).

Children and adolescents may encounter many crises (traumatic events) such as injury, divorce, death, natural disasters, acts of war and terrorism, and abuse (i.e., physical, emotional, sexual, and spiritual). The most common crisis or traumatic event that may lead to hospitalization and is the leading cause of death in children and adolescents is unintentional injury (Berkowitz & Fein, 2013). Often noticed in children and adolescents following traumatic injury, emotional distress may be caused by traumatic abuse (emotional, physical, or sexual), and psychological support may be needed (Berkowitz & Fein, 2013). A childhood traumatic injury (as in traumatic child abuse) can have detrimental consequences for the developing child's ability to self-regulate (Levers, 2012). The etiology of BPD is an example of the potential impact of nontraumatic and traumatic failures in autonomy support, particularly the need for relatedness, as well as failures on the part of caregivers in providing supports for the need for autonomy (Levers, 2012). A disruption in both autonomy and relatedness, among other consequences, can result in a later adolescent's inability to recognize their own inner needs (a capacity which is essential for self-regulation and is represented by a traumatic injury in the form of abuse at the hands of caregivers (Levers, 2012).

Research has consistently shown the effects of childhood trauma on children and adolescents. Childhood trauma can have negative effects on individuals in adulthood (e.g., shame, guilt, attachment anxiety and avoidance, emotional regulation, and interpersonal relationships; Cattane et al., 2017). Though adolescents may deal with some of the same crises as

younger children, suicide attempts among this developmental group may be the result of a traumatic injury, especially from traumatic abuse, which is a common crisis among them (Miranda & Shaffer, 2013). Even though there is a low prevalence of actual deaths from suicide among adolescents, suicide attempts among this developmental group are more common than in any other developmental stage (Miranda & Shaffer, 2013). Risk factors such as self-harming behaviors, depression, and a previous suicidal attempt are inclined to be the focus of studies on suicidal factors among adolescents (Miranda & Shaffer, 2013). An understanding of the circumstances that happen before suicide attempts, including cognitive and emotional responses that come prior to suicidal ideation and the nature of suicide ideation, is a critical part of preventing the potentially fatal attempt (Miranda & Shaffer, 2013).

**Borderline Personality Disorder Diagnosis Criteria**

Though there are still some psychiatrists who consider the diagnosis of adolescent BPD to be invalid, there is a consensus that BPD becomes apparent in adolescence (Sharp & Fonagy, 2015). Many clinicians are still hesitant to use a BPD diagnosis prior to the age 18 or even 21 (Schmeck, 2022) because of concerns over the stigma associated with a BPD diagnosis and a diagnosis being made while personality development is in flux (Chanen et al., 2004, as cited in Chanen & McCutcheon, 2008). However, over the past two decades a significant amount of evidence has been collected that a diagnosis can be validly and reliably made in adolescents (Chanen et al., 2017). BPD constitutes a valid and reliable diagnosis in adolescence for psychopathology that persists over a year and should not be explained as a transient phenomenon (Sharp & Fonagy, 2015).

According to Section II of the American Psychiatric Association's (2013) *DSM-5*, BPD may be applied to children and adolescents when the maladaptive personality traits of the

individual appear to be pervasive, persistent, and unlikely to be limited to another mental disorder or a particular developmental stage over 1 year in contrast to 2 years necessary for adult diagnosis. Symptoms that meet the *DSM-5* Section II criteria and that can be distinguished from typical adolescence by their severity, pervasiveness, and time course as well as from pure internalizing and externalizing disorders include abandonment fears, unstable and intense interpersonal relationships, identity disturbance, impulsivity, suicidal behaviors, affective instability, chronic feelings of emptiness, inappropriate intense anger and transient, stress-related paranoid ideation, or severe dissociative symptoms (Sharp & Fonagy, 2015).

Section III of the *DSM-5* requires clinicians to consider two sets of criteria (Criterion A and B) in the assessment of BPD in contrast to Section II (Sharp & Fonagy, 2015). Criterion A is judgment of severity of problems in identity (i.e., asking "Who am I?"), self-direction, empathy, and intimacy (Feldman, 2017). Criterion B is the presence of four or more of the following seven pathological personality traits: emotional liability, anxiousness, separation insecurity, depressivity, impulsivity, risk-taking, and hostility; at least one must be impulsivity, risk-taking, or hostility (Sharp & Fonagy, 2015).

## Situation to Self

I was a former at-risk school counselor in career and technical education (CTE), retiring from public education at the end of the 2020-2021 school year. During my years in public education as an at-risk counselor, I served as a CTE special populations coordinator, CTE career development coordinator, reintegration specialist, and student advocate. Prior to becoming an at-risk counselor, I was a CTE family and consumer science and CTE business, finance, and information technology classroom teacher. My experience as an educator along with personal ontological assumptions led to this choice of research. I believe that recovery processes and

treatment are important to the treatment of BPD, especially cognitive behavioral therapies, and I feel these align with a Christian worldview. Following a Christian worldview to lead and help others, research to help remove stigma and make recovery processes and treatments available to those with BPD is vital.

In the capacity as an at-risk counselor, I worked with at-risk students (economically disadvantaged, special populations, non-traditional students, student parents, connected military, foster students, students with discipline and behavioral problems, truancy, and exceptional children students) who were at risk of failing and/or dropping out of school. I also ensured the members of special populations, at-risk, and students with disabilities received services and job training, including working closely with case managers and attending individual education plan (IEP) meetings as well as working with the North Carolina Department of Public Instruction's Comprehensive Exceptional Children Accountability System to review student IEP's, review of accommodation's special education information, and exceptional children forms. I provided special services for special populations to ensure equal access to recruitment, enrollment, and placement activities, and coordinated with other service providers to reduce the number of direct service contacts and the duplication of efforts. I identified each member of special populations enrolled in the school's CTE program to meet the broad assurances of the law and helped students to enter the program to enhance their chances of selecting an appropriate career pathway. I provided career guidance, vocational assessment, and monitoring, and I coordinated career development services and promoted career awareness, exploration, and planning for special populations and regular education students.

During my tenure as an educator, especially in my positions as an at-risk high school counselor, I came across many students who were having problems that warranted outside

referral for mental health care and counseling. These students were recommended for outside services, as mental health services were not part of the public-school counseling. Many times, parents of students and students themselves refused referral, most often because of the associated stigma with mental illness, especially BPD. In addition, I recognized reluctance of mental health counselors to work with students who met the criteria for a BPD diagnosis because of the stigma associated with a BPD diagnosis and belief that BPDs are difficult to work with. Personally, I believe had there been no stigma for BPD, I may have received diagnosis and treatment as a young adult and possibly avoided the many years of anguish suffered as an adult. The desire to overcome this stigma and the challenges to recovery processes and treatment associated with a BPD diagnosis and the desire to educate future educators to better serve students with mental illness, especially BPD, led me to this research.

## Problem Statement

BPD can be difficult to diagnose, and treatment and resources are frequently a challenge to acquire because of the stigma associated with individuals diagnosed with BPD. Patients with BPD and other severe personality disorders have a strong impact on clinicians (Bodner et al., 2015), and pessimistic views result from the diagnostic label of BPD (Lam et al., 2016). Clinicians anticipate those with BPD traits being the most difficult to manage (Resick et al., 2017). These views can lead to negative attitudes toward clients diagnosed with BPD, creating barriers among the BPD population (Bodner et al., 2015).

Despite stigma being a barrier to receiving and accessing quality care among those with BPD, there is a gap in research of health care professionals, especially for building and delivering anti-stigma training and education (Ungar et al., 2016). Health care providers, law enforcement, criminal justice workers, educators, and family members can benefit from anti-

stigma interventions designed specifically for them (Sheehan et al., 2016). Limited research suggests interventions combining biological etiology with positive messages of potential recovery with mental health provider education may improve attitudes of stigma among mental health workers (Sheehan et al., 2016). Individuals could meet their treatment goals with a favorable working clinician relationship (Katsakou et al., 2012). Studying clinicians addressed the gap in research on how to create anti-stigma programs for this population (see Ungar et al., 2016). Research of clinicians' perspectives leading to training that addresses negative attitudes toward BPD clients is significant in solving the problem with the associated stigma.

## Purpose Statement

The purpose of this transcendental phenomenological study was to describe licensed clinicians' experiences with diagnosing and treating BPD in North Carolina. To gain a better understanding of clinicians' attitudes and perspectives toward clients with BPD, this study focused on the lived experiences of licensed clinicians with at least 5 years of experience working with individuals diagnosed with BPD. I aimed to find common themes experienced by clinicians regarding clinicians' BPD clients, what experiences (successes and challenges) of clinicians led to perspectives toward treating BPD clients, and what perspectives clinicians have regarding what resources (e.g., education and training) are available to help remove the stigma associated with treating BPDs and help clinicians work with BPD clients. There is a gap in research among service providers who treat clients diagnosed with BPD compared to the research among services users (i.e., clients). By understanding clinicians' lived experiences, especially their perspectives on what education, training, and resources may help remove the stigma among this population, making treatments for BPD can be more readily available.

## Significance of the Study

This qualitative, transcendental phenomenological study focused on describing what clinicians have in common as they treat clients with BPD, allowing for a better understanding of the attitudes and beliefs of the participants. Grounded by both SCT (Bandura, 1989) and TLT (Mezirow, 1997), using this approach allowed for more thorough focus on participants' lived experience with individuals diagnosed with BPD and allowed for a better understanding of their attitudes and beliefs. Finding commonalities among clients (e.g., childhood trauma, barriers to recovery processes and treatment because of associated stigma) from a study of clinicians' perspectives who treat individuals who have been diagnosed with BPD was significant. Research such as this would continue to be effective in removing barriers and challenges to recovery processes and treatment for this population. Particularly, understanding the stigma associated with a BPD diagnosis, the barriers to recovery processes and challenges to treatment for BPD individuals because of the associated stigma, and the difficulty in treating them from clinicians' perspectives would be beneficial for future training of clinicians and most importantly, future treatment of BPD.

## Research Questions

This research provides insights from clinicians' perspectives rather than BPD clients' perspectives on treating individuals with BPD. Recovery processes and treatment for individuals diagnosed with BPD may be affected by the negative attitudes of clinicians toward BPD clients (Bodner et al., 2015). It is imperative that clinicians learn to counther negative attitudes, because they can influence treatment outcomes (Bodner et al., 2015). The following research questions guided the study:

- Central Question: How do clinicians in North Carolina describe their experience in

working with BPD clients?

- Research Question 1: How do clinicians describe the successes in dealing with BPD clients?
- Research Question 1: How do clinicians describe the challenges in working with BPD clients?
- Research Question 3: How do clinicians describe resources (e.g., education and training) available to them to treat BPD clients?

## Definitions

*Borderline personality disorder (BPD):* BPD is defined as "a pervasive pattern of instability of interpersonal relationships, self-image, affects, and marked impulsivity, beginning by early adulthood and present in a variety of contexts," and diagnosis is indicated by five or more of the nine diagnostic criteria in the American Psychiatric Association's (2013) *DSM-5*.

*Childhood trauma:* Trauma experienced as a child or adolescent. The *DSM-5* defined trauma as exposure to actual or threatened death, severe injury, or sexual violation where intense fear, horror or helplessness predominates and can occur through either one single event or multiple and repeated traumatic events (Sanderson, 2013). But some clinicians have criticized the requirement that trauma be limited to "exposure to actual or threatened death, serious injury, or sexual violation" in the definition of trauma, because many events may be traumatic to individuals even though threat of life or injury is not an issue (Briere & Scott, 2015). Individuals can experience trauma as witnesses to the events in person that occurred to others, learning that the traumatic events occurred to a close friend or family member that must have been accidental or violent, or experiencing extreme or repeated exposure to aversive details of traumatic events (Brier & Scott, 2015).

*Clinicians:* The American Psychological Association (2008) defined a service provider (i.e., a psychiatrist, psychologist, psychotherapist, mental health counselor, counselor, or therapist) of counseling psychology as a general practice and health service provider specialty in professional psychology that focuses on how individuals' function in their relationships and personally at all ages of development.

*Stigma:* A characteristic or mark of shame or discredit (Merriam-Webster Dictionary, n.d.-b). Speaking to the complexity of the stigma construct, discrimination, status loss, separation, stereotyping, and the co-occurrence of labeling may be a definition of stigma (Modgill et al., 2014)

*Recovery processes:* A process of change for recovery of mental disorders through which a person can strive to reach their full potential, live a self-directed life, and improve their health and wellness (Substance Abuse and Mental Health Services Administration [SAMHSA], 2019).

*Treatments:* Treatments for BPD include cognitive behavioral therapy (CBT) and related therapies such as dialectical behavioral therapy (DBT), mentalization-based treatment (MBT), mindfulness-based stress reduction (MBSR), mindfulness-based cognitive therapy (MBCT), and acceptance and commitment therapy (ACT).

## Summary

A synopsis of the research and gaps in related literature on the lived experience of clinicians who treat individuals diagnosed with BPD were presented in this chapter together with an emphasis on the stigma associated with such a diagnosis and the subsequent barriers to recovery. Guided by both SCT (Bandura, 1989) and TLT (Mezirow, 1997), this study describes the lived experiences of licensed clinicians who have a minimum of 5 years' experience treating clients diagnosed with BPD and what the clinicians have in common with their experience of

treating such clients. This will help close the gaps in research and allow for a better understanding of the attitudes and beliefs toward these clients. This can be beneficial in removing barriers to recovery processes and treatment for individuals living with BPD.

# CHAPTER TWO: LITERATURE REVIEW

## Overview

Though it is important to study the relationship between childhood trauma and BPD to allow for continued development of disorder-specific approaches for the successful treatment of BPD individuals (Kverme et al., 2019), it was equally important to understand the lived experiences and attitudes of licensed clinicians who treat these individuals because of the stigma associated with a BPD diagnosis, which causes barriers to recovery processes among this population. Mental health care professionals are a caring group who strive to help individuals with mental illness; however, stigma is a major barrier to receiving and accessing quality care among those diagnosed with BPD (Ungar et al., 2016). Limited research suggests that interventions combining biological etiology with positive messages of potential recovery with mental health provider education may improve attitudes of stigma among mental health workers (Sheehan et al., 2016).

The intent of this chapter was a review of the current literature on BPD and childhood trauma, focused on the limited literature concerned with this phenomenon. This chapter also provides the theoretical framework for this study. Valuable information pertaining to BPD, the relationship of childhood trauma, recovery processes and treatment, circumstances of stigma among clinicians, and barriers to recovery processes and treatment are also discussed. This review supports the need for this phenomenological study of the lived experiences and attitudes of clinicians who treat individuals diagnosed with BPD to understand their perspectives toward treating this population and overcome the associated stigma and barriers to treatment.

## Theoretical Framework

There are several models that have been proposed to understand the pathogenesis and

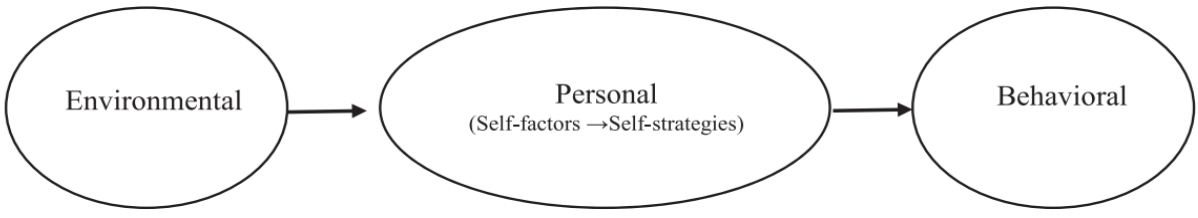
causes of BPD, because it is one of the most difficult psychiatric conditions (D'Agostino et al., 2018). Since this study focused on the lived experience of clinicians who work with BPD clients rather than focusing on BPD clients and the pathogenesis and causes of BPD core psychopathology (D'Agostino et al., 2018), both a developmental and learning theoretical framework underpinned this study. SCT (Bandura, 1989) and TLT (Mezirow, 1997) guided this study for a better understanding of clinicians' perspectives, which may lead to removing the stigma associated with a BPD diagnosis among clinicians and help remove the barriers and challenges to recovery processes and treatment for BPD individuals.

## Social Cognitive Theory

Several factors operating through different processes govern human behavior in SCT (Bandura, 1986b). To describe the factors influencing human agency that shape human functioning, Bandura proposed a triadic model (see Figure 1) that examines the interactions between environmental (e.g., social support), personal (e.g., self-strategies and self-factors), and behavioral (e.g., educational outcomes) factors (Burns et al., 2018). Bandura (1997) explored these three factors and the way they affect each other inside the process of learning.

**Figure 1**

*Social Cognitive Theory Triadic Model*




Perceived self-efficacy is also conceptualized by SCT (Bandura, 1986a). Individuals' attitudes and behaviors are influenced by their activities and environments, which shapes their efficacy beliefs (Bandura, 2001). Personal development of an individual can be significantly

affected by any factor that influences chosen behavior (Bandura, 2001), such as negative attitudes of clinicians toward BPD clients. SCT can help explain how clinicians describe how they perceive their attitudes toward treating BPD clients (Bandura, 1997). It can also explain and help clinicians become self-aware of negative attitudes and biases they may have toward BPD clients (Bandura, 1997). Understanding the shared lived experiences of clinicians in this study may help finding commonalities of their attitudes and beliefs, what experiences led to any negative perceptions, and what would be beneficial in helping remove those negative attitudes and biases.

**Transformative Learning Theory**

Comprising generic structures, elements, and processes of adult learning, TLT was intended by Mezirow (1994) to be a comprehensive, idealized, and universal model. Which of these structures, elements, or processes will be acted on depends on experiences and cultures of adult learners (Mezirow, 1994). Core to an adult individual making meaning and thus learning, assumptions of TLT are a constructivist orientation, which describes the way individuals learn to interpret and reinterpret their sense experience (Mezirow, 1994). As a blueprint to action, the social process of understanding and allocating a new or revised interpretation of an individual's experience is the meaning of learning with critical reflection and rational discourse the processes of adult learning (Mezirow, 1994). In adult learners, autonomous thinking is developed by transformative learning (Mezirow, 1997).

TLT provided a framework for this study helping to change negative attitudes and biases of clinician toward BPD clients, since it is an adult model of learning that is best described as "a comprehensive and complex description of how learners, construe, validate, and reformulate the meaning of their experience" (Cranton, 2005, as cited in Fazio-Griffith & Ballard, 2016, p. x).

Grounded in critical social theory and psychoanalytic theory, three common themes of TLT are centrality of experience, critical reflections, and rational discourse (Fazio-Griffith & Ballard, 2016). When the frames of reference (i.e., feelings, behaviors, and ways of thinking) of adults are challenged and their points of view (i.e., beliefs and values), they have the greatest learning according to TLT (Mezirow, 2000). Through critical reflection of their worldview that caused preceding points of view or habits of mind and discussion, or problem-solving transformative learning can happen once their frames of reference are challenged (Mezirow, 2000). Four ways adult learning occur are (a) elaboration on current frames of reference, (b) learning new current frames of reference, (c) transformation of points of view, and (d) transformation of habits of mind (Mezirow, 2000).

## Related Research

### Borderline Personality Disorder

Numerous studies of related of literature on those diagnosed with BPD are reviewed in this chapter, including diagnosis and recovery, adolescents and young adults, the relationship of childhood trauma, clinicians and caregivers, recovery processes and treatment, and challenges to recovery processes and treatment. The literature reviewed provides a foundation to this study to close the gap in research of service providers' (health care providers, including clinicians) lived experiences and attitudes, which can lead to the continued research and development of treatment approaches for the successful recovery processes and treatment of individuals diagnosed with BPD. Further research among service providers' lived experiences and attitudes of clinicians who treat these individuals may lead to further development of anti-stigma interventions for clinicians, thus helping remove challenges and barriers to recovery processes and treatment of this population.

***Diagnosis***

In 1980 BPD became an official part of the psychiatric diagnostic nomenclature, with the term *borderline* first being used by Adolph Stern in 1938 (Courtney-Seidler et al., 2013). Beginning in early adulthood and present in a variety of contexts, an individual with a pervasive pattern of instability of interpersonal relationships, self-image, affects, and marked impulsivity, is diagnosed with BPD when five or more of the following indicated nine diagnostic criteria are met (American Psychiatric Association, 2013):

1. Frantic efforts to avoid real or imagined abandonment. (Note: Do not include suicidal or self-mutilating 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., spending, sex, substance abuse, reckless driving, binge eating). (Note: Do not include suicidal or self-mutilating behavior covered in Criterion 5).
5. Recurrent suicidal behavior, gestures, threats, or self-mutilating behavior.
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, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights.
9. Transient, stress-related paranoid ideation or severe dissociative symptoms.

One of the most closely specified etiological models of BPD is Linehan's (1993) biosocial theory of BPD. As maintained by her, principally a disorder of emotion dysregulation, BPD appears from transactions between individuals with specific environmental influences and biological vulnerabilities (Crowell et al., 2009). She described persons with BPD as having a heightened emotional sensitivity, inability to regulate intense emotional responses, and slow return to emotional baseline consequential to dysfunction of a broad dysregulation over all aspects of emotional responding (Crowell et al., 2009). Characterized by intolerance toward the expression of personal emotional experiences, especially those that are not supported by observable events, BPD development occurs within an invalidating developmental context (Crowell et al., 2009). According to Linehan, coping with emotions internally and without parental support and emotional exhibitions are simultaneously communicated to the child, even though extreme emotional expressions are intermittently reinforced by invalidating environments (Crowell et al., 2009). As a result, the child learns to alternate between extreme emotional inequity and emotional inhibition, instead of learning how to tolerate, regulate, label, or understand emotional responses; thus, adding to these emotional reactions, they fail to learn how to problem solve (Crowell et al., 2009).

General practitioners are significant sources for assessment, diagnosis, treatment, and care for BPD individuals who are more likely to seek primary care than the general population (Wlodarzcyk et al., 2018). But during adolescence, the diagnosis of personality disorder before the ages of 16 and 17 years of age has been controversial (Barnicot & Ramchandani, 2015; Ramleth et al., 2017). Childhood trauma can have negative effects on individuals in adulthood (i.e., shame, guilt, attachment anxiety and avoidance, emotional regulation, and interpersonal relationships), which can contribute to the reluctance to treat individuals with BPD (Cattane &

Rossi et al., 2017). Diagnosis and treatment of individuals with BPD are often delayed, although it often has its onset in young people (Chanen, 2015). Treatment is needed to match individual development and phase and stage of the disorder, and workforce development strategies need updating of knowledge, culture, and practice in connection with young BPD individuals to advance early intervention (Chanen, 2015). Early detection and intervention for categorical BPD or subsyndromal borderline pathology beyond an extended developmental period are supported from evidence of recent findings (Chanen et al., 2020). Most of the cases of individuals that develop BPD in early adolescence can expect to be remitted within 4 years, supporting the validity of a diagnosis of BPD in adolescents (Biskin et al., 2011). Though the role of treatment elements in successful outcomes is not clear, a variety of structured treatments are effective for BPD in young persons, and a stronger focus on functional outcomes is justified, especially vocational and social outcomes (Chanen et al., 2020). There is danger in ignoring the care of adolescents, where there is a normalizing ascension in personality disorder feature (Crawford et al., 2005).

With little information about its treatment or phenomenology among young adults in college, the impact of BPD on this population has not been studied well (Brickell, 2018). Improved diagnostic procedures and guidelines of best-practice are needed to create on-campus treatment for young adult students diagnosed with BPD (Brickell, 2018). Strong interventions that can provide symptom remedy and make it possible for further treatment are as simple as educating college students about the BPD and disclosing the diagnosis (Brickell, 2018). To address the understudy of BPD among this population as well as the impact of other interventions than DBT, more research is recommended (Brickell, 2018).

### *Childhood Trauma and BPD*

Research has supported that adverse childhood experiences (ACEs) are related to symptom severity of BPD, but the onset of BPD depends on a combination of environmental and genetic factors, as there may be alterations in many biological processes and brain morphological features that relate to childhood traumatic experiences and BPD (Cattane et al., 2017). ACEs are not sufficient to explain the reason some persons may develop BPD whereas others may not (Cattane et al., 2017). However, there has been a wide range of research in the etiology of BPD and the role of ACEs (Courtney-Seidler et al., 2013). Individuals with BPD have reported more types of childhood trauma that began in early childhood and were repeated over longer periods of type and suffered abusive experiences more often than other individuals (Herman et al., 1989). A greater occurrence of childhood abuse and neglect are reported by persons with BPD compared to others diagnosed with personality disorders and Axis I disorders (Courtney-Seidler et al., 2013). Further, violence during adolescence is related to both BP pathology and posttraumatic stress symptoms (Buckholdt et al., 2014). Post traumatic reactions to childhood trauma have been connected to an increased risk of developing posttraumatic symptoms, substance abuse problems, conduct problems, depression, psychotic symptoms, in addition to behavioral and emotional problems (Cohen et al., 2017).

Although it is not in the *DSM-5*'s diagnostic criteria, there is often a background of physical abuse, emotional abuse, or sexual abuse during childhood in individuals with BPD (O'Connell & Dowling, 2014). High rates of traumatic childhood experiences (65 to 75%) have been demonstrated in adolescent and adult borderline patients, including sexual abuse, physical abuse, and witnessing violence (Chu, 2011). Childhood abuse is often the critical factor in the development of borderline psychopathology as suggested by a growing body of evidence (Chu,

2011). Individuals who have experienced prolonged physical or sexual abuse may have complex traumatic reactions that lead to physical symptoms from the emotional distress as well as addictive and self-injuring behaviors (Sanderson, 2013). Most important is the disruption of trust and attachment (Luyten et al., 2020). An invalidating environment, childhood adversities, and neglect and maltreatment as well as attachment, parenting style, and interpersonal interactions seem to play a role in the development of BPD (Courtney-Seidler et al., 2013). Complex trauma experienced during childhood or adolescence can mold the adult personality where there is an avoidant attachment or dissociative self-states, which can lead to passive or controlling, submissive or aggressive, impulsive, or volatile behaviors, with avoidance high in individuals diagnosed with BPD (Sanderson, 2013).

**Borderline Personality Disorder Theories**

In studying BPD and what makes up its core psychopathology, there are many theoretical models, each having its own unique features as well as related treatment model (Gunderson et al., 2018). Different conceptualizations of the core psychopathology of BPD include excess aggression (Kernberg, 1967), emotional dysregulation (Linehan, 1993), failed mentalization (Fonagy & Luyten, 1999, as cited in Gunderson et al., 2018), and interpersonal hypersensitivity (Gunderson & Lyons-Ruth, 2008). In these four models, the primary core psychopathology of BPD is placed in a different core; excessive aggression places it in the self/cognitive core, emotional dysregulation in the emotion core, and failed mentalization and interpersonal hypersensitivity both placing it in the interpersonal core (Gunderson et al., 2018). BPD's other core symptomology can be explained as secondary in each theory, with the noteworthy exception of emotional dysregulation not recognizing the self-core (Gunderson et al., 2018).

Consideration of the four theoretical models (excess aggression, emotional dysregulation,

failed mentalization, and interpersonal hypersensitivity) and multiple other theories in the study of BPD, should be taken within the broader framework of developmental psychopathology (Crowell et al., 2009). BPD can be explained by many interacting risk factors, dynamic processes, and casual events inside of the developmental psychopathology (Crowell et al., 2018), since at multiple levels of analysis (e.g., genetic, neural, behavioral, familial, and social) emphasis on the underlying psychopathology mechanistic processes are placed by its perspective (Cicchetti, 2008, as cited in Crowell et al., 2009). Developmental psychopathology explained how the interaction between contexts and individuals across development is influenced as well as the how and why of psychological disorders developing over time, which is especially appropriate for understanding the continuity of the development of problems during adolescents throughout adulthood (Cummings et al., 2000, as cited in Crowell et al., 2009).

Providing a bedrock for research and initial effective treatments, Dr. Gunderson helped institute BPD as a stand-alone diagnosis (Carey, 2019). Discovering that many of his participants who had been diagnosed with schizophrenia had received the wrong diagnosis, Dr. Gunderson recognized these individuals did not have recurring psychoses (the significant symptom of schizophrenia; Carey, 2019). Instead, he found they had a syndrome first described in 1938 by Adolf Stern, a German American psychiatrist (Carey, 2019). The mental state of these individuals was on the "border" between regular neurosis and complete psychosis. Dr. Gunderson made a firm diagnosis for BPD from a collection of descriptive accounts, in his collaborative 1975 study, "Defining Borderline Patients: An Overview," with Margaret Singer (Carey, 2019). This provided a foundation for continued research of BPD that did not exist, leading to BPD's inclusion as a stand-alone diagnosis in the 1980 third edition of the *Diagnostic and Statistical Manual* (Carey, 2019). In addition, he developed a diagnostic interview that set

the standard for identifying BPD (Carey, 2019). With his research came the interpersonal hypersensitivity model for BPD development.

Among the most comprehensively detailed etiological models of BPD is Linehan's (1993) biosocial theory of BPD that is based on her research that BPD comes from transactions between certain environmental influences with biological vulnerabilities and is mainly a disorder of emotional dysregulation (Crowell et al., 2009). She proposed that dysfunction is one of wide dysregulation over all features of emotional responding with the construct of emotion dysregulation including emotion-linked cognitive process, biochemistry and physiology, muscle and facial reactions, action urges, and emotion-linked actions, which eventually during emotionally challenging events leads to dysfunctional response patterns (Crowell et al., 2009). Linehan also proposed that BPD individuals learn to oscillate between extreme emotional liability and emotional inhibition instead of learning how to comprehend, label, regulate, or handle emotional responses because BPD develops within an invalidating developmental complex (Crowell et al., 2009). Linehan is the developer of evidence-based treatments for individuals' multiple, severe mental disorders and an elevated risk for suicide, including DBT (Linehan, 2014).

### *Recovery Processes and Treatment for BPD*

Recovery processes are a process of change through which a person with mental illness can strive to reach their full potential, live a self-directed life, and improve their health and wellness (SAMHSA, 2019). A life in recovery is supported by four major dimensions (SAMHSA, 2019):

1. Health: physical and emotional well-being supported by making informed, heathy decisions.

2. Home: having a safe and stable place to live.
3. Purpose: engaging in meaningful daily activities (i.e., school, job, caring for one's family, volunteering, or being creative), and working for one's income, independence, and resources to be a part of society.
4. Community: support that is provided by building social networks and relationships.

Although the recovery processes for BPD are not understood (Katsakou et al., 2019), there are numerous leading practice models found to be effective (Bliss & McCardle, 2014). Disorder-specific approaches have been developed with a better understanding of BPD (Dhaliwal et al., 2020). Most clients with BPD need treatment focused on their symptoms (Bateman, 2012), and symptom improvement is more common than previously hypothesized in individuals with BPD (Katsakou et al., 2012). However, there is a need to assess whether less complex interventions may be developed that are scalable among health systems, since summary effective treatments for individuals with BPD are scarcely available internationally (Chanen et al., 2020). In addition to diagnosis, a clinical staging model that addresses clinical distress and co-occurring psychopathology should be considered (Chanen et al., 2020).

Treatments for BPD include CBT and other behavioral therapies including DBT, MBT, MBSR, MBCT, and ACT. In borderline individuals much more attention has been given to actual occurrences of traumatic childhood experiences in recent years (Chu, 2011). Clinicians can offer borderline patients effective and compassionate treatment, making behavioral therapies effective. Using a phase-oriented or stage-oriented approach has been advocated by several clinician-investigators, and this includes cognitive-behavioral approaches (Chu, 2011). But considering which major interventions from each model (i.e., DBT, MBT, or transference-focused psychotherapy) to use for a specific client instead of considering whether to use one model

should be a consideration of clients (Bliss & McCardle, 2014).

DBT, supported by empirical research, is the preferred therapy primarily used by most clinicians to treat borderline patients. CBT offers empirically supported treatments like DBT and MBT for individuals with BPD, which aligns with a Christian worldview. Behavior therapy reminds an individual they are not totally free, even as beings created in the image of God, because of its attention to environmental control on human behavior and the significance of the contingencies of conditioning and reinforcement (Tan, 2011). From a Biblical perspective it has both strengths and weaknesses; however, it can result in sinful self-sufficiency in addition to self-efficacy and encourage skills to cope constructively with the problems an individual may experience from its attention on powerful and effective techniques for behavior change (Tan, 2011). Because a Biblical/Christian worldview and behaviorism shape this study, CBT and the evidenced-based behavioral therapies (DBT, MBT, MBSR, MBCT, and ACT) used to treat BPD were a focus of this study.

**Cognitive Behavior Therapy.** CBT incorporates components of cognitive-behavioral approach and emphasizes cognitions over behaviors (Seligman & Reichenberg, 2014). Key figures of CBT are Albert Ellis, who founded rational emotive behavior therapy, and A. T. Beck, who founded cognitive therapy (Corey, 2009). Stressing the role of thinking and belief systems as the root of personal problems, rational emotive behavior therapy, one of the first cognitive behavior therapies, is a highly didactic, cognitive, action-oriented therapy (Corey, 2009). Thinking as it influences behavior is the primary role of cognitive therapy (Corey, 2009).

Not specific to one approach, CBT is a combination of many techniques and treatments sharing the common principle that behaviors and feelings are caused by thoughts instead of external circumstances (Seligman & Reichenberg, 2014). CBT is a short-term treatment

approach that combines both behavioral and cognitive principles and methods (Corey, 2009). CBT is time-limited and brief, structured to rely largely on psychoeducation cognitive tools (i.e., the inductive method and Socratic questioning; Seligman & Reichenberg, 2014). Homework between sessions is an important part of CBT used to help individuals progress and apply what they have learned (Seligman & Reichenberg, 2014). Associated with exposure to trauma, several disorders have been shown to be significantly reduced by empirically based, cognitive-behavioral approach structured mindfulness interventions (Briere & Scott, 2015). For example, TF-CBT has been effective in treating children and adolescents traumatized from parental substance abuse (Cohen & Mannarino, 2020).

**Dialectical Behavior Therapy.** Developed by Linehan for treating individuals with BPD, DBT is a mix of behavioral and psychoanalytic techniques that emphasizes the importance of the psychotherapeutic relationship, client validation, the etiologic importance of the client as a child experiencing an "invalidating moment," and confrontation of resistance (Corey, 2009). Mindfulness training, improvement in interpersonal relationships, distress tolerance, and affect regulation are the main components of DBT (Corey, 2009). Including both individual therapy and group skills training, skills training of DBT is not a quick fix approach and normally requires at least 1 year of treatment and a behavioral contract (Corey, 2009).

A comprehensive resource for clinicians who treat clients with BPD, Linehan's (2014) *DBT Training Manual* provides important tools for implementing DBT skills training. The manual gives thorough instructions for orienting clients diagnosed with BPD to DBT (Linehan, 2014). Included are reproducible worksheets, handouts, and teaching notes for a complete range of distress tolerance skills, emotion regulation, interpersonal effectiveness, and mindfulness for use by clinicians (Linehan, 2014). Since all clinicians who work with BPD clients may not have

DBT training, it is significant that clinicians have a knowledge of "borderline" behavior (Chugani, 2016). In other words, a knowledge that the client's behavior was allowed to develop and be reinforced by experiences they had throughout their life; the clinician can then use interventions that may be more effective and validating of those experiences that may be facilitated by the clinician (Chugani, 2016). To provide consistent, effective, and coherent therapy, adherence to the dialectical and behavioral theoretical foundations of DBT could be used as an integrative approach (Chapman et al., 2011).

Multiple researchers have supported the effectiveness of DBT in treating BPD and trauma. In treating nonsuicidal and suicidal self-harm, there is much research that supports the efficacy of using DBT and prolonged exposure for both veteran and nonveteran individuals (Scheiderer et al., 2017). This integration of both therapies is because of clinical complexities such as constraints on treatment settings, substance abuse, and nonsuicidal self-injury (Scheiderer et al., 2017). Moreover, adolescents may have a higher risk for self-injury and difficulties with self-regulation, which DBT for adolescents has been shown to improve (Yeo et al., 2020). In terms of treatment models, therapeutic intervention may be more effective with DBT, as the needs of clients with BPD are not always addressed successfully in assertive community treatment (Drake & Deegan, 2008, as cited in Burroughs & Sommerville, 2013).

**Mentalization-Based Therapy.** MBT was developed to be effective and universally available due to the increased suicide rates and prevalence among BPD individuals (Bateman & Fonagy, 2010). From his research of the failed mentalization model for BPD, Fonagy was instrumental in the development of MBT (Allen & Fonagy, 2006). Bateman and Fonagy's (2016) *Handbook of Mentalizing in Mental Health Practice* is devoted to encouraging clinicians to integrate mentalizing into their clinical practice, empirical research on the development of

mentalizing origins, and how to improve outcomes for patients by focusing on mentalizing. Mentalizing is applicable to a range of mental health conditions, including personality disorders such as BPD, trauma, eating disorders, depression, substance abuse, and psychosis (Bateman & Fonagy, 2016). MBT is a time-limited treatment that arranges interventions that promote the further development of mentalizing (Bateman & Fonagy, 2010). This improves the ability of clients to identify themselves as feeling and thinking in the context of high levels of emotional arousal and powerful bonds, helping them understand their own mental state (Bateman & Fonagy, 2010).

MBT has been shown to be an effective treatment for individuals diagnosed with BPD. Though there is limited documentation of how increasing severity of PDs affect outcomes of highly specialized treatments (Feenstra et al., 2017), mentalization is argued as a core component in the treatment of BPD because the possibility of causing injury is reduced for individuals who might have a higher degree of sensitivity to inadequate psychotherapeutic interventions in addition to addressing the main problem of the client (Allen & Fonagy, 2006). Mentalization must be the basis for successful treatment of individuals with BPD because vulnerability to interpersonal and social interaction from a fragile mentalizing capacity is thought to be a primary feature of BPD (Bateman & Fonagy, 2010). Mentalization, particularly in the context of attachment, moves numerous higher-order social-cognitive functions that support interpersonal interaction (Allen & Fonagy, 2006). Clients are helped to experience their emotions in a safe setting of therapy where they can learn to use their emotions as a guide to what is important or necessary in their lives rather than avoiding or controlling their feelings by emotion-focused therapists (Greenberg, 2011).

**Mindfulness-Based Stress Reduction/Mindfulness-Based Cognitive Therapy.** Aimed at cultivating mindfulness, sitting meditation and mindful yoga are skills taught by the MBSR approach, and a body scan mediation that helps clients observe all situations in their body is included in this approach (Corey, 2009). This approach encourages clients to practice formal mindfulness meditation for 45 minutes per day and is mainly designed to teach individuals to relate to external and internal sources of stress in constructive ways and teach them how to live in the present more fully (Corey, 2009). The MBSR program can help clients observe all body sensations, encouraging mindfulness in all areas of daily life (i.e., in eating, walking, or standing; Corey, 2009).

MBSR may not be recommended for BPD individuals in its own context but may be helpful integrated with other mindfulness-based treatments, particularly DBT (Biegel et al., 2009; Gawrysiak et al., 2018). Other studies have shown it particularly helpful with social anxiety among individuals (Stefan et al., 2018), and self-care for mental health professionals (Shapiro et al., 2007). For clinicians who treat individuals diagnosed with BPD, using MBSR for self-care would be beneficial with the challenge in treating such individuals.

Originally developed as a relapse-prevention treatment for depression, MBCT is an experiential cognitive therapy treatment approach, which uses mindfulness meditation practice while focusing on cognitive change (Seligman & Reichenberg, 2014). This treatment helps an individual to break the cycle of ruminative thoughts that erupt in a situation to solve the problems seen by them as not acceptable (Seligman & Reichenberg, 2014). Negative thoughts that stay in the mind because of avoidant or aversive thoughts are removed through the practice of acceptance and mindfulness meditation through MBCT (Seligman & Reichenberg, 2014). Delivered over an 8-week course, MBCT is a group program that is divided into two parts

(Woods et al., 2019). Attention is on making mindful awareness and attention more stable and stronger during the first half of the program, and the second half aids clients in moving toward challenging and difficult states of mood and mind by providing various cognitive exercises and mindfulness practices that build on the base of the first half (Woods et al., 2019). With discussion between clinician and client (called "inquiry") following the teaching of mindfulness practice, each session lasts 2-and-a-half hours (Woods et al., 2019).

In the study of MBCT used for clients diagnosed with depression and anxiety or with a substantial risk of suicide, researchers like Saches et al. (2011) considered the feasibility of its use for persons diagnosed with BPD. Findings on the use of MBCT on individuals with a history of suicidal depression suggest the association between depressive symptoms and suicidal thinking could be reduced with training in mindfulness, thereby significantly reducing a relapse to suicidal depression (Barnhofer et al., 2015). However, with individuals with more severe histories of suicidal thinking, though mindfulness may be beneficial, more often these individuals require quite different approaches such as DBT for clients diagnosed with BPD (Barnhofer et al., 2015).

**Acceptance and Commitment Therapy.** Helping individuals fully accept present experience and let go of obstacles are involved in this mindfulness approach that is based on acceptance and commitment, and the goal of this approach is to allow for increased psychological flexibility (Corey, 2009). In ACT cognition is accepted, and clients are taught to accept feelings and thoughts they may have tried to deny, which contrasts with cognitive behavioral approaches where cognition is disputed or challenged (Corey, 2009). Instead of fighting to controlling or modifying unpleasant feelings, ACT helps individuals accept experiences that are painful (Tan, 2011). Commitment to an individual's own values and taking

action to live by those values are emphasized along with an emphasis on acceptance (Tan, 2011). Committed action, values, self as context that is focused on a transcendent sense of self, being present, cognitive defusion, and acceptance are the six major components of ACT (Tan, 2011). Letting go of obstacles in the mind and accepting experience in the present are involved in ACT (Corey, 2009). Though there are existing treatments that have a broad evidence base for the treatment of BPD, ACT offers an alternative approach; however, more research in documenting its use for this population is needed (Morgan & Aljabari, 2019).

## Stigma Associated with a Borderline Personality Disorder Diagnosis

Research has shown a stigma associated with individuals who are diagnosed with BPD and difficulties in treating them among clinicians. It is imperative that clinicians learn to counter negative attitudes, because they can influence treatment outcomes for individuals diagnosed with BPD (Bodner et al., 2015). Stimga is still a barrier to early diagnosis of BPD in day-to-day clinical practice despite evidence for a reliable and valid diagnosis (Chanen & McCutcheon, 2013). Research suggests many clinicians avoid using a BPD diagnosis with the goal of protecting clients from discriminatory or harsh treatment practices, adding to the perception that a BPD diagnosis is controversial (Chanen & McCutcheon, 2013). This reluctance is associated not only with BPD clients' self-stigma but stigmatization among health care professionals (Chanen & McCutcheon, 2013). Moreover, stigma can lead to challenges in advances in psychiatric treatment and mental health care (Schulze, 2007).

### *Clinicians (Service Providers)*

Because this study explored the lived experiences and attitudes of clinicians toward treating BPD clients (service users) diagnosed with BPD, it is important to understand their role as a mental health service provider. The American Psychological Association (2008) defined a

service provider of counseling psychology as a general practice and health service provider specialty in professional psychology that focuses on how individuals' function in their relationships and personally at all ages of development. This includes a psychiatrist, psychologist, psychotherapist, mental health counselor, counselor, or therapist. Emotional, social, school, work, and physical health concerns individuals may experience at various stages in life are addressed by counseling psychology (American Psychological Association, 2008). Typical stresses of life as well as issues that are more severe that individuals may struggle with either individually or as part of groups, organizations, and families are focused on (American Psychological Association, 2008). Individuals with emotional, mental, and physical health problems are helped with alleviating feelings of distress, resolving crises, and improving their sense of well-being by clinicians who may also provide assessment, diagnosis, and treatment of psychological symptoms that may be more severe (American Psychological Association, 2008).

Assisted by clinicians, clients are the self-healing, engaged agents in therapy (Bohart, 2000). It is vital that clinicians understand that client involvement and the client–clinician relationship is most important in their clients' successful therapy is between them and their clients. Critical to successful therapy is the fact that active client involvement is necessary (Bohart & Tallman, 2010). Though the significance of the clinician–client relationship revolves around the idea that the corrective experience is provided by the clinician, client involvement is encouraged by a good clinician–client relationship (Bohart, 2000). Clients may be more susceptible to see their therapy as a safe space to learn and take risks if they feel related to in an empathetic, warm manner from their clinician (Bohart, 2000). This would be especially so for BPD clients, who are more cautious about their clinician–client relationship (Bohart, 2000). More significant than the clinician's professional expertise is their ability to offer their clients

hope and involve them in their therapy (Bohart, 2000).

### *Biases Toward BPD Among Service Providers*

Those diagnosed with BPD have reported feelings of being invalidated and discriminated against by mental health service providers (Carrotte et al., 2019). An experience of interpersonal conflict with a BPD client may cause negative attitudes and biases to develop in clinicians, which may cause these negative stereotypes to be applied toward other clients diagnosed with BPD (Carrotte et al., 2019). Clinicians may also experience feelings of incompetence and confusion from a lack of education and training about recovery processes and may further spread these negative attitudes and biases among other staff members (Carrotte et al., 2019). The negative attitudes of psychiatric nursing staff and other mental health professionals toward individuals diagnosed with BPD is a concern to the profession in addition to the many challenges faced in providing care for individuals with BPD (Deans & Meocevic, 2014).

Several mental health professionals, including psychiatrists, psychologists, and nurses have negative attitudes toward treating individuals with BPD regardless of evidence-based treatments for BPD clients (Bodner et al., 2011). These attitudes are often harsh and negative (Shanks et al., 2011). Clinicians prefer to avoid these clients despite considering BPD a valid diagnosis (Black et al., 2011). Many pessimistic views can be generated among clinicians from the diagnostic psychiatric label of BPD in individuals (Lam et al., 2016), and BPD clients can often be a challenge for clinicians (Katsakou et al., 2012). Persons diagnosed with BPD are described by mental health nurses as the most challenging patients they encounter in their practice (Bland & Rossen, 2005).

Even among enthusiastic clinicians who are willing to treat BPD, because of the clients' neediness due to insecure attachments and intolerance of aloneness, even a caring clinician

willing to make special efforts to be available become frustrated and set limits on their availability (Gunderson, 1996). This in turn can cause the BPD client to feel betrayed, which may lead to flight or suicidal gestures, resulting in the discouragement among clinicians to want to treat these clients (Gunderson, 1996). Regardless of the therapeutic approach of clinicians, the counter-transference reactions are systematically related to the pathology of clients' personality (Bodner et al., 2015). For these reasons, a process of consistent, dependable, and durable availability is needed in the correction of the BPD client's disturbed forms of attachment (Gunderson, 1996).

Many BPD clients are not able to access appropriate care because of perceptions of mental health professionals (Links et al., 2015). Therefore, postgraduate psychiatric and other mental health worker training should include explicit stigma education (Abbey et al., 2011). Reducing stigmatizing attitudes and behaviors on mental health and illness can be done by integration of exposure through role play, lectures, and co-taught seminars with individuals who have recovered from mental illness (Abbey et al., 2011). To minimize stigma of individuals with mental illness, assertive action and honest reflection should be taken by the nursing profession (Ross & Goldner, 2009). To identify clinical interventions and proper service frameworks that aid in more effective clinical management of individuals with BPD, more research is needed (Deans & Meocevic, 2014).

### *Barriers to Recovery Processes and Challenges to Treatment Among BPD*

Most individuals with BPD want recovery, not only for their specific behaviors and symptoms, but to meet a variety of recovery outcomes (Mohi et al., 2018). Individuals with BPD want recovery for their health and well-being and close relationships with romantic partners, friends, and family (Mohi et al., 2018). But because of the challenges in treating individuals,

negative attitudes, and the stigma associated with a BPD diagnosis among health care providers, BPD clients encounter barriers to recovery processes and treatment. Examples of these barriers and challenges include being seen as lying, resource-wasting, seeking attention, or being manipulative by service providers or (Veysey, 2014, as cited in Carrotte et al., 2019); feeling shunned by service providers; or experiencing longer waiting times when seeking treatment for harming themselves (Carrotte et al., 2019). BPD service users also often experience "long, non-linear journeys" with recovery processes and treatment impacted by systemic barriers and stigma (Carrotte et al., 2019).

Because there is such a gap in research on the attitudes and biases among clinicians, especially those who treat clients with BPD, it is important to understand BPD and the stigma that is associated with a BPD diagnosis. Stigma can interfere with wellness, health, living independent, and goals that are significant to work, having a harmful and notable impact on individuals diagnosed with serious mental illness (Corrigan et al., 2010). Stigma leads to a high prevalence of unemployment among individuals with BPD, adding to their failing mental and physical health and social exclusion (Juurlink et al., 2019). Access to mental health care is also compromised for BPDs due to the widespread stigma that produces major health inequities for these individuals (Klein et al., 2021). Finding treatment can be impacted by the fear of being judged (Bartsch et al., 2016). How clinicians tolerate the emotional reactions, thoughts, and actions of individuals diagnosed with BPD can be affected by the associated stigma (Aviram et al., 2006). The prevalent self-injuring behaviors and high suicidality of individuals with BPD is a significant challenge for health care providers in the care of this population (Antai-Otong, 2016).

The degree of which an individual can improve is also placed with a BPD diagnosis (Ferentz, 2015). This diagnosis creates powerful counter-transferential responses among

clinicians and is seen as a death sentence, since BPD is code for "hopeless" among many mental health clinicians (Ferentz, 2015, p. 13). But changing the label to something like "trauma survivor" should be what is meant by a BPD diagnosis and could create more hopeful and empathetic responses from clinicians instead of the negative counter-transferential responses that are caused by the BPD label.

## Summary

The theoretical framework that guided this study, SCT and TLT, were discussed in this chapter. The review of the literature also supports addressing the gap in research among clinicians' lived experience and attitudes in treating individuals diagnosed with BPD. Closing the gap in this research would continue to further the theoretical basis for framework and development of anti-stigma intervention approaches for clinicians who treat BPD. Expert theorists who have made large contributions in diagnosis and assessment, scientific research, and development of therapeutic approaches for treatment of individuals with BPD were also examined.

Review of related literature of service users diagnosed with BPD were examined in addition to diagnosis and recovery, adolescents and young adults, the relationship of childhood trauma, clinicians and caregivers, recovery processes and treatment, and challenges to recovery processes and treatment. Review of related literature of individuals diagnosed with BPD provides a foundation to close the gap in research of mental health providers. In order to create ways to reduce the negative impact of stigma, it is necessary to utilize the experiences and perspectives of health care providers (Huggett et al., 2018). Further research among this populations' lived experiences and attitudes who treat these individuals may lead to further development of anti-stigma interventions for health care providers and pave the way for better

access to care and treatment among BPD individuals.

# CHAPTER THREE: METHODS

## Overview

The aim of this qualitative, transcendental phenomenological study was to focus on the lived experience of licensed clinicians with at least 5 years' experience treating individuals with BPD. Specifically, I explored clinicians' perspectives on common experiences regarding clinicians' BPD clients, what successes and challenges were experienced by clinicians that led to their attitudes and perspectives toward treating BPD, and what perspectives they hold regarding what resources and education are available to help clinicians overcome the stigma to work with this population. Clinicians were included from those who are licensed to practice in the Greater Triangle (Raleigh, Durham, Chapel Hill, and surrounding areas) of North Carolina who have treated individuals with BPD. Data were collected through participant interviews, recording of the interviews, and field notes of observations. Using the simplified version of Moustakas' Modified Stevick-Colaizzi-Keen Method, phenomenological data analysis was conducted (Moustakas, 1994). Data were coded for significant phrases, and meanings were developed that were clustered into themes that I then presented as an exhaustive description of the phenomenon (see Creswell & Poth, 2018).

## Design

Because this study involved understanding the lived experiences of licensed clinicians, a qualitative design was chosen as opposed to a quantitative design, since comprehending the complexity of individuals lives by examining individual perspectives in context is involved in a qualitative study (Heppner et al., 2016). The process by which people make and provide meanings to their lived realities and social experiences is especially stressed by qualitative methodology in which the significance of context in helping people understand a phenomenon of

interest is emphasized (Heppner et al., 2016). Using a qualitative design allowed me to capture the clinicians' points of view through interviews and observations (Heppner et al., 2016).

Of the five qualitative approaches—narrative, phenomenological, grounded theory, ethnographic, and case study(Creswell & Poth, 2018)—a phenomenological approach was chosen as most suited for this study. The research focus and research problem for the narrative research approach involves exploring the life of a person and telling stories of firsthand experiences. Phenomenological research focuses on understanding the essence of the experience and the research problem involves describing the essence of a lived phenomenon. The ethnographic research approach involves describing and interpreting a culture-sharing group and describing and interpreting the patterns shared of culture of a group. Grounded theory involves developing a theory grounded in data from the field and grounding a theory in the views of the study's participants. Finally, developing an in-depth description and analysis of a single or many cases and providing an in-depth comprehension of a case or cases are involved in the case study approach (Creswell & Poth, 2018). The phenomenological approach allowed for more thorough focus on participants' experience with individuals diagnosed with BPD and allowed for a better understanding of their attitudes and beliefs. This approach was valid for this study because it focused on describing what clinicians have in common as they experienced the phenomenon of treating clients with BPD.

Most of Moustakas's (1994) procedures were followed for the research process of this phenomenological study. These included finding a topic and question that involved importance and social meanings and are rooted in autobiographical values and meanings; carrying out a thorough review of the research and professional literature; creating a set of topics or questions to lead the interview process; carrying out and recording of the long one-on-one interview and

paying attention to a bracketed question and topic allowed for a follow-up interview if required; and analyzing and organizing collected data aided a synthesis of structural and textural essences and meanings, a composite structural description, a composite textural description, and construction of individual structural and textural descriptions. These met the disciplined, organized, and systematic study requirements of this study. The epoche process was also followed to set aside any preconceived ideas, prejudices, or biases.

## Research Questions

Central Question: How do clinicians in North Carolina describe their experience in working with BPD clients?

Research Question 1: How do clinicians describe the successes in dealing with BPD clients?

Research Question 2: How do clinicians describe the challenges in working with BPD clients?

Research Question 3: How do clinicians describe resources (e.g., education and training) available to them to treat BPD clients?

## Setting

Licensed clinicians who practice in the Greater Triangle (Raleigh, Durham, Chapel Hill, and surrounding areas) of North Carolina who treat individuals with BPD were used as interviewees. One-on-one interviews via Liberty University's approved online meeting platform, Microsoft Teams, were conducted. All participants had a minimum of 5 years' experience treating clients with BPD and were to articulate their lived experiences (see Creswell & Poth, 2018). Because the study took place using Liberty's approved online platform, Covid-19 restrictions did not present a challenge to the research setting.

## Participants

For this study, five participants (appropriate for saturation for this study) were used. Permission was gained from the Liberty University Institutional Review Board (IRB) prior to recruitment. Criterion sampling was used in this study, because it is when participants represent those who have experienced the phenomenon, which was useful for quality assurance in this study (Creswell & Poth, 2018). The population sampling criterion for this study were clinicians who are practicing licensed clinicians with at least 5 years of experience treating individuals with BPD. After gaining permission and approval from the IRB (Appendix A), licensed clinicians from the Greater Triangle area of North Carolina who met inclusion criteria were recruited. Snowball sampling was used to find participants for this study among clinicians sampled, first using participants known to me after gaining their permission from them through email of a permission request letter (Appendix B) and finding other participants on a referral basis from participants' participant referral lists (see Appendix C; Creswell & Poth, 2018). Recruitment of participants was through email of a participation recruitment letter (Appendix D) and participant recruitment questionnaire (Appendix E). A consent form (Appendix F) was given to participants 1 week prior to their scheduled interview to be signed and returned at the time of the interview. All participants had lived experience in treating clients with BPD and were able to articulate their experiences. Participation was voluntary with no monetary compensation.

## Procedures

A research plan was submitted to the Institutional Review Board (IRB). Observation of participants was conducted as a participant during the interview process while interviewing with a digital journal and field notes taken during interview process (Creswell & Poth, 2018). Research was analyzed from the digital journal and field notes taken during the interview process

and transcription of recorded interviews through Microsoft Teams recording and the transcription service Speechpad (Creswell & Poth, 2018). Procedural steps in this study for preparing and conducting interviews were as follows (Creswell & Poth, 2018):

- Following proper interview procedures and protocol, a set of interview semi-structured open-ended questions were designed and functioned as a procedural guide.
- Research questions that were answered by interviewees were determined.
- Adequate recording procedures were used to collect data when conducting one-on-one interviews.
- A distraction-free web-based platform Microsoft Teams was used.
- Prior to the interview, a recruitment letter (Appendix C) and consent form (Appendix D) approved by the IRB sent via email, were used to obtain consent from interviewees to participate.
- Transcription logistics for data collection and analysis included the use of Microsoft teams to record participant interviews, the web-based service Speechpad was used to transcribe data collection from participants' interviews, and the computer software MAXQDA was used to organize and prepare data to be analyzed.

Procedures included phenomenological data analysis. For this approach, data was analyzed for significant phrases, meanings developed, and clustered into themes (Creswell & Poth, 2018). It involved individual experiences described by the researcher with the phenomenon in this study, developing a list of significant statements and grouped into broader units of information, creating a description of "what" the participants experienced with the phenomenon

and “how” the experience happened, and writing a composite description of the phenomenon (Creswell & Poth, 2018). Following the steps of this approach were important so that focus could be directed to the participants, describing individual experiences allowed the researcher to set them aside, though could not be done completely (Creswell & Poth, 2018).

Listing significant statements (horizontalization of the data) and treating them as having equal worth that were found in the interviews and other data sources about how individuals experienced this topic and grouping them into larger units called themes or meaning units provided I the foundation for interpretation since it removed repetition and created clusters (Creswell & Poth, 2018). Using what is called a textural description of participants experiences, creating a description of what happened included verbatim examples (Creswell & Poth, 2018). Using what is called a structural description, I reflected on the context and setting where the phenomenon was experienced (Creswell & Poth, 2018). Representing the culminating aspect of this phenomenological study and considered the “essence” of this experience, a composite description was incorporated both the textural and structural descriptions (Creswell & Poth, 2018).

## The Researcher’s Role

I had lived experiences with the stigma of a BPD diagnosis and the negative attitudes and biases it may have caused. As a former at-risk high school counselor, I have also referred students to clinicians and found finding therapists for students difficult at times. Diagnosis of adolescents and young adults was difficult at best, and clinicians who were hesitant to treat adults with BPD were even more hesitant to treat adolescents and young adults diagnosed with BPD. My Christian worldview may have also had an impact on this study. Through bracketing, any biases or preconceptions from lived experiences were set aside to understand the view of

participants, clinicians who treated BPD individuals (Moustakas, 1994, as cited in Creswell & Poth, 2018; van Manen, 1990, as cited in Bloomberg & Volpe, 2019). This helped to develop relationships and patterns of meanings through studying a small number of participants (Moustakas, 1994, as cited in Bloomberg & Volpe, 2019).

## Data Collection

Data collection for this study was through participant interviews, observations (direct and indirect), and documentation (verbatim transcription of participant interviews and notes taken from direct and indirect observations). A focus group of participants to discuss findings was not used due to participation issues. Member checking allowed for credibility and internal validity of data collected (Bloomberg & Volpe, 2019). Using the online platform Microsoft Teams as a resource to conduct interviews of participants remotely provided participants with space and time flexibility that gave more time to consider and respond to information requests and had the advantages of time and cost efficiency and data transcription and cost of travel (Creswell & Poth, 2018). This helped make a non-threatening environment for participants where they could have a deeper reflection of the topics discussed and provided more ease for them to discuss sensitive topics (Creswell & Poth, 2018). Most important, for participants who may have been marginalized from qualitative research due to disability, language or communication barriers, practical restraints (such as Covid-19 restrictions and social distancing), online data collection offered an alternative for those hard-to-reach groups (Creswell & Poth, 2018).

### Interviews

This study used in-depth interviews, the process for collecting information in a phenomenological study (Creswell & Poth, 2018). One-on-one interviews were conducted via the web-based platform, Microsoft Teams. Clinicians who are licensed to practice in the Greater

Triangle (Raleigh, Durham, Chapel Hill, and surrounding areas) of North Carolina who have at least 5 years' experience treating individuals with BPD were used as interviewees. Semistructured and open-ended questions were used; semistructured questions allowed me to construct relevant interview questions and allowed participants to discuss further information relevant to this study (Peoples, 2021), and open-ended questions allowed participants to take any direction by establishing territory to be explored (Creswell & Poth, 2018). An example of interview questions (Appendix E) for this study were as follows:

1. What is/was your initial reaction or thoughts when presented with working with a client diagnosed with BPD?
2. Share your experience in working with BPD clients.
3. What common themes have you experienced among your BPD clients?
4. What successes in working with your BPD clients have you encountered?
5. What challenges in working with your BPD clients have you encountered?

**Observations**

Observations were conducted by me as a participant during the interview process as an observer (see Creswell & Poth, 2018). Videotape of the interviews and field notes of observations were digitally documented. The web-based service Speechpad was used to transcribe data from participants' interviews, and the computer software MAXQDA was used to organize and prepare data to be analyzed.

**Follow-Up Focus Group**

A focus group of participants to discuss findings after their review of transcripts was not conducted to discuss findings due to participation issues. This would have been beneficial for participants to share their experiences and feel more supported to discuss findings that may be

difficult to discuss (Peoples, 2021). However, using member checking provided credibility and internal validity of accuracy and interpretation of participant transcripts (Bloomberg & Volpe, 2019).

## Data Analysis and Reflection

### Phenomenological Data Analysis

Phenomenological data analysis was conducted using the simplified version of Moustakas's Modified Stevick-Colaizzi-Keen Method (Creswell & Poth, 2018). Since qualitative data analysis, especially transcendental phenomenological qualitative data analysis, involves a large amount of researcher judgment (Amanfi, 2019), MAXQDA was used to help evaluate and interpret the qualitative text (Creswell & Poth, 2018). Data were analyzed for significant phrases, then I developed meanings and clustered them into themes. Listing significant statements (horizontalization of the data) and treating them as having equal worth that were found in the interviews and grouping them into larger units called themes or meaning units provided the foundation for interpretation since it removed repetition and created clusters.

### Phenomenological Reflection

Using what is called a textural description of participants experiences, I created a description of what happened included verbatim examples. Using what is called a structural description, I reflected on the context and setting where the phenomenon was experienced. Representing the culminating aspect of this phenomenological study and considered the "essence" of this experience, a composite description incorporated both the textural and structural descriptions. I developed a list of significant statements and grouped them into broader units of information, creating a description of "what" the participants experienced with the phenomenon and "how" the experience happened, which created a composite description of the

phenomenon. Following the steps of this approach was important so that focus could be directed to the participants. This also involved bracketing personal biases and experiences.

## Trustworthiness

### Credibility

For the reader to understand the position from which I undertook this inquiry, I disclosed my biases, values, and experiences that were brought to the qualitative study from the beginning (see Creswell & Poth, 2018). I sought to clarify any biases and engage in reflexivity. Through this self-reflection and clarifying biases that may have been brought to this study, biases and subjective perspectives were continually monitored (Creswell & Poth, 2018).

I also solicited participants' views of credibility of the findings and interpretations (Creswell & Poth, 2018). Considered by some researchers to be a critical technique for establishing credibility, this approach involved taking back to participants the data, analyses, interpretations, and conclusions, so they could judge the credibility and accuracy of the account (Creswell & Poth, 2018). This was done for the credibility of this study through a follow-up with a transcription and through member checking to ensure participants' and their ideas were presented accurately (Bloomberg & Volpe, 2019). Additionally, the committee chair and committee member familiar with the research were utilized for an external check. This kept me honest by asking challenging questions about the methods, meanings, and interpretations (Creswell & Poth, 2018).

### Dependability

I made sure this research process is logical, traceable, and clearly documented for dependability (Creswell & Poth, 2018). Though not assessed through statistical procedures, dependability paralleled with the quantitative notion of reliability (Creswell & Poth, 2018). To

address and support the dependability of this study, satisfactorily tracking all the procedures and processes used to collect and interpret the data was achieved through triangulation and sequencing of methods and an audit trail (thorough and detailed explanations of how data were collected and analyzed by keeping a well-maintained clear record of transcripts and field notes; Creswell & Poth, 2018).

### Transferability

To the extent this research will relate to the broader population, showing the applicability of this research can make it possible for connections across studies (Creswell & Poth, 2018). Transferability makes it possible for readers to decide if similar processes will work in their own communities and settings (Creswell & Poth, 2018). Through thick descriptions transferability was assessed by completely describing this study's setting, participants, and related experiences (Creswell & Poth, 2018). This created a way for communicating a whole and comprehendible picture and allowed readers to form contextualized meaning (Creswell & Poth, 2018).

## Ethical Considerations

Reporting was tailored to diverse audiences, with language aimed at target audiences with clarity in mind (see Creswell & Poth, 2018). Honest and trustworthy reports were also created by avoiding falsifying authorship, evidence, data, findings, and conclusions (see Creswell & Poth, 2018). The *Publication Manual of the American Psychological Association* (APA, 2020) was followed to avoid plagiarism (Creswell & Poth, 2018).

In terms of data, names were masked, and aliases were assigned to avoid disclosing information that could cause harm to participants (Creswell & Poth, 2018). Composite participant profiles were created for situations where data may have been identifiable to a source (Creswell & Poth, 2018). Opportunities for sharing procedures and results and member-checking

were also embedded to limit access to analysis procedures and lack of agreement about how findings will be represented (Creswell & Poth, 2018). Multiple perspectives reflective of a complex picture were presented when siding to avoid siding with participants and only disclosing positive results (Creswell & Poth, 2018).

## Summary

An outline of methods and design of this research, a qualitative design with a transcendental phenomenological approach, was provided in this chapter. Research questions were detailed, along with a description of the setting, participants, procedures, interviews, observations and document analysis, and data analysis and reflection. Trustworthiness and ethical considerations were also detailed.

# CHAPTER FOUR: FINDINGS

## Overview

The purpose of this qualitative transcendental phenomenological study focused on the lived experience of licensed clinicians with at least 5 years' experience treating individuals with BPD. I aimed to find clinicians' perspectives on their lived experiences treating BPD clients; what common themes, successes, and challenges were experienced by clinicians that led to their attitudes and perspectives toward treating BPDs; and what perspectives they hold regarding what supports (resources, education, and training) are available to help clinicians overcome the stigma to work with this population. This research is necessary in helping to remove barriers to recovery processes and challenges to resources and treatment for persons diagnosed with BPD. Chapters 1 and 2 of this study offered an introduction and review of the related literature, identifying the research problem, and the methodology of this study was described in Chapter 3.

Data were collected through participant interviews, observations (direct and indirect), and documentation (verbatim transcription of participant interviews and notes taken from direct and indirect observations). Data analysis was conducted by coding and theme analysis from which emerging themes were identified, which are described in this chapter. Prior to conducting data analysis using the software MAXQDA, data were organized and prepared by breaking up data files according to the research questions guiding this study. Methods used for data collection and organization allowed corroboration of data from participant interviews and successful import of data into MAXQDA. Interview questions were developed in relation to this study's research questions, with participant interview transcripts were organized into transcript files pertaining to each research question:

- Central Question: How do clinicians in North Carolina describe their experience

in working with BPD clients?

- Research Question 1: How do clinicians describe the successes in dealing with BPD clients?
- Research Question 2: How do clinicians describe the challenges in working with BPD clients?
- Research Question 3: How do clinicians describe resources (e.g., education and training) available to them to treat BPD clients?

## Participants

Snowball sampling was used to find participants among clinicians sampled, first using a convenience sample of those who met the parameters of this study. Five participants, licensed clinicians from the Greater Triangle area of North Carolina who met inclusion criteria, were asked to participate in this study. Though many attempts were made to recruit more participants, these were unsuccessful. However, saturation and common themes were gleaned from the research participants.

Participants' real names were not used for identification. They are identified as P1–P5 to protect their identity. All five participants were licensed clinicians, two in their 40s and three in their 50s, and all females. The criteria to participate in this study was met by all five participants having at least 5 years of experience in treating BPD clients and practice in the Greater Triangle Area of North Carolina.

### P1

P1 was a 56-year-old female licensed clinical mental health counselor supervisor, a national clinical counselor, and certified clinical trauma professional, and owner of a clinical practice with more than 10 years' experience treating BPD clients. Utilizing CBT, DBT, solution

focused brief therapy, ACT, cognitive processing therapy, mindfulness, motivational interviewing, TF-CBT, EMDR, and internal family systems (IFS), she treats adolescents 14-years-old and up and adult clients suffering from trauma, emotional dysregulation, bipolar, and borderline. She holds a Bachelor of Arts degree in Psychology and a masters in counseling and has EMDR Level 1 training.

**P2**

P2 was a 43-year-old female licensed clinical social worker (LCSW) and therapist in a clinical practice with more than 5 years' experience working with BPD clients. Her treatment approach utilized mindfulness techniques, CBT, DBT, cognitive processing therapy, IFS, and attachment theory, psychodynamic work and spirituality. She offers treatment to adolescents, adults, and families. She holds a masters in social work and has been a practicing clinician for over 9 years.

**P3**

P3 was a 52-year-old female LCSW with over 18 years' experience providing clinical assessment and over 10 years' experience in private practice and treating BPDs. Utilizing CBT and IFS, she treats children, adolescents, adults, and families. She previously worked in child protective services working with intact families, children and families within the foster care system, adoptive/foster parents, and community agencies. She holds a masters in social work and has received specialized training in trauma, loss, and grief.

**P4**

P4 was a 48-year-old female LCSW and therapist with over 18 years' experience in clinical practice and treating BPD. Working in a clinical practice, she utilizes CBT and family therapy to treat children, adolescents, adults, families, and couples. As an Army veteran, she also

works with military personnel and their families. Trained in TF-CBT, she also works with clients who have experienced traumatic life events. She holds a masters in social work.

**P5**

P5 was a 52-year-old female LCSW and therapist with over 24 years' experience in clinical practice and over 17 years' experience treating BPD clients owning her own practice. Utilizing CBT and specializing in DBT, she treats adolescents and adults. She began her career as a social worker and began her clinical career in a long-term mental health facility before entering private practice. She holds a masters in social work and is certified in DBT, having been trained by an individual who was trained under Dr. Marsha Linehan.

## Results

This study examined the lived experience of licensed clinicians who work with BPD clients, aiming to find common themes experienced by clinicians regarding clinicians' BPD clients, what challenges and successes experienced by clinicians led to their attitudes and perspectives toward treating BPD clients, and what perspectives clinicians had regarding what resources (e.g., education and training) that are available in helping clinicians work with BPD clients. The results detail data collected from individual interviews, direct observations during participant interviews, indirect observations through review and repeated review of audio and video of participant interviews and reading and rereading of participants' interview transcripts, and notes and memos.

The data were analyzed using the simplified version of Moustakas' Modified Stevick-Colaizzi-Keen Method (Creswell & Poth, 2018). The data were analyzed for significant phrases and meanings that were clustered into themes. I first created and organized data using MAXQDA. A list of significant statements was then developed and grouped into broader

meaning units or themes of information. A textural description (including verbatim examples) of "what" the participants experienced with the phenomenon was created. A structural description of "how" the experience happened was also drafted, reflecting on the setting and context of the experienced phenomenon. A composite description of the phenomenon was written incorporating both the textural and structural descriptions.

Data analysis results are presented in this section under the two headings: theme development and research question responses. Thematic code categories and subcategories and emerging themes and subthemes as they relate to this phenomenon were organized under the first heading of this section. The concluding answers to the research questions that guided this study under the second heading.

**Theme Development**

Evidence for this study was collected from all participants in remote online interviews via Microsoft Teams, documentation, and direct and participant observations. To minimize any bias, positive and negative participant perspectives were included from participants' perspectives in analysis. Data analysis began with viewing and listening to individual video and audio recordings of participant interviews and reading and rereading of participants' interview transcriptions and observation notes taken during the interview and review of data. Each participant interview was listened to at a minimum of four times, taking notes and memos of observations while observing and listening to the audio and video recorded interviews. Data files of interview transcripts were broken up according to the research questions guiding this study and imported into MAXQDA after data were organized and prepared.

Though clinician participants' experiences may have differed, there were similar thematic factors that connected participants' experiences. After using MAXQDA software to organize and

code themes, sort and condense codes, codes were analyzed for commonalities and deeper meanings from which the three themes and 14 subthemes emerged:

1. Self-awareness: (a) fear of working with a BPD client, (b) lack of understanding of a BPD diagnosis, (c) self-assessment of their own ability and training, and (d) the importance of the BPD therapeutic relationship.
2. Commonalities: (a) difficulty seeking or finding treatment and recovery processes misdiagnosis of BPD, (b) comorbidity and co-diagnoses, (c) history of childhood trauma, (d) BPD characteristics among BPD clients, (e) difficulty with the therapeutic relationship, (f) successes with empirically supported treatments and therapies.
3. Supports: (a) specialized BPD resources, education, and training beyond degree, (b) specialized trauma resources, education, and training, (c) supportive advice to new clinicians from experienced clinicians, (d) more resources needed at the degree level

The three themes emerged from the findings from participant interviews, participants' verbatim interview transcriptions and observation notes taken during the interviews and review of data in this study that were initially arranged under seven thematic code categories: initial reactions, overall experience, common themes, successes, challenges, resources and education, and recommended resources and education. Theme 1 emerged from the initial reactions and overall experience thematic codes; Theme 2 from common themes, successes, and challenges thematic codes; and Theme 3 from resources and education and recommended resources and education thematic codes (see Table 1).

**Table 1**

*Themes with Definitions and Thematic Codes with Definitions*

| Themes | Theme Definitions | Thematic Codes | Thematic Code Definitions |
|---|---|---|---|

| | | | |
|---|---|---|---|
| Self-Awareness | Clinicians' self-awareness of lived experiences toward treating BPD clients. | Initial Reactions | Initial reactions of clinicians toward treating BPD clients. |
| | | Overall Experience | Overall experience of clinicians working with BPD clients. |
| Commonalities | Common themes found among clinicians' BPD clients. | Common Themes | Common themes among clinicians' BPD clients. |
| | | Successes | Successes among clinicians treating BPD clients. |
| | | Challenges | Challenges among clinicians treating BPD clients. |
| Supports | Supports (resources, education, and training for clinicians to treat BPD clients) | Resources and Education | Resources and education used by clinicians to treat BPD clients. |
| | | Recommended Resources and Education | Recommended resources and education to future clinicians to treat BPD clients. |

The number of thematic code subcategories developed within each thematic code and frequency of thematic subcategory codes across participants are in the data summary table in Appendix F. Of the seven thematic codes, the recommended resources and education theme had the greatest number of subcategory codes attached to it (12), followed by the challenges theme (11), overall experience theme (nine), initial reactions theme (eight), common themes theme (eight), successes (five), with the resources and education theme having the least (two). The total number of associated subcategory codes per participant per thematic code showed overall experience had the greatest (38), followed by recommended resources and education (35), challenges (29), common themes (28), initial reactions (22), successes (18), with the resources and education theme being least (8).

### *Theme 1: Self-Awareness*

Self-awareness is the awareness of one's own individuality or personality (Merriam-Webster, n.d.-a). For this study, this refers to the self-awareness of the participants' awareness of their own lived experiences, perspectives, and attitudes toward treating BPD clients. Theme 1, self-awareness, emerged from data analysis of the thematic codes, initial reactions, and overall experience. From the thematic subcategory code analysis of the thematic codes initial reactions and overall experience emerged the overarching subthemes for Theme 1:

1. Fear of working with a BPD client (because of stigma associated with treating clients diagnosed with BPD from other clinicians and mental health professionals because of the difficult BPD traits in BPD clients)
2. Lack of understanding of a BPD diagnosis (and other diagnoses related to a BPD diagnosis)
3. Self-assessment of their own ability and training (to be able to successfully treat BPD clients and seeing the need of more resources, education, and training to effectively treat BPD clients).
4. The importance of the BPD therapeutic relationship (handling the difficult BPD traits, setting boundaries and maintaining treatment)

Of the eight thematic subcategory codes attached to the initial reactions thematic code, fear of working with a BPD client because of stigma associated with treating clients diagnosed with BPD from other clinicians and mental health professionals had the highest appearance among participants ($n$ = 4). Handling the difficult BPD traits in BPD clients, lack of understanding and experience diagnosing clients presenting with other diagnoses and understanding BPD versus other diagnoses, feeling the BPD client will be challenging to provide

successful treatment, and clinician assessing their own ability and training to be able to successfully treat BPD clients had the second-highest appearance among participants ($n$ = 3). Difficulty setting boundaries with BPD clients, fear in BPD client seeking treatment due to stigma associated with a BPD diagnosis, and seeing the need of more resources, education, and training to effectively treat BPD clients appeared the least ($n$ = 2) among participants. Example narratives from participant interviews that relate to the first theme and these code initial reactions are as follows:

- P1: I felt a little bit out of my element and had some impostor syndrome.
- P2: There's going to be a lot of drama and they're going to be hard to work with." I don't have those feelings about it (now) because I've had so much success … So, I'm, in those first initial conversations, I'm kind of assessing some of that severity and the willingness and openness for treatment to be possible.
- P3: And typically, with that (lack of understanding and experience diagnosing BPD vs. other diagnoses), with borderline, you would typically see something like PTSD or some other kind of mood disorder.
- P4: So, I guess initially, I do kind of get a little weary, and kind of worry a little bit more than other populations I might work with.
- P5: we had two ladies in the shelter that had borderline personality disorder. And they loved me. I was also very young, at the time, and they were older … as I was getting more months into working … as soon as I started having to set limits with them, I became the devil.

The overall experience across the participants were the importance of experience and specialized training to treat BPD clients; self-harming, suicidal ideation and attempts behavior

among BPD clients; use of treatments and therapies empirically supported to treat BPD clients; history of childhood trauma or abuse among the majority of BPD clients; attachment issues and unstable relationships among BPD clients; and other common BPD characteristics among BPD clients (risk-taking, emotional regulation, etc.), followed by clients presenting with a misdiagnosis of BPD and attachment issues and unstable relationships among BPD clients. Two participants noted the importance of length of therapy and resources used for BPD clients—not short term. Narrative examples from participant interviews that relate to these code initial reactions are as follows:

- P1: So, definitely feel a lot more comfortable now. I've taken considerable amount of training, read books, collaborating with colleagues, things like that.
- P2: Also see, number one symptomatic is difficulty with emotional regulation.
- P3: Another big concern coming out of that for me is suicidality or having thoughts of suicide. So, that would be another question in my mind. "Do they have that? Is that there? And where are they with that currently?
- P4: Certainly, we know that personality disorder is more of a learned behavior, and so, you definitely learn that from trauma. So, I would say that yes and therapeutically that makes sense that there is also PTSD associated with that.
- P5: Yes, I totally agree (DBT and CBT are one of the better ones. And I'm finding there's some others that are closely related that are also successful.)

***Theme 2: Commonalities***

Theme 2 emerged from commonalties in participants' lived experiences, perspectives, and attitudes with their BPD clients and successes and challenges experienced by them in treating this population. From the thematic subcategory code analysis of the thematic codes'

common themes, successes, and challenges six overarching subthemes emerged for the second theme of this study:

1. Difficulty seeking or finding treatment and recovery processes (found among BPD clients because of the stigma associated with a BPD diagnosis)
2. Misdiagnosis of BPD, comorbidity and co-diagnoses (most often PTSD among BPD clients)
3. History of childhood trauma (childhood trauma, ACEs, and abuse among BPD clients)
4. BPD characteristics among BPD clients (self-harm, risk taking, suicidal ideation and attempts, black and white thinking, cognitive distortions, emotional regulation, anxiety issues, impulsivity, manipulative, victim mentality, unstable relationships, abandonment, and attachment issues, etc.)
5. Difficulty with the therapeutic relationship, (i.e., honoring boundaries set by the clinician among BPD clients and not completing therapy, leaving, not willing to do the therapy work among BPD clients vs. other clients)
6. Success with empirically supported treatments and therapies (i.e., BPD clients' acceptance of and overcoming stigma associated with a BPD diagnosis and seeking treatment and recovery processes, development of successful skill building and strategies among BPD clients, and BPD clients who go on to become clinicians themselves)

The highest appearance among participants for the thematic subcodes ($n$ = 5) were unstable relationships, abandonment, and attachment issues and BPD characteristics among BPD clients (self-harm, risk taking, suicidal ideation and attempts, black and white thinking, cognitive

distortions, emotional regulation, anxiety issues, impulsivity, manipulative, victim mentality, etc.) for the thematic code common themes. The second highest ($n$ = 4) was history of trauma, childhood trauma, and abuse among BPD clients and difficulty with the therapeutic relationship, (i.e., honoring boundaries set by the clinician among BPD clients) with comorbidity and co-diagnoses, most often PTSD and difficulty seeking or finding treatment and recovery processes because of stigma associated with a BPD diagnosis among BPD clients. Least high ($n$ = 2) was misdiagnosis of BPD among BPD clients and not completing therapy, leaving, not willing to do the therapy work among BPD clients versus other clients. The following are participant interview example narratives that relate to the second theme and this thematic code:

- P1: I usually find there's a sexual abuse component 75% of the time.
- P2: Oh, I'm the queen of boundary work because these folks have very porous boundaries overall because of that blurry sense of self.
- P3: What I also see is the willingness of therapists to diagnose that, I think, sometimes. Because, I'll be honest, that's something I have been hesitant to do. I often treat PTSD and, you know, sometimes I think there could be possibly that borderline personality diagnosis.
- P4: Common things I see I think are things like constant failed relationships just over and over, failed relationships whether it's intimate, personal relationships, or just work friends or friend friends just any type of relationship.
- P5: Many adults (adult BPD clients), finding that they had barriers to finding treatment, or even diagnosis because of stigma.

For the thematic code, successes, the highest appearance among participants ($N$ = 5) was success with empirically supported treatments and therapies (i.e., CBT, DBT, ACT, TF-CBT,

IFS) used to treat BPD clients. Acceptance of and overcoming stigma associated with a BPD diagnosis and seeking treatment and recovery processes, development of successful skill building and strategies among BPD clients, and stable relationships among BPDs with therapy appeared the next most often among participants ($n$ = 3), with BPD clients who go on to become clinicians themselves appearing the least ($n$ = 2). Participant interview narratives that related to Theme 2 and this thematic code are as follows:

- P1: So, if I get a lot of validation for their feelings, they tend to feel much more stable in having those feelings and being okay with them.
- P2: Yeah, when people can recognize their triggers and their patterns. When they're able to interact and disrupt those patterns.
- P3: I think when the main symptoms of whatever other, the anxiety or the depression or the PTSD symptoms, whenever there's a "learned enough strategies" to manage those, then often don't see the lack of follow through to deal with relationship and managing some of the other issues.
- P4: So, the most success I've had is when they do the work wholeheartedly, when they're open to it, when they are honest, or if I can tell they're not, but I can challenge them on it and then they kind of can open up and work through it.
- P5: I find that that level of awareness helps people to be more successful in their relationships with other people, as well as valuing themselves.

For the challenges thematic code, BPD characteristics among BPD clients (e.g., self-harm, risk taking, suicidal ideation and attempts, black and white thinking, cognitive distortions, emotional regulation, anxiety issues, impulsivity, manipulative, and victim mentality) had the highest appearance among participants for this thematic code ($N$ = 5). The second highest

responses ($n$ = 4) included therapeutic relationship problems, honoring boundaries, acceptance of diagnosis by BPD clients due to stigma associated with a BPD diagnosis, and history of trauma and not understanding of traumatic effects. This was followed by suicide of BPD client, quitting therapy and/or not willing to do the therapy work, anger and aggression toward clinician, BPD clients themselves, and misdiagnosis with BPD. Medication problems and other problems (i.e., eating disorders and substance abuse) appeared least ($n$ = 2). Participant interview narratives related to the second theme and this thematic code include:

- P1: And so, sometimes, you have to be okay with clients having the choice and the right to do what they want.
- P2: I have a client who has borderline personality, who came to me, who is actually getting their degree in this as well, because they've been doing so great in their work. They sat in a class that was taught by a social worker and the social worker went on for about 30 minutes about how awful it is to work with clients with borderline, how these people are so difficult, and you should run the other way, were her words.
- P3: Because I think a fear that I have, I'm sure other therapists do too, is because in borderline personality, you do tend to see more self-harm and more thoughts, the suicidal piece, my concern is safety, safety for my client.
- P4: And then getting them to do the work outside of therapy, which is a challenge for every single client you have, that getting them to do this work, you can't just talk in here, you have to leave and do it, you have to have your list of coping skills.
- P5: And so, but now, now when I see that there might be somebody that I'm going to see that has a borderline personality disorder, I have no problem. I mean, I think I love them, you know? I understand that their journey is their journey, and I try to

> remember not to take anything like that if there was something to come out at me, that for me not to take it personal. This is not about me, it's about their journey.

### *Theme 3: Supports*

The third theme, supports, emerged from the last two thematic codes of this study, resources and education. This was most important to this study because all participants' experiences in having more specialized training in working with BPD helped remove their fear of working with this population. The consensus was that with these supports available, more clinicians would be open toward treating BPD, thereby leading to the removal of barriers and challenges to treatment for BPD. From the thematic subcategory code analysis of the thematic codes' resources and education and recommended resources and education emerged the following four overarching subthemes for Theme 3:

1. Specialized BPD resources, education, and training beyond degree (in treatments and therapies empirically supported for BPDs)
2. Specialized trauma resources, education, and training (in treatments and therapies to treat trauma among BPD clients)
3. Supportive advice to new clinicians from experienced clinicians (who treat BPD clients and work and collaborate with other clinicians who treat BPD)
4. More resources needed at the degree level (to educate future clinicians to help remove the stigma associated with clinicians' reluctance to treat BPD clients)

The thematic code, resources and education, had only two thematic subcategory codes. All participants emphasized the importance of specialized training in treatments and therapies empirically supported for BPD beyond degree work. Specialized training in treatments and therapies for treating trauma among BPD clients had the least responses ($n$ = 3). Related

participant interview narratives to the third theme and this thematic code are as follows:

- P1: I've also taken a considerable amount of trauma training. I have a certificate in trauma that helps, that lends me more experience understanding how to manage people who come in with different types of abuse and experience trauma.
- P2: I'm currently getting trained in IFS. IFS is internal family systems. And let me just tell you, I can talk your ear off for hours about this because I'm so excited. It's taking what I've already known instinctually and now I found this is a therapeutic approach that's going to just infinitely work amazing for my clients.
- P3: Pretty much just education that I've sought out through different training…And then specifically I've done some training on self-harm and just understanding those dynamics and how to help.
- P4: So of course, going through college and graduate school, and getting your degree you learn not a ton about each specific diagnosis, but you get some. And then, I think over the years, just for me it's been, some is trial by fire. You're just in it and you have to figure it out. And then CEUs of course, just continuing it over the years.
- P5: I find it [DBT] very practical. And so, I actually have several master-level social work people who are trying for their license that I supervise, and so, I pass it on to them and start teaching them about how to engage other people working through the skills and things like that.

For the last of the thematic codes, recommended resources and education, the highest responses ($N = 5$) was for training in treatment and therapies that treat self-harming behaviors and suicide ideation prevention, CBT training, and more resources needed at the degree level to educate future clinicians to help remove the stigma associated with clinicians' reluctance to treat

BPD clients. This was followed by advice to new clinicians' who treat BPD clients and DBT training ($n$ = 4); IFS training ($n$ = 3); and learning acceptance and recovery language toward BPDs, TF-CBT training, and other therapy training successful for BPD (e.g., ACT, EMDR; $n$ = 2). The least frequency thematic subcategory code for this thematic code across participants was work and collaborate with other clinicians who treat BPDs; training to understand and treat the inner child versus adult part among BPDs; and attachment, shame, and relationship stability treatments and therapies training ($n$ = 1). Following are participants interview narratives that relate to Theme 3 and this thematic code:

- P1: And so, absolutely, education. If you find yourself in that situation, learning a lot about a DBT model is going to be incredibly helpful, because it's not unfamiliar from CBT, it's just another level beyond CBT, which most of us get in grad school.
- P2: So yeah, my trauma training, first and foremost, if I were to, again, recommend to other clinicians moving forward, do not treat borderline if you do not have expertise in trauma.
- P3: So, just being able to have some (specialized) training that helps you to feel more comfortable with understanding the (BPD) diagnosis.
- P4: I think just taking some of the continuing education, learning…So, I think that that's very helpful is just kind of focusing on your interest area, but also learning more about it, because certainly yes, you could talk to clinicians, and they're going to scare you away from that population but, you don't know until you try.
- P5: Yeah (more resources and education needed to remove the stigma). I think a lot of times when people don't have a purpose, they get all wound up and tied up in their own internal chaos that they don't see that they can...you know, that God does have a

reason for them here, and they just need to find it, so they can live it out.

## Research Question Responses

The three themes and 14 subthemes identified provided answers to the research questions that guided this study. For an overall view of the themes' subthemes see Table 2. They encompass the phenomenon of the shared lived experiences of the clinician participants who treat BPD individuals. The emerging themes and subthemes that emerged from the correlated thematic codes and thematic subcategory codes are found in Appendix G.

**Table 2**

*Theme and Subthemes*

| Themes | Subthemes |
|---|---|
| Self-Awareness | • Fear of working with a BPD client (because of stigma associated with treating clients diagnosed with BPD from other clinicians and mental health professionals because of the difficult BPD traits in BPD clients)<br>• Lack of understanding of a BPD diagnosis (and other diagnoses related to a BPD diagnosis)<br>• Self-assessment of their own ability and training (to be able to successfully treat BPD clients and seeing the need of more resources, education, and training to effectively treat BPD clients)<br>• The importance of the BPD therapeutic relationship (handling the difficult BPD traits, setting boundaries and maintaining treatment) |
| Commonalities | • Difficulty seeking or finding treatment and recovery processes (found among BPD clients because of the stigma associated with a BPD diagnosis)<br>• Misdiagnosis of BPD, comorbidity and co-diagnoses, (most often PTSD among BPD clients)<br>• History of childhood trauma (childhood trauma, ACEs, and abuse among BPD clients)<br>• BPD characteristics among BPD clients (self-harm, risk taking, suicidal ideation and attempts, black and white thinking, cognitive distortions, emotional regulation, anxiety issues, impulsivity, manipulative, victim mentality, unstable relationships, abandonment, and attachment issues, etc.)<br>• Difficulty with the therapeutic relationship, (i.e., honoring boundaries set by the clinician among BPD clients and not completing therapy, leaving, not willing to do the therapy work among BPD clients vs. other clients)<br>• Success with empirically supported treatments and therapies (i.e., BPD clients' acceptance of and overcoming stigma associated with a BPD diagnosis and seeking treatment and recovery processes, development of successful skill building and strategies among BPD clients, and BPD clients who go on to become clinicians themselves) |
| Supports | • Specialized BPD resources, education, and training beyond degree (in treatments and therapies empirically supported for BPDs)<br>• Specialized trauma resources, education, and training (in treatments and therapies to |

| | |
|---|---|
| | treat trauma among BPD clients)<br>• Supportive advice to new clinicians from experienced clinicians (who treat BPD clients and work and collaborate with other clinicians who treat BPDs)<br>• More resources needed at the degree level (to educate future clinicians to help remove the stigma associated with clinicians' reluctance to treat BPD clients) |

### *Central Question*

The central research question was "How do clinicians in North Carolina describe their experience in working with BPD clients?" Participants provided descriptions of their lived experiences in working with clients diagnosed with BPD. Clinicians' answers were descriptive and provided information regarding their initial reactions toward treating BPD clients, common themes found among clinicians' BPD clients, and their overall experiences working with BPD individuals. Table 3 represents Theme 1 with subthemes identified within this study's central research question with an example of participant responses for each subtheme.

**Table 3**

*Theme 1, Subthemes and Participant Examples within Research Central Question*

| Theme | Subthemes | Examples of Participants' Responses |
|---|---|---|
| Self-Awareness | • Fear of working with a BPD client | P1: Honestly, I was a little bit afraid. I didn't quite know what it was. |
| | • Lack of understanding of a BPD diagnosis | P5: So, when I was first told about having to work with folks that have borderline personality disorder, I was clueless. It's probably my first reaction. |
| | • Self-assessment of their own ability and training | P4: Now, I probably have the same reaction as a lot of people have, oh "Okay, this one is pre-diagnosed with that," and they're coming to me, and I'm probably more, "Oh gosh, this is going to be difficult. This is going to be a challenge?" |
| | • The importance of the BPD therapeutic relationship | P4: So, getting them to see us as an ally, I think that's a big key, |

### *Research Questions 1 and 2*

The first and second research questions were "How do clinicians describe the successes

in dealing with BPD clients?" and "How do clinicians describe the challenges in working with BPD clients?" Participants provided detailed descriptions of their lived experiences with successes and challenges in working with clients diagnosed with BPD. Clinicians' answers were descriptive and provided information regarding their perspectives and attitudes among their BPD clients. Table 4 represents Theme 2 with subthemes identified within this study's first and second research questions with an example of participant responses for each subtheme.

**Table 4**

*Theme 2, Subthemes and Participant Examples Within Research Questions 1 and 2*

| Theme | Subthemes | Examples of Participants' Responses |
|---|---|---|
| Commonalities | • Difficulty seeking or finding treatment and recovery processes | P2: Well, I got to tell you, often in that first initial phone call or first referral source when a client reaches out, they often are not disclosing borderline, which says a lot about the stigma that's out there. |
| | • Misdiagnosis of BPD, comorbidity and co-diagnoses | P5: I do think that some of them are incorrectly diagnosed with bipolar when in fact, it's more of a BPD that isn't. |
| | • History of childhood trauma | P2: Certainly, first and foremost is trauma. There's always trauma…So it shows up and it comes with the work, which is why I've had to learn how to manage it as part of working in trauma. |
| | • BPD characteristics among BPD clients | P5: I would say the black-and-white thinking and helping them to get more comfortable in the gray. For BPD clients that are constantly cutting or suicidal, I think those are very challenging, and trying to help them be able to regulate better. |
| | • Difficulty with the therapeutic relationship | P1: They fire me a lot. |
| | • Success with empirically supported treatments and therapies | P2: So many. I could scream from a mountaintop. Successes. Well, my favorite successes are those that go on to be clinical therapists themselves. |

### *Research Question 3*

The third research question was "How do clinicians describe resources (education, training, etc.) available to them to treat BPD clients?" Participants provided detailed descriptions of their lived experiences with supports (resources, education, and training) used by them and recommended to future clinicians. Clinicians' answers were descriptive and provided information regarding their perspectives and attitudes toward this theme. Table 5 represents the third theme with subthemes identified within this study's third research question with an example of participant responses for each subtheme.

**Table 5**

*Theme 3, Subthemes and Participant Examples Within Research Question 3*

| Themes | Subthemes | Examples of Participants' Responses |
|---|---|---|
| Supports | • Specialized BPD resources, education, and training beyond degree | P3: I think that would probably be good to do more specialized training, and that would be good if we had more available on the different personality disorders but specifically borderline. |
| | • Specialized trauma resources, education, and training | P2: I have taken (and recommend) Level 1 and Level 2 certified trauma specialist training. |
| | • Supportive advice to new clinicians from experienced clinicians | P4: So, definitely getting your feet wet, having other clinicians that you can speak to or supervise or whichever that you can speak to if you're stuck, if you have problems. |
| | • More resources needed at the degree level | P2: Teach about recovery and destigmatize the diagnosis overall (at the degree level)<br>P5: I would recommend more resources, while they're at the school, to go ahead and learn the different techniques that work. |

## Summary

The results of the research were presented in this chapter. A transcendental

phenomenological approach allowed this research to focus on describing what clinicians have in common as they experience the phenomenon of treating clients with BPD, allowing for a better comprehension of the attitudes and perspectives of the participants. Data were collected through participant interviews, direct and indirect observations, and documentation of verbatim participants' interview transcripts and notes taken from observations. Data analysis findings were conducted by coding and theme analysis from which emerging themes and subthemes were identified and described in this chapter. Answers to the research questions that guided this study were provided by the three themes identified.

Overall, the data gave a descriptive portrayal of the lived experiences of clinicians who treat BPD clients, who appear resilient in treating BPD clients despite the associated stigma with how difficult they may be to treat. Three themes with subthemes emerged from the data analysis that helped understand clinician participants' attitudes and perspectives toward treating BPD individuals. From their self-awareness and commonalities experienced among their BPD clients, most important from this study was participants' reorganization of the importance of supports (resources, education, and training) available to clinicians to be able to overcome the stigma among treating this population for clinicians to work with and treat BPD clients.

# CHAPTER FIVE: CONCLUSION

## Overview

The purpose of this study focused on the lived experience of licensed clinicians with at least 5 years of experience treating individuals with BPD. I aimed to find clinicians' perspectives on common themes experienced by clinicians regarding clinicians' BPD clients, what successes and challenges were experienced by clinicians that led to their attitudes and perspectives toward treating BPDs, and what perspectives they hold regarding what resources and education are available to help clinicians overcome the stigma to work with individuals diagnosed with BPD. This chapter provides (a) a summary of the findings, (b) a discussion of the findings and the implications considering the theoretical framework and review relevant literature, (c) implications (methodological and practical), (d) an outline of the study delimitations and limitations, and (e) recommendations for future research.

## Summary of Findings

The central and three research questions were answered by the data collected from the five clinician participants. Data for this research was collected through participant interviews, direct and indirect observations, and documentation of verbatim participants' interview transcripts and notes taken from observations. Data analysis was conducted by coding and theme analysis. Three themes and 14 subthemes emerged from the data analysis that helped understand clinician participants' attitudes and perspectives toward treating BPD individuals. The three main themes that emerged include:

1. Self-awareness—clinicians' self-awareness of lived experiences toward treating BPD clients.)
2. Commonalities—common themes found among clinicians' BPD clients.

3. Supports—resources, education, and training for clinicians to treat BPD clients.

Definitive answers to the central and three research questions that guided this study were provided by the seven themes that emerged from this study of participants' lived experiences treating BPD. Overall, participants' experiences described were similar to experiences found in related research on BPD, characteristics of the disorder, stigma associated with the diagnosis, and the limited related research on clinicians' perspectives toward BPD clients and treating this population.

An overview of the answers to each of the research questions follows. The central research question posed was "How do clinicians in North Carolina describe their experience in working with BPD clients?" Answers to this question were provided by the first theme that emerged from the first two thematic codes. Participants shared their experiences of their initial reactions toward treating BPD when first presented with a BPD client as an inexperienced clinician and when presented with a BPD client as an experienced clinician. They detailed their initial difficulties setting boundaries, fears of both clinicians and clients because of the stigma associated with BPD, handling the difficult BPD traits, lack of understanding and experience of BPD versus other diagnoses, challenges to successful treatment, assessment of their own ability, and seeing the need for more specialized training, resources, and education.

Views of their overall experience working with BPD clients included the importance of experience and specialized training to treat BPD, self-harming and suicidal ideation behaviors among BPD clients, use of empirically supported therapies, comorbidity and co-diagnoses among BPD clients, history of childhood trauma among BPD, clients presenting with a misdiagnosis of BPD, other common BPD characteristics among BPD, and seeing the importance of the length of therapy and resources for BPD clients. Theme 2 emerged from the

third thematic code along with the fourth and fifth thematic codes that answered the first and second research questions. The central question was also partly answered by participants' perceptions of the third thematic code, common themes among their BPD clients. Their perceptions of commonalities among their BPD clients with comorbidity and co-diagnoses included difficulty of BPD clients seeking or finding treatment and recovery processes because of the associated stigmas; misdiagnosis of BPD; history of childhood trauma and abuse, unstable relationships, abandonment, and attachment issues; BPD characteristics; difficulties with the therapeutic relationship; and BPD clients leaving therapy or unwillingness to do the work.

The first research question posed was "How do clinicians describe the successes in dealing with BPD clients?" The fourth thematic code of this study answered this research question. Participants shared their successes with use of empirically supported treatments and therapies; the acceptance of and overcoming stigma associated with the diagnosis; development of successful skill building, strategies, and stable relationships among their BPD clients; and BPD clients who go on to become clinicians themselves.

"How do clinicians describe the challenges in working with BPD clients?" was posed in the second research question and was answered by the fifth thematic code that emerged from this study. Perceptions of participants' experiences include BPD characteristics, the actual suicide of a BPD client, quitting or not willing to do the work of therapy, anger and aggression toward the clinician, problems in the therapeutic relationship, medication problems, BPD clients themselves, acceptance of the diagnosis by BPDs due to the associated stigma, other problems among BPD, history of trauma and not understanding the traumatic effects, and misdiagnosis of BPD.

Answered by the third theme of this study that emerged from the last two thematic codes, the third research question posed was, "How do clinicians describe resources (education,

training, etc.) available to them to treat BPD clients?" Participants' views pertaining to resources and education they used to treat BPD individuals were having specialized training in treatments and therapies empirically supported to treat BPDs beyond degree work and specialized training in treatments and therapies to treat trauma among BPD clients. Their views pertaining to resources and education they would recommend to clinicians and future clinicians to treat individuals diagnosed with BPD included advice to new clinicians from those experienced in treating BPDs, to work together and collaborate with other clinicians, training in treatments and therapies that treat self-harming and suicidal ideation behaviors, training to understand the inner child versus the adult part of BPD individuals, training in treatments and therapies that treat attachment, shame, and relationship stability behaviors, CBT training, DBT training, TF-CBT training, IFS training, other therapies that are successful in treating BPDs training, and agreement that more resources at the degree level to education clinicians to remove the stigma associated with treating BPD.

## Discussion

The purpose of this section is to discuss the findings of this study in relation to the empirical and theoretical research literature reviewed. It is important to understand BPD and the stigma that is associated with a BPD diagnosis, because there is such a gap in research on the attitudes and biases among clinicians, especially those who treat BPD clients. Evidence found in review of current literature in studying BPD and childhood trauma focused on the limited literature concerned with this phenomenon. Additionally, a connection between the findings of this research and the theoretical framework guiding this study, SCT (Bandura, 1989) and TLT (Mezirow, 1997), are discussed in this section.

**Empirical**

A recurring theme found from research of childhood trauma and BPD was the stigma associated with a BPD diagnosis that may lead to barriers to treatment among this population (Resick et al., 2017). Research has shown this diagnosis to be greatly stigmatized, as feelings of being invalidated and discriminated against by mental health service providers have been reported by this population (Carrotte et al., 2019). The literature review supported the need to address the lack of understanding of health care professionals versus BPD clients themselves, especially for building and delivering anti-stigma training and education for mental health care professionals (Ungar et al., 2016). Many BPD individuals cannot access appropriate care because of the challenges to recovery processes and treatment (Links et al., 2015). Gaining a better understanding from research of mental health service providers could lead to appropriate education and training to overcome negative attitudes toward BPD individuals and would be significant in solving the problem in finding recovery processes and treatment with the associated stigma.

Research was reinforced on health care professionals who care for BPD clients suggesting they are the most difficult to treat and manage in addition to the need for further education and training to help work with those individuals (Bland & Rossen, 2005). Much detail was given to participants' perceptions of their lived experience treating BPD clients, how they described the successes and challenges in treating BPD clients, and how they described resources (e.g., education and training) available to clinicians to treat BPD clients. Notably they described what led to reluctance of clinicians to treat BPD because of the perceived stigma associated with a BPD diagnosis, and the importance of and need of more resources for clinicians, especially specialized training in treating BPDs both at the degree level and post degree.

Insight was also provided on clinicians' initial reactions when presented with a BPD client and their overall experience of working with BPD. Description of participants' initial reaction of fear of working with a BPD client because of the stigma associated with treating clients diagnosed with BPD from the influence of other clinicians and mental health professionals' negative attitudes was especially significant in supporting previous research. Regardless of evidence-based treatments for BPD individuals, many mental health care professionals still maintain negative attitudes toward treating this population (Bodner et al., 2011). Even if clinicians consider a diagnosis of BPD valid, they may have negative attitudes toward BPD, preferring to avoid those clients (Black et al., 2011). From lack of education and specialized training in recovery processes and treatment to treat BPD, clinicians may experience feelings of incompetence and confusion, which may lead to and spread of negative attitudes and biases among other service providers (Carrotte et al., 2019).

In addition, the findings reinforce research that both internalizing and externalizing symptoms within BPD include abandonment fears, unstable and intense interpersonal relationships, identity disturbance, impulsivity, suicidal behaviors, affective instability, chronic feelings of emptiness, inappropriate intense anger and transient, stress-related paranoid ideation, or severe dissociative symptoms (Sharp & Fonagy, 2015). Rich, detailed descriptions of participants' perceptions was given on their overall experience treating BPD clients with all five participants describing how they see the importance of experience and specialized training to treat BPD clients; their encounters of the self-harming, suicidal ideation and attempts behavior among their BPD clients; their use of treatments and therapies empirically supported to treat BPD clients; their seeing a history of childhood trauma or abuse among the majority of their BPD clients; as well as encountering attachment issues and unstable relationships among their

BPD clients, and other common BPD characteristics among their BPD clients (risk-taking, emotional regulation, etc.). Also reiterated from participants perceptions of their overall experience with BPDs was research on BPD that it is characterized as a chronic disturbance in which there is a pervasive pattern of instability of interpersonal relationships, self-image and affects, marked impulsivity which starts by early adulthood and present in a variety of contexts (American Psychiatric Association, 2013). Perceptions and views of participants for this phenomenon reiterated the behaviors of BPD individuals, especially the high suicidality and prevalence of self-harming, to be a significant challenge for mental healthcare service providers who treat this population (Antai-Otong, 2016).

Participants also expressed perceptions of childhood trauma and not understanding of the traumatic effects on their BPD clients. Although it is not in the *DSM-5* diagnostic criteria, often there is a background of physical abuse, emotional abuse, or sexual abuse during childhood among individuals diagnosed with BPD (O'Connell & Dowling, 2014). Perceptions and view of clinician participants was further reinforced by research that has supported that ACEs are a related symptom severity in BPD, and of those who met the criteria for a BPD diagnosis in adulthood were neglected or abused during childhood (Cattane et al., 2017). This is important because post traumatic reactions to childhood trauma continue to be investigated by researchers and has shown a connection between increased risk of developing.

Clinician participants also described their success with use of empirically supported treatments and therapies (i.e., CBT, DBT, ACT, TF-CBT, IFS) with their BPD clients, their BPD clients' acceptance of and overcoming stigma associated with a BPD diagnosis, successful development of skill building and strategies among their BPD clients, and their BPD clients maintaining stable relationships. CBT, and other therapies including DBT, MBT, MBSR, MBCT,

and ACT, are supported by empirical research (Bateman, 2012), with DBT being the method primarily used. Participants' views were reinforced by TF-CBT that was developed to address the need for evaluations and interventions developed to address childhood trauma, which has been effective in treating BPD individuals (Cohen et al., 2017). Although recovery processes for BPD are not understood (Katsakou et al., 2019), there are numerous leading practice models that have been found effective in treating BPD clients (Bliss & McCardle, 2014). Regardless of the therapeutic approach of clinicians treating BPD, clinicians' understanding that client involvement and the client–clinician relationship is the most important for successful therapy between clinicians and their clients, and active client involvement is critical to successful therapy (Bohart & Tallman, 2010).

Participants also detailed their recommended resources and education for future clinicians, including training in treatment and therapies that treat self-harming behaviors and suicide ideation prevention, CBT training, and more resources needed at the degree level and after to educate future clinicians to help remove the stigma associated with clinicians' reluctance to treat BPD clients. Views on training and therapy to treat BPDs, including training to treat self-harming and suicidal ideation behaviors, were reinforced by research that showed behavioral therapies (including CBT and especially DBT) may be effective, particularly BPD individuals, and effective and compassionate treatment can be offered by clinicians (Chu, 2011). Research suggests that interventions that combine biological etiology with positive messages of potential recovery with service provider education may improve attitudes of stigma among mental healthcare professionals (Sheehan et al., 2016). Mental health care professionals can benefit from anti-stigma interventions especially designed for them (Sheehan et al., 2016). Participants' views and perspectives were also reiterated with research that recovery processes and treatments for

BPD individuals may be affect by the negative attitudes of clinicians toward BPD clients, suggesting it is imperative that clinicians learn to counter negative attitudes because of the influence they can have on treatment outcomes (Bodner et al., 2015).

**Theoretical**

SCT and TLT were the theoretical framework chosen to guide this study. There are several models that have been suggested to understand the pathogenesis and causes of BPD, since it is one of the most difficult psychiatric conditions to work with (D'Agostino et al., 2018). The chosen theoretical framework for this study was important because understanding the self-awareness of lived experiences of clinicians who treat BPD clients, the commonalities of the themes, successes and challenges encountered among their BPD clients, and the supports (resources education, and training) used by participants and recommendations for supports for future clinicians to treat BPD individuals could be beneficial in overcoming the stigma that is associated with a BPD diagnosis and help in removing barriers and challenges to recovery processes and treatment for this population. Rather than having focused on BPD clients and the pathogenesis and causes of BPD core psychopathology (D'Agostino et al., 2018), the focus on the lived experience of clinician participants who treat BPD through the chosen theoretical framework was appropriate. Studying clinicians and other mental health care professionals who treat BPD clients can provide significant findings in training future clinicians and other health care professionals to work with this population (Sheehan et al., 2016).

In this study, SCT permitted clinicians to describe how they perceived their attitudes toward treating BPD clients by employing SCT (Bandura, 1997). It also could explain and help clinicians become self-aware of biases and negative attitudes they may have toward BPD clients (Bandura, 1997). Bandura (1989) proposed that by one's own efforts to change, situations could

be affected by individuals, because judgments and actions are partially self-determined. Finding what experiences led to any negative perceptions and what perspectives participants shared and supports used and recommended by participants could be advantageous in helping remove those negative attitudes and biases among clinicians to treat this population.

Because TLT is an adult model of learning that is best described as "a comprehensive and complex description of how learners, construe, validate, and reformulate the meaning of their experience" (Cranton, 2005, as cited in Fazio-Griffith & Ballard, 2016, p. x), it could help change negative attitudes and biases of clinician toward BPD clients. Grounded in critical social theory and psychoanalytic theory, three common themes of TLT are centrality of experience, critical reflections, and rational discourse (Fazio-Griffith & Ballard, 2016). When feelings, behaviors, and ways of thinking of adults are challenged and their views and perceptions, then they can experience the greatest learning according to TLT (Mezirow, 2000). The four ways in which adult learning occurs are defined by Mezirow (2000): elaboration on current frames of reference, learning new current frames of reference, transformation of points of view, and transformation of habits of mind. This supports learning for future clinicians through specialized training, resources, and education both at the degree level and beyond among clinicians and future clinicians could remove the stigma associated with a diagnosis of BPD, which could be beneficial in removing the barriers to treatment for this population.

## Implications

The findings of this study gave a better understanding of the lived experiences of clinicians who treat individuals with BPD; their views and perspectives on common themes experienced among their BPD clients; the successes and challenges they experienced that led to their attitudes and perspectives toward treating BPDs; and the views and perspectives they hold

regarding what resources, education, and training (supports) were available to them to overcome the stigma to work with individuals diagnosed with BPD. The most notable significance of this study included supports the clinician participants used themselves to treat BPD clients, and the importance they placed on the need of more support through resources, education, and training for future clinicians at the degree level and beyond to help with more willingness among them to treat BPD individuals. This information along with the descriptive detail of their lived experience treating BPDs adds significantly to current research. Implications (empirical, theoretical, practical, and Christian worldview) on the summary of research are provided in this section.

**Empirical**

Overall, clinician participants' experiences described in Chapter 4 were related to experiences found in related research on individuals diagnosed with BPD, BPD characteristics, the stigma associated with a BPD diagnosis, and the limited related research on clinicians' perspectives toward BPD clients and in treating this population. Implications from this study reinforce research on BPD and the stigma that is associated with a BPD diagnosis among mental health care professionals (service providers) that may lead to barrier to recovery processes and challenges to treatment for BPD clients (service users). Importantly, this study reinforced the importance of more research among clinicians and other health care professionals who treat BPD individuals to help remove the stigma of a BPD diagnosis leading to challenges to treatment for this population.

**Theoretical**

Theoretical implications from the clinician participants' views and perceptions of this phenomenon be beneficial in overcoming the stigma that is associated with a BPD diagnosis and help remove barriers and challenges to recovery processes and treatment for this population.

Since the thought (learning) process that leads to action is caused by the three factors—environmental or external, personal, and behavioral (Bandura, 1986b), changing the negative attitudes through learning could be possible with more specialized training, resources, and education for clinicians and other mental health care professionals. Challenging their feelings, behaviors, and ways of thinking can lead to greater learning and a change to positive attitudes and perceptions toward BPDs (Mezirow, 2000). As stated, learning for future clinicians through specialized training, resources, and education both at the degree level and beyond among clinicians and future clinicians could remove the stigma associated with a diagnosis of BPD could be beneficial.

**Practical**

Practical implications from this study with regards to stakeholders (clinicians and other mental health care professionals who treat BPD individuals) include the need for more support of specialized resources and education for clinicians to help remove the stigma associated with a BPD diagnosis that fosters negative attitudes and biases toward treating BPDs. Clinicians especially can benefit from comprehension of this phenomenon to help change the negative perspectives and attitudes that make it difficult for BPDs to find effective recovery processes and treatment due to the reluctance of many clinicians to treat BPDs because of the stigma associated with BPD. This is especially important since often it is other clinicians who influence other clinicians to not work with BPDs because of these negative attitudes and biases.

**Christian Worldview**

Implications from a Christian worldview informs an interpretation of this study that could lead to a change in realities for clinicians and other health care professionals. Clinicians like researchers hold to different realities (Creswell & Poth, 2018). From a Biblical perspective,

humans were created in the image of God and with a free will. All humanity has one of two choices: accept or reject God. Though born with a sinful nature, because of free will, one can choose to follow God and through continual study and meditation on scripture and continual daily renewing through prayer, change in behavior from a sinful to a Godly nature can occur. Comparatively, clinicians and other health care professionals, through the learning process and change in behavior, negative attitudes and biases can be changed to positive attitudes and perspectives toward treating BPD.

## Delimitations and Limitations

Purposeful decisions were made to define the parameters and inclusion criteria of this study. Five participants, licensed clinicians from the Greater Triangle area of North Carolina who met inclusion criteria, were used for this study. Because of time constraints and full schedules, there was difficulty in finding clinician participants for the number preliminarily proposed for this study. Though many attempts were made to recruit more participants, saturation was gained for this study from the five participants. However, a follow-up focus group of participating participants to discuss findings after their review of transcripts was not conducted to discuss findings due to the lack of time in participants' schedules. This could be a limitation although credibility and internal validity of accuracy and interpretation of participant transcripts was still provided for this study using the research strategy member checking (Bloomberg & Volpe, 2019).

Additionally, of mental health care professional service providers, only clinician service providers were used for this study. Psychiatrists, nurses, general practitioners, and other mental healthcare professionals were not part of the parameters of this study. This lack of diversity among these service providers could be a limitation. Further, only gender and age were

considered for this study. Though efforts were made to have more gender diversity, a limitation to this study was only female participants willing to participate. In addition, though race was not a consideration and participants' race and ethnicity were not identified, a potential lack of diversity could also be limitation to this study.

Other potential limitations and weaknesses to this study include unknown biases and truthfulness, since participants may have had unknown biases when they were interviewed and asked to give open and honest answers to the interview questions. Though biases were put aside, I could have unknown biases. Transferability could also be a potential limitation to this study as participants in other locations may have different lived experiences in treating BPD individuals.

## Recommendations for Future Research

Designed and conducted to acquire a better understanding of clinicians' attitudes toward clients with BPD, this qualitative phenomenological transcendental study focused on the lived experience of licensed clinicians with a minimum of 5 years' experience who treat individuals with BPD. For future research, another phenomenological study could be conducted with clinicians who do not have a minimum of 5 years of experience to capture attitudes and perceptions prior to significantly treating BPD as well as a study of participants with more than 5 years of experience. This would give insight into perspectives before and after treating BPD to gain a better understanding of how attitudes and perceptions toward this population are affected by more effective training. This would allow a deeper understanding of this phenomenon.

In addition, further research of other mental health care professionals other than clinicians, such as psychiatrists, nurses, general practitioners, and others who encounter individuals with BPD such as law enforcement and first responders would be beneficial in understanding their lived experiences, attitudes, and perceptions of BPD individuals. This would

be beneficial because of the varied types of relationships they have in working with this population and would add a greater understanding of the negative attitudes and biases that lead to the stigma associated with a BPD diagnosis. This study focused on clinicians (service providers) and their lived experiences in connection with challenges to recovery processes and treatment due to the associated stigma versus BPD clients (service users). Further research and understanding of the lived experiences of service providers in these areas may also improve attitudes and perceptions and lead to a further understanding of this population and lead to the development of anti-stigma interventions for service providers.

## Summary

The objective of this study was to focus on the lived experience of licensed clinicians with at least 5 years' experience treating individuals with BPD, aiming to find clinicians' perspectives on common themes experienced by clinicians regarding clinicians' BPD clients, what successes and challenges were experienced by clinicians that led to their attitudes and perspectives toward treating BPD, and what perspectives they hold regarding what supports resources, education, and specialized training are available to help clinicians overcome the stigma to work with this population. This study provided detailed descriptions of the lived experiences of clinicians' perspectives pertaining to this phenomenon, revealing that they feel more specialized training, resources, and education for clinicians and future clinicians are necessary for overcoming the stigma of a BPD diagnosis to help remove the barriers and challenges to recovery processes and treatment for this population.

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## Appendix A: IRB Approval Email

LIBERTY UNIVERSITY.
INSTITUTIONAL REVIEW BOARD

February 8, 2023

Tracy Messina
Stacey Lilley

Re: IRB Exemption - IRB-FY22-23-783 Studying Borderline Personality Disorder and Childhood Trauma: Exploring Clinicians' Lived Experiences and Attitudes Toward Treating BPD Individual

Dear Tracy Messina, Stacey Lilley,

The Liberty University Institutional Review Board (IRB) has reviewed your application in accordance with the Office for Human Research Protections (OHRP) and Food and Drug Administration (FDA) regulations and finds your study to be exempt from further IRB review. This means you may begin your research with the data safeguarding methods mentioned in your approved application, and no further IRB oversight is required.

Your study falls under the following exemption category, which identifies specific situations in which human participants research is exempt from the policy set forth in 45 CFR 46:104(d):

Category 2.(iii). Research that only includes interactions involving educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior (including visual or auditory recording) if at least one of the following criteria is met:
The information obtained is recorded by the investigator in such a manner that the identity of the human subjects can readily be ascertained, directly or through identifiers linked to the subjects, and an IRB conducts a limited IRB review to make the determination required by §46.111(a)(7).

YOUR STAMPED CONSENT FORM(S) AND FINAL VERSIONS OF YOUR STUDY DOCUMENTS CAN BE FOUND UNDER THE ATTACHMENTS TAB WITHIN THE SUBMISSION DETAILS SECTION OF YOUR STUDY ON CAYUSE IRB. Your stamped consent form(s) should be copied and used to gain the consent of your research participants. If you plan to provide your consent information electronically, the contents of the attached consent document(s) should be made available without alteration.

Please note that this exemption only applies to your current research application, and any modifications to your protocol must be reported to the Liberty University IRB for verification of continued exemption status. You may report these changes by completing a modification submission through your Cayuse IRB account.

If you have any questions about this exemption or need assistance in determining whether possible modifications to your protocol would change your exemption status, please email us at [redacted]

Sincerely,
G. MICHELE BAKER, MA, CIP
*Administrative Chair of Institutional Research*
RESEARCH ETHICS OFFICE

## Appendix B: Participant Recruitment Letter

Dear [Recipient],

As a graduate student in the School of Behavioral Sciences at Liberty University, I am conducting research as part of the requirements for a doctoral degree. The purpose of my research is to explore the lived experience of clinicians who work with Borderline Personality Disorder (BPD) clients, to find common themes experienced by clinicians regarding clinicians' BPD clients, to examine what successes and challenges experienced by clinicians led to their attitudes and perspectives toward treating BPD clients, and to examine what perspectives clinicians have regarding what resources (education, training, etc.) are available in helping clinicians work with BPD clients. Understanding clinicians' perspectives may lead to the removal of the stigma associated with a BPD diagnosis and thereby remove the barriers to recovery processes and challenges to treatment; therefore, I am writing to invite eligible participants to join my study.

Participants must be:

- A licensed mental health clinician in the Greater Triangle Area (Raleigh, Durham, Chapel Hill and surrounding areas).
- Have at least five years' clinical experience treating BPD clients.

Participant, if willing, will be asked to:

- Sit down for a private, virtual, audio- and video-recorded interview at an agreed upon time and place that will last 30 minutes to an hour.
- After the interview is transcribed, read the transcripts so you can verify the interpretation of your words. You can comment on or alter your interview by marking changes on the transcript.
- Participate in a follow-up focus group to discuss the study's findings. This will take 45-60 minutes, be conducted virtually, and be audio- and video-recorded.

Participants' names and other identifying information will be requested as part of this study, but the information will remain confidential.

To participate please complete and sign the attached Participant Recruitment Questionnaire and return to me by email to [redacted] to schedule an interview.

A consent document will be emailed to you one week prior to your scheduled interview. The consent document contains additional information about my research. If you choose to participate, you will need to sign the consent document and return it to me at the time of your interview.

Participants will not receive financial compensation or direct benefits for participating in this study.

Sincerely,

Tracy Messina
Doctoral Candidate

## Appendix C: Participant Recruitment Questionnaire

**PARTICIPANT INORMATION:**

_____

Name of Participant Date

**QUESTIONNAIRE GUIDELINES:** Please complete each question truthfully. Circle the answer or fill in the blank.

**QUESTIONS:**

1. Are you a licensed mental health clinician practicing in the Greater Triangle Area (Raleigh, Durham, Chapel Hill and surrounding areas)? **Yes or No**

2. Do you have at least five years' clinical experience treating Borderline Personality Disorder (BPD) clients? **Yes or No**

**OPTIONAL QUESTIONS:**

3. What is your age? _____

4. What is your gender? _____

**Contact Information:**_____
**Phone**

_____
**Email**

**Email completed questionnaire to:**

**Tracy Messina**
**Doctoral Student**

## Appendix D: Consent

**Title of the Project:** Studying Borderline Personality Disorder and Childhood Trauma: Exploring Clinicians' Lived Experiences and Attitudes Toward Treating BPD Individual
**Principal Investigator:** Tracy Messina, Doctoral Candidate, Department of Community Care and Counseling in the School of Behavioral Sciences at Liberty University.

### Invitation to be Part of a Research Study

You are invited to be in a research study. To participate you must be a licensed mental health clinician in the Greater Triangle Area (Raleigh, Durham, Chapel Hill and surrounding areas) and have at least five years' clinical experience treating Borderline Personality Disorder (BPD) clients. Taking part in this research is voluntary.

Please take time to read this entire form and ask questions before deciding whether to take part in this research.

### What is the study about and why is it being done?

The purpose of my research is to explore the lived experience of clinicians who work with BPD clients, to find common themes experienced by clinicians regarding clinicians' BPD clients, to examine what successes and challenges experienced by clinicians led to their attitudes and perspectives toward treating BPD clients, and to examine what perspectives clinicians have regarding what resources (education, training, etc.) are available in helping clinicians work with BPD clients. Understanding clinicians' perspectives may lead to the removal of the stigma associated with a BPD diagnosis and thereby remove the barriers to recovery processes and challenges to treatment.

### What will happen if you take part in this study?

If you agree to be in this study, I will ask you to do the following things:

- Sit down for a private, virtual, audio- and video-recorded interview at an agreed upon time and place that will last 30 minutes to an hour.
- After the interview is transcribed, read the transcripts so you can verify the interpretation of your words. You can comment or alter your interview by marking changes on the transcript.
- Participate in a follow-up focus group to discuss the study's findings. This will take 45-60 minutes, be conducted virtually, and be audio- and video-recorded.

### How could you or others benefit from this study?

Participants should not expect to receive direct benefit from this study.

Benefits to society could include furthering the theoretical basis for a framework, and the development of anti-stigma intervention approaches for clinicians who treat BPD.

**What risks might you experience from being in this study?**

The expected risks from participating in this study are minimal, which means they are equal to the risks you would encounter in everyday life.

**How will your personal information be protected?**

The records of this study will be kept private. Published reports will not include any information that will make it possible to identify a subject. Research records will be stored securely, and only the researcher will have access to the records.

- Participant responses will be kept confidential by replacing names with pseudonyms.
- Interviews will be conducted in a location where others will not easily overhear conversations.
- Confidentiality cannot be guaranteed in focus group settings. While discouraged, other members of the focus group may share what was discussed with persons outside of the group.
- Data will be stored on a password-locked computer. After seven years, all electronic records will be deleted.
- Recordings will be stored on a password-locked computer for seven years. The researcher will have access to these recordings.

**How will you be compensated for being part of the study?**

Participants will not be compensated for participating in this study.

**Is study participation voluntary?**

Participation in this study is voluntary. Your decision to participate will not affect your current or future relations with Liberty University. If you decide to participate, you are free to not answer any question or withdraw at any time without affecting those relationships.

**What should you do if you decide to withdraw from the study?**

If you choose to withdraw from the study, please inform the researcher at the email address/phone number included in the next paragraph. Should you choose to withdraw, data collected from you, apart from focus group data, will be destroyed immediately and will not be included in this study. Focus group data will not be destroyed, but your contributions to the focus group will not be included in the study if you choose to withdraw.

**Who, do you contact if you have questions or concerns about the study?**

The researcher conducting this study is Tracy Messina. You may ask any questions you have now. If you have questions later, **you are encouraged** to contact her at [redacted] or [redacted]

You may also contact the researcher's faculty sponsor, Dr. Stacey Lilley, at [redacted]

**Whom do you contact if you have questions about your rights as a research participant?**

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher, **you are encouraged** to contact the IRB. Our physical address is Institutional Review Board, 1971 University Blvd., Green Hall Ste. 2845, Lynchburg, VA, 24515; our phone number is [redacted], and our email address is [redacted]

*Disclaimer: The Institutional Review Board (IRB) is tasked with ensuring that human subjects research will be conducted in an ethical manner as defined and required by federal regulations. The topics covered and viewpoints expressed or alluded to by student and faculty researchers are those of the researchers and do not necessarily reflect the official policies or positions of Liberty University.*

**Your Consent**

By signing this document, you are agreeing to be in this study. Make sure you understand what the study is about before you sign. You will be given a copy of this document for your records. If you have any questions about the study after you sign this document, you can contact the study team using the information provided about.

*I have read and understood the above information. I have asked questions and have received answers. I consent to participate in the study.*

☐ The researcher has my permission to audio-record/video-record me as part of my participation in this study.

_____
Printed Subject Name

_____
Signature & Date

## Appendix E: Interview Questions

**Lived experience working with Borderline Personality Disorder (BPD) clients.**

1. What is/was your initial reaction or thoughts when presented with working with a client diagnosed with BPD?

2. Share your experience in working with BPD clients.

**Common themes, challenges, and successes experienced among BPD clients.**

3. What common themes have you experienced among your BPD clients?

4. What successes in working with your BPD clients have you encountered?

5. What challenges in working with your BPD clients have you encountered?

**Resources (Supports) available to clinicians in working with BPD clients.**

6. What resources have you had (education, training, etc.) that are available in helping clinicians work with BPD clients.

7. What recommendations would you make to a new or future clinicians to work with BPD clients?

## Appendix F: Frequency of Thematic Codes and Thematic Subcategory Codes Across Participants

| Thematic Codes | Number of Thematic Subcategory Codes Per Thematic Code | Thematic Subcategory Codes | Thematic Subcategory Code Across Participants | Total Number of Associated Subcategory Codes Across Participants Per Thematic Code |
|---|---|---|---|---|
| Initial Reactions | 8 | • Difficulty setting boundaries with BPD clients | 2 | 22 |
| | | • Fear of working with a BPD client because of stigma associated with treating clients diagnosed with BPD from other clinicians and mental health professionals | 4 | |
| | | • Fear in BPD client seeking treatment due to stigma associated with a BPD diagnosis | 2 | |
| | | • Handling the difficult BPD traits in BPD clients | 3 | |
| | | • Lack of understanding and experience diagnosing clients presenting with other diagnoses and understanding BPD vs. other diagnoses | 3 | |

| | | | | |
|---|---|---|---|---|
| | | • Feeling the BPD client will be challenging to provide successful treatment<br>• Clinician assessing their own ability and training to be able to successfully treat BPD clients<br>• Seeing the need of more resources, education, and training to effectively treat BPD clients | 3<br>3<br>2 | |
| Overall Experience | 9 | • See the importance of experience and specialized training to treat BPD clients<br>• Self-harming, suicidal ideation and attempts behavior among BPD clients<br>• Use of treatments and therapies empirically supported to treat BPD clients<br>• Comorbidity and co-diagnoses among BPD clients, especially PTSD<br>• History of childhood trauma or abuse among majority of BPD clients | 5<br>5<br>5<br>3<br>5 | 38 |

| | | | | |
|---|---|---|---|---|
| | | • Clients presenting with a misdiagnosis of BPD<br>• Attachment issues and unstable relationships among BPD clients<br>• Other common BPD characteristics among BPD clients (risk-taking, emotional regulation, etc.)<br>• See importance of length of therapy and resources used for BPD clients – not short term | 3<br>5<br>5<br>2 | |
| Common Themes | 8 | • Comorbidity and co-diagnoses, most often PTSD<br>• Difficulty seeking or finding treatment and recovery processes because of the stigma associated with a BPD diagnosis among BPD clients<br>• Misdiagnosis of BPD among BPD clients<br>• History of trauma, childhood trauma, and abuse among BPD clients | 3<br>3<br>2<br>4 | 28 |

| | | | | |
|---|---|---|---|---|
| | | • Unstable relationships, abandonment, and attachment issues<br>• BPD characteristics among BPD clients (self-harm, risk taking, suicidal ideation and attempts, black and white thinking, cognitive distortions, emotional regulation, anxiety issues, impulsivity, manipulative, victim mentality, etc.)<br>• Difficulty with the therapeutic relationship, (i.e., honoring boundaries set by the clinician among BPD clients)<br>• Not completing therapy, leaving, not willing to do the therapy work among BPD clients vs. other clients | 5<br>5<br>4<br>2 | |
| Successes | 5 | • Success with empirically supported treatments and therapies (i.e. CBT, DBT, ACT, TF-CBT, | 5 | 16 |

| | | | | |
|---|---|---|---|---|
| | | IFS…)used to treat BPD clients<br>• BPDs acceptance of and overcoming stigma associated with a BPD diagnosis and seeking treatment and recovery processes<br>• Development of successful skill building and strategies among BPD clients<br>• Stable relationships among BPDs with therapy<br>• BPD clients who go on to become clinicians themselves | 3<br>3<br>3<br>2 | |
| Challenges | 11 | • BPD characteristics among BPD clients (self-harm, risk taking, suicidal ideation and attempts, black and white thinking, cognitive distortions, emotional regulation, anxiety issues, impulsivity, manipulative, victim mentality, etc.)<br>• Suicide of BPD client<br>• Quitting therapy and/or not willing | 5<br>2<br>2 | 29 |

| | | | | |
|---|---|---|---|---|
| | | to do the therapy work<br>• Anger and aggression toward clinician<br>• Therapeutic relationship problems, honoring boundaries, etc.<br>• Medication problems<br>• BPD clients themselves<br>• Acceptance of diagnosis by BPDs due to stigma associated with a BPD diagnosis<br>• Other problems, (i.e., eating disorders and substance abuse)<br>• History of trauma and not understanding of the traumatic effects<br>• Misdiagnosis with BPD | 2<br>4<br>1<br>2<br>4<br>1<br>4<br>2 | |
| Resources and Education | 2 | • Specialized training in treatments and therapies empirically supported for BPDs beyond degree work<br>• Specialized training in treatments and therapies for to treat trauma among BPD clients | 5<br>3 | 8 |

| | | | | |
|---|---|---|---|---|
| Recommended Resources and Education | 12 | • Advice to new clinicians from experienced clinicians who treat BPD clients<br>• Work and collaborate with other clinicians who treat BPDs<br>• Training in treatment and therapies that treat self-harming behaviors and suicide ideation prevention<br>• Learning acceptance and recovery language toward BPDs<br>• Training to understand and treat the inner child vs. adult part among BPDs<br>• Attachment, shame, and relationship stability treatments and therapies training<br>• CBT training<br>• DBT training<br>• TF-CBT training<br>• IFS training<br>• Other therapy training successful for BPD (ACT, EMDR, etc.)<br>• More resources needed at the degree level to educate future clinicians to help | 4<br>1<br>5<br>2<br>1<br>1<br>5<br>4<br>2<br>3<br>2<br>5 | 35 |

| | | | | |
|---|---|---|---|---|
| | | remove the stigma associated with clinicians' reluctance to treat BPD clients | | |

## Appendix G: Themes and Subthemes with Correlating Thematic Codes and Thematic Subcodes

***Theme 1 - Self-Awareness:*** *Clinicians' self-awareness of lived experiences toward treating BPD clients*.

| Theme | Subthemes | Thematic Codes | Thematic Subcodes |
|---|---|---|---|
| Self-Awareness | • Fear of working with a BPD client<br>• Lack of understanding of a BPD diagnosis<br>• Self-assessment of their own ability and training<br>• The importance of the BPD therapeutic relationship | Initial reactions | • Difficulty setting boundaries with BPD clients<br>• Fear of working with a BPD client because of stigma associated with treating clients diagnosed with BPD from other clinicians and mental health professionals<br>• Fear in BPD client seeking treatment due to stigma associated with a BPD diagnosis<br>• Handling the difficult BPD traits in BPD clients<br>• Lack of understanding and experience diagnosing clients presenting with other diagnoses and understanding BPD vs. other diagnoses<br>• Feeling the BPD client will be challenging to provide successful treatment<br>• Clinician assessing their own ability and training to be able to successfully treat BPD clients<br>• Seeing the need of more resources, education, and training to effectively treat BPD clients |
| | | Overall experience | • See the importance of experience and specialized training to treat BPD clients |

| | | | |
|---|---|---|---|
| | | | • Self-harming, suicidal ideation and attempts behavior among BPD clients<br>• Use of treatments and therapies empirically supported to treat BPD clients<br>• Comorbidity and co-diagnoses among BPD clients, especially PTSD<br>• History of childhood trauma or abuse among majority of BPD clients<br>• Clients presenting with a misdiagnosis of BPD<br>• Attachment issues and unstable relationships among BPD clients<br>• Other common BPD characteristics among BPD clients (risk-taking, emotional regulation, etc.)<br>• See importance of length of therapy and resources used for BPD clients – not short term |

***Theme 2 - Commonalities:*** *Common themes found among clinicians' BPD clients*.

| **Theme** | **Subthemes** | **Thematic Codes** | **Thematic Subcodes** |
|---|---|---|---|
| Commonalities | • Difficulty seeking or finding treatment and recovery processes<br>• Misdiagnosis of BPD, comorbidity and co-diagnoses,<br>• History of trauma<br>• BPD characteristics among BPD clients<br>• Difficulty with the therapeutic relationship<br>• Success with empirically | Common Themes | • Comorbidity and co-diagnoses, most often PTSD<br>• Difficulty seeking or finding treatment and recovery processes because of the stigma associated with a BPD diagnosis among BPD clients<br>• Misdiagnosis of BPD among BPD clients<br>• History of trauma, childhood trauma, and abuse among BPD clients<br>• Unstable relationships, abandonment, and attachment issues |

| | | | |
|---|---|---|---|
| | supported treatments and therapies | | • BPD characteristics among BPD clients (self-harm, risk taking, suicidal ideation and attempts, black and white thinking, cognitive distortions, emotional regulation, anxiety issues, impulsivity, manipulative, victim mentality, etc.)<br>• Difficulty with the therapeutic relationship, (i.e., honoring boundaries set by the clinician among BPD clients)<br>• Not completing therapy, leaving, not willing to do the therapy work among BPD clients vs. other clients |
| | | Successes | • Success with empirically supported treatments and therapies (i.e., CBT, DBT, ACT, TF-CBT, IFS…)used to treat BPD clients<br>• BPDs acceptance of and overcoming stigma associated with a BPD diagnosis and seeking treatment and recovery processes<br>• Development of successful skill building and strategies among BPD clients<br>• Stable relationships among BPDs with therapy<br>• BPD clients who go on to become clinicians themselves |
| | | Challenges | • BPD characteristics among BPD clients (self-harm, risk taking, suicidal ideation and attempts, black and white thinking, cognitive distortions, emotional regulation, anxiety issues, impulsivity, manipulative, victim mentality, etc.)<br>• Suicide of BPD client |

| | | | |
|---|---|---|---|
| | | | • Quitting therapy and/or not willing to do the therapy work<br>• Anger and aggression toward clinician<br>• Therapeutic relationship problems, honoring boundaries, etc.<br>• Medication problems<br>• BPD clients themselves<br>• Acceptance of diagnosis by BPDs due to stigma associated with a BPD diagnosis<br>• Other problems, (i.e., eating disorders and substance abuse)<br>• History of trauma and not understanding of the traumatic effects<br>• Misdiagnosis with BPD |

***Theme 3 - Supports:*** *Supports (resources, education, and training for clinicians to treat BPD clients).*

| **Theme** | **Subthemes** | **Thematic Codes** | **Thematic Subcodes** |
|---|---|---|---|
| Supports | • Specialized BPD resources, education, and training beyond degree<br>• Specialized trauma resources, education, and training<br>• Supportive advice to new clinicians from experienced clinicians<br>• More resources needed at the degree level | Resources and Education | • Specialized training in treatments and therapies empirically supported for BPDs beyond degree work<br>• Specialized training in treatments and therapies for to treat trauma among BPD clients Seeing the need of more resources, education, and training to effectively treat BPD clients |
| | | Recommended Resources and Education | • Advice to new clinicians from experienced clinicians who treat BPD clients<br>• Work and collaborate with other clinicians who treat BPDs<br>• Training in treatment and therapies that treat self- |

| | | | |
|---|---|---|---|
| | | | harming behaviors and suicide ideation prevention<br>• Learning acceptance and recovery language toward BPDs<br>• Training to understand and treat the inner child vs. adult part among BPDs<br>• Attachment, shame, and relationship stability treatments and therapies training<br>• CBT training<br>• DBT training<br>• TF-CBT training<br>• IFS training<br>• Other therapy training successful for BPD (ACT, EMDR, etc.)<br>• More resources needed at the degree level to educate future clinicians to help remove the stigma associated with clinicians' reluctance to treat BPD clients |