"How SAD"

Stigma and Discrimination of People with Borderline Personality Disorder (BPD)

Stigma is a mark of disgrace associated with a particular circumstance, quality or person. Stigma sets people apart. Discrimination is the unjust or prejudicial treatment of different categories of people. Discrimination is the effect of stigma.

Borderline Personality Disorder (BPD) is the most stigmatised condition in mental health. Increasing research shows that mental health professionals often have negative attitudes towards people with BPD that reveal themselves in lowered empathy, reduced availability of services and also reduced quality of services (Sheehan, 2016). Active dislike of patients with BPD and a wish to avoid them is frequently reported by clinicians from all areas of mental health treatment: this will have significant adverse effects on people with BPD who are predisposed to feeling rejected. As a result, sensing rejection from treating clinicians can lead to: permanent damage to the treatment relationship; acts of self-harm or suicidality; or to premature withdrawal from treatment. Many clinicians simply refuse to treat people with BPD if they suspect the diagnosis.

The Australian Parliamentary Senate Select Committee on Mental Health in 2006 found that a "diagnosis of BPD closes the door to already limited mental health services. It leads to social rejection and isolation. Sufferers are blamed for their illness, regarded as 'attention seekers' and 'trouble makers'." Indeed, "Borderline Personality Disorder seems to be as much a recipe for marginalisation as it is a diagnosis." Then, in 2008 the report of the Australian Parliament Senate Standing Committee on Mental Health added, "People with BPD have so far been overlooked, or perhaps it is more appropriate to say deliberately excluded, from mental health services and mental health reforms."

A recent literature review conducted in 2015 (H. Wilding, St Vincent's Hospital) revealed that from 2000 to 2015 there were eighty references to people with BPD that included adjectives such as *difficult, untreatable, manipulative, unmanageable, attention seeking, impossible, hateful*, while ninety articles referred to stigma in relation to BPD among mental health clinicians.

People who have chosen to work in the mental health field are caring, well-intentioned people. It is always challenging for someone to face their own stigmatising, prejudiced and discriminating behaviours. This may help to explain the findings from an extensive 2013 literature review that revealed frequent social distancing by clinicians in relation to people with BPD. Other clinician responses included defensiveness, being less helpful, expressing less empathy and expressing anger. The authors suggested that these data 'simply reflect a very human reaction to the complex and pathological behaviours of these patients.' (Sansome & Sansome 2013). These 'complex and pathological behaviours' are maladaptive, but usually represent desperate means by which the person with BPD endeavours to get help and understanding for their deep emotional pain. Sadly, blaming the patients is a way of avoiding responsibility for the clinicians' own unhelpful responses to them.

A number of other researchers provide further analysis of this phenomenon. They have found as follows:

A. People with BPD are often seen as less deserving of treatment than others with mental illness

Misinterpretation of the behaviours of people with BPD:

- People with BPD may present as intense and challenging which can be interpreted by the mental health professional as a decision by the patient to be personally demanding. "The perception that patients have control over their own behaviour can perpetuate the stigmatisation of Personality Disorders in general and BPD in particular" (Aviram, 2006).
- People with BPD are seen as having self-control: suicide attempts and chronic self-harm are seen as attention seeking. When a diagnosis of BPD is present, "clinicians form pejorative, judgemental and rejecting attitudes" (Lewis & Appleby, 1988). In his study on stigma, Aviram suggests that stigmatisation could be reduced if it was accepted that BPD is a legitimate illness and not an example of moral failing or lack of willpower. (Aviram, 2006).

Outdated attitudes to the diagnosis of BPD:

- Gunderson in 2009 wrote that borderline personality disorder's validity remains suspect because it has, 'neither a specific pharmacotherapy nor a unifying neurobiological organisation from which biological psychiatry can find purchase'. (Gunderson, 2009) Gunderson has been an effective advocate for the recognition of BPD as a valid mental illness over many years. Its validity is now well established on the basis of significant heritability and specific and effective psychotherapeutic treatments.
- The outdated belief that BPD is untreatable is still held by some clinicians. There is much discussion in the current literature about what constitutes remission, recovery, or cure for BPD. This confusion of terms may add to the stigmatising of BPD, because it could obfuscate the fact that there are now many empirically validated treatments for BPD with good treatment outcome, including recovery.
- In 1993 Linehan published her Training Manual for treating BPD. As someone who publicly identifies as having had BPD herself, Linehan is a living example of a person who no longer suffers from it. There are many others like her. The Australian National Clinical Guidelines for the Management of BPD (2013) identifies 10 different forms of treatment for BPD which were examined according to the rigorous requirements of the National Health and Medical Research Council for meta-analysis of data.

BPD is treatable and treatment may lead to remission or a full recovery. To say there is no cure, or that BPD is untreatable, or that recovery is not possible, is to add to the stigmatisation of the disorder.

B. The patient is seen as the problem, not the illness

The effect of a neutral stance:

- Mental health professionals are described as emotionally retreating from people with BPD under the guise of a 'scientific attitude'. People with BPD are considered "'difficult' because they evoke personal emotional difficulties that challenge the clinical assumptions about professional neutrality." (Hinshelwood, 1999)
  Hinshelwood wrote this in 1999, when psychoanalytic psychotherapeutic approaches were still widely used for BPD. These approaches advocate 'technical neutrality' on the part of psychotherapists. Current treatment manuals of all the empirically validated treatments for BPD advocate an active, collaborative, validating engagement with these patients –not a neutral stance. It is indeed unfortunate if some clinicians continue to feel conflicted about the strong emotions that can be aroused during work with these patients, because these can be used to understand the patient at a deeper level than would otherwise be the case.
- A neutral, unengaged stance can lead to problems. People with BPD are hypersensitive: in the face of a neutral stance, they feel disliked or rejected. When the person treating them offers the face of professional neutrality as a way of distancing themselves from the patient, this would not be productive for the therapy.
- People with BPD also have difficulties with self-identity; they look to others as a way to define themselves. If they are faced with a professionally neutral response, they are challenged to know where they stand. This can be therapeutically unhelpful.
- People with BPD have difficulties with maintaining and keeping relationships. Sound therapeutic relationships are essential to support their treatment. When faced with professional neutrality, this can only serve to undermine the therapeutic relationship.

When the patient is seen as the problem:

- A negative attitude or stigma towards BPD in the mind of the clinician can result in a self-fulfilling prophecy. If the therapist believes the patient to be difficult and possibly manipulative, then it is reasonable to expect that this attitude would be unconsciously communicated to the patient. It "can activate the patient's self-critical tendencies and a cycle that involves self-loathing and self-injury, followed in turn by the therapist's confirmation of the stigma and his or her own emotional withdrawal from the patient" (Aviram, 2006). The consequences of this include increased self-harm and withdrawal from treatment.

C. The consequences of stigma have wide-ranging effects

The invisibility of stigma and discrimination:

- A recent critical review that discussed mental illness in the news and information media (Pirkis and Francis, 2015) found that the media had a tendency to stigmatise mental illness in general. BPD was not included in this research, although schizophrenia and mood disorders were.

- Psychotherapists “may justify and rationalise” why “they turn down referrals or when individuals with BPD terminate therapy prematurely” (Aviram, 2006). Such therapists are unlikely to be aware that their decisions are being unconsciously shaped by pre-existing stigma, making these behaviours and prejudice difficult to challenge effectively. Nonetheless, stigma undoubtedly would have an effect upon such decisions.

Misdiagnosis and underdiagnosis:

- Questions about the legitimacy of the diagnosis and concerns about issues of stigma contribute to misdiagnoses. In particular people with BPD today are often misdiagnosed with bipolar disorder.(Ruggero, C. J., Zimmerman, M., Chelminski, I., & Young, D., 2010). Similarly, where there is co-morbidity with other disorders such as an eating disorder, drug dependency disorder, anxiety or depression, a therapist may focus on these conditions rather than the underlying BPD. “Clinicians may wish to avoid making diagnoses associated with stigma.” (Paris, J. 2007). Confusion as to whether a diagnosis should be BPD with PTSD or Complex PTSD, also confounds. (Ford & Courtois, 2014). When a person fails to receive a correct diagnosis and effective treatment, recovery is impaired, inhibited, undermined. The damage of misdiagnoses is immense.

Underfunding of research in BPD:

- Research on BPD in the USA “… receives a total of only about $6 million annually in NIMH funds, less than 2% of the amount allocated to research on schizophrenia … and less than 6% of that for bipolar disorder” (Gunderson, 2009, p535). This is a serious imbalance.

Stigma in the wider world:

- Stigma towards BPD exists outside the clinical world. On the internet there is some extremely hurtful stigmatising and discriminatory information. In the general public however, BPD is primarily unknown and given it’s prevalence in the community this is further evidence of discrimination.
- If the world of mental health stigmatises and discriminates against people with BPD, then the rest of the world is likely to follow their lead.

In conclusion, it appears that stigma and discrimination by mental health practitioners can have a significantly detrimental impact on the lives of people suffering from BPD and that attempts to find ways of modifying these prejudices and the behaviours described are of paramount importance.

It is clear that the clinical community needs to receive education that assists the development of empathy and understanding of people with BPD.

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