Attitudes Among Psychologists Working With Borderline Personality Disorder

Lindsey J. Nelson

A Clinical Research Project presented to the faculty of the Hawai'i School of Professional Psychology at Argosy University in partial fulfillment of the requirements for the degree of Doctor of Psychology in Clinical Psychology.

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This Clinical Research Project by Lindsey J. Nelson, directed and approved by the candidate's Research Project Committee, was approved by the faculty of the Hawai'i School of Professional Psychology at Argosy University in partial fulfillment of the requirements of the degree of Doctor of Psychology in Clinical Psychology.

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Sean W. Scanlan, Ph.D., Program Dean
College of Clinical Psychology

Clinical Research Project Committee

_____
Kathryn M. Chun, Ph.D.
Chair

_____
Sean W. Scanlan, Ph.D.
Committee Member

_____
Date

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Hawai'i School of Professional Psychology at Argosy University - 2018

The purpose of the study is to provide a baseline for the attitudes of psychologists responding to patients identified as meeting criteria for borderline personality disorder (BPD). A review of the literature has indicated that psychiatric nurses are the most common group studied. To provide a baseline of psychologists' attitudes, an online self-report survey was devised through extensive literature review of items and themes found in similar surveys, with heaviest weight given to studies completed with psychologists. The multiple linear regression model demonstrates that although training and years of experience do not have a significant effect on psychologists' attitudes, the post-hoc correlation analysis shows that psychologists have the ability to hold and integrate multiple attitudes related to the BPD patient which are dichotomous. Included in the correlation is the finding that increased attendance at BPD-specific trainings reduces negative attitudes in working with BPD patients.

Dedication

This work is dedicated to all the people who inadvertently, have demonstrated the applicable points of this paper in everyday life.

For Mom, a gifted educator and who balanced benevolence at home with discipline in the classroom. For Dad, who taught me to be a responsible steward of my minutes, but to be kind and mindful of others along the way.

For Grandma, who valued fun as equally as she appreciated her work.

For Mark: master chef, laundry magician, mechanic, proofreading extraordinaire, late-night coffee barista, early morning running companion and still the independent man I love. Any success attributed to me I count as ours.

Acknowledgments

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I wish to individually acknowledge Dr. Kathryn Chun, whose ability to remain mindful of timelines, writing clarity, and scientific rigor while remaining patient and kind has been a good model for future practice. I am also thankful for the help of Dr. Sean Scanlan, who helped with statistical analysis and contributed significantly to narrowing the hypothesis to a more digestible format for this work. Both members demonstrate the innate ability to support students when vital, and critically challenge them when and where it is appropriate.

Finally, I wish to thank the Hawai'i Psychological Association (HPA) who granted permission to disseminate the survey on their Listserv to members who chose to participate. To the participants who responded to the survey and gave of their personal time to contribute to the outcome and findings of this study, I thank you also. It is my hope that it provides a very basic foundation for understanding the attitudes of psychologists working with Borderline Personality Disorder and a catalyst for future research inquiries.

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CHAPTER I

INTRODUCTION

The prevalence of patients with characteristics of borderline personality disorder (BPD) varies widely, but has been estimated to be as high as 20% within inpatient psychiatric settings (Svoboda, 2013). At a time when communities are focusing on how to best distribute healthcare funding, staffing, and other resources to those most in need, research shows that BPD patients frequently move in and out of the system at a high rate. Among participants classified as high utilizers of inpatient hospitalization in a recent study, 42% were categorized as qualifying for meeting BPD criteria (Comtois & Carmel, 2016). While clinicians have made respectable efforts at lobbying hierarchical government for improved staffing and cost structures related to the care of BPD patients in public healthcare, an area of concern is how clinicians are responding and interacting to patients diagnosed with BPD.

Recently described as "kings and queens of chaos," the conceptualization and trajectory through treatment for the BPD patient is a relatively new concept (Svodoba, 2013, p. 78). Prior to Bonet's convergence of multiple and varying moods into one diagnosis in the 17th century, the two presentations were thought to be separated and, thus, were treated as such. Conceptualizations and confusions around the presentation of what the field considers BPD persisted throughout the next two centuries until theories began to emerge in the 19th century with Sigmund Freud's concept of the ego, Karl Kahlbaum's focus on vacillating manic and melancholic symptoms, and Emil Kraeplin's idea that the disorder was singular, yet cyclical in its presentation (Millon, 1992). It was not until the 1930s that the term *borderline* emerged, signifying a type of volleying act between neurosis and psychosis.

The latter half of the 20th century denoted a shift in the refinement of nosological research as the field attempted to gain a better grasp of the BPD presentation. Focus was placed on the refinement of diagnostic criteria, the establishment of treatment methods, and the reduction of pejorative language related to this identified group of patients (Lewis & Appleby, 1988). As awareness of negative attitudes grew, became apparent, and was magnified in the literature, research began to explore the scope of negative attitudes, who was affected, and in what ways clinical work was affected.

Rationale

What is known about clinicians' interactions with BPD is that those interactions are often negative. There is a lesser amount of research indicating neutral or positive interactions (James & Cowman, 2007). Clinicians often experience a wide range of emotions as a direct result of the emotional expressions of the BPD patient. Among these emotions experienced by the clinician listed in the literature are anxiety, feelings of inadequacy, feelings of being manipulated, exhaustion, and social distancing from patients with BPD (Jorm & Oh, 2009; Rizq, 2012; Sansone & Sansone, 2013). There is a smaller amount of research that has posited constructive results. For example, Bodner, Cohen-Fridel, and Iancu (2011) studied nurses, psychologists, and psychiatrists and found that seniority is a mediating factor that may reduce negativity in treating patients with BPD. Higher number of years working with BPD patient was associated with lower negative attitudes.

Psychologists interacting with BPD patients are in a unique role. They may act to conduct psychological assessment as well as psychotherapy. There appear to be a very limited number of studies focusing solely on psychologists and their personal interactions or experiences with the BPD patient (Millar, Gillanders, & Saleem, 2012). Evaluating the psychologist's attitudes will be

helpful in future research gains. Additionally, beginning to understand if experience and training contribute to providing better quality of care for BPD patients will be a catalyst for future training baselines. Perspectives on what type of psychologists see BPD patients may assist in understanding effectiveness in treatment and ongoing training that psychologists may attend (Krawitz, 2004).

Review of Literature

Although the term 'borderline' did not emerge until the 1930s as a result of the research of Adolf Stern, its implication or ideology—that is, the concept that a person vacillated between neuroses and psychoses—was circulated during the days of Sigmund Freud (Stern, 1938). It was Freud who wrote, "mankind never lives entirely in the present" and on this precipice, could never fully separate himself from his characteristics (what he is) from what he was experiencing (his symptoms) (Freud, 1933, p. 52; Lester, 2012). Individuals diagnosed with BPD often have difficulty maintaining healthy relationships due to fear of abandonment. They frequently waver between mood of grandiosity and deflated self-appraisal and may exhibit impulsive behavior. Suicidal behaviors, threats, and/or attempts may be common. Anxiety that lasts hours or days may be frequent. BPD patients may experience periods of intense loneliness and emptiness and may dissociate from experiences around them. He or she may have difficulty coping with anger in an appropriate fashion. These are some of the diagnostic criteria for BPD in the current *Diagnostic and Statistical Manual for Mental Health Disorders-5* (DSM-5; American Psychiatric Association, 2013).

Historical Underpinnings

The mood of BPD patients can shift rapidly as they attempt to meet their needs. Millon, Grossman, Millon, Meagher, and Ramnath (2004) noted the historical importance of Bonet's

recognition of *folie maniac-melancolique* in 1684 as the first conceptualization to signify multiple moods within one diagnosis. Aronson (1985) rightfully noted however, that the term 'borderline' has undergone an evolution throughout the 20th century. Since that time, many researchers theorized about the BPD construct including Kahlbaum and Kraeplin. Kraeplin wrote about the circular nature of the BPD presentation, and believed the concept to be central to this newly identified group of patients.

Unfortunately, at the time that the term fully emerged in the 1930s, there were four categorical uses for 'borderline', each representing a thematic school of thought. This led to some confusion and conceptual ambiguity about the diagnosis, which still appears to surround the BPD framework today. Aronson (1985) noted the original concepts included borderline schizophrenia, borderline affective disorder, BPD, and a psychoanalytic explanation of the borderline as a byproduct of problematic early development.

Of Aronson's four offerings, BPD persisted into the *Diagnostic and Statistical Manual of Mental Health Disorders, 3rd Edition*, which was the most current edition at the time and throughout subsequent editions (American Psychiatric Association, 1980). Aronson's critique raises questions about whether there may be sufficient evidence for subtypes or additional classifications within BPD. On a final note in Aronson's research is his work on 'borderline' as a pejorative term. Noting common abuses of the term in institutions particularly, using the term in a manner which does not communicate compassion hinders the opportunity to guide future clinicians toward empathic service is outlined.

Emotional dysregulation is a core component of BPD and stabilization of emotional states is a focal point of treatment. Emotional dysregulation is a term that has given historical gravity to the conceptualization of Kraeplin, the psychoanalytic work of Freud and Stern, and the

work of mid-century theorists. As Millon suggests, however, consistent research is needed to gain and understanding of a disorder that appears to have a high rate of variability not only in its presentation, but within the research as well. Current research also supports that BPD patients are especially perceptive to negative feedback, sensitive to rejection, and may overreact when they feel judged negatively by others (Jeung, Walther, Korn, Bertsch, & Herpertz, 2018).

Components of Borderline Personality Disorder

The current prevalence in the DSM-5 states that BPD occurs at a rate of 1.6%, but may be as high as 5.9% in a non-patient sample. However, as expected, in primary care settings, the prevalence rate is slightly higher (6%), and in outpatient mental health clinics, higher still (10%). The DSM-5 estimates BPD prevalence rate in psychiatric inpatient settings at 20% (American Psychiatric Association, 2013). It is generally accepted that personality disorders emerge earlier in life and should be identified to streamline treatment (Lester, 2012). Practical concerns about diagnosing personality disorders too early and thus, harpooning efforts at successful treatment are preeminent in research as well, evident in the DSM-5, and circulate among practicing clinicians.

Much of the research surrounding BPD is consumed with its etiology. There is a considerable amount of attention in the literature given to the apparent overlap with other disorders, most notably, posttraumatic stress disorder (PTSD) and other trauma related problems. The assertion that BPD stems from difficulties with the primary caregiver or from problems with attachment in early childhood is well-documented (van Dijke, Ford, van Son, Frank, & van der Hart, 2013; Weinstein et al., 2016). There is considerable intersection between patients diagnosed with PTSD and/or with BPD. Older estimates regarding the presence of a trauma history co-occurring with a BPD diagnosis have been as high as 25% to

56% (Mueser et al., 1998; Zanarini et al., 1998). A more current study conducted by Pagura, Stein, Bolton, Cox, Grandt, and Sareen (2010) estimated: The prevalence of lifetime PTSD was 6.36% and the prevalence of BPD was 5.9%. The challenge in disassembling PTSD and BPD symptoms is in understanding if they are a separate diagnosis as the DSM-5 indicates, and if so, how they may be treated differently. A study interested in the subtypes of trauma investigated high betrayal trauma. Based on Freyd's high betrayal trauma theory (BTT) and the Brief Betrayal Trauma Survey (BBTS), high-betrayal trauma was the principal predictor of BPD features (Freyd, 1996; Kaehler & Freyd, 2012). Clinicians who treat patients for BPD also treat many of the same patients for trauma- related problems. Recent research trends in trauma-informed care have assisted in how to better relay treatment to victims of trauma within the clinical setting. More research is needed to better understand how to blend therapeutic techniques needed to treat and manage BPD while compassionately treating for trauma history. Managing these polarities with patients who often find it difficult to navigate boundaries with others, including boundaries with their therapists, make these advancements challenging.

Other etiologies appear to be less popular. One emerging within the research is the heritability of personality disorders, and within them, BPD. Twin and adoption studies are a strong case for this argument. Dependent upon the personality disorder, the heritability estimates range from 30% to 80% with a shared environment to 25% to 70% in a non-shared environment (Fontaine & Viding, 2008). BPD was found to have greater where environmental stressors such as abuse were also a factor. Moreover, monozygotic and dizygotic twin studies completed by Torgensen et al. (2000) showed significant familial transmission of BPD. Additionally, the study could define clusters of symptoms genetically transferrable, and in doing so, affirm Linehan's theory for biological contribution to BPD:

> Linehan and Korner maintain that the basis for borderline PD is an inherited biological predisposition to emotional stimuli, intense reaction to such stimuli, and a slow, delayed return to a quieter emotional level. In addition, this dysregulation means a lack of ability to suppress inappropriate behavior related to strong positive and negative effects, a lack of ability to comfort oneself when strong affects produce intense psychologic outcomes, problems in turning the attention toward other aspects, and finally difficulties in organizing and coordinating actions to reach important aims. (Torgensen et al., 2010, p. 423)

Torgensen et al. (2000) went on to state that those personality disorders which include neuroses—of which BPD is a part—are those most closely associated with genetic correlation in studies of twins raised in shared and non-shared environments. This research increases the importance of the responsibility of clinicians to gather complete family histories at intake, including any psychiatric history of the patient's family of origin if it can be known.

Cultural, social, and historical factors may also influence the development of BPD. Paris and Lis (2012) pointed out that BPD might present differently in various cultures and throughout the course of time. Considering the days of Hippocrates, Bonet, Kraeplin, and Freud, the identification and treatment of patients who are now known to have traits matching a BPD diagnosis are quite different. While BPD is recognizable across varying cultures, it is less common in non-Western cultures. Paris and Lis (2012) offered several theories including societal behavior that is impulsive, the prevalence of substance abuse, individualistic versus a collectivistic culture, as well as suicide attempts.

Theodore Millon's name circulates frequently in current BPD and personality disorder research. His conclusion regarding etiology is that research is largely confusing, and far too

early to be conclusive. His critique of modern personality research is that it is often too overreaching in its claims for causal arguments. Irrespective of these points, Millon agrees with the fact that research up to this point has shown that human beings are impacted by their experiences—most deeply by their earliest experiences (Millon et al., 2004).

An examination of the literature would confirm that BPD does in fact have a strong relationship to attachment and relationships formed in early developmental stages. However, BPD is not excluded from being influenced by a number of other factors including heritability, culture, and trauma history. The position of this paper is that the research posited in each position has not discounted the framework of the others, indicating in all likelihood that the actual etiology is still being understood. Furthermore, until a more precise understanding is reached, it appears that the clinical presentation of BPD emerges from a conglomeration of factors, including those mentioned previously in this section. A multi-faceted view appears to be in the best interest of the patients and of the field at this time.

Accurate diagnosis is critical in successful in the treatment of BPD. The presentation of BPD can appear as a myriad of different diagnoses complication of slowing the process of treatment. This is a particularly relevant point for psychologist who may partially identify with both roles. A combined search of ‘borderline personality disorder’ and ‘diagnosis’ on PsychINFO and PsychARTICLES resulted in 3,146 publications, many of which offered alternative diagnoses and presentations for BPD ranging from complex-PTSD to bipolar and panic disorder. Other suggestions included attention-deficit/hyperactivity disorder, narcissistic and obsessive-compulsive personality disorders, and depression states or mood disorders. With some frustration, some authors suggested that that DSM-5’s broadening of the Bipolar II criteria for hypomanic episodes from 2 days (DSM-IV-TR) to 4 days was to help eliminate

false positives in diagnostic criteria. They argue that Bipolar II was expanded to exclude BPD patients from meeting criteria for Bipolar II. The authors go on to note how they diagnose BPD, expanded beyond the parameters of the diagnostic manual, to include genetic components, family histories, sexual trauma, and self-harm histories (Ghaemi, 2016). While most clinicians agree that the DSM-5 is not a perfect diagnostic system, most would agree that one of its primary benefits is its ability to create a common language across varied providers of patient care. Alternatively, clinical judgment and the experience of the patient should not be discounted when determining diagnosis.

Clinicians' Responses to BPD Patients

Understanding the perspective of clinicians that have worked with patients identified as being diagnosed with BPD can be a complicated topic. The literature most widely available is the research conducted on psychiatric nurses who likely spend the most time and remain in closest contact with BPD patients. Less is currently known about the attitudes of psychiatrists and psychologists. Psychiatrists and psychologists will also be examined within this review.

Psychiatric Nurses

As previously stated, due to the amount of time spent with BPD patients, psychiatric nurses appear to have the greatest level of exposure to BPD patients. Psychiatric nurses are often the first target of intense anger and emotional instability exhibited within a psychiatric hospital. Repetitively, nurses become fatigued and may respond in kind to patients, becoming verbally or even physically abusive, prone to stigmas, and judgmental (Bland, Tudor, & McNeil Whitehouse, 2007). To qualify their experience with BPD patients, one research participant stated that caring for a BPD patient was like getting caught up in a "whirlwind" (Woollaston & Hixenbaugh, 2008, p. 705). A meta-analysis of psychiatric nurses' interactions with BPD

patients found BPD patients to be destructive, angry and controlling, prompting negative moods from staff, and eliciting less empathy over time (Winship, 2010). Lack of resources in psychiatric facilities appears to be a frequent complaint in working effectively with BPD patients. In a small study (n = 65) of psychiatric nurses in Ireland, 80% of nurses reported BPD patients as being more challenging than other patients, while 81% identified the care BPD patients received as inadequate (James & Cowman, 2007). The highlights the fact that BPD is not merely a problem in the United States, rather, that triangulation between resources, funding, and patients is a widespread problem.

Similarly, another comparable study examined psychiatric nurses working in an inpatient unit with individuals diagnosed with BPD. Nurses' experiences included perceptions of BPD patients as negative and manipulative, endorsing personal feelings of anger and an inability to know how to best care for BPD patients (Deans & Meocevic, 2006). Most apropos to this current literature is the research of the diagnostic label itself. Research conducted by Markham and Trower (2003) explored the effects of the BPD diagnostic label of psychiatric nurses' perceptions about causal attitudes and behaviors. A questionnaire was administered to a group of psychiatric nurses with a description of a patient with a diagnosis matching depression, schizophrenia, or BPD. The nurses (n = 50) were asked to diagnostically identify a likely cause of the behavior, and then on a Likert-type scale asked to rate several items, including how well the patients might be able to stabilize or control his or her behavior based on the identified cause. Of the three diagnoses, the BPD diagnosis attracted the highest level of negative responses regarding the ability to control behaviors. The diagnosis garnered less overall empathy and a greater number of negative attitudes from the psychiatric nurses. Another study was replicated with similar results (Markham, 2003). When resources are low, and the demand on staff working

directly with BPD patients is high, the result may frequently be burnout. Rossiter and Black (2009) insinuate *therapeutic pessimism* about the futility of treatment before it begins stems from the lack of resources at the government level and thus, influences how well treatment goes, and may act as a trajectory for the interactions between psychiatric nurses and BPD patients.

Recently, a study in which psychiatric nurse participants were asked to watch a documentary about a BPD patient's first-hand account with the disorder accounted for attitudes immediately after the viewing. Measures were gathered on understanding of the disorder, attitudes, and judgments about contacts with a BPD patient similar to the patient seen in the documentary, and the usefulness of treatment. The mixed methods design yielded results showing that psychiatric nurses' understanding of BPD patients did not change before or after viewing the film. Discussions about BPD can provoke uneasiness among clinicians about BPD patients while simultaneously promoting facilitation of learning how to best help (Dickens, Lamont, & Stirling, 2018).

Due to their ongoing exposure to BPD patients, psychiatric nurses are some of the most richly studied caretakers of BPD patients. Moreover, due to their proximity and recurrent contact with BPD patients, their perceptions and attitudes may be captured more negatively than other groups (e.g., psychiatrists, psychologists) who have breaks in between seeing patients.

Psychiatrists

Among the group of clinicians that have garnered the least amount of research and attention are psychiatrists. Sansone and Sansone (2013) pointed out in their meta-analysis that of all the different types of clinicians studied, the overlap between psychiatrists' responses to BPD patients is the least explored. One of the few findings is Lewis and Appleby's (1988) research on psychiatrists' responses to personality disorders. The name of the article captures the

researchers' critique of the pejorative language circulating at the time: *Personality Disorder: The Patients Psychiatrists Dislike*. A Google Scholar search of their publication indicated that is has been referenced 222 times between 2007 and 2017, irrespective of the fact that the research is now nearly 30 years old. Perhaps this speaks to the thirst of the mental health community for quantifiable research on the attitudes of clinicians who work with BPD patients to correct a looming problem. Their research consisted of case vignettes, very similar to what has been discussed previously in this literature review. The vignettes were dispersed to psychiatrists, followed by a questionnaire to assess attitudes associated with the inclination to diagnose. In some of the vignettes, the diagnosis was revealed to the psychiatrist, or certain labeling was used to imply a diagnosis. Lewis and Appleby (1988) concluded that when psychiatrists were led to a certain diagnostic conclusion prior to the introduction of the vignette, their attitudes toward the patient were less favorable.

While the language throughout is leading, Lewis and Appleby (1988) appear to be making an effort to reduce the pejorative language of the day by making the case that patients may not be in full control of their actions. A more current assessment of the psychiatric responses is a literature review by Paris (2007). Paris offered a brief review providing rationale delineating why psychiatrists may be disinclined to diagnose BPD. Paris' article was published during the use of the *Diagnostic and Statistical Manual of Mental Health Disorders-IV-Text Revision* (DSM-IV-TR), so some of his rationale may be contextual (American Psychiatric Association, 2000). First, Paris posits that Axis I diagnoses are more familiar to psychiatrists than Axis II diagnoses. Determinations on Axis II diagnoses also require greater degrees of clinical judgment and have broader diagnostic criteria. This results diagnostic determinations which are less precise. A second notion raised may be rooted in the historical thought that that

BPD conditions are somehow untreatable. If these positions are held by the psychiatrist, pharmacological tools may not be of use, and the psychiatrist may deem it unethical to continue to extend treatment in exchange for payment of services with no clear benefit to the patient.

Alternatively, very few psychiatrists offer psychotherapy (Paris, 2007). A third position offered is that psychiatrists may not want to make a diagnosis correlated so strongly with stigma. Paris (2007) referenced outcomes of rejection within the mental health system of care to reduce the stigma associated with BPD, some researchers have called for the diagnosis to be disbanded or reclassified on this basis—including Lewis and Appleby (1988). However, Paris (2007) made a worthy note: "It is an unfortunate reality that a diagnosis of BPD can indeed lead to rejection by the mental health system . . . However, stigma cannot be removed by reclassification. Patients who are chronically suicidal and who do not form strong treatment alliances will continue to be just as difficult, even under a different diagnostic label" (p. 36).

Psychologists

Like the research on the dynamic between psychiatrist and BPD patient the literature limited to the relationship between the psychologist and the BPD patient is scarce. The nature of a psychologist's interaction with the BPD patient is altogether different, and may include assessment and/or treatment and may be inclusive of group or individual psychotherapy. Because of the intensive experiences involved in psychotherapy, psychologists have a unique perspective on these patients however, there appears to be limited research on this specific group. Research conducted by Millar, Gillanders, and Saleem (2012) included a qualitative study examining the experiences of clinical psychologists and psychology trainees working with BPD patients. The research was conducted by focus groups and lasted 80 minutes. Several note-worthy themes emerged from the study. Millar et al. (2012) noted that psychologists endorsed a common

posture of feeling overwhelmed when seeing BPD patients. As it is common that BPD patients have significant safety concerns (i.e., self-harm or suicidal ideation/plans), psychologists feel a burden to act to protect the patient or to avoid liability. This burden to act is also closely related to what Millar, Gillanders and Saleem (2012) entitled "low self-efficacy" of the psychologist—that is, the psychologist's attitude that there is little that he or she may be able to do to help (p. 116). Positive perceptions about the patient included their overall likability and "possibility of change," this appears to be in contrast with another theme: "ability to change is limited" (p. 116). This study illuminates the differences in attitudes that psychologists take in approaching BPD patients. It illustrates the need for not only further research that quantifies how often such experiences occur among psychologists, but also expands upon their experiences. Further research should also focus on evaluating the quality and severity of such attitudes psychologists assume when seeing BPD patients.

An older study replicated a design used in other studies using a vignette for patients with BPD, schizophrenia, and depression. In this design, which also gathered information on other subsets of clinicians, Brody and Farber (1996) identified that, among the vignettes, clinical psychologists had the highest rating for anger and irritation on the BPD vignette when contrasted with the vignette for schizophrenia or depression. These are similar to results of other studies with different types of clinicians (Lewis & Appleby, 1988).

Mixed Samples

Meta-analysis offers the benefit of comparing outcomes among groups within the same study. There is not an overwhelming amount of mixed sample research conducted on various clinicians' attitudes as they interact with BPD patients.

Similar to the findings of Lewis and Appleby (1988), a study recently conducted in the United Kingdom measured the attitudes and judgments among psychiatrists, psychologists, social workers, psychiatric nurses, and students to determine if these attitudes were affected in a singular case of panic disorder. In the study, respondents were also notified that the case of interest was comorbid for BPD, as researchers used manipulation of this comorbid diagnosis to determine if the addition of BPD would moderate attitudinal outcomes. In fact, the BPD diagnosis was associated with higher endorsements of negative judgments and attitudes throughout the study (Lam, Salkovskis, & Hogg, 2016).

In a sample of 110 crisis and triage clinicians, Purves and Sands (2009) evaluated the attitudes of a broad range of practitioners working with patients with any diagnosis of personality disorder. A few negative attitudes including negative judgments, rejections, and vulnerability were common. The variable of years of postgraduate education and experience was a correlate for more positive experience with BPD patients (Purves & Sands, 2009).

In a large sample (n = 418), Krawitz (2004) studied training as a moderator to improve clinical interactions between patients and staff. Participants included nurses, psychologists, social workers, and occupational therapists and doctors. Pre, post, and 6-month testing were administered using ANOVA to measure results. All six variables measured (willingness, optimism, enthusiasm, confidence, theoretical knowledge, and clinical skill) maintained statistical significance throughout pre, post, and 6-month intervals. Krawitz's (2004) research implicates that training may be effective in providing clinicians with needed rest while at the same time equipping them with necessary tools with which to help BPD patients stabilize.

Furthermore, there is updated research to support that BPD is as equally trait-like, as it is state- like, with life circumstances of the BPD patient having a significant varying effects

(Conway, Hopwood, Morey, & Skodol, 2018). With this research bearing out, indicative of the fact clinicians may be able to do more than help patients manage the disorder, additional training and clinical confidence may have an essential impact.

The broadest samples of research on this subject cover psychiatric nurses whose skills and work differ widely from that of the psychologists and psychiatrists. Overall, the research yields mostly negative experiences with BPD patients. The positive experiences notated appear to have been documented most recently indicating a shift from negative attitudes reported in the research of Lewis and Appleby (1988). Additionally, training and seasoned experience may be a positive moderator.

Purpose of the Study

It is generally understood through the demonstration of the literature review that quality of service is affected when attitudes of those providing care for patients identified as meeting criteria for Borderline Personality Disorder are altered positively or negatively. The focus of this study is not so much to focus on the nature of the quality of service and how it is changed, but to understand and to provide a baseline for psychologist attitudes in interacting with patients of this diagnosis. In gathering this data, this research may be able to posit a baseline in such efforts for future work. As previously identified, studies that isolate psychologists as research subjects are limited when pertaining to this subject matter. In studying the attitudes of psychologists toward BPD patients or clients, the research seeks to begin to understand areas for improvement including attitudinal posture, opportunities for training, awareness of limitations, and an underscoring of psychologists' strengths in working with BPD patients. Additionally, this research may also aid in better understanding a positive pattern for other clinical professions to model or pattern after (i.e., psychiatry, social work, psychiatric nursing).

Research Questions and Hypotheses

Research Question

Regarding the literature examined, it is known that much of the research is consumed with psychiatric nurses' negative experiences with BPD patients. Psychologists' attitudes in interacting with BPD patients are not well understood, and most studies seek to study psychologists alongside other groups of clinicians, versus as an individual and isolated group of subjects. While there is interest in understanding if attitudes—either positive or negative—affect psychologists' ability to properly diagnose, the first primary step is to understand the attitudes of psychologists. As stated, while some research has qualified the experience of psychologists, quantifying their experience as a separate group appears to be a novel concept (Millar et al., 2012). This type of undertaking not only quantifies attitudes, but takes note of how severe those attitudes might be as well. To narrow the focus of this study and define its parameters, the research question is defined as such: What are the attitudes of psychologists working with BPD patients?

Hypotheses

The general hypothesis asked within this survey centers around understanding the clinical attitudes of psychologists as they interact with the BPD patient. Demographic questions seek to isolate extraneous variables that may be responsible for interacting with the data. Working setting and duties are also recorded, as this data may shape the psychologist's perceptions. Demographic data also helps to illuminate the diversity of the sample.

The dependent variable studied is the individual attitudes of psychologists. The first independent variable is training and is defined workshops attended specific to BPD within the past five years. A secondary independent variable is experience and is operationalized in two

ways: years in the field as a psychologist as well as practice in working with patients identified as being diagnosed with BPD. Independent variables used within this study have been identified in the past as having a positive impact on clinical interactions with a variety of different clinicians (Krawitz, 2004). The hypothesis is as follows: Training and experience affect psychologists' attitudes with BPD patients.

Because these two variables are being tested in harmony, they have the potential to yield rich data. There are no instruments that have been proven reliable or valid relating to attitudes of psychologists working with BPD patients, so no previous instrument could be used or amended. At the suggestion of the committee, the principal investigator is employing the use of self-report questions to gain the most face-valid data, with understanding of its limits for generalizability.

Significance of the Study

While Lewis and Appleby's (1988) study of psychiatrists clarified that there was a relationship between the negative attitudes of psychiatrists and the manner in which they diagnosed personality disorders, a reasonable first step for psychologists is gaining an understanding of and providing a baseline for attitudes of psychologists and their effect on providing service. If it is found that psychologists do harbor negative attitudes, then further research on how those attitudes interact with assessment and psychotherapy can be better isolated for study. Finding may also provide a current pulse as to the availability of training on Borderline Personality Disorder and its adequacy (e.g., frequency, depth). The study will assist in uncovering some presuppositions that psychologists may have in interacting with BPD clients as well as some personal experiences that they encounter.

CHAPTER II

METHODS

Sample and Selection Criteria

The targeted group of participants for this survey includes 30–40 psychologists who have graduated from a doctoral-level psychology program. Professionals seeing BPD patients while seeking supervision were excluded to provide clarity. Sources of sampling were initiated from the Hawai'i Psychological Association (HPA) Listserv. If needed, additional participants were accumulated from the principal investigator's online survey interface, SurveyMonkey who meet the specific inclusion criteria previously listed. These participants may have been compensated for their time by SurveyMonkey, but they were not be compensated by the principal investigator or research team.

Instrument

The instrument was developed using common responses in several measures and literature reviews with varied practitioners (i.e., psychologists, psychiatrists, and psychiatric nurses). Heavier weight was given to the inclusion of phrases that was found among all groups repeatedly used in multiple studies. When verbiage was used in qualitative studies from practitioners that were repeated in other qualitative studies, there was a special effort made to include the concept in some way and to use the verbiage in the survey as it was used in the qualitative work, while still reworking the rest of the phrases and questions. Heaviest weight was given to the qualitative study conducted on psychologists and the quantitative research on attitudes referenced specifically in the literature review (Lewis & Appleby, 1988; Millar et al., 2012). As this is a newly developed instrument, there are no pilot studies that have been conducted to ensure its reliability and/or validity.

Procedures

As this study was using human subjects, the study required approval from Hawai'i School of Professional Psychology at Argosy University's (HSPP) Institutional Review Board (IRB). The IRB process ensures that human subject participants are protected throughout the research process. Provisions of this board include ensuring that the principal investigator as well as the research chair completed required appropriate training to conduct ethical research practices (APA, 2017, 8.01). The principal investigator and research chair completed this training. With a study of this nature, anonymity of human subjects is of great importance. For this reason, data security is of parallel status and it is the burden of the principal investigator to both provide it and explain it to research participants. As suggested by Pallant (2013), data security was provided by preparing a codebook, defining and labeling variables by assigning numbers to possible responses while keeping identifying information separate from statistic generating programs. Data is stored on the password-protected hard drive of the principal investigator's password protected laptop and stored behind two locked doors, accessible only by the principal investigator. Members of the committee discussed data in a private location only.

In compliance with IRB requirements, the *APA Ethical Principles and Code of Conduct*, as well as the nature of the profession itself, participants were recruited on a completely voluntary basis (APA, 2017, 8.02). The purpose of this research was clearly outlined in the opening statement of the survey. Points of contact were explicitly noted in the informed consent should the participant have any questions or concerns. These contacts list the principal investigator and the research chair. Participants, in keeping with their right to participate or decline, had the ability to disengage from the survey at any time if the survey becomes too

distressing, or if for any other reason, s/he wished to no longer participate. It was estimated that the survey took less than 10 minutes.

Because this survey attempted to draw out the clinical attitudes and training/experience of psychologists as they have interacted with BPD patients, participants who prematurely disengage in the survey may feel irritation or anger that their experiences were not properly given voice. While not all participants who disengage may share the same experience or may disengage from the survey for the same reason, it is worthwhile noting that it is not the intention of the researcher to vilify psychologists in this manner. However, it is ethical practice to notify participants of these potentialities should they choose to disengage from the survey (APA, 2017, 8.02.1.a.3).

Regarding results, the principal investigator employed the use of the research committee and to evaluate data to ensure that the data produced and the conclusions are not overreaching (APA, 2017, 8.10). All literary works quoted and referenced throughout the research are properly cited and the entire research work was generated through Turnitin® as required by the Comprehensive Research Project (CRP) manual prior to final defense to avoid unintentional plagiarism (APA, 2017, 8.11).

The statistical analysis most suitable and relative to the research question and hypothesis is standard multiple regression. Since there are two independent variables and there is considerable interest in not only the attitudes (descriptive statistics), but also in how each independent variable affects attitudes, multiple regression is an appropriate selection. Observations for future discussions along with further opportunities for research (i.e., gender, years of experience, job duties, place of work, specific BPD training attended, and frequency of BPD patient interaction) are grounds for investigation should the final sample size allow.

The survey was collected using the SurveyMonkey platform. Research has indicated that the return rate for online surveys is relatively low and for this reason, the principal investigator may have accumulated additional participants through SurveyMonkey's service (Aerny-Perreten, Esteban-Vasallo, Dominguez-Berjon, & Garcia-Riolobos, 2015; Saleh & Bista, 2017). To ensure both anonymity and security several measures were taken, many of which were more closely outlined in the IRB application. Briefly, the principal investigator and research team (including the research chair and committee member) employed the use of secure socket layer encryption as data is passed from user to user. Additionally, the principal investigator will ensure that IP tracking remains disabled throughout the data collection phase on the SurveyMonkey website. IP addresses make it possible to track survey results to a computer, but not necessarily to a respondent. Disabling this feature provides additional surety to the participant that results are not tracked back to the participant. These facts, along with other items outlined in the procedures section are explained plainly to the participant at the onset of the survey. No participant can gain access to the survey without first accepting informed consent terms. It was made clear to potential participants that there is no penalty should s/he choose not to participate.

CHAPTER III

RESULTS

Previous literature provided evidence of negative attitudes posited by mental health professionals as well as some positive attitudes of clinicians exposed to working with patients meeting criteria for BPD. Little was known about the attitudes of psychologists in working with these patients, and the research with psychologists was largely comprised of qualitative or mixed sample inquiries. The turning point in this study was to better understand the attitudes of psychologists interacting with BPD patients and to clarify the nature of these attitudes toward more effective outcomes where indicated. The hypothesis was that training and experience in the field of psychology affected psychologists' attitudes in working with BPD patients.

Method

Design and Procedures

Over an approximately 1-month period, members of a state psychology association were solicited to participate via an email hyperlink in an online survey assessing attitudes related to their work with BPD patients. The study received approval from the Hawai'i School of Professional Psychology IRB at Argosy University, as well as approval from the HPA prior to survey solicitation. In order to participate, participants were required to agree to the informed consent and were required to have graduated from a doctoral-level psychology program. The survey tracked gender, years of experience, and years of training of psychologists. Other information recorded included place of work, work function, and exposure to BPD patients. Finally, on a 6-point Likert-type scale, the survey measured a number of attitudes that psychologists may hold relating to treatment of BPD patients (manipulativeness; feeling overwhelmed; positive treatment potential; pressure to act; difficulty to assess; enjoyableness;

limited ability for change; limited scope for psychologists' to help; patients' control over therapy; capacity for empathy; limited ability to control behavior; frustrating aspects of public health; and management of the disorder).

Participants

The original research proposal suggested that survey results be analyzed with a multiple regression in an effort to understand how training and years of experience interacted with attitudes. The study garnered 34 total responses (n = 34); however, a number of responses were removed based on predetermined exclusionary criteria. Additionally, as outlined in the informed consent in keeping with IRB guidelines and the *APA Ethical Principles and Code of Conduct* (APA, 2017), participants were allowed to bypass any survey item (with the exception of the exclusionary items) that they wished to leave blank. For this reason, each survey item has a different completion rate. The highest number of participants who proceeded past the exclusionary items and answered other survey items is 31.

Description of Sample

To encourage maximum participation, a limited amount of demographic information was obtained from participants. Information gathered from participants included sex (67.7% female, 19.4% male, and 12.9% prefer not to respond/left blank), number of years practicing as a psychologist (M = 15.85, SD = 12.136), primary place of work (reflected in Tables 2, 3, 6; see Appendix F), and primary work function as a psychologist (see Table 4 in Appendix F). Other information gathered included the number of trainings psychologists attended within the past 5 years related to BPD, as well as a binomial question related to whether or not psychologists had exposure to BPD patients (see Tables 1 and 5 in Appendix F). Descriptive information relating to the sample can be found in Appendix F.

Information from the survey was downloaded, all personally identifiable coding was removed, and then the data was uploaded to SPSS for analyses. Data was assigned dummy codes where necessary (i.e., "1" represented male; "2" represented female). Participants who chose not to respond to items were also coded as such. The first moderating variable in the regression information included the number of years practicing, followed by the number of trainings attended in the past 5 years specifically pertaining to BPD.

Regression

Of the 31 total participants, 27 replied to the question relating to the psychologists' number of years practicing. The participants shared a mean of 15.85 years of experience (*SD* = 12.136). Regarding the number of trainings attended recently, within the past 5 years, a mean of 1.39 trainings were distributed among the 23 respondents. (*SD* = 1.852). The attitudinal composite score was comprised by averaging each participant's survey score (on Likert-scale items only) in order to have a singular score item for each participant capable of regression.

Overall, 27 participants had a mean of 3.289 (*SD* = .7329) on a 6-point Likert-type scale (see Table 7 in Appendix G). The attitudinal composite should not be presumed to be correlated with all negative attitudes and experiences, the fact that only two items that survey positive attitudes is reiterated. Thus, elevated attitudinal results on the survey will be referred to from this point forward as equated with negative attitudes unless otherwise denoted.

In order to identify to what extent training and years of practice had on clinical attitudes, multiple linear regression was used to control for two factors during the primary analysis. A linear regression was conducted to determine the impact of training and years of practice on clinical attitudes. Following entry of the regression, total variance explained by the model was 22.8%, demonstrated by $R^2 = .228$, $F(2,20) = 2.957$, $p = .075$, and leaving 77.2% of total

variance in the model unaccounted for. The two predictors (years of experience, number of BPD-specific trainings attended) were also separately controlled for, but not did not yield statistically significant findings. Of the two predictors, training had a greater effect (b = -.362, SE = .012, p = .081) over years of practice (b = .281, SE = .269, p = .170). Results of the regression are available in Appendix G, Tables 7–10.

Correlation

Knowing the limitation of the study imposed by its size, post-hoc analyses of relationships between survey variables and against the clinical attitude composite were conducted to determine additional correlations and relationships that might exist. This allowed a closer, more detailed look at any relationships that may not have been accounted for in the regression. Pearson's r correlation was used to explore the relationships between clinical attitudes. Based on the survey items and the attitudinal composite, the correlational analyses were presented in a table reflected in Tables 11–12 in Appendix H. Following Cohen's (1988) guidelines, relationships with statistical results with absolute values ranging from .50 to 1.0 are considered strong correlations, while .30 to .49 is a *moderate* designation. Results in the table ranging from .10 to .29 are low in strength.

The strongest relationship within the correlational study is the relationship between psychologists with negative attitudes and those who identified with feeling as though patients meeting criteria for BPD make them doubt or wonder if there is anything they can do to help (r = .758). Also highly correlated, psychologists within the sample who have a higher attitudinal mean appear to endorse the fact that treating BPD patients is an enjoyable part of their practice (r = .732).

Psychologists with elevated negative attitudes reported greater frustration and difficulty working with BPD due to the constraints of or problems associated with public health (r = .719). Limitations imposed by the study's failure to operationalize the term *public health* are addressed to a greater degree in the next chapter.

Psychologists who endorsed finding BPD patients enjoyable to treat also acknowledged their ability to, at times, manipulate and sabotage treatment efforts (r = .703). This may also be connected to the finding that psychologists with negative attitudes find BPD patients to manipulate and sabotage treatment as well (r = .677).

Psychologists who have elevated negative attitudes also show significant elevations in their attitudes about BPD patients and their limited ability to change (r = .643). Closely related is the finding that psychologists who endorsed BPD patients as having a limited ability to change were closely related to those who doubted or wondered if there was anything they could do to help (r = .640).

Defensive practices may contribute to survey responses as reflected in negative attitude elevations paired with elevations in participants who endorsed anxiety and feeling a pressure to act due to safety concerns with BPD patients (r = .629). Safety concerns are a viable threat with BPD patients.

Those participants who also have elevated negative attitudes also are highly correlated with endorsing an attitude that BPD patients often control therapy or treatment sessions (r = .626). Psychologists who also sense this among BPD patients also appear to have the same difficulty wondering about their limited ability to help as previously mentioned (r = .584). There is a strong relationship between psychologists who show elevated negative attitudes and those who also endorse feelings of being overwhelmed in addressing BPD patients (r = .558). The

negative attitude is a mean (including positive attitudinal factors) generated for each participant based on individual scores.

Psychologists who concurred with higher levels of difficulty working with BPD patients in a public health setting also noted their ability to sabotage and manipulate treatment (r = .557). Complications with admitting high-risk patients with manipulative behavioral patterns for inpatient hospitalization where beds are limited may support these results and contribute to psychologists' concerns about treating this specific patient group (Comtois & Carmel, 2016).

A complex finding and relationship is that psychologists who endorsed the survey item that BPD patients have a limited ability to change are some of the same psychologists who endorsed BPD patients as an enjoyable part of their practice (r = .556). This is one of the more interesting findings from the study and is discussed in detail in the following section.

Psychologists reporting feeling as if there is little s/he can do to help a BPD patient also show a positive relationship to an attitudinal posture toward BPD as manipulative in treatment (r = .548). This coincides with the large correlation that is shown between psychologists who again feel difficulty in helping, but simultaneously feel pressure to act due to safety concerns with which BPD patients present (r = .532).

There is a significant relationship between psychologists who attended more training and psychologists who acknowledged BPD patients as exerting control over therapy or treatment sessions (r = .501). Additionally, psychologists appear to have complaints and frustrations with working within the public health system with this population, but still find the patients to be an enjoyable part of their practice (r = .527).

Another significant relationship was found between psychologists who noted an inclination to empathize with patients other than those presenting with BPD and a reflection by

psychologists that their work with BPD patients caused them to wonder if it was helpful (r = .522).

Psychologists also related BPD patients to being enjoyable, but also to controlling treatment and therapy sessions (r = .519). Additionally, BPD patients are acknowledged to have good treatment outcomes but are also overwhelming to psychologists (r = .516).

The sensibility that psychologists feel overwhelmed when also endorsing that BPD patients cause significant anxiety concerns or threats is noted (r = .510). Given the coefficients presented thus far, it is perhaps surprising that this relationship did not emerge more prevalent than it did given what is present in the extant literature (Millar et al., 2012; Paris & Lis, 2012).

Regarding relationships of medium size (see Table 11 in Appendix H) is the correlation between psychologists who acknowledge difficulty working with BPD patients in a public health setting and psychologists noting that BPD patients have a limited ability to change (r = .496). A similar relationship of parallel strength is indicative of the fact that psychologists endorse frustration with public health and doubt their ability to help (r = .493) and is worsened by their sense of feeling overwhelmed that is caused by the disorder itself (r = .489).

An expected finding was that psychologists endorsing attitudes about BPD patients' limited ability to change, also wonder about their own ability to help (r = .487). The attitudinal composite is also related to judgments regarding symptom management as best practice for BPD (r = .476).

A relationship exists between psychologists who endorsed that BPD patients have good treatment outcomes and psychologists who felt pressure or anxiety to act due to significant safety concerns with which BPD patients presented (r = .480). Psychologists with negative attitudes also appear to view BPD patients as difficult to assess at intake and challenging to diagnose from

other similarly appearing diagnoses (r = .477). Of the 13 attitudinal measures items on the survey, only two of the items measured positive effects associated with good treatment outcomes or enjoying BPD patients. The remainder of the items measured negative attitudes and judgments. While the attitudinal composite includes both positive and negative items from the survey, an elevated attitudinal composite is generally associated with negative attitudes due to the representative items on the survey. Individual analysis per respondent may vary. Difficulty in assessment reappeared in another relationship in complications and difficulty with public health to a slightly lesser degree (r = .471).

Psychologists who also endorsed difficulty working with BPD patients in public health settings described having positive outcomes with patients (r = .462). There also appears to be a moderate relationship between the attitudes of psychologists with a disinclination for empathy towards BPD patients, and psychologists who also find BPD patients to be manipulative in treatment (r = .457). Awareness of these attempts to sabotage or manipulate treatment by the psychologist may heighten empathy and further explain this relationship. This coincides with overall negative attitudes in relationship to difficulty with empathy (r = .447). This may also explain why psychologists find work with manipulative BPD patients somewhat limited (r = .449).

If psychologists endorsed public health to mean utilization as crisis care, emergency room, or inpatient admission, then the relationship between best care as management of symptoms and that of frustration with public health is understandable (r = .445). This relationship is expressed elsewhere in a variety of forms within this data, as well as within the literature (Comtois & Carmel, 2016).

Endorsed by psychologists who acknowledged BPD patients often controlled therapy and treatment sessions, was also the attitudinal posture that the public health system made working with patients exceedingly frustrating and difficult (r = .443). This is also reflected in the anxiety that psychologists expressed in the pressure to act when engaged in these public health settings with patients who have caused significant safety concerns (r = .437).

The relationship invoking more years of practice involves attitudes that patients meeting criteria for BPD often manipulate or sabotage treatment (r = .441). Regarding years of practice, this relationship was the only correlative factor discussed in this writing, although enjoyableness nears the designated threshold (r = .366).

Psychologists acknowledge their difficulty in demonstrating empathy when compared to other patients, but still acknowledge BPD patients as enjoyable overall (r = .441). However, there is also a negative relationship between psychologists who attended more training and psychologists who endorsed attitudes of feeling overwhelmed (r = -.414).

Although some psychologists appear to have attitudes that management is the best that can be done for patients with BPD, there is a relationship between psychologists with this attitudinal posture and psychologists who find BPD patients to be an enjoyable part of their practice (r = .423).

Regarding psychologists with elevation on the survey item indicating that BPD patients control treatment and therapy settings is positively related to the feeling of the pressure to act when safety concerns with BPD patients are known to be a factor (r = .402).

Although it is a relationship of moderate strength, it has direct conclusions innate to the hypothesis as it implicates one of two predictor variables: number of BPD-specific trainings

attended. Psychologists endorsing attending a higher number of training occurrences endorsed fewer overall negative attitudes (r = -.373).

CHAPTER IV

DISCUSSION

Discussion of Findings

The challenging aspect of working with BPD patients has been previously established in the literature review and has been demonstrated and endorsed by survey respondents. As will be discussed, although the attitudinal composite did not establish that training and years of experience significantly affect attitudes of psychologists in this sample, a magnified factor-by-factor correlation of each attitude yielded a richer understanding of psychologists' attitudes.

Operationalization of Attitudinal Composite

The attitudinal composite is a mean used in this study to generate a mean among the 13 individual survey factors (manipulativeness; feeling overwhelmed; positive treatment potential; pressure to act; difficulty to assess; enjoyableness; limited ability for change; limited scope for psychologists to help; patient control over therapy; capacity for empathy; limited ability to control behavior; frustrating aspects of public health; management of the disorder). While the survey includes screening primarily negative attitudes related to treating and assessment of BPD, it also gauges two positive attitudes of psychologists who interact with BPD patients. As previously stated, elevated attitudinal results on the survey are referred to as equated with negative attitudes unless otherwise noted. Included in the scoring were three oppositely worded items measuring propensity for positive treatment outcomes; the ability of the psychologist to enjoy the BPD patient; and the ability of the BPD patient to control his or her behaviors.

Correlations

In this discussion, relationships of greatest significance will be discussed first, with relationships of less significance explained in descending order. Other results are integrated into

discussions when they confirm other results or match other findings. The relationship emerging with the greatest significance is between psychologists who have a higher overall attitudinal mean and those who endorse feelings of helplessness about what they can do for BPD patients. One possibility distinguishing psychologists from other clinicians (i.e., social workers, psychiatrists, licensed mental health counselors, etc.) could be that psychologists receive training which focus more heavily on assessment and less on treatment of the disorder. Similarly, elevated attitudinal means were also associated with psychologists who acknowledged that they enjoy treating patients diagnosed with BPD. Blending what is known about the prior relationship, it could be that while psychologists may have feelings of being ill- equipped to treat BPD patients, they find the process unilaterally challenging and pleasurable.

Psychologists with higher composites reported greater hindrances and difficulties associated with public health when trying to assist BPD patients. A limitation of this survey item was that public health was not clarified to mean managed care. Additionally, independent participants were likely to interpret their own perception of difficulties of public health concerns based on their own clinical experiences with no room to expound upon them (i.e., limited inpatient admission space; constraints of session length/session occurrences; treatment modalities, etc.). Since this is one of the strongest relationships generated within the correlation and one of ever-growing concern, perhaps it is worth exploring with psychologists at a deeper level (i.e., qualitatively, mixed methods). A complication that is included with the attitudinal composite is that it includes a limited number of factors also (i.e., potential for positive treatment outcomes). Moreover, elevations and subsequent relationships are not necessarily attributable to negative effects. Conclusions and implications drawn from the attitudinal composite outside of

the regression (for which it was originally composed) are offered cautiously. They are helpful for generating future theories and hypotheses.

An interesting finding with strong relationship is that psychologists endorsing BPD patients as enjoyable can collinearly be mindful of their difficulties in manipulating and sabotaging treatment. This appears to be an indication that while psychologists appear to enjoy the challenge of treating BPD patients as indicated previously, they also are rooted in the reality that one way in which BPD patients seek control is by destabilizing the therapeutic environment.

Psychologists with elevated negative attitudes appeared to acknowledge the manipulative behavior of BPD patients as well as an attitude about their overall limited ability to change.

These attitudes about constraints on change as embraced by psychologists are associated with a sense of wondering what, if anything, can be done to help the patient. This attitude or feeling of helplessness juxtaposed with the patient's lack of forward progress contributes to a working hypothesis that negative attitudes may be repeatable throughout the survey.

Defensive practices have been initially investigated in working with BPD patients (Krawitz & Batcheler, 2006). When anxiety is conceptualized as an attitudinal factor comprised of concern or worry about future events that have not yet occurred, it is congruent with the findings that psychologists endorsing anxiety and a pressure to act regarding BPD patients' safety concerns also show elevations in overall negative attitudes. One additional reason elevations may exist at this level of practice (versus licensed counselor, social worker, etc.), is that most psychologists practice at the doctorate level. Requirements for participation were that survey participants were to have graduated from a doctorate-level program in psychology. Many psychologists take on supervisory roles, which adds an additional level of accountability and risk

to practice, adding to the hypothesis that psychologists are mindful of ethical and legal pitfalls surrounding these patients.

Controlling therapy or treatment settings is a method applied by patients at times trauma-affected, to apply direct regulation over what feels to the patient like an overwhelming environment. This can be counterproductive to therapy and often frustrating to psychologists. Psychologists with elevated negative attitudes and endorsing the high factors of patient control expressed this conundrum. These feelings of frustration may lead to feelings of being overwhelmed expressed as a pattern throughout the remainder of the results.

As previously noted, future studies where specific clarification of the term 'public health' can be operationalized will be helpful. Suicidality and parasuicidality are contributory reasons why clinicians practice defensively when working with BPD patients (Krawitz & Batcheler, 2006). This is consistent with the findings in this study that psychologists agreeing with the difficulty of working within the parameters of public health subsequently found it challenging to manage the sabotaging and manipulative behaviors of patients. Previous constraints on inpatients' space may be a part of the problem.

Returning to the ability of the psychologist to hold two seemingly competing attitudes simultaneously, is the finding that psychologists appear to embrace the posture that BPD patients have a limited ability to change while enjoying them as part of their practice. Plausible hypotheses for this relationship may include the fact that psychologists who interact with BPD patients enjoy the challenge of treating the population, may feel duty/responsibility to treat them irrespective of their trajectory for change, or hope that their case may be exceptional in some way.

It is clear through the results of the survey that while psychologists want to render competent care, they appear to often endorse feelings of helplessness in attempting to do so, and these feelings are closely related to the patients' behaviors of manipulation and sabotaging of treatment. One possibility is that as the psychologist attempts to offer treatment, these attempts by the patient to manipulate and sabotage are perceived as counteractive and counterproductive, which exhaust the psychologist's internal resources at offering competent care. It is apparent that clinicians are mindful that BPD patients present with often urgent concerns, and clinicians may have an internal response of inadequacy or helplessness regarding treatment rendered.

The relationship between attendance at BPD-specific training and attitudes regarding patients' control over treatment sessions was indicative of the fact that psychologists attending higher occurrences of trainings endorsed a greater number of concerns related to patient control over sessions. It could be that training aided in honing their ability to detect when patients were controlling sessions. The survey item did not garner information that indicated whether or not well-trained psychologists found BPD patients efforts to control the session troublesome. Future research may be helpful in looking specifically at this small group in determining their response and subsequent recommendations to these behaviors. As previously stated, there were fewer respondents in the survey endorsing multiple BPD-specific trainings, so caution is used in interpreting these relationships directly.

Psychologists appear to have difficulty empathizing with the BPD patient when compared to other patients. This capacity to understand life and experience of another from the perspective of the BPD patient appears to be associated to their doubts about their personal ability to help. It could be that as psychologists are attempting to understand the experiences of

BPD patients, this empathic approach is overwhelming and collides with feelings of inadequacy and helplessness.

It is possible for psychologists to enjoy BPD patients while holding the attitude that BPD patients control treatment and therapy. An aforementioned hypothesis closely relatable to this data is that while psychologists find BPD patients to be enjoyable, the fact that they work to disrupt the session and control it is challenging to psychologists and may be enjoyable comparative to other patients who may be less active during sessions. Psychologists have previously made clear within this data that BPD patients are enjoyable, and within this relationship are capable of achieving good treatment outcomes. Moreover, the cost within the therapeutic relationship may be that the psychologist is overwhelmed, resulting in burnout and treatment failure for the patient.

As previously noted, psychologists do feel overwhelmed when BPD patients cause significant anxiety concerns, but it is surprising that this relationship did not emerge more prominently in the results. That it did not may be attributable to the fact that "anxiety concerns" and "threats" from BPD patients are decreasing, or that psychologists feel better equipped to engage BPD patients in discussions regarding them.

An emerging relationship shows that psychologists acknowledge difficulty working with BPD patients in public health settings while endorsing their limited ability to change. This may be an experience of frequent crisis situations and the difficulty of admitting BPD patients. Significant safety concerns and the subsequent nature of problematic cyclic inpatient-outpatient treatment may contribute to a better explanation of this hypothesis.

In a collision of expected findings, psychologists' own attitudes about the patients' limited abilities to change were also closely related to attitudinal postures maintained about their

own ability to help. This imbalance appears to pervade other relationships. For example, there is also a similar finding about management of the disorder as being the best that psychologists can do for BPD patients. This is relatable to beliefs about the BPD patient's ability to change and symptom management as best practice for care.

A relationship emerging from the results appears to be that psychologists have the ability to perceive positive treatment trajectory for patients, while seamlessly feeling pressure about safety concerns associated with the disorder. This dynamic is consistent with the previous finding that psychologists are capable of holding two dichotomous attitudes at one time—one that is hopeful, and one that is anxious that the patient is capable of self-injurious behavior.

An enduring description of psychologists is as assessment specialists. One tertiary trait of this survey was to determine if BPD patients' symptoms or characteristics might be interfering with the ability of psychologists to function effectively. Psychologists with elevated overall negative attitudes concurrently view BPD patients as difficult to assess at intake or challenging to distinguish from other similarly appearing diagnoses. This attitude in difficulty with assessment was also seen in relationship to public health settings in which psychologists found it increasingly difficult to practice.

Continuing with a theme of two bipolar factors, psychologists describe engaging in frustrations with public health while endorsing having positive treatment outcomes with BPD patients. This is a similar finding to other results in other relationships throughout the study: although psychologists are confronted with challenges with BPD patients in one area (i.e., public health), they are able to envision success for patients (i.e., treatment outcomes) irrespective of difficulties.

Disinclination for empathy of the psychologist and the manipulativeness of the patient appear to share commonality. Plausibly, psychologists could be aware of these attempts to manipulate and sabotage treatment as a means to place controls on an environment that feels out of control for the often trauma-affected patient. Improving empathy of psychologists may provide a deeper level of awareness providing understanding of what the patient may or may not be trying to achieve through his/her manipulation.

Psychologists seemed to endorse the frustration with public health throughout the survey. This challenge is related to psychologists' attitudes that the best care for BPD patients as defined by some psychologists is management (vs. treatment) of the disorder. A clear hypothesis between these two factors given BPD patients' higher utilization of crisis care is that while BPD patients may clearly benefit from treatment that is effective is reducing crisis visits, many psychologists endorse attitudes that support that they are managing, instead of treating, the disorder (Comtois & Carmel, 2016). One other possibility is that personality disorders can be difficult to navigate with managed care and insurance. Since many respondents within the study identified as private practice providers, it could be that difficulties with public health may fall into this category. As stated, the heterogeneity of this term is a weakness of this survey item and study, subsequent limitation, and since it was a repeated correlative throughout the study, one that bears further study. BPD patients who seek to control treatment and therapy further complicate frustrations with the public health system. Irrespective of the application or operationalization of the term 'public health' as aforementioned, the BPD patients' application of control over treatment makes the inpatient admission process, insurance claim process, and crisis (emergency room) process more difficult for psychologists.

One of the two hypotheses tested within this study regarded whether years in practice affected attitudes. The only relationship correlated with years of experience is with attitudes of manipulation. As mentioned, of the 27 participants who responded to the years of practice survey item, these participants shared a mean of slightly over 15 years of experience. It could be that psychologists do not note improvement in this domain over time (i.e., manipulativeness, sabotaging behavior) or it could be that as psychologists become more skilled and seasoned, these patient behaviors become more recognizable to them. Although psychologists acknowledged difficulty in practicing empathy in comparison to other patients, psychologists continued to endorse enjoyable interactions with them. Psychologists may not fully understand the life of the BPD patient but still appreciate positive interactions with them through treatment, assessment, and clinical activities.

Psychologists noting increased attendance at BPD-specific trainings reported reduced feelings of being overwhelmed by the BPD patient. Of particular note, the number within the sample that identified as having attended a higher number of trainings was relatively small, so caution is taken is generalizing relationships on too large a scale (see Table 5 in Appendix F). Current conjecture includes that limited participants on the upper end of training exposures attended trainings that may have been helpful in reducing feelings of being overwhelmed. Regarding psychologists who acknowledged fewer or a singular training, one explanation may include the fact that subsequent BPD-specific trainings did not follow, or that a singular training was not sufficient enough to address the needs of psychologists in addressing attitudinal affects in working with this specific patient population. In the future, one way to investigate which attitudes are associated with psychologist-patient attitudinal improvement may be to ask

psychologists which attitudes garner the greatest improvement post-training completion. This model has been used previously with other clinical groups (Krawitz, 2004).

Psychologists who embrace the attitude that management of the disorder is the best that can be done for BPD patients also appear to find BPD patients as an enjoyable part of their practice. The field of psychology is diverse in not only its providers, but in the skills that they can provide to patients. A hypothesis may be that some psychologists are particularly gifted at (and BPD patients may subsequently respond well to) providing management of the disorder versus a more manualized treatment. Indeed, some inpatient BPD patients focus more on symptom management than on treatment.

Psychologists who attended a greater number of BPD-specific trainings acknowledged more positive treatment outcome attitudes with patients of the same. Since there was not a large number of participants endorsing greater than two trainings, a hypothesis is cautiously offered. A clear possibility is that those attending multiple trainings with BPD patients bolster their attitudinal posture regarding treatment outcomes.

Psychologists indicate that BPD patients may exert control over treatment and therapy settings and is relatable to the feeling of the pressure to act when safety concerns are known to be a factor. Whether psychologists' attitudes are that BPD patients use self-injurious behavior (i.e., safety concerns) as a means to control treatment is beyond the scope of this study, but certainly worthy of further investigation.

Although the relationship between psychologists attending more training and fewer negative attitudes was not large, the fact that training appears to have had an impact on overall negative attitudes is present in the correlational results. Future research should focus on clinicians who attend multiple trainings, and perhaps not only what helps reduce negative

attitudes within the trainings, but what in the psychologists draws the psychologist to seek additional training (i.e., psychologists may not have the resources to attend, psychologists interest in treating this group may vary). In doing so, examining the qualities of this group may help make clinical interactions and even treatment, more helpful.

The only factor that did not meet thresholds for correlation in any way was the factor measuring whether or not psychologists endorsed attitudes that BPD patients could not control certain aspects of their behavior. As a group, the respondent pool indicated that BPD patients in fact have command over behaviors. This ability to control behaviors, paradoxical to the appearance of the patient's insistence to sit in behaviors that are dysfunctional may contribute to attitudinal and clinical frustration on the part of the psychologist.

Clinical Implications

One of the difficulties present in patients with BPD is that they often struggle with dichotomous (often referred to as black and white) thinking. This thinking often drives patients to perceive between two values, relationships, and life choices as separate without demonstrating the ability to be cohesive. Many psychologists offer treatments that stress integration and perspective-taking to patients in an attempt to shift their viewpoint. A significant finding of this study is the ability of psychologists to hold and integrate two attitudes with what appears to be competing polarities. For example, the psychologists who found BPD patients the most enjoyable to treat, also acknowledged strongly, their capacity to sabotage and manipulate treatment. Another such relationship exists in psychologists doubting their abilities to help while simultaneously holding their ability to enjoy treating BPD patients. The focus of this study has not been on elements of effectiveness for psychologists working with BPD patients. Additionally, abstinence from reactivity in spite of the patient's behavioral difficulties may be

perceived as being an intervention all of its own. Psychologists' ability to consistently enjoy their experiences with these patients in spite of their challenges is fundamental.

One factor not addressed in this study was the element of time that it takes to treat the BPD patient. Beyond the demandingness and the manipulative behavior that exhausts many clinicians, endorsed by respondents herein, treatment itself is lengthy. Whether specialized treatments such as dialectal behavior therapy, mentalization-based treatment, or dynamic therapy, a recent meta-analysis on the effectiveness of specialized treatments versus protocol treatment demonstrated that initial treatment spanned from no fewer than 20 weeks to the upper limits of 156 weeks. One follow up week treatment in the study incurred a 104-week commitment, on the heels of a 52-week initial course of treatment (Oud, Arntz, Hermens, Verhoef, & Kendall, 2018). Considering the personal investment, resources, and time it takes to treat patients diagnosed with BPD, it is perhaps not surprising that attitudes are affected.

Particularly in community, mental health settings were BPD patients may frequent, when resources are low, and demand on psychologists is high, the result may be burnout. At the time that the survey was disseminated to participants in the HPA, there were approximately 334 members who would have received the invitation for the survey. Of those members, 260 had a status not indicative of "student" which would have encouraged them to take the survey. An implication of sending out a survey associated with a specialized diagnosis is perhaps that respondents may be more inclined to reply to those surveys in which they have express interest. It may be that psychologists responding think that they something to contribute to the survey by way of experience. It also could be that they feel compelled to respond on the basis that BPD patients are indeed a difficult population with which to work as a result of their own experiences and wish to contribute to research as a means of contributing to better treatment outcomes.

While there is a hypothesis that some psychologists may have responded to the survey as a result of direct interest in the topic, the adverse could also be true. Psychologists endorsed having a wide range of experiences with patients, both positive and negative throughout the survey. An implication of negative experiences with BPD patients includes knowing personal limits as a clinician, including when to refer out to another psychologist who can have a positive experience of enjoying and acknowledging difficult behaviors.

Limitations

The measure used in this study was comprised of a number of factors indicated as significant variables affecting the attitudes of clinicians from a broad group of treatment specialties. It can be presumed that there are some factors among attitudinal variables that resonate more with certain psychologists, and perhaps some variables that hold no bearing with other psychologists. For this measure to stand up over time it would need to undergo tests for reliability and validity, which is in itself, separate studies. Due to limitations of time and resources, the survey did not have reliability and validity tests at the time of dissemination. The limitation in engaging in a study of this nature is that in conducting an attitudinal study without a clear signal related to the reliability and validity of the measure, it is difficult to say if variance is attributable to participants' attitudes, or if variance is innate within the measure.

An additional limitation imposed on the results is use of attitudinal mean (referred to as the negative attitudes). Use of a mean for regression or throughout statistics involves grouping large amounts of individual participant data together. In doing so, there is potential loss of individual, item-by-item data. For example, it is understood that there is a relationship between psychologists who have a higher overall negative attitudes and who also endorse higher levels of finding BPD patients to manipulate and sabotage treatment. However, it is also true that within

the attitudinal composite are scores that include enjoyableness and good treatment outcomes which also elevate the overall attitudinal outcome.

While the study addressed a number of attitudinal variables including the ability to help, it did not address the psychologists' ability or attitude of confidence in treating the BPD patient. In conducting regression as well as analyzing each relationship individually, it occurred that this theme, closely related to an ability to help, might have been endorsed at a frequent rate. Furthermore, factors such as helping and confidence are areas in which training might be effective in addressing.

An additional limitation often imposed in survey studies is the operationalization of terms. For example, public health is a broad and sweeping term encompassing several different perceptions and understandings. A benefit of survey is that it draws in participants with anonymity in part, by means of brevity. To go to great means to operationalize terms takes time away from participants and runs the risk of clarifying terms at the cost of losing interest along the way. Adversely, participants draw personal interpretive meaning about what survey items convey, yielding varied results.

Recommendations for Future Study

Because of the sample size of the study, there was a limited number of psychologists who endorsed have greater than a singular exposure to BPD-specific training. Moreover, it is difficult to correlate with any direct clarity, the amount of relationship that is attributable between training and psychologists' attitudes in working with BPD patients. Herein lies an opportunity for future study—perhaps with a broader, non-localized sample.

Of all the factors measured, public health garnered the greatest attention. As previously addressed, additional clarification on what this term may mean to different psychologists is

helpful. Also, understanding the severity and how public health inhibits or complicates their work specifically with BPD patients may warrant greater consideration. Do public health constraints extend to other diagnoses? If so, is it more pronounced with this diagnosis?

At times, significant opportunities for future study can be found in insignificant data. This is seen in what psychologists appear to believe consistently across the sample about the ability of the patient to control their behavior(s). A line of further inquiry may exist in parsing out what these beliefs may be informed by (i.e., clinical interactions with patient; institutional training).

Overall, there were fewer significant relationships in the area of assessment than expected. It could be that future research may focus on how psychologists arrive at a BPD diagnosis at intake (records review [carryover], psychodiagnostic testing, clinical interview, mixture of both). As very little research to our knowledge has focused on psychologists and BPD interaction, there is plenty of breadth and depth for expansion and exploration.

Conclusion

The literature review and the respondents have affirmed the challenging nature of treating and assessing BPD patients. Given the treatment protocols with which research has found most effective, skills taught to the patient are apparently the same attitudes beholden to the psychologist as s/he sits with the patient. It is a profound quality, and unexpected recurring theme resounding throughout the results that psychologists are modeling these attitudes and even behaviors they wish to see in their BPD patients through their clinical posture.

It is clear that not all psychologists in this study endorsed similar patient experiences, training occurrences, and years of practice. It does appear initially, that training is helpful in reducing how psychologists feel about patients' control over therapy. It may also have a positive

effect on how well psychologists' think about patients' treatment trajectory. The specific extent to which each variable is a contributing factor bears further quantitative query and qualitative understanding. From the small sample of respondents, it appears so far that the diagnosis contributes to at least some of the attitudinal variability that the psychologist senses as he or she treats the patient. In plain language, what is sensed from across the room from the patient appears to be sensed within. Conceptually, psychologists appear to be able to integrate the information, balance it as well as they can and demonstrate enjoyableness towards patients who are admittedly very difficult at times to treat. For many patients who have been shown what is unstable, this is welcome news indeed.

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APPENDIX A

INSTITUTIONAL REVIEW BOARD CERTIFICATION

ARGOSY UNIVERSITY

February 23, 2018

Lindsey Nelson
87-1033 Kaihoolulu Street
Waianae, HI 96792

lindseynelson@stu.argosy.edu

Dear Ms. Nelson,

Your application, "Attitudes Among Psychologists Working With Borderline Personality Disorder," is fully certified by the Institutional Review Board as of 2-23-2018.

You need to abide by the requirements in any letters of permission you have obtained.

Please note that research must be conducted according to this application that was certified by the IRB. Your proposal should have been revised to be consistent with your application. Please note that you also need to abide by any requirements specified in your letter of permission. Any changes you make to your study need to be reported to and certified by the IRB.

Any adverse events or reactions need to be reported to the IRB immediately.

Your full application is certified for one year from 2-23-2018. Please be aware that if your study is not likely to be completed one year from 2-23-2018, you will need to file a **Continuing Review for IRB or Continuing Certification of Compliance** form with the IRB at least two months before that date to obtain recertification. If your proposal is not recertified within the year specified (365 days), your IRB certification expires and you must immediately cease data collection.

When you have completed your research you will also need to inform the IRB of this in writing and complete the required forms. You may use the **Project Completion Report** form for this purpose. Records must be retained for at least three years.

Good Luck with your research!

Honolulu, 1003 Bishop Street | Suite 138 | Honolulu, HI 96813 | 808.536.5555 | Fax: 808.536.5505 | 888.323.2777 | argosy.edu

Please be careful not to lose this letter.

If you have questions please feel free to contact me.

Sincerely,

Robert M. Anderson Jr., Ph.D., Co-Chair
Institutional Review Board

cc: Dr. Kathryn Chun

APPENDIX B

INSTITUTIONAL WAIVER

HAWAI`I SCHOOL OF PROFESSIONAL PSYCHOLOGY®
AT ARGOSY UNIVERSITY

Response to Student Petition

Student Name: **Lindsey Nelson**

Nature of Petition: Register for CRP ahead of Study Plan

Date Received: 7/20/17 Date of Response: 7/20/17

Response to Petition:

☑ Granted ☐ Denied ☐ Deferred

Comments:

Student has met with her advisor and has a clear path to completion.

Program Dean Signature: Sean W. Scanlan, Ph.D. Digitally signed by Sean W. Scanlan, Ph.D. Date: 2017.07.20 13:13:42 -10'00'

cc:
☑ Registrar
☑ Academic Advisor
☑ Student
☐ Other

Rev (1/9/14)

APPENDIX C

INSTITUTIONAL WAIVER

HAWAI`I SCHOOL OF
PROFESSIONAL PSYCHOLOGY®
AT ARGOSY UNIVERSITY

To: Sean Scanlan, Ph.D.
Program Dean, Clinical Psychology Programs

From: Kathryn M. Chun, Ph.D.

Date: July 20, 2017

Re: Lindsey Nelson's petition to begin working on her Clinical Research Project (CRP) prior to completing PP7043 Qualitative Inquiry

Lindsey Nelson and I have had several informal conversations about her CRP topic and she might implement a study investigating it. We have also discussed our fit with respect to the proposed study.

I have agreed to support her in this endeavor. I believe she is well prepared to begin designing and conducting this study at this time. She demonstrates an understanding of her topic area, has explored research methods that would best apply, intends to use a quantitative research approach, and understands the lengthy duration of a quantitative research data collection process. She also demonstrates qualities of personal responsibility, efficiency, professional responsibility, openness to feedback, and strong writing skills.

I hope that you will deeply consider her request to begin registering for CRP credit in Fall, 2017, and working on her project prior to the Spring term of her third year in the program. This early start will allow her to have adequate time to collect and analyze the data associated with her research question. Please let me know if you have any further questions that may be helpful in reviewing her petition.

Sincerely,

Digitally signed by
kchun@argosy.edu
DN: cn=kchun@argosy.edu
Date: 2017.07.20 10:32:46 -10'00'

Kathryn M. Chun, Ph.D.
Assistant Professor

1001 Bishop Street. Suite 400. Honolulu, HI 96813. Phone: 808-536-5555. Fax: 808-536-5505. Toll Free: 888-323-2777. HSPPHawaii.com

APPENDIX D

COPY OF INFORMED CONSENT FORM

My name is Lindsey Nelson and I am a doctoral student in the Clinical Psychology program at Hawai'i School of Professional Psychology at Argosy University working on my dissertation. I am conducting a survey to explore and better understand the attitudes of psychologists when working with patients/clients meeting criteria for Borderline Personality Disorder.

Your participation in this survey is strictly voluntary and your responses will be kept confidential. By participating you do not need to provide your address, name, or the specific place that you work. If you participate in this research, you will be asked to complete a self-report survey involving your attitudes towards patients/clients identified as meeting criteria for Borderline Personality Disorder. You will not be required to document personal account with patients/clients. By completing this survey, you are giving your consent for your information and data submitted to be used in this study. You may decline to answer any question on the survey without penalty. Not participating in this survey is your right. To participate, you must have graduated from a doctoral-level psychology program. The survey should take less than 10 minutes to complete, and you must be at least 18 years-old to participate.

Data collected from the survey will be secured at all times by the principal investigator. The information you provide for this research will be treated confidentially. All written data and materials will be stored in a locked file cabinet, and the principal investigator is the only person who has the key. All other data will be stored on the principal investigator's individual laptop, and will remain under password protection at all times The principal investigator is the only person who has access to the passwords to the hard drive and the laptop. Survey submissions will be collected through one source, SurveyMonkey, in which IP address tracking will be turned off at all times during the data collection phase. This will provide added assurance to you, the participant that no personally identifiable information from the data will be transferred to analysis or results. Results of the research will be reported as summary data only, and no individually identifiable information will be presented. All consent forms will be stored securely for three (3) years, as per Hawai'i School of Professional Psychology at Argosy University's Institutional Review Board requirements, and in keeping with ethical research practices. After September 01, 2021, all digital will be deleted and any printed information, shredded. While all efforts will be made to keep your information confidential, confidentiality cannot be guaranteed without rare exception by the research team (for example, subpoena for records).

There is no direct benefit from the principal investigator directly to you, the participant, for your participation in this study. Indirectly, benefits to the profession may include the opportunity for you to share your experience with the research community on this important topic. Potential risks may involve uncomfortable feelings and/or memories associated with past interactions with patients/clients. In an attempt to better understand and provide a baseline for the attitudes of psychologists as they interact with these patients/clients, it is not the intent of the principal investigator to vilify those who treat and assess them. Should any questions or concerns surface before, during, or following your interaction with the survey, please do not hesitate to contact the principal investigator as listed below or the research chair. Please keep this letter for your

records. If you would like to know the results of the study, please contact the principal investigator at the information below. For questions regarding participants' rights please contact Dr. Robert Anderson, IRB Chair, Argosy University-Hawaii Campus, 1001 Bishop Street, Suite 400, Honolulu, HI 96813, or by phone at 808.791.5207.

Principal Investigator
Lindsey J. Nelson, M.S.
lindseynelson@stu.argosy.edu
Phone: 808.222.3959

Research Chair
Dr. Kathryn Chun, Ph.D.
kchun@argosy.edu
Phone: 808.791.5224

APPENDIX E

COPY OF INSTRUMENT

1. I have read the consent form detailing the purpose and procedures for this research, and I am completing this survey as evidence of my consent to be a voluntary participant in this research project.
2. I have graduated from a doctoral-level psychology program.
3. What is your gender?
4. How many years have you been working as a psychologist?
5. What is your primary place of work as a psychologist? (Please select only one).
6. What is your primary work function as a psychologist? (Please select only one).
7. Please state how many trainings you have attended within the last ***5 years*** related to treating or diagnosing Borderline Personality Disorder.
8. Have you in the past, or do you now see patients who meet criteria for Borderline Personality Disorder?

The following items relate to attitudes among psychologists working with patients meeting criteria for Borderline Personality Disorder (BPD). We value and safeguard the confidentiality of your responses.

Please rate the following statements using the corresponding 6-point scale below each item:

9. Patients meeting criteria for Borderline Personality Disorder often manipulate or sabotage treatment.

Disagree					Agree
1	2	3	4	5	6

10. Patients meeting criteria for Borderline Personality Disorder cause me to feel overwhelmed.

Disagree					Agree
1	2	3	4	5	6

11. Patients meeting criteria for Borderline Personality Disorder have good treatment outcomes. (*Reverse Scoring*)

Disagree					Agree
1	2	3	4	5	6

12. Patients meeting criteria for Borderline Personality Disorder cause anxiety and pressure to act due to significant anxiety concerns or threats.

Disagree					Agree
1	2	3	4	5	6

13. Patients meeting criteria for Borderline Personality Disorder may have presentations at intake that may be difficult to assess; it may be challenging to differentiate the diagnosis from other similarly appearing diagnoses.

Disagree					Agree
1	2	3	4	5	6

14. I often experience patients meeting criteria for Borderline Personality Disorder as an enjoyable part of my practice as a psychologist. (*Reverse Scoring*)

Disagree					Agree
1	2	3	4	5	6

15. Patients meeting criteria for Borderline Personality Disorder have a limited ability to change.

Disagree					Agree
1	2	3	4	5	6

16. Patients meeting criteria for Borderline Personality Disorder make me doubt or wonder if there is anything I can do to help.

Disagree					Agree
1	2	3	4	5	6

17. Patients meeting criteria for Borderline Personality Disorder may often control therapy or treatment sessions.

Disagree					Agree
1	2	3	4	5	6

18. When compared to patients who have a different diagnosis, I am more inclined to show empathy to patients who do not meet criteria for Borderline Personality Disorder.

Disagree					Agree
1	2	3	4	5	6

19. Patients meeting criteria for Borderline Personality Disorder do not have the ability to control aspects of their behavior. (*Reverse Scoring*)

Disagree Agree

1 2 3 4 5 6

20. I find that working with patients identified as meeting criteria for Borderline Personality Disorder within the public health system to be exceedingly frustrating or difficult.

Disagree Agree
1 2 3 4 5 6

21. The best that psychologist can "do" for patients meeting criteria for Borderline Personality Disorder is to help them with management of the disorder.

Disagree Agree
1 2 3 4 5 6

APPENDIX F

DESCRIPTIVE TABLES

Table 1

Number of BPD Trainings Attended

Respondents (*n* = 23)	Valid Percent
Standard Deviation	1.722
Mean	1.35
Range	6

Table 2

Number of Years Practicing

Respondents (*n* = 27)	Valid Percent
Standard Deviation	12.136
Mean	15.85
Range	37

Table 3

Place of Work

Respondents (*n* = 31)	Valid Percent
Community Mental Health Center	6.5
Child/Adolescent Center	6.5
Private/Group Practice	54.8
School/Educational Setting	3.2
Blank/Prefer Not to Respond	29

Table 4

Work Function

Respondents (*n* = 31)	Valid Percent
Management/Administration	9.7
Teaching/Education	3.2
Assessment	9.7
Psychotherapy/Treatment	64.5
Blank/Prefer Not to Respond	12.9

Table 5

Exposure to BPD Patients in Clinical Practice

Respondents (*n* = 31)	Percent
Yes	87.1
Blank/Prefer Not to Respond	12.9

Table 6

Sex

Respondents (*n* = 31)	Percent
Male	19.4
Female	67.7
Blank/Prefer Not to Respond	12.9

APPENDIX G

REGRESSION TABLES

Table 7

Attitudinal Composite

	n	*SD*	Mean
Composite Score	27	.7392	3.289

Table 8

Regression Summary[b]

Model	R	R Square	Standard Error
1	.478[a]	.228	.6811

[a]Predictors: Number of Trainings Attended within past 5 years; Number of years Practicing
[b]Dependent: Attitudinal Composite

Table 9

ANOVA[a]

	df	*F*	Sig.
Regression	2	2.957	.075[b]

[a]Dependent: Attitudinal Composite
[b]Predictors: Number of Trainings Attended within past 5 years; Number of years Practicing

Table 10

Regression Coefficients[a]

Model	Standard Error	Coefficient	Significance
Years of Practice	.012	.281	.170
Number of BPD Trainings Attended	.079	-.362	.081

[a]Dependent Variable: Attitudinal Composite Score

APPENDIX H

CORRELATION MATRIX

Table 11

Correlation Matrix of Variables†

Correlations Between Measures of Attitudes Among Psychologists Working with BPD Patients, Training, and Years in

Variable	***1***	***2***	***3***	***4***	***5***	***6***	***7***	***8***	***9***	***10***	***11***	***12***	***13***	***14***	***15***
1-Manipulativeness															
2-Overwhelming	.209														
3-Outcomes	.140	.516**													
4-Pressure to Act	.290	.510**	.480*												
5-Assessment	.050	.362	.153	.277											
6-Enjoyable	.703**	.144	.035	.298	.173										
7-Change	.449*	.331	.185	.277	.054	.556**									
8-Help	.548**	.209	.143	.532**	.182	.640**	.487*								
9-Treatment	.248	.369	.160	.402*	.342	.519**	.278	.584**							
10-Empathy	.457*	.002	.352	.003	.051	.441*	.392	.522**	.245						
11-Behavior	-.063	.148	-.124	.115	.281	-.029	-.029	.004	.213	-.054					
12-Public Health	.289	.489*	.462*	.437*	.471*	.527**	.496*	.493*	.443*	.217	-.007				
13-Management	.557**	.185	.211	.153	.085	.423*	.476*	.319	.056	.035	-.243	.445*			
14-Composite	.677**	.558**	-.138	.629**	.477*	.732**	.643**	.758**	.626**	.447*	.269	.719**	.476*		
15-Training	.067	-.414*	-.394	-.297	-.256	-.164	-.310	-.268	.501*	-.291	-.122	-.240	.183	-.373	
16-Yrs. Practice	.441*	.008	-.010	.069	.125	.366	.276	.301	.269	.348	-.113	.093	.167	.314	-.064

*Correlation is significant at the 0.05 level (2-tailed). ** Correlation is significant at the 0.01 level (2-tailed)

†A supplementary table describing enumerated correlation variables is available in Appendix I.

APPENDIX I

CORRELATION VARIABLE DESCRIPTORS

Table 12

Correlation Variable Descriptors

Variable on Correlational Table	Information Gathered from Survey
1	BPD patients manipulate/sabotage treatment
2	BPD patients cause feelings of being overwhelmed
3	BPD patients have good treatment outcomes
4	BPD patients cause pressure to act due to safety concerns/threats
5	BPD patients can be difficult to assess
6	BPD patients are an enjoyable part of psychology practice
7	BPD patients have a limited ability to change
8	BPD patients cause doubt about the ability to help
9	BPD patients may control treatment
10	Inclination to show empathy to BPD patients vs. other patients
11	BPD patients do have control over aspects of their behavior
12	Work with BPD patients in the public health system is frustrating
13	Management of the disorder is the best that psychologists can do
14	Attitudinal Composite (Mean of Variables 1–13)
15	Number of trainings Attended specific to BPD in the past 5 years
16	Number of years practicing as a psychologist