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Clinician's Negative Attitudes Toward Borderline Personality Disorder: Implications For Diagnosis And Treatment Recommendations

Sarah Aldridge
Indiana State University

CLINICIAN'S NEGATIVE ATTITUDES TOWARD BORDERLINE PERSONALITY DISORDER: IMPLICATIONS FOR DIAGNOSIS AND TREATMENT RECOMMENDATIONS

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Sarah Aldridge

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ProQuest LLC.
789 East Eisenhower Parkway
P.O. Box 1346
Ann Arbor, MI 48106 - 1346

COMMITTEE MEMBERS

Committee Chair: June Sprock, Ph.D.

Professor of Psychology

Indiana State University

Committee Member: Kevin Bolinskey, Ph.D.

Associate Professor of Psychology

Indiana State University

Committee Member: Veanne Anderson, Ph.D.

Professor of Psychology

Indiana State University

ABSTRACT

There is a significant amount of stigma associated with Borderline Personality Disorder (BPD) among mental health professionals (Aviram, Brodsky & Stanley, 2006). Although gender has been found to influence attitudes towards psychological disorders (Wirth & Bodenhausen, 2009), findings concerning the effects of gender on the diagnosis of BPD have been inconsistent. Moreover, BPD is a heterogeneous disorder (Lewis et al., 2012), but little is known about the impact of BPD symptom presentation on diagnosis, treatment, or clinician attitudes. This study used a vignette methodology to examine the effect of clinician attitudes toward BPD, client gender, and BPD symptom presentation on diagnosis and treatment recommendations. Clinicians read one of four BPD vignettes that varied by client gender and symptom presentation (i.e., female-type or male-type BPD symptoms), and then provided a diagnosis and representativeness ratings of BPD and other personality disorder diagnoses and symptoms. They also rated severity, prognosis, likelihood the client would benefit from treatment, likelihood they would disclose the diagnosis to the client, willingness to work with the individual, and various treatment recommendations. Finally, they completed measures of attitude towards BPD, social desirability, and a demographic questionnaire. The results indicated that clinicians' attitudes toward BPD were not predictive of a BPD diagnosis, BPD representativeness or symptom ratings, severity ratings, or treatment recommendations. However, clinicians' attitude towards BPD had a small effect on ratings of prognosis and likelihood the client would benefit from treatment, and a moderate effect on their willingness to work with client. The gender of the client

had a significant effect on treatment recommendations, with the female clients recommended effective treatments more often than male clients. The type of BPD symptom presentation had a significant impact on the diagnosis of BPD, BPD representativeness ratings, and treatment recommendations. There were no significant interactions between gender and symptom presentations. There are several limitations of the study, particularly the use of a vignette methodology. Nevertheless, the results have implications for the diagnosis and treatment of BPD.

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CHAPTER 1

INTRODUCTION

The stigma and negative attitudes associated with mental illnesses have long been a topic of discussion in the literature. Research suggests that the overall level of stigma associated with mental illness is generally more negative than the stigma associated with physical disabilities (Corrigan et al., 2000), and the stigma is worse when someone is diagnosed with particular mental disorders (Corrigan, 2007). For instance, the stigma associated with personality disorders is more negative and enduring than the stigma associated with Axis I disorders, such as depression (Lewis & Appleby, 1988). Consistent with previous research on the stigma associated with personality disorders, research has demonstrated that there is a significant amount of stigma and negative attitudes associated with Borderline Personality Disorder (BPD) among the general public, psychiatric nurses, as well as clinicians (Aviram et al., 2006).

Clinicians and other mental health professionals describe individuals with BPD using negative terminology (e.g., manipulative, attention-seeking, and difficult; Lewis & Appleby, 1988), have negative emotional reactions to individuals with BPD (Holmqvist & Jeanneau, 2006), and have been shown to distance themselves from clients with BPD (Markham, 2003). One major concern with the stigmatization of BPD is that clinicians often associate the diagnosis of BPD with a poor prognosis due to the common misconception that BPD is resistant to treatment (Hersh, 2008; Krawitz, 2004). However, several forms of psychotherapy developed for

BPD, including Dialectical Behavior Therapy (Linehan, Armstrong, Suarez & Allmon, 1991) and Mentalization-Based Treatment (Bateman & Fonagy, 2008), have been shown to be effective in the treatment of BPD (Bateman & Fonagy, 2008; de Groot, Verheul, & Trijsburg, 2008), sometimes in combination with medications (e.g., SSRIs or low-dose antipsychotics). The effect of the stigma associated with BPD on the treatment and outcome of individuals with BPD is unknown. However, stigma has been shown to have a negative impact on individuals diagnosed with a mental illness, leading to lower self-esteem and quality of life (Marcussen, Ritter, & Munetz, 2010). Stigma has been described as a barrier that affects treatment and recovery from mental illness (Abbey et al., 2011; Link, Struening, Neese-Todd, Asmussen, & Phelan, 2001; Wahl, 2012).

Moreover, the stigma associated with psychological disorders is further influenced by a person's gender. For instance, research by Wirth and Bodenhausen (2009) suggests that psychological disorders considered more common for one gender (i.e., depression in women) elicit more negative attitudes than if that same disorder is present in the other gender (i.e., depression in men). The research suggests that clinicians may associate BPD with women (American Psychiatric Association [APA], 2000), although gender differences in prevalence are debatable (Grant et al., 2008). Additionally, certain BPD criteria have been shown to be more commonly associated with male behaviors (i.e., intense anger, hostility, as well as impulsive substance abuse), whereas the remaining BPD criteria (e.g., fear of abandonment and impulsive binge eating) are commonly associated with female behaviors (Sprock, Blashfield, & Smith, 1990; Zlotnick, Rothschild, & Zimmerman, 2002). This research suggests that men and women may exhibit different symptom presentations of BPD, and that similar presentations of BPD in men and women may elicit different levels of stigma and negative attitudes. As such, the

individual's gender may be an important variable in understanding the stigma of BPD. However, the effect that gender may have on the relationship between stigma and BPD has not been examined.

Few studies have examined the implications of clinicians' attitudes toward BPD for diagnosis, prediction of outcome, and treatment recommendations. It is important to understand if the stigma associated with BPD affects behaviors of clinicians. The purpose of the study was to examine the relationship between attitudes of clinicians towards BPD and the diagnoses they assign, perceptions of severity and prognosis, and treatment recommendations, as well as the effect of the client's gender and BPD symptom presentation. A national sample of clinicians was asked to read one of four vignettes representing BPD that varied by symptom presentation and client gender, and provide a diagnosis and rating of confidence in their diagnosis. They also provided ratings of representativeness of BPD and other PDs, the presence and severity of BPD symptoms, overall severity, prognosis, the likelihood of the client responding to different treatment options, their likelihood of disclosing the diagnosis to the client, and willingness to work with the individual. They also provided treatment recommendations. Finally, they completed a measure of attitudes towards BPD, a measure of social desirability, and a demographic questionnaire.

Based on results of past research regarding the stigma associated with BPD (Aviram et al., 2006), it was hypothesized that clinicians would hold negative attitudes towards clients with BPD. In addition, it was predicted that more negative attitudes would be associated with higher symptom ratings, lower ratings of prognosis and the likelihood of benefiting from treatment, less willingness to work with the client, and treatment recommendations that are less effective and appropriate. Given that past research has suggested that BPD is more frequently diagnosed in

women (APA, 2000), it was predicted that the vignettes describing the client as female would be more likely to receive a diagnosis of BPD and higher BPD representativeness ratings than the same vignettes presenting the client as male. It was also hypothesized that there would be differences regarding diagnosis, BPD representativeness ratings, BPD symptom ratings, and treatment recommendations based on the type of symptoms (i.e., female-type/dependent or male-type/angry) presented in the vignette, although due to the dearth of research in this area, no specific hypotheses regarding the direction of these differences were made. Finally, it was hypothesized that there would be an interaction between the type of BPD symptom presentation described in the vignette and the gender of the client. Overall, this study was developed to contribute to the literature on the stigma associated with BPD, and provide information on the influence of stigma and the attitudes of clinicians on diagnosis and treatment recommendations for individuals with BPD.

CHAPTER 2

LITERATURE REVIEW

Overview of Borderline Personality Disorder

Description. In the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR), Borderline Personality Disorder (BPD) is defined as a pervasive pattern of interpersonal difficulties, impulsive behavior, and affective dysregulation, as well as difficulties maintaining a stable self-image (APA, 2000). This pattern is present by early adulthood and is manifested across a variety of settings. Individuals with BPD are also sensitive to rejection or feelings of abandonment, and often react in a negative, dysregulated manner when faced with these situations in an attempt to maintain the relationship (e.g., intense anger or suicidal gestures). Other features of BPD include chronic feelings of emptiness and dissociative or brief psychotic symptoms in response to stress. In general, the BPD criteria consist of a mixture of cognitive, affective, and behavioral symptoms. The diagnosis of BPD may be associated with increased distress when individuals with BPD are feeling overwhelmed, are faced with the ending of relationships, or have comorbid disorders (Skodol et al., 2002). The DSM-IV-TR requires that a minimum of five of the nine criteria for BPD be met before a diagnosis of BPD is assigned (see Appendix A for the DSM-IV-TR BPD criteria).

Epidemiology. Research suggests that BPD is one of the most commonly encountered personality disorders (Krawitz & Batcheler, 2006). The prevalence of BPD is approximately 2%

in the general population, approximately 8 to 11% in outpatient facilities, and up to 20% among individuals in inpatient settings (APA, 2000; Bateman & Fonagy, 2004; Torgersen, Kringlen, & Cramer, 2001). BPD is commonly comorbid with Axis I disorders, including mood disorders, bipolar disorders, Posttraumatic Stress Disorder (PTSD), eating disorders, and substance-related disorders (APA, 2000; Grant et al., 2008; Skodol et al., 2005). BPD is also often comorbid with other personality disorders, particularly Dependent, Avoidant, and Paranoid personality disorders (APA, 2000; Zanarini et al., 2004).

Course. According to the DSM-IV-TR, BPD begins in young adulthood and is characterized by a pattern of emotional and impulse dysregulation and interpersonal difficulties that is pervasive and relatively stable across an individual's lifespan (APA, 2000). However, the DSM-IV-TR notes that the course of BPD may vary and that the disorder is often most impairing during young adulthood. In fact, recent research has indicated that personality disorders are not as stable as originally thought (Zanarini et al., 2005). For instance, longitudinal research has found evidence suggesting that personality disorders, such as BPD, often diminish with age and may even go into remission (Cohen et al., 2005; Paris, 2002; Skodol et al., 2005). Paris and Zweig-Frank (2001) followed up with individuals with BPD twenty-seven years after they had been diagnosed, and found that the majority of the individuals no longer met full criteria for BPD. Overall, current research provides evidence that BPD is not as enduring as previously believed and the disorder may improve with time.

History. Historically, the concept of BPD emerged from psychoanalytic theory. BPD was originally thought to be closely related to psychosis and was initially referred to as "borderline schizophrenia" (c.f., Zanarini, 2005). Stern (1938) was one of the first psychoanalysts to use the term "borderline," and he described several broad characteristics of these individuals (e.g.,

anxiety and emotional sensitivity). However, one of the main contributions to the development and conceptualization of BPD came from Kernberg (1967) who proposed a construct he labeled the borderline personality organization (BPO). Kernberg described BPO as more severe than the neurotic personality organization, due to identity disturbance, but less severe than the psychotic personality organization, due to adequate reality testing capabilities. Aspects of Kernberg's description of BPO (i.e., impulsivity, anxiety, and splitting) have been retained as a part of the current understanding of BPD (Stone, 2005).

Gunderson and Singer (1975) introduced the term "borderline personality disorder." They developed an operational definition of BPD and found that it could be reliably distinguished from other mental and personality disorders. However, BPD was not considered a diagnosable disorder until the 1980's, when it was officially added to the DSM-III (APA, 1980; Stone, 2005). The DSM-III provided more specific criteria for BPD than had been used in the historical description of "borderline," including a better description for impulsivity, identity disturbance, and acts of self-harm or self-mutilation (APA, 1980). The BPD criteria have remained similar to the original DSM-III criteria, undergoing only a few changes and slight rewording in subsequent versions of the DSM (Gunderson, 2009). One significant change, though, was the addition of transient paranoid or severe dissociative symptoms in response to stress in the DSM-IV (APA, 1994; 2000).

Etiology. The etiology of BPD is currently hypothesized to be due to the interaction of biological, social, and psychological factors (Cartwright, 2008; Paris, 2005a). For instance, biological research has found the heritability rate of BPD to be approximately 0.69 (Torgersen et al., 2000), indicating that there is a high degree of genetic influence in the etiology of BPD. Further advances in neuroimaging have revealed brain structures (Berdahl, 2010) and

neurotransmitters (e.g., serotonin) (Mauchnik, Schmahl, & Bohus, 2005) that are implicated in BPD. Although there appears to be a genetic component to BPD, social factors such as parental attachment (Skodol et al., 2005), as well as both abuse (i.e., physical, sexual, and emotion) and neglect experienced in childhood (Zanarini, Williams, Lewis, & Reich, 1997) have been associated with BPD. A clear understanding of the interplay of the biological, social, and psychological components has not yet been attained; however, a diathesis-stress interaction between the biological and environmental factors is likely, in that environmental factors may exacerbate the preexisting vulnerability to developing BPD (Cartwright, 2008). Overall, the exact etiological pathways of BPD are still being examined; however, researchers have suggested that different etiological pathways may provide at least a partial explanation for the heterogeneous symptom presentations seen among individuals with BPD (Zanarini et al., 2005).

Prognosis and treatment. Historically, the prognosis of BPD has been considered poor (Zanarini, 2012) given the severity of symptoms, impulsivity, and high rates of suicidal ideation and suicide attempts associated with the diagnosis (Lieb, Zanarini, Schmahl, Linehan, & Bohus, 2004). Clinicians often associate the diagnosis of BPD with a poor prognosis due to the common belief that BPD is resistant to treatment (Hersh, 2008; Krawitz, 2004). However, based on a recent review of the literature, Cartwright (2008) reported that BPD responds well to treatment and that individuals with BPD can have a good prognosis and outcome. For instance, several forms of psychotherapy developed for BPD have empirical support, including Dialectical Behavior Therapy (Linehan et al., 1991), Schema Therapy (Kellogg & Young, 2006; Young, 2000), Mentalization Based Treatment (Bateman & Fonagy, 2004), and Transference-Focused Psychotherapy (Clarkin, Yeomans & Kernberg, 1999). Zanarini (2009) conducted a literature review of psychotherapies for BPD and concluded that DBT, Schema Therapy, Mentalization

Based Treatment, and Transference-Focused Psychotherapy all lead to significant decreases in the severity of BPD or at least some of the symptoms of BPD.

Dialectical Behavior Therapy (DBT) was first developed using a biosocial theory to address individuals with BPD who were chronically suicidal (Linehan et al., 1991). Since the development of DBT, there has been numerous research studies supporting the effectiveness of DBT and it has been added as an effective treatment for BPD in the APA's practice guidelines for BPD (APA, 2001; Linehan et al., 1991; Linehan, Heard, & Armstong, 1993; Linehan et al., 2006). Research has demonstrated that when compared to treatment as usual, DBT shows higher reductions in self-injurious behavior, hospitalization, anger, and improved social adjustment (Linehan et al., 1991; Linehan et al., 1993). Randomized control trials continue to find that DBT is more efficacious and effective than treatment as usual (i.e., treatment by experts in a community setting) (Linehan et al., 2006). Lynch, Trost, Salsman, and Linehan (2007) completed a literature review of the empirical evidence for DBT and concluded that DBT is an effective and efficacious treatment for BPD that results in reduced self-injurious behavior, suicide attempts, depression, hopelessness and symptoms of bulimia. There appears to be sufficient evidence that DBT is an effective and appropriate treatment for BPD.

Schema Therapy utilizes CBT, attachment, and psychodynamic concepts to address dysfunctional schemas in individuals with BPD (Kellogg & Young, 2006). A randomized controlled trial of Schema Therapy and Transference-Focused Psychotherapy found that Schema Therapy lead to more clinical improvements and a greater reduction in severity of BPD symptoms than TFP, although both were considered effective and lead to improvements (Giesen-Bloo et al., 2006). Farrell, Shaw, and Webber (2009) conducted a randomized controlled trial of Schema Therapy versus treatment as usual and found that Schema Therapy lead to improved

functioning and reductions in BPD over the treatment as usual group. The researchers concluded that the trial provides support for Schema Therapy as an effective treatment for BPD. Moreover, a review of the empirical evidence for Schema Therapy concluded that treatment using Schema Therapy has been found to be effective in several studies (Jacob & Arntz, 2013).

Mentalization-based treatment (MBT) was developed specifically for individuals with BPD to improve the individual's ability to think (i.e., mentalize) about themselves and others, as the authors believe that this process is damaged as a result of attachment problems that occur in the development of BPD (Bateman & Fonagy, 2004). The authors suggest that teaching individuals to mentalize will help them to learn to identify their own thoughts and feelings, as well as thoughts and feelings of other people. There is evidence from randomized control trials that MBT is more effective at reducing self-injurious behaviors, hospitalization, depression and anxiety symptoms and increased medication compliance compared to than treatment as usual during the initial treatment phase (Bateman & Fonagy, 1999) at both the 18 month follow-up (Bateman & Fonagy, 2001) and an 8 year follow-up (Bateman & Fonagy, 2008). These results support the idea that MBT is considered an appropriate treatment for BPD.

Transference-focused psychotherapy (TFP) was developed to reduce symptoms of BPD, especially self-injurious behaviors by using transference to modify how clients see themselves and others. TFP, along with DBT, demonstrated improvements in depression, social and global functioning, anxiety, and reduced suicidal behaviors. TFP was also associated with improvements in anger verbal/physical assaults, and impulsivity (Clarkin, Levy, Lenzenweger, & Kernberg, 2007). Doering et al., (2010) conducted a randomized controlled trial comparing TFP to treatment in the community for BPD and found that individuals receiving TFP had decreased suicide attempts and hospitalization, were less likely to drop out of treatment, and demonstrated

more improvement in psychosocial functioning compared to individuals receiving treatment in the community. These results support the idea that TFP can be considered an appropriate treatment for BPD.

Moreover, some pharmacological treatments, such as selective serotonin reuptake inhibitors (SSRIs; e.g., Fluoxetine or Fluvoxamine), mood stabilizers (e.g., Valproate Semisodium), or low-dose antipsychotics (e.g., Olanzapine) have been shown to lead to improvement in BPD symptoms (Bellino, Paradiso, & Bogetto, 2008; de Groot et al., 2008). The APA Practice guidelines stated that psychopharmacological treatments may be helpful in targeting affective dysregulation, impulsivity, and cognitive-perceptual symptoms. These guidelines recommend the use of antidepressant agents and mood stabilizers for affective dysregulation and impulsivity, and antipsychotics for cognitive-perceptual symptoms (APA, 2001). Ingenhoven, Lafay, Rinne, Passchier, and Duivenvoorden (2010) conducted a meta-analysis of randomized controlled trials examining the effectiveness of pharmacotherapy for personality disorders. They concluded that antipsychotics were found to be effective in treating symptoms in the cognitive-perceptual domain, having a moderate effect on anger and psychotic-like features in BPD. Additionally, their meta-analyses found that antidepressants were effective in reducing anger and anxiety, but the effect size was small. Mood stabilizers had a large effect on impulsivity, anger, and anxiety, a moderate effect on depression, and appeared to have a positive impact on overall global functioning. Overall, it appears that several pharmacological treatments aid in reducing symptoms associated with BPD. Although the APA practice guidelines and other research continues to indicate that using integrated forms of treatment (i.e., psychotherapy combined with pharmacotherapy) with individuals with personality disorders may preferred over psychotherapy or pharmacotherapy alone (APA, 2001; Livesley, 2008).

On the other hand, treatments such as hospitalization, long-term inpatient, benzodiazepines, tricyclic antidepressants (TCAs), monoamine oxidase inhibitors (MAOIs), and substance abuse treatment have limited evidence regarding their effectiveness, or have been found to be less effective, in the treatment of BPD (Abraham & Calabrese, 2008; APA, 2001; Bellino, Paradiso, & Bogetto, 2008; Paris, 2004). Research has found that hospitalization (i.e., brief inpatient) or long-term inpatient treatment may not be beneficial for individuals with BPD and should be avoided, as these treatment settings may actually encourage maladaptive behaviors (e.g., suicide attempts) due to the amount of attention and concern BPD individuals receive in such environments (Hörz, Zanarini, Frankenburg, Reich, & Fitzmaurice, 2010; Paris, 2004). Abraham and Calabrese (2008) reviewed evidence for pharmacological treatments of BPD and concluded that there was little evidence of the effectiveness and efficacy of benzodiazepine alprazolam and TCAs in the treatment of BPD. Additionally, benzodiazepines are considered to be a less effective treatments for BPD due to the high risk of abuse, as well as the potential for overdose possible with these medications (APA, 2001). Past research has also found that benzodiazepines were associated with behavior dyscontrol (Gardner & Cowdry, 1985) and increased risk of suicide in clients with a diagnosis of BPD (Lekka, Paschalis, & Beratis, 2002). Bellino, Paradiso, and Bogetto (2008) reviewed the efficacy and tolerability of medications for BPD and concluded that TCAs and MAOIs are considered alternative treatments for BPD due to the risk of side effects and toxicity, which limits the use of these medications with individuals diagnosed with BPD in clinical practice. The practice guidelines state that MAOIs are not considered a first-line treatment choice for BPD due to the necessity to adhere to certain dietary restrictions, which could be problematic (APA, 2001). According the practice guidelines, substance abuse treatment is not listed as a first-line treatment for BPD (APA, 2001). There is

little evidence examining substance abuse treatment as the sole treatment of BPD. This is likely because substance abuse is one of the possible impulsive symptoms of BPD (APA, 2000). Linehan et al. (1999) noted that individuals with comorbid BPD and substance abuse are "uniformly more disturbed than substance abusers without a personality disorder," indicating that standard substance abuse treatment may not be enough on its own. Thus, substance abuse treatment may be helpful in treating a symptom of BPD, but may not fully address the underlying personality disorder.

Controversies with BPD Diagnosis

The BPD diagnosis has been criticized since it was added to the DSM-III (APA, 1980). The criteria have been criticized for several reasons including heterogeneity (Burgmer, Jessen, & Freyberger, 2000), possible gender bias, and possible gender differences in the presentation and diagnosis of BPD (Boggs et al., 2005, 2009; Grant et al., 2008).

Heterogeneity. Due to the polythetic definition of BPD in the DSM-IV-TR, which requires only five out of the nine criteria to be met in order to diagnose BPD, there are 126 different symptom presentations for the disorder (Critchfield, Levy, & Clarkin, 2007). Moreover, it is possible for two individuals diagnosed with BPD to only have one symptom in common (Chmielewski, Bagby, Quilty, Paxton, & McGee Ng, 2011). Thus, there is considerable variability in the symptom presentations, which has led to continued debate about the validity of BPD as a diagnostic category (Cartwright, 2008; Oldham, 2004; Tyrer, Gunderson, Lyons, & Tohen, 1997).

However, research has also found support for BPD as a valid and coherent diagnostic category (Clifton & Pilkonis, 2007; Chmielewski et al., 2011; Johansen, Karterud, Pedersen, Gude, & Falkum, 2004; Sanislow et al., 2002). It has a set of core features (i.e., affective

dysregulation, relationship difficulties, and identity disturbance) that allow it to be differentiated from other disorders (Burgmer et al., 2000; Gunderson & Singer, 1975; Skodol et al., 2002). Research has indicated that the core features of the disorder (e.g., affective and interpersonal difficulties) may be given more weight by clinicians than less common features (e.g., cognitive symptoms) when making diagnostic decisions (Burgmer et al., 2000). In the DSM-IV-TR, all of the nine criteria for BPD have the same weight in their contribution to the diagnosis (i.e., no one symptom is needed to meet the diagnosis); thus, the differing symptom presentations affect the accuracy of the diagnosis of BPD.

Additional research has examined whether the heterogeneous symptom presentations follow specific patterns that could potentially form meaningful subtypes of BPD (Fossati et al., 1999; Leihener et al., 2003; Lenzenweger, Clarkin, Yeomans, Kernberg, & Levy 2008; Millon, Grossman, Millon, Meagher, & Ramanth, 2004). The different symptom presentations and possible subtypes of BPD have long been a topic of discussion in the literature. For example, Leihener et al. (2003) proposed autonomous and dependent subtypes of BPD. Millon et al. (2004) subdivided BPD into discouraged (i.e., depressed, vulnerable, hopeless/helpless), self-destructive (i.e., internalizing, punishing, easily upset, moody, possibly suicidal), impulsive (i.e., superficial, seductive, agitated, irritable, potentially suicidal), and petulant (i.e., pessimistic, impatient, defiant, easily insulted and disappointed) subtypes. Conklin, Bradley, and Westen (2006) differentiated internalizing-dysregulated, externalizing-dysregulated, and histrionic-impulsive subtypes. They described the internalizing-dysregulated subtype as consisting of individuals who move between emotional constriction and emotional flooding, have difficulty expressing anger, feel worthless/self-hatred, and likely use internal strategies (e.g., rumination) that may lead to self-mutilation or suicide attempts. The externalizing-dysregulated subtype

included individuals who use externalizing strategies (e.g., alcohol) to cope or may even attack or try to control others. Conklin et al. described the histrionic-impulsive type as consisting of individuals who are impulsive and do not have any ability to delay gratification.

Researchers have examined whether BPD subtypes could be identified using multivariate statistics. Lenzenweger et al. (2008) found three phenotypically distinct groups in a sample of 90 individuals diagnosed with BPD using finite mixture modeling (FMM) to identify latent groups within the sample. Group 1 demonstrated low levels of antisocial, paranoid, and aggressive features and was healthier and higher functioning overall. Group 2 was characterized by high levels of paranoia, and Group 3 demonstrated high levels of antisocial behavior and aggression. Lenzenweger and colleagues suggested that these groups provide support for possible subtypes of BPD. More recently, Lewis, Caputi, and Grenyer (2012) used factor analysis to examine potential subtypes of BPD in an outpatient clinical sample of 95 adults diagnosed with BPD. The results of the principle component analysis revealed three subtypes which they titled, "affect dysregulation," "rejection sensitivity" and "mentalization failure." The affect dysregulation subtype was comprised of three main criteria: impulsivity, affective instability and anger. The rejection sensitivity subtype consisted of three criteria: suicidal behavior, efforts to avoid abandonment, and chronic feelings of emptiness. The mentalization failure subtype was comprised of criteria such as stress-related paranoia and identity disturbance, and the authors noted that the individuals fitting into this subtype lack the ability to differentiate between self and others. Evidence for possible subtypes of BPD continues to increase; however, there is a lack of agreement or consistent support for the proposed subtypes of BPD (Tyrer et al., 2011). Nevertheless, acknowledging and understanding the different symptom presentations of BPD may provide important information pertaining to the diagnosis and treatment of BPD.

Gender differences. A great deal of controversy and debate in the literature has concerned the possible existence of gender differences in prevalence and potential gender bias in the diagnosis of BPD. Past research often found a higher prevalence rate for BPD in women than men (i.e., 3:1 ratio; APA, 2000). However, more recent research examining the prevalence of personality disorders in a large community sample has suggested that there is no gender difference in the prevalence of BPD (Grant et al., 2008). Skodol and Bender (2003) suggested that sampling bias might explain the gender differences in BPD found in earlier studies. Currently, gender differences in the prevalence of BPD remain unknown (Grant et al., 2008; Skodol & Bender, 2003).

Concerns have been raised that the BPD criteria might be biased because they represent an exaggerated female stereotype (i.e., exaggerated dependent and demanding behavior) and such behaviors might be overlooked in men (Gunderson & Zanarini, 1987; Simmons, 1992). However, some researchers have concluded that there is little evidence of gender bias in the BPD criteria (Funtowicz & Widiger, 1999; Kass, Spitzer, & Williams, 1983).

Sprock, Blashfield, and Smith (1990) examined the gender weighting of the DSM-III-R personality disorder criteria as rated by 50 laypersons. They found that some of the BPD criteria were seen as masculine behaviors (i.e., intense anger, hostility, and substance abuse), whereas the remaining criteria were associated with feminine sex role behaviors. Although they did not conclude that the BPD criteria were biased, the gender weighting of the BPD diagnostic criteria could potentially influence the symptom presentations of BPD in men and women.

More recently, Boggs et al. (2005, 2009) investigated possible sex bias in the diagnostic criteria of four personality disorders (Borderline, Avoidant, Schizotypal, and OCPD) by examining the association between diagnostic criteria and levels of functioning for men and

women using data from the Collaborative Longitudinal Personality Disorders Study (CLPDS). Impairment was measured via self-report and diagnostic interview, and personality disorders were assessed using a semi-structured interview. Using regression analyses to identify differences in level of functioning, they found little evidence of gender bias for most of the PD criteria. However, eight of the nine BPD criteria demonstrated differential functional impairment based on biological sex. The authors concluded men and women with the same symptoms may differ in their overall level of functioning, with women functioning better than men, suggesting that the BPD criteria might underestimate level of functioning for women.

Aggen, Neale, Røysamb, Reichborn-Kjennerud, and Kendler (2009) used item response theory (IRT) to examine the measurement invariance in the DSM-IV diagnostic criteria for BPD for a sample of 2794 Norwegian twins. The researchers concluded that there appeared to be sex differences in the BPD criteria. Women were higher on the BPD criteria overall than men. The results also suggested the presence of a sex by age interaction in that women were higher on the affective instability criterion, whereas men were higher on the impulsivity criterion; however, these differences appeared to be more prevalent in younger than older participants (Aggen et al., 2009). Overall, their results suggested that the impulsivity and affective instability criteria were moderated by sex and age. McCormick et al. (2007) also found that women with BPD had higher ratings of affective instability and also endorsed the dissociation criterion more frequently than men, although the overall level of severity was similar. Barnow et al. (2007) found that men with BPD were more likely to demonstrate explosive temperament and higher levels of novelty seeking compared to women. Additionally, Posick, Farrell, and Swatt (2013) examined gender differences in the expression of distress (i.e., deviance) based on the general strain theory, which posits that the experience of and expression of emotions will differ based on gender. Posick et al.

found that both men and women experience the same emotions, but these emotions are expressed differently based on gender, with men engaging in externalizing behaviors (e.g., fighting) and women engaging in internalizing behaviors (e.g., cutting). Differences in emotional expression of distress or strain likely contribute to differences in symptom presentations based on gender.

Sharp et al. (2014) used IRT to examine each of the DSM-based BPD criteria. They found that seven out of the nine BPD criteria demonstrated no gender bias. However, two criteria, impulsivity and uncontrolled anger, demonstrated possible gender bias with these two criteria being more likely to be assigned to men than women. The authors cautioned that the bias could be due to the assessment tool (SCID-IV) and how the questions were worded rather than the criteria themselves, especially because impulsivity and anger can be considered more stereotypically masculine behaviors (Sharp et al., 2014). Overall, these results further suggest that gender may impact the symptom presentation of BPD.

Further research has investigated gender differences regarding patterns of symptom presentation and comorbidity (Banzhaf et al., 2012; Grant et al., 2008; McCormick et al., 2007; Sansone & Sansone, 2011; Tadić et al., 2009). Research suggests that women with BPD experience comorbid depression, anxiety, and eating disorders more frequently than men, whereas men with BPD more commonly experience comorbid substance use disorders and antisocial personality disorder (Banzhaf et al., 2012; Grant et al., 2008; McCormick et al., 2007; Tadić et al., 2009). These gender differences in comorbid disorders further contribute to the differences in symptom presentations for women and men with BPD.

Zlotnick et al. (2002) examined differences in comorbid disorders and degree of impairment in 130 outpatients with BPD. Aside from BPD, the participants were also evaluated for impulse-related disorders, posttraumatic stress disorder, and overall level of impairment.

Disorders were evaluated using two semi-structured interviews. The overall degree of impairment was assessed based on the participant's history of suicide attempts, number of psychiatric hospitalizations, as well as answers to questions regarding social and work functioning that were taken from the Schedule for Affective Disorders and Schizophrenia (Endicott & Spitzer, 1978). The researchers found that men with BPD endorsed a lifetime history of more substance abuse disorders, antisocial personality disorder, and intermittent explosive disorder, whereas women with BPD were more likely to meet criteria for eating disorders. However, they did not find gender differences in the comorbidity of PTSD. Also, there were no differences found between men and women regarding the degree of overall impairment. The authors concluded that men and women with BPD may not differ in level of impairment, but there appear to be differences in the expression of distress and psychopathology.

Johnson et al. (2003) examined gender differences in comorbidity, diagnostic criteria, and level of functioning in individuals with BPD using data from the Collaborative Longitudinal Personality Disorders Study (CLPDS). BPD diagnosis and comorbidity were assessed using a semi-structured interview, and overall functioning was determined based on a semi-structured interview that assessed psychosocial functioning. Overall, the authors concluded that men and women with BPD were more similar than different; however, there appear to be gender differences in comorbid disorders. Men with BPD were more likely to have comorbid substance abuse disorders, and antisocial, schizotypal, and narcissistic personality disorders, whereas women were more likely to have comorbid eating disorders and PTSD. In regard to diagnostic criteria, only one criterion demonstrated gender differences, with women more likely to endorse experiencing identity disturbance. The researchers did not find any significant differences in the overall level of functioning between men and women with BPD. McCormick et al., (2007) also

found that women with BPD had more comorbid internalizing disorders (anxiety, eating, and somatoform disorders), whereas men had more comorbid antisocial personality disorder.

Tadić and colleagues (2009) investigated gender differences in the symptom presentation of BPD and comorbid disorders in 159 German individuals who were diagnosed with BPD. The authors reported differences in symptom presentations; women with BPD more commonly demonstrated affective dysregulation, whereas men more commonly demonstrated "intensive anger." They also found higher comorbid alcohol dependence and antisocial personality disorder in men, and comorbid depression, anxiety, and eating disorders in women.

Banzhaf et al. (2012) conducted an exploratory study to examine possible gender differences in comorbidity, psychopathology, and personality traits in 171 individuals with BPD. BPD diagnoses and comorbid disorders were assessed by semi-structured interviews, a symptom checklist was used to evaluate the degree of psychopathology, and personality traits were examined via personality questionnaires. The researchers found that men with BPD were more likely to endorse comorbid binge-eating disorder, childhood behavioral disorders, antisocial and narcissistic personality disorders, whereas women were more likely to have comorbid PTSD, bulimia nervosa, and panic disorder. When examining differences in personality between men and women with BPD, the researchers found that women were higher in agreeableness and neuroticism than men, but no further differences were noted. There were no differences between men and women with BPD in their overall degree of psychopathology endorsed. Overall, the researchers suggested that men and women with BPD differ slightly in clinical presentation and personality traits related to BPD, but the most profound gender difference was in terms of comorbid diagnoses.

In a review of the literature, Sansone and Sansone (2011) concluded that there are also gender differences in treatment utilization for individuals with BPD which appear to reflect the differing comorbid disorders and symptom presentations in men and women with BPD. For instance, women with BPD are more likely to receive psychotherapy and pharmacotherapy than men, whereas men with BPD are more likely than women to receive rehabilitation services, which may be due to men having more comorbid substance abuse disorders. Thus, these possible differences need to be further examined.

Overall, research has found support for gender differences in clinical presentations of BPD and comorbid disorders (Banzaf et al., 2012; Johnson et al., 2003; McCormick et al., 2007; Tadić et al., 2009; Zlotnick et al., 2002), which may result in different patterns of treatment utilization (Sansone & Sansone, 2011). Despite the findings of gender differences in the clinical presentations of BPD, results have varied, suggesting that the exact differences remain unclear. Moreover, there is no known research looking at implications of these differences. Therefore, understanding the gender differences in presentation of BPD and how they influence diagnosis and treatment needs to be further examined.

Stigma

Goffman (1963) defined stigma as a characteristic that is considered undesirable and degrading. Goffman's definition has been expanded by recent research, which suggests that the term stigma represents an overall negative connotation associated with a group of individuals that has been devalued by society due to an undesirable characteristic that they are perceived to possess (Hinshaw, Cicchetti & Toth, 2006). Researchers have proposed that stigma may be an attribute that could potentially lead to stereotyping (i.e., cognitive labeling), prejudice (i.e., negative affective reaction), and discrimination (i.e., negative behaviors toward others; Corrigan,

2007; Hinshaw & Stier, 2008), which has prompted researchers to further examine the negative effects of stigma. A review of the literature indicates that stigma has been associated with mental illnesses (Corrigan, 2000; Schumacher, Corrigan, & Dejong, 2003) and physical illness, as well as low social economic status (Major & O'Brien, 2005), low psychological well-being, and low self-esteem (Link et al., 2001; Marcussen et al., 2010).

Stigma and mental illness. In the past, individuals with mental illnesses were frequently stigmatized (Rabkin, 1974), and there continues to be a significant amount of stigma associated with mental disorders (Hayward & Bright, 1997). For example, mental disorders have been associated with a number of negative attributes, such as being weak, emotionally unstable, dishonest, irrational, or dangerous (Horsfall, Cleary & Hunt, 2010). Research has consistently found evidence suggesting that mental illness is one of the most stigmatized and negatively-viewed disabilities (Westbrook, Legge, & Pennay, 1993). Corrigan et al. (2000) examined the amount of stigma associated with mental illnesses (drug addiction, depression, psychosis, and mental retardation) compared to physical illnesses (AIDS and cancer) in 152 college students and found that mental illnesses were viewed and described more negatively than physical illnesses. Moreover, research has indicated that attributes such as odd behavior (e.g., delusions), poor physical appearance, and poor social skills have been linked to stigmatization (Corrigan, 2000), and that positive symptoms (e.g., odd behaviors) were found to be more likely to elicit stigma than negative symptoms (e.g., poor social skills) (Schumacher et al., 2003).

Lepping, Steinert, Gebhardt, and Röttgers (2004) examined attitudes toward individuals admitted to a hospital with a mental illness in both the general public and mental health professionals in Germany and England. They found that both professionals and laypeople held

similar negative attitudes toward these individuals and there was no difference in attitudes based on location.

Stigma and personality disorders. Research indicates that there appears to be differing levels of stigma associated with different psychological disorders. Lewis and Appleby (1988) examined the stigma associated with personality disorders (PDs) in a sample of 240 psychiatrists. The participants read one of six possible case vignettes. There were three diagnostic cases (i.e., depression, personality disorder, no diagnosis), and there were two versions of each case. One version of the case contained a statement requesting the participant to disregard the diagnostic information noted in the case, and a second version of the case was without the statement. The participants then completed several questionnaires (i.e., semantic differential scales). Lewis and Appleby found that the stigma associated with PDs appeared to be more negative and enduring than the stigma associated with Axis I disorders, and that individuals with a previous diagnosis of a PD were described in negative terms (e.g., noncompliant, less likely to recover, and undeserving of sympathy or mental health resources). Thus, a diagnosis of a personality disorder has been described as stigmatizing (Newton-Howes et al., 2008), and there continues to be a significant amount of stigma associated with PDs.

Stigma and borderline personality disorder. In a review of the literature, Aviram et al. (2006) found that there appears to be a significant amount of stigma associated with BPD among the general public and mental health professionals. Hersh (2008) compiled and discussed some of the common misconceptions that are associated with BPD. Such misconceptions included that BPD is rare and not a valid disorder, and that clinicians assign the diagnosis of BPD to clients they do not like. Additional myths commonly associated with BPD included: it is beneficial to delay giving a diagnosis of BPD (i.e., until after treating Axis I disorder), it is detrimental to

disclose the diagnosis of BPD to the client, treating clients with BPD always leads to liability difficulties, and that the stigma associated with BPD would be removed by renaming it (Hersh). These misconceptions likely continue to reinforce and propagate the stigma associated with the BPD diagnosis.

Commons Treloar (2009) further examined how mental health professionals in Australia and New Zealand viewed BPD. The participants, 140 clinicians who had treated clients with BPD, were asked to describe their experiences of working with individuals with BPD. Commons Treloar used a thematic analysis procedure to code the open-ended comments, which revealed that clinicians experienced uncomfortable reactions to BPD, and there appeared to be a general belief that individuals with BPD could not be adequately treated. Additionally, the author noted that clinicians and other mental health professionals often described individuals with BPD using negative terminology (e.g., manipulative, difficult, chaotic, poor coping, time consuming), which likely reflects and perpetuates the stigma associated with BPD.

The above-referenced studies have provided evidence that there is a stigma associated with personality disorders, and with BPD in particular. In general, stigma is thought to influence feelings, attitudes, and behaviors of the general public and mental health professionals. Past research has indicated that the stigma associated with mental illnesses, PDs, and BPD goes beyond just a perception of characteristics that are considered undesirable (i.e., stigma), leading to negative attitudes and discrimination against individuals with mental illnesses (Thornicroft, Rose, & Kassam, 2007). Thus, it is important to have a better understanding of how the stigma associated with BPD may influence the attitudes of clinicians towards their clients with BPD.

Negative Attitudes

Considering that stigma is conceptualized as a negative attribute that can lead to stereotyping and prejudice (Hinshaw et al., 2006), researchers commonly measure stigma via attitude scales (Link & Phelan, 2001). An attitude has commonly been defined as an evaluation of an object or concept based on its perceived characteristic attributes (e.g., good-bad, likable-dislikeable, pleasant-unpleasant; Ajzen, 2001; Eagly & Chaiken, 1993). Within the literature, it is commonly accepted that attitudes are important for understanding and predicting behavior (Ajzen, 2001). By examining the impact of stigma via attitude measures, researchers are better able to understand and possibly predict how individuals react to the negative attributes perceived in others (e.g., BPD characteristics) (Link & Phelan, 2001).

The impact of stigma has been examined in terms of negative attitudes and reactions toward mental illness, personality disorders, and especially BPD. Moreover, research has examined attitudes toward mental illnesses, and studies have revealed that mental health professionals hold negative attitudes towards mental illnesses (Gateshill, Kucharska-Pietura, & Wattis, 2011; Rao et al., 2009). Additionally, psychiatrists have been found to hold rejecting, judgmental, and derogatory attitudes towards individuals with personality disorders (Lewis & Appleby, 1988).

Negative attitudes toward BPD. Attitudes toward individuals with BPD have generally been found to be negative (Holmqvist, 2000; Markham, 2003). Research has indicated that clinicians use negative terminology to describe individuals with BPD (Aviram et al., 2006; Commons Treloar, 2009), which likely further contributes to the negative attitudes held toward these individuals (Bourke & Grenyer, 2010; Krawitz & Watson, 2003). For example, mental health professionals have been found to express less empathy toward individuals diagnosed with

BPD compared to other psychological disorders (Fraser & Gallop, 1993; Westwood & Baker, 2010).

Research has revealed that individuals with personality disorders, including BPD, are less likely to be viewed as having a mental illness because they are seen as being in control of their behaviors, and consequently, are believed to be less deserving of compassion (Krawitz & Watson, 2003). For instance, Markham (2003) examined attitudes toward BPD in 71 mental health nurses. The researcher collected ratings of optimism for change, dangerousness, and social distance attitudes toward individuals with BPD, and then compared them with attitude ratings toward individuals with schizophrenia and depression. The results indicated that mental health nurses assigned higher ratings of social rejecting attitudes and dangerousness to individuals with BPD than individuals diagnosed with schizophrenia. Overall, nurses demonstrated less empathy and optimism for individuals with BPD compared to individuals with schizophrenia or depression.

Further research examining the negative attitudes towards BPD comes from Deans and Meocevic (2006) who surveyed the reactions to individuals with BPD in 65 psychiatric nurses in Ireland. Their results indicated that 38% of the nurses viewed individuals with BPD as a "nuisance," and approximately one-third of the nurses reported being angered by clients with a diagnosis of BPD. Additionally, one third of the nurses indicated that they were unsure of how to properly care for individuals with BPD. Reviews of literature support these findings, indicating that nurses have been found to commonly react negatively to individuals with BPD in the form of negative attitudes, anger, decreased optimism, and social rejection that has led to distancing themselves from the client (Bland et al., 2007; Westwood & Baker, 2010).

Research has also suggested that mental health clinicians (e.g., psychiatrists and psychologists) tend to have negative attitudes toward individuals with BPD. Bourke and Grenyer (2010) examined the cognitive and emotional reactions of 80 clinicians to individuals with BPD compared to individuals with Major Depressive Disorder (MDD). The clinicians participating in the study were required to be actively treating individuals with BPD and MDD. The researchers used the Relationship Anecdotes Paradigm[1] to conduct interviews with the clinicians regarding their reactions to their clients. The interviews were then coded for core conflictual relationship themes. Bourke and Grenyer found that the clinicians' emotional responses were more negative toward individuals with BPD than individuals with MDD. Also, the clinicians appeared to be less satisfied with the therapeutic relationship with individuals diagnosed with BPD compared to clients diagnosed with MDD.

Impact of negative attitudes. Given that clinicians hold negative attitudes toward BPD, it has been suggested that those attitudes might influence the clinicians' behaviors and treatment of those individuals (Gallop et al., 1989; Krawtiz & Watson, 2003). To further investigate the impact of these negative attitudes, research has recently started to examine areas such as clinicians' willingness to disclose the BPD diagnosis to the client, predicted prognosis of individuals with BPD, and the quality of treatment provided (Aviram et al., 2006; Krawtiz & Watson, 2003).

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[1] The Relationship Anecdotes Paradigm is a semi-structured interview that uses open-ended questions and particular prompts as a way to gather more elaborate and detailed information about the client and or their situation that was developed by Luborsky in 1988 (as cited in Bourke and Grenyer, 2010).

Due to the stigma and negative attitudes associated with BPD, there has been some concern regarding the issue of disclosing a diagnosis of BPD to the individual. Lequesne and Hersh (2004) discussed the pros and cons of disclosing the BPD diagnosis. Reasons not to disclose the diagnosis included concerns regarding the legitimacy of the BPD diagnosis and possible transference and countertransference reactions, as well as concerns that the stigma associated with the BPD diagnosis would be harmful to the client (e.g., provoking anger or suicidal behaviors). On the other hand, potential benefits associated with disclosing the diagnosis of BPD to the client included psychoeducation, normalization of symptoms, enhancing the therapeutic alliance by increasing client-therapist collaboration, and increasing the autonomy of the client. Overall, the authors indicated that disclosing the diagnosis of BPD would likely be beneficial to clients with BPD, their families, and clinicians. However, regardless of the above possible benefits of disclosing a BPD diagnosis to clients, clinicians appear to have reservations about informing them of the BPD diagnosis (Hersh, 2008).

In addition, clinicians appear to associate BPD with a poor prognosis (APA 2000; Zanarini, 2012), which might negatively affect treatment. Some research has demonstrated that clinicians' expectancies and perceived prognosis for improvement can predict treatment outcomes (Meyer et al., 2002). Spinhoven, Giesen-Bloo, van Dyck, and Arntz (2008) examined the relationship between clinicians' prediction of prognosis, client characteristics (e.g., age, gender, number of Axis I and Axis II diagnoses, and severity of symptoms), and treatment success in 71 clients diagnosed with BPD. The researchers found that the clinicians' expected prognoses predicted actual treatment outcome. Surprisingly, however, the authors found that the accuracy of a clinician's prediction of the client's prognosis did not appear to be associated with the specific characteristics examined in this study, including number of diagnoses and severity of

symptoms. This suggests that the factors that influence prediction of prognosis are unknown and might differ among clinicians. Given the relative dearth of research and the unknown characteristics that lead to such accurate predictions, the authors acknowledged that further research needs to be conducted. Thus, it is important to examine how a clinician's prediction of prognosis for BPD might be influenced by client characteristics given the findings suggesting that clinicians expect a poor prognosis for BPD (APA, 2000) and the continued misconception that individuals with BPD are not likely to recover (Hersh, 2008).

Moreover, Fraser and Gallop (1993) suggested that negative attitudes lead to inconsistencies in the treatment of individuals with BPD. There appears to be a commonly held belief that BPD is one of the most challenging psychological disorders to treat (e.g., Hersh, 2008). For instance, Cleary, Siegfried, and Walter (2002) surveyed the experiences and the attitudes of 229 mental health professions and found that 80% of the individuals surveyed described individuals with BPD as "moderately difficult" to "very difficult" to work with and treat. Additionally, the majority (84%) of the mental health professions surveyed reported that dealing with a client diagnosed with BPD was more difficult than dealing with clients diagnosed with other mental disorders.

Krawitz and Batcheler (2006) surveyed 29 clinicians working with individuals diagnosed with BPD to examine "defensive practice," which they defined as utilizing overly cautious treatments (e.g., lengthy observations or hospitalizations). Clinicians completed a self-report survey regarding their beliefs about treating individuals with BPD. Krawitz and Batcheler found that the surveyed clinicians commonly reported behaving in an overly cautious and defensive manner when treating individuals with BPD. Moreover, the majority (i.e., 85%) of the clinicians felt that they practiced in a manner that they do not believe was in the best interest of their client.

Schulze (2007) reviewed the literature to examine the role of mental health professionals in perpetuating stigma and negative attitudes toward mental illness. In a majority of the studies examined, both the general public and mental health professionals were found to hold negative attitudes toward mental illness (e.g., reluctant to interact with individuals with a mental illness). Schulze further addressed how mental health professionals can help reduce the stigma, such as acknowledging the existence and effects of stigma (e.g., the effects of certain diagnoses), staying informed and providing the information to the clients and their families, speaking out against the discrimination, and campaigning for adequate resources to assist individuals with mental illnesses.

The previously discussed research findings suggest that mental health professionals hold negative attitudes toward individuals with BPD (Bourke & Grenyer, 2010), and that these attitudes are more negative than their attitudes toward other psychological disorders (Cleary et al., 2003; Markham, 2003). Additionally, research suggests that the attitudes a clinician holds about BPD could influence a clinician's willingness to disclose the diagnosis (Hersh, 2008; Lequesne & Hersh, 2004), their prediction of the client's prognosis (Spinhoven et al., 2008), and the quality of service provided (Fraser & Gallop, 1993; Krawtiz & Watson, 2003). However, research in this area is new and there has been relatively little research examining the consequences of negative attitudes. Further research is needed to determine how negative attitudes toward BPD may impact treatment recommendations, which could be important to outcome, given that there are effective treatments for BPD (Livesley, 2008; Paris, 2004). Thus, it is important to examine the relationship between the attitudes that clinicians hold toward BPD and the assigned diagnosis, perceived prognosis, and treatment recommendations provided.

Negative attitudes and gender. Recent research has suggested that the gender of an individual with a psychological disorder may influence how others (e.g., clinicians) perceive the individual, and level of stigma associated with the diagnosis (Reavley & Jorm, 2011), although findings concerning the impact of client gender on negative attitudes are inconsistent. For example, Wirth and Bodenhausen (2009) found that psychological disorders that are more common for one gender (i.e., depression in women) elicited more negative attitudes for individuals of that gender than if the same disorder was present in the other gender (e.g., depression in men). However, other research has found the opposite results (c.f., Bodenhausen, 1988). For instance, Costrich (1975) found that people have a tendency to react negatively to individuals who deviate from traditional gender roles (i.e., gender deviance), which suggests that men diagnosed with a disorder that is more common in women (e.g., depression) might be rated as more severe than a woman diagnosed with the same disorder. Given these contradictory results, the influence of gender on the relationship between negative attitudes and BPD should be further examined.

The above findings regarding the influence of the individual's gender on negative attitudes and stigma (Costrich 1975; Wirth & Bodenhausen, 2009) suggest that men and women with BPD might elicit different levels of negative attitudes. Moreover, the heterogeneous symptom presentations of BPD, along with the fact that some BPD symptoms are seen as male-typed behaviors while others are seen as female-typed behaviors (Sprock et al., 1990; Tadić et al., 2009), suggests that client gender may interact with the specific symptoms they exhibit. Thus, different symptom presentations of BPD may elicit a different level of negative attitudes as a function of the client's gender. However, research examining the influence of the client's

gender on negative attitudes toward BPD has yet to be performed. Therefore, it is important to examine the effects of gender on the relationship between BPD and negative reactions.

Present Study

The present study examined clinicians' negative attitudes toward BPD and the possible implications for diagnosis, prediction of prognosis, and treatment recommendations. Moreover, given concerns regarding the different symptom presentations and heterogeneity of BPD (Lenzenweger et al., 2008), possible gender bias (APA, 2000; Grant et al., 2008), and the possible influence of gender on the attitudes toward psychological disorders (Wirth & Bodenhausen, 2009), this study also examined the effects of symptom presentation as well as client gender on the relationship between clinicians' negative attitudes and BPD. Research suggests that the values and attitudes that clinicians hold toward their clients are likely to have an impact on the type and quality of the treatment services provided (Krawtiz & Watson, 2003). However, few studies have examined the possible implications of clinicians' attitudes toward BPD for prediction of prognosis and treatment recommendations, at the same time as examining the effects of the client's gender and symptom presentation.

The current study used a vignette methodology in which clinicians were asked to read one of four vignettes portraying BPD. Due to the heterogeneity of BPD (Asnaani Chelminski, Young & Zimmerman, 2007), two vignettes depicting different symptom presentations of BPD were selected from the literature. One of the case vignettes was selected to exhibit more female-type BPD symptoms (e.g., needy, fear of abandonment, dependent) and the other vignette presented with BPD symptoms more associated with male-type BPD symptoms (e.g., anger, impulsivity, and substance abuse; Sprock et al., 1990; Zlotnick et al., 2002). Male and female versions of each vignette, differing only in pronouns and stated sex, were used to examine the

effects of gender. For each case, clinicians were asked to assign a DSM-IV-TR diagnosis, rate their confidence in their diagnosis, and rate the presence and severity of symptoms of the cluster B personality disorders and dependent personality disorder due to the symptom overlap among these disorders. Also, the clinicians provided ratings of the representativeness of BPD and other PD diagnoses, the individual's prognosis and likelihood of benefiting from treatment, their willingness to work with the individual, and likelihood of disclosing the diagnosis to the client. They also selected treatment recommendations from a drop-down menu that included treatments demonstrated to be effective for BPD as well as other less effective treatments. After completing the diagnostic and symptom ratings, clinicians were asked to complete an attitude measure of personality disorders modified to be specific to BPD. A measure of social desirability followed the attitude measure to account for socially desirable responding. Finally, participants were asked to provide demographic information and information regarding their professional experience. The study was conducted over the Internet.

The following hypotheses were proposed:

1. It was hypothesized that more negative attitudes towards BPD would be predictive of:
    a. A diagnosis of BPD.
    b. Higher ratings of BPD representativeness, BPD symptom ratings, and overall ratings of severity.
    c. Lower ratings of prognosis, likelihood of benefiting from treatment, willingness to disclose the diagnosis, and willingness to work with the client.
    d. Treatment recommendations that are less effective and appropriate.
2. It was hypothesized that there would be differences regarding diagnosis and treatment recommendations based on the gender of the individual in the vignette.

   a. Regarding differences in diagnosis, it was predicted that the female version of the vignettes would be more likely to:
      i. Receive a diagnosis of BPD.
      ii. Receive higher representativeness ratings of BPD.
   b. Given the research regarding treatment differences (Sansone & Sansone, 2011), it was predicted that there would be a difference between the male and female versions of the case regarding treatment recommendations. Due to dearth of research in this area, no specific hypotheses about the direction of the differences or types of treatment were made.
3. It was hypothesized that there would be differences regarding diagnosis, BPD representativeness ratings, BPD symptom ratings, and treatment recommendations based on the type of BPD symptoms (i.e., female-type/dependent/needy or male-type/angry/hostile) presented in the vignette.
   a. Differences between vignettes presenting different gender-type BPD symptom presentations were expected in regard to BPD diagnosis, BPD representativeness ratings, BPD symptom ratings and treatment recommendations, although due to the dearth of research in this area, no specific hypotheses regarding the direction of these differences were predicted.
4. Finally, it was hypothesized that there would be an interaction between the type of BPD symptom presentation described in the vignette and the gender of the individual in the vignette.
   a. It was predicted that vignettes presenting different gender-typed BPD symptom presentations (i.e., female-type/dependent/needy or male-type/angry/hostile)

would receive different levels of BPD representativeness ratings and severity ratings based on the gender of the individual presented in the vignette. Given the inconsistent findings in the research, no specific hypotheses about the direction of the differences were predicted.

CHAPTER 3

METHODS

Design

The study used a quasi-experimental design. Clinicians read a case vignette presenting BPD symptoms and were asked to assign a diagnosis and ratings for the case. Participants were randomly assigned to receive a case vignette with either a male-type or female-type BPD symptom presentation and either the male or female version of the case. The primary predictor variable in this study was the total score on a measure of attitude towards BPD. The primary criterion variables included: categorical diagnosis of BPD; BPD representativeness and BPD symptom ratings; ratings of severity, prognosis, and likelihood of benefiting from treatment; and treatment recommendations selected. Other criterion variables included: the number of symptoms of BPD endorsed as being present in the vignette, confidence in their diagnosis, willingness to work with the individual, and the likelihood of disclosing the diagnosis. In order to examine the effects of gender of the client on the relationship between attitudes and BPD, the study contained an experimental component, manipulation of the gender (male or female) of the client presented in the vignette. There was also a manipulation of the type of BPD symptom presentation in the vignette (female-type/dependent/needy or male-type/angry/hostile).

Power Analysis

A power analysis using a power of .80 and alpha of .05 suggested that 76 participants were be needed in order to detect a medium effect size for a multiple regression design using three predictors (Cohen, 1992).

Participants

Licensed psychologists were randomly selected from several online websites that can be used by the public to locate psychologists. The websites that were selected contained an online directory or a method of sending emails to the psychologists from the website. Members of these sites were randomly selected and sent an email inviting them to participate. Based on studies using online survey methods (e.g., Crosby & Sprock, 2004), a response rate of 10-20% was anticipated; thus, 1000 psychologists were invited to participate. Due to the low response rate and a large number of the emails being returned as invalid, more email addresses were collected with a total of 3,564 participants invited to participate. A total of 101 clinicians participated in the study; however, three participants were excluded for large amounts of missing data. The final number of participants was 98.

Demographic and professional characteristics of the participants are displayed in Tables 1 and 2. The age of participants ranged from 28 through 71 years, with a mean of approximately 51 years, and there were more women than men. Most of the participants identified themselves as Caucasian. The majority of the sample had a Ph.D. doctorate degree followed by a Psy.D. degree; three participants indicated they had master's degrees and one was completing a post-doctoral position in neuropsychology. Years of experience ranged from 1 through 42 years with an average of approximately 18 years of clinical experience. A majority of the participants reported that they worked in private independent or group practice and spend most of their time

engaged in clinical work with adults ages 18-64. Cognitive-Behavioral was the most frequently identified theoretical orientation followed by Integrative/Eclectic. Participants rated themselves as being very familiar with the DSM-IV-TR, but only moderately familiar with the DSM-5. Participants rated their familiarity with BPD as moderately high, and more than half of the participants indicated that they commonly work with individuals diagnosed with personality disorders.

Case Vignettes

Two cases were selected from the literature to represent different symptom presentations of BPD to represent the heterogeneity of BPD. The first case was selected to represent more female-type BPD behaviors (e.g., needy/dependent, fear of abandonment, emotional liability), whereas the second case was selected to represent more male-type BPD behaviors (e.g., angry, hostile, impulsive, substance abuse). The selection of the male and female-type symptom presentations was based on past research (Sprock et al., 1990; Zlotnick et al., 2002), which demonstrated that certain BPD criteria are more commonly associated with masculine behaviors (anger, hostility, impulsive substance abuse) and the remaining criteria were associated with feminine behaviors (e.g., needy/dependent). Vignette 1 (female-type BPD) was taken from Fauman (2002) and described a symptom presentation that contained the following BPD criteria: efforts to avoid real or imagined abandonment, unstable relationships, identity disturbance, recurrent suicidal behavior or self-mutilating behavior, affective instability, feelings of emptiness, and anger. Vignette 2 (male-type BPD) was excerpted from Oldham, Skodol, and Bender (2009), and contained the following criteria: efforts to avoid real or imagined abandonment, unstable relationships characterized by alternating between extremes of idealization and devaluation, impulsivity in at least two areas that are potentially self-damaging,

affective instability due to a marked reactivity of mood, inappropriate, intense anger/difficulty controlling anger (see Appendix B). There was a male and a female version of each case that differed only in the individual's reported gender and the pronouns in the case, resulting in a total of four cases. Both vignettes included enough symptoms to meet criteria for a diagnosis of BPD. Pilot testing was conducted to examine the symptoms present in the vignettes, and to ensure differences in symptom presentation and representativeness of BPD. Graduate students from the Psy.D. program in clinical psychology (n = 8) read the vignettes and provided ratings of representativeness for the personality disorders and rated which symptoms they believed were present within the vignettes. Results of the pilot study indicated that the cases contained the intended symptoms and were representative of the intended diagnosis (BPD).

Measures

Diagnostic questionnaire. After reading the case vignette, participants were asked to assign a diagnosis and rate their confidence in their diagnosis on a 7-point Likert scale (1 = *not at all confident* to 7 = *very confident).* The diagnosis was selected via a drop down menu containing a list of all 10 of the DSM-IV-TR Axis II PDs and the two PDs listed in the appendix of the DSM-IV-TR (Depressive PD and Passive-Aggressive/Negativistic PD). Participants then rated the representativeness of each of the personality disorders for the case using a 7-point Likert scale (1 = *not at all representative* to 7 = *highly representative*). Next, participants rated the presence and severity of a series of PD symptoms for the case using a 7-point Likert scale (1 = *not present/not severe* to 7 = d*efinitely present/severe*). The symptoms included in the list were the DSM-IV-TR criteria for BPD, the other cluster B PDs (Histrionic, Narcissistic, and Antisocial) as well as Dependent PD, due to their overlap with BPD. The Qualtrics program presented the symptoms in random order. The participants then rated the overall severity (1 = *very mild* to 7 = *very severe*), the predicted prognosis (1 = *very poor* to 7 = *very good*), the

likelihood of benefiting from treatment (1 = *not at all likely* to 7 = *very likely*), the likelihood of disclosing the diagnosis to the client (1 = *not at all likely* to 7 = *very likely),* and their willingness to work with the client (1 = *not at all willing* to 7 = *very willing*). Participants were also asked to rate the likelihood of recommending a series of treatment options for the client (1 = *not at all likely* to 7 = *very likely*). The list included the treatments demonstrated to be effective (i.e., antipsychotic medication, cognitive-behavioral therapy, day hospital, dialectical behavior therapy, mentalization therapy, mood stabilizer, schema therapy, selective serotonin reuptake inhibitor, serotonin-norepinephrine reuptake inhibitors, transference-focused psychotherapy), as well as treatments that have been shown to be less effective (i.e., benzodiazepines, brief inpatient, long-term inpatient, monoamine oxidase inhibitors, substance abuse treatment, tricyclic antidepressant, no treatment). Finally, they selected their first and second choice treatment recommendations for the client from a drop-down menu with the same options (see Appendix C for the Diagnostic Questionnaire).

Attitude to Personality Disorder Questionnaire (APDQ). The Attitude to Personality Disorder Questionnaire (APDQ; Bowers & Allan, 2006) is a 37 item self-report attitude measure that was used to measure attitudes toward BPD. The APDQ consists of 37 affective statements regarding personality disordered clients (e.g., I feel angry toward PD people) that are intended to represent both positive and negative attitudes toward individuals with PDs (see Appendix D for the APDQ). These items were modified to be specific to Borderline Personality Disorder for the present study by substituting "Borderline Personality Disorder" for "Personality Disorder" (and "BPD" for "PD"). The respondents used a 6-point Likert scale (1 = Never, 2 = Seldom, 3 = Occasionally, 4 = Often, 5 = Very Often, and 6 = Always) to rate the frequency they experience these feelings. An overall total attitude score is calculated based on the responses, with higher

scores representing more positive attitudes. Total scores range from 37 to 222 and all negative items are reverse scored. The authors found that the APDQ has very good internal consistency (α = 0.94) with adequate test–retest reliability (Pearson's r = 0.71). In the current study, the APDQ also demonstrated very good internal consistency (α = 0.93). Five factors, Enjoyment versus Loathing, Security versus Vulnerability, Acceptance versus Rejection, Purpose versus Futility, and Enthusiasm versus Exhaustion, can also be derived from the responses. Due to the limited amount of support for these factors and this study's focus on overall negative attitudes, the factors were not examined in this study.

Social desirability measure. Merrill, Laux, Lorimor, and Thornby (1995) developed a social desirability scale for use in medical settings. The scale is a self-report measure of social desirability (i.e., need for approval) consisting of seven true-false items intended to measure social desirability in medical students. The seven items were selected via factor analysis from an original set of 12 items based on naming factor loadings greater than 0.42 (α = 0.62) (see Appendix E). Scores range from 0 to 7 with higher scores representing more socially desirable responding (i.e., impression management). The researchers found that the social desirability measure had questionable reliability (α = 0.62), but noted that this scale had a moderate positive relationship (r = 0.37) with a short form of the more traditional and well-validated Marlowe-Crowne Social Desirability Scale (SDS; Reynolds, 1982). This social desirability scale was selected because it is less familiar to clinicians than the Marlowe-Crowne Scale and the items are less transparent. In this study, Cronbach's alpha was .57 for the social desirability measure.

Demographic questionnaire. After completing ratings on the vignette and the attitude measure, participants were asked to provide demographic information (e.g., age, ethnicity, sex) as well as information regarding their professional training and clinical experience. They were

also asked to rate their familiarity with the DSM-IV-TR, the DSM-5, as well as their experience and familiarity with BPD (see Appendix F).

Procedure

The Qualtrics online survey program was used to create an internet based survey. An email (see Appendix G) was sent to psychologists who were randomly selected from websites inviting them to participate in the study. When participants accessed the online survey via a webpage link from the email, they were presented with the informed consent explaining the purpose and procedures of the study as well as a reminder that their participation is voluntary (see Appendix H). The consent form also noted that they may enter a raffle to win one of three gift cards as an incentive for participating in the study. Once clinicians indicated that they were willing to participate, they were taken to a webpage with the instructions and the case vignette. They received one of the four vignettes randomly assigned via the Qualtrics program. Then, participants completed the diagnostic questionnaire.

Once they completed the diagnostic questionnaire, the Qualtrics survey program was set so that the participants were no longer able to go back and change their answers. The participants were then asked to complete the attitude measure, followed by the social desirability measure. The demographic questionnaire was the last measure the participants were asked to complete. The participants were then asked to select the "submit" button to complete the survey. The online program is designed so that the data from the survey are immediately entered into a database after participants submit their survey. Finally, the participants were presented with a webpage thanking them for their participation and offering them the option of entering their contact information (i.e., name/email address) in order to have a chance to win an Amazon gift card. The

participants' names and email addresses were not linked to the questionnaires. The gift card winners were chosen at random after the data collection was completed.

CHAPTER 4

RESULTS

Overview of Data Analysis

The data were collected by the Qualtrics online survey software and analyzed using the IBM SPSS statistical software version 19 (IBM corp., 2010). The first step in the data analysis involved examining the data for outliers or excessive missing data. As noted earlier, the participants with excessive missing data were eliminated. Mean replacement was used for participants that were missing one or two items on the measure of attitudes towards BPD (i.e., APDQ). A total of 98 participants provided enough responses to be included in some analyses. Ten of the 98 participants did not complete the APDQ, thus 88 participants were included in analyses using the APDQ. Descriptive statistics are presented for the key variables, followed by correlations between the primary predictors and dependent measures. Chi-square analyses, logistic regressions, and MANCOVAs were used to test the hypotheses. Results are presented for each vignette and across both cases.

Descriptive Information

Tables 3, 4, and 5 provide descriptive information regarding the diagnosis of BPD, BPD representativeness ratings, BPD symptom ratings, and the number of BPD symptoms endorsed (i.e., rated 3 or higher on the 7 point scale). Results are presented for the male and female versions of each vignette and across both vignettes. Across vignettes, BPD was the most frequent

diagnosis, with nearly all participants assigning a diagnosis of BPD (90.8 %). Participants demonstrated a moderately high level of confidence in their diagnosis (M = 4.96, SD = 1.32) on the 7 point scale, and the representativeness ratings for BPD was high across the vignettes. The mean for BPD symptom ratings was moderately high, and the average number of symptoms endorsed across vignettes was 6.46, indicating that the vignettes would meet criteria for BPD (i.e., 5 or more of the symptoms are required).

The participants rated the vignettes as demonstrating moderately high severity and moderately poor prognosis (see Table 6). Participants' ratings of their likelihood of disclosing the diagnosis to the client were moderately high, with moderate ratings regarding their willingness to work with the client and the likelihood the client would benefit from treatment. Regarding treatment recommendations, the majority of the participants selected effective treatment recommendations for the clients in the vignettes, with approximately half of the participants recommending DBT as their first treatment choice, followed by CBT (see Table 7). If "other" was selected it was coded as an effective treatment if "Psychodynamic," an appropriate medication, or a referral to psychiatrist was entered in the text box, and was coded as a less effective treatment if "psychotherapy," medication only," "responsibility-based therapy," or "ACT" was entered.

Vignette 1 (female-type BPD). Vignette 1 was intended to represent a female-type BPD symptom presentation, emphasizing needy and dependent symptoms. For both the male and female versions of Vignette 1, BPD was diagnosed by all participants except for one, who assigned a diagnosis of Schizoid Personality Disorder (see Table 3). Vignette 1 was rated as highly representative of BPD, and received moderately high BPD symptom ratings, with an average of 6.78 symptoms endorsed. Vignette 1 was also rated as moderately high in severity

and received a low rating for prognosis. Participants indicated that they were moderately likely to disclose the diagnosis to the client and would be moderately willing to work with the client. They rated the individual in Vignette 1 as moderately likely to benefit from treatment (see Table 6). Regarding treatment recommendations, nearly all of the participants (91.2%) selected effective treatment recommendations for Vignette 1, with nearly two-thirds of the participants recommending DBT as their first treatment choice, followed by CBT and then "other" treatment (see Table 8).

Vignette 2 (male-type BPD). Vignette 2 was intended to represent male-type BPD symptoms, emphasizing the anger and impulsivity symptoms. For both of the male and female versions of Vignette 2, BPD was the most frequently assigned diagnosis. The male version of this case demonstrated more variability in diagnoses assigned, receiving diagnoses of Antisocial PD, Depressive PD, and Passive Aggressive PD (see Table 3). Ratings of representativeness of BPD were moderately high for both male and female versions (see Table 4) as were BPD symptom ratings, with an average of 6.05 symptoms being endorsed (see Table 5). Vignette 2 was also rated as moderately high in severity, and received a low rating for prognosis. Participants rated that they would be moderately likely to disclose the diagnosis to the client, moderately willing to work with the client, and that the individual in Vignette 2 was moderately likely to benefit from treatment (see Table 6). Regarding treatment recommendations for Vignette 2, the majority of the participants (63.4%) selected effective treatments for the client in the vignette, with approximately one-third selecting DBT as the first treatment choice, followed by both substance abuse treatment and CBT (see Table 9).

Effect of Negative Attitudes

The first hypothesis predicted that negative attitudes towards BPD (i.e., APDQ score) would be predictive of a diagnosis of BPD, higher BPD representativeness ratings and BPD symptom ratings, and higher ratings of severity. Negative attitudes were also expected to predict lower ratings of prognosis, likelihood of benefiting from treatment, willingness to disclose the diagnosis, and willingness to work with the client, as well as selection of treatment recommendations that are less effective. Results were examined across both vignettes.

Initially, correlational analyses were used to examine the relationship between the primary predictor (total APDQ attitude score) and the key variables. Higher scores on the APDQ represent more positive attitudes towards BPD and lower scores represent more negative attitudes towards BPD. Table 10 displays the results of the correlational analyses. There was not a significant correlation between the APDQ total scores and confidence in the diagnosis, BPD representativeness ratings, mean BPD symptom ratings, the number of BPD symptoms endorsed, ratings of severity, or the likelihood of disclosing the diagnosis. A significant positive relationship was found between APDQ total scores and ratings of predicted prognosis, willingness to work with the client, and ratings of the likelihood that the individual would benefit from treatment, with more positive attitudes associated with higher ratings of these variables. Significant negative correlations were found between APDQ total score and the likelihood of recommending several types of treatments, such as brief inpatient treatment, MAOIs, SSRIs, and SNRIs (see Table 10).

Next, a quartile split was used to separate participants into “low” (negative attitude) and “high” (positive attitude) groups on the APDQ attitude measure. Low scores (i.e., lowest 25%) included scores of 132 or below and the high scores (i.e., top 25%) included scores of 161 and

above. Chi-square analyses were used to examine the differences between the low (i.e., negative attitude) versus high (i.e., positive attitude) groups on each of the categorical dependent variables. Treatment recommendations were categorized into those considered effective or less effective. A chi-square analysis showed that the diagnosis of BPD did not differ significantly for participants in the "low" and "high" APDQ groups (see Table 11). There were also no differences in recommending effective versus less effective treatment. ANOVAs were used to compare the groups on the continuous variables (see Table 12). No differences were found between "low" (negative attitude) and "high" (positive attitude) APDQ groups on ratings of BPD representativeness, BPD symptoms, severity, or likelihood of disclosing the diagnosis. A significant difference was found between "high" (positive attitude) and "low" (negative attitude) APDQ groups in regard to predicted prognosis, willingness to work with the individual, and the likelihood the client would benefit from treatment, with the "low" (negative attitude) APDQ group assigning significantly lower ratings (see Table 13). The effect size for prognosis and likelihood of benefiting from treatment was small, whereas there was a moderate effect size for willingness to work with the individual.

Gender of the Vignette

The second hypothesis predicted that there would be differences regarding diagnosis and treatment recommendations based on the gender of the individual in the vignette, with the female version of the vignette receiving more BPD diagnoses, higher BPD representativeness ratings, and higher BPD symptom ratings. A chi-square analysis was performed to compare the assigned diagnosis (BPD versus other diagnosis) for the male versus female versions across the cases. Results indicated that there was not a significant difference in diagnosis of BPD based on the gender of the client featured in the vignette, $\chi^2(1, N = 98) = 1.55, p = .21, \phi = -.126$. Additional

chi-square analyses were also conducted comparing the assigned diagnosis for the male versus female versions of Vignette 1 and Vignette 2. Results indicated that there was not a significant difference in diagnosis based on client gender for Vignette 1 or for Vignette 2 (see Appendix I for Table I.1).

One-way ANOVAs were used to compare BPD representativeness and BPD symptom ratings for the male versus female versions across the cases. No differences were found between the male and female versions of the cases on ratings of BPD representativeness, F (1, 95) = 2.937, p = .09, partial eta squared = .030, or BPD symptoms, F (1, 87) = 1.559, p = .22, partial eta squared = .018. Additional ANOVAs comparing the BPD representativeness ratings and BPD symptom ratings for the male versus female versions of Vignette 1 and Vignette 2 also were not significant (see Appendix J for Table J.1).

To examine gender differences in treatment recommendations, a chi-square analysis was performed comparing the first choice treatment recommendations (effective versus less effective) based on the gender of the client presented in the vignette. The analysis revealed a significant difference in treatment recommendations based on the gender of the individual in the vignette, $\chi^2(1, N = 89) = 7.36, p = .007, \phi = -.288$, with female clients being more likely to be recommended effective treatments than male clients. Again, separate chi-square analyses were conducted for Vignette 1 and Vignette 2 to compare the selection of treatments (effective versus less effective) for the male and female versions of each vignette. There were no significant differences in treatment recommendations based on client gender for Vignette 1 (female-type BPD). However, there was a significant difference in the recommendation of effective versus less effective treatments based on gender for Vignette 2 (male-type BPD), with the male version

of the vignette receiving less effective treatment recommendations more often than the female version (see Appendix I for Table I.1).

BPD Symptom Presentation

The third hypothesis predicted that there would be differences in diagnosis, BPD representativeness ratings, BPD symptom ratings, and treatment recommendations based on the BPD symptom presentation of the vignette (i.e., female-type/dependent vs. male-type/angry). A chi-square analysis was performed to compare the assigned diagnosis (BPD versus other diagnosis) for Vignette 1 (female-type) and Vignette 2 (male-type). Results indicated a significant difference in BPD diagnosis based on the type of symptom presentation in the vignette, $\chi^2(1, N = 89) = 9.02$, $p = .003$, $\phi = -.303$, with Vignette 2 (male-type BPD) being diagnosed with disorders other than BPD more often than Vignette 1 (female-type BPD). Additional chi-square analyses were also conducted comparing the assigned diagnosis for the different symptom presentations of the vignettes in regard to the gender of the client. Results revealed a significant difference in diagnosis based on the type of symptom presentation for the male versions of the vignettes, with the male version of Vignette 2 (male-type BPD) being assigned diagnoses other than BPD more frequently than the male version of Vignette 1 (female-type BPD) (see Appendix I for Table I.2). However, there was not a significant difference in diagnosis based on symptom presentation for the female versions of the Vignettes; both Vignette 1 (female-type BPD) and Vignette 2 (male-type BPD) were assigned BPD diagnoses the majority of the time.

One-way ANOVAs were used to compare BPD representativeness and BPD symptom ratings for the different symptom presentations of the vignettes (female-type and male-type). A significant difference was found between female-type and male-type symptom presentations in

regards to BPD representativeness ratings, F (1, 95) = 9.70, p = .002, partial eta squared = .093, with Vignette 1 (female-type BPD) being rated as more representative of BPD than Vignette 2 (male-type BPD). No differences were found between female-type and male-type symptom presentations for BPD symptom ratings, F (1, 87) = 1.52, p = .221, partial eta squared = .017.

Additional ANOVAs were also conducted comparing the BPD representativeness ratings and BPD symptom ratings for Vignette 1 and Vignette 2 in regard to gender. Results indicated that there was a significant difference in BPD representativeness ratings based on symptom presentation for the male versions of the vignettes, with Vignette 1 (female-type BPD) being rated as more representative of BPD than Vignette 2 (male-type BPD), but there was not a significant differences for the female versions of the vignettes (see Appendix J for Table J.2). There was not a significant difference in BPD symptom ratings based on BPD symptom presentation for the either the female or the male versions of the vignettes.

Chi-square analyses revealed a significant difference in treatment recommendations based on the type of symptom presentation in the vignette, $\chi^2(1, N = 89) = 13.27$, $p < .001$, $\phi = -.386$, with Vignette 2 (male-type BPD) receiving less effective treatment recommendations more often than Vignette 1 (female-type BPD). Again, separate chi-square analyses were conducted for the male and the female vignettes to compare the selection of treatments (effective versus less effective) based on the BPD symptom presentation. Results revealed a significant difference in treatment recommendations based on the type of symptom presentation for the male versions of the vignettes, with the male version of Vignette 2 (i.e., male-type BPD with male client) being recommended less effective treatments more frequently than the male version of Vignette 1 (female-type BPD with a male client) (see Appendix I for Table I.2). However, there was not a significant difference in treatment recommendations based on symptom presentation for the

female versions of the vignettes, with both Vignette 1 and Vignette 2 receiving effective treatment recommendations the majority of the time.

Logistic Regression

In order to further examine the hypotheses, step-wise logistic regressions were used to explore the degree to which the attitude measure (APDQ total score) and the independent variables were predictive of a diagnosis of BPD (BPD versus other diagnosis) as well as treatment recommendations (effective versus less effective). APDQ total score was used as the predictor in the first step, and the independent variables (client gender, female-type versus male-type BPD symptom presentation) and social desirability were added in the second step. The logistic regression analyses revealed that the predictive value of a model using only the APDQ total score as a predictor of BPD diagnosis was not significant, $\chi^2(1, N = 86) = 3.57, p = .059$ (Cox and Snell R Square = .041; Negelkerke R Square = .113). The second step of the logistic regression using the APDQ, social desirability, gender of the client, and female versus male-type BPD symptom presentation as predictors of a diagnosis of BPD was significant, $\chi^2(3, N = 86) = 12.73, p = .005$ (Cox and Snell R Square = .173; Negelkerke R Square = .482). However, none of the individual predictors reached the .05 level of significance. Table 14 shows the coefficients, associated Wald statistics, and significance level for the predictor in the model. The model correctly predicted 94.2% of the diagnoses of BPD, but did not result in an increase in prediction over classification without using the predictors (i.e., base rates).

The second step-wise logistic explored the degree to which the APDQ and the other independent variables were predictive of effective versus less effective treatment recommendations. Step one of the predictive model using the APDQ total score as the sole predictor of treatment recommendations was not significant, $\chi^2(1, N = 88) = .001, p = .94$ (Cox

and Snell R Square < .001; Negelkerke R Square < .001). The second step of the logistic regression using the APDQ, gender of the client, female versus male-type BPD symptom presentation, and social desirability significantly predicted effective versus less effective treatment recommendations, $\chi^2(3, N = 88) = 19.69$, $p < .001$ (Cox and Snell R Square = .207; Negelkerke R Square = .401). BPD symptom presentation of the case and the gender of the client presented in the vignette were significant predictors of treatment recommendations. The APDQ attitude score and the social desirability scores were not significant predictors of a recommendation of effective versus less effective treatment. Table 15 shows the coefficients, associated Wald statistics, and significance levels for each of the predictors in the model. Overall, the model correctly predicted 85.9 % of the treatment recommendations, which was comparable to the base rate of effective versus less effective treatment recommendations.

MANCOVAS

In order to further test the hypotheses, a 2 (client gender) by 2 (BPD symptom presentation) multivariate analysis of covariance (MANCOVA) was performed to examine the effect of the gender of the client (male versus female) and BPD symptom presentation (female-type versus male-type) on BPD representativeness ratings, BPD symptom ratings, ratings of severity, prognosis, likelihood of benefiting from treatment, willingness to work with the individual, and the likelihood of disclosing the diagnosis. The attitude measure (i.e., APDQ total score) was a continuous predictor variable that was coded as a covariate. The social desirability scale served as the covariate. The results showed a significant multivariate effect for the APDQ, Wilks' $\lambda = .589$, $F(7, 70) = 6.99$, $p < .001$, partial eta squared = .411, but no significant multivariate effects for gender of the client, BPD symptom presentation, or interaction between the BPD symptom presentation and gender of the client (see Table 16).

The univariate effects were also examined and the results are presented in Table 16. The APDQ total score was a significant predictor of prognosis, ratings of the likelihood the client would benefit from treatment, and willingness to work with the client. BPD symptom presentation had a significant effect on BPD representativeness ratings, with Vignette 1 (female-type BPD) rated significantly more representative of BPD than Vignette 2 (male-type BPD). There were no significant effects of client gender, although BPD representativeness ratings and BPD symptom ratings were somewhat higher for female than male vignettes. The interaction between BPD symptom presentation and client gender was not significant for any of the variables.

To further examine the effect of gender of the client and BPD symptom presentation, MANCOVAs were performed separately for each of the vignettes (i.e., female-type and male-type). Ratings of BPD representativeness, BPD symptoms, severity, prognosis, likelihood of benefiting from treatment, willingness to work with the individual, and the likelihood of disclosing the diagnosis were the dependent variables, the attitude measure (i.e., APDQ total score) was a continuous variable that was coded as a covariate, and the social desirability scale served as the covariate. The multivariate results showed a significant effect of the APDQ for Vignette 1 (female-type BPD), Wilks' $\lambda = .432$, $F\ (7, 38) = 7.138$, $p < .001$, partial eta squared = .568, but not for Vignette 2 (male-type BPD) (see Tables 17 and 18). For both Vignette 1 and Vignette 2 there were no significant multivariate effects for the gender of the client. The univariate results for Vignette 1 (female-type BPD) revealed that the APDQ total score was a significant predictor of ratings of severity, prognosis, likelihood of benefiting from treatment, and willingness to work with the client (see Table 17). The univariate results for Vignette 2 (male-type BPD) revealed that the APDQ total score was a significant predictor of only the

severity ratings and willingness to work with the client; however, social desirability had a significant effect on ratings of severity (see Table 18).

Participant Characteristics

Although not part of the hypotheses, additional between-group analyses were conducted to examine the impact of participant characteristics, including gender, years of experience, and theoretical orientation on the diagnosis of BPD, BPD representativeness ratings, and treatment recommendations. Years of experience was divided into three categories (10 years or less, 11-20 years, more than 20 years). Theoretical orientation was also divided into three categories based on the most frequent theoretical orientations (CBT, integrative/eclectic, and other). Chi-square analyses revealed no significant differences in diagnosis of BPD or treatment recommendations based on participant characteristics (see Table 19). Separate ANOVAs revealed no significant effects of participant characteristics on BPD representativeness ratings, ratings of prognosis, or severity (see Table 20).

CHAPTER 5

DISCUSSION

Overview

The purpose of this study was to examine clinicians' negative attitudes toward BPD and the possible effects on diagnosis, prediction of prognosis, and treatment recommendations using a vignette methodology. It was hypothesized that more negative attitudes would be predictive of a diagnosis of BPD, higher BPD representativeness and symptom ratings, and higher ratings of severity, and lower ratings of prognosis, the likelihood the client would benefit from treatment, willingness to disclose the diagnosis to the client and willingness to work with the client, and treatment recommendations that are less effective and appropriate. This study also examined the effects of client gender and BPD symptom presentation on diagnosis, ratings, and treatment recommendations by using two case vignettes presenting different symptom presentations of BPD (i.e., female-type BPD and male-type BPD) and manipulating the gender and pronouns used to describe the individual presented in the vignettes. It was predicted that the female version of the vignettes would be more likely to receive a diagnosis of BPD and receive higher BPD representativeness and symptom ratings than male versions of the vignettes, and treatment recommendations would differ based on gender (Sansone & Sansone, 2011), although no specific hypotheses were made concerning treatment due to the dearth of research. It was also hypothesized that there would be differences in BPD diagnoses, representativeness, and

symptom ratings, and treatment recommendations based on the BPD symptom presentation in the case (i.e., female-type/dependent or male-type/angry), and a significant interaction effect of BPD symptom presentation and the gender of the individual in the vignette on BPD representativeness ratings and severity ratings. Due to the inconsistent research findings, no specific hypotheses were made about the direction of the differences for the latter hypotheses.

Hypothesis one, examining the effects of clinicians' negative attitudes towards BPD, was only partly supported. Negative attitudes were predictive of prognosis, willingness to work with the client, and likelihood of benefiting from treatment, but not BPD diagnosis or ratings, or treatment recommendations. Regarding the second hypothesis, the only significant effect of gender of the individual in the vignette was that male clients received more recommendations of less effective treatment options than female clients. Moreover, there was a significant difference based on the type of BPD symptom presentation in terms of diagnoses, BPD representativeness ratings, and treatment recommendations. The vignette portraying the male-type BPD symptoms was seen as less representative of BPD and received more recommendations of less effective treatments. The final hypothesis, that there would be significant interactions between the gender of the client and BPD symptom presentation of the vignettes, was not supported in the multivariate and univariate analyses. However, gender differences were found for the vignette portraying male-type BPD symptoms, but not for the female-type BPD symptom case, suggesting that there might be an interaction between case presentation and gender that was not detected in the multivariate analyses. Finally, examination of the participant characteristics (i.e., gender, years of experience, and theoretical orientation) revealed no significant effects on the diagnosis of BPD or BPD representativeness ratings. The results for each of the hypotheses,

possible reasons for the findings, as well as limitations and strengths of the study, and directions for future research are discussed below.

Negative Attitudes

Previous research has found that there is a significant amount of stigma and negative attitudes associated with Borderline Personality Disorder (BPD) among mental health professionals, including psychiatric nurses, psychiatrists, and psychologists (Aviram et al., 2006; Bourke & Grenyer, 2010; Holmqvist, 2000; Markham, 2003). Research has demonstrated that mental health professionals tend to react negatively toward individuals diagnosed with BPD (Commons Treloar, 2009; Holmqvist & Jeanneau, 2006), use negative terminology (e.g., "difficult") when describing individuals with BPD (Lewis & Appleby, 1988), express less empathy toward individuals with BPD compared to other psychological disorders (Fraser & Gallop, 1993; Westwood & Baker, 2010), and distance themselves from clients with BPD (Markham, 2003). Research has also suggested that clinicians' attitudes toward BPD could influence their willingness to disclose the diagnosis (Hersh, 2008; Lequesne & Hersh, 2004), their prediction of the client's prognosis (Spinhoven et al., 2008), and the quality of service provided (Fraser & Gallop, 1993; Krawtiz & Watson, 2003).

In the present study, it was hypothesized that negative attitudes would be predictive of a diagnosis of BPD and higher BPD representativeness ratings and BPD symptom ratings, and that more negative attitudes would also be associated with more negative ratings (i.e., higher severity; lower ratings of prognosis, likelihood of benefiting from treatment, willingness to disclose the diagnosis, and willingness to work with the individual), and less effective treatment recommendations. This hypothesis was partially supported. Participants' attitudes (i.e., APDQ total scores) were not predictive of a diagnosis of BPD, BPD representativeness or symptom

ratings, or less effective treatment recommendations. However, correlations and results of the ANOVAs and MANCOVA indicated that negative attitudes towards BPD (i.e., low scores on the APDQ) were associated with lower ratings of prognosis, lower ratings of the likelihood the client would benefit from treatment, and less willingness to work with the individual.

The fact that negative attitudes towards BPD did not affect BPD diagnoses, BPD representativeness or symptom ratings, ratings of severity, and treatment recommendations is positive, and may mean that clinicians are able to appropriately diagnose BPD and select effective treatment recommendations regardless of their attitudes. However, the failure to find significant effects may be due to a ceiling effect, because nearly all of the participants assigned a diagnosis of BPD and most selected effective treatment recommendations. All of the vignettes received high BPD representativeness ratings and moderately high BPD symptom ratings, which likely accounts for the lack of variance in diagnosis, and may explain the lack of significant effect of attitude on these variables.

However, negative attitudes towards BPD were predictive of ratings of prognosis, the likelihood the client would benefit from treatment, and willingness to work with the client. The findings regarding prediction of prognosis and likelihood of benefiting from treatment are consistent with past research by Zanarini (2012) who found that clinicians associate BPD with a poor prognosis. These findings could be due to the common belief that BPD has poor prognosis and is resistant to treatment (Comons Treloar, 2009; Hersh, 2008; Krawitz, 2004). Past research has found that nurses and mental health professionals hold negative attitudes towards BPD and decreased optimism regarding treatment and outcome (Bland et al., 2007; Markham, 2003; Westwood & Baker, 2010). However, recent research suggests that BPD responds well to treatment and that individuals with BPD can have a good prognosis and outcome (e.g.,

Cartwright, 2008; Linehan et al., 1991; Livesley, 2008; Paris, 2004). Several treatment approaches have been demonstrated to be effective for BPD including, Dialectical Behavior Therapy (Linehan et al., 1991), Schema Therapy (Kellogg & Young, 2006; Young, 2000), Mentalization Based Treatment (Bateman & Fonagy, 2004), Transference-Focused Psychotherapy (Clarkin, Yeomans & Kernberg, 1999), and some medications (i.e., SSRIs, mood stabilizers, and low-dose antipsychotics) (Bellino et al., 2008; de Groot et al., 2008). This discrepancy between clinician's beliefs and the empirical findings indicates that further education is needed regarding the actual prognosis and treatment outcomes for individuals with BPD.

Negative attitudes towards BPD also predicted less willingness to work with the client. Cleary et al. (2002) found that 80% of the mental health professions in their study described individuals with BPD as "moderately difficult" to "very difficult" to work with and treat. Additionally, the majority of their participants indicated that dealing with a client diagnosed with BPD was more difficult than dealing with clients with other mental disorders. Hersh (2008) found that clinicians believe that treating clients with BPD is difficult and could lead to liability. The relationship between negative attitudes and clinicians' willingness to work with clients diagnosed with BPD found in the present study may relate to such beliefs.

Negative attitudes were not predictive of the clinicians' ratings of their willingness to disclose the diagnosis of BPD to the client. In the present study, clinicians were generally willing to disclose the diagnosis regardless of their attitudes toward the client. In contrast, Hersh (2008) found that clinicians had reservations about informing clients about the BPD diagnosis. Possible reasons for this difference could be due to the increased number of clinicians ascribing to CBT or integrative theoretical orientations, as well as the emphasis on evidence based practice, which

each promote more of a collaborative approach to treatment, including disclosing diagnoses to the clients and providing psychoeducation as a part of treatment.

Regarding treatment recommendations, past research has suggested that negative attitudes lead to inconsistencies in the treatment of individuals with BPD (Fraser & Gallop, 1993). Therefore, it was hypothesized that clinicians' with more negative attitudes towards BPD would be less aware of effective treatment and select treatment recommendations that were less appropriate. This hypothesis was not supported. In this study, the majority of clinicians recommended effective treatments for BPD regardless of their attitudes toward BPD. One explanation for the difference from previous findings is that clinicians are receiving more continuing education and therefore have more knowledge of appropriate treatments for BPD.

These findings contradict research by Krawitz and Batcheler (2006), who found that clinicians working with individuals diagnosed with BPD often engage in "defensive practice," utilizing overly cautious treatments, such as hospitalizations, which are not generally preferred (Paris, 2004). One possible reason for these differences could be due to the use of vignettes rather than actual clients, which may have allowed participants to more objectively assess the symptoms, recognize the diagnosis, and select appropriate treatment options regardless of negative attitudes. Unlike real clients, the influence of negative emotion in response to a vignette is far lower, and there are no consequences for failure to utilize defensive practices. The present study also listed many treatment options, which may not be available in all clinical settings. Nevertheless, regardless of their negative or positive feelings towards individuals with BPD, the clinicians were able to recognize the appropriate treatments for BPD.

Overall, these results suggest that clinicians' negative attitudes do not overtly impact diagnosis and treatment recommendations. However, their attitudes could subtly affect

interactions with the client and/or potential treatment outcomes. Merton's (1948) concept of the self-fulfilling prophecy (i.e., treating someone in such a way that leads them to the expected response) is one way in which attitudes may impact treatment of the client. Clinicians' attitudes may lead clinicians to treat clients in a manner that elicits the very behavior they were expecting, and if the expected behavior or outcome is poor, this could have negative effects on the process and outcome of treatment. For example, Meyer et al. (2002) examined clinician treatment expectancies, therapeutic alliance, and treatment outcomes and found that the clinician's expectancies for client improvement predicted treatment outcome. Thus, the clinicians' beliefs about the client's prognosis could potentially have an impact on treatment outcome. Recent research on psychotherapy outcome has focused on the common factors across psychotherapy approaches that predict outcome (e.g., Lambert, 1992; Messer & Wampold, 2002; Reiter, 2010). The common factors, especially the therapeutic alliance, are affected by clinicians' attitudes, which can then influence treatment outcomes (Messer & Wampold, 2002). Research indicates that clinician characteristics (e.g., optimism, critical, distant, tense, or distracted) affect the therapeutic alliance (Ackerman & Hilsenroth, 2001; 2003; Lambert, 1992), which is a significant contributor to treatment outcome (Beutler, Machado, & Neufeldt, 1994). In the current study, clinicians' negative attitudes were also significantly associated with their willingness to work with the client, which would likely negatively affect the therapeutic alliance, further impacting treatment course and outcome.

Client Gender

Research continues to debate the existence of gender differences in BPD. Some research suggests a gender bias in the diagnosis of BPD, which may be due to the higher prevalence rate for BPD in women than men (i.e., 3:1 ratio; APA, 2000). There is also evidence of gender bias

and differential item functioning in the BPD criteria (Aggen et al., 2009; Boggs et al., 2005, 2008). However, some research examining the prevalence of personality disorders in a large community sample suggested that there is not a gender difference in the prevalence of BPD (Grant et al., 2008) and others failed to find gender bias in the criteria (Funtowicz & Widiger, 1999). Gender differences have also been found in regard to comorbid disorders (Banzhaf et al., 2012; Fossati et al., 1999; Johnson et al., 2003; Lewis et al., 2012; Tadić et al., 2009) and treatment utilization (Sansone & Sansone, 2011). Researchers have suggested that these gender differences in treatment utilization for individuals with BPD may be related to the gender differences in symptom presentations and comorbid disorders in men and women with BPD (Sansone & Sansone, 2011).

This study hypothesized that there would be differences in diagnosis and treatment recommendations based on the gender of the individual in the vignette. First, it was predicted that vignettes featuring a female client would be diagnosed with BPD more often and receive higher BPD representativeness and symptom ratings compared to vignettes featuring a male client. This hypothesis was not supported in the current study; chi-square analyses and ANOVAs indicated no significant differences in the diagnosis of BPD, BPD representativeness ratings, or BPD symptom ratings based on the gender of the client. Although these findings contradict past research suggesting that BPD is diagnosed more frequently in women (APA, 2000) and that clinicians over-diagnose BPD in women (Becker & Lamb, 1994), they are consistent with findings that there is no gender difference in the prevalence of BPD (Grant et al., 2008). However, the failure to find differences in BPD diagnosis or BPD ratings may be due to the ceiling effects discussed earlier.

It was also predicted that there would be a difference between the male and female versions of the case regarding treatment recommendations. Due to the limited amount of research in this area, no predictions about the direction of the differences or types of treatment were made. This part of the hypothesis was supported. Vignettes featuring a female client elicited recommendations for effective treatments more often than vignettes featuring a male client. When examining the two vignettes individually, no gender differences were found for Vignette 1 (female-type BPD symptom presentation). However, for Vignette 2 (male-type BPD symptom presentation), the male version of the vignette received less effective treatment recommendations more frequently than the female version. Sansone and Sansone (2011) suggested that the gender differences in treatment utilization they found in their review were related to differing comorbid disorders and symptom presentations in men and women with BPD. Given that gender differences were found for treatment recommendations for the male-type BPD case but not the female-type BPD case, BPD symptom presentation and/or the interaction between gender and BPD symptom presentation may have played a role in the findings.

BPD Symptom Presentation

Due to the polythetic definition of BPD in the DSM-IV-TR and DSM-5, there are 126 different symptom presentations for the disorder, making it possible for two individuals diagnosed with BPD to only have one symptom in common (Chmielewski, Bagby, Quilty, Paxton, & McGee Ng, 2011). Research has also found some support for subtypes of BPD (Fossati et al., 1999; Leihener et al., 2003; Lenzenweger et al., 2008; Lewis et al., 2012; Millon et al., 2004). There continues to be a debate about which subtypes are the most valid, and some research has suggested that these could be based on gender (Tadić et al., 2009). Some of the BPD criteria may be associated with a male sex role (i.e., inappropriate, intense anger, substance

abuse), whereas the remaining criteria may be associated with a female sex role (Sprock et al., 1990). Further research supports gender differences in the manifestation of BPD, with women being higher in affective instability, and men higher on the impulsivity and anger criteria (Aggen et al., 2009; Barnow et al., 2007; McCormick et al., 2007; Sharp et al., 2014; Tadić et al., 2009). Posick et al. (2013) suggested that the ways in which emotional distress is expressed differs based on gender roles, with men externalizing their symptoms and women internalizing their symptoms, which could lead to gender differences in the symptom expression of BPD. There are also gender differences in comorbid disorders associated with BPD, with men more commonly diagnosed with comorbid substance use disorders and antisocial personality disorder, and women more commonly diagnosed with comorbid depression, anxiety, and eating disorders (Banzhaf et al., 2012; Grant et al., 2008; McCormick et al., 2007; Tadić et al., 2009). Due to the heterogeneity of BPD, the possibility of subtypes, and gender differences in clinical presentations of BPD and comorbid disorders, it is likely that these differences in symptom presentation would impact diagnosis and treatment.

In the present study, the effect of different BPD symptom presentations on diagnosis, BPD representativeness and symptom ratings, and treatment recommendations was examined by using two vignettes with different combinations of symptoms. Given the gender difference in BPD symptoms, one vignette was selected to present female-type BPD symptoms (Vignette 1) and the other was selected to present male-type BPD symptoms (Vignette 2). It was hypothesized that there would be differences in BPD diagnosis, BPD representativeness and symptom ratings, and treatment recommendations based on the BPD symptom presentation in the vignette. This hypothesis was partially supported. Significant differences were found in regard to diagnosis of BPD, BPD representativeness ratings, and treatment recommendations

based on the symptom presentation of the vignette. Vignette 2 (male-type BPD) was diagnosed with disorders other than BPD more often than Vignette 1 (female-type BPD), was rated as less representative of BPD, and received more treatment recommendations not considered effective for BPD. One possible explanation for this finding is that the behaviors in the male-type BPD symptom presentation are consistent with other disorders associated with male gender roles and behaviors (e.g., substance abuse, impulse control disorders, antisocial personality disorder) that could have overshadowed the presence of other BPD symptoms and influenced diagnosis and treatment recommendations. Based on the diagnosis and BPD representativeness ratings, the male-type BPD symptom presentation was seen as less representative of BPD than the female-type BPD symptom presentation, suggesting that clinicians associate a diagnosis of BPD with female-type BPD symptoms. Examination of the individual cases indicated that the male version of Vignette 2 (male-type BPD) was assigned diagnoses other than BPD more frequently than the male version of Vignette 1 (female-type BPD), whereas there was not a significant difference in diagnosis based on symptom presentation for the female versions of the vignettes (male-type and female-type). The interaction between gender and BPD symptom presentation is discussed below.

There was also a significant difference in treatment recommendations based on the type of symptom presentation in the vignette. The male-type BPD symptom presentation (Vignette 2) received less effective treatments more frequently than the female-type BPD symptom presentation (Vignette 1). This is consistent with findings that the female-type symptom presentation was seen as more representative of BPD, so that treatments that are effective for BPD were more likely to have been recommended for the female-type BPD case. When the vignettes were examined individually, no significant differences were found in treatment

recommendations based on gender for Vignette 1 (female-type BPD); however, in Vignette 2 (male-type BPD), the male version of the vignette received less effective treatment recommendations more frequently than the female version. The interaction between gender and BPD symptom presentation is discussed further below.

Interaction between Client Gender and BPD Symptom Presentation

The heterogeneous symptom presentations of BPD, along with possible differences in BPD symptom presentation based on gender (Sharp, et al., 2014; Sprock et al., 1990; Tadić et al., 2009), suggests that client gender may interact with the specific BPD symptoms that are exhibited. Thus, it was hypothesized that there would be an interaction between BPD symptom presentation and gender of the client in the case on BPD representativeness ratings and severity ratings. Given the inconsistent findings in the research, no specific hypotheses about the direction of the differences were made.

This hypothesis received some minimal support. No significant interactions between BPD symptom presentation and gender of the client in the case were found in the multivariate analyses or follow-up univariate analyses. However, examination of the individual cases indicated that the male version of the male-type BPD symptom case (Vignette 2) received more diagnoses other than BPD and less effective treatment recommendations compared to the female version of that case, and compared to the male version of the female-type BPD symptom case (Vignette 1). These results suggest that gender may impact diagnosis and treatment recommendations for different types of BPD symptom presentations. For example, the female-type BPD symptom presentation was seen as more representative of BPD than the male-type BPD symptom presentation; regardless of the gender of the client in the case, clinicians assigned a diagnosis of BPD and recommended appropriate treatments for this case. The male-type BPD

symptom presentation was seen as less representative of BPD. Being presented with a vignette in which the BPD symptom presentation (male-type BPD symptoms) and gender of the client (male) was atypical of BPD may have resulted in uncertainty about the diagnosis and treatment recommendations. These results are somewhat consistent with research suggesting that BPD may represent an exaggerated female stereotype (i.e., exaggerated dependent and demanding behavior) and that such behaviors might be overlooked in men (Gunderson & Zanarini, 1987; Simmons, 1992) or interpreted as manifestations of other disorders more typically seen in men. The failure to find significant interaction effects in the MANCOVA may be due to the ceiling effect discussed earlier, with both of the vignettes seen as highly representative of BPD.

Past research suggested that negative attitudes towards BPD might interact with client gender and symptom presentations (Costrich, 1975; Wirth & Bodenhausen, 2009) raising the possibility of influencing diagnosis, ratings and treatment recommendations. However, no interactions between negative attitudes and gender or symptom presentation, or 3-way interactions, were found in the present study. Wirth and Bodenhausen (2009) found that disorders consistent with ones' gender (i.e., depression in women) elicited more negative attitudes for individuals of that gender than when the same disorder was present in the other gender (e.g., depression in men). On the other hand, Costrich (1975) found that people have a tendency to react negatively to gender deviance, indicating that individuals presenting with a disorder that is not common or consistent with their gender would lead to more negative attitudes and higher ratings of severity compared to someone diagnosed with a gender consistent disorder. There are several explanations for why these interaction effects were not found to influence diagnoses and ratings in the present study, including the ceiling effects discussed earlier as well as methodological limitations of the study discussed below.

Other Demographic and Professional Variables

The effect of participant characteristics (i.e., gender, years of experience, and theoretical orientation) on the diagnosis of BPD, BPD representativeness and symptom ratings, prognosis, severity, treatment recommendations, and other ratings was also examined. Past research findings suggest that younger, less experienced, clinicians assign a diagnosis of BPD more readily than older, more experienced, clinicians (Becker & Lamb, 1994; Morey & Ochoa, 1989). The current findings did not find an effect of clinician years of experience on diagnosis or ratings, which may be due to characteristics of this sample, with the majority of the participants having 10 or more years of experience. Past research provides mixed evidence regarding the impact of clinician gender on the diagnosis of BPD (Becker & Lamb, 1994; Woodward, Taft, Gordon, & Meis, 2009). The current study did not find a significant effect of clinician gender on the diagnosis of BPD, BPD representativeness ratings, or any of the other ratings, which is consistent with Woodward et al. (2009). However, Woodward et al. (2009) found that a clinician's theoretical orientation had an effect on the diagnosis of BPD. Woodward et al. found that clinicians with a CBT orientation diagnosed BPD less frequently than psychodynamically oriented clinicians. The current study found no significant effect of the participant's theoretical orientation on the diagnosis of BPD, BPD representativeness ratings, prognosis, severity, or treatment recommendations. The failure to find an effect of theoretical orientation in the present study may be due to the limited variability in the theoretical orientations found in the sample, with the majority of the clinicians identifying themselves as eclectic/integrative or CBT.

Limitations and Strengths

This study had several limitations. First, the use of case vignettes rather than actual clients, limits the generalizability of the results to real world settings. Vignettes are less complex

than actual clients and may not elicit the same reactions or negative attitudes from clinicians as an actual client presenting with BPD symptoms (Hughes & Huby, 2004). Reading about a client, rather than meeting with a client, may have allowed clinicians to objectively assess the diagnosis and select treatment options. Also, with only two vignettes, the responses obtained in this study could be due to the particular characteristics and symptom presentations of the case vignettes that were selected. Other differences between the vignettes include demographic information (age, marital status, employment) as well as length. It is unknown what effect these may have had on the differences between the two cases. Moreover, as noted earlier, both of the vignettes were rated as very representative of BPD, which resulted in ceiling effects in which nearly all clinicians diagnosed BPD and most selected effective treatments, which limited the chance to find effects of the variables of interest.

An additional limitation was that participants were forced to choose one DSM-IV-TR Axis II diagnosis for the case, yet comorbid diagnoses are very common. Also, options commonly used in clinical settings, such as "no diagnosis," "features," "Not Otherwise Specified (NOS)" or "diagnosis deferred" were not provided. Thus, the diagnosis may not reflect what would occur in a real clinical setting, although participants were allowed to skip the question if desired. It is important to note that assigning a diagnosis for a case vignette does not indicate that the same diagnosis would be assigned to an actual client being seen in a clinical setting. Clinicians base their diagnosis of PDs on behavior observations, patterns of interpersonal behaviors, and their interactions with the client, not just symptom reports (Westen, 1997).

Another limitation is that the responses in a vignette study are subject to social desirability response sets; thus, a measure of social desirability was included in the study. Also, the Attitude toward Personality Disorder Questionnaire (APDQ) was designed to measure the

attitude of mental health providers toward individuals with personality disorders in general, and was not specifically designed to examine the attitudes of psychologists toward Borderline Personality Disorder. The current study made a minor modification in wording (i.e., "personality disorder" was changed to "borderline personality disorder"), which could have affected the properties of the scale. However, the modified scale demonstrated internal consistency that was comparable to the original scale.

Other limitations include the inherent difficulties when collecting data via the internet. For instance, one limitation of internet research is having less control over the environment in which the data are collected, although other types of survey methods (e.g., mail surveys) have the same limitation. There was also a low response rate so that self-selection biases may have occurred; the individuals who participated in the study may have different characteristics than those who chose not to participate. For example, because participants were selected from websites listing practitioners, there was a high percentage of individuals in private or independent practice. It is unknown if differences in results would have been obtained if other sampling methods were used.

On the other hand, there were several strengths to this study. One of the main strengths of this study is that a national sample of licensed psychologists were recruited to participate. A majority of these participants were actively involved in clinical work and on average, the participants had many years of clinical experience. Overall, they rated themselves as very familiar with BPD and the DSM-IV. Therefore the participants were likely very familiar with the BPD diagnosis and treatment. Thus, even though this was a vignette study, the reactions these participants had to the cases provide useful information given that they could imagine working with individuals with BPD with similar symptoms. On the other hand, their familiarity with the

diagnosis of and treatment of BPD may have contributed to the ceiling effects. Another strength of this study is that the vignettes were taken from well-respected sources in the literature. Each of the vignettes contained five or more BPD criteria to meet conditions for the diagnosis, but with different symptom presentations, and therefore, were representative of BPD. Additionally, the use of a vignette methodology allowed for the manipulation of the symptom presentations and gender that would not be possible with actual clients. Also, this study controlled for socially desirable responding by utilizing a social desirability measure that was specifically developed for health care providers. It was thought that this measure would be more appropriate for psychologists than the well-known Marlowe-Crowne Social Desirability Scale, which is quite transparent and likely very familiar to psychologists.

Implications and Future Directions

The results of this study suggest that clinicians' attitudes are not predictive of a BPD diagnosis, BPD representativeness or symptom ratings, or treatment recommendations. However, clinicians' attitudes appear to have a small effect on prediction of prognosis and likelihood the client would benefit from treatment, and a moderate effect on their willingness to work with client. These findings suggest that clinicians' attitudes may not be overtly affecting their clinical diagnosis or treatment, but may impact how they view the client's possible outcome or their desire to work with an individual diagnosed with BPD, which could potentially impact the therapeutic process and outcome. For example, research on common factors suggests that optimism is a predictor of outcome (Lambert, 1992; Reiter, 2010). Clinicians with negative attitudes toward BPD and negative beliefs about prognosis may have less successful outcome when working with these clients. Negative attitudes towards BPD were also associated with lower ratings of the likelihood the client would benefit from treatment. These results point to the

need for increased education and training for clinicians about the effective treatments available for BPD, and to correct misperceptions about the prognosis and likelihood of clients with BPD benefiting from treatment. These factors, as well as others that could influence clinicians' work with clients with BPD, are areas to examine in future research.

Additionally, gender had less of an effect on diagnosis than expected, suggesting differences may be related to other factors, such as type of symptom presentation of BPD. Gender of the client significantly affected treatment recommendations, which could potentially impact treatment outcomes and should be further researched. However, closer examination indicated this was only for the case with male-type BPD symptom presentation. The type of BPD symptom presentation in the case had a significant impact on diagnosis, BPD representativeness ratings, and treatment recommendations, which could potentially impact treatment outcomes. This finding suggests that the particular symptom constellation of BPD may influence diagnosis and treatment recommendations and there may be an effect of client gender depending on the symptom presentation. Because the BPD diagnostic criteria only require five of the nine symptoms, BPD is a particularly heterogeneous disorder. Further research examining various symptom constellations is needed, including research on subtypes of BPD and how these symptom constellations affect diagnosis and treatment recommendations. Clinicians might benefit from more training in identifying less typical symptom presentations of BPD.

Future studies may also address some of the limitations of the present study, such as conducting a similar study in a clinical setting to increase the generalizability of the results. Clinicians who are currently working with men and women diagnosed with BPD could be surveyed about their attitudes towards the BPD, and their treatment recommendations and predictions of prognosis for their client. The relationship between their attitudes towards BPD

and therapy process and outcome could also be examined. This would provide a more ecologically valid way of examining how attitudes may impact actual clinician behavior and treatment of individuals with BPD. Additionally, response rates for this study were very low, although it is likely that response rates could have been increased by offering larger incentives or payment for participation, which should be addressed in future studies using similar sampling methods. Research examining the impact on gender on treatment selection and outcomes in a clinical sample could be used to verify the findings in regard to gender and treatment recommendations found in the present study. Generally, there is a need for further research examining other potential variables influencing symptom presentations and treatment recommendations, such as comorbid diagnoses as well as age and other demographic variables. Given the significant differences found based on BPD symptom presentation, subsequent studies might focus on subtypes of BPD, and examine treatment recommendations and predictions of prognosis, as well as investigate differences in outcome or response to specific treatments based on BPD symptom constellations.

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Table 1

Participant Characteristics: Means and Standard Deviations

Variable	Participants (n = 88)[a]	
	M	*(SD)*
Age	51.14	(11.50)
Years Clinical Experience	18.11	(10.70)
Percent time in Activities		
Clinical	71.20	(26.82)
Administration	13.45	(18.18)
Supervision	5.13	(9.30)
Teaching	4.40	(9.15)
Other	3.05	(12.58)
Research	2.81	(8.26)
Percent Time Age Groups		
Adults 18-64	64.82	(27.35)
Adolescents 13-17	16.99	(20.12)
Older Adults 65+	10.65	(13.53)
Children 0-12	7.55	(15.87)
DSM-IV-TR Familiarity[b]	6.08	(1.10)
DSM-5 Familiarity[b]	3.70	(1.61)
BPD Familiarity[b]	5.67	(1.22)

[a]10 participants did not complete the Demographic Questionnaire
[b]Scale ranges from 1 (not at all familiar) to 7 (very familiar)

Table 2

Participant Characteristics: Frequencies and Percentages

Variable	Frequency (n = 88)[a]	Percentage
Sex		
Women	52	(59.10%)
Men	36	(40.90%)
Ethnicity		
Caucasian	82	(93.20%)
Biracial	4	(4.50%)
Asian/Pacific Islander	1	(1.10%)
Hispanic/Latino/Latina	1	(1.10%)
Type of Degree		
Ph.D.	56	(63.60%)
Psy.D.	25	(28.40%)
Ed.D.	3	(3.40%)
Other	3	(3.40%)
Not Reported	1	(1.10%)
Theoretical Orientation		
Cognitive-Behavioral	35	(39.80%)
Integrative/Eclectic	26	(29.50%)
Psychodynamic	12	(13.60%)
Other	6	(6.80%)
Interpersonal	4	(4.50%)
Humanistic	4	(4.50%)
Behavioral	1	(1.10%)
Work Setting		
Private Independent or Group Practice	64	(72.70%)
Hospital or Medical Center	13	(14.80%)
Community Mental Health	4	(4.50%)
Other	4	(4.50%)
University/School Department	3	(3.40%)
Work with Personality Disorders	55	(62.50%)

[a]10 participants did not complete the Demographic Questionnaire

Table 3

Diagnoses Assigned Based on the Type of BPD Symptom Presentation, Gender of Client, and Across Vignettes: Frequency and Percentages

Vignette 1: Female-Type	Borderline	Antisocial	Other
Female (n = 34)	33 (97.1%)	0 (0.0%)	1 (2.9%)
Male (n = 23)	23 (100.0%)	0 (0.0%)	0 (0.0%)
Total (n = 57)	56 (98.2%)	0 (0.0%)	1 (1.8 %)
Vignette 2: Male-Type			
Female (n = 18)	16 (88.9%)	0 (0.0%)	2 (11.1%)
Male (n = 23)	17 (73.9%)	4 (17.4%)	2 (8.7%)
Total (n = 41)	33 (80.5 %)	4 (9.8%)	4 (9.8%)
Overall (n = 98)	89 (90.8 %)	4 (4.1%)	5 (5.1%)

Note. Other = Narcissistic PD, Schizoid PD, Avoidant PD, Depressive PD, Passive-Aggressive PD

Table 4

BPD Representativeness Ratings by Vignette and Client Gender: Means and Standard Deviations

	BPD Representativeness	
	M	*(SD)*
Vignette 1: Female-Type		
Female (*n* = 33)	6.21	(1.02)
Male (*n* = 23)	6.17	(0.83)
Total (*n* = 56)	6.20	(0.94)
Vignette 2: Male-Type		
Female (*n* = 18)	5.83	(1.20)
Male (*n* = 23)	5.13	(1.60)
Total (*n* = 41)	5.44	(1.50)
Overall (*n* = 97)	5.88	(1.24)

Note. Scale ranged from 1 (not at all representative) to 7 (very representative)

Table 5

BPD Symptom Ratings and Number of BPD Symptoms Endorsed by Vignette, Client Gender, and across Vignettes: Means and Standard Deviations

	Symptom Rating		Symptoms Endorsed	
	M	*(SD)*	*M*	*(SD)*
Vignette 1: Female-Type				
Female (*n* = 29)	5.00	(0.89)	7.03	(1.57)
Male (*n* = 21)	4.74	(0.95)	6.43	(1.75)
Total (*n* = 50)	4.89	(0.91)	6.78	(1.66)
Vignette 2: Male-Type				
Female (*n* = 18)	4.74	(1.18)	6.17	(1.86)
Male (*n* = 21)	4.53	(1.05)	5.95	(1.96)
Total (*n* = 39)	4.63	(1.11)	6.05	(1.89)
Overall (*n* = 89)	4.78	(1.00)	6.46	(1.80)

Note. Scale ranged from 1 (not present) to 7 (present-severe). Symptoms were considered to be endorsed if rated 3 or higher on the 7 point scale.

Table 6

Ratings of Severity, Prognosis, and other Treatment Indicators by Vignette, Client Gender, and across Vignettes: Means and Standard Deviations

	Severity[a]	Prognosis[b]	Disclose Diagnosis[c]	Willingness to Work[d]	Benefit Treatment[c]
	M (*SD*)	*M* (*SD*)	*M* (*SD*)	*M* (*SD*)	*M* (*SD*)
Vignette 1 (Female-Type)					
Female (*n* = 31)	5.50 (0.62)	3.59 (1.10)	4.35 (2.06)	4.19 (2.01)	4.53 (1.46)
Male (*n* = 21)	5.52 (0.81)	3.52 (1.12)	5.24 (1.90)	4.43 (1.99)	4.71 (1.15)
Total (*n* = 52)	5.51 (0.70)	3.57 (1.10)	4.71 (2.02)	4.28 (1.98)	4.60 (1.34)
Vignette 2 (Male-Type)					
Female (*n* = 18)	5.56 (0.71)	3.28 (0.96)	4.39 (1.94)	4.22 (1.52)	4.44 (1.42)
Male (*n* = 20)	5.55 (0.76)	3.45 (1.10)	4.45 (1.88)	4.10 (2.17)	4.20 (1.51)
Total (*n* = 38)	5.55 (0.72)	3.37 (1.03)	4.42 (1.88)	4.16 (1.87)	4.32 (1.45)
Overall (*n* = 90)	5.53 (0.71)	3.48 (1.07)	4.23 (1.93)	4.48 (1.39)	4.59 (1.96)

[a]Scale ranged from 1 (not present) to 7 (present-severe)
[b]Scale ranged from 1 (very poor) to 7 (very good)
[c]Scale ranged from 1 (not at all likely) to 7 (very likely)
[d]Scale ranged from 1 (not at all willing) to 7 (very willing)

Table 7

Participants' Recommendation of Effective versus Less Effective Treatments and their First Treatment Choice Across Vignettes: Frequency and Percentages

Treatments	Frequency (%)
Effective Treatments	78 (79.6%)
Less Effective Treatments	11 (11.2%)
First Treatment Recommendation	
DBT[1]	52 (53.1%)
CBT[1]	12 (12.2%)
Substance Abuse[2]	7 (7.1%)
Other[3]	7 (7.1%)
Mood Stabilizer[1]	4 (4.1%)
Day Hospital[1]	2 (2.0%)
Transference-Focused[1]	2 (2.0%)
Mentalization Therapy[1]	1 (1.0%)
SSRIs[1]	1 (1.0%)
TCA[2]	1 (1.0%)
Brief Inpatient[2]	0 (0.0%)
Long-Term Inpatient[2]	0 (0.0%)
Schema Therapy[1]	0 (0.0%)
Antipsychotics[1]	0 (0.0%)
Benzodiazepines[2]	0 (0.0%)
MAOIs[2]	0 (0.0%)
SNRIs[1]	0 (0.0%)
No Treatment[2]	0 (0.0%)
Not Reported	9 (9.2%)

Note. Effective versus less effective treatment was based on the participants' first choice treatment recommendation. MAOI = monoamine oxidase inhibitor, SNRI = serotonin-norepinephrine reuptake inhibitor, SSRI = selective serotonin reuptake inhibitor, and TCA = tricyclic antidepressant.

[1]Effective treatment

[2]Less effective treatment
[3]Other was classified as effective if the participant entered "Psychodynamic," an appropriate medication, or a referral to psychiatrist, and less effective if they entered "Psychotherapy," Medication only," "Responsibility-based therapy," or "ACT."

Table 8

Participants' Recommendation of Effective versus Less Effective Treatments and their First Treatment Choice for Vignette 1: Frequencies and Percentages

	Vignette 1: Female-Type BPD		
Treatments	Female (n = 32)	Male (n = 21)	Total (n = 53)
Effective	32 (94.1%)	20 (87.0%)	52 (91.2%)
Less Effective	0 (0.0%)	1 (4.3%)	1 (1.8%)
First Treatment Recommendation			
DBT[1]	23 (67.6%)	13 (56.5%)	36 (63.2%)
CBT[1]	4 (11.8%)	1 (4.3%)	5 (8.8%)
Other[3]	2 (5.9%)	1 (4.3%)	3 (5.3%)
Day Hospital[1]	1 (2.9%)	1 (4.3%)	2 (3.5%)
Transference-Focused[1]	0 (0.0%)	2 (8.7%)	2 (3.5%)
Mood Stabilizer[1]	1 (2.9%)	1 (4.3%)	2 (3.5%)
Mentalization Therapy[1]	1 (2.9%)	0 (0.0%)	1 (1.8%)
SSRIs[1]	0 (0.0%)	1 (4.3%)	1 (1.8%)
TCA[2]	0 (0.0%)	1 (4.3%)	1 (1.8%)
Substance Abuse[2]	0 (0.0%)	0 (0.0%)	0 (0.0%)
Brief Inpatient[2]	0 (0.0%)	0 (0.0%)	0 (0.0%)
Long Inpatient[2]	0 (0.0%)	0 (0.0%)	0 (0.0%)
Schema Therapy[1]	0 (0.0%)	0 (0.0%)	0 (0.0%)
Antipsychotics[1]	0 (0.0%)	0 (0.0%)	0 (0.0%)
Benzodiazepines[2]	0 (0.0%)	0 (0.0%)	0 (0.0%)
MAOIs[2]	0 (0.0%)	0 (0.0%)	0 (0.0%)
SNRIs[1]	0 (0.0%)	0 (0.0%)	0 (0.0%)
No Treatment[2]	0 (0.0%)	0 (0.0%)	0 (0.0%)
Not Reported	2 (5.9%)	2 (8.7%)	4 (7.0%)

Note. Effective versus less effective treatment was based on the participants' first choice treatment recommendation. MAOI = monoamine oxidase inhibitor, SNRI = serotonin-norepinephrine reuptake inhibitors, SSRI = selective serotonin reuptake inhibitor, and TCA = tricyclic antidepressant.

[1]Effective treatment
[2]Less effective treatment
[3]Other was classified as effective if the participant entered "Psychodynamic," an appropriate medication, or a referral to psychiatrist, and less effective if they entered "Psychotherapy," Medication only," "Responsibility-based therapy," or "ACT."

Table 9

Participants' Recommendation of Effective versus Less Effective Treatments and their First Treatment Choice for Vignette 2: Frequencies and Percentages

	Vignette 2: Male-Type BPD		
Treatments	Female (*n* = 18)	Male (*n* = 18)	Total (*n* = 36)
Effective	16 (88.9%)	10 (43.5%)	26 (63.4%)
Less Effective	2 (11.1%)	8 (44.8%)	10 (24.4%)
First Treatment Recommendation			
DBT[1]	12 (66.7%)	4 (17.4%)	16 (39.0%)
CBT[1]	4 (22.2%)	3 (13.0%)	7 (17.1%)
Substance Abuse[2]	1 (5.6%)	6 (26.1%)	7 (17.1%)
Other[3]	1 (5.6%)	3 (13.0%)	4 (9.8%)
Mood Stabilizer	0 (0.0%)	2 (8.7%)	2 (4.9%)
Day Hospital[1]	0 (0.0%)	0 (0.0%)	0 (0.0%)
Mentalization Therapy[1]	0 (0.0%)	0 (0.0%)	0 (0.0%)
SSRIs[1]	0 (0.0%)	0 (0.0%)	0 (0.0%)
TCA[2]	0 (0.0%)	0 (0.0%)	0 (0.0%)
Transference-Focused[1]	0 (0.0%)	0 (0.0%)	0 (0.0%)
Brief Inpatient[2]	0 (0.0%)	0 (0.0%)	0 (0.0%)
Long Inpatient[2]	0 (0.0%)	0 (0.0%)	0 (0.0%)
Schema Therapy[1]	0 (0.0%)	0 (0.0%)	0 (0.0%)
Antipsychotics[1]	0 (0.0%)	0 (0.0%)	0 (0.0%)
Benzodiazepines[2]	0 (0.0%)	0 (0.0%)	0 (0.0%)
MAOIs[2]	0 (0.0%)	0 (0.0%)	0 (0.0%)
SNRIs[1]	0 (0.0%)	0 (0.0%)	0 (0.0%)
No Treatment[2]	0 (0.0%)	0 (0.0%)	0 (0.0%)
Not Reported	0 (0.0%)	5 (21.7%)	5 (12.2%)

Note. Effective versus less effective treatment was based on the participants' first choice treatment recommendation. MAOI = monoamine oxidase inhibitor, SNRI = serotonin-norepinephrine reuptake inhibitors, SSRI = selective serotonin reuptake inhibitor, and TCA = tricyclic antidepressant.

[1]Effective treatment
[2]Less effective treatment

[3]Other was classified as effective if the participant entered “Psychodynamic,” an appropriate medication, or a referral to psychiatrist, and less effective if they entered “Psychotherapy,” Medication only,” “Responsibility-based therapy,” or “ACT.”

Table 10

Relationship between APDQ Total Score and the Dependent Variables: Results of Correlational Analyses

Variables	*r*	*p*
Confidence in Diagnosis	.06	.579
BPD Representativeness	.13	.220
Mean BPD Symptom Rating	.07	.535
Number of BPD Symptoms Endorsed	.07	.522
Severity	- .07	.519
Predicted Prognosis	.33	.002**
Likelihood of Disclosing the Diagnosis	.08	.480
Willingness to Work with the Individual	.58	<.001**
Likelihood of Benefiting from Treatment	.45	<.001**
Likelihood of recommending the following:		
Brief Inpatient Treatment	- .24	.024*
CBT	.08	.467
Day Hospital	- .16	.133
DBT	.10	.359
Long-term Inpatient	- .08	.460
Mentalization Therapy	.08	.463
Schema Therapy	.05	.671
Substance Abuse Treatment	- .01	.965
Transference-Focused	- .11	.295
Antipsychotics	- .17	.107
Benzodiazepines	.02	.876
Mood Stabilizer	- .16	.147
MAOIs	- .28	.011*
SSRIs	- .36	.001**
SNRIs	- .36	.001**
TCA	- .16	.149
No Treatment	.08	.495
Other	.37	.196

* $p < .05$ ** $p < .01$

Note. MAOI = monoamine oxidase inhibitor, SNRI = serotonin-norepinephrine reuptake inhibitors, SSRI = selective serotonin reuptake inhibitor, and TCA = tricyclic antidepressant.

Table 11

Comparison of APDQ "Low" (Negative Attitude) versus "High" (Positive Attitude) Groups on BPD Diagnosis and Treatment Recommendations: Results of Chi-square Analyses

Variables	*N*	χ^2	*df*	*p*	ϕ
Diagnosis of BPD	46	3.21	1	0.07	0.26
Effective[a] versus Less Effective Treatment[b]	46	0.00	1	1.00	0.00

Note. Effective versus less effective treatment was based on the participants' first choice treatment recommendation.

[a]Effective treatments = antipsychotics, cognitive-behavioral therapy (CBT), day hospital, Dialectical Behavior Therapy (DBT), Mentalization Therapy, mood stabilizer, Schema Therapy, selective serotonin reuptake inhibitor (SSRIs), serotonin-norepinephrine reuptake inhibitors (SNRIs), Transference-Focused Psychotherapy, or "other" if the participant entered "Psychodynamic," an appropriate medication, or a referral to psychiatrist.

[b]Less effective treatments = benzodiazepines, brief inpatient, long-term inpatient, monoamine oxidase inhibitors (MAOIs), substance abuse treatment, tricyclic antidepressant (TCA), no treatment, or "other" if the participant entered "psychotherapy," medication only," "responsibility-based therapy," or "ACT."

Table 12

Comparison of APDQ "Low" (Negative Attitude) versus "High" (Positive Attitude) Groups on Ratings: Results of One-way ANOVAs

Variables	*F*	*p*	*Partial* η^2
BPD Representativeness[a]	.36	.55	.008
BPD Symptom Rating[b]	.17	.68	.004
Severity[a]	.61	.44	.014
Prognosis[a]	13.86	.001**	.240
Likelihood of Disclosing the Diagnosis[c]	.92	.34	.021
Willingness to Work with the Individual[a]	37.03	<.001**	.460
Likelihood of Benefiting from Treatment[a]	21.70	<.001**	.330

* $p < .05$ ** $p < .01$
[a] $df = 1, 44$
[b] $df = 1, 42$
[c] $df = 1, 43$

Table 13

APDQ "Low" (Negative Attitude) versus "High" (Positive Attitude) Groups: Means and Standard Deviations

	Low APDQ Negative Attitude (n = 23)		High APDQ Positive Attitude (n = 23)	
Variables	*M*	*(SD)*	*M*	*(SD)*
BPD Representativeness	5.87	(1.18)	6.09	(1.28)
BPD Symptom Rating	4.75	(0.93)	4.88	(1.25)
Severity	5.61	(0.58)	5.43	(0.90)
Likelihood of Disclosing the Diagnosis	4.52	(1.73)	5.05	(1.94)
Prognosis	3.09	(0.79)	4.17	(1.15)
Likelihood Benefit from Treatment	3.87	(1.25)	5.48	(1.08)
Willingness to Work with Individual	2.91	(1.62)	5.61	(1.37)

Table 14

Prediction of BPD Diagnosis from APDQ Total Scores, Client Gender, Type of Vignette, and Social Desirability: Results of Logistic Regression

Predictor	*B*	Wald	*p*	Exp (*B*)	95% Confidence Interval for Exp(*B*) Lower	Upper
Step 1						
APDQ Total	.044	3.221	.073	1.045	.996	1.097
Step 2						
APDQ Total	.064	3.263	.071	1.066	.992	1.142
Client Gender	1.269	0.974	.324	0.281	.023	3.496
BPD Symptom Presentation	19.404	0.000	.997	0.000	.000	.
Social Desirability	.118	0.083	.774	1.125	.505	2.507

Note. APDQ = Attitude toward Personality Disorder Questionnaire.

Table 15

Prediction of Treatment Recommendations from APDQ Total Scores, Client Gender, Type of BPD Symptom Presentation, and Social Desirability: Results of Logistic Regression

Predictor	*B*	Wald	*p*	Exp (*B*)	95% Confidence Interval for Exp(*B*) Lower	Upper
Step 1						
APDQ Total	.001	.006	.940	1.001	.970	1.034
Step 2						
APDQ Total	- .011	0.252	.616	.989	.947	1.032
Client Gender	2.160	5.274	.022*	.115	.018	0.729
BPD Symptom Presentation	3.106	7.505	.006**	.045	.005	0.413
Social Desirability	- .230	0.571	.450	.794	.437	1.444

* $p < .05$ ** $p < .01$

Note. APDQ = Attitude toward Personality Disorder Questionnaire.

Table 16

Effect of Client Gender and Type of BPD Symptom Presentation on Dependent Variables across both Vignettes: Results of MANCOVA and Univariate Analyses

Multivariate Results[a]	*Wilks' Lambda*	*F*	*p*	*Partial* η^2
Social Desirability	.941	.62	.736	.059
APDQ Total Score	.589	6.99	< .001**	.411
Client Gender	.936	.67	.683	.064
Type of Presentation	.850	1.76	.109	.150
Gender X Type of Presentation	.943	.60	.754	.057

Univariate Results[b]	*F*	*p*	*Partial* η^2
Social Desirability			
BPD Representativeness	.62	.434	.008
Symptoms	.38	.539	.005
Severity	1.28	.262	.017
Prognosis	.08	.780	.001
Benefiting from Treatment	.19	.668	.002
Willingness to Work	.12	.731	.002
Disclosing the Diagnosis	.001	.972	.000
APDQ Total Score			
BPD Representativeness	2.40	.125	.031
Symptoms	.19	.662	.003
Severity	.15	.698	.002
Prognosis	10.89	.001**	.125
Benefiting from Treatment	17.29	< .001**	.185
Willingness to Work	37.81	< .001**	.332
Disclosing the Diagnosis	.47	.495	.006
Client Gender			
BPD Representativeness	2.84	.096	.036
Symptoms	3.28	.074	.041
Severity	.08	.777	.001
Prognosis	.32	.575	.004
Benefiting from Treatment	.17	.685	.002
Willingness to Work	.03	.867	.000
Disclosing the Diagnosis	1.03	.312	.013

Univariate Results[b]	*F*	*p*	*Partial* η^2
BPD Symptom Presentation			
BPD Representativeness	7.74	.007**	.092
Symptoms	1.91	.171	.024
Severity	.06	.808	.001
Prognosis	.46	.499	.006
Benefiting from Treatment	.87	.354	.011
Willingness to Work	.62	.432	.008
Disclosing the Diagnosis	.79	.377	.010
Gender X BPD Symptom Presentation			
BPD Representativeness	1.55	.217	.020
Symptoms	.09	.769	.001
Severity	.12	.728	.002
Prognosis	.27	.606	.004
Benefiting from Treatment	.27	.603	.004
Willingness to Work	.02	.888	.000
Disclosing the Diagnosis	.58	.451	.008

* $p < .05$ ** $p < .01$
[a] $df = 7, 70$
[b] $df = 1, 76$

Table 17

Effect of Client Gender, Social Desirability, and the APDQ on ratings of Dependent Variables for Vignette 1 (Female-Type BPD): Results of MANCOVA and Univariate Analyses

Multivariate Results[a]	*Wilks' Lambda*	*F*	*p*	*Partial* η^2
Social Desirability	.878	.751	.631	.122
APDQ Total Score	.432	7.138	< .001**	.568
Client Gender	.848	.971	.466	.152

Univariate Results[b]	*F*	*p*	*Partial* η^2
Social Desirability			
BPD Representativeness	1.107	.299	.025
Symptoms	1.107	.305	.024
Severity	.032	.859	.001
Prognosis	.078	.781	.002
Benefiting from Treatment	.540	.466	.012
Disclosing the Diagnosis	.481	.492	.011
Willingness to Work	.057	.813	.001
APDQ Total Score			
BPD Representativeness	.456	.503	.010
Symptoms	.033	.856	.001
Severity	5.171	.028*	.105
Prognosis	13.683	.001**	.237
Benefiting from Treatment	29.463	< .001**	.401
Disclosing the Diagnosis	.497	.485	.011
Willingness to Work	31.260	< .001**	.415
Client Gender			
BPD Representativeness	.160	.691	.004
Symptoms	1.710	.198	.037
Severity	.000	.991	.000
Prognosis	.001	.971	.000
Benefiting from Treatment	.802	.375	.018

Univariate Results[b]	*F*	*p*	*Partial* η^2
Disclosing the Diagnosis	1.727	.196	.038
Willingness to Work	.076	.784	.002

* $p < .05$ ** $p < .01$
[a]$df = 7, 38$
[b]$df = 1, 44$

Table 18

Effect of Client Gender, Social Desirability, and the APDQ on ratings of Dependent Variables for Vignette 2 (Male-Type BPD): Results of MANCOVA and Univariate Analyses

Multivariate Results[a]	*Wilks' Lambda*	*F*	*p*	*Partial* η^2
Social Desirability	.762	1.070	.412	.238
APDQ Total Score	.592	2.367	.054	.408
Client Gender	.808	.814	.585	.192
Univariate Results[b]		***F***	***p***	***Partial*** η^2
Social Desirability				
BPD Representativeness		.000	.987	.000
Symptoms		.047	.830	.002
Severity		4.916	.034*	.141
Prognosis		.001	.973	.000
Benefiting from Treatment		.001	.977	.000
Disclosing the Diagnosis		1.409	.245	.045
Willingness to Work		.744	.395	.024
APDQ Total Score				
BPD Representativeness		2.651	.114	.081
Symptoms		.735	.398	.024
Severity		6.530	.016*	.179
Prognosis		.352	.557	.012
Benefiting from Treatment		.535	.470	.018
Disclosing the Diagnosis		.004	.953	.000
Willingness to Work		8.135	.008**	.213
Client Gender				
BPD Representativeness		2.065	.161	.064
Symptoms		.945	.339	.031
Severity		.176	.678	.006
Prognosis		.188	.668	.006
Benefiting from Treatment		.127	.724	.004
Disclosing the Diagnosis		.094	.762	.003
Willingness to Work		.042	.838	.001

* $p < .05$ ** $p < .01$
[a] $df = 7, 24$
[b] $df = 1, 34$

Table 19

Effect of Participant Characteristics on Diagnosis of BPD and Effective versus Less Effective Treatment Recommendations: Results of Chi-Square Analyses

Participant Characteristics	*N*	χ^2	*p*	ϕ
<u>BPD Diagnosis</u>				
Gender				
Female (*n* = 52)	49	.002	.966	-.005
Male (*n* = 36)	34			
Years of Experience				
10 years or less (*n* = 25)	24	.661	.718	.087
11-20 (*n* = 25)	24			
More than 20 years (*n* = 37)	34			
Theoretical Orientation				
CBT (*n* = 35)	33	.393	.821	.067
Integrative/Eclectic (*n* = 26)	24			
Other (*n* = 27)	26			
<u>Treatment Recommendations</u>				
Gender				
Female (*n* = 51)	47	1.615	.204	.136
Male (*n* = 36)	30			
Years of Experience				
10 years or less (*n* = 24)	22	3.583	.167	.204
11-20 (*n* = 25)	24			
More than 20 years (*n* = 37)	30			
Theoretical Orientation				
CBT (*n* = 35)	29	2.593	.274	.173
Integrative/Eclectic (*n* = 26)	25			
Other (*n* = 26)	23			

Note. N = Number that diagnosed BPD or recommended to effective treatment. Years of experience was divided into 3 categories: 10 years or less, 11-20, more than 20 years. Theoretical orientation was divided into three categories: CBT, Integrative/Eclectic, and Other.

Table 20

Effect of Participant Characteristics on BPD Representativeness Ratings, Prognosis, and Severity: Results of One-Way ANOVAs

Participant Characteristics	*F*	*df*	*p*	*Partial* η^2
Representativeness				
Gender[1]	.62	1	.43	.007
Years of Experience[3]	.71	2	.50	.017
Theoretical Orientation[2]	.18	2	.83	.004
Prognosis				
Gender[1]	2.67	1	.11	.030
Years of Experience[3]	.62	2	.54	.015
Theoretical Orientation[2]	.02	2	.98	.001
Severity				
Gender[1]	.65	1	.42	.008
Years of Experience[2]	.17	2	.85	.004
Theoretical Orientation[3]	.41	2	.66	.010

Note. Years of experience was divided into 3 categories: 10 years or less, 11-20, more than 20 years. Theoretical orientation was divided into three categories: CBT, Integrative/Eclectic, and Other.
[1]$df = 1, 86$
[2]$df = 2, 85$
[3]$df = 2, 84$

APPENDIX A

DSM-IV-TR DIAGNOSTIC CRITERIA FOR BORDERLINE PERSONALITY DISORDER

A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. frantic efforts to avoid real or imagined abandonment.
2. a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.
3. identity disturbance: markedly and persistently unstable self-image or sense of self
4. impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating).
5. recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior
6. affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability or anxiety usually lasting a few hours and only rarely more than a few days).
7. chronic feelings of emptiness.
8. inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).
9. transient, stress-related paranoid ideation or severe dissociative symptoms.

Note. American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders (4th ed., text revision)* (pp. 710). Washington, DC: Author.

APPENDIX B

CASE VIGNETTES

Vignette 1: Female-type BPD Symptom Presentation

Emily (Eric), a 24-year-old graduate student, recently moved into an apartment with three other women (men). The relationship between Emily (Eric) and her (his) roommates appeared to go well initially. S(he) became very attached to one of the women (men) and idealized her (him) to the point that s(he) began dressing like the roommate. The woman (men) started to feel uncomfortable when Emily (Eric) confided that s(he) felt so much like the roommate that they could be twins. The other roommates began feeling uneasy when s(he) demanded more of their time. Emily (Eric) seemed to need constant attention and complained of feeling bored and empty. S(he) had mood swings, feeling elated at one moment and depressed or empty the next.

Emily (Eric) was attractive and dated several men (women). S(he) described each man (woman) in glowing terms initially and usually had sex soon after the first date. These relationships were brief, intense, and usually ended after a few weeks. One of the men (women) confided to a roommate, “I can’t walk out of the apartment without her (him) asking me where I’m going and accusing me of not caring for her (him).” Emily (Eric) felt depressed and empty when the relationships ended. Following the end of another relationship, a roommate found Emily (Eric) cutting her (his) thigh with a razor blade. Two days later the roommates decided that Emily (Eric) had to move out. S(he) was devastated but agreed to go after telling them that they were all worthless and would be sorry. S(he) moved out the next day. Subsequently, all

three roommates found that several of their clothes had been slashed with a razor blade and ruined.

Note: Case vignette adapted from Fauman, M. A. (2002). *Study Guide to DSM-IV-TR* (pp. 382-383). Arlington, VA: American Psychiatric Publishing.

Vignette 2: Male-Type BPD Symptom Presentation

Carl (Claire) is a 29-year-old, married male (female) computer technician referred for treatment of his (her) impulsive aggressive outbursts in the context of a threatened separation from his (her) wife (husband) of 4 years. Carl (Claire) reports impulsive aggressive outbursts since his (her) mid-teens. These outbursts typically involve screaming, shouting, and throwing things around; (s)he has only occasionally physically hit anyone. However, these aggressive outbursts occur several times a month and usually several times a week, particularly when Carl (Claire) is "held up" in traffic.

Most recently, (s)he has been having serious marital difficulty, and his (her) wife (husband) is now threatening to leave him (her) if (s)he does not get help for his (her) anger problem. (S)He reports that his relationship with his (her) wife (husband) is often "stormy," with frequent fighting that sometimes goes on for hours. Sometimes in the aftermath of these fights Carl (Claire) runs off and gets exceedingly drunk and drives recklessly around town while high. Still, at other times, (s)he frantically pleads with his (her) wife (husband) not to leave him (her); once (s)he took an overdose of aspirin, in front of his (her) wife (husband), to get her (him) to stay with him (her). Carl (Claire) reports a history of alcohol abuse in his (her) late teens and early twenties and a history of gambling in excess up until 1 year prior to evaluation.

Note: Case vignette adapted from Oldham, J. M., Skodol, A. E., & Bender, D. S. (2009). *Essentials of personality disorders* (pp. 115-116). Arlington, VA US: American Psychiatric Publishing, Inc.

APPENDIX C

DIAGNOSTIC QUESTIONNAIRE

Choose one diagnosis most representative of the above case

___ Paranoid PD	____ Borderline PD	____ Dependent PD
___ Schizoid PD	____ Histrionic PD	____ Obsessive-Compulsive PD
___ Schizotypal PD	____ Narcissistic PD	____ Depressive PD
___ Antisocial PD	____ Avoidant PD	____ Passive-Aggressive PD

Rate how confident you are in you diagnosis for the case

1	2	3	4	5	6	7
Not at all Confident			Moderate			Very Confident

Rate the representativeness of the following diagnoses for the case using the following scale

1	2	3	4	5	6	7
Not at all representative						Very Representative

___ Paranoid PD	____ Borderline PD	____ Dependent PD
___ Schizoid PD	____ Histrionic PD	____Obsessive-Compulsive PD
___ Schizotypal PD	____ Narcissistic PD	____ Depressive PD
___ Antisocial PD	____ Avoidant PD	____ Passive-Aggressive PD

Rate the presence of the following symptoms in the case using the following scale

1	2	3	4	5	6	7
Not Present		Possibly Present Mild		Present Moderate		Present Severe

1. Has difficulty making everyday decisions without an excessive amount of advice and reassurance from others
2. Is suggestible, i.e., easily influenced by others or circumstances
3. Chronic feelings of emptiness.
4. Urgently seeks another relationship as a source of care and support when a close relationship ends
5. Is interpersonally exploitative, i.e., takes advantage of others to achieve his or her own ends
6. Considers relationships to be more intimate than they actually are
7. Has a grandiose sense of self-importance (e.g., exaggerates achievements and talents, expects to be recognized as superior without commensurate achievements)
8. Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior

9. Irritability and aggressiveness, as indicated by repeated physical fights or assaults
10. Is unrealistically preoccupied with fears of being left to take care of himself or herself
11. Failure to conform to social norms with respect to lawful behaviors as indicated by repeatedly performing acts that are grounds for arrest
12. Transient, stress-related paranoid ideation or severe dissociative symptoms
13. Has difficulty expressing disagreement with others because of fear of loss of support or approval.
14. Reckless disregard for safety of self or others
15. Identity disturbance: markedly and persistently unstable self-image or sense of self.
16. interaction with others is often characterized by inappropriate sexually seductive or provocative behavior
17. Requires excessive admiration
18. Has difficulty initiating projects or doing things on his or her own (because of a lack of self-confidence in judgment or abilities rather than a lack of motivation or energy)
19. Is uncomfortable in situations in which he or she is not the center of attention
20. Shows arrogant, haughty behaviors or attitudes
21. Feels uncomfortable or helpless when alone because of exaggerated fears of being unable to care for himself or herself
22. Transient, stress-related paranoid ideation or severe dissociative symptoms.
23. Impulsivity or failure to plan ahead
24. Shows self-dramatization, theatricality, and exaggerated expression of emotion
25. Frantic efforts to avoid real or imagined abandonment.
26. Lacks empathy: is unwilling to recognize or identify with the feelings and needs of others
27. Lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another
28. Has a style of speech that is excessively impressionistic and lacking in detail
29. Goes to excessive lengths to obtain nurturance and support from others, to the point of volunteering to do things that are unpleasant
30. Deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure
31. Has a sense of entitlement, i.e., unreasonable expectations of especially favorable treatment or automatic compliance with his or her expectations
32. Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).
33. Consistently uses physical appearance to draw attention to self
34. A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation. This is called "splitting."
35. Consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations
36. Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).

37. Believes that he or she is "special" and unique and can only be understood by, or should associate with, other special or high-status people (or institutions)
38. Displays rapidly shifting and shallow expression of emotions
39. Needs others to assume responsibility for most major areas of his or her life
40. is preoccupied with fantasies of unlimited success, power, brilliance, beauty, or ideal love
41. Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating).
42. Is often envious of others or believes that others are envious of him or her

Rate the overall severity of this client presented in the case

1	2	3	4	5	6	7
Very Mild			Moderate			Very Severe

Rate what prognosis you would give this client

1	2	3	4	5	6	7
Very Poor			Moderate			Very Good

Rate the likelihood that this client will benefit from treatment

1	2	3	4	5	6	7
Not at all Likely			Moderate			Very Likely

Rate how likely you would be to disclose the diagnosis to the individual in the case

1	2	3	4	5	6	7
Not at all Likely			Moderate			Very Likely

Rate your willingness to work with the client from the vignette

1	2	3	4	5	6	7
Not At all Willing			Moderate			Very Willing

Rate the likelihood of recommending the following treatments for the case using the following scale

1	2	3	4	5	6	7
Not at all Likely			Moderate			Very Likely

____ Brief Inpatient
____ Cognitive-Behavioral Therapy
____ Day Hospital
____ Dialectical Behavior Therapy
____ Long-term Inpatient
____Mentalization Therapy
____ Schema Therapy
____ Substance Abuse Treatment
____ No treatment
____ Antipsychotic Medication
____ Benzodiazepines
____ Monoamine Oxidase Inhibitor (MAOI)
____ Mood Stabilizer
____ Selective Serotonin Reuptake Inhibitor
____ Serotonin-Norepinephrine Reuptake Inhibitors
____ Tricyclic Antidepressant
____ Transference-Focused Psychotherapy

Please select first and second treatment choices that you would recommend for this individual from the drop down menu:

____ Brief Inpatient
____ Cognitive-Behavioral Therapy
____ Day Hospital
____ Dialectical Behavior Therapy
____ Long-term Inpatient
____Mentalization Therapy
____ Schema Therapy
____ Substance Abuse Treatment
____ No treatment
____ Antipsychotic Medication
____ Benzodiazepines
____ Monoamine Oxidase Inhibitor (MAOI)
____ Mood Stabilizer
____ Selective Serotonin Reuptake Inhibitor
____ Serotonin-Norepinephrine Reuptake Inhibitors
____ Tricyclic Antidepressant
____ Transference-Focused Psychotherapy

APPENDIX D

ATTITUDE TO PERSONALITY DISORDER QUESTIONNAIRE

Now please take a moment to reflect upon your experience of patients with Borderline Personality Disorder (BPD).

For the purpose of this questionnaire we would like you to think about your feelings toward BPD patients overall. We realize that you may have different mixtures of feelings about different BPD patients you have cared for in the past. For this questionnaire we would like you to try and average those out and tell us what your responses are in general toward BPD patients as a whole.

For each response listed below please indicate the frequency of your feelings toward people with Borderline Personality Disorder. Please choose your choice quickly, rather than spending a long time considering it. We want to know your honest, gut feelings.

	Never	Seldom	Occasionally	Often	Very Often	Always
1. I like BPD patients. (Enjoyment vs. Loathing)	1	2	3	4	5	6
2. I feel frustrated with BPD clients.* (Enthusiasm vs. Exhaustion)	1	2	3	4	5	6
3. I feel drained by BPD patients.* (Enthusiasm vs. Exhaustion)	1	2	3	4	5	6
4. I respect BPD patients. (Enjoyment vs. Loathing)	1	2	3	4	5	6
5. I feel fondness and affection for BPD patients. (Enjoyment vs. Loathing)	1	2	3	4	5	6
6. I feel vulnerable in a BPD patients company. * (Security vs. Vulnerability)	1	2	3	4	5	6
7. I have a feeling of closeness with BPD patients. (Enjoyment vs. Loathing)	1	2	3	4	5	6

8. I feel manipulated or used by BPD patients. * (Security vs. Vulnerability)	1	2	3	4	5	6
9. I feel uncomfortable or uneasy with BPD patients. * (Security vs. Vulnerability)	1	2	3	4	5	6
10. I feel I am wasting my time with BPD patients. * (Purpose vs. Futility)	1	2	3	4	5	6
11. I am excited to work with BPD patients. (Enjoyment vs. Loathing)	1	2	3	4	5	6
12. I feel pessimistic about BPD patients. * (Purpose vs. Futility)	1	2	3	4	5	6
13. I feel resigned about BPD patients. * (Purpose vs. Futility)	1	2	3	4	5	6
14. I admire BPD patients. (Enjoyment vs. Loathing)	1	2	3	4	5	6
15. I feel helpless in relation to BPD patients. * (Security vs. Vulnerability)	1	2	3	4	5	6
16. I feel frightened of BPD patients.* (Security vs. Vulnerability)	1	2	3	4	5	6
17. I feel angry toward BPD patients.* (Acceptance vs. Rejection)	1	2	3	4	5	6
18. I feel provoked by BPD patients.*	1	2	3	4	5	6
19. I enjoy spending time with BPD patients. (Enjoyment vs. Loathing)	1	2	3	4	5	6
20. Interacting with BPD patients makes me shudder. * (Acceptance vs. Rejection)	1	2	3	4	5	6
21. BPD patients make me feel irritated. * (Acceptance vs. Rejection)	1	2	3	4	5	6
22. I feel warm and caring toward BPD patients. (Enjoyment vs. Loathing)	1	2	3	4	5	6
23. I feel protective toward BPD patients. (Enjoyment vs. Loathing)	1	2	3	4	5	6

24. I feel oppressed or dominated by BPD patients. * (Security vs. Vulnerability)	1	2	3	4	5	6
25. I feel that BPD patients are alien, other, strange. *(Acceptance vs. Rejection)	1	2	3	4	5	6
26. I feel understanding toward BPD patients.(Enjoyment vs. Loathing)	1	2	3	4	5	6
27. I feel powerless in the presence of BPD patients. * (Security vs. Vulnerability)	1	2	3	4	5	6
28. I feel happy and content in BPD patients company. (Enjoyment vs. Loathing)	1	2	3	4	5	6
29. I feel cautious and careful in the presence of BPD patients. *	1	2	3	4	5	6
30. I feel outmaneuvered by BPD patients. * (Security vs. Vulnerability)	1	2	3	4	5	6
31. Caring for BPD patients makes me feel satisfied and fulfilled. (Enjoyment vs. Loathing)	1	2	3	4	5	6
32. I feel exploited by BPD patients.* (Security vs. Vulnerability)	1	2	3	4	5	6
33. I feel patient when caring for BPD patients. (Enjoyment vs. Loathing)	1	2	3	4	5	6
34. I feel able to help BPD patients. (Enjoyment vs. Loathing)	1	2	3	4	5	6
35. I feel interested in BPD patients. (Enjoyment vs. Loathing)	1	2	3	4	5	6
36. I feel unable to gain control of the situation with BPD patients.* (Security vs. Vulnerability)	1	2	3	4	5	6
37. I feel intolerant. I have difficulty tolerating BPD client behavior.* (Acceptance vs. Rejection)	1	2	3	4	5	6

38. Please indicate your overall sense of the difficulty in treating BPD patients as compared to others by selecting only one of the options below.
    a) The care & treatment of BPD patients is relatively free from difficulty
    b) Care & treatment poses some mild difficulty
    c) Care & treatment is moderately difficulty
    d) Care & treatment is very difficult
    e) Care & treatment difficulty is extreme

39. Good use of care and treatment. Please indicate your opinion about whether BPD patients make good use of care and treatment. How much do they profit from care and treatment, and how satisfactory will eventual adjustment be? Please ignore financial considerations in making this rating. Please select only one of the options.
    a) I am very optimistic about care and treatment outcomes and confident BPD patients will make good use of care and treatment.
    b) I am optimistic about care and treatment outcomes
    c) I am quite unsure about what kind of care and treatment outcomes to expect
    d) I am pessimistic about care and treatment outcomes but think there is some possibility for good outcomes
    e) I am extremely pessimistic about care and treatment outcomes and have little hope for positive outcomes

---

* reverse scored items

Note. For the purposes of this study, the questionnaire was modified by substituting Borderline Personality Disorder for Personality Disorder and BPD for PD.

Bowers, L., Carr-Walker, P., Allan, T., Callaghan, P., Nijman, H., & Paton, J. (2006). Attitude to personality disorder among prison officers working in a dangerous and severe personality disorder unit. *International Journal of Law and Psychiatry, 29*, 333-342. doi: 10.1016/j.ijlp.2005.10.005

APPENDIX E

SOCIAL DESIRABILITY SCALE (MEDICAL VERSION)

1. I listen attentively to everything my patients say. T/F

2. I always give my patients my best treatment. T/F

3. I always introduce myself to a new patient. T/F

4. I never treat patients as adversaries. T/F

5. I treat every patient as a unique individual. T/F

6. I always do a thorough history on new patients. T/F

7. I always answer my patients' questions. T/F

Note. Merrill, J. M., Laux, L. F., Lorimor, R. J., & Thornby, J. I. (1995). Measuring social desirability among senior medical students. *Psychological Reports, 77*, 859-864. doi: 10.2466/pr0.1995.77.3.859

APPENDIX F

DEMOGRAPHIC QUESTIONNAIRE

1. Please indicate your sex
   ___Male
   ___Female

2. Please indicate your age:

3. Please indicate your ethnicity
   ___African American
   ___Asian/Pacific Islander
   ___Caucasian
   ___Hispanic/Latino/Latina
   ___Native American
   ___Other (please specify _____)

4. Please indicate the type of degree that you hold.
   ___Ph.D.
   ___Psy.D.
   ___Ed.D.
   ___Other (please specify _____)

5. Please indicate your primary work setting:
   ___Community Mental Health
   ___Correctional Facility
   ___Hospital or Medical Center
   ___Private Practice
   ___University/School Department
   ___Other (please specify _____)

6. Please indicate your theoretical orientation.
   ___Behavioral
   ___Cognitive-Behavioral
   ___Integrative/Eclectic
   ___Interpersonal
   ___Humanistic
   ___Psychodynamic

___Other (please specify _____)

7. Please indicate the years of clinical experience you have had since completing your doctoral degree: _____

8. Please indicate the percent of your time in the following activities:
____ Administration
____ Clinical
____ Research
____ Teaching
____ Supervision
____ Other (please specify _____)

9. Please indicate the percentage of time that you work with the following groups:
____ Children (0-12)
____ Adolescents (13-17)
____ Adults (18-64)
____ Older adults (65+)

10. Please indicate which of the following disorders you commonly work with:
____ Adjustment Disorders
____ Anxiety Disorders
____ Childhood Disorders
____ Eating Disorders
____ Impulse Control Disorders
____ Mood Disorders
____ Personality Disorders
____ Schizophrenia/Psychotic disorders
____ Somatoform Disorders
____ Substance-related Disorders

11. Please indicate your familiarity with DSM-IV-TR

1	2	3	4	5	6	7
Not at all familiar			Moderate			Very familiar

12. Please indicate your familiarity with DSM-5

1	2	3	4	5	6	7
Not at all familiar			Moderate			Very familiar

13. Please indicate your familiarity with borderline personality disorder

1	2	3	4	5	6	7
Not at all familiar			Moderate			Very familiar

APPENDIX G

EMAIL INVITATION

I would like to invite you to participate in my dissertation research on diagnostic and treatment decision making. If you agree to participate, you will be asked to read a case vignette and rate it on a variety of measures. **Please take note of the letter of the vignette you read at the beginning.** I ask that you do not consult the DSM-IV-TR or DSM-5 when completing the survey, as I am interested in your initial reactions based on your clinical judgment. I am sure that your schedule is very busy, but I hope that you will take a few moments to participate. This study should take approximately 20 minutes to complete. Completion of this survey is entirely voluntary and greatly appreciated. This study has been approved by the IRB. All reasonable precautions have been taken to preserve participants' anonymity and no identifying information will be collected.

You can access the web study with the following link and will need to provide the following verification code (password): abc123

Link to study: https://qtrial.qualtrics.com/SE/?SID=SV_bjYu90hSRNJdCAZ.
Verification code: abc123

If you cannot access the website by clicking on the link, you can copy and paste the address into your browser.

If you have any questions, you may contact me by email at saldridge1@sycamores.indstate.edu or my faculty sponsor, Dr. June Sprock at June.Sprock@indstate.edu.

Thank you in advance for your time and effort. I greatly appreciate your willingness to share your clinical expertise by participating in this research. If you agree to participate you will have the opportunity to be entered into a raffle with a chance to win one of three gift cards for Amazon.com.

We would like to get as many participants as possible. If you know other psychologists who might be interested in participating, please send this email along to them.

Sincerely,

Sarah Aldridge, M.S.
Doctoral Candidate
Indiana State University

APPENDIX H

INFORMED CONSENT

Clinicians' Negative Attitudes toward Borderline Personality Disorder: Implications for Diagnosis and Treatment Recommendations

You are being invited to participate in a research study about on diagnostic and treatment decision making. This study is being conducted by Sarah Aldridge and Dr. June Sprock, from the Department of Psychology at Indiana State University. The study is being conducted as part of my dissertation.

If you agree to participate, you will be asked to read a case vignette and rate it on a variety of measures. Please do NOT consult the DSM-IV-TR when completing the survey, as I am primarily interested in your initial reactions based on your clinical judgment. The questionnaire will take approximately 20 minutes to complete.

There are no known risks if you decide to participate in this research study. There are no costs to you for participating in the study. The information you provide will contribute further information regarding clinicians' clinical judgment, diagnosis, and treatment recommendations. The information collected may not benefit you directly, but the information learned in this study should provide more general benefits in terms of clinical decision making. If you agree to participate you will have the opportunity to be entered into a raffle with a chance to win one of three $100 gift cards for Amazon.com.

This survey is anonymous. All reasonable precautions will be taken to preserve each participant's confidentiality. Although IP addresses will not be collected, absolute anonymity cannot be guaranteed over the Internet. Once the survey is complete, the information is automatically saved to a database, which is password protected so that only the researcher will have access to the information. No one will be able to identify you or your answers, and no one will know whether or not you participated in the study. The Institutional Review Board may inspect these records. Should the data be published, no individual information will be disclosed.

Your participation in this study is voluntary. By completing and submitting your responses online you are voluntarily agreeing to participate. You are free to decline to answer any particular question you do not wish to answer for any reason.

If you have any questions about the study, please contact me by email at saldridge1@sycamores.instate.edu or my faculty sponsor, Dr. June Sprock at June.Sprock@indstate.edu.

If you have any questions about your rights as a research subject or if you feel you've been placed at risk, you may contact the Indiana State University Institutional Review Board (IRB) by mail at Indiana State University, Office of Sponsored Programs, Terre Haute, IN, 47809, by phone at (812) 237-8217, or by e-mail at irb@indstate.edu.

APPENDIX I

RESULTS OF CHI-SQUARE ANALYSES WITHIN EACH VIGNETTE

Table I. 1

Effects of Client Gender on Diagnosis of BPD and Effective versus Less Effective Treatment Recommendations within each Vignette: Results of Chi-Square Analyses

	N	χ^2	*df*	*p*	ϕ
BPD Diagnosis					
Vignette 1 (Female-Type BPD)					
Female Version (*n* = 34)	33	0.69	1	.41	.110
Male Version (*n* = 23)	23				
Vignette 2 (Male-Type BPD)					
Female Version (*n* = 18)	16	1.44	1	.23	-.188
Male Version (*n* = 23)	17				
Effective[a] versus Less Effective[b] Treatment					
Vignette 1 (Female-Type BPD)					
Female Version (*n* = 32)	32	1.55	1	.21	-.171
Male Version (*n* = 21)	21				
Vignette 2 (Male-Type BPD)					
Female Version (*n* = 18)	16	4.99	1	.03*	-.372
Male Version (*n* = 18)	10				

* $p < .05$ ** $p < .01$

Note. N = Number of Participants who Diagnosed BPD or Assigned Effective Treatment

[a]Effective treatments = antipsychotics, cognitive-behavioral therapy (CBT), day hospital, Dialectical Behavior Therapy (DBT), Mentalization Therapy, mood stabilizer, Schema Therapy, selective serotonin reuptake inhibitor (SSRIs), serotonin-norepinephrine reuptake inhibitors (SNRIs), Transference-Focused Psychotherapy, or other if listed as "Psychodynamic," an appropriate medication, or a referral to psychiatrist.

[b]Less effective treatments = benzodiazepines, brief inpatient, long-term inpatient, monoamine oxidase inhibitors (MAOIs), substance abuse treatment, tricyclic antidepressant (TCA), no treatment, or other if listed as "psychotherapy," medication only," "responsibility-based therapy," or "ACT."

Table I. 2

Effects of BPD Symptom Presentation on Diagnosis of BPD and Effective versus Less Effective Treatment Recommendations within each Vignette: Results of Chi-Square Analyses

	N	χ^2	*df*	*p*	ϕ
BPD Diagnosis					
Female Version (n = 52)					
Vignette 1: Female-Type BPD (*n* = 34)	33	1.45	1	.229	-.167
Vignette 2: Male-Type BPD (*n* = 18)	16				
Male Version (n = 46)					
Vignette 1: Female-Type BPD (*n* = 23)	23	6.90	1	.009**	-.387
Vignette 2: Male-Type BPD (*n* = 23)	17				
Effective[a] versus Less Effective[b] Treatment					
Female Version (n = 50)					
Vignette 1: Female-Type BPD (*n* = 32)	32	3.70	1	.054	-.272
Vignette 2: Male-Type BPD (*n* = 18)	16				
Male Version (n = 46)					
Vignette 1: Female-Type BPD (*n* = 21)	20	8.60	1	.003**	-.470
Vignette 2: Male-Type BPD (*n* = 18)	10				

* $p < .05$ ** $p < .01$

Note. N = Number of participants who diagnosed BPD or assigned effective treatment

[a]Effective treatments = antipsychotics, cognitive-behavioral therapy (CBT), day hospital, Dialectical Behavior Therapy (DBT), Mentalization Therapy, mood stabilizer, Schema Therapy, selective serotonin reuptake inhibitor (SSRIs), serotonin-norepinephrine reuptake inhibitors (SNRIs), Transference-Focused Psychotherapy, or other if listed as "Psychodynamic," an appropriate medication, or a referral to psychiatrist.

[b]Less effective treatments = benzodiazepines, brief inpatient, long-term inpatient, monoamine oxidase inhibitors (MAOIs), substance abuse treatment, tricyclic antidepressant (TCA), no treatment, or other if listed as "psychotherapy," medication only," "responsibility-based therapy," or "ACT."

APPENDIX J

RESULTS OF ONE-WAY ANOVAS WITHIN EACH VIGNETTE

Table J.1

Gender Differences in BPD Representativeness and BPD Symptom Ratings within each Vignette: Results of One-way ANOVAs

Variables	*F*	*p*	*Partial* η^2
Within Each Vignette			
BPD Representativeness			
Vignette 1 (Female-Typed BPD)[a]	0.022	.883	< .001
Female Version (*n* = 33)			
Male Version (*n* = 23)			
Vignette 2 (Male-Typed BPD)[b]	2.459	.125	.059
Female Version (*n* = 18)			
Male Version (*n* = 23)			
BPD Symptom Rating			
Vignette 1 (Female-Typed BPD)[c]	1.011	.320	.021
Female Version (*n* = 29)			
Male Version (*n* = 21)			
Vignette 2 (Male-Typed BPD)[d]	0.332	.568	.009
Female Version (*n* = 18)			
Male Version (*n* = 21)			

[a] *df* = 1, 54
[b] *df* = 1, 39
[c] *df* = 1, 48
[d] *df* = 1, 37