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## The stigma toward BPD

In response to Dr. Mark Zimmerman's article, "Improving the recognition of borderline personality disorder" (Current Psychiatry. October 2017, p. 13-19), I think the topic of improving the diagnosis of borderline personality disorder (BPD) requires us to examine our own biases and stigma toward this diagnosis. Let's be honest: many psychiatrists don't make the diagnosis because they don't want to give their patient that diagnosis and they don't want to treat a patient with that diagnosis. Evidence suggests that a great proportion of stigma aimed at BPD is initiated by mental health professionals.[1,2]

Why all the stigma? Because mental health professionals don't have complete information. The assumption used to be that BPD was "intractable" with no treatment. Even if this were true, it still would not be a reason to fail to disclose a diagnosis, because in other fields of medicine, the concept of "therapeutic privilege" fell by the wayside long ago. However, we now know that in many individuals with BPD, symptoms improve over time, and there are several effective treatments.

In DSM-II, published in 1968, obsessive-compulsive disorder (OCD) was characterized as an "obsessive compulsive neurosis." It was not reclassified as the current OCD diagnosis until DSM-III-R was published in 1987, after the FDA approved clomipramine. Why is this important? Because once people realized that there was a treatment, they started acknowledging OCD more often.

The first step in addressing the stigma toward BPD is that mental health professionals must recognize their own bias toward this diagnosis. We must be re-educated that this diagnosis carries hope, symptoms improve, and that there are effective treatments. This is how professionals will increase the recognition of BPD.

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**References**

1. Unruh BT, Gunderson JG. "Good enough" psychiatric residency training in borderline personality disorder: challenges, choice points, and a model generalist curriculum. Harv Rev Psychiatry. 2016;24(5):367-377.
2. Sheehan L, Nieweglowski K, Corrigan P. The stigma of personality disorders. Curr Psychiatry Rep. 2016;18(1):11.

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### The author responds

*I agree with Dr. Shapiro that stigma by mental health clinicians contributes to the underdiagnosis of BPD. Mental health professions often hold a negative view of patients with personality disorders, particularly those with BPD, and see these patients as being more difficult to treat.[1-3] They are the patients that some clinicians are reluctant to treat.[3,4] Clinicians perceive patients with personality disorders as less mentally ill, more manipulative, and more able to control their behavior than patients with other psychiatric disorders.[3,5] Consistent with this, clinicians have less sympathetic attitudes and behave less empathically toward patients with BPD.[5,6] The term "borderline" also is sometimes used pejoratively to describe patients.[1]*

*As I described in my article, there are several possible reasons BPD is underdiagnosed. Foremost is that mood disorders, anxiety disorders, and substance use disorders are common in patients with BPD, and the symptoms of these other disorders are typically patients' chief concerns when they present for treatment. Patients with BPD do not usually report the features of BPD—such as abandonment fears, chronic feelings of emptiness, or an identity disturbance—as their chief concerns. If they did, BPD would likely be easier to recognize. On a related note, clinicians do not have the time, or do not take the time, to conduct a thorough enough evaluation to diagnose BPD when it occurs in a patient who presents for treatment of a mood disorder, anxiety disorder, or substance use disorder. Our clinical research group found that when psychiatrists are presented with the results of a semi-structured interview, BPD is much more frequently diagnosed.[7] Such a finding would not be expected if stigma was the primary or sole reason for underdiagnosis.*

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*Dr. Shapiro highlights the clinical consequence of underrecognition and underdiagnosis: the underutilization of empirically supported psychotherapies for BPD. A corollary of underdiagnosing BPD is overdiagnosis of bipolar disorder and overprescription of medication.[8]*

*There are other consequences of bias and stigma toward BPD. Despite the high levels of psychosocial morbidity, reduced health-related quality of life, high utilization of services, and excess mortality associated with BPD, this disorder is not included in the Global Burden of Disease Study. Thus, the public health significance of BPD is less fully appreciated. Finally, there is evidence that the level of funding for research from the National Institutes of Health is not commensurate with the level of psychosocial morbidity, mortality, and health expenditures associated with the disorder.[9] Thus, the stigma toward BPD exists in both clinical and research communities.*

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**References**

1. Cleary M, Siegfried N, Walter G. Experience, knowledge and attitudes of mental health staff regarding clients with a borderline personality disorder. Int J Ment Health Nurs. 2002;11(3):186-191.
2. Gallop R, Lancee WJ, Garfinkel P. How nursing staff respond to the label "borderline personality disorder." Hosp Community Psychiatry. 1989;40(8):815-819.
3. Lewis G, Appleby L. Personality disorder: the patients psychiatrists dislike. Br J Psychiatry. 1988;153:44-49.
4. Black DW, Pfohl B, Blum N, et al. Attitudes toward borderline personality disorder: a survey of 706 mental health clinicians. CNS Spectr. 2011;16(3):67-74.
5. Markham D, Trower P. The effects of the psychiatric label 'borderline personality disorder' on nursing staff's perceptions and causal attributions for challenging behaviours. Br J Clin Psychol. 2003;42(pt 3):243-256.
6. Fraser K, Gallop R. Nurses' confirming/disconfirming responses to patients diagnosed with borderline personality disorder. Arch Psychiatr Nurs. 1993;7(6):336-341.
7. Zimmerman M, Mattia JI. Differences between clinical and research practices in diagnosing borderline personality disorder. Am J Psychiatry. 1999;156(10):1570-1574.
8. Zimmerman M, Ruggero CJ, Chelminski I, et al. Is bipolar disorder overdiagnosed? J Clin Psychiatry. 2008;69(6):935-940.
9. Zimmerman M, Gazarian D. Is research on borderline personality disorder underfunded by the National Institute of Health? Psychiatry Res. 2014;220(3):941-944.